OFFICE OF LEGISLATIVE RESEARCH
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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 2017-R-0152.
This report has been updated by OLR Report 2019-R-0288.

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, such as (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. Nor does the report include laws imposing criminal penalties for violating drug laws.

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Access to Opioid Antagonists

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, emergency medical services (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).

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 practice. Legislation passed in 2015 also 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, codified at CGS § 20-633c).

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 federal Food and Drug Administration (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 such an 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 codified at CGS § 20-633d).

Third-Party Prescriptions

Opioid antagonists, such as Narcan, rapidly reverse the symptoms of an opioid drug overdose. They are not addictive and do not cause a "high" or pose any serious health effects when taken by a person not suffering from a drug overdose. Historically, Connecticut prohibited the prescription of 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 individuals) to treat or prevent a drug overdose (PA 12-159, codified at CGS § 17a-714a).

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 contain measurable goals, including reducing the number of opioid-induced deaths in the state.

Legislation passed in 2017 expands 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, 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 must report the results of the study to the Public Health Committee by January 1, 2019 (PA 17-131, 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 Department of Mental Health and Addiction Services (DMHAS) website for health care providers and pharmacists to use and encourage them to disseminate it to anyone (1) a provider treats for opioid use disorder symptoms, (2) to whom a provider issues a prescription for or administers an opioid drug or opioid antagonist, or (3) to whom a pharmacist dispenses an opioid drug or issues a prescription for or dispenses an opioid antagonist (PA 17-131, codified at CGS § 17a-667a).

The fact sheet is available here:
http://www.ct.gov/dmhas/lib/dmhas/prevention/opioid_factsheet.pdf

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, 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, 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, codified at CGS §§ 19a-88 and 20-126c).

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

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 its subsequent use or (2) deemed as violating their professional standard of care (CGS § 17a-714a). Legislation passed in 2016 extended this immunity to all licensed health care professionals (PA 16-43).

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

Seeking Emergency Medical Care for a Drug Overdose

PA 11-210 provides civil and criminal immunity to individuals who seek or receive emergency medical care for themselves or another person they reasonably believe is experiencing a drug overdose (CGS § 21a-279).

Health Insurance

Coverage for Substance Use Disorder

Legislation passed 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 who have been diagnosed with a substance use disorder. (These terms are defined in the same way as in the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions.)

The law 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; or (4) hospital or medical services, including those provided under an HMO plan. The federal Employee Retirement Income Security Act (ERISA) preempts state insurance benefit mandates from applying to self-insured benefit plans (PA 17-131 codified at CGS §§ 38a-492p and 38a-518p).

Prior Authorization for Opioid Antagonists

The law prohibits certain health insurance policies from requiring prior authorization for coverage of opioid antagonists. Specifically, 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, state insurance benefit mandates do not apply to self-insured benefit plans (PA 16-43, codified at CGS §§ 38a-510b and 544b).

Limits on Opioid Drug Prescriptions

Maximum Supply

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 with the minor along with their custodial parent, guardian, or legal custodian, if present, the risks associated with opioid drug use. Legislation passed in 2017 additionally requires prescribers to have such discussions with adult patients, including:

1. the associated risks of addiction and overdose;
2. the dangers of taking opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants; and
3. the reason why the prescription is necessary (PA 17-131, codified at CGS § 20-14o).

Exceptions

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 the person's 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 patient's condition. The law does not apply to medications to treat opioid drug dependence or abuse, including opioid antagonists and agonists (PA 17-131, codified at CGS § 20-14o).).

Provision of Controlled Substances to Self or Family

Legislation passed in 2018 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 such 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).

Voluntary Non-Opioid Directive Form

Legislation passed in 2017 requires the Department of Public Health (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 a person 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, codified at CGS § 20-14r).

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 and PA 17-131, codified at CGS § 17a-714a).

Overdose Reporting

Starting January 1, 2019, a 2018 law requires any hospital or EMS personnel that treat a patient for an opioid overdose to report the overdose to DPH. Starting January 1, 2020, 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.

Specifically, by July 1, 2020, municipal and district health departments must use this data to develop preventive initiatives on a local level to address the incidences of opioid, heroin, and other drug overdoses in Connecticut. By law, the data is confidential in accordance with existing law for records provided to DPH (PA 18-166).

Prescription Drug Monitoring Program (PDMP)

PA 06-155 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. 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).

Recent legislation made various changes to the program, such as (1) expanding who can serve as a prescriber's authorized agent, (2) modifying reporting deadlines, and (3) allowing the DCP commissioner to share certain program information with other state agencies for certain drug abuse studies (PA 16-43 and PA 17-131).

Studies and Working Groups

Combating the Opioid Epidemic

A 2018 law requires the ADPC to convene a working group to evaluate ways to combat the opioid epidemic in the state. The group must investigate various matters, such as the number of people annually receiving services from DMHAS-funded methadone treatment programs, the rate at which such people relapse, and the number of people who die from drug overdose while participating in such programs.

By January 1, 2019, the working group must report its findings to the council chairpersons, who must then report to the Public Health Committee the findings and any recommendations for legislation (PA 18-166).

Opioid Drug Prescriptions

Legislation passed in 2016 required the Public Health Committee chairpersons, by October 1, 2016, to convene a working group to address 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. It also had to report the study results to the Public Health Committee by February 1, 2017 (PA 16-43).

Opioid Intervention Court Feasibility Study

Legislation passed in 2018 requires 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 must report the study results to the Judiciary Committee by January 1, 2019 (PA 18-166).

Safe Disposal of Opioid Drugs

Legislation passed in 2017 requires the ADPC to convene a working group to advise the council 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 must report to the Public Health Committee on the working group's recommendations by February 1, 2018 (PA 17-131).

Substance Abuse Treatment Referral Programs

Recent legislation also requires 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 must identify any barriers these programs face as well as the feasibility of implementing such programs statewide. The council must report on the working group's findings to the Public Health and Public Safety and Security committees by February 1, 2018 (PA 17-131).

Miscellaneous 2016-2018 Legislative Changes

Legislation enacted from 2016 to 2018 (PA 16-43, PA 17-131, and PA 18-166) make various changes to help prevent and treat opioid drug abuse, including:

1. extending a Department of Correction methadone maintenance pilot program, expanding the program's scope if federal funds are available, and requiring a new report on the program's results by July 1, 2019;

2. generally requiring prescriptions for controlled substances to be transmitted electronically to a pharmacy, which must have the technology to accept such prescriptions;

3. allowing certain registered nurses employed by home health care agencies, with a patient's designated representative's permission, to destroy or dispose of the patient's controlled substances;

4. requiring DPH to state on its website how a prescribing practitioner may obtain certification to prescribe take-home medications to treat opioid use disorders (e.g., Suboxone);

5. requiring alcohol or drug treatment facilities to use admission criteria developed by the American Society of Addiction Medicine;

6. expanding the settings in which certain certified, unlicensed individuals may practice auricular acupuncture to treat alcohol and drug abuse (they must do so under a physician's supervision);

7. specifying activities included in an alcohol and drug counselor's scope of practice, such as (a) developing an opioid use consultation report for review by a person's primary care provider and (b) conducting substance use disorder screenings to document a person's use of pain medications, prescription drugs, illegal drugs, and alcohol; and

8. adding to the list of reasons the DCP commissioner may take disciplinary action against a controlled substance registrant (a) failing to implement administrative safeguards to protect electronic health information required by the federal Health Insurance Portability and Accountability Act (HIPAA) and (b) breaching these safeguards by a prescribing practitioner's authorized agent.

A complete summary of the legislation is available on OLR's website.

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