Maryland-DC Society of Addiction Medicine
A Chapter of American Society of Addiction Medicine

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

HB 681 Recovery Residence Grant Program - Establishment
Health & Government Operations Committee March 7, 2023

LETTER OF INFORMATION
On behalf of both The Maryland Association for the Treatment of Opioid Dependence as well as the Maryland-DC Society of Addiction Medicine.

Both of our organizations strongly support the idea of greater funding, and grants, to recovery residences and to recovery services generally.

However, we disagree with the "zero tolerance" requirement. Discharging a resident for one or more episodes of drug use or a positive drug screen may be appropriate but should be an individualized determination with consideration of harms to the milieu vs. potential harms to the individual, which could be catastrophic. Other interventions may be available. This kind of rigid, potentially harmful requirement should not be in statute, and probably not in regulation either.

We feel that some other aspects of the bill should be in regulation rather than in statute.

Our main concern is the need for an amendment that assures that the grantee follows basic quality standards for patients with opioid use disorder (OUD) that goes beyond certification by the state.

SUGGESTED AMENDMENT:

A grantee shall not limit or restrict access to FDA-approved medication for opioid use disorder (MOUD) by residents or prospective residents who choose to use MOUD in consultation with a healthcare provider. Limitations to MOUD access include mandatory caps on the maximum medication dose, mandated medication tapers, limits on the number of beds reserved for residents on MOUD, or refusing admission to those who have chosen or will choose to use MOUD in consultation with a healthcare provider.

An exception to this requirement may be granted by the credentialing agency on a case-by-case basis only after the recovery residence submits a request accompanied by documentation that a good faith effort to provide reasonable accommodation to the resident or prospective resident for MOUD access is not possible. An exception shall not be granted on the basis of the recovery resident's philosophy concerning MOUD, or the effect of MOUD use on other residents.

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Limiting access to medications for OUD (MOUD), contrary to a person's wishes, violates the most basic standard of care for OUD and amounts to discrimination based on stigma. It also potentially violates federal law (1). It is our impression that many or most certified Recovery Residences in Maryland discriminate against MOUD and the people who need them.

The state's MCORR program (Maryland Certification of Recovery Residences) grants certification regardless of whether residences fail to meet this basic standard of care.

The great majority of people with moderate to severe OUD benefit from methadone or buprenorphine unless they make a truly informed choice for injectable naltrexone, or for no medication. Methadone and buprenorphine are the "gold standard" OUD treatments, and the only treatments that reduce overdose deaths. They are the "first-line" treatments for OUD, confirmed by publications of the American Society of Addiction Medicine and by scores of clinical trials (2, 3, 4, 5, 6).

On the website of the National Institute of Drug Abuse (NIDA), the NIDA Director writes that "[MOUD] is considered the standard of care in the treatment of OUD whether or not it is accompanied by some form of behavioral therapy" (6). According to the National Academy of Science, Engineering and Medicine, "All studies of MOUD tapering and discontinuation demonstrate very high rates of relapse, although some patients may be able to successfully taper off without a return to use" (7).

In treatment settings, behavioral treatment without MOUD is ineffective for patients described above - whether outpatient or inpatient. Patients with ineffective long-term inpatient treatment for OUD commonly return to drug use when they transition to community living.

Lack of access to MOUD is perhaps the greatest single barrier to recovery from OUD, and may also be the greatest barrier to making progress in reducing opioid overdose death rates. Lack of access to MOUD is based on stigma and misunderstanding of our most effective life-saving treatment: MOUD. This is sometimes called 'medication stigma.'

Although randomized trials of the benefits of counseling as a supplement to MOUD are mixed, these services should be available and encouraged, but mandatory psychosocial services can be a barrier and should not be a condition of treatment with MOUD, according to the World Health Organization (8), the American Society of Addiction Medicine (9), the National Academy of Sciences, Engineering and Medicine (10) and the Substance Abuse and Mental Health Services Administration (11).

Stigma and misunderstanding of methadone and buprenorphine, which are themselves opioids, largely stems from conflating "addiction" with "physical dependence." Despite the widespread misunderstanding that the use of methadone or buprenorphine is "trading one addiction for another," "addiction" is the wrong word for these medications. The definition of "addiction" includes causing harm (12). There is a very important, but more limited role for long-acting injectable naltrexone, a non-opioid medication (3).

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An annotated bibliography of some peer-reviewed publications indicating the scientific consensus on the primary role of MOUD (for most people with moderate to severe OUD who choose this treatment in conjunction with a healthcare provider) is at https://www.stopstigmanow.org/research-articles/

Respectfully,

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2. Wakeman SE, Lee J, Alvanzo AAH, eds. Pocket Addiction Medicine. Wilger's Kluwer Health, 2023. (a publication of the American Society of Addiction Medicine). (See pgs. 9-67 – 9-68). https://www.vitalsource.com/products/pocket-addiction-medicine-sarah-e-wakeman-joshua-d-v9781975166397
3. Long-Acting Injectable Naltrexone is Not a First-Line Treatment for Most Individuals with Opioid Use Disorder 2022, https://www.stopstigmanow.org/ssn-policies-2/#Injectable_Naltrexone
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   Annotation: In a study of over 40,000 individuals with OUD, only treatment with buprenorphine or methadone reduced the risk of overdose and serious opioid-related acute care use, compared with no treatment, during 3 and 12 months of follow-up. Neither inpatient detoxification, residential services, intensive behavioral health, or naltrexone treatment resulted in a reduction in overdose deaths.
6. Five Areas Where "More Research" Isn't Needed to Curb the Overdose Crisis. August 31, 2022 By Dr. Nora Volkow. accessed at https://nida.nih.gov/about-nida/noras-blog/2022/08/five-areas-where-more-research-isnt-needed-to-curb-overdose-crisis (free)
7. Medications for Opioid Use Disorder Save Lives. National Academies of Sciences, Engineering, and Medicine. 2019. Washington, DC: The National Academies Press. (see quoted text, pg. 40) accessed at https://nap.nationalacademies.org/catalog/25310/medications-for-opioid-use-disorder-save-lives
8. WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. WHO Press, World Health Organization, Geneva, Switzerland. 2009, World Health Organization. 2009 https://www.who.int/publications/i/item/9789241547543 (free)
   Excerpt: "Treatment services should not deny effective medication if they are unable to provide psychosocial assistance, or if patients refuse it." (Pg. 19)
9. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, updated 2020. The American Society of Addiction Medicine. www.asam.org/Quality-Science/quality/2020-national-practice-guideline (free)
   Excerpt: "A patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment of opioid use disorder with appropriate medication management." Pg. 37

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10. IBID Medications for Opioid Use Disorder Save Lives. Excerpt: "It is generally accepted that the best outcomes are typically achieved through a combination of pharmacological and behavioral therapies, but there is evidence that some individuals may respond adequately to medications plus medical management alone (e.g., evaluation of medication safety and adherence, monitoring, or advice by the prescribing provider)." (pg. 48)

11. Federal Register, Notice of Proposed Rule Making: Medications for the Treatment of Opioid Use Disorder. A Proposed Rule by the Health and Human Services Department (Substance Abuse and Mental Health Services Administration) 12/16/2022. Excerpt: "Patient refusal of counseling shall not preclude them from receiving MOUD." pg. 77358 of the PDF document, middle column https://www.govinfo.gov/content/pkg/FR-2022-12-16/pdf/2022-27193.pdf

12. Adams, Joseph A. Stigma: The Greatest Barrier to Effective Treatment of Opioid Use Disorder. Maryland Medical Journal. March 2023; Volume 24, Issue #1 In Press. https://www.stopstigmanow.org/wp-content/uploads/2023/03/article-MMJ-Adams-stigma-3-2023.pdf