State Senator Sheila Harsdorf

Date: January 29, 2014

To: Senate Committee on Health and Human Services

From: Senator Sheila Harsdorf

RE: HOPE Legislation

Chair Vukmir and Committee Members:

Thank you for holding a public hearing on the HOPE legislation which is a package of bills intended to address the growing heroin epidemic in our state. I appreciate the opportunity to share with you the importance of this legislation.

Assembly Bill 445(AB 445) would require individuals to show identification in order to pick up certain prescription drugs and would require pharmacies to keep a record of individuals that have picked up the dispensed drugs. This step will work to deter individuals that may seek out powerful prescription drugs to feed their addictions. Additionally, by having this information on hand, pharmacies can assist law enforcement in solving crimes and identifying those that are abusing prescription drugs. It is important to note that law enforcement would still be required to follow proper legal procedures to obtain the information from pharmacies.

Assembly Bill 446 (AB 446) as amended by the State Assembly would allow all levels of EMT and first responders, to be trained in order to administer an opioid antagonist such as naloxone, which is commonly known as Narcan. Additionally, this bill also allows a law enforcement agency or fire department to enter into a written agreement with an ambulance service to obtain a supply of Narcan and receive training for proper administration of the drug. Finally, this bill provides that any person may possess and deliver Narcan to another person, may be prescribed Narcan, and will be immune from civil or criminal liability for any outcomes resulting in the delivery of Narcan. Training will be required for safe administration of the drug when prescribed by a physician.

Assembly Bill 447 (AB 447) would provide limited immunity for simple possession of a controlled substance or drug paraphernalia when an individual brings another person that has overdosed or is experiencing an adverse reaction to drug use to a health care facility or calls for police or emergency medical assistance.

Assembly Bill 448 (AB 448) seeks to update existing state law in order to clearly provide statutory authority for drug disposal programs. Communities across the state operate drug disposal programs by accepting and properly disposing unwanted prescription drugs, including controlled substances. These programs provide an important service by ensuring

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that they are not readily available to those who may abuse them and that unwanted prescription drugs do not enter the water supply.

While the use of heroin is on the rise across our state, it is hitting western Wisconsin especially hard. One of my constituents, Phil Drewiske is here to share his personal story with you. Phil has had the support of his family and community and works every day to reach out to others who are battling addiction. While we are fortunate that Phil is here today to share his story with you, there are many that have been tragically lost to this drug. In 2013, in Hudson alone there were 7 deaths due to heroin overdose. One of these individuals was a beautiful and talented young Hudson woman named Alysa. Karen Hale, Alysa's mother, is now devoting her time and energy to working to save other young people and their families from facing a similar tragedy. Karen was unable to attend today's hearing, but has provided written testimony sharing her story which I have submitted for you.

The H.O.P.E package is an important step towards saving lives and avoiding further tragedies as we fight drug addiction. I am encouraged by the broad bipartisan support this legislation has received, including unanimous passage in the State Assembly and I urge your support and timely passage of these bills.

Chairwoman Vukmir and Committee Members,

My name is Karen Hale of Hudson, WI and I am strongly in favor of the four bills being presented before you under the Hope Package. The bills hold a personal significance and are deeply close to my heart since my county; St. Croix has been severely impacted by the heroin and prescription drug epidemic. In less than one year my community of Hudson has lost seven (7) young people to this epidemic of prescription drug medication/heroin abuse.

I speak from personal experience since I lost my 21 year old daughter, Alysa Ivy on May 18, 2013 to this epidemic. As a parent I never wished for my daughter to become addicted to prescription drugs and transcend to heroin nor did she ever wish this upon herself. My daughter's journey and my nightmare began when at my insistence she had her wisdom teeth extracted. The dentist prescribed Alysa Tylenol 3 and then when her pain was elevated due to swelling was given a 30 day prescription of Oxycotin, thus my nightmare and our journey began.

My community of Hudson is no different than many communities across our state of Wisconsin; we have a huge epidemic within our state reaching into every crossroads of our counties, and communities both in suburbia homes and in rural areas. Being a border town, our county is exposed to some of the highest quality of heroin crossing into our state from Minnesota and it is imperative stronger initiatives need to be in place and implemented.

These bills being presented before you are addressing the increase of prescription drug/heroin use impacting so many individuals, families and our communities across the state. I am just one family which this epidemic gravely impacted and "lost" their child in the battle of this epidemic, but I speak for many families who are struggling with addiction or lost their loved ones.

Bill AB 445 will insure prescriptions are being picked-up for the person intended since if you have ever lived a life of either an addict or experienced your child with an addiction they are master manipulators and will stop at nothing in order to feed their illness and disease. This bill will hold pharmacists and those distributing the prescriptions accountable that the medications are going into the correct hands. The bill will reduce those seeking these drugs under false identities and will insure they are properly distributed to the intended parties.

Bill AB 446 Saves lives! Statistics show that drug overdoses now kills more people a year in the United States than **motor vehicle accidents**, or death from choking or accidental falls. Naloxone/Narcan is an important safe, non-abusable and inexpensive medicine for empowering our communities to protect the health of our people. Naloxone or Narcan MUST be in every EMT and first responder's hands since in cases of overdoses there are only a matter of minutes to revive an overdose victim and this medicine can prevent deaths. It is critical our emergency and first responders have this life saving medicine in their hands for such emergency situations due to this explosive epidemic across our state.

In our society with addiction we normally do not recognize second chances, but with Naloxone/Narcan this will allow a second chance for an addict. Reviving an overdose victim can be a very powerful motivator to help the addict change their behavior or a wake-up call that they have hit their bottom and seek the necessary help with their addiction. I personally know many young adults who have been saved by this medication and it has helped tremendously turn their lives around and given them a second chance in life.

Bill AB 447 is the bill which is closest to my heart since if this bill was in place my daughter Alysa could potentially be here today. My daughter went into overdose distress at the Super 8 motel in Hudson only to be placed onto the bed, no one called for help and she was left to die. Her autopsy report showed she passed at 2am on May 18th but was pronounced at 1:52pm that very day. As a mother I cannot fathom the heartless act of these individuals not to seek the necessary medical help, but if she was having a heart attack, or some other accident not drug related; helped would have been called or initiated. That did not happen in my daughter's case and she laid there for over 9 hours as though her life had no meaning before the police and medical examiner were notified.

When situations arise in a case of an overdose victim, most people hesitate to call 911 for fear of police involvement. People using illegal drugs are usually never alone. When an overdose occurs, the others in presence fear often times of arrest, and one way to encourage anyone witness to an overdose is to be exempt from criminal prosecution. A life as in my daughter's case was lost and as a parent I cannot grasp why anyone would not hold value to a person's life, but fear came into place over saving her life. The legislation policy being proposed only protects the caller and overdose victim from arrest and prosecution for simple drug possession, possession of paraphernalia, and/or being under the influence and it is not asking to protect from arrest of selling or trafficking illegal drugs.

This bill if put into place would help so many families not to have to mourn the loss or make funeral arrangements for their loved ones like in my case, and could potentially become a life saving avenue by allowing emergency 911 calls to be placed without repercussions. Everyone's life is worth saving; even an addicts!

Bill AB 448 Some drug addictions of our young children/adults start right at home within our medicine cabinets! As many of us having young children locked our cleaning supplies under our kitchen sinks, placed protective covers over our electrical outlets and made sanctions to child-proof our homes, but one area of neglect is our medicine cabinets. This is due to over prescribed or need for opiates, pain medication, and benzodiasepines being prescribed by our entrusted doctors. Parents and grand-parents without realizing since they were prescribed by an entrusted doctor have highly addictive unwanted or unused medicine in their homes. The road towards heroin abuse potentially starts with prescription drugs found right within our homes. This bill would help educate and dispose of properly any unused prescription drugs. It is imperative we keep these highly addictive drugs away or not as easily available or accessible and properly dispose of and save lives.

When you look at the bills being presented today; they are to Save Lives!! We have a huge epidemic in the State of Wisconsin and so many other states have led the way to fight this epidemic rapidly increasing across our nation. None of these bills will bring back my daughter; Alysa but if my speaking out in favoritism can save one person, one family, one life the heartache I live with each and every day, no parent should have to endure this pain and sorrow or bury their child, these bills can and will save lives. We must continually remember that no one wakes up wishing to become an addict nor does a parent or individual desire this for their child or loved one.

Each of these bills only taps into the surface of this epidemic in our state of Wisconsin, but it is a starting point to combat the issue within our communities. This drug shows no bias, no

discriminatory factor, or holds any weight on a family's economical status. These bills will and can saves lives of so many within our state. It is time for the state of Wisconsin to foster change and embrace these bills since the people of our state are so worth living and saving!! I hope you take into consideration the empowerment that each of these bills will have on our state and be leaders in their approvals.

Wisconsin has the opportunity to be a champion of hope to the countless communities across our state. We can stand at the forefront of this fight and lead the way for other states to emulate our commitment and stance against this epidemic that is devastating homes, families and futures of our people. We can be the wind of change that will blow across this nation. We can light the way which will allow our state to bring hope to our people and also be recognized by other states so they too can help their communities.

It is time for Wisconsin to recognize that the people of this fine state are worth saving. I implore you to embrace these bills and support their passage within our Senate. My daughter, Alysa was so worth saving. If she was your daughter, wouldn't she be worth saving too? An addict's life *is* worth saving. I ask you to consider and pass the bills before you. Please…won't you save a life?

Thank you,

Karen Hale
725 Glenna Drive
Hudson, WI 54016

Dear Chair Vukmir and Committee Members,

I would like to start off by thanking you for your time and allowing me to share some of my life with you and the committee. My name is Phil Drewiske. I am 23 years old, and I have been a Heroin addict since I was 16 years old. I served 24 months in the Wisconsin penitentiary. I was released from prison on April 22nd, 2013 from CVCTF (Chippewa Falls Correctional Treatment Facility) in Chippewa Falls Wisconsin, where I participated in their ERP (Earned Release Program) so I could be released early and began a new chapter in my life. In this testimony, I would like to explain a little bit to you about my struggles in life with this drug or drugs in general and how I think these four bills that we are talking about today that will be crucial to others struggling with this addiction in life.

I started my drug use with prescription drugs when I was 13 years old. A friend I used to have in middle school would bring 20MG Oxycontins to school. His dad had Cancer so his supply of Pain killers was what it seemed like unlimited. My tolerance kept increasing with this drug, until a few weeks before I turned 16 years old when I tried Heroin for my first time. From that very moment in my life when I met the drug Heroin, I compared it to meeting the Devil. Since I was 16 years old, I have been in 13 treatment centers in Minnesota, South Dakota, and Wisconsin. I have been in 1 treatment center in the past 2.5 years. This drug has the reputation of being a "Homeless" drug. When really this drug has been a nightmare for everyone, including middle and upper class people.

I have had several visits to the hospital due to drug overdoses, crashing cars, detoxing to get into treatment centers, and even getting stabbed. I call Heroin the "Hopeless" drug. It doesn't matter if you are happy, sad, or mad, you have no hope in yourself or just life in general. The best way I can describe to someone the feeling you get from heroin, is being in a possessed, none caring euphoric state where nothing matters to you. Everyone knows what is right and wrong, but honestly at least for me I just didn't care as long as I would get high. I lied, cheated, manipulated, and used everyone I knew, including my loved ones. I ended up robbing my best friend's house in 2009 during the day when I should have been at school. I lied to his face about it for months until I was questioned July 20th, 2009 by the Hudson Police department. I was in such bad shape due to my drug use, the detectives told my father that they need to take me to the hospital and go to treatment before they will put me in jail or further the investigation. Hazelden Treatment center in Plymouth Minnesota would not except me until I went to detox where I was for 3 days. I was 135 pounds and had trouble talking. I was in Detox for over 2 weeks at Hazelden. After my 28 day program there, they sent me to Canton South Dakota to a treatment center that specialized in Heroin rehabilitation. I relapsed 2 weeks after I got out of treatment and was using drugs even worse than I was before.

I have a 3 year old son named Blake. He is my light in life. I was on Drug Court in St. Croix County for 13 months. I was taking 4 drug tests a week and I still could not stay sober. I eventually ran from Drug Court and my probation which resulted in me being sent to prison and leaving my son and his mother when my son was only 4 months old. My father picked me up at a drug house in St. Paul Minnesota where I was for 3 weeks. Being a desperate father who would do anything to get his son back, drove to a

place no one should ever see. I didn't see my little boy again for almost 18 months, until my birthday July 25th, 2012 when I was in Prairie Du Chein Correctional Institution. Blake is my world, and I will do ANYTHING so he won't have to see his dad like he was over 2 years ago. So if that means I need to open up and share my experience to people and bring awareness to everyone about this drug, I will do it.

When I was in prison, it became a routine for my parents to come see me and tell me that one of my friends have died from Heroin. Tyler Hole, Alysa Ivey, Ellie Berg, and Brett Simpson are a few of them. In the Hudson community where I currently live, there has been 10 people who have died from drug overdoses in 12 months. Hudson is right on the border of Minnesota.. 15 minutes from the Twin Cities where there is the purest drugs in the country according to the DEA. Five of the ten overdose deaths were very close friends of mine. This community of 15,000 people and this state has an epidemic going on here, and we do not know what to do.

I want to explain to everyone how these 4 bills will benefit so many lives and bring hope to people who struggle with this addiction every single day.

AB 445/ Senate Bill 353: Photo ID when picking up prescription drugs. This bill is a HUGE start to stopping the prescription drug problem that is going on. When I was younger we used to buy the whole prescription from whoever was prescribed it. I can remember over half the time we were never carded walking into the Pharmacy to pick up the prescription. You could tell them you were their son or boyfriend, and you would be walking out of the pharmacy with 30, 80MG Oxycontins. This Bill will also limit people from going from Pharmacy to Pharmacy buying peoples prescription.

AB 446/ SB 352: Narcan. This Bill will save more lives than we realize. With this drug Heroin, you do not have enough time to drive to hospital to receive this life saving injection. You are lucky if you make it by the time the EMT arrives. This bill will bring so much hope to people including the EMT's who now will have a fighting chance and saving many more lives than they would without this bill being passed.

AB 447/ SB 350- Good Samaritan: This Bill is the biggest one in my opinion. Tyler Hole and Alysa Ivey who were my good friends died from Heroin overdose. This Bill would have saved both of their lives. Tyler was found in a house with none of his clothes on, and everything in the house taken. He was left to die because nobody there was going to call 911 because they knew they would have got in trouble. Alysa was found in a hotel where she was left to die and was not found for over 12 hours after when someone called 911. This Bill will save lives. This bill encourages people to call 911 to save people's lives. This Bill would have saved my friends lives let alone thousands of other peoples in this state.

AB 448/ SB 351: Drug Disposal. This Bill is great because it starts in every ones homes. A lot of addictions start inside your own homes with the medicine cabinets. This will reduce a lot of issues that happen inside your home with addiction. This will eliminate another option someone may have to support their addiction. I also look at this bill also as

a good way to dispose these prescription drugs so younger kids don't get into them. I don't want my 3 year old son getting into the medicine cabinet with medication that should have been disposed of.

Heroin has been taking thousands of lives in this state. These 4 bills will give so many people that positive light at the end of the tunnel that so many people need right now. I want to personally thank you Chair Vukmir and Committee Members for giving me the opportunity to speak in front of you about a very passionate topic. I would also like to thank you on behalf of everyone that could not be here today. These 4 Bills are an amazing start for saving people's lives and giving them more resources for if or when that time does come where they need to use any of these Bills.

Phil Drewiske

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Testimony of DNR on AB 448 and SB 351
Senate Committee on Health and Human Services
January 29, 2014

Good morning, Chairwoman Vukmir and committee members. My name is Barb Bickford. I am the Medical Waste Coordinator for the Wisconsin Department of Natural Resources. Thank you for this opportunity to testify, for information only, on Assembly Bill 448, relating to the disposal of prescription drugs, including controlled substances and drug-related items.

The disposal of unused drugs is both an environmental issue and a public health issue. There is a lot of public interest from diverse stakeholders, including law enforcement, community coalitions, healthcare providers, public health agencies, schools, local governments, wastewater treatment plant operators and environmental groups.

In 2012, DNR initiated a study to examine household pharmaceutical collection. We found that most if not all of Wisconsin's counties have drug collection programs. And while many were one-day collection events, an increasing number of the programs were being run 24/7 by local law enforcement, due to US Drug Enforcement Administration (DEA) regulations about controlled substances. At last count, there are nearly 200 ongoing local collection programs in Wisconsin.

Wisconsin residents do use collection programs and local communities take great pride in what they collect. Wisconsin has consistently ranked among the top states in the nation for drugs collected and disposed of through a free program offered by the DEA during the past several years.

However, a very small percentage of the available household medications are being collected and properly destroyed. Of the approximately 13 million pounds of prescription and over-the-counter medications the DNR study estimated were dispensed and sold in 2010, approximately 1/3 or 4.4 million pounds, went unused. In 2011, voluntary collection programs in Wisconsin collected 93,500 pounds of unused medications. This was only about 2 percent of the amount generated. The remaining 98 percent were discarded in the trash, flushed down the drain, abused or stored indefinitely in our medicine cabinets.

Clearly, there is a need for drug collection programs, and this bill addresses some key aspects of the issue. We would like to thank Representative Nygren for allowing us to provide him comments on this bill as it was being developed. The bill gives the Wisconsin Department of Justice authority to authorize drug disposal programs, which among other things, must comply with federal and state laws that apply to transportation and delivery of unused prescription drugs, controlled substances, controlled substance analogs and certain medical and drug delivery devices. These laws include but are not limited to rules adopted by the DEA, the EPA and the DNR. The bill would also expand the ability of designated persons such as spouses, guardians and others to

properly dispose of unused medications, addressing a current gap in the law governing drug disposal.

This bill takes into account that both DEA and EPA are in the process of revising their rules related to collection and disposal of unused prescription drugs. DNR will likely need to update its rules and guidance as DEA and EPA regulations change. We will continue to collaborate with DOJ and other agencies to maximize the amount of drugs that are properly collected and destroyed.

Thank you, and I'd be happy to answer any questions you may have.

ARCW
AIDS Resource Center of Wisconsin
Excellence in HIV Health Care

Testimony by ARCW Vice President Bill Keeton in Support of the Heroin Opiate Prevention and Education (HOPE) Legislative Package

Good morning Chairwoman Vukmir and Committee Members,

Thank you for allowing me the opportunity to speak with you today in support of the HOPE legislative package. My name is Bill Keeton and I am the Vice President for Government and Public Relations at the AIDS Resource Center of Wisconsin, also known as ARCW.

I would like to take a moment to publicly thank Representative Nygren and Senator Harsdorf for their courage and leadership in introducing these bills. ARCW has worked closely with their in the creation of these important and timely pieces of legislation.

As many of you know, ARCW is one of the nation's leading HIV prevention, care and treatment providers. We have more than 150 staff across Wisconsin directly providing more than 3,000 HIV patients with unparalleled access to the medical, dental, and mental health care as well as social and pharmacy services they need to live a long, healthy life. Today's outstanding medicines combined with our medical home model of care are producing outstanding patient outcomes. Today, Wisconsin is leading the nation with the lowest HIV mortality rate in the United States.

While our health and social services are critical to fighting AIDS in Wisconsin, we also are committed to preventing new HIV infections to the greatest extent possible. It is through our HIV prevention work that we encounter a large number of injection drug users – most of whom are using opiates likes heroin.

Since 1994, ARCW has been providing HIV prevention services to injection drug users across the state. At our core, we believe in the value of all life and at the heart of our mission is a commitment to keeping people alive by helping them avoid HIV or unnecessary death resulting from overdose. Our interventions with injection drug users include HIV prevention and testing, opiate overdose prevention and direct referral and access to AODA treatment either at ARCW or through our partners.

To be clear, I want to emphasize that ARCW does not condone, encourage or approve of illicit drug use – in fact we encourage everyone we reach to choose sobriety and work with them to reach this goal.

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However, like all of you we are all too well aware that heroin use and opiate overdose deaths are on the rise throughout Wisconsin for numerous reasons. The statistics in this area are alarming, and the impact on families and communities is very real.

The increase in heroin use led to a marked increase in the demand for HIV and overdose prevention services ARCW provides. We now reach roughly 17,000 injection drug users in Wisconsin annually. One of the interventions we provide include training individuals who are likely to witness or experience an overdose in the use of Naloxone - an otherwise harmless drug that can immediately counteract the effects of an opiate overdose.

ARCW has trained 2,491 people in how to safely administer naloxone since starting our opiate overdose prevention program in 2005. Since that time, 2,134 individuals trained by ARCW have returned to ARCW to report that they have saved someone else's life because of our program.

Assembly Bill 445/Senate Bill 353 will help curb drug diversion of narcotic pain medications. ARCW supports an amendment to AB 445 that creates an exception from the ID requirement provided a pharmacist knows the person picking up the prescription. We believe this is an adequate compromise that will reduce the potential burden created on small pharmacies – such as the one at ARCW – that provide services to a limited and well-known patient population.

By increasing the availability of Naloxone and successfully training more individuals on how to use it, Assembly Bill 446/Senate Bill 352 will help save lives. Related specifically to the ARCW opiate prevention program, the substitute amendment will allow for the individuals we train to administer naloxone to someone they witness experiencing an overdose. These individuals are in a position to provide this life saving treatment in a matter of seconds, as opposed to having to wait for first responders to arrive on the scene.

By eliminating a barrier that keeps individuals from activating emergency services during an overdose, Assembly Bill 447 will help ensure that individuals witnessing an overdose will call for help. The overwhelming majority of opiate use and overdoses occur in group settings where at least one other individual is a witness. Unfortunately, often these witnesses are reluctant to activate first responders out of fear of criminal prosecution related to their drug possession. AB 447 provides that an individual who aids someone who is overdosing is immune from prosecution for drug possession.

Lastly, Assembly Bill 448/SB 351 will help curb drug diversion by allowing additional drug disposal sites to be set up throughout the state. This will help reduce the supply of the kinds of pharmaceutical pain medications that can create addiction – especially when left over bottles of narcotic-based pain medications are inadvertently left in medicine cabinets because their owners do not know what to do with them when they no longer need them.

Thank you again for your time today. I would be happy to answer any questions you may have about my testimony or about ARCW and our role in preventing opiate overdose deaths.

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Senate Committee on Health and Human Services
Senator Leah Vukmir, Chair

FROM: Mark M. Grapentine, JD
Senior Vice President – Government Relations

DATE: January 29, 2014

RE: Support for HOPE package

On behalf of more than 12,000 members statewide, the Wisconsin Medical Society thanks the committee for this opportunity to share our support for three Assembly Bills that are part of State Assembly Rep. John Nygren's and State Senator Sheila Harsdorf's HOPE (Heroin Opiate Prevention and Education) legislative package:

- Senate Bill 351/Assembly Bill 448 – drug disposal programs
- Senate Bill 352/Assembly Bill 446 – training and agreements for administering naloxone
- Assembly Bill 447 – 911 Good Samaritan immunity

The Society supports all of these bills based on our current policy and continued research into these areas. We applaud Rep. Nygren and Sen. Harsdorf for their vigorous advocacy in this area of need.

Accompanying this memo are two studies produced by the Wisconsin State Council on Alcohol and Other Drug Abuse (SCAODA), which has examined all three issue areas in some detail. Both studies advocate for efforts contained in the HOPE legislation.

Senate Bill 351/Assembly Bill 448 - Better Drug Disposal Efforts
The earlier study, "Reducing Wisconsin's Prescription Drug Abuse: A Call to Action" (January, 2012) provides a broad set of recommendations from SCAODA's Controlled Substances Work Group (CSW) to "provide practical, cost effective recommendations to reduce and prevent the amount of prescription medications diverted" (page 2). The report declares proper prescription drug proposal as a priority area:

> In many areas of the state . . . there are no safe and secure disposal options available to consumers. Furthermore, consumers may be unaware of how to dispose of medications properly. In order to maximize compliance with disposal programs, voluntary disposal of medications should be convenient, easily accessible, and at low or no cost to the consumer.

(page 20)

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By updating the state's criminal statutes and prescription drug regulations to reflect local drug disposal efforts, Assembly Bill 468 can help advance the state's drug disposal efforts.

Senate Bill 352/Assembly Bill 446 - Naloxone Availability
The drug often provided in these overdose situations is naloxone, which can prevent or reverse the effect of opioids. Training a wider range of emergency services personnel to properly administer naloxone will only increase the availability of this life-saving drug.

There are few downsides in achieving the goal of wider naloxone availability. Naloxone is not addictive, which means it is very unlikely to be diverted or misused. The increase in the number of lives saved through more rapid deployment of naloxone treatment for overdose victims is the fundamental reason for the Society's support for Assembly Bill 446.

Assembly Bill 447 - 911 Good Samaritan
Another CSW recommendation in the "Call to Action" report was for SCAODA to examine further issues related to the creation of a "Good Samaritan" law for opioid overdoses. That effort resulted in the second report accompanying this memo: "911 Good Samaritan Recommendations" (August 2013). A broad panoply of stakeholders -- health care, law enforcement, prosecutors, public health and treatment providers -- collaborated to make recommendations on creating both a Good Samaritan law and legislation creating greater access to naloxone, a drug that can save the life of someone experiencing an opiate overdose.

Studies show that most overdose deaths occur within just one to three hours after a person has taken an opioid drug, with most of these deaths happening in the presence of other persons (see "Recommendations," page 7). Many of these witnesses choose not to call 911 when they see an overdose situation, however, fearing arrest, prosecution and/or other adverse consequences for themselves or the overdose victim.

Assembly Bill 447 attempts to promote life-saving emergency calls by removing some of these disincentives for those who can summon aid for overdose victims. Similar legislation in Washington State -- followed by data analysis following the law's enactment -- seems to be fostering greater willingness to call 911 when an overdose occurs, helping to prevent overdose deaths.

Thank you for this opportunity to share the Society's opinions on this issue. If you have further questions, please feel free to contact the Society at any time.

Reducing Wisconsin's Prescription Drug Abuse: A Call to Action


Critical steps toward building a healthier Wisconsin

January 2012

Wisconsin State Council on Alcohol and Other Drug Abuse
Prevention Committee
Controlled Substances Workgroup

State of Wisconsin
State Council on Alcohol and Other Drug Abuse
1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

Table of Contents

The Controlled Substances Workgroup (CSW) was committed to producing a report that represents the full breadth and scope of the prescription drug abuse epidemic. To that end, CSW consulted with a broad range of individuals and organizations representing key stakeholders impacted by this issue. The CSW would like acknowledge the contributions of the following: Wisconsin Dental Association, Tribal State Collaborative for Positive Change, Pharmaceutical Waste Working Group, Dane County Public Health Safe Communities, Wisconsin State Health Lab, Pharmacy Examining Board, Tanya Bakker (Wisconsin State Opioid Treatment Authority, Department Health Services), Robert Block (Wisconsin Crime Laboratory, Drug Identification Unit Leader, Retired and Wisconsin Controlled Substances Board – Chair), Danielle Luther, Bob Kovar, Joe Willger, Raj Panneerselvan, and Paula Hensel, RN, MSN, APNP (all of Marshfield Clinic) and the Wisconsin Narcotics Officers Association.

Charge to the Controlled Substances Workgroup

Communities around the state report that prescription narcotic abuse, such as oxycodone and hydrocodone, along with illegal narcotic substances, such as heroin, are on the rise. The Wisconsin State Council on Alcohol and Other Drug Abuse (SCAODA), in recognition that prescription drug abuse and narcotic abuse is a growing problem in Wisconsin, established a Controlled Substances Prevention Sub-Committee. The committee, known as the Controlled Substances Work Group (CSW) convened for the first time in July 2010. CSW was charged with identifying prescription and non-prescription drugs that are most often abused in Wisconsin, focusing upon legal opiates (opioid analgesics) and illegal opiates, as well as other drugs of abuse with high consequences. Additionally, CSW was tasked with examining the prevalence and burden of use and to determine if an adequate surveillance system exists in Wisconsin.

CSW also examined the role of community coalitions, substance abuse prevention and treatment providers, law enforcement and the judicial system, the medical community, schools, and legislative and state agencies in preventing drug abuse. CSW also identified key educational messages targeting the health care community in the broad scope including; physicians, pharmacists and other key health care stakeholders, and to determine if there are preventive measures that can be employed when prescribing or dispensing drugs with a high potential for abuse. CSW examined community based education targeting the general population and specific subgroups (such as high risk populations) to help avoid abuse and its deadly consequences.

CSW identified the urgency in establishing a Prescription Drug Monitoring Program (PDMP) as well as an accessible and cost effective system for prescription drug disposal in Wisconsin.

The work of CSW culminated in this report that outlines strategies and recommendations to prevent and reduce substance abuse in Wisconsin.

During the initial two meetings of CSW in July and August 2010, considerable time was spent discussing the charge to the group and to identify a scope of work. CSW recognized the correlation between the abuse of prescription medications and illicit drugs, but a report that addresses both legal and illicit drugs would be too broad in scope. CSW came to the consensus that for the purpose of this report, the scope would be limited to Food and Drug Administration (FDA) approved prescription medications. Given the fact that opioid analgesics (legal opiates) are the most highly diverted and abused class of medication, particular emphasis was placed on providing recommendations to reduce and prevent the misuse, abuse and diversion of these controlled substances.

CSW recognizes the inextricable link between the misuse, abuse and diversion of opioid analgesics and the use of illegal opiates (heroin). This report is designed to provide practical, cost effective recommendations to reduce and prevent the amount of prescription medications diverted. Inevitably, with the reduction in prescription drugs being misused, abused and diverted, there will be an increase in the use of illegal opiates. *CSW recommends that SCAODA convene a work group to examine the use and related consequences of illicit drug use in Wisconsin, focusing upon illegal opiates.*

CSW deliberated the merits of a Good Samaritan Law for Wisconsin. The CSW recommends that SCAODA examine the issues related to a Good Samaritan Law as a strategy to reduce opioid related overdose deaths in Wisconsin.

Charge to the Controlled Substances Workgroup

Use and Consequences of Commonly Prescribed Medications*			
	Effects of short-term use	**Effects of long-term use** **Potential for physical dependence & addiction**	**Should not be used with**
Pain Relievers	Alleviates pain Drowsiness Constipation Depressed respiration (depending on dose)	Severe respiratory depression or death following a large single dose	Other substances that cause CNS depression Alcohol Antihistamines Tranquilizers/ sedatives
Tranquilizers & Sedatives	A "sleepy" and uncoordinated feeling during the first few days; as the body becomes accustomed (tolerant) to the effects, these feelings diminish.	Seizures following a rebound in brain activity after reducing or discontinuing use	Other substances that cause CNS depression Alcohol Prescription pain reliever medicines Some over the counter cold/ allergy medications
Stimulants	Elevated blood pressure Increased heart rate/ respiration Suppressed appetite Sleep deprivation	With high doses possibly dangerously high body temperature/ irregular heartbeat/ hostility/ paranoia Cardiovascular failure/ lethal seizures	Over the counter decongestant medications Antidepressants, unless supervised by a physician Some asthma medications

*Prescription Drugs: Abuse and Addiction. (2005) National Institute on Drug Abuse. U.S. Department of Health and Human Services. www.drugabuse.gov/ResearchReports/Prescription/prescription8.html

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Background

The continuum of unauthorized use of prescription medications begins with diversion and ends with non-medical use, often by youth. The continuum of health impacts begins with risky use and extends through harmful use and can end in overdose deaths.

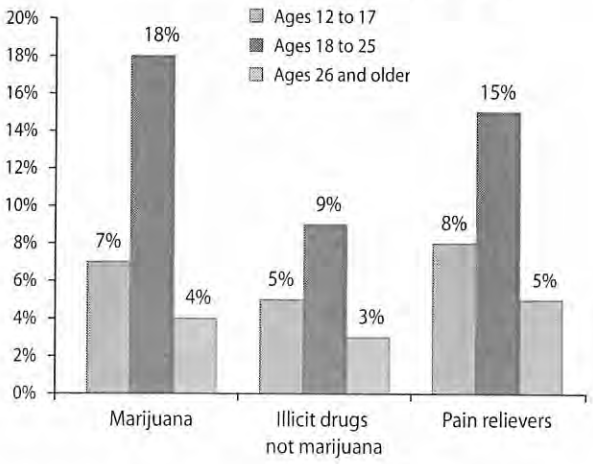
While all classes of prescription medications have the potential for abuse, opioid analgesics, which are controlled substances, are particularly dangerous given their highly addictive nature and abundant supply. The increase in supply is clearly illustrated through data tracking the sale of Vicodin®, a powerful narcotic painkiller that is a combination of hydrocodone and acetaminophen. According to the Center for Disease Control and Prevention (CDC), between 1997 and 2007, there was a 627 percent increase in the sale of Vicodin®, resulting in it being the most widely prescribed medication in the United States.[1] Currently, there is enough Vicodin® prescribed in the nations to provide every American 5 mg every 4 hours for three weeks. Interestingly, data related to opiate related overdose deaths from 1999-2007 rose from 2,901 to 11,499, a 296 percent increase.[2]

Nationally, the average number of prescriptions per resident is 12.9 per year, in Wisconsin the rate is 12.7 per year.[3] In Wisconsin, 5.5 million prescriptions were dispensed each month in 2009, this includes all prescription medications as well as prescription refills.[4] With such an abundant supply of medications in society, it is no surprise that prescription medications are now commonly misused, abused and diverted for non-medical use.

Between 2007 and 2008, 15% of Wisconsin adults reported using pain relievers for non-medical purposes.[5] National trends show that, in many states, unauthorized prescription drug use has now overtaken marijuana use as the most common illegal drug used by youth (alcohol remains the most common drug used by youth even though its use by youth is illegal). Given the fact that the trend patterns in Wisconsin tend to follow suit, it stands to reason that prescription drug use in Wisconsin will soon top marijuana use. Recent data indicate that in Wisconsin, prescription drugs are the second most common drug used for recreational purposes after marijuana. In 2009, 20.5% of Wisconsin high school students reported ever taking a prescription drug (such as OxyContin®, Percocet®, Vicodin®, Adderall®, Ritalin®, or Xanax®) without a doctor's prescription. This is identical to the US average of 20%.
Figure 1 shows that pain reliever use for non-medical purposes peak among 18-25 year olds, but is more common than marijuana use among residents ages 26 and older (see Fig. 1).

> "Prescription drug abuse is an epidemic. Throughout the nation it is a growing problem with no signs of slowing down."
> - CDC 2010 -

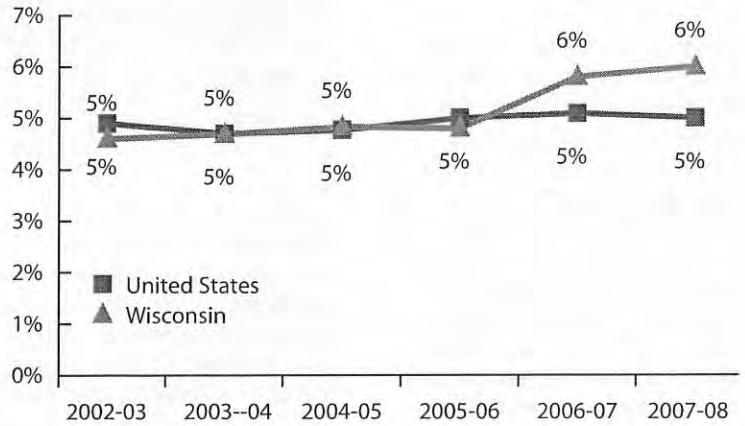
Figure 1:
Illicit drug use in Wisconsin, by age



Background (continued)

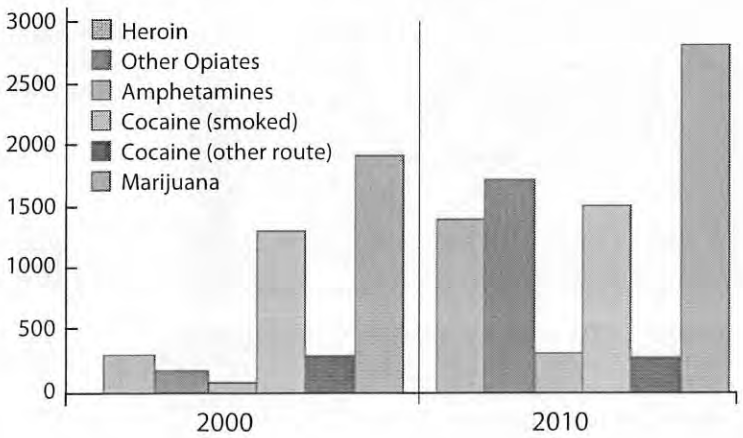
The most recent data available shows that Wisconsin is actually outpacing national averages in the rate of overall prescription drug misuse (see Fig. 2).

Figure 2: Prescription Drug Misuse, US and Wisconsin, ages 12 and older



Misuse of prescription drugs leads to abuse, dependence and addiction. Nationally, between 2000 and 2009, "other opiate" (non-heroin) treatment episodes increased 609%, the largest increase of any drug tracked in the Treatment Episodes Data Set (TEDS) of the Center for Substance Abuse Treatment (see Fig. 3).

Figure 3: Treatment Episodes by Drug, 2000 and 2010

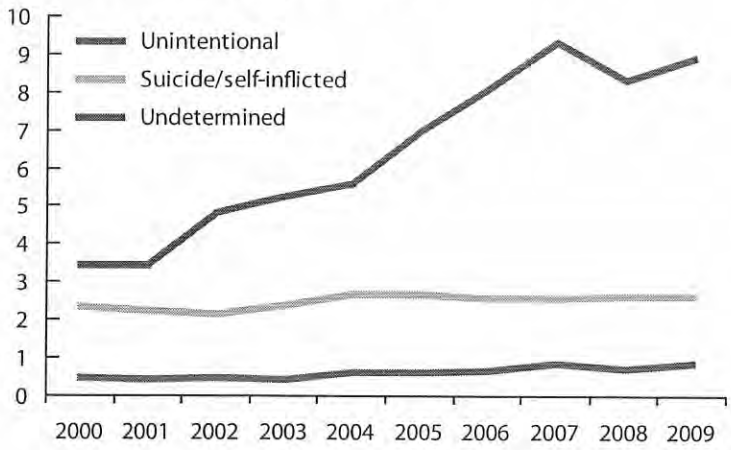


Misuse of prescription drugs can also lead to death. According to national statistics, the rate of deaths due to unintentional poisonings[a] increased four-fold between 1999 and 2008 with no concurrent rise in suicides from poisoning in general (see Fig. 4). The majority of all poisonings are due to prescription, over-the-counter and illicit drugs.

[a] An unintentional poisoning is a poisoning in which the individual exposed to the substance is not attempting to cause harm to himself or herself or others. It can result from misuse and abuse of prescription or recreational drugs, overuse of drugs prescribed for medical reasons and exposure to chemicals, gases, vapors, venoms, biological toxins and other substances.

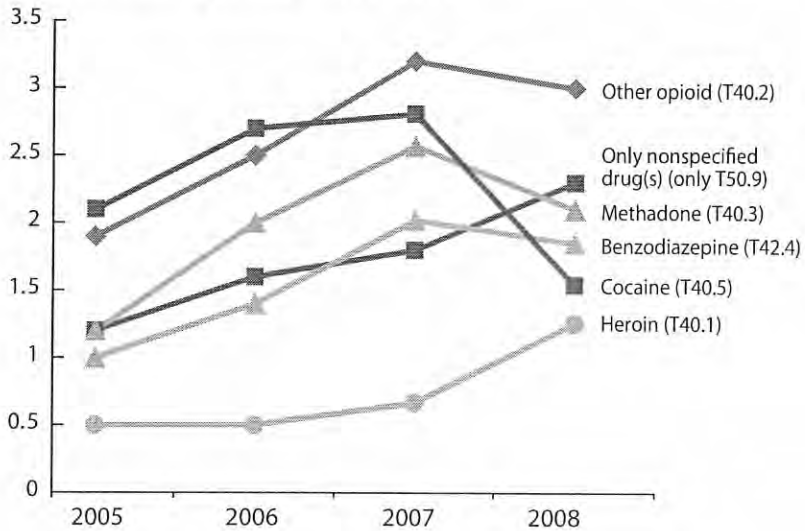
Background (continued)

Figure 4: Deaths due to Poisoning, 1999-2009



Using multiple causes of death, one can examine the types of drugs that led to overdoses. Opioids other than heroin and methodone were the most common drug mentioned on the death certificate as one cause of death. Mentions of benzodiazapines also increased sharply between 2005 and 2008 (see Fig. 5).

Figure 5: Cause of Death by Drug, 2005-2008



According to the CDC, prescription drugs are now involved in more overdose deaths than heroin and cocaine combined.[6] While no state is immune from this epidemic, currently Wisconsin lacks adequate surveillance to systematically monitor the problem or identify trends at the local and state level. One of the primary goals of this report is to identify an effective way to measure the problems, starting with the number of legal prescriptions written, and ending, tragically, with the number of overdose deaths attributable to prescription drugs. Results will come via prevention, but measurement of the problem and its components, as well as measurement of results, must be the foundation of evidence-based prevention and intervention efforts. In Wisconsin, no real progress will be made in reducing the burden of prescription drug abuse until there is an effective way to measure the problem.

Executive Summary

Prescription drug abuse is America's fastest growing drug problem.[7] While all classes of prescription medications have the potential for abuse, narcotic pain medications (also referred to as painkillers or opioid analgesics) are particularly dangerous given their highly addictive nature and abundant supply. The United States makes up only 4.6 percent of the world's population, but consumes 80 percent of its opioids, and 99 percent of the world's hydrocodone, the opioid that is in Vicodin®.[8] There have been a number of reports issued at the federal level (2010, 2011 – ONDCP, SAMHSA) that serve as clear illustration that prescription drug abuse is an epidemic that requires swift and comprehensive action. In fact, reducing prescription drug abuse is a national priority as documented in the 2011 National Drug Control Strategy Report, along with the recently produced document, *Epidemic... Responding to America's Prescription Drug Abuse Crisis.*

While the risks associated with misuse of prescription drugs pose a significant threat to the healthy development and wellbeing of all Wisconsin citizens, adolescents and young adults are particularly at risk, as overdose deaths are a significant contribution to overall mortality. In many states, the first illegal drug used by youth is no longer marijuana, it is non-medical use of prescription drugs. One in five Wisconsin high school students report having taken a prescription drug without a doctor's prescription at least once in their lifetime.[9] Taking into account the national trends, it is expected that non-medical use of prescription drugs will soon surpass marijuana as the most commonly used drug by Wisconsin youth. Based on the fact that the onset of addiction is usually prior to age 21, and sometimes prior to age 15, many experts make the point that addiction is a pediatric disease and have used "delaying the age of onset of first use" as an evidence-based strategy for preventing the incidence of addiction.

Exacerbating the problem is the fact that Wisconsin does not have a Prescription Drug Monitoring Program (PDMP). A well designed PDMP will provide an early warning system for emerging drug abuse trends, assist in enhancing patient care, and serve as a vehicle for communication with other states subsequently reducing doctor shopping across state lines. In addition, with appropriate confidentiality protections built into the Wisconsin PDMP for patient-identifiable health information, a PDMP will enhance the ability of law enforcement to conduct investigations of the illegal diversion of prescription medications.

Wisconsin must recognize that prescription drug abuse is first and foremost a compelling public health issue, and as such, the solutions are broad-based and not limited by any means to law enforcement initiatives. The health care community plays a key role in curbing the prescription drug epidemic. In this report, the health care community refers to a broad spectrum including nurse practitioners, physician assistants, nursing homes and veterinarians and veterinary hospitals. Policies and practices must be implemented in health care settings to ensure the provision of adequate medications to patients for legitimate medical purposes, but reduce the amount of medications that are prescribed and subsequently misused, abused and diverted. Particular emphasis must be placed on the development of policies and practices that reduce the number of narcotic pain medication doses that are prescribed.

Public policy initiatives and governmental actions are critical in addressing these issues, but sustainable solutions will only be achieved through coordinated efforts at the local, state and federal level. This report identifies state recommendations for action, building upon and taking into consideration federal recommendations. In addition, the report also identifies recommendations for local communities, coalitions, health care and other key stakeholders as a starting point for action. In terms of achieving significant and sustained reductions in rates of prescription drug abuse and related consequences, Community Anti-Drug Coalitions' of America (CADCA) frameworks are acknowledged in this report. It is essential to understand the critical role of broad-based community anti-drug coalitions as the central framework through which to coordinate and implement many of these initiatives.

Executive Summary (continued)

Wisconsin's recommendations are deeply rooted in the accomplishments of other states who have led the way in taking steps to reduce and prevent prescription drug abuse. We gratefully acknowledge several reports that served as a blueprint for Wisconsin's report. The CSW focused primarily on the work done in the following states:

California (http://www.adp.ca.gov/Director/pdf/Prescription_Drug_Task_Force.pdf),

Ohio (http://www.odh.ohio.gov/features/odhfeatures/drugod/drugoverdose.aspx), and

Maryland (http://www.oag.state.md.us/Reports/PrescriptionDrugAbuse.pdf),

as well as the 2010 and 2011 National Drug Control Strategy reports of the White House Office of National Drug Control Policy (ONDCP). It is important to note that the recommendations outlined in this report are those that have largely state level implications. The National Drug Control Strategy (2010, 2011) includes not only many of the recommendations included in Wisconsin's report, but recommendations that address the epidemic at the national level. The CSW endorses all the recommendations outlined in the National Drug Control Strategy.

While this report was written in response to a compelling community health crisis, it is also important to recognize that some communities have already come together in response to this issue with notable accomplishments. Exciting and successful initiatives such as the Lakeland Area Prescription Drug Abuse Task Force in Vilas and Oneida counties, and the public awareness campaign "Good Drugs Gone Bad" in the Fox Valley, are two examples of local communities developing effective programs and services that are seeing positive results. The CSW would like to acknowledge that the initiatives highlighted in this report represent only a small portion of the work being done in Wisconsin. At its root, substance abuse is a local issue. And all across Wisconsin, communities are coming together to find creative solutions.

The recommendations are categorized by priority areas. After careful deliberation, the CSW opted not to rank the recommendations or the priority areas. Each and every recommendation in this report is an important component in successfully combating the prescription drug abuse epidemic. The final section of this document identifies recommendations that have been identified as being the most actionable and impactful in terms of next steps. The members of the CSW undertook this project with the commitment to identify long term, sustainable solutions to an epidemic that is taking a grave toll on Wisconsin, not only in terms of financial costs, but in lives lost and families destroyed by addiction. Each recommendation in this report is a critical step toward building a healthier Wisconsin.

Priority Area: **Fostering Healthy Youth**

This report is rooted in the belief that prevention is the long term solution, not only to reduce prescription drug abuse, but in addressing the serious threat to public health that Wisconsin faces due to substance misuse, abuse and addiction. Prevention is most effective when it is targeted to the youngest populations at risk for development of a chronic health condition. The landmark 2009 Institute of Medicine (IOM) report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People,* sums up over 20 years of prevention research with this opening sentence: "Several decades of research have shown that the promise and potential lifetime benefits of preventing mental, emotional, and behavioral (MEB) disorders[b] are greatest by focusing on young people and that early interventions can be effective in delaying or preventing the onset of such disorders."

The good news is, Prevention Works!

It would be shortsighted not to recognize that as a society, we need to provide programs and services that will build resiliency and ensure access to services that will address mental and behavioral health issues, including substance use disorders. Not everyone who engages in non-medical use of prescription drugs has a pattern of use or features of use confirming the presence of an addictive disorder, but many regular users of opioid analgesics do develop an addiction to them. When it comes to the abuse of prescription drugs, the end-point can be an overdose death – an end-point all of Wisconsin should work to prevent.

Based on the above considerations, Wisconsin should:

Recommendation 1: Support communities to foster healthy youth.

- ✓ Support communities in adopting and sustaining evidence-based prevention programs that build mental, emotional, and behavioral health from early childhood to young adulthood, and to implement universal, selective, and indicated prevention activities for mental health and substance use disorders as outlined in the IOM Continuum of Care Model http://www.cars-rp.org/publications/Prevention%20Tactics/PT8.13.06.pdf
- ✓ Evidence-Based Prevention programs and practices should be made available to all individuals through appropriate channels including healthcare providers, media, employers, public agencies, communities, and schools. See Appendix A: National Registry of Evidence-based Programs and Practices.

[b] MEB disorder is defined as a diagnosable mental or substance use disorder.

Priority Area: Community Engagement & Education

Prescription drug diversion and abuse is a complex issue. Enhanced education and awareness should be at the forefront of strategies to address this growing problem and its related consequences. While Wisconsin has made great strides in raising awareness about the dangers of underage alcohol use, there is much to be done at the state and local level to raise awareness about the many issues related to prescription drug diversion, misuse, and overdose deaths – from perception of risk (the beliefs persons have about the likelihood of encountering harm from engagement in a given behavior), to safe storage and disposal of home supplies of prescription drugs. Comprehensive, *locally implemented* public education and awareness campaigns will heighten community concern and ultimately increase a community's readiness to address the problem. On the continuum of prevention initiatives, education and awareness seeks to lay the foundation for population level changes in attitudes, behaviors and policies related to the way prescription medications are obtained, used, stored and disposed.

Community Engagement: Coalitions

Broad-based community coalitions are endorsed at both the federal and state levels as the primary vehicle through which to launch efforts to address substance abuse problems. In Wisconsin, networks of coalitions are supported by a strong prevention infrastructure that includes technical assistance and training to implement the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Strategic Prevention Framework (SPF). SPF provides the theoretical framework through which to develop and implement comprehensive community action plans in order to prevent and reduce prescription drug abuse (see Appendix B). SPF is a systemic, community-based approach to prevention which aims to ensure that substance abuse prevention programs can, and do, produce results. SPF is based upon findings from public health research along with evidence-based prevention policies, practices and programs to build capacity within States, Tribes, local communities and the prevention field as a whole. SPF places strong emphasis upon the implementation of environmental strategies to achieve and sustain population-level reductions in substance dependence (addiction) and in harmful or risky use of prescription drugs. It is important to acknowledge that while broad educational messages are an important element in addressing prescription drug abuse, *education does not change behavior.* Following the SPF, education and public awareness must be implemented as part of a comprehensive plan that is data driven, evidence-based and thoroughly evaluated. When communities come together through coalitions and address this issue through a public health lens, positive outcomes will be achieved.

Education

According to the National Survey on Drug Use and Health (NSDUH), over 70 percent of people who reported non-medical use of prescription drugs obtained their supplies from friends or relatives.

Prescription drug abuse is a growing, yet misunderstood, risk to Wisconsin communities. Many citizens are still misinformed of the risks associated with non-medical use of prescription drugs. "Parents Who Host Lose the Most" is one great illustration of a community education campaign that can achieve success in terms of educating the public about risky behaviors related to underage drinking. In that campaign, the target message focuses on the risks associated with adult provision of alcohol to minors. Similar campaigns should be implemented to inform and educate the community about the risks of prescription drug use, misuse and addiction.

Priority Area: Community Engagement & Education (continued)

In terms of safe disposal of prescription drugs, consumers need to be made aware of how and where to dispose of unused and unwanted medications. Anecdotal information suggests that there is a tendency on the part of consumers to hold on to unused prescription pain medications (opioid analgesics) in the event that they sustain a future episode of painful injury or illness - the idea being that by keeping unused medications around, it will save a future trip to the doctor or the expense of filling a new prescription in the future. This is a particularly dangerous practice, as it results in narcotics being readily available for youth to access, not to mention that it sends a strong message to youth that it is acceptable to use these dangerous medications outside of the direction of a licensed prescriber. Communities of all sizes must establish or have access to nearby facilities and programs for authorized drop-off of unused medication, especially controlled substances, and consumers need to be educated on the proper way to secure, drop-off and dispose of prescription medications. Community "take-back" events utilizing permanent drop-off locations should be widely promoted. Emphasis should also be placed upon proper disposal methods to ensure that prescription drug disposal is environmentally responsible. In particular, older adults and their caretakers require education in terms of safe and secure storage of medications at home, as well as the risks of prescription theft. Unfortunately, older adults are often unknowingly targeted for their prescription supplies by drug seekers.

In addition to the proper storage and disposal of medications at home, parents and other adults need to be made aware of the issues and trends related to youth and adult misuse of prescription drugs, including the signs to look for relating to medication abuse and dependence. Parents need to be informed of the high tendency of youth to experiment with prescription drugs due to the low perception of risk, (a commonly held belief that since prescription medications originally came from a physician, they are "safe"). Youth require education to combat the low perception of risk of using/misusing prescribed medications, including those prescribed by dentists, and the possible consequences associated with substance use, misuse, and addiction.

> "A friend of my 16 year old daughter has recently started abusing prescription drugs – taking them from her parents."

Health education classes should address the signs of drug overdose and steps that should be taken to mitigate adverse outcomes when a case of drug overdose is encountered.

Given that persons seeking supplies of controlled substances have learned that particular locations or circumstances provide a higher likelihood of success in obtaining drugs than others, it is necessary to educate certain sectors of the business community, including real estate agents and funeral directors, using relevant, targeted educational messages to reduce prescription drug diversion.

Successful Wisconsin Initiatives

This report endorses "Good Drugs Gone Bad" as a Wisconsin-based program that is being reviewed to become an evidence-based program (Appendix C). In addition, the CSW recognizes other Wisconsin-based efforts to reduce access to diverted prescription medications, such as in Fond du Lac County, where in 2008 the City of Fond du Lac became the first community in Wisconsin to have a permanent drug drop-off location. Other communities have followed suit with permanent drop boxes as well as "take-back" events. To find more information on how Fond du Lac worked to establish a permanent drop-off location and organize take back events visit http://www.drugfreefdl.com/drugdrop.html.

Based on the above considerations, Wisconsin should:

Priority Area: Community Engagement & Education (continued)

Recommendation 2: Launch a public outreach and education campaign

Outreach and education campaigns should include the following:

- ✓ Information to families with children that, even though prescription drugs are FDA approved and have a legitimate medical purpose, when they are misused or abused they can be extremely dangerous and unauthorized use can lead to unintended injury, addiction, and even death.
- ✓ Consumer education regarding how and where to dispose of unused and unwanted medications, linked with efforts to educate consumers to make use of such opportunities and dispose of all unused medications.
- ✓ Community-wide public awareness campaigns, including participation in national and local prescription drug "take-back" events, advertising of permanent prescription drug drop-off locations, public service announcements, printed materials and media advocacy efforts.
- ✓ Educational messages for youth, which should be delivered through various vehicles, including accredited evidence-based school programs, health care classes, advocacy groups, social service organizations, and social media.
- ✓ Educational messages for the businesses community, which can be accomplished through intersecting with public health networks, professional associations, newsletters, lunch and learn opportunities, and civic organizations.
- ✓ Educational messages to parents, delivered through public health networks, PTAs, parent networks, employers, newsletters, school workshops, as well as community-wide public service announcements, print media campaigns and media advocacy efforts.
- ✓ Educational programs and information for older adults, delivered through public health networks, hospitals and clinics, senior centers, retirement communities, public health nurses, in-home care providers and others.

> "A grandma at our senior center has a 4 year old great granddaughter whose parents give the girl a 'little pill' to help her sleep."

- ✓ Education for law enforcement about the environmentally safe collection and disposal of pharmaceuticals and other controlled substances in compliance with waste regulations and Drug Enforcement Agency (DEA) regulations regarding chain-of-custody for delivery and handling of controlled substances.
- ✓ Drug Information for Teachers and Educational Professionals (DITEP) training sessions should be expanded throughout the state.

Recommendation 3: Support community coalitions as the vehicle through which communities will successfully prevent and reduce prescription drug diversion, abuse and overdose deaths.

Local community coalitions should contact Alliance for Wisconsin Youth (AWY), Northwoods Coalition, or CADCA to seek training in utilizing the SPF, to address community-specific local conditions regarding prescription medication abuse.

As coalitions conduct a comprehensive assessment of local conditions, build coalition capacity to address the issue and then develop, implement and evaluate a comprehensive plan that involves all community sectors, they should look towards using a logic model that addresses root causes, local conditions and the *Eight Strategies for Effective Community Change developed by CADCA* (see Appendix D). Using these evidence-based approaches will lead to measureable reductions in prescription drug abuse and related consequences.

Priority Area: **Health Care Policy and Practice**

Prescription drug problems are unique in that, unlike illicit drugs, prescription drugs have a legitimate medical purpose, and when properly prescribed and administered they relieve suffering and treat illness. In particular, prescription pain medications have a specific purpose in the continuum of pain control for those who live with chronic pain. When diverted and misused, however, pain medications can lead to powerful addiction. The most common initial source of prescription drugs that are later associated with misuse and overdose deaths, is a legitimate prescription written by a dentist, a physician, or other health care provider.

> "My brother-in-law (age 50's) just went to sleep and never woke up. He could never stand pain and would always go to the doctor to get medicine for any toothache or headache. He also had medicine for knee replacement, ankle surgery, and carpel tunnel surgery. He was always on some pills."

While drug diversion and misuse is often considered a problem to be addressed by law enforcement and the judicial system, the fact is that substance use disorders, including addiction, are fundamentally complex medical conditions, and not just social or criminal justice problems. The health care community plays a critical role in establishing policies and practices that address the prescription drug problem. Prescribers, and the professional societies to which they belong, are central in the implementation of practice standards and guidelines to address the types and doses of medications prescribed, the number of prescriptions and the number of tablets authorized, the subpopulations of patients at increased risk for addiction or drug misuse, the impact of drug-seeking behaviors, and the development and provision of patient education about the risks of potentially addictive prescription medications. Licensed health professionals with prescribing privileges play an important role in the education of parents, grandparents and all patients. In addition, steps should be taken to ensure that workers with access to controlled substances in the course of their daily work (such as pharmacy technicians) undergo adequate background checks as a strategy to reduce theft. In terms of addressing the growing number of overdose deaths, first responders should be trained how to recognize and manage overdoses, and should have access to opioid antagonists in the field.

Controlled Substances Prescribing

Opioid analgesics are associated with mortality from accidental or intentional overdose at an increasing rate in Wisconsin. But these agents are also tremendously beneficial for patients when prescribed appropriately and when used as prescribed. Decades of data have shown that physicians have under-prescribed opioids in some clinical situations and that even cancer patients have not always had adequate access to proper dosages of analgesics. Physicians in some instances have been hesitant to prescribe because they have not understood well enough what addiction and substance use disorders are, have misinterpreted physical dependence or "medication-seeking behaviors" as signs of addiction, have not known how to use clinical drug testing appropriately, and have had fears about the threat of professional sanction they may face due to their prescribing practices.

Priority Area: Health Care Policy and Practice (continued)

Through the assistance of entities such as the Pain Policy Project of the University of Wisconsin, the Federation of State Medical Boards (of which the Wisconsin Medical Examining Board is a member) Model Guidelines for regulatory bodies have been developed. The Model Guidelines oversee medical practice, making clear that proper diagnosis, proper treatment planning and clinical documentation should include a balanced approach to cancer pain and chronic non-cancer pain such that physicians can treat pain patients with opioids without fear of undue regulatory scrutiny.

Recently, the federal government and the governments of specific states such as Florida, have taken steps to investigate and develop new regulations for pain medicine practice sites which appear to grossly overprescribe opioid analgesics or other controlled substances. The term "pill mill" has entered official language at the level of the White House Office of National Drug Control Policy (ONDCP) to describe profiteering and unethical physicians who establish clinics which dispense large doses of opioids to persons without adequate medical examinations to document clinical necessity or ongoing documentation of the results of prescriptions on the improvement of symptoms and functioning in patients provided with controlled substances. The medical professional and the regulatory community continue to struggle to identify a true balance between the needs of patients for appropriate pain control and the needs of public health and public safety with respect to controlled substances diversion and overdose deaths. Practice guidelines developed by professional societies that identify best practices can assist clinicians in making the most appropriate clinical decisions when prescribing controlled substances.

Opioid Treatment Programs (OTPs)

OTPs, previously known as methadone clinics, play an important role in providing avenues for treatment for persons addicted to heroin or other opiates. These outpatient treatment facilities provide Medication Assisted Treatment (MAT) through the use of methadone, Suboxone®, and most recently Vivitrol® as well as individual and group counseling by certified addictions counselors. Methadone, Suboxone® and Vivitrol® are designed to be a part of a comprehensive treatment program which involves psychosocial counseling. This vital combination of medication and counseling helps the patient enter sobriety and ultimately, recovery. There are 14 OTPs in Wisconsin and all are regulated by both Federal guidelines, (42 CFR, Part 8) and Wisconsin State Administrative Code, Chapter DHS 75. Best practice standards via outcome-based treatment are continually being recognized as a successful means to help addicted persons remain in recovery. The opportunity exists to enhance the current treatment protocols for the OTPs in Wisconsin. Standard treatment protocols should be developed for OTPs to include treatment plans, discharge plans and patient to counselor ratios. Treatment plans should include information that indicates a clear expectation on the part of the clinic and the patient that the use of medication assisted treatment is only one aspect of professional treatment. To this end, availability of and access to addiction counseling needs to be increased and solidified according to best practice standards, so that patients can maintain recovery.

The Dental Community

Dentists have an important role to play in reducing prescription drug abuse. According to the Journal of The American Dental Association, dentists prescribe 12 percent of the [immediate release] opioids, particularly hydrocodone and oxycodone. Given this fact, it is a natural assumption that a portion of the pain medications being prescribed by dentists are being diverted and used for nonmedical purposes. To explore this issue, a steering committee of the Tufts Health Care Institute (THCI) Program on Opioid Risk Management convened a panel of experts. The panelists held a meeting in Boston in March 2010. Findings from that meeting were published in the Journal of the American Dental Association in July 2011. The article, "Prevention of Prescription Opioid Abuse: the Role of the Dentist" highlights many important aspects of the prescription abuse issue.[10] Specifically, the article concludes that the dental community should review current peer-reviewed recommendations for the treatment of dental-related pain and that the appropriate use of opioids requires dentists to follow responsible and tailored prescribing practices to provide adequate pain control while limiting opportunities for abuse and diversion.

Priority Area: Health Care Policy and Practice (continued)

Drug Testing

Currently, the Wisconsin State Laboratory of Hygiene (WSLH) is the primary forensic laboratory in Wisconsin for detecting drugs in OWI cases as well as in coroner/medical examiner cases. The WI State Crime Laboratory system performs some of this testing and the Milwaukee County Medical Examiner's office performs a significant number of post-mortem drug tests for Milwaukee and surrounding counties. Inadequate funding coupled with a dramatic increase in drugged driving cases in Wisconsin have resulted in a large backlog of drug testing cases at the WSLH. Turnaround times for drug testing results are currently 8-9 months. As a result, many medical examiners send toxicology samples out of state to fee-for-service labs which can provide faster turn-around times.

In addition, laboratories providing forensic drug testing face constant challenges to keep up with newly developed drugs and with existing drugs that are prescribed for new treatment protocols. Drug testing, especially in blood, is complicated, time-consuming and resource intensive. The identification of abused drugs comes at a high cost, making it difficult for laboratories to provide the desired level and scope of testing.

Based on the above considerations, Wisconsin should:

Recommendation 4: Mandate education and training for health care professionals.

Mandated education should include:

- ✓ Education about substance use disorders and addiction, the differences between addiction and physical dependence, and the complex interfaces of pain and addiction in patient populations.
- ✓ Education for current and future prescribers regarding appropriate prescribing practices for pain medications and other medications subject to non-medical use.
- ✓ Education for current and future prescribers regarding their role in prevention of prescription drug diversion, misuse and addiction, including their role in providing education to patients, especially those who are parents and grandparents.
- ✓ Information and training for pharmacists and physicians regarding the altering or theft of prescriptions, how to detect fraudulent prescriptions, and how to detect and prevent both "doctor shopping" and the use of fraudulent prescriptions by patients or persons posing as patients.
- ✓ Information and training for the broad spectrum of prescribers, from the dental community, nurse practitioners and physician assistants to veterinarians.
- ✓ A workgroup should be convened to identify state medical and health care associations, spanning the scope of the health care community including dental, nursing, and other professional associations, particularly the Pharmacy Society of Wisconsin and the Wisconsin Veterinary Medical Association. A formal request for their commitment should be made so that the issue is integrated into meetings, conferences, courses, websites and newsletters of professional associations. In addition, support should be solicited for policy changes in Wisconsin that would mandate education and training for their members.
- ✓ Mandated education in Wisconsin will ideally be aligned with mandates for education deriving from national policy initiatives, including Risk Evaluations and Mitigation Strategies (REMS) developed by pharmaceutical manufacturers in response to FDA mandates, or mandates developed to link with national prescriber registration processes of the U.S. DEA for controlled substances prescribing.

Priority Area: Health Care Policy and Practice (continued)

Recommendation 5: Ensure that chronic pain sufferers have safe and consistent access to care.

- ✓ Support the Wisconsin Medical Society in the dissemination and the updating of the comprehensive report and recommendations of its Task Force on Chronic Pain, and encourage professional societies for other professionals with prescribing privileges to develop similar recommendations for their members. Encourage the adoption of professional standards that would allow for smaller less-lethal supplies of opioids to be prescribed at each visit, and paid for by pharmacy benefit plans.
- ✓ Provide education on the safe use of methadone as a treatment for chronic pain, recognizing that many current prescribers offer generic methadone to patients (especially Medicare patients), because of its lower cost without appreciating the unique and intricate safety issues that must be attended to in order to prevent inadvertent overdose deaths.
- ✓ Work with professional associations to encourage development or updating of best-practice guidelines and professional standards of practice regarding the evaluation and management of chronic cancer pain and non-cancer pain along with risk-management strategies to identify substance use disorders, minimize non-medical use of prescription drugs, and improve prescribing practices.
- ✓ Work with professional societies to generate continuing medical education specifically addressing safe initiation of methadone therapy in pain patients.
- ✓ Health care organizations should establish standards to advise the prescription of short-term supplies until the patient is stable, including in the case of prescriptions for buprenorphine and methadone. Additionally, work with commercial health plans to assure that patient co-pays will not be adversely affected by the implementation of safe prescribing practices.

Recommendation 6: Establish standard prescribing practices for urgent care and emergency departments.

- ✓ In some Wisconsin communities, health care providers have come together to explore the feasibility of standardizing prescribing practices in urgent care and emergency departments, which is due to the fact that drug seekers commonly utilize these types of facilities to obtain prescription narcotics. In particular, the Lakeland Area Prescription Drug Task Force in Vilas and Oneida counties is currently working to standardize policies within that region. This report suggests that health care systems throughout Wisconsin undertake the same process to reduce the number of drug seekers that are successful in their attempts to fraudulently obtain controlled medications (see Appendix E for a sample policy.)

Recommendation 7: Develop standard screening methodologies for drug-testing labs to use in detecting the presence of drugs to include all commonly misused opioids, benzodiazepines, psychostimulants, and related agents, and assure that drug-testing methodologies used in clinical settings and in post-mortem settings (including the State Crime Lab system) are aligned in order to generate the most consistent and useful data.

- ✓ Encourage stakeholders to promote the use of clinical drug testing by prescribers as part of "Universal Precautions[11]" as suggested by physician organizations, and to assure payment for medically necessary testing of urine and other body fluids by commercial and state health plans (including Medicaid).

Priority Area: Health Care Policy and Practice (continued)

- ✓ Work with national and state organizations to improve the design and utilization of clinical drug testing. Additionally, work with commercial health plans, Medicaid, and regional Medicare carriers to assure that medically necessary urine drug testing is paid for on a par with diagnostic laboratory testing in other clinical scenarios, so that pain medicine physicians, addiction medicine physicians, psychiatrists and other physicians caring for pain and addiction patients and other patients prescribed controlled substances which have a potential for addiction, diversion, and overdose, will be able to order, and will order, drug testing as part of chronic disease management plans.
- ✓ Encourage WSLH, the State Crime Lab and the Milwaukee County Medical Examiner's Office to collaborate with the medical community to align drug testing procedures with clinical drug testing.
- ✓ Funding for WI forensic laboratories should be provided to develop and implement the expanded testing protocols needed to identify all of the targeted prescription drugs. Laboratories would also need support for increasing their capacity to develop testing methods for new drugs with abuse potential.
- ✓ Increase support to County Coroner and Medical Examiner offices to support toxicology screening to make accurate determination of cause of death.
- ✓ Provide guidance to Coroners and Medical Examiners regarding recommended drug testing protocols to ensure that fee-for-service laboratories they choose are able to provide the desired scope of testing.

Recommendation 8: Develop a standard set of treatment protocols for Opioid Treatment Programs (OTPs).

- ✓ Convene a workgroup under the State Opioid Treatment Authority that includes representatives from OTPs, Wisconsin Department of Health Services (DHS), and other key stakeholders.
- ✓ Determine a reciprocity system with bordering states to address the unmet need for OTP services in the far northwestern and far southeastern regions of Wisconsin.

Recommendation 9: Establish guidelines to reduce the diversion of prescription drugs by those who handle prescription medications in the course of their daily work.

- ✓ Require individuals who work with controlled substances to have criminal background checks performed as a condition of employment.
- ✓ Require reporting by co-workers or supervisors, to both the employer and law enforcement, of all cases of theft or diversion of controlled substances.

Recommendation 10: Equip healthcare providers and first responders to recognize and manage overdoses.

- ✓ Require that all ambulances carry opioid antagonists such as naloxone, and ensure that all EMTs and paramedics are trained and authorized by law to administer it.
- ✓ Examine other state and local programs that provide training, administration equipment for the use of rescue doses, and supplies of opioid antagonist medications to patients and illicit drug users through public health departments or other distribution systems, so that lay persons can reverse coma in cases of opioid overdose in the field before professional first responders arrive.

Recommendation 11: The Wisconsin Dental Association and Wisconsin Dental Examining Board should endorse and implement the findings of the Tufts Health Care Institute Program on Opioid Risk Management and the School of Dental Medicine, Tufts University.[c]

- ✓ Recommendations include patient education regarding sharing prescriptions, utilizing prescription drug monitoring programs, reviewing prescribing practices, and screening of patients for signs of substance use disorders.

[c] As reported in the Journal of the American Dental Association, July 2011.

Priority Area: **Prescription Medication Distribution**

Prescription medications enter the community through many channels, and there are many points where they can be obtained for diversion. Prescription medications may be diverted through robberies of pharmacies, delivery vehicles and other storage facilities. Diversion may also take place through the use of fraudulent prescriptions or by individuals who legally obtain them with minimum barriers, and subsequently abuse them or sell them for profit. Lastly and most common, left-over prescription medications are shared, passed on or taken between family members, relatives and friends.

Based on the above considerations, Wisconsin should:

Recommendation 12: Convene a work group to develop recommendations to increase security measures in the dispensing of prescriptions for controlled substances

- ✓ The work group should consider electronic, fax, written and verbal prescription processes addressing security options, effectiveness of security options, and barriers to implementation. For example, the workgroup should consider tamper-resistant paper, unique prescriber identifiers for verbal and electronic prescriptions, or requirements on how to write the prescription to eliminate fraud on strength or quantity changes.

> "I had my identity stolen by someone in order to obtain prescription drugs."

Recommendation 13: Implement a system to ensure that, for controlled substance prescriptions, patients are identified in a manner similar to photo identification as required to obtain pseudoephedrine.

- ✓ To ensure that controlled medications are given only to patients with legitimate prescriptions, a system should be utilized that requires photo identification or some other validation of identity for the person receiving the dispensed prescription.

Recommendation 14: Support a system that increases security and traceability of controlled substances from manufacturer to patient.

- ✓ Develop a resource tool for providers and consumers to recognize and identify problem diversion opportunities.
- ✓ Some controlled substance medications are lost in transit via mail and other delivery methods utilized. Systems including radio frequency identification (RFID) can be utilized in various distribution steps to provide security or traceability of the medications. Other non-technological options can be utilized, for example, consumers verifying the count of prescription medications received in the mail or packaging medications in manners such that handlers may not know what is being delivered and therefore are less likely to divert.

Priority Area: **Prescription Medication Disposal**

The CSW collaborated with the Wisconsin Pharmaceutical Waste Working Group (PWWG) in the development of recommendations in this priority area. The PWWG was established around the same time as the CSW and a partnership was established to align work and avoid duplication of effort. The PWWG represents a wide variety of stakeholders interested in household pharmaceutical waste disposal in Wisconsin. It is an ad hoc group co-chaired by UW Extension's Solid and Hazardous Waste Education Center and the Wisconsin Department of Natural Resources. Its mission is to reduce the negative impacts of pharmaceutical waste on Wisconsin's environment and communities.

Among its approximately 35 members, PWWG includes healthcare providers (including hospice and home care), pharmacists, law enforcement, waste haulers, reverse distributors, county/municipal solid waste and health departments, educators, colleges and universities, technical assistance providers and regulators.

The PWWG grew out of a smaller working group that met from 2006 to 2008. The former group developed educational materials and a plan that led to the pilot mail-back medication collection program in two Wisconsin counties in 2008. Based on this pilot, UW Extension secured an Environmental Protection Agency (EPA) Great Lakes Restoration Initiative grant to offer a pharmaceutical mail-back program to residents of the 36 Wisconsin counties that drain to the Great Lakes. This mail back program, known as "Get the Meds Out," began in August 2011 and ran until early December.

The work of the PWWG focuses primarily upon pharmaceutical collection and disposal. The group also promotes strategies to reduce pharmaceutical waste and the concept of product stewardship for funding collections. The group collaborates with other pharmaceutical waste working groups in Minnesota, Michigan, Illinois, Indiana and Ohio.

For more information on the Pharmaceutical Waste Working Group, visit http://fyi.uwex.edu/pharma/ or contact co-chairs Barb Bickford, Medical Waste Coordinator, DNR, 608-267-3548, barbara.bickford@wisconsin.gov or Steve Brachman, Waste Reduction Specialist, UW Extension, 414-227-3160, steve.brachman@ces.uwex.edu.

Accessible Medication Disposal

Current medication disposal options are neither clearly defined nor consistent. Some communities have permanent drop boxes, some have collection events once a year, and in a few communities, mail-back programs were piloted. In many areas of the state, however, there are no safe and secure disposal options available to consumers. Furthermore, consumers may be unaware of how to dispose of medications properly. In order to maximize compliance with disposal programs, voluntary disposal of medications should be convenient, easily accessible, and at low or no cost to the consumer. A permanent and sustainably financed program is necessary to protect the health of our families from prescription drug abuse and to protect our waterways from pharmaceutical pollution. See Appendix F for *Key Elements of Pharmaceutical Collection and Disposal Programs: A Vision for the Great Lakes Region.* This document was developed by a group of state and local governments and environmental and public health organizations throughout the region. It calls for the creation of a permanent, convenient and secure collection program for unused and unwanted pharmaceuticals.

Priority Area: Prescription Medication Disposal (continued)

Cost Effective Medication Disposal System

There are very few options in Wisconsin for physically destroying medications in a manner that complies with both safety and environmental laws and that does not violate federal controlled substances statutes. Most collected medications are either transported out of state for destruction or destroyed locally in combustion units that may not meet environmental rules. These two options are costly, inconvenient and, in the case of inadequate combustion, unhealthy. The lack of options limits the successful implementation of a pharmaceutical waste disposal program in Wisconsin. As a result, it is probable that a significant portion of unused drugs are being released into Wisconsin's surface waters directly through flushing or indirectly by being deposited in landfills and subsequently being removed as landfill leachate and sent to waste water treatment plants which are not designed to remove pharmaceutical compounds.

(For more information on the environmental effects of pharmaceuticals, see http://fyi.uwex.edu/pharma/ or http://dnr.wi.gov/org/aw/wm/pharm/pharm.htm or www.epa.gov/ppcp/)

Product Stewardship

Medication disposal and destruction has a cost. The cost is off-set, in theory, by lower rates of crime, fewer health consequences associated with prescription drug abuse, greater efficiencies in drug production and distribution, and less harmful impact on the environment. Product stewardship is a policy that ensures that all those involved in the lifecycle of a product share responsibility for reducing its health and environmental impacts, with producers bearing primary financial responsibility.

Expanding the number of parties responsible for disposal costs provides a powerful incentive to reduce the amount of medications in distribution that ultimately require disposal. For example, pharmaceutical waste may be reduced if pharmaceutical manufacturers and mail order pharmacies package medications so there is less waste when medications are no longer needed; if insurance companies and government change reimbursement and benefit structures; and if consumers and healthcare providers communicate and coordinate care to minimize medication waste when patient prescriptions are changed.

Wisconsin should examine the various options for involving all stakeholders in funding or establishing permanent pharmaceutical collection programs.

Community-Based Health Care

Community-based health care is in a difficult position when it comes to drug disposal. These entities provide health care, including managing and assisting with medications. An inherent challenge exists in that while these entities have the same environmental requirements as large health care institutions, they do not have the same capacity for regulations and infrastructure to support medication disposal that institutions such as hospitals have in place. In some cases, as with controlled substance medications, the only method long-term care and assisted living facilities currently employ to dispose of controlled medications pragmatically and affordably is to flush them into the sewer system.

Based on the above considerations, Wisconsin should:

Recommendation 15: Establish a coordinated statewide system for providing secure, convenient disposal of consumer medications from households.

- ✓ Establish a range of disposal options including but not limited to permanent collection boxes or facilities and take back events in community locations convenient to all consumers (such as pharmacies and hospitals).
- ✓ Clearly brand the program (education, logo, color) on drop boxes or collection locations statewide.
- ✓ Coordinate the collection of pharmaceuticals in a manner that ensures that waste streams do not get mixed. For example, pharmaceuticals should not end up in the same waste streams as medical sharps, inhalers and mercury thermometers. New processes for safe disposal which keep waste streams appropriately separated should be addressed with appropriate revisions to s. NR 526.09(5), Wis Admin. Code.
- ✓ Change regulations and offer incentives as necessary to allow for voluntary collection of pharmaceuticals from households.

Priority Area: Prescription Medication Disposal (continued)

Recommendation 16: Integrate medication collection with the Wisconsin Drug Repository.

The Wisconsin Drug Repository utilizes volunteer pharmacies and medical facilities to accept properly packaged medications that would normally be disposed of and subsequently, redistributes them to persons in need.

- ✓ If federal controlled substance laws change, allow controlled substances to be accepted in this program.
- ✓ Widely inform the public, hospice, other health care providers, and other stakeholders that the program is an option for unused medications.
- ✓ Add more pharmacies to the program to handle increased use of it and to make it more convenient for consumers to use.

Recommendation 17: Create an infrastructure for the destruction of drugs in compliance with state and federal environmental regulations.

- ✓ Identify a network of Wisconsin incinerators and boilers capable of destroying pharmaceuticals in Wisconsin in order to to minimize the cost of transportation to out-of-state incinerators.
- ✓ Provide incentives and modify permits as needed to allow Wisconsin incinerators and boilers to burn all pharmaceuticals.
- ✓ Enable identification of alternate means of destruction.
- ✓ Convene a workgroup under the leadership of the Wisconsin PWWG to assess opportunities and challenges for the safe and environmentally sound destruction of household pharmaceuticals within Wisconsin.

Recommendation 18: Identify the causes for prescription drug waste and implement proactive solutions.

- ✓ Analyze the causes for prescription drug waste in Wisconsin, with emphasis on controlled substance drugs that may be misused.
- ✓ Implement solutions that minimize the amount of medication waste. For example, consider permitting closed pharmacy deliveries that adjust prescriptions on a weekly basis or in some cases within a few days, for in-home deliveries.

Priority Area: Prescription Medication Disposal (continued)

RECOMMENDATION 19: Identify a sustainable means for funding collection and disposal in cooperation with key stakeholders including pharmaceutical producers, local governments, law enforcement, waste management companies, health care providers, pharmacies and consumers.

- ✓ Establish a collaborative process, involving key stakeholders, for choosing a funding option that works for Wisconsin.
- ✓ Use the process to examine a variety of voluntary or mandatory options to implement fees, taxes or incentives to producers, deliverers and consumers to pay for a disposal program.

RECOMMENDATION 20: Establish a system for effective disposal of consumer medications in all care programs and facilities which complies with state and federal waste management laws.

- ✓ Support changes in regulations to allow disposal of controlled substances through channels hospitals have available (requires DEA regulation changes).
- ✓ Support changes in regulations to help all health care entities manage health waste easier and more cost effectively, with minimal impact on the environment.

RECOMMENDATION 21: Establish regulations that would permit registered nurses employed by home health agencies and hospices to transport unused medications, including controlled substances, to designated drug drop-off and disposal facilities, so that when patient medications are no longer needed, such nurses are allowed by law to assist in their safe destruction.

- ✓ Encourage home health agencies and hospices to standardize procedures to ensure that good faith effort is made to dispose of all unused prescription medications.
- ✓ Regulations should address medications no longer needed by living patients as well as those who are recently deceased.

Priority Area: **Law Enforcement and Criminal Justice**

While the abuse of prescription drugs is very much a medical issue, the abuse and diversion of prescription drugs is ultimately dealt with by law enforcement and the criminal justice system. Every effort must be made to support law enforcement in investigating criminal activity and in establishing effective enforcement guidelines for new and existing laws related to prescription drug diversion.

Community-Based Law Enforcement Efforts

In addition to traditional law enforcement activities, this report recognizes the need to establish strategic partnerships and working relationships with community anti-drug coalitions locally, regionally and at the state level. As acknowledged in the ONDCP's National Drug Control Strategy, law enforcement has a very important role to play in community education, data collection and other initiatives related to the prevention of prescription drug abuse.[12]

Law enforcement plays a critical role in delivering, preventing and enforcing policies and practices, therefore should be encouraged to actively participate in community prevention efforts. Law enforcement officers should participate in community prevention programs in schools, community anti-drug coalitions, civic organizations and faith-based organizations.

Support Investigations

It is important to keep in mind that there are legitimate medical uses for prescription medications. The vast majority of prescribers in health care and dental settings follow responsible prescribing practices. Unfortunately, there are a small number of practitioners who do not follow responsible prescribing practices, and over prescribe medications under the guise of legitimate medical care. Every effort must be made to ensure that law enforcement has adequate information and resources at their disposal to fully investigate these cases. Access to information provided by a comprehensive, proactive, PDMP will be a tremendous advantage in stopping illegal activity on the part of prescribers.

Drugged Driving

The national data on the risks of drugged driving are compelling. Among drivers killed in motor vehicle crashes with known drug test results, one in three tested positive for drugs. In a 2007 national roadside survey conducted by the Department of Transportation (DOT), one in eight night time weekend drivers tested positive for an illicit drug. This number rose to one in six when pharmaceuticals with the potential to impair driving (i.e., opioid analgesics, tranquilizers, sedatives, and stimulants) were included.13 At the federal level, the ONDCP's National Drug Control Strategies (2010, 2011) have articulated clear calls to action to make the issue of drugged driving a national priority. In Wisconsin, the scope of the drugged driving problem is difficult to gauge as currently there is no statewide surveillance system in place. In addition, there is an opportunity to improve law enforcement training so that officers are equipped with the skills necessary to identify drugged drivers.

Drug Courts

Approximately 80% of criminal offenders abuse drugs or alcohol and nearly one half are clinically addicted. Comparable rates of substance abuse and dependence are found among other groups of individuals involved with the justice system, including parents in family dependency proceedings and juveniles in delinquency proceedings.[14]

Priority Area: Law Enforcement and Criminal Justice (continued)

Many of the prescription drug abusers that enter the criminal justice system would benefit from effective, and ongoing, supervised treatment. Effectively run drug courts allow communities to provide treatment to offenders while reducing recidivism. Evidence-based sentencing through drug courts relies on scientific data to balance the interests of public safety, cost and the psychosocial impacts of various dispositions on individuals coming before the courts. Rather than over-apply any one policy, the goal of evidence-based sentencing through drug courts is to match individuals to specific programs and services that are most likely to improve their outcomes in the most cost-efficient and safety-conscious manner. Evidence of success is gauged by reducing recidivism, reducing substance abuse and related dysfunction, and doing so with a better cost/benefit ratio than alternative programs.

Based on the above considerations, Wisconsin should:

Recommendation 22: Build bridges between law enforcement and community-based prevention efforts.

- ✓ Law Enforcement agencies should designate an officer to be active on local community anti-drug coalitions.
- ✓ Community groups and law enforcement agencies should actively participate in each others' respective conferences and trainings. (Wisconsin State Prevention Conference, Wisconsin Narcotics Officers Association, Wisconsin Chapter of the National Association of Drug Diversion Investigators, Wisconsin Association of Treatment Court Professionals, etc).

Recommendation 23: Make drugged driving a priority issue

- ✓ Explore the possibility of instituting a statewide pilot drugged driving surveillance system specifically geared toward traffic stops where blood can legally be drawn. This should be done in an effort to determine the extent of the problem and could potentially be sponsored by the Wisconsin DOT. This may include requiring blood draws for Operating While Intoxicated (OWI) stops to include a toxicology screen for prescription drugs.
- ✓ Encourage the Department of Health Services (DHS) to conduct a comprehensive science-based survey to understand the breadth of the problem of drugged driving.
- ✓ Enhance prevention of drugged driving by educating communities and professionals (Good Drugs Gone Bad) about the effects of prescription drugs on a person's ability to operate a vehicle.
- ✓ Provide training to law enforcement on identifying drugged drivers, specifically Drugged Recognition Expert (DRE) training, currently available at technical colleges and other private vendors.
- ✓ Consider funding through the Law Enforcement Training and Standards Board (LESB) to ensure that every officer in Wisconsin receives at least 4 hours of training per year in drugged driving detection and practices.
- ✓ Support and seek grant funding to provide DRE training for a minimum number of one patrol officers per shift per department.

Recommendation 24: Support Drug Courts

- ✓ This committee supports the Board of Directors of the National Association of Drug Court Professionals (NADCP), who unanimously endorsed principles of evidence-based sentencing and dispositional reform for substance abusing individuals involved with the justice system. These principles reflect reliable findings from the research literature that should guide the dispositional process and lead to more rational, effective and humane sentencing and other dispositional policies. NADCP's "*Principles of Evidence-Based Sentencing and Other Court Dispositions for Substance Abusing Individuals*"[4] presents information on the general principles of dispositional reform and makes specific recommendations concerning how drug courts and other problem-solving collaborative courts should fit within the broader spectrum of programs that are currently available for substance abusers involved with the justice system.

Priority Area: **Surveillance System**

This report recognizes the need to establish systems that will enable Wisconsin to effectively gauge the scope and breadth of the prescription drug abuse epidemic as well as to provide further research in this area.

Public Health Systems

The public health community should address the prescription drug epidemic more systematically, with epidemiologists developing more accurate and complete baseline statistics as well as trend data regarding what is prescribed, in what amounts, how much of it is diverted for non-medical use, the subpopulations at increased risk for addiction or drug misuse, the incidence and prevalence of drug-seeking behaviors, and the numbers of deaths where prescription drugs of various types are the direct, the indirect or the contributory cause of death.

> "There are many more deaths where drug abuse contributes to the death than appear on the death certificate. The cause of death for a person who drowns while intoxicated would be drowning even though the drowning is attributable to the intoxicants."
>
> - WI County Coroner -

Accurate and timely information on mortality trends is necessary to develop effective prevention, treatment, and policy change. In order to have accurate, actionable data, there must be consistent terminology in the completion of death certificates, the actions and data entry of coroners and medical examiners, and the vital statistics, including mortality statistics, tabulated by state government. More consistency is also required in the areas of clinical pathology and forensic pathology, so that tests of body fluids and tissues analyze controlled substances in a way that accurately identifies prescription drugs, individually and by drug class, ultimately supporting better epidemiology and mortality trend evaluation. Deaths attributable to opioid analgesics, sedative-hypnotics, and combined exposures to these potentially addictive and potentially lethal compounds, must be better understood, so that policy decisions are developed in a proactive, guided manner.

Prescription Drug Monitoring Program

Prescription Drug Monitoring Programs (PDMPs) are databases that record prescription drug distribution at the state level. Although there is no standard format for PDMPs, all collect information on controlled substances that include information on patients, prescribers, dispensers, size of prescription and date dispensed. The information is stored in a secure database. Health care entities and law enforcement are the primary recipients of the information collected and stored through a PDMP. State's should consider reviewing The American Society of Addiction Medicine's Public Policy Statement on PDMPs when developing their own programs (http://www.asam.org/policycategory.cfm).

Currently, 34 states have implemented PDMPs. In May 2010, Wisconsin passed a law mandating that the Pharmacy Examining Board (PEB) create a PDMP for Wisconsin. Subsequently, the PEB commissioned a cost-benefit analysis of developing and maintaining a PDMP in Wisconsin, which was published in December 2010. That report focused on the costs and benefits of the program as they impact society including the burden to state budget, prescribers, pharmacists, law enforcement, and Wisconsin citizens in general. Based upon those criteria, the recommendation was for the PEB to contract with the vendor Health Information Designs (HID) to implement and run Wisconsin's PDMP.

Community Early Warning System

Wisconsin should establish a community early warning system that tracks indicators at the local level and is comprised of both youth and adult surveys. Drug overdose data often serve as an early warning system to emerging trends and issues at the local level. Currently, there is no system through which to track drug overdoses in Wisconsin and reporting of drug abuse cases across the state is inconsistent. Collaboration with the federal CDC may be useful in designing and implementing monitoring systems to generate accurate epidemiological data on drug overdose deaths in the state of Wisconsin.

Priority Area: Surveillance System (continued)

Self-Reported Use Surveys

Self-reporting of prescription drug use, misuse and abuse through state-wide youth and adult surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS) should be expanded to include specific questions about different classifications of drugs.

Wisconsin should explore improvement of the YRBS questions in order to better understand the different patterns of misuse and abuse for stimulants and opioid analgesics through the use of questions that have been tested for validity. Communities should be encouraged to use standardized state questions so that there are valid, comparable data at the national, state and local levels. This report recommends the use of the online version of the YRBS that is administered through the Department of Public Instruction (DPI). In terms of financial considerations, the online YRBS is currently offered to school districts at no cost. In addition, encouraging school districts and community coalitions to utilize a standard survey instrument will lead to reliable data that are uniform in their collection.

The Alliance for Wisconsin Youth (AWY) should coordinate the work of coalitions in collecting self-reported use information via youth surveys through the development of standard and widely accepted prescription drug questions that incorporate both the National Outcome Measures and risk and protective factors. AWY should then work with DPI to have standard questions added to the online YRBS and promoted to school districts and community coalitions throughout the state.

Based on the above considerations, Wisconsin should:

Recommendation 25: Design and implement an electronic Prescription Drug Monitoring Program.

✓ Support the work of the Pharmacy Examining Board in developing a Prescription Drug Monitoring Program including collaborating with other states to link prescription monitoring systems.

Recommendation 26: Develop a community early warning and monitoring system that tracks use and problem indicators at the local level.

✓ Problem indicators include:

- Pharmacy robberies
- Lost in transit reports
- Consumer thefts outside of pharmacies
- Emergency room drug admissions
- School incident reports
- Aids Resource Centers of Wisconsin (ARCW) needle exchange program naloxone use reports

Recommendation 27: Develop a community monitoring and early warning system that tracks overdoses at the local level.

✓ A community monitoring program should include:

- Instances of Narcan® dosing by EMS personnel as well as in Emergency Rooms,
- Naloxone use reports from needle exchange programs such as the program of the AIDS Resource Centers of Wisconsin (ARWC),
- Positive tests for non-medical prescription drug use,
- Emergency room reports for overdoses, and
- Reportable diseases related to injection drug use, such as hepatitis or HIV.

Recommendation 28: Improve consistency in reporting drug use and abuse across the state.

✓ This would include:

- Training for coroners and medical examiners,
- Linking coroners and medical examiner data statewide, and
- Guidelines for when and what to test for at the time of death

Priority Area: **Early Intervention, Treatment & Recovery Across Lifespan**

While this report ultimately seeks to provide recommendations that will prevent the initiation of prescription drug abuse, more must be done to adequately identify those at risk for substance use disorders, provide access to those with dependence and addiction, and provide adequate support for recovery across the lifespan. The disease of addiction is addressed in this recommendation. However, when considering prescription pain medications specifically, one must also include chronic pain sufferers, surgical patients, sickle-cell patients, and cancer patients that seek relief from pain. While patients such as these are prescribed pain medication by their physicians for legitimate medical reasons, there is a risk of addiction. These individuals are not addicts in the stereotypical sense, but people with legitimate medical conditions who find themselves in the same situation as persons with drug addiction. It is imperative that effective screening is in place to identify patients that may initiate their use of prescription pain medications for legitimate medical reasons, but who are at risk of developing addiction.

Currently, in Wisconsin there are no standard screening protocols across health care settings that could increase identification of those in need of treatment or for those who engage in the hazardous use of substances long before the user progresses to dependency or addiction. In addition, there are currently no standard screening protocols before prescribing potentially addictive medication.

In terms of early intervention, the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program is endorsed by SAMHSA[15] and the ONDCP[6] as an effective, evidence-based approach to identifying and curbing unhealthy behaviors before they turn into life threatening conditions. The National Institute on Drug Abuse (NIDA) endorses drug screening in medical settings as a strategy to identify drug users early and briefly educate them about the adverse consequences of continued drug use. Screening provides the opportunity to offer resources for quitting and enhances medical care by increasing awareness of the potential impact of substance use on physical health, more specifically, the interaction of substance use with a patient's medical care, including potentially fatal drug interactions. In addition, NIDA endorses drug screening as a vehicle to improve linkages between primary and secondary health care services and specialty drug and alcohol treatment services.[7]

Improvement in terms of access and standardization of treatment is recommended for OTPs, expansion of Drug Court options, as well as access to high quality medication management and psychosocial treatment that is offered in clinical settings. Approximately one million Americans are dependent on heroin, prescription painkillers and other opioids, but the vast majority of them, (as many as 800,000) are not receiving any treatment.[8] When combined with psychological counseling, opiate substitutes that prevent withdrawal are among the most effective treatments for such addictions.[9] Persons with opioid addiction sometimes avoid OTPs due to the inconvenience of their locations, their hours of operation, or because of the stigma that even potential patients of OTPs may attach to opioid maintenance treatment. Even though they would like to enroll, they are sometimes discouraged due to limited treatment slots. Recent approval by the FDA of buprenorphine as a part of behavioral and psychosocial treatment has expanded opportunities for effective treatment.

Priority Area: Early Intervention, Treatment & Recovery Across Lifespan (continued)

Screening, Brief Intervention and Referral to Treatment

Over the last five years, a number of medical clinics in Wisconsin participated in a SBIRT pilot program. This program aims to screen for substance use/abuse in the primary care setting and offer brief intervention to help patients reduce their use in an effort to improve their health or refer to treatment if needed. Specifically, screening and brief intervention strategies stress the importance of the patient-doctor relationship in identifying unhealthy behaviors before they evolve into life threatening conditions. While still being evaluated, the program has resulted in positive outcomes for both alcohol and marijuana use. This report recommends the expansion of and enhanced reimbursement for SBIRT services.

Based on the above considerations, Wisconsin should:

Recommendation 29: Establish guidelines to screen for substance use in all health care settings.

Wisconsin should develop guidelines for health care organizations in all health care settings in the screening of patients for risks of substance abuse. Standards should be based upon the list of clinical indications developed by the NIDA, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and SAMHSA.

These screening guidelines and indications should be:

1. A part of any routine examination,
2. Conducted before prescribing any medication that interacts with alcohol,
3. Mandatory in urgent care or emergency departments, and
4. When seeing patients who:
   a. Are pregnant or trying to conceive;
   b. Are likely to drink heavily, such as smokers, adolescents, and young adults;
   c. Have health problems that might be AODA induced or exacerbated by use; such as cardiac arrhythmia, dyspepsia, liver disease, trauma, insomnia, depression or anxiety;
   d. Have a chronic illness that is not responding to treatment as expected, such as; chronic pain, diabetes, gastrointestinal disorders, depression, heart disease, or hypertension.

Recommendation 30: Promote and support evidence-based screening and early intervention for mental health and substance abuse.

- ✓ Increase adoption and reimbursement of SBIRT billing codes by commercial and public insurance plans, including Medicaid.
- ✓ Expand the provision of SBIRT services by training more health providers so they are skilled in offering these services.

Recommendation 31: Integrate high quality medication management and psychosocial interventions for substance use disorders so that both are available to consumers as their conditions indicate.

- ✓ Wisconsin should increase the network of physicians who are certified to prescribe buprenorphine and should also provide new opportunities for psychologists and therapists to get involved in pharmacotherapy-based substance abuse treatment by making such treatments available in a wide variety of settings and by increasing the number of patients who use pharmacotherapies and who therefore need the counseling and behavioral treatments that psychologists can provide.
- ✓ Services should be available and provided in the appropriate "therapeutic dose".

Recommendation 32: Make addiction treatment and recovery support services available both on a stand-alone basis and on an integrated basis with primary health care services, as well as in other relevant community settings.

Conclusions

Financial Considerations

While the cost of prescription drug abuse is obviously high, given the available prevalence and economic data, there are no current cost analyses that include opioid as well as non-opioid prescription drugs (tranquilizers, stimulants, and sedatives). This represents a significant gap in our knowledge, given that 20.6 percent of Americans have abused prescription drugs in their lifetimes. More is known at this point about prescription pain killer abuse, the most common type of prescription drug abuse, reported by 13.9 percent of Americans. According to Baldasare in the "Cost of Prescription Drug Abuse", the cost to society of pain reliever abuse alone was $8.6 billion in 2001.[20] Since that time, the number of Americans who have ever abused prescription pain relievers has escalated from approximately 22 million in 2001 to roughly 35 million in 2009, an increase of nearly 13 million or 58 percent, and associated costs have presumably risen as well in response (NSDUH, 2009). Costs of non-opioid prescription drugs are likely to vary significantly from opioids, due to different health and social consequences and co-occurring health conditions.[1] Currently in Wisconsin, inadequate surveillance and tracking systems prevent the accurate analysis of the financial burden of prescription drug abuse to the state, which is why one of the priority areas in this report is focused on surveillance. There is no doubt, however, that the costs are substantial, when one includes health care, criminal justice and societal costs in the equation. The toll in terms of loss of human life is incalculable.

This report has identified recommendations around eight broad areas that, if implemented, would significantly reduce prescription drug abuse in Wisconsin. Some recommendations become sustainable as a result of a policy enactment, others through re-distribution of current resources, while others would require new sustainable funding. Federal grant funds may become available to support some of these activities, although none have been identified currently. It is estimated that funding in the amount of $1.3 Million would be needed annually to support the recommendations.

Those recommendations that would require new sustainable funding include:

- Launching a public outreach and education campaign ($500,000 for statewide media and education campaign).
- Education and training for providers, prescribers and health care professionals ($30,000 for statewide training events).
- Establish a coordinated statewide system for providing secure, convenient disposal of consumer medications from households and care facilities that meets compliance with state and federal air environmental regulations ($125,000 increase in the "Clean Sweep Program", Department of Agriculture, to fund permanent drug drop-off and disposal sites. There is currently $75,000 available through this program).
- Establish surveillance systems that provide early warning and monitoring to track use, problem indicators and overdoses at the local level ($65,000 to fund Epidemiological reports through DHS, Division of Public Health).
- Increased support for Law Enforcement for DRE training and to investigate and prosecute those who illegally abuse prescription drugs ($400,000 to the Department of Justice to support increased law enforcement investigations).
- Increased support to County Coroner and Medical Examiner offices to support toxicology screening to make accurate determination of cause of death ($200,000 to provide supplemental funding for toxicology screens).

Conclusions (continued)

The estimates provided total $1,320,000. Funding for these activities could be achieved through a two-cent surcharge on each prescription filled in the State of Wisconsin. Based on estimates from the Henry Kaiser Family Foundation, 66,188,884 retail prescriptions were written in Wisconsin in 2009, or approximately 5.5 Million prescriptions per month (this does not include mail order prescriptions sent from outside of Wisconsin). A two-cent surcharge would generate approximately $1,323,776 annually. Although some might argue this places a financial burden on those obtaining prescriptions, the State could collect this fee directly from the pharmaceutical companies as opposed to passing it on to the consumer. Total retail sales of prescription drugs filled at pharmacies in Wisconsin for 2009 is estimated at $3,948,738,128 according to www.statehealthfacts.org. Pharmaceutical companies actively promote their products but the CSW feels they could be more active in preventing abuse of their products.

Next Steps

The CSW did not rank the recommendations. Prescription drug misuse, abuse and diversion are multifaceted, and unfortunately, there is no silver bullet that will solve the problem. Significant and sustained outcomes will only be achieved through actively engaging key community sectors and stakeholders in adopting the recommendations outlined in this report. In terms of next steps, however, the CSW has identified recommendations that need to be implemented without delay, as they will have the most immediate impact.

First and foremost, Wisconsin must continue its efforts to implement a well designed PDMP, which will be an effective tool across a number of priority areas including health care, surveillance and law enforcement. At the time this report was published, the Wisconsin PEB was awarded federal funding through the Harold Rogers Prescription Drug Monitoring Program, which is an initiative of the Office of Justice Programs, Bureau of Justice Assistance.

At its root, substance abuse is a local issue, and locally implemented community education campaigns such as Good Drugs Gone Bad can be launched by local anti-drug coalitions and other community groups at little or no cost. In addition, the health care community must recognize the severity of the prescription drug epidemic and provide staff development and continuing medical education opportunities so that prescribers are better equipped to recognize drug seeking behavior and to identify patients at risk of developing substance use disorders. Key stakeholders must work together to identify local trends and issues and to coordinate efforts.

Wisconsin is making strides in establishing permanent drop off locations for prescription drug disposal, and the number of Wisconsin communities participating in national and state prescription "take back" events, such as those sponsored by the DEA, is increasing. Despite these efforts, there are an inadequate number of venues for consumers to properly dispose of unwanted and unused prescription medications. Wisconsin should establish a coordinated, statewide system of prescription medication disposal, and look to the Wisconsin PWWG for leadership in this initiative.

Consumers should monitor prescription medications in the home and properly dispose of unwanted and unused medications. Additionally, we must all examine our own behaviors and patterns, especially related to consuming pain medications. While it is acknowledged that legal opiates have legitimate medical purposes, there is simply no question that as a state and a nation, we consume an extraordinarily large amount of prescription narcotics.

Controlled Substances Workgroup Recommendation Summary

Priority Area: Fostering Healthy Youth

RECOMMENDATION 1: Support communities to foster healthy youth.

Priority Area: Community Engagement and Education

RECOMMENDATION 2: Launch a public outreach and education campaign.

RECOMMENDATION 3: Support community coalitions as the vehicle through which communities will successfully prevent and reduce prescription drug diversion, abuse and overdose deaths.

Priority Area: Health Care Policy and Practice

RECOMMENDATION 4: Mandate education and training for health care professionals.

RECOMMENDATION 5: Ensure that chronic pain sufferers have safe and consistent access to care.

RECOMMENDATION 6: Establish standard prescribing practices for urgent care and emergency departments.

RECOMMENDATION 7: Develop standard screening methodologies for drug-testing labs to use in detecting the presence of drugs to include all commonly misused opioids, benzodiazapines, psychostimulants, and related agents, and ensure that drug-testing methodologies used in clinical settings and in post-mortem settings (including the State Crime Lab system) are aligned in order to generate the most consistent and useful data.

RECOMMENDATION 8: Develop a standard set of treatment protocols for Opioid Treatment Programs (OTPs).

RECOMMENDATION 9: Establish guidelines to reduce the diversion of prescription drugs by those who handle prescription medications in the course of their daily work.

RECOMMENDATION 10: Equip healthcare providers and first responders to recognize and manage overdoses.

RECOMMENDATION 11: The Wisconsin Dental Association and Wisconsin Dental Examining Board should endorse the findings of the Tufts Health Care Institute Program on Opioid Risk Management and the School of Dental Medicine, Tufts University.

Priority Area: Prescription Medication Distribution

RECOMMENDATION 12: Convene a workgroup to develop recommendations to increase security measures in the dispensing of prescriptions for controlled substances.

RECOMMENDATION 13: Implement a system to ensure that, for controlled substance prescriptions, patients are identified in a manner similar to picture identification as required to obtain pseudoeffedrine.

RECOMMENDATION 14: Support a system that increases security and traceability of controlled substances from manufacturer to patient.

Priority Area: Prescription Medication Disposal

RECOMMENDATION 15: Establish a coordinated statewide system for providing secure, convenient disposal of consumer medications from households.

RECOMMENDATION 16: Integrate medication collection with the Wisconsin Drug Repository.

RECOMMENDATION 17: Create an infrastructure for the destruction of drugs in compliance with state and federal environmental regulations.

Controlled Substances Workgroup Recommendation Summary (continued)

RECOMMENDATION 18: Identify the causes for prescription drug waste and implement proactive solutions.

RECOMMENDATION 19: Identify sustainable means for funding collection and disposal in cooperation with key stakeholders including pharmaceutical producers, local governments, law enforcement, waste management companies, health care providers, pharmacies and consumers.

RECOMMENDATION 20: Establish a system for effective disposal of consumer medications in all care programs and facilities which complies with state and federal waste management laws.

RECOMMENDATION 21: Establish regulations that would permit registered nurses, employed by home health agencies and hospices, to transport unused medications, including controlled substances, to designated drug drop-off and disposal facilities, so that when patient medications are no longer needed, such nurses are allowed by law to assist in their safe destruction.

Priority Area: law Enforcement and Criminal Justice

RECOMMENDATION 22: Build bridges between law enforcement and community-based prevention efforts.

RECOMMENDATION 23: Make drugged driving a priority issue.

RECOMMENDATION 24: Support drug courts.

Priority Area: Surveillance System

RECOMMENDATION 25: Design and implement an electronic Prescription Drug Monitoring Program (PDMP).

RECOMMENDATION 26: Develop a community early warning and monitoring system that tracks use and problem indicators at the local level.

RECOMMENDATION 27: Develop a community monitoring and early warning and monitoring system that tracks overdoses at the local level.

RECOMMENDATION 28: Improve consistency in reporting drug use and abuse across the state.

Priority Area: Early Intervention, Treatment & Recovery Across Lifespan

RECOMMENDATION 29: Establish guidelines to screen for substance use in all health care settings.

RECOMMENDATION 30: Promote and support evidence-based screening and early intervention for mental health and substance abuse.

RECOMMENDATION 31: Integrate high quality medication management and psychosocial interventions for substance use disorders so that both are available to consumers as their conditions indicate.

RECOMMENDATION 32: Make addiction treatment and recovery support services available both on a stand-alone basis and on an integrated basis with primary health care services, as well as in other relevant community settings.

Frequently Used Acronyms

AWY – Alliance for Wisconsin Youth
BRFSS – Behavioral Risk Factor Surveillance System
CADCA – Community Anti-Drug Coalitions of America
CDC – Center for Disease Control and Prevention
CSW – Controlled Substances Workgroup
DEA – Drug Enforcement Agency
DHS – Department of Health Services
DITEP – Drug Information for Teachers and Educational Professionals
DOT – Department of Transportation
DPI – Department of Public instruction
DRE – Drugged Recognition Expert
FDA – Food and Drug Administration
IOM – Institute of Medicine
NADCP – National Association of Drug Court Professionals
NIDA – National Institute on Drug Abuse
NSDUH – National Survey on Drug Use and Health
ONDCP – Office of National Drug Control Policy
OTP – Opioid treatment Program
OWI – Operating While Intoxicated
PDMP – Prescription Drug Monitoring Program
PEB – Pharmacy Examining Board
PWWG – Pharmaceutical Waste Working Group
SAMHSA – Substance Abuse and Mental Health Services Administration
SBIRT – Screening, Brief Intervention, and Referral to Treatment
SCAODA – State Council on Alcohol and Other Drug Abuse
SPF – Strategic Prevention Framework
WSLH – Wisconsin State Laboratory of Hygiene
YRBS – Youth Risk Behavior Survey

Definitions

Abuse: Any use of an illegal drug or the intentional self-administration of a medication for a nonmedical purpose such as altering one's state of consciousness (for example, "getting high"). Both misuse and abuse are dangerous and can be harmful – even life threatening.

Addiction: A primary, chronic, neurobiological disease, with genetic, psychosocial and environmental factors influencing its development and manifestations; it is characterized by behaviors that include impaired control over drug use, compulsive use, continued use despite harm and craving or a combination of these. Addiction can be viewed as a continued involvement with a substance or activity despite the negative consequences associated with it. Pleasure and enjoyment would have originally been sought, however over a period of time involvement with the substance or activity is needed to feel normal.

Controlled Prescription Drug: A drug or chemical substance whose possession and use are regulated under the Controlled Substances Act (1970), which regulates the prescribing and dispensing, as well as the manufacturing, storage, sale, or distribution of substances assigned to five schedules according to their 1) potential for or evidence of abuse, 2) potential for psychic or physiologic dependence, 3) contribution to a public health risk, 4) harmful pharmacologic effect, or 5) role as a precursor of other controlled substances.

Controlled Substances Act: The Controlled Substances Act (CSA) was enacted into law by the Congress of the United States as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970. The CSA is the federal U.S. drug policy under which the manufacture, importation, possession, use and distribution of certain substances is regulated. The legislation created five Schedules (classifications), with varying qualifications for a substance to be included in each. Two federal agencies, the Drug Enforcement Administration and the Food and Drug Administration, determine which substances are added to or removed from the various schedules.

Drug Diversion: In the terminology of the United States Drug Enforcement Administration, diversion is the use of prescription drugs for recreational purposes. The term comes from the "diverting" of the drugs from their original purposes.

Drug Scheduling: The drugs and other substances that are considered controlled substances under the CSA are divided into five schedules. A listing of the substances and their schedules is found in the DEA regulations, 21 C.F.R. Sections 1308.11 through 1308.15. A controlled substance is placed in its respective schedule based on whether it has a currently accepted medical use in treatment in the United States and its relative abuse potential and likelihood of causing dependence. Some examples of controlled substances in each schedule are outlined below.

NOTE: Drugs listed in schedule I have no currently accepted medical use in treatment in the United States and, therefore, may not be prescribed, administered, or dispensed for medical use. In contrast, drugs listed in schedules II-V have some accepted medical use and may be prescribed, administered, or dispensed for medical use.

Schedule I Controlled Substances

Substances in this schedule have a high potential for abuse, have no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of the drug or other substance under medical supervision. Some examples of substances listed in schedule I are: heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxymethamphetamine ("ecstasy").

Schedule II Controlled Substances

Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence. Examples of single entity schedule II narcotics include morphine and opium.

Definitions (continued)

Schedule II Controlled Substances (continued)

Other schedule II narcotic substances and their common name brand products include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®), and fentanyl (Sublimaze® or Duragesic®). Examples of schedule II stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®). Other schedule II substances include: cocaine, amobarbital, glutethimide, and pentobarbital.

Schedule III Controlled Substances

Substances in this schedule have a potential for abuse less than substances in schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence. Examples of schedule III narcotics include combination products containing less than 15 milligrams of hydrocodone per dosage unit (Vicodin®) and products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with codeine®). Also included are buprenorphine products (Suboxone® and Subutex®) used to treat opioid addiction. Examples of schedule III non-narcotics include benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as oxandrolone (Oxandrin®).

Schedule IV Controlled Substances

Substances in this schedule have a low potential for abuse relative to substances in schedule III. An example of a schedule IV narcotic is propoxyphene (Darvon® and Darvocet-N 100®). Other schedule IV substances include: alprazolam (Xanax®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

Schedule V Controlled Substances

Substances in this schedule have a low potential for abuse relative to substances listed in schedule IV and consist primarily of preparations containing limited quantities of certain narcotics. These are generally used for antitussive, antidiarrheal, and analgesic purposes. Examples include cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC® and Phenergan with Codeine®).

Drug Misuse: Use of a medication (prescribed for a medical purpose) other than as directed or as indicated whether willfully or unintentionally and whether or not harm results.

Prevention: The group has discussed a number of definitions for prevention, but in terms of this work group, there is no single definition that is applicable. Ideally, this group seeks to prevent initiation of drug use, but at the other end of the spectrum, this work group seeks to prevent drug related overdose and deaths.

Opiate: In medicine, the term opiate describes any of the narcotic opioid alkaloids found as natural products in the opium poppy plant, as well as many semi-synthetic chemical derivatives of such alkaloids. In the traditional sense, *opiate* has referred to not only the alkaloids in opium but also the natural and semi-synthetic derivatives of opium. The term is often incorrectly used to refer to all drugs with opium- or morphine-like pharmacological action, which are more properly classified under the broader terms *opioid*.

Opioid: Any morphine-like synthetic or non-synthetic narcotic that produces the same effects as drugs derived from the opium poppy (opiates), such as pain relief, sedation, constipation and respiratory depression.

Product Stewardship: Product stewardship is a policy that ensures that all those involved in the lifecycle of a product share responsibility for reducing its health and environmental impacts, with producers bearing primary financial responsibility.

Extended Producer Responsibility: Extended Producer Responsibility (EPR), a central tenet of product stewardship, is a policy approach in which the producer's responsibility for their product extends to the post-consumer management of that product and its packaging.

Appendices

Appendix A: National Registry of EBPP

Evidence-Based Program Registries

Revised August 2009

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A RESOURCE FROM *WHAT WORKS, WISCONSIN*

The following websites contain registries, or lists of evidence-based programs that have met specific criteria for effectiveness. Program registries are typically sponsored by federal agencies or other research organizations that endorse programs at different rating levels based on evidence of effectiveness for certain participant outcomes. The registries listed below cover a range of areas including substance abuse and violence prevention as well as the promotion of positive outcomes such as school success and emotional and social competence. Generally, registries are designed to be used for finding programs for implementation. However, registries can also be used to learn about evidence-based programs that may serve as models as organizations modify aspects of their own programs.

Best Practices Registry for Suicide Prevention

http://www.sprc.org/featured_resources/ebpp/index.asp

This registry, developed by the Suicide Prevention Resource Center (SPRC) and the American Foundation for Suicide Prevention, includes two registries of evidence-based programs. The first draws directly from a larger registry- that of the Substance Abuse and Mental Health Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP). Users interested in finding out more about programs drawn from this registry will be directed to the NREPP site. The second registry was developed by SPRC in 2005 and lists Effective and Promising evidence-based programs for suicide prevention. This portion has fact sheets in PDF format for users interested in learning more about the listed programs.

California Child Welfare Clearinghouse

http://www.cachildwelfareclearinghouse.org/

This is a program listing designed to inform the California child welfare community of research evidence for specific child welfare related programs. The registry programs can be accessed by a complete program listing or by child welfare related topic areas. The programs listed by topic area are all the recommendations of experts in that particular topic area. The programs are rated on a scale of one to five for strength of research evidence and a scale of one to three for child welfare relevance, where the number one indicates the highest rating.

Appendix A:
National Registry of EBPP (continued)

Center for the Study and Prevention of Violence, Blueprints for Violence Prevention

http://www.colorado.edu/cspv/blueprints/index.html

This research center site provides information on model programs in its "Blueprints" section. Programs that meet a strict scientific standard of program effectiveness are listed. These model programs (Blueprints) have demonstrated their effectiveness in reducing adolescent violent crime, aggression, delinquency, and substance abuse. Other programs have been identified as promising programs. Endorsements are updated regularly, with programs added to and excluded from the registry based on new evaluation findings.

The Collaborative for Academic, Social, and Emotional Learning (CASEL)

http://www.casel.org/programs/selecting.php

The *Safe and Sound* report developed at CASEL lists school-based programs that research has indicated are effective in promoting social and emotional learning in schools. This type of learning has been shown to contribute to positive youth development, academic achievement, healthy behaviors, and reductions in youth problem behaviors. Ratings are given on specific criteria for all programs listed, with some designated "Select" programs. This registry has not been updated since programs were reviewed in 2003.

Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs

http://www.ed.gov/admins/lead/safety/exemplary01/index.html

The Department of Education and the Expert Panel on Safe, Disciplined and Drug-Free Schools identified nine exemplary and 33 promising programs for this 2001 report. The report, which can be found at this site, provides descriptions and contact information for each program. The focus is on programs that can be implemented in a school setting whether in the classroom, in extracurricular activities, or as after-school programming.

Helping America's Youth

http://www.findyouthinfo.gov/ContentPage.aspx?cpid=55

This registry is sponsored by the White House and was developed with the help of several federal agencies. Programs focus on a range of youth outcomes such as academic achievement, substance use, and delinquency, and are categorized as Level 1, Level 2, or Level 3 according to their demonstrated effectiveness. The registry can be searched with keywords or by risk or protective factor, and is updated regularly to incorporate new evidence-based programs.

Northeast Center for the Application of Prevention Technology (CAPT) Database of Prevention Programs

http://www.hhd.org/search/node/

This site features a simple or advanced search function to find substance abuse and other types of prevention programs and determine their effectiveness according to a variety of criteria. Also

Appendix A:
National Registry of EBPP (continued)

included is information about the sources those agencies used for their evaluations, contact information, websites, domains, relevant references, and a brief description of each program.

Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide

http://ojjdp.ncjrs.org/programs/mpg.html

The OJJDP Model Programs Guide is a user-friendly, online portal to prevention and intervention programs that address a range of issues across the juvenile justice spectrum. The Guide now profiles more than 200 programs - rated Exemplary, Effective, or Promising - and helps communities identify those that best suit their needs. Users can search the Guide's database by program category, target population, risk and protective factors, effectiveness rating, and other parameters. This registry is continuously updated and contains more programs than other well-known registries, although many of these are Promising rather than Exemplary or Effective.

Promising Practices Network on Children, Families and Communities

http://www.promisingpractices.net/programs.asp

A project of the RAND Corporation, the Promising Practices Network website contains a registry of Proven and Promising prevention programs that research has shown to be effective for a variety of outcomes. These programs are generally focused on children, adolescents, and families. The website provides a thorough summary of each program and is updated regularly.

Social Programs that Work, Coalition for Evidenced-Based Policy

http://www.evidencebasedprograms.org/

This site is not a registry in the conventional sense of the word in that it does not include and exclude programs based on some criteria of effectiveness. Instead, it summarizes the findings from rigorous evaluations of programs targeting issues such as employment, substance use, teen pregnancy, and education. Some of the programs have substantial evidence of their effectiveness, while others have evaluation results suggesting their ineffectiveness. Users are welcome to sign up for emails announcing when the site is updated.

Strengthening America's Families: Effective Family Programs for Prevention of Delinquency

http://www.strengtheningfamilies.org/

This registry summarizes and rates family strengthening programs which have been proven to be effective. Programs are designated as Exemplary I, Exemplary II, Model, or Promising based upon the degree, quality and outcomes of research associated with them. A program matrix is also included, which can be helpful in determining "at a glance" which programs may best meet community needs. This registry was last revised in 1999.

Appendix A:
National Registry of EBPP (continued)

Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices

http://nrepp.samhsa.gov/

The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable database with up-to-date, reliable information on the scientific basis and practicality of interventions. Rather than categorizing programs as Model, Effective, or Promising, NREPP rates the quality of the research findings separately for each outcome that has been evaluated, as well as readiness for dissemination. Users can perform customized searches to identify specific interventions based upon desired outcomes, target populations and settings.

Youth Violence: A Report of the Surgeon General

http://www.surgeongeneral.gov/library/youthviolence/chapter5/sec3.html

This report designates programs as Model or Promising and goes further than many other registries to also include a "Does Not Work" category. General approaches and specific programs for the prevention of youth violence are described at three levels of intervention: primary, secondary and tertiary. This report has not been updated since its publication in 2001, but it is rare in that it discusses the cost-effectiveness of the programs.

What Works Wisconsin: Evidence-based Parenting Program Directory

http://whatworks.uwex.edu/Pages/2parentsinprogrameb.html

This directory provides an overview of currently available evidence-based parenting programs, a subset of the larger body of evidence-based programs. It is intended to serve the needs of parent educators, family practitioners, program planners and others looking for effective programs to implement with parents and families. The directory is divided into three sections: section one focuses on parenting education/training for parents of children within a single age range; programs in section two include options for parenting education/training across multiple age ranges; and section three consists of multiple-component programs where one of the components is parenting education.

WHAT WORKS, WISCONSIN

This is one of a series of resources on effective prevention and intervention programs for children, youth, and families prepared by the *What Works, Wisconsin* team at the University of Wisconsin–Madison, School of Human Ecology, and Cooperative Extension, University of Wisconsin–Extension. All of the resources can be downloaded from: http://whatworks.uwex.edu/.

Appendix B:
Strategic Prevention Framework

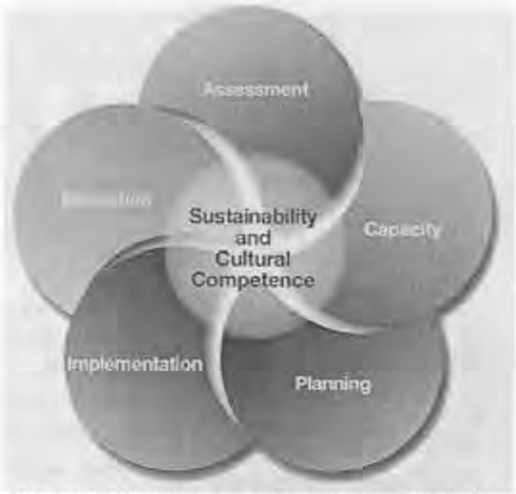
The Strategic Prevention Framework (SPF) developed by the Substance Abuse Mental Health Services Administration (SAMHSA) asserts that to be effective, communities must move away from the traditional approaches that are designed to affect individuals or families to focus on impacting the larger community through the implementation of comprehensive strategies to achieve population level change.

SPF is a systemic community-based approach, that works to ensure that substance abuse prevention programs can and do produce results. SPF involves five steps: assessment, capacity, planning, implementation and evaluation; and two key elements: sustainability and cultural competence which are designed to be incorporated into every step. The five steps and two overarching elements are designed to lead coalitions through the process of developing an effective coalition infrastructure, conduct a comprehensive assessment of local conditions that are leading to the issues related to substance abuse, develop and implement a comprehensive plan, and evaluate the process and the outcomes. A brief overview of each of the SPF steps and elements is provided below:

Assessment: Coalitions undertake a process to gather both qualitative and quantitative data related to substance abuse in the community. To accomplish this, a coalition identifies the geographical boundary they want to work within, decide what substance or issue they want to assess, gather enough data to determine the root causes and local conditions, and the level of community readiness to address the issue.

Capacity: This refers to the ongoing process of identifying the key community decision makers and stake holders who need to be involved in the efforts, mobilizing them to take action, and taking steps to ensure that everyone is on the same page and that the coalition is well structured and running efficiently.

Planning: Upon completion of a comprehensive assessment, coalitions develop a logical, thoughtful plan that is designed to address the root causes and local conditions that are leading to the substance abuse problems. Plans include a logic model, a strategic plan that identifies short and long-term objectives, and a work plan that details tasks, responsible persons and required resources.



Implementation: Following the development of a well designed plan, the coalition puts the plan to work making sure to involve every member of the coalition, leveraging the unique skills that each member brings to the table.

Evaluation: Evaluation helps a coalition plan programs and strategies, monitor their implementation, and ultimately, provide information that will enable the coalition to make adjustments where necessary to improve results. Evaluation is taken into account in every step of the SPF process.

Sustainability: Sustainability goes beyond funding to include human and social resources. It involves focusing attention on organizational structures and relationships that need to be maintained in order to provide effective prevention policies, practices and programs. Sustainability also means maintaining outcomes over time. Sustainability is taken into account in every step of the SPF process.

Cultural Competence: Communities include many different cultures. Even specific cultures may have important intergroup differences. Therefore, to be successful, coalitions need to identify, learn about and include members of the different cultures that exist in their communities. In this way, a coalition's vision can better reflect the diverse perspectives of how the coalition would like the community to look in the future. Cultural competence is taken into account in every step of the SPF process.

Appendix C:
Good Drugs Gone Bad Fact Sheet

Fact Sheet

A program to combat prescription drug abuse

Fact Sheet updated
November 7,2011

What have we done?

Delivered message to over 600 students!

Delevered message to over 2,300 adults!

Presented to groups such as:

- **WI Coroners & Medical Examiners Association**
- **WI Crime Prevention Practitioners Association**
- **WI Social Services Associaiton**
- **National Multi-Jurisdictional Conference**
- **WI Prevention Network**

Distributed over 300 toolkits at train-the-trainer sessions

- **Oshkosh, WI 2010**
- **LaCrosse, WI 2010**
- **Eagle River, WI 2011**
- **Whitewater, WI 2011**

Implemented pharmaceutical disposal boxes at police departments in Oshkosh and Neenah, WI.

Epidemic

When people speak of drug abuse, one immediately thinks of drugs such as marijuana and cocaine. However, people rarely think of the common drugs found in their homes and medicine cabinets. These pharmaceuticals are typically used for medicinal or "good" purposes; however we are starting to see an alarming trend of abuse of this medicine which has resulted in an increase in crimes, hospitalizations and even death.

- Illegally diverted pharmaceuticals are considered a top threat in the Fox Cities.
- Thefts, burglaries, robberies, even homicides have been attributed to prescription drug abuse.
- 24% of Winnebago County high school students have taken a prescription drug to get high without a doctors prescription.

Response

Law enforcement officials, health care workers, judicial system staff , coalition representatives, and parents have collaborated with state and national organizations to develop the Good Drugs Gone Bad Toolkit to decrease the harm caused by prescription drug abuse. The Toolkit provides resources and materials to reach target audiences including: youth, adults, senior citizens and health care professionals.

Get Involved

Is there a prescription drug abuse concern in your community? Use the Good Drugs Gone Bad Toolkit to reach targeted audiences with:

- Presentations
- Videos
- Handouts
- Public Service Announcements

Ongoing Prevention Efforts

The Good Drugs Gone Bad Toolkit is part of a statewide effort that supports the prevention of prescription drug abuse. In addition, the coalition continues to evaluate and update the toolkit.

For More Information or to Request a Copy of the Good Drugs Gone Bad Toolkit, contact:

Jason Weber, Town of Menasha Police, 920-720-7109
OR
Lisa Brown, re:THINK, Winnebago's Healthy Living Partnership, 920-232-3009

Appendix D:
Eight Strategies for Effective Community Change*

1) **Providing Information –**

Educational workshops or dissemination of information via other sources and other venues. This can also include a public awareness or education campaign.

2) **Enhancing Skills –**

Workshops, programs or other activities designed to develop skills and competencies among youth, parents, teachers, and/or families to prevent substance abuse.

3) **Providing Support –**

Creating opportunities to support people to participate in activities that reduce risk, enhance protection, and prevent substance abuse.

4) **Enhancing Access/Reducing Barriers –**

Improving systems and processes to increase the ease, ability, and opportunity to utilize those systems and services.

NOTE- This strategy also can be reversed to **Reducing Access/Enhancing Barrier**s. Prevention science tells us that when more resources (money, time, etc.) are required to obtain a substance, use declines. So, when community coalitions establish barriers to underage drinking or other illegal drug use, they decrease its accessibility and so reduce use.

5) **Changing Consequences –**

Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior.

6) **Physical Design –**

Changing the physical design or structure of the environment (e.g., parks, landscapes, signage, lighting, outlet density) to reduce risk or enhance protection.

7) **Modifying/Changing Policies –**

Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures, public policy actions, systems change within government, communities and organizations.

8) **Strengthening Coalitions –**

How the coalition manages and mobilizes its relations and other resources in order to collaboratively conduct the strategies needed to prevent substance abuse in their communities.

* Adapted from
http://coalitioninstitute.org/SPF_Elements/Implementation/SevenStrategies4CommunityChange.pdf

Appendix E:
Sample Emergency Room Opioid Policy

The following outlines Bay Area Hospital's Emergency Room policy for the prescription of narcotic and similarly regulated medications.

The Emergency Department provides evaluation and treatment for persons presenting with a wide variety of acute medical conditions including complaints associated with varying degrees and acuity of pain that sometimes requiring the prescription of a short course of narcotic pain medication and other similar, highly regulated medications. However, this prescriptive ability needs to be balanced by societal and regulatory concerns that these restricted and potentially highly addictive medications will be diverted or otherwise misused. It is beyond the scope and abilities of the ER setting and the scope of practice of the ER physician, to prescribe narcotics for chronic pain conditions or recurrent ER visits for recurrent, non-malignant pain.

Objective:

To provide guidance on appropriate provision, and subsequent prescription, of narcotic pain medications to patients being treated in and discharged from the Emergency Room.

Procedure:

1. Every patient who presents to the emergency room will be evaluated and treated appropriately based on their presenting complaint and screening medical examination.
2. If after a medical screening examination, a person is found not to have an emergency medical condition warranting narcotic analgesia, then only non-narcotic pain treatments will be prescribed.
3. The following situations are examples of non-emergency conditions for which narcotic analgesia will not be prescribed :

   A. The ER physician will not prescribe narcotic analgesia to patients with chronic pain conditions requesting refills.

      1) It is a patient's responsibility to maintain active prescriptions with his or her primary care physician, specialty physician, or pain specialist.

      2) The ER cannot refill prescriptions that have run out or otherwise lapsed.

      3) Patients with chronic pain conditions may receive non-narcotic pain medications and other non-narcotic treatment modalities as appropriate.

   B The ER physician will not prescribe narcotic analgesia for patients whose narcotic pain medications have been lost or stolen, even if the patient has documentation from legal authorities.

   C. Patients who have frequent, multiple visits to the ER with recurrent complaints of painful conditions will be considered to have a chronic pain syndrome, and once identified as having such, will no longer receive narcotic pain medications.

      1) These painful conditions include (but are not limited to) recurrent headaches, back pain, dental pain, pelvic pain, and fibromyalgia. Patients with these conditions may receive non-narcotic pain medications and other non-narcotic treatment modalities as appropriate.

Appendix E:
Sample Emergency Room Opioid Policy (continued)

4. Pain contracts: The ER physician may provide acute pain treatment to a patient with a chronic condition if that person has an established pain contract, available to the ER physician, specifying ER treatment for episodic exacerbations of severe pain not responding to appropriate outpatient therapies. The conditions and appropriate use of a pain contract will be monitored by both the primary care provider and the emergency room.

5. Any patient treated in the ER with an oral or injected narcotic or sedative will be required to have a driver present before being discharged home.

6. Any narcotic prescription given for an acute painful condition at the time of discharge from the ER will be limited to a small quantity intended to last only until the patient can reasonably follow up with a non-emergency room provider or to cover a painful condition which is by nature self-limited and temporary.

7. This policy in no way supersedes the clinical judgment of the emergency room physician in deciding appropriate care and treatment of persons presenting to the ER.

Appendix F: Key Elements and Vision of Pharmaceutical Collection and Disposal Programs: A Vision for the Great Lakes Region

Key Elements of Pharmaceutical Collection and Disposal Programs: A Vision for the Great Lakes Region

Significant progress has been made to establish safe and secure medicine collection and disposal programs in the Great Lakes Region. These programs include collections through retail pharmacies, clinics, law enforcement agencies, and municipal facilities, as well as through mail-back programs. Due primarily to funding constraints, programs are unable to fully meet the needs of residents throughout the region. The following key elements of a model program were developed by local and state agencies, organizations, and other stakeholders, with the goal to expand effective pharmaceutical collection and disposal programs throughout the region.

- **Programs should protect public health and the environment** by maximizing prompt collection and proper disposal of unused pharmaceuticals, including controlled substances. To this end, programs should be:
  - **On-going.** Residents should have year-round access to safe disposal opportunities for pharmaceutical drugs, reducing the need for home storage.
  - **Convenient throughout the Great Lakes region.** Programs should be available to all residents throughout the Great Lakes region. Eventually, there should be ongoing collection sites in every county, and every town or city of a population of 5,000 or greater. Mail-in services can help to fill gaps.
  - **Set up to collect all types of pharmaceutical drugs.** To the extent feasible under state and federal regulations, programs should accept all types of pharmaceuticals from households.
  - **Secure.** All programs must be operated in a secure manner, and in compliance with all state and federal regulations. Security is critical to minimizing the risk of illegal diversion.
  - **Free at the point of delivery for disposal.** There should be no charge to the public when they deliver unwanted pharmaceutical drugs via a collection location or mail-in service.
  - **Widely promoted.** A high level of public awareness must be created about the importance of safely storing and promptly disposing unused medications through the program. Public education should be a shared responsibility of all key stakeholders including those who prescribe, dispense, and manufacture pharmaceuticals.

- **Programs should minimize the impact on the environment** by ensuring that collected medicines are destroyed in compliance with federal, state, and local regulations. When possible, all material collected should be destroyed through high temperature incineration, or with the best available technology, to minimize the risk of environmental contamination. To the extent possible, transportation of wastes should be minimized.

- **Programs should be sustainably and adequately funded** to ensure continued service and widespread public outreach. Those who benefit from the manufacture, sale, and use of pharmaceutical drugs have the greatest responsibility for ensuring program success. Pharmaceutical companies should fund the expansion of existing programs and/or the development of new ones. Other stakeholders, including state and local governments, pharmacies, and prescribers should partner with pharmaceutical companies to educate the public, provide collection services, and/or implement other activities consistent with their capabilities and mission.

- **Programs should also identify and address the underlying drivers that contribute to pharmaceutical waste.** Reducing the quantity of drugs that become waste not only reduces environmental and public health risks, it also has the potential to improve medical care and reduce medical costs for individuals and taxpayers through Medicare and Medicaid programs. It may also reduce costs for manufacturers, distributors and retail establishments.

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911 Good Samaritan Recommendations



Analysis and Recommendations for Reducing Drug-Related Overdoses in Wisconsin

August 2013

Wisconsin State Council on Alcohol and Other Drug Abuse
Prevention Committee
911 Good Samaritan Ad-hoc Committee

State of Wisconsin
State Council on Alcohol and Other Drug Abuse
1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

Table of Contents

Charge to the 911 Good Samaritan Ad-hoc Committee

There is growing evidence that drug overdose deaths are increasing nationally and in Wisconsin. The increasing number of deaths caused by heroin and opiates, prescription drugs like OxyContin®, Vicodin® and morphine, is a major concern. Poisoning deaths have surpassed vehicle crashes as the number one cause of accidental death in Dane County and two-thirds of these poisoning deaths are drug overdoses. In recognition of this growing problem, the Wisconsin State Council on Alcohol and Other Drug Abuse (SCAODA) established the 911Good Samaritan Ad-hoc Committee in January 2012. The Ad-hoc Committee was charged with researching and discussing the incidence of opiate overdoses in Wisconsin and 911 Good Samaritan Laws as a tool to reduce fatal overdoses. The Ad-hoc Committee will report out on their findings and develop recommendations to SCAODA for possible legislation as it relates to overdose prevention.

911 Good Samaritan Ad-hoc Committee Membership
(Listed alphabetically)

Randall Brown, MD
Center for Addictive Disorders, UW Hospitals and Clinics

Lisa Bullard-Cawthorne
Public Health – Madison & Dane County

Ruth Burich
AIDS Resource Center of Wisconsin

Barry Busby
Winnebago County Coroner

David Frazer
Center for Urban Population Health

Tanya Hiser
State Opioid Authority, Wisconsin Department of Health Services

Gloria Reyes
Madison Police Department

Rick Sandvig
AIDS Resource Center of Wisconsin

Brad Schimel
Waukesha County District Attorney's Office

David Spakowicz
Wisconsin Department of Justice

Scott Stokes (Co-Chair)
AIDS Resource Center of Wisconsin

Skye Tikkanen (Co-Chair)
Connections Counseling

Thomas Wright, MD
Roscrance Health Network

Committee Staff

Arlene Baker
Wisconsin Department of Health Services

Christine Niemuth
Wisconsin Department of Health Services

Louis L. Oppor
Wisconsin Department of Health Services

Mary Raina Zwadzich
Wisconsin Department of Health Services

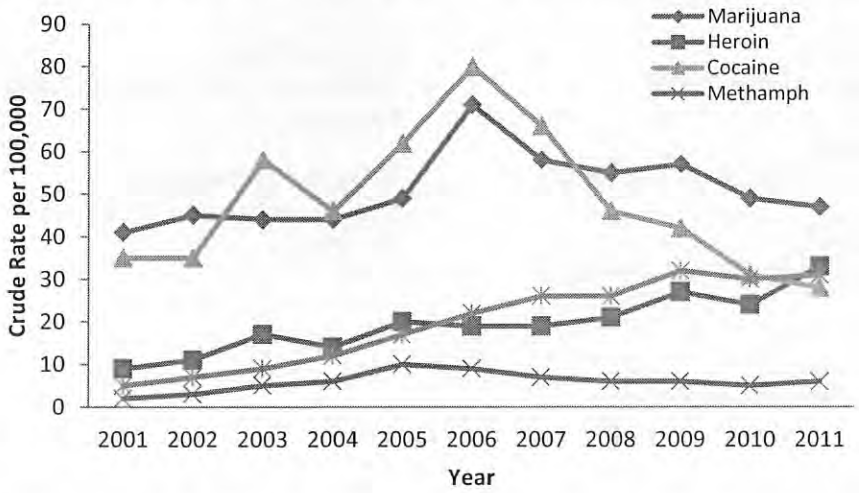
Background

Drug Overdose is a Major Public Health Problem

As stated in *Reducing Wisconsin's Prescription Drug Abuse: A Call to Action* (2012), Wisconsin has an alarmingly increasing problem with opiate use, with both prescription medications (pain relievers) and non-prescription (heroin and opium). This category of drugs is particularly dangerous, due to their highly addictive nature and abundant supply. The misuse of opiates leads to a variety of health consequences such as dependence or abuse, overdose and death. This is indicated by recent increases in the number of treatment admissions for opiate abuse (Figure 1), the number of hospital visits for opiate overdose (Figure 2) and the number of naloxone (Narcan®) administrations (Figure 3).

As a result of opiate misuse, there have been dramatic increases in repeated substance abuse treatment episodes and an increased need for funding treatment programs. Public-funded substance abuse treatment episodes in Wisconsin have continually increased since 2001 (Figure1). In addition, each year between 2001-2011, showed a 5-9% increase in admissions to Wisconsin opioid treatment programs, where methadone and Suboxone® are utilized to treat opiate and heroin addiction. In 2011, there were 5,203 people enrolled in 14 methadone clinics across the state.

Figure 1: Wisconsin Public-Funded Substance Abuse Treatment Episodes 2001-2011

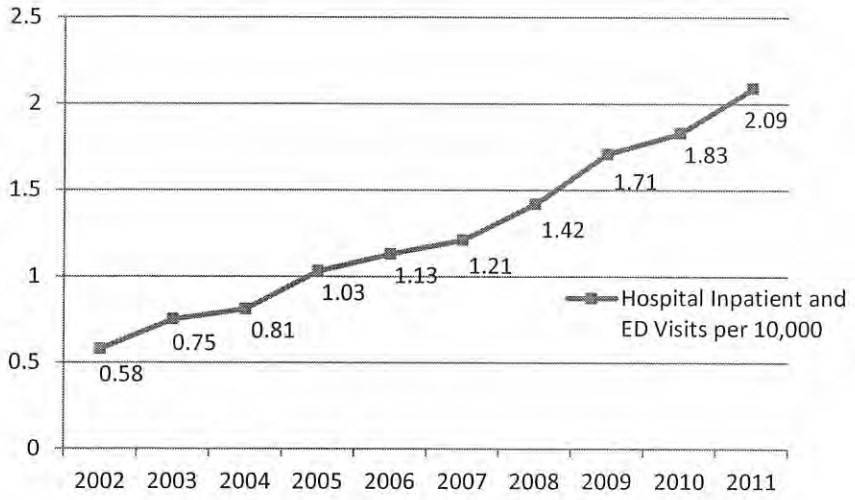


Source: Substance Abuse Mental Health Administration Treatment Episode Data Set (TEDS).

Throughout Wisconsin, opiate-related hospitalizations and response calls have increased in the last decade. In 2011, there were 246,833 drug-related hospital visits (inpatient and emergency department visits) in Wisconsin; 1,193 (2.1 hospital visits per 10,000) were for unintentional opiate-related poisoning (overdose) (Figure 2), and 11,298 (20 visits per 10,000) were for opiate dependence and non-dependent abuse.

Background (continued)

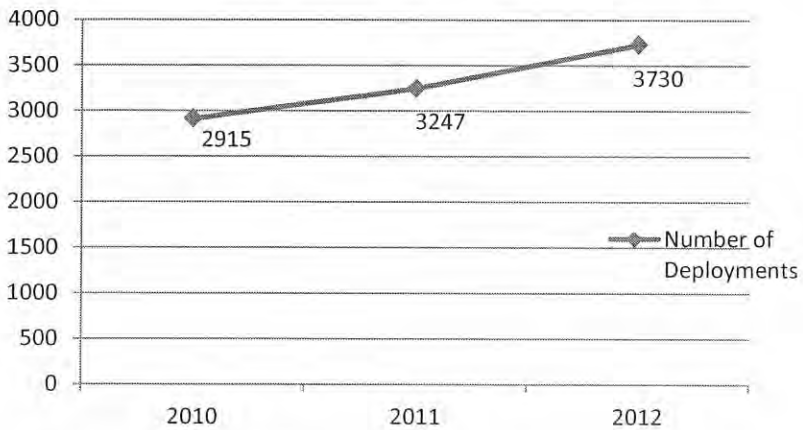
Figure 2: Unintentional Opiate Poisoning Hospitalizations & Emergency Department Visits per 10,000 people; Wisconsin, 2002-2011



Source: Wisconsin Department of Health Services, Hospital Patient Data System
Note: Figure does not include three VA Hospitals. Emergency department visit counts exclude those admitted as inpatients.

Since 2010, emergency medical services (EMS) across the state have seen an increased need to deploy naloxone for potential overdoses. There was a total increase of 815 deployments from 2010-2012 (Figure 3). It should be noted that this data is under reported and there may be some inaccuracies (e.g. some ambulance companies do not report into this system and county data from an ambulance company may include deployments from other counties).

Figure 3: Pre-Hospital Narcan® Deployments by Wisconsin EMS, 2010-2012



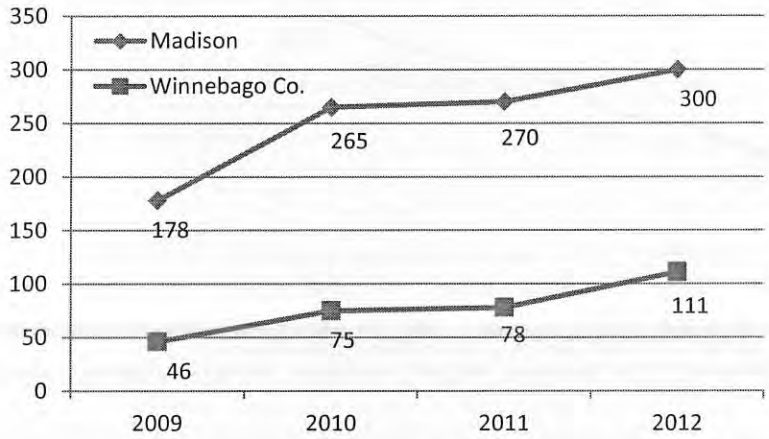
Source: Wisconsin Ambulance Run Data System

Background (continued)

Information provided by two local communities – Winnebago County and the City of Madison (located in Dane County), both indicate that EMS calls where naloxone was deployed for potential overdose increased at an alarming rate between 2009 and 2012 (Figure 4):

- EMS calls, where naloxone was deployed, in Winnebago County more than doubled from 46 in 2009 to 111 in 2012.
- Naloxone EMS calls in Madison, nearly doubled from 2009 (178) to 2012 (300).

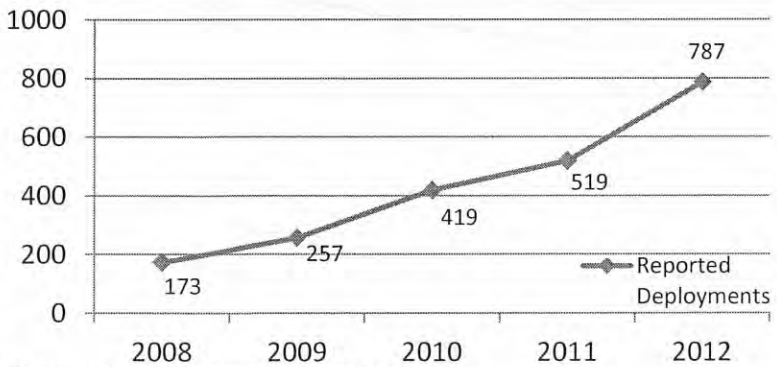
Figure 4: Naloxone Deployments by Madison and Winnebago County EMS, 2009-2012



Source: Madison Fire and EMS; Oshkosh Fire and Rescue & Gold Cross Ambulance (Winnebago Co. only).

There has also been an increase in the number of times naloxone has been administered by non-medical personnel in the community. The Lifepoint Fatal Overdose Prevention program began in 2005 through the AIDS Resource Center of Wisconsin (ARCW). This program has reported 2,158 lives saved across Wisconsin from 2005 through 2012 with the use of naloxone (Figure 5).

Figure 5: ARCW Lifepoint Program Reported Naloxone Deployments, 2008-2012



Source: AIDS Resource Center of Wisconsin Lifepoint Program

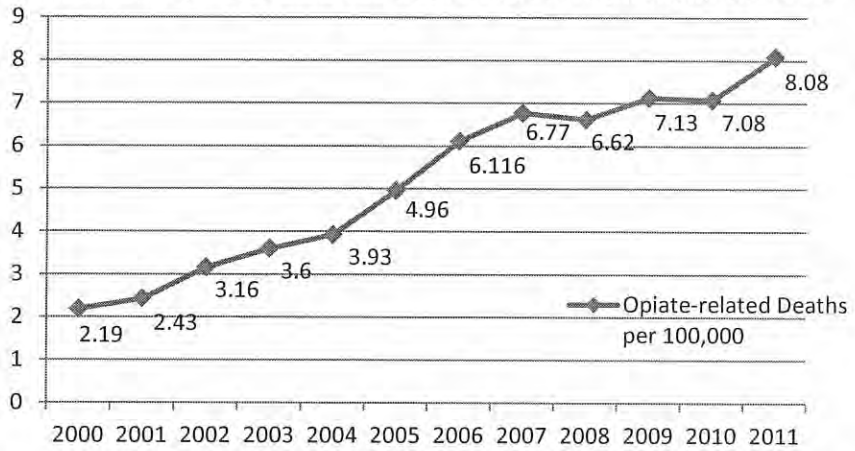
Background (continued)

A Dane County overdose survey (Public Health – Madison & Dane County, 2013) indicated how common opiate overdoses are in the community:

- One hundred sixty-five, or 33%, of over 500 current and past drug users surveyed reported that they had a personal overdose experience.
- Seven hundred and eighty-three, or 75%, of over 1,000 survey respondents (Dane County law enforcement, EMS and current/past drug users) reported that they had witnessed an overdose.

Drug overdose fatalities, in particular those due to opioid medications, have continued to increase nationally. In Wisconsin, drug-related deaths in which heroin or other opioids were mentioned on the death certificate increased between 2000 and 2011 (Figure 6).

Figure 6: Wisconsin Opiate-related Deaths per 100,000 Population, 2000-2011



Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics: Hospital Patient Data System
Note: Includes all deaths to Wisconsin residents or occurring in Wisconsin

In 2011, there were 711 drug-related deaths in Wisconsin (1.4% of all deaths); 65% of these deaths were opiate-related.

Increases in drug overdose deaths, particularly due to opiates, were also seen at the local county level. In Dane County, there were 14 opiate-related deaths (3.3 per 100,000) in 2000 and 45 opiate-related deaths (9.2 per 100,000) in 2010. In Winnebago County, drug overdose deaths ranged from 13-17 (9.1 per 100,000) between 2008 and 2010. However, in 2011 and 2012, the number of drug overdose deaths increased to 25-27 (14.9 per 100,000) – the majority of which were opiate-related[1].

[1] Note: Dane County and Winnebago County data is reported due to its availability to the Ad-hoc Committee. Given the overall statewide increases in opiate-related overdose deaths, other counties are likely to have experienced increases as well.

Background (continued)

Drug Overdose Deaths are Preventable

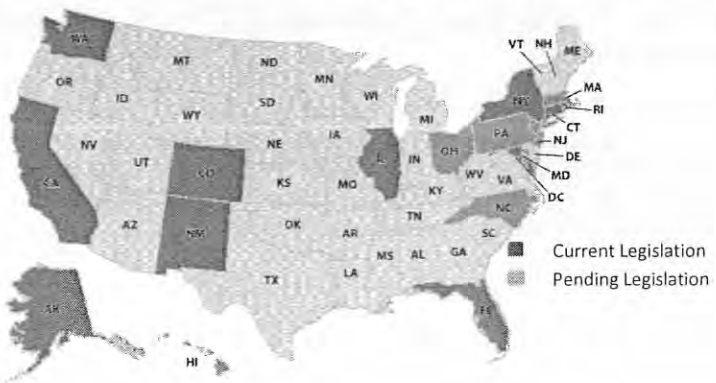
The majority of overdose deaths occur within one to three hours after the individual has taken an opiate and most of these deaths occur in the presence of others (Davidson et al., 2003). This situation gives a significant amount of time for witnesses to the overdose to intervene and call for medical assistance. Unfortunately, fear of arrest and prosecution, as well as the stigma attached to drug use, prevent many witnesses from calling 911 and summoning emergency medical assistance. If these barriers were removed, countless lives could be saved, offering survivors the opportunity for recovery.

States Have Responded by Passing 911 Good Samaritan Laws

Currently, according to Wisconsin law, in an emergency situation an individual who, in good faith, provides emergency care to an individual facing a possible fatal overdose is not protected from prosecution in criminal court. A 911 Good Samaritan Law could change this. A 911 Good Samaritan Law could assure in the event of an overdose, that an individual(s) providing emergency care and the individuals(s) receiving emergency care are granted limited immunity from criminal prosecution. The care is defined as the action of administering naloxone (or another opiate antagonist), and/or calling 911, and/or transporting the overdosing individual to a medical facility. Limited immunity from criminal prosecution covers only possession of drugs at the scene of the overdose or administration of a drug that reduces the effects of the overdosing opiate (naloxone).

Nationally, many states have either enacted or are currently developing 911 Good Samaritan legislation. At this time, thirteen states have some form of legislation with limited immunity from arrest or prosecution for people who call 911 in an overdose situation (Figure 7). These states are; Alaska, California, Colorado, Connecticut, Florida, Illinois, Maryland, Massachusetts, New Mexico, New York, North Carolina, Rhode Island and Washington. Similar measures are also pending in other states including; Hawaii, New Jersey, Ohio, Pennsylvania and the District of Columbia.

Figure 7: Good Samaritan Legislation and Pending Legislation, United States - 2013



Background (continued)

Washington State passed a 911 Good Samaritan Drug Overdose Law in 2010. An initial evaluation by Banta-Green, Kuszler, Coffin & Schoeppe (2011) indicated the following:

- Opiate overdoses were common:
  - 42% of opiate users and 62% of Seattle police reported being present at the scene of a serious opiate overdose in the prior year.
- 911 Good Samaritan Drug Overdose Law had impact on planned behavior:
  - 88% of opiate users indicated that they were aware of the law and would be more likely to call 911 during future overdoses.
- The 911 Good Samaritan Drug Overdose Law made the existing informal law enforcement policy, (most police were not arresting people who called 911 for possession) into formalized state law.
- Despite lingering concerns about possible negative consequences of the new law, no evidence of negative consequences has been found to date.

In addition to state-level legislation, a growing number of national and state-based organizations support 911 Good Samaritan laws to prevent overdose deaths and increase access to emergency medical assistance. In 2008, the U.S. Conference of Mayors passed a resolution calling for a comprehensive approach to overdose prevention, including the passage of 911 Good Samaritan laws.

Executive Summary

The misuse of opiates, both prescription (pain relievers) and non-prescription (heroin and opium) lead to a variety of health consequences such as dependence or abuse, overdose and death. Recent increases in the number of treatment admissions for opiate abuse, the number of hospital visits for opiate overdoses and the number of naloxone (Narcan®) administrations statewide are clear indicators that Wisconsin is facing a growing public health concern related to opiate use.

For 12-months, the 911 Good Samaritan Ad-hoc Committee of the Wisconsin State Council on Alcohol and Other Drug Abuse (SCAODA) examined opiate misuse and abuse in Wisconsin. The Ad-hoc Committee focused on data related to the overall scope of opiate use and abuse as well as factors that can remediate the fatal consequences associated with opiate abuse. The Ad-hoc Committee comprises stakeholders that are closely affected by opiate abuse including; law enforcement, health care, prosecutors, public health and treatment providers.

The Ad-hoc Committee reviewed national, statewide and county-level data in order to better understand the range and scope of opiate abuse. The Ad-hoc Committee also consulted with experts in states that currently have 911 Good Samaritan Legislation in order to understand the components of current legislation and the findings from evaluations conducted before and after legislative passage. Most notably, the Ad-hoc Committee worked with representatives from Washington State, who shared evaluation findings from surveys conducted of substance users, law enforcement officials and first responders related to perceptions of the 911 Good Samaritan Drug Overdose Law.

This report details the research findings and recommendations that the 911 Good Samaritan Ad-hoc Committee developed after careful discussion and review of available data and materials. The recommendations are grouped into four broad categories with recommendations under each. Listed below is a summary of the categories and recommendations.

911 Good Samaritan Legislation Recommendations:

Recommendation 1: Draft a 911 Good Samaritan Law to meet Wisconsin's needs.

- Language providing limited immunity from prosecution for possession to those who call for or receive medical assistance in an overdose situation.
- Language providing deferred prosecution with the option of treatment for persons who call for or receive medical assistance in an overdose situation.
- Language incorporating the provision of Screening Brief Intervention and Referral to Treatment (SBIRT) services for persons who call for or receive medical assistance in an overdose situation (see *"Additional Recommendations"*, pg. 24 for more information on SBIRT). Language providing individuals, acting in good faith, the legal right to receive, possess, or administer naloxone to an individual suffering from an apparent overdose (see "*Naloxone Recommendations*" pg. 18).

Recommendation 2: Provide education and outreach regarding legislation to all stakeholders.

Naloxone Recommendations

Recommendation 3: Pass a 911 Good Samaritan Law that allows a person acting in good faith to receive a naloxone prescription, possess naloxone, or administer naloxone to an individual suffering from an apparent overdose without penalty.

Recommendation 4: Adapt and deliver research-based educational materials and

Executive Summary (continued)

training curricula to paraprofessionals and others who may administer naloxone; e.g. police officers, fire fighters, non-paramedic EMTs.

Recommendation 5: Train substance abuse treatment providers and their clients, including medication assisted treatment programs in overdose education and response.

Recommendation 6: Provide education within correctional facilities in overdose prevention and reversal.

Data Recommendations

Recommendation 7: Conduct surveys to gather information on public perception of current laws and practices as well as establishing factual accounts of emergency medical services and law enforcement practices related to life-saving calls for overdose assistance.

Recommendation 8: Develop standards for reporting incidents of fatal overdoses such that reports are consistent across jurisdictions/departments and the presence of individual drugs is specified.

Recommendation 9: Provide ongoing support for the monitoring of opioid overdoses and fatalities as well as other consequences that opiates have on the community at the state and county level.

Additional Recommendations

Recommendation 10: Create a workgroup to address the problem of heroin addiction.

Recommendation 11: Increase access to substance use disorders (SUDs) and AODA treatment.

Recommendation 12: Establish Drug Treatment Courts throughout the State.

While, the goal of this Ad-hoc Committee was to provide recommendations in order to improve health outcomes, we recognize there is no silver bullet when it comes to reducing the misuse and abuse of opiates. The recommendations in this report are designed to assist Legislators in drafting a 911 Good Samaritan Law that addresses the needs of Wisconsin residents. A 911 Good Samaritan Law can provide a useful tool for law enforcement, health care providers and first responders when responding to an overdose situation, while also reducing the stigma that is associated with substance abuse.

911 Good Samaritan Legislation Recommendations

Background

Death from opiate overdose usually takes place within three hours from the time the drug is administered (Davidson et al., 2003; Zador et al. 1992). This offers emergency services a valuable window to intervene and save lives, however, they must be contacted to intervene. Rates of survival when paramedics are present at opiate overdoses reach almost 100 percent (Sporer, 1996). Therefore, interest is growing nationwide in 911 Good Samaritan laws aimed at saving lives by encouraging people who witness drug overdoses to call 911. The laws typically provide legal immunity from drug possession prosecution for the person who overdoses and the individual who calls emergency services.

The legislation is designed to save lives by eliminating legal concerns that may prevent people from seeking proper medical treatment. Proponents maintain that Good Samaritan policies reduce barriers to help-seeking behavior (Rowe, 2005). Opponents maintain that by removing these repercussions, such policies may enable or encourage drug abuse or decrease opportunities for treatment.

Research

The first study on 911 Good Samaritan policy was conducted by Lewis & Marchell (2006) on the campuses of Cornell University. Cornell University recognized the need for a change in their policy regarding underage alcohol consumption after an undergraduate student survey revealed that of the 19 percent of students who had considered calling emergency services for an alcohol overdose, only four percent had made the call. The top two reasons reported for not calling emergency services were: not knowing if the situation was serious enough to call, and fear of consequences for the individual overdosing. In response to their findings, Cornell University implemented an educational program providing all students the ability to better recognize an overdose and steps that can be taken in order to provide medical intervention when needed.

They also implemented a medical amnesty policy that provided immunity for an individual who calls emergency services in an alcohol overdose situation along with the hosting organization (i.e. fraternity and sorority houses). The individual who experienced the alcohol overdose would be granted immunity if they completed two sessions of Brief Alcohol and Screening Intervention for College Students. This intervention, similar to Screening, Brief Intervention, and Referral to Treatment (SBIRT), utilizes cognitive-behavioral and motivational interviewing techniques to decrease alcohol consumption and related risk behaviors. The student surveys found that by the second year of implementation, 80 percent of students were aware of the policy, and that the percentage of students not calling for fear of getting the individual that experienced the overdose in trouble dropped 2.3 percent. Cornell's Emergency Medical Services records showed a 22 percent increase in calls for alcohol-related emergencies for the first two years following implementation of the policy. The researchers compared this data to the rate of alcohol use on Cornell's campus to verify that the increase in calls was not due to a general increase in alcohol consumption and found no significant change in total consumption rates. The emergency room and health center records showed increases in utilization of Brief Alcohol and Screening Intervention for College Students from 22% prior to implementation to 52% following implementation.

911 Good Samaritan Legislation Recommendations
(continued)

Out of the eleven states that have passed Good Samaritan laws, Washington State is the first state to comprehensively study the effects of the law, which not only provides legal immunity, but also allows the prescribing of an opioid antidote medicine, (naloxone) to drug users and their partners. The study examined the legal intent, implementation and outcomes of the law. Preliminary results of the study have been released and are summarized below. Ultimately, this study will provide a report on how the law is impacting overdoses and 911 calls.

Law enforcement and prosecutors' associations initially opposed the Washington Good Samaritan law, thinking it was unnecessary because people are rarely arrested or prosecuted for drug possession during overdoses. However, as they heard from their constituents, such as campus police supportive of Good Samaritan laws, and learned about the dramatic increase in the use and abuse of pharmaceuticals by people across the age spectrum, they became supportive. Banta-Green et al. (2011) found, "The law gives legal cover to what's been standard practice for a long time". Legislators and organizational stakeholders agreed that framing the law as a public health issue, not as a legal issue, was also key to its passage.

A survey conducted by Public Health-Seattle and King County in 2012 found that 42 percent of heroin users had witnessed an opiate overdose in the prior year and 911 was called in half of the cases. Police responded along with paramedics 62 percent of the time, but just one person was reported to have been arrested at the scene of an overdose. Only one-third of heroin users had heard of the Good Samaritan law. According to the survey, 88 percent indicated that now that they were aware of the law, they would be more likely to call 911 during future overdoses.

In Wisconsin, a recent survey conducted in Dane County (10/12 – 1/13), with current and past drug users, indicated that 911 was not called at an overdose more that 50% of the time. The majority of the reasons for not calling were related to being worried about charges, or police, or a friend being mad at them because they might be arrested.

Seattle paramedics reported that police are usually at the scene of overdoses, but arrests of those that overdose or bystanders rarely occur. Sixty-two

The story of Chase Newman: Life that could have been.

My name is Jeff Newman and I am the father of Chase Newman, an opiate addict who also suffered from Bi-Polar Disease and Depression.

On March 23rd of 2010 my wife and I received a call from a Madison Police Officer who asked if we were Chases' parents. He then told me that they had received a call from a friend of Chase about a non-responsive adult male and an ambulance was dispatched to the house.
When we met with police, one of the things they told us was that the paramedics had to give Chase a drug called Narcan® to bring him back to life. My wife and I were almost knocked off our feet when we heard this; being quite naïve about drugs we thought that when police mentioned "unresponsive" they meant passed out like someone who had drank too much, not someone who is dead!

The police told us that Chase was really lucky because when his friend had gotten concerned about Chase's condition he had left the house for a short while and when he returned he called for help. The police told us that his friend probably left to take his drugs and drug paraphernalia to some other location so that he wouldn't be caught with them. I don't condone the use of drugs at all but if his friend wouldn't have had to worry about his drugs, he may not have been as harrowing an experience for Chase, his friend or Chase's mother and me.

Chase received help to fight his addiction from many agencies and programs and stayed clean for over a year before he had a relapse. On May 2, 2012 he lost the battle to an accidental overdose.

The autopsy report tells about one of his roommates returning home and finding him sleeping on the couch and snoring. In the morning she went to work and reported that he was still on the couch snoring heavily. At 7:15 her boyfriend/roommate got up to leave for work and also tried to wake Chase. He went to ask a neighbor for help, but the neighbor concluded that Chase was simply sleeping heavily. The roommate was concerned enough to contact his girlfriend later and at 10:45 she returned from work to find Chase unresponsive and not breathing. We don't blame Chase's roommates for his death, but we wonder if an earlier call to the proper authorities may have saved his life.

Your mother and I miss you Chase.

911 Good Samaritan Legislation Recommendations (continued)

percent of police surveyed said the law would not change their behavior during a future overdose because they would not have made an arrest for possession anyway, 20 percent were unsure what they would do, and 14 percent said they would be less likely to make such an arrest.

The survey results show that with limited changes to law enforcements' behaviors at the scene of an overdose, a 911 Good Samaritan Law can increase the likelihood that emergency services will be contacted. The results also highlight the importance of community education regarding the law. Banta-Green et al. (2011) stated "These findings indicate we need to make sure we're getting information into the hands of police and the community at large".

This data is the basis for the Ad-hoc Committee to recommend that any drafted Wisconsin legislation should include an education component.

911 Good Samaritan Draft Legislation
Through a thorough review of all States' 911 Good Samaritan Laws, the Ad-hoc Committee found the law written for Washington State to be the most comprehensive and well researched. The following are some key points from the law as it is written in Washington (for the full Washington Law see Appendix A).

(1) (a) A person acting in good faith who seeks medical assistance for someone experiencing a drug-related overdose shall not be charged or prosecuted for possession of a controlled substance pursuant to RCW 69.50.4013, or penalized under RCW 69.50.4014, if the evidence for the charge of possession of a controlled substance was obtained as a result of the person seeking medical assistance.
(b) A person acting in good faith may receive a naloxone prescription, possess naloxone and administer naloxone to an individual suffering from an apparent opiate-related overdose.
(2) A person who experiences a drug-related overdose and is in need of medical assistance shall not be charged or prosecuted for possession of a controlled substance pursuant to RCW 69.50.4013, or penalized under RCW 69.50.4014, if the evidence for the charge of possession of a controlled substance was obtained as a result of the overdose and the need for medical assistance.
(3) The protection in this section from prosecution for possession crimes under RCW 69.50.4013 shall not be grounds for suppression of evidence in other criminal charges. [2010 c 9 § 2.]

Table 1: Myths and Facts about 911 Good Samaritan Laws

Myth	Fact
This law would allow drug dealers to escape prosecution.	The law does not allow immunity for charges of drug distribution, only drug possession.
Criminals could use this law to get immunity if their home is about to be raided by police.	The law only protects those who have police contact as a result of a good faith effort to seek medical attention.
This law would prevent prosecutions for reckless homicide under the Len Bias Law.	The law offers no protection for those who would be charged with reckless homicide, however by reducing overdose fatalities there may be decreases in the number of these cases.
This law would decrease treatment admissions.	Research by Wagner et al. (2010) showed an increase in treatment and a decrease in substance use for those that receive overdose prevention training.

Education and Outreach
In order for 911 Good Samaritan law to be effective those who are impacted must be aware of the law. There are a number of targeted groups that will need to be educated and taught how to utilize this law to better the community as a whole. Education and outreach serve a secondary purpose of decreasing stigma and misconceptions relating to the law.

Based on the above considerations, the 911 Good Samaritan Ad-hoc Committee developed the following recommendations:

911 Good Samaritan Legislation Recommendations (continued)

Recommendation 1: Draft a 911 Good Samaritan Law to meet Wisconsin's needs.
In drafting 911 Good Samaritan Legislation in Wisconsin, the following options for inclusion should be considered:

- Language providing limited immunity from prosecution for possession to those who call for or receive medical assistance in an overdose situation.
- Language providing deferred prosecution with the option of treatment for persons who call for or receive medical assistance in an overdose situation.
- Language incorporating the provision of Screening Brief Intervention and Referral to Treatment (SBIRT) services for persons who call for or receive medical assistance in an overdose situation (see *"Additional Recommendations"* on pg. 24 for more information on SBIRT).
- Language providing individuals, acting in good faith, the legal right to receive, possess, or administer naloxone to an individual suffering from an apparent overdose (see *"Naloxone Recommendations"* pg. 18).

Note, none of the above proposed options would allow for immunity from prosecution for drug distribution.

Recommendation 2: Provide education and outreach regarding legislation to all stakeholders.
Outreach to Law Enforcement and the Justice System:

- Informational meetings on the 911 Good Samaritan law, naloxone information and overdose prevention should be offered to law enforcement and judiciary agencies. Law enforcement should identify trainers, utilizing syringe exchange staff to develop trainings for roll calls, district hearings and meetings dedicated to disseminating information about overdose. By utilizing existing resources a budget would not be needed for these outreach efforts.
- Published literature will identify resources for law enforcement and judicial officers.
- Education will include available materials and resources. For example, Washington State has offered the use of the video they created to train officers about the law. This is available on-line at no cost.
- Informational meetings should be provided on any current or new policies adopted related to this report.

Consumer (Drug User) Education:

- Syringe exchange sites in the community should take the lead in disseminating published and oral education materials for consumers that clarifies how this law impacts them.
- Treatment centers and social service programs should be utilized as information dissemination sites.
- Substance use recovery organizations should provide educational materials regarding the law and the increased risk of overdose for their clients in recovery.

Healthcare Workers and First Responders:

- Education should be provided at staff meetings on how this law impacts their work, policies and practices, including the increased access to community-based naloxone.

General Community:

- The general community should be targeted to increase knowledge of the law for those people who are actively using but not engaged in services.
- Community education should be designed to increase support for overdose prevention and decrease stigma associated with addiction.
- The general community should be reached by press releases from stakeholder agencies, social media and news coverage.

Naloxone Recommendations

Background
Narcan® administration can be a vital part of saving a life in an event of an opiate overdose. Naloxone is the generic name for this medication. This section will provide information about naloxone, explain its uses, and provide recommendations that will allow for greater access to this life-saving antidote to opiate overdose.

Prescribed Usage
Naloxone prevents or reverses the effects of opioids including respiratory depression, sedation and hypotension. It works by blocking the central nervous system effects of several types of opiate medications such as morphine, oxycodone, methadone or heroin (U.S. National Library of Medicine, 2012). When properly administered, and in the absence of another opioid or opioid antagonist, there is no pharmacological effect on the patient.

When naloxone is administered intravenously, the onset of action is generally apparent within two minutes. The onset of action is slightly less rapid when it is administered intranasal or intramuscularly. The duration of action is dependent upon the dose and route of administration of naloxone. Intramuscular administration produces a more prolonged effect than intravenous administration. Since the duration of action of the antagonist may be shorter than that of some opiates, the effects of the opiate may return as the effects of naloxone dissipates. The requirement for repeat doses of the medicine will also be dependent upon the amount, type and route of administration of the opioid being antagonized.

"Having naloxone saved my girlfriend's life, I was so glad I had it. Thank you for another saved life"

-22 year old white male 2012

The patient who has satisfactorily responded to overdose reversal should be kept under continued surveillance and repeated doses should be administered, as necessary, since the duration of action of some opioids may exceed that of naloxone.

Naloxone has not been shown to produce tolerance or cause physical or psychological dependence. In the presence of physical dependence on opioids, naloxone will produce withdrawal symptoms. These opiate withdrawal symptoms may appear within minutes of naloxone administration and subside within about two hours. The severity and duration of the withdrawal symptoms are related to the dose and to the degree and type of opioid dependence.

Access to Naloxone
1. Some community overdose prevention programs provide emergency opiate overdose education and a take-home supply of naloxone for people who use/abuse opiate medication or heroin and their family members, friends, or caregivers to use in case of an opiate overdose. Currently, ARCW is the only agency in Wisconsin providing a program like this. It is available after a training program by prescription only. Intramuscular naloxone is the only route of administration currently being provided through the ARCW's needle exchange program.
2. Presently physicians can write a prescription for naloxone that can be filled at any pharmacy. However, many prescribers are hesitant to do this because, the person it is prescribed to will most likely use it on another individual, who does not have a prescription, which is currently illegal in Wisconsin.
3. Emergency room personnel/physicians and paramedics can administer naloxone. However, many first responders including police officers, fire fighters and EMT Basics are not permitted under current law to administer naloxone.

Naloxone Recommendations (continued)

Shortage of Naloxone
There is only one manufacturer of naloxone in the United States. The Food and Drug Administration (FDA) does not allow importing this life-saving drug from outside of the United States. This has resulted in a supply shortage and rising costs. For the health and safety of the general public, the FDA or other intervention agencies should advocate for increased availability and price reduction.

Table 2: Pros and Cons of Naloxone Administration

Pros	Cons
Naloxone administration can be a vital part of saving a life in an event of an opiate overdose.	A person who is administered naloxone in large amounts may experience severe withdrawal symptoms. This may lead to additional use, bringing back the overdose.
Naloxone prevents or reverses the effects of opiates including respiratory depression, sedation and hypotension. In the absence of opiates, it exhibits no pharmacologic activity when deployed.	Some view wider availability of naloxone as a means to continue drug use and delay initiation of AODA treatment.
Naloxone has not been shown to produce tolerance or cause any physical or psychological dependence.	Shortage of naloxone and higher costs may limit access.
Naloxone provides immediate care until EMS arrives.	Reduces 911 calls with further medical care.

Based on the above considerations, the 911 Good Samaritan Ad-hoc Committee developed the following recommendations related to naloxone:

Recommendation 3: Pass a 911 Good Samaritan law that allows a person acting in good faith to receive a naloxone prescription, possess naloxone, or administer naloxone to an individual suffering from an apparent overdose without penalty.
See Appendix A for draft legislative language.

- The administration, dispensing, prescribing, purchase, acquisition, possession, or use of naloxone to anyone shall not constitute unprofessional conduct or violation of law if said conduct results from a good faith effort to assist a person experiencing, or likely to experience an opiate-related overdose.
- Persons administering naloxone in good faith shall not be subject to civil or criminal liabilities.

Recommendation 4: Adapt and deliver research-based educational materials and training curricula to paraprofessionals and others who may administer naloxone; e.g. police officers, fire fighters, non-paramedic EMTs.

Recommendation 5: Train substance abuse treatment providers and their clients, including medication assisted treatment programs in overdose education and response.

- Education should include information on access to naloxone for clients and the increased risk of overdose after prolonged absence of a drug from one's system.

Recommendation 6: Provide education within correctional facilities in overdose prevention and reversal.

- Education should include information on access to naloxone after release from a correctional facility and the increased risks of overdose after prolonged absence of drug use.

Data Recommendations

When the Ad-hoc Committee began reviewing the merits of a 911 Good Samaritan Law for Wisconsin, a number of data-related questions arose. In order to fully understand the incidence and scope of opioid-related overdose fatalities in Wisconsin, available data sources needed to be reviewed and additional data sources needed to be identified. After reviewing available data, it became clear that one of the barriers to fully understanding this issue, and consequently proposing strategies to reduce the incidence of overdose deaths, is the availability of reliable data that consistently shows the depth and breadth of the problem. Three main focus areas related to data collection and availability were evident.

Perception Versus Practice

Anecdotal testimony indicates that there is a gap between what opioid users perceive will happen in the event they call 911 for assistance in an overdose situation and what police report regarding their practices and policies when responding to an emergency overdose situation. Treatment providers report that opioid users are fearful of calling 911 for assistance because they do not want to be arrested and prosecuted for drug possession. Conversely, some law enforcement agencies report that it is not their practice to make a drug possession arrest in a situation where someone is in need of medical assistance for an overdose. However, these practices and policies are not consistent across law enforcement agencies.

Surveying opioid users regarding their overdose experiences and perceptions and law enforcement personnel regarding their practices will help to understand this dynamic. In order to increase opportunities for and decrease barriers to receiving timely life-saving assistance, a knowledge-base for making informed decisions related to the creation of consistent practices and laws aimed at reducing the incidence of opioid-related fatalities must be established. Surveying groups affected by opioid abuse will lay the foundation for making educated, solution-focused decisions.

Uniform Reporting Across Disciplines

Many community sectors are affected by persons using and abusing opioids for non-medical purposes. These groups have the ability to track outcomes related to their involvement with an opioid users' care. In researching the scope of opioid fatalities in Wisconsin, the Ad-hoc Committee found that there is inconsistent reporting of data across organizations and departments. Some Emergency Medical Service (EMS) departments may collect data on dispensing naloxone, while others may not. There are no standard practices for reporting the presence of drugs on death certificates by coroners and medical examiners. Police departments within the same county may have different policies for arresting users, and court systems have varying conviction or treatment options available to offenders.

Consistency in data monitoring and tracking within community sectors is integral to identifying drug use patterns and trends. Standardization of data within disciplines provides all sectors the opportunity to have up to date, reliable information with which to make informed policy decisions. Standardizing not only data collection and tracking but organizational practices will provide a more consistent standard of care statewide.

Monitoring and Evaluation

The need for continued monitoring of non-medical opioid use patterns is clear. Tracking the use, misuse and abuse of prescription opioids (OxyContin®, methadone, etc.) and the abuse of non-prescription opioids (heroin, opium) provides much needed insight into who, what, where and how people are abusing a substance and the negative outcomes that result from abuse. There are many strategies that could be implemented to reduce mortality related to the abuse of opioid analgesics. Although the scope of this report is to investigate the merits of a 911 Good Samaritan Law for persons seeking limited immunity from prosecution in drug-related life-threatening situations, there are other policies or strategies that would help to reduce the incidence of opioid-related overdose fatalities that could be pursued based on an assessment of need and appropriateness to the community. For this reason, regardless of whether a 911 Good Samaritan Law is proposed or passed in Wisconsin, there is a need for ongoing monitoring of use and abuse patterns and the consequences to individuals and the community,

Data Recommendations (continued)

as well as evaluation as it relates to public perception, institutional practices and societal burden. Evaluation should be supported across all centers of care to ensure that policies are meeting need, should inform policy decisions and inform community education and services in order to close the gap between public perception and institutional policies/practices.

Based on the above considerations, the 911 Good Samaritan Ad-hoc Committee developed the following recommendations related to data:

Recommendation 7: Conduct surveys to gather information on public perception of current laws and practices as well as establishing factual accounts of emergency medical services and law enforcement practices related to life-saving calls for overdose assistance.

- Current and past opioid users should be surveyed through needle exchange programs, methadone clinics and recovery organizations in an effort to understand why calls for medical assistance may or may not be made.
- Law enforcement and emergency medical services in both urban and rural settings should be surveyed to determine current practice, current perceptions of practices and levels of support for additional institutionalized policies.
- Collaboration should be established with local police chief and EMS chief associations.

Recommendation 8: Develop standards for reporting incidents of fatal overdoses such that reports are consistent across jurisdictions/departments and the presence of individual drugs is specified.

- The Wisconsin Medical Examining Board should establish standard reporting requirements and provide training in these requirements to members.
- Resources should be made available so that timely drug testing can be done in cases of overdose death.
- The data gathered should be centralized and made available and usable on a statewide level.
- Link coroner and medical examiner data statewide and provide guidance and training regarding recommended drug testing protocols at time of death to ensure that fee-for-service laboratories chosen are able to provide the desired scope of testing.

Recommendation 9: Provide ongoing support for the monitoring of opioid overdoses and fatalities as well as other consequences that opiates have on the community at the state and county level.
The Division of Mental Health and Substance Abuse Services (DMHSAS) and the Division of Public Health (DPH) already produce a biannual *Wisconsin Epidemiological Profile on Alcohol and Other Drugs,* which contains consumption and consequence indicators for substance abuse. For ongoing monitoring of opiates, it is recommended that additional data be included in the Profile:

- Drug-related deaths by county,
- Further detailed data of drug-related deaths to include opiate-related deaths,
- Further detailed data of drug-related hospital visits (emergency department and hospital admissions), to include poisoning by substance type (state and by county), opiate poisoning (state and by county) and opiate-related abuse and dependence (state),
- EMS calls for naloxone dosing,
- Naloxone deployments from community naloxone overdose prevention programs (state-wide),
- Publicly funded substance abuse treatment admissions (by drug type, including heroin and other opiates), and
- Data on local methadone clinic admissions.

See Appendix B for further details of data indicators and data sources.

Additional Recommendations

Background
During the course of Ad-hoc Committee meetings there were a number of topics that continually came up for discussion but were not directly related to the Ad-hoc Committee's charge. The following recommendations identify those areas that Ad-hoc Committee members feel should be addressed moving forward.

Creation of a Heroin Workgroup
In order to examine the extent of heroin use in the state of Wisconsin, it is recommended that a workgroup be developed that will be dedicated to identifying and examining the many facets that lead to heroin use.

Historically, the use of heroin in the state of Wisconsin until the mid-1990's was limited to a small number of users. Due to the low purity of the heroin available, the predominant method of use was through intravenous injection. Beginning in the late 1990's, Wisconsin began to experience an increase in the availability and use of heroin. This mirrored a national trend that severely impacted the eastern United States, and then spread to the Midwest and subsequently to Wisconsin. Between 2006 and 2011, Wisconsin experienced a 350% increase in heroin samples submitted to the Wisconsin State Crime Laboratory by law enforcement. In addition, according to the 2011 Milwaukee High Intensity Drug Trafficking Area, Drug Trafficking Trends Survey of law enforcement agencies across the state, many agencies reported that heroin is an increasing problem within their jurisdiction, or in many instances, the number one drug problem in their jurisdiction.

Heroin use is not only a law enforcement problem, but affects many other factions of society as well. From emergency medical services that have to intervene when a heroin- related overdose incident occurs, to hospital staff that treat the patient, to insurance companies that may have to cover the cost of treatment, to addiction counselors and opiate treatment facilities that work with the patient upon release. All of these different entities that deal with someone who uses heroin have been negatively impacted by the increase in the use of heroin. Even more troubling is innocent citizens across the state have also been negatively impacted by the increase in the use of heroin. Either by being a victim of a crime perpetrated by someone in order to support their heroin use, or involved in an accident by someone who was impaired by heroin while operating a motor vehicle.

Therefore, a multidisciplinary workgroup should be formed in order to comprehensively examine the causes of the increase in heroin use in the state of Wisconsin.

Increase Access to Treatment
A meta-analysis of the research literature on opiate addiction undertaken by the National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction (1998) found that treatment involvement reduces the risk of overdose for those dependent on opiates.
According to the National Survey of Substance Abuse and Treatment Services Profile (2011) out of the 17, 385 Wisconsin residents who received substance
abuse treatment only 18 percent, or 3,165, were in Opioid Treatment Facilities. While the 2010 Treatment Episodes Data Set (TEDS) report shows out of the 29,354 Wisconsin residents in substance abuse treatment less than 11 percent, or 3,103 clients, entered treatment for heroin or other opiate abuse.
Therefore, we reiterate the recommendation of the Wisconsin State Council on Alcohol and Other Drug Abuse Prevention Committee Controlled Substances Workgroup to:

> Integrate high quality medication management and psychosocial interventions for substance abuse disorders that both are available to consumers as their conditions indicate.

Additional Recommendations (continued)

There are two primary treatment options that this committee supports, 1) Medication Assisted Treatment (MAT) and 2) Screening, Brief Intervention and Referral to Treatment (SBIRT.)

1) MAT has three primary goals. The first is to reduce the severity of the addiction of heroin and prescription opiates and to allow the addict to function on a day-to-day basis. Second, MAT seeks to reduce the negative impact heroin/opiate addiction has on communities by reducing criminal behavior and thereby enhancing public safety. A final goal of MAT is to improve public health by decreasing the transmission of AIDS and other diseases associated with heroin use. There are currently 15 Opioid Treatment Programs (OTPs) that utilize medication to treat heroin/opiate addiction in Wisconsin. These programs utilize methadone and Suboxone® in conjunction with individual and group counseling to stop cravings and withdrawal symptoms which allow the patient to focus on sobriety and finally recovery.

2) SBIRT is a model that provides Physicians, treatment providers, pharmacists and other individuals who provide services in a one-on-one setting, with the tools to screen for risky or hazardous substance misuse and to provide a brief intervention tailored to the level of risk identified in the screening process. This affords an opportunity to reinforce protective factors and assist the individual to change risky behaviors or reduce substance use. SBIRT has been implemented predominantly in medical settings and research has shown the model to be effective in assisting individuals in reducing their risky or hazardous substance use (Solberg et al., 2008). The interventions take into account not only the individuals' screening results, but also their overall risk of overdose. Thus, those at varying levels of risk for overdose receive specific information during a brief intervention designed to target his/her most risky behavior.

Establish and Support Drug Treatment Courts Throughout the State

One of the promising approaches that law enforcement has undertaken over the past 20 years is the use of Drug Treatment Courts (DTC). DTC have been effective in increasing treatment retention and decreasing recidivism, (Carey, Finigan, & Pukstas, 2008). For a summary of the effectiveness of Drug Treatment Courts, on a national level, see http://www.nadcp.org/learn/facts-and-figures. The National Institute of Justice's Multi-site Adult Drug Court Evaluation compiled by the Urban Institute (2011), found that DTC programs significantly reduce drug use, both during and after program participation. Another research project found that those who are engaged in treatment are far less likely to overdose, (Best, Gossop, Man, Stillwell, Coomber, & Strang, 2002). From these findings it can be inferred that those who are actively in a DTC program are less likely to overdose.

Figure 7: Drug Treatment Courts in Wisconsin, 2011

Source: http://www.wicourts.gov/courts/programs/altproblemsolving.htm

There are a number of counties across the state that have already established DTCs and are seeing the benefits of these programs. In Dane County, two studies have shown the effectiveness of their DTC. Brown's (2011) study found a reduction of recidivism for DTC clients, especially among women, older individuals, minorities, and those with more serious criminal histories. Another DTC study, focused on the effectiveness of opiate agonist therapy

Additional Recommendations (continued)

among the prison population and found that if methadone was initiated prior to or immediately after release from prison, it increases treatment entry and reduces heroin use at 6 months compared to counseling only, (Gordon, Kinlock, Schwartz, & O'Grady, 2008).

See Figure 7 for a map on Drug Courts in Wisconsin and for a directory of Wisconsin DTC programs, see http://wicourts.gov/courts/programs/altproblemsolving.htm.

Another recommendation is to restructure or increase current state funds for treatment programs and other supportive services. Wisconsin advocacy group, Wisdom, and Human Impact Partners, an Oakland, California-based nonprofit, studied the effects of public policies on communities. The report projected with increase financial support of the criminal justice system that the benefits would include 3,100 fewer prisoners a year, 21,000 fewer jail admissions, a reduction in repeat crimes and between 1,150 and 1,619 parents who remain in the community and are not separated from their children. The group suggested that $95 million a year would cut the cost of keeping such non-violent offenders in prison.

Based on the above considerations, the Good Samaritan committee developed the following recommendations:

Recommendation 10: Create a workgroup to address the problem of heroin addiction. Suggested members of the group should include, but not be limited to:

- A Research Specialist – This representative shall be charged with conducting research of the data needed for the group as a whole.
- Addiction Treatment Professional – This representative will be able to provide insight as to the physical and mental aspects of heroin addiction.
- Criminal Intelligence Analyst – This representative will be able to provide historical data in regard to heroin use in Wisconsin and provide a strategic analysis of future heroin trends.
- State Opiate Treatment Authority – This representative will be able to provide insight in regard to the state opiate addiction treatment protocols.
- AIDS Resource Center of Wisconsin – This representative will be able to provide insight in regard to current needle exchange programs, naloxone deployment and trends amongst user populations.
- Emergency Medical Service – This representative will be able to provide insight and data in regard to emergency medical services response to opiate-related incidents.
- Medical Examiner – This representative will be able to provide input and data in regard to heroin-related deaths throughout the state.
- Bureau of Vital Statistics – This representative will be able to provide data in regard to heroin-related incidents occurring throughout the state.
- Wisconsin State Hygiene Lab – This representative will be able to provide insight and data in regard to opiate-related Operating While Intoxicated incidents.
- Law Enforcement – This representative will be able to provide insight and information in regard to the impact heroin use has on the law enforcement community.
- Wisconsin Legislator – This representative will be able to assist in developing legislation that may aid in the reduction in heroin use.
- Wisconsin State Crime Lab – This representative will be able to provide data and trends analysis in regard to heroin submissions in the state of Wisconsin.
- District Attorney – This representative will be able to provide insight and data in regard to the number of heroin-related prosecutions and other criminal activity related to heroin use.

Additional Recommendations (continued)

Recommendation 11: Increase access to substance use disorders (SUDs) and AODA treatment.

- Integrate high quality medication management and psychosocial interventions for substance abuse disorders such that both are available to consumers as their conditions indicate.
- Based on conversations with treatment providers, increased access to treatment should include medication management, residential treatment, when appropriate, and easier access to the treatment system through a one point entry system.
- Increase the affordability and access to opiate agonist therapy (MAT) throughout the state rather than a general increase in traditional AODA treatment.
- Increase access to SBIRT services.

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Recommendation 12: Establish Drug Treatment Courts throughout the State.

- Those counties that currently do not have drug treatment courts should convene workgroups to determine the feasibility of establishing a DTC.
- All drug treatment courts should follow the Ten Key Components recommended by the National Association of Drug Treatment Court Professionals (see Appendix C)

Overview of Development of Waukesha Drug Treatment Court

By 2010, law enforcement and public health officials in Waukesha County were alarmed by a consistent trend of approximately three dozen annual deaths per year resulting from opiate overdoses. The nature of the problem was presented to the Criminal Justice Collaboration Council. The Council then directed the formation of an Ad- hoc Drug Abuse Trends Committee.

A broad coalition of law enforcement, county government, public health officials, educators, treatment providers and others came together to examine the problem. The committee brought in experts on drug trafficking enforcement, drug abuse treatment, evidence-based drug treatment court models and criminal justice programs aimed at addressing drug addiction currently operating in southern Wisconsin.

Based on that experience and the results of the alcohol committee's year-long examination of the nature of the opiate problem and the potential solutions available, the Drug Abuse Trends Committee ultimately recommended that Waukesha County establish a Drug Treatment Court (DTC).Waukesha County implemented Wisconsin's first Alcohol Treatment Court six years ago, and has experienced great success in addressing addiction and reducing criminal recidivism.

The program, which utilizes the Ten Key Components recommended by the National Association of Drug Treatment Court Professionals, is free to participants. The program includes funding for intensive case management, training for the drug treatment court team (judges, DA's Office, Public Defender, Human Services, law enforcement and case managers), participant incentives and rewards, drug testing and treatment. Additional funds were procured to fund administration of prescription medications to assist in sobriety maintenance.

Waukesha County residents who are high-risk, drug-addicted and charged with felonies and habitual criminality misdemeanors are potentially eligible to participate in the DTC. Offenders with a current or past violent offense are not eligible. A participant enters a plea or pleas under an agreement reached between the prosecutor and defense counsel. The judge takes the plea(s), but withholds entry of judgment pending the defendant's completion of the DTC.

The program can only accommodate approximately 25 participants at once so there is a waiting list.

Since the DTC began serving participants in March of 2012, several individuals have been discharged unsuccessfully from the program. At least one has suffered an overdose from which he was brought back to life by a Sheriff's Deputy utilizing naloxone, and one suffered a fatal overdose. It is clear to us that this population of offenders will be very difficult to manage. While no participant has completed the program yet, we are encouraged by the short-term success of the majority of our participants.

Our hope is to establish a record of measurable success that would make a compelling case for the county to continue funding the program. Our DTC team recommends that the State of Wisconsin encourage the development of DTC programs statewide.

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Appendix A:
Washington State Legislative Language

Washington State adopted SB5516 in 02/05/2010. The language used for the bill to pass the 911Good Samaritan legislation as follows:

In NEW SECTION 1: The legislature intends to save lives by increasing timely medical attention to drug overdose victims through the establishment of limited immunity from prosecution for people who seek medical assistance in a drug overdose situation. Drug overdose is the leading cause of unintentional injury death in Washington State, ahead of motor vehicle related deaths. Washington State is one of sixteen states in which drug overdoses cause more deaths than traffic accidents. Drug overdose mortality rates have increased significantly since the 1990s, according to the centers for disease control and prevention, and illegal and prescription drug overdoses killed more than thirty-eight thousand people nationwide in 2006, the last year for which firm data is available. The Washington state department of health reports that in 1999, unintentional drug poisoning was responsible for four hundred three deaths in this state; in 2007, the number had increased to seven hundred sixty-one, compared with six hundred ten motor vehicle related deaths that same year. Many drug overdose fatalities occur because peers delay or forego calling 911 for fear of arrest or police involvement, which researchers continually identify as the most significant barrier to the ideal first response of calling emergency services.

In NEW SECTION **2:** A new section is added to chapter 69.50 RCW to read as follows:
(1)(a) A person acting in good faith who seeks medical assistance for someone experiencing a drug-related overdose shall not be charged or prosecuted for possession of a controlled substance pursuant to RCW 69.50.4013, or penalized under RCW 69.50.4014, if the evidence for the charge of possession of a controlled substance was obtained as a result of the person seeking medical assistance. (b) A person acting in good faith may receive a naloxone prescription, possess naloxone, and administer naloxone to an individual suffering from an apparent opiate-related overdose.
(2) A person who experiences a drug-related overdose and is in need of medical assistance shall not be charged or prosecuted for possession of a controlled substance pursuant to RCW 69.50.4013, or penalized under RCW 69.50.4014, if the evidence for the charge of possession of a controlled substance was obtained as a result of the overdose and the need for medical assistance.
(3) The protection in this section from prosecution for possession crimes under RCW 69.50.4013 shall not be grounds for suppression of evidence in other criminal charges.

In NEW SECTION **3:** A new section is added to chapter 18.130 RCW to read as follows:
The administering, dispensing, prescribing, purchasing, acquisition, possession, or use of naloxone shall not constitute unprofessional conduct under chapter 18.130 RCW, or be in violation of any provisions under this chapter, by any practitioner or person, if the unprofessional conduct or violation results from a good faith effort to assist:

(1) A person experiencing, or likely to experience, an opiate- related overdose; or

Appendix A:
Washington State Legislative Language (continued)

(2) A family member, friend, or other person in a position to assist a person experiencing, or likely to experience, an opiate- related overdose.

In SECTION **4:** RCW 9.94A.535 and 2008 c 276 s 303 and 2008 c 233 s are each reenacted and amended to read as follows: The court may impose a sentence outside the standard sentence range for an offense if it finds, considering the purpose of this chapter, that there are substantial and compelling reasons justifying an exceptional sentence. Facts supporting aggravated sentences, other than the fact of a prior conviction, shall be determined pursuant to the provisions of RCW 9.94A.537.

Whenever a sentence outside the standard sentence range is imposed, the court shall set forth the reasons for its decision in written findings of fact and conclusions of law. A sentence outside the standard sentence range shall be a determinate sentence. If the sentencing court finds that an exceptional sentence outside the standard sentence range should be imposed, the sentence is subject to review only as provided for in RCW 9.94A.585(4). A departure from the standards in RCW 9.94A.589 (1) and (2)governing whether sentences are to be served consecutively or concurrently is an exceptional sentence subject to the limitations in this section, and may be appealed by the offender or the state as set forth in RCW 9.94A.585 (2) through (6).

(1) Mitigating Circumstances - Court to Consider The court may impose an exceptional sentence below the standard range if it finds that mitigating circumstances are established by a preponderance of the evidence. The following are illustrative only and are not intended to be exclusive reasons for exceptional sentences.

(a) To a significant degree, the victim was an initiator, willing participant, aggressor, or provoker of the incident.

(b) Before detection, the defendant compensated, or made a good faith effort to compensate, the victim of the criminal conduct for any damage or injury sustained.

(c) The defendant committed the crime under duress, coercion, threat, or compulsion insufficient to constitute a complete defense but which significantly affected his or her conduct.

(d) The defendant, with no apparent predisposition to do so, was induced by others to participate in the crime.

(e) The defendant's capacity to appreciate the wrongfulness of his or her conduct, or to conform his or her conduct to the requirements of the law, was significantly impaired. Voluntary use of drugs or alcohol is excluded.

(f) The offense was principally accomplished by another person and the defendant manifested extreme caution or sincere concern for the safety or well-being of the victim.

Appendix A:
Washington State Legislative Language (continued)

(g) The operation of the multiple offense policy of RCW 9.94A.589 results in a presumptive sentence that is clearly excessive in light of the purpose of this chapter, as expressed in RCW 9.94A.010.

(h) The defendant or the defendant's children suffered a continuing pattern of physical or sexual abuse by the victim of the offense and the offense is a response to that abuse.

(i) The defendant was making a good faith effort to obtain or provide medical assistance for someone who is experiencing a drug-related overdose.

(2) Aggravating Circumstances - Considered and Imposed by the Court The trial court may impose an aggravated exceptional sentence without a finding of fact by a jury under the following circumstances:

(a) The defendant and the state both stipulate that justice is best served by the imposition of an exceptional sentence outside the standard range, and the court finds the exceptional sentence to be consistent with and in furtherance of the interests of justice and the purposes of the sentencing reform act.
(b) The defendant's prior unscored misdemeanor or prior unscored foreign criminal history results in a presumptive sentence that is clearly too lenient in light of the purpose of this chapter, as expressed in RCW 9.94A.010.

(c) The defendant has committed multiple current offenses and the defendant's high offender score results in some of the current offenses going unpunished.

(d) The failure to consider the defendant's prior criminal history which was omitted from the offender score calculation pursuant to RCW24 9.94A.525 results in a presumptive sentence that is clearly too lenient.

(3) Aggravating Circumstances - Considered by a Jury -Imposed by the Court Except for circumstances listed in subsection (2) of this section, the following circumstances are an exclusive list of factors that can support a sentence above the standard range. Such facts should be determined by procedures specified in RCW 9.94A.537.

(a) The defendant's conduct during the commission of the current offense manifested deliberate cruelty to the victim.
(b) The defendant knew or should have known that the victim of the current offense was particularly vulnerable or incapable of resistance.

Appendix A:
Washington State Legislative Language (continued)

(c) The current offense was a violent offense, and the defendant knew that the victim of the current offense was pregnant.

(d) The current offense was a major economic offense or series of offenses, so identified by a consideration of any of the following factors:(i) The current offense involved multiple victims or multiple incidents per victim;(ii) The current offense involved attempted or actual monetary loss substantially greater than typical for the offense;(iii) The current offense involved a high degree of sophistication or planning or occurred over a lengthy period of time; or(iv) The defendant used his or her position of trust, confidence, or fiduciary responsibility to facilitate the commission of the current offense.

(e) The current offense was a major violation of the Uniform Controlled Substances Act, chapter 69.50 RCW (VUCSA), related to trafficking in controlled substances, which was more onerous than the typical offense of its statutory definition: The presence of ANY of the following may identify a current offense as a major VUCSA:(i) The current offense involved at least three separate transactions in which controlled substances were sold, transferred, or possessed with intent to do so;(ii) The current offense involved an attempted or actual sale or transfer of controlled substances in quantities substantially larger than for personal use;(iii) The current offense involved the manufacture of controlled substances for use by other parties;(iv) The circumstances of the current offense reveal the offender to have occupied a high position in the drug distribution hierarchy;(v) The current offense involved a high degree of sophistication or planning, occurred over a lengthy period of time, or involved a broad geographic area of disbursement; or(vi) The offender used his or her position or status to facilitate the commission of the current offense, including positions of trust, confidence or fiduciary responsibility (e.g., pharmacist, physician, or other medical professional).

(f) The current offense included a finding of sexual motivation pursuant to RCW 9.94A.835.

(g) The offense was part of an ongoing pattern of sexual abuse of the same victim under the age of eighteen years manifested by multiple incidents over a prolonged period of time.

(h) The current offense involved domestic violence, as defined in RCW 10.99.020, and one or more of the following was present:(i) The offense was part of an ongoing pattern of psychological, physical, or sexual abuse of the victim manifested by multiple incidents over a prolonged period of

Appendix A:
Washington State Legislative Language (continued)

time;(ii) The offense occurred within sight or sound of the victim's or the offender's minor children under the age of eighteen years; or(iii) The offender's conduct during the commission of the current offense manifested deliberate cruelty or intimidation of the victim.(iv)The offense resulted in the pregnancy of a child victim of rape.

(j) The defendant knew that the victim of the current offense was a youth who was not residing with a legal custodian and the defendant established or promoted the relationship for the primary purpose of victimization.

(k) The offense was committed with the intent to obstruct or impair human or animal health care or agricultural or forestry research or commercial production.

(l) The current offense is trafficking in the first degree or trafficking in the second degree and any victim was a minor at the time of the offense.

(m) The offense involved a high degree of sophistication or planning.
(n) The defendant used his or her position of trust, confidence, or fiduciary responsibility to facilitate the commission of the current offense.

(o) The defendant committed a current sex offense, has a history of sex offenses, and is not amenable to treatment.

(p) The offense involved an invasion of the victim's privacy.

(q) The defendant demonstrated or displayed an egregious lack of remorse.

(r) The offense involved a destructive and foreseeable impact on persons other than the victim.

(s) The defendant committed the offense to obtain or maintain his or her membership or to advance his or her position in the hierarchy of an organization, association, or identifiable group.

(t) The defendant committed the current offense shortly after being released from incarceration.

(u) The current offense is a burglary and the victim of the burglary was present in the building or residence when the crime was committed.

Appendix A:
Washington State Legislative Language (continued)

(v) The offense was committed against a law enforcement officer who was performing his or her official duties at the time of the offense, the offender knew that the victim was a law enforcement officer, and the victim's status as a law enforcement officer is not an element of the offense.

(w) The defendant committed the offense against a victim who was acting as a Good Samaritan.

(x) The defendant committed the offense against a public official or officer of the court in retaliation of the public official's performance of his or her duty to the criminal justice system.

(y) The victim's injuries substantially exceed the level of bodily harm necessary to satisfy the elements of the offense. This aggravator is not an exception to RCW 9.94A.530 (2).

(z)(i)(A) The current offense is theft in the first degree, theft in the second degree, possession of stolen property in the first degree, or possession of stolen property in the second degree; (B) The stolen property involved is metal property; and (C) The property damage to the victim caused in the course of the theft of metal property is more than three times the value of the stolen metal property, or the theft of the metal property creates a public hazard. (ii) For purposes of this subsection, "metal property" means commercial metal property, private metal property, or nonferrous metal property, as defined in RCW 19.290.010.

(aa) The defendant committed the offense with the intent to directly or indirectly cause any benefit, aggrandizement, gain, profit, or other advantage to or for a criminal street gang as defined in RCW 9.94A.030, its reputation, influence, or membership.

SECTION **5:** RCW 18.130.180 and 2008 c 134 s 25 are each amended to read as follows: The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the

Appendix A:
Washington State Legislative Language (continued)

statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising this is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which create an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) Except when authorized by section 3 of this act, the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers, documents, records, or other items;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

Appendix A:
Washington State Legislative Language (continued)

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule; (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving.

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter 19.68 RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or

Appendix A:
Washington State Legislative Language (continued)

witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding; (23)
Current misuse of: (a) Alcohol; (b) Controlled substances; or (c) Legend drugs;(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health- related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards."
On page 1, line 1 of the title, after "prevention;" strike the remainder of the title and insert "amending RCW 18.130.180; reenacting and amending RCW 9.94A.535; adding a new section to chapter 69.50 RCW; adding a new section to chapter 18.130 RCW; and creating a new section."

EFFECT: A person will not be charged or prosecuted for possession of a controlled substance under the Uniform Controlled Substances Act if: (1) That person believes he or she is witnessing a drug-related overdose and seeks medical assistance for that person in good faith; or(2) that person experiences a drug-related overdose and is in need of medical assistance. A person will also not be charged if the evidence for the charge of possession of a controlled substance under RCW 69.50.4013, or penalty under RCW 69.50.4014, was obtained as a result of that person seeking or receiving medical assistance. However, that person remains liable for charges of manufacturing or sale of a controlled substance. This protection does not apply to suppression of evidence in other criminal charges.

A person acting in good faith may receive, possess, and administer naloxone to an individual suffering from an apparent opiate-related overdose. Health practitioners or persons who administer, dispense, prescribe, purchase, acquire, possess, or use naloxone in a good faith effort to assist a person experiencing or likely to experience an opiate-related overdose will not be in violation of professional conduct standards or provisions.

A court may impose an exceptional sentence below the standard range if it finds that mitigating circumstances are established by a preponderance of the evidence including, but not limited to, a defendant's good faith effort to obtain or provide medical assistance for someone experiencing a drug-related overdose.

Appendix B:
Wisconsin Data Indicators and Sources

Expansion of WI Epidemiological Profile on Alcohol & Other Drugs

- Drug-Related Deaths [by county]
- Poisoning Deaths, opiate-related deaths or multi-drug deaths with opiates mentioned [statewide and county, if possible]
  Data source: Division of Public Health, Office of Health Informatics
- Drug Poisoning and Opiate Poisoning Hospital Visits (ED & Hospital Admissions)- [statewide and by county]
- Drug-related Substance Related Disorder (abuse, dependence and psychosis) and Opiate Non-Dependent Abuse & Dependence [statewide]
  Data source: Division of Public Health, Office of Health Informatics
- EMS Calls for Naloxone Dosing [Select agencies within Counties]
  Data source: County Emergency Medical Service providers
- Naloxone Use (saves) Report in Community Programs (Overdose Prevention) [statewide and by Region]
  Data source: ARCW's Lifepoint Fatal Overdose Prevention Program
- Police Report Drug Data - All Drug Overdoses & Deaths and Opiate Overdoses and Deaths by type [by County]
  Data source: WI Department of Justice, Div. Of Criminal Investigation, Field Operations Bureau and local County law enforcement agencies - narcotics
- Drug Behavior (Consumption) for Youth:
  - Use of prescription drugs for non-medical purposes (regional data?)

  Data source: National Survey on Drug Use, SAMSHA, *Division of Public Health, Office of Health Informatics*
  - Heroin use (lifetime) [by county]

  Data source: Youth Risk Behavioral Surveillance System, WI of Public Instruction
- Substance Abuse Treatment - Methadone Clinic admissions [statewide & by local geographic area]
  Data source: Division of Mental Health and Substance Abuse Services, Bureau of Treatment, Prevention & Recovery; local methadone clinic

Appendix C:
Ten Key Components of Drug Treatment Courts

1. Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

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