



Connecticut Association of Addiction Professionals

**Public Health Committee Public Hearing – March 18, 2015
Testimony on Governor Malloy's Bill- *6856 An Act Concerning Substance Abuse and
Opioid Overdose Prevention***

**Submitted by:
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To: Senator Terry Gerratana, Co-Chair of the Public Health Committee
Representative Matthew Ritter, Co-Chair of the Public Health Committee
Senator Joe Markley, Ranking Member
Representative Prasad Srinivasan, Ranking Member
Members of the Public Health Committee

c. Governor Dannel Malloy

The Connecticut Association of Addiction Professionals (**CAAP**) submits the following testimony in support of Governor Dannel Malloy's Raised Bill 6856, intended to meet the challenge of the heroin epidemic in our State. For the record, the CT Association of Addiction Professionals represents the State's workforce of over 850 addiction specialists. It is led by an all-volunteer Board of Directors. The Association's mission is to advocate on a state and national level for public policy and legislation that ensures our workforce's delivery of best practice Substance Abuse treatment and services to Connecticut residents.

CAAP endorses Governor Malloy's Bill because it contains important legislative mandates that will create a strong infrastructure to curb the abuse of opiate prescriptions thru legislative measures for monitoring and electronic surveillance systems that have proven successful in States across the nation. Governor Malloy's Bill includes the life-saving mandate for the acquisition of prescribed agonist medication, Narcan, to treat victims of opiate overdose. The workforce of credentialed addiction specialists thanks the Governor for his efforts to mitigate the horrific suffering of opioid addicts and their families and partners!

On behalf CAAP, I am requesting that the Public Health Committee favorably consider the Association's three recommendations that may be included in the Governor's bill, subject to the appropriate language and format required for State legislation.

CAAP's Advocacy 2015 Recommendations:

- 1. A Team Approach to the Prevention, Intervention, and Treatment of Opiate Addiction in Primary Care Settings- An Addiction Specialist and Primary Care Provider Collaboration.**
- 2. The Implementation of Uniform Standards of Practice in the Use of Suboxone, Medication-Assisted Treatment, by Public and Private Practitioners.**
- 3. Addiction is a Primary Disease: Diagnosis, Treatment, and Recovery Management of Opioid Dependence equal to Treatment of Medical Disorders.**

The three recommendations add a new dimension to the Governor's Bill because they propose evidence-based **prevention, intervention, and treatment strategies for breaking the cycle of opioid addiction in Connecticut.** It is important to note that some State medical and behavioral health providers are offering similar services, like CAAP's recommendations, at a variety of hospital, community-based agencies, primary medical services, and independent practices. The issue, however, is that the provision of these services is currently offered in a random fashion relative to location, availability of specialty providers, and lack of consistency in standards of practice.

CAAP respectfully requests that the members of the Public Health Committee review the merits of the recommendations relative to:

- EXPANSION OF ACCESS TO TREATMENT OF OPIOID DEPENDENCE**
- BUDGET NEUTRALITY**
- FIDELITY TO CONNECTICUT'S PRIMARY CARE MEDICAL INITIATIVE**

The recommendations evolve from an informal survey conducted by CAAP's Board of Directors and members over a three month period, October 2014-December 2014. The Respondents represented a wide array of stakeholders including, providers of addiction services from the criminal justice system, behavioral health public/private agencies, hospital based SUD programs, academic settings, and independent practitioners. Other respondents included psychiatrists, licensed masters level, behavioral health providers, PCPs, and consumers of opioid addiction treatment. In addition, the findings were presented to former DMHAS Commissioner Pat Rehmer in support of DHMAS's efforts to combat the heroin epidemic.

From a personal perspective, my thirty five years as a provider of substance abuse and mental health treatment has consistently demonstrated that opioid dependence is an addiction that has unfortunately confounded addiction science for over 50 years. An opiate dependent individual faces three outcomes- taking highly addictive agonist medications, which he or she may remain on for many years, even an entire lifetime, gain total

abstinence, or death thru overdose. I can still remember the words of one recovering heroin addict whom I was treating. The gentleman was also HIV positive. "HIV is a terrible disease, but at least I have my freedom, hope, and the choice to live my life, the way I want to". I detoxed in prison, tough, but nothing compared to the horrible deal of being on methadone, relapsing, and chasing my addiction on the streets, 24-7!"

Introduction

The *Middletown Press* reported "more than 300 (307) people died of opioid overdose in 2014", as reported by the Office of the Chief Medical Examiner. "The report stated that "...273 of the deaths" were attributable to heroin. The article noted that the numbers of death due to overdose had doubled since 2012. On a daily basis, the workforce of CT's credentialed addiction specialists are confronted with the daunting challenge of treating opiate addicted women and men, many between the ages of 16- 30 years old, with few treatment options, The treatments produce outcomes less than promising.

Respondents described a bleak picture for consumers with an opiate addiction in 2015. In Connecticut and across the nation, clients, who seek treatment, have two treatment options- medication assisted therapy or abstinence. Consumers are given highly addictive medications, agonist agents, Methadone or Subxone (buprenorphine/naltraxone) that are offered at specialized clinics or thru private physicians. These medications are "replacements" transferring the dependence from a street drug to a prescribed drug with the long -term goal of abstinence. The Institute for Clinical and Economic Review's "*Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Reports*", (cepac, icer review) May 2014 presented a cohort model of 1,000 hypothetical patients entering treatment . The model 's results of efficacy of treatment between Methadone Maintenance and Subxone & Subxone taper were remarkably similar (pp.7-10). Around 28% were drug free in two years, but each group had similar %s of relapses, 55%-a dangerously high rate. Unfortunately, these treatments are currently all addiction science has to offer.

Respondents were in agreement that unfortunately, often the first point of service for the opiate addicted individual is the local ER. The consumer is rushed in by a family member or first responders due to an overdose. Given the harsh reality and complexity of the heroin epidemic in 2015, CAAP proposes policy / treatment recommendations, as beginning steps to reduce the great suffering of CT individuals and their families and friends caused by this epidemic.

I. A Team Approach to the Prevention, Intervention, and Treatment of Opiate Addiction in Primary Care Settings- An Addiction Specialist and Primary Care Provider Collaboration

CAAP's first recommendation centers on preventing and intervening in opiate abuse by integrating the services of an addiction specialist into primary care practices across our State.

At a high-powered meeting of CT Senators, State Officials, consumers, and the Acting Director, Office of National Drug Control Policy, held in April 2014 at the Cornell Scott Hill Health Center, the Director of the Drug Control Policy, Michael Botticicelli shared that his addiction to prescription drugs began in his Dentist's office with a prescription for Percoset (*New Haven Independent*, April 18, 2014). There appears to be a consensus among MDs, Addiction Specialists, and opiate addicted consumers that prevention of opiate addiction needs to begin on the front line, at the office of a primary care provider.

In 2014, the Connecticut Association of Addiction Professionals submitted an extensive document to the State's *SIM initiative-Connecticut Healthcare Innovation Plan Public Comments*. The reader may refer to CAAP's comments via the [CT Healthcare Advocate's Website](#). The document included evidence of the addiction specialist's essential scope of services, which enhance the patient's medical and behavioral health treatment outcomes.

In May 2013, SAMHSA-HRSA released the report; *Innovations in Addictions Treatment-Addiction Treatment Providers Working in Integrated Primary Care Services (SAMHSA-HRSA Center for Integrated Health Solutions)*. The report underscored the importance of this complement of services:

" When persons with addictions have co-occurring physical illnesses, they may require medical care that is not traditionally available in, or linked to, specialty substance abuse care. The high quality treatment needed by individuals with addictions requires a team of different professionals that includes both specialty substance abuse providers and primary care providers. The integration of primary and addiction care can help address these often interrelated physical illnesses by ensuring higher quality care."

Throughout the 2014 legislative session, several proposed bills were raised to provide basic training to MDS, APRNS, PAs, and LCSWs in specialized addiction screening methods and brief Intervention strategies in substance abuse treatment. CAAP offered compelling evidence that proved that LADCs already possess the requisite training and skill sets to provide these services! CAAP's SIM document contains numerous citations and references to HRSA's & SAMSHA's major advocacy goal (June 2013)- *the inclusion of an addiction specialist in emerging models of integrated, multidisciplinary, and coordinated primary care medical delivery systems*.

Today, CT PCPs are challenged daily by the limitations of time and fiscal resources in providing a comprehensive evaluation of their patient's substance abuse history and current substance usage. The ICER 2014 Draft on *Treatment of Patients with Opiate Dependence* cites numerous studies that a "comprehensive assessment by a clinical addiction specialist to determine a patient's overall risk, presence of co-morbid disorders, including chronic pain or co-occurring substance abuse... and extent of dependence is crucial... in designing a comprehensive, individualized care plan to address the patient's needs. (ICER 2014 pp.73-74). By the inclusion of an addiction specialist, as a key provider, in primary care settings, or referral to an independent practitioner, this specialist will provide the patient with a rapid diagnosis, assessment of disease progression, and develop a treatment plan based upon best practice standards for the prevention or treatment of all forms of Substance Abuse Disorders (SUD)

CAAP strongly recommends that Governor Malloy endorse a 2015 public policy initiative to prevent the onset of opiate addiction by supporting the integration of credentialed addiction specialists into primary care settings. CT PCPs will need to develop a protocol for standard of care and referral for patients, whose opiate prescriptions exceed medical need for their presenting condition. This referral to an addiction specialist is, as critical as, medical protocols for referrals of patients with diabetes, cardiac disease, depression, etc. Opiate addiction is a primary disease. CAAP advocates for best practice treatment of these patients treated across CT at its diversity of Primary Care settings. The opiate abusing/dependent patients would be routinely referred to a licensed addiction specialist, who can offer comprehensive evaluation, referral, and specialized treatment. **By intervening at the time of the patient's entry into a primary care setting, the threat of opiate dependence, which may lead to overdose and/or death can be immediately addressed and effectively treated.**

II. The Implementation of Uniform Standards of Practice in the Use of Suboxone, Medication-Assisted Treatment, by Public and Private Practitioners ***

***** CAAP recommends that Raised HB 5906 be subsumed into the Governor's omnibus bill on opiate dependence and substance abuse prevention. CAAP submitted written testimony and a Friendly Amendment on this Bill for the March 11, 2015 Public Hearing. The following brief narrative presents the evidence on II recommendation:**

When Suboxone was introduced early 2000s, it was lauded as a "silver bullet" to address opioid addiction- a safe, less addictive, and short-term medication- assisted treatment with specialized counseling. Suboxone researchers described the medication as a promising alternative to long-term methadone maintenance. Fast forward to 2014, Suboxone's fidelity to its original treatment assurance has been severely tarnished. Suboxone is now a financially hot property on the street for drug trafficking, and for less than scrupulous MDs in private practice, who can boost their revenues by thousands of dollars with little external oversight. The loser is the opioid dependent client.

As respondents to the CAAP 2014 survey stated, their experiences with individuals treated with Suboxone showed a critical lack of uniform standards for treatment. As an example, clients, who participate in a Suboxone program at a not-for profit substance abuse treatment setting, hospital-based IOP, or criminal justice diversion program receive more structured and consistent monitoring of their medication. In these programs, clients are required to attend specialized recovery management groups. Also, clients in these settings, who present with co-occurring disorders, are much more likely to gain access to additional behavioral health services thru the agency's or program's referral network- thus boosting a client's treatment outcomes. Individuals, who choose to seek Suboxone treatment from a certified private physician are often likely to receive treatment that lacks structure, compliance oversight (ex., random UAs), and no counseling except a brief check-in session conducted by a nurse or practice assistant. CAAP respondents report that many physician- based Suboxone private practices have a caseload of 80- 100 patients receiving the medication. These programs, due to the size of client caseloads, are unable to diligently monitor signs of relapse, use of other drugs, and the critical psycho-social factors, which will positively or negatively impact the client's path to recovery.

CAAP found that our respondents are unanimous in the need for conjoint counseling for clients being treated with Suboxone. It is important to note that when Suboxone was introduced, the protocol advocated 6- 18 months of treatment with a target of successful tapering of doses till the client gained abstinence. Currently in Connecticut, Suboxone therapy now mirrors methadone-maintenance. Clients average 2-3 years of treatment on Suboxone with treatment interruptions due to non-compliance, illegal activity, etc. The message for the possibility of a drug-free life seems to be minimized. CAAP supports the position posted an article in *Addiction Treatment Magazine*:

" Studies have shown individuals who are being treated with prescription Suboxone and also take part in counseling have a much better outcome than those who continue on Suboxone alone. Counseling would prove more effective at helping the individual begin to make changes in their behavior and lifestyle so that he or she can focus on long-term recovery goals.. The counseling occurs in tandem with Suboxone treatment makes the process easier and more effective." (Nov. 2011).

As one CAAP Board member stated: "Clients who are on Suboxone with no counseling, are missing an essential process for their recovery. The treatment is inferior. It is like asking an individual with a broken leg to use only one crutch for his or her rehabilitation.

III Addiction is a Primary Disease: Diagnosis, Treatment, and Recovery Management, for Opioid Dependence Equal to Medical Disorders.

CAAP recommends that parity for access to comprehensive, patient-centered substance abuse treatment along the life span.

In 2014 Connecticut providers and affected residents shared the consensus that the treatment site for the majority of opiate addicts was the local Emergency Room. The General Assembly acknowledged the lethal potential of the heroin epidemic, joining with other states across the nation, by passing legislation that will protect “good Samaritans”, who administer Narcan in a life-saving gesture from legal liability. Thus giving access to a medical intervention that will prevent a family member or friend from death by overdose.

CT addiction treatment providers fully acknowledge the enormity of the challenge to facilitate recovery from opiate addiction. The legislation will surely save lives, but it is only a stop-gap, emergency measure to intervene in the rapid cycling process of opiate addiction to overdose. The question remains for all stakeholders in this deadly epidemic- Can Connecticut do Better?

CAAP, as the advocate for the State workforce of addiction professionals, believes that a major shift in the paradigm of how medical providers, key influencers and residents view and treat addiction may be a crucial step in addressing the problem. There still remains an insidious and subtle barrier that CT residents, and their significant others, encounter in accessing care in both in-patient and out-patient settings. It is the frankly dangerous and unfair perception that addiction is a second tier disorder. I repeat - **Addiction is a Primary Disease!**

In Connecticut, and many other states, the denial of prompt and critical SA treatment, based upon a blaming and negative model of care that directs the access to services on a protocol of **failure**, continue to strengthen the barriers of shame and stigma related to SUD.

The State has identified adolescents and young adults as a key consumer group who are in greatest need of less problematic access to SA treatment. As an example of the synergy between shame and barriers to treatment, it is not unusual for youth and young adults to be denied inpatient treatment until these consumers have “failed “ at out-patient and intensive outpatient treatment.

With this sector of the population presenting at great risk due to soaring rates of opioid addiction and overdoses leading to death, this model is an egregious and barbaric system of care. Dr. Sharon Levy in her presentation at the *2014 Harvard Medical School's Symposium on Addictions (March 1.2014)* stated that the use prescription painkillers by adolescents was 2nd only to marijuana.

In contrast, Connecticut's health care treatment standards do not block or withhold necessary medical intervention and treatment from youth and adults, who have a non-compliant episode with their diabetes meds, by withholding insulin medication until the patient has a diabetic induced shock. But current SA treatment practice clings to the stigmatizing standard of “failure of SA treatment level” for the patient to gain a higher and therapeutically appropriate level of care.

The 2014 passage of legislation which provides Medicaid reimbursement to LADCs in independent practice was a positive step towards expanding access to best practice

substance abuse treatment. Unfortunately, CT residents with commercial insurance continue to face huge barriers to substance abuse treatment. Our state has the 4th highest insurance costs in the nation. CT has a moral obligation to provide its residents, families, and partners impacted by the disease of addiction with insurance coverage that promotes swift access to evidence-based levels of care, qualified specialists, and fiscal coverage and reimbursement policies that are equal to the complexities inherent to medical diseases. Let us always remember that addiction is a treatable disorder, but if not treated with appropriate standards of practice, as the heroin epidemic has tragically demonstrated, addiction is a terminal illness.

End Notes:

In my 2 ½ years as President of the Connecticut Association of Addiction Professionals, my most heart-wrenching experiences have been to meet and speak with consumers and their family members from across the State, who are dealing with active opiate dependence.

As an example, at community meeting in New Haven last summer, I and a Sargent from the New Haven police force offered a presentation on the Heroin epidemic – from a law enforcement perspective and an addiction treatment perspective. The Sargent and I were stunned by the number of audience members, who freely shared, that they knew of individuals, who died from an opiate overdose and the tragedies experienced by their families and partners. As the 2014 statistics demonstrate, these tragic personal losses are experienced by residents in most Connecticut cities and towns.

Addiction to opiates is an extremely multi-faceted problem. There **are no simple solutions**. CAAP respectfully requests that the Public Health Committee pass the Governor's Bill **with CAAP's recommendations out of Committee**. CAAP believes that this legislative action will clearly demonstrate that our State government has responded to the public's Call for Action and taken CT's residents suffering to heart!

I want to thank the members of the Public Health Committee for their valued time, attention, and most importantly, dedication of personal service on behalf of CT residents. Please always know that your legislative efforts contribute to the quality of life in our great State.

After reviewing my testimony, if you require further information, I encourage you to contact me.

Great Thanks for All You Do!
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