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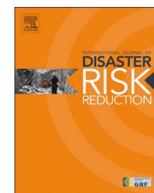

Disaster preparedness among opioid treatment programs: Policy recommendations from state opioid treatment authorities

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ABSTRACT

Recent natural disasters in the US have demonstrated the enormous potential for opioid treatment programs (OTP) to be rendered inoperable, disrupting methadone dispensing for their patients. Discontinuation of dispensing has severe consequences for OTP patients, ranging from withdrawal, resumption of injection behaviors bearing risk of blood-borne disease transmission, and overdose risk. Interviews with OTP directors, staff, and patients generated a set of recommendations for strengthening OTP disaster preparedness which were then presented to 15 state opioid treatment authorities (SOTAs) from disaster-prone US states. SOTAs' responses to recommendations were analyzed and then discussed with representatives of the Drug Enforcement Agency (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Findings include an enumeration of concrete improvements to disaster preparedness and point to the need for greater clarity within states about the SOTA's role and regulatory authority and greater interagency cooperation to overcome misconceptions and obstacles to implementation.

1. Introduction

On October 29th, 2012, Hurricane Sandy's impact on New York City exceeded the calculations of a 500-year event and revealed countless vulnerabilities in coastal infrastructure, health care and human services [9]. These vulnerabilities affected a broad social cross-section in the Northeast, but those enrolled in opioid treatment programs (OTPs) represented a particularly disadvantaged population, since the majority of these patients must report daily to their program to receive maintenance medications. Many methadone maintenance patients and, to a somewhat lesser degree, buprenorphine patients, faced serious obstacles to obtaining medication and other treatment services in the aftermath of Hurricane Sandy. Service disruptions of this nature put patients and their communities at risk for transmission of infectious diseases (e.g., HIV injection risk behaviors) and other negative consequences associated with relapse such as loss of employment and criminal activities. Interruptions in OTP services, combined with shortages of illicit substances like heroin, during emergency situations also serve to create increased—and sometimes unmanageable—demand for services at nearby OTPs and hospital emergency departments.

2. Background

2.1. Disasters and their impacts on opioid treatment programs

Studies assessing OTP preparedness in the wake of the 9/11 attacks and Hurricane Katrina [2,21] have demonstrated the efforts of treatment program staff to assure compliance with emergency procedures and ensure continuity of care for displaced patients. Despite the extensive efforts of OTP staff and state authorities to achieve a continuity of care amidst the disorder of a disaster, however, the impacts of even short-term disruption in medication access can be severe.

Those who have witnessed a major disaster, such as the 9–11 terrorist attacks [23] or Hurricane Katrina [3], have been observed to increase their substance use. For those in opioid treatment programs, disaster-related closure of methadone clinics represents a particularly potent form of resource loss with serious implications for public health [14,15]. In a study of NYC opioid users, almost half of the subsample of those enrolled in OTPs reported use of heroin or diverted prescription opioids alone or in combination with maintenance medications to avoid withdrawal after being displaced from their home programs in the wake of Hurricane Sandy [16]. Disruption in access to agonist medication is compounded by the psychological consequences (e.g., PTSD) following

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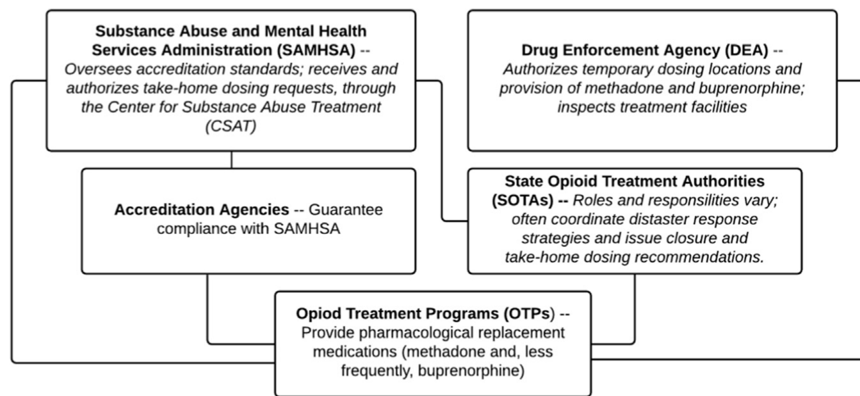

Fig. 1. Bureaucratic Organization of Opioid Treatment in the U.S.

exposure to a disaster [2], which may make patients especially vulnerable to resuming illicit opioid use both to stave off withdrawal and self-medicate their traumatic experience. A further risk is that overdose risk substantially increases after patients leave methadone maintenance treatment, especially during the first few weeks after treatment separation [5].

2.2. State opioid treatment authorities

Opioid treatment programs are subject to a complex patchwork of state and federal regulations in the U.S. (see Fig. 1). At the federal level, the DEA oversees the movement of controlled substances, including methadone and buprenorphine, and local field agents assure the compliance of OTPs in their regions. Additionally, OTPs are accountable to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), which coordinates accreditation through third-party agencies like the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Council on Accreditation (CoA), and authorizes requests for take-home dosing (as opposed to in-office daily, supervised dosing) through its Center for Substance Abuse Treatment (CSAT). At the state level, OTPs are the jurisdiction of State Opioid Treatment Authorities (SOTAs; sometimes still referred to as State Methadone Authorities). These state officials were originally designated during the 1970–1974 regulatory process which resulted in the Narcotic Addict Treatment Act of 1974 [17]. Despite broad variation in state regulations applying to OTPs, these SOTAs represent critical intermediaries between the day-to-day operation of OTPs and both the DEA and SAMHSA and are thus ideally situated to coordinate emergency response efforts and engage in policy-making to strengthen disaster preparedness among OTPs.

This study responds to a recent mandate for increased attention to the legal and practical challenges facing OTPs during disasters [18] by developing concrete recommendations for OTPs while also identifying the complex bureaucratic, legal, and sociocultural obstacles that make some policy recommendations much easier to implement than others. We had earlier identified many of these recommendations though interviews with OTP staff, directors and patients whose programs experienced significant disruption from Hurricane Sandy [14]. This study represents an expansion of our earlier study and draws on reports elicited from a nationwide sample of OTP directors and SOTAs from disaster prone states as well as federal officials.

3. Method

For this analysis, we adopted a hybrid of stakeholder and thematic analyses to evaluate and categorize narratives about OTP response and service continuity during natural disasters and other emergency conditions. Stakeholder analysis [1,12,22] presents multiple viewpoints on a shared topic of concern, attempting to represent the interests and subjectivities of each systematically and without undue bias. Thematic analysis [10,11] offers a typically inductive approach to qualitative data in which themes of importance to participants are identified and used as organizational tools in subsequent coding procedures.

We organized the study's component tasks (see Figure 1.1) to achieve a combination of inductive and deductive approaches. An emphasis on the tenets of grounded theory (e.g., [4]) in the early phases of the project resulted in a number of emergent themes related to policy areas that SOTAs in New York and New Jersey identified as salient to the task of strengthening OTP disaster preparedness. Those categories were then presented to OTP directors who were asked to evaluate the utility/desirability and feasibility (including perceived obstacles to implementation) of each and to contribute additional suggestions. These emergent categories were assigned thematic labels and added to the list, and this process of refinement was repeated again for both SOTAs and federal authorities (Fig. 2).

3.1. Designation of disaster-prone states

The sampling frame for this analysis is derived from a number of sources identifying the most vulnerable states and cities in the US, both in terms of natural disasters and terrorist targets. Sources included insurance-based rankings of the 10 states with the highest past-decade property losses (Kiplinger.com,[13,24]), reporting based on geological survey data [7], and a recent monograph on national security and terrorist targets [8]. The final list comprised 21 states with high degrees of vulnerability to disasters and/or attacks and included: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Ohio, Oklahoma, North Carolina, South Carolina, Tennessee, Texas, and Virginia. Interviews with two local (New York and New Jersey) SOTAs had already been conducted.

3.2. Recruitment

OTP Directors. 197 Clinical and program directors from disaster-

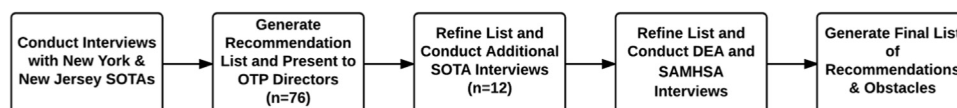

Fig. 2. Flow-chart of Study Methods.

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