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**Statement for Committee on Energy and Commerce
United States House of Representatives
October 8, 2015**

Recommendations on Increasing Access to Effective Treatment for Opioid Addiction from the American Association for the Treatment of Opioid Addiction (AATOD)

My name is Mark Parrino, and I am writing on behalf of the American Association for the Treatment of Opioid Dependence (AATOD), which represents 1,000 Opioid Treatment Programs throughout the United States, treating 340,000 patients on any given day. These are the treatment programs that treat opioid addiction under certification through the Substance Abuse and Mental Health Services Administration. All of these programs must comply with SAMHSA’s operating requirements, which were promulgated during 2001. All of the Opioid Treatment Programs (OTPs) must also comply with the Drug Enforcement Administration’s security requirements. Finally, all of the OTPs are regulated by the State Opioid Treatment Authorities, which have different, and at times more stringent, standards of regulation.

The Committee and its representatives understand that our country is experiencing a public health crisis of untreated opioid addiction. It is useful to reference a recent article on this topic, which was published in the New England Journal of Medicine on January 15, 2015, “Trends in Opioid Analgesic Use and Mortality in the United States”. Dr. Richard Dart is the lead author in this article, which made the following point: “Whatever the measure, the past few decades have been characterized by increasing use and diversion of prescription drugs, including opioid medications, in the United States. An estimated 25 million people initiated non-medical use of pain relievers between 2002 and 2011.”

As the Committee knows, there have been a number of national reports from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC), documenting the increase in the use of prescription opioids. SAMHSA has also documented the fact that 80% of new heroin addicted individuals report using prescription opioids as a gateway drug.

Need for Public Education

One of AATOD’s primary recommendations, which has been made to the representatives at the Department of Health and Human Services and other federal agencies which have jurisdiction in this area, is the need to provide a meaningful and clear public education campaign for Americans, underscoring the dangers of opioid abuse and addiction. There has been a loss of intergenerational knowledge given the fact that people do not understand how

they can get into trouble when abusing prescription opioids. Additionally, Americans need to understand that heroin use is not a safe alternative when they do not have access to prescription opioids. We recommend that the Department of Health and Human Services (HHS), in conjunction with its agencies, work with the White House Office of National Drug Control Policy in developing these clear messages to the American public. This would need to be a sustained campaign, since it took years for the American people to get to the current place of prescription and heroin abuse.

AATOD supports a number of the elements in Congressman Bucshon's legislation, especially in providing guidance to medical practitioners who work under the aegis of the Drug Abuse Treatment Act of 2000. Such practices need to provide greater education to their patients about the available medications to treat their illness.

Recommended Policy Initiatives

At the present time, 49 states have either enacted or implemented statewide Prescription Drug Monitoring Programs (PDMPs). These programs need to be utilized by physicians in general practice in addition to dentists and substance abuse treatment providers. It is understood that not all of these PDMPs are easy to use and should also be utilized by other clinical/administrative support personnel in a medical practitioner's office. Ultimately, medical practitioners must utilize these databases as a method of treating their patients with a greater margin of safety. Increasing such utilization of PDMPs will help in better treating individuals who are abusing opioids. However, it is part of a solution, not the only solution.

The Use of Medications to Treat Chronic Opioid Addiction

There are three federally approved medications to treat chronic opioid addiction in the United States: methadone, buprenorphine, and Vivitrol/Naltrexone. It is recommended that all three medications be used in conjunction with other clinical support services, including counseling. Methadone is primarily offered through OTPs, while buprenorphine is primarily offered through DATA 2000 practices. Injectable Naltrexone products may be used in any medical setting including OBOTs and OTPs.

The National Institutes on Drug Abuse (NIDA) has funded numerous studies in support of the use of these medications in treating chronic opioid addiction. There are guidelines for the use of such medications through the Treatment Improvement Protocol series, published by SAMHSA, in addition to recently released guidelines for the use of medications in treating opioid addiction through the American Society of Addiction Medicine. Physicians need to be trained in how such medications are used and when opioid addicted people would benefit from each of the three medications, as stated above.

Opioid Overdose Prevention Toolkits

AATOD agrees with the recommendations of ONDCP and HHS in increasing the utilization of opioid overdose prevention toolkits. We have already seen the benefits of widespread availability through emergency responders and police forces in different cities of the United States. The key recommendation is to ensure that individuals who receive such overdose prevention toolkits get access to emergency room care once they have been revived. The Vermont Hub and Spoke model provides even more support in how such treatment is coordinated once the individual is saved, brought to an emergency room, and then referred to treatment through the available resources.

Recommendations to Increase Access to Medication Assisted Treatment for Opioid Addiction

Congress passed the Drug Abuse Treatment Act of 2000 and subsequently amended it so that physicians who are DATA 2000 waived could treat up to 100 patients per practice. It is understood that a few congressional offices and HHS are considering how to increase access to such care under the aegis of DATA 2000. For the record, our Association has opposed the elimination of this patient limit as proposed by the TREAT Act.

- Before federal agencies and congressional offices proceed with recommendations to increase access to such treatment options, there needs to be a better understanding of what treatment is offered through DATA 2000 practices at the present time.
- If there is going to be any consideration in adjusting this patient number, there should be clear conditions placed on practices that wish to treat a greater number of patients. Illustratively, physicians should be offering counseling services and conducting toxicology profiles on patients to better guide success in treatment.
- Such practitioners also need to be accessing PDMP databases before and during the patient's care.
- The practitioner needs to assess the patient for their clinical needs, which may include counseling and other ancillary support services to treat co-morbidities such as infectious diseases (Hepatitis C) or psychiatric co-morbidity (depression, anxiety).
- Patient outcomes need to be followed as a method of better understanding the success of such treatment interventions. In this case, physicians need to be able to provide information about the length of time a patient remains in treatment and relapse rates.

Increasing Access to the Use of Medications in Opioid Treatment Programs

At the present time, SAMHSA has certified approximately 1,300 OTPs, which operate in 49 states. Approximately 350,000 patients are treated through these OTPs at any given point in time. AATOD has identified the lack of Medicaid reimbursement for OTP services as a major impediment in 17 states in this country. AATOD has also learned that utilization of such services increases by a factor of 25% when Medicaid reimbursement is available. Accordingly, AATOD is working with a number of policy partners to address this impediment.

If the experience of OTPs provides any guidance to Congress and this Committee in its deliberations, the following illustration provides an important reference. OTPs expanded quickly in the late 1960s without any operating requirements. Congress passed legislation that created a regulatory oversight structure for these OTPs in 1972. The House Select Committee on Narcotics Abuse and Control directed the United States General Accounting Office to develop a report on Methadone Maintenance Treatment. This report was published in March 1990 “Methadone Maintenance – Some Treatment Programs are Not Effective; Greater Federal Oversight Needed”. SAMHSA published its first Treatment Improvement Protocol in 1993 “State Methadone Treatment Guidelines” as a method of responding to the recommendations of the GAO report. The FDA asked the Institute of Medicine to evaluate the federal regulation of methadone treatment. The IOM released its findings in 1995, laying the foundation for the FDA to end its oversight of the OTPs and transition the oversight to SAMHSA. This was finalized in 2001. SAMHSA also published more detailed guidelines for OTPs in 2007 and these were revised during March 2015. The point in citing these references is to advise Congress that it took these interventions to improve the quality and practices of OTPs.

Conclusion

In summary, AATOD is pleased to work with members of Congress on the best methods of increasing access to treatment for opioid addiction and in educating America about the dangers of opioid abuse. This will take a sustained and coordinated effort so that federal policy and legislation need to be based on evidence and what is known to be effective. We have learned a great deal over the past 50 years of the most effective methods of treating opioid addiction. It is clear that our nation got into this problem in major part as a result of the improper and unsupervised prescribing of opioids for pain management. The way out is not to provide a different medication without appropriate supervision and the provision of essential services, which must be used in support of opioid addicted individuals. This explains our opposition to the element of the TREAT Act which completely eliminates the existing 100 patient restriction. Additionally, we are asking Congress to expand access to OTPs through Medicaid and Medicare to remove the existing impediments as stated above. We look forward to working with the House and other members of the legislature as these issues move forward.

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