



American Association for the Treatment of Opioid Dependence

## **AATOD's Response to ASAM's Public Policy Statement on Office-based Opioid Agonist Treatment (OBOT)**

*March 25, 2005*

AATOD is in agreement with many of the principles, which were contained in ASAM's OBOT public policy statement of July 27, 2004, but not all. It is understood that not all patients require access to the full array of services throughout their treatment experience. This was the focus of a CSAT TIP on the topic "Matching Treatment to Patient Needs in Opioid Substitution Therapy".<sup>1</sup>

We understand that the preponderance of research has repeatedly demonstrated that patients do better when served in an integrated treatment delivery system, combining approved pharmacotherapies to treat opioid addiction in addition to providing needed psychosocial services. This point was repeatedly made in NIDA's 1999 publication "Principles of Drug Addiction Treatment".<sup>2</sup>

AATOD also understands that there is a broader context in terms of federal oversight of the OTP system. OTP's have recently completed the first triennial accreditation review period, which began during May 2001 and concluded during May 2004. Meeting all of these accreditation standards has been extremely costly to individual programs within the treatment system and it is understood that meeting such heightened standards was a means of improving

the standard of care to patients across the United States.

It is understood that heroin addiction and addiction to prescription opioids is critically serious and an increasing problem in the United States. We need to better determine why the use of prescription opioids has increased so markedly over the course of the last several years, especially the prescription of methadone as an analgesic. According to independent sources, a greater number of people were prescribed methadone for chronic pain in the second quarter of 2004 (more than 275,000)<sup>3</sup> as compared to the number of patients currently treated for opioid addiction in accredited OTP's (approximately 215,000).

This matter was referenced in the February 2004 SAMHSA/CSAT publication with regard to Methadone Associated Mortality.<sup>4</sup> The report noted, "the greatest incremental growth in methadone distribution in recent years is associated with the use of the drug as an analgesic and its distribution through pharmacies rather than OTP's". The report also noted that "the data (DEA/FDA) confirmed a correlation between increased methadone distribution

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<sup>1</sup>Matching Treatment to Patient Needs in Opioid Substitution Therapy. Treatment Improvement Protocol (TIP) Washington D C: Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMSHA). October, 1995

<sup>2</sup>Principles of Drug Addiction Treatment A Research-Based Guide, NIDA, NIH, 1999

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<sup>3</sup> Vector One: Total Patient Tracker; Verispan, LLC, Yardley, PA 2004.

<sup>4</sup> Methadone-Associated Mortality: Report of a National Assessment, US Dept of Health and Human Services, SAMHSA, CSAT 2004

through pharmacy channels and the rise in methadone associated mortality". It would appear that physicians are prescribing methadone as an analgesic to an increasing number of patients without providing appropriate therapeutic safeguards. It also appears that pharmacies, which are involved in the distribution chain, are not adequately educating the patients with regard to the safe use of methadone as an analgesic.

AATOD is not criticizing the use of methadone as an analgesic to treat severe and chronic pain. We are concerned when physicians, who lack competence in identifying people with substance use disorders or the appropriate use of opioid medications in treating severe and chronic pain, use these medications.

The SAMHSA/CSAT Mortality Report was crucial in making a series of recommendations to reduce methadone related mortality. It was recommended that uniform definitions be established so that coroners and medical examiners will draw upon the same criteria for reporting on a methadone toxicity overdose. The report was equally clear in underscoring the need to have health professionals receive improved training in order to treat pain and addiction.

The ASAM statement also references states, which do not provide access to methadone treatment. AATOD has been acutely aware of this matter and has consistently brought this to the attention of all of the appropriate federal authorities and national professional associations. Mississippi is a state with the most documented track record in not providing methadone treatment to its own residents. It has been repeatedly documented over the years that at least 600 Mississippi residents cross the border to access care in other states.

AATOD has also been in support of the OBOT concept since 1998 when our organization's first guidelines were published on the topic. The following points underscore AATOD's primary concerns in considering ASAM's public policy statement on OBOT.

### **Safety**

AATOD is extremely concerned about the safe and effective use of opioid medications in treating severe and chronic pain and opioid addiction. AATOD's objections to the ASAM OBOT guidelines form along several different principles. Primarily, the ASAM statement does not appear to take the aforementioned considerations into account.

### **Training**

We still do not know how effective the 8-hour training programs have been with regard to providing adequate information with regard to the use of buprenorphine "Schedule III" medication to treat opioid dependence in the private practice settings. We know that more than 6,000 physicians<sup>5</sup> have been trained by the federally approved entities, however, less than half of these trained practitioners, have been actively prescribing the medication within their private practice settings. We also understand that buprenorphine is generally being used as a detoxification agent with limited treatment duration and not as a maintenance medication. We recognize that this is a slow process and hope for increasing interest on the part of an informed physician community.

The ASAM policy recommends that physicians receive 16 hours of additional training in order to be able to use methadone as an alternative to buprenorphine if the patients would benefit from that medication. What is the basis of this particular recommendation?

We question the ASAM training recommendation given the context of the increasing prescription of methadone as an analgesic and the increasing incidence of methadone associated mortality as a direct result of such prescribing practices. We still need additional information about the efficacy of the training as it relates to buprenorphine and treatment outcome.

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<sup>5</sup> CSAT communication

### **Continuum of Care**

The ASAM statement discusses continuum of care issues and indicates that the least restrictive environment is always appropriate to treat the nature and stage of the patient's illness. This is understood and makes implicit sense, especially after the patient has achieved continued stability in an OTP. The entire structure of the OTP's in the United States has been based on a balance of patient needs at different times within the treatment continuum.

The ASAM statement also discusses that OTP reimbursement levels should be more closely linked to levels of care provided. AATOD has encouraged this kind of reimbursement practice for many years and has come to recognize that most private and public insurers do not have the ability to implement such differentiated reimbursement models.

AATOD's longstanding OBOT statement underscores the value of giving the patients an option to leave the treatment program and enter a treatment setting with an affiliated physician to the OTP. It was also understood that there were certain medically underserved areas where this could not occur and other non OTP affiliated arrangements need to be created.

### **Need for Additional Research**

AATOD concurs with ASAM in recommending that treatment models be evaluated so that we can better understand how to increase access to OBOT using methadone.

### **The Unique Experiences of Other Nations**

The ASAM statement also made reference to other nations and their particular practices and policies in treating chronic opioid dependence with approved medications (buprenorphine/methadone). It is important to underscore that each country has its own cultural traditions and own regulatory apparatus. Each

country has its own method of paying for treatment services and there are interesting differences in how treatment is made available depending on a particular nation's governance.

Illustratively, Spain did not have a positive early experience with buprenorphine when it was offered only in injectable form. The central government in Spain increased access to methadone treatment from having 3,000 patients in methadone treatment in 1991 to more than 85,000 patients in 2004. Buprenorphine is not widely used by patients in Spain at the present time.<sup>6</sup>

On the other hand, France restricted the use of methadone to highly specialized treatment programs (15,000) and buprenorphine has been made widely available to more than 75,000 patients. France has an interesting situation with regard to the pricing of methadone and buprenorphine. It is the only country in the world where both products are similarly priced. There is one small company in France that manufactures methadone and this product is priced at a high level when compared to similar products in other nations. Buprenorphine appears to have the lowest pricing structure in France when compared to any other country.<sup>7</sup>

In summary, AATOD supports many of the principles, which were written into the ASAM statement on OBOT. Our concerns have been stated above. In setting rational and effective public policy, the experiences of the past must be taken into account in addition to knowing what is best for the patients. It is important to improve a treatment continuum but not to destabilize an established treatment system. It is also important to understand current trends as we try to effectively increase access to this valuable treatment system so that we will ensure that patients receive good quality care during their treatment experience.

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<sup>6</sup> Personal communications with Dr. Marta Torrens Hospital del mar, Barcelona, Spain

<sup>7</sup> Personal communications with Dr. Didier Touzeau, Clinique Liberte, Bagneux, France