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Euphoria: The Transition from Prescription Opioids to Heroin in Kentucky

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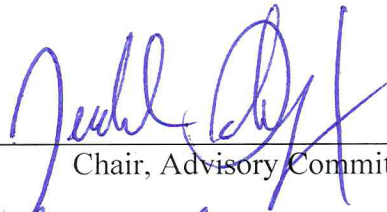
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Euphoria:
The Transition from Prescription Opioids to Heroin in Kentucky

By

Alexander Cundiff

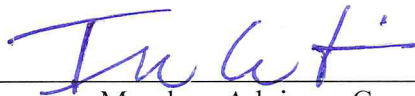
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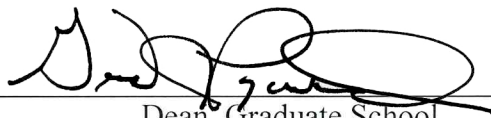
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Euphoria:
The Transition from Prescription Opioids to Heroin in Kentucky

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Submitted to the Faculty of the Graduate School of
Eastern Kentucky University
in partial fulfillment of the requirements
for the degree of
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DEDICATION

This thesis is dedicated to my brothers
Bradley and Daniel Cundiff
for their unwavering support.

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I would like to thank my thesis chair, Dr. Judah Schept, for his guidance, patience, and full support of this study. I would also like to thank the other committee members, Dr. Gary Potter and Dr. Travis Linnemann, for their comments and assistance. I would like to also express my thanks to Carl Root for his guidance, and all the times he allowed me to interrupt him in his office when he was busy. He encouraged me, and helped with this project more than he knows. Lastly I would like to thank Dr. Michael Land for being my mentor through college, and always being there for me when I needed him.

ABSTRACT

The demand for and availability of prescription opioids has been quite prevalent in the state of Kentucky primarily since the early 1990's. But between 2010 and 2012, reformulations of opioids OxyContin and Opana, along with the passing of HB 217 and mandatory KASPER (Kentucky All Schedule Prescription Electronic Reporting) reports made the acquisition of diverted pharmaceutical opioids much more difficult. As a result, prices per pill increased and once opioids became nearly impossible to find on the streets, users then moved to another opiate, heroin. Since 2012, heroin related overdoses have increased significantly in the Bluegrass State. The purpose of this study is to better understand the transition from prescription opioid abuse to heroin among prior users in the city of Louisville. Relying on interviews, existing academic literature, Louisville Courier-Journal news media articles, and federal official reports, this paper argues that after a long history of over prescribing opioids and the creation of pills mills, followed then by the implementation of harsh prohibition laws against opioids, many individuals relied on the more dangerous and cheaper drug heroin to support their opiate dependence.

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CHAPTER I

INTRODUCTION

Although this research goes as far back as the early 1990's, the inspiration behind finding the pattern of prescription opioid addiction and the transition to heroin begins with my story in 2010. Following a knee surgery from playing football, I was prescribed Percocet (5 milligrams) to help with post surgery chronic pain. Being someone who had never partook in recreational drug use, I never thought about opioid dependence or addiction. After following the doctor's orders of taking three pills per day for the first two weeks, he then recommended slowly lowering my dosage to one pill per day before my prescription bottle was empty. One particular night I found myself in a predicament when I couldn't find my prescription bottle anywhere. A little voice in the back of my mind began to convince me that without my nightly pill, I wouldn't be able to sleep. My mind kept repeating the line "you're in pain; you need that pill." Coincidentally during this time period my older brother had an opioid addiction himself. Seeing how much it hurt my family, and not wanting to follow in his footsteps, the next morning I flushed the rest of my prescription pills down the drain and tore apart the prescription written for my refill. Following that day I became curious of how common it was for others to become dependent on prescribed opioids, and who else had heard that little voice in the back of their head telling them "this pill will make everything better".

The purpose of this research is to examine the several factors that made many Kentuckians transition from their addiction with prescription opioids to heroin. Through in-depth interviews (conducted between 2016 and 2017) with recovering addicts living in the city of Louisville, I found similar narratives to mine among the younger participants.

They began their path to opioid addiction first by recreational use with pills like Lortabs or Percocets, usually followed by OxyContin or Opana, before transitioning to heroin.

Being known as having the first documented pill mill (Quinones, 2015), Kentucky made quite a reputation for its legal drug misuse. Dating back to the late 1990's Kentucky created KASPER (Kentucky All Schedule Prescription Electronic Reporting) along with implementing harsh laws (House Bill 1/127) in 2012 to try and fight its "war on opioids." Once every pain management clinic and doctor's office had to make patient reports to KASPER, it seemed as if the Opioid War was won. But with the price increase per pill doubling its original amount, and opioids becoming more difficult to buy on the streets, many users then moved to heroin. Research has begun to identify connections between OA (Opioid Analgesic) misuse and heroin use, although this relationship remains under explored (Harocopos, Allen, Paone, 2016). Relying on 9 interviews, extant academic literature, Louisville Courier-Journal news media articles, and federal official reports, the present study concludes that once transitioned, many users started abusing heroin by nasal inhalation, followed by injection to get the same if not better euphoric high they received originally from abusing prescription opioids. In the following chapter, I begin with a review of the literature examining the relationship between opioid misuse and heroin at both the national and state levels. Chapter III provides the methodology used along with an historical account of Kentucky's legal drug misuse. Chapter IV will present my overall findings based on the historical news media articles and 9 interviews. Lastly, Chapter V will discuss my preliminary conclusions along with the limitations of this research. Some sections of this paper will rely heavily on direct quotes from interviewees telling their narratives of what led them to the transition of heroin.

CHAPTER II

LITERATURE REVIEW

Recent studies (Peavy et. al, 2012; Mars et. al., 2013; Maxwell, 2015; Harocopos et. al., 2016; Carleson et. al, 2016) have investigated the relationship of prescription opioid abuse and the transition to heroin. Results have shown that once the government cracked down on the supply of pills, and eventually shook off its reputation of having the worst of the notorious “pill mills,” the twist came that state officials hadn’t predicted, addicts of prescription opioids turned to heroin (McGreal, 2016). According to the Office of Drug Control Policy in Kentucky, one key driver behind the uptick in heroin abuse was the reformulation of two widely abused prescription pain drugs (OxyContin & Opana) making them harder to crush and snort.

Before moving to the different reasons for the transition from prescription opioids to heroin, it is important to define key terms, and explain the similarities between pharmaceutical opioids and heroin. One similarity between the two is they both are narcotics that are derived from the opium poppy plant. “The term narcotic signifies a legal category of drugs that refer to opium and opium derivatives of their synthetic substitutes” (Lyman & Potter, 1998 p87). Narcotics generate euphoria, an intense voluptuous, orgasm-like sensation, followed by the feeling of well-being, tranquility, ease, and calm, the sensation that everything in the user’s life is just fine (Goode, 2014). Opioids are generally prescribed due to their highly effective pain-relieving, or analgesic, characteristics (NDIC, 2001).

Since 2012, Kentucky has made it mandatory that all controlled substances scheduled II through V be placed on an individual's KASPER report once they have been prescribed that particular drug. In 1970 it was the Controlled Substances Act (CSA) that placed all substances regulated under existing federal law into one of five schedules (Drug Enforcement Agency, 2015). Schedule I substances are drugs that have a high potential for abuse, and have no currently accepted medical use in treatment in the United States, and example drugs for this schedule include heroin, lysergic acid diethylamide (LSD), marijuana, and methaqualone (DEA, 2015). Schedule II substances are drugs that have a high potential for abuse, are current medically accepted treatment options, but may lead to psychological or physical dependence, and examples for this schedule include morphine, methadone, and fentanyl (DEA, 2015). Schedule III controlled substances are drugs that have less potential for abuse than the drugs or other substances in Schedules I and II, currently accepted in medical practice in the United States, and include drugs like anabolic steroids, codeine and hydrocodone products with aspirin or Tylenol® (DEA, 2015). Schedule IV drugs have a low potential for abuse, accepted in the medical field in the United States, and include drugs like alprazolam, clonazepam, and diazepam (DEA, 2015). Schedule V are drugs that also have a low potential for abuse, and are also accepted in the medical field in the United States, and include drugs like cough medicines with codeine (DEA, 2015).

Opiophobia

Prior to 1990, it was common for many doctors not to prescribe opioids to help their patients with severe chronic pain. It was referred to as "opiophobia" where doctors believed if they were to give any dose of opioids to patients, they would in no time

become addicted. As Dr. Hal Talley, who was featured in the 2016 documentary about overprescribing opioids titled “Dr. Feelgood” states, “In Medical School, it was taught that you should only prescribe opioids to an individual who is a 1-2 day Post-op patient and treat their pain while in the hospital. Or if the patients is sure to die in 2-3 weeks. But if anyone is to go on living will be turned to an addict if given opioids for chronic pain.”

But in 1986 Drs. Kathleen Foley and Russell Portenoy published a journal article in *Pain* titled “Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 cases.”

The publication went on to become a declaration of independence for the vanguard of pain specialists interested in using opiates for chronic pain (Quinones, 2015). The article had two key myth busters that went on to change the mindset for many doctors throughout the country. The first argument was that opiates themselves were not addicting, but instead certain people are born to have an addict mindset. In their study, Foley and Portenoy found that in all 38 of their patients, only 2 became addicted after using opioids to help with their chronic pain. The 2 individuals who became addicted had a prior history with drug abuse; the conclusion, therefore, was that it was the person not the medicine. The second argument they made was that no dose was too high to handle. The study showed that risk of addiction was low when opiates were actually being used for treating patients who had pain. Soon after the publication, doctors were convinced to use opioids for not only individuals with cancer, but to use them to help with other forms of pain such as lower back pain, knee pain, and etc. If the individual’s tolerance level for the original prescription increased, it was believed to be completely okay to up the dosage until the pain goes away again for the patient. Doctors were urged to begin attending to the country’s pain epidemic by prescribing these drugs (Quinones, 2015).

Prohibition

Many scholars have argued that harsh implemented laws on prescription opioids have led to the transition to heroin. Hari (2015) uses the terminology “the iron law of prohibition,” to argue that prohibition always narrows the market to the most potent possible substance. Prohibitory legislation has repeatedly backfired in ways unanticipated by its framers, and yet the response to failure has been to do more of the same (Schneider, 2008). Better known as the substitution effect: if the government prohibits a drug, many people may switch to another (and possibly more dangerous) drug (Kappeler & Potter, 2005). Hari (2015) describes the transition from drugs like OxyContin and Vicodin to heroin use with the metaphor of college football games in the United States. He claims,

On Saturday’s during the college football season, we always see students and football fans primarily drinking beer in the parking lots as they tailgate. But once inside the stadium where most NCAA schools will not allow the sale of beer, we find many individuals sneaking in plane size bottles of liquor or flask thereby changing them from beer drinkers to whiskey drinkers. When all legal routes were cut off, beer disappeared during prohibition and whiskey won. When all legal routes to opiates are cut off, Oxy disappears, and heroin prevails (Hari, 2015, p. 230-231).

Heroin users today

Data has shown that the demographic composition of heroin users entering treatment has shifted over the last 50 years such that heroin has changed from an inner-city, minority-centered problem to one that has a more widespread geographical distribution, involving primarily white men and women in their late 20s living outside of large urban areas (Cicero et. al, 2014). In 2000, the group with the highest rate of drug poisoning deaths related to heroin were non Hispanic blacks aged 45-64; however by 2013, the highest rates of drug poisoning deaths were among non-Hispanic whites aged

18-44 (Jones, Logan, Gladden, & Bohm, 2015). Among those who began abusing opioids in the 1960s, more than 80 percent started with heroin. Of those who began abusing opioids in the 2000s, 75 percent reported their first opioid was a prescription drug (Cicero et. al., 2014).

In this study, users of prescription opioids transitioned to heroin for a number of reasons. The next chapter provides the methodology used, along with the historical aspect of both the nation and Kentucky's legal drug misuse.

CHAPTER III

METHODS

The purpose of this qualitative study was to understand the reasoning behind the increase in heroin use, and explain how the prior misuse of prescription opioids led many individuals to such a seamless transition between the two. The city of Louisville was chosen because of the recent attention the city has received pertaining to heroin-related overdose calls that Louisville EMS unit receives on a daily basis. In January of 2017, nearly 700 drug related overdose calls (primarily heroin related) were made to Louisville Kentucky's EMS (Teller, 2017). During the second week of February, Louisville made headline news across the country with a reported 151 overdose calls in a four-day period, and 52 of them within the first 32 hours (Ellis & Allen, 2017).

For the interviews, a purposive sampling approach was used whereby only those individuals who had personal experience with the transition from pharmaceutical opioid use/abuse to Heroin, or who had concurrent Heroin and pharmaceutical use/abuse, were approached for possible participation. Recruitment for interviewees began at a weekly fellowship meeting for recovering addicts sponsored by a local Christian church in the city of Louisville where participants were verbally recruited. Upon making initial contacts, a snowball sample was then used to recruit others who had gone through the transition. All participants were interviewed once between 2016 and 2017. Interviews were conducted in a private area inside a local Christian church. Eastern Kentucky University's Institutional Review Board approved the location once they received a letter of support for off-campus research signed by one of the Deacons of the church.

Interviews lasted on average between one and one and a half hours, with the exception of one interview that lasted three hours.

The interviews were open-ended, but an interview guide was created to help as a starting point for the interview. The interview-guide was theme-based, not a semi-structured questionnaire. Therefore, the approach with every participant was quasi-conversational allowing her/him to introduce as much unique, historical, and contextual detail as possible based on their experiences while remaining attentive to the specific transition identified. The guide included questions on the respondent's drug use history, age of initiation, their transition from pharmaceutical opioids to Heroin or concurrent Heroin/pharmaceutical use/abuse, and lastly their involvement (if any) with the criminal justice system. All the interviews were recorded on an audio recorder for transcription purposes. Along with the recording, field notes were taken as well. In the end, there were a total of nine participants that were interviewed. Before recording, a pseudonym was given to participants for their protection. Eastern Kentucky University's IRB approved the study protocol.

CHAPTER IV

FINDINGS AND RESULTS

Kentucky's Opioid History

In October of 1990, a Louisville doctor was indicted on charges of writing prescriptions to individuals who had no legitimate medical need. Dr. Edmund S. Lee wrote 26 prescriptions for 822 doses of controlled drugs including painkillers and codeine products between May 30 and Aug. 21 (Yetter, 1990). After an investigation, the DEA went undercover as patients in Lee's office stating they were addicts and they needed pills. Lee then went on to write a prescription for 20 codeine pills. In that same year in December of 1990, the majority of known opiate addicts in the inner city area were addicted to prescription drugs such as Dilaudid, Demerol, Percodan that were prescribed by doctors along with the street purchased heroin (Gil, 1990). Throughout the year, Louisville was trying to expand their methadone clinics in response to the doubling of the number of opiate addicts who were seeking treatment. At the time, the clinic downtown was only serving 63 people and had a waiting list of more than 100 individuals (Gil, 1990). Methadone was the only FDA approved maintenance drug that many believed was the perfect remedy to get over their opiate addiction. But with a waiting list so high, many people found themselves traveling as far as Indianapolis and other cities to get their daily doses of methadone because Louisville couldn't keep up with the number of addicts they had (Holland, 1991).

More broadly, throughout the state of Kentucky, many individuals became doctor shoppers seeing different doctors and pharmacists and receiving thousands of prescription

painkillers to help with their opioid addiction. In one example, a patient named Danny Lowe received more than one thousand painkillers in a total of four months (Stewart & Dunlop, 1994). For many doctors, they were prescribing painkillers because patients would come in complaining about having bad chronic pain, and during this time period, doctors were taught that prescribing opiates was the best option. Addiction wasn't talked about much during this time period. In 1996 only 17 percent of the state thought drugs were the top problem the nation was facing according to one Bluegrass State Poll (Cross, 1996). The number of opioid overdose cases didn't have epidemic numbers like it has today. Moreover, doctors report that one of the more difficult aspects of their job is the subjective nature of pain reporting. Many times doctors had to trust their instinct during their evaluation of a patient when they came in stating their pain level is between 8 and 10 on the pain Likert scale. With that though, there were also doctors who were prescribing to patients without an evaluation or any medical reason at all.

Kentucky throughout the 1990's was known for prescribing opioids and other drugs to individuals seeking them without a medical need. Around 1996 Kentucky was known as a magnet for people who were seeking diet pills Fenfluramine and Phentermine (Stewart, 1996). Before the uptick in pain clinics throughout the state, diet clinics began to pop up, including four within one year in the city of Louisville. Residents of Ohio, Tennessee, and Indiana were all traveling to Kentucky because at the time there were no specific restrictions on the prescribing of diet pills (Merek, 1996).

Kentucky's documented Pill Mills

In 1992, Kentucky sold more drugs containing the pain reliever codeine per person than any other state according to the federal Drug Enforcement Administration. When it came to codeine usage, Kentucky averaged 17,828 grams of usage per 100,000 people compared to the nation's average of 9,983 (Stewart & Dunlop, 1994). In 1992, one doctor known by others in his field as the "candyman" was seeing more than 100 patients per day. To his patients he was most known for his line "What do you need?" Without ever being examined, Dr. James Sanders was writing a prescription for his patients and sending them on their way. For one patient, Dr. Saunders prescribed 200 Percodan tablets in a 17 day period (Stewart, 1994). Dr. Sanders' office was located in Barbourville, and Kentucky records from five different pharmacies in the area showed that more than 1,700 of his patients received an average of five prescriptions, including refills, from April 1992 to October of 1992 (Stewart, 1994). According to Barbourville Historian Mike Mills, "Records show Dr. James Sanders wrote a total of 229,000 prescriptions in a three month period in 1992, and one pharmacy filled over 200 prescriptions per day coming from just his office alone."

During the 1990's the vast majority of doctors and pharmacies did not overprescribe or over dispense, but in fact were trying to help the prescription opioid addiction problem. But in many counties throughout the state, there would be at least one doctor who was writing prescriptions left and right to every patient they saw. According to Lyman and Potter (1998) the main motivating factors for the doctor's who over prescribed were greed, sexual favors, salvaging a failing medical practice, self-addiction, senility, and rationalization. The best known doctor who illegally prescribed to his

patients came from South Shore, Kentucky. David Proctor was known by many as a mind reader, supposedly having the ability to see a patient and tell them exactly what they needed. His answer to all pain of course was opioids. He was not only prescribing for severe chronic pain, but also minor neck, leg, and lower back pain. Prior to 1996, Proctor was prescribing Valium to a number of his patients. But once OxyContin hit the market, his office parking lot was filled with new patients and soon he became known as having the first documented Pill Mill. Proctor stated he saw as many as 80 patients a day, charging \$80 to \$100 in cash only deals in exchange for writing a prescription for Narcotics. Proctor then lost his medical license due to a brain injury from a car accident in 1999. But losing his medical license didn't slow him down; he hired several physicians to continue his work. With his new drive thru pill mill operations, investigators in one instance counted more cars pulling out of his business than there were cars going through a drive thru at a fast food chain in the city of South Shore. His operations soon ended after that in 2002 when it was taken down by the federal drug enforcement. In 2016 ironically his mansion was bought by Recovery Works and turned into a treatment facility for recovering addicts (Graves, 2016).

OxyContin

After a three-month clinical trial with terminal cancer patients, it was December of 1995 when the FDA approved Purdue Pharma's OxyContin (Hansen, 2015).

OxyContin was the first formulation pill containing oxycodone that allowed dosing every 12 hours instead of the average of every 4 to 6. According to the FDA, OxyContin was approved because it was believed that the controlled-release formulation would result in less abuse potential, since the drug would be absorbed slowly and there would not be an

immediate “rush” or high, the drug wouldn’t promote abuse. One factor that led to their approval was FDA’s judgment on the prior marketing history of Purdue Pharma’s similar product, MS Contin. MS Contin, which had been used in the medical community since 1987, was found to have no significant reports of abuse and misuse. Therefore they believed OxyContin would have the same results.

Once approved, within the first three years of being on the market, Purdue hosted 5,000 physicians, nurses, and pharmacists at all-expense paid luxury resort trainings on pain management, and hired 671 drug representatives to visit community-based generalist doctors (Van Zee, 2009). In the first year, Purdue spent an astounding \$200 million on campaigning alone. In 1997, the FDA eased restrictions on what prescription drugs could be advertised on television. , and OxyContin then created the “I got my life back” commercial that followed the lives of several individuals who claimed OxyContin saved their lives from chronic pain. OxyContin was marketed and sold as a prescribed opioid that could be used for a wide range of pain issues that were not previously treated with opioids, such as chronic lower back pain, without the risk of getting addicted.

Chris: When OxyContin hit the streets. That was the final bell for me. Game over. I was in Love

Keratin: OxyContin was the most popular drug on the street. But it was dangerous when in the game (selling drugs). If you wanted to be a dealer, the Big Man would come from Detroit to meet you. He would leave but make one of the people under him stay and watch you and live with you for a couple of months and watch the operations.

In 2007, the State of Kentucky filed a lawsuit against Purdue Pharma for illegally marketing OxyContin as non-addictive. Because of their campaign, Kentucky made accusations that the painkiller created addiction with opioids for the entire state.

Primarily the 484 Kentuckians who died from OxyContin overdosed in 2006 alone

(Armstrong, 2014). Prior to the law suit, only one other state (West Virginia) had filed a law suit against the company. Prior to that, the company never faced trial but won dismissals against 400 personal-injury lawsuits related to OxyContin. In Kentucky, the lawsuit was transferred to a federal court along with other cases from other states. In May of 2007, Purdue Pharma agreed to pay \$634 million in national settlement in which it pled guilty to intentionally misleading patients, doctors and the government about OxyContin's addictive risks. However, Kentucky refused its \$500,000 portion of the settlement, and its lawsuit was transferred back to Pike County where Kentucky originally established their case. In 2014, Kentucky settled their lawsuit with Purdue Pharma for \$24 million. Now \$600 million may have seemed like a lot of money for a national settlement at the time. But in 2015, the Sackler Family (Owners of Purdue Pharma) made the list of America's richest families with their \$14 Billion dollar net worth most of which was made from their sales of OxyContin. So in the end, Purdue only paid 4% of their total net worth in national settlement for misleading the country into believing their opioid pill was non-addictive.

The Reformulation

In August of 2010, Purdue Pharma reformulated their Oxycontin pills from Oxycontin Continuous to Oxycontin Purdue. Both the OC and the OP still had the same active ingredient, Oxycodone. The difference was the original OxyContin OC pills were able to be crushed down and snorted, or diluted down with water and injected. Street prices before the reformulation for an 80 mg Oxy were in the ballpark of \$60-\$80. Once reformulated, the price of Oxy OC went up to the ranges of \$200-\$250 per 80 mg pill. The new reformulated OxyContin was covered with a special coating that would stay

together in clumps if a user tried to ground it down, making it difficult to chew, break, or dissolve. Users could still get high if taking the new reformulated pill orally like its original intention, but it did not have the immediate euphoric effect that the original formulated OxyContin pill had when it was snorted or injected. Users tried different remedies to try and break down the newly reformulated pill, but didn't find much success. Kaitlyn (25) describes one of the remedies users tried below:

When the new formula came out, many of my friends tried their best to break it down... The craziest shit they did was baking it.. After they bake it, they put it in the freezer. Once at a certain point, they could snort it, but hurt like a bitch..So in the end it wasn't even worth it anymore.

KASPER

As pharmaceutical misuse increased in the state of Kentucky in the mid 1990's, the Kentucky Attorney General created a drug abuse task force in 1997. One of the first recommendations from the task force was that Kentucky should have a drug monitoring program created as a public health initiative. It wasn't until July 15th of 1998 that the Kentucky Legislature passed the law to establish an electronic drug monitoring program (Kentucky All Schedule Prescription Electronic Reporting) that would be used to monitor controlled substances and establish penalties for illegal use of the system (CHFS, 2006). The original regulation required dispensers of controlled substances in Kentucky to report dispensing Schedule II through V controlled substances every 16 days. In the beginning, small staff numbers and the unanticipated demand for KASPER reports made it difficult to provide data requestors in a timely manner. By 2004, the KASPER staff was behind six months in processing of KASPER report requests (CHFS, 2006). Because of the delay many health care practitioners quit requesting reports. The biggest issue was those who

used the KASPER program wanted to obtain KASPER reports any time of the day, primarily when a patient was still sitting in the office. In 2003, Kentucky started the development of the enhanced Kasper (eKASPER). But it wasn't until March of 2005, that the eKASPER was launched statewide. Since the creation of the eKAPSPER, the request for a patients report went from six months to 15-20 seconds.

The KASPER Effect

According to Kentucky's Cabinet for Health and Family Services, when a patient's KASPER report is created, the report will show the following

- Date range for the report
- Patient names and date of birth
- Prescription information such as date filled, quantity, days supply
- Doctor name and city
- Drug name and strength, and
- Pharmacy name and city

The Kentucky All Schedule Prescription Electronic Reporting program since its origin has consequently had contradicting circumstances for Kentuckians who are prescribed controlled substances scheduled II through V. KASPER has become the new background check for all government issued benefits and/or inquiries. One example comes from Kristi (42):

It seems like ever since my KASPER report has been made, I'm no longer seen as a patient, but as an electronic report to which I have no access to seeing, or to appeal.

The original intention of KASPER was to monitor individuals who were doctor shopping, and also monitor offices and pharmacies themselves to investigate who was

legally/illegally writing prescriptions for profits. The KASPER reports were to be used as direct evidence by the prosecution in court. It was originally used for law enforcement, patients, prescribers, pharmacists, and data sharing as a whole to improve patient care.

But its practices have become a report that discriminates and excludes individuals who legitimately are seeking help. For example, if pulled over by a law enforcement officer, and if that officer has a reasonable suspicion of the individual being under the influence, that officer is able to check to see if they have a KASPER. If the individual does have a KASPER report that shows they have been prescribed a particular drug, the officer can then use this as a basis for a DUI citation. Once in court, there is no legal defense for an individual with a KASPER because they cannot prove the case that they were not under the influence without contradicting compliance with their prescribed medication, which could then lead them to losing their medicine.

Since the KASPER was initiated, many Kentuckians found themselves with no other recourse except to move to the black market for their scheduled narcotics. Many dealers who were originally getting prescriptions from doctors in Kentucky started traveling to states like Florida, which at the time had no prescription drug monitoring programs, therefore became a pill mill paradise. By 2011, Florida was supplying an estimated 60 percent of Kentucky's illicit prescription drugs (Ungar, 2011).

House Bill 217

Following the creation of KASPER, the Kentucky Legislature passed House Bill 1, otherwise known as "the pill mill bill". In 2013 House Bill 1 was then amended to House Bill 217. House Bill 1 was passed to combat prescription drug abuse in Kentucky

through the close regulation of pain management clinics and the implementation of new standards on those prescribing and dispensing controlled substances. HB 1's main target was hydrocodone, and it was passed to raise hydrocodone to being a Schedule II controlled substance so that KASPER could place it on individuals reports if prescribed. HB1 also expanded the KASPER system, requiring all prescription providers of controlled substances to register. According to a 2009 KASPER report, less than a third of Kentucky doctors were registered on the system at that time. Therefore many pain clinics closed shop once it was required to have a registered system. But along with the good, it was soon found that House Bill 1 had unintended consequences.

As the passing of the "pill mill bill," progressed, many individuals who no longer were being prescribed controlled substances as low as hydrocodone, found themselves moving to the black market to illegally buy prescription opioids. Once HB 217 was amended, doctors no longer wanted to treat patients due to the fear of being considered the next pill mill doctor and losing their license. Along with putting pressure on doctors, HB1 made it mandatory for individuals who revisit their doctors for a refill in their prescription to submit to random drug testing. The law became useless and made many individuals angry especially those of the older generations who had to take drug test for their prescribed medication. Mandatory drug tests were not covered by insurance or the state, therefore someone could be charged hundreds of dollars within one year due to every drug test they are required to take before getting their refill.

Another consequence of having a KASPER report is mandatory pill counts. According to one nurse who wished to remain anonymous, "many individuals who are on

prescription medication can receive a call at any time to come in for their pills to be counted. Two participants that were interviewed for this study reported their KASPER has been flagged because they either called their clinic back saying they didn't have access to getting a ride to the clinic... or for someone who receives 200 pills like Melody did, she didn't count them at the counter and ended up having several missing because she originally didn't receive her full amount." There are many other problems that can occur with the law of having a KASPER report.

Opana

Once OxyContin's formula was changed to OP, Purdue Pharma lost nearly 80% of its original OC formulated pill's revenue. When enforcement efforts on certain drugs become more successful and effective, drug dealers must shift their market strategies to increasingly more popular drugs, or re-emerge older drugs that have not been popular for awhile (Lyman & Potter, 1998). Once the market for OxyContin decreased due to the reformulation made in August of 2010, it was as early as that November that Kentucky saw a surge in the illegal use of the painkiller, Opana (Oxymorphone). Opana became the new OxyContin, but was known as a more powerful and dangerous version. Opana's original purpose was to treat Stage 4 terminal cancer for pain. By April of 2011, Opana was linked to 9 overdose deaths in the city of Louisville.

Opana Reformulates

Due to a surge in abuse with the drug Opana, in December of 2011, the FDA approved for Endo Pharmaceutical to reformulate their product into a crush resistant tablet just like Purdue Pharma did in 2010 with OxyContin. In January of 2012, as Opana's original formula became more difficult to find, the Louisville Metro Narcotics

Unit busted six people who were a part of a Detroit-Louisville Drug Ring. Nearly 1,500 Opana (original formulated pills) were seized from the group. In addition to seizing other drugs, the Narcotics Unit arrested Reginald Forsythe, the main distributor of Opana's in Louisville. With the reformulation made the month prior, once the main distributor of Opana's was arrested, the disappearance of the Oxymorphone drug took a toll on Louisville's Opana drug users. Between 2010 and 2011, Opana's were sold on the street for \$40-\$60 for one 40 mg pill. Once they became near impossible to find, some users paid up to \$160 for a whole, and between \$60-\$75 for a half, of a single 40 mg dose. As Danny (29) describes:

It affected the streets big time tho cuz I remember my dealer never reupped again after n I remember him tellin me his dealers dealer got busted comin back from Detroit. The narcs were on to them good.

Between late 2012 and 2013, times seemed good according to the 2012 Kentucky Incentives for Prevention School survey that showed prescription drug abuse among high school students has dropped drastically due to the 2012 Kentucky House Bill 1 law. According to the survey prescription drug abuse dropped from 15.2 percent to 9 percent among seniors, 14.1 percent to 7.6 percent among sophomores. The survey was given to 122,718 students. The results seemed great at the time, but there was one problem with the survey. It asked no questions about teenagers use with heroin. Looking at a 2011 survey by the Centers for Disease Control and Prevention, 5.2 percent of Kentucky's high school students reported using heroin, nearly doubling the national average.

The Transition

Once OxyContin and Opana left the city of Louisville, many opioid abusers found themselves with no other choice, and turned to heroin. This was especially true coming from the testimonies of many of the individuals interviewed for this study.

McLovin (23): No one had pills, and I was starting to go through withdrawals. I originally went downtown to look for pills, but literally everyone told me they only had heroin. I eventually ran into one of my buddies who introduced me to heroin. I told him I was starting to get dope sick, and all he said was, try this [heroin], its an opiate.

Keratin (29)- Once Opana's left I was introduced to heroin. Originally I HATED it! I at one point rather pay \$150 for an Opana than doing Heroin again.

Kaitlyn (25): Once pills became hard to find, they became too expensive and I transitioned to heroin. It was cheaper and easier to find

Chris (32): I was already shooting up pills, and spending everything I had and some for it. So I said fuck it, what difference is Heroin to what I already was doing. So I switched it up.

Danny (29): I had started with Lortabs n Percocets to Roxi's to Oxycontin to Opana's, then once they became hard to find I went to heroin

Davis (32): Opana's was a hell of a lot stronger than OxyContin. Once addicted to them, and they up and lef I moved to Heroin.

In 2011, just one person was booked on heroin trafficking charges in Louisville, according to data from the Louisville Metro Department of Corrections. By the next year, the number was up to 53. Many dealers throughout the city had to convince their customers that heroin and prescription opioids were the same thing. For the suburban interviewees in this paper, heroin wasn't popular until 2012. The same results happened in the 90's as well. As Chris (32) tells us:

At a party or just hanging out, me and my friends could lay out any drug you could think of on the table. Everything was welcomed; pills, cocaine, even meth...whatever. But on the other table laid heroin. We made a pact that no one was to do heroin. It was the taboo of all drugs. No one was to fuck with it. If you was even caught with it on you, you was an outcast to us for now on.

Opioids were very easy to acquire in the state of Kentucky, and users knew what they were getting. For heroin, it was a taboo not only because it could have been laced with anything, but also during the 90's, the United States was still in a moral panic from the AIDS era in the 1980's. Shooting up meant you were a junkie, not a chipper or recreational user. For those interviewed, 5 out of the 7 who transitioned to heroin absolutely hated it the first few times they tried it. But it beat having to go through withdrawals.

Treatment, Recovery, and Relapse

According to the National Institute on Drug Abuse the body actually has its own natural opioids or proteins that send receptors to the brain when someone is in pain. Once an individual takes prescribed opioids, those drugs attach to the opioid receptors and reduce the perception of pain and can produce a sense of well-being, while also having a euphoric effect on the brain. As the body develops a tolerance to the point where it actually can no longer produce enough of the natural opioids, it becomes dependent on the external opioid the person was taking. Once becoming dependent, and not acquiring the external opioid, the individual then feels discomfort and goes through withdrawal, because the brains euphoria has been clouded with the perception that opioids are the only reward the body needs (Volkow, 2014). Davis offered the best description of the experience of withdrawals and detoxification, noting that it was akin to having every sickness you've ever had in your whole life come together all at once and lasting 1 to 2 weeks. This is why when many who go to facilities to detox they are given Gabapentin (Nerve pain medication) and Clonidine (Blood pressure medication) to help somewhat get through this period. As Davis continues:

Withdrawals are the worst kind of flu on earth times two. You can't function, you have no desire to do anything. You can't even hold on a conversation. At times the thought of being dead would have been better.

Methadone, Suboxone, and Vivitrol

As of today, there is no real or supernatural answer, which is 100% effective in eliminating opioid dependence. As Danny states:

There is no real answer to fighting addiction, because everyone is different in both their body and mind. If there was a way with a 100% success rate, everyone would be doing it.

Even though there is no one size fits all answer, the FDA has approved three drugs for treatment of opioid dependence. The first of the three was methadone. Beginning in the 1950's moving into the early 1960's heroin abuse skyrocketed exponentially, with the growing death rate increasing annually. Politicians and experts in the medical field had to come up with a solution quickly. It wasn't until the mid 1960's when researchers at the Rockefeller Foundation developed a system of dosing heroin addicts with methadone. Originally prescribed for chronic pain, methadone became the new popular medically-assisted treatment. Starting in New York, methadone clinics began to gain ground all across the United States. By 1998, there were approximately 79,000 patients nationwide. But for Kentucky, by 1988 seven counties dropped their methadone program because of local criticisms that it substituted one addiction with another, and the withdrawal from it was far worse than it was from an opiate withdrawal (Cunningham, 1990). As of today, those who support it as a treatment option argue there are too few clinics providing it mirroring the same problem Louisville had in the 90's. With only a few clinics in Louisville and Southern Indiana, the center stays full. As Keratin describes:

I was very faithful to have the resources that I had when I started on Methadone. My very good friends helped pay for the first six months, and I was also fortunate to have a car to get to the clinic on a daily basis. Many people struggle to stay on methadone because they may not have a way of getting there, or even being able to pay the \$112 per week.

In the early 2000's Suboxone (Buprenorphine) was introduced to the United States. In the beginning, Suboxone was the miracle drug for opioid dependent users and helped with withdrawals. But with any new trend came repercussions. Many individuals were selling their Suboxone Film (Paper-like strips administered under the tongue), and with it being a long-term, assisted-treatment drug, many people found themselves withdrawing harder from it than they did with heroin. But in addition, there are few doctors certified to use Suboxone in the state, along with a shortage of certified drug counselors to even consider Suboxone a successful assisted-drug.

The last FDA approved assistant-drug is Vivitrol (Naltrexone). Vivitrol was introduced in 2010, and was found to block the "high" of opioid drugs and helps prevent relapse. Unlike Methadone and Suboxone, which are opioid analgesics themselves, Vivitrol is an opiate antagonist according to the U.S. National Library of Medicine. Along with being hard to find, because very few doctors are prescribing it in the state of Kentucky, the hardest thing about getting on Vivitrol is users have to go through detox for 10-14 days. Another problem some face is paying out of pocket \$1,200 to \$1,700 per month for one dose, because most insurance companies will not pay for it. So far no study has shown Vivitrol to be more effective than more traditional medications, but it's starting to gain popularity as an assistant-drug (Blessing, 2016). In Louisville places like Our Lady of Peace (a non-profit substance abuse treatment center) have started prescribing it to individuals with an opioid/heroin addiction.

Along with the FDA approved assistant-drugs mentioned above, remedies like Kratom (mitragynine and 7-hydroxymitragynine) have also been found to help with addiction treatment. Kratom is used in folk medicine as a stimulant (at low doses), sedative (at high doses), recreational drug, pain killer, medicine for diarrhea, and treatment for opiate addiction (Siebert, 2016). In the United States, Kratom was being used as an herbal drug being mixed into tea. According to Chris Bell (director of Prescription Thugs), “after having several cravings, Kratom has made his transition to sobriety easier.” But in 2016 the DEA announced Kratom will be banned from the United States and placed next to drugs like heroin as a Schedule I drug. But with numerous comments and petitions from the public, in October of 2016 DEA withdrew their notice of intent to ban Kratom. Of the 9 individuals interviewed for this paper, only one has had success with methadone, and another has had success with Vivitrol. The others went through rehab or their own remedies to get off heroin.

It is important to note that after attending several Narcotics Anonymous meetings in the Louisville area, it became apparent to me that an addiction never goes away. I listened to one man who has been sober for 20 years, but to this day every now and then thinks about doing the drugs he was once doing everyday for years and years. He described his path to sobriety through methadone, and how he went through the whole process but after several years he still on occasions wants to call his old friends and get high. As Danny and Keratin describe:

An addiction is a disease that makes people lose touch of who they are and become disconnected with feelings and reality for their only purpose in life was to fuel

their addiction no matter what it took. And once you have the disease you have it for life. But the longer you go without it, the easier it is to control (Danny).

Addiction is very complex, yet very simple... it is something that doesn't discriminate... and doesn't care if you're rich or poor, or if you have a great family or a non-existent one. It doesn't matter your age, gender, social economic status, or whether or not you're educated... it's something I wouldn't wish on my worst enemy! It's something that could bring the strongest person to their breaking point. And if you make it through the madness it leaves a pretty nasty scar... it'll be sort of a monkey on your back for the rest of your life! It's a lifelong battle that sometimes even those closest to you don't even know you're fighting! (Keratin).

Drug Courts

Drug courts began in 1989 in the state of Florida in response to the cocaine era, where the jails were being filled with cocaine addicts. The first drug court was created to bring drug treatment into the criminal justice system. In 1993, Jefferson County in Louisville was the first to implement drug courts in the state of Kentucky with a total of 94 patients starting the program (Logan et. al, 2001). Starting out, Jefferson County's Drug Court accepted both offenders with felonies and misdemeanors. As of today, Kentucky has Drug Courts for its three Adult, Juvenile, and Family divisions. According to the National Association of Drug Court Professionals (NADCP), drug courts are alternative courts for non-violent drug offenders whose substance abuse problems with drugs or alcohol are the primary cause of the crimes with which they are charged. Therefore instead of spending time in jail or on traditional probation, offenders who are granted drug courts undergo a rigorous substance abuse treatment program under a

judge's supervision. Jefferson County's drug court was ran by the Drug Court Division up until 2007 when they were then administered by the Administrative offices of the Courts (AOC).

Kristie takes us through the process of a drug court in Kentucky, she describes, During the rigorous program, drug court you are required to undergo random drug tests (at least 3 a week). For most drug courts, drug test I remember are taken nearly every day including weekends in the first few months of the program. That became obnoxious. Also the participant must attend court hearings several times a month; meet with drug court staff; attend treatment sessions; attend a 12-step; live in court-approved housing; you must make progress toward obtaining full-time job; be approved for employment; pay court obligations; and remain drug free for a specified number of consecutive days. The treatment program usually lasts for at least 1 year.

According to University of Kentucky Center on Drug and Alcohol Research, since Kentucky implemented Drug Courts, those that have graduated from the program has saved more than \$101 million in prison costs. Moving drug addiction out of the typical criminal justice process, the drug courts have had great success with those who graduate from the program. But as of today, at the Jefferson County courthouse, drug courts have been swamped by heroin cases, and there have been increasing demands for staff because heroin users in the diversion program require more intensive supervision and case management than individuals on other drugs due to the high rate of relapses (Kenning, 2014)

Rehab

Once heroin hit Louisville, many rehab centers found themselves filling more than half of their beds for heroin addicts. Five of the nine individuals interviewed for this study started their rehab journey at the Brook (Mental Health and Substance Abuse Treatment Service Center). The interviewee that stayed the longest at the Brook was 8 days.

Kaitlyn: It wasn't a good environment. They were putting addicts and individuals with mental disorders in the same areas. I hated it and got out as soon as I could.

For the 5 that went to rehab, not one stated that it helped. Brian argued that he got more from going to jail than he did going to rehab. Chris went to 30 different rehabs throughout the U.S. and still found his way back into another after relapsing. According to the 5 that went, once they got out they realized it didn't prepare them for reality. As Keratin explains:

When you're in rehab, you are literally in a bubble. They do things that help you, but don't prepare you for when you move back home and go back into the old environment you once lived in.

One form of rehab is a faith-based program. In a faith based program, the directors try to encourage those that come that God forgives them for whatever they have done in the past, and uses religion as a new "high" for individuals. While during my fieldwork I met two individuals who got off drugs through faith-based programs, one problem occurs for most once they are out.

McLovin: While I was in there I really wanted uhh to change my life toward God ya know. I got baptized an all that in the beginning... and things were goin great. But one of the dangers that I saw while I was in der was when many people got out, somethin bad would happen in their life and it was so easy to blame God, ya know what I'm sayin... as if it was his fault that happen. Therefore to punish God, individuals relapsed and found their way back into the program.

Even as rehab didn't work out for the individuals in this study, there is evidence of its efficacy more broadly. The Healing place (an Addiction Recovery Center) has had much success with their 8 month residential program. In the late 2000's not even five addicts who went to Louisville's Healing place were heroin addicts. But now heroin addicts account for more than half of their clients. One problem many addicts face is some rehabs have no room, and individuals who want to seek treatment right away have to be put on a waiting list, hoping they can get a bed before they do something as bad as overdose. Bourgois and Schonberg (2009) argue that relapse is "normal" and that every single day of sobriety should be considered a success, but the challenge is that the difficulties of treatments are exacerbated by inadequate public funding and by a lack of coordination between detox programs and long-term social support services.

CHAPTER V

RESULTS

In the sample, 5 of the participants were men and 4 were women. All but 1 participant (who was raised in West Palm, Florida) grew up in and around the city of Louisville. All 9 of the participants were Caucasian. At the time of the interviews all the participants were either recovering addicts still getting treatment (4), or have been sober between 1-2 years (5). Out of the 9 interviewed, 8 of the participants were between the ages (23-32) and 1 was 42 years old. Of the younger participants, it was found that 7 of the 8 transitioned from opioid misuse to heroin, and 1 transitioned to methamphetamine. Among the younger opioid pill initiates, the mean year of initiating opioids was 2004. The mean year of those that started heroin was 2012 (When HB 212 was implemented). The 1 older user who initiated into opioids in 1994 transitioned to other drugs such as cocaine, and methamphetamine, before ever trying heroin. All of the users snorted their opioid pills, with the exception of 1 whom had injected (Dilaudid) before transitioning to heroin. The most common street sold opioids among the younger users were Loritab, Percet, Roxicet, OxyContin, and Opana. OxyContin was the most popular misused drug, but once reformulated in 2010, 6 of the 7 opioid users moved to Opana. Once Opana's became nearly impossible to find on the streets, all 7 of those participants transitioned to heroin. All 9 of the participants considered themselves opiate-dependent before transitioning to other drugs, including the 7 who transitioned to heroin. Once transitioned to heroin, all 7 of the users snorted it on an average of several months to 2 years before initiating to injecting heroin.

Table 1 shows the market prices of prescription opioids sold on the street, along with the most popular milligram bought according to the interviewees. It is important to include that once on the path to opioid use, 5 interviewees started with pills like Loritab and Percocet before moving up to Roxicents, then leading to OxyContin and Opana's. From there, they rarely went back to Loritabs or Percocets unless that was the only thing their dealer had on them at the time.

Table 1. Louisville Opioid Street Prices 2010-2011

Louisville, Kentucky 2010-2011		
Opioid	Miligram	Price
Loritab	10	\$5-7
Percocet	10	\$7-9
Roxicet	30	\$25-30
Opana	40	\$40-60
OxyContin	80	\$60-70

Also prior to 2010, heroin wasn't really marketed to those that lived in suburbs in the city of Louisville. As mentioned earlier, in 2011, just one person was booked on heroin trafficking charges in Louisville.

Kristie states:

In fact, up until five years ago, no one had heroin or really knew where to get it or who to get it from.

As Danny (29) states:

It really wasn't heard of. My dealer was never selling it, and a lot of my friends didn't hear much about it. Opioids were so easy to get, and knowing they were prescribed by

doctors I actually knew what I was getting. With drug like heroin you didn't know what you was putting into your body.

This research did not look deep into it, but heroin may have been sold in the inner city, but during this time, all of the participants for this study stated their prescription opioid dealers were "white guys" living throughout the suburbs or on the outskirts of the inner city. Once heroin became the only option because Opana's left the streets, all 7 of the participants that transitioned stated they only went to "black guys" for heroin.

As the price of pills went up in the streets of Louisville, all 9 of the interviewees admitted to committing some form of crime to help pay for their addiction. The most common crime performed was refund fraud. According to the National Retail Federation (NRF) Return Fraud Survey, in 2013, refund fraud cost US retailers over 9 billion dollars. Refund fraud in layman's terms is when an individual walks into a store and steals something off the shelf or a clothes rack and takes it straight to the customer service counter giving the storyline of losing the receipt but returning the items. Most stores like Wal-Mart will only give a gift card in the amount of items returned with no receipt. But the individual would then sell that gift card to a friend for a cheaper price of what it is worth, or took it to a pawn shop where it is sold for 60-80% of its total value. Once pawning off items from family and friends houses, maxing out credit cards, and writing cold checks was no longer an option, it became hard for many individuals to find ways to get money to help with feeding their addiction. Two of the four women interviewed for this study engaged in sex work, as did one of the five men interviewed.

(Madison) It got to the point I would do anything for pills. I'll even admit this. For one pill that would've cost me over \$150 I just had... four guys... have their way with me. But the thing was the whole time I just looked at that pill sitting on the counter.

One of the women who didn't engage in prostitution actually went to the Internet and chatted with men who would tell her how "pretty" and "hot" she was. She would go on to tell them a sob made up story of how she can't pay for her LG&E bill, and within a few messages, men were sending her money through Western Union. Finally it got to the point that paying \$150 to \$250 for a single pill was too expensive due to the fact that users needed multiple to get through the day, therefore heroin became the smarter option because of the cheaper price difference. For the interviewees who transitioned to heroin, an average of a half a gram of heroin could be used to support their opiate dependence per day. A half of a gram of heroin was being sold for \$50-\$65, a fraction of the cost of the equivalent amount in pills.

CHAPTER VI

CONCLUSION

Kentucky has been quite known for its misuse in prescription opioids since as early as the 1990's according to this research and study. Around the time period that KASPER reports became mandatory for all clinics that prescribed Schedule II-V drugs, and once House Bill 127 went into effect, the transition from opioids to heroin was common among the individuals interviewed in this study. Among the younger users, 7 out of the 8 transitioned from prescription opioids to heroin. As OxyContin and Opana vanished from the black market, and became too expensive to feed the interviewees' habits, heroin was the logical next choice.

Several limitations should be noted from this study. Many of the participants came from similar communities within Louisville, primarily from middle to upper class family households. Many had commonalities within both their social and cultural circumstances. In addition with all 9 of the participants being white, racial identity was not explored in depth. Lastly, the interviews were semi-structured therefore the interviewees accounts of drug use and patterns of use may be subject to bias. But previous studies have shown that individuals who use drugs are able to accurately report on their substance use history (Darke, 1998). The findings from this study indicate a need for further research in the trajectory of prescription opioid abuse and its relationship with heroin.

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APPENDIX A:
Interview Guide

The Transition from Prescription Pills to Heroin

Interview guide

This is a theme-based interview guide and not a semi-structured questionnaire. Therefore, the approach with every participant is quasi-conversational allowing her/him to introduce as much unique, historical, and contextual detail as possible on his or her experiences while remaining attentive to the specific transition identified.

AIMS:

This interview will aim to elicit personal drug using history relevant to the transition from pharmaceutical opioid use/abuse to Heroin or concurrent Heroin and pharmaceutical use/abuse. The Interview Guide is to preserve the participant's perspective by assisting each in identifying what s/he considers key factors or significant events in their experience.

APPROACH:

Interviews will last approximately one hour.

Keep in mind that the conversation should focus on how and why individuals transitions from pharmaceutical opioids to Heroin (or concurrent Heroin and pharmaceutical use/abuse). In other words, the transition from pharmaceutical opioids to Heroin or concurrent Heroin and pharmaceutical use/abuse should be the primary issue guiding the conversation.

The guide should direct conversation for approximately the first half of the session.

The second half should provide participants the opportunity to expand on any previously disclosed event or issue raised. It should also permit for the interviewer to probe any questions not fully covered and/or to clarify any questions that emerged previously.

All interviews are to be voice recorded digitally and transcribed.

Demographic

Age/sex/race

Drug Use History

What is their drug use history (“Can you tell me about your history using drugs?”)

Age at initiation (“How old were you the first time you used drugs?”)

Experiences with drug use (“Could you tell me about specific experiences with pharmaceutical opioids? With Heroin?”)

Transition from pharmaceutical opioids to Heroin or concurrent Heroin/pharmaceutical use/abuse (“When/how/why did you start using Heroin?”)

Involvement with criminal justice system (“Has your drug use ever caused you to become involved with the CJS?”)

Drug Treatment Experience and Attitudes

Has participant ever received treatment for substance use?

What type?

Voluntary or court-ordered?

How long?

Satisfaction with treatment?

General

What could make their lives better, easier, etc.?

Do they feel they need/want help with substance abuse?

Do they want to be drug free?

Ask participant their general outlook at present. What are their hopes, concerns, priorities and plans?

Provide participants the opportunity to clarify or expand on any previously disclosed event or issues raised, also for interviewer to probe any questions not fully covered and/or to clarify any questions that emerged.