



Legislation to Combat the Opioid Crisis in Wisconsin

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Overview

For several years, the epidemic of opioid abuse has been prominent in news headlines and legislative agendas across the country. Many health, law enforcement, and political institutions have labeled the significant impact of opioid abuse on human lives and state resources a crisis. The Wisconsin Legislature responded in a bipartisan manner over the past three sessions by passing large packages of legislation aimed at opioid abuse treatment, prevention, and awareness. This report discusses the opioid epidemic at the national and state levels and the Wisconsin Legislature's response in the 2013, 2015, and 2017 legislative sessions.

Background on the opioid crisis

From the late 1990s to the present, the sale of opioid analgesics, overdose deaths, and substance abuse–related treatment involving opioid analgesics have risen rapidly.¹ Opioids include illegal substances like heroin as well as prescription drugs such as fentanyl, oxycodone, hydrocodone, codeine, and morphine. Popular painkillers like OxyContin and Vicodin combine an opioid with another analgesic such as aspirin, acetaminophen, or ibuprofen. Vicodin, a combination of acetaminophen and hydrocodone, became widely known to Wisconsin residents in the late 1990s when Brett Favre, the high profile quarterback for the Green Bay Packers football team, admitted to having substance abuse issues. During the mid-1990s, opioid analgesics, specifically OxyContin, were marketed to doctors as being less likely to be abused;² as a result, prescriptions for such drugs soared during this period. The federal government began to take notice of this rise, as well as the potential for abuse, in the early 2000s.³ By the time the epidemic was widely reported by the media, the abuse of opioid painkillers had taken a widespread toll across communities large and small, affecting drug overdose rates, crime rates, and medical costs.

Reports from the Centers for Disease Control on the increase of both opioid prescriptions and opioid drug abuse prompted several states to act. In Wisconsin, the State Council on Alcohol and Other Drug Abuse (SCAODA) organized workgroups on both prescription drug abuse (in 2010) and related heroin abuse (2013). Reports issued in

1. Centers for Disease Control, "Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999–2008," November 4, 2011, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w.

2. Esch, Caitlin, "How one sentence helped set off the opioid crisis," Marketplace, December 13, 2017, <https://www.marketplace.org/2017/12/13/health-care/uncertain-hour/opioid>.

3. U.S. Government Accountability Office, *Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem*, GAO-04-110, December 2003, <https://www.gao.gov/new.items/d04110.pdf>.

January 2012⁴ and July 2014⁵ identified issues concerning opioid abuse and called for strategies and community efforts to combat the epidemic. While many of the suggested strategies involved implementation on a local scale, others required statewide action and indicated the need for state legislation. Representative John Nygren (R-89), from Marinette, took the lead in the legislature; northern Wisconsin was hit particularly hard by the opioid abuse epidemic, and the representative's own family was affected by the crisis.⁶ The assembly used these personal experiences and the information gathered in the SCAODA reports to create a package of proposals to present to the full legislature aimed at stemming the tide of opioid-related drug abuse.

2013–14 legislation

The first wave of legislation representing the Wisconsin Legislature's strategy to combat opioid abuse was introduced in a group of bills presented as the HOPE (Heroin and Opioid Prevention and Education) Agenda. Representative Nygren was the lead author of the seven bills in the package: four were introduced in October 2013, three were introduced in January 2014, and all carried bipartisan support. These bills proposed laws that mirrored the strategies and recommendations proposed in the SCAODA reports on prescription drug abuse and heroin abuse. The first four bills focused on responding to incidents of opioid overdose, addressing issues related to obtaining and disposing of opioid prescriptions, and expanding or creating treatment programs on the local level.

Arguably the most high-profile bill of the first HOPE Agenda package was 2013 Assembly Bill 446 (2013 Wisconsin Act 200), which focused on the administration of Naloxone, commercially known as Narcan, by safety officers and Good Samaritans. Naloxone is an opioid antagonist used in emergency situations to counter the effects of an opioid overdose. The bill, as amended in committee, provided the opportunity for training first responders, emergency medical technicians, and police and fire officers in the administration of the drug as a way to lower the mortality rate of heroin and prescription opioid overdoses; in addition, it required EMTs to carry a supply of Naloxone and keep records of how it is administered. The bill also allowed physicians to prescribe Naloxone to trained individuals who were attempting to assist a person at risk of an overdose. Finally, it created immunity from civil and criminal liability for prescribers and administrators of Naloxone, with certain exceptions.

4. Wisconsin State Council on Alcohol and Other Drug Abuse, Prevention Committee, Controlled Substances Workgroup, *Reducing Wisconsin's Prescription Drug Abuse: A Call to Action*, January 2012, <https://scaoda.wisconsin.gov/scfiles/prevspf/FINAL01032012CSWReport.pdf>.

5. Wisconsin State Council on Alcohol and Other Drug Abuse, Prevention Committee, Heroin Ad-hoc Committee, *Wisconsin's Heroin Epidemic: Strategies and Solutions*, July 2014, <https://scaoda.wisconsin.gov/scfiles/docs/SCAODAHeroinReportFinal063014.pdf>.

6. Opoien, Jessie, "Lead by state Rep. John Nygren, Wisconsin families caught in heroin's grasp fight back," *The Capital Times*, December 2, 2015.

Like Assembly Bill 446, 2013 Assembly Bill 447 (2013 Wisconsin Act 194) took on an immediate problem of the opioid epidemic: addressing the fear of criminal prosecution that is sometimes a hindrance to those who would otherwise summon help for another person in the event of an overdose.⁷ In its amended form, the bill provided a person immunity from criminal prosecution for possession of a controlled substance and possession of drug paraphernalia if that person acted as an “aider” to someone suffering from a drug overdose. This meant that a companion of someone experiencing an overdose would be immune from possession charges if he or she took the overdosing person to the emergency room or called emergency services in order to aid them. Known popularly as the “911 Good Samaritan law,” the proposal was developed from the recommendations of SCAODA and the Department of Justice.⁸

The remaining two bills in the first HOPE Agenda package, 2013 Assembly Bills 445 (2013 Wisconsin Act 199) and 448 (2013 Wisconsin Act 198), focused on preventing prescription opioid abuse. In AB 445, lawmakers grappled with prescription fraud by requiring a person to show identification when picking up a prescription for a schedule II or schedule III drug.⁹ In addition, the bill required that the pharmacist record the name of the person and send that information to the Prescription Drug Monitoring Program (PDMP)¹⁰, which maintains information on all monitored prescription drugs dispensed to patients in the state.¹¹ Misuse of prescriptions was also addressed in AB 448, which authorized and regulated drug disposal programs through the Department of Justice and local governments. Drug disposal programs are aimed at getting unused prescription painkillers out of the hands of children or household members that would misuse them, since many people do not consider prescription drugs to be as dangerous as illegal narcotics and might use leftover doses of the drugs in a non-prescribed manner.

The final three bills of the first HOPE Agenda package focused on the ways that people who abuse opioids are sanctioned or receive treatment. Assembly Bills 668 and 701 expanded existing treatment programs by increasing funding and created pilot treatment programs in underserved areas. Assembly Bill 702 aimed to create a system of short-term but impactful sanctions for habitual drug offenders who violate probation or parole by possessing drugs.

In 2013 Assembly Bill 668 (2013 Wisconsin Act 197), the legislature used programs

7. Harsdorf, Sheila, testimony on 2013 Assembly Bill 447, hearing materials submitted to Legislative Council, January 9, 2014, 6.

8. Nygren, John, testimony on 2013 Assembly Bill 447, hearing materials submitted to Legislative Council, January 9, 2014, 3.

9. “Schedule” refers to the list in Chapter 961, Wisconsin Statutes, *Uniform Controlled Substances Act*. Several types of synthetic opiates and substances related to opium can be found in schedules II and III.

10. The PDMP was authorized in 2009 Wisconsin Act 362, and was established by federal funds; it began collecting information and issuing reports in 2013.

11. The requirement to supply the recorded name was implemented in April 2017. Wisconsin Department of Safety and Professional Services, “Wisconsin ePDMP,” March 20, 2017, <https://content.govdelivery.com/accounts/WIDSPS/bulletins/18d9900>.

that the state already had in place to help solve the opioid crisis. Treatment Alternatives and Diversion (TAD) programs overseen by the Department of Justice (DOJ) have been an effective tool against drug and alcohol abuse. In TAD programs, district attorneys and judges may offer someone the opportunity to receive substance abuse treatment instead of jail or prison time. The TAD programs' potential was expanded under AB 668, which allotted an additional \$1.5 million for the DOJ to provide grants to counties for TAD programs. The bill also required reports from both counties and the DOJ to continue to determine the effectiveness of the TAD programs.

The opioid epidemic affected all areas of the state, but hit rural areas of Wisconsin especially hard because many of those areas did not have treatment networks already established or as easily accessible as urban areas. 2013 Assembly Bill 701 (2013 Wisconsin Act 195) identified the rural areas most in need of help and created pilot programs to treat individuals from those communities who had opioid abuse issues. The proposal required the Department of Health Services (DHS) to establish two or three regional treatment programs in "rural and underserved, high-need areas." The department used specific benchmarks to determine which areas of the state to define as "rural," "underserved," and "high-need."¹² Once it determined which areas fit those guidelines, the DHS then reviewed proposals to create treatment programs. The treatment programs had to include specific components, including (1) an assessment of individuals in need to determine the type of treatment that was required and, if necessary, the transitioning of those individuals to a licensed residential program; (2) a residential program that provided counseling, medication-assisted treatment, and abstinence-based treatment; and (3) the transition of individuals, once they completed treatment, to county-based or private care. The programs were not allowed to offer methadone treatment. Contracts with three treatment organizations, located in northeastern, north central, and northwestern Wisconsin, were executed in June 2015.¹³

While treatment and diversion options for people with substance abuse issues were the focus of 2013 Assembly Bills 668 and 701, Assembly Bill 702 (2013 Wisconsin Act 196) created "swift and certain" punishments for those on extended supervision, parole, or probation, or subject to a deferred prosecution agreement, who possessed or attempted to possess a narcotic drug under schedule I or II. The bill, fashioned after a Hawaiian initiative, required the DOC to create a system of short-term sanctions for violations of release and to take into account several factors when using such sanctions, including the objective in imposing the sanction, correction of the offender's behavior, the safety of the community, flexibility, and the impact on the offender's family members and his or her employment. This "rapid response model" is based on research that

12. Wisconsin Department of Health Services, *Opioid Treatment Programs: 2016 Report to the Legislature*, April 2016, 3.

13. *Ibid.*, 5.

finds that an offender who knows a violation has immediate consequences is less likely to reoffend.¹⁴

All seven bills of the 2013–14 HOPE Agenda passed unanimously or on a voice vote in both houses of the legislature, and all seven were signed by the governor on April 7, 2014. The legislation passed in the 2013 session created or expanded laws, programs, and grants, establishing a baseline from which the state could confront the opioid crisis on many levels, from prevention to treatment. But that work was only just beginning, as an epidemic decades in the making would require the implementation of many different strategies and a combination of government and community resources.

2015–16 legislation

A second package of HOPE Agenda bills was introduced in the 2015 session, with Representative Nygren again the lead author. The package built on the legislation of the previous session, expanding access to Naloxone, broadening the reporting requirements for the PDMP, allocating more money to TAD programs, and creating a number of other laws to allow the state to rein in opioid abuse in Wisconsin.

Access to the opioid antagonist Naloxone was further expanded under 2015 Assembly Bill 427 (2015 Wisconsin Act 115). The bill authorized a physician to issue a standing order to one or more persons and allowed a pharmacist to dispense Naloxone under that standing order. The law essentially allows a pharmacy to sell Naloxone to patients without a specific written prescription and further clarifies the intentions of the 2013 law.¹⁵ The bill was signed into law on December 8, 2015. In the fall of 2017, the chief medical officer at the DHS signed a statewide standing order for Wisconsin pharmacies, effective September 2017.¹⁶

2015 legislation increased the use of Wisconsin's PDMP to monitor prescription opioid use in Wisconsin. Three bills were introduced to specify what information must be submitted to the PDMP, and by whom, and how the Controlled Substances Board (CSB) was to use the information that was collected. Under 2015 Assembly Bill 364 (2015 Wisconsin Act 266), the amount of time that physicians have to report that a prescription was filled was shortened from seven days to twenty-four hours. This measure was to help prevent “doctor-shopping” by patients attempting to fill their prescription at more than one pharmacy before anything was noticed in the PDMP system.¹⁷ The bill also required

14. Harsdorf, Sheila, testimony on 2013 Assembly Bill 702, hearing materials submitted to Legislative Council, February 6, 2014, 10.

15. Julal, Nicole, testimony on 2015 Assembly Bill 427, hearing materials submitted to Legislative Council, October 22, 2015, 4–5.

16. Wisconsin Department of Health Services, “Opioids: Standing Order for Naloxone,” September 2017, <https://www.dhs.wisconsin.gov/opioids/standing-order.htm>.

17. Schimel, Brad, testimony on 2015 Assembly Bill 364, hearing materials submitted to Legislative Council, October 14, 2015, 5.

practitioners to review the records of a patient in the PDMP before issuing an opioid prescription. That provision will sunset in April 2020. Other parts of the bill specified how and when information gathered by the PDMP could be disclosed to law enforcement, medical professionals, and certain other individuals. This bill and several others in the 2015–16 HOPE Agenda package were signed into law on March 17, 2016.

Similarly, 2015 Assembly Bill 365 (2015 Wisconsin 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. The report must include names and birthdates of the individuals involved. The PDMP must then disclose that information to the relevant practitioners, pharmacists, and others.

2015 Assembly Bill 766 (2015 Wisconsin Act 267) tasked the CSB with reporting the PDMP-collected data. A quarterly review of the PDMP with actual and projected outcomes, as well as quarterly and annual reports on the results of the quarterly reviews, must be submitted to the Department of Safety and Professional Services (DSPS) until the end of 2020. Contracting with an analytics firm, the CSB will use the PDMP data to “detect problematic behaviors” of doctors, pharmacists, and patients related to opioid prescriptions. In order to deal with the “problematic” behaviors detected by the PDMP data, 2015 Assembly Bill 660 (2015 Wisconsin Act 269) allowed several of the licensing boards under the umbrella of DSPS, including the Medical Examining Board, to create best practices for prescribing controlled substances. The goal was to reduce the “overprescribing” of opioids by medical professionals.¹⁸ The Medical Examining Board published its opioid prescribing guidelines in August 2017.¹⁹ The guidelines recommended that if physicians prescribe opioids for treating acute pain, they do so only in low doses, and in most cases for fewer than three days. It also discouraged the use of oxycodone due to studies indicating its addictive qualities.

In an effort to prevent the proliferation of “pill mills” in the state,²⁰ 2015 Assembly Bill 366 (2015 Wisconsin Act 265) gave the DHS oversight of pain management clinics. The bill generally defined a “pain clinic” as a privately owned facility that devotes the majority of its practice to pain management and prescribes opioids for that purpose, with certain exceptions. Further, the bill gave the DHS the authority to set certification and operation requirements for pain clinics. The DHS can also penalize pain clinics that no longer comply with the certification rules by revoking their certification and imposing a \$1,000 forfeiture per day for continued violations. The law also specifies that pain clinics may accept only a traceable method of payment from patients.

The legislature also gathered more information from methadone clinics in the state.

18. Governor’s Task Force on Opioid Abuse, *Combating Opioid Abuse: A Report to the Governor*, 2016, January 2017, 6.

19. Wisconsin Medical Examining Board, Wisconsin Medical Examining Board Opioid Prescribing Guideline, August 16, 2017, <https://dps.wi.gov/Documents/BoardCouncils/MED/20170816MEBGuidelinesv6.pdf>.

20. Governor’s Task Force on Opioid Abuse, *Combating Opioid Abuse: A Report to the Governor*, 2016, January 2017, 5.

Methadone is a prescribed drug used to treat substance abuse patients by tapering them off of opioid narcotics. Because of the nature of their work, methadone clinics have the ability to provide a wealth of information related to opioid substance abusers' behavior and their treatment outcomes. 2015 Assembly Bill 367 (2015 Wisconsin Act 262) requires methadone clinics to annually send information to the DHS²¹ related to staffing ratios at each clinic; relapse rates; how far patients are traveling to get to the clinic; the number of patients receiving behavioral health services in addition to methadone treatment; and other relevant statistical information. The clinics must ensure that individual patients cannot be identified in these reports.

The 2015 HOPE Agenda package also expanded treatment options for those dealing with opioid substance abuse by providing further funding for TAD programs and aligning Wisconsin statutes on opioid treatment services with federal standards. 2015 Assembly Bill 657 (2015 Wisconsin Act 388) transferred \$2 million from the DHS to the DOJ in the 2015–16 fiscal year to use as grant money for TAD programs. The law also specified that a TAD program cannot prohibit a person from participating in the program if that person is using an FDA-approved medication for the treatment of substance abuse. 2015 Assembly Bill 659 (2015 Wisconsin Act 263) updated Wisconsin's oversight of opioid treatment programs, as state statutes were previously more stringent than federal regulations. Under prior DHS rules, opioid treatment services were certified for two years, compared to three years under federal rules; DHS rules also required such services to directly employ all counselors, while federal rules allowed for substance abuse counseling services to be contracted out. The law also removed DHS restrictions on where and how long a patient receives treatment.

Assembly Bill 658 (2015 Wisconsin Act 264) was also introduced in the 2015 legislative session and prohibited the use of a masking agent in order to pass a lawfully administered drug test. The penalty for using, possessing, or advertising a masking agent is a fine up to \$500, 30 days' imprisonment, or both. People who deliver or manufacture a masking agent can receive up to a \$1,000 fine, 90 days in jail, or both.

Though the HOPE Agenda bills were the primary tool used to address the opioid epidemic, the legislature also used its budgetary approval power. Sections of the 2015–17 budget act (2015 Wisconsin Act 55) provided funds to support substance abuse programs. For example, the budget allocated \$5,386,300 in the 2016–17 fiscal year to extend Wisconsin Medicaid coverage to residential substance abuse services.²² This extension of services was based on the idea that the living environment of someone in recovery contributes significantly to his or her chances of successfully changing habits.²³ In addition,

21. DHS certifies methadone treatment centers under DHS 75.15, Wisconsin Administrative Code.

22. Sections 1808 and 1809 of 2015 Wisconsin Act 55, <http://docs.legis.wisconsin.gov/2015/related/acts/55>.

23. Dyck, John, Paper #352, 2015–17 Biennial Budget Papers, Wisconsin Legislative Fiscal Bureau, May 21, 2016.

the DOC was charged with implementing a pilot program for offenders with an opiate addiction. The program would provide these offenders with a monthly Vivitrol injection alongside other rehabilitation programming and treatments. The budget appropriated \$1,670,400 (\$876,700 per fiscal year) for this purpose for 2015–17 and placed it in the Joint Committee on Finance’s (JCF) supplemental appropriation. Upon submitting a detailed plan for the pilot program, the DOC could request the release of funds from the JCF.²⁴ The DOC submitted its plan in a report on December 9, 2015.

Tomah VA scandal

While bipartisan work in the legislature was addressing the opioid crisis, a scandal broke concerning the Tomah Veterans Administration Hospital in west-central Wisconsin. In January 2015, the Center for Investigative Reporting published a story on the surge of prescriptions for opioids under the then-chief of staff, as well as the death of a patient who was reported to be on more than a dozen drugs.²⁵ The report described a culture of fear among employees that kept them from questioning the use of prescription narcotics and complaints of overmedicated patients who were drowsy or fell asleep during therapy sessions. Two families believed their sons had died because of the amount of drugs given to them by doctors at the Tomah VA. According to the report, prescriptions for opiates such as hydrocodone, oxycodone, methadone, and morphine rose from 50,000 in 2004 to 712,000 in 2012. This news story was a reflection of larger issues faced by the Veterans Administration in recent years, as well as the nationwide scourge of opioid painkiller addiction, and it also shone a light on how invasive and damaging the epidemic had become at the local level. It was affecting chronic pain patients and their families in communities around the state of Wisconsin.

The scandal evoked responses at the state and federal levels. Congressional hearings were called for and eventually held in late March 2015, with both of Wisconsin’s U.S. senators allowed to participate in the questioning.²⁶ It was also reported by the *La Crosse Tribune* on March 14 that several congressional offices had been contacted by whistleblowers regarding the prescription opioid issues at Tomah well before 2015, but staffers either failed to notify the congressperson or senator or mishandled the information. The Office of Inspector General at the Veterans Administration was also faulted for how it handled its investigation into the whistleblower allegations. Many other hearings and investigations were opened as a result of the revelations about the Tomah VA, and the

24. Section 9108 (1d) of 2015 Wisconsin Act 55, <http://docs.legis.wisconsin.gov/2015/related/acts/55>.

25. Glantz, Aaron, “Opiates hand out like candy to ‘doped-up’ veterans at Wisconsin VA,” *Reveal from the Center for Investigative Reporting*, January 8, 2015, <https://www.revealnews.org/article-legacy/opiates-handed-out-like-candy-to-doped-up-veterans-at-wisconsin-va>.

26. Gilbert, Craig, “VA official vows accountability at Tomah site,” *Milwaukee Journal Sentinel*, March 27, 2015.

publicity surrounding the scandal gave new urgency to the efforts of state government to face the issue of opioid abuse.

Governor's task force on opioid abuse and special session

With the final piece of legislation of the 2015–16 HOPE Agenda signed in April 2016, several state efforts to combat the opioid epidemic were well on their way to making a difference in communities around the state. With more state funds and better data resources, the DHS and the DOJ could begin to measure treatment efforts. But, as the Tomah VA scandal demonstrated, the work on the opioid crisis was still ongoing. In early 2016, the National Governor's Association (NGA) began a coordinated effort to reduce the use of opioid painkillers by developing prescribing protocols. In July 2016, the Association announced that 46 governors, including Wisconsin Governor Scott Walker, had signed "A Compact to Fight Opioid Addiction," committing the signing states to developing prescription guidelines, raising awareness of the issue through various channels of communication, and reducing barriers to treatment services.²⁷

In September 2016, the governor issued an executive order creating the Governor's Task Force on Opioid Abuse. The governor appointed Representative Nygren and Lieutenant Governor Rebecca Kleefisch as co-chairs of the task force; they were to lead a group that included the attorney general; the secretaries of the Departments of Corrections, Health Services, and Safety and Professional Services; the Commissioner of Insurance; members of the legislature from each party (Senator Leah Vukmir, Senator Janet Bewley, and Representative Jill Billings); members of law enforcement and public health and state medical societies and organizations; and residents of Wisconsin personally affected by the opioid crisis.²⁸ The task force was charged with advising and assisting the governor and coordinating the fight against the opioid epidemic. To gather information, the task force held meetings in Green Bay, Westin, La Crosse, and Madison in 2016 and in Milwaukee, Minocqua, Wausau, and again Madison in 2017.

In addition to the task force, Executive Order #214 called on the state health officer to issue a public health advisory on opioid abuse. The advisory was issued "to inform the public of the alarming statistics" related to the opioid crisis.²⁹ In the executive order, the DHS was also directed to use its powers under the statutes³⁰ "to do what is reasonable and necessary for the prevention and suppression of opioid abuse." The DHS was also ordered to provide staff support to the task force. A total of eight state agencies were required to

27. National Governor's Association, *A Compact to Fight Opioid Addiction*, July 2016, <https://www.nga.org/cms/news/2016/opioid-compact>.

28. Executive Order #214, issued September 22, 2016.

29. Wisconsin Department of Health Services, Division of Public Health, *Public Health Advisory*, September 26, 2016, <https://www.dhs.wisconsin.gov/opioids/opioid-public-health-advisory.pdf>.

30. Section 250.04, Wisconsin Statutes.

develop “agency steering committees” to develop a strategic plan to address opioid abuse and coordinate with the task force.

The task force submitted a report to the governor in January 2017 with a list of recommendations for tackling the opioid crisis. The recommendations offered ideas for legislation but also for programs, funding, and grants at the state and local levels, actions that could be initiated at the executive agency level, and community and medical industry best practices. The recommendations built on both the achievements of the HOPE Agenda and the information received by the task force in 2016. As a direct result of the task force report, Governor Walker issued Executive Order #230, calling for a special session of the legislature focused on opioid abuse. The eleven points enumerated in the executive order mirrored the report’s recommendation and were all introduced as separate pieces of legislation. The special session convened in January 2017 and concluded in June 2017. All eleven bills passed, and they were signed on July 17, 2017.

Special Session Assembly Bill 1 (2017 Wisconsin Act 29) provided civil immunity for school employees to administer Naloxone to students experiencing an overdose. The bill was based on statutes that allow school personnel to administer epinephrine in the case of anaphylactic shock.³¹ It also built on the HOPE Agenda’s 2013 911 Good Samaritan law. The original bill was amended to include residence hall directors employed by the UW System, the Technical College System, and private colleges. Special Session Assembly Bill 3 (2017 Wisconsin Act 33) expanded the 2013 911 Good Samaritan law by extending immunity to the “aided” (the person experiencing an overdose) from revocation of parole, probation, or extended supervision if that person completed a treatment program or, if a program was not available or was financially prohibitive, agreed to spend 15 days in county jail.³² The bill’s supporters hoped to further encourage people to call for emergency help without fear of arrest.³³

Most of the bills introduced in the special session focused on the treatment of opioid addiction, including expanding treatment options and programs for those suffering from opioid addiction, authorizing additional money for recovery programs and treatment centers, and providing more opportunities to people working in the addiction treatment field. Special Session Assembly Bill 2 (2017 Wisconsin Act 32) added further funding to TAD programs to make drug treatment courts more widely available as a resource for prosecutors, judges, and people addicted to opioids. The bill continued the \$2 million in funding for fiscal years 2017–18 and 2018–19, plus \$150,000 in each of these years to grant to additional counties. The bill also created a pilot program to divert nonviolent

31. Kulow, Chris, testimony on January 2017 Special Session Assembly Bill 1, hearing materials submitted to Legislative Council, March 2, 2017, 9.

32. The bill also required the aided to be offered a deferred prosecution agreement that included a treatment program.

33. Nygren, John, testimony on January 2017 Special Session Assembly Bill 3, hearing materials submitted to Legislative Council, March 8, 2017, 1.

offenders. Similarly, Special Session Assembly Bill 8 (2017 Wisconsin Act 27) allotted an additional \$2 million per fiscal year to the DHS to fund treatment centers in underserved, high-need areas, this time without requiring the areas to be identified as “rural.”

Under Special Session Assembly Bill 6 (2017 Wisconsin Act 30), the Office of Educational Opportunity in the University of Wisconsin System may contract out the establishment of a charter school for high school students in recovery. The contract may be for up to four consecutive school years; after three years, the office must report to the DHS on the school’s effectiveness. The school will take up to fifteen students who are in treatment for substance abuse, are able to maintain sobriety, and will submit to drug testing. Money for the school will come from a combination of (1) federal funding; (2) a sum sufficient appropriation from the state to provide per pupil payments; and (3) a onetime grant of \$50,000 that will be awarded upon the procurement of matching funds. The legislature also gave more power to schools to identify and treat addiction among students with Special Session Assembly Bill 11 (2017 Wisconsin Act 31), which provided \$200,000 in fiscal year 2017–18 and again in fiscal year 2018–19 to train educators, school nurses, and administrators in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method. The method is an evidence-based tool used to address the mental and behavioral health needs of students.

Medical professionals treating addiction also received financial support in the special session legislation. Special Session Assembly Bill 7 (2017 Wisconsin Act 26) appropriated monies to fund DHS grants that are awarded to hospitals that expand fellowship positions in addiction medicine or addiction psychiatry.³⁴ Special Session Assembly Bill 9 (2017 Wisconsin Act 28) provided \$500,000 each in fiscal years 2017–18 and 2018–19 for the DHS to create an addiction medicine consultation program. The “doctor-to-doctor” program will serve medical professionals who need resources for best practices in dealing with a patient with a substance abuse issue. It is modeled on the existing Child Psychiatry Consultation Program.³⁵

In addition, Wisconsin law enforcement was granted funds to help curb illegal access to opioids. Under Special Session Assembly Bill 10 (2017 Wisconsin Act 35), the DOJ was authorized to add four criminal investigation agents to focus on opiate-related matters.³⁶ The four agents will partner with all levels of government to gather intelligence on heroin trafficking.

The special session also empowered family and friends to get help for someone who is suffering from opioid addiction. Special Session Assembly Bill 5 (2017 Wisconsin Act

34. The law was later modified through the budget bill, 2017 Wisconsin Act 59, sections 378k, 2265t, and 9220 (1m).

35. Nygren, John, testimony on January 2017 Special Session Assembly Bill 9, hearing materials submitted to Legislative Council, March 8, 2017, 2.

36. Schimel, Brad, testimony on January 2017 Special Session Assembly Bill 10, hearing materials submitted to Legislative Council, March 2, 2017, 6–7.

34) expanded existing laws that allow for the involuntary commitment of people suffering from alcohol abuse. Now, if three separate people petition the court stating that the person is a danger to himself or herself or others because of drug addiction, the person can be held in emergency detention for up to 72 hours, offering the person a chance to break the cycle of drug use and be convinced to enter treatment.³⁷

Finally, under Special Session Assembly Bill 4 (2017 Wisconsin Act 25), codeine cough syrup and certain other substances will require a prescription to obtain. Codeine is an opiate on the schedule V list of controlled substances.³⁸

Results of legislation so far

With the combined legislation of three sessions now on the books, and at least a decade of knowledge about the opioid epidemic and its effects on society, methods to turn the tide are beginning to show results. By establishing programs through legislation, providing agencies with funds and directives to implement treatment protocols, clarifying laws to encourage people to get treatment, and creating new laws to deal with the ever-widening scope of the opioid crisis, legislators, the executive branch, and the courts have collaborated to provide a supportive framework for people with opioid abuse issues.

Grants for TAD programs provided by the DOJ continue to allow the court system to operate pretrial diversion and adult drug courts for nonviolent offenders. In 2017, TAD programs were funded in forty-six counties and two tribal governments.³⁹ The DOJ, with the endorsement of the Criminal Justice Coordinating Council,⁴⁰ has created a web-based reporting system for TAD outcomes called the Comprehensive Outcomes, Research and Evaluation (CORE) Reporting System, which will share performance measures among the different drug courts in Wisconsin.

In late 2017, the DOC reported on its first year running the Opioid Addiction Treatment Pilot Program, which was provided \$1.6 million in the 2015–17 state budget. The program works with inmates about to be released into the community who have a history of opioid use. Using a combination of alcohol abuse treatments and other drug abuse treatments, cognitive behavioral therapy, mental health counseling, and Vivitrol injections, inmates are continually assessed and treated according to their needs. At the time of the report, the program was serving about 100 people per day who were going to be

37. Nygren, John, testimony on January 2017 Special Session Assembly Bill 5, hearing materials submitted to Legislative Council, March 8, 2017, 1–2.

38. Section 961.22 (2), Wisconsin Statutes.

39. Criminal Justice Coordinating Council, “Treatment Alternatives and Diversion Program (TAD),” August 15, 2017, <https://cjcc.doj.wi.gov/initiative/tad-0>.

40. The Criminal Justice Coordinating Council is a special committee created by the governor and attached to the Department of Justice “for the purpose of the purpose of assisting the Governor in directing, collaborating, and coordinating the services of state and local governmental agencies and nongovernmental entities in the criminal justice system to increase efficiencies, effectiveness, and public safety.” Executive Order #180, November 18, 2015.

released into eight northern Wisconsin counties. As of September 8, 2017, 24 people had completed the program.⁴¹

The PDMP continues to make upgrades and add information that will help Wisconsin legislators, doctors, and law enforcement to create better policy regarding opioid abuse. In November 2017, Representative Nygren noted that the PDMP reported that 17.5 million fewer opioid dosages were dispensed over the April to June 2017 period compared to the same period in 2016, a 12 percent decrease over the year.⁴² The PDMP (relaunched in January 2017 as the “enhanced” or ePDMP) releases monthly statistics on its website regarding the number of controlled substance prescriptions dispensed, the number of healthcare professional patient queries (utilization), and the number of law enforcement alerts reported.⁴³ It also keeps an archive of monthly, quarterly, and yearly statistics going back to 2013. Though still in development, the ePDMP reported that as of December 2017, the number of opioid prescriptions dispensed was down 20 percent between 2015 and 2017 (5,105,729 prescriptions dispensed in 2015 to 4,066,083 prescriptions dispensed in 2017).⁴⁴

The three opioid treatment centers that were authorized in 2013 Wisconsin Act 195 continue to operate. The centers chosen in 2015 were asked by DHS to reapply in 2016, and all three were re-awarded contracts. Each program received \$672,000 in grant money. Under the statutes, DHS must issue an annual report to the legislature on these programs.⁴⁵ The most recent report available, issued in April 2017 for the 2016 calendar year, provided data on the patients in the northeastern, north central, and northwestern regional treatment centers.⁴⁶ Overall, 277 people were treated in 2016: 99 in the northeastern region, 131 in the north central region, and 47 in the northwestern region. The ratio of female to male participants was relatively equal in each region except for the north central region, where 59 percent of participants were female. Most of the patients in all regions were between the ages of 18 and 45. While 86 percent of participants in the northeastern region were Caucasian, in the north central region, 57 percent of participants were Caucasian and 39 percent were American Indian, and in the northwestern region, 63 percent of participants were American Indian. Most people in the programs were being treated for addiction to an opioid other than heroin, and most people had at least a high school education, though in the northwestern region, 41 percent of participants had an education beyond high school. In total, the programs treated 44 pregnant

41. Wisconsin Department of Corrections, “Opioid Addiction Treatment Pilot Program,” September 8, 2017, <https://doc.wi.gov/Documents/AboutDOC/PressReleases/170912VivitrolPilotFactSheet.pdf>.

42. Office of Representative John Nygren, “Opioid Prescriptions Fall Drastically” [Press release], November 6, 2017.

43. Wisconsin ePDMP Statistics Dashboard, <https://pdmp.wi.gov/statistics>.

44. Wisconsin Controlled Substances Board, Wisconsin ePDMP Report 3, January 1–December 31, 2017, <https://dsps.wi.gov/Documents/BoardCouncils/CSB/WIePDMPReport2017Q4.pdf>.

45. Section 51.422 (3), Wisconsin Statutes

46. Wisconsin Department of Health Services, *Opioid Treatment Programs, 2017 Report to the Legislature*, April 2017.

woman, 34 of them in the north Central region. Each program uses different methods to track outcomes, but all generally reported high satisfaction rates among program participants.

The future of opioid-related policy in Wisconsin

The Governor's Task Force on Opioid Abuse continues to operate. It released a second report to the governor in January 2018 with an overview of the implemented strategies and further recommendations. In response to this report, the governor issued Executive Order #273, which directed the Departments of Health Services, Corrections, Children and Families, and Transportation to incorporate best practices, to develop technology and uniform standards to track opioid abuse across the state, and to work together to ensure continuity of care for people reentering society during treatment. Executive Order #274, creating the Commission on Substance Abuse Treatment Delivery, was based on the task force's recommendation to create a "hub and spoke" model to organize substance abuse treatment across Wisconsin communities. The hub and spoke model works by creating regional hubs to serve as centers for addiction treatment, while spokes are created in communities to refer patients to and take referrals from a hub.⁴⁷

At the end of January 2018, Representative Nygren introduced two more bills related to the HOPE Agenda. Both bills had bipartisan support and were passed unanimously by the two houses of the legislature. Under 2017 Assembly Bill 906 (2017 Wisconsin Act 261), \$2.75 million in grant programs were created. The grants were related to non-narcotic drug treatment in county jails and family and juvenile treatment courts and to fund law enforcement responses to drug trafficking. The law also appropriated \$500,000 in federal grant money in the 2018–19 fiscal year for programs to provide evidence-based substance abuse prevention to at-risk children and their families. Additionally, the law authorized two additional attorney positions in the DOJ to assist district attorneys in prosecuting drug-related offenses. Finally, the law created a provision that allows the courts to order a person convicted under the Uniform Controlled Substances Act to attend a victim impact panel that demonstrates the adverse effects of substance abuse. The second law, 2017 Assembly Bill 907 (2017 Wisconsin Act 262), focused on health care providers and education on substance abuse. The law specified who is allowed to treat alcohol and substance abuse as a specialty. It also created the Behavioral Health Review Committee appointed by the DSPS to semiannually review the requirements to obtain a license in substance abuse counseling, social work, marriage and family therapy, or certain other professions in the behavioral health field. It also provided the Department of Children and Families with \$50,000 to develop an online resource for social workers

47. Governor's Task Force on Opioid Abuse, *Combating Opioid Abuse: A Report to the Governor, 2017*, January 2018, 8–9.

who deal with substance abuse. Further, the law provided \$250,000 in the 2018–19 fiscal year to increase the number of students in graduate psychiatric nursing education at the University of Wisconsin–Madison, creating more opportunities for people to become mental health professionals. It also required school boards to incorporate prescription drug abuse awareness into health instruction programs. Both bills were signed into law in April 2018, bringing the total number of opioid-related laws enacted under the HOPE Agenda to 30.⁴⁸

Through innovative diversion programs, legislation, and administrative directives, the legislative, executive, and judicial branches are continually working together to respond to the opioid crisis. The legislature’s role will continue to be vital, as funding programs through the budget and through grant moneys will be a significant factor in determining who gets treatment and how that treatment is administered. Representative Nygren and the other legislative members of the Governor’s Task Force on Opioid Abuse will continue to have the ear of the governor’s office and be able to make recommendations for executive actions that will aid the DHS, DSPS, DOC, and DOJ in creating policy and programs that focus on opioid abuse. This collaborative effort has led the federal government to look to Wisconsin for strategies to implement in the wake of the opioid crisis.⁴⁹ The bipartisan efforts within the Wisconsin Legislature have contributed to a wave of innovative actions to reduce the power of opioid abuse in America and have confronted an expansive, complex issue that continues to deeply affect people around the state. ■

48. Office of Representative John Nygren, “HOPE Agenda Bills Signed by Governor Walker” [Press Release], April 9, 2018.

49. WISN 12 News, “Federal government looks to Wisconsin for help in battling opioid epidemic,” updated March 21, 2018, <http://www.wisn.com/article/federal-government-looks-to-wisconsin-for-help-in-battling-opioid-epidemic/19554241>.

