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opioid crisis -- state and federal response

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Introduction

Opioids are a class of natural or synthetic substances with similar effects on nerve cell receptors in the brain. Naturally occurring opioids, derived from the opium poppy, are called opiates, and include morphine, codeine, heroin, and opium. Other opioids, such as hydrocodone, oxycodone, fentanyl, and methadone, are synthesized from organic chemical substrates.

Some opioids are commonly prescribed to provide short-term pain relief following surgery, injury, and trauma, and to relieve ongoing pain caused by cancer and severe, chronic, and disabling diseases. Prescription opioids include OxyContin (oxycodone), Vicodin (hydrocodone with acetaminophen), Dilaudid (hydromorphone), and morphine. Other opioids, such as heroin, have no accepted medical purpose and are produced and sold illicitly.

Opioids are addictive because they artificially trigger the release of endorphins, neurotransmitters that dampen perceptions of pain and boost feelings of pleasure. Repeated use of opioids reduces a body's natural production of endorphins. Over time, an individual who abuses opioids must continue to increase the amount of opioids they use to maintain the same level of feelings of pleasure (tolerance).

Opioid use disorder (OUD) is a substance use disorder that leads to significant impairment or distress. Individuals with OUD typically use opioids in larger amounts or for longer periods than prescribed, spend much time obtaining, using, and recovering from opioid use, and experience persistent or recurrent social or interpersonal problems caused by, or exacerbated by, the effects of opioids. Individuals who try to reduce or terminate regular use of opioids usually suffer symptoms of withdrawal, characterized by anxiety, restlessness, diarrhea, abdominal cramping, nausea, and vomiting. Based on national survey data, the federal Substance Abuse and Mental Health Services Administration estimates that, in 2018, approximately 2.1 million people in the United States had OUD.

The National Institutes of Health describes the origin and progression of the national opioid epidemic as follows:

In the late 1990s, pharmaceutical companies that manufactured opioids assured health care providers that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at greater rates. This subsequently led to widespread diversion and misuse of these medications before it became clear that these medications could indeed be highly addictive. Opioid overdose rates began to increase. In 2017, more than 47,000 Americans died as a result of an opioid overdose, including prescription opioids, heroin, and illicitly manufactured fentanyl, a powerful synthetic opioid. That same year, an estimated 1.7 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers, and 652,000 suffered from a heroin disorder (not mutually exclusive).

Experts describe the national opioid epidemic as occurring in three waves, or phases. The first began in 1999, when deaths involving opioids began to rise following a significant increase in opioid prescribing. The second followed about ten years later, when deaths involving heroin began to increase, as the price of heroin decreased and heroin became more accessible. This occurred as a result of increased production and importation of

heroin, primarily from Mexico and Columbia. Individuals who had become dependent on prescription opioids during the first wave were particularly susceptible to heroin addiction. (The National Institute on Drug Abuse indicates that nationally, 80% of heroin users reported using prescription opioids prior to heroin.) The third phase began around 2014, when synthetic drugs (notably fentanyl) became more readily available. Fentanyl, which may be 50 to 100 times more potent than morphine, can be mixed with heroin, cocaine, methamphetamines, and other drugs to produce a cheaper, but more potent, alternative to other opioids.

This paper provides a summary of recent state and federal legislation enacted to reduce opioid use and improve access to services to individuals who abuse opioids. It also provides information on opioid use and abuse in Wisconsin.

Wisconsin's Prescription Drug Monitoring Program (PDMP)

2009 Wisconsin Act 362 directed the Pharmacy Examining Board to develop, by rule, a program to monitor dispensing of controlled substances in Wisconsin that have the potential for abuse. The act specified various program requirements, provided certain legal protections for prescribers and pharmacists that used the program, and directed the Department of Regulation and Licensing [now, the Department of Safety and Professional Services (DSPS)] to seek federal funding for the development and operation of the program. The program began operating in June of 2013. DSPS developed an enhanced version of the program, the ePDMP, which began operating in 2017.

The program is authorized under s. 961.385 of the statutes, and its operations are governed by the Controlled Substances Board (CSB), based on rules promulgated under CSB 4.

The program requires dispensers (pharmacists and health care providers authorized to dispense monitored prescription drugs) to compile specified information each time they dispense a monitored drug, including the date a drug was dispensed, the quantity, the estimated days of drug therapy, the number of refills authorized by the prescriber, and the patient's name, address, and date of birth. Dispensers may delegate this reporting responsibility to a managing pharmacist of the pharmacy or an agent or employee of a practitioner. Dispensers are required to submit the information electronically to the Prescription Drug Monitoring Program (PDMP) by 11:59 p.m. of the next business day after dispensing a monitored drug. If a dispenser did not dispense a monitored drug on the previous day, he or she is required to submit a "zero report," that accounts for each business day on which the dispenser did not dispense a monitored drug. The rules specify several exemptions to the submission requirements, including: (a) drugs administered directly to a patient; (b) drugs that the dispenser prepares, but that are not delivered to a patient; and (c) drugs that are not narcotic drugs that are dispensed pursuant to a prescription order that is intended to last the patient seven days or less.

The CSB is authorized to refer any dispenser or delegate that fails to submit dispensing information or zero reports, or submits false dispensing information, to the appropriate licensing or regulatory board for disciplinary action. Healthcare professionals may access monitored drug history reports if they are directly treating or rendering assistance to a patient, or if the healthcare professional is being consulted regarding the health of a patient, by an individual who is directly treating or rendering assistance to the patient.

Law enforcement agencies are required to submit reports to the PDMP under the following circumstances: (a) when an officer suspects that a person violated the federal Controlled Substances

Act with a prescription drug; (b) when a person is suspected of having experienced a fatal or non-fatal opioid-related overdose; or (c) when a person reports to the agency that his or her controlled substance prescription has been stolen. The PDMP provides summary information on these alerts by time period, county, and type of alert.

The statutes require the CSB to submit quarterly reports to DSPS that includes specified information, such as the program's impact on referrals of pharmacists, pharmacies, and practitioners to licensing or regulatory boards for discipline and to law enforcement agencies for investigation and possible prosecution, and assessment of the trends and changes in the use of monitored prescription drugs in this state. In addition, DSPS has created an interactive dashboard that provides aggregated information on the dispensing of controlled substances, utilization of the PDMP, law enforcement alerts, and a statistics archive. The dashboard can be accessed at https://pdmp.wi.gov/statistics.

Federal Legislation

During the past several years, Congress enacted three major bills to address the national rise in drug misuse and addiction -- the Comprehensive Addiction and Recovery Act (P.L. 114-198), the 21st Century Cures Act (P.L. 114-255), and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients (SUPPORT) Act (P.L.115-271). A brief summary of the most significant features of these acts, as they relate to addressing the opioid epidemic, is provided below.

CARA. The Comprehensive Addiction and Recovery Act (CARA), enacted in July of 2016, created several programs, and expanded others, as part of a broad strategy to increase prevention and education, and promote treatment and recovery. Among its many provisions, the act: (a) created several federally-funded grant programs to reduce overdose deaths, and to support overdose reversal medication programs, recovery services, and training for first responders and emergency services personnel in treating persons who overdose; (b) increased federal support for, and promoted interoperability between state prescription drug monitoring programs; (c) created a grant program to implement or expand treatment alternatives to incarceration; (d) directed the Attorney General, in coordination with other agencies, to expand drug "take back" programs; (e) expanded access to medication-assisted treatment; (f) expanded recovery support for students in high school or enrolled in institutions of higher learning; and (g) expanded prevention and educational efforts, including those aimed at teenagers, parents and other caretakers, and aging populations.

CARA also reauthorized a grant program for residential opioid addiction treatment of pregnant and postpartum women and their children and created a pilot program for state substance abuse agencies to address identified gaps in the continuum of care, including non-residential treatment services. Finally, the act addressed opioid therapy, pain management, and health services available to veterans.

Although CARA authorized federal agencies to implement new programs and expand previously authorized programs, the act did not directly fund these programs. Instead, funding for these programs was provided through Congress' annual appropriation process.

The 21st Century Cures Act. The 21st Century Cures Act, enacted in December of 2016, included provisions that made significant changes to several aspects of the U.S. health system, including medical research and the development of new drugs and medical devices, mental health research and care, and electronic health records.

In addition, the act authorized one-time funding of $500 million in federal fiscal years (FFYs)

2015-16 and 2016-17 to support grants for state targeted responses to the opioid crisis (state opioid response grants). Of these amounts, Wisconsin received approximately $7,637,000 annually for use during a two-year period (May 1, 2017 through April 31, 2019).

Federal SUPPORT for Patients and Communities Act. The federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-227), enacted in October, 2018, addressed substance abuse exclusively. The act established new federal grant programs, reauthorized and modified existing programs, and included provisions relating to Medicare and Medicaid services and state PDMPs.

The act created 21 new grant programs administered by several federal agencies, including the Department of Health and Human Services, and the Departments of Housing and Urban Development, Justice, and Labor. Most of the programs were created as competitive grant programs, although two new programs authorized formula grants to states -- one to ensure the safety, permanency and well-being of infants affected by substance use, funded as part of the child abuse prevention and treatment grant program, and one to fund stable housing for individuals in recovery from substance abuse disorders.

The act reauthorized the state opioid response grant program that was created in the 21st Century Cures Act, and authorized $500 million annually for the program through fiscal year 2022-23. (For FFY 2018-19, Congress authorized $1.5 billion for this program.) As a result, Wisconsin's allocations increased to $11,979,300 per year for FFY 2016-17 and 2017-18 and to $18,233,000 in FFY 2018-19. For FFY 2019-20, Wisconsin was allocated $16,728,000.

In addition, the act made several changes to Medicaid to improve access, treatment, and recovery services. For example, the act authorizes individuals with substance use disorders in institutions for mental disease to receive more Medicaid-covered services, and requires states to provide Medicaid coverage for all drugs approved by the federal Food and Drug Administration for medication-assisted treatment.

As a result of the enactment of these three federal acts and subsequent federal budget enactments, the amount of federal funding provided to address the opioid crisis has increased significantly during the past several years. Federal Funds Information for States, a nonprofit research agency that provides information to states on the federal budget, reports that federal funding for programs created specifically to address the opioid crisis increased from approximately $155.5 million in FFY 2014-15 to $3.2 billion in FFY 2018-19.

For states, the single largest source of federal funding provided to support opioid prevention, treatment, and recovery services has been the state opioid response grant program. The Wisconsin Department of Health Services (DHS) maintains a website with information on the services that have been funded with these grants, including an annual summary report (www.dhs.wisconsin.gov/opioids/federal-grants.htm).

In addition to receiving funding under the state opioid response grant program, which is available to fund prevention, treatment, and recovery services, Wisconsin received a three-year grant of , $15,585,000 from the Centers for Disease Control and Prevention as part of the Overdose Data to Action program. This funding is available to support state, territorial, county, and city health departments in obtaining higher quality, more comprehensive, and timelier data on overdose morbidity and mortality and using these data to improve prevention and response efforts. The grant period runs from September 1, 2019 through August 31, 2022.

State Legislation

In 2013, the Legislature began enacting a series of bills, collectively referred to as the HOPE (Heroin and Opioid Prevention and Education) Agenda, to address the opioid epidemic. The acts have focused on improving responses to overdose incidents, the dispensing and disposal of opioid medications, and expanding treatment and recovery services. In addition, funding for program services has been provided through biennial budget acts. Brief summaries of the provisions of these acts are presented below.

2013 Session

Act 20 (the 2013-15 biennial budget act). Provided $64,600 GPR in 2013-14 and $1,282,700 GPR in 2014-15 for DHS to distribute grants to regional peer-run respite centers for people with mental health or substance abuse concerns, with the goal of improving crisis treatment and reducing inpatient hospitalizations. Provided funding to support: (a) three regional peer-run centers, beginning in 2014-15, each with an annual allocation of $400,000 ($1,200,000 total); and (b) one position to administer the program ($64,600 in 2013-14 and $82,700 in 2014-15.) (Although not considered a part of the HOPE agenda, a subsequent act passed during the 2013 session provided an additional $125,000 for peer-run centers.)

Increased funding for the treatment alternatives and diversion (TAD) program administered by the Department of Justice (DOJ), by $1,000,000 GPR annually, beginning in 2013-14. In 2012-13, base funding for the program was $1,085,900, which was supported from program revenues from the justice information surcharge ($1,078,400) and the drug abuse program improvement surcharge and drug offender diversion surcharge ($7,500).

Provided an additional $500,000 GPR annually for DOJ to provide grant funding to counties to establish and operate drug courts. Defined a "drug court" as a court that diverts a substance-abusing person from prison or jail into treatment by increasing direct supervision of the person, coordinating public resources, providing intensive community-based treatment, and expediting case processing.

Act 194. Provided immunity from criminal prosecution for a person who possesses a controlled substance or drug paraphernalia if the person provides aid to a person who is, or is believed to be, experiencing an overdose by taking them to an emergency room or calling emergency services to assist.

Act 195. Directed DHS to create two or three regional comprehensive opioid treatment programs to provide treatment for opiate addiction in rural and underserved, high-need areas. Specified various program components, and directed DHS to submit annual reports on the programs' outcomes. In the 2013-15 biennium, it required DHS to seek funding for the programs by making one or more funding requests to the Joint Committee on Finance. The Committee approved $1,056,000 for this grant program 2014-15 and established the base funding at $2,016,000 for 2015-16.

Act 196. Directed the Department of Corrections (DOC) to develop a system of short-term sanctions for individuals who are on extended supervision, parole or probation, or subject to a deferred prosecution agreement who possess, or attempt to possess a narcotic drug, in order to provide clear and immediate consequences for violations. Specified that the system must include several features, such as taking into account the public's safety, correcting the individual's behavior, holding the person accountable, and rewarding offenders for compliance.

Act 197. Increased funding for the treatment and diversion (TAD) grant program administered by DOJ, by $1,500,000 GPR annually, beginning

in 2013-14. Required counties that receive grant funding to submit monthly data to DOJ, and required DOJ to produce a progress report that evaluates the effectiveness of the grant program. It also required DOJ to produce, every five years, a comprehensive report that analyzes program data, and a cost benefit analysis of the grant program.

Act 198. Authorized the operation of drug disposal programs approved by DOJ, and established requirements for persons, cities, villages, towns, and counties that operate such programs. Created definitions of "household pharmaceutical items" for these purpose, and specified that all of the act's provisions would take effect July 1, 2015.

Act 199. Required individuals to provide an identification (ID) card at the time a controlled substance is dispensed or delivered, and required the dispenser to record the name of each ID card, and maintain the record for a period determined by the Controlled Substances Board. Provided immunity to pharmacists for any act taken by the pharmacist, in reliance on an ID card that the pharmacist reasonably believed was authentic and displayed the name of the person to whom the drug was being delivered, if the sale was made in good faith.

Act 200. Provided for the administration of naloxone (Narcan), an opioid antagonist used in emergency situations to counter the effects of an opioid overdose. Authorized certified first responders, emergency medical technicians (EMTs), law enforcement officers, and firefighters to administer naloxone or another opioid antagonist to individuals who are undergoing, or believed to be undergoing, an opioid-related drug overdose. Required DHS to permit all EMTs to administer naloxone, and directed DHS to require EMTs to undergo any training necessary to safely and properly administer naloxone or another opioid antagonist. Required ambulance service providers to have a supply of naloxone or other opioid antagonist available for administration by EMTs, to the extent that the opioid antagonist is available to the ambulance service provider.

Authorized a licensed physician, physician assistant and advanced practical nurse (APRN) who is certified to issue prescription orders to prescribe an opioid antagonist to a person who is in a position to assist another person who is at risk of experiencing an opioid-related drug overdose, either directly or by using a standing order, if: (a) the person to whom the drug is delivered or dispensed has the knowledge and training necessary to safely administer it to an individual who is experiencing an opioid-related overdose; and (b) the person to whom the drug will be delivered or dispensed will ensure that any individual to whom the person further delivers or dispenses the drug has or receives that knowledge and training necessary to safely administer it to an individual experiencing an opioid-related overdose. (A standing order allows a pharmacy to dispense the opioid antagonist without a patient-specific prescription.)

Provided that a licensed physician, licensed physician assistant, or APRN, who, while acting in good faith, prescribes, delivers or dispenses an opioid antagonist in accordance with procedures created in the act may not be subject to professional discipline for any outcomes resulting from prescribing, delivering or dispensing that drug, and is immune from criminal or civil liability. Created the same immunity from professional discipline and criminal or civil liability for pharmacists, who, in good faith, deliver opioid antagonists.

Provided that any person who, acting in good faith, delivers or dispenses an opioid antagonist to another person is immune from civil or criminal liability for any outcomes resulting from delivering or dispensing the opioid antagonist.

2015 Session

Act 115. Clarified provisions created in 2013 Act 200 relating to the use of standing orders that

authorize prescribing and dispensing of opioid antagonists by APRNs, physicians, and pharmacists by adding references to these orders in Chapter 441 (Regulation of Nursing), 448 (Medical Practices) and 450 (Pharmacy Examining Board).

Act 264. Prohibited an individual from using or possessing, with the primary purpose to use, a masking agent, which is defined as any substance or device that is intended for use to defraud, circumvent, interfere with, or provide a substitute for a bodily fluid in conjunction with a lawfully administered drug test. Prohibited advertising to promote the sale of a masking agent. Established penalties for violations of these prohibitions.

Act 265. Provided for the regulation and certification of pain clinics by DHS. Defined a "pain clinic" as either of the following: (a) a privately owned facility where a majority of the health care providers, practicing within the scope of their licenses, devotes a majority of their practices to the treatment of pain syndromes through the practice of pain medicine or interventional pain medicine; or (b) a privately owned facility that advertises or otherwise holds itself out as providing pain medicine services and that has one or more employees or contractors who prescribe opioids or opiates, benzodiazepines, barbiturates, or carisoprodol (muscle relaxers) as chronic therapy for pain syndromes.

Required pain clinics to be certified by DHS in order to operate, and to meet certification requirements established by DHS. Provided that operating certificates issued by DHS are valid for three years, and may be renewed. Exempted certain types of health care providers, including hospitals, medical schools, hospices, and nursing homes, from the certification requirements. Authorized DHS, after consulting with the Medical Examining Board, to promulgate rules governing the operation of pain clinics.

Act 266. Required pharmacy or practitioners to submit a record to the PDMP documenting each dispensing of a monitored prescription drug by 11:59 p.m. of the next business day after the drug is dispensed. (Previously, there was no time frame required for the submission of a record.) Required a practitioner to review a patient's PDMP records before issuing a prescription order for the patient for a monitored drug, with specified exceptions.

Required the Controlled Substance Board to permit disclosure of PDMP information to: (a) relevant prosecutorial units; (b) individuals authorized to treat alcohol or substance dependency or abuse; (c) a practitioner, pharmacist, registered nurse, or substance abuse counselor who is treating or rendering assistance to the patient; (d) certain individuals for the purposes of evaluating the job performance of a practitioner or performing certain quality assessment and improvement activities, if the information disclosed does not contain personally identifiable information; and (e) a state board or agency, law enforcement agency, or prosecutorial unit if a written request is made, the requester is engaged in an active investigation or prosecution of a drug violation, and the record is reasonably related to that investigation or prosecution.

Applied PDMP requirements relating to the dispensing of monitored drugs by pharmacists to also apply to monitored drugs dispensed pursuant to a prescription order issued by a veterinarian for an animal patient. However, veterinarians are not required to submit information to the PDMP.

Act 267. Created review and reporting requirements relating to the PDMP, effective through October 30, 2020 (and subsequently extended). Required the Controlled Substances Board ("the Board") to conduct a quarterly review of the PDMP to evaluate program outcomes, including: (a) the satisfaction with the program of pharmacists, pharmacies, practitioners and users; (b) the program's impact on referrals of pharmacists, pharmacies, and practitioners to licensing or regulatory boards for discipline and to law enforcement agencies for investigation and possible

prosecution.

Required the Board to provide quarterly reports to DSPS that includes all of the following: (a) the results of the Board's reviews, as described above; (b) an assessment of the trends and changes in the use of monitored prescription drugs in the state; (c) the number of practitioners, by profession, and pharmacies submitting records to the Board in the previous quarter; (d) a description of the number, frequency, and nature of submissions by law enforcement agencies; (e) a description of the number, frequency, and nature of requests made in the previous quarter for disclosure of records generated under the program; (f) the number of individuals receiving prescription orders from five or more practitioners or having monitored prescription drugs dispensed by five or more pharmacies within the same 90-day period at any time over the course of the program; (g) the number of individuals receiving daily morphine milligram equivalents of one to 19 milligrams, 20 to 49 milligrams, 50 to 99 milligrams and 100 or more milligrams in the previous quarter; and (h) the number of individuals to whom both opioids and benzodiazepines were dispensed within the same 90-day period at any time over the course of the program.

Authorized the Board to contract with an analytics firm to augment the PDMP with an analytics platform that provides data integration, advanced analytics, and alert management capabilities to detect problematic behaviors of practitioners, pharmacies, pharmacists and patients. Created statutory goals for such augmentation.

Act 268. Required law enforcement officers to report to the PDMP the inappropriate or illegal use of monitored prescription drugs, opioid-related drug overdoses, and reports of stolen prescription drugs. Specified that the report must include names and birthdates of individuals involved in these cases, which must be available to relevant practitioners, pharmacists and others.

Act 388. Provided $2,000,000 PR in 2016-17 of unallocated program revenue DHS collects for the operation of DHS care and treatment facilities to the Department of Justice to provide as grants to counties under the treatment and diversion grant program.

Modified the TAD program to specify that counties receiving funding must allow a participant to use a medication that is approved by the U.S. Food and Drug Administration if all of the following are true: (a) a licensed health care provider, acting in the scope of his or her practice, has examined the person and determined that the person's use of the medication is an appropriate treatment for the person's substance use disorder; (b) the medication was appropriately prescribed by a person authorized to prescribe medication in Wisconsin; and (c) the person is using the medication as prescribed as part of a treatment for a diagnosed substance use disorder.

2017 Session

Act 25. Prohibited certain narcotic drugs that contain nonnarcotic, medicinal active ingredients, such as codeine cough syrup, from being dispensed without a prescription.

Act 26. Provided $63,000 GPR annually, beginning in 2017-18, to support fellowships in addiction medicine or addiction psychiatry in graduate medical training programs. Authorized DHS to award these funds to hospitals to increase the number of physicians trained in an addiction specialty.

Act 27. Provided $1,000,000 GPR annually, beginning in 2017-18, to create two or three additional regional comprehensive opioid and methamphetamine treatment programs, and expanded the treatment program created in 2013 Act 195 to include methamphetamine treatment programs.

Act 28. Provided $500,000 GPR annually, beginning in 2017-18, to create an addiction medicine consultation program that assists

participating clinicians in providing enhanced care to patients with substance use addiction, and offers provider referral support for patients with substance use disorder. Specified conditions a qualified organization must meet in order to contract with DHS to provide these services, and that these consultations could be provided by teleconference, voice over Internet protocol, electronic mail, pager, or in-person conference.

Act 29. Provided civil immunity for school employees who administer an opioid antagonist to students who experience an overdose if, as soon as practicable, the employee reports the drug overdose by dialing 911 or the telephone number for an emergency medical service provider.

Authorized a residence hall director employed by the University of Wisconsin (UW) System, a technical college district, or the governing body of a private college to administer an opioid antagonist to a student or any other person who appears to be undergoing an opioid-related drug overdose if the residence hall director received training approved by his or her employer, and he or she reports the drug overdose by dialing 911 or the telephone number for an emergency medical service provider. Provided civil immunity for the residence hall director, or the employer who approved training for the residence hall director, for acts or omissions in administering the opioid antagonist, unless the act or omission constitutes a high degree of negligence. Specified that this civil immunity does not apply to health care professionals.

Act 30. Provided one-time funding of $50,000 GPR in 2017-18 to fund start-up costs for the Office of Educational Opportunity (OEO) in the University of Wisconsin System to contract for the establishment of a charter school for high school students in recovery, but required OEO to secure matching funds to access the state funds. In addition, funding to operate the charter school was provided from federal funds and a sum sufficient appropriation from the state to provide per pupil payments.

Specified that the OEO Director may contract to establish, as a pilot project, one recovery charter school that operates only high school grades, for four consecutive school years, and required that the charter school operator: (a) provides academic curriculum that satisfies state high school graduation requirements; (b) provides therapeutic programming and support for pupils recovering from substance use disorder or dependency; (c) establishes suspension and expulsion policies, modeled after state expulsion law; and (d) permits a pupil to withdraw from the school upon completion of any required treatment program. Limited enrollment at the charter school to no more than 15 pupils at a time.

Specified that, as a condition of enrollment, a pupil must: (a) begin treatment in a substance use disorder or dependency program; (b) maintain sobriety for at least 30 days prior to attending the school; and (c) submit to a drug screening assessment, and, if indicated, a drug test. To maintain enrollment, students must receive counseling from substance use disorder or dependency counselors employed by the school, and, if the pupil has coverage for mental health service under a health plan, submit claims for coverage of therapy and counseling provided by the school to that plan.

Required health policies, plans and contracts to cover mental health or behavioral health treatments or services provided in a recovery charter school if they would cover the same treatments or services provided by another health care provider. Required the OEO Director to report to DHS on the operation and effectiveness of the charter school following the third year the charter school operates. (To date, OEO has not implement this provision.)

Act 31. Provided $200,000 GPR annually, beginning in 2017-18, for the Department of Public Instruction (DPI) to establish a mental health training support program, under which DPI provides training on the 'screening, brief intervention, and referral to treatment' program, an evidence-based

strategy related to addressing mental health issues in schools, to school district staff and instructional staff of charter schools.

Act 32. Provided additional funding for diversion programs as follows: (a) increased funding for grants under the DOJ treatment and diversion grant program by $2,000,000 GPR annually, beginning in 2017-18 to replace one-time PR funding provided under 2015 Act 388; (b) increased funding for the DOJ treatment and diversion grant program by $150,000 GPR annually, beginning in 2017-18, to expand the grant program to additional counties; and (c) provided $261,000 GPR annually, beginning in 2017-18, in the Joint Committee on Finance program supplements appropriation, to fund a new diversion pilot program for nonviolent offenders to be diverted to a treatment option. Required DOJ to submit a request of the release of this funding to support the pilot program, under a 14-day passive review process. Repealed a new appropriation to fund the pilot program on July 1, 2019.

Act 33. Expanded the provisions created in 2013 Act 200 (the "Good Samaritan Law') by extending immunity to a person experiencing an overdose from revocation of parole, probation, or extended supervision if that person completes a treatment program or, if the program was not available or financially prohibitive, agrees to spend 15 days in a county jail. Includes several clarifying provisions to Act 200.

Act 34. Modified provisions authorizing emergency civil commitments for intoxicated persons and involuntary civil commitments of alcoholics to include persons who have drug dependence, who are incapacitated by the use of drugs, and who habitually lack self-control as to the use of drugs. Provided for the voluntary treatment of drug-dependent persons at approved public treatment facilities.

For these purposes, defined "drug dependence" as a disease that is characterized by a person's use of one or more drugs that is beyond the person's ability to control to the extent that the person's physical health is substantially affected.

Act 35. Provided $420,000 GPR annually, beginning in 2017-18, to fund an additional 4.0 GPR criminal investigation agents in DOJ that are focused on drug interdiction and drug trafficking. Provided that any unencumbered portion of this funding increase that results from a delay in filling the positions by June 30, 2018, may be transferred to increase support for the DOJ treatment and diversion program, subject to approval by the Joint Committee on Finance under a 14-day passive review process.

Act 59 (the 2017-19 biennial budget act). Authorized DHS to provide MA coverage for services provided in an institution for mental disease (IMD) for persons ages of 21 through 64 to the extent permitted under federal law or under waiver agreement, if federal financial participation is available to support these services. (DHS had submitted a federal waiver to allow the state to receive federal matching funds for IMD services for persons requiring substance abuse treatment.)

Act 202. Authorized the Department of Children and Families (DCF) to provide grants to counties and Indian tribes to establish and operate evidence-based treatment programs, including substance abuse treatment services, to develop intake and court procedures that screen, assess, and provide dispositional alternatives for parents whose children have come under a court's jurisdiction. Specified requirements for grantees and reporting requirements for DCF.

Act 261. Provided $750,000 GPR annually, beginning in 2017-18, for DHS to distribute as grants to counties and tribes to provide nonnarcotic, nonaddictive, injectable medically assisted treatment to jail inmates who voluntarily receive the treatment within the five days immediately preceding release from jail. Required participating counties

and tribes to ensure that all program participants are enrolled in Medicaid and will continue to receive treatment after an inmate leaves county or tribal jail custody.

Provided $500,000 FED from the temporary assistance to needy families (TANF) block grant annually, beginning in 2018-19, for DCF to provide as grants for evidence-based programs and practices for substance abuse prevention to at-risk youth and their families. Prohibited DCF from awarding a grant to county or a tribe that offered these services in the preceding fiscal year unless these services were previously funded under this grant program.

Provided $250,000 GPR annually, beginning in 2017-18, to fund family and juvenile treatment court grants program created in 2017 Act 202.

Provided $1,000,000 GPR annually, beginning in 2018-19, for DOJ to fund grants to Wisconsin and tribal law enforcement agencies to support law enforcement response to drug trafficking, and directed DOJ to establish policies and procedures for the distribution of these grants. Limited grant awards to $50,000 per application and $100,000 per agency. Required applicants to use grant funds for new programs or purposes within an agency, and prohibited grant recipients from using the awards to supplement an existing program.

Provided $300,000 GPR annually, beginning in 2017-18, to fund 2.0 attorney five-year project positions to assist the DOJ Division of Criminal Investigation in the field offices of Wausau and Appleton and to assist district attorneys in prosecuting drug-related offenses. Directed DOJ to submit an annual report to the Joint Committee on Finance describing the activities and assessing the effectiveness of these positions.

Authorized a court to order a person who pleads guilty or is found guilty of a drug violation to attend a program, such as a victim impact panel, that demonstrates the adverse effects of substance abuse on an individual or an individual's family. Authorized the court to order the person to pay a reasonable fee, based on the person's ability to pay, to offset the costs of assembling and hosting the program.

2019 Session

Act 9 (the 2019-21 biennial budget act). Provided DOJ $1,000,000 GPR in both 2019-20 and 2020-21 in one-time funding to increase support for the treatment alternatives and diversion (TAD) program.

Provided DOJ $261,000 GPR annually in both 2019-20 and 2020-21 to continue funding for the nonviolent offender treatment diversion pilot program created in 2017 Act 32. Extended the repeal of the program to July 1, 2021, from July 1, 2019.

Provided the Department of Safety and Professional Services $186,300 FED in 2019-20 and $52,500 FED in 2020-21 to create a data exchange between the Wisconsin Ambulance Run Data System (WARDS) and the PDMP so that Naloxone administered by ambulance service providers can be entered into the PDMP database. Provided $17,500 FED in 2019-20 and $4,400 FED in 2020-21 to create opioid naïve alerts that notify prescribers that a patient may never have been prescribed opioids before.

Repealed a provision that prevented the regional comprehensive opioid treatment programs, funded from DHS, from offering methadone treatment.

Act 121. Extended for five years, from April 1, 2020 to April 1, 2025, the requirement that a practitioner review a patient's records under the PDMP before issuing a prescription order for a monitored prescription. Extended for five years, from October 30, 2020 to October 30, 2025, the requirement that the Controlled Substances Board conduct a quarterly review of the PDMP to evaluate actual outcomes of the PDMP, compared with projected outcomes.

Trends in Opioid Prescribing, Opioid-Related Medical Emergencies and Deaths

The PDMP statistics dashboard presents data on prescribing patterns for opioids and other monitored drugs for the past several years. Table 1 shows the number of prescriptions filled for all monitored drugs, including opioids, by drug class in each year from 2014 through 2019. Notably, the number of prescriptions dispensed for opioids decreased each year during this period.

Table 2 shows the decrease in the average monthly number of Wisconsin residents who were prescribed monitored drugs from 2016 through 2019.

The PDMP uses data analytics to assess a patient's controlled substance prescription history and provides monthly reports on the number of patients who met the criteria for each type of patient history alert. Table 3 shows the annual number of patients that met the criteria for a PDMP alert in 2016 through 2019.

Wisconsin hospitals are required to submit, on a quarterly basis, administrative billing data on their discharges, including emergency room and inpatient services they provide. These data are collected on behalf of the state by the Wisconsin Hospital Association Information Center, and are combined with other information on the hospital services provided in neighboring states to Wisconsin residents.

Table 4 shows the number of opioid-related emergency room and inpatient discharges for calendar years 2007 through 2019. The table shows the rise in these opioid-related emergency room and inpatient discharges, but a decrease in opioid-related hospital services during the past few years.

The DHS Office of Health Informatics collects information from Wisconsin death certificates to summarize the cause of death of Wisconsin residents. Table 5 shows the number of opioid-related deaths of Wisconsin residents, including the steep increase in deaths involving synthetic opioids, such as fentanyl, between calendar year 2014 and 2019.

Table 1: Number of Prescriptions Dispensed, by Drug Class

	2014	2015	2016	2017	2018	2019
Opioids	5,081,327	5,014,011	4,709,813	4,062,133	3,569,147	3,319,308
Benzodiazepines	2,309,729	2,322,047	2,287,051	2,065,815	1,879,410	1,764,997
Stimulants	1,540,167	1,624,227	1,719,575	1,709,511	1,707,048	1,747,747
Other	1,386,763	1,465,327	1,388,612	1,287,585	1,195,616	1,139,702
Total	10,317,986	10,425,612	10,105,051	9,125,044	8,351,221	7,971,754

Table 2: Average Monthly Number of Patients Dispensed Monitored Substances, by Sex and Year

	2016	2017	2018	2019
Males	207,399	192,719	183,590	176,048
Females	270,593	249,689	237,227	226,909
Total	481,647	443,404	421,633	403,757

Table 3: Number of Patients Meeting PDMP Alert Criteria, by Calendar Year

	2016	2017	2018	2019
Early Refill	103,879	88,701	75,908	65,081
Concurrent Benzodiazepine and Opioid	169,344	139,960	114,910	99,281
Long-Term Opioid Therapy	147,091	130,650	113,654	104,094
Multiple Prescribers or Pharmacies	111,227	87,334	69,044	61,708
Multiple Same Day Prescriptions	8,516	8,120	5,353	5,156
High Opioid Daily Dose	179,668	143,300	108,686	80,774
Total	719,725	598,065	487,555	416,094

Note: A patient can be included in the count for more than one alert type. Further, although these alerts were not available in the PDMP prior to January 17, 2017, DSPS applied the criteria to meet these alerts to data from previous years to give an indication of how many alerts would have existed during those years.

Table 4: Opioid-Related Emergency Room Visits and Inpatient Discharges

	Number of Emergency Room Discharges				Number of Inpatient Discharges			
	Heroin	Methadone	Other	Total	Heroin	Methadone	Other	Total
2007	94	50	577	714	56	167	871	1,068
2008	122	64	589	765	101	140	990	1,206
2009	191	44	690	914	104	138	1,018	1,236
2010	253	44	688	975	133	150	1,050	1,303
2011	403	41	769	1,197	178	118	1,109	1,371
2012	545	44	786	1,361	209	116	1,259	1,547
2013	599	34	732	1,350	231	90	1,196	1,491
2014	706	42	771	1,489	292	81	1,183	1,528
2015	1,024	36	1,007	2,040	373	77	1,178	1,601
2016	1,352	30	1,122	2,485	420	85	1,265	1,733
2017	1,738	30	1,303	3,050	481	78	1,183	1,707
2018	1,386	25	1,024	2,426	359	50	852	1,245
2019	1,409	21	1,141	2,549	382	38	780	1,181

Table 5: Wisconsin Opioid-Related Deaths, by Opioid Type

	Heroin	Prescription	Synthetic	All Opiods*
2000	28	66	23	111
2001	20	87	24	132
2002	27	126	26	172
2003	25	136	42	194
2004	21	161	42	220
2005	30	199	52	270
2006	29	253	54	333
2007	34	285	55	370
2008	67	262	51	359
2009	75	260	76	396
2010	91	281	65	410
2011	134	286	60	469
2012	187	288	60	502
2013	226	329	80	588
2014	269	336	90	628
2015	281	298	112	613
2016	381	376	283	850
2017	415	369	468	932
2018	327	297	504	839
2019	285	282	651	916

*The sum of the columns exceeds the totals because some deaths are attributable to more than one type of opioid.

National and State Prescription Opiate Litigation

In response to over 2,000 pending lawsuits filed against manufacturers, retailers and distributors of prescription opiate drugs, the United States Judicial Panel on Multi-District Litigation assigned a federal district judge of the Northern District of Ohio, Judge Dan Polster, to oversee consolidated litigation, known as the National Prescription Opiate Litigation. Although it is possible that these lawsuits will go to trial in the original courts where the cases were filed, it is most likely that the lawsuits will be resolved through settlement agreements. In general, drug manufacturers are accused of aggressively marketing their opioid products, while downplaying risks of addiction and overdose. Distributors are accused of failing to detect, question, and report suspicious orders.

In September, 2019, Judge Polster approved a plan to establish a "negotiation class" that authorized attorneys from 49 local governments to negotiate a settlement on behalf of every city and county that filed a lawsuit, unless a city or county chooses to opt out of the agreement. Any settlement agreement negotiation by the attorneys and a company must be approved by a vote of the negotiation class, which would resolve all of the consolidated federal lawsuits against the company, and prevent cities and counties from filing future lawsuits in federal court against the company.

State governments are not part of the federal consolidated litigation. Instead, states attorneys general have generally filed lawsuits against drug manufacturers, retailers and pharmacies in state courts.

In May, 2019, the Wisconsin Department of Justice filed a lawsuit in the Dane County Circuit Court against Purdue Pharma LP, Purdue Pharma Inc. and Mr. Richard Sackler (the former president of Purdue Pharma, Inc.). The complaint asks the Court to: (a) to permanently enjoin the defendants, their agents, employees and others from engaging in untrue, misleading, and deceptive practices in the marketing, promotion, selling and distributing of their opioid products; (b) order the defendants to pay civil penalties of between $50 to $200 for each violation of Wisconsin's laws prohibiting false representations and fraudulent drug advertising; (c) order the defendants to pay all consumer protection surcharges, attorney fees, supplemental forfeitures and amounts reasonably necessary to remedy the harmful effects of the state violations; (d) order the defendants to abate the nuisance, to reimburse the cost of Wisconsin's abatement efforts, and to pay compensatory damages; and (e) grant such further relief as the Court deems necessary or appropriate to remedy the effects of the defendants' conduct. The case is not yet resolved.

In November, 2020, Judge Robert Drain of the U.S. Bankruptcy Count in White Plains, New York approved an $8.34 billion settlement between Purdue Pharma LP and the U.S. Department of Justice Department. The settlement requires Purdue Pharma to plead guilty to three felonies over its marketing and distribution of OxyContin and to support state and local government programs that address the opioid crisis. In addition, the settlement establishes a framework for the company to convert itself into a “public benefit company” that would focus on addressing the opioid crisis.

As of this writing, it is not known how these cases will be resolved, or what funding will become available to states and local governments as a result of this litigation.

Additional Resources

Additional state and federal information on the opioid epidemic is available through the following resources:

Wisconsin Department of Health Services -- OPIOIDS Home Page
https://www.dhs.wisconsin.gov/opioids/index.htm.

Wisconsin Department of Safety and Professional Services -- PDMP
https://pdmp.wi.gov/.

Wisconsin Department of Justice -- Prescription Painkiller Abuse Prevention
https://doseofrealitywi.gov/.

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration -- Home
https://www.samhsa.gov/.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention -- Opioid Overdose Data
https://www.cdc.gov/drugoverdose/data/index.html.