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Commentary: Providing Technical Assistance for the State Targeted Response for Opioid Use Disorders: Time is of the Essence

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Drug overdose deaths in the United States reached an alarming level in 2016 and continue to rise. Research shows that more than half of the 64,000 drug overdose deaths were due to opioids.¹ Moreover, the synthetic opioid, fentanyl, a medication that is at least 50 times more potent than heroin, has been implicated in over 20,000 of these deaths.¹ How did this happen? Who is to blame? In the early 1990's there was a shift in prescribing opiates/opioids for acute pain to the use of these medications for chronic, non-cancer pain conditions. Pharmaceutical company representatives and key opinion leaders who were experts in pain management stressed that addiction was a minimal concern for patients prescribed opiates/opioids for pain and encouraged physicians to use opioids/opiates for a myriad of chronic pain conditions. Many physicians chose to do so, although there were little data to support this.^{2,3}

Over the subsequent decade, the rates of opioid use disorders (OUDs) rose leading to more than a doubling of the rate of individuals seeking treatment for an opioid addiction (although most individuals with OUDs did not seek treatment).⁴ Moreover, rates of opioid-related deaths began to rise. Unfortunately, even though rates of new use of prescription opiates stabilized, albeit at a rate much higher than in the early 1990's, the rates of opioid use disorders continue to rise.^{5,6} With the increased availability and lower cost of heroin, many individuals transitioned to heroin and became addicted. Unfortunately, this, along with other factors, has led to a dramatic increase in heroin-related deaths. It is not entirely clear, however, that restriction of prescription pills has contributed to the persistent rise in heroin overdose rates from 2010 to 2015.⁵ In the past year, the opioid overdose death rates has continued to go up due to opioid laced with fentanyl, an even cheaper and more deadly product.

The treatment system was (and still is) woefully inadequate to deal with this epidemic. The majority of treatment programs and healthcare providers in the United States have been ill-

prepared to provide empirically-based treatment interventions. Meanwhile, longitudinal studies have demonstrated that individuals treated with pharmacologic agonist interventions such as methadone and buprenorphine effectively reduce opioid craving and use.^{7,8} Detoxification without maintenance on one of these life-saving medications greatly increases the risk of overdose and death.^{9,10} More recently, several studies have found that extended-release naltrexone (vivitrol) is equally effective as agonist treatments in reducing the risk of relapse once an individual is successfully inducted onto extended-release naltrexone.^{11,12} Several research groups have carried out work on how to facilitate induction onto this life-saving product; however, work in this area is still desperately needed.^{13,14}

Despite the availability of these effective medications to save lives, they are not widely used in the existing health care settings. It has been estimated that only one third of individuals entering a substance use disorder treatment for an OUD receive one of the 3 FDA-approved treatments for OUDs. This needs to change.

For the past decade, SAMHSA has supported healthcare professional training in providing medications for addiction treatment. Starting with the Physician Clinical Support System for Buprenorphine (PCSS-B) to the current Providers' Clinical Support System for Medication Assisted Treatments (PCSS-MAT, <https://pcssmat.org/>), and Providers' Clinical Support System for Opioid Therapies (PCSS-O) for chronic pain and opioid use disorders, the American Academy of Addiction Psychiatry PCSS, has led a consortium of other addiction organizations (AOAAM, ASAM, APA, AMERSA) and leading primary care national organizations in providing clinical education and support. Collectively PCSS partners and steering committee organizations represent over one million health professionals and key stakeholders. The currently funded PCSS consists of four primary components: (i) an educational resource program that includes trainings for primary care providers and multidisciplinary teams to prevent, identify, and treat opioid use disorders including the required 8 h (MD) and 24 h (NP and PA) course to meet the requirement to apply for the waiver to prescribe buprenorphine; (ii) a prescriber waiver training program that includes information on all FDA-approved medications (ie, methadone, naltrexone, buprenorphine), overdose prevention using naloxone, other aspects of addiction practice, specialized settings (eg, Drug Courts) and MAT implementation; (iii) a mentoring program that allows health professionals to access a variety of resources for timely and accurate responses to questions about treatment with a *Mentor on Call* (MOC) supported by each of the DATA 2000 organizations (AAAP, ASAM, APA, AOAAM) and AMERSA. The mentoring programs include: a national listserv/discussion forum, a telephone consultation service, a monthly clinical case discussion in small group format, and a one-on-one, longitudinal coaching opportunity; and (iv) a medication assisted treatment implementation program (MIP) that is a new initiative that aims to increase the capacity of organizations to integrate MAT for substance use disorders into their settings. Currently, each MIP Pilot site team is linked with a DATA 2000 organization taking the lead for two pilot clinical sites each year working with a multidisciplinary team of staff to assess and overcome barriers to implement MAT and provide evidence based practices. Each implementation team meets monthly for consultation and technical assistance to overcome those barriers and meet the needs of the clinical site.

Through this last initiative as well as our extensive experience in providing waiver trainings, we have learned several valuable lessons. First, most providers who receive MAT waiver training do not prescribe buprenorphine (or other medication treatments for addictions) or only prescribe to a handful of patients. The reasons for this are multifactorial but often what we have learned from discussions and surveys is that physicians and other prescribers have not been trained in addictions and are not “comfortable” treating these patients and do not have the time to provide adequate care. Second, byzantine insurance coverage can lead to difficulties in accessing appropriate treatment. For example, Medicare coverage does not currently cover methadone maintenance so patients who turn 65 find that they are no longer eligible for methadone maintenance treatment. Third, potential prescribers who may want to prescribe medications to treat addictions often do not have adequate support to do so. They need their allied health professional and administrative staff to be trained and understand treating addictions. Another major barrier is access to behavioral health services or adequate linkage to behavioral treatment. Moreover, developing streamlined systems that allow immediate access to treatment, including use of medications requires a commitment of the health care setting’s leadership to ensure that the organizational structure and policies support this approach. All of these internal and external barriers need to be aggressively dealt with to allow appropriate treatment to take place. Lastly, stigma remains a major barrier in all settings. While each clinical setting is unique with strengths and weaknesses more often than not stigma is the number one barrier to overcome before you can get staff from the front desk to the CEO willing to address the need for prevention, identification and treatment of all substance use disorders and in particularly OUDs and co-occurring mental disorders.

For many years, we have referred to MAT as medication assisted treatment but this is clearly a misnomer. Medication for OUDs should be “front and center” and should be considered first-line treatment. Psychotherapies, whether it be 12-step facilitation, motivational therapy or cognitive behavioral therapy or some combination of these approaches are important components of treatment but should not be delivered in lieu of providing medications. Further, all programs that purport that they have the capability to treat patients with OUDs should demonstrate that they have the resources and commitment to providing evidence-based practices including FDA approved medications for addiction treatment. However, this cannot be accomplished without an overhaul of our current treatment system. The 21st Century Cures Act has been critical in providing support to all of the single state agencies throughout the Country and US territories. However, even with this infusion of a billion dollars, the capacity of these agencies to ensure that medication addiction treatments are efficiently and competently delivered remains inadequate.

In an effort to address this need, SAMHSA released a request for applications that focuses on providing technical assistance to all 50 states and 7 territories receiving CURES funding. The American Academy of Addiction Psychiatry was recently awarded the grant to lead a large coalition of national organizations and experts in an effort to address this public health crisis across our nation. AAAP, with over 1,800 addiction psychiatrists and other physicians specializing in the prevention and treatment of addictions and mental disorders, will be leading this consortium called the State Technical Assistance Team Education and Support (STATES) Consortium. This consortium is an unprecedented alliance of physicians, nurses,

allied healthcare workers, recovery, prevention, and behavioral health organizations with broad national, regional, and state networks and technical expertise in preventing, treating, and supporting recovery from substance use disorders (SUDs) focusing on OUDs. The STATES Consortium is uniquely positioned to immediately deliver tailored, state-of-the-art clinical, and implementation technical assistance (TA) and training and clinical support to health professionals and communities. The STATES Consortium combines SAMHSA's investment in active initiatives (including: Providers' Clinical Support System [PCSS], Addiction Technology Transfer Center [ATTC] Network, Bringing Recovery Supports to Scale Technical Assistance Center Strategy [BRSS TACS]), with highly regarded experts and professional health care professional networks to maximize the impact of the Opioid STR grantees' programs. PCSS, led by AAAP, builds clinical proficiency of prescribers and others to address chronic pain, OUDs, and delivery of medication assisted treatment (MAT). Partnering with the core collaborators (AAAP, ATTC, RTI, CSI, Community for Anti-Drug Coalitions of America [CADCA], Boston Children's Hospital and Columbia University) along with numerous stakeholder and professional organizations, a monumental and nationwide effort will be implemented to provide technical assistance to each of the states and customize support based on the needs of each of the states. A major emphasis of this effort is to: (i) build on existing efforts enhancing and augmenting but not overlooking or competing with them; (ii) streamline operations to make them user-friendly and economical to maintain resources and sustainable after funding ends; (iii) create local mentors and support; (iv) fill in gaps where education and training are needed, and do not recreate the wheel.

While this mission is daunting, the stakes have never been higher. However, the expertise and commitment of the consortium and the numerous stakeholders cannot be overstated. Rather than being defeated by the enormity of the crises, we are heartened by how many people want to bring about change and combat the scourge of this opioid crisis.

If you have not joined in this effort we urge you to be a part of the solution and join AAAP and the consortium to help others.

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