OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

ResearchReport

# Connecticut's Opioid Drug Abuse Laws

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## Issue

This report describes Connecticut's opioid drug abuse laws. It updates OLR Report 2022-R-0168.
This report has been updated by OLR Report 2024-R-0085.

## Summary

Like many other states, Connecticut continues to face an increase in the number of emergency room visits and drug overdose deaths involving opioid analgesics (e.g., prescription painkillers such as oxycodone, hydrocodone, and fentanyl).

In recent years, the legislature responded to this trend by enacting laws to reduce and prevent opioid drug abuse. This includes (1) increasing access to opioid antagonists (i.e., medication to treat a drug overdose); (2) providing immunity for people who (a) seek emergency medical assistance for themselves or another person experiencing a drug overdose or (b) prescribe and administer opioid antagonists to a person experiencing a drug overdose ("Good Samaritan" laws); (3) establishing a statewide prescription drug monitoring program; and (4) limiting the amount of certain opioid drugs that may be prescribed to adults and minors.

This report highlights provisions of Connecticut law intended to reduce or prevent opioid drug abuse. It does not include all of the laws' provisions; to read the laws in their entirety, visit the Connecticut General Assembly's website. The report also excludes laws imposing criminal penalties for violating drug laws.

# Table of Contents

# Access to Opioid Antagonists

## *EMS Provision of Opioid Antagonist Kits*

Under new legislation, Emergency Medical Services (EMS) personnel must give kits with opioid antagonists and a related one page fact sheet to certain patients (such as those showing symptoms of opioid use disorder) or their family members, caregivers, or friends. The new law (1) allows EMS organizations to obtain opioid antagonists from pharmacists to distribute through the program; (2) creates a related account to provide this medication to eligible entities, including EMS organizations; and (3) requires EMS personnel to document certain information about the kits they distribute (PA 23-97, § 5, effective October 1, 2023).

## *Encouragement to Obtain Opioid Antagonists*

A new law requires prescribing practitioners, when prescribing an opioid, to encourage the patient to obtain an opioid antagonist. If the patient is a minor, the prescriber must also encourage the patient's custodial parent, guardian, or other person with legal custody to obtain an opioid antagonist, if they are present when the prescription is being issued (PA 23-97, § 6, effective October 1, 2023).

## *Expanding Opioid Antagonist Access Through New Means of Distribution*

Legislation passed this session allows prescribing practitioners and pharmacists to enter into agreements with community health organizations, EMS providers, government agencies, law enforcement agencies, local and regional boards of education, and syringe services programs to distribute opioid antagonists through secured boxes or machines or vending machines. The new law specifies how these boxes and machines must be operated and maintained and provides liability protection to prescribing practitioners and pharmacists who enter into agreements to supply opioid antagonists through these means (PA 23-52, § 12, effective upon passage).

## *Higher Education Institutions*

Legislation passed in 2019 required higher education institutions to (1) develop and implement policies on the availability and use of opioid antagonists by students and employees and (2) generally notify emergency medical providers when an opioid antagonist is used (PA 19-191, § 7, codified at CGS § 10a-55t).

## *Law Enforcement Units*

In 2021, the legislature enacted a law that requires law enforcement units to (1) require their police officers to be trained in using opioid antagonists and (2) acquire and maintain a supply of these medications for use by the officers when responding to a medical emergency. A police officer who completes the training must be permitted to carry opioid antagonists and administer the

medication to a person whom the officer believes in good faith is experiencing an opioid-related drug overdose (PA 21-108, § 1, codified at CGS § 7-294u).

## *Opioid Antagonist Bulk Purchase Fund*

A new law creates an Opioid Antagonist Bulk Purchase Fund as a separate, nonlapsing General Fund account. Starting by January 1, 2024, the Department of Mental Health and Addiction Services (DMHAS), in collaboration with the Department of Public Health (DPH), must use the account's funds to provide opioid antagonists to municipalities, EMS organizations, and other eligible entities and for EMS personnel to provide this medication to certain members of the public.

The DMHAS commissioner, within available appropriations, may contract with a drug wholesaler or distributer to purchase and distribute opioid antagonists in bulk to eligible entities through the program (PA 23-97, § 5, effective October 1, 2023).

## *Opioid Antagonist Program for Local Agencies*

Legislation passed in 2018 allows prescribing practitioners and pharmacists authorized to prescribe an opioid antagonist to enter into an agreement with a law enforcement agency, EMS provider, government agency, or community health organization ("agencies") to distribute and administer opioid antagonists.

The prescribers and pharmacists must train the above listed agencies that will distribute or administer opioid antagonists under such an agreement. But they cannot, as a result of an agency's administration or dispensing of an opioid antagonist, be (1) held liable for damages in a civil action or (2) subjected to administrative or criminal prosecution (PA 18-166, § 3, codified at CGS § 21a-286).

## *Prescriptive Authority for Pharmacists*

Connecticut law allows physicians, dentists, podiatrists, optometrists, physician assistants (PAs), advanced practice registered nurses (APRNs), nurse-midwives, and veterinarians to prescribe opioid antagonists within the scope of their professional practice. Legislation from 2015 additionally allows pharmacists to prescribe these medications, if they do the following:

1. complete a training and certification program approved by the Department of Consumer Protection (DCP) commissioner,
2. act in good faith,
3. train the recipient of the opioid antagonist in how to administer it,
4. maintain a record of the dispensing and training under the law's record keeping requirements, and

5. refrain from delegating or directing another person to prescribe the medication or provide the training to the recipient (PA 15-198, § 6, codified at CGS § 20-633c).

## *Sales and Use Tax Exemption for Nonprescription Opioid Antagonists*

This session, the legislature added nonprescription opioid antagonists to the list of nonprescription drugs that are exempt from the state sales and use tax. The federal Food and Drug Administration (FDA) recently approved a four-milligram naloxone hydrochloride nasal spray for over-the-counter, nonprescription use (PA 23-204, § 380, effective July 1, 2023, and applicable to sales made on or after that date).

## *Standing Orders for Pharmacies*

Legislation passed in 2017 allows a practitioner authorized to prescribe an opioid antagonist to issue a standing order (i.e., non-patient specific prescription) to a licensed pharmacist for an opioid antagonist that is:

1. administered nasally or by auto-injection;
2. approved by the FDA; and
3. dispensed by the pharmacist to a person at risk of an opioid drug overdose or family member, friend, or other person who may assist a person at risk of the overdose.

When dispensing an opioid antagonist under a standing order, the pharmacist must train the person to administer it and keep a record of the dispensing and training under the law's recordkeeping requirements. The pharmacist must also send a copy of the dispensing record to the prescribing practitioner who entered into a standing order agreement with the pharmacy. Additionally, the pharmacy must provide DCP with a copy of each standing order it enters into with a prescribing practitioner (PA 17-131, § 12, codified at CGS § 20-633d).

## *Third-Party Prescriptions*

Opioid antagonists, such as Narcan, rapidly reverse opioid drug overdose symptoms. They are not addictive and do not cause a "high" or pose serious health effects when taken by someone not suffering from a drug overdose. Historically, Connecticut prohibited prescribing these medications to a person other than the drug user in need of intervention (i.e., third-party prescriptions), but in 2012 the legislature changed the law to allow licensed health care practitioners authorized to prescribe opioid antagonists to prescribe, dispense, or administer them to anyone (e.g., family members or other people) to treat or prevent a drug overdose (PA 12-159, codified at CGS § 17a-714a).

### *Use of Opioid Settlement Funds to Equip Police With Opioid Antagonists*

A new law expands the purposes for which the Opioid Settlement Fund may be used to include providing funds to municipal police departments to equip officers with opioid antagonists. Under the act, priority for these funds must be given to departments that do not currently have a supply of them (PA 23-204, § 193, effective July 1, 2023).

## Alcohol and Drug Policy Council

### *Expanded Responsibilities*

Connecticut's Alcohol and Drug Policy Council (ADPC) is charged with (1) reviewing state policies on substance abuse treatment programs and criminal sanctions and programs and (2) developing and coordinating a statewide plan for these matters. The statewide plan must have measurable goals, including reducing the number of opioid-induced deaths in the state.

Legislation passed in 2017 expanded the council's responsibilities to include (1) developing a one-page fact sheet on opioid drugs and (2) examining the feasibility of implementing certain opioid abuse public education initiatives (PA 17-131, § 7, codified at CGS § 17a-667a).

### *Feasibility Study on Opioid Abuse Public Education Initiatives*

A 2017 law requires the ADPC to examine the feasibility of (1) developing a marketing campaign and making monthly public service announcements on opioid drugs and (2) establishing an electronic information portal (i.e., internet website or application) on the availability of substance use disorder treatment beds in Connecticut facilities. The council had to report the study's results to the Public Health Committee by January 1, 2019 (PA 17-131, § 7, codified at CGS § 17a-667a).

### *Opioid Fact Sheet*

By law, the ADPC must develop a one-page fact sheet on opioid drugs that includes the (1) risks of opioid drug use, (2) symptoms of opioid use disorders, and (3) available services in Connecticut for those experiencing these symptoms or who are otherwise affected by an opioid use disorder.

The council must make the fact sheet available on the DMHAS website for health care providers and pharmacists to use and encourage them to disseminate it to anyone whom (1) a provider treats for opioid use disorder symptoms, (2) a provider issues a prescription for or administers an opioid drug or opioid antagonist, or (3) a pharmacist dispenses an opioid drug or issues a prescription for or dispenses an opioid antagonist (PA 17-131, § 7, codified at CGS § 17a-667a).

# Continuing Medical Education

Connecticut law requires physicians, APRNs, PAs, and dentists to take continuing education (CE) in pain management and prescribing controlled substances to reduce pain as follows:

1. for physicians, at least one contact hour (i.e., 50 minutes) of risk management training or education that includes pain management and prescribing controlled substances (a) during their first license renewal period in which CE is required and (b) at least once every six years after that (PA 15-198, § 1, codified at CGS § 20-10b);

2. for APRNs, at least one contact hour every two years of substance abuse training or education that includes pain management and prescribing controlled substances (PA 15-198, § 2, codified at CGS § 20-94d); and

3. for PAs and dentists, at least one contact hour every two years of training or education in pain management and prescribing controlled substances (PA 15-198, §§ 3 & 4, codified at CGS §§ 19a-88 and 20-126c).

By law, physicians and APRNs generally must complete 50 hours of CE every two years, starting with their second license renewal. Dentists generally must complete 25 hours of CE every two years, also starting with their second license renewal. PAs must have the mandatory CE requirements needed to maintain national certification in order to renew their licenses.

# Department of Correction

## *Opioid Treatment Information for Inmates*

A 2019 law requires the Department of Correction (DOC) commissioner to give information on treatment options to inmates who self-identify as suffering from or relapsing into an opioid use disorder. The information must (1) be provided at least 45 days before the inmate's release from DOC custody and (2) include ways to access treatment options after being released into the community (PA 19-167, codified at CGS § 18-81mm).

## *Pilot DOC Methadone Treatment Program*

In 2018, the legislature extended a DOC pilot methadone treatment program for certain inmates, expanded its scope if federal funds were available, and required a new report on the program's results (PA 18-166, §§ 6 & 7, codified at CGS § 18-100j).

## *Pilot Program for Certain Arrestees*

A 2017 law required the chief state's attorney to establish a pilot program to identify and track homeless, addicted, or mentally ill individuals entering the criminal justice system and refer them to certain programs (PA 17-205, codified at CGS § 51-286i).

### *Special Parole*

"Special parole" is parole ordered by the court as part of the sentence when someone is convicted of a crime. Among other changes to special parole, a 2018 law eliminated special parole as a sentencing option for convictions of offenses related to dependency-producing drugs (PA 18-63, codified at CGS § 51-286i).

## Drug Disposal

### *Controlled Substance Disposal by Certain Nurses*

A 2017 law allows registered nurses employed by home health care agencies, with a patient's designated representative's permission, to oversee the destruction or disposal of the patient's controlled substances (PA 17-131, § 2, codified at CGS § 21a-262).

### *Pharmacy Disposal Programs*

In 2017, the legislature required the DCP commissioner to adopt regulations on allowing a certain number of licensed pharmacies to accept and dispose of unused prescription drugs (PA 17-109, § 1, codified at CGS § 20-576a).

## Good Samaritan Laws

### *Prescribing or Administering Opioid Antagonists*

Connecticut law allows licensed health care practitioners authorized to prescribe an opioid antagonist to prescribe, dispense, or administer it to treat or prevent a drug overdose without being (1) civilly or criminally liable for the action or for the antagonist's subsequent use or (2) deemed to violate their professional standard of care (CGS § 17a-714a). Legislation from 2016 extended this immunity to all licensed health care professionals (PA 16-43).

Additionally, anyone, if acting with reasonable care, may administer an opioid antagonist to a person he or she believes, in good faith, is experiencing an opioid-related drug overdose. The law generally gives civil and criminal immunity to the person when administering the opioid antagonist (PA 14-61, codified at CGS § 17a-714a).

### *Seeking Emergency Medical Care for a Drug Overdose*

A 2011 law gives civil and criminal immunity to people who seek or receive emergency medical care for themselves or another person they reasonably believe is experiencing a drug overdose (PA 11-210, codified at CGS § 21a-279).

# Health Insurance

## *Coverage for Substance Use Disorder*

Legislation enacted in 2017 requires certain individual and group health insurance policies to cover medically necessary (1) medically monitored inpatient detoxification services and (2) medically managed intensive inpatient detoxification services for insureds or enrollees diagnosed with a substance use disorder (PA 17-131, §§ 8 & 9, codified at CGS §§ 38a-492p and -518p).

Additionally, a 2019 law prohibits certain health insurance policies from applying non-quantitative treatment limitations (e.g., prior authorization) to mental health and substance use disorder benefits in a way that is substantially different from how they apply these limitations to medical and surgical benefits. The law also generally prohibits health insurance policies from denying coverage for substance abuse services solely because a court order provided for them (PA 19-159, codified at CGS §§ 38a-488c and -514c).

## *Direct Payments for Substance Use Disorder Treatments*

In 2017, the legislature required certain health insurance policies to directly pay any out-of-network health care providers eligible for reimbursement for diagnosis or treatment rendered in Connecticut for a substance use disorder (PA 17-157, §§ 1 & 2, codified at CGS §§ 38a-488a and -514).

## *Opioid Antagonist Prescriptions and Life Insurance and Annuity Policies*

The legislature enacted a law in 2019 prohibiting life insurance or annuity policies or contracts delivered, issued, renewed, or continued in the state from excluding coverage solely due to a person having received a prescription for naloxone (i.e., an opioid antagonist) or for a naloxone biosimilar or generic (PA 19-191, § 5, codified at CGS § 38a-447a).

## *Prior Authorization for Opioid Antagonists*

The law prohibits certain health insurance policies from requiring prior authorization for coverage of opioid antagonists. It applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including those provided under an HMO plan; or (5) single ancillary services (e.g., prescription drugs). Because of ERISA (*Employee Retirement Income Security Act)*, state insurance benefit mandates do not apply to self-insured benefit plans (PA 16-43, §§ 2 & 3, codified at CGS §§ 38a-510b and -544b).

# Local EMS Plans and Data Reporting

## *Local EMS Plans*

By law, local EMS plans must require that at least one EMS provider who is likely to arrive first on the scene of a medical emergency carry an opioid antagonist and complete a DPH-approved training on how to administer it. Each municipality had to amend its local EMS plan to include this requirement by October 1, 2017 (PA 16-43, § 1, and PA 17-131, § 11, codified at CGS § 17a-714a).

## *Overdose Reporting*

A 2018 law requires hospital or EMS personnel that treat a patient for an opioid overdose to report the overdose to DPH. DPH must provide the data to the municipal or district health department that has jurisdiction over the location where the overdose occurred, or, if the location is unknown, the location where the hospital or EMS personnel treated the patient, as DPH, in its discretion, deems necessary to develop preventive initiatives.

Municipal and district health departments must use this data to develop preventive initiatives on a local level to address opioid, heroin, and other drug overdoses. By law, the data is confidential in accordance with existing law for records provided to DPH (PA 18-166, § 5, codified at CGS § 19a-127q).

# Opioid and Controlled Substance Prescriptions

## *Electronic Prescriptions Generally Required*

A 2017 law generally requires prescriptions for controlled substances to be transmitted electronically to a pharmacy, which must have the technology to accept them (PA 17-131, § 3, codified at CGS § 21a-249).

## *Maximum Supply for First-Time Outpatient Use*

Connecticut law prohibits a practitioner authorized to prescribe an opioid drug from issuing a prescription for more than a seven-day supply to an adult for first-time outpatient use. Legislation passed in 2017 reduced, from a seven-day supply to a five-day supply, the maximum amount of an opioid drug that may be prescribed to a minor under age 18.

When prescribing an opioid drug to a minor, the law requires the practitioner to discuss the risks associated with opioid drug use with the minor and his or her custodial parent, guardian, or legal custodian, if present. Legislation from 2017 additionally requires prescribers to have these discussions with adult patients (PA 17-131, § 5, codified at CGS § 20-14o).

The law allows the practitioner to prescribe a larger supply of an opioid drug to a minor or an adult for first-time outpatient use if, in his or her professional judgment, the drug is required to treat an acute medical condition, chronic pain, cancer-associated pain, or for palliative care. The practitioner must document the patient's condition in his or her medical record and indicate that an alternative to the opioid drug was not appropriate to treat the condition. The law does not apply to medications to treat opioid drug dependence or abuse, including opioid antagonists and agonists (PA 17-131, § 5, codified at CGS § 20-14o).

## *Prescribing Controlled Substances Using Telehealth*

A 2018 law allows telehealth providers authorized to prescribe controlled substances, under specified conditions, to prescribe non-opioid Schedule II or III controlled substances using telehealth to treat a psychiatric disability or substance use disorder, including medication-assisted treatment (PA 18-148, codified at CGS § 19a-906).

## *Prescription Labeling Requirement*

Starting January 1, 2024, new legislation requires pharmacies to affix a fluorescent orange sticker or label with black ink that says "DANGER TO CHILDREN KEEP OUT OF REACH" on any container or packaging in which an opioid drug or schedule II, III, IV, or V controlled substance is sold or dispensed. It also requires the DCP commissioner to adopt regulations and implement policies and procedures to provide guidance to pharmacies in implementing the new law (PA 23-100, § 1, effective upon passage).

## *Provision of Controlled Substances to Self or Family*

In 2018, the legislature enacted a law that generally prohibits prescribing practitioners from prescribing, dispensing, or administering Schedule II to IV controlled substances to themselves or immediate family members. It allows an exception for up to a 72-hour supply of the drugs if there is no other qualified prescriber available. In that case, the prescriber must, among other things, (1) perform an assessment for the patient's care and treatment and (2) medically evaluate the patient's need for the controlled substance (PA 18-166, § 2, codified at CGS § 21a-252).

## *Treatment Agreement for Certain Patients Prescribed Opioids*

Under a 2019 law, practitioners who prescribe more than a 12-week supply of an opioid drug to treat a patient's pain must establish a treatment agreement with the patient or discuss a care plan for chronic opioid drug use. The agreement or plan must include (1) treatment goals, risks of opioid drug use, urine drug screens, and expectations for continued pain treatment with opioids and (2) to the extent possible, non-opioid treatment options (PA 19-191, § 6, codified at CGS § 20-14s).

In 2022, the legislature added chiropractic and spinal cord stimulation to the list of nonopioid treatment options that, to the extent possible, must be included on a patient's treatment

agreement or care plan. Existing law already required the agreement or plan to include manipulation, massage therapy, acupuncture, physical therapy, and other treatment regimens or modalities (PA 22-108, § 1, codified at CGS § 20-14s).

### *Voluntary Non-Opioid Directive Form*

Legislation enacted in 2017 requires DPH, in consultation with DCP and DMHAS, to establish a voluntary non-opioid directive form and publish it on the DPH website for public use. A patient may file the form with a prescribing practitioner, indicating that he or she asks not to be issued a prescription or medication order for an opioid drug.

The law generally grants civil and criminal immunity to:

1. prescribing practitioners acting with reasonable care for refusing to issue a prescription or medication order for an opioid pursuant to a voluntary non-opioid directive form,
2. anyone acting in good faith as a duly authorized guardian or health care proxy for revoking or overriding the form, and
3. emergency departments' prescribing practitioners acting with reasonable care for issuing a prescription or administering an opioid drug to someone with a voluntary non-opioid directive form if they had no knowledge of the form or deemed that an opioid was medically necessary at that time (PA 17-131, § 4, codified at CGS § 20-14r).

## Opioid Litigation Proceeds

### *Opioid Settlement Fund*

In 2022, the legislature established an Opioid Settlement Fund as a separate non-lapsing fund administered by an Opioid Settlement Advisory Committee (see below) with assistance from DMHAS. The fund must contain moneys the state receives from opioid-related judgments, consent decrees, or settlements finalized on or after July 1, 2021. (Connecticut is part of a $26 billion multistate opioid settlement agreement with several prescription drug manufacturers and is expected to receive approximately $300 million over 18 years; the state will receive an additional $95 million to fund an Opioid Survivors Fund resulting from a separate settlement agreement with Purdue Pharma and the Sackler family.)

Under the law, Opioid Settlement Fund moneys must generally be used prospectively and only for specified substance use disorder abatement purposes. If the DMHAS commissioner and the attorney general certify that a judgment's, consent decree's, or settlement's purpose is inconsistent with the fund's intent, it establishes a process for them to deposit the moneys into an alternative account or fund. Generally, proceeds may only be allocated to municipalities with an agreement to participate in the settlement and follow its terms (PA 22-48, codified at CGS § 17a-674c).

In addition, new legislation requires municipalities that receive opioid settlement funds directly from a settlement administrator to report to the state's Opioid Settlement Advisory Committee on their expenditures for the prior year on a form the committee prescribes. Under the act, municipalities must report by October 1, 2023, and annually afterwards, until they spend all their settlement funds. The committee must also publish the reports it receives on its website (PA 23-92, §§ 2 & 3, effective July 1, 2023).

### *Opioid Settlement Advisory Committee*

Legislation enacted in 2022 established an Opioid Settlement Advisory Committee to ensure (1) Opioid Settlement Fund moneys are allocated and spent on specified substance use disorder abatement purposes and (2) robust public involvement, accountability, and transparency in allocating the accounting for the fund's moneys (PA 22-48, codified at CGS § 17a-674d).

New legislation increased the committee membership from 37 to 45; it currently consists of 37 state and local government officials and eight public members and is chaired by the DMHAS commissioner and a municipal representative. The committee must meet quarterly and annually report to the Appropriations and Public Health committees on the fund's activities and PA 23-97, § 35, effective July 1, 2023).

## Patient Care and Treatment

### *Drug Use Harm Reduction Centers*

A new law requires DMHAS, by July 1, 2027, to create a pilot program consisting of harm reduction centers where people with substance use disorder can access counseling, fentanyl and xylazine test strips, and various other services. These centers must be established in three municipalities the DMHAS commissioner chooses, subject to their chief elected officials' approval, and in consultation with DPH. The centers are not subject to DPH regulation until after the pilot program ends and are exempt from the requirement to obtain certificate of need approval from the Office of Health Strategy. The centers must employ licensed providers with experience treating people with substance use disorders (PA 23-97, §§ 3 & 4, effective upon passage).

### *Mental Health Screenings for Certain Patients*

A 2019 law requires hospitals to administer a mental health screening or patient assessment on patients treated for a nonfatal opioid drug overdose, and provide the results to the patient or certain other people, if it is medically appropriate to do so (PA 19-191, § 11, codified at CGS § 19a-127q).

## *Mobile Pharmacies*

New legislation allows retail pharmacies to apply to DCP to operate a mobile pharmacy that conducts temporary opioid antagonist training and prescribing events. It requires pharmacies to obtain prior approval from DCP in order for their mobile pharmacies to (1) operate in one place for more than seven consecutive days; (2) operate for more than 14 days within a five-mile radius of the prior mobile pharmacy location; or (3) serve as an overnight storage space for drugs (PA 23-19, § 3, effective July 1, 2023).

## *Mobile Units for Dispensing Controlled Substances*

Legislation passed in 2022 allows practitioners authorized to prescribe controlled substances (e.g., methadone) to treat patients by dispensing them from a mobile unit. To do so, the prescribing practitioner must take certain actions, such as notifying DCP of his or her intent to transport the controlled substances and reporting the dispensing to the state's Prescription Drug Monitoring Program (PDMP) (PA 22-108, § 3, codified at CGS § 21a-317).

## *Multicare Institutions and Methadone Treatment*

By law, multicare institutions are hospitals, psychiatric outpatient clinics for adults, free-standing facilities for substance abuse treatment, psychiatric hospitals, or general acute care hospitals that provide outpatient behavioral health services that (1) have more than one facility or one or more satellite units owned and operated by a single licensee and (2) offer complex patient health care services at each facility or satellite unit.

A 2019 law specifies that multicare institutions' services may include methadone delivery and related substance use treatment services to people in nursing homes (PA 19-118, §§ 5 & 6, codified at CGS § 19a-493).

Legislation passed in 2022 further expanded these institutions' services to include behavioral health services or substance use disorder treatment services to patients in mobile narcotic treatment programs (NTPs). Under federal regulation, NTPs provide maintenance or detoxification treatment with Schedules II-IV controlled substances at a location remote from, but within the same state as, the registered NTP (PA 22-108, § 4, codified at CGS § 19a-493).

## *Patient Education Requirements for Treatment Programs*

A 2019 law requires DMHAS-operated or –approved substance use treatment programs that treat patients with opioid use disorder to offer education on opioid antagonists to these patients and their relatives. It also requires affiliated prescribers to provide a prescription for at least one dose of an opioid antagonist to a patient the prescriber determines would benefit from it (PA 19-191, § 9, codified at CGS § 17a-673a).

### *Pilot Program Providing Opioid Use Disorder Services*

A 2021 law required DMHAS, within available appropriations, to establish a pilot program in up to five urban, suburban, and rural communities to serve people with opioid use disorder. Under the law, each participating community must form a team of at least two peer navigators who must, among other things, (1) travel throughout the community to address the health care and social needs of people with opioid use disorder and (2) complete regularly updated training on non-coercive and non-stigmatizing methods for engaging these people, as determined by the DMHAS commissioner.

In 2022, the legislature extended, by one year until January 1, 2023, the date by which DMHAS must establish the program. And it correspondingly extended by one year, until January 1, 2024, the date by which the commissioner must report to the Public Health Committee on the pilot program, including its success and any recommendations to continue or expand it (PA 21-113, and PA 22-108, § 7, codified at CGS § 17a-673b).

### *Substance Exposed Newborns*

Legislation enacted in 2017 and 2018 addresses Department of Children and Families (DCF) policies and guidelines on the safe care of newborns born with signs of prenatal substance exposure. For example, the 2018 act requires that the guidelines instruct health care providers on their participation in the discharge planning process, including creating written safe care plans between the provider and the newborn's mother. A provider involved in delivering or caring for a substance exposed newborn must notify DCF of the newborn's condition (PA 17-210, codified at CGS § 17a-54b and PA 18-111, § 5, codified at CGS § 17a-102a).

## Prescription Drug Monitoring and Oversight

### *Connecticut's Prescription Drug Monitoring Program (PDMP)*

Legislation enacted in 2006 required DCP to establish an electronic PDMP to collect prescription information from pharmacies on Schedules II through V controlled substances to prevent improper or illegal drug use or improper prescribing (PA 06-155, codified at CGS § 21a-254). The program subsequently expanded by requiring prescription information reporting by (1) out-of-state pharmacies that ship or deliver prescription drugs into Connecticut and (2) any other drug dispensing practitioner, such as physicians, dentists, veterinarians, podiatrists, and researchers (PA 13-172).

Generally, dispensers must report prescription information within one business day to DCP, such as the dispensing date, dispenser identification and prescription numbers, and patient identifying information. If the program is not operational, the pharmacy or dispenser must report by the next business day after regaining program access.

Certain substances and dispensers are exempt from the program's reporting requirements, such as (1) controlled substances dispensed to hospital inpatients and (2) institutional pharmacies operated by licensed health care institutions when dispensing or administering opioid agonists to a patient to treat a substance use disorder.

By law, before prescribing more than a 72-hour supply of a controlled substance, the prescribing practitioner or his or her authorized agent must review the patient's records in the PDMP. The practitioner or agent must also periodically review a patient's records in the program when the practitioner prescribes controlled substances for continuous or prolonged treatment (CGS § 21a-254(j)).

There have been various changes to the program, such as (1) expanding who can serve as a prescriber's authorized agent, (2) allowing the DCP commissioner to share certain program information with other state agencies for certain drug abuse studies, and (3) requiring the DPH and DCP commissioners to review pharmacists' and prescribing practitioners' compliance with program requirements (PA 16-43, PA 17-131, and PA 18-100).

## *Drug Paraphernalia*

In 2022, the legislature removed from the statutory definition of "drug paraphernalia" products used by licensed drug manufacturers for permitted activities or by people to test a substance before they ingest, inject, or inhale it (e.g., fentanyl testing strips), as long as they are not using the products to engage in unlicensed manufacturing or distribution of controlled substances (PA 22-108, § 2, codified at CGS § 21a-240).

## *Hospice Disposal of Controlled Substances*

Legislation passed in 2022 requires licensed hospice and hospice care programs that provide hospice home care services for terminally ill people to dispose any controlled substance that they dispensed or administered to a terminally ill person as soon as practicable after the person's death, in a way that complies with state and federal laws (PA 22-81, § 21, codified at CGS § 19a-492f).

## *Reporting Opioid Agonists*

Under certain conditions, a 2021 law requires institutional pharmacies and pharmacists' drug rooms operated by licensed health care institutions to report to the PDMP when dispensing or administering opioid agonists (e.g., methadone or morphine) directly to patients to treat a substance use disorder. (Prior law exempted them from the program's reporting requirement.)

The act requires these pharmacies and pharmacy drug rooms to report the information only when (1) the patient has consented to disclosure and (2) it complies with federal substance abuse confidentiality regulations. If a patient withdraws consent, the institution must discontinue reporting opioid agonist information related to the patient (PA 21-192, § 5, codified at CGS § 21a-254(j)).

### *Reporting Suspicious Controlled Substance Orders*

A 2018 law requires drug manufacturers and wholesalers to identify and report suspicious controlled substance orders to DCP's Drug Control Division (PA 18-16, § 3, codified at CGS § 21a-70). Additionally, a 2019 law requires drug manufacturers and wholesalers to report to DCP certain decisions to terminate or refuse an order from a pharmacy or prescribing practitioner for Schedule II to V controlled substances because of potential diversion concerns (PA 19-191, § 4, codified at CGS § 21a-70).

### *Safe Storage of Opioid Drugs*

Legislation passed in 2022 required DCP, by December 1, 2022, to develop documents on the safe storage and disposal of opioid drugs and cannabis and cannabis products and, by December 15, 2022, post the documents on the department's website. The act also required pharmacies, cannabis retailers, and hybrid retailers, by January 1, 2023, to post notices about these documents on their premises (PA 22-81, §§ 18-20, codified at CGS § 21a-12g).

## Sober Living Homes

A 2018 law contains several provisions on the oversight of sober living homes. Among other things, it (1) allows a certified sober living home's owner to report the home's certified status to DMHAS, (2) requires DMHAS to post on its website a list of these certified homes as well as the number of available beds at each home and update the information weekly, and (3) establishes certain advertising requirements and restrictions for operators.

It also requires operators who report their home's certified status to maintain at least two doses of an opioid antagonist on the premises and train all residents in how to administer it. The operator must do this when the home is occupied by at least one resident diagnosed with an opioid use disorder (PA 18-171, codified at CGS § 17a-716).

## Studies and Working Groups

### *Combating the Opioid Epidemic*

A 2018 law required the ADPC to convene a working group to evaluate ways to combat the opioid epidemic in the state. The group had to investigate various matters, such as how many people annually receive services from DMHAS-funded methadone treatment programs, the rate at which those people relapse, and how many people die from drug overdose while participating in the programs. The working group reported its findings and recommendations to the Public Health Committee on January 1, 2019 (PA 18-166, § 4).

## *Home-Based Opioid Treatment Literature Review*

A 2019 law required DMHAS, in collaboration with DPH and the Department of Social Services (DSS), to review and report to the legislature on literature about the efficacy of providing home-based treatment and recovery services for opioid use disorder to certain Medicaid beneficiaries (PA 19-191, § 8).

## *Opioid Drug Prescriptions*

Legislation enacted in 2016 required the Public Health Committee chairpersons to convene a working group to address, and report back on, the issuance of opioid drug prescriptions by prescribing practitioners. The group had to study whether it is a best practice for prescribing practitioners to limit prescriptions to minors to no more than a three-day supply to treat an acute medical condition (PA 16-43).

## *Opioid Intervention Court Feasibility Study*

Legislation from 2018 required the chief court administrator, in consultation with certain officials, to study the feasibility of establishing one or more courts that specialize in hearing criminal or juvenile matters where a defendant is an opioid-dependent person, who could benefit from intensive court monitoring and being placed in a substance abuse treatment program. The chief court administrator submitted its final report to the Judiciary Committee (PA 18-166, § 1).

## *Police Detention Protocol*

A 2019 law required DMHAS, in collaboration with DPH, to study and report on the protocol for the police detaining people whom they suspect of having experienced an opioid overdose and the implications of involuntarily transporting people who overdosed to emergency rooms and referring them to recovery coaches. The department was required to submit its final report to the Public Health Committee by January 1, 2020 (PA 19-191, § 13).

## *Safe Disposal of Opioid Drugs*

Legislation passed in 2017 required the ADPC to convene a working group to advise it on any legislative or policy changes to enable first responders or health care providers to safely dispose of a person's opioid drugs upon the person's death. The council had to report to the Public Health Committee on the working group's recommendations by February 1, 2018 (PA 17-131, § 7).

## *Substance Abuse Treatment Referral Programs*

A 2017 law required the ADPC to convene a working group to study municipal police departments' substance abuse treatment referral programs. These programs refer people with an opioid use disorder or who are seeking recovery from drug addiction to treatment facilities. The study had to identify any barriers these programs face as well as the feasibility of implementing the programs

statewide. The council was required to report on the working group's findings to the Public Health and Public Safety and Security committees by February 1, 2018 (PA 17-131, § 7).

## Miscellaneous 2018-2023 Legislative Changes

Legislation enacted over the last five years made various other changes affecting opioid drug abuse and related issues, such as the following:

1. specifically making instruction on opioid use and related disorders part of the state's required public school program of instruction (existing law already required instruction on substance abuse prevention) (PA 18-182, § 2);

2. granting civil immunity, under certain conditions, to people or entities that provide or maintain an automatic external defibrillator in a cabinet which also contains an opioid antagonist (PA 19-169);

3. requiring the DSS commissioner to amend the state Medicaid plan to provide an $88.52 minimum weekly reimbursement rate for a Medicaid beneficiary's methadone maintenance treatment from chemical maintenance providers but also making this rate contingent on meeting certain performance measures (PA 19-117, § 311);

4. authorizing the attorney general to enter into agreements concerning any statewide claim on opioid manufacturing, marketing, distribution, sales, or related activities (PA 21-2, June Special Session, § 39);

5. requiring Regional Behavioral Health Action Organizations, within available appropriations, to provide training in administering opioid antagonists and distribute them to communities (PA 22-69);

6. requiring the Department of Transportation to conduct a public awareness campaign about the dangers of driving under the influence of certain over-the-counter drugs and prescription drugs, with an emphasis on opioids and cannabis (PA 23-116, § 8); and

7. requires DMHAS, the Department of Children and Families, and certain other state agencies to evaluate or report on various supports and related issues for parents, other child caregivers, or pregnant individuals with substance use disorder (PA 23-97, §§ 29-34).

Complete summaries of the legislation are available on OLR's website.

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