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How Health Reform Will Affect OTPs— An Interview With A. Thomas McLellan



This summer, as he was winding down his tenure as deputy director of the Office of National Drug Control Policy (ONDCP), A. Thomas McLellan, PhD, reflected on how changes in Washington will affect medication-assisted treatment (MAT). The interwoven laws of health care reform and parity will have the biggest impact, he told *AT Forum* in an exclusive interview.

“Health care reform removes what has been de facto segregation of addiction treatment from the rest of health care,” said Dr. McLellan, noting that two pieces of legislation—the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA)—will make this integration happen. “Until now, there has been no provision for benefits, training, teaching, or development, or even recognition that care for substance use disorders is part of general health care.”

What the substance abuse treatment field in general would like to see is more funding, more slots, more beds. The Obama administration has been focusing more on prevention and early intervention initiatives, such as increased screening and brief interventions by primary care providers. But this will ultimately result in more referrals for opioid treatment programs (OTPs) and other providers, said Dr. McLellan. When general health care providers screen for substance abuse problems, specialty treatment will get more referrals—and they will come from the medical field, not just from

criminal justice and welfare. “Currently, specialty addiction treatment gets fewer than three percent of its referrals from medical providers,” he said.

The ACA will also mean that many more patients will have private insurance. Some health plans still expressly refuse to pay for MAT, in violation of parity. “We don’t think they have the right to do that,” said Dr. McLellan. Lawsuits against these plans are probably going to be coming from the states and the federal government.

Dr. McLellan noted that when patients have insurance, it means providers need to know how to bill. “I think that in the future, methadone maintenance programs at the state level will be able to bill for medication, counseling, and follow-up, as you would bill for any other chronic illness, through the Affordable Care Act.” Payment would be made by Medicaid or by private insurance—and almost everyone would be covered, regardless of income level. This represents a major change from current practice, one that will make it possible for many more patients to access OTPs.

In addition, the Obama administration is planning to make recovery-oriented services accessible through the Substance Abuse Prevention and Treatment block grant awarded to the states by the Substance Abuse and Mental Health Services Administration. These services, which include items such as job training, would be paid for by the block grant, and would be something new that OTPs could offer to patients to support their recovery.

(continued on page 7)

“I think that in the future, methadone maintenance programs at the state level will be able to bill for medication, counseling, and follow-up, as you would bill for any other chronic illness, through the Affordable Care Act.”

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In This Issue

Readers Respond to Pennsylvania Proposal to Limit Length of MAT

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The Summer 2010 issue of *AT Forum* included a news item about a proposal from Pennsylvania legislators to severely restrict access to medication-assisted treatment (MAT), including State Senator Kim Ward's statement in the interview: "It doesn't help to keep people on methadone for 10 years."

We received two letters thanking us for the article and expressing great concern about the proposal and the senator's comment.

- "Does it also do 'no good' to have someone on insulin for 10 years, or on Prozac, or lithium? What on earth is her basis for such a remark? What possible science would back this up? As a Certified Methadone Advocate, I wrote to Senator Ward and the other senators involved with the bill weeks ago when it was being proposed. I included careful explanations and appropriate scientific and medical references. I received not a single response. The senator can easily ignore letters from patients like me, but what would she say if confronted in public with proof of the error of her proposal? Methadone maintenance treatment is too often viewed as a reward to lure addicts into counseling, not as a treatment in and of itself. If people understood more about the physical aspects of opioid addiction and brain chemistry, it would go a long way towards acceptance of MAT as a valuable treatment option. Thanks for the article!"
- "I've been on methadone maintenance treatment 12 years, many of these years at 600 milligrams, and at 480 milligrams for the past several years. Senator Kim Ward probably would suggest I was an example of what she was referring to when

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she said, "It doesn't help to keep people on methadone for 10 years." Fortunately for me, my family, and my employer, she hasn't had control of my state's methadone clinics. I'm fortunate to have a clinic doctor who understands much more than these politicians do. I'm certain my doctor was given much grief from the State Agency over the years, because of my need for higher than average levels of methadone, yet he held his ground and has kept me where I needed to be. I also know without a doubt that if Senator Kim Ward were to meet me in a social, business, or professional setting, she would never guess I was an MMT [methadone maintenance treatment] patient, and if told my daily dose, probably would not believe it. As you point out over and over, these people and their laws and their proposed laws are based on everything and anything but science."

Your feedback is important to us. Comments or suggestions for articles are always welcome.

Sue Emerson, Publisher
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Pennsylvania: Single Bill Emerges From Package With Full Support from OTPs



From a package of bills that would, in varying degrees, restrict medication-assisted treatment (MAT) in Pennsylvania, one has emerged that has the full support of opioid treatment programs (OTPs). This bill, sponsored by treatment champion Rep. Gene DiGirolamo (R-Bucks County), would provide for a team to "conduct a methadone death review" for any methadone-related death. The "death review team" would also be a "repository for complaints and any problems arising from the operation of opioid treatment programs," according to the bill.

The impetus for the death review bill came from families who lost loved ones due to methadone, Rep. DiGirolamo told *AT Forum*. "I really wanted to look into this and see if it is a big problem across the state."

Deaths and incidents related to methadone prescribed for pain will be reviewed as well, he said. "Are the doctors getting the right information and the right education about methadone, and about how it reacts with the other medications that might be involved?" asked Representative DiGirolamo.

The groups endorsing the bill include: Drug and Alcohol Service Providers Organization of Pennsylvania (DASPOP), the Pennsylvania Association of County Drug and Alcohol Administrators, the Pennsylvania Recovery Organizations Alliance, and the Pennsylvania Association for the Treatment of Opioid Dependence (PATOD). In addition, Mark Parrino, president of the American Association for the Treatment of Opioid Dependence (AATOD), and Mark Sarneso, vice president for government relations for CRC Health Group, a member of DASPOP and PATOD, also support the bill.

So does Rick Froncillo, the patient ombudsman for Discovery House, who is also the Pennsylvania representative to AATOD. "We believe methadone-related deaths are not coming from OTPs," Froncillo told *AT Forum*. "We think that once and for all people will see that these incidents are from other sources and not coming out of methadone clinics," he said. "The majority of people in PATOD voted to support it because we're tired of being held responsible for morbidity and mortality not related to our system."

The other bills probably will not be brought up—at least not this year.

Feds Vindicate OTPs: Most Methadone Overdose Deaths Due to Pain Prescribing



Opioid treatment programs (OTPs) were exonerated by federal regulators this summer in the increase in methadone overdose deaths that occurred over the past decade. Early on in the epidemic, many people didn't realize that methadone was prescribed for pain, and assumed that overdoses were related to methadone maintenance treatment for opioid addiction. In recent years several reports have clearly pointed to pain prescribing as causing the problem, but July's "methadone mortality summit" marked the first time all of the key federal agencies agreed that methadone-related overdose deaths are mainly due to pain prescribing.

While this isn't news—several reports, including one from the Government Accountability Office (GAO) and the Centers for Disease Control and Prevention (CDC), issued since the last methadone mortality summit in 2007, have said the same thing—it is news for the regulatory agencies to say it in unison.

For all of the agencies in charge of overseeing OTPs to agree—and to finally publicly state that OTPs were not responsible for most methadone-related overdoses—is a huge but hard-won victory for the field.

Bob Lubran, director of pharmacologic therapies at the Center for Substance Abuse Services (CSAT), the agency that regulates OTPs, was particularly strong in vindicating OTPs, telling *AT Forum* that a link between diverted take-homes and overdoses is "not on anyone's radar screen."

That's a big step from three years ago, when CSAT and other agencies said there was not enough evidence to blame the overdoses on pain prescribing. The shadow cast over OTPs at the time had been deepened by anti-methadone groups.

In addition to CSAT, the Drug Enforcement Administration (DEA), the CDC, the National Institute on Drug Abuse (NIDA), and the Food and Drug Administration (FDA) participated in the summit.

Mark Parrino, president of the American Association of Opioid Treatment Programs (AATOD), who also participated in the summit, commended CSAT for recognizing that overdose problems are mainly related to methadone prescribing through pharmacies. In particular, he was impressed by the agreement among agencies. "This was the most coordinated I've seen them," he says. "Federal officials are on the same general page."

But OTPs should not take this message to mean that they don't need to be vigilant about preventing diversion and making sure physicians and staff are adequately trained in the pharmacology of methadone. CSAT's risk management approach extends to training physicians who prescribe methadone for pain, but there is a desire to train OTP medical personnel as well. "I've always been concerned about this," said Mr. Parrino. "Doctors in OTPs are generally more informed about addiction." But he also added there needs to be adequate physician coverage in the programs, and in some cases better training for the physicians.

According to Mr. Lubran, the area of greatest concern for patients in OTPs is induction, and CSAT is looking at this closely. "Start low, go slow" is the key for safe induction, since this is the most risky part of treatment for patients. "Even one or two deaths are too many," he said, citing the "small number of deaths" reported in the voluntary OTP death-reporting program.

For all of the agencies in charge of overseeing OTPs to agree—and to finally publicly state—that OTPs were not responsible for most methadone-related overdoses is a huge but hard-won victory for the field.

The next step is for the government to publicize the report on the summit, which was expected to be available from CSAT this fall. OTPs can use the summary of the meeting in their own anti-stigma campaigns.



Association for Behavioral and Cognitive Therapies
November 18-21, 2010
San Francisco, California
Contact: www.abct.org

American Academy of Addiction Psychiatry 21st Annual Meeting and Symposium
December 2-5, 2010
Boca Raton, Florida
Contact: www2.aaap.org

The American College of Psychiatrists (ACP) Annual Meeting
February 23-27, 2011
San Francisco, California
Contact: www.acpsych.org

The American Counseling Association (ACA) Conference and Expo
March 23-27, 2011
New Orleans, Louisiana
Contact: www.counseling.org

The American Academy of Pain Medicine (AAPM) 27th Annual Meeting
March 24-27, 2011
Washington, DC
Contact: www.painmed.org

Events to Note

Peer Recovery Support in MAT—The MARS Pilot Project

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Walter Ginter, CMA, has been one of the country's leading advocates of medication-assisted treatment (MAT) for opioid addiction over the past decade. He has been in recovery for more than 30 years. In September we talked with him about the success of his pilot project on peer recovery support in the Bronx, New York.

If Walter were to post a credo on his office wall, it might read something like this:

- Opioid addiction is a brain disorder
- Opioid addiction is a chronic disease
- Some people will be prescribed methadone maintenance for an indefinite time

The medical community wasn't convinced of these facts 30 years ago, when Walter began methadone treatment. At several intervals over the next 20 years, his counselors and family told him it was time to quit MAT—despite his successful therapy. Each time he tried to quit, he relapsed to illicit opioids.

It wasn't until the late 1990s, when Walter met advocates from the National Alliance for Medication-Assisted Recovery (NAMA), that he was introduced to the science of addiction and methadone.

His initial response was anger. "Why did I have to go through 20 years of feeling miserable about myself because I couldn't get off of methadone?"

"After I got over my anger, I didn't want others to go through what I did. That's when I became a patient advocate supporting recovery."

The MARS Project

In short, what happened to Walter many years ago led to his becoming the founder and director of the Medication Assisted Recovery Services (MARS) Project, a peer-initiated and peer-based recovery support project sponsored by NAMA. Funded in the fall of 2006 through the Recovery Community Support Program (RCSP) under the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT), MARS is the first project funded for MAT patients, and the first recovery support project created and carried out by MAT patients themselves. According to Walter, "the learning curve of grant writing is steep, and the project didn't succeed until its third submission round."

MARS is a collaboration between NAMA and Albert Einstein College of Medicine (AECOM), Division of Substance Abuse (DoSA), in the Bronx, New York. "AECOM provided our space. It's not actually inside the OTP, but it's right next door and gives us convenient access. We provide peer recovery support services; Einstein provides treatment, from primary care to medication-free services, links to vocational rehab, and mental health services. MARS offers a place for all patients who want to take part to meet and share experiences, strengths, and resources, and to support each other."

MAT patients are welcome to participate in MARS as regular

attendees or on a drop-in drop-out basis. The depth of participation is their choice; there are no "stages" or "phases" to pass through.

Core Training on Addiction and Methadone

"The most important thing we do is our core training," Walter explains. "We realized patients were missing exactly what I missed during those early years: an understanding of what opioid addiction is, how it affects your brain, its chronic nature, and how methadone works. The MARS project differs from other programs in that we teach about medications, including stabilization during induction, the half-life of methadone, and the importance of coming to the clinic every day to receive medication. And why some patients may need methadone for the rest of their lives, like me; how each patient is an individual."

"For a long time, the medical community had two views about methadone. The 'magic bullet' view, 'Just take the methadone, that's all you need.' On the other side was, 'You don't need methadone, just go to groups and control your behavior.'"

"Now we know that opioid addiction has two components. Many patients need medication, and methadone works. But opioid addiction has behavioral components as well; managing them may require peer recovery support services that traditionally have been available only in the medication-free or drug-free recovery community."

Group Sessions and Advocacy

"We've registered about 450 peers in MARS. About 50 are at our recovery project on a given day. MARS has 12 peer leaders who come from the community of patients at Einstein."

"We established a MARS council, where peers decide weekly what the project is going to do, what groups they want, what events they want to hold, and what their plans are for the future. We plan for recovery month events each September. The peers make decisions regarding recovery and project issues."

"Each week there is one peer-leader training session and 18 group sessions. We also provide two types of advocacy for patients: one with treatment providers, such as Albert Einstein; the other with social services. Some peers are intimidated when they try to enroll in Medicaid, so they walk out without getting a card. We go back with them and help them obtain Medicaid and other entitlements."

"Except for core training, our groups are peer initiated and peer led. Many groups are about health and wellness. Peers choose the topics; they know what they need—such as information about hepatitis C. We also have groups on HIV, trauma, and other health and mental health issues."

"Every Friday, MARS conducts a relapse-prevention course that addresses the upcoming weekend, and is designed to help peers maintain their recovery focus through to Monday morning. That was something the peers wanted. MARS also holds off-campus events funded from the grant. We visit museums, often go bowling, and



have picnics. We don't go to movies. Instead, we focus on places where our peers are able to communicate with one another. Many peers don't know how to socialize without a glass of wine or some cocaine or marijuana. Just learning to socialize, to talk with people, is so important.

"When patients come into an OTP, they view being on medication as the low point of their life. 'I'm now in the methadone program.' Many will say, 'I'm just going to be here for three months, until I get my act together, then I'm going to detox, and then I'll be off.' If they want to try to taper, we support their choice. I tell them, 'I'm not selling medication, I'm selling an informed decision.' I want them to have all of the answers I didn't have."

Are They Patients... or Peers?

"When we first became part of the RCSP community, we were encouraged to use the term 'peers' instead of 'patients.' It took a long time for our people to refer to themselves as 'patients' instead of 'clients,' and it wasn't something I was prepared to abandon. But those in MARS made the decision for me. They decided that when they're at the OTP, they're patients, but when they're in the MARS recovery project, they're peers—and peers in the purest form: equals. That was one of my happiest days, because I knew that they had taken ownership of the MARS project, as well as their own recoveries."

"Those in MARS have decided that when they're at the OTP, they're patients, but when they're in the MARS recovery project, they're peers—and peers in the purest form: equals."

Recovery Is... and Isn't...

Recovery is a key component of the MARS project, and something few people understand. "Some patients come in believing that recovery is something that happens after you leave treatment," Walter says. "At some 12-step meetings, methadone patients are often forbidden to speak. They're viewed as using a mind-altering drug [methadone] and as still getting high.' That's not true, of course.

"So, many come away with the attitude, 'I'm less worthy than somebody who's medication-free'—the same way I felt years ago. 'What's the matter with me?' Well, it's just the nature of the disease of opioid addiction.

"Our core training helps patients understand that if they stop using alcohol and illicit drugs, they're *in* recovery. If they start using less, they're *on the road* to recovery.

"Recovery has nothing to do with giving up or not giving up medication. Those who stop using are *in recovery*, whether they're taking medication as part of treatment or not."

For Additional Reading

White, WL. *Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services, 2009. <http://www.oregon.gov/DHS/addiction/recovery/peer-addiction-recovery-support.pdf?ga=t>. Accessed October 12, 2010.

Center for Substance Abuse Treatment. *What Are Peer Recovery Support Services?* HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009. http://rcsp.samhsa.gov/_pubs/peer_rss.pdf. Accessed October 12, 2010.

The Future of MARS

The MARS project is now up for renewal. Walter notes: "During our four-year pilot project we've proved our premise: There are certain things patients—peers—can do better than treatment providers can."

Peer recovery support provides someone to share experiences with, someone to learn from, "and," Walter notes, "more important, *someone to teach the lessons I didn't learn during those first 20 years*."

"The MARS pilot project is a huge responsibility for our peers. They realize this project is unique. People go out of their way to help one another, because we all want MARS to be successful and to continue beyond the initial funding."

As Walter notes, the current success of MARS is especially remarkable because the clinic is located in the south Bronx, a poverty epicenter in our nation, with the highest rates of addiction and HIV infection in New York City. "We're located next door to the OTP. Patients leaving the OTP have a conscious decision to make—a right turn into the elevator, then out to the street, where heroin and crack cocaine are easily available, or a left turn into our MARS project, and an investment in recovery."

The fact that so many patients choose that left turn into MARS describes much better than words the success of the MARS project.

In addition to his work at MARS, where he is a project director and director of training and recovery services, Walter Ginter represents NAMA as a planning partner for National Alcohol and Drug Addiction Recovery Months. Walter served as a board member of Faces and Voices of Recovery, and remains an active member of that group. He is often called upon by SAMHSA/CSAT to represent medication-assisted recovery on panels and workgroups, and delivers presentations at major conferences throughout the nation on this topic.

Walter received the Richard Lane Advocacy Award at the April 2009 conference of the American Association for the Treatment of Opioid Dependence (AATOD).

As *AT Forum* went to press, Walter received word that the MARS project will be funded for four more years.

"If patients stop using alcohol and illicit drugs, they're in recovery. If they start using less, they're *on the road* to recovery. Those who stop using are *in recovery*, whether they're taking medication as part of treatment or not."

Hooked on Prescription Opioids, Some Users Turn to Heroin and Other Street Drugs

6



Most patients hospitalized for opioid detoxification don't fit the "hooked on

street drugs" stereotype, according to a recent small study from the University of Buffalo. About 40 percent of the 75 study patients became addicted to opioids legitimately prescribed for pain. Another 32 percent initially obtained prescription opioids from the family medicine cabinet, driven by pain or curiosity, or from a friend—often at "pill parties." Only about 27 percent—20 patients—said they first became hooked on street drugs.

Almost all—92 percent—eventually bought street drugs, primarily heroin, finding them more effective and less expensive than prescription drugs. They continued using in order to "feel normal" or "feel like a better person," or because the drugs "helped to take away my emotional pain and stress."

Users said prescription drugs are available in high schools, "at the prom," and are used by athletes "to make it through the game," and to get high during weekends and off-seasons.

Patients in the study had an average age of 32 years. About 65 percent were men, 75 percent were white, and 75 percent had a high school diploma or equivalent. Those who became addicted from taking drugs legally prescribed for pain were more likely to be older and female, have a college degree, and take the drugs orally.

When asked if any doctor had ever questioned them about a substance use problem before writing a prescription, 74 percent of the 53 participants who answered the question said no.

Recently published in the *Journal of Addiction Medicine*, the study will be used to educate physicians about screening, treating, and referring patients before addiction becomes life-threatening.

Source: University of Buffalo, August 20, 2010.

OTP Patients Need Confidentiality Protections of 42 CFR Part 2

The Federal regulations protecting the confidentiality of patients in substance abuse treatment, known as 42 CFR (Code of Federal Regulations) Part 2, have special meaning for patients in medication-assisted treatment (MAT). These patients bear the brunt of stigma, as health care professionals often view MAT with suspicion, whether they are being denied adequate postoperative pain medication, dubbed drug-seeking by emergency department (ED) physicians, or in general viewed with skepticism by medical professionals who are insensitive to or uninformed about MAT.

Robert Newman, MD, director of the Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center in New York City, is "totally opposed to any change in the current CFR, unless it's to tighten it up," he told *AT Forum*. "If you want to know if someone is on methadone, you ask them."

Patients list the medications they are on, in general, when asked by a doctor or nurse in primary health care, or in an ED. "If they don't list methadone, there's a reason," he said. "It's because they feel it's not in their best interest." They have learned not to list the fact that they are in MAT because they are often treated less than adequately when they do, he said, noting that their fear is "very well founded." For example, "If they seek treatment for pain, their likelihood of getting adequate analgesic medication is drastically reduced if it is known they're on methadone maintenance."

It's bad enough that the public at large views patients on methadone maintenance as merely substituting one drug for another, said Dr. Newman. "The tragedy in my view is that the stigma against methadone treatment and the methadone patient is at least as great among medical professionals as in the community."

Dr. Newman has a very personal involvement in confidentiality issues, dating back to 1972, before 42 CFR Part 2 was in effect. "I was working for the New York City health department, and the Manhattan district attorney subpoenaed photographs of all black men in one of our methadone clinics, in connection with a murder investigation." Dr. Newman refused to comply, and the DA sought and obtained a contempt of court citation. Dr. Newman was sentenced to 30 days in jail.

The City's Corporation Counsel refused to defend Dr. Newman, but a clause in the contract of civil service employees allowed a personal attorney in such situations, and Dr. Newman was represented pro bono by his brother, a lawyer. "My brother prevailed," Dr. Newman said. "The jail sentence was stayed and the conviction was reversed on appeal. The DA appealed to the U.S. Supreme Court, but it refused to hear the case." *People v Newman* was cited when 42 CFR was introduced as an example of the need for stringent protections of OTP patient privacy.

Under 42 CFR Part 2, a substance abuse treatment program receiving federal support that includes virtually all opioid treatment programs (OTPs) may not divulge any identifying information about a patient without that patient's consent. The consent must be in writing, must state to whom the information will be released, and must include an expiration date for the consent.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for promulgating the confidentiality regulations, and this summer stated categorically that it would not change





the regulations, despite continual pressure from some groups and individuals. Earlier this year, SAMHSA and the Office of the National Coordinator (ONC) issued FAQs, written by the Legal Action Center, stating that the confidentiality regulations would remain. And at an August 4 public meeting on the FAQs, H. Westley

Clark, MD, JD, director of SAMHSA's Center for Substance Abuse Treatment (CSAT), made it clear that the major objection to the regulations, that they would be impossible to implement in an era of the electronic health record (EHR), was incorrect. Groups claiming that requiring a specialized consent would hamper the implementation of EHRs pressured SAMHSA to remove the consent process.

But even if there were a technological solution to the EHR issue, the groups that wanted to weaken 42 CFR Part 2 would still object, on the grounds that free circulation of substance abuse treatment information among health care providers was essential to quality clinical care. If health care providers didn't know that a patient

was on methadone, for example, this group, loosely under the direction of Eric Goplerud, PhD, asserted that patients could be given a contraindicated medication. In fact, when Dr. Goplerud's group first proposed revising the regulations, it used many examples involving methadone medication and OTP patient consents.

The OTP community—and CSAT—viewed this attitude as paternalistic. "Sometimes we talk about paternalism—what providers think is best," Dr. Clark said at the August 4 public meeting. "But we also need to think about benevolence, not causing harm, autonomy, and the rights of patients to influence their own lives."

Patient advocates present at the August 4 meeting spoke eloquently of the need to preserve 42 CFR Part 2. "We think it's very important to maintain confidentiality for people who are on medication for their addiction treatment," said Joycelyn Woods, national director of the National Alliance for Medication Assisted Recovery (NAMA). Many patients want to be the ones to tell a doctor, face to face, when seeking care, if they are in MAT. "If that information goes ahead of them, the likelihood of their receiving any medical care at all goes to zero," she said.

This is an important part of the "two-way trust" between physician and patient, said Dr. Clark. The physician has to trust that the patient will explain what is needed in order for the physician to deliver care, and the patient has to trust the physician to use that information appropriately.

Thomas McLellan, PhD, then deputy director of the Office of National Drug Control Policy, also spoke in support of retaining full confidentiality protections. "I started with grave worries that we would not be able to comport between the EHR and the prevailing privacy and confidentiality regulations." The main thing that changed Dr. McLellan's mind was the "wish of patients to have privacy." Many states don't think HIPAA (the Health Insurance Portability and Accountability Act of 1996) is adequate to protect privacy, and want greater restrictions, Dr. McLellan

noted. Under HIPAA, information can be shared in order to provide medical care, without consent. "HIPAA is not going to reassure the person who presents for treatment, because anybody who wants their information can get it if they ask for it," said Dr. Clark.

Additionally, SAMHSA and ONC put concerns about EHR-42 CFR conflicts to rest by showing that the technology of record segmentation makes it possible to preserve 42 CFR Part 2 within an electronic environment. Patients can still consent to share their information if they choose to with specific health care providers.

The health care system itself, not law enforcement, is now the biggest threat to patient confidentiality and to the integrity of MAT, said Dr. Newman. He was not able to attend the August 4 hearing, but shared his feeling about confidentiality in an interview with *AT Forum*.

In particular, he believes that before there's discussion of loosening 42 CFR there is a need to sanction and stop existing practices that violate the regulations. He cited a "methadone registry" operated by the State of New York that refuses to expunge identifying information on many tens of thousands of former patients who are no longer in treatment, even though federal law makes it illegal to utilize such data for any purpose whatsoever. He notes that the one and only permitted purpose of such registries, according to 42 CFR, is to prevent multiple enrollment—obviously not an issue with individuals

known to have left treatment. In fact, Dr. Newman claims the registry releases information on these former patients as a matter of routine. He has sought intervention of the U.S. Attorney's office, but it has refused to get involved.

"I'm not worried about the cops. I'm worried about the medical care providers and government agencies that ignore the protections established decades ago," Dr. Newman said.

"The tragedy in my view is that the stigma against methadone treatment and the methadone patient is at least as great among medical professionals as in the community."

How Health Reform Will Affect OTPs— An Interview With A. Thomas McLellan

(continued from page 1)

"We've been criticized for emphasis on primary care, and people say we should have doubled the block grant instead," said Dr. McLellan, for whom this is clearly a sore point. "But what they fail to understand is that so many services will be available, and will be 100 percent federally reimbursed."

This new landscape doesn't mean that OTPs will in any way be watered down or subsumed under a new system—in fact, they will grow.

According to Dr. McLellan, the emphasis on primary care, and on medications such as buprenorphine, will help attract patients to addiction treatment. But buprenorphine will not replace methadone or OTPs, because it won't be adequate for many patients in a primary care setting. Instead, Dr. McLellan said, patients will need the more comprehensive care provided in OTPs, with methadone maintenance and behavioral counseling. "This is the great boon, that patients with substance use disorders will have more and better choices.

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Variations in States' Approaches to Alcohol Misuse in OTPs



A patient arrives for daily dosing at his opioid treatment program (OTP) under the influence of alcohol. What happens next?

That depends in part on the policies of the patient's state opioid treatment authority (SOTA). Each state is required to have a single state agency in order to

receive block grant funds. States that operate OTPs need to designate a state authority, the SOTA, to oversee the OTP system. Usually the SOTA is one person in a single state agency, but this varies from state to state.

Policies of SOTA personnel show a surprising variation among states, according to a study in the *Journal of Substance Abuse Treatment*. Gathering data from telephone interviews of 46 participating SOTAs, the authors found:

- 29 SOTAs require or recommend that the OTP staff know how to treat patients' alcohol misuse
- 27 have guidelines in place for addressing patients' alcohol misuse
- 23 require or recommend alcohol education for all OTP patients
- 21 require OTPs to assess and monitor treatment outcomes for at least some patients who misuse alcohol
- 17 specify actions to take if patients arrive for daily dosing under the influence of alcohol
- 7 discharge patients for continued alcohol abuse

The authors point out that SOTAs are in an ideal position to influence alcohol-related issues and help patients reduce or eliminate alcohol intake. They note that SOTAs need to avoid extensive regulation of patients' alcohol use, and that OTPs and clinicians need latitude in making treatment decisions.

Although SOTAs gave a high rating to the importance of addressing patients' alcohol issues, their policies and guidelines did not always reflect this assessment. The authors recommend SOTAs improve their treatment standardization and strive to be more proactive in the points listed above—such as monitoring treatment outcomes and specifying actions to take if patients arrive for dosing after drinking alcohol.