AN ACT RELATIVE TO SUBSTANCE USE TREATMENT, EDUCATION AND PREVENTION

Section 1. Increases continuing education requirements for practitioners.

This act requires practitioners who prescribe controlled substances to receive 5 hours of training every 2 years related to: (i) effective pain management; (ii) identification of patients at high risk for substance abuse; and (iii) counseling patients about the side effects, addictive nature and proper storage and disposal of prescription medications. This act also requires practitioners to certify compliance with this requirement at the time the practitioner renews his or her license.

Section 2. Reduces excessive prescribing practices.

This act limits first time exposure to opioids. Under this act, the first time a patient obtains a prescription for an opioid, the patient will be limited to receiving a 72-hour supply. Also, the first time a patient obtains a prescription for an opioid from a new doctor, even if the patient has previously taken opioids, the patient will be limited to receiving a 72-hour supply. The bill provides an exception for emergency situations and permits the department of public health to identify additional exceptions to the 72-hour limit.

Section 3. Increases PMP use prior to issuing an opiate prescription.

This act requires every practitioner to check the prescription monitoring program (PMP) prior to prescribing an opiate. Currently, a practitioner in the emergency department does not have to check the PMP if the practitioner is writing a prescription for a controlled substance in schedules II-V for less than a five-day supply.

Sections 4 and 5. Educates athletes and their parents about the dangers of opioid use and misuse.

This act requires information about the dangers of opioid use and misuse to be distributed during the annual mandatory head injury safety training program. All public schools and any school subject to the Massachusetts Interscholastic Athletic Association rules are required to receive the training. This training reaches a wide audience, including: coaches, trainers and parent volunteers for any extracurricular athletic activity; physicians and nurses who are employed by a school or school district or who volunteer to assist with an extracurricular athletic activity; school athletic directors; directors responsible for a school marching band; and a parent or legal guardian of a child who participates in an extracurricular athletic activity.

Sections 6, 7, 8, 9 and 10. Improves treatment options for patients involuntarily committed under Chapter 123, Section 35.

The act retains existing statutory provisions that authorize a court to order the involuntary commitment of a person to a secure treatment facility for up to 90 days when the court finds that the person suffers from an alcohol or substance use disorder and that as a result there is a serious risk of harm. The legislation improves the quality of treatment that will be provided to women committed under section 35 by eliminating commitments to MCI-Framingham. The legislation provides that women requiring an enhanced level of security may be committed instead to new secure treatment facilities approved by the Department of Public Health or the Department of Mental Health. The administration has already

begun work to establish new secure treatment facilities for women at Taunton State Hospital and at the Lemuel Shattuck Hospital which it anticipates will be available to receive section 35 patients beginning in January 2016. The treatment facility at MCI-Bridgewater will continue to provide a secure place of treatment for men who are committed for treatment and who require a heightened level of security.

In addition, the act seeks to expand treatment capacity for patients committed under section 35 by:

- Requiring the department of public health to identify for the court the facility where a bed is available for the treatment of an individual committed under section 35;
- Expanding access to treatment beds by authorizing the department of mental health to identify DMH licensed beds, with enhanced security comparable to that now maintained at the Men's Addiction Treatment Center, in Brockton, and the Women's Addiction Treatment Center, in New Bedford, that are available to treat individuals with a substance use disorder who have been committed under section 35;
- Clarifying the executive branch's existing authority to transfer patients between facilities while the patient is committed under section 35 and receiving treatment services.

Section 11 and 15. Creates a new emergency admission pathway to treatment.

This act creates a new emergency admission pathway for the clinical assessment and treatment of individuals with a substance use disorder that will be available 24/7/365. Year over year, our courts are seeing an increasing number of section 35 petitions to commit an individual to treatment involuntarily. In the Commonwealth, too often the "front door" to treatment is a courtroom and a correctional facility.

This is not ideal for many reasons, including the fact that individuals who are experiencing withdrawal symptoms are waiting in courtrooms throughout the Commonwealth for a hearing and then for transportation to a treatment facility or correctional facility. This also means that the "front door" is only open when courts are in session: Monday through Friday during business hours, excluding holidays.

This act will provide medical professionals with the ability to clinically asses a patient for 72-hours and work to engage the patient in voluntary treatment. Acknowledging that voluntary treatment is the best avenue for therapeutic success, this new statute requires clinicians to try to engage the individual in voluntary treatment before pursuing involuntary treatment. However, if after 72-hours the individual is not able to consent to treatment and the individual poses an imminent risk to himself/herself by reason of his/her substance use disorder, then the clinician may petition the court to commit the person to treatment involuntarily.

Procedurally, the process is similar to the section 12 "pink paper" process that currently exists for individuals with a mental health issue that are at risk of harm, as detailed below.

- A physician, qualified psychiatric nurse, mental health clinical specialist, psychologist, independent clinical social worker, or in certain circumstances a police officer, can authorize the restraint of a person, if he or she believes that failure to commit such person for treatment would create a likelihood of serious harm because of the person's alcohol or substance use

disorder. Once restrained, the individual is transported to a facility, approved by either DPH or DMH, for the treatment of individuals with a substance use disorder.

- Upon admission to the treatment facility, a physician must examine the person. If the physician determines that failure to treat the person would create a likelihood of serious harm because of the person's alcohol or substance use disorder, then the physician may admit the person for care and treatment. **The individual must be provided an opportunity to voluntarily commit to treatment.**
- If the individual refuses to consent to treatment voluntarily, then he or she may be evaluated for a 3-day period, during which time medical professionals will continue to try to engage the individual in voluntary treatment or the facility, where the individual is being evaluated, may petition the court for a commitment order.
- If the facility petitions the court for a commitment order, a hearing must commence within 5 days. If, after the hearing, the court determines that (1) the person has an alcohol or substance use disorder, and (2) the discharge of such person from the facility would create a likelihood of serious harm as a result of the person's alcohol or substance use disorder, then the court must commit the person for a period of time, not to exceed 90 days.
- This process will become effective nine months from the effective date of the act.

Section 12. Increases transparency of insurance carrier opioid policies.

This act requires insurers regulated by the Division of Insurance (DOI) to file opioid management policies annually with DOI. Specifically, the annual attestation must outline:

- the prior authorization policies that the carrier utilizes to encourage safe opioid prescribing practices;
- any member or provider outreach efforts related to education about the risks of opioid use and misuse;
- the protocols in place to ensure that carriers are monitoring provider compliance with the 72-hour limit on the first opioid prescription, as required by section 2 of the bill;
- alternative pain management therapies that are covered by the carrier; and
- the policies that ensure appropriate access to pain medication for individuals suffering from chronic pain.

Section 13. Improves access to recovery high schools.

Recovery high schools (RHS) provide a safe, sober and supportive learning environment for students who have been diagnosed with a substance use disorder. Currently, students attending a RHS do not receive funding from the Commonwealth to cover transportation costs. This act requires the department of public health and the department of elementary and secondary education to develop a transportation plan for students who attend a recovery high school.

Section 14. Requires DPH and DMH to promulgate regulations related to the implementation of this act.