Executive Order Number 29
Governor's Task Force on Prescription Drug and Heroin Abuse
DRAFT Minutes of the Treatment Workgroup
November 12, 2014
Patrick Henry Building
Richmond, Virginia

Co-Chairs
Delegate John O'Bannon, M.D.
Jennifer Lee, M.D., Deputy Secretary, Health and Human Resources

Members Present:
Chuck Adcock
Jaime Areizaga-Soto
Jan Brown
Lillian Chamberlain
Duffy Ferguson
Nancy Finch
Chief Mary Gavin
Cynthia Kirkwood, PharmD
Sheriff Gabe Morgan
Patricia Shaw
Art Van Zee, M.D.
Senator Jennifer Wexton

Members Absent
Nassima Ait-Daoud, M.D.
Debra Ferguson, M.D.
Dana Schrad
Diane Strickland

Staff
Mellie Randall
Holly Mortlock
Jamie Hoyle

Guests
Mike Herzog

Call to Order and Introductions
Delegate O'Bannon called the meeting to order and asked individuals present to introduce themselves and share something about their interest in prescription drug and heroin abuse.

Senator Wexton introduced herself as an attorney who had previously served as the Commonwealth Attorney for Loudoun County, and had served as a member of the community services board. She mentioned that Loudoun County had, until recently had a drug treatment court.

Nancy Finch introduced herself by saying that she was from Chesterfield County where she had served on the community services board substance abuse committee, had served on the board of the Department of Criminal Justice Services, was a member of Chesterfield County SAFE Board of Directors, and that she had lost her son to a drug overdose in 1994.

Jaime Areizaga-Soto introduced himself as the Deputy Director of the Department of Veterans Affairs, is a member of the National Guard, and is from Arlington.

Chuck Adcock is the part-owner of a treatment program, Family Counseling Center for Recovery, which has three sites. He said that he has served on the faculty at Virginia Commonwealth University in the departments of social work, rehabilitation counseling and psychiatry and that he is interested in improving education for those who provide treatment. He has been in recovery for more than 30 years and his orientation, until the 1990s, was always abstinence based, when he was first exposed to medication-assisted treatment. He noted that there seem to be two camps in substance abuse policy: harm reduction and abstinence, and that he was interested in bringing these two viewpoints together.

Sheriff Gabe Morgan is the Sheriff of is the Sheriff of Newport News, Virginia. He is very interested in improving education in behavioral health for law enforcement professionals.

Patricia Shaw is the President of the Virginia Drug Treatment Court Association and the administrator of the Henrico Drug Treatment Court. She is interested in how treatment can work in conjunction with the legal system.

Art Van Zee, M.D., is a general practitioner in a clinic in St. Charles and has been practicing since 1976. He is board certified in addiction medicine and started prescribing Suboxone in 2003. He has witnessed up close the "tsunami of OxyContin."

Mary Gavin is the Chief of Police in Fall Church and was previously at the Arlington Police Department. She spoke of her knowledge of the Baltimore-Virginia HIDTA (High Intensity Drug Trafficking Area) project which supports treatment and prevention as well as law enforcement.

Lillian Chambers has been working in the field of substance abuse treatment for 30 years and at the Norfolk CSB for 21 years where she oversees outpatient treatment, including administration of the opiate treatment program. In 2001, Norfolk CSB participated in the first clinical trials of Suboxone sponsored by the National Institute on Drug Abuse. She stressed that there is no single path to recovery and said that she was excited about participating and discussing medication assisted treatment.

Cynthia Kirkwood, PharmD., is a board certified psychiatric pharmacist and teaches substance abuse in the VCU School of Pharmacy; she has a family member who has been in recovery for ten years.

Duffy Ferguson is a social worker who recently retired from the New River Valley CSB where she worked primarily with youth and families.

Holly Mortlock (staff) is a policy analyst at DBHDS and recently moved to Virginia from Washington State where she was involved with legislation related to naloxone.

Mellie Randall (staff) is the Director of the Office of Substance Abuse Services at DBHDS where she has worked since 1987; she has been working in the field of addiction since 1973, and has spent a fair amount of time focused on treating addiction to prescription pain medication in the far southwestern part of the state.

Jennifer Lee, M.D., (co-chair) is the Deputy Secretary of Health and Human Resources. For eight years, she worked as an Emergency Department physician where she saw many patients who were addicted to opioids and had experience with naloxone. She served on the Board of Medicine from 2008-2011.

Jamie Hoyle (guest) is the Chief Deputy Director of the Department of Health Professions. Previously she worked at the Joint Commission on Health Care where she focused on issues related to behavioral health. She has also worked at the Crime Commission.

Mike Herzog (guest) is the CEO of Kaléo.

Delegate John O’Bannon, M.D., (co-chair) is a neurologist. He recounted that Russell Portnoy at Sloan Kettering Cancer Institute in New York had actively promoted the use of opioids for relief of long-term pain in the 1990s; previously, physicians had been very hesitant to use opioids due the risk of addiction. He said that medicine had become very focused on pain management without understanding the risk to the population. He said that in the past year he had treated four patients who were either brain-dead or brain-damaged who had histories of addiction and who had been prescribed opioids for pain and had then also drunk alcohol. He said that he was very interested in expanding the use of naloxone beyond the pilot areas.

Questions for Discussion
Dr. Lee reviewed the language of the Executive Order that specified the tasks of the Treatment Workgroup, which she had placed on a chart that includes columns for recommendation, action steps, fiscal impact, responsible party and deadline for each of the three tasks. The three tasks are:

- Improve access to and availability of treatment services;
- Foster best practices and adherence to standards for treatment of individuals addicted to opioids;
- Strengthen and expand the capacity of Virginia’s health workforce to respond to substance abuse treatment needs, including encouraging health professions schools and continuing education programs to provide more education about how to identify and treat substance abuse.

Dr. Lee suggested that there were other resources on which the workgroup could draw, including information from the Centers for Disease Control and Prevention (CDC), the Office of National Drug Control Policy (ONDCP), reports from other relevant task forces. She stressed that the workgroup needed to do its work in two phases. The short-term recommendations needed to be documented by the end of December in order to have impact on the 2015 Session of the General Assembly. The final work of the entire Task Force must be completed by the end of June, 2015.

Dr. Hazel briefly joined the group and said that he would like to see some emphasis on prevention and specifically mentioned that, in his experience on medical missions in South America, he had seen how pain was successfully managed using non-narcotic medications with other medications, such as nonsteroidal anti-inflammatory drugs.(NSAIDS).

Dr. O'Bannon agreed, noting that 99% of all the hydrocodone in the world was prescribed in the US.

Sheriff Morgan asked that the slides shown in the Task Force meeting be shared and Dr. Lee assured him that they would be available. Dr. Lee agreed that this would happen.

Dr. Lee noted that other groups would also be looking at prevention efforts and that Task Force staff would be working on coordinating and identifying potential overlaps.

Dr. Lee mentioned that the Task Force had grown out of a recommendation from the state's participation in a policy conference sponsored by the National Governors Association (NGA).

Mellie Randall gave a brief history of that effort, which was a group of seven states chosen by the NGA to participate in its first policy conference on preventing abuse of prescription drugs. The conference was structured around the tenets of the ONDCP strategy which focused on education, enforcement, data and monitoring, and storage and disposal. During the year-long process of participating in the NGA project it became clear that more emphasis needed to be placed on treatment, resulting in the NGA including treatment as a focus in its current policy conference.

Dr. Lee pointed out the all of the workgroups were purposefully diverse, so that the membership of the Treatment Workgroup wasn't composed solely of treatment experts but also included individuals from other disciplines so assure that expertise from other related systems was included. Input from these various sources would help the group identify barriers.

Dr. O'Bannon indicated that it was important to look at this from the perspective of the whole state and to include private providers as well as public.

Jan Brown indicated that there was significant bias and stigma about individuals in recovery.

Lillian Chambers shared that many CSBs don't know how to assess clinical need for treatment services when it comes to people who are addicted to opioids. Many clinicians have a personal bias against medication assisted treatment, that many drug treatment courts don't allow the use of medication assisted treatment among participants.

Chuck Adcock said that providing opiate treatment (methadone/Suboxone) is lucrative but that some private clinics don't actually provide the level of treatment, in addition to medicine, that is necessary to support recovery because it affects the bottom line. To counter that, some states won't allow for-profit providers of medication-assisted treatment for opiate addiction to operate and limit services to only public providers. He said that he would like to see more support for public-private liaisons.

Delegate O'Bannon said that he was intrigued by the idea of public-private relationships in this area. He noted that the market for opiate treatment programs was evidently very competitive and that public safety needed to be addressed.

Chief Gavin noted that there was significant stigma about methadone as a treatment for opioid addiction.

Lillian Chambers said that that stigma was due to negative stereotypes of who was served at opioid treatment programs but that these clinics really do serve the public by providing medication that allows the individuals who receive it to fully function. She noted that only four CSBs directly operate opioid treatment programs and stressed that many CSB staff do not know how to appropriately assess an individual to ascertain whether or not medication assisted treatment would be appropriate. She also stressed that the use of medication assisted treatment had to be part of a comprehensive package of services that included counseling.

Sheriff Morgan shared that his impressions of opioid addicts and methadone treatment were shaped by his experience of being in New York City in the 60s and 70s where he saw the worst of methadone treatment. In his current position, he has worked closely with the CSB but he fears that, due to ongoing budget cuts and a dependence on fees for services, CSBs have moved away from prevention and are fee-driven. He wondered what private-public partnership would look like. He explained that he uses jail funds to support the services to two counselors in his jail and that he does not have the capacity to provide any medication to treat opioid addiction in his jail. He stressed that his jail does not offer treatment because the individual's length of time in jail is relatively short, and when the individual leaves, he is still addicted. He estimates that 70 percent of the individuals incarcerated in his jail are there because of some act related to their substance abuse.

Ms. Chambers pointed out that for treatment to be effective it has to be individualized and that some individuals are so lacking in basic life skills that their treatment has to focus on habilitation as opposed to rehabilitation; therefore, the appropriate length of stay in treatment is specific to the individual.

Dr. Van Zee shared that science and his own experience indicated that the brains of individuals who are addicted to opioids are different and that most will need medication assisted treatment. He said that research indicates that the use of medication assisted treatment supports better overall functioning for the individuals and that, overtime, the rates of relapse are 80%-90% if medication assisted treatment is stopped because the medication relieves the brain of its obsession and craving for the drug. He told the story of a graduate student whom he had treated with Suboxone who had asked to be taken off the drug when he completed his graduate program. The man had relapsed and had come back to Dr. Van Zee to be put back on medication and had continued to be clinically stable (not using illegal opioids) since then.

Jaime Ariega-Soto expressed concern about the stigma.

Lillian Chambers said that community physicians who are not trained in the addictions also have considerable bias about medication assisted treatment. She shared the experience of a pregnant woman who was being successfully treated with methadone who went to the hospital to deliver. The attending physician refused to order her maintenance level methadone dose for her so the woman had to go through labor and withdrawal simultaneously.

Sheriff Morgan expressed concern that methadone clinics were potentially another avenue to create another addiction problem with physicians over prescribing and creating demand for methadone so that the owners of the businesses could make a larger profit.

Mellie Randall (staff) explained the difference between methadone treatment (which is highly regulated by several layers of government) and Suboxone® which is prescribed and administered by physicians with special training and special permission from the DEA.

Dr. O'Bannon said that he would like to see the use of naloxone go to the next level beyond the pilot currently operating in Metro Richmond and the far southwest. He also said that he would like for the workgroup to explore whether or not the Mental Health Parity and Addiction Equity Act (2008) was being adequately implemented. He would also like to know more about how peer supports were being used.

Jan Brown said that she had been treated with a different drug, naltrexone, which requires the patient to be very motivated and is not utilized very much. She said that she had experienced a lot of stigma among traditional peer support programs, such as Narcotics Anonymous because that group had a strong tradition against medication assisted treatment. She said that she had not been well accepted while she was taking the medication and had quit using 12 Step support groups during that time and had created her own peer support. She said that treatment providers who use medication assisted treatment and then urge the individual to participate in a 12 Step group are putting these individuals in a bind.

Senator Wexton shared that as a former prosecutor, she had observed different outcomes between those who sought treatment voluntarily and those who were court ordered to seek treatment. She said that methadone wouldn't be acceptable court ordered treatment because of the court's reliance on urine drug screens to monitor individuals under supervision.

Delegate O'Bannon reminded workgroup members that the charge to the group was to foster best practices.

Patricia Shaw shared that many drug treatment courts use medication assisted treatment but that some don't. At the national level among drug courts, there is a big push to consider medication assisted treatment. The Henrico County Drug Treatment Court tried letting participants be medicated with Suboxone® but the individuals "shared" their medication so the court does not currently permit it, but there is continued awareness that it could again become an option. There are also some logistical issues and concerns about having individuals who are on medication participate in the same treatment activities as individuals who are not on medication. In addition, individuals who are seeking recovery from other types of addiction, such as alcohol and cocaine, resent that there isn't medication for them. Sheriff Morgan asked if urine drug screen testing was problematic for individuals on Suboxone, in terms of distinguishing the illegal use of opioids from the medication; Ms. Shaw explained that the toxicology was able to distinguish between the two substances.

Ms. Ferguson pointed out that other therapeutic services are necessary in addition to medication and wondered how well those were provided for individuals receiving medication assisted treatment. Ms. Chambers shared that all opioid treatment programs (which provide methadone, and may also provide other medications including Suboxone) must be accredited by either the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and that a condition of accreditation is that individuals receive counseling and other supports.

Delegate O'Bannon expressed concern that people with addictions, a lifelong condition, were not being treated equitably by private insurance companies and wondered if insurers were in compliance with the Mental Health Parity and Addiction Equity Act. Ms. Shaw indicated that few of the individuals who participate in drug treatment courts have private insurance and are not eligible for Medicaid, and that finances definitely play a role in access to medications, especially Suboxone.

Delegate O'Bannon pointed out that the third objective the workgroup needed to address focused on identifying appropriate metrics. Jan Brown said that, as a measure of quality treatment, it was important for treatment to involve the family.

Chief Gavin expressed concern that individuals who overdose may be subject to criminal sanctions and suggested that the event could be used as a catalyst to treatment with no criminal charges if the only crime were possession of the opioid. She raised the prospect of using a CIT type model to address the intersection between criminalizing addiction and seeking treatment.

Delegate O'Bannon said that the family issues raised are similar to those that arise with individuals who are mentally ill.

Chief Gavin wondered if entering jail might be a catalyst to treatment. Chuck Adcock said that he used to see parents work to keep their (adult) children out of jail at all costs, but now they want to keep them in jail because they know they are not using drugs while they are incarcerated.

Nancy Finch asked about research concerning best practices among different approaches to treating addiction. Jan Brown said that the types of effective treatment may differ throughout the lifespan. .Delegate O'Bannon said that appropriate treatment differs among individuals, the age of the individual, and other factors but that most people need a "wrap-around" approach. Jan Brown said that she would send staff links to the National Institute on Drug Abuse (NIDA) publications on the principles of treatment for drug abuse. Dr. Lee asked if staff could get information about the regulations pertaining to methadone and if Dr. Van Zee could send links to some research.

Dr. Kirkwood said that she thought the major issues were access to treatment, funding and resources, and expertise. She pointed out that there was considerable difference among CSBs and that the CSBs decide what services to offer.

Next Steps

There was some discussion about when the next meeting of the workgroup would be – sometime during the first week of December. Mellie will be in touch with the time and place.

Delegate O’Bannon concluded the meeting.