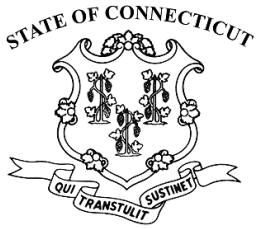

Substitute Senate Bill No. 483

Public Act No. 18-166

AN ACT CONCERNING THE PREVENTION AND TREATMENT OF OPIOID DEPENDENCY AND OPIOID OVERDOSES IN THE STATE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (*Effective from passage*) (a) The Chief Court Administrator or his or her designee, in consultation with the Chief Public Defender, Chief State's Attorney and the dean of The University of Connecticut School of Law, or their respective designees, shall study the feasibility of establishing one or more courts that specialize in the hearing of criminal or juvenile matters in which a defendant is an opioid-dependent person, who could benefit from intensive court monitoring and placement in a substance abuse treatment program.

(b) The study shall include an examination of: (1) The testing of certain arrestees for opioid use and the timing of such testing, (2) innovative and different treatment placement options for opioid-dependent arrestees, (3) the development of a rapid integration team of individuals who focus on meeting the treatment needs of opioid-dependent arrestees, (4) the development of judicial processes that include daily court monitoring of opioid-dependent arrestees, and (5) the use of curfews and electronic-monitoring tools as a means of facilitating success completion of a substance abuse treatment program.

(c) The Chief Court Administrator, or his or her designee, shall report on the results of such study to the joint standing committee of the General Assembly having cognizance of matters relating to the judiciary, in accordance with the provisions of section 11-4a of the general statutes, not later than January 1, 2019.

Sec. 2. Section 21a-252 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) A physician, in good faith and in the course of the physician's professional practice only, may prescribe, administer and dispense controlled substances, or may cause the same to be administered by a physician assistant, nurse or intern under the physician's direction and supervision, for demonstrable physical or mental disorders but not for drug dependence except in accordance with state and federal laws and regulations adopted thereunder. Notwithstanding the provisions of this subsection the Department of Consumer Protection may approve protocols allowing the dispensing of take-home doses of methadone, by a registered nurse or licensed practical nurse, to outpatients in duly licensed substance abuse treatment facilities. Such dispensing shall be done pursuant to the order of a licensed prescribing practitioner and using computerized dispensing equipment into which bulk supplies of methadone are dispensed by a pharmacist. The quantity of methadone dispensed by such nurse shall not exceed at any one time that amount allowed under federal or state statutes or regulations governing the treatment of drug dependent patients. The Department of Consumer Protection shall conduct inspections of such treatment facilities to ensure that the computerized dispensing equipment and related dispensing procedures documented in the approved protocols are adhered to.

(b) A dentist, in good faith and in the course of the dentist's professional practice only, may prescribe, administer or dispense controlled substances, or may cause the same to be administered by a

nurse under the dentist's direction and supervision, to the extent permitted by the federal Controlled Substances Act, federal food and drug laws and state laws and regulations relating to dentistry.

(c) A podiatrist, in good faith and in the course of the podiatrist's professional practice only, may prescribe, administer and dispense controlled substances in schedules II, III, IV or V, or may cause the same to be administered by a nurse under the podiatrist's direction and supervision, to the extent permitted by the federal Controlled Substances Act, the federal food and drug laws and state laws and regulations relating to podiatry.

(d) A veterinarian, in good faith in the course of the veterinarian's professional practice only, and not for use by a human being, may prescribe, administer and dispense controlled substances, and may cause them to be administered by an assistant or orderly under the veterinarian's direction and supervision, to the extent permitted by the federal Controlled Substances Act, the federal food and drug laws and state laws and regulations relating to veterinary medicine.

(e) An advanced practice registered nurse licensed pursuant to section 20-94a, in good faith and in the course of such nurse's professional practice only, may prescribe, dispense, and administer controlled substances in schedule II, III, IV or V, or may cause the same to be administered by a registered nurse or licensed practical nurse under the advanced practice registered nurse's direction and supervision, to the extent permitted by the federal Controlled Substances Act, the federal food and drug laws and state laws and regulations relating to advanced nursing practice.

(f) A nurse-midwife licensed under chapter 377, in good faith and in the course of the nurse-midwife's professional practice only, may prescribe, dispense, and administer controlled substances in schedules II, III, IV and V, or may cause the same to be administered by a

registered nurse or licensed practical nurse under the nurse-midwife's direction and supervision, to the extent permitted by the federal Controlled Substances Act, the federal food and drug laws and state laws.

(g) A physician assistant licensed pursuant to section 20-12b, in good faith and in the course of the physician assistant's professional practice only, may prescribe, dispense, and administer controlled substances in schedule II, III, IV or V, or may cause the same to be administered by an advanced practice registered nurse, registered nurse, or licensed practical nurse who is acting under a physician's direction, to the extent permitted by the federal Controlled Substances Act, the federal food and drug laws and state laws and regulations relating to physician assistant practice.

(h) An optometrist authorized to practice advanced optometrical care, in good faith and in the course of the optometrist's professional practice only and who is duly authorized by section 20-127, may prescribe, administer or dispense controlled substances in schedule II, III, IV or V to the extent permitted by the federal Controlled Substances Act, the federal food and drug laws and state laws and regulations relating to optometry.

(i) Any person who has obtained directly from a physician, dentist, podiatrist, optometrist, veterinarian, physician assistant, advanced practice registered nurse or nurse-midwife any controlled substance for self-administration or administration to a patient during the absence of such physician, dentist, podiatrist, optometrist, veterinarian, physician assistant, advanced practice registered nurse or nurse-midwife shall return to such physician, dentist, podiatrist, optometrist, veterinarian, physician assistant, advanced practice registered nurse or nurse-midwife any unused portion of such controlled substance, when it is no longer required by the person or the patient, or may surrender such controlled substance to the

Commissioner of Consumer Protection for proper disposition.

(j) (1) A prescribing practitioner, as defined in section 20-14c, shall not, except in an emergency, prescribe, dispense or administer controlled substances in schedules II to IV, inclusive, to a member of his or her immediate family. For purposes of this section, "immediate family member" means a spouse, parent, child, sibling, parent-in-law, son or daughter-in-law, brother or sister-in-law, step-parent, step-child, step-sibling or other relative residing in the same residence as the prescribing practitioner and shall not include an animal in the residence. In an emergency, a prescribing practitioner may prescribe, dispense or administer not more than a seventy-two-hour supply of such controlled substances to an immediate family member only when there is no other qualified prescribing practitioner available.

(2) A prescribing practitioner who prescribes, dispenses or administers any controlled substance to a member of his or her immediate family pursuant to subdivision (1) of this subsection shall perform an assessment for the care and treatment of the patient, medically evaluate the patient's need for such controlled substance and document such assessment and need in the normal course of his or her business. The prescribing practitioner shall document the emergency that gave rise to the prescription, dispensing or administering of such controlled substance to the immediate family member.

(k) A prescribing practitioner, as defined in section 20-14c, shall not, except in an emergency, prescribe, dispense or administer controlled substances in schedules II to IV, inclusive, for his or her own use. In an emergency, a prescribing practitioner may prescribe, dispense or administer not more than a seventy-two-hour emergency supply of such controlled substances for self-use only when there is no other qualified prescribing practitioner available.

Sec. 3. (NEW) (*Effective July 1, 2018*) (a) For purposes of this section:

(1) "Opioid antagonist" shall have the meaning set forth in section 17a-714a of the general statutes.

(2) "Prescribing practitioner" shall have the meaning set forth in section 20-14c of the general statutes.

(3) "Pharmacist" shall have the meaning set forth in section 20-609a of the general statutes.

(b) A prescribing practitioner or a pharmacist certified to prescribe naloxone pursuant to section 20-633c of the general statutes may enter into an agreement with a law enforcement agency, emergency medical service provider, government agency or community health organization related to the distribution and administration of an opioid antagonist for the reversal of an opioid overdose. The prescribing practitioner or pharmacist shall provide training to persons who will distribute or administer the opioid antagonist pursuant to the terms of the agreement. Persons other than the prescribing practitioner or pharmacist shall receive training in the distribution or administration of opioid antagonists prior to distributing or administering an opioid antagonist. The agreement shall address the storage, handling, labeling, recalls and recordkeeping of opioid antagonists by the law enforcement agency, emergency medical service provider, government agency or community health organization which is party to the agreement.

(c) A prescribing practitioner or pharmacist who enters into an agreement pursuant to subsection (b) of this section shall not be liable for damages in a civil action or subject to administrative or criminal prosecution for the administration or dispensing of an opioid antagonist by such law enforcement agency, emergency medical service provider, government agency or community health organization.

(d) The Commissioner of Consumer Protection may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 4. (*Effective from passage*) (a) The Alcohol and Drug Policy Council established under section 17a-667 of the general statutes shall convene a working group to evaluate methods of combating the opioid epidemic in the state. The working group shall investigate and advise the cochairpersons of the council regarding the following:

(1) The number of persons annually who receive services from each methadone treatment program funded by contract with the Department of Mental Health and Addiction Services, the rate at which such persons relapse and the number of such persons who die as the result of a drug overdose while participating in such program;

(2) The availability of opioid antagonists, as defined in section 17a-714a of the general statutes, at each such methadone treatment program and each state-funded treatment program for persons with substance use disorder;

(3) The advantages and disadvantages of a licensed mental health professional at each such methadone treatment program and each treatment program for persons with substance use disorder being permitted to dispense an opioid antagonist directly to a person at the time of such person's discharge from such program without the need for such person to obtain the opioid antagonist from a pharmacy under section 20-633c or 20-633d of the general statutes;

(4) Whether a nonfatal drug overdose at a hospital or outpatient surgical facility should qualify as an adverse event under section 19a-127n of the general statutes;

(5) The role of health carriers, as defined in section 19a-755b of the general statutes, in shortening a person's stay at a treatment program

for persons with substance use disorder;

(6) The availability of federal funds to supply emergency medical services personnel in the state with opioid antagonists and provide training to such personnel in the administration of opioid antagonists;

(7) The development and implementation of a state-wide uniform prehospital data reporting system to capture the demographics of prehospital administration or use of an opioid antagonist and opioid reversal outcomes as a result of such administration or use;

(8) The development of a state-wide strategy to (A) identify potential sources of federal funding for treatment and prevention of opioid use disorders, and (B) maximize federal reimbursement and grant funding for state initiatives in combatting the opioid epidemic in the state; and

(9) Whether the use of physical therapy, acupuncture, massage and chiropractic care can reduce the need for opioid drugs, as defined in section 20-14o of the general statutes, in mitigating a patient's chronic pain.

(b) On or before January 1, 2019, the working group shall report its findings to the cochairpersons of the Alcohol and Drug Policy Council. The cochairpersons shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding such findings and any recommendations for legislation.

Sec. 5. (NEW) (*Effective July 1, 2018*) (a) On and after January 1, 2019, any hospital licensed pursuant to chapter 368v of the general statutes or emergency medical services personnel, as defined in section 20-206jj of the general statutes, that treats a patient for an overdose of an opioid drug, as defined in section 20-14o of the general statutes, shall report

such overdose to the Department of Public Health in a form and manner prescribed by the Commissioner of Public Health.

(b) On or before January 1, 2020, the Department of Public Health shall provide the data reported pursuant to subsection (a) of this section to the municipal health department or district department of health that has jurisdiction over the location in which such overdose occurred, or, if such location is unknown, the location in which the hospital or emergency medical services personnel treated the patient, as the department, in its discretion, deems necessary to develop preventive initiatives.

(c) Data reported to the Department of Public Health by a hospital or emergency medical services personnel shall at all times remain confidential pursuant to section 19a-25 of the general statutes.

Sec. 6. (*Effective from passage*) (a) As used in this section:

(1) "Opioid agonist" has the same meaning as provided in section 17a-714a of the general statutes;

(2) "Long-term injectable opioid antagonist" means naltrexone for extended-release injectable suspension or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of opioid use disorder;

(3) "Opioid drug" has the same meaning as provided in section 20-14o of the general statutes; and

(4) "Partial opioid agonist" means a medication that binds to the opiate receptors and provides relief to individuals in treatment for abuse of or dependency on an opioid drug and that causes less conformational change and receptor activation in the central nervous system than a full opioid agonist.

(b) Not later than January 15, 2019, the Department of Correction, in consultation with the Departments of Mental Health and Addiction Services, Public Health, and Social Services and the Office of Policy and Management, shall review the pilot program established pursuant to section 18-100j of the general statutes, as amended by this act, that provides medication-assisted treatment to inmates with opioid use disorder in correctional facilities and report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and the judiciary regarding the following:

(1) A comprehensive plan for expanding the pilot program to serve all inmates with opioid use disorder state-wide, including estimates of the lives saved by the pilot program, the costs, short-term savings and long-term savings of the pilot program, including, but not limited to, savings to other state departments and agencies, and the availability of federal funds for expansion of the pilot program;

(2) Opportunities to expand the pilot program without incurring additional costs, including, but not limited to, through the use of existing programs that make long-term injectable opioid antagonists available to the state at a reduced cost or no cost; and

(3) The feasibility of the Department of Correction embedding, within available resources, treatment of opioid use disorder in its health care delivery system.

(c) The Departments of Correction and Mental Health and Addiction Services shall seek, within available resources, all available federal funds for expanding access to medication-assisted treatment for opioid use disorder in correctional facilities. If federal funds are available, the Department of Correction shall expand the pilot program, including, but not limited to, by offering the program in additional correctional facilities, increasing the number of inmates

with access to the program or providing partial opioid agonists through the program. Not later than January 1, 2020, the Commissioners of Correction and Mental Health and Addiction Services shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to the judiciary and public health regarding the availability of funds and the plan for expansion of the pilot program.

Sec. 7. Section 18-100j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Not later than October 1, 2013, the Department of Correction may initiate, with support from the Departments of Mental Health and Addiction Services and Public Health, a pilot treatment program for methadone maintenance and other drug therapies at facilities including, but not limited to, the New Haven Community Correctional Center. The pilot program shall **[**be for eighteen months and shall**]** serve sixty to eighty inmates per month. The Department of Public Health may waive public health code regulations that are not applicable to the service model of the pilot program. Not later than **[**October 1, 2014, and April 1, 2015**]** July 1, 2019, the Department of Correction shall report on the results of the program to the joint standing committee of the General Assembly having cognizance of matters relating to human services, the judiciary, public health and appropriations and the budgets of state agencies.

Approved June 14, 2018