April 27, 2020

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

We are the Drug Policy Alliance.

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

On behalf of the Drug Policy Alliance, the nation's leading nonprofit fighting for drug policies grounded in science, compassion, health and human rights, I write to express our support and offer recommendations for improvement for the Drug Enforcement Administration's (DEA) proposed rule to allow a narcotic treatment program (NTP) to operate a mobile component as a coincident activity and without separate registration. This proposal, especially if our recommendations are incorporated, will expand NTP access to underserved communities across the country.

Methadone and buprenorphine are the most effective treatments available for opioid use disorders (OUDs).[1] Despite this, these medications remain highly underutilized.[2] As the DEA has noted, increased demand for these medications has resulted in waiting lists and high services fees. Further, rural areas often lack access to these treatments due to geographic, transportation, and financial barriers.[3]

The proposed rule seeks to increase access to NTP services by waiving the requirement that a mobile component of an NTP separately register with the DEA. Instead, the NTP would need to secure approval from the local DEA field office before operating the mobile component. This is a positive step towards increasing access to methadone and buprenorphine to underserved communities. NTPs will be able to utilize mobile components to reach people in rural areas and also provide services to incarcerated people and those reentering the community through partnerships with law enforcement.

Mobile components will be required to abide by strict operating protocols. Among these are the requirement that a mobile component may only provide services in the same state where the NTP is registered and that a mobile component must return to the DEA-registered location at the end of each day. We recognize the DEA has proposed these measures to deter diversion. However, these requirements may serve to hinder the effectiveness of this rule in providing services to underserved communities, particularly in rural areas.

For many rural communities, the closest NTP may be across state lines. In one study, eight percent of all NTP patients traveled across state lines to access services, with 24 percent and 14 percent doing so in the Midwest and southeast, respectively.[4] These areas are among the hardest hit by the ongoing overdose crisis. NTPs that are best positioned to serve rural communities through a mobile component by crossing state lines should be allowed to do so, so long as the NTP abides by applicable state laws and secures local DEA field office approvals. We urge the DEA to revise the provision prohibiting mobile components from operating across state lines to allow NTPs located in one state to provide services to underserved areas in neighboring

[1] National Academies of Sciences, Engineering, and Medicine, "Medications for Opioid Use Disorder Save Lives," (National Academies Press, Washington, DC, 2019), 38, doi: 10.17226/25310.
[2] *Id.* at 19.
[3] Stacey. C Sigmon, "Access to Treatment for Opioid Dependence in Rural America," *JAMA Psychiatry* 71, no. 4 (2014): 359, doi: 10.1001/jamapsychiatry.2013.4450.
[4] Andrew Rosenblum et al, "Distance Traveled and Cross-State Commuting to Opioid Treatment Programs in the United States," Journal of Environmental and Public Health (2011): 5, doi: 10.1155/2011/948789.

states. One way to do this would be to authorize an NTP's mobile component to operate across state lines so long as it remains within a 200-mile radius of the DEA-registered site. This will increase access to remote areas that will otherwise remain underserved.

Requiring a mobile component to return each day to the DEA-registered site will also pose serious implementation barriers. Underserved areas can be over one hundred miles from the closest NTP.[5] Mobile components will need to travel from the DEA-registered site to the mobile component service site and back each day, increasing staff time, travel costs, and wear and tear on vehicles. These expenses could easily rival the cost of opening a new brick-and-mortar NTP. Given that the DEA is proposing to apply existing security protocols to mobile components, we urge DEA to revise the requirement that the mobile component return to the DEA-registered site daily. Instead, returning once a week should suffice to ensure increased access while safeguarding against potential diversion.

We also wish to take this opportunity to highlight that additional NTP restrictions will minimize the impact that mobile components could have. The requirement that new NTP patients accessing methadone come daily to get their medication essentially dictates that a mobile component will need to go to the same location every day to serve new NTP patients, which many if not most of these patrons will be given their location in underserved areas. This undercuts the utility of a mobile component, which could be going to various underserved areas throughout the course of a week or month. We urge the DEA to work with the Substance Abuse and Mental Health Services Administration (SAMHSA) to revise regulations restricting take-home medications, which will limit the reach of newly operationalized mobile components. The DEA should also work with SAMHSA to allow NTP providers to prescribe medications to be filled at community pharmacies and to allow non-NTP providers to prescribe methadone.

The Drug Policy Alliance supports the DEA's efforts to make these life-saving medications more available to communities in need. We urge you to include our recommendations for improving the feasibility of providing mobile NTP services. Should you have any questions or concerns, please do not hesitate to contact me at krussoniello@drugpolicy.org or (509) 389-0534.

Sincerely,

Kellen Russoniello, JD, MPH
Senior Policy Manager, Drug Policy Alliance

[5] *See id.* at 4.