Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

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In This Issue...

Legal Action Center: Comments on proposed changes to confidentiality regulations

The most recent proposal of changes to 42 CFR Part 2, the federal regulation protecting confidentiality of substance use disorder (SUD) treatment records, chips away yet again at what began 12 years ago as a gutting of the rule. *ADAW* has covered every change. For more information, go to the website (www.alcoholismdrugabuseweekly.com) and use the search function. You will find abstracts of every story; subscribers will find full text.

The main reasons for the changes have nothing to do with clinical needs, but more to do with the electronic health record and the way medicine is delivered today — by chart and data. Clinicians have said that it helps the patient if the doctor knows everything about his or her treatment.

Bottom Line...
The lead organization in watchdogging the confidentiality regulations has released its comments on the proposed rule.

But this assumes that the patient won't tell the doctor — it assumes there is a lack of trust.

The Legal Action Center is the one organization that has had its sights set on every change that occurred.

Although treatment program officials themselves have said they want to see these changes, these programs are the ones that would most likely be sued by patients if information that resulted in damage — as SUD treatment information could — gets out. The damage includes loss

See Confidentiality page 2

NYC leaders, harm reduction backers tout progress of OPCs

Just over a year into operation of two pioneering and controversial overdose prevention centers (OPCs) in New York City, harm reduction advocates and city leaders are pointing to numerous successes stemming from the sites' presence. They have said that the latest data on the operations in East Harlem and Washington Heights highlight the importance of the earliest possible public health response for individuals at risk of a fatal overdose.

Bottom Line...
Despite evidence of public health benefit from the presence of two supervised consumption sites in New York City, uncertainty about the long-term viability of the operations remains.

As of late November, the two OPCs run by OnPoint NYC have treated 672 overdoses among more than 50,000 individual visits covering more than 2,000 distinct users, with no deaths, according to the operator's data. Moreover, New York City Deputy Health Commissioner Jonathan Giftos, M.D., told *ADAW*, only 10 visitor events have required activation of emergency medical services, due in large part to the supervised consumption made possible at the OPCs.

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of custody of children, loss of job, and loss of liberty, i.e., jail time.

Not all of the changes are bad. Some are welcome, including moving the enforcement of Part 2 out of the Department of Justice (DOJ) oversight — which rarely investigated or enforced the privacy law — and into the realm of the U.S. Department of Health and Human Services' (HHS) Office for Civil Rights (OCR). The rulemaking also proposes a new reporting requirement for law enforcement and its use of certain court orders to access Part 2 records or place undercover officers in Part 2 programs.

"However, the rulemaking also proposes some changes that will seriously compromise individuals' rights and put people with SUD treatment records at risk of increased discrimination, stigma or prosecution," the Legal Action Center noted in its highlights brief, obtained by *ADAW* last week.

Below are highlights from the Legal Action Center's comments on the proposed changes to the federal privacy regulations (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33628 for story on the NPRM that came out last fall). The rulemaking is required by the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, which enacted substantial changes to align 42 CFR Part 2 with the HIPAA Privacy Rule.

The Legal Action Center urges others to comment. Through the public comment process, HHS needs to hear from directly impacted individuals, providers and consumer advocates about the importance of patient privacy rights in the below areas.

Single written consent

As authorized by the CARES Act amendments, the proposed rule would permit, but not require, patients to sign a single, written consent for all future uses and disclosures for treatment, payment and health care operations (TPO) purposes, which can include non-clinical-related recipients. As the CARES Act also provides, once a patient signs this type of broad consent, HHS proposes to permit Part 2 programs, HIPAA-covered entities, and business associates that receive the records to further redisclose the records as permitted by the HIPAA Privacy Rule (with some exceptions). But the proposed rule does not create clear enough requirements to ensure that patients, Part 2 programs, and recipients of Part 2 records will meaningfully understand how records will be used, disclosed and protected, nor that they have the right not to sign that broader consent or limit disclosures to more limited TPO purposes.

A better alternative: The CARES Act requires HHS to give patients the option to waive their privacy rights and authorize disclosures and redisclosures pursuant to the weaker HIPAA standard, but HHS must continue offering patients the option of authorizing more limited disclosures for TPO purposes without being forced to waive their privacy rights generally. In the preamble of the rulemaking, HHS has said that it believes it has preserved patients' choice to limit disclosures and redisclosures, but the proposed rules themselves are not clear. HHS needs to hear from patients, former patients and advocates that the revised regulations must clearly state that everyone has the right to consent to more limited TPO disclosures. In order to adequately protect and enforce that right, the revised regulations should explicitly delineate how to give patients notice of their right to sign a more limited consent form. It is critically important that the revised regulations center the individual in the decision-making process about how to share their information.

Criminal investigations

HHS proposes to permit the use and disclosure of Part 2 records in a criminal investigation or prosecution of the patient, so long as the patient signs a written consent form. This marks a major departure from the long-standing privacy protections for individuals with SUD treatment records; for the last 40 years, only

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a special court order could authorize the use or disclosure of patient records in a criminal investigation or prosecution.

Why it matters: Patient-centered care means protecting individuals' right to decide when and how to share their health information. Individuals who do not want their SUD treatment records to be used and shared pursuant to the weaker HIPAA standard should still be able to authorize sharing only with their doctor, insurance company or care coordinator.

Why it matters: Expanding law enforcement's ability to access and use individuals' SUD treatment records will cause harm to patients and exacerbate racial disparities in access to SUD treatment and treatment outcomes. For Black and brown communities, access to SUD treatment and services has historically been denied by criminal legal systems and entities, and this proposal should not provide an additional opportunity to support that framework. Individuals should not be asked to consent to disclosures of their protected SUD treatment records that could be used against them or as a condition of a plea deal, sentencing, parole or release from custody.

A better alternative: While the CARES Act apparently requires HHS to permit disclosures with consent in the criminal legal system, HHS should take steps to ensure that there will be protections against patients being coerced, tricked or forced into signing consent forms that can be used against them in a criminal case. Patients also need a way to enforce their rights if they are violated, like requiring a court to disregard records that were inappropriately used or shared in violation of the law.

Anti-discrimination

The CARES Act weakened some aspects of patients' privacy rights but also introduced new anti-discrimination protections for individuals in a variety of settings, including health care, housing and employment. The current rulemaking, however, only addresses the CARES Act's privacy changes; HHS indicated that it would pursue the anti-discrimination protections in a separate rulemaking.

A better alternative: HHS should sync the effective date of the weaker privacy standards to coincide with the corollary anti-discrimination protections required by the CARES Act.

Why it matters: Even though Congress introduced the changes at the same time, the current rulemaking only implements the changes weakening patient privacy rights, without the corresponding anti-discrimination protections. As individuals' SUD treatment information is used and disclosed in new ways and with increasing frequency, it will be even more important for the anti-discrimination protections required by the CARES Act to take effect.

"…HHS should take steps to ensure that there will be protections against patients being coerced, tricked or forced into signing consent forms that can be used against them in a criminal case."

Legal Action Center

Additional proposed changes

- The proposed new complaint procedures (§2.4) should include a way for patients to file a complaint with OCR without being limited to filing complaints with a Part 2 program, which may be the subject of the complaint or may not have the authority to investigate the complaint.
- The proposed changes to the consent form requirements (§2.31) should prioritize transparency and specificity, and also preserve patients' choice to authorize granular disclosures of their treatment records. Ambiguous consent forms with no expiration date and vague descriptions of how information will be shared do not meaningfully promote patients' understanding of how their information will be used and shared for years to come. Those proposed changes should be removed.
- The proposed new safe-harbor provision — which protects investigative agencies (§2.3) that obtain protected SUD treatment information without authorization because they did not realize it was from a program covered by Part 2 — should include more accurate methods of how investigative agencies can determine whether a provider offers SUD treatment services, such as checking the federal Substance Abuse and Mental Health Services Administration Locator or the state oversight agency's list of licensed and certified providers. Checking a Prescription Drug Monitoring Program (PDMP) is not sufficient for determining whether a provider offers SUD treatment services since many SUD treatment providers do not share information with PDMPs. •

For more information from the Legal Action Center, join the community webinar on Jan. 19, 2023, on the 42 CFR Part 2 rulemaking. Go to https://www.lac.org/events.

NSDUH: More consumers reporting SUD, mental health problems

Last week, the Substance Abuse and Mental Health Services Administration (SAMHSA) released its 2021 National Survey on Drug Use and Health (NSDUH) data.

Highlights include:

Substance use in past month

Among people aged 12 or older in 2021, 57.8% (or 161.8 million people) used tobacco, alcohol, or an illicit drug in the past month (also defined as "current use"), including 47.5% (or 133.1 million people) who drank alcohol, 19.5% (or 54.7 million people) who used a tobacco product, and 14.3% (or 40 million people) who used an illicit drug.

Tobacco product use or nicotine vaping

In 2021, 13.2 million people aged 12 or older (or 4.7%) used an e-cigarette or other vaping device to vape nicotine in the past month. The percentage of people who vaped nicotine was highest among young adults aged 18 to 25 (14.1% or 4.7 million people), followed by adolescents aged 12 to 17 (5.2% or 1.4 million people), then by adults aged 26 or older (3.2% or 7.1 million people).

Among people aged 12 to 20 in 2021, 11% (or 4.3 million people) used tobacco products or an e-cigarette or other vaping device to vape nicotine in the past month. Among people in this age group, 8.1% (or 3.1 million people) vaped nicotine, 5.4% (or 2.1 million people) used tobacco products and 3.4% (or 1.3 million people) smoked cigarettes in the past month.

Alcohol Use

Among the 133.1 million current alcohol users aged 12 or older in 2021, 60 million people (or 45.1%) were past-month binge drinkers. The percentage of past-month binge drinkers was highest among young adults aged 18 to 25 (29.2% or 9.8 million people), followed by adults aged 26 or older (22.4% or 49.3 million people), then by adolescents aged 12 to 17 (3.8% or 995,000 people).

Among people aged 12 to 20 in 2021, 15.1% (or 5.9 million people) were past-month alcohol users. Estimates of binge alcohol use and heavy alcohol use in the past month among underage people were 8.3% (or 3.2 million people) and 1.6% (or 613,000 people), respectively.

Vaping

Among people aged 12 or older who vaped any substance in the past month, 71.1% vaped nicotine, 40.1% vaped marijuana and 19.2% vaped flavoring.

Illicit drug use

In 2021, marijuana was the most commonly used illicit drug, with 18.7% of people aged 12 or older (or 52.5 million people) using it in the past year. The percentage was highest among young adults aged 18 to 25 (35.4% or 11.8 million people), followed by adults aged 26 or older (17.2% or 37.9 million people), then by adolescents aged 12 to 17 (10.5% or 2.7 million people).

Opioid misuse

Among people aged 12 or older in 2021, 3.3% (or 9.2 million people) misused opioids (heroin or prescription pain relievers) in the past year. Among the 9.2 million people who misused opioids in the past year, 8.7 million people misused prescription pain relievers compared with 1.1 million people who used heroin. These numbers include 574,000 people who both misused prescription pain relievers and used heroin in the past year.

Substance use disorder

In the 2021 NSDUH, the presence of a substance use disorder (SUD) in the past year was assessed based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). Respondents were asked SUD questions for any alcohol or drugs they used in the 12 months prior to the survey. Drugs included marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, and any use of prescription stimulants, tranquilizers or sedatives (e.g., benzodiazepines) and pain relievers. Thus, the DSM-5 SUD criteria in 2021 for prescription drugs applied to people who used, but did not misuse, prescription drugs in the past year, in addition to people who misused them.

In 2021, the percentage of people aged 12 or older with an SUD was highest among young adults aged 18 to 25 (25.6% or 8.6 million people), followed by adults aged 26 or older (16.1% or 35.5 million people), then by adolescents aged 12 to 17 (8.5% or 2.2 million people).

Mental health among youth

Among adolescents aged 12 to 17 in 2021, 20.1% (or 5 million people) had a past year major depressive episode (MDE) and 14.7% (or 3.7 million people) had a past year MDE with severe impairment.

Adolescents aged 12 to 17 in 2021 with a past year MDE were more likely than those without a past year MDE to have used most illicit drugs in the past year. For example, 27.7% of adolescents aged 12 to 17 with a past year MDE used illicit drugs in the past year compared with 10.7% of those without a past year MDE.

Mental health among adults

Among adults aged 18 or older in 2021, 22.8% (or 57.8 million people) had any mental illness (AMI) in the past year. The percentage of adults aged 18 or older with AMI in the past year was highest among young adults aged 18 to 25 (33.7% or 11.3 million people), followed

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Consider new options for treating OUD in designing trials

Although there are already three approved medications to treat opioid use disorder (OUD) — methadone, buprenorphine, and naltrexone — "novel treatments" are needed, according to a review published this month in *JAMA Psychiatry.* Partly because of long-standing barriers to treatment with methadone and buprenorphine, the review looked at possible treatments that go "beyond the endogenous mu-opioid receptor [MOR] system. For the review, a public–private partnership including members of the federal Food and Drug Administration (FDA) and the Analgesic, Anesthetic, and Addiction Clinical Trial Translations, Innovations, Opportunities, and Networks (ACTTION) group met to look at potential treatments for OUD, including cannabinoids, psychedelics, sedative-hypnotics and vaccines. The consensus recommendations for clinical trial design included targeting the stage of treatment (e.g., seeking treatment, early abstinence, long-term recovery), looking at the role of treatment, looking at primary outcomes informed by patient preferences, and considering adverse events, including the potential for relapse or overdose in the case of relapse. The study, "Clinical Trial Design Challenges and Opportunities for Emerging Treatments for Opioid Use Disorder," is by Brian D. Kulik, Ph.D., and colleagues, and funded by the ACTTION public–private partnership with the FDA. •

Key Recommendations and Considerations

Study Objectives

- Prospective trial registration prior to the start data collection in publicly accessible database, including primary and secondary outcomes, hypotheses, and study objectives.
- Priority should be given to specifying the stage in OUD treatment that will be targeted with the intervention (eg, current active use of opioids, acute abstinence, nonmedically supervised withdrawal, and/or supervised withdrawal, early recovery, or long-term recovery) and determining whether the emerging treatment will be adjunctive to or independent of existing OUD treatments.

Clinical Trial Design

- Study design will ideally be double-blind RCT.
- Comparators should include a placebo group (when ethically appropriate) and/or an active control comparison(s).
- If the novel treatment is a stand-alone intervention, then comparison should include an existing, evidence-based OUD treatment (eg, methadone, buprenorphine, naltrexone, or behavioral/psychosocial support).

Sample

- Participants should be a representative, diverse population of patients (ie, age, sex, sexual orientation, race and ethnicity, socioeconomic status, and history of substance use).
- Exclusion criteria that are too restrictive and may negatively affect the generalizability of the study should be carefully evaluated and included on the basis of safety or another enhanced rationale considered (eg, exclusion of participants with concurrent medical, physical, or mental health issues).

Primary End Point

- Primary outcomes should be chosen to align with the study objectives and the phase of treatment that is to be targeted (eg, symptoms of opioid withdrawal or craving will be more important to measure in early recovery rather than during long-term recovery). In addition, primary outcomes will need to be tailored to the expected treatment indication (eg, sleep measures for a sleep intervention).
- At minimum, we recommend that primary outcomes for trials beyond phase I include opioid use behavior, treatment retention, and at least 1 outcome that addresses global functioning (eg, change in DSM criteria, quality of life).
- A dichotomous measure to define responder (based on opioid abstinence or reduction in opioid use) should be a primary outcome, but also consider continuous measures of opioid use (ie, quantity, frequency).
- Selection of end points should be informed by input from patients and family members to determine the most salient OUD symptoms/experiences and outcomes.

Secondary Outcomes

- Potential secondary outcomes should include opioid withdrawal and/or craving, treatment adherence and satisfaction, physical and mental health, risk of misuse of study intervention, patient-focused outcomes, such as psychosocial functioning (including employment and legal issues), sleep, pain, and cognitive functioning, and health outcomes (eg, viral load if positive for HIV or hepatitis C virus).

Assessment of Harms

- Adverse events, including opioid-related adverse events (eg, hospitalization, naloxone administration, visits to emergency department), and reasons for premature terminations from trial should be collected and carefully reviewed with sensitivity to relapse risk and overdose.

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by adults aged 26 to 49 (28.1% or 28.8 million people), then by adults aged 50 or older (15% or 17.7 million people).

In 2021, 5.5% of adults aged 18 or older (or 14.1 million people) had serious mental illness (SMI) in the past year. The percentage of adults aged 18 or older with SMI was highest among young adults aged 18 to 25 (11.4% or 3.8 million people), followed by adults aged 26 to 49 (7.1% or 7.3 million people), then by adults aged 50 or older (2.5% or 3 million people).

Nearly half of young adults aged 18 to 25 in 2021 (45.8% or 15.3 million people) had either an SUD or AMI in the past year. This percentage was higher than corresponding percentages among adults aged 26 to 49 (39.5% or 40.4 million people) and adults aged 50 or older (22.6% or 26.7 million people).

Treatment gap

People were classified as needing substance use treatment if they had an illicit drug or alcohol use disorder in the past year, or if they received substance use treatment at a specialty facility in the past year. Among people aged 12 or older in 2021, 15.6% (or 43.7 million people) needed substance use treatment in the past year.

Among the 40.7 million people aged 12 or older in 2021 with an illicit drug or alcohol use disorder in the past year who did not receive treatment at a specialty facility, 96.8% (or 39.5 million people) reported that they did not feel they needed treatment, 2.1% (or 837,000 people) felt that they needed treatment but did not make an effort to get treatment, and 1.1% (or 447,000 people) said they felt that they needed treatment and made an effort to get treatment. •

Federal official on reports — "Tell us what we don't know"

There are so many reports on opioid use disorder (OUD) that it's hard to keep up with them. Except for one thing: They all say the same thing, something that has been known for years, even decades. *ADAW* dutifully reports on the availability of most of them. But the fact was clearly laid out by a frustrated, at times, angry federal official in a background interview with *ADAW* last week.

"I'm so tired of people writing reports," he said. "Instead of writing another report on what we already know, write about what we don't know."

For example, more reports on the benefits of harm reduction, including all of its permutations, not just treatment, are needed, he said. The federal government funds many of these reports, and under the federal government's rules, the only harm reduction services that are covered are naloxone, fentanyl test strips and syringe services programs. Injection services are not covered. And federal funding, mainly from the Substance Abuse and Mental Health Services Administration (SAMHSA), drives the services that are provided (see "SAMHSA funding drives harm reduction activities," *ADAW*, June 3, 2022; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33455).

Now, harm reduction, including "safe" injection sites, is becoming mainstream (see story, page 1). And that, according to this federal official, is all for the good. Lives are being saved. So is treatment, which also saves lives, he said.

Now that the buprenorphine regulations have been eliminated (see "Spending bill includes X-waiver elimination," *ADAW*, Dec. 30, 2022; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33651), prescribers can "finally start treating people," he said. "So many people in this field think they need government to tell them what to do. But the moment you start treating folks, you see benefits."

Even in the new proposed methadone rules (see "SAMHSA proposes reforms to methadone rules, keeps OTPs in charge," *ADAW*, Dec. 16, 2022; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33643), there's an "out" in terms of initial dosing limits, he said. "It's driven by the prescriber's judgement," the official said of methadone. "It's not as if there isn't any oversight."

But where controlled substances are concerned, there is always "plenty of oversight, and fear of the oversight." Look at what happened when the federal Centers for Disease Control and Prevention (CDC) issued guidelines — only guidelines, not a rule — for prescribing opioids for pain. Patients in pain were denied medication as their prescribers started to fear drug enforcement and even state medical boards.

The federal official also had this criticism for the CDC, saying the agency "didn't pay attention to the fact that opioid use moved from prescribed opioids to heroin decades ago."

The greatest benefit of safe injection sites is the naloxone reversals of overdoses, which is a huge benefit. No, the naloxone given that day "is not going to save them the next day," he said. "But if you do nothing to try to engage people, they will die."

The safe injection sites are welcoming facilities to drug users. They provide a helping hand, not a critical judgmental voice. To be clear, ADAW is aware of many treatment centers and OTPs that do the same thing. But they require health insurance, and in many states, Medicaid won't even pay for treatment in an OTP.

The federal official strongly approves of the methadone notice of proposed rulemaking (NPRM), but

he said it "took way too long." He read it and re-read it. "We have to put the message out there that the methadone proposed rule is way more than more take-homes," he said.

In addition, the federal official urged everyone to read the FAQ document that the Justice Department Office of Civil Rights issued earlier this year (see https://archive.ada.gov/opioid_guidance.pdf). If a state is trying to reduce access to treatment by barring new OTPs, for example, this is a violation of the Americans with Disabilities Act.

"People in the state that does that [limits treatment] will die, and eventually someone will figure it out," he said. "Why wouldn't some advocacy group in a restrictive state, say a state that won't let Medicaid cover methadone treatment, find the plaintiffs and sue? Or get a group together and make it a class action?"

What everyone listens to: their lawyers. More reports are just more noise that nobody listens to, he said. What is needed is action. "Start treating people and see what happens." There are states that do this, such as Rhode Island, which has impending legislation for safe injection sites, and New York, which has one. They are good role models to follow for any state that is concerned about overdoses, he said. •

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"These sites are being utilized, extensively utilized, and I think that was and is important," Giftos said. "People are benefiting from the programs' wraparound services as well," delivered at the two syringe service program (SSP) sites that have housed the OPCs since late 2021.

City leaders and harm reduction advocates cite the importance of using these established multi-use sites in countering the argument from some city residents that the OPCs have resulted in a surge in open drug use activity in their surrounding communities.

"These services were incorporated into SSPs that had a presence in these communities for many years," Giftos said. "OPCs redirect public drug use into spaces that are safer."

Naloxone not as prominent

One of the striking observations about the OPCs' first year in operation has been the degree to which operators have not had to rely heavily on naloxone in overdose response. The vast majority of overdoses have been successfully addressed with only oxygen, averting the need to administer a reversal drug that, while lifesaving, can also send individuals into highly uncomfortable withdrawal.

"If people don't feel well after an administration of naloxone, they could make [risky] choices," such as resuming drug use, Sheila Vakharia, deputy director of research and academic engagement at the Drug Policy Alliance (DPA), told *ADAW*. Only a staffed operation with close monitoring of use in real time, such as an OPC, could be in a position to administer oxygen in this way as a first option to rescue an individual, Vakharia said.

Leaders also point to the emergence of the OPCs as primary sites for use of drug-checking technology in the city. Vakharia said a former DPA intern has been working with the city's department of health to bring this technology to both of the sites that house the OPCs; two other SSPs in the city are also using the technology. This has become critical not only to detect the presence of fentanyl in the drug supply, but also to test for the increasingly prominent xylazine, a non-opioid that does not respond to naloxone (see "Potent

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Onpoint NYC is hiring

Here are some of the recent job announcements posted by the New York City OPC:

- The Executive Assistant (EA) will provide high-level administrative support to the Executive Director. This team-oriented professional has the administrative skills and background to help carry forward the organization's mission. The Executive Assistant will provide critical assistance and support to the Executive Director and others as assigned.
- We are currently looking for a Part-time Registered Nurse to work in our Winnebago, also known as a "Mobile Health Unit." This position is NOT office based.
- This position is responsible for driving our mobile health unit - Winnebago - while providing an array of street-based harm reduction services to people actively using drugs, including injection drug users (IDUs), sex workers, and people living with HIV/AIDS and/or Hepatitis C. The Winnebago provides no barrier care to our most vulnerable participants including harm reduction supplies, bathrooms, respite, harm reduction education, case management, and motivational clinical care.
- The Harm Reduction Specialist works on the Winnebago, also known as a "Mobile Health Unit." This position is NOT office based. This position works outdoors and on the Winnebago stationed in neighborhoods of high need or on foot. This position provides services to people who use drugs (PWUD) and engage in sex work, monitor public injection diversion bathrooms, intervene in overdoses, distribute harm reduction supplies, provide harm reduction education and counseling, and clean up hazardous waste.

For more information, go to https://onpointnyc.org/careers/

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non-opioid xylazine emerges as overdose threat without antidote," *ADAW*, Sept. 26, 2022; https://doi.org/10.1002/adaw.33557).

The city has demonstrated its commitment to the OPC sites, Giftos said, by investing opioid settlement dollars into a substantial enhancement of drop-in services available at the OnPoint sites. The city has not committed dollars directly to the safe consumption component of the operations, as officials await more direction from both the state and the federal government on the appropriateness of using public funds to support activities around supervised consumption of illegal drugs.

Less has been revealed publicly at this point about the degree to which visitors to the supervised consumption sites have utilized the other services available at the locations. *ADAW*'s requests for comment from several leaders of the OnPoint NYC programs were not answered by press time.

Supporters of the concept of supervised consumption said that if public funding were available (the OPC activities at OnPoint currently subsist solely on private donations), hours could be expanded, and drug users would have a more accessible alternative to using alone or on the streets. "We've seen people die when these operations are closed," Giftos said.

In an article published last month on the New York City-based news site THE CITY, Harlem resident David D'Alessio said he thinks the neighborhood surrounding the Harlem operation has seen a deterioration since the OPC opened there.

"I have witnessed things I've never seen before, including brazenly open dealing, people defecating (in broad daylight), users with needles openly using injection drugs ... and even a man receiving oral sex between parked cars," D'Alessio wrote in an email to the news site, THE CITY reported.

THE CITY's article reported that narcotics arrests in the East Harlem area where one of the OPCs is located were up more than 100% in a 28-day period last November.

Giftos said the city plans to partner with New York University to conduct an evaluation of the OPCs' effect on the surrounding communities. However, he said, research evidence from existing programs in other countries has suggested little change to the neighborhoods that house them.

An uncertain future

"We absolutely need to scale-up these services to meet the demand," Vakharia said. The obstacles to round-the-clock operations, she said, are not vastly different from the hurdles that operators of opioid treatment programs face in expanding access to treatment.

"When we have stigma built into our drug policies, it trickles down to the services that are available on the ground," Vakharia said. She added, "Some people are reluctant to support something unless it is made clear that the feds won't get involved, and the state also."

Giftos said the city remains deeply committed to the OPCs' sustainability, supporting the expansion of health care and other wraparound services at the sites while awaiting clearer policy direction from the federal government and the state regarding funding of supervised consumption. Mayor Eric Adams and several other city leaders remain strong supporters of expanding access to supervised consumption sites. •

Coming up...

The CADCA 2023 **Leadership Forum and SAMHSA's Prevention Day** will be held **Jan. 30–Feb. 3** in Washington, D.C. For more information, go to **https://www.cadca.org/forum2023**

The 2023 **Rx and Illicit Drug Summit** will be held **April 10-13** in Atlanta, Georgia. For more information, go to **https://www.rx-summit.com/**

The 2023 **ASAM conference** will be held **April 13-16** in Washington, DC. For more information, go to **https://annualconference.asam.org/**

The 2023 **American Psychiatric Association conference** will be held **May 20-24** in San Francisco, California. For more information, go to **https://www.psychiatry.org/psychiatrists/meetings/annual-meeting**

In case you haven't heard...

The most recent NSDUH (see story, page 4) found that almost as many people use stimulants as use opioids. Yet the federal government still imposes a $75 limit on payment for contingency management — the only treatment proven to work for stimulant use disorders — if the payment is high enough (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33437). Seventy-five dollars is not high enough to keep someone who is addicted to stimulants from using them. So it's significant that providers, like the American Society of Addiction Medicine, are taking notice. The organization recently — but before the NSDUH was released — signed on to a letter to the White House Office of National Drug Control Policy requesting a change in this policy. For the letter, go to https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/advocacy/letters-and-comments/letter-to-ondcp-on-contingency-management-policy-barriers.pdf?sfvrsn=a84585e6_7/Letter-to-ONDCP-on-Contingency-Management-Policy-Barriers.pdf). What is the government waiting for, another drug crisis? If so, it's already here. Time to act.