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IN THIS ISSUE...

Our lead stories this week look at how New York regulates the treatment industry to achieve quality programs, and at an economics paper on naloxone which aroused ire among experts.

... See stories, beginning on this page

Bupe urged for all youth by researchers in U.S.-funded study

... See page 4

NAATP seeks to dissuade consumers from treatment scams

... See page 5

Christie gives powerful speech at AATOD awards banquet

... See page 6



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AATOD report: Challenges and successes in N.Y., biggest OTP state in country

New York hosted the national meeting of the American Association for the Treatment of Opioid Dependence (AATOD) last week, so it was fitting that state officials described the successes and challenges of treatment in the state.

Over the last 15 years, 50 percent of admissions to treatment programs have been for opioid use disorders (OUDs), said Office of Alcoholism and Substance Abuse Services (OASAS) General Counsel Robert A. Kent. “The epidemic has struck the whole state,” he said. Even though the conference was in New York City, the state has huge swaths of rural areas in the north and west.

Noting that nine out of 10 people with substance use disorders (SUDs) don’t get treatment — and

Bottom Line...

New York has a strict regulatory system for treatment providers, with more OTPs than in any other state, and also initiatives to encourage flexibility and accountability for Medicaid providers, and a move to target out-of-state brokering scams.

this has been true historically — Kent pointed out that with fentanyl’s lethality, nine out of 10 people means thousands of overdose deaths.

New York state has more patients in opioid treatment programs (OTPs) than any other state: 41,000 in licensed programs. There are also 11,500 licensed beds for residential SUD treatment, according to Kent. As

See [AATOD](#) page 2

Naloxone paper regarding opioid abuse and crime generates chorus of protests

A working paper drafted by two economists, suggesting that laws expanding access to the overdose-rescue drug naloxone have resulted in greater opioid abuse and opioid-related crime, has produced incendiary reactions in the addiction research community.

Responses, mainly in a number of online forums since the paper’s March 6 release, have ranged from outright condemnation of the

research to milder warnings that the paper offers some compelling arguments but is hampered by highly flawed methodology.

Two research leaders who were interviewed by *ADAW* last week say that because the paper’s authors did not sufficiently control for factors occurring at the same time that laws expanding access to naloxone took effect, the study suffers from the same issues plaguing research a generation ago that suggested fledgling needle-exchange programs were making HIV transmission more likely, not less.

“They have not controlled for the effects of collinearity,” involving the many trends and initiatives occurring

See [NALOXONE](#) page 7

Bottom Line...

Addiction researchers are roundly criticizing a working paper with conclusions that link broadened access to naloxone to more opioid abuse and opioid-related crime.

AATOD from page 1

for the number of office-based opioid treatment (OBOT) prescribers of buprenorphine, he doesn't know.

Medicaid managed care, fully implemented for SUDs and mental illness in 2015 in the state, means that patients "can go outside the four walls" of licensed facilities, said Kent. "We can use that to reimburse staff who work in a center that is not licensed or certified by us, so we can engage people when they show up for care," he said. "Addiction isn't a convenient disease that only shows up 9 to 5 Monday to Friday."

Buprenorphine

Engaging patients in the emergency department (ED) is a "work in progress," said Kent, who acknowledges that many patients do end up there, either as a result of naloxone reversal of an overdose, or other health issues, or addiction itself. For example, certified peers in the OASAS system can be reimbursed by Medicaid, and can go into the ED to facilitate treatment.

But starting patients on buprenorphine in the ED isn't as straightforward as it should be, Kent told *ADAW*.

If a patient goes to an ED, that patient can be started on buprenorphine even without a waiver "if the staff wants to do it," said Kent. But in

general, EDs are not enthusiastic about the time needed to spend on a buprenorphine induction, or perhaps on the time needed to work with a new addiction patient. "If you're in an ED, you have a line of people waiting to be seen," said Kent. "They're into immediate gratification. They want to address issues immediately. They focus on medical stabilization and moving on." For this reason, OASAS is telling them they can help. "But the fact is an ED isn't an addiction treatment program, and shouldn't be," said Kent.

There are problems with OBOT buprenorphine, as well — mainly not enough access. Most of the waived providers do not prescribe to the maximum-patient cap. Instead of getting more physicians waived, the state is focused on "how do we get more out of those who are already authorized," he said. The state is also trying to get more midlevel prescribers waived. "Some folks seem to miss that it's medication-assisted treatment," he said, emphasizing the word "treatment." He noted, "It's not just writing buprenorphine prescriptions."

Mobile vans

Earlier this month, the state announced awards for mobile vans — outpatient clinics that can get people started in treatment for OUDs. More

than 20 vehicles have been purchased by nine providers so far in this \$1.6 million program. The providers are:

Capital Region and Mohawk Valley

- New Choices (Saratoga and Montgomery counties): Two cars to be used for transport, with plans to buy four more vans, which will be outfitted for telepractice.
- Twin Counties (Greene County): One van that will be outfitted as a mobile clinic, with plans to buy two additional vehicles to be outfitted as mobile clinics.

Central New York

- Syracuse Brick House (Onondaga, Cayuga, Madison and Oswego counties): Four vehicles to be used for transport and mobile services.

Finger Lakes

- Finger Lakes Area Counseling and Recovery Agency (Yates and Ontario counties): Two vehicles to provide transport and telepractice.

Mid-Hudson Valley

- Catholic Charities (Sullivan and Ulster counties): Four vehicles to be used for transport.

North Country

- Credo (Jefferson County): One vehicle to provide transport services.



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Southern Tier

- Trinity (Tioga and Tompkins counties): Two RVs that will be outfitted as mobile clinics.
- Addiction Center of Broome County (Tioga and Tompkins counties): Two vans that will be outfitted for telepractice.

The following vehicle purchase was announced previously but is part of the same initiative:

Western New York

- Best Self Behavioral Health, formerly Lake Shore Behavioral Health (Erie and Niagara counties): Six vehicles, two outfitted as mobile clinics, others to be used for transport.

Telemedicine

New York, like other states, is constrained by the Ryan Haight Act, which does not allow the initial visit for buprenorphine to be done via telemedicine, but rather requires a face-to-face visit with the physician (see *ADAW*, August 21, 2017). “We have adopted a telepractice regulation, but it’s frustrating to know that you still have to see the person face-to-face in order to start them on buprenorphine,” said Kent. “We’ve suggested to the federal government that they might want to rethink this rule.”

Kent is more concerned that clinicians won’t participate in telemedicine, not that they will. “We’re trying to make this as easy as possible,” he said.

Medicaid

Over the past several years, the state has carved treatment for substance use disorders into the Medicaid system. “There is no prior authorization for medications or any level of service in our system,” said Kent. “We don’t guard the front door. All we’re focused on is access and quality care.”

The Medicaid transformation from fee-for-service to managed care started in 2011. With it came a move to “value-based payment,” explained Medicaid Director Jason Helgeson. “We can delink payment from individual services,” he said, which

gives providers flexibility in what they offer as services. “But with that flexibility comes accountability,” he said. “We expect providers to do things differently and better.”

Instead of fee-for-service, in which payers get paid for delivering a service such as therapy or medication administration, value-based payment means that the state wants to see outcomes.

Seventy percent of emergency department readmissions involve patients with mental illness, SUDs or both, said Helgeson, who added that these readmissions are all avoidable. “We should not tolerate a health care system in which hospitals and providers rely on individuals to get sick in order for them to survive,” he said.

because they provide comprehensive, wraparound care. Kent agreed. “OTPs are uniquely qualified,” he said.

OBOT prescribers of buprenorphine, however, are not under the auspices of OASAS, noted Kent. “We can’t require them to do anything,” he said, noting that OBOT prescribers are regulated by the federal government.

Out-of-state scams

Recently, New York announced an initiative to stop out-of-state treatment providers from luring residents to substandard facilities (see *ADAW*, Feb. 19). “We’re trying to get legislation passed to make patient brokering a crime,” said Kent. It is already a crime in Florida. Kent said OASAS is sharing information with Dave

‘There is no prior authorization for medications or any level of service in our system. We don’t guard the front door. All we’re focused on is access and quality care.’

Robert A. Kent

So far, fewer than half of the Medicaid claims are value-based payments, so there is still work to be done, he said.

We asked Helgeson what measures the state Medicaid program will use to determine value. This too is a work in progress. “There are Tier One measures that we can measure today,” he said, such as readmissions. “These are the measures that are driving payments.” But Tier Two measures will be rolled out in the future, and go beyond the “traditional health care space,” said Helgeson. “We should be holding managed care organizations accountable for employment, job training and inability to find employment,” he said.

In this regard, OTPs are “ahead of the game,” said Helgeson,

Aronberg, state attorney for Palm Beach County, who is heading up the task force there on addiction treatment and sober home fraud. “We want to make sure they know what we know,” said Kent, adding that most of the patient brokering targeting New York residents is coming from Florida facilities.

Kent described a typical example of what has been happening in New York. The patient broker goes to family support meetings, may be in early recovery himself and is working with one or more Florida programs. “They look for people with private insurance with an out-of-network benefit, and they use the out-of-network benefit,” he said. “They make the call to access the insurance from Florida — when the

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patient is already there.”

Kent’s office is currently investigating one bill for “a couple of months in treatment” for \$279,000, most of which was for drug testing. “This is all about economics and greed,” he said. “We have to disrupt the economic model.”

“I get calls from families whose

loved one is back in New York, who spent their annual or lifetime cap in Florida, and still need help,” said Kent. “I do help them; I get them into care,” he said. But in the meantime, the Florida facility already collected the 20-percent copay. “Twenty percent of \$150,000 is a lot of money,” said Kent.

And there is no need for New

York residents to go to Florida, even if it’s residential treatment they want. “We have beds available every day,” he said. “If you go to our find addiction treatment site, you will find empty beds.” •

For the New York state treatment locator, go to <https://find.addictiontreatment.ny.gov>.

Bupe urged for all youth by researchers in U.S.-funded study

Expansion of treatment for adolescents and young adults — ages 15 to 25 — with opioid use disorders (OUDs) is critical at a time when there are increasing overdoses, as well as significant barriers to care, researchers write in the current issue of the *American Journal of Drug and Alcohol Abuse*. Extensive literature on the adult population shows that medication-assisted treatment is an important, even essential, aspect of care for OUDs for most youth. The researchers looked at the dilemmas and questions regarding MAT for youth, and proposed possible solutions.

Onset of substance use disorder (SUD) is concentrated, in general, in adolescence and young adulthood. The brain regions associated with motivation and impulsivity are still developing during these years, suggesting that treatment prognosis and strategies may be different for young people than for adults, the researchers wrote in “Medication-Assisted Treatment for Youth With Opioid Use Disorder: Current Dilemmas and Remaining Questions.” In particular, reducing barriers to care and answering questions about clinical issues for youth with OUDs are needed, the researchers wrote.

For adults, treatment with methadone or buprenorphine is recommended. Most recently, the Ameri-

can Academy of Pediatrics also recommended such therapies for youth, as have a number of agencies. However, there are few studies of these medications with youth, and the literature has mainly looked at buprenorphine (see *ADAW*, March 12). Buprenorphine not only improves treatment outcomes, but is

‘Decision to taper should be governed by the principle ‘when in doubt, do not taper’ while taking into account the potential risks of relapse and overdose as well as access to chronic relapse prevention care....’

D.C. Chang et al

cost-effective, and youth viewed it as less stigmatizing than methadone. Based on the strong evidence among adults, and the available evidence among youth, first-line treatment with buprenorphine should be recommended for youth, with methadone as an alternative when

buprenorphine is not effective on maximal doses, or when induction is challenging, researchers have found.

Practical questions

But there are practical questions regarding age and duration of treatment. Buprenorphine is currently approved for OUDs at age 16 in the United States and age 18 in Canada. Methadone can be prescribed to youth under the age of 18, but federal regulations in the United States require documentation of two failures at drug-free attempts, as well as written consent from a parent or guardian. This policy, the researchers wrote, should be re-evaluated. That’s because youth who are treated in abstinence-based programs are more likely to overdose upon relapse, due to reduced tolerance.

Among adults, 26.3 percent with heroin addiction receive medication-assisted treatment, compared to 2.4 percent of adolescents with heroin addiction. While further safety data regarding opioid agonist therapy for youth are warranted, the benefits of treatment are likely to be greater than the risks, the researchers wrote.

Another question is the duration of treatment — including how to make tapers successful. Among adults, duration is not as intense a question, although tapers still require more research. But among youth, whose OUD histories are shorter than those of adults, it’s important to determine the best way to minimize relapse. The longer the taper, the better, studies have found

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— for example, one randomized controlled trial (RCT) published in 2016 found that 56 days is better than 28 days. Guidelines in the province of British Columbia, Canada, recommend that if adults are tapered, the duration of the taper should be at least 52 weeks, with close monitoring during and after.

Another issue is naltrexone: while not nearly as well-studied, the opioid antagonist is preferred by some patients and family members. Oral naltrexone has been associated with low compliance, so the researchers do not recommend it. People who do not take the pill may relapse and overdose. One study evaluated extended-release injectable naltrexone for youth, and may be beneficial in particular for young people who have been tapered off of buprenorphine. It can only be administered to patients who have been opioid-free for a week, however, creating the “detox hurdle.” More studies are needed to compare the effectiveness of buprenorphine and methadone to naltrexone, the researchers wrote.

Common OUD treatment among youth consists of short-term detoxi-

fication, with referrals to individual or group therapy, either in residential or outpatient settings, despite the “paucity of research on the evidence of psychosocial approaches among youth,” the researchers wrote. In fact, psychosocial intervention on its own is associated with high dropout rates, and a Cochrane review found that opioid agonist therapy is more effective in retaining youth in treatment than medication combined with psychosocial interventions.

However, there seems to be a problem in buprenorphine retention among young people, with one study finding 56 percent of youth aged 18–25 years retained at six months, compared with 78 percent among older adults. And extended-release naltrexone also has only 50 percent retention rates among adults at six months; rates may be even lower among youth.

It may not be ethical to even study psychosocial treatment alone, due to the high risk of dropout, relapse and overdose, the researchers wrote. “Thus, we do not necessarily think more studies on psychosocial treatment alone are warranted,” they wrote.

‘When in doubt, do not taper’

The Prescription Opioid Addiction Treatment Study (POATS) funded by the National Institute on Drug Abuse found that tapering off of buprenorphine after 12 weeks of treatment was associated with a 90 percent relapse rate, regardless of ongoing counseling, the researchers noted. So psychosocial treatment following a taper is also not recommended, and may be dangerous, given the risk of overdose, they wrote. For some patients maintained on buprenorphine, psychosocial interventions, especially contingency management, may be helpful.

“Decision to taper should be governed by the principle ‘when in doubt, do not taper’ while taking into account the potential risks of relapse and overdose as well as access to chronic relapse prevention care; close monitoring is essential during and after the taper completion,” the researchers concluded. Given the proven effectiveness of opioid agonist therapy with buprenorphine or methadone, they recommend these medications be provided “regardless of age.” •

NAATP seeks to dissuade consumers from treatment scams

The National Association of Addiction Treatment Providers (NAATP) has issued a reminder to consumers that there is a better way to find quality treatment than Google, which can lead them to scams, patient brokers and poor-quality treatment.

In a March 9 blog post by NAATP Executive Director Marvin Ventrell, the problems plaguing the industry — mainly coming from bad apples who are not NAATP members — are clearly laid out. And as consumers continue to be lured to low-quality programs, the bad news

continues to be broadcast, with the result that many in the public think that all “rehab” is bad.

Stop saying ‘rehab’

For one thing, it’s time to stop using the word “rehab,” which is not accurate, and which minimizes the seriousness of the disease, said Ventrell. (The correct word is “residential” treatment.)

The next is to stop using internet searches that rely on advertising to find treatment. “Locating good healthcare is never easy but for most conditions, consumers follow a sensible path,” wrote Ventrell. “We seek the advice of trusted professionals who work in the field. We inquire with those who have experienced

the condition. We ask our primary healthcare provider for a referral. We contact our insurer to find out what services are covered.”

But instead of following this path, consumers searching for addiction care “are prone to falling into a web of marketing deception,” wrote Ventrell. “Rather than focusing on appropriate health care criteria, the consumer can be lured toward flashy amenities, false promises, and economic bargains. These are not sensible healthcare selection criteria. It is alarming to think that a lifesaving healthcare selection would be influenced by luxury accommodations and whether the facility has a pool or is near the beach.”

[Continues on next page](#)

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As has been pointed out many times, patients and family members searching for treatment are in crisis and turn to Google, “which is itself a function of marketing and the aggregation of consumer identity and behavior,” wrote Ventrell. “The system is not built to help the consumer find the best care. It is built to help the advertiser direct the consumer.” Ventrell noted that NAATP is working with Google, which suspended AdWords temporarily for addiction treatment due to unscrupulous marketing (see *ADAW*, Sept. 25, 2017).

Advertising disguised as directories

As for online private treatment directories, these may be “disguised advertising tools for one or more treatment centers or treatment brokers,” noted Ventrell. They may list other programs (without permission, usually) but they still direct the consumer to an 800 number, where patients with the right kind of insurance (typically out of network) are directed to one program. “These directories are not, as some have suggested, analogous to the phonebook yellow pages, nor are they the Yelp of treatment,” wrote Ventrell. “The buying and selling of patient leads can also be facilitated by online directories.”

Buying and selling patient leads — patient brokering — is prohibited by the NAATP Code of Ethics, said Ventrell.

The Substance Abuse and

Mental Health Services Administration (SAMHSA) has an online directory, which Ventrell called “important and useful.” However, he noted that its selection criteria may make it less than useful for someone looking for treatment. In fact, the SAMHSA treatment directory is not “curated,” beyond the fact that states are allowed to have a program removed if it does not meet their criteria.

“Good consumerism requires discernment based on objective criteria,” wrote Ventrell, who urges consumers to use NAATP’s guide to treatment program selection. The guide is based on these four principles:

1. Addiction treatment is health care and must be chosen as such.
 - Do not be swayed by the photography and marketing of luxury amenities rather than necessary core health care services.
2. There are knowable indicia of quality in addiction treatment.
 - Indicia include descriptions of evidence-based practices, professionally credentialed staff and accreditation. A visit and tour of the facility will reveal much.
3. Transparency of treatment center information is essential.
 - The deeper you look, the more useful information you should find, including location, years of operations, outcomes data (but not “guarantees”), depth of clinical information, inquiries into consumer medical history and

in-network insurance information.

4. A treatment program should pledge compliance and accountability to a code of ethics.

- Has the program adopted the NAATP Code of Ethics or similar comprehensive criteria to which it holds itself accountable, including an accountability system?

NAATP prohibits deceptive online marketing practices by its members, which likely reduces the number of dues-paying members and the revenue for the organization (see *ADAW*, Dec. 18, 2017). Through the NAATP Quality Assurance Initiative, the organization is continuing to promote quality. Looking for NAATP membership on a program’s website can serve as a quality indicator for consumers.

Membership in NAATP requires demonstrated licensing for all services provided at all treatment locations. “Membership in NAATP means something,” as Ventrell put it. “NAATP members have made a commitment to be part of the solution by holding themselves to a higher standard.” All NAATP treatment provider members are listed in the NAATP Addiction Industry Directory.

“We make no referrals,” wrote Ventrell. “We have no favorites. There are no sponsored ads.” •

For the NAATP member directory, go to <https://www.naatp.org/resources/addiction-industry-directory>.

Christie gives powerful speech at AATOD awards banquet

Chris Christie, former governor of New Jersey and head of President Trump’s opioid commission, described himself as a “recovering politician” in a charming and passionate speech at the awards banquet of the American Association for the Treatment of Opioid Dependence (AATOD) in New York City last week. Speaking at the end of a

dinner under the purple chandeliers of the Marriott Marquis for almost 2,000 attendees, Christie won over the audience.

The recipient of AATOD’s Friend of the Field Award, Christie focused on stigma. “My mother was an addict — she was addicted to nicotine,” he said. She smoked for 55 years and “tried every way to quit,”

he said. “Then almost inevitably, as she turned 71 years old, she was diagnosed with lung cancer.”

After the diagnosis, friends and family helped to find treatment. “No one said to us, ‘Well, Chris, she smoked for 55 years, and for 35 of those years she knew that this could kill her,’” he said. No one said “This was a choice,” he said. “They saw

her as the victim of a disease, not as a morally flawed person who was getting what she deserved.”

But, he said, what would have happened if his mother had been addicted to opioids? “Would people have reacted the same way? Would we have even told our neighbors and friends and co-workers? You all know the answer to this. You all know there is still the stigma,” he said.

There were also several other awards handed out during the evening. Recipients of the Nyswander/Dole “Marie” Awards at the banquet, sponsored by Mallinckrodt Pharmaceuticals, were Gloria Baciewicz,

M.D. (a psychiatrist based in Rochester, New York, who broke ground 25 years ago in getting upstate communities to start to accept methadone); C. Hope Bolger (among many other credits, she has been the State Opioid Treatment Authority for Virginia, where the number of opioid treatment programs tripled during her tenure), W. Jonas Coatsworth (a leader in methadone and recovery in South Carolina); Gabriele Fischer, M.D. (an Austria-based psychiatrist who has promoted methadone maintenance through the World Health Organization and the United Nations Office on Drugs and

Crime); Kathleen Maurer, M.D. (the medical director of Connecticut’s Department of Correction, where she instituted methadone maintenance treatment in prisons); Stacey Pearce (opioid treatment program director and methadone treatment advocate in Georgia); and Vickie L. Walters (an advocate for treatment based in Maryland).

The Richard Lane/Robert Holden Patient Advocacy Award went to Paul Bowman, Boston National Alliance for Medication Assisted Recovery chapter director, patient advisor to Habit OPCO, consultant to residency programs and more. •

NALOXONE from page 1

simultaneously to the expansion of access to naloxone, said Daniel Ciccarone, M.D., M.P.H., professor of family medicine at the University of California, San Francisco School of Medicine.

To Ciccarone, the most critical variable contributing to adverse outcomes from opioid abuse has been the advent of deadly fentanyl and its analogs. In the National Bureau of Economic Research (NBER) working paper from Jennifer L. Doleac and Anita Mukherjee, fentanyl is categorized as a study outcome but should be seen as a predictor instead, Ciccarone said.

Doleac (University of Virginia School of Leadership and Public Policy) and Mukherjee (University of Wisconsin School of Business) cite what they consider suggestive evidence that broader access to naloxone encourages use of more potent substances containing fentanyl, even though drug users and often dealers are unaware if a given substance even contains fentanyl.

“There is no evidence that naloxone leads more people to search for fentanyl,” Ciccarone said. “Are people choosing it? No. [Users] don’t have control over it.”

Format of study

The controversial paper is titled

“The Moral Hazard of Lifesaving Innovations: Naloxone Access, Opioid Abuse, and Crime” (“moral hazard” is a term widely used in economic theory, and its inclusion in this title, it should be stressed, does not suggest a morality argument related to drug use). Doleac and Mukherjee examine whether state laws that have facilitated widespread distribution and use of naloxone have led to unintended consequences of increased opioid abuse, increased crime and higher overdose death rates.

and overdose and examined Centers for Disease Control and Prevention mortality data to evaluate deaths resulting from opioid overdose.

They wrote, “We control for a variety of factors and examine pre-existing trends to ensure as best we can that changes in the outcomes studied are attributable to the causal effects of broadening naloxone access, rather than to other differences between places that broaden access to this drug.” But they do this without any evaluation of actual nalox-

‘There is no evidence that naloxone leads more people to search for fentanyl.’

Daniel Ciccarone, M.D., M.P.H.

The researchers collected information on the timing of state naloxone access laws, including those covering legal immunity for prescribers and laypersons and those establishing standing orders at pharmacies for the drug. They evaluated local interest in naloxone via Google Trends data on internet searches, used 2010–15 data from the National Incident-Based Reporting System to measure opioid-related criminal behavior, used emergency room visit data to measure opioid-related abuse

one use in any of the communities, an omission that addiction researchers say compromises the quality of their research.

“They have no data on naloxone,” said Keith Humphreys, Ph.D., professor in the Department of Psychiatry and Behavioral Sciences at Stanford University. “They are assuming that these policies have changed the use of naloxone,” said Humphreys, but they haven’t accounted for other policies being

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enacted at the same time, such as Medicaid expansion and federal grants for naloxone distribution in the states.

These methods call into question the economics researchers' findings, including that broadening access to naloxone led to a 17 percent increase in monthly arrest rates for opioid possession, a 30 percent increase in opioid-related theft and a 15 percent increase in quarterly opioid-related ER visits (the paper cited no overall effect on opioid-related mortality rates). The researchers reported that negative effects were most pronounced in the Midwest, one of the regions hit hardest by the opioid epidemic.

Moral hazard has some merit

Humphreys emphasizes that the theory that an individual might feel safer in using a dangerous substance because of the presence of a safeguard such as naloxone is a plausible one. It resembles the argument, supported in research, that the presence of seat belts and automobile insurance leads to more dangerous driving, for example.

But in general, the positive effects a safeguard generates outweigh the possible negatives of bringing about a continuation of risky behavior. This is why when some argued a generation ago that needle exchange would actually cause more problems by encouraging continued injection drug use, what was eventually seen was that the effect of someone continuing their drug-using career was actually much smaller than the lifesaving benefit of using clean needles, Humphreys said.

Humphreys also illustrates the problems with this controversial paper by pointing out that another newly released NBER working paper (authored by Daniel I. Rees and colleagues) looked at the same data and reached an opposite conclusion — that naloxone access laws actually reduced deaths. Humphreys

Coming up...

The **National Rx Drug Abuse and Heroin Summit** will be held **April 2–5** in **Atlanta**. Go to <https://vendome.swoogo.com/2018-rx-summit/61096> for more information.

The **American Society of Addiction Medicine** will hold its annual conference **April 12–15** in **San Diego**. For more information, go to <https://www.asam.org/education/live-online-cme/the-asam-annual-conference>.

The annual meeting of the **National Council for Behavioral Health** will be held **April 23–25** in **National Harbor, Maryland**. Go to www.thenationalcouncil.org/events-and-training/conference for more information.

The **National Addiction Leadership Conference** will be held **May 20–22** in **Denver**. For more information, go to <https://www.naatp.org/training/national-addiction-leadership-conference>.

The **National Association of State Alcohol and Drug Abuse Directors** will hold its annual meeting **May 21–24** in **Bethesda, Maryland**. For more information, go to <http://nasadad.org/2018/01/nasadad-annual-meeting-2018>.

added that this analysis also did not account for enough variables, and said he has no great faith in its conclusions either.

Ciccarone says he was surprised the moral hazard argument resurfaced and was applied to naloxone. “I actually thought the argument was dead,” he said. He has no argument with the study coming from the economics arena, just with the researchers' failure to account for all of the risk factors, effects and interventions surfacing at the same time during an epidemic.

“It's challenging to study epidemics when they're unfolding,” he said.

Ciccarone fears the attention that studies with flawed methodology receive will have members of the

public looking at science through whichever ideological lens they wear. “If we can't stand together and make sound evidence-based policy statements, it's going to sound to people like it's all a matter of opinion,” he said. •

Alcoholism & Drug Abuse Weekly

welcomes letters to the editor from its readers on any topic in the addiction field. Letters should be no longer than 350 words. Submit letters to:

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Email: adawnewsletter@gmail.com

Letters may be edited for space or style.

In case you haven't heard...

When commercial insurance companies finally figure out how opioid treatment programs (OTPs) work, they will be able to design a benefit that works as well. Until then, here's what happens: patients have health insurance that covers everything with a \$25 copay per visit. OTP patients go to the clinic to get medication six days a week. “You do the math,” say frustrated OTP administrators, who have been dealing with this situation since long before the Affordable Care Act, which made it possible for many more people to have health insurance. Unless patients have Medicaid, they basically have to self-pay for treatment in an OTP, whether it's out of their own pocket for a copay or just out of their own pocket.