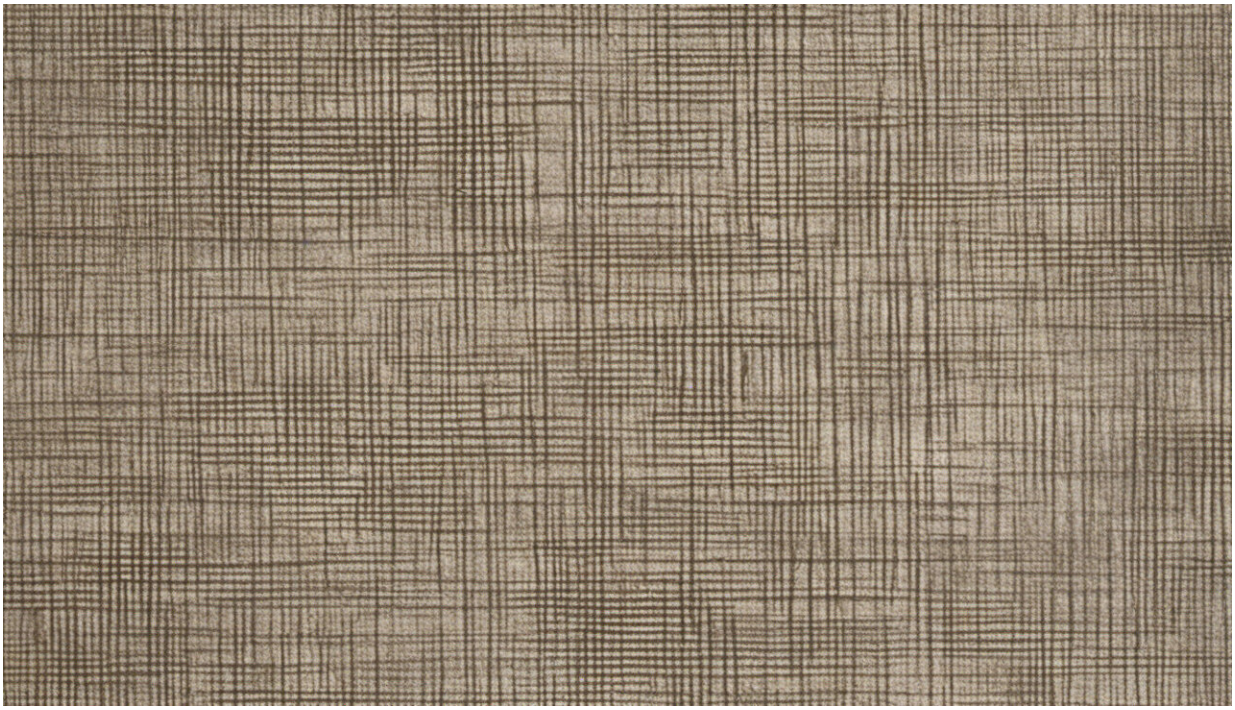
Despite national efforts to fight addiction, states can make cuts anyway

July 20 2016, by Sheryl Strasser



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The U.S. Senate approved a bill July 13 with a vote of 92-2 to treat the nation's opioid addiction crisis. It's worth noting that one state – Georgia – recently passed a law that could block, rather than expand, access to treatment. Could other states also go in Georgia's direction? Could it possibly be a good idea?

In 2014, more than 47,000 Americans died from drug overdoses, and two-fifths of these were from opioid-based medicines for pain control, with the most common forms being hydrocodone and oxycodone.

Individuals with prescription drug addiction are also more likely to use cheaper, but more deadly forms of opioid-based illicit drugs, including heroin. Drug addiction is recognized as a chronic health condition, but only 11 percent of the 23.5 million Americans (ages 11 and older) with substance use disorder actually receive treatment.

These disturbing trends have triggered national responses in addition to the bill passed July 13, which provides treatment and law enforcement professionals with more tools to help those with addiction. The bill would expand access to naloxone, a drug that reverses overdoses. It also would expand treatment programs for those in jails and prisons.

The White House Office of Drug Control Policy, National Institute of Drug Abuse, Substance Abuse and Mental Health Services Administration (SAMHSA), and U.S. Centers for Disease Control and Prevention, have sounded the alarm to enhance efforts to end the prescription drug abuse epidemic through multiple avenues.

Those efforts include: increasing access to evidence-based medication assisted treatment (MAT), enhancing prescription drug monitoring efforts, and strengthening prescribing guidelines for clinicians. Private foundations, professional organizations, educational institutions, and states are stepping up to meet the national calls for action.

Too many clinics, says the Peach State

And then, there is Georgia.

The Empire State of the South recently placed a moratorium on new

treatment clinics that would treat those with addictions. The legislative action appears to truly go against the tide of progress that is being made nationally.

Georgia's action also highlights the fact that each state has authority to control many aspects of how to fight this battle. While a federal agency, Substance Abuse and Mental Health Services Administration (SAMHSA), offers rules and guidelines for treatment, states have some leeway in licensing treatment clinics. They can also choose how much money they will direct to treat those affected by the epidemic. Thus, to some degree, the likelihood that a person will receive effective treatment depends on which state they live in.

While the death rates have steadily risen from prescription drug overdose in the past few years, the reality is that addiction treatment has been established for nearly two decades. Medication-assisted treatment, or MAT, has proven effective in helping some people who are addicted to opioids, and 12-Step programs and counseling are proving to be useful, additional therapy. In 2001, SAMHSA became the recognized federal entity to oversee the approval process for MAT programs through the enactment of the Drug Abuse Treatment Act of 2000.

Since the pharmacological agents involved in addiction treatment, such as methadone, buprenorphine and naltrexone, mimic or stimulate brain receptors similarly to the primary prescriptions abused, there is a risk of developing dependence on these medications. Deliberate safeguards have been established by lawmakers to minimize such risks.

On the clinical side, medication therapies require direct observation by staff to ensure treatment medicine is not misused. On a wider scale, safeguards exist for eligible clinicians seeking to administer such therapies. In order to become an approved MAT provider, SAMHSA has created a two-stage approval process.

Upon initial approval of being a MAT provider, clinicians are limited to treating 30 patients in the first year. The subsequent approval application increases the cap to 100; although in 2016, SAMHSA revised this limit to 200 patients. In other words, cautionary principles overseeing MAT providers on both the clinical and patient side run deep.

State differences

But despite a coordinated effort by federal agencies to increase or expand access to MATs, states play a role as gatekeeper. States typically require interested MAT clinicians to submit a certificate of need to a public health authority, which relies on the applicant to demonstrate a justifiable demand for MAT services.

The applicant must typically allow financial oversight of MAT services and also provide an address of access issues among intended recipients. Georgia does not mandate such certificates for MAT approvals. Perhaps, this can explains the discrepancy in the number of MAT clinics in the South.

The demand for MAT programs in the South far outweighs the supply. Mississippi has one MAT center, Alabama has 24, Tennessee 12, and Florida has 65. Georgia has the most - with 67 - and this has perplexed Georgia legislators. Questions surrounding why Georgia has the most clinics in the South, especially in proportion to its population, have been raised by legislators. Who is using these clinics? If the users are from out of state, what does this mean for Georgia residents? What are the financial implications for the state?

A new state law (SB 402: Drug Abuse Treatment and Education Programs) was passed in May in response to these questions. The law effectively creates a one-year moratorium on approving MAT facilities and providers. It also creates a State Commission on Narcotic Treatment

Programs to study licensure requirements.

Is treatment on their minds?

Why put the brakes on MAT providers when every federal agency is advocating for more resources, more treatment options, doubling the number of patients in MAT programs serve to 200?

While it is not known if other states are going to follow suit, it does not at present appear so. In the meantime, Georgia leaders are missing an opportunity to serve individuals with the chronic disease of addiction preferring instead to investigate the matter further.

What is most disturbing is that legislators do not have the same concerns on the front end of the epidemic, such as finding out how many prescriptions for controlled substances are being filled in Georgia. Why not question if individuals filling prescriptions are from out of State, or be curious about the financial implications of not having patient limits in terms of prescribing controlled substances versus the federal limits set for MAT patients.

The answers to these questions are difficult to answer in part because Georgia's Prescription Drug Monitoring Program legally safeguards data collected. That blocks the public from understanding what might be fueling the prescription drug abuse problem in Georgia.

I believe that Georgia's moratorium on MATs hurts those who truly need the life-saving treatments the most. There are wait lists for treatment nationally. Prescription drug overdose death rates in Georgia could increase during the time it takes for legislators to gain a sense of utilization trends of MAT patients.

Who is to blame? This time, it cannot be erroneously attributed to

individuals battling the chronic disease of addiction, who are dying while waiting for MAT access. At this time, it appears that no other states are following suit, and there is no good policy reason for them to do so.

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