Expanding Access to Buprenorphine by Changing the Educational Requirement for Prescribing

Mark W. Parrino, M.P.A.
February 7, 2020
New York Society of Addiction Medicine (NYSAM)
Methadone Treatment in Jail

MARK W. PARRINO

Heroin addiction is a devastating reality. It is also a treatable disease. According to the White House Office of National Drug Control Policy, there are more than 800,000 heroin-dependent individuals in the United States.¹ Drug Enforcement Administration data indicate that heroin is increasingly available at purer levels and the National Institute on Drug Abuse has cited an alarming increase in the number of young people using heroin in suburban and urban areas.

The New York State Division of Substance Abuse Services completed a study in 1991 and found that the annual per person cost of untreated heroin addiction amounts to $45,000.⁶ Another study was completed in California in 1994 and found that drug and alcohol abuse creates an annual cost to taxpayers in the amount of $3.1 billion with 35 percent of the costs being absorbed by the nation’s criminal justice system.⁷

²

AMERICAN JAILS May/June 2000 • 9
AATOD Fact Sheet
Medication-Assisted Treatment for Opioid Use Disorder in the Justice System
October 2017

Introduction

Many publications over the last decade have documented the alarming increase in use and abuse of prescription opioids and heroin (Cicero, Inciardi, & Munoz, 2005; Davis, Severtson, Bucher-Bartelson, & Dart, 2014; GAO, 2009; Paulozzi, Budnitz, & Xi, 2006; Pletcher, Kertesz, Kohn, & Gonzalez, 2008; Reifler, et al., 2012; Schneider, et al., 2009). This surge resulted largely from the significant increase in physician/dentist prescription of opioid medications to treat chronic pain during the 1990s, when a sizeable subset of patients became dependent on and/or addicted to the medications. A report from the Substance Abuse and Mental Health Services Administration (SAMHSA) cited that 79.5 percent of heroin users had previously used prescription pain relievers for nonmedical reasons (Muhuri, Gfroerer, & Davies, 2013). More recent media reports have indicated that over 120 people die of an opiate related overdose each day (2017).

The National Institute on Drug Abuse (NIDA) has clearly established that Medication-Assisted Treatment (MAT) “increases patient retention and decreases drug use, infectious disease transmission, and criminal activity” (NIDA, 2012). This type of treatment combines counseling with medications that block opioids’ euphoric effects and relieve relapse-inducing cravings. “To
JAIL-BASED MEDICATION-ASSISTED TREATMENT

PROMISING PRACTICES, GUIDELINES, AND RESOURCES FOR THE FIELD

October 2018
To authorize the Attorney General to make grants to, and enter into cooperative agreements with, States and units of local government to develop, implement, or expand one or more programs to provide medication-assisted treatment to individuals who have opioid use disorder and are incarcerated within the jurisdictions of the States or units of local government.

IN THE HOUSE OF REPRESENTATIVES
JUNE 26, 2019

Ms. Kuster of New Hampshire (for herself, Mr. Turner, Ms. Blunt Rochester, and Mrs. Walorski) introduced the following bill, which was referred to the Committee on the Judiciary.

A BILL

To authorize the Attorney General to make grants to, and enter into cooperative agreements with, States and units of local government to develop, implement, or expand one or more programs to provide medication-assisted treatment to individuals who have opioid use disorder and are incarcerated within the jurisdictions of the States or units of local government.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Community Re-Entry through Addiction Treatment to Enhance Opportunities Act” or as the “CREATE Opportunities Act”.

SEC. 2. MEDICATION-ASSISTED TREATMENT CORRECTIONS AND COMMUNITY REENTRY PROGRAM.

(a) Definitions.—In this section—

(1) the term “Attorney General” means the Attorney General, acting through the Director of the National Institute of Corrections;

(2) the term “certified recovery coach” means an individual—

(A) with knowledge of, or experience with, recovery from a substance use disorder; and

(B) who—

(i) has completed training through, and is determined to be in good standing by—

(I) a single State agency; or
Total Prescriptions Filled: Buprenorphine 2009 - 2017

IMS Data
Misuse of Pain Reliever Subtypes in Past Year among Persons Aged 12 and Up\(^9\)

PAST YEAR, 2018 NSDUH, 12+ SUBTYPE USERS

- Hydrocodone: 3.5M, 11.5%
- Oxycodone: 1.4M, 12.8%
- Codeine: 2.4M, 8.4%
- Tramadol: 1.5M, 8.3%
- Buprenorphine: 738K, 23.3%
- Morphine: 485K, 7.9%
- Methadone: 256K, 23.3%
- Fentanyl: 269K, 12.7%

---

\(^7\) Treatment Center Programs Combined, 2008-2018, RADARS\(^*\) (Researched Abuse Diversion Addiction Related)


\(^9\) The National Survey on Drug Use and Health: 2018, SAMHSA
Funding for this initiative was made possible (in part) by grant no. 6H79TI080816 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
The Mainstreaming Addiction Treatment (MAT) Act: Fact-Checking the “Fact” Sheet

Don’t make important policy decisions without good data. Examine what is happening in our own country before eliminating training and oversight.

OPPOSE H.R. 2482 and S. 2074

<table>
<thead>
<tr>
<th>The MAT Act “Fact” Sheet</th>
<th>✓ FACT CHECK</th>
</tr>
</thead>
<tbody>
<tr>
<td>“For two decades, buprenorphine has been used as a safe, effective and life-saving medication-assisted treatment (MAT) for individuals suffering from a substance use disorder.”</td>
<td>It’s true that buprenorphine, in combination with psychosocial services, has been effectively used for two decades. However, the vast majority of individuals currently receive no counseling. This has led to lower treatment retention and poor clinical outcomes.1,2 Simply prescribing medication alone is not MAT.</td>
</tr>
<tr>
<td>“Medical professionals need a special DEA waiver to prescribe buprenorphine to treat substance use disorder, which leads to treatment bottlenecks and a lack of providers.”</td>
<td>No such bottleneck exists. SAMHSA approves applicants within 45 days. There are currently more than 72,000 waivered prescribers approved to treat 4.3 million patients.3 This is more than double the number of estimated individuals living with an opioid use disorder in our country. However, only about half of the waivered medical practitioners are actually prescribing.4</td>
</tr>
<tr>
<td>“This outdated waiver requirement has stuck around even though medical professionals can prescribe the same drug for pain without jumping through bureaucratic hoops.”</td>
<td>Federal and state authorities have been working urgently to implement prescribing limits and increase prescriber education to mitigate the practices that led to the current opioid epidemic. This legislation moves in the opposite direction by removing education requirements and limits, making it easier to prescribe a medication known to be highly diverted and misused.</td>
</tr>
<tr>
<td>“Removing this barrier will massively expand treatment access, making it easier for medical professionals to integrate substance use disorder treatment into primary care settings.”</td>
<td>Eliminating the waiver and training requirements will massively expand access to medication, not treatment*. This legislation does not provide medical professionals with the resources needed to integrate quality substance use disorder treatment into their settings. Only 8% of American medical schools offer education on addiction.5 Yet this legislation will reduce education for medical professionals wishing to treat this disorder.</td>
</tr>
<tr>
<td>“After nearly 20 years of safe treatment, there is no good reason to maintain a separate, more burdensome regulatory regime restricting access to safe, proven addiction treatments including buprenorphine.”</td>
<td>There are no data on the efficacy or quality of MAT provided in primary care settings. There is, however, data available on the rates of misuse and risks of overdose associated with buprenorphine.6 The RADARS® (Researcher Abuse Diversion Addiction Related) surveillance system found that during 2018, individuals presenting for opioid treatment in the U.S. reported misuse of buprenorphine in 27.4% of cases and within these, 15.3% indicated misuse of buprenorphine by injection (unpublished data on file).</td>
</tr>
</tbody>
</table>
The Mainstreaming Addiction Treatment (MAT) Act: Fact-Checking the “Fact” Sheet

<table>
<thead>
<tr>
<th>The MAT Act “Fact” Sheet</th>
<th>✓ FACT CHECK</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The additional waiver requirement reflects a <strong>longstanding stigma</strong> around substance use treatment and sends a message to the medical community that they lack the knowledge or ability to effectively treat a patient with substance use disorder.”</td>
<td>The stigma surrounding MAT for opioid use disorder is generated in large part when diversion and misuse of these medications occur. Diversion control plans are not required of MAT provided in a primary care setting. <strong>The rate of buprenorphine diversion has been steadily increasing</strong> as more buprenorphine is prescribed. The number of opioid treatment admissions reporting buprenorphine as a primary drug of MISUSE has also steadily increased.</td>
</tr>
<tr>
<td>“Practitioners are <strong>already required to obtain a license</strong> to prescribe controlled substances and meet any state-level requirements to prescribe buprenorphine.”</td>
<td>The requirement to obtain a license has already proven insufficient to <strong>ensure safe prescribing practices</strong>. A prior lack of adequate training and best practice guidelines for pain management and opioid prescribing led to inadvertently bad prescribing outcomes and deaths. Practitioners are not trained to use opioid treatment medications. The waiver requirement helps protect consumers from untrained practitioners inappropriately prescribing powerful opioids.</td>
</tr>
<tr>
<td>“After <strong>France took similar action</strong> to make buprenorphine available without a specialized waiver, opioid overdose deaths declined by 79 percent over a four-year period.”</td>
<td>This legislation fails to address key differences between France and the model that would be created in the U.S. as a result of this legislation. In France, practitioners can only prescribe for seven days at a time and must specifically justify a longer duration. No such limits exist in the U.S. where schedule III drugs like buprenorphine can be refilled up to 5 times without requiring a new prescription. Pharmacies in France supervise administration for the induction period and for some time beyond. U.S. pharmacies are not equipped to oversee daily administration of medication to patients. Also, widespread co-prescribing of benzodiazepines in France suggests a need for more practitioner training: <a href="http://www.fda.gov/advisorycommittees/committees/2019/02/21183/"><strong>further efforts to improve the safety of buprenorphine are warranted</strong></a>, and potential means for achieving this goal in France include <a href="http://www.fda.gov/advisorycommittees/committees/2019/02/21183/"><strong>increased control of buprenorphine prescriptions</strong>, physician training</a> on the risks of excessive dosing and co-prescription of other psychotropics with buprenorphine (especially benzodiazepines).”</td>
</tr>
</tbody>
</table>
Mark W. Parrino, M.P.A.
President
American Association for the Treatment of Opioid Dependence, Inc.
225 Varick Street, 4th Floor
New York, New York
Phone: (212) 566-5555
Fax: (212) 366-4647
E-mail: mark.parrino@aatod.org
www.aatod.org