

Opiate Pharmacotherapy Whitepaper January 2007

The *Drug Addiction Treatment Act of 2000 (DATA 2000)*, among other things, allows physicians to prescribe a narcotic for the treatment of addiction in a regular office setting. For decades this was only allowable in highly regulated methadone treatment programs. DATA 2000 is the most recent of a long line of legislation that has impacted the delivery of substance abuse treatment - with one major difference. Rather than add more layers of regulations and infrastructure, this signals their loosening. Boards, under their obligation as the planning agency (See *ORC 340.033 (A)*) for alcohol and drug treatment services in their area should explore the opportunities, benefits, challenges, and risks these new regulations pose for their service delivery structure.

HISTORICAL CONTEXT

In 1900 there were estimated to be over half a million opiate addicts in the United States alone (Musto, 1981). Attempts to solve this malady with pharmacological intervention date back further. In 1898 the chemist Heinrich Dresser, in collaboration with the Bayer Company, designed a new drug - Heroin. Dresser wrote, "the very name seemed to guarantee the opiates bright future as it had heroic properties in therapy." (Morgan, 1981) Thus, Bayer registered Heroin (meaning 'heroic treatment' from the German word *heroisch*) as a trademark (<http://en.wikipedia.org/wiki/Heroin>). Originally this was seen as a solution to the opium problem, just as Cocaine had been 20-years previously. (Musto, 1987)

The patent medicine craze of the 1890s, combined with refined opiate medications, led to growing public concern, and ultimately legislation that allowed the medical profession to have the most influential part in limiting medications to medical purposes only. One of the first bills was the *District of Columbia Pharmacy Act of 1906*. This regulated the non-medical use of many substances, including opiates. Physicians now had to write prescriptions. Next came the *Pure Food and Drug Act of 1906*, which was designed to regulate proprietary medicine, and served as an equivalent to a new consciousness to the dangers of drugs. (Musto, 1994)

Strict federal regulation related to the medical prescribing of opioids began with the *Harrison Narcotic Act of 1914*. Treasury officials, assigned to enforcing the legislation, strongly discouraged the prescribing of opiates for addiction maintenance. As a direct consequence, opiate addicts receiving these medically supervised maintenance medications were cut off, street prices escalated, and the

medical profession was divided. In 1919 the United States Supreme Court supported the Treasury Department's interpretation of the Act (Webb et. al., v. United States), thus reinforcing opposition to maintenance therapy. The American Medical Association (AMA) also condemned the practice and for much of the next 50 years, physicians who continued the practice were left at risk for prosecution and conviction (CSAT 2003; Jaffe & O'Keefe, 2003).

Attitudes against medication-assisted treatment began to soften post-World War II. The increase in death rates associated with illicit heroin use, in spite of federal regulations, fueled new thinking. In 1958 a joint committee of the American Bar Association and the American Medical Association urged studies on prescribing opioids to treat addiction. (CSAT 2003) Soon after, Dole, Nyswander, and the Rockefeller Institute (Glassgote et al, 1972) showed that heroin addicts maintained on oral methadone could lead productive lives. Over the next several years methadone maintenance became a major public health initiative, and by the 1970s, evolved into a publicly funded system of service delivery (CSAT, 2003) - *albeit highly regulated*.

In 1992 the Institute of Medicine (IOM) reviewed the impact of these methadone regulations on the service delivery of medication-assisted treatment. It concluded that the multiple layers of regulations:

- overemphasized the dangers of drug diversion;
- created redundant and unnecessary paperwork;
- dampened clinical judgment;
- reduced access to treatment; and
- contributed to patient "drop out" rates.

This new perspective on the regulatory impact increased discussion on loosening rules and looking towards more accessible service delivery models for medication-assisted treatment. DATA 2000 is a direct response to this, and carries the following restrictions:

1. A prescribing physician must have training in addictions treatment.
2. The prescribing physician has to register with the Secretary of Health and Human Services (HHS).
3. The prescribing physician will receive a special number to add to his/her DEA license to prescribe scheduled drugs.
4. The drug prescribed has to be approved by the FDA as useful in the treatment of addiction.
5. The drug prescribed may not be a schedule II narcotic (e.g. *Methadone, LAAM*), only III, IV, or V. (e.g. *Buprenorphine, Suboxone*)
6. The physician may only have 30 patients on the treatment at any one time.

7. The physician must have the capacity to refer patients to counseling services. (OMIROR, 2003)

TYPES OF OPIATE PHARMACOTHERAPY

Examples of opiate drugs: heroin, Percocet, Percodan, Tylox, Demoral, morphine, Vicodin, Oxycontin, Dilaudid.

How opioids work:

1. Opioids attach to the *mu* receptor in the brain
2. Activation of this receptor results in pleasure
3. After repeated use, the brain becomes altered and more is required to produce the same effect.

Medications and behavioral treatments have been developed in light of this knowledge.

Classifications:

Drugs are classified according to their function at the opioid receptor sites: *agonist, partial agonist, and antagonist*

Agonists: Drugs that activate receptors in the brain are termed agonists. Agonists occupy a receptor and turn it on - they produce an effect in the organism. Most opioids that are abused fall into this category. Examples include heroin, morphine, and methadone.

Partial Agonists: Share some of the characteristics of a full agonist, in that they bind to and activate receptors; however, they don't produce a full effect. Buprenorphine is an example of a partial agonist.

Antagonists: Also bind to receptors, but instead of activating the receptors, they effectively block the receptors. Antagonists don't turn on the receptor, but they do prevent the receptor from being activated by an agonist compound. It is as if an antagonist is a key that fits in a lock but doesn't open it.

Current Medications Used:

Methadone

- Available 30 years
- Full *mu* agonist
- DEA Schedule II drug (i.e. not available for office-based practice)
- Oral solution
- Much research citing effectiveness for opioid dependence
- Consumption of illicit drugs decline
- Crime reduction

- Associated with increase in compliance with medical, psychiatric and prenatal care
- Associated with a decrease in HIV infection, Hepatitis , Tuberculosis and sexually transmitted diseases
- Carries a diversion risk
- Never formally approved by FDA
- Can be used in:
 - Certified Opiate Treatment Programs
- Inexpensive (approximately \$13.00 per dose)

LAAM

- More expensive than methadone
 - Full *mu* agonist
 - DEA Schedule II drug (i.e., not available for office-based practice)
- Similar efficacy to methadone
- Oral solution
- FDA approved 1993
- Can be used in:
 - Certified Opiate Treatment Programs

{LAAM has been associated with cardiac related adverse events and has been given the "black box" label by the FDA; as a result it has been discontinued as an option by many providers (Leavitt, 2005, SAMHSA TIP 43, 2005)}

Buprenorphine

- Partial μ -opioid agonist
- Sublingual tablet
- DEA Schedule III drug
- FDA approved 2002
- High receptor affinity/occupancy
 - 95% occupancy at 16 mg (Greenwald et al, 2003)
- Blockade effect on the use of additional opioids
 - Favorable safety profile due to ceiling effect
 - Lower street value
 - Lower abuse potential (Walsh and Eissenberg, 2003)
- Can be used in:
 - Certified Opiate Treatment Programs
 - Physicians office based practice
 - Other healthcare settings

Naloxone

- Acts as a competitive antagonist at the μ receptor
 - Prevents binding of other opioids to the receptor

- Precipitates withdrawal when injected in opioid-dependent individuals
- Short acting
- Oral tablet
- DEA not scheduled
- FDA approved 1984
- Can be used in:
 - Certified Opiate Treatment Programs
 - Physicians office-based practice
 - Other healthcare settings

Suboxone (combination Buprenorphine and Naloxone)

- Partial μ -opioid agonist and *mu* antagonist
- Constructed to reduce diversion / misuse
 - Buprenorphine works when placed under tongue
 - Naloxone works when injected
 - Suppresses withdrawal and craving when taken sublingually
 - Precipitates withdrawal when injected by opioid-dependent patients
- Sublingual tablet
- DEA Schedule III drug
- Different from other medications used to treat opioid dependence.
 - Office-based availability.
 - Dosing
 - Safety
 - Less severe physiologic withdrawal syndromes
 - Reduced diversion potential
- Most insurance reimburse medication costs (16mg x 30 days= \$270.)
- FDA approved 2002
- Can be used in:
 - Certified Opiate Treatment Programs
 - Physicians' office-based practice
 - Other healthcare settings

THE CURRENT OPIATE "PROBLEM"

There are a myriad of issues that have contributed to the recent escalation of opiate-related admissions to Ohio treatment programs.

- Heroin is cheaper and purer than it was in 1970. For instance, in 1970 street heroin in northeast Ohio had 3 - 5% purity levels and one bag (1/10th gram) cost \$25.00; in 2005 street heroin in northeast Ohio achieved 30 - 70% purity levels and one bag (1/10th gram) cost \$10.00. In the past many have avoided heroin due to fear associated with needles. Current street heroin is pure enough that new users can achieve euphoric effects via intranasal

drug delivery. This has opened the door to a new, often younger, heroin user. Many of whom quickly evolve into intravenous drug users (IVDUs). Stella Maris, Inc., a subacute detoxification provider for Lorain and Cuyahoga County residents, has seen an emerging trend of heroin addicts under 30 years old requesting detoxification services (SFY 2005 Agency CQI reports).

- IVDUs are listed as a federal priority consumer. (42 U.S.C. 300x-23(a)(2): *...ensure that each individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment not later than - (A) 14 days after making the request; or (B) 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.*) Although specific drugs are not named in this priority, the majority of IVDUs entering the system are opiate-addicted.
- There has been an escalation of individuals addicted to prescription opiate analgesics (e.g. OxyContin, Demoral, Percodan, Vicodin, etc.). In 2002, 1.5 million individuals reported dependence or abuse of prescription pain medications. (SAMHSA) Pain medications implicated in drug abuse-related emergency room visits rose 20% in 2002. A large portion of these involved oxycodone. (DAWN Report)
- Prescription pain medications offer a high abuse potential and are being diverted into the street economy. For example, OxyContin has an estimated street value of \$1.00/milligram or \$50.00/50mg., and is interchangeable with heroin. Some users who begin with prescription pain medications default to heroin use; often heroin is less expensive and more accessible than schedule II, III or IV drugs.
- The opiate epidemic is creating additional burdens on this already taxed system. Subacute detoxification from opiates may require a seven-day protocol; whereas subacute detoxification from alcohol may require only three. Thus, the increase in opiate detoxification requests has a direct impact on the number of individuals who can be served. In Lorain County over 75% of all detoxification referrals are now for opiate-related withdrawal syndromes per SFY 2005 provider reports.

All said there is sufficient rationale for investigating a cost-effective, alternative approach to working with this population.

IMPORTANCE TO ADAMH and ADAS BOARDS

Section 340.033(A) of the Ohio Revised Code delineates the Boards' responsibilities as the planning agency for alcohol and drug addiction services. Among the responsibilities described in the statute are:

- Assessing the service needs and evaluating the need for programs;
- Setting priorities;

- Developing operational plans in cooperation with other local and regional planning bodies;
- Reviewing and evaluating addictions treatment and prevention programs;
- Promoting, arranging, and implementing working agreements with public and private social agencies; and
- Assuring services are effective and of high quality.

Efficiency and effectiveness are intrinsic to Boards. Thus, we must give a long look to any practice that can expand treatment to meet need, increase consumer access, and increase collaboration with medical professionals. DATA 2000 offers opportunity to take *“a fresh look at the cost benefit of making opioid addiction treatment more accessible and less stigmatized by moving it from clinics to private physicians’ offices.”* (Jaffee & O’Keefe 2003) Further, lessening stigma, increasing access, and transferring science to service are all overarching priorities named by the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) National Outcomes Measures (NOMs), the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), and the Governor’s “Performance Ohio” initiative.

METHADONE MAINTAINANCE TREATMENT (MMT) VS. OFFICE-BASED OPIATE PHARMACOTHERAPIES

Benefits of methadone maintenance treatment (MMT):

- Methadone maintenance treatment was developed as a part of a comprehensive treatment available for opiate addiction that included psychosocial counseling and vocational rehabilitation. MMT has been extensively researched and proven to significantly reduce the negative consequences associated with opiate addiction such as HIV transmission, Hepatitis B and C, and tuberculosis. Additionally, MMT has been associated with positive outcomes such as increased employment and reduced crime and incarceration.
- MMT is currently the most well-researched of the available pharmacological interventions, with a proven history of success.
- MMT does not cause euphoria, thus allowing the painful symptoms of opiate withdrawal and craving associated with withdrawal to be avoided and allowing patients to more fully participate in life activities.

Barriers to methadone maintenance treatment:

- Methadone for opiate addiction can only be administered in a certified opiate treatment program and is not available for office-based practices, thus reducing the accessibility of this treatment.
- Methadone carries a diversion risk and is a Schedule II medication.

- Methadone must be taken daily to avoid the onset of withdrawal symptoms. The daily dosing can be problematic for patients with limited support or transportation difficulties.
- The use of methadone continues to carry an associated stigma. Public misconceptions regarding “methadone clinics” continue to be fostered by the mass media.

Benefits to introducing office-based opiate pharmacotherapy:

- Addiction treatment has received varying support from medical professionals over the years. This can be attributed to a number of issues including: lack of addictions training in medical schools, limited addictions treatment outcomes data, and poor communication between treatment providers and prescribing and/or primary care physicians. DATA 2000 requires physicians to have addictions-specific training *and* the capacity to refer patients to counseling services. This is a clear opportunity for treatment providers and Board areas to develop a collaborative relationship with the medical profession.
- Treatment retention is directly related to positive patient outcomes. Court mandates that patients complete treatment as prescribed is a key reason coerced patients are retained in treatment and, as a result, experience treatment success. (Lurigio, 2002) Oftentimes opiate addicts are not coerced, or otherwise mandated into treatment; they present for services due to the physical discomfort of withdrawal or their continued use of opioids despite harm to themselves. Once this discomfort leaves (read: after detox), they reject the continuation of care and experience poor recovery outcomes. Some present for services again within months--thus creating a revolving door of treatment failure. When Suboxone-prescribing physicians *require* treatment attendance, it offers a strong incentive for individuals to remain in drug addiction services.
- Upon the completion of treatment, resolution of familial issues, obtaining vocational/financial stability, and stabilizing and enhancing recovery support networks, individuals may be removed from Suboxone therapy. Thus, this modality can fit within “*abstinence is (as) the goal*” philosophy.
- Office-based delivery of opiate pharmacotherapies can possibly be woven into existing county treatment systems without having to introduce an additional certified treatment agency.
- Augmenting treatment with office-based delivery of opiate pharmacotherapy allows some individuals, formerly served in residential care, to succeed at an outpatient level of care and, by result, contribute to the local economy by remaining in the workforce.

Barriers to introducing office based opiate pharmacotherapy:

- A typical effective dose of Suboxone is 16mg/day (or less) at a cost of \$270/month/patient. Most insurance, *including Medicaid and Recovery Health Assistance (RHA)*, will cover this cost. However, the majority of opiate-addicted individuals approaching publicly funded detox programs are indigent males. So Boards must consider the cost of introducing this strategy.
- Although there have been substantial studies on the efficacy of Suboxone therapy, few have tracked patients after prescription discontinuation. Consumers may need to be re-engaged in a group therapy level of care for additional support during the discontinuation process.
- Opiate pharmacotherapy, being outside what some view as traditional treatment, may receive skepticism and resistance among some treatment providers.
- Physicians must take a recognized course hosted by ASAM / AAAP / APA / AOA /AMA before they are authorized to prescribe scheduled narcotic pharmacotherapies. Once certification is obtained, they can only carry thirty (30) patients on the treatment at any one time; these patients may be on the treatment for two years. Thus treatment capacity is directly proportional to the number of certified physicians in a system. (*Note: Certified methadone programs are not limited by the 30-patient cap*). Most recently we have seen certified physicians reach their maximum patient capacity much quicker, and with more insurance patients than they originally anticipated. This unanticipated volume of insurance patients, combined with limited cap space, further depletes the availability of this service for indigent populations.

What needs to be in place before introducing office-based opiate pharmacotherapy?

(Note: The following was published in 2003 by the Northwest Frontier Addiction Technology Transfer Center (NFATTC) Department of Public Health and Preventive Medicine Oregon Health & Science University, 3414 Cherry Avenue NE, Suite 150, Salem, OR 97303 under grant No. 1 KD1 T113568-01 from SAMHSA's Center for Substance Abuse Treatment (CSAT). The material is in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT or the authors.)

A Synthesis of Local Practice Guidelines

This section provides practical steps, processes and issues for all collaborators in the delivery of office-based treatment for opioid dependence to consider as part of the treatment regimen. These guidelines are a synthesis of documents developed in several rural Oregon counties as part of the Opiate Medication Initiative for Rural Oregon Residents (OMIROR), a project funded by the

SAMHSA Center for Substance Abuse Treatment and implemented by the Oregon Health & Science University Department of Public Health and Preventive Medicine.

- I. Buprenorphine hydrochloride is a prescription drug approved in 2002 for the treatment of opiate addiction. It is a partial opiate agonist, which satisfies the dependent patient's need for an opiate to avoid painful withdrawal. At the same time, it does not provide the user with the same level of psychoactive effect typically associated with opiate drugs. It can, therefore, be a useful adjunct to treatment for those addicted patients wanting to establish a more normal lifestyle without the need to constantly be seeking the next high to forestall withdrawal. This is the first such medication available to physicians for use in their office-based practice.
- II. There are a number of issues that need to be addressed and resolved before Buprenorphine finds its way into common practice in rural areas. Some of those issues are:
 - A. Cost of the medication. Will insurance cover the cost? Will Medicaid? What will be the monthly cost for patients who pay their own way?
 - B. Collaboration between physician and addiction treatment agency. Buprenorphine is not sufficient treatment for opiate dependence. Typically, counseling and other related services are needed to assure minimum standards for opiate dependency treatment are met.
 - C. Treatment planning and case management. Who is going to work with the patient to develop a full spectrum treatment plan? How will the ongoing progress of the patient be monitored and by whom?
- III. Resources for the practitioner. In preparing to implement a Buprenorphine regimen, the following references will be useful to the practitioner:
 - A. McNicholas, Laura and Howell, Elizabeth (2000) Buprenorphine Clinical Practice Guidelines (BCPG). Draft document submitted to the Center for Substance Abuse Treatment.
 - B. American Society of Addiction Medicine (ASAM) Clinical Practice Guidelines and assessments.
 - C. American Psychiatric Association (2000) Diagnostic and Statistical Manual-IV. Criteria for Opioid Intoxication and Withdrawal (292.89 & 292.0).

Preparation for Treatment

- I. Physicians, community treatment providers and pharmacists meet and discuss which office assumes responsibility for the various tasks included in the Buprenorphine protocol.
- II. Physicians and community treatment providers agree upon a prompt referral system, allowing the prospective patient a medical appointment within an agreed-upon number of days from the initial contact.
- III. A flowchart is developed, with names assigned to each task in the protocol. The flowchart is shared with each partner, modified when appropriate (based upon experience) and re-published.
- IV. Partners set aside a regular “staffing” time to discuss mutual Buprenorphine patients.
- V. Communities develop an education campaign to inform medical and other professionals about the availability and use of Buprenorphine in the treatment of opiate dependence. Included in this effort (but not limited to it) would be physician organizations, community addiction treatment providers, methadone clinics, Narcotics Anonymous (NA), law enforcement personnel, detoxification facilities, local hospitals and urgent care centers.
- VI. Patients come from any source, including, but not limited to, other physicians, community treatment providers, law enforcement, local hospitals, Narcotic Anonymous, methadone clinics, etc. encourage a “No Wrong Door” philosophy. Treatment personnel should reference the BCPG for a more detailed discussion.
- VII. Narcotics Anonymous is contacted and requested to establish a Buprenorphine-only group. The position against opiate pharmacotherapy of some NA members may be challenging.

Patient Screening and Enrollment

- I. Not all patients are appropriate for Buprenorphine. Eligibility criteria must be determined. Some resources that might be useful include Buprenorphine Office Tools (BOT), which can be found in Appendix 1, ASAM forms and the DSM-IV criteria for opiate dependence.
- II. Consistent with “No Wrong Door,” screening is done at community drug treatment facilities, medical clinics, physicians’ offices or other participating agencies. Screening forms can be found in the BOT. Screening instruments are described in the BCPG. (McNicholas and Howell, 2000) Phone screening may be done by front office personnel or by the clinician. Training of personnel to do phone screening is a key factor in initial patient selection.
- III. Availability of benefits to cover the cost of treatment is determined. Insurance compensation, state support, and patient financial commitment must be ascertained as part of the assessment process to ensure continuity of care.

- IV. The patient, family members and significant others are educated about Buprenorphine. The benefits and risks, including a review of treatment options and a discussion of contractual compliance, should be explained in full. Patients that decline family involvement or the family that refuses involvement may indicate the patient is not appropriate for Buprenorphine.
- V. Special care is taken regarding confidentiality issues, especially in small rural communities. HIPAA requirements are understood and met.
- VI. Patients agree to each organization's contracts, including (but not limited to) compliance with confidentiality issues and sharing of information between the physician, addiction treatment provider, pharmacist and others with a need to know. Patients who do not make such a commitment are probably not good Buprenorphine candidates. Likewise, patients that have transportation problems, personality disorders or are evasive in answering questions on the screening tools may not be appropriate for this drug.

Patient Assessment

- I. Clarify who will do what portions of the assessment and which instruments or diagnostic tools will be utilized.
- II. Conduct urine toxicology screen for opiates, methadone, benzodiazepines, cocaine, amphetamines and other drugs of abuse in the patient's community.
- III. Clarify assessment guidelines for special populations including adolescents, pregnant patients, the elderly, and patients with renal failure or compromised hepatic functions, HIV-positive and healthcare professionals. The BCPG includes some helpful information about special populations.
- IV. After the assessment and screening procedures are complete, the physician and addiction treatment provider conference to decide appropriateness of Buprenorphine and potential treatment plan. The initial medical assessment is described in the BCPG.

Treatment Plan

- I. Team members consult the BCPG, ASAM, and DSM-IV references as they develop the patient diagnosis, determining appropriateness of treatment, identifying medical or psychiatric disorders, assessing withdrawal potential and formulating an initial treatment plan including contraindications. In the event that additional addiction expertise is required, a clinician reference line is available (*Reckitt Benckiser Pharmaceuticals, Inc.*)
- II. The treatment plan indicates which community partner provides each service included in the plan.

- III. Treatment plan includes activities and assignments consistent with immediate and long-term goals. The BCPG's section on treatment protocols provides a valuable outline for understanding the options available to the patient. Treatment goals are linked to issues and problems described in the patient's assessment.

Detoxification

- I. Manage withdrawal from opiates by using Buprenorphine for a limited period of time, then gradually reducing Buprenorphine dosing schedule. Rule out patient need for detoxification facility and/or addiction specialist for support during managed withdrawal.
- II. Transition from methadone maintenance to Buprenorphine maintenance. Gradually reduce methadone dosage to the recommended amount prior to the transition to Buprenorphine.
- A. Stabilization/Maintenance.
1. During the first three or four physician office visits, the patient begins to participate in professional addiction treatment activities from a community provider.
 2. A plan for monitoring treatment progress is established by the treatment team, including urine analysis testing.
 3. Frequency of visits to the community treatment provider will be established as appropriate for the patient.
 4. Physician sees patient at least monthly for first six months.
 5. If appropriate, the patient may have up to one month of "take-home" medications.
 6. If a prescription is not refilled, the pharmacist will advise the community treatment provider.
 7. In some cases observed dosing may be indicated. This could be carried out at the physician's office, at the treatment agency or in the pharmacy.
- B. Long-Term Management.
1. Referral to Narcotics Anonymous or other 12-step program.
 2. Assess patient's ability to continue on take-home medications.
 3. Minimum of monthly check-in with community treatment provider. If and when appropriate, the counselor refers the patient to the physician.
 4. Plan for monitoring progress, including making adjustments to the treatment plan, is in place.
 5. Consult the BCPG for more details and options.
- C. The patient accepts the treatment plan. The plan anticipates barriers to treatment, including family dynamics, economic issues, transportation problems and other potential problems the patient identifies.

- D. Patient appointments with treatment provider and physician are coordinated to support the patient.
- E. Staffing-time is regularly scheduled.
- F. Patient induction protocol, as described in the BCPG, is conducted in the physician's office.
- G. Referrals are made for patients who need a higher level of care, or who are not making progress in treatment. Patient agreements guide discontinuation of services for non-adherence or aberrant behavior.

RECOMMENDATIONS OF THE OHIO ASSOCIATION OF COUNTY BEHAVIORAL HEALTH AUTHORITIES

1. Boards should explore the benefits of DATA 2000 to their service delivery structure including:

- a. Assessing the impact of opiate users to their current treatment structure. Based on that assessment:
 - i. Identify the viability of addressing the issue with medication-assisted treatment (MAT) protocols.
 - ii. Determine if modification to the local structure is warranted and if so:
 - iii. Determine which protocols would "best fit" their current service models (*i.e., MAT via office-based practice vs. MAT via certified methadone provider vs. standard detoxification protocols*).

2. Gain clarification on Federal priority consumers (IVDUs)

Interpretation on the priority status of IVDUs as related to waiting lists is varied. Although it is clear that IVDUs are given priority status on admission into treatment, it is less clear whether that priority is for movement through any level of care within the structure. This raises some of the following questions:

- a. Does a community detox provider have to admit IVDUs as a priority to that level of care regardless of how many times an individual has already received that service that year?
- b. If patients are already involved in services at a lower level of care, do they receive priority as they move up/down to different levels across the continuum?
- c. Can the patient described in question (a.) be offered "priority entry" into services at a lower level of care (level I-a, I-b) to work on treatment resistance/motivation vs. admission to detox (level III-c) whenever the patient self determines?

3. Explore the benefits of having a State level Chief Clinical Officer or Medical Consultant for the AoD system.

Historically, there has not been a coordinated professional relationship between primary care providers (physicians) and addictions treatment providers. Between the two there exist differences in theoretical constructs, educational frame of reference, and even treatment philosophy. DATA 2000, with its requirements for physicians to receive training in addictions and have the capacity to refer patients to counseling services, provides an opportunity to foster improved partnerships between the two disciplines.

Access to a centralized Chief Clinical Officer of Medical Consultant for the state addictions field, or a formal consultative relationship with an Ohio medical school, may be beneficial for a variety of reasons including:

- a. Providing addictions training for physicians (grand rounds), or other allied health professionals throughout the state.
- b. Recruiting and certifying physicians for Buprenorphine.
- c. Serving as an advocate for the addictions field in the larger primary health arena.
- d. Providing formal “positions” on new medications claiming to benefit consumers with addictions / gambling issues.
- e. Raising the addictions field’s credibility in the primary health care arena.