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# Wisconsin Briefs

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## HEROIN RESURGENCE

The *National Survey on Drug Use and Health* (NSDUH) has reported that since 2007, people who claim to have used heroin within the past year has more than doubled. Despite heroin only being used by a small percentage of the overall population, its effects have been felt across many communities and taken a toll on those who have lost friends and relatives due to addiction. The uptick in heroin usage has prompted lawmakers from nearly every state to establish study committees or introduce legislation to address heroin addiction.

This brief provides an overview of heroin use, user trends, proposed policy changes to combat its recent resurgence, as well as a brief description of recent Wisconsin legislation related to opiate use.

### HEROIN OVERVIEW

Heroin is an illegal substance derived from morphine, which is an opioid analgesic found in the seed pods of certain poppy plants. Morphine is a drug used in hospital settings as an analgesic, or pain killer. Pure heroin has a white powder appearance and is sometimes “cut” with other substances such as sugar or powdered milk, which reduces its purity. Heroin may also be found in a form known as “black tar.” Such form resembles roofing tar or coal due to the crude processing methods that result in impurities.

The most pure types of heroin may be smoked or snorted. As the purity decreases, users will dissolve or dilute the substance and inject it using a hypodermic needle. Once heroin enters the body, it interacts with receptors in the brain known as mu-opioid receptors (MORs), which then triggers a euphoric sensation.

The immediate bodily effects of heroin largely depend on the amount used, how quickly the drug enters the brain, and how fast it binds to MORs. Once it is converted into morphine and binds to MORs, users commonly feel an intense pleasure. The intense pleasure can be so overwhelming that a user may begin to itch, feel nauseated, or vomit. Additionally, users may experience dry mouth, pupil constriction, flushing of the skin, disorientation, and an extreme sense of dead weight in the extremities. After the initial effects wear off, users may feel drowsy for several hours. If too much heroin is used at once, it can depress a person’s breathing, slow heart rate, render a person unconscious, or lead to death.

Prolonged heroin use leads to addiction. Over time it will physically alter the structure and physiology of the brain. Such changes lead to long-term hormonal imbalances, some of which are irreversible. Eventually users may develop a tolerance to the drug, leading to an increase in the amount needed in order to achieve the same high. If heroin intake is reduced or eliminated, users will experience withdrawal symptoms including muscle and bone pain, insomnia, cold flashes, and vomiting. Such consequences can last for up to a week, and in some cases, for several months. Once a user is addicted and attempts to quit, he or she may relapse and experience an uncontrollable urge to use heroin again to avoid experiencing the symptoms of withdrawal.

### SCOPE AND DEMOGRAPHICS OF HEROIN USE

The NSDUH reported that in 2012, approximately 669,000 Americans used heroin

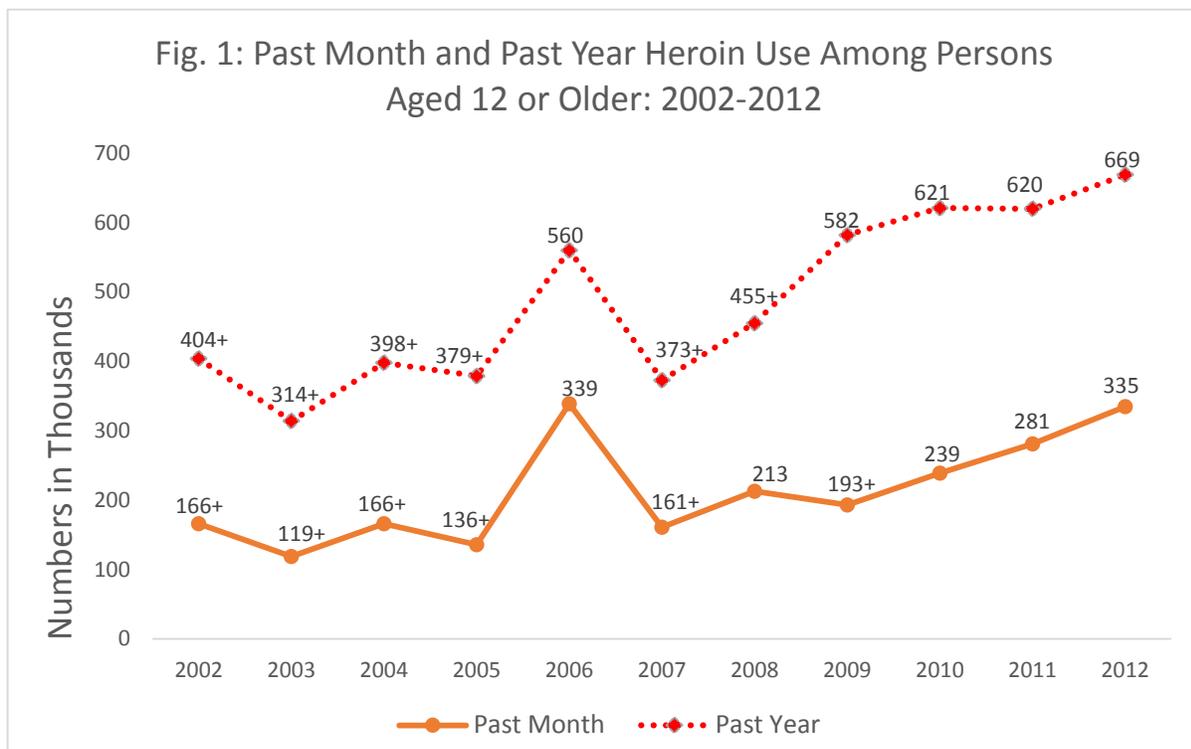
within the past year, and about 335,000 were reported to have used heroin within the past month. Although statistically significant differences are not present within the last few years, the general trends for heroin use within the past month and year have increased (see Figure 1). Approximately 156,000 of survey respondents aged 12 or older reported using heroin for the first time within the past year. Those results are significantly higher than those surveyed in 2006 (90,000). The data suggests that the increase in heroin use is bolstered by those between the ages of 18-25.

Not all heroin addicts begin their addiction with heroin. Many users will begin their addiction using pain killers, either obtained illegally or through a prescription. The Centers for Disease Control and Prevention data shows that over 12 million people in 2010 abused pain killers. Studies suggest that approximately half of young users who inject heroin reported abusing prescription pain killers before beginning their heroin use.

Since heroin is cheaper than obtaining prescription pain killers, users tend to switch to heroin as a cost-saving method.

At one time, heroin use was mostly limited to urban areas. In recent years, it appears that the problem has crept its way into rural areas and middle-class suburbs. Few systemic studies on heroin user demographics exist, however a recently published article by the *Journal of American Medical Association of Psychiatry* examined data from the nationwide Survey of Key Informants' Patients (SKIP) Program. The study reviewed the general demographics of current heroin users and compared them to users from the 1960s.

A majority of respondents indicated that they live in small urban or nonurban areas (75.2%) versus those who live in large urban areas (24.8%). Seventy-five percent of survey respondents that began using opiates in the 2000s indicated that their first regular opioid used was a prescription drug. However, those who began their opioid use in the 1960s



+ Difference between this estimate and the 2012 estimate is statistically significant at the .05 level.

**2003 County Heroin Deaths**

County	Deaths	Deaths per 100,000
Kenosha	5	3.2
Milwaukee	13	1.4
Ozaukee	1	1.2
Racine	2	1.0
Dane	4	0.9
Waukesha	1	0.3
State Total	26	0.5

**2013 County Heroin Deaths**

County	Deaths	Deaths per 100,000
Marinette	6	14.4
Kenosha	14	8.4
Waushara	2	8.2
Dane	36	7.2
Milwaukee	67	7.0
Walworth	7	6.8
Wood	5	6.7
Racine	12	6.1
Green	2	5.4
Washington	7	5.3
Green Lake	1	5.2
Kewaunee	1	4.9
Sauk	3	4.8
Adams	1	4.8
Douglas	2	4.5
Iowa	1	4.2
Marathon	5	3.7
Door	1	3.6
Jefferson	3	3.6
Trempealeau	1	3.4
Dodge	3	3.4
Winnebago	5	3.0
Clark	1	2.9
Oneida	1	2.8
Sheboygan	3	2.6
La Crosse	3	2.6
Waukesha	10	2.6
Pierce	1	2.4
Shawano	1	2.4
Brown	6	2.4
St. Croix	2	2.3
Ozaukee	2	2.3
Monroe	1	2.2
Fond du Lac	2	2.0
Grant	1	1.9
Rock	3	1.9
Outagamie	3	1.7
Portage	1	1.4
Manitowoc	1	1.2
State Total	227	4.0

Death rates were calculated using death data from Gannett Media and the Wisconsin Department of Health Services, and population data from the Wisconsin Department of Administration.

indicated that they began their opioid abuse with heroin. Sexes and ethnicities of heroin users have also changed since the 1960s. In the 1960s, the majority of users were male (82.8%) and equal between whites and non-whites. Current data for the 2010 decade suggests that heroin users are now roughly equal between the sexes and predominately white (90.3%).

Using raw data provided by the Wisconsin Department of Health Services and Gannett Media, Wisconsin had a total of 227 heroin related deaths in 2013, up from 26 deaths in 2003. The state heroin related death rate also increased from 0.5 deaths per 100,000 in 2003, to 4 deaths per 100,000 in 2013 (see Table 1). The county with the highest death rate for 2013 was Marinette County, which had 14.4 deaths per 100,000 persons, nearly double the rate of any other county and over three times the rate of the state.

**TREATMENTS FOR HEROIN ADDICTS**

Those who seek help for heroin addiction may be prescribed medication or undergo behavioral therapy. While a user undergoes a detoxification (allowing the body to eliminate a drug), they will experience withdrawal symptoms. Medications can be administered to help ease withdrawal severity so that the chances of relapse are reduced.

Behavioral therapy is used in outpatient and residential settings. An approach known as contingency management encourages addicts to remain clean by providing points to those who achieve negative drug tests. The points can be used to obtain items that encourage a healthier lifestyle. Addicts can also undergo cognitive-behavioral therapy, which helps the patient modify their expectations with respect to drug use, and provide stress coping mechanisms. Therapy may also include a multifaceted approach where an addict may be treated with medication in conjunction with behavioral modification.

## RECENT HEROIN POLICY CHANGES

No one disputes the fact that the rise in heroin use is damaging to both users and their communities. Over half of the states have either passed laws or introduced bills to stop the rising heroin use trend. In general, the laws and introduced bills create programs that prevent people from becoming addicted to opiates, or help those who are trying to quit. There is support for the measures states have put into place, but some have expressed concerns about their potential effectiveness.

Nearly every state has passed a law designed to make it more difficult to obtain prescription painkillers. Such laws typically require some form of identification to obtain a prescription. Other laws attempt to curb so-called “doctor shopping,” which occurs when an addict will go to many different doctors to obtain prescriptions for painkillers. Despite these efforts, some argue that this has only caused a spike in the price of illegal prescription drugs. As a consequence, addicts have turned to heroin when the increased prescription drug cost becomes a financial burden.

Some cities and states have enacted laws that allow law enforcement officers to carry the heroin overdose antidote known as naloxone, an opioid antagonist. When naloxone is administered to a person experiencing an overdose, it blocks opioid receptors and reduces the likelihood of a fatality. Equipping officers with naloxone has received support from the United States Attorney General and the Drug Enforcement Administration (DEA). While the effects of these policies remain to be seen, some argue about whether all first responders should be equipped with naloxone, or if it should be administered over-the-counter without a prescription.

Heroin users who experience an overdose or witness someone else experiencing an overdose sometimes choose not to seek medical attention due to a fear of arrest for possession or other drug-related charges. Since some overdoses can be reversed, several

states have enacted so-called Good Samaritan laws that protect users who call for help when they may be experiencing an overdose, or witness another person overdosing. Under these laws, a person who seeks help for themselves or others is criminally immune from prosecution for certain drug-related offenses. Nineteen states, including Wisconsin, have enacted some form of Good Samaritan law.

Critics of Good Samaritan laws argue that providing immunity in certain cases amounts to a get-out-of-jail-free card. Legislators have made an attempt to curb these concerns by taking a defendant’s criminal history into consideration to determine whether immunity is appropriate. Other states limit the scope of immunity by providing protection only under certain circumstances such as reasonable belief that a person is experiencing an overdose; reporting an overdose in good-faith to medical providers, law enforcement, or 911 operators; remaining at the scene until help arrives; identifying themselves and/or the overdose victim; and cooperating with law enforcement and medical personnel.

Although nonexistent in the United States, safe-injection facilities have been built in British Columbia and some parts of Europe. These facilities provide addicts with a safe place to use preobtained prescription drugs. If a user experiences an overdose at a facility, a trained health care provider is on-site to administer naloxone. Opponents of safe-injection facilities argue that if built, such places will increase area crime and heroin use. However, several peer-reviewed studies that examined a facility in Vancouver did not observe an increase in crime, and one study calculated a 35% decrease in area overdoses.

## RECENTLY PASSED WISCONSIN LAWS TARGETING THE HEROIN PROBLEM

The 2013 Wisconsin Legislature introduced and passed several bills in an attempt to combat Wisconsin’s heroin problem.

**2013 Wisconsin Act 194** (Assembly Bill 447) provides immunity from criminal prosecution for individuals aiding another person experiencing a drug overdose. The act prevents an aider from being prosecuted for possessing drug paraphernalia or a controlled substance. A person is considered to be an aider if they believe the other person is suffering from an overdose and either brings the other person to an emergency room; dials 911 for medical service; or summons a law enforcement officer, ambulance, emergency medical technician, or other health care provider to help the other person.

**2013 Wisconsin Act 195** (Assembly Bill 701) requires the Wisconsin Department of Health Services (DHS) to create two or three new, regional comprehensive programs designed to treat opiate addiction in rural and underserved, high-need areas. It also requires the program to offer individual assessments in order to determine the appropriate treatment. Two years after the program begins, DHS must submit a progress report on the outcome of the program to the Joint Committee on Finance and related standing committees.

**2013 Wisconsin Act 197** (Assembly Bill 668) creates additional data collection and reporting requirements and provides additional funding for the Treatment Alternatives and Diversion (TAD) program. Any county that receives a TAD grant must submit any requested data to the Wisconsin Department of Justice (DOJ) on a monthly basis. The act requires DOJ to perform annual analyses on the submitted data and prepare a report that describes the effectiveness of the grant program. DOJ must also create a comprehensive report on the county data and annual reports every five years.

**2013 Wisconsin Act 198** (Assembly Bill 448) relates to the authority to dispose of prescription drugs and operate prescription drug disposal programs. It prohibits any unauthorized person from receiving a household phar-

maceutical item pursuant to a drug disposal program. However, if a person lawfully possesses a pharmaceutical item, they may dispose of the item at a drug disposal program authorized by the Wisconsin Department of Justice or under federal law.

**2013 Wisconsin Act 199** (Assembly Bill 445) creates requirements for the dispensing of Schedule II and III controlled substances. The act generally requires an acceptable form of identification in order to obtain a Schedule II or III drug from a pharmacist or other authorized person. Acceptable forms of identification include a motor vehicle operator's license, a state issued identification card, an identification card issued by the United States uniformed service, or a passport. Those dispensing or delivering the drugs must maintain identification records for an amount of time specified by the Pharmacy Examining Board (Board) or until that information is submitted to the Board through the Prescription Drug Monitoring Program (PDMP).

A person is exempt from the identification card requirement under circumstances including: 1) a health care practitioner directly administers the drug to a patient; 2) the person dispensing the drug has personal knowledge of the person to whom the drug is dispensed or delivered and that the person is the ultimate user or the ultimate user's authorized representative; or 3) the drug is delivered to a health care facility and will be administered in the health care facility. The act also provides civil or criminal immunity for any act taken by a pharmacist in reliance on an identification card that the pharmacist reasonably believed was authentic.

Under the act, the name on an identification card used to obtain a Schedule II or III drug must be reported to the Board through the PDMP. This requirement will not go into effect until April 9, 2016.

**2013 Wisconsin Act 200** (2013 Assembly Bill 446) authorizes trained certified first responders to administer naloxone or other opi-

oid antagonists. The act also requires that all EMTs be allowed to administer naloxone or other opioid antagonists, and that ambulance service providers ensure that each supervised EMT has a supply to the extent of availability. Certified first responders and EMTs under the supervision of an ambulance service provider are required to maintain records of opioid antagonist usage and submit those records to DHS.

The act allows a law enforcement agency or fire department to enter into an affiliate agreement with an ambulance service provider or a physician to obtain a supply of naloxone or another opioid antagonist. The agreement may also allow law enforcement officers and fire fighters to receive training to administer naloxone to individuals who are undergoing an opioid-related overdose.

Finally, the act also allows licensed physicians, physician assistants, or advanced practice nurses to prescribe and dispense opioid antagonists to individuals who are able to assist other persons at risk for an opioid-related overdose. Subject to certain exceptions, any person who delivers an opioid antagonist to another person, or any person who administers an opioid antagonist to another person who is reasonably believed to be undergoing an opioid-related overdose, is immune from criminal and civil liability.

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