NAADAC Position Statement on the Opioid Epidemic

The American public continues to hear much about the rise of the opioid epidemic and its devastating impact on individuals, families, and communities around the country. Now more than ever, it is important that we focus our efforts on curtailing this crisis. NAADAC, the Association for Addiction Professionals, will continue to champion treatment and recovery services that are inclusive, holistic, and unique to the individual needs of each affected person. In recognizing that treatment is not one dimensional, nor is there a 'one size fits all' method, NAADAC encourages the use of comprehensive treatment plans that encompass bio-psycho-social-spiritual needs as one begins his or her road to sustained recovery.

The enormous costs and staggering consequences of America's substance misuse problem led the U.S. Surgeon General to release a historical report in 2016: *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health*. Published by the Department of Health and Human Services, this report sheds further light on the public health impacts of drug and alcohol misuse — the first of its kind to ever do so. We at NAADAC are committed to keeping in perspective the impact of alcohol and other drugs, including marijuana, that are even more devastating in the number of people affected and the number of deaths. However, this Position Paper is specifically focused on the opioid crisis, and highlights NAADAC's continued support of the prevention, intervention, treatment, and recovery for people who are affected by opioid use, misuse, and addiction, as well as our call to elected officials and policy makers to insure affected individuals have services available that support their desire to obtain and sustain recovery.

The Enormity of the Problem and the Legislative Response

In 2015, an estimated 2 million people in the United States met diagnostic criteria for substance use disorder related to prescription opioid pain medications, and another estimated 600,000 met diagnostic criteria for opioid use disorder, specifically heroin.[1] Whereas heroin addiction was once viewed as the "seedier" end of the addiction spectrum, we now see individuals from all walks of life turning to this less expensive, and often easier to obtain, street drug as prescription opiates become more difficult to access and/or more expensive. Opioid (both prescription and illicit) overdose deaths increased nearly four-fold from 1999 to 2014[2], and in 2014, 28,647 people died from a drug overdose involving some type of opioid, including prescription pain relievers and heroin[3], bringing much government and media attention to what is now termed the "Opioid Epidemic."

The Comprehensive Addiction and Recovery Act (CARA) of 2016 was signed into law by President Obama. Many of its provisions address this epidemic, including provisions that:

- Improve education for healthcare providers in managing pain and safe prescribing practices;
- Create widespread availability of the overdose reversing drug, Naloxone, and training for first responders;
- Expand availability of medication assisted treatment to include counseling and urine drug screening;
- Increase the availability of prescription drug monitoring programs;
- Expand prevention programs, including those aimed at misuse of heroin and other opioids; and
- Improve the availability of long term recovery support services.

The Cures Act, which was also passed in 2016, provided funding of $1 billion over two years for many of CARA's provisions, with special requirements to focus on medication-assisted treatment (MAT) for those with opioid use disorder.

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The Importance of Treating the Whole Person

MAT is considered evidence-based and a best practice for treatment of opioid addiction, but opioid agonist medications, like buprenorphine and methadone, are not meant to act as stand-alone treatment. As addiction counselors, we know substance misuse and addiction to alcohol and other drugs have oftentimes devastating impacts on multiple life areas for the individual and those around them, including harm to one's physical, emotional, psychological, and spiritual health, as well as his or her family network, social wellbeing, and work/school life. Opioid agonist medications will hold off withdrawal symptoms and may help to heal some of the impact other drugs have had on brain function, yet a broader approach to treatment is needed. Hal Cohen, the Agency of Human Services Secretary in Vermont, said, "Each patient presents with different and usually complex needs. Physicians who treat patients with opioid addiction in the office-based setting must consider and plan for the full range of their patients' needs before initiating treatment. Candidates for buprenorphine treatment of opioid addiction should be assessed for a broad array of biopsychosocial needs in addition to opioid use and addiction, and should be treated and/or referred for help in meeting those needs."[4]

NAADAC recognizes the need for treatment approaches that address the biological, psychological, social, and spiritual needs of the individual. Many national experts support this view.

In its National Practice Guidelines, the American Society of Addiction Medicine (ASAM) states, "Psychosocial treatment is recommended in conjunction with any pharmacological treatment of opioid use disorder. At a minimum, psychosocial treatment should include the following: psychosocial needs assessment, supportive counseling, links to existing family supports, and referrals to community services."[5]

SAMHSA's publication, TIP 40 Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, dictates, "Pharmacotherapy alone is rarely sufficient treatment for substance use disorders. Treatment outcome literature demonstrates that adding psychosocial treatment to buprenorphine treatment is correlated with better patient outcomes."[6]

Federal opioid treatment standards set forth under 42 C.F.R. §8.12 "require that opiate treatment programs (OTP) provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment."

"In October 2015 President Obama issued a memorandum to all federal departments and agencies that provide, contract for, reimburse or are involved with health benefits. In it he stated, 'MAT is the use of Food and Drug Administration (FDA)-approved medications, such as buprenorphine, buprenorphine-naloxone combination products, methadone, and naltrexone — in combination with counseling, other behavioral therapies, and patient monitoring — to provide treatment for opioid use disorders.'"[7]

In 2016, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* credited evidence-based behavioral interventions as influential in "increasing patients' motivation to change, increase their self-efficacy…, or help them identify and change disrupted behavior patterns and abnormal thinking."[8]

The requirement for counseling was even directly stated in the approved product indication: "SUBOXONE sublingual film is indicated for treatment of opioid dependence and should be used as part of a complete treatment plan to include counseling and psychosocial support."[9] This language demonstrates that prescribing buprenorphine products without a comprehensive treatment plan is 'off label' use.

Several studies have shown retention rates for medication assisted treatment using buprenorphine to range between 44% and 48.4% for a three to six month time period.[10, 11, 12] Retention rates for treatment using methadone were higher, ranging between 55.3% and 74%.[13, 14] In both populations, positive urine drug screens for opiate and/or other drugs were over 50%.[15] The most frequently given reasons for dropping out of MAT were not unlike reasons why individuals with substance use disorders drop out of other treatment modalities: "craving for drugs; concomitant use of illicit drugs; family/partner influence; lack of motivation; concomitant use of legal drugs; doubt ability to lead a drug-free life; and confident can get along without therapy."[16]

In all published guidelines for MAT, the inclusion of a robust program to provide counseling and other behavioral therapies, along with patient monitoring through urine drug screening, is recommended or even required. Despite these recommendations, many patients report they receive only minimal services, if any at all, which may offer some explanation for the reasons given for discontinuing treatment, even though treatment of physical withdrawal and the associated craving are the target of MAT.

Important Role of Addiction Specialty Counselors and Aspects of Care

NAADAC believes counselors specifically trained and experienced in addressing addiction play a key role in the overall treatment of opioid dependent individuals, as well as those suffering from other types of substance use disorders. Understanding the multi-dimensional components of addiction, as well as the primary nature of the disease process, is paramount in effective treatment. And while we agree with President Obama when he said, "It doesn't do much good to talk about recovery after folks are dead,"[17] NAADAC also believes recovery is about more than overdose prevention.

Addiction counseling helps patients avoid relapse while overcoming the major challenges they face on their road to recovery. ASAM, in summarizing many models of relapse prevention, identified these components to minimize the risk of relapse, or attenuate the severity of a relapse episode:

- Identify environmental cues and stressors that act as relapse triggers;
- Learn to identify and manage negative emotional states;
- Work toward a more balanced lifestyle;
- Develop skills to cope with stressful life events;
- Understand and manage cravings;
- Learn to identify and interrupt lapses and relapses;
- Develop a recovery support network, such as joining a self-help group; and
- Utilize clinical resources available to patients, such as counseling.[18]

Licensed and/or certified addiction counselors are uniquely qualified to assist individuals to develop these skills and resources, and should be part of a multi-dimensional treatment approach for those receiving MAT. Addiction counselors also have a responsibility to be trained and competent to work with those individuals seeking recovery with the assistance of medication.

Naloxone for Overdose Prevention

The use of naloxone has proven to be a lifesaving medication to prevent death from opioid overdose. Addiction is a chronic disease with the potential for relapse. Those with a history of opioid use disorder who relapse to opioid use have a higher risk of death from overdose. As addiction counselors we have a responsibility to educate our clients about the use of naloxone for overdose prevention and relapse planning. We also recognize the critical importance of naloxone being available to all first responders across the country.

Call for Public Policy to Address Opioid Epidemic

As addiction professionals, we bring firsthand knowledge of the nature of addiction and the devastating impact on individuals, families, and communities. We also know the possibilities of recovery and the hope and healing that occurs. We are in a unique position to advocate for public policy and state and federal legislation that will support addiction prevention, treatment, and recovery. Each of us has that responsibility. In the case of the opioid epidemic, NAADAC will call for:

- Authorization of expanded funding for CARA;
- Maintaining the increased access to quality care the Affordable Care Act, along with the Mental Health and Addiction Treatment Equity Act, have brought to those struggling with substance use disorders;
- Strong requirements for, and expanded funding of, comprehensive treatment planning and counseling services by competent licensed/certified addiction professionals, along with monitoring through urine drug screens, to accompany medication assisted treatment;
- Expansion of MAT to reduce waiting lists and provide access, especially in rural areas;
- Funding to educate addiction counselors in MAT and its integration into psychosocial treatment approaches;
- Funding to have naloxone in the hands of all first responders;
- Inclusion of naloxone, naltrexone and Suboxone in the formularies of approved medications for insurance coverage; and
- Good Samaritan legislation that provides a defense to prosecution for an individual who calls for help for him/herself and/or someone else at risk of overdose.

The opioid epidemic has had a devastating effect on our country. Many lives have been lost, but addressing the opioid epidemic is to go beyond preventing overdose. Recovery in all areas of life is possible and what we believe all individuals with opioid use disorder can achieve.

(Endnotes)

[1]U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (p. 1-9). Washington, DC: HHS, November 2016.

[2]U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (p. 1-14). Washington, DC: HHS, November 2016.

[3]U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (p. 1-1). Washington, DC: HHS, November 2016.

[4]Knopf, Alison (2015, December). Vivitrol pilot in Vermont focuses on recently released inmates. *Alcoholism & Drug Abuse Weekly, 27*(46).

[5]American Society of Addiction Medicine. (2015). *National Practice Guidelines* (p. 103).

[6]U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration, *KAP Keys For Physicians Based on TIP 40 Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Washington, DC: HHS, 2005.

[7]Knopf, Alison (2015, November). President calls for more MAT to fight opioid epidemic. *Alcoholism & Drug Abuse Weekly, 27*(42).

[8]U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (p. ES-14). Washington, DC: HHS, November 2016.

[9]Indivior. (2016). SUBOXONE Film, retrieved from: https://www.suboxone.com/treatment/suboxone-film.

[10]Soyka, M., Zingg, C., Koller, G., & Kuefner, H. (2008). Retention rate and substance use in methadone and buprenorphine maintenance therapy and predictors of outcome: results from a randomized study. *International Journal of Neuropsychopharmacology Study, 11*(5), 641-653.

[11]Burns, L., Gisev, N., Larney, S., Dobbins, T., Gibson, A., Kimber, J., Larance, B., Mattick, R., Butler, T., & Degenhardt, L., (2015). A longitudinal comparison of retention in buprenorphine and methadone treatment for opioid dependence in New South Wales, Australia. *Addiction, 110*(4), 646-655.

[12]Hser, Y.I., Saxon, A.J., Huang, D., Hasson, A., Thomas, C., Hillhouse, M., Jacobs, P., Teruya, C., McLaughlin, P., Wiest, K., Cohen, A., Ling, W. (2014). Treatment retention among patients randomized to buprenorphine/naloxone compared to methadone in a multi-site trial. *Addiction, 109*(1), 79-87.

[13]Soyka, M., Zingg, C., Koller, G., & Kuefner, H. (2008). Retention rate and substance use in methadone and buprenorphine maintenance therapy and predictors of outcome: results from a randomized study. *International Journal of Neuropsychopharmacology Study, 11*(5), 641-653.

[14]Hser, Y.I., Saxon, A.J., Huang, D., Hasson, A., Thomas, C., Hillhouse, M., Jacobs, P., Teruya, C., McLaughlin, P., Wiest, K., Cohen, A., Ling, W. (2014). Treatment retention among patients randomized to buprenorphine/naloxone compared to methadone in a multi-site trial. *Addiction, 109*(1), 79-87.

[15]Soyka, M., Zingg, C., Koller, G., & Kuefner, H. (2008). Retention rate and substance use in methadone and buprenorphine maintenance therapy and predictors of outcome: results from a randomized study. *International Journal of Neuropsychopharmacology Study, 11*(5), 641-653.

[16]Soyka, M., Zingg, C., Koller, G., & Kuefner, H. (2008). Retention rate and substance use in methadone and buprenorphine maintenance therapy and predictors of outcome: results from a randomized study. *International Journal of Neuropsychopharmacology Study, 11*(5), 641-653.

[17]Miller, J., (2016). Obama underlines a collective approach to addiction. Behavioral Healthcare, retrieved from https://www.behavioral.net/article/obama-underlines-collective-approach-addiction.

[18]Kraus, M., Alford, D., Kotz, M., Levounis, P., Mandell, T., Meyer, M., Salsitz, E., Wetterau, N., & Wyatt, S. (2011). Statement of the American Society of Addiction Medicine Consensus Panel on the Use of Buprenorphine in Office-Based Treatment of Opioid Addiction. *Journal of Addiction Medicine, 5*(4), 254-263.