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April 23, 2014

The Honorable Pamela Hyde
Substance Abuse and Mental Health Services Administration
US Department of Health and Human Services
1 Choke Cherry Road
Rockville, MD 20857

Dear Administrator Hyde:

In the past decade, prescription opioid drug use has increased dramatically and so have the harms resulting from drug use —including destruction of families and communities, burdens of increased theft and incarceration, and rise in overdose deaths. Like all addictions, the first step to recovery for opioid abusers is typically detoxification followed by therapy and treatment. To date the Food and Drug Administration (FDA) has approved three medication-assisted treatment (MAT) options for opioid addictions. [1] These MAT options help the brain readjust to the absence of the abused substance and/or quiet the cravings that typically lead to relapse. Some of these more recently approved treatments can be administered, managed and integrated into outpatient primary care settings, such as community health centers that typically are the source of comprehensive care for underserved populations. As the federal government refocuses its efforts to combat the prescription drug abuse epidemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) plays a critical role in providing technical leadership, research findings, and program supports to expand access to substance abuse treatments and to help address some of the barriers that exist between primary care and expert services to address substance abuse.

Many persons with substance use disorders do not seek services from addiction specialists, but may access primary care for a broad array of services. However, as indicated in assessments by the National Association of Community Health Centers (NACHC) in 2010 and 2011, sufficient access to detoxification and linkage to ongoing treatment in community health center settings has been challenging. Only 15 percent of Federally Qualified Health Centers (FQHCs) provide medically-assisted treatments for opiate abuse. The NACHC concluded that, "the proportion of patients with substance use conditions whose illnesses are recognized and

[1] Methadone in use for addiction treatment since the 1960s; buprenorhpine, approved for opioid addiction treatment in 2002; intramuscular naltrexone, approved for opioid relapse prevention in 2010. http://www.drugabuse.gov/publications/topics-in-brief/medication-assisted-treatment-opioid-addiction

treated [at FQHCs] is miniscule."[2] The assessments identified several barriers to why substance abuse is not more frequently and routinely addressed in FQHCs, including continued negative attitudes toward treatment of substance abuse, difficulty training and retaining qualified staff, and inadequate reimbursement.

Additionally, access to medication-assisted treatment for patients can be limited because of specific restrictions placed on medical professionals wishing to use certain approved treatments. For example, to prescribe buprenorphine products for treatment of opioid addiction, physicians who are not mental health or addiction specialists must complete additional training, submit a notice of intent, and receive a DEA "waiver" to prescribe. Additionally, even when these criteria are met and such a waiver is granted, physicians are limited to prescribing for only 30 patients the first year and 100 patients following years for buprenorphine treatment.[3]

Since 2007, the Massachusetts Department of Public Health (DPH) has partnered with Boston Medical Center to integrate office-base opioid treatment into community health centers. Specifically, DPH has funded 14 community health centers, including 11 FQHCs to employ registered Nurse Care Managers and medical assistants to assist primary care physicians in providing buprenorphine using a "Best Practice" model that combines the use of medication with behavioral health counseling and random drug screening and monitoring. Boston Medical center also received funds to provide technical assistance to the programs at these community health centers. To date, 7,200 clients have been served through these programs. Federal supports for such strategies could expand such models both across Massachusetts and across the country.

Addiction science has taught us there is no panacea for all substance use disorders. Each individual affected requires personalized treatment that may involve a combination of MAT and behavioral therapies. In order to increase access to appropriate treatment programs and modernize our addiction treatment system, it is imperative that as new treatments become available they are scaled up in the appropriate settings, access is simplified, monitoring programs are in place, and implementation science analyzes how to best 'match' patients with the treatment option that gives them the optimal chance of success.

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[2] NACHC 2010 Assessment of Behavioral Health Services in Federally Qualified Health Centers http://www.nachc.com/client/NACHC%202010%20Assessment%20of%20Behavioral%20Health%20Services%20in%20FQHCs_1_14_11_FINAL.pdf. NACHC Assessment of FQHCs' Integrated Behavioral Health Services (2011) http://www.nachc.com/client//2011%20Assessment%20of%20FQHCs%20Integrated%20Behavioral%20Health%20Services.pdf

[3] Physician Waiver Qualifications. http://buprenorphine.samhsa.gov/waiver_qualifications.html

share any white papers, meeting results, or recommendations on pathways to resolve payment barriers.

5. What challenges in provider willingness, training, or availability has SAMHSA identified as limitations to expansion of addiction treatment and recovery services, including MAT options? Please share any white papers, meeting results, or recommendations of service models or solutions to addressing these limitations. What actions, if any, has SAMHSA taken or supported to address these limitations?
6. Does SAMHSA collaborate with other federal agencies, such as the Department of Justice (DOJ), to support intramuscular naltrexone or other MAT options in settings of incarceration and re-entry? If so, please describe these programs, including the types of support (i.e.: financial, technical) provided by SAMHSA, the types of treatments provided, the number of clients receiving specified treatments and any data or results stemming from these programs.
7. How does SAMHSA work with the various agencies that comprise the Department of Health and Human Services (HHS), such as Health Resources and Services Administration (HRSA), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), to support the expansion of MAT programs? Please describe the nature of this work, including frequency of formal meetings, agendas, or actions taken.
8. How does SAMHSA estimate the need for these services across public and private providers and the degree to which that need is being met?
9. What additional resources, special studies, or data systems would be required to more fully track the expansion of addiction treatment services and the adequacy of this expansion to meet need and demand for treatment services?
10. What tools are needed for SAMHSA to assess the quality and outcomes of addiction treatment services that are provided through SAMHSA or HHS-funded programs?

Thank you for your assistance and cooperation in responding to this request by May 23, 2014. Should you have any questions, please have your staff contact Dr. Shannon Hader or Dr. Avenel Joseph of my staff at 202-224-2742.

Sincerely,

Edward J. Markey

Edward J. Markey
United States Senator

cc:
Michael Botticelli, Acting Director, White House Office of National Drug Control Policy
Mary Wakefield, Administrator, HHS/Health Resources and Services Administration