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News for policy and program decision-makers

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In This Issue...

Our top lead this week looks at the lack of attention paid by the media to the successes of treatment. The bottom lead looks at a Maryland initiative linking emergency room overdose visits to treatment.
. . . *See stories, beginning on this page*

Early feedback on 42 CFR Part 2 proposal . . . *See page 4*

From the Field
When to refer pain patients for an addiction evaluation
. . . *See page 5*

Virginia, Medicaid and waiting lists: Funding, stigma problems
. . . *See page 6*

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Hope: The missing piece in news coverage about the opioid epidemic

The attention to addiction issues, driven by opioid overdose deaths, is both welcome and worrisome to the treatment community. On the positive side, any attention to a problem that has been given short shrift by both policymakers and payers since the late 1980s is welcome. But the concern is that the way the story is being told in the media is wrong — that treatment is ineffective — according to treatment experts we talked to last week.

"A false narrative is being created that suggests that addiction treatment that provides recovery has not been available, but that medicine and psychology are here to save the day," said Marvin Ventrell, executive director of the National Association of Addiction Treatment Providers (NAATP). "Even the mainstream media, such as *The New York Times*, have been reporting this narrative — that treatment is ineffective."

There are two reasons this narrative is false, said Ventrell: (1) people do recover and (2) medicine and psychology have been used in treatment for decades. Typically, NAATP

See **Hope** page 2

Bottom Line...

Instead of stories focusing on tragedy and harm reduction, the news media is called upon to look at addiction treatment and how it really works.

Maryland uses peers to target overdose survivors for treatment

A Maryland initiative with funding support from both federal and state sources is using trained peers in hospital emergency departments to link opioid overdose survivors to addiction treatment services. The Overdose Survivors Outreach Program (OSOP), which seeks to match services to individual patient needs, has been in operation for about a month at one hospital in Anne Arundel County and will launch at three sites in the city of Baltimore within the next two months.

Local health departments are serving as the hub for the outreach, with Anne Arundel County's agency employing the paid peers in recovery who meet with patients at the potentially transformative moment of a survived overdose, said Brian Holler, overdose prevention and response program manager at the Maryland Department of Health and Mental Hygiene. The effort is designed to establish more than a one-time contact between patient and peer, with ongoing engagement post-hospital discharge for patients

See **Maryland** page 7

Bottom Line...

Maryland's Overdose Survivors Outreach Program will station peers at hospital emergency rooms to engage opioid overdose survivors on treatment opportunities, with the intent of establishing an ongoing patient-peer relationship where needed.

Hope from page 1

doesn't even have a voice in these stories: they just assume that "all treatment is 12-Step," said Ventrell. "Good centers have been providing cognitive behavioral therapy for decades," he said. "Those stories are just not accurate."

Quality of life

There is also the issue of spirituality, an important aspect of treatment that is often — wrongly — confused with religion, said Ventrell. "We have to figure out a way to talk about the suspicion surrounding spiritual care," he said. It's a difficult concept to communicate, particularly when the 12-Step community is anonymous, he said. "It is the responsibility of those of us in the 12-Step community to be able to communicate what this means as a part of psychosocial care."

Ventrell agrees that addiction is a brain disease but said that doesn't mean the only treatment is medical. "Sitting down with your peer group, looking them in the eye, and telling them what is going on with you is part of a healing process," he said.

Joseph Garbely, M.D., medical director of Caron Treatment Centers, said that the overreliance on medication that has come with opioid use disorders has led to neglecting other lifestyle changes that are essential to recovery. "The public has eliminated the 'assisted' and just gone to 'medication,'" he said, referring to medication-assisted treatment. "It's like a diabetic relying too heavily on insulin and not diet and exercise," he said. "It's the same for chemotherapy for cancer, in which adjunctive spiritual care and music and art therapy have proven helpful" in quality of life.

The journalists and bloggers who deride AA and NA do so because they don't understand what it is, said Garbely. And they can't really be blamed, because AA and NA are, by definition, anonymous. "AA is a secret society," he said. "People on the outside make fun of people on the inside because they don't understand it — because they're not allowed to understand it."

Sensationalism

Much of the conversation treatment providers have is around reimbursement. In Illinois, for example, there is no FY 2016 budget, and many providers haven't been paid since June. This is not making headlines, however.

The treatment providers who are in the trenches working daily to help patients recover rarely get called upon to come up with success stories — and when they do, the stories veer off toward the negative. "Whether you're selling clicks or newspapers, it's the sensational headline that is exciting, the tragedy that is exciting," said Carlton Kester, on the NAATP board and president of Lakeside-Milam Recovery Centers, a chain in Washington state. Kester recalled a local television station that interviewed one of the program's experts who is in decades-long recovery from opioid addiction. "The station interviewed him for 45 minutes, but the 15-second snippet they ran was about how he used drugs and went to work — years ago," he said.

However, Kester is glad there is a greater understanding of addiction as an illness and not a moral failing. "Unfortunately, though, because of the opioid epidemic and specific interventions for opioids, we're not talking about treatment outcomes and the improvement of quality of life that people are achieving through treatment," he said. Rather, the bar has been lowered to survival, with the undeniable truth in the statement that recovery is impossible if someone dies.

Ventrell noted that harm reduction — continuing to use drugs or alcohol but in less harmful ways —

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is being promoted as a new concept that is necessary to save lives, but actually has been around for a long time in the treatment field. "It's not our ideal — we want people to live full lives," he said. "But it's not new."

Pharmacology

Ventrell added that economics are part of the problem, with the pharmacology industry promoting, in particular, branded versions of buprenorphine and naltrexone, which are approved to treat opioid use disorders. The only other medication with this approval — methadone — gets a lot less attention because it's generic and only available in methadone clinics, which get very little attention from the media. Incidentally, there has been growth in the for-profit methadone clinic sector as a result of the opioid epidemic, but not in publicly funded clinics. In addition, the buprenorphine expansion expected as a result of an anticipated change in the number of patients a physician is allowed to treat is likely to focus additional resources on medication-only treatment, depending on the wording of the regulations.

"If I knew how to move the discussion from specific interventions to long-term outcomes, I would," said Kester. "Medication is part of treatment, but it's not the whole conversation."

There is also the fact — unacknowledged in news stories about medication-assisted treatment for opioid use disorders — that most patients "come to us on more than one chemical," said Kester. "Why is the narrative almost exclusively about interventions for only one drug?" In addition, the news is late on heroin, said Kester.

Despite the many attestations to addiction being a brain disease, this isn't really accepted in many circles, said Garbely. "Addiction is still seen as a moral failing or a lack of willpower, despite scientific proof that it is a disease," he said. Doctors themselves are included in this. "I teach in multiple medical schools, and there's limited education about the disease concept of addiction," he said. "My second residence was in psychiatry, and I didn't get the addiction education there — where you would expect it," he said. "Medical education has to catch up."

Calling on SAMHSA and ONDCP

The treatment providers we interviewed all called for help in communicating their message from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the White House Office of National Drug Control Policy (ONDCP). "NAATP's voice needs to be louder and stronger, but we also need to hear from SAMHSA and the ONDCP," said Ventrell. "Michael Botticelli knows full well what 12-Step looks like," he said, referring to the ONDCP director in long-term recovery from alcoholism. "I'm not saying we need to slow down the pharmacology — NAATP embraces it as a component" of treatment, he said.

SAMHSA needs to be more vocal about "recovery," our sources agreed. "It's nice to have buzzwords and it's nice they have adopted the word, but what does recovery look like?" asked Garbely. "We have to start talking about remission, healing, sustained results, and then perhaps we can move beyond the discussion of what we need to do in the first two weeks of treatment."

Kim Johnson, Ph.D., the new director of SAMHSA's Center for Substance Abuse Treatment, noted that the most common outcome for people with substance use disorders, and opioid use disorders in particular, is in fact recovery. She called up data showing for the majority of people with SUDs, recovery is attained (see below for citations). "It may take multiple treatment attempts, and in some cases people recover with official treatment, but the message we need to give to people is that recovery is the main outcome," she said.

The media attention is a "double-edged sword," she said. "All of the energy about the tragedy of overdoses is what is helping to bring support, whether in funding or attention to treatment and recovery," she said.

'It may take multiple treatment attempts, and in some cases people recover with official treatment, but the message we need to give to people is that recovery is the main outcome.'

Kim Johnson, Ph.D.

Untreated addiction is a fatal disease, said Johnson, but the odds of dying from opioids are much higher, which is why harm reduction is getting such attention. "You can't treat someone who is dead, so keeping people alive is an important first step," she said. "But it is a first step." The next step — "improving the quality of life with treatment and recovery — is the message we have to convey," she said. She urged treatment programs like Kester's to continue reaching out to the press. The result of the example he described — the television station's focus on past bad news instead of current good news — is unfortunate, she said. "But they did the right thing. They need to get people out there who are in recovery, to talk about

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the recovery process, to talk about the fact that there is hope."

Here are citations for articles showing that recovery is the most common outcome for people with substance use disorders:

- Dennis ML, Scott CK, Funk R, et al. The duration and correlates of addiction and treatment careers. *J Subst Abuse Treat* 2005; 28(Suppl 1):S51–62.
- Hubbard RL, Craddock SG, Anderson J. Overview of 5-year followup outcomes in the drug abuse treatment outcome studies (DATOS). *J Subst Abuse Treat* 2003 Oct; 25(3):125–134.
- Potter JS, Dreifuss JA, Marino EN, et al. The multi-site prescription opioid addiction treatment study: 18-month outcomes. *J Subst Abuse Treat* 2015 Jan; 48(1):62–69. doi: 10.1016/j.jsat.2014.07.009. Epub 2014 Aug 2.
- Weiss RD, Potter JS, Griffin ML, et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. *Drug Alcohol Depend* 2015 May 1; 150:112–119. doi: 10.1016/j.drugalcdep.2015.02.030. Epub 2015 Mar 6. •

Early feedback on 42 CFR Part 2 proposal

Two knowledgeable authorities on all things related to 42 CFR Part 2 — the federal confidentiality regulations governing substance use disorder treatment records — have weighed in with responses to the proposal by the Substance Abuse and Mental Health Services Administration (SAMHSA) to allow for general consent (see *ADAW*, February 15). Comments on the proposed rule are due April 11, but the Legal Action Center — which helped draft the initial regulations — and H. Westley Clark, M.D., former director of SAMHSA's Center for Substance Abuse Treatment and a vocal critic of weakening the regulations — have already weighed in on how they feel.

Support from Legal Action Center

The Legal Action center on March 7 issued a press release saying it "welcomes" the efforts to "modernize" the rule. After careful analysis, the Legal Action Center "SAMHSA has struck an appropriate balance in its attempts to achieve two important objectives: preserving the confidentiality rights of substance use disorder ("SUD") patients, while also facilitating the sharing of health information as needed to provide quality care in a new health care delivery environment, including through electronic exchange of health information."

The proposed rule "maintains Part 2's core confidentiality protections, including consent requirements and the prohibition on re-disclosure of patient-identifying information without patient consent," the Legal Action Center noted in its press release. The rule makes it easier for electronic health records to contain the information by enabling patients to consent to disclosures through a general designation — such as to an entire health system, instead of to an individual, named person. "We support this approach as the best available mechanism for facilitating communication between patients' substance use disorder caregivers and their other treating professionals while preserving patient control through the continued requirements of signed consent and prohibitions on redisclosure."

Discouraging patients from seeking treatment

Clark, on the other hand, is very concerned about the changes. In his draft comments on the proposal obtained by *ADAW*, he noted that the proposed rule itself acknowledges that the main reason for 42 CFR Part 2 was the fact that if their information would be shared, many SUD patients would not seek treatment. The proposed rule also acknowledges that disclosure "has the potential to lead to a host of negative consequences including: loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest, prosecution and incarceration," Clark noted.

The reasons for abandoning 42 CFR Part 2 lie in new technologies, such as electronic health records, and new service delivery models, such as accountable care organizations, said Clark. Researchers and health service providers "find the consent requirements of 42 CFR Part 2 inconvenient and burdensome," he said. Clark was at CSAT when these forces started lobbying to change the rule.

The proposed rule, said Clark, "makes substantial concessions to the institutional stakeholders, both providers and researchers, who wish to mine what they perceive as a rich treasure trove of information about those who present for substance use disorder diagnosis, treatment and referral to treatment." He noted that the law that 42 CFR Part 2 is based on reflected the need for consent and privacy, and added that Congress recognized that the discrimination and stigma of SUD treatment could be a threat long after the patient had left treatment and was in recovery. "This approach recognizes that it is the patient, not the Part 2 provider, the researcher, the auditor, the evaluator or other entity who would bear the brunt of any resulting harm."

Clark also noted that the penalty for violating 42 CFR Part 2 is small compared to the harm that a patient

Continues on page 6

FROM THE FIELD

When to refer pain patients for an addiction evaluation

By Lynn Webster, M.D.

Most providers have had little to no training in assessing and treating persistent noncancer pain and even less training in assessing and treating opioid use disorder (OUD). Due to the prevalence of moderate to severe pain and lack of treatment options covered by most payers, opioids have been the default treatment for millions of Americans with persistent noncancer pain. A conundrum of opioid prescribing within the medical community is knowing who to treat and when to discontinue opioids or refer for OUD treatment. The major challenge of opioid prescribing for persistent noncancer pain is to determine who really needs opioids and how to safely prescribe them.

When prescribing an opioid for chronic noncancer pain, every office visit is a decision point to continue prescribing or to look for an alternative strategy. To determine if the potential benefit outweighs the possible harm, the following series of questions should be considered on every visit:

- Are there dose-limiting side effects?
- Are there safer alternatives?
- Are aberrant, drug-related behaviors too risky to manage?
- Has improvement to physical, psychological functioning or quality of life been documented?
- What is the evidence of physical/psychological improvement?

The prevalence of OUD — or addiction — in patients prescribed opioids for persistent noncancer pain is close to 1 in 20, according to a recent study published in the April 2015 journal *Pain*. However, problematic opioid behaviors range from less than 1 percent to more than 35 percent, depending on definitions of abuse and addiction and populations studied. A wide range of behaviors are used to determine whether someone is misusing, abusing or has met the criteria of opioid addiction. Patient aberrant, drug-related behaviors can exist anywhere along a spectrum from none to egregious. Obviously the more egregious behaviors are usually consistent with a diagnosis of addiction. Behaviors can change over time depending on environmental factors like emotional support or financial stress.

Concerning behaviors

Behaviors that are concerning for addiction from less suggestive to more suggestive include the following:

- Requests for an increase in opioid dose;
- Requests for specific opioid by name ("brand name only");
- Non-adherence with other recommended therapies (e.g., physical therapy);
- Running out of medication early (i.e., unsanctioned dose escalation);
- Resistance to change in therapy despite adverse effects (e.g., oversedation);
- Deterioration in function at home and work;
- Non-adherence with monitoring methods (e.g., pill counts, urine drug tests);
- Multiple "lost" or "stolen" opioid prescriptions; and
- Illegal activities (e.g., forging scripts, selling opioid prescriptions).

There are biomarkers that could suggest OUD as well. These would include unexplained and inconsistent urine drug tests and multiple providers or pharmacies recorded on the prescription monitoring report.

Provider level of expertise in managing patients with aberrant, drug-related behaviors varies, and patient management decisions should match the provider's level of training and expertise. The provider should discuss with the patient any specific behaviors that generate concern for possible addiction. This would include observations of the appearance of loss of control, compulsive use and continued use despite harm. The provider is advised to document the behaviors, conversation and follow-up measures in the patient record. It is important to remember that patients may suffer from both pain and addiction. In addition, behaviors that would be suggestive of addiction may be normal in a nonaddicted person whose pain is poorly controlled. Here is where it becomes challenging, because the provider may need to determine if the behavior is being primarily driven by the disease of addiction or the disease of chronic pain. It may be that the patient and the provider will have to agree to disagree on what the basis is for the behavior and move on with the best, yet compassionate plan.

When to refer

The following are suggestions for when to consider referring to an addiction medicine specialist:

- When a patient is using illicit drugs;
- When a patient is experiencing problems with other prescription drugs (e.g., benzodiazepines);
- When a patient has an addiction to or abuse of alcohol;
- When a patient agrees he or she has an opioid addiction and wants help; and
- When a patient has a multiple diagnosis of any

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Continued from previous page

combination of pain, addiction and psychiatric disease.

There is no single recipe for managing patients on opioids with persistent noncancer pain that works for all providers. Providers who feel uncomfortable diagnosing and treating patients with pain and addiction should develop relationships with professionals who understand the intersection of the two disorders. Most important, it must be remembered that people with overlapping persistent noncancer pain and addiction deserve to be treated with dignity. People do not choose to have addictions or volunteer to live in pain. They have a right to be treated compassionately like all other patients.

Lynn Webster, M.D., is past president of the American Academy of Pain Medicine, and author of The Painful Truth. *For more information, go to www.lynnwebstermd.com and www.thepainfultruthbook.com.*

Continued from page 4

might experience from release of records. The fine is limited to $500 for the first offense, and not more than $5,000 in the case of each subsequent offense. This is the fine in the current regulations, and also in the proposed rule.

Consent not required for research

A network can receive a patient's information, if the patient consents under the new form — and this can even be a Health Information Exchange.

The proposed rule also allows a research institution to obtain patient identifying information without consent.

The proposed rule is silent on who pays for the list of disclosures — which the patient can get upon request, but may have to pay for, noted Clark. "Thus, the patient may be charged a fee just to ascertain who has received unconsented information about their personal identifying information."

There is no sample consent form in the proposed rule, said Clark, noting that this means every program will have to develop their own form, and that there will be a variation in form and content.

Confirming understanding

The new rule does include a requirement that the patient confirm their understanding of the information on the consent form, which the existing regulations do not require. Clark is in favor of this. However, these confirmation statements "quickly become rote and lose their meaning," he said. "People early in treatment may sign a document without fully understanding it."

"Harm is a reality for those with alcohol or drug use disorders," concluded Clark in his draft comments. "Seeking help for an alcohol or drug use disorder should not expose the person seeking help to harm. While it is asserted that altering 42 CFR Part 2 is good for the person experiencing a substance use disorder, diminishing that person's autonomy and right to know who knows about their personal identifying information does not achieve the goodness of effort alleged."

Finally, the Legal Action Center is also concerned about patient harm caused by improper redisclosures when health care professionals receive patient information from SUD providers. So one change the Legal Action Center will be recommending to the proposed rule will be related to enforcement. •

For our February 15 article on the notice of proposed rulemaking from SAMHSA, which includes links to the Federal Register notice and information on how to comment, go to www.alcoholismdrugabuseweekly.com/Article-Detail/42-cfr-part-2-proposed-rule-would-allow-general-consent.aspx.

Virginia, Medicaid and waiting lists: Funding, stigma problems

At first, the news story on heroin started the way many others do: "Kristin Roope knew she'd be dead soon, and most nights wished for it." But the February 27 story, in the *Richmond Times-Dispatch*, ended with good news: Roope's recovery at The McShin Foundation. She had been very sick for a long time and homeless, and five years ago was hungry and barefoot at the Richmond Behavioral Health Authority, where she was told she had to go on a waiting list. There is a two-month list for either methadone or buprenorphine or detoxification. The problem is lack of funding, especially in Richmond, according to the article.

Virginia now has a plan that it said would reduce waiting lists in a phased-in program starting January 2017. A proposal to add $11 million in state funds, which would be matched by the federal government, is under consideration in the General Assembly. It would expand SUD treatment to all Medicaid members and increase reimbursement rates, which would encourage more providers to offer services. "Starting Jan. 1, 2017, the goal is that you won't have to wait," Katherine Neuhausen, M.D., incoming chief medical officer at the Department of Medical Assistance Services, told the paper. "A Medicaid member, at least, can walk into any facility and get treatment."

Implementation would begin in Richmond, and would be extended

to the entire state in 2018.

Some treatment providers are worried about expanding access to buprenorphine without accompanying counseling. The state, in an effort to address that concern, will also increase Medicaid reimbursement for counselors who work with physicians who prescribe buprenorphine, and is also recruiting peers to support patients.

One state legislator, Del. John O'Bannon III, who is a practicing physician, told the newspaper, "We had better coverage for substance abuse in the '90s than we do today, because we've seen insurance companies treat this as low-hanging fruit; a frailty, a personal problem or moral failing instead of the illness it is." And O'Bannon blames Virginia for not expanding Medicaid.

Another problem is stigma. Karen Kimsey, a deputy director in Virginia's Department of Medical Assistance Services, which administers Medicaid, said many people would rather pay out of pocket — or not seek treatment at all — than have a "paper trail" of their drug use.

State officials told the newspaper that they don't know how many people in Virginia are on waiting lists for treatment. In 2013, there were 1,104 in the first three months of the year, with two in five remaining on a waiting list for more than three months.

There were 244 heroin overdose deaths in Virginia in the first three quarters of 2015 — more than in all of 2014.

Raising Medicaid rates — and allowing reimbursement for everyone on Medicaid — will help expand treatment slots and beds. But there are still 400,000 low-income people who can't get Medicaid, because the state didn't expand it. That means low-income adults without children — mainly, men — not only can't get SUD treatment, but can't get any health care.

Virginia only started paying for Medicaid SUD treatment in 2007, and even then the rates were so low that nobody wanted to take Medicaid.

The bottom line: pregnant women are the only Medicaid recipients who are eligible for residential treatment. And 50 percent of women who lost their children to foster care because of their addictions had to wait more than a year for SUD treatment — which was mandated by the court.

Eventually, Roope, who has three children, did get a room, four years ago at the McShin Foundation. McShin gets no funding from the state but had a bed the day she asked for it. Now she works there, and has been in steady recovery ever since. The solution for all addicts in the state is for help to be available when they ask for it, not weeks or months later, treatment providers and state officials agree. But providers can't provide treatment unless they are paid, and the state, so far, isn't willing to have Medicaid pay for treatment for everyone who needs it. •

Maryland from page 1

who do not choose to pursue treatment right away.

The initiative is debuting in Anne Arundel County and in Baltimore because of the magnitude of the opioid crisis in those communities and because of the state's close working relationships with the local health departments there, Holler told *ADAW*. A 2015 Substance Abuse and Mental Health Services Administration (SAMHSA) grant is funding the Anne Arundel County program, while state funds are being used to pay for the effort in Baltimore.

The state agency is seeking to counteract the reality that many fatal overdose victims had visited a hospital emergency room at least once prior to the fatal overdose. Officials also are hoping to facilitate more collaboration among local health departments, hospitals and specialty treatment facilities. "We see this as allowing for greater coordination of care," said Holler.

He added that in designing their program, state officials spoke with leaders in Rhode Island who in 2014 initiated a similar state-funded program using recovery coaches in emergency departments (see *ADAW*, Oct. 26, 2015).

Treatment options

The programs will be structured slightly differently in the two communities that are executing the initial launch of OSOP. The Anne Arundel County effort is already in place at the Baltimore-Washington Medical Center, where two peers are embedded in the emergency room setting during peak periods of activity. "We're encouraging all the health departments and hospitals to use credentialed peers," said Holler. "All of the peers being used so far are credentialed or are getting set to be."

The peers are trained in Motivational Interviewing (MI) approaches with patients, allowing them to assess patients' readiness for change and to identify potential barriers to treatment. Holler said the state's research into the overdose crisis led officials to conclude that the ER visit (as opposed to the emergency responders' response site or a post-ER location) constituted the best and safest moment for reaching someone and presenting the possibility of opioid dependence treatment.

"Peers provide a unique ability to use this difficult and potentially transformative moment to provide linkages to treatment," Holler said.

He said that in Anne Arundel County, if a patient is ready to receive treatment upon that first peer encounter, he/she can be transferred immediately to methadone "gap treatment" services that are readily available locally. Other medication-assisted treatment options also may be sought, although at present methadone is the only medication treatment that is provided directly by the county, Holler said.

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Peers also will seek to identify treatment options that speak to individualized needs. "If they're working with a mother with a young child, they will look to send them to a place with housing for minors," Holler said. "Other patients might prefer to work with a faith-based program." The initiative is taking a "no wrong door" approach to potential treatment modalities, he said.

The state funding that will support the programs in Baltimore and in other communities is somewhat limited and pays only for the peers' services and their ongoing training and supervision, not for any follow-up specialty treatment that a patient might receive. With $300,000 in state money set aside annually for OSOP, officials will have to determine in the coming months what the state can afford in terms of the number of hours peers are stationed at ERs, as well as the duration of ongoing contact between peer and patient when a peer does not pursue treatment services immediately.

The Baltimore city efforts, which will launch by early April at two hospitals and by mid-May at a third, will build on peers' existing presence in city emergency rooms for the delivery of screening, brief intervention and referral to treatment services to other segments of the hospital patient population, Holler said. The peers in the ER settings in Baltimore under OSOP will transition the patient to working with another peer (employed by a city-funded agency) for follow-up after discharge.

Seeking data

Holler said the state will be reporting data to SAMHSA quarterly regarding the Anne Arundel County effort; he believes initial data will be available within the next three to five months. Anecdotally, "Within the first two weeks, two individuals were linked to treatment, and the overall feedback about the effort has been excellent," he said.

He said he did not know what type of treatment the initial referred patients had received, and clearly it will take a while for state officials to know whether OSOP is having a tangible impact on curbing the opioid crisis.

Some hospitals do not even have exact data that tracks every overdose survivor who has been seen, as codes for some patients might not reflect that they had overdosed, Holler said. But OSOP's goal remains to "engage 100% of the overdose survivors admitted to emergency departments when a peer is on site," he said. •

Coming up...

The **Innovations in Recovery** conference will be held **April 4–7** in **San Diego**. For more information, go to **http://foundationsevents.com/innovations-in-recovery**.

The **American Society of Addiction Medicine** will hold its annual conference **April 14–17** in **Baltimore**. Go to **www.asam.org/education/live-and-online-cme/the-asam-annual-conference** for more information.

The annual national **TASC Conference on Drugs, Crime and Reentry** will be held **April 25–27** in **Chicago**. Go to **http://nationaltasc.org/annualconference** for more information.

The **American Psychiatric Association** will hold its annual meeting **May 14–18** in **Atlanta**. For more information, go to **http://annualmeeting.psychiatry.org/about-the-meeting/future-meeting-dates**.

The annual conference of the **National Association of Addiction Treatment Providers** will be held **May 15–17** in **Ft. Lauderdale, Florida**. Go to **www.naatp.org** for more information.

In case you haven't heard...

Daily exercise and a good diet are keeping President Barack Obama in excellent health, according to his doctor, Reuters reported last week. A former smoker, the 54-year-old president still uses nicotine gum "once in a while" and takes medication for occasional acid reflux. His physical examination showed that the president's health has improved from his 2014 exam, with lower body mass and cholesterol levels.

Names in the News

Ray Tamasi, Gosnold CEO, receives National Council leadership award

Last week, **Ray Tamasi**, president and CEO of Gosnold on Cape Cod, received the Visionary Leadership Award from the National Council on Behavioral Health. Announced at the National Council's annual meeting in Las Vegas, the award was for Tamasi's 42 years in the field. Selected from more than 1,000 nominations, Tamasi has created a prevention division, has integrated behavioral health and primary medical care and has instituted a school-based counseling program. The recognition includes a $10,000 cash award, which Tamasi will direct to Gosnold's prevention division.