Bill as Introduced

SB 445-FN – AS INTRODUCED

2000 SESSION

00-2748
01/09

SENATE BILL ***445-FN***

AN ACT establishing an opioid treatment pilot program.

SPONSORS: Sen. Wheeler, Dist 21; Sen. Squires, Dist 12; Sen. Russman, Dist 19; Rep. Chabot, Hills 48; Rep. Flora, Hills 15; Rep. O'Keefe, Rock 21; Rep. Taylor, Straf 11

COMMITTEE: Public Institutions, Health and Human Services

ANALYSIS

This bill requires the commissioner of health and human services to establish and administer a 2-year pilot program for the treatment of individuals who are addicted to opioid substances, including heroin. The commissioner is granted rulemaking authority to implement the provisions of the bill.

This bill is a result of the committee established in 1998, 247 as amended by 1999, 255.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

00-2748
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand

AN ACT establishing an opioid treatment pilot program.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Opioid Treatment Pilot Program Established.

I. The department of health and human services shall establish and administer a 2-year pilot program for treatment of individuals who are addicted to opioid substances, including heroin.

II. The commissioner of health and human services shall convene a panel of addiction medicine specialists and health care researchers to advise the department on the development of best clinical practices and program evaluation procedures for methadone maintenance therapy and other means of opioid agonist treatment.

III. The pilot program shall be exempt from the provisions of RSA 318-B to the extent necessary to carry out the program; provided, that the treatment provided through the program complies with all applicable federal laws and regulations.

IV. The commissioner shall adopt rules, under RSA 541-A, regarding the operation of the program relative to:

(a) Designation of participating providers, who shall be New Hampshire based private non-profit organizations.

(b) The components of a comprehensive treatment program, including individual and group counseling and treatment alternatives.

(c) Referral procedures and collaborations with other community agencies to assure that clients receive the appropriate health care, including mental health care, and educational, vocational, and other services as may be required to promote recovery.

(d) The fees which shall be charged to clients based on their ability to pay.

2 Reports. On or before January 1, 2002 the commissioner shall report to the senate president, the speaker of the house of representatives, and the governor regarding the implementation of the pilot program. On or before January 2, 2003 the commissioner shall further report to the senate president, the speaker of the house of representatives, and the governor regarding the operation and efficacy of the pilot program and shall make recommendations relative to the continuation of the pilot program.

3 Applicability. The commissioner of the department of health and human services shall initiate rulemaking, pursuant to RSA 541-A, for the pilot program established in section 1 of this act, and such rules shall be filed with the director of legislative services under RSA 541-A before the pilot program is implemented.

4 Repeal. Sections 1-3 of this act, relative to an opioid treatment pilot program, are repealed.

5 Effective Date.

I. Sections 1-3 of this act shall take effect January 1, 2001.

II. Section 4 of this act shall take effect July 1, 2003.

LBAO
00-2748
12/16/99

SB 445-FN - FISCAL NOTE

AN ACT establishing a opioid treatment pilot program.

FISCAL IMPACT:

The Department of Health and Human Services indicates this bill will increase state expenditures by $76,000 in FY 2001, by $424,000 in FY 2002, by $224,000 in FY 2003 and FY 2004 and by an indeterminable amount each year thereafter. There will be no fiscal impact on state, county, and local revenues or on county and local expenditures.

METHODOLOGY:

The Department assumes 112 of the estimated 371 heroin users in New Hampshire would seek treatment in the pilot program, and 56 of these users will require state assistance. The average cost per client for existing programs is $4,000 per year. General funds would be required since only five percent of the clients would be Medicaid-eligible. The Department would require a consultant experienced in methadone treatment to develop the program and assist with establishing the rules and the approval of participating providers. To complete the required report on program operation and efficacy the Department proposes a university-based study in FY 2002. Expenditures beyond the pilot program would be necessary to support continued treatment for clients participating in the pilot. Based on the effective date of January 1, 2001, the program would be operational on April 1, 2001.

	FY 2001	FY 2002	FY 2003	FY 2004
Treatment (56 clients $4,000)	$56,000	$224,000	$224,000	$224,000
Evaluation Study				
Personnel and Consultants		129,000		
Supplies, travel , lab fees, etc.		30,000		
University Overhead Costs		41,000		
Program Consultant	20,000			
Totals	$76,000	$424,000	$224,000	$224,000

Amendments

Sen. Wheeler, Dist. 21
February 16, 2000
2000-3501s
01/09

Amendment to SB 445-FN

Amend subparagraph IV(a) as inserted by section 1 of the bill by replacing it with the following:

(a) Designation of participating providers, who shall be New Hampshire-based health care providers.

Public Institutions, Health and Human Services
February 23, 2000
2000-3582s
01/10

Amendment to SB 445-FN

Amend subparagraph IV(a) as inserted by section 1 of the bill by replacing it with the following:

(a) Designation of participating providers, who shall be New Hampshire-based health care providers.

Committee Minutes

Date: February 22, 2000
Time: 1:30 PM
Room: LOB 102

The Senate Committee on Public Institutions/Health Human Services held a hearing on the following:

SB 444-FN relative to methadone maintenance treatment.

SB 445-FN establishing an opioid treatment pilot program

Members of Committee present: Senator Squires
Senator Wheeler
Senator Fernald
Senator Gordon
Senator McCarley
Senator Pignatelli

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The Chair, Senator James Squires, opened the hearing. Is that your desire, Senator Wheeler, to introduce 444 and 445? What would you like to do?

Senator Katherine W. Wheeler, D. 21: I think they should be voted on separately but I think the topic is the same, although, there are different issues surrounding the two of them. I don't think I need to testify twice and if there are people who don't feel the need to testify twice it's all right but there may be people who have different positions on the bills. They might support one and not support the other. So, I guess I would like you to have the flexibility that you just said you had and let people testify as they wish if that's alright with you.

Senator James W. Squires, D. 12: I think that's fine. I will only ask people when they're going to testify to just tell us to which one you're speaking or both. If the general sentiment is consistent with both bills, that's fine. If there is theoretically someone that might be in favor of 444 but not in 445 just indicate that so we can have that in the record. Having said that perhaps you could introduce them, Senator Wheeler.

Senator Katherine W. Wheeler, D. 21: Thank you Senator Squires and members of the Committee. I am Senator Katie Wheeler from District 21. I'm here in support of both Senate Bill 444 and 445.

These bills are both the results of a study committee that's gone on so far for two years to study the substance abuse treatment system in the state of New

Hampshire. We didn't have an agenda in mind when we started except to try to find out where there gaps in treatment, where we might be able to make improvements in substance abuse treatment. So, we weren't looking for an issue but this issue came to us. The members of the study committee have learned a great deal from this and we had some extensive hearings with a lot of people coming and educating us. So I'm hoping we're starting that broader process of education now in the Senate and that it will go onto the House.

If I could do what I would really like to do, I think the simplest thing to do would be simply to repeal the part in our statute right now that prohibits us allowing methadone maintenance – it keeps us from allowing methadone maintenance treatment in New Hampshire. We're one of 8 states that have this prohibition and I think it's time we learned from the rest of the world about what works.

Methadone is one treatment to use for heroin addiction. As we know from what we read in the newspaper, from what we hear from our constituents heroin is a growing public health problem. Somebody called me and said that people are even breaking into veterinarian's offices for ketamine, I wrote down but I'm not sure of what it is for sure, and selling it for heroin. I've seen in my local newspaper in Dover the rise of heroin use among young people.

What I'm also hearing is that methadone maintenance treatment is being used by a lot of people in New Hampshire but to use it they have to go out-of-sate. I got an anonymous e-mail form a person in my community who said that he's going to Maine everyday for treatment because he's a heroin addict and he doesn't want his children to know this. So before he goes to his job everyday in the Durham/Dover area he's driving across the border to Maine to get his dose of methadone.

I would have thought that this was a "no brainer". If I hadn't gone to a meeting where Lynn Cope Moyer's son spoke at the University a couple of years ago on substance abuse and the perception that we have of people who are addicted to drugs and alcohol. He showed us a picture that was, I think it was on the cover of Time or Newsweek but it really showed a very distorting kind of monster-like face and this is the face that many of us see as the face of an addict. We don't see our faces when we look at the face of an addict. But the truth of the matter is that in our society the person that looks just like you sitting next to you at a meeting is just as likely to be an addict of some kind as someone with a monster face. But we've stigmatized addiction and we stigmatize the treatment.

I went to a panel in San Diego at the NCSL Conference on Healthcare Policy and I went to the one on the Politics of Substance Abuse. I learned a lot from that because I learned that this is a very political issue. It's much more political than it is medical. There is documented evidence that methadone maintenance

works. There is evidence that detox without maintenance is virtually useless yet in our state we allow methadone to be used for detox and for pregnant women. Once again we have carved out pregnant women as a special category but the minute the woman gives birth, she's gone. No more treatment. It was only to protect the baby. So, we don't have a very grown-up, non-political view to this treatment option.

I learned in the study committee that we're talking about a neuro-biologic change that results from addiction. We're not just talking about "Gee I'm having 5 drinks a night and I've got to cut back to 1." It really is much harder to stop your addictive behavior when you had a physiological change in your brain.

I'm going to stop my testimony because there are so many experts here who will testify but the two bills do two different things.

The bill that you're hearing second sets up a pilot program and you may well ask and I ask myself why do we need a pilot program? We know this is something that works. It would be so much better if we could just go ahead and establish methadone maintenance treatment in New Hampshire. However this was the approach that Health and Human Services recommended to us some months ago and they may have changed in their opinion since then too. Nobody has to be held to that but in the meantime I'm hearing from my constituents and I'm hearing from your constituents that we need a New Hampshire option for people who want to stop their heroin addiction and want to be able to have accessible treatment in New Hampshire.

So the first bill, 444, allows the treatment to happen in New Hampshire now until the pilot program has taken effect and the maintenance can only be offered by entities that are currently, as of the beginning of this year, offering detox services. So these are entities that know how to do it and are doing it without problems and it doesn't open the door to a whole bunch of new people coming in without any regulation. It says that those entities have to meet the National Accreditation Standards and I feel very comfortable with that. I think this is something whose time has come. It's here and we should embrace it for the sake of all of our continuants and understand that people with substance abuse problems need an opportunity to have a treatment that works for them. This is an option that is very successful for some people.

So, thank you for listening and do try to remember when you're thinking about this bill that there's a medical issue and there's a political issue. I hope that we care more about the medical issue. Thank you.

Senator James W. Squires, D. 12: Any questions? Thank you Senator Wheeler. I see Representative Flora.

Representative Kathleen Flora, Hills. D. 15: Senator, I just wish to note that I am in support of the bill and don't wish to testify.

Senator James W. Squires, D. 12: Alright. Are any of the other sponsors here? Alright. Then you understand we're hearing testimony on both these bills. If you want to confine your remarks to just one that's certainly acceptable and you can come back again. The first name on 444 is Mr. Grasso.

Peter Grasso, Board of Pharmacy: Thank you Mr. Chairman and members of the Committee. My name is Peter Grasso and I'm the Chief Compliance Investigator for the NH Board of Pharmacy. I'm here today to speak on behalf of the Board in support of the bill as amended.

Currently, the healthcare facilities licensing which would normally license outpatient clinics their rules have expired and the methadone clinics and the methadone detox that we have no and the proposed methadone maintenance clinics have no state license in the State currently and therefore, there is no oversight involved. In part of the original bill that Senator Wheeler proposed indicated that the providers would be monitored by the Department of Health and Human Services during their clinic operations. We've proposed an amendment to the bill to create licensing terminology as a Limited Retail Drug Distributor's License.
Senator Katherine W. Wheeler, D. 21: Mr. Grasso can I interrupt? Does everybody have a copy of the amendment? We had 30 copies so they must have gotten stuck somewhere. It should 3543s. **See Attachment A.** Thank you very much. I'm so sorry to interrupt.

Mr. Grasso: Limited Retail drug Distributor License would bring the methadone clinic under the guide and jurisdiction and monitoring of the NH Board of Pharmacy. Currently there would be no fiscal impact. We would be adding one clinic to our usual and customary inspection procedures. The licensing category is very applicable to the methadone clinic and I would be more than happy to answer any questions that you may have relative to that amendment.

Senator James W. Squires, D. 12: Any questions? Mark.

Senator Mark Fernald, D. 11: The amendment says that people who are providing methadone detoxification services as of January 1 that just passed can continue as long as they meet certain criteria. How many were there? Do we know?

Mr. Grasso: We have 1 clinic that's probably operating now in the southern part of the state. They've been in operation now for probably 6 to 7 months and they

are primarily, and I'm sure that Dr. Potter or one of the other people will speak, but they're primarily methadone detoxification clinic and by federal law they are allowed to provide detoxification to people for a period of 180 days. After the 180 days arrives they have to either stop or they have to put them onto another drug. The purpose of the bill is to convert the methadone detox facility that's there now, to allow them to continue to provide maintenance to these clients that they have.

Senator Mark Fernald, D. 11: How long has that one place been ...

Mr. Grasso: I'm not really sure. I'm sure that the people from the Merrimack River Associates will speak to that issue.

Senator James W. Squires, D. 12: Senator Pignatelli.

Senator Debora B. Pignatelli, D. 13: This is a technical question. I don't know if you can answer it but you're on methadone detoxification therapy for 180 days and then how long do you need to be on methadone maintenance? Do you slowly taper off? You're not on methadone maintenance for the rest of your life, are you?

Mr. Grasso: I'm going to yield to more expert opinion on that question.

Senator James W. Squires, D. 12: Any other questions? Seeing none, thank you. Dr. Dalco.

Dr. John Dalco, NH Medical Society: Written testimony handed in. See Attachment B and C.

Senator James W. Squires, D. 12: What's the nature of your TB Screening?

Dr. Dalco: We do PTB which is sub-containious (sic) tests and people who have tuberculosis will react to the protein and then they are referred to their primary care physician. We kind of nag them all very much to have a primary care physician or it's arranged for them to attend one of the free clinics the Hudson Nashua area.

Senator James W. Squires, D. 12: So you're not treating them based on a positive PTB?

Dr. Dalco: No. We refer them out and then we check very carefully that they have kept the appointments that we have arranged for them.
Senator Katherine W. Wheeler, D. 21: Can I ask a question? Thank you. Dr. Dalco, since you are working with this now, I was reading in a report from

Vermont because I know that Vermont is dealing with this issue also, that they have not found methadone clinics to attract other drugs users and that methadone itself is rarely diverted into illegal uses. I wondered if you had or if somebody else testifying had any lean on about that? I know that that's a concern that many people raise.

Dr. Dalco: Well, I don't have any data for you but the methadone is administered as a liquid and you stand right at the counter and drink it with one of the nurses administering the methadone. It's not distributed in pill form so that you can gum it or stick it under your tongue or stick it in your cheek and walk out with it. It's kind of hard to walk out with a mouth full of methadone. It's also kind of hard to sell it second hand on the street. Most of the methadone that's being sold in the street is in pill form. So that's coming from some place else either people are using it for chronic pain or distributing it some other way. I don't think any off the street methadone is coming – it's certainly not coming out of our clinic at the present time. I don't think it's coming out of any of the other clinics either.

Senator Katherine W. Wheeler, D. 21: Just one follow-up question. I'm glad you mentioned the chronic pain because it is my understanding that we allow it in our state to be used for chronic pain.

Dr. Dalco: Yes. It's all how you word it.

Senator Katherine W. Wheeler, D. 21: Thank you.

Senator James W. Squires, D. 12: Thank you. Dr. Tuttle.

Dr. Georgie Tuttle, NH Medical Society: I'm Georgia Tuttle and the immediate past-President of the NH Medical Society. I'll start off by saying that when Senator Wheeler first brought these bills forward and I started to work with our Pain Management Group at the Medical Society, I probably had some of the same prejudices that Senator Wheeler mentioned. I didn't really know anything about methadone maintenance. What I've learned in the process of this legislative effort on her part is a lot about the concepts of methadone and how they work and I've done a fair amount of reading so that I hope that those who might be sitting here are feeling that this is not a good idea will step back and take a long hard look at our attitudes about drug abusers and really work hard to get this legislation pass.
The thing that impressed me the most as we talked (inaudible) some of this issue, what I've learned is about 400 people in New Hampshire travel out of state every day to get their methadone maintenance and I sat back and looked at my own life and tried to see if I could take 2 hours out of my life now and

continue to work at the level that I do and go to get methadone maintenance. The answer to that question was absolutely not.

I think that we're asking individuals who have a medical condition to go to extreme lengths to treat themselves and I hope that as we work through this process we'll understand and look at our own lives and realize that it is impossible for somebody to drive 2 hours, get medication and continue to work and be productive.

So I would just speak in favor of this legislation and support Senator Wheeler's efforts. Thank you.

Senator James W. Squires, D. 12: Any questions? Mark.

Senator Mark Fernald, D. 11: My question which maybe our Chairman can answer but line 16 of the amendment talks about "legend" drugs. I'm just curious about what that means. Do you have the amendment?

Dr. Tuttle: Yes I do. I don't that is.

Dr. Dalco: Legend drugs is a prescription drug. The legend they talk about is that on the label of the bottle it says *Caution: Something is wrong with drug. There are no prescriptions.*

Senator Mark Fernald, D. 11: Thank you.

Senator James W. Squires, D. 12: Dr. Charlesworth has signed up to speak on 445 but not 444.

Dr. Charlesworth, NH Medical Society: I'm here to support both bills. Thank you.

Senator James W. Squires, D. 12: Would you like to speak?

Dr. Charlesworth: No.

Senator James W. Squires, D. 12: Alright. Palmer Jones. (turn over tape)

Palmer Jones, NH Medical Society: ....with methadone. There are some people who will be on methadone the rest of their life. There are some that won't be. I think that's the only thing – I don't think I can add anything to what Dr. Dalco or Dr. Tuttle said but many of them will be for a long time and you cannot ....about that.

Senator Mark Fernald, D. 11: Is there a way or a methodology to wean people off the methadone or?

Dr. Dalco: They can be detoxed. It's pretty much at the discretion of the patient. They can make the decision so that their life is sufficiently stable to stay on the methadone or if they want to be detoxed after they have been stable for a year and they can be slowly detoxed in very small increments which has a much greater chance of success. So, at a great extent, it's the patient's decision as to whether they want to continue with this. It causes them no harm to be on methadone but it's a little inconvenient. They no have cognitive deficits. They can fly airplanes. If you look there are 6 physicians – there are none in New England, rest assured. (laughter) There are 6 of them in New York City who are practicing medicine while using methadone. No cognitive, no motor difficulties. You can drive a car or .....

Senator James W. Squires, D. 12: Thank you. Dr. Kassels.

Dr. Steven Kassels, Merrimack River Medical Services: I would like to thank the Committee for giving me the opportunity to speak. Before I go into my somewhat prepared presentation, I'd just like to talk about an issue that was brought up and that's the whole issue of the physiology of heroin and opioids. If we can think about it in a very simplistic sense that we all have receptors in our brain that respond to our (door closing) or internal opiates called endorphins. No different than a person for example who has an endocrinology disease in which they – from a person who makes their own indoginance steroids and we give them an external drug similar to the steroid and it turns off their external mechanism to produce that drug and I'm sure people have heard about that. Asthmatics for example are given steroids and then they're tried to be taken off the steroids and their own adrenal glands do not produce the steroids and then they have to be on the steroids for a long period of time and are slowly weaned off of it until their own body mechanism readjusts. Sometimes they cannot be fully weaned off of it.

We think of heroin as the same type of situation in which the use of heroin is flooding our receptors in our brains to such the extent as Dr. Dalco eloquently put that there's a neuro-chemical mechanical change in the brain so that now when you take the heroin away, the internal endorphins have been repressed, there's been a receptor resetting in the brain and in fact these people are in withdrawal.

So I would just like to clarify that and so what methadone does is it replaces not the heroin per say but replaces what our internal endorphins would be doing for us and therefore it's a stabilizing drug not a destabilizing drug like heroin. I hope that clarifies some of the issues.

I am Steven Kassels and I am one of the physician owners of the treatment facility in Hudson, New Hampshire. I feel my goal today is to help to reinforce the need to expand addiction medicine services in New Hampshire and to explain how we as an organization can assist in meeting the need. We feel that a lot of the people who went ahead of me, Dr. Dalco and Senator Wheeler, discussed a lot of the issues that I was going to discuss and I don't want to belabor those points.

For the record I'd just like to give my personal credentials. I believe in a packet given to you, **See Attachment D**, you have them but in summary I am residency trained and board certified in emergency medicine. I am certified by the American Society of Addiction Medicine. I've held positions including Chief of the Department of Emergency Medicine and also I have been the Medical Director for a not-for-profit hospital owned inpatient and outpatient adult and adolescent substance abuse treatment program which included the treatment of opiate dependency with methadone detoxification and methadone maintenance for both adolescents and adults.

I presently serve as one of two experts medical consultants for CARF which is an organization which was designated by the Center for Substance Abuse Treatment, Federal Agency in Washington, to accredit outpatient treatment facilities across the Country. I won't belabor you with other personal information.

On a personal level and a personal statement, I must admit that my personal involvement in addiction medicine came long before I ever realized that I was involved in it and that was when I was in fulltime practice in Emergency Medicine.

It took me a while to grasp and I had some of the same biases of a lot of the people that have spoken to you today. Here's another druggie in the emergency room just wanting their pills, feigning pain or whatever.

It didn't take me that long to realize that more than 50% in some areas of all emergency department visits are related to drug or alcohol use whether it be domestic violence, psychiatric manifestations, severe trauma, medical emergencies, cardiac problems, respiratory disease, etc. So my passion is to provide care to these individuals and these families and my passion runs deep for this.

Separate from the medical and my own personal passion issues, if we looked at this on a pure economic basis it makes sense because there's a marked cost of not treating these patients. Not just from a medical issue but from the point of

view of a treatment in a therapeutic community, a halfway house, costs twice what it costs to maintain one person in methadone treatment with physical exams, laboratories and counseling each year. It's certainly much less expensive than incarceration and the averages of AIDS, Hepatitis C and etc. don't need to be discussed any further. I think Dr. Dalco did a fine job of that.

I cannot overemphasize the importance of ensuring quality care by all entities who provide this service just as all entities or groups who provide any medical services and therefore, I do recommend strongly that New Hampshire adopt the CARF accreditation standards as standards to be the basis of oversight but I feel as well that any state regulatory oversight and or academic research evaluative process that you feel important would certainly be personally and organizationally welcome.

I do support, strongly, the Board of Pharmacy's amendment, the state regulatory oversight on a state level. I do strongly believe that we to allow all currently licensed methadone treatment clinics to participate in the expansion of services and I know that that's a very self-serving comment but I think we do a good job and I think we're a strong organization and I would encourage any of you to please come and visit us. I think you'll find us to be just like you would find an average physician's office.

So I support the ability to maintain our current patients who are given treatment and also to encourage those who are traveling great distances and unable to be employed because of it to be allowed to have methadone maintenance treatment in the state of New Hampshire. I believe that CARF standards apply with state regulatory oversight would provide the consumer, in this case the patient, with protection that's needed.

We are intimately concerned with the delivery and improvement of addiction medical care and to the patients whose needs we are discussing today. Our organization, Merrimack River Medical Services also called Community Substance Abuse Centers, voluntarily without compensation has and continues to participate with many institutions or Higher Learning and Research and Education Center. We have had ongoing relationships through research with the University of Connecticut Medical Center. We are entering into an agreement for research with the Brown University School of Medicine. We have had and continue to have relationships with Smith College and Burndust University at a presented seminar to residents at the Dartmouth-Hitchcock Medical Center.

Our position with CARF Consultants is performed without compensation and so I wanted to make that clear that I was not trying to drum up business for myself by recommending that CARF be the oversight board. What I'm really trying to

convey is our longstanding commitment to the advancement of quality addiction medical services.

So in closing, I would like to address two final comments. In making the decision regarding the expanding treatment options to patients in New Hampshire I hope it's understood that opiate dependency all be it is a somewhat of a self-inflicted disease but it is no different than other diseases such as alcoholism, nicotine dependency plus certain types of lung disease, cardiac disease or liver disease or diabetes in which they are also self-inflicted to some degree.

We know that there are patients who have cardiac disease and they continue to go home and eat bags of potato chips and then keep coming back into the hospital with congestive heart failure, intensive care unit our cost level and we don't refuse them their ability to be treated appropriately just because they have not complied with treatment. I think that if we apply those same sorts of directives towards people with addictive diseases it would be helpful.

Methadone is an oral medication. It's a stabilizing medication. LAAM is a drug as well and I know people who are interested in LAAM, which is called levo alpha acetyl methadol, which is a drug similar to methadone. It is long acting. It works as a maintenance medication or a long-term medication in many but does not work in all. One of its limitations is that people with underlying liver disease may not tolerate the drug well and some people do not respond to that particular drug well.

So I'm really here to say that people with addictive diseases as people with all diseases need to have all the appropriate medications available to them to treat them from the medical point of view.

I'd like to just draw an analogy with hypertensive medications and I think this will address some of the issues as was asked about the length of treatment for methadone. We know that people with hypertensive diseases, my mother for example, would need her medication during the winter time but during the summer time she would not need her hypertensive medications because of her loss of salt during the summer months and during the winter months being indoors she would become more sedentary and wouldn't change her lifestyle appropriately.

There are other patients who need blood pressure medications on an ongoing basis and there are patients who need blood pressure medications for a short period of time until they have gone through the lifestyle changes that would enable them to live without their medications.

I would like to bring up the analogy that treatment of the heroin addict is no different, that there are some people who can be detoxed by methadone in a very short period of time and there are people who need it for life and there are those people with appropriate lifestyle changes and a resetting of the bio-chemical changes that have occurred inside their body and you can't predict up front who will be able to accommodate those changes or not, will only need methadone for a limited period of time. Certainly more than 6 months but maybe not for the rest of their lives.

So in summary, we do not place legislative time limits on length of treatment for other illnesses. Methadone maintenance is essential and proven treatment option. I refer you to, I believe all of you have a blue NIH book and specifically on pages 16, 17 and 24 it speaks to the issue and the ethicacy better than I can in a short period of time.

Opiate dependency patients need to have all treatment mortalities provided to them and the notion that by treating with methadone we are feeding a habit with another drug is just not correct as I've discussed. I would love to have the opportunity, if time allows, to answer any other questions you may have.

As a physician owner I just wanted to let people know who worry about this and we are in touch every day with the care of our patients. Dr. Dayno or I who function as Co-Medical Directors are on beeper 24 hours a day, 365 days a year.

Just before coming to this hearing today I was in Hudson, New Hampshire and saw a patient who wished to be admitted today. The 46 year old gentleman who had 3 years of college education, was working as an apprenticeship farmer and on the weekends was an (cough) medical care who was doing phlebotomy, drawing blood on pother patients as a part-time worker. This gentleman of 46 years has a 20-year history of opiate dependency. He had never been on methadone treatment. He has tried to kick the habit himself. He wishes to try and detoxify over a very short period of time. I encourage him to do so with the understanding just as I would encourage a hypertensive to change their lifestyle and to see if we can't get them off their hypertensive medications in a short period of time, but would love to give him the option of being able to continue his own chosen treatment if in fact he is unable to wean himself off methadone in a short period of time.

Norma Reppucci who is a registered nurse and our clinical coordinator who is also going to testify I think will be able to put a face on many of the patients we treat.

Because Norma won't tell you this I would like to. Norma was a recipient of the Dole–Nyswander Award given by the National Treatment Association in

recognition of advancement and commitment to the treatment of opiate dependentations. (sic) I think Norma is truly a representative of our organization and the type of care that we give.

Thank you very much for the opportunity to testify here today.

Senator James W. Squires, D. 12: Any questions? Senator Pignatelli.

Senator Debora B. Pignatelli, D. 13: Thank you Mr. Chairman. Where are you located in Hudson?

Dr. Kassels: The exact address is 323 Derry Road.

Senator Debora B. Pignatelli, D. 13: I just have one more question. As someone who has been waiting and hoping for that endorphin kick in after exercising, unsuccessfully I might add, I just want to ask a question about how this works. It's my understanding that people that are taking heroin get some kind of a feeling from taking heroin. Then they become addicted but they still get that feeling. Then when you replace, and I may not be right about this, but when you replace the heroin with methadone they don't have the addiction from heroin anymore but don't they still miss that feeling?

Dr. Kassels: There's – if you look at addiction in general not just heroin you need to think of it as a bio-psycho-social disease. It has a biological component. It has a psychological component and it has a social component. If I can divert just for a second, I went to a lecture once where they said if there are 100 cocaine addicts in this room and none of them had used cocaine for 3 years and I put a line of cocaine on this table, 20 people would die because the 80 people would trample them trying to get to the one line of cocaine. That's the psychological social context of the disease. Heroin gives you – it's a short acting drug which gives you an euphoric affect. Methadone is a long acting stabilizing drug. Because it's long acting, it's ...life is 24 to 36 hours not 1 to 3 hours. It doesn't not give you an euphoric affect. So what it does is it replaces the chemicals in a very simplistic way in the receptors in your brain and by doing so takes away the withdrawal symptoms of sweating, abdominal cramps, nausea, diarrhea, fast heart rate, etc. It does not make you high. It can make you sleepy if not given in the appropriate doses. That's why we see our patients on a daily basis to monitor this.

So I hope that answers your question.

Senator Debora B. Pignatelli, D. 13: I just have one short follow-up question. So if you're not getting high but you don't have the addiction is there a likelihood

that you might take the methadone treatment but also supplement it with a small dose of heroin?

Dr. Kassels: Absolutely. You may supplement it with many other drugs. The nice thing about methadone is it bonds to the same receptors that heroin bonds to and therefore it has a blocking effect on the heroin high. What you will find is that people will initially attempt to use heroin on top of their methadone to get high and they soon find out that in fact they can't get the high. So they do one of two things: They drop out of treatment and they go back to shot their heroin or they come to us and say "Man I've been trying to get high and I still can't get high". We say, "then it's about time to start dealing with the real issues here on why you want to get high." That's where the counseling component jumps in. Then we're treating like any other psychological disease and need for ongoing counseling which again can take more than 6 months to achieve.

I hope that answers your question.

Senator Debora B. Pignatelli, D. 13: It does. Thank you.

Senator Mark Fernald, D. 11: Two quick questions that are rolled together. The first question is whether your facility is licensed by the state or federal (cell phone ringing) and the second question is, is there something in state law that would actually prevent your facility from being New Hampshire except for the fact that you're a federal (cell phone still ringing)?

Dr. Kassels: I don't know if there's anything prohibiting me. I'm licensed to practice medicine in New Hampshire. It's a service that's under the rules and regulations of the state of New Hampshire as an allowed service. So I don't know – we are federally licensed. As far as a state license, I think Mr. Grasso discussed the issue of the fact that we would encourage there to be a licensing body and on oversight body. Specifically the Board of Pharmacy I think would be an excellent choice and that's not uncommon to have that. I know that's one of the mechanisms in the state of Connecticut that they get the Board of Pharmacy involved.

As far as answering any of the specific questions, if I could turn to people who are more administratively involved than I am, they might be able to better answer that. Would it be all right if I solicited an opinion?

Senator James W. Squires, D. 12: Certainly.

Senator Mark Fernald, D. 11: Maybe I should ask a more direct question. I think I understand – that right now in New Hampshire you can do – it is permitted to do methadone detoxification but not methadone maintenance.

Dr. Kassels: Correct.

Senator Mark Fernald, D. 11: We've got a bill here that affirmatively states that people can do maintenance. I guess what I'm trying to figure out – what is the portion of New Hampshire statute that prohibits methadone maintenance now? Whatever that law is we don't seem to be amending it or changing it. I'm just trying to figure out how we get to the place where we want to be.

Dr. Kassels: It's my understanding that by law you cannot give methadone for greater than a 6 month period at a time.

Senator Mark Fernald, D. 11: Is that New Hampshire law?

Dr. Kassels: Yes. That's New Hampshire law and I believe Dr. Squires – there are only 6 other states maybe 7 who do not allow methadone maintenance. The exception in New Hampshire is for the pregnant patient who has to be detoxed 6 months or thereafter delivery. It can be kept on through the duration of the pregnancy or the 9 months.

Senator James W. Squires, D. 12: Thank you. Norma Reppucci.

Norma Reppucci, Merrimack River Medical Services: My name is Norma Reppucci. I'm a registered nurse. I've been a nurse for almost 29 years and I've worked primary in psychiatry and substance abuse treatment.

You've heard a lot of information today. I would like to just briefly tell you a little bit about our patients and try to personalize the issue. Many of our patients – I've spoken to them about coming to this meeting. Some of their family members wrote letters that I would like to submit today, **See Attachment E and F**, but I think I'd like to start with just reading a brief section of one of the letters from one of the mothers of our patients.

> *"My son was to the point of losing his job because he couldn't keep his mind on work. When we first brought him there he was going through bad times, with the help of the people at the clinic and the clinic itself has done a lot of good for him and a lot of others that go there."*

I think that one of the nice things about this job especially being a nurse is that you really do see patients get better. I think that they get better in their own way. Some people think that people shouldn't use any drugs at all and not use any methadone at all to be better but there are some patients that can't do that

and they need assistance. They need assistance with medication and they need assistance psychiatrically or socially. As Dr. Kassels said it's a bio-psycho-social disease and we address their medical issues first by stabilizing them on medication that will then help them not have to not go to work, create havoc in their lives, not be responsible people to their families.

When someone is stabilized then you can begin the route of treatment of dealing with why they're using, what they do in their life to put in place of using. All the things that go along with rehabilitating your life. Some people catch on very quickly and do very well and can detox and leave with support and do very well. Other patients need a longer-term use. A lot of our patients are short-term users. They're young people. They have jobs. They're in college and we work to get them back into the community as quickly as possible. A lot of our patients are long-term users. As Dr. Kassels stated this morning, a 28 day use sometimes takes a little bit longer to work with and to rethink your life and also put in positive things in your life that you haven't had that you need work on.

Eighty percent of our patients currently work. Many of them change jobs immediately after starting treatment.

We also try to – when we get into a community one of the first things we do is try to collaborate with other programs. Most of our referrals (change tapes) at least two to five times a week I get phone calls from a patient or a potential patient or their family member saying they've heard there's a clinic. Are you the clinic? A lot of these patients right now are going to programs in Massachusetts or in Maine. A lot of them keep in touch with me on a weekly basis to find out when methadone maintenance will be available because they're stable and they're on maintenance now and they don't want to go and transfer closer to their homes because they do not want to detox. They're not ready to detox, their lives are stable and they want to be able to detox when they feel ready to.

A case in point is a phone call I had Friday from a gentleman who lives in New Hampshire. His son lives with him in Pelham. His son travels to a clinic in Lowell. They live in Pelham. He drives to Lowell everyday, then turns around and drives all the way to Manchester to his job. He asked me about the clinic and he's going to keep in touch with me. Once his son can transfer so that he doesn't have to drive the hours that he's driving.

I could tell you story after story but I'd like to just close with a line from another letter from another patient's mother:

> *"He has been attending the methadone clinic in Hudson, New Hampshire since October 1999. For the first time I feel there is hope."*

Thank you for having us here today and I am in support of methadone maintenance treatment in New Hampshire.

Senator James W. Squires, D. 12: That completes the list of speakers. We have some time pressures here. We haven't heard anybody against it. Yes?

Tim Hartnett, Department of Health and Human Services: May I speak?

Senator James W. Squires, D. 12: Certainly.

Mr. Hartnett: My name is Tim Hartnett. Good afternoon Mr. Chairman, Committee members. I'm the state's new Director for the Division of Alcohol and Drug Abuse Prevention and Recovery. I'm here today to respond to both Senate Bill 444 and 445. Although I think I'm listed on your sheet as a speaker in opposition, I'm really not here in opposition but simply to inform.

Since the mid-1980's our nation has experienced a rise in heroin and other opiates. Unfortunately New Hampshire has not been fortunate enough to avoid this national trend. Reports from our state's hospital emergency rooms and our treatment providers indicate a steady rise in heroin use across all geographic areas of the state and all demographic categories. Heroin abuse is clearly a problem and it has never gone away and is now worsening.

For several decades the use of methadone detoxification and maintenance has proven effective in the treatment of opiate dependency. In fact New Hampshire is one of only 6 or 7 states, and by the way I can't really find out whether it's 6, 7, or 8 and I want you to know I've read stuff that said 7 but it's somewhere of a fairly low number – that still prohibit the use of methadone maintenance for non-pregnant addicts. The expansion of methadone treatments to include methadone maintenance represents a significant policyship in New Hampshire. Present New Hampshire law expressly forbids practice of methadone maintenance but no meaningful state regulations in place to ensure adequate standard of practice.

Senate Bill 444 relies on the standards of the Commission of the Accreditation of Rehab Facilities or CARF as they were referred to earlier, as a short term substitute for state regulatory structure. I would just want to inform this Committee that in my view these standards are a poor substitute for adequate regulation. They are best understood simply as guidelines. As guidelines they lack the vigor I believe would be present in New Hampshire regulatory structure. For example, CARF standards require programs to have a licensed physician, nurse or pharmacist and primary counselor but fail to identify any staff to client

ratios. The standards require individual, group and family counseling but fail to define frequency, duration or purpose of these activities.

CARF standards fail to address a procedure to ensure that clients are not enrolled in multiple programs. CARF standards fail to acquire monthly or bimonthly urine screenings. They simply require that a urine testing procedure be in place. CARF requires individualize treatment plans but again fails to provide a meaningful structure for these plans. In my view these services would essentially be provided in a regulatory vacuum.

Over the past 30 years a great deal has been learned about the characteristics of a successful methadone treatment program. Methadone maintenance requires a regulatory structure that includes comprehensive assessment, vocational referral and training, routine structured counseling, enhanced linkage with medical, behavioral health and other substance abuse treatment services, routine and comprehensive urine screening, a state-wide client tracking system and state board of pharmacy oversight.

I would like to just for a moment talk a little bit about Senate Bill 445. As a new director I would like you to know that I've begun to rethink the necessity of a pilot program. Over 42 states, as we've mentioned, have comprehensive methadone maintenance programs. We're in the process of gathering regulations from these states and it's my view that with some consultation the collective wisdom of all these other states might not make it necessary for us to go through the lengthy pilot program proposal. I'd like the opportunity to work with this committee to work a little further to examine what kinds of legislative alternatives may be possible short of a pilot.

In short I would want you to know that I am in full support of methadone maintenance but like a lot of this stuff the devil is in the details and we really need to take a closer look at this stuff.

Senator James W. Squires, D. 12: Senator Fernald.

Senator Mark Fernald, D. 11: Thank you. Do you what the RSA is that prevents methadone maintenance?

Mr. Hartnett: You know I was quickly trying to hustle over there when you asked –

Dr. Dalco: It's under 318-B.

Senator Mark Fernald, D. 11: It is under 318-B?

Dr. Kassels: It's a one line under 318-B.

Senator Caroline McCarley, D. 6: Just a clarification question in terms of your point of view on 444 in which you said with some increased standards or oversight or whatever you would be prepared in this point in time to consider the state going ahead with a methadone maintenance treatment clinic without the need of a necessary pilot program?

Mr. Hartnett: Right.

Senator Caroline McCarley, D. 6: Thank you.

Senator James W. Squires, D. 12: These bills have been heavily docketed as they were since January and we have two weeks to go which if they are not successful they would have wait another year. Do you think you could advice the Committee and sponsors as to have it improved? If there are 42 states out there with programs, there must be some model for regulations, some way language can be appropriated here. There's just some practical issues here. We have to get this bill, in some way, to the Senate Floor in three weeks. So what can you do you help us accomplish that?

Mr. Hartnett: The only thing I can assure you today is that it's at the top of my list to try and find some alternative to the pilot program.

Senator James W. Squires, D. 12: Okay. The practical problem with that is that we would bring essentially a completely different bill without public debate, without a public hearing. What do you think?

Senator Debora B. Pignatelli, D. 13: As another alternative we could pass it and then in the House where there's been a lot more time for the bill and they seem to have a lot more time than we always do to deal with the devil over there.

Senator James W. Squires, D. 12: What do you think about that?

Mr. Hartnett: I say let's give it a try.

Senator James W. Squires, D. 12: A try to write a new bill or to get it done in the House?

Mr. Hartnett: Probably pass this one and see if we can't fix it in the House.

Senator James W. Squires, D. 12: Yes. I think that makes sense. Other than the devil being in the details the devil's also in trying to rush things. Send them both. Okay. Thank you. Anybody else wishing to speak? Yes.

Dr. Kassels: I have already testified but may I just make a comment about what Mr. Hartnett said? I would support what Tim said about the CARF guidelines and standards need to be or could be more specific. It is the intent certainly of the survey when they come into the site to evaluate whether the patients are getting and this is the key, individualized treatment. Certainly a person who has been on methadone for 6 years readily employed doesn't need weekly urines. The person new in treatment may need urines twice a week. So, I support the concerns that Tim has but on the other hand I would say that CARF has really taken over for the FDA and the FDA has very strict regulations which a lot of the states have adopted. Some have made them more stringent some a little less as far as how many times you need to give urines etc. etc.

I'd also like to say I think the issue about counseling to patient ratios is an important one and I think some of these issues could easily be addressed. Thank you.

Senator James W. Squires, D. 12: Thank you. Yes ma'am?

Alice Deloria: I haven't spoken but I was wondering if I could have a chance to? My name is Alice Deloria and I'm here to represent the New England Chapter for the National Alliance Methadone Advocates.

I am working in Vermont right now and I've brought a copy of the report. We're in the same process in Vermont that you are in New Hampshire. We had a summer study committee which has now put out a report and doing the same things that we're going here.

Because I work with the National Alliance Methadone Advocates I speak to a lot of people that are from New Hampshire that are in need of methadone treatment. As you've probably heard many people testified there are people going out of state to get methadone treatment and what we'd like to see obviously is that treatment be accessible to anybody who needs it and who is an opiate addict.

I believe that the clinics as far as having good clinics – I think it's an excellent idea. I think that you should keep open to the idea of also considering a rural model which is set up such as a system with a clinic without walls. What it would be was a physician prescribing, a pharmacy dosing.

What we did was we had ansulary services such as counseling, vocational rehab and mental health services that are available right in these communities. We had, over in Vermont, Bob Lubrun from the Center for Substance Abuse Treatment come up and testify and we had a number of people: Tom Pate from Texas testified. I also have a letter here form Dennis McCarthy who is the Police Chief in Greenfield as to the success at the Greenfield clinic and how it has not in anyway caused any problems in the Greenfield community. There was a lot of resistance at first and so far the Police Chief has said to us he was originally opposed. He is now very much an advocate for treatment.

I know this treatment works. I was a methadone patient myself. I'm now on chronic pain medication but I brought somebody here with me today who is also a member of NAMA and is also a patient in the Greenfield Clinic who I'd like to be able to have speak to you if possible.

Senator James W. Squires, D. 12: I'd be happy to do that but I'm trying to get this bill moved. You don't understand, nobody is objecting except for complaints and observations on the part of Health and Human Services.

Ms. Deloria: Well if nobody is objecting.

Senator James W. Squires, D. 12: I will close the hearing on Senate Bill 444 and Senate Bill 445 to go into executive session.

Hearing closed at 2:45 PM.

Respectfully submitted,

Merideth A. Chandler,
Committee Secretary

Speakers

SENATE PI-HHS COMMITTEE

Date 2/22/00 Time 2:00 PM Public Hearing on SB 445

Appearing in FAVOR: (Please print)			Please check box at left to speak.
Speaking?	Name	Address	Representing
☒ NO	Rebecca Rupe	Hillsboro	Self
☑	Jack D. Wakeman MD	Concord	NH Med Soc.
☑	Georgia Tuttle, MD	Lebanon, N.H.	N.H. Med. Soc.
☑	David C Chamberlain, MD	Bedford, N.H.	N.H. Med. Soc
☑	Palmer P. Jones	Concord, N.H.	N.H. Med. Soc.
☐	Monica Haley	Somersworth NH	N.E. Pain Consult Hants
☐	Tim Hartnett	Dept. HHS	
☑	Steven J. Kassels, MD	Hudson, NH	Merim. Riv. Med. Serv.
☐	Norma Repucci, RN	" "	" " " "
☐	Rep Patricia O'Kane	Rock 21	

Appearing in OPPOSITION: (Please Print)	Please check box at left to speak.
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Committee Report

Date: Febraury 22, 2000 Time: 1:30 PM

The Senate Committee on Public Institutions/Health Human Services held its hearing in Room 102, LOB, Concord, New Hampshire.

BILL NO.: SB 445-FN TITLE: establishing an opioid treatment pilot program.

Members of the Committee present:

Senator Squires
Senator Wheeler
Senator Fernald
Senator Gordon
Senator McCarley
Senator Pignatelli

Those appearing in favor:

Name and Address	Representing
See Attached.	

Those appearing in opposition:

Name and Address	Representing
See Attached.	

REPORT OF THE COMMITTEE:

- ☐ Ought to Pass
- ☒ Ought to Pass w/ Amendment
- ☐ Inexpedient to Legislate
- ☐ Rereferred
- ☐ Interim Study
- ☐ Continued Hearing
- ☐ Postponed Hearing

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: February 23, 2000

THE COMMITTEE ON Public Institutions/Health Human Services

to which was referred Senate Bill 445-FN

AN ACT establishing an opioid treatment pilot program.

VOTE: 5-0

2000-3582s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Katie Wheeler
For the Committee