#StoptheSpiral

A Project of

The Christopher D. Smithers Foundation, Inc.

Columbia University Medical Center
Department of Psychiatry

March 9, 2018

The Honorable
Dan Aaron Polster
Carl B. Stokes United States Court House
801 West Superior Avenue, Courtroom 18B
Cleveland, Ohio 44113-1837

Dear Judge Polster:

We read with great appreciation your comments in the March 6, 2018 story about the consolidation of the litigation brought against some of the pharmaceutical and other companies charged with contributing to the opioid epidemic ravaging the country.

We are most hopeful that you can achieve the quick resolution you are seeking and find "meaningful solutions" to this crisis. While we cannot speak to the legal issues, or directly to the costs incurred by towns, cities and states, we can speak to the impact this epidemic has had on countless individuals and their families and how as a country we have failed to meet the needs of these people despite a robust evidence base for how to effectively treat Opioid Use Disorder.

By way of background, The Smithers Foundation and Columbia Psychiatry have worked together to provide direct service to individuals battling addiction as well as to educate the public that addiction is a medical illness from which people can and do recover. The Smithers Foundation was started more than 60 years ago and continues to fund research focused on addiction as well as working with partners to encourage prevention programs and activities, with an emphasis on high risk populations and to reduce and eliminate the stigma that is associated with the illness of addiction.

Columbia Psychiatry's Division on Substance Use Disorders is playing a major role supported by funds allocated by the federal government to provide clinical expertise to all 50 states to respond to the opioid epidemic. The Division on Substance Use Disorders, within the Columbia University Irving Medical Center's Department of Psychiatry, a pioneer in the treatment of Opioid Use Disorder for 25 years is committed to improving the practice as well as the science of addiction treatment.

Together, Columbia Psychiatry and the Smithers Foundation recently launched a national awareness campaign to increase access to evidence-based treatment for opioid use disorder. Told from the perspective of a teenager and his family, the "Hey Charlie" video shows how quickly the use of recreational substances in social situations can seamlessly spiral into a devastating addiction to opioids. The site and video are available here: www.StopTheSpiral.com

We write today to encourage you to consider a few important components of any potential settlement or resolution related to the case you are presiding over, most importantly access to the three FDA-approved medications that are proven to assist those patients with Opioid Use Disorder (OUD): buprenorphine, methadone, XR-naltrexone.

As you may know, more than 2.5 million Americans are addicted to opioids**, but** fewer than 50% of private sector treatment programs offer medications for OUD and only one-third of patients in those programs receive them. Imagine the uproar if Americans with other illnesses like diabetes or cancer were not provided access to approved medications.

As doctors and others involved in the addiction space, we've seen that traditional treatment, which begins with detox and relies on lifelong abstinence, is no match for today's opioid addiction. These medications significantly diminish cravings and reduce the risk of relapse.

We hope you will keep these general guidelines in mind as you work through the resolution:

- All patients with Opioid Use Disorder should have access to one of three FDA-approved medications (buprenorphine, methadone, XR-naltrexone) as their primary treatment.

- Medication assisted treatment should continue for a minimum of one year, without a pre-defined length of treatment, under a long-term medical model.

- As detoxification alone for Opioid Use Disorder is an ineffective and potentially dangerous practice, it should not be the choice for most patients. The primary goal should be to stabilize patients on FDA-approved medications.

- 12-step based approaches are insufficient and dangerous when used to stabilize and treat patients with OUD. 12-step based treatment does not protect against overdose and should only be introduced as an option in combination with pharmacological treatment and medical supervision.

- Financial and insurance barriers to treatment should be removed to hasten same-day access to evidence-based treatment nationwide.

Specifically, we encourage you to require municipalities and other recipients of any settlement to dedicate a significant portion of those funds to provide evidence-based treatment for people combating OUD, including monies committed to provide access, free of financial and insurance barriers, to Medication Assisted Treatment (MAT).

We recently proposed a mechanism for funding access to MAT in the New England Journal of Medicine, excerpted here:

"Even with improved access [to providers], MAT's cost would remain a substantial barrier for many patients, since those with insurance often face burdensome prior-authorization requirements. In 1987, after the FDA approved zidovudine, the first HIV–AIDS medication, Congress approved $30 million in emergency funding to states to pay for HIV medications — laying the groundwork for what became the AIDS Drug Assistance Program (ADAP), which was authorized by the Ryan White Comprehensive AIDS Resources Emergency Act in 1990. ADAPs now exist in every U.S. state and territory, and states determine their own eligibility criteria within federally set parameters.

"The creation of ADAP-like programs or vouchers (covering MAT medications and the overdose-reversal agent naloxone), perhaps as a new mechanism under the Substance Abuse Prevention and Treatment Block Grant program or Medicaid demonstration waivers, could provide access for many people with OUD, even in states that haven't expanded Medicaid under the ACA. Although the mental health parity law of 2008 requires most managed-Medicaid and private insurance plans that cover substance-abuse treatment to do so at the same level as other medical care, violations abound.[5] Despite the requirement that substance-abuse treatment be considered an essential health benefit, and despite the fact that the National Institute on Drug Abuse deems MAT the first-line treatment for OUD, the Centers for Medicare and Medicaid Services has not yet made methadone or buprenorphine maintenance treatment for OUD a mandated benefit."

You can access the full article here: http://www.nejm.org/doi/full/10.1056/NEJMp1604223#t=article

We are available to provide additional information if you would find that helpful on any of the above considerations. Thank you for your attention to this matter. We look forward to hearing from you.

Sincerely,

Christopher Smithers

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