

Opioid Addiction: *A Call to Action*



U.S. Senator Richard Blumenthal

A Message from United States Senator Richard Blumenthal

Rampant opioid addiction is sweeping our nation like a hurricane — leaving overdose deaths and heartbroken families in its wake. And Connecticut has not been spared. In 2015, opioid overdoses claimed the lives of 700 people in our state. Mothers, fathers, daughters, sons, sisters, brothers all gone too soon — affecting thousands of families and friends.

In the face of this surging opioid crisis, I have held roundtables across Connecticut, listening to law enforcement officials, first responders, doctors, addiction specialists, elected officials, and many others. Most importantly, I have heard from those struggling with opioid addiction and those who have lost a loved one to the dreaded disease.

The report draws on their recommendations — grassroots, community based solutions proposed by those who have firsthand knowledge of the pervasive problem and successful solutions. I want to thank all those in Connecticut who shared their stories with me. It is your experiences — and the insight you gained through heart wrenching ordeals — that serve as the foundation for these recommendations.

Thank you for bravely taking personal tragedy and transforming it into *A Call to Action*.



Sincerely,


U.S. Senator Richard Blumenthal

Executive Summary

Opioid Addiction: A Call to Action

April 2016

The Problem

Opioid addiction is sweeping our nation—leaving overdose deaths and heartbroken families in its wake. The over-prescribing of opioid painkillers has made the United States the epicenter of the prescription opioid epidemic, with the skyrocketing use of opioids contributing to the rising heroin crisis. According to the Centers for Disease Control and Prevention (CDC), the heroin epidemic is at an all-time high with over 43,000 people dying from either a prescription opioid or heroin related overdose in 2013.¹ By comparison, overdose deaths now outnumber deaths from gunshot wounds and motor vehicle accidents in the United States. In Connecticut alone, opioid overdoses claimed the lives of 700 people in 2015.² Mothers, fathers, daughters, sons, sisters, brothers all gone too soon – affecting thousands of families and friends.

Hearing from Connecticut

Senator Blumenthal spoke with hundreds of people over nine roundtable discussions on the challenges with and ideas for combating the prescription drug abuse and heroin use epidemics. Senator Blumenthal heard from law enforcement officials, first responders, doctors, addiction specialists, elected officials, and many others. Most importantly, Senator Blumenthal heard from those struggling with opioid addiction and those who have lost a loved one to this disease.



Roundtables Around Connecticut

- August 10, 2016 - Western Connecticut Mental Health Network in Torrington, CT
- August 18, 2016 - Connecticut Department of Veterans' Affairs in Rocky Hill, CT
- August 27, 2016 - Windham Recovery Community Center in Willimantic, CT
- September 2, 2016 - Connecticut Police Chief's Association in Wethersfield, CT
- February 1, 2016 - Community Mental Health Affiliates in New Britain, CT
- February 15, 2016 - Alliance for Living in New London, CT
- February 16, 2016 - Lawrence and Memorial Hospital in New London, CT
- February 26, 2016 - Yale School of Medicine in New Haven, CT
- March 4, 2016 - Southwest Community Health Center in Bridgeport, CT

¹ Jose L. Gonzalez, *120 deaths a day: US heroin & prescription drugs epidemic spinning out of control*, RT (July 29, 2015), <https://www.rt.com/usa/311023-congress-heroin-epidemic-source>.

² *Id.*

Action Plan to Address Constituent Concerns

This report details the following five primary areas of concern identified in the roundtable discussions as well as recommended actions to address them. Some of the actions that Senator Blumenthal has taken and advocated are substantial first steps, but federal agencies, state governments, and many other actors must come together to do their part to address the opioid epidemic.

PRESCRIBING PRACTICES: We must change prescribing practices through mandatory training and increased use of alternative pain management methods.

Recommendations:

- ❖ Mandate training to reduce opioid over-prescribing and encourage alternatives
- ❖ Encourage compliance with CDC opioid prescribing guidelines
- ❖ Establish FDA risk evaluation and mitigation strategy for immediate release opioids
- ❖ Promulgate DEA guidelines for partial fill of opioid prescriptions

TREATMENT: We must expand access to quality substance abuse programs and behavioral health services.

Recommendations:

- ❖ Require annual reports by insurers on mental health parity implementation
- ❖ Institute federal audits of insurers' compliance with mental health parity
- ❖ Establish consumer clearinghouse on mental health parity and complaint filing
- ❖ Enhance access to comprehensive medication-assisted therapy

EMERGENCY MEDICAL RESPONSE: We must strengthen emergency response and coordination in crisis situations through expanded access to affordable Naloxone.

Recommendations:

- ❖ Encourage insurers to reimburse pharmacists for providing naloxone
- ❖ Eliminate insurer copays and other restrictions on take-home naloxone and kits
- ❖ Increase federal funding for naloxone and first responder training for this treatment
- ❖ Provide federal and state protection for good faith use of naloxone in an emergency

LAW ENFORCEMENT: We must provide federal, state and local law enforcement resources to fight drug trafficking and to address addiction that leads to criminal acts.

Recommendations:

- ❖ Maintain or increase federal funding for federal-state narcotics task forces
- ❖ Expand funding for the federal High Intensity Drug Trafficking Areas Program
- ❖ Increase federal funding for alternatives to incarceration for drug addicted criminals

- ❖ Fund law enforcement training to recognize and respond to suspected criminals with substance abuse and mental health disorders
- ❖ Increase substance abuse and mental health services to the incarcerated
- ❖ Expand drug takeback programs to hospitals, pharmacies, and other locations
- ❖ Expand funding for state-operated prescription drug monitoring programs and allow access to non-identifying information in these programs for research

VETERANS ADMINISTRATION TREATMENT, RESEARCH, AND EDUCATION: We must enhance VA leadership in education, research and treatment of opioid misuse and abuse.

Recommendations:

- ❖ Establish more consistent, safe VA prescribing practices
- ❖ Make more non-opioid pain management therapies available to veterans
- ❖ Create an integrated service model for mental health and pain management
- ❖ Require VA participation in state prescription drug monitoring programs

Background

Pain can be characterized in terms of intensity—mild to severe—and duration—acute or chronic. A report from the Institute of Medicine stated that more than 100 million Americans are affected by chronic pain.³ The class of prescription pain medication called opioids, provides relief for many patients in pain, but can be misused or abused if taken in a manner other than prescribed. Some individuals experience intense feelings of euphoria when taking opioids, since these drugs also affect the brain regions involved in reward. Those who misuse or abuse opioids may seek to intensify their experience.⁴

Generally, abuse and misuse of prescription pain medication falls into three categories:

1. Individuals using prescription pain relievers with the intent to get high, whether or not they were prescribed the drugs;
2. Individuals using prescription pain relievers that were not prescribed to relieve pain—such as borrowing a prescription pill from a friend in order to treat pain; and
3. Individuals incorrectly using prescription pain relievers that were prescribed to them—such as by taking more than prescribed.⁵

Most Common Rx Opioids

- **Codeine**—an ingredient in some cough syrups and in one Tylenol® product
- **Hydrocodone**—Vicodin®, Lortab®, or Lorcet®
- **Oxycodone**—Percocet®, OxyContin®, or Percodan®
- **Hydromorphone**—Dilaudid®
- **Morphine**—MSContin®, MSIR®, Avinza®, or Kadian®
- **Propoxyphene**—Darvocet® or Darvon®
- **Fentanyl**—Duragesic®
- **Methadone**

Source: Centers for Disease Control and Prevention

Prescription Opioid Use in the United States

Although the United States is less than five percent of the world's population, Americans use around 80 percent of the global opioid painkillers and 99 percent of the global supply of hydrocodone, the active ingredient in Vicodin.⁶ Misuse or abuse of prescription pain relievers has serious risks such as addiction or death. Depending on the amount taken, even a single dose

³ INSTITUTE OF MEDICINE, *RELIEVING PAIN IN AMERICA: A BLUEPRINT FOR TRANSFORMING PREVENTION, CARE, EDUCATION, AND RESEARCH* (2011), available at <http://www.ncbi.nlm.nih.gov/books/n/nap13172/pdf>.

⁴ NATIONAL INSTITUTE ON DRUG ABUSE, *PRESCRIPTION DRUG ABUSE: HOW DO OPIOIDS AFFECT THE BRAIN AND BODY?* available at <https://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/how-do-opioids-affect-brain-body> (last updated Nov. 2014).

⁵ U.S. GOV'T ACCOUNTABILITY OFFICE, *GAO-12-115, PRESCRIPTION PAIN RELIEVER ABUSE: AGENCIES HAVE BEGUN COORDINATING EDUCATION EFFORTS, BUT NEED TO ASSESS EFFECTIVENESS* (2011), available at <http://www.gao.gov/assets/590/587301.pdf>.

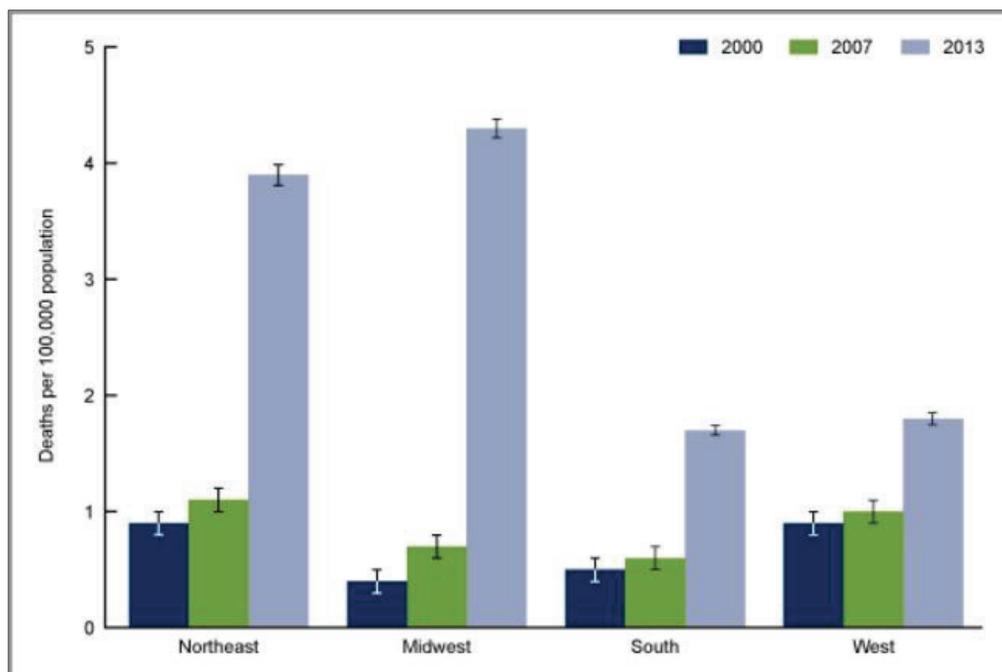
⁶ *America's Addiction to Opioids: Heroin and Prescription Drug Use: Hearing Before the S. Caucus on International Narcotics Control*, 113th Cong. (2014) (statement of Nora D. Volkow, Director, National Institute on Drug Abuse), available at <http://www.drugcaucus.senate.gov/sites/default/files/Volkow%20Testimony.pdf>.

could cause death if taken by an individual who does not regularly use such pain relievers and whose body is not accustomed to their effects.

Using alcohol or other drugs with prescription pain relievers can also increase the risk of dangerous side effects. According to the Government Accountability Office, agency officials have suggested that following an increased focus on pain management, there has been an increase in the availability of prescription pain medication and in risky behaviors by those who abuse the drugs which, in turn, leads to an increase in adverse health outcomes connected to opioids. The CDC recently released statistics showing that there was a 16 percent increase in the number of prescription opioid deaths between 2013 and 2014. More than six in ten drug overdose deaths were caused by opioids in 2014, leading to 18,893 deaths related to prescription pain relievers.⁷

Illicit Opioid Use in the United States

Heroin is a highly addictive opioid drug, and its use has repercussions that extend far beyond the individual user. The potential medical and social consequences of drug use—such as hepatitis, HIV/AIDS, birth defects, crime, violence, and disruptions in family, workplace, and educational environments—have a devastating impact on society and cost billions of dollars each year.



The skyrocketing use of opioids in America is also contributing to the rising heroin crisis, particularly among populations with historically low rates of heroin use. As experts note, many painkiller and heroin addicts start abusing opioids after receiving a legitimate prescription for pain-related medical issues.⁸ In three recent studies, nearly half of young people who inject heroin reported abusing prescription opioids before starting to use

Age-adjusted rates for drug-poisoning deaths involving heroin, by census region: United States, 2000, 2007, 2013

Source: Centers for Disease Control and Prevention

⁷ Lenny Bernstein, *Deaths from opioid overdoses set a record in 2014*, WASH. POST (Dec. 18, 2015), <https://www.washingtonpost.com/news/to-your-health/wp/2015/12/11/deaths-from-heroin-overdoses-surged-in-2014>.

⁸ Daniel J. McGraw, *How Big Pharma Gives America Its Heroin Problem*, PACIFIC STANDARD (Nov. 30, 2015), <https://psmag.com/how-big-pharma-gave-america-its-heroin-problem-34f1de02048d#.7i1vsul8a>.

heroin.⁹ In a 2014 survey of people in treatment for opioid addiction, 94 percent of respondents said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain.”¹⁰

The heroin epidemic reached new heights in recent years with over ten thousand people dying from a heroin related overdose in 2014 – double the rate from 2011.¹¹ Nationally,

CDC found that heroin-related deaths surged 39 percent from 2013 to 2014 with 10,574 overdose deaths related to heroin in 2014.¹²

Between 2012 and 2015 the number of fatal heroin, morphine, or codeine overdoses in Connecticut skyrocketed from 195 to 444—an astounding 127 percent.¹³ During the same period of time, prescription drug overdoses soared 75 percent from 2012 to 2015.¹⁴ The following table shows the total number of reported prescription drug overdoses and fatalities in Connecticut from 2012 through 2015.

Year	Fatal heroin, morphine or codeine overdoses in Connecticut	Prescription drug overdoses in Connecticut
2012	195	145
2013	284	177
2014	347	221
2015	444	254

Source: *Connecticut Medical Examiner Report*, November, 2015.

This rise in deaths and the increasing addiction rates for heroin are inextricably connected with the availability of illegal drugs, the lack of adequate resources to address addiction and the over-prescription of pain relievers.¹⁵

⁹ *Drug Facts: Heroin*, NATIONAL INSTITUTE ON DRUG ABUSE, <https://www.drugabuse.gov/publications/drugfacts/heroin> (last updated Oct. 2014).

¹⁰ Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry*. 2014;71(7):821-826.

¹¹ Press Release, Ctrs. for Disease Control & Prevention, New Research Reveals the Trends and Risk Factors Behind America’s Growing Heroin Epidemic (July 7, 2015), <http://www.cdc.gov/media/releases/2015/p0707-heroin-epidemic.html>.

¹² Lenny Bernstein, *Deaths from opioid overdoses set a record in 2014*, WASH. POST (Dec. 18, 2015), <https://www.washingtonpost.com/news/to-your-health/wp/2015/12/11/deaths-from-heroin-overdoses-surged-in-2014>.

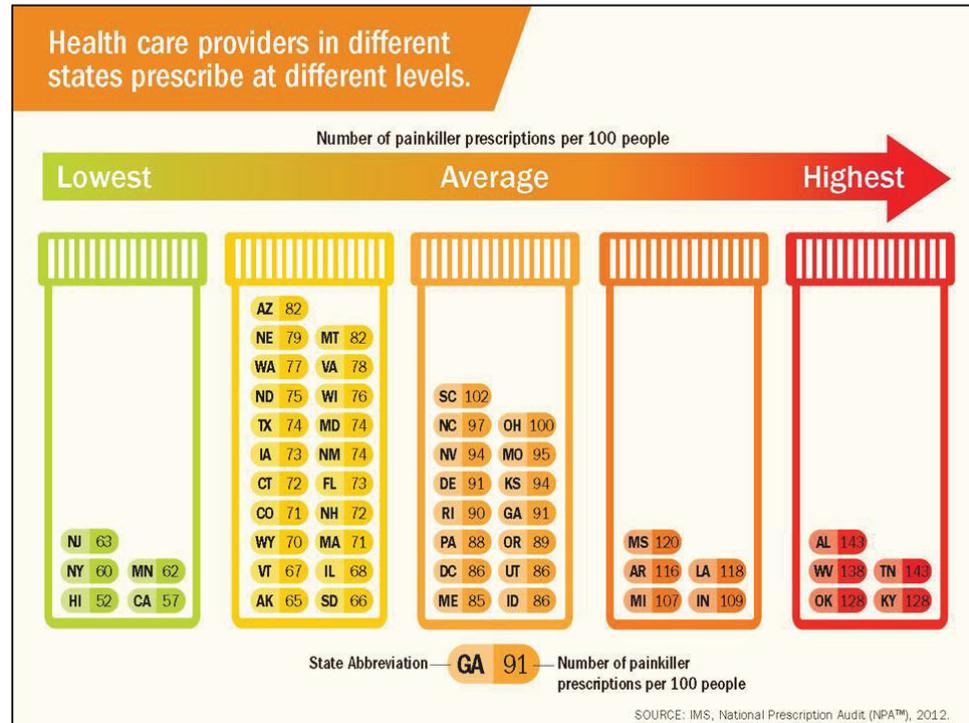
¹³ *Connecticut Medical Examiner Report*, November, 2015.

¹⁴ *Id.*

¹⁵ Dave Altimari, *Heroin-Related Overdose Deaths Soar In Connecticut*, HARTFORD COURANT (Feb. 14, 2016), <http://www.courant.com/news/connecticut/hc-2015-heroin-deaths-increase-20160214-story.html>.

PRESCRIBING PRACTICES: Improve prescribing practices through mandatory training and increased use of alternative pain management methods

More than 259 million prescriptions for pain relievers were written by health care practitioners in 2012, enough for every American adult to have a bottle of pills.¹⁶ As experts note, many pain relievers and heroin addicts start misusing and abusing opioids after receiving a legitimate prescription for pain-related medical issues.¹⁷ Most troubling is that 90 percent of people who survived a prescription opioid overdose were able to obtain another prescription.¹⁸



Health care practitioners can play an important role in preventing prescription drug misuse and abuse. The most important step toward reversing the opioid epidemic is to educate prescribers of controlled substances—physicians, nurse practitioners, and physician assistants—on responsible prescribing practices, alternative forms of

therapy for pain management, appropriately screening patients for substance misuse and abuse, and providing referrals for evidence-based addiction treatment services.

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Safer Prescribing of Controlled Substances Act

In February 2016, the Senate Committee on the Judiciary held a hearing on how to address the country’s opioid epidemic. The hearing revealed that a large number of physicians, nurse practitioners, and physician assistants often overprescribe opioid pain relievers leading to large amounts of unused pain medication being inappropriately used. At the hearing, Dr. Nora D. Volkow, the Director of the National Institute on Drug Abuse, testified that “education is [a] critical component of any effort to curb the abuse of prescription medications, and it must target every segment of society, including healthcare providers (doctors, nurses, dentists, and pharmacists),

¹⁶ CTRS. FOR DISEASE CONTROL & PREVENTION, INCREASES IN DRUG AND OPIOID OVERDOSE DEATHS — UNITED STATES, 2000–2014 (2016), available at <http://www.cdc.gov/mmwr/pdf/wk/mm6450.pdf>.

¹⁷ Daniel J. McGraw, *How Big Pharma Gives America its Heroin Problem*, PACIFIC STANDARD, November 30, 2015, <http://www.psmag.com/health-and-behavior/how-big-pharma-gave-america-its-heroin-problem>.

¹⁸ Felice Freyer, *Most who OD on opioids are able to get new prescriptions*, BOSTON GLOBE, December 28, 2015, available at <https://www.bostonglobe.com/metro/2015/12/28/most-patients-who-survive-overdoses-get-more-opioid-prescriptions-afterward-study-finds/rzseuxI4L14R10wnlY9pNK/story.html>.

patients and families.”¹⁹ In order to cut down on overprescribing, prescribers should receive training on responsible prescribing practices. Having these education requirements in place will equip health care providers with tools to prescribe responsibly and consider alternative pain treatments.

Senator Blumenthal and Senator Ed Markey (D-Mass.) introduced, S. 1392, *Safer Prescribing of Controlled Substances Act*. The legislation would require prescribers who are applying for or renewing a Drug Enforcement Agency (DEA) license to prescribe controlled substances to complete education programs that will train providers on responsible prescribing practices. The bill also provides free online training through the Substance Abuse and Mental Health Services Administration and requires the Secretary of Health and Human Services to evaluate and issue a report describing how exposure to the training required in this bill affects prescribing patterns of controlled substances.

There needs to a reduction of the amount of over prescription of these drugs and provide greater oversight to how these drugs are prescribed. — Connecticut Roundtable Participant

Promoting Responsible Opioid Prescribing (PROP) Act

In April 2016, Senator Blumenthal, along with Senators Joe Manchin (D-W.VA), Ron Johnson (R-Wis.), and John Barrasso (R-WY) introduced S. 2758, the *Promoting Responsible Opioid Prescribing (PROP) Act*. The *PROP Act* would disconnect physician and hospital Medicare reimbursement from pain management questions on the Hospital Consumer Survey of Healthcare Providers and Systems (HCAHPS). HCAHPS is a standardized survey used to measure patient perspectives and satisfaction on the care patients receive in hospital settings. The Centers for Medicaid and Medicare (CMS) use these survey results to calculate incentive payments for hospitals that perform well and reductions in payment for hospitals that perform poorly.

The legislation would remove the pain management questions from the survey for consideration when CMS conducts a hospital payment analysis. Therefore, the hospitals performance on these questions would no longer be linked to payment. The remaining HCAHPS questions would continue to be tied to payment.

It is absurd how frequently and for minor cases patients are offered opioids for a pain killer. — Connecticut Roundtable

By severing the relationship between the HCAHPS questions on pain management and payment, doctors will be relieved of the undue pressure to prescribe opioid narcotics. Several Connecticut neurologists raised this issue in our March meeting. They said that they often feel pressure to prescribe opioid pain relievers because the HCAHPS survey ties patient satisfaction with how their

pain was managed to these hospital incentive payments. This simple change will alleviate some of the pressure doctors currently face to prescribe opioids.

¹⁹ *Attacking America’s Epidemic of Heroin and Prescription Drug Abuse: Hearing Before the S. Comm. on the Judiciary*, 114th Cong. (2016) (statement of Nora D. Volkow, Director, National Institute on Drug Abuse), available at <http://www.judiciary.senate.gov/download/01-27-16-volkow-testimony>.

Centers for Disease Control Guidelines on Prescribing Opioids for Chronic Pain

As the nation's leading public health agency, the Centers for Disease Control and Prevention (CDC) has been on the front lines of the opioid epidemic. Recently, CDC released commonsense prescribing guidelines to aid prescribers and their patients in understanding the risks and responsibility associated with prescribing opioid pain relievers for chronic pain. CDC's guidelines help providers take into account the very real and prevalent danger of dependency, addiction, and overdose when prescribing opioids. The CDC guidelines for more cautious opioid prescribing apply to primary care practices for chronic pain and do not pertain to cancer patients, palliative care or end-of-life conditions.²⁰

These guidelines will ultimately encourage smarter prescribing practices leading to fewer opioid pain relievers and ultimately, fewer overdose deaths. They encourage physicians to recommend non-pharmacological therapy as the preferred treatment for chronic, non-cancer pain, prescribe the lowest dose and the fewest number of pills considered effective for the patient, and regularly evaluate the risks to the patient.²¹ These guidelines can help the United States reduce opioid addiction and diversion and save lives without compromising access to needed treatment.

Opioid Use Among Teens

- One in four teens reports having misused or abused a prescription drug at least once in their lifetime.
- More than a quarter of teens mistakenly believe that misusing and abusing prescription drugs is safer than using street drugs.
- 33 percent of teens say they believe "it's okay to use prescription drugs that were not prescribed to them to deal with an injury, illness or physical pain."

Source: The Partnership Attitude Tracking Study (PATS)

FDA Should Implement a Risk Management Strategy for Immediate-Release Opioids

The Food and Drug Administration (FDA) has a crucial tool at its disposal to regulate drugs that pose a higher risk to the public health. This tool, the Risk Evaluation and Mitigation Strategy (REMS), is a safety strategy that ensures that the benefits of a certain prescription drugs outweigh their risks.²² FDA may require a REMS for a drug to manage a known or potential serious risk such as addiction or overdose associated with the drug. A REMS enables patients to have continued access to such medicines by managing their safe use.

In 2012, FDA established a REMS for extended release opioids but has not yet done so for immediate-release opioids.²³ Two FDA advisory committees have suggested that immediate-

²⁰ CTRS. FOR DISEASE CONTROL & PREVENTION, CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN — UNITED STATES, 2016 (2016), *available at* <http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>.

²¹ *Id.*

²² FOOD AND DRUG ADMINISTRATION, A BRIEF OVERVIEW OF RISK EVALUATION AND MITIGATION STRATEGIES (REMS), *available at* <http://www.fda.gov/downloads/AboutFDA/Transparency/Basics/UCM328784.pdf>.

²³ FOOD AND DRUG ADMINISTRATION, OUTPATIENT PRESCRIPTION OPIOID UTILIZATION IN THE U.S., YEARS 2000-2009 (2010), *available at* <http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/AnestheticAndLifeSupportDrugsAdvisoryCommittee/UCM220950.pdf>.

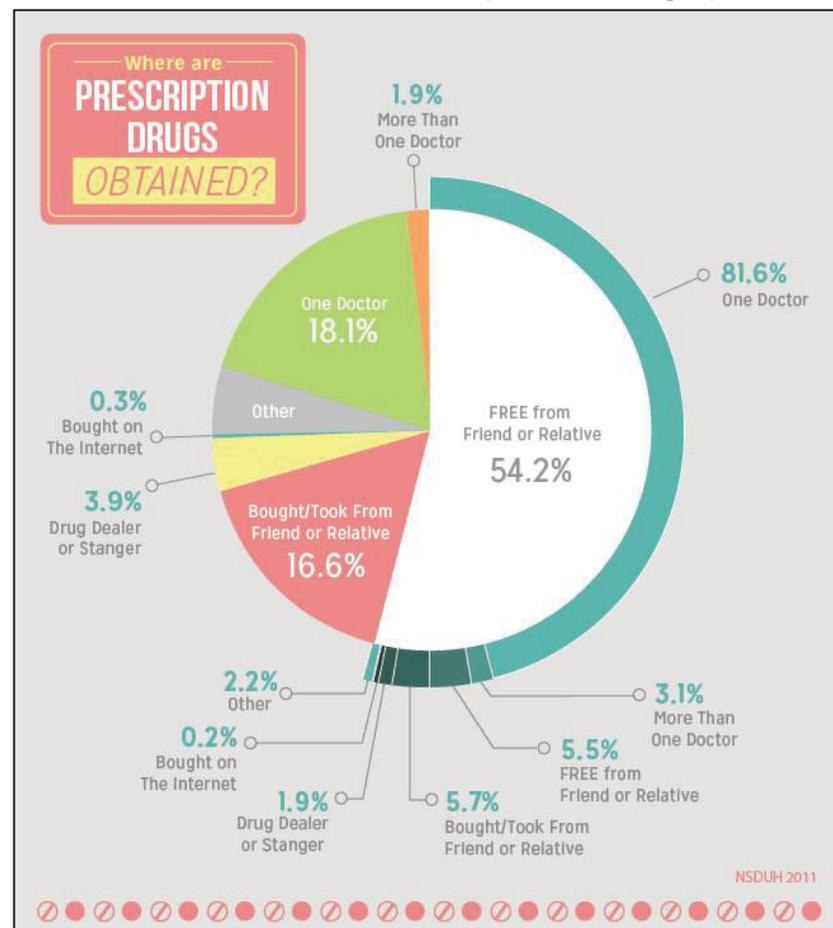
release opioids should have a REMS, offering another step to curb overprescribing of opioids. During their discussions, both advisory committees “believed that [REMS] should be mandatory for all opioids, not just the extended-release/long-acting opioids.”²⁴ Both Committees reasoned that “the public health concern was related to misuse and abuse of all opioids and as such warranted a universal approach to both extended- and immediate-release opioid preparations.”²⁵ This consensus by both FDA advisory committees was ultimately ignored by FDA.

Prescriptions for immediate-release opioids increased from 164.8 million in 2000 to 234 million in 2009.²⁶ With immediate-release opioids making up over 90 percent of all opioids prescribed, it

make sense that they should be subject to a REMS. Senator Blumenthal has called on FDA to require an effective risk management strategy for immediate-release opioids. This is a step that will ensure both prescribers and patients are knowledgeable about the risks associated with all opioids.

The DEA Should Issue Guidance Regarding Partial-Fill Prescription

A major facet of the opioid crisis stems from drugs that are legally prescribed to one individual and then misused and abused by another. In fact, the National Institute on Drug Abuse estimates that over 70 percent of adults who misuse prescription opioids get them from friends or relatives.²⁷ In short, many patients filling legitimate prescriptions for opioids



are not using all of the medication. In fact, the largest source of misused prescription opioids is

²⁴ Marta J. Brooks, *Mitigating the Safety Risks of Drugs with a Focus on Opioids: Are Risk Evaluation and Mitigation Strategies the Answer?*, 89 MAYO CLINIC PROCEEDINGS 1673-1684, available at [http://www.mayoclinicproceedings.org/article/S0025-6196\(14\)00794-0/fulltext](http://www.mayoclinicproceedings.org/article/S0025-6196(14)00794-0/fulltext) (last visited Apr. 13, 2016).

²⁵ *Id.*

²⁶ James B. Ray, *Implications of the Extended-Release/Long-Acting Opioid REMS for Managed Care*, 21 AM. J. MANAGED CARE S177a -S187a (2015), available at https://ajmc.s3.amazonaws.com/_media/_pdf/ACE0029_Aug15_PainREMS_Ray.pdf. http://www.ajmc.com/journals/supplement/2015/ace0029_aug15_painrems/ace0029_aug15_painrems_ray.

²⁷ NATIONAL INSTITUTE ON DRUG ABUSE, POPPING PILLS: PRESCRIPTION DRUG ABUSE IN AMERICA (2011), available at <https://www.drugabuse.gov/related-topics/trends-statistics/infographics/popping-pills-prescription-drug-abuse-in-america> (last updated Jan. 2014).

the family medicine cabinet.²⁸ One measure that could reduce the number of unused pills is to permit the partial filling of opioid prescriptions.

The Drug Enforcement Agency (DEA) should release guidelines on pharmacists' ability to partially fill opioid prescriptions. These guidelines would clarify and allow for prescriptions of opioid pain relievers to be partially filled by pharmacists at the request of patients or doctors. The remainder of the prescription could be filled but not beyond the date that the original prescription would have expired. DEA guidelines would enable prescribers, pharmacists, and patients to work together in determining how much medication is needed at one time to properly manage pain. In doing so, patients can get some of their prescription filled every few days up to the full prescription. This helps ensure that excess opioids are not left over for potential misuse.

TREATMENT: Expand access to quality substance abuse programs and behavioral health services.

Each day, 120 Americans die from drug overdoses, now exceeding motor vehicle accidents as a leading cause of death.²⁹ Opioid addiction is a chronic disease, like heart disease or diabetes.

In 2014, 22.5 million people or 8.5 percent of the U.S. population aged 12 or older needed treatment for an illicit* drug or alcohol use problem

Only 18.5 percent of those who needed treatment received any substance use treatment in the same year.

Source: SAMHSA's National Survey on Drug Use and Health

Because addiction is a chronic disease, most patients need long-term or repeated care to stop using completely and recover their lives.³⁰

One of the largest obstacles facing many Americans accessing quality services is inconsistent insurance coverage of mental health services and substance use treatment programs. Among those able to access treatment, nearly half reported using their own money to pay for their care.³¹

The *Mental Health Parity and Addiction Equity Act (MHPAEA)* was signed into law in 2008 by President George W. Bush, requiring health insurers and group health plans to provide the same level of benefits for

mental and/or substance use treatment and services that they do for medical and surgical care. The Affordable Care Act further expanded the MHPAEA's requirements by ensuring that qualified plans offered on the [Health Insurance Marketplace](#) cover many behavioral health treatments and

²⁸ *Id.*

²⁹ Jose L. Gonzalez, *120 deaths a day: US heroin & prescription drugs epidemic spinning out of control*, RT (July 29, 2015), <https://www.rt.com/usa/311023-congress-heroin-epidemic-source>.

³⁰ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION: FACTS FOR FAMILIES & FRIENDS (2014), available at <http://store.samhsa.gov/shin/content//SMA14-4443/SMA14-4443.pdf>.

³¹ OPEN SOCIETY FOUNDATIONS, DEFINING THE ADDICTION TREATMENT GAP, available at <https://www.opensocietyfoundations.org/sites/default/files/data-summary-20101123.pdf>.

services.³² However, the United States Departments of Health and Human Services (HHS) and Labor (DOL) have provided only limited guidance on how states must comply with MHPAEA and enforcement of the law has been inconsistent health plans often fail to release information about how coverage decisions are made, leaving consumers in the dark about whether the law is being enforced.

Broaden Insurance Coverage for Effective Substance Use Treatment Programs and Mental Health Services.

Many health insurers unfairly create additional barriers to accessing mental health and substance use disorder services including failing to provide necessary details about the in-network providers and services for mental health and substance use disorder services. Parity for mental health and substance use coverage is essential to ensuring that all Americans living with mental health and substance use conditions are able to access critical services and support.

Senator Blumenthal along with Senators Elizabeth Warren (D-Mass.), Al Franken (D-Minn.), Tammy Baldwin (D-Wis.) and Sherrod Brown (D-Ohio) have introduced legislation that would increase transparency and strengthen accountability for insurers so that patients receive the mental health and substance use coverage they are entitled to

under the law. *The Behavioral Health Coverage Transparency Act*, S. 2647, would require, insurance companies to disclose annually to federal regulators the analysis they perform in making parity determinations as well as the rates and reasons for mental health claims denials versus medical and surgical denials. It also would require the United States Department of Health & Human Services, the Department of Labor and the Department of Treasury to undertake a minimum of 12 random audits of health plans per year to discourage noncompliance with existing parity laws. Finally, it would establish a Patient Parity Portal, allowing consumers to easily access all publicly available parity information and submit complaints in a central online clearinghouse.

People are sending kids to Florida for treatment because insurance companies would rather pay for out-of-state treatment. Then the consequence is kids return to the same toxic environment.
— Connecticut Roundtable Participant

When you have cancer the insurance will say that you can get chemo until you don't need it any longer, but when you have mental illness or substance abuse problems you will only be given said number of visits. This is causing a high rate of relapse and not addressing the immediate problem, addiction in this situation.—Connecticut Roundtable Participant

This critical legislation will close that unacceptable gap by bolstering transparency and requiring periodic audits of health plans to ensure compliance with the law.

With a crippling opioid crisis facing the United States today, this gap is particularly troubling, because many people who struggle with substance abuse also struggle with depression

and anxiety. Truly combatting the opioid epidemic requires enforcement of mental health parity.

³² *Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act> (last updated Mar. 18, 2016).

Advocate for Increased Access to Medication Assisted Therapy with Appropriate Oversight and Control

Although addiction is a treatable disease, only 18 percent of those who need treatment are receiving it.³³ Discoveries in the science of addiction have led to advances in opioid addiction treatment that can help people stop misusing and abusing drugs. Medication-assisted treatment (MAT) is one way to help those struggling with opioid addiction reclaim their lives. MAT is the use of medication along with counseling and other support to overcome addiction. The most common medications used to combat opioid addiction are methadone, buprenorphine (Suboxone), and naltrexone (Vivাত্রol). Benefits of MAT, for certain patients are well-documented. In fact, a survey of patients and physicians by the Substance Abuse and Mental Health Services Administration (SAMHSA) showed that use of buprenorphine, one of the most common MATs, led to an 80 percent reduction in illicit opioid use.³⁴

While MAT is extremely effective, it is not a stand-alone treatment, but must be part of an overall science-based approach to treatment that includes behavioral, cognitive and other interventions.³⁵ MAT treatment paired with a counseling component has shown to improve patients' lifestyle stabilization, health, chances of employment, and decrease criminal behavior, drug use, and risk of relapse.

To increase the number of people who receive MAT, Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) should be allowed, with proper certification, to prescribe Suboxone. At this time, only physicians are able to prescribe Suboxone for addiction treatment. There have been reports in some states about long waitlists for those seeking Suboxone treatment because of a 100 patient per physician limit. With over 150,000 nurse practitioners³⁶ and over 95,000 certified PAs³⁷ many more patients would have access to Suboxone treatment for opioid addiction.

There must be more of a focus on the need for greater family supports. Many families feel ashamed, leading to both emotional stress and delays in seeking care. We need to work collectively to let both families and patients know that this disease is neither rare nor shameful, and judgment free help is available. — Connecticut Roundtable Participant

³³ *The Science of Addiction: Drugs, Brains, and Behavior*, NIH MEDLINEPLUS 15-17 (2007), available at <https://www.nlm.nih.gov/medlineplus/magazine/issues/pdf/spring2007.pdf>.

³⁴ *Buprenorphine Waiver Management*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management> (last updated March 10, 2016).

³⁵ Laura K. Howard, Region VII Reg'l Adm'r, Substance Abuse and Mental Health Servs. Admin., *The Importance of Treatment for Opioid Abuse Disorders*, Presentation at the National Conference on Pharmaceutical and Chemical Diversion (Oct. 1, 2014), available at http://www.deaddiversion.usdoj.gov/mtgs/drug_chemical/2014/howard.pdf.

³⁶ *Occupational Outlook Handbook, 2016-2017 Edition, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners*, BUREAU OF LABOR STATISTICS (December 17, 2015), <http://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm>.

³⁷ NAT'L COMM'N ON CERTIFICATION OF PHYSICIAN ASSISTANTS, 2013 STATISTICAL PROFILE OF CERTIFIED PHYSICIAN ASSISTANTS (2014), available at <https://www.nccpa.net/Upload/PDFs/2013StatisticalProfileofCertifiedPhysicianAssistants-AnAnnualReportoftheNCCPA.pdf>.

EMERGENCY MEDICAL RESPONSE: Strengthen emergency response and coordination in crisis situations through expanded access to affordable Naloxone.

Increasingly, naloxone, or Narcan, is being used to resuscitate those who have overdosed on heroin or prescription opioids. This is a lifesaving antidote that revives a person within minutes, allowing enough time for the person to receive further medical attention. For many years, community-based programs have offered opioid overdose prevention services to people who might witness an overdose, such as people who use illicit drugs and their families and friends. Naloxone has proven essential for law enforcement and first responders arriving at the scene of an overdose, but it has also been used by friends and families of those addicted to opioids to help reverse its deadly effects. As a result, it is crucial for naloxone to be widely accessible and remain affordable for consumers to use in an emergency.

Connecticut law allows for anyone to be prescribed naloxone, with a 2015 state law increasing access to naloxone by expanding pharmacists' scope of practice to include prescribing of naloxone after being certified and trained by the Connecticut Department of Consumer Protection. It also clarifies that prescriptions written by pharmacists can be covered by health insurance, eliminating this financial barrier.³⁸

Naloxone Manufacturers and Insurance Companies Should Keep Life-saving Drug Affordable

As prescription drug and heroin overdoses have skyrocketed, communities in Connecticut and around the country are becoming increasingly reliant on naloxone to save lives. While naloxone has become an indispensable tool in communities ravaged by the opioid epidemic, the price for the lifesaving drug has steadily increased by as much as 50 percent over the last year.³⁹ It has become clear that the price of naloxone began rising just as the crisis was beginning to hit the country the hardest.

➤ Individual Consumers

While most public and private insurance plans cover naloxone with a minimal copay or coinsurance, many pharmacies and consumers have complained that insurance companies refuse to reimburse pharmacists for prescribing naloxone and training patients on proper administration. Further, insurance plans are less likely to cover naloxone kits, which generally include two doses of naloxone, gloves, dispense mechanism, and an informational pamphlet. Insurance companies should reimburse pharmacists who are certified to prescribe naloxone for prescriptions and counseling in its use. Insurance companies should also consider eliminating any copayment or coinsurance associated with take-home naloxone [formulations] and naloxone kits.

³⁸ Conn. Gen. Stat. § 20-10b.

³⁹ *All Things Considered: Price Soars For Key Weapon Against Heroin Overdoses*, NATIONAL PUBLIC RADIO (Sept. 10, 2015), available at <http://www.npr.org/sections/health-shots/2015/09/10/439219409/naloxone-price-soars-key-weapon-against-heroin-overdoses>.

➤ **First Responders and Law Enforcement**

Recent steep price increases for naloxone have drastically cut into the budgets of state and local law enforcement, first responders, and firefighters. In 2009, the average cost of this overdose antidote cost a Connecticut police department anywhere from \$13.00 to \$15.00 per 2mg dose. That price has now skyrocketed to around \$37.00 to \$54.00 for the same dose.⁴⁰ Keeping police forces, EMTs, and others stocked with naloxone has become very expensive as demand increasingly rises.

After hearing from law enforcement, first responders, hospitals and pharmacies reported price increases for naloxone, Senator Blumenthal called on Amphastar, a manufacturer of naloxone most commonly used by law enforcement and first responders, urging them to keep the lifesaving antidote affordable. Senator Blumenthal has also written to several national and Connecticut insurance companies about their plans coverage of naloxone and has advocated for and supported more federal funding of naloxone at the state and local level.

Expanding Access to Naloxone for First Responders

First responders are on the front lines of the opioid epidemic, doing everything in their power to keep our communities healthy and safe. Last year, Stratford's director of emergency services stated that first responders used naloxone 61 times. In Milford last year, that number was closer to about 40. And in the New London region, from late January and early February, first responders used naloxone nearly two dozen times on overdose victims.⁴¹ First responders have been and continue to save lives throughout our state with naloxone, and it is essential to support them in doing so. The *Comprehensive Addiction and Recovery Act* will be pivotal in ensuring that first responders not only have the access they need to naloxone, but also the training necessary to utilize this lifesaving antidote to opioid overdoses.

The *Comprehensive Addiction and Recovery Act*, S.524 would provide states with the funds needed to ensure that our first responders have naloxone readily available in emergency situations. The grants would also be used to give first responders the training needed to properly administer naloxone. This would greatly increase our states ability to respond to the immediate threat of opioids while continuing to work towards permanent, long-term solutions. Further, priority will be given to states that have civil protections in place. Connecticut passed one of these laws in 2014, helping to prioritize our state when federal funding is distributed through this bill.⁴²

Encourage States to Pass Naloxone “Good Samaritan” Legislation

Connecticut has made great strides in expanding and encouraging the use of naloxone in the state. In 2011, the Connecticut legislature passed a law that would protect people calling for emergency medical services during an overdose from arrest for drugs.⁴³ This state law

⁴⁰ Press Release, Office of Sen. Richard Blumenthal, Blumenthal Calls on Amphastar to Reverse Obscene and Immoral Narcan Price Hike, Urges FTC to Investigate Prescription Drug Profiteering and Price Gouging (Oct. 9, 2015), <http://www.blumenthal.senate.gov/newsroom/press/release/blumenthal-letter-amphastar-narcan-pricing>.

⁴¹ David Altimarti, *Heroin-Related Overdose Death Soar in Connecticut*, NEW HAVEN REG., Feb. 14, 2016.

⁴² Conn. Gen. Stat. § 17a-714a.

⁴³ *Id.* at § 21a-279.

encourages those around an overdose victim to act quickly and without fear of retribution so emergency responders can quickly provide naloxone and other necessary medical attention.

Further, in 2014, Connecticut expanded on this by protecting bystanders and first responders that treat an overdose victim with naloxone from civil liability and criminal prosecution.⁴⁴ These protections for bystanders once again protect them from fear of retribution when saving a life. These state developments are extremely important. Still, more can be done to increase naloxone use. Senator Blumenthal strongly supports the *Opioid Overdose Reduction Act*, S.707 which would provide nationwide protections for those trained in the use of naloxone from liability.

LAW ENFORCEMENT: Provide federal, state and local law enforcement resources to fight drug trafficking and to address addiction that leads to criminal acts.

Law enforcement has worked tirelessly to combat the opioid crisis that has gripped communities across the nation. Many recognize that incarceration alone will not effectively address this problem. According to a 2011 Government Accountability Office report, participants that completed drug court programs had rearrest rates that ranged from 12 to 58 percentage points below those in the comparison group⁴⁵ In addition, initiatives such as the High Intensity Drug Trafficking Areas (HIDTA) program allow law enforcement partners to communicate effectively with ?. In 2014 HIDTA assisted with 19,500 investigations, investigated more than 8,200 drug trafficking and money laundering organizations, and apprehended over 31,000 fugitives nationwide.⁴⁶ Combating the opioid crisis requires cooperation between federal, regional, and local partners, providing alternatives to incarceration to help individuals fight substance abuse, and providing the resources necessary to allow law enforcement to focus on this issue.

We cannot incarcerate our way through this problem. Jail does not work. Too many people in jail that should be in treatment instead. More recovery is needed, less jail time.
— Connecticut Roundtable Participant

Increase Federal Funding for the Task Force and the Federal High Intensity Drug Trafficking Areas (HIDTA) Program

The Connecticut State Police and the U.S. Drug Enforcement Administration (DEA) report seeing a tremendous rise in heroin trafficking and use in the Northeast and the entire United States. The Statewide Narcotics Task Force, which is a coordinated effort between the Connecticut State Police, local law enforcement agencies and the DEA, needs expanded federal funding to handle the rise in "tainted" heroin and trafficking. Senator Blumenthal has called for stable federal funding for the Task Force and the federal High Intensity Drug Trafficking Areas (HIDTA) Program that can be directed towards cracking down on trafficking rings and suppliers in Connecticut's largest cities that are the main source of heroin for the state.

⁴⁴ *Id.* at § 17a-714a.

⁴⁵ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-53, ADULT DRUG COURTS: STUDIES SHOW COURTS REDUCE RECIDIVISM, BUT DOJ COULD ENHANCE FUTURE PERFORMANCE MEASURE REVISION EFFORTS 19 (2011).

⁴⁶ HIGH INTENSITY DRUG TRAFFICKING AREAS, 2014 HIDTA PROGRAM SUMMARY EFFECTIVENESS (2014), *available at*: <http://prvihidta.org/default.aspx?MenuItemID=193&MenuGroup=About&AspxAutoDetectCookieSupport=1>.

Encourage Substance Use Treatment as an Alternative to Incarceration Programs

Treatment offers the best alternative for interrupting the drug use/criminal justice cycle for offenders with drug problems. However, only 10 percent of incarcerated individuals diagnosed with a substance use disorder receive any help for their illness and only 11 percent of individuals with co-occurring serious mental illness (SMI) and substance use disorders receive care for both.⁴⁷ Untreated substance using offenders are more likely to relapse into drug use and criminal behavior, jeopardizing public health and safety and taxing criminal justice system resources.

Drug Courts Facts

- Nationwide, 75percent of Drug Court graduates remain arrest-free at least two years after leaving the program.
- Drug Courts significantly reduce crime as much as 45 percent more than other sentencing options.
- Nationwide, for every \$1.00 invested in Drug Court, taxpayers save as much as \$3.36 in avoided criminal justice costs alone.
- Drug Courts are six times more likely to keep offenders in treatment long enough for them to get better.
- Family re-unification rates are 50% higher for Family Drug Court participants.

Source: *National Association of Drug Court Professionals*

Additionally, treatment consistently has been shown to reduce the costs associated with lost productivity, crime, and incarceration caused by drug use.⁴⁸

Recognizing the importance of substance use treatment as an alternative to incarceration, in March 2016 the United States Senate passed S. 524, the *Comprehensive Addiction and Recovery Act (CARA)*. This legislation directs grants to state and local governments to develop, implement, or expand treatment alternatives to incarceration for eligible participants. Some of these alternatives include law enforcement training on recognizing and responding to substance abuse disorders and accompanying mental health disorders, receiving centers as alternatives to jails, and specialized response units for substance abusers. These resources can help ensure substance abusers receive the care they need over unnecessary incarceration. Further, CARA creates important options for substance abusers who are going through court proceedings, including specialized clinical case management, pretrial services related to substance use disorders and co-occurring mental illness, specialized probation, and treatment and rehabilitation programs and recovery support services.

The most commonly used alternatives to incarceration are:

- **Law Enforcement and Crisis Intervention Teams**
Crisis intervention teams and police-mental health co-responder teams are trained to link people with substance use disorders and mental illnesses to treatment without arrest. These partnerships coordinate health providers in the community and designated police units, with the aim of

identifying serious mental illness, de-escalating situations with minimal police force, decreasing

⁴⁷ *Health, Mental Health, and Substance Use Disorders FAQs*, COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, <https://csgjusticecenter.org/substance-abuse/faqs> (last visited Apr. 11, 2016).

⁴⁸ *Principles of Drug Abuse Treatment for Criminal Justice Populations – A Research-Based Guide*, NATIONAL INSTITUTE ON DRUG ABUSE, <https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles> (last updated Apr. 2014).

stigmatization, and when appropriate linking a person to treatment rather than booking them into jail.⁴⁹

➤ Jail Diversion

Jail diversion helps people with substance use disorders and behavioral health needs receive treatment through various alternatives to incarceration. While programs that divert people to treatment incur health-care system costs, providing treatment in the community is typically less expensive than serving people in criminal justice settings. There is also the potential for large cost offsets, because diversion can prevent further criminal justice involvement. Jail diversion helps reduce expenditures associated with unnecessary arrests and detentions.⁵⁰

➤ Drug Courts

Research demonstrates that drug courts provide a highly effective alternative to incarceration for individuals whose involvement in the criminal justice system is rooted in serious addiction to drugs and alcohol. A drug court is a special court that targets criminal offenders who have drug addiction and dependency problems. These programs provide offenders with intensive court supervision, mandatory drug testing, substance-abuse treatment, and other social services as an alternative to adjudication or incarceration. As of June 2010, there were over 2,500 drug courts operating nationwide, of which about 1,400 target adult offenders.⁵¹ By keeping offenders with drug addiction and dependency problems out of jail and in treatment, drug courts have been proven to significantly reduce drug abuse and crime while saving money.⁵²

There must be a focus on getting people into treatment, and not just locking them up.

— Connecticut Roundtable Participant

Connecticut already has strong programs in place with similar goals. The first is a pre-trial drug education program (DEP), where the court orders the defendant to undergo an evaluation and can assign him or her to drug education classes and community service while suspending the criminal prosecution. Another option in Connecticut is a pretrial diversion program that allows courts to order addicted defendants to treatment in lieu of jail. Finally, Connecticut has a separate “drug court,” for offenders with drug addiction or dependency problems that focuses on treatment and supervision over incarceration. Additional resources should be considered to encourage state implementation of these alternatives to incarceration.

⁴⁹ DAVID CLOUD & CHELSEA DAVIS, SUBSTANCE USE AND MENTAL HEALTH PROGRAM, TREATMENT ALTERNATIVES TO INCARCERATION FOR PEOPLE WITH MENTAL HEALTH NEEDS IN THE CRIMINAL JUSTICE SYSTEM: THE COST-SAVINGS IMPLICATIONS (2013), available at <http://www.vera.org/sites/default/files/resources/downloads/treatment-alternatives-to-incarceration.pdf>.

⁵⁰ *Id.*

⁵¹ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-53, ADULT DRUG COURTS: STUDIES SHOW COURTS REDUCE RECIDIVISM, BUT DOJ COULD ENHANCE FUTURE PERFORMANCE MEASURE REVISION EFFORTS 19 (2011).

⁵² *Drug Courts Work- Facts and Figures*, NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS, <http://www.nadcp.org/learn/facts-and-figures> (last visited Apr. 11, 2016).

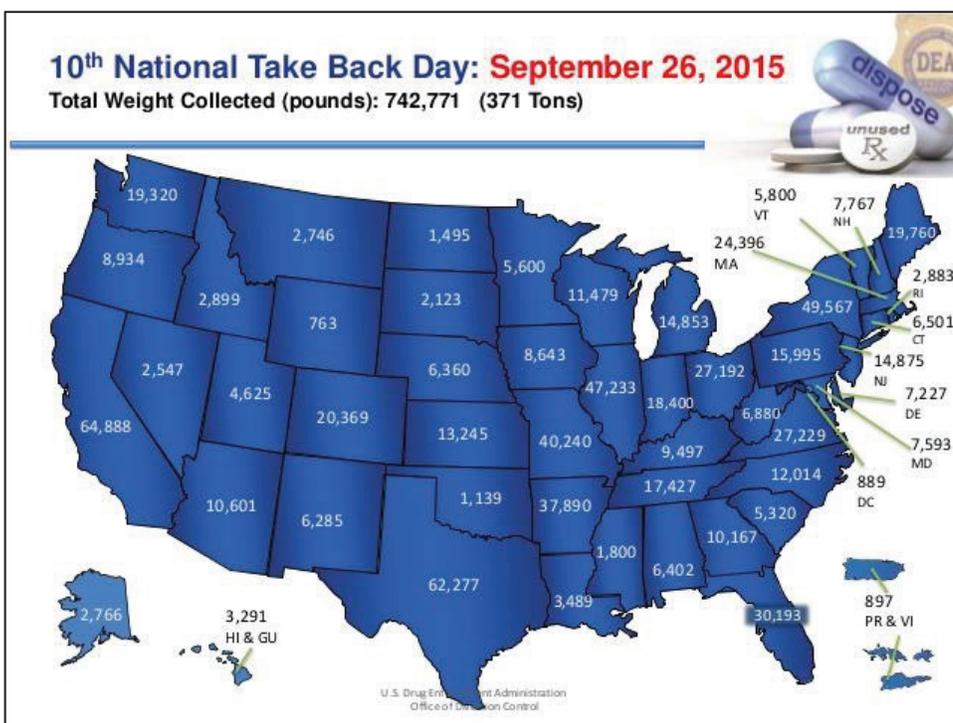
Improve Substance Use Treatment and Behavioral Health Services for Incarcerated Individuals

Of the more than 2.3 million people incarcerated in American prisons and jails, more than 65 percent meet the medical criteria for substance abuse addiction while nearly half had a symptom of a mental disorder, such as depression, anxiety, or personality disorders.⁵³ More funding is needed to expand substance use and mental health treatment in prisons and jails.

The Comprehensive Addiction and Recovery Act provides up to \$5 million per year in grants to state, local, and tribal corrections facilities for drug and behavioral treatment for incarcerated people. The money must be used toward a medication assisted treatment (MAT) program, paired with counseling or therapy. The funds are also to be used for training personnel on medication-assisted treatment and providing recovery coaches for help people adjust prior to release. This will ensure that the funds are being used most effectively to help substance abusers get the help they need and can become full functioning members of society once again.

Expand Drug Takeback Programs

Without proper disposal, unwanted and leftover medicines present numerous risks. Improperly disposed medication can be hazardous to waterways and aquatic life and unused medicine can be misused and abused. Currently, the Drug Enforcement Administration (DEA) sponsors the National Prescription Drug Take-Back Day, which gives citizens an opportunity to



safely and conveniently drop off unused medication at locations across the country. So far there has been 10 National Prescription Drug Take-Back Day Initiatives with over 5,525,021 pounds of drugs collected.⁵⁴

Although DEA expanded a rule to allow hospitals, clinics, retail pharmacies and other authorized collectors to establish and operate disposal programs in October 2014,⁵⁵ many have not

⁵³ KiDEUK KIM, MIRIAM BECKER-COHEN & MARIA SERAKOS, URBAN INSTITUTE, THE PROCESSING AND TREATMENT OF MENTALLY ILL PERSONS IN THE CRIMINAL JUSTICE SYSTEM (2015), available at <http://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system>.

⁵⁴ Press Release, DEA’s Prescription Drug Take-Back Effort—A Big Success (Oct. 1, 2015), <http://www.dea.gov/divisions/hq/2015/hq100115.shtml>.

⁵⁵ See 21 C.F.R. §§ 1300, 1301, 1304, 1305, 1307, and 1317 (2015).

established programs because of the cost and security associated with disposal programs. Until recently, most drug disposal sites were located at local police stations.

However, Walgreens, one of the largest retail pharmacies in the United States, announced in March 2016 that it has taken an important step in fighting prescription drug abuse, misuse, and overdoses by announcing that it will be installing safe medication disposal kiosks in 500 stores in nearly 39 states, including Connecticut.⁵⁶ The kiosks provide customers with a safe, easy, and free method of disposing of unused medication and is a great start to preventing misuse, either intentional or unintentional, of dangerous prescription drugs.

These are significant first steps to expand the DEA drug takeback program. More retail pharmacies, hospitals and clinics should also consider installing safe medication disposal sites at their locations. More disposal sites means greater flexibility for consumers to dispose of their unwanted medications.

In Connecticut, public and private organizations can sponsor drug takeback collections. The Department of Consumer Protection or a local police department oversees the collection and disposal of the collected medication and the Department of Consumer Protection lists upcoming drug takeback collection events on their website. In addition, dozens of local police departments have medication drop boxes in their lobbies. Citizens can drop off any unused or unwanted prescription medications, with no questions asked, and the police will properly dispose of them.

Expand Funding for and Access to Prescription Drug Monitoring Programs

Prescription Drug Monitoring Programs (PDMPs) are searchable online patient databases of controlled substances that collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. Prescription data is provided only to entities authorized by state law to access the program, such as health care practitioners, pharmacists, regulatory boards and law enforcement agencies. Information collected by PDMPs may be used to support access to and legitimate medical use of controlled substances; identify or prevent drug abuse and diversion; facilitate the identification of prescription drug-addicted individuals and enable intervention and treatment; outline drug use and abuse trends to inform public health initiatives; or educate individuals about prescription drug use, abuse, and diversion as well as about PDMPs.⁵⁷

➤ *National All Schedules Prescription Electronic Reporting (NASPER) Reauthorization Act*

The National All Schedules Prescription Electronic Report (NASPER) program supports state prescription drug monitoring programs in order to ensure that appropriate law enforcement, regulatory, and state professional licensing authorities have access to prescription history information for the purposes of investigating drug diversion and prescribing and dispensing practices of controlled substances. This Congress, Senator Jeanne Shaheen introduced S. 480, the NASPER Reauthorization Act, which authorizes grants to be used to maintain and operate

⁵⁶ Anna Bisaro, *Walgreens to Install Kiosks to Dispose of Opioids, Prescriptions*, NEW HAVEN REG., Feb. 9, 2016, <http://www.nhregister.com/health/20160209/walgreens-to-install-kiosks-to-dispose-of-opioids-prescriptions> (last visited Apr. 11, 2016).

⁵⁷ LISA N. SACCO, ERIN BAGALMAN & KRISTIN FINKLEA, CONG. RESEARCH SERV., R42593, PRESCRIPTION DRUG MONITORING PROGRAMS (2016).

existing state PDMPs, expands the program to any commonwealth or territory of the United States, and allows the DEA, a state Medicaid program, state health department, or a state substance abuse agency receiving non-identifiable information from a controlled substance monitoring database to make such information available to other entities for research purposes.

This legislation also ensures that health care providers have access to the accurate, timely prescription data that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction.

➤ ***Expanding Access to Prescription Drug Monitoring Programs Act***

As nurse practitioners and physician assistants continue to take on more responsibility in providing health care services, it is important to recognize their ability to help curb prescription drug abuse. Although nurse practitioners and physician assistants wrote over 32 million opioid prescriptions in 2012, few states permit them to consult and submit prescribing data to the state PDMP for controlled substances.⁵⁸

In order to track prescribing data for patients of nurse practitioners and physician assistants Senator Blumenthal and Senator Jeff Coats (R-Ind.) introduced S.2479, *the Expanding Access to Prescription Drug Monitoring Programs Act*. This bill was included in the Senate passed version of the *Comprehensive Addiction and Recovery Act*. The legislation ensures states with prescription drug monitoring programs (PDMPs) fully utilize these databases to reach their maximum potential to reduce drug abuse and diversion by allowing all prescribers of controlled substances to consult and submit data to their state PDMP.

VETERANS ADMINISTRATION PRACTICE, RESEARCH, AND EDUCATION: Enhance VA leadership in treatment, research, and education for opioid use and abuse

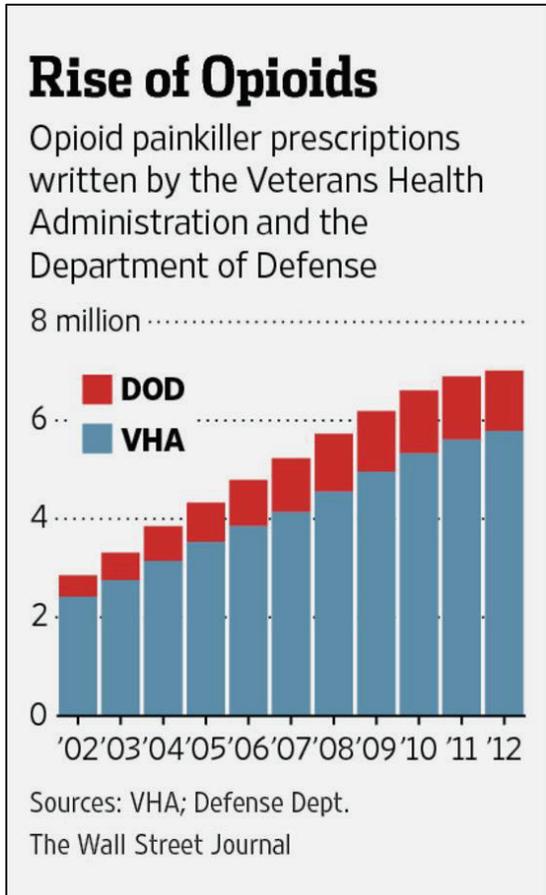
As one of the nation's largest health care systems, VA is in a unique position to be a leader—an innovator—in the fight against misuse and abuse of opioid medications both for our country's veteran population and for the nation's health care system in general. Through the use of its affiliations with medical schools and universities, VA has become the largest provider of healthcare training in the United States, and approximately 70 percent of physicians in this country receive some of their medical training through the VA system.⁵⁹

Given the high number of healthcare providers who spend some portion of their training or clinical careers at a VA facility, there is a tremendous opportunity for VA to educate healthcare providers and carry out meaningful research on opioid prescription and use patterns. VA's leadership in this area is critical given that the impact of the over-prescription of opioids is particularly devastating when it impacts those who have served our country. Approximately 44 percent of veterans report having chronic pain after deployment compared to 26 percent in the general

⁵⁸ BENJAMIN LEVY, MD ET AL., TRENDS IN OPIOID ANALGESIC-PRESCRIBING RATES BY SPECIALTY, U.S., 2007–2012 (2015).

⁵⁹ Bob McDonald, Secretary, U.S. Dep't of Veterans Affairs, Remarks to the Ass'n of Medical Colleges Council of Deans Spring Meeting (March 29, 2015), *available at* <http://www.blogs.va.gov/VAntage/18655/mcdonald-academic-affiliations-a-source-of-strength-for-the-va-medical-schools/>.

public.⁶⁰ For veterans who have deployed overseas and may be dealing with the effects of the invisible wounds of war, such as traumatic brain injury and post-traumatic stress, in addition to chronic pain, it is especially important that providers utilize therapies appropriately. When treating multiple conditions, the increased risk of drug interactions with prescription opioids creates additional concerns and potential dangers for patients. This reinforces how absolutely essential it is for VA to provide excellent training and careful coordination of care to ensure the health and safety of the veterans who are prescribed opioid medications.



Jason Simcakoski Memorial Opioid Safety Act

In March 2015, the Senate Veterans Affairs Committee held a hearing on opioid prescription policy, practices and procedures at the VA. The hearing revealed disturbing variations in prescribing practices and inconsistent utilization of the tools that are available to VA providers to better inform patients of the risks of long-term use of opioids. Senator Blumenthal, along with, Senators Tammy Baldwin and Joni Ernst, introduced the *Jason Simcakoski Memorial Opioid Safety Act*. The bill is named after a veteran who tragically passed away after a long battle with addiction. This bill would improve the opioid therapy guidelines and safety measures, such as the Opioid Safety Initiative, at the VA to ensure more consistent, safe prescribing practices.⁶¹ It would also provide additional resources for veterans and their families who would seek alternative therapies to avoid the use of opioids as well as increase oversight and transparency of VA’s hiring practices for of health care providers. For example, the bill would require VA to carry out a 3-year program to assess the feasibility of integrating a range of complementary and integrative health services with other health care services provided by the VA for

veterans’ mental health diagnoses, pain management, and chronic illness.

Alternatives for Pain Management

Because chronic pain is a common problem among active-duty military personnel and veterans, the VA and other federal agencies are sponsoring research to see whether complimentary and

⁶⁰ Press Release, Nat’l Insts. of Health, NIH and VA address pain and related conditions in U.S. military personnel, veterans, and their families (Sep. 25, 2014), <http://www.nih.gov/news-events/news-releases/nih-va-address-pain-related-conditions-us-military-personnel-veterans-their-families>.

⁶¹To address the growing problem of inappropriate use and overprescribing of opioids, VA established the Opioid Safety Initiative in 2012. The goal of the Opioid Safety Initiative is to make the totality of opioid use visible at all levels of VA to ensure safe use. According VA, from July 2012 through December 2014, 13 percent fewer patients were receiving opioids, and 28 percent fewer patients were receiving an opioid and benzodiazepine combination.

integrative approaches can help.⁶² For example, the National Institutes of Health has funded studies to test the effects of adding mindfulness meditation, self-hypnosis, or other complementary approaches to pain management programs for veterans. The goal is to improve patient well-being and function and reduce the need for pain medications such as opioids. These approaches are important because far too often, opioids are prescribed for chronic pain when other complementary and integrative therapies have not been considered. While opioids can help manage pain for many patients, other, less risky options may be as or more effective. For example, chiropractic care is available at some VA facilities and is an important option for patients seeking pain management. Senator Blumenthal, along with his colleague Senator Jerry Moran, introduced the *Chiropractic Care Available to All Veterans Act of 2015* (S. 398). This bill would expand access to chiropractic services by requiring the VA to hire more chiropractors.

Improved Access to State Prescription Drug Monitoring Programs for VA

State Prescription Drug Monitoring Programs (PDMPs) are important tools utilized by providers and law enforcement to understand the prescribing practices in their states. At the March 2015, hearing on VA's opioid prescription policy, practice, and procedures John Gadea, Director of Connecticut's State Drug Control Division of the Department of Consumer Affairs, testified about the challenges that the Connecticut PDMP faced in providing the information to the West Haven VA. Senator Blumenthal wrote a letter to the VA Secretary, asking for better information-sharing between VA databases and relevant state PDMPs. Shortly after sending the letter, the West Haven VA fully participated in the Connecticut PDMP ensuring providers both inside and outside of the VA can see what prescriptions veterans have been prescribed. This was an important step toward information-sharing and collaboration and should be happening across all VA locations. Senator Blumenthal will continue to work to make sure all state PDMPs are able to work with VA facilities to increase the understanding of opioid prescribing practices in their locations.

Veteran Treatment Courts

Many veterans face serious challenges when they return home from service, particularly from the invisible wounds of war such as post-traumatic stress, traumatic brain injury, or substance abuse including opioid addiction. These challenges can sometimes lead to criminal or other destructive behaviors. The Justice Department's most recent statistics on substance abuse among incarcerated veterans show that an estimated 60 percent of the 140,000 veterans in Federal and State prisons were struggling with a substance use disorder, while approximately 25 percent reported being under the influence of drugs at the time of their offense.⁶³ Many of these issues can be connected to the trauma of combat and other service-related experiences and require specially tailored measures to address them. Veterans Treatment Courts are designed to treat veterans suffering from a substance abuse and/or mental health disorder, while helping ensure public safety. Veterans Courts promote sobriety, recovery, and stability through a coordinated response involving the traditional partners found in drug courts and mental health courts, as well as the VA healthcare networks, volunteer veteran mentors, and veterans family support

⁶²The term "complementary" refers to the use of non-mainstream health practices together with conventional medicine. "Integrative" health care involves bringing conventional and complementary approaches together in a coordinated way.

⁶³MARGARET E. NOONAN & CHRISTOPHER J. MUMOLA, BUREAU OF JUSTICE STATISTICS, VETERANS IN STATE AND FEDERAL PRISON, 2004 (2007), available at <http://www.bjs.gov/content/pub/pdf/vsfp04.pdf>.

organizations.⁶⁴ Senator Blumenthal supports expanding access to Veterans Treatment Courts, whether through grants or other means of making these vital services available to those veterans who need them.

Expanding Access to Naloxone in VA Facilities

Naloxone—a drug used to reverse the potentially fatal respiratory depression caused by heroin and other opioids—is an important tool in the fight against the deadly scourge of opioid addiction. For many years, community-based programs have offered opioid overdose prevention services to people who might witness an overdose, such as people who use illicit drugs and their families and friends. VA requires that all medical facilities have naloxone in their emergency departments. In addition, VA's pharmacy units do outreach to encourage facilities to obtain and dispense kits along with prescription opioids. While all VA facilities have naloxone on emergency crash carts, only 77 percent of VA facilities are currently dispensing naloxone rescue kits for patients to take home to use in an emergency. However, not all VA pharmacies have such kits immediately on hand for dispensing and must order them or have them mailed to patients who are prescribed rescue kits. Senator Blumenthal believes that VA should expand access to naloxone by requiring every VA pharmacy to have it on hand for dispensing and to expand the naloxone take home program. While very few veterans are asked to pay copayments for prescription drugs, those who do would still be asked to pay copayments for a naloxone kit. Senator Blumenthal supports eliminating copayments for naloxone for all veterans. Blumenthal is actively working to require VA to take these steps which would expand access to naloxone for veterans and could save lives.

⁶⁴OFFICE OF NAT'L DRUG POLICY, VETERANS TREATMENT COURT FACT SHEET (2010), *available at* https://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/veterans_treatment_courts_fact_sheet_12-13-10.pdf.

Hearing From Connecticut: Senator Blumenthal's Notes

Personal Stories

- One young man who spoke discussed how he used to be prescribed opioids very often. Then suddenly they were taken away. He quickly went from opioids to heroin because it was cheaper and easily accessible. When he overdosed, he couldn't get Narcan. He lost family support and had nowhere to go. He went into Perception programs and then to the Connecticut Community for Addiction Recovery (CCAR). The sober house was only available to him for a month, which was not enough time to adequately treat his illness. He has no car and there are only three CCAR centers in Connecticut, making treatment through CCAR difficult.
- One woman had bladder surgery six months ago. Before the surgery she warned her doctors that she did not want opiates as she is a recovering addict. During preparation she asked the nurse what she was about to give her through her IV and it was a narcotic. She eventually met with the hospital director to place a complaint. She says doctors and other staff simply don't communicate well enough, nor did they seem sympathetic to those in recovery.
- One mother spoke out about three of her children, who became addicted to heroin after using prescription opiates for injuries, and after using marijuana. Her children have been in and out of treatment facilities across the state, but now recognizes that the three or five months allotted for treatment are not long enough, and at least 12 months is necessary. Today, her children are either in prison or still using.

Prescribers

- We should allow advanced practice nurses (APRNs) to prescribe lifesaving drugs. This change would be particularly beneficial to Veterans Affairs hospitals due to the high number of APRNs practicing there.
- Better education and training of prescribers is needed, starting in the primary care office. We need to increase the knowledge around addiction care, even if there are a limited number of specialists in pain management. As many health care workers as possible should have the basic knowledge needed to help prevent prescription drug abuse and recognize the warning signs of addiction.
- Currently medical students receive up to six hours of training on pain management and opioid abuse. They should be getting around 25 hours of training.
- We need to train residents more thoroughly on addiction. About 30 percent of medical schools spend six hours or less on pain management and opioids. About 50 to 80 percent of doctors do not feel like they are adequately trained on issues surrounding prescription drug abuse.
- Many physicians report not being aware that all pain medications are not appropriate for everyone. There should be more education for prescribers on the effects of narcotics and information on how to better utilize and prescribe them. Additionally, a neuroscience

class would help prescribers to better understand substance abuse. Understanding the potentially deadly side effects of prescription opioids is crucial.

- Any time that an opiate is prescribed, two other things should accompany the prescription: a discarding kit for people to dispose of extra pills and naloxone. Doctors should further counsel their patients on the dangers of opiate use.
- VA doctors are required to counsel their patients before the patient signs a consent form. This ensures opioid addiction is being discussed seriously and understandably.
- We should require treatment centers that use methadone to report to the Connecticut Department of Consumer Protection's (DPH) prescription drug monitoring program (PDMP). This will guarantee that other providers know who's been given the drug.
- There needs to be a centralized data hub on prescription drugs. There's no single agency or clearinghouse to compile data. Currently, prescription data goes to DCP, police data goes to the Department of Corrections, youth addiction data goes to the Department of Children and Families (FCDP), adult addiction data goes to the Department of Mental Health and Substance Abuse Services (DMHAS), and practitioner data goes to the Department of Public Health (DPH).

Young People

- There needs to be special services for adolescents who are exposed to these drugs at a young age.
- One in four children who try prescription opioids will develop an addiction. This statistic is absolutely unnecessary and deplorable.
- There are currently less resources for people under 18 years of age – kids are “better off” if they're over 18 because there are more services available to them.
- Fairfield Warde High School has substance abuse counseling in school for students and parents, which was described as being “very helpful.” This included one school period per week of group counseling.
- Some families are sending their children to Florida for care because insurance companies would rather pay for out-of-state treatment. This is not conducive to youth who leave the state for treatment only to be sent back to the potentially toxic environment that exacerbated their addiction.
- There should be a serious look taken into the prescribing practices of dentists. They tend to overprescribe, leading some young people to have an excess of prescription drugs to misuse personally or share with friends. Rather than prescribing just a few painkillers, like Vicodin, dentists are writing scripts for 30 days supplies.
- It is difficult to provide teachers with the needed training to help identify those students at risk or already addicted. More services need to be directed towards education of people that frequently deal with young people so they're prepared to intervene when necessary.

- DCF has been good at providing training to help professionals identify addiction in young children.
- Doctors should use Access Mental Health CT, which is a program that offers free, timely consultation to primary care providers (PCPs) seeking assistance in treating youth with behavioral health concerns under the age of 19 years, regardless of insurance. Specialists are available to answer questions and provide valuable resources for mental health treatment in respective communities. This should be considered an essential tool to PCPs throughout the state.

Treatment for Substance Use and Mental Health Disorders

- There needs to be insurance parity for mental health and addiction. Many families still worry that they will continue to be denied medical coverage by their insurer for important mental health and addiction treatments.
- Insurance will frequently only pay for what they think a patient needs, not what sort of treatment or medication the patient actually requires. This hurts patients, families, and providers by denying essential and medically necessary coverage in dire circumstances.
- One participant made a strong analogy between cancer and addiction. When you have cancer the insurance company will help you pay for chemotherapy or other needed treatments until the patient no longer needs it. Conversely, when that same patient has a mental illness or substance abuse problem, they are only given a specific number of visits. This is causing a high rate of relapse and not adequately addressing the immediate problem of addiction, which often requires long-term treatment.
- We need more evidence based treatment after recovery. There are not enough drugs for the detox process, forcing people to suffer through it without the medication assisted treatment they need. Medically sound treatments should be available for all people struggling with addiction.

Law Enforcement

- Addiction is an illness, not a moral failing. We must change the perspective our society and judicial system take when dealing with addiction.
- We cannot arrest our way to the solution. There must be a focus on treatment.
- Law enforcement officials need to be better linked to services in their area. This should include mental health services. By educating law enforcement and connecting them with the appropriate partners, they will be more prepared to deal with mental health and addiction situations.
- There continues to be a great need for more available services. Even after 28 days, people struggling with addiction still need structure. Once they leave the half way home or program, they are once again exposed to their old lifestyle, making it harder to stay clean and even more essential for services and treatment to remain available.

Opioid Addiction: *A Call to Action*

Learn more: www.Blumenthal.Senate.gov

U.S. Senator Richard Blumenthal