Policy Landscape for Substance Use Treatment and Prevention

Social Workers on the Front Line of the Opioid Epidemic Learning Collaborative

Today's Presenters

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Agenda

- Snapshot: Current State of Substance Use in the US
- Snapshot: Policy Changes
- Substance Use Continuum of care
  - Early intervention
  - Harm Reduction
  - Treatment (MAT)
- Other Critical Areas of Knowledge Development

Mental Illness and Substance Use Disorders in America

PAST YEAR, 2018 NSDUH, 18+

Among those with a substance use disorder:
- **3 IN 8 (38.3% or 7.4M)** struggled with illicit drugs
- **3 IN 4 (74.5% or 14.4M)** struggled with alcohol use
- **1 IN 8 (12.9% or 2.5M)** struggled with illicit drugs and alcohol

Among those with a mental illness:
1 IN 4 (23.9% or 11.4M) had a serious mental illness

7.8% (19.3 MILLION) People aged 18 or older had a substance use disorder (SUD)

3.7% (9.2 MILLION) People 18+ had BOTH an SUD and a mental illness

19.1% (47.6 MILLION) People aged 18 or older had a mental illness

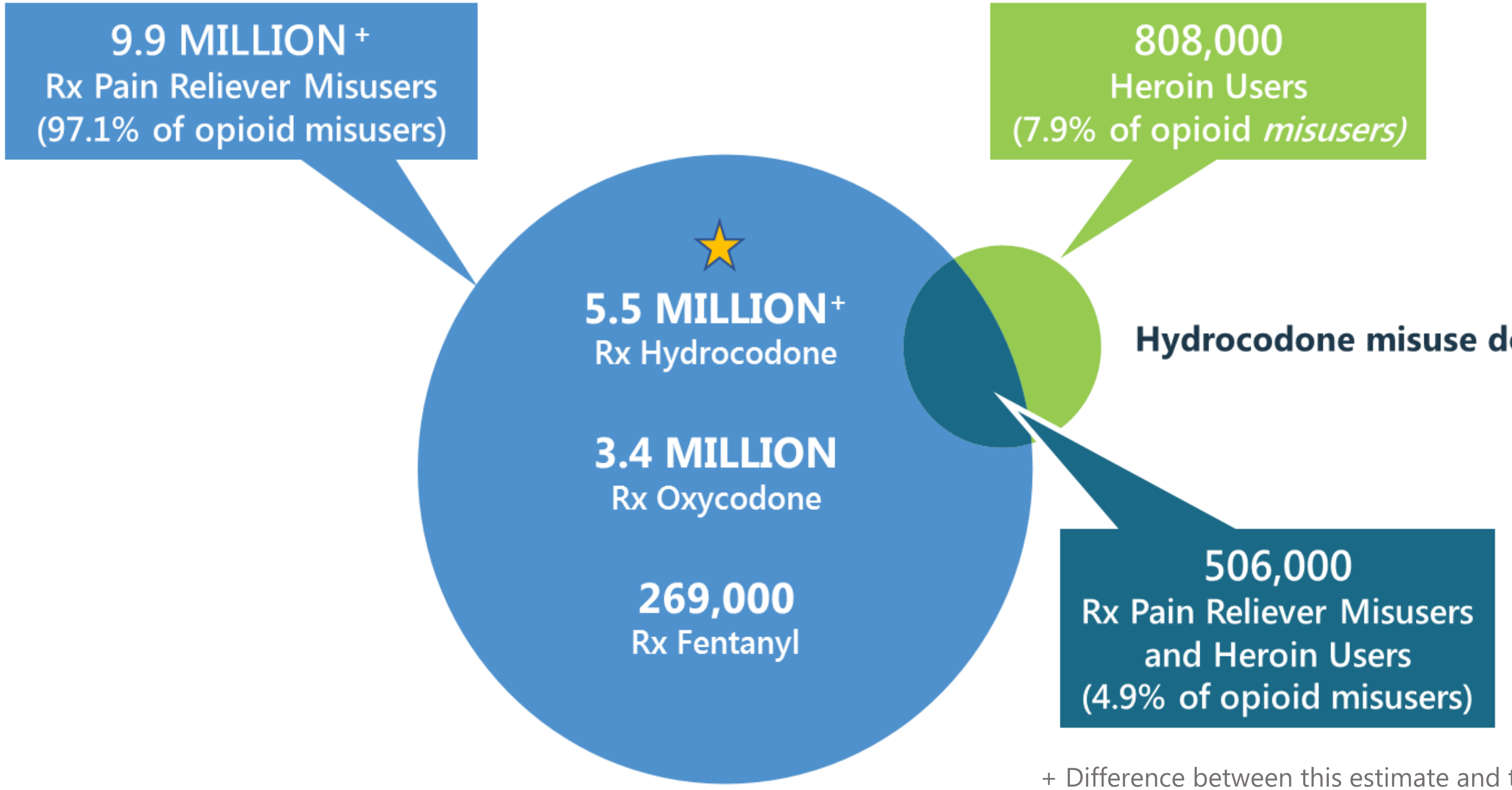
In 2018, **57.8M** Americans had a mental and/or substance use disorder.

Opioid and Prescription Pain Reliever Misuse

PAST YEAR, 2018 NSDUH, 12+

★ **Significant decrease from 11.4M opioid misusers in 2017**

10.3 MILLION PEOPLE WITH OPIOID MISUSE (3.7% OF TOTAL POPULATION)



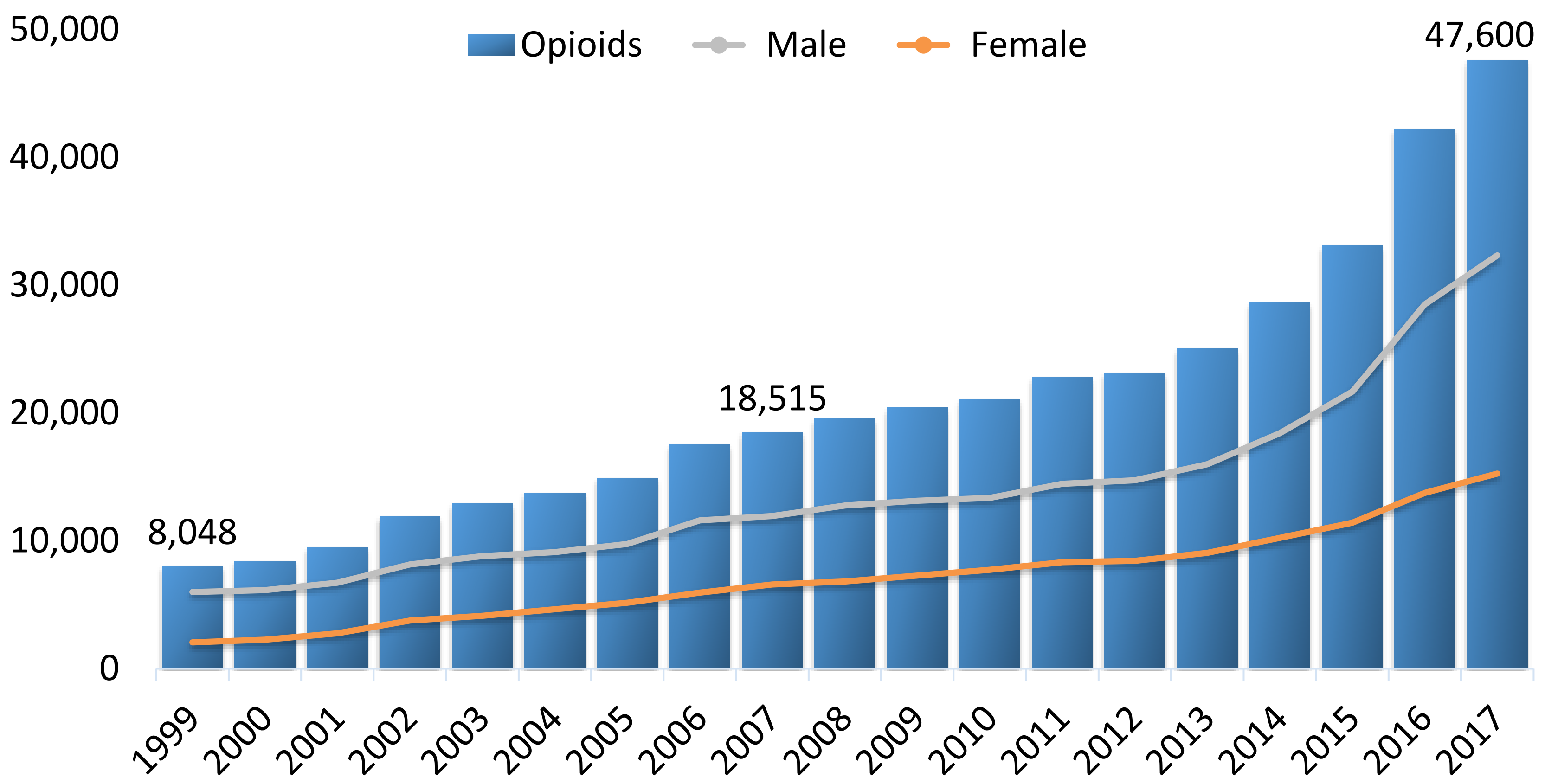
Hydrocodone misuse down from 6.3M in 2017

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Rx = prescription.

Opioid misuse is defined as heroin use or prescription pain reliever misuse.

Figure 3. National Drug Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2017



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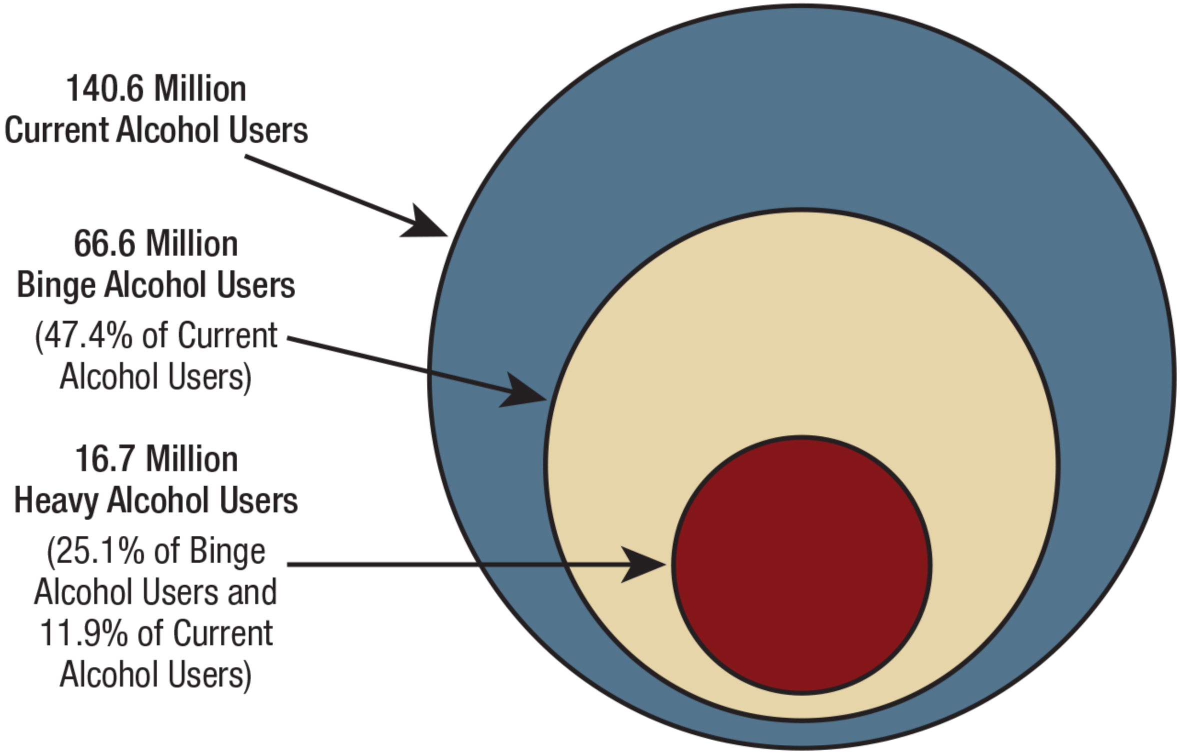
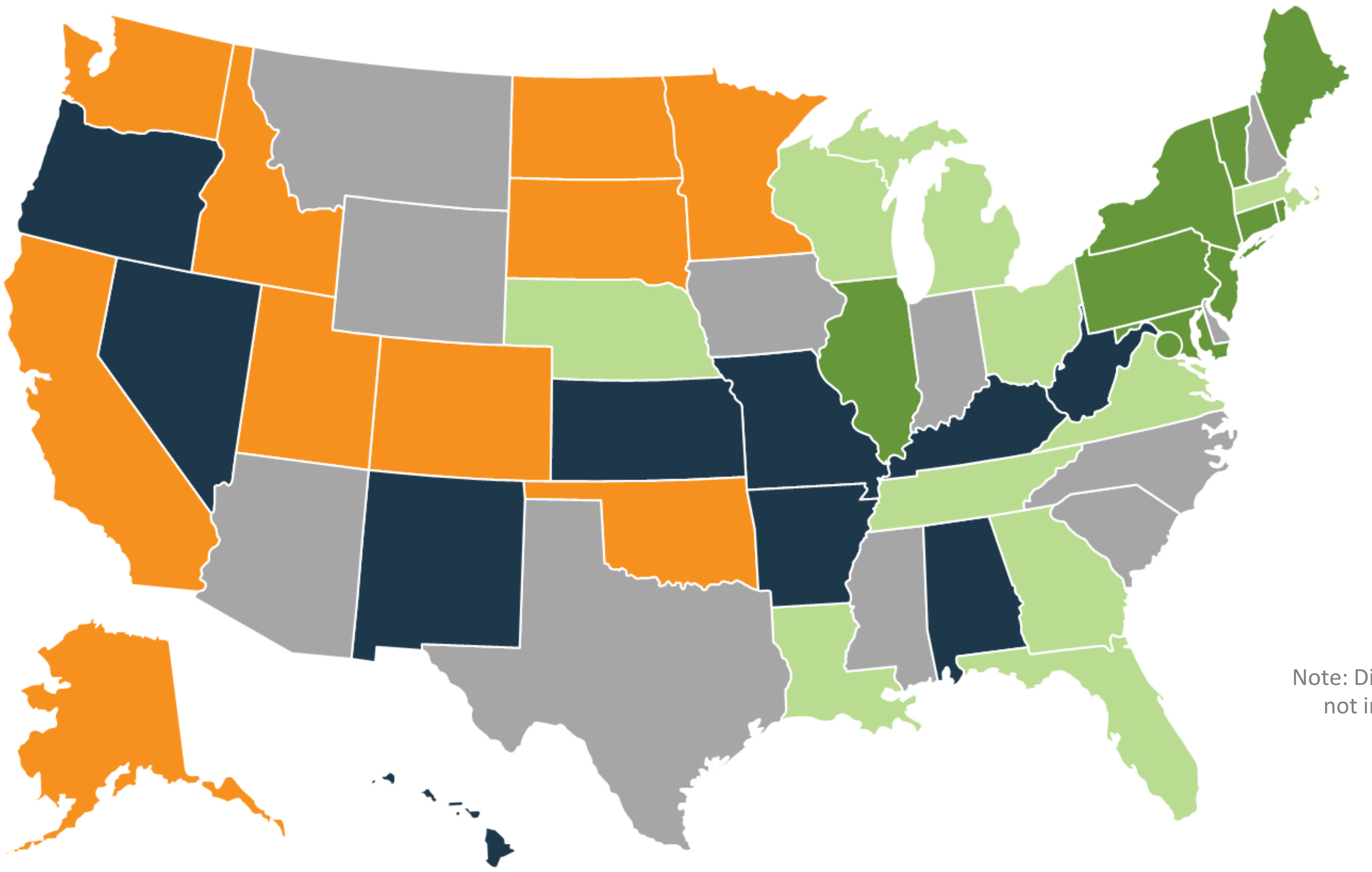
Current, Binge, and Heavy Alcohol Use Among People Aged 12 or Older: 2017



- Note: Since 2015, the threshold for determining binge alcohol use for males is consuming five or more drinks on an occasion and for females is consuming four or more drinks on an occasion.

Methamphetamine Use by State

PAST YEAR, POOLED 2016-2017 NSDUH, 12+



Percentages of People Aged 12 or Older

- 0.98-1.57
- 0.74-0.97
- 0.54-0.73
- 0.33-0.53
- 0.08-0.32

Note: Differences in colors across states do not indicate significant differences in estimates.

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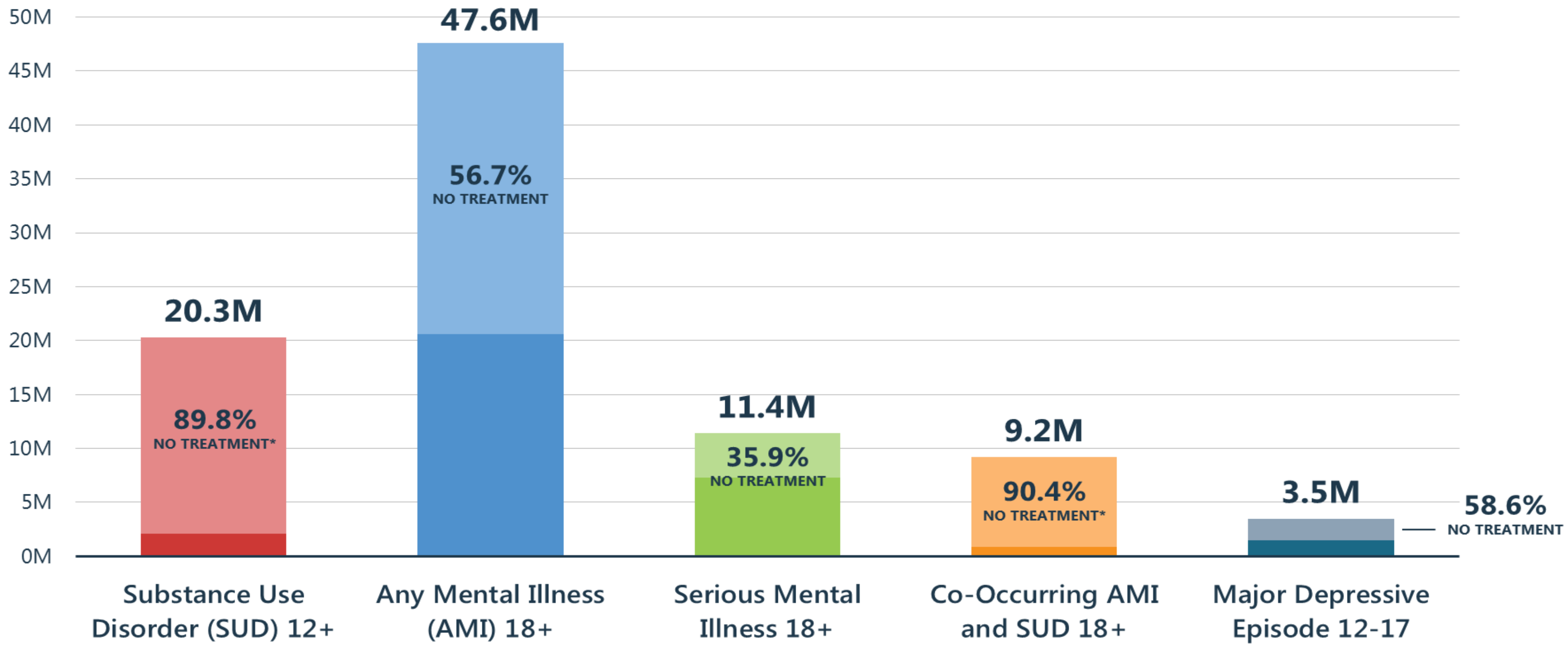
Despite Consequences and Disease Burden, Treatment Gaps Remain Vast

PAST YEAR, 2018 NSDUH, 12+



* No Treatment for SUD is defined as not receiving treatment at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.

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Current State of Workforce

- Shortages and mal-distribution of behavioral health providers complicate the behavioral health landscape by constraining access to essential care and treatment for millions of individuals with mental illness or substance use disorders.*

- A recent study conducted by the HRSA suggested that at the national level, the supply of addiction counselors is projected to increase 6% between 2016 and 2030. Demand for addiction counselors may increase anywhere between 21 to 38 percent by 2030, resulting in a deficit of addiction counselors.**

- https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/Behavioral-Health-Workforce-Projections.pdf

- **https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/addiction-counselors-2018.pdf

Policy Changes

Drug Addiction Treatment Act of 2000 (DATA 2000)

Permits physicians who meet certain qualifications to treat opioid dependency with narcotic medications approved by the Food and Drug Administration (FDA) including buprenorphine, in treatment settings other than OTPs.

The Mental Health Parity and Addiction Equity Act (MHPAEA) 2008

Requires 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/surgical care.

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Recent Policy Changes

The Affordable Care Act (ACA) 2010

Includes substance use disorders as one of the ten elements of essential health benefits. This means that all health insurance sold on Health Insurance Exchanges or provided by Medicaid to certain newly eligible adults starting in 2014 must include services for substance use disorders.

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Policy Changes

21st Century CURES Act 2016

- FY 2016: Created $1 billion for STR grant program to States to address the opioid crisis
- FY 2018: An additional $1 billion through the SOR grant program
- FY 2019: Congress appropriated $1.5 billion to continue SOR
- Proposed FY 2020: requested $1.5 billion to extend SOR

The SUPPORT for Patients and Communities Act of 2018

The SUPPORT Act extends the privilege of prescribing buprenorphine in office-based settings to Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives (CNSs, CRNAs, and CNMs)* until October 1, 2023.

Policy Changes

HR 2482: Mainstreaming Addiction Treatment Act

A bipartisan bill that would allow doctors and physicians to prescribe buprenorphine for addiction without the DEA waiver, as is currently allowed for pain relief.

HR 3925: Reducing Barriers to Substance Use Treatment Act

Would prohibit state Medicaid programs from using onerous utilization management techniques—including prior authorization requirements—to make it harder for patients to get medication-assisted treatments (MAT) for opioid use disorder.

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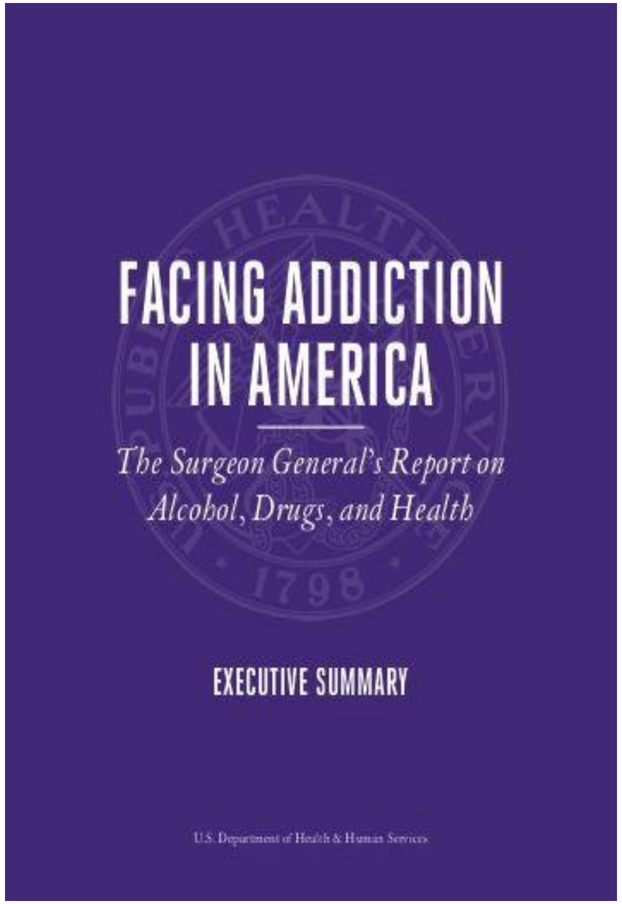
Changing the Addiction Paradigm



- Moving from addiction as a moral failing to a chronic brain disorder
- Moving from criminal justice approaches to public health strategies
- Dropping old, stigmatizing language and developing new terminology
- Developing a science base that informs policy and practice
- Addressing substance use, misuse, and disorders across a full continuum and the lifespan: *prevention, treatment, recovery management*

Substance Use Disorder Treatment Continuum of Care

Enhancing Health

- Promoting optimum physical and mental health and well being through health communications and access to health care services, income and economic security and workplace certainty

Primary Prevention

- Addressing individual and environmental risk factors for substance use through evidence-based programs, policies and strategies

Early Intervention

- Screening and detecting substance use problems at an early stage and providing brief intervention, as needed, and other harm reduction activities

Treatment

- Intervening through medication, counseling and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual and mental health and maximum functional ability

Recovery Support

- Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal and other services that facilitate recovery, wellness and improved quality of life

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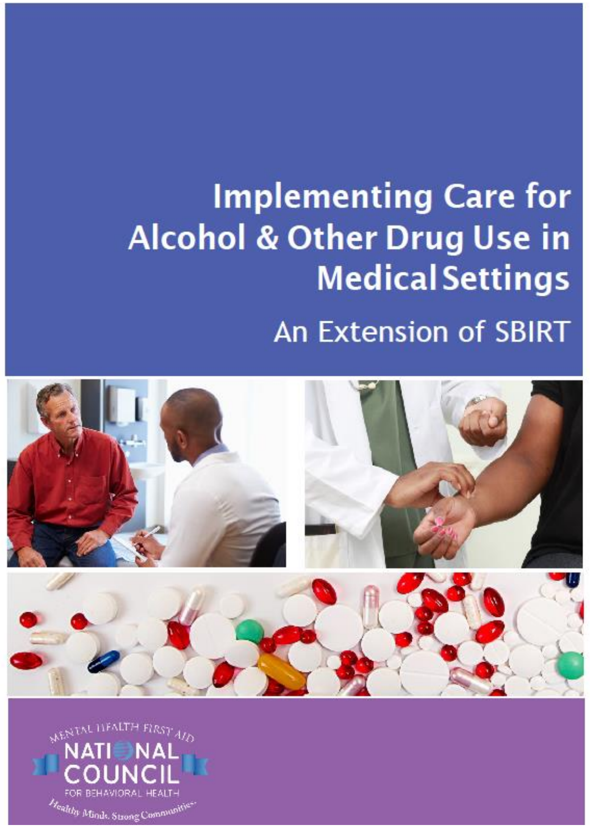
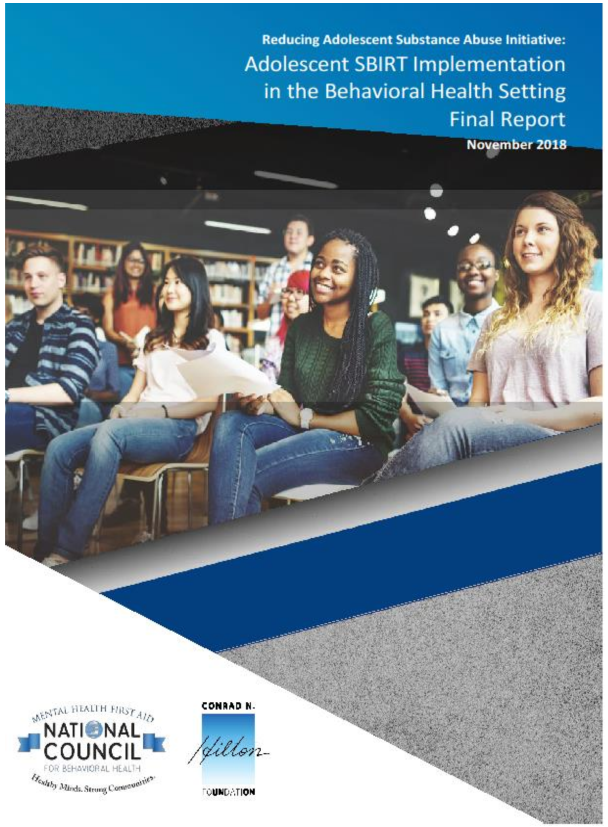
Early Intervention and Engagement is KEY

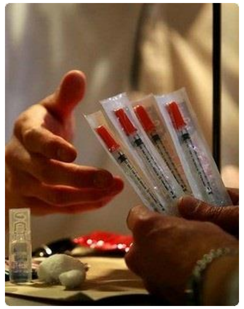




- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Harm Reduction

Harm Reduction

Naloxone Distribution



Syringe Exchange

Peer Support & Community Mobilization

Harm reduction refers to a range of services and policies that lessen the adverse consequences of drug use and protect public health. Unlike approaches that insist that people stop using drugs, harm reduction acknowledges that many people are not able or willing to abstain from illicit drug use, and that abstinence should not be a precondition for help.

Low Barrier Drop-In Spaces

Safe Consumption Sites

Legal Support & Policy Reform

[1]Open Society Foundations: "What is harm reduction?" https://www.opensocietyfoundations.org/explainers/what-harm-reduction

Medication-assisted Treatment (MAT) aka Medications for Opioid Use Disorder (MOUD)

"We have highly effective medications, when combined with other behavioral supports, that are the standard of care for the treatment of opiate addiction."

- *Michael Botticelli, Former Director ONDCP*

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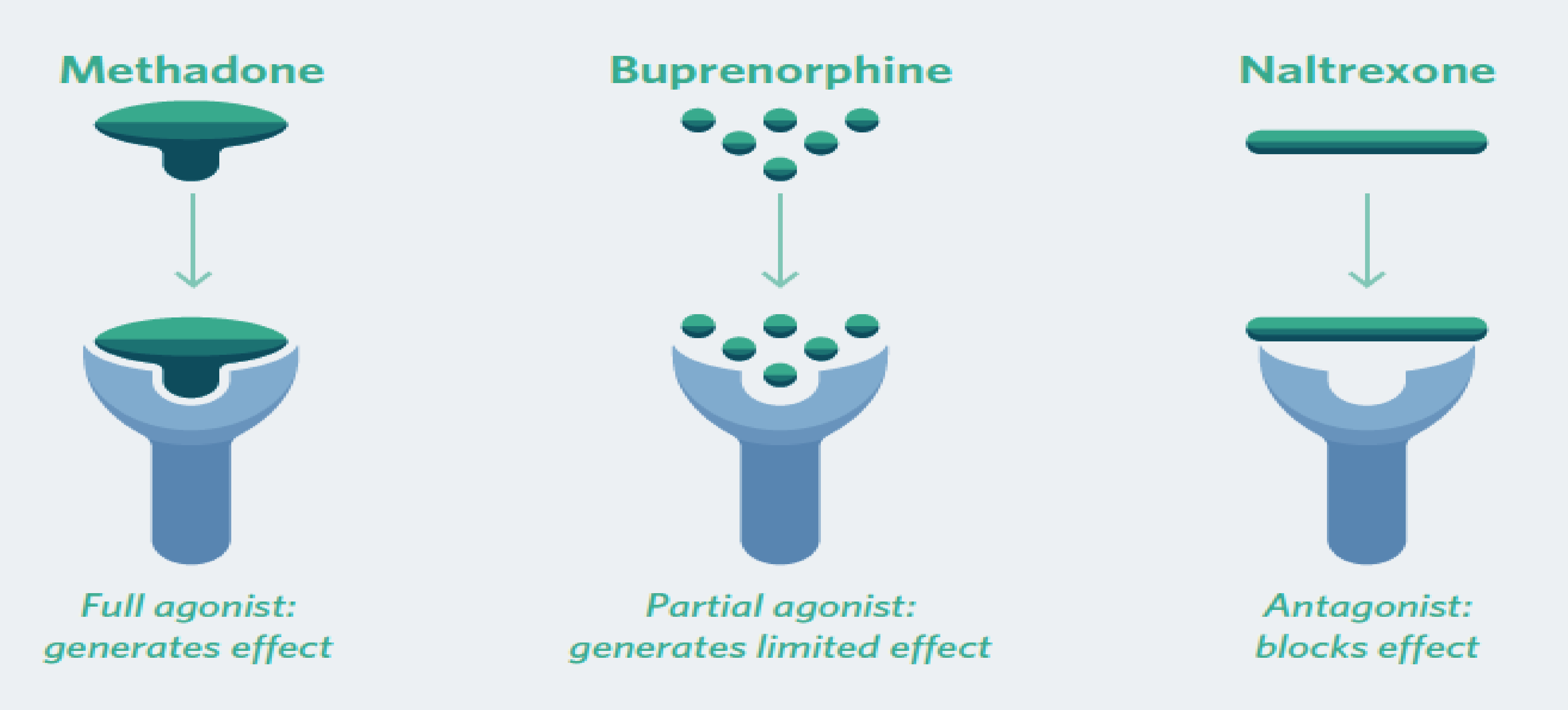
Three FDA-approved Medications for OUD

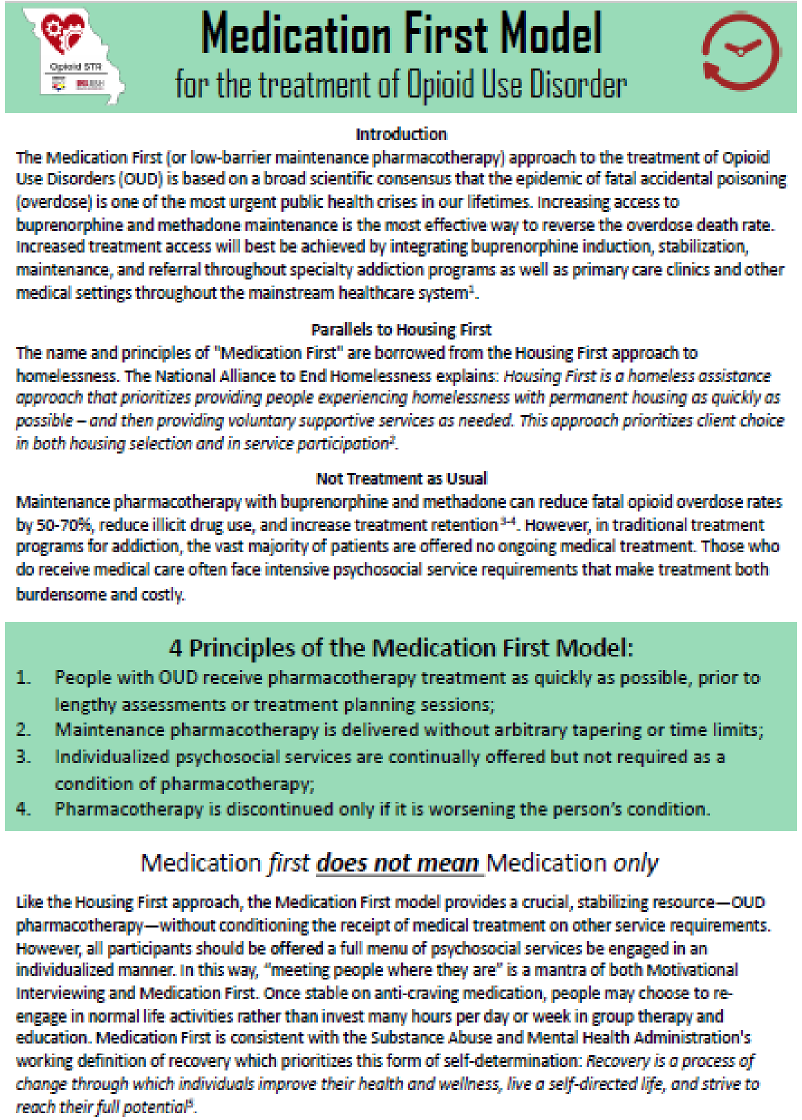


http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder

Medications/Pharmacotherapy for Opioid Use Disorder

Medication	Frequency of Administration	Route of Administration	Who May Prescribe or Dispense
Methadone	Daily	Orally as liquid concentrate, tablet or oral solution of diskette or powder.	SAMHSA-certified outpatient treatment programs (OTPs) dispense methadone for daily administration either on site or, for stable patients, at home.
Buprenorphine	Daily for table or film (also alternative dosing regimens)	Oral tablet or film is dissolved under the tongue	Physicians, NPs and PAs with a federal waiver. Prescribers must complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.
Probuphine (buprenorphine implant)	Every 6 months	Subdermal	
Sublocade (buprenorphine injection)	Monthly	Injection (for moderate to severe OUD)	
Naltrexone	Monthly	Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional.	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.

Adapted from Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide (SMA14-4892R)


Medication First Model
for the treatment of Opioid Use Disorder

Introduction

The Medication First (or low-barrier maintenance pharmacotherapy) approach to the treatment of Opioid Use Disorders (OUD) is based on a broad scientific consensus that the epidemic of fatal accidental poisoning (overdose) is one of the most urgent public health crises in our lifetimes. Increasing access to buprenorphine and methadone maintenance is the most effective way to reverse the overdose death rate. Increased treatment access will best be achieved by integrating buprenorphine induction, stabilization, maintenance, and referral throughout specialty addiction programs as well as primary care clinics and other medical settings throughout the mainstream healthcare system[1].

Parallels to Housing First

The name and principles of "Medication First" are borrowed from the Housing First approach to homelessness. The National Alliance to End Homelessness explains: *Housing First is a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed. This approach prioritizes client choice in both housing selection and in service participation*[2].

Not Treatment as Usual

Maintenance pharmacotherapy with buprenorphine and methadone can reduce fatal opioid overdose rates by 50-70%, reduce illicit drug use, and increase treatment retention[3-4]. However, in traditional treatment programs for addiction, the vast majority of patients are offered no ongoing medical treatment. Those who do receive medical care often face intensive psychosocial service requirements that make treatment both burdensome and costly.

4 Principles of the Medication First Model:

1. People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;
2. Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
3. Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
4. Pharmacotherapy is discontinued only if it is worsening the person's condition.

Medication *first* ***does not mean*** Medication *only*

Like the Housing First approach, the Medication First model provides a crucial, stabilizing resource—OUD pharmacotherapy—without conditioning the receipt of medical treatment on other service requirements. However, all participants should be offered a full menu of psychosocial services be engaged in an individualized manner. In this way, "meeting people where they are" is a mantra of both Motivational Interviewing and Medication First. Once stable on anti-craving medication, people may choose to re-engage in normal life activities rather than invest many hours per day or week in group therapy and education. Medication First is consistent with the Substance Abuse and Mental Health Administration's working definition of recovery which prioritizes this form of self-determination: *Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential*[5].

Medication First Model

- Relieves distress caused by withdrawal symptoms
- Stabilizes the person
- Decreases craving
- Creates mental ability for person to engage in psychosocial
- Increases treatment retention
- Decreases overdose deaths

Medication-assisted Treatment: A 3-Legged Stool

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Common Thoughts Regarding MAT

Is medication- assisted treatment right for me and my recovery?

What are the options?

What about non-medication approaches to recovery?

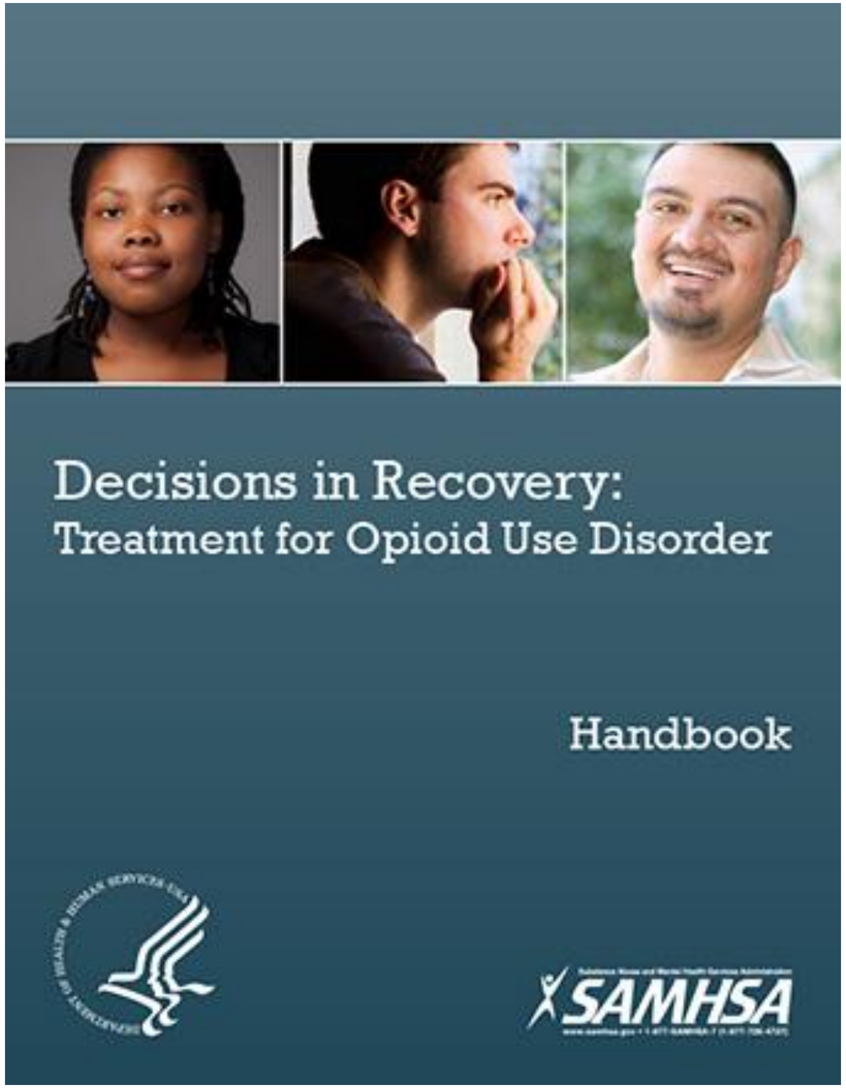
What should I expect? Am I ready for that?

Does one medication work better than another?

Which is best for me?

What are the risks?

How will it affect my life, my bones, work, unborn child?



Shared Decisions between Patient and Professional

- Is medication right for me?
- Which medication is best for me?
- What is an appropriate dosage for me?
- What is a suitable duration of the medication plan?
- What psychosocial services are available?
- What recovery supports may be helpful?

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MAT/MAR: The Controversy Continues

- Methadone and buprenorphine are regulated as controlled substances
- Methadone and buprenorphine: issues of diversion and street value
- Beliefs widely-held by practitioners, recovery community members, and general public that MAT is:
  - Substitution therapy
  - Use of a crutch
  - “Getting high”
  - Pseudo-recovery
  - Not abstinence-based

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MAR = Medication-assisted Recovery

- **Medication assisted treatment (MAT)** refers to using a one of three FDA-approved medications to assist a person in addressing an opioid use disorder.
- **Medication assisted recovery (MAR)** emphasizes a commitment to engaging in recovery supports to achieve long-term abstinence-based recovery while using medication.

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Summary

- The US continues to experience an Opioid (Addiction) Epidemic, as well as an Overdose Epidemic
- We can expect more policy changes that address access to treatment, recovery, and care
- All interventions – including prevention and harm reduction – are necessary
- Medication for OUD is slowly gaining acceptance in the treatment field and recovery community.

Questions

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