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News for policy and program decision-makers

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In This Issue...

Our two lead stories this week focus on the national opioid epidemic, with the CDC's recent reporting highlighting major increases in heroin and illicit fentanyl overdose deaths, and on security issues related to policies on patients bringing guns into treatment centers.
. . . *See stories on this page*

To open an OTP, prepare for up-front funding and paperwork
. . . *See page 3*

More best and worst of last year; hopes, fears for the new one
. . . *See page 6*

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CDC report shows heroin and illicit fentanyl overdoses increasing

Drug overdose deaths have increased 137 percent — 200 percent for opioids — since 2000, the federal Centers for Disease Control and Prevention (CDC) announced in its January 1 *Morbidity and Mortality Weekly Report (MMWR)*. The analysis looked at overall increases in overdose deaths from 2000 to 2014, and focused specifically on increases from 2013 to 2014.

Bottom Line...
The CDC reports on increases in opioid overdoses, showing significant increases in heroin and illicit fentanyl, while it continues its efforts to restrict opioid prescribing for pain.

The majority (61 percent) of the drug overdoses in 2014 involved some type of opioid, according to the report.

Deaths counted more than once

Some overdose deaths were counted more than once. "Some deaths involve more than one type of opioid; these deaths were included in the rates for each category (e.g., a death involving both a synthetic opioid and heroin would be included in the rates for synthetic opioid deaths and in the rates for heroin deaths)," the report stated.

We asked Rose A. Rudd, CDC

See **CDC** page 2

Threat of potential gun violence propels centers to strengthen policies

In many respects, addiction treatment facilities are no different from other businesses in being exposed to the potential dangers of a violence-prone society. Throw in a transient patient population and access to prescription medications at some sites, however, and the need for formalized procedures to prevent or mitigate the effects of incidents becomes more acute. But facility leaders interviewed by *ADAW* also emphasize that any decisions made in this area should strike a balance between protecting safety and preserving a therapeutic environment.

Bottom Line...
The risk of on-premises violence at addiction treatment facilities appears to affect all levels of care, and facility leaders strive to some degree to establish flexible policies that serve multiple interests.

"We don't want our facilities to have any criminal justice feel to them," said Jeffrey Hillis, president of AdCare Hospital, which operates a main inpatient campus in Worcester, Mass., and half a dozen outpatient sites in Massachusetts and Rhode Island.

Several of the leaders interviewed for this article believe that comparatively few treatment centers have initiated detailed conversations about violence prevention in their operations, for incidents brought on

See **Violence** page 4

CDC from page 1

health scientist and lead author of the report, about the over-counting of overdose deaths.

"Some deaths do include more than one type of drug," responded Rudd in an email to *ADAW*. "In 2014, there were 12,159 deaths involving a natural or semi-synthetic opioid; 3,400 deaths involving methadone; 5,544 deaths involving a synthetic opioid (exclusive of methadone); and 10,574 deaths involving heroin. There were 28,647 deaths that involved any opioid: this number of deaths does not the sum to the other categories, as deaths do include more than one type of drug."

That is not to discount the severity of the opioid epidemic, and the increase in heroin and illicit fentanyl use and overdose deaths.

Heroin and illicit fentanyl (not the prescribed medication) were responsible for most of the increase, the report stated. There was a particularly sharp increase in deaths involving synthetic opioids (other than methadone), which, the report said, was in line with law enforcement reports of an increase in illicit fentanyl on the streets. However, pharmaceutical fentanyl cannot be distinguished from illicit fentanyl in death certificates.

Between 2013 and 2014, overdose rates involving methadone were unchanged, but deaths involving opioid pain relievers increased 9 percent, deaths involving heroin increased 26 percent and deaths involving synthetic opioids (other than methadone) increased 80 percent.

"These findings indicate that the opioid overdose epidemic is worsening," the report stated. "There is a need for continued action to prevent opioid abuse, dependence, and death, improve treatment capacity for opioid use disorders, and reduce the supply of illicit opioids, particularly heroin and illicit fentanyl."

The greatest increases were in 25–44-year-olds and people 55 and over; in whites and blacks; and in the Northeastern, Midwestern and Southern regions of the United States.

Hardest-hit states

The report singled out the five states with the highest rates of drug overdose deaths in 2014: West Virginia (35.5 deaths per 100,000), New Mexico (27.3), New Hampshire (26.2), Kentucky (24.7) and Ohio (24.6). In addition, states with statistically significant increases in the rate of overdose deaths from 2013 to 2014 included Alabama, Georgia, Illinois, Indiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Mexico, North Dakota, Ohio, Pennsylvania and Virginia.

Specific codes

The CDC relied on the National Vital Statistics System multiple cause-of-death mortality files, which classify drug overdose deaths based on International Classification of Diseases, Tenth Revision underlying cause-of-death codes. The basic codes are X40–44 (unintentional), X60–64 (suicide), X85 (homicide) or Y10–Y14 (undetermined intent). Then the type of opioid involved is indicated by a T code (T40.0, T40.1, T40.2, T40.3, T40.4 or T40.6); natural and semisynthetic opioids (including morphine, oxycodone and hydrocodone) are T40.2; methadone is T40.3; synthetic opioids (including fentanyl and tramadol, as well as illicit fentanyl) other than methadone are T40.4; and heroin is T40.1. If more than one opioid was found, both were listed, accounting for the fact that some deaths were reported more than once.

The increase in heroin overdoses mirrors large increases in heroin use across the country, the report stated, and it adds that heroin use is "closely tied to pain reliever misuse and dependence."

The increased availability of

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'There is a need for continued action to prevent opioid abuse, dependence, and death, improve treatment capacity for opioid use disorders, and reduce the supply of illicit opioids, particularly heroin and illicit fentanyl.'

Rose A. Rudd, in CDC *MMWR*

heroin and its low price compared with prescription opioids, as well as high purity, are "major drivers of the upward trend in heroin use and overdose," the report stated.

Limitations

In addition to counting deaths more than once, there were other limitations to the study. The authors admit that toxicology laboratory tests performed at autopsy vary based on jurisdiction; in addition, in 2013, 22 percent of drug overdose deaths did not include any information on the death certificates about the specific drugs, and 19 percent in 2014 did not include such information. Finally, some heroin deaths might have been misclassified as morphine, because the drugs are metabolized similarly and testing might not have been done that can distinguish between them.

Message still prescription opioids

The conclusion of the report was the same message the CDC has been promoting (as it has been tasked with by the White House) — to reduce the prescribing of opioids. As the CDC's Leonard J. Paulozzi, M.D., told us last year, people who are initiating the use of heroin started with the use of prescription opioids, and "if we can stop feeding that pool now, it will help," while at the same time saying, "If you have a large cohort of people who are already physiologically dependent on heroin or prescription opioids, those people aren't going to go away. They're going to seek drugs, and they will need to get into treatment" (see *ADAW*, May 4, 2015).

However, the fact is that opioid prescribing has been reduced substantially, and at the same time, heroin use is going up, and the CDC's main focus is still on reducing prescribing of opioids.

The *MMWR* was posted online as an early release December 18, shortly after the CDC announced it would issue draft guidelines on opioid analgesic prescribing for primary care providers (see *ADAW*, Dec. 21, 2015). •

For the January 1 *MMWR*, go to www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w.

Editor's note: A report from 2013 examined variation in certifying manner of death and drugs involved in drug intoxication deaths by type of death investigation system: http://s3.documentcloud.org/documents/1151267/heroin-project-2014-study-on-overdose-deaths.pdf.

To open an OTP, prepare for up-front funding and paperwork

The process of opening an opioid treatment program (OTP) — even if there are no NIMBY (not in my back yard) problems — is cumbersome, especially at the local level, based on the experience of Zac Talbott, who last year began the process of opening Counseling Solutions of Chatsworth in Georgia (see *ADAW*, Aug. 17, 2015).

When we talked to Talbott last week, he already had 100 patients on the waiting list — and the program wasn't even open yet. He only has room for 300 patients, and all 100 are from the immediate area. "I figured we would draw on a big radius," said Talbott, noting that he chose the site because there is a lack of treatment in a widespread area surrounding it.

The most recent holdup in opening has been from the local Drug Enforcement Administration (DEA) agent — the final step in the process before opening. The agent was "condescending" as well, responding by email that she knew Talbott wanted to get his "lucrative" business started, but that she was busy and had other programs to tend to as well. "I fired back that I have been in patient advocacy for years; this is not just about a business interest," he said. Talbott is not the DEA registrant — as a methadone patient, he can't be — but his partner, Keith Jones, is. (Like everyone involved in the OTP, Talbott had to take a drug test, which was positive for his treatment medication, "and it was never an issue," he said.)

And when Jones first contacted the agent to clarify procedure, he was told "'I'm not here to hold your hand or walk you through this — if you want someone to walk you through this, you can pay whoever you need to.'" There was never any suggestion along the way that anyone be paid a bribe, however, said Talbott.

The DEA is the final hurdle in a

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Continued from previous page
series of hurdles, Talbott said. The process began last May, when he signed the lease for the building. He had to start paying for the building and paying staff.

Money up-front

The first step in opening an OTP in Georgia is to retain a doctor (at $100 an hour, typically) and get a building. "Money was flying out the door," said Talbott. In June, he applied for accreditation — and that was the most positive experience in the entire process — for $1,800 with the Joint Commission. After the accreditation, there was the application to the Substance Abuse and Mental Health Services Administration (SAMHSA), which was fairly straightforward.

In Georgia, OTPs have pharmacy board oversight — which is unusual, and means that there needs to be a separate pharmacy staffed by a pharmacist, who prepares all the doses. Nurses cannot pump the methadone into bottles in Georgia. The pharmacy has to have a safe, separate alarm zone and separate application process.

So there are two state applications for OTPs in Georgia — the state application and the state pharmacy board application. Both are in the same department, but it took two months to determine which of these two came first. "This was a big source of our frustration," said Talbott. The same state regulator who was confusing the issue also told Talbott that he needed to get the DEA application in first, but the DEA told them no, they needed to have all the state applications done first. It finally took someone from SAMHSA's Center for Substance Abuse Treatment to clear it up.

The pharmacy board did the site visit in September, and within a couple of weeks Talbott got that license.

Corruption, incompetence

Then he submitted the application to the state, but the state did not come until December. Part of the problem, said Talbott, was that the state surveyor had left to take a job with another OTP chain, which left only one surveyor for the entire state of Georgia. And the first surveyor — who had left for a competitor — gave Talbott incorrect information about what to put on the DEA application. "So there was incompetence, there was corruption," he said.

> **'Money was flying out the door.'**
>
> Zac Talbott

The state did the survey on December 2, and finally the DEA came to inspect on December 22. "We were confident," said Talbott. "On all of our site visits — whether pharmacy board, state or DEA — there was not a single plan of correction, not a single black mark." The DEA agent also found no problems and told them the certification would be in about two weeks but not less than a month. She told them the DEA would send the 222s — the forms for ordering the methadone — overnight, so they could get started right away.

DEA role

On January 4, Talbott sent the DEA agent an email asking how things were going — and that's when he got the email saying she was busy and that she knew he was anxious to open the "lucrative" OTP. He responded that he was "less concerned with beginning business than I am with the number of folks who are on our waiting list," that everyone knows the risks of overdose and that the window of getting people into treatment when they want to is very small. "Their continued calls are what prompted me to contact you," he emailed the DEA agent. What he was trying to say, he told us, was that "business issues or not, do you realize there are people who could die because of you?"

He is now planning to open on January 18 — Martin Luther King Day, on which he would normally be closed, but he sees it as the first possible day to open. •

For the OTP's website, go to www.counselingsolutions.clinic.

Violence from page 1
by either visitors or program participants. In several of their own cases, an actual minor incident at least in part fueled the desire to enact policies to try to prevent something worse from happening in the future.

Bringing in security

Around a year after its establishment at the start of this decade, Massachusetts-based CleanSlate Addiction Treatment Centers decided to have a security officer present at each of its treatment sites that offer buprenorphine prescribing and supportive therapy. The organization's rapid development of neighborhood sites across Massachusetts fueled some of this, and one memorable incident played a part as well.

As CEO Amanda Wilson explains, a patient entered one of the CleanSlate sites with a knife visibly attached to his belt, reminiscent of a "Crocodile Dundee"–like scene. The patient was told he could never have the knife with him on future visits, and was required to relinquish it temporarily in order to complete that day's clinical visit. All patients today are familiarized from the start about the organization's weapons-free policy.

Wilson said the organization was particularly mindful of not wanting its female staff members to feel intimidated in cases where a patient might not be fulfilling all terms of

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treatment and may pose a diversion risk (even though medication is not actually dispensed at the CleanSlate treatment sites; patients get their medication at local pharmacies). "We won't discharge patients for struggling with their illness, but we will discharge for diverting," she said.

At each of the CleanSlate sites in Massachusetts, a security officer employed by Aron Security is present in the building during all hours when clinical services are being delivered (on days with extended hours for appointments into the evening, that means a security presence from 9 a.m. to 8 p.m.). Aron will be subcontracting this function to other entities in the other states to which CleanSlate is expanding.

"They're present with patients in the waiting room," Wilson said. "It helps guard against inappropriate drug talk in the waiting room, which we don't want patients who are struggling to hear. It keeps patients from taking photos of each other."

In one more problematic instance, a security officer was quickly able to subdue and escort from one of the sites a patient who unexpectedly pushed a nurse practitioner to the floor, Wilson said.

She believes the lack of actual medication dispensing at the CleanSlate sites mitigates the organization's violence risk somewhat. "Members of the community know that if they were to raid us, all they would get would be computers," she said.

The organization's New Bedford location did fall victim to gunfire shot into its foyer area in an after-hours incident when no patients or staff were present, but this was not believed to have been related to the work done there (CleanSlate shares the New Bedford location with other medical offices in the working-class community).

OTP considerations

Opioid treatment programs (OTPs) that offer methadone dosing directly to patients are no different from other addiction treatment programs when it comes to worries about guns. Zac Talbott, administrator of Counseling Solutions of Chatsworth (CSC), a new OTP in Georgia slated to open this month (see article beginning on page 3), says the program has a policy on guns that is stated in its handbooks: "Refrain from bringing any weapon, gun, or other form of illegal contraband into CSC."

Georgia is an open-carry state. But CSC, like any other private company in the state, does have the right to restrict this. And in the company's official policies and procedures manual, it is stated that the administrator has the right to approve open-carry on a case-by-case basis, Talbott told us.

"We're hoping the policy isn't questioned," he said. "I have a right to draw a hard line in the sand. But these are our patients, who we know."

> **'We don't want our facilities to have any criminal justice feel to them.'**
>
> Jeffrey Hillis

If a patient wants to wear a pistol on the hip, that's one thing, he said. "I'm not going to approve an AK-47," he said.

Residential campus discussion

National Association of Addiction Treatment Providers (NAATP) Executive Director Marvin Ventrell indicated that the topic of on-site violence has not been a prominent one in association members' discussions of late. But he referred us to his former employer of Harmony Foundation in Colorado, which in recent years re-evaluated security procedures for its sprawling 42-acre campus in the Rocky Mountains and instituted a number of new policies.

In a state that has had its share of nationally high-profile gun crimes, it is somewhat ironic that the event that arguably touched Harmony Foundation staff the most in recent years was the Sandy Hook school shooting that took place across the country in Newtown, Conn. It was around that time that Harmony's leaders concluded that they needed to have a more systematic way of tracking activity across the campus, said CEO Dorothy Dorman.

Staff members, patients and visitors are now all required to wear badges that are color-coded to identify the various roles. Harmony worked closely with its local police department in Estes Park to help staff understand how to respond to an active shooter incident; the police conducted "train the trainer" sessions for human resource leaders and safety managers, Dorman said.

One aspect of this training came as unexpected to Harmony's CEO. "I was surprised by the lack of clear messaging," Dorman said. There is no playbook that can cover every detail of this type of incident, she discovered. Rather, staff members are taught to be observant and to exercise their own judgment as to whether a specific situation warrants hiding, fleeing or engaging the perpetrator. Over a process that took about three months, staff members engaged in role-play exercises to familiarize themselves with some of the variables they'd have to consider in an actual situation.

"Our policy doesn't say, 'You go to Building A, you go into lockdown,'" Dorman said. "That is not realistic." Each incident would unfold differently and the responses to it are deeply personal, she said. "You can give guidance, but you cannot dictate," she said.

AdCare's Hillis, who chairs the Addiction Treatment Committee for the National Association of Psychiatric Health Systems (NAPHS), says weapons-free and active shooter pol-

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Continued from previous page
icies are important components of a treatment facility's policy manual. Some important safeguards include nurturing a workplace culture in which all employees feel empowered to report on potential risks, and having sound assessment protocols so that patients are receiving the proper level of care at the proper time.

Still, Hillis indicates that the most prominent threat to treatment facilities likely comes from the outside as opposed to from their own treatment population, and no facility can protect itself 100 percent. "Those who are receiving treatment are in a better position than those who are not," he said. •

More best and worst of last year; hopes, fears for the new one

*There wasn't room in the Preview Issue (*ADAW*, Jan. 4) to run all of the important reflections from stakeholders in the addiction field on the highs and lows of 2015 and the challenges they face in 2016; the additional comments are included below. (Note: Inclusion in "Part 2" doesn't signify that these comments are any less important than those in "Part 1.")*

The 2015 highlight for the Illinois Alcoholism and Drug Dependence Association (IADDA) was the passage of Illinois House Bill 1 — the most comprehensive piece of heroin legislation in the country! Our membership successfully advocated for the bill and worked with the sponsor, State Representative and Deputy Majority Leader Lou Lang, to not only pass the legislation but also secure enough votes to override the governor's amendatory veto. There are many great things included in this legislation, which is hopefully a model for other states, but there is also more work to be done. In 2016, I would like to see our policymakers recognize the need for a broader focus on prevention (beyond overdose prevention), and our state and federal budgetary priorities reflect the increased attention that addiction is receiving in Washington and around the country.

— Sara Moscato Howe, CEO, IADDA

The highlight for the field (and the lowlight for so many) is the federal government's continuing recognition of the opioid epidemic and the focus on combating it, from the president's recent statements on MAT [medication-assisted treatment] to the large amount of legislation in committee and on the floor of the House and Senate addressing opioids.

For 2016, I would like to see the Markey bill (TREAT Act) passed to create additional treatment options for those in need, and to see workforce development be a priority as more treatment options become available.

— Jeffrey Quamme, executive director, Connecticut Certification Board

The escalating opioid epidemic among middle-class Americans drew unusual attention this year to our field across a wide public sphere of elected officials, leaders of medical and scientific communities, members of criminal justice and law enforcement agencies, and the mainstream media.

While this attention is welcome, we need to make sure the urgent need for treatment is reflected in the stabilization and expansion of services for vulnerable populations. As states (including New York, with high-need, disadvantaged populations) look to contain costs under Medicaid managed care, we must work hard to ensure that the federal block grant is maintained, the IMD [Institutions for Mental Disease] exclusion is eliminated and parity under the ACA [Affordable Care Act] is fully enforced. Without these essential provisions built in to federal and state budgets and policies, nonprofit organizations that provide the bulk of safety net services will find it harder and harder to meet the increased demands for care.

At Odyssey House, we have been preparing for the impact of managed care for quite some time and have established new systems to both contain costs and streamline care. These include: electronic health record keeping and linkages with hospital and other community-based providers; evidence-based practices and medication-assisted treatment; and extended outpatient and housing support services.

My hope as we look to 2016 is that we will not only continue to provide quality care for disadvantaged substance abusers (who often require intensive residential services in order to have a chance at achieving and maintaining a functional life), but that their needs will be reflected in the ongoing national debate on how best to treat addiction and its accompanying social ills.

— Peter Provet, Ph.D., president and CEO, Odyssey House, New York

Of course, substance abuse treatment and prevention did staggeringly well in the federal budget, with increases not only for the Substance Abuse Prevention and Treatment block grant and the Centers for Disease Control and Prevention (CDC), but new programs at AHRQ [the Agency for Healthcare Research and Quality] and the CDC as well. Of course, none of this would have been possible without a bipartisan budget deal that once again raised sequester caps, which allowed Congress and the White House to fund

these critical programs. I'm so proud to have been a part of that effort, which benefited all of public health. As we know, those in need of substance abuse treatment are often in need of other health services, and the entire public health community was a winner.

My hopes for 2016: That candidates — not just for president, but governor and Congress — keep talking about this issue the way they have — as one of public health, where criminal justice reforms are needed, and with approaches to the problem that are educated, realistic and plausible. I also hope we continue to make progress on the IMD exclusion. Lawmakers are listening, and we've seen some incremental change. Continued progress would be welcome.

But with all of the campaigning taking place in 2016, I'm afraid we may end up with a continuing resolution. Of course, doing so well in this budget cycle softens that blow a little bit.

— Andrew Kessler, principal, Slingshot Solutions

The best part of 2015 was that at the end of the year, our entire field did so fabulously well in the final omnibus bill with increases from last year's appropriated levels for the Drug Free Communities program, the Substance Abuse Prevention and Treatment block grant, the Center for Substance Abuse Prevention, NIDA [the National Institute on Drug Abuse] and NIAAA [the National Institute on Alcohol Abuse and Alcoholism], along with new funding in the CDC to deal with the prescription drug and heroin crises. The worst part of 2015 was the additional states that decided to legalize, commercialize and normalize marijuana, with all the myriad negative consequences associated with increased use that are totally underreported by the press and misunderstood by the general public. My hope for 2016 is that bona fide substance abuse prevention will be put back on the radar screen of elected officials, so that we can prevent drug use before it starts and reduce the horrific downstream consequences of addiction, overdose and death that have become such a crisis in our nation.

— Sue Thau, public policy consultant, Community Anti-Drug Coalitions of America

My biggest hope is that we continue to translate interest in addiction policy at the state and federal levels into more tangible action. We saw some action in 2015 for sure. But we need more. In particular, I hope the president's budget for 2016 includes proposals that recommend increases in key programs, including those within SAMHSA, the Department of Justice and the ONDCP [Office of National Drug Control Policy]. I hope Congress passes the Comprehensive Addiction and Recovery Act and the Improving Treatment for Pregnant and Postpartum Women Act. Finally, my hope is that action in addiction policy will move forward with initiatives that address the continuum — including a strong emphasis on prevention.

My fear is of course that we see more opioid overdose deaths and more admissions to treatment because of inaction or inadequate action.

— Rob Morrison, executive director, National Association of State Alcohol and Drug Abuse Directors

The best of 2015 could be centered on the expansion the political and public recognition of addiction/substance use disorders. Political recognition has come as a result of the Affordable Care Act, with consumers from districts and states now able to receive treatment; added to that is the expansion of Medicaid in many states across America. Political attention is high as well due to the media attention that the opioid epidemic is drawing from all social and economic classes. Politically we see the IMD expansion, the Medicaid waiver promotions, more bills coming into conversation to support treatment and higher levels of funding for the coming year; this has been a star year for political support. Law enforcement and treatment are working more cooperatively together in the push to decriminalize nonviolent offenders and release thousands from jails and prisons. The public is more aware and engaged in the conversation of addiction/substance use disorders due to the opioid epidemic. ONDCP Director Michael Botticelli has made history as the first ONDCP director in recovery; he has appeared on *The Dr. Oz Show* and *60 Minutes*, raising the public's awareness and view of these diseases and the need for an approach that is medically based. UNITE to Face Addiction also brought more public awareness as approximately 700 groups — national, state and local — gave their support to this effort. NAADAC itself has grown to over 41,000 constitutes, including members and certified addiction and co-occurring focused professionals spreading the good works of prevention, intervention, treatment and recovery support.

NAADAC's biggest hope for 2016 is that there be more focus, support and funding for the recruitment, training and education, and retention of the addiction professionals will be invested in by Congress, and federal agencies. We also hope and plan that the addiction profession will continue to be rec-

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Continued from previous page

ognized as a specific specialty and as a necessary part of an integrated team. The fears: that the attention that addiction/substance use disorders will increase the need for services, but that there won't be the workforce necessary to achieve support. We will need to address and sustain (1) workforce support, including recruitment and retention efforts; (2) medication as a tool with counseling for the person who is addicted and for family members; (3) increased education, training and collaboration with the medical communities and addiction professionals and treatment programs in a variety of integration models; (4) attention to medical and recreational marijuana use and its unintended consequences for individuals, families and communities; (5) more standardized use of evidence-based practices and promising practices; (6) more research on the effects of alcohol and drugs on the individual and the relationship to recovery; and (7) sustained political and public will to make a difference in addiction/substance use disorders to protect current and future generations.

— Cynthia Moreno Tuohy, executive director, NAADAC, The Association for Addiction Professionals

The addiction service provider industry has done excellent work and we have built much of the infrastructure necessary for us to leap forward to provide more and better service in 2016. We know what we need to do to treat this disease and we have many of the tools to do it. My hope is that we exercise wisdom and balanced decision-making in the growth process. I think we are on a good evolutionary track. It is important that we declare a kind of victory, recognize our accomplishments and then begin to move forward yet again. In order to move forward, we need to move away from emotional and ideological thinking to more balanced, evidence-based decision-making. One area of balanced observation worth noting is that, as we better address a myriad of harmful substances with which we are faced, we remember alcohol is still the biggest offender. Alcoholism is the leading cause of preventable death in the U.S., and over 30,000 Americans died from alcohol-induced causes last year, not including fatal accidents and drunk driving crashes. That is more than heroin and prescription painkiller deaths combined.

In the big picture, I see 2016 as a time when we could really grow out of our professional adolescence. As a profession, when we measure ourselves against other credible professions, like law or medicine, for example, we can see that we do not yet adequately demonstrate the traits that are hallmarks of a mature and respected profession. And we must do so in order to produce best results and gain the respect and recognition that the disease demands.

We are still a relatively young profession, and it is understandable and natural for a "cause-driven" enterprise with "social movement" components to struggle as it grows from cause to profession, from a humanitarian effort to a professional service. We have been on that growth path, and I see now as a time when we can really deliver. Professions hold themselves to high standards of workforce training and education. They reward professional work with professional compensation. They embrace licensing and accreditation of workers and institutions. They welcome scrutiny and accountability with transparency. They measure their effectiveness and they embrace growth and new evidence. Most of all, they stress data over personal ideology.

A perfect application of this is treatment service integration. As we synthesize, and we should, our spiritual and scientific, we need to do it as critical thinkers, not "dogmaticians." If we can do that, and we can, we are going to help a lot of people get well.

— Marvin Ventrell, executive director, National Association of Addiction Treatment Providers •

In case you haven't heard...

Jerry L. Gillen, former director of operations at Faces & Voices of Recovery, died from an accidental overdose of heroin and methamphetamine last July, Faces & Voices Executive Director Patty McCarthy Metcalf announced on the organization's website New Year's Eve. The details were not known until his family was informed of the cause of death by the medical examiner. "I am sharing this with you, our members, with a very heavy heart," Metcalf wrote. "While we debated about whether we would share this sensitive information publicly, in the end, the importance of the work and our mission was the deciding factor. We must not allow the shame and stigma that has historically kept our friends and families shrouded in a cloak of secrecy to regain any traction. We are a recovery movement founded on the value of sharing our stories to help the public better understand addiction and recovery. We work hard to eliminate negative public perception and to reduce the discrimination that keeps people from seeking recovery or moving on to better lives once they achieve it. We are reminded how precious life and recovery are and of the reality of relapse in the chronic nature of addiction." Gillen had been in recovery, and was deeply committed to the mission of Faces & Voices, she wrote. "When tragedy hits home we MUST do more to make long-term recovery possible for even more individuals and families," she wrote.