THE PEW CHARITABLE TRUSTS

2005 Market Street, Suite 2800 215.575.9050 Phone
Philadelphia, PA 19103-7077 215.575.4939 Fax

901 E Street NW, 10th Floor 202.552.2000 Phone
Washington, DC 20004 202.552.2299 Fax
www.pewtrusts.org

April 27, 2020

Scott A. Brinks
Drug Enforcement Administration
8701 Morrissette Drive
Springfield, VA 22152

RE: RIN 1117-AB43/Docket No. DEA–459 Registration Requirements for Narcotic Treatment Programs With Mobile Components

Dear Mr. Brinks:

Thank you for soliciting feedback on the Drug Enforcement Administration's proposed regulation that would allow narcotic treatment programs—otherwise known as opioid treatment programs (OTPs)—to operate mobile units. This proposal will help make evidence-based treatment for opioid use disorder (OUD) more widely available.

The Pew Charitable Trusts is a national non-profit research and policy organization. Pew's substance use prevention and treatment initiative (SUPTI) develops and supports state and federal policies that expand access to evidence-based medication treatment for OUD, including methadone, buprenorphine and naltrexone – the most effective therapy for people with OUD. SUPTI provides technical assistance to states on approaches to increase access to treatment for OUD. These engagements have revealed widespread interest in adopting mobile OTP strategies.

This proposed rule will help states and OTPs close the gap between people who need treatment and individuals receiving evidence-based care. In 2018, less than 20 percent of individuals with OUD – approximately 400,000 people aged 12 or older—received treatment at a specialty facility, including OTPs and other types of providers.[i] Medications, including methadone, are the standard of care for people with OUD. They have been proven to improve long-term treatment outcomes and reduce overdose deaths.[ii] Mobile units provide another option for making evidence-based care available in facilities, such as jails and residential treatment centers, that may struggle with incorporating onsite access to medications.

OTPs, which will operate mobile units, are the only sites where methadone is available for OUD, though counseling and other medications also are available. Access to methadone remains woefully inadequate, especially in rural and criminal justice settings. Because OTP patients typically receive daily supervised doses, geographic gaps in availability and inconsistent access to transportation are significant barriers to treatment. DEA's proposed rule would give providers a lower cost option for reaching patients where it may not be otherwise financially feasible to establish a brick-and-mortar presence.

This proposed rule will allow programs to expand their reach to patients in three important ways:

1) providing another method of medication delivery during emergencies,
2) enhancing options for serving rural populations, and
3) facilitating access in criminal justice settings.

While this rule will expand access to treatment, it is important to note that OTPs can offer an array of services. This includes testing for infectious disease and other co-morbidities, and counseling. The same barriers to accessing daily treatment also may affect whether individuals can initiate OUD treatment. Therefore, in finalizing this rule, DEA should make it clear that mobile units will be permitted to provide all services available at an OTP.

Emergency Circumstances

The ongoing public health emergency caused by COVID-19 serves as a reminder of the importance of treatment availability to initiate care for new patients and provide continuity for existing patients during crisis situations. Additionally, it is important to pursue strategies that reduce the number of patients coming to the facility each day to reduce potential exposure. DEA, Substance Abuse and Mental Health Services Administration, state regulators and OTPs have taken steps to ensure continued access by changing dosing schedules to limit face-to-face contact, facilitating access to telehealth and allowing home delivery to quarantined patients to prevent the spread of COVID-19.

Mobile OTPs have largely been unavailable to providers in responding to emergency situations. During Hurricane Sandy in 2012, affected OTPs employed strategies such as alternative transportation, take-home dosing and guest dosing at nearby programs to ensure continued access to treatment. These actions had varying degrees of execution and success. Mobile units were considered as an option for reaching patients when facilities were destroyed, but one unit was being repaired at the time and the other was not able to operate because there was not a functioning brick-and-mortar facility to store the methadone.[iii]

Additionally, research shows OTPs and other providers of medication treatment for OUD should anticipate an increase in demand for treatment in a disaster due to a disruption in the supply and distribution of street-based drugs. People in recovery from OUD may have more difficulty coping with stress during disaster situations,[iv] and therefore may be at increased risk for relapse.[v] In a survey of 74 OTP clinicians post-Hurricane Sandy, about half indicated that their program enrolled people new to treatment due to changes in the availability of street drugs.[vi]

Rural Access

In the proposed regulation, DEA identifies the challenge of accessing NTPs in rural areas. Although a shortage of OTPs exists nationally, this gap is widest in rural areas: 88.6 percent of large rural counties do not have a sufficient number of OTPs. People with OUD living in rural communities often face barriers to accessing medication treatment, including fewer transportation and treatment options compared with those available in urban areas.[vii] For instance, patients in low or moderately populated areas must usually travel farther to access OTPs.[viii]

Seniors, in particular, are adversely affected by these barriers. A large and growing share of the rural population is comprised of individuals age 65 (17.5 percent) compared to urban areas (13.8

percent).[ix] In January, CMS began Medicare payments for services provided by OTPs. This change should make medication treatment more accessible for this patient population, but other barriers persist that could be eased by mobile units. One strategy may be to bring methadone to skilled nursing facilities through mobile units.

Criminal Justice Settings

Treatment gaps are even more pronounced in criminal justice settings. Although 55 percent of local jail inmates met criteria for SUD, less than 7 percent of those individuals received treatment while incarcerated.[x] Atlantic County, New Jersey is one example where mobile units have successfully delivered treatment to inmates. There, a van comes onsite to provide medication (methadone, buprenorphine and naltrexone) and counseling to those who are incarcerated, and links those leaving to community-based OTPs. In more than two years, the unit has treated more than 1,000 inmates, who have subsequently been found to have a lower recidivism rate compared to the general jail population.[xi] Other treatment providers have prepared to provide similar treatment in criminal justice and urban settings.[xii]

In closing, Pew appreciates the opportunity to comment on this proposed regulation and urges you to expeditiously finalize this regulation to make evidence-based treatment for OUD more widely available.

Should you have any questions or if Pew can be of assistance, please contact me at econnolly@pewtrusts.org or 202-540-6735.

Sincerely,

Beth Connolly
Project Director
Substance Use Prevention and Treatment Initiative

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[i] Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report.

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[iii] Harlan Matusow, Ellen Benoit, Luther Elliott, Eloise Dunlap, and Andrew Rosenblum. "Challenges to opioid treatment programs after Hurricane Sandy: Patient and provider perspectives on preparation, impact, and recovery." Substance use & misuse 53, no. 2 (2018): 206-219.

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[v] Nora D. Volkow, "Collision of the COVID-19 and Addiction Epidemics," *Annals of Internal Medicine*, April 2, 2020, https://annals.org/aim/fullarticle/2764313/collision-covid-19-addiction-epidemics.

[vi] Harlan Matusow, Ellen Benoit, Luther Elliott, Eloise Dunlap, and Andrew Rosenblum. "Challenges to opioid treatment programs after Hurricane Sandy: Patient and provider perspectives on preparation, impact, and recovery." Substance use & misuse 53, no. 2 (2018): 206-219.

[vii] John A.Gale, Anush Y.Hansen, and Martha Elbaum Williamson, "Rural Opioid Prevention and Treatment Strategies: The Experience in Four States," Maine Rural Health Research Center (2017), https://muskie.usm.maine.edu/Publications/rural/WP62-Rural-Opioid-Prevention-Treatment-Strategies.pdf**.**

[viii] Andrew Rosenblum et al., "Distance Traveled and Cross-State Commuting to Opioid Treatment Programs in the United States," *Journal of Environmental and Public Health* no.948789 (2011), https://doi.org/10.1155/2011/948789**.**

[ix] Smith, Amy Symens, and Edward Trevelyan, "The Older Population in Rural America: 2012–2016," ACS-41, *American Community Survey Reports*, U.S. Census Bureau, https://www.census.gov/content/dam/Census/library/publications/2019/acs/acs-41.pdf.

[x] Redonna Chandler, Bennett Fletcher, and Nora Volkow, "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," (2009) JAMA 301, no. 2: 183-190.

[xi] Personal communication, Michael Santillo, Chief Executive Officer, John Brooks Recovery Center, April 2020.

[xii] Christine Vestal, "Federal Ban on Methadone Vans Seen as Barrier to Treatment," The Pew Charitable Trusts, March 23, 2018, https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/03/23/federal-ban-on-methadone-vans-seen-as-barrier-to-treatment.