ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

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In This Issue...

The tide is turning on decriminalization: Saved from the brink of drowning?

Recent news from Oregon and California indicate that decriminalization has failed and encouraging public drug use isn't actually a success either. Measure 110, passed in Oregon three years ago, decriminalized possession of small amounts of all illegal drugs. Overdose rates went up, as more drug users were attracted to the state. The streets of San Francisco and Oakland, California, just for example, have been populated by out-of-state drug users looking for cheap fentanyl, government hand-outs, and most recently, free housing.

Bottom Line...
Politicians, spurred by public disgust at open air drug use and homeless, are backtracking their liberalization of drug laws.

Oregon

In November 2020, Oregon passed the first statewide drug decriminalization measure in the country, allowing personal-use possession of illegal drugs, including heroin, methamphetamine and cocaine. The ballot initiative, Measure 110, which was sponsored mainly by the Drug Policy Alliance (DPA), allowed people to either pay a $100 fine or go to an "addiction recovery center" that would be funded by the regulated legal marijuana industry in the state.

See **Decriminalization** page 2

Coalitions lifted barriers to MOUD through CADCA-Indivior initiative

A pair of anti-drug coalitions in Hunterdon County, New Jersey, took a step beyond their core work in primary prevention to advance the provision of medications for opioid use disorder (MOUD) in their community. Their efforts came about as part of a coalition training partnership jointly sponsored by Community Anti-Drug Coalitions of America (CADCA) and pharmaceutical company Indivior, maker and distributor of brand-name Suboxone products for OUD.

Bottom Line...
Community coalition leaders in Hunterdon County, New Jersey, were able to build local support for medications for opioid use disorder (MOUD), culminating in the initiation of prescribing at the local hospital emergency department.

One of the local coalition leaders told *ADAW* that a turning point in gaining community support for MOUD occurred last June when she and a colleague arrived at a charity golf tournament dressed in similar attire and wearing hats emblazoned with "MOUD Saves Lives. Ask Me How." The local hospital system was sponsoring the tournament, and an influential doctor reacted by saying he would wear the hat during the event. Hunterdon Healthcare has since been initiating MOUD in its emergency department and

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But it didn't work. By September 2022, strikingly low engagement in substance use evaluation and subsequent treatment has renewed sharp criticism of the landmark measure. At that time, there was no indication that the state's leaders were ready to reverse course on an initiative voters approved as Measure 110. However, some were openly wondering whether a measure that virtually eliminates the role of law enforcement lacked the accountability needed to encourage drug users to pursue treatment (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.32905).

Supporters of the measure (mainly, the DPA, which sponsored it) promised that millions of dollars would go to funding treatment centers. That didn't happen. Yes, there were millions of dollars that were supposed to go from the cannabis industry tax revenues to the state, and the money did in fact go to the state, but the state apparently didn't have the money or the workers to figure out how to respond to the applications for funding. The treatment programs and voters were hoodwinked.

So last month, the legislature voted overwhelmingly to repeal the measure. As *ADAW* went to press, the bill repealing it was in the hands of the governor, who was almost sure to sign it.

"With Oregon's drug overdose deaths growing at 20 times the national rate, defending Measure 110 became impossible."

Keith Humphreys

What went wrong?

Here's what Keith Humphreys, Ph.D., Professor of Psychiatry and Behavioral Sciences at Stanford University, told *ADAW*: "With Oregon's drug overdose deaths growing at 20 times the national rate, defending Measure 110 became impossible."

Many people point to Portugal as an example of successful decriminalization, but they ignore the great amount of money the country put into treatment. In addition, Humphreys pointed to cultural differences. "Removing legal controls on drug use doesn't make much difference in a culturally conservative, communal society like Portugal, but it opened the floodgates in the culturally libertarian ethos of Oregon."

Here's the DPA's analysis:

- "Oregon's Measure 110 was meant to address the harms of criminalization and make needed investments in addiction services and social supports. It did just that.
- Policymakers could have made Measure 110 stronger but ignored advocates' recommendations.
- Politicians scapegoated Measure 110 for the problems caused by their own failures.
- External factors like increased evictions and homelessness created more suffering in Oregon's streets.
- Research proves [that] Measure 110 did not increase crime, homelessness, or overdose deaths.
- Oregon leaders re-criminalized drug possession as a false promise of change.
- Despite the rollback, Measure 110 supported Oregon's public health goals."

What about treatment? "Measure 110 redirected the majority of Oregon's marijuana tax revenue into funding addiction services," the DPA fact sheet states. "This included low-barrier substance use disorder treatment, harm reduction and overdose prevention services, housing, recovery and peer support services, and employment supports. Measure 110 required that these services be available in every county in the state through at least one Behavioral Health Resource Network. Measure 110

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resulted in over $300 million to expand addiction services in its first two years alone, resulting in dramatic increases in the number of clients accessing services." According to DPA, substance use disorder (SUD) treatment increased 114% after the passage of Measure 110. "Even the proponents of its repeal have admitted that Measure 110 was successful in improving service provision, agreeing the services it created must stay in place even after recriminalizing possession."

The DPA laid the blame at the feet of the Oregon Health Authority, which failed to "effectively implement or improve" Measure 110 along the way. "This resulted in a significant delay in funding getting to service providers." In addition, the DPA said the "state failed to provide any training or standardized citation forms to law enforcement, many of whom were opposed to Measure 110." Finally, "policymakers caved to a rollback effort bankrolled by business interests and led by the former chief of Oregon's prisons."

However, what constituents saw on the streets of Portland, for example, was open air drug use and homelessness. Their formerly pristine town, which even was the feature of a television program, was becoming an eyesore, not appealing to local businesses or tourists. And more importantly, overdose deaths were ballooning.

Unfortunately, legislators had the same motives for passing Measure 110 in the first place — public opinion — as they had for repealing it. Instead of looking at how the initiative was rolling out — and in fact, there was little in the measure that required accountability — the policymakers just let the problems grow until nobody could stand them anymore. The benefits of decriminalization, that is, helping someone get into treatment instead of potentially ruining their life by putting them in the criminal justice system, were lost in this colossal failure in Oregon.

The DPA laid the blame at the feet of the Oregon Health Authority, which failed to "effectively implement or improve" Measure 110 along the way.

San Francisco

The same thing happened in San Francisco. First, years ago, a liberal district attorney (who was subsequently recalled) discouraged arresting anybody for drug possession. Then, the mayor closed the city's only overdose prevention center, because fewer than 1% of participants had been referred to treatment (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33793). Finally, by last spring when *ADAW* visited, the city — still beautiful in some areas — had started to become known for open air drug use, dead bodies on the street, organized shoplifting gangs, car thefts, and any number of problems that the local residents blamed on liberal politicians.

The backlash was, as in Oregon, swift. Even those living far away from the Tenderloin district, where drug use and homelessness were concentrated, had had enough. And they demanded change in the form of elections from their leaders.

Whether in fact this was the fault of the lawmakers is unclear. What is clear is that drug users, knowing that they could come to San Francisco for easy access to drugs, went there. Many who collect various benefits from the generous city are not even residents, although surely, they deserve benefits because they are, in fact, homeless.

This moment is not the time to go back to the Dark Ages, it's the time to "make recovery a reality," said Thomas Wolf, an activist in San Francisco who walked the Tenderloin with us last year (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33786). "We can seize the opportunity," he said, "by making elected leaders that drive policy and funding build out a full continuum of care for drug and mental health treatment." Building this treatment is "just as important as building out housing," he said. "Once we achieve parity in this area, we will begin to see results. We can no longer rob Peter to pay Paul on treatment. We must have a set aside of billions of dollars as we do with housing to achieve results."

Wolf was an addict who spent time in prison. He is now in recovery.

Incidentally, the state of Washington is also doing badly on the overdose front. It also decriminalized.

"Measure 110 proved that if you allow people to use as many drugs as they want wherever and whenever they want, they will," said Humphreys. In addition, the very Oregonians who most strongly wanted Measure 110 repealed were African Americans and Hispanics — the people the DPA claimed the initiative was helping, he noted.

Let's hope the next steps are taken carefully, with science and health, and not politics, in mind. Nobody wants to go back to the days when a drug user was called a criminal. But America's overdose rate, the decline of its most vaunted urban spaces, and the people's desire to finally draw the line on mayhem and death is something politicians will need to keep in mind. •

OTP leaders on Part 2: Tell patients what consent means

The confidentiality regulation governing substance use disorder (SUD) treatment records has been constantly weakened since 2010. Most recently, the final rule came out (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.34035) which further weakens privacy, most importantly by allowing the first initial consent to release of patient information, signed by the patient, to be used forever, to go to almost anyone, except for law enforcement. When the Department of Health and Human Services (HHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly released that final rule, they did not comply with the requirement by Congress in the CARES Act that while sharing of information should be easier, anti-discrimination provisions needed to be tightened. There was no addition of anti-discrimination provisions.

ADAW has asked HHS and SAMHSA every week since the final rule came out why this lapse occurred and what they plan to do about it. We have received no response. We have told them we will ask the same question every week and print their response or lack of it — and we will. This is our 351st article on 42 CFR Part 2 since 2010 and we're not stopping now.

We talked to two leaders in the opioid treatment program (OTP) field this week about how the change affects them.

Mainly, they agreed that they will need to tell patients up front what signing that initial consent means. It could mean loss of custody of their children, loss of a job, loss of life insurance benefits and many other consequences if organizations are allowed to pass on the information that this individual is in treatment with methadone for opioid use disorder.

"We have to tell those who come to use for care that their information will be shared," said Linda Hurley, president and CEO of CODAC, an OTP based in Rhode Island. And she knows that they will be discriminated against because of this.

Allegra Schorr, president of the Coalition of Medication-Assisted Treatment Providers and Advocates, a membership organization in New York state, agreed. "We have to make everybody aware of this," she told *ADAW*.

"This has definitely been chipped away at over a period of time," said Schorr.

The Part 2 final rule comes on the heels of the massive Part 8 final rule (see tk), and probably is eclipsed by it. Taking effect next month, the Part 8 changes greatly expanded flexibilities for OTPs and OTP patients, including making it easier to get take-home doses of methadone and eliminating various requirements for admission.

Law enforcement

"At least there's some protection on the law enforcement side" in the Part 2 changes, said Schorr, who is also owner and vice president of West Midtown Medical Group, an OTP, outpatient substance use disorder treatment program and primary care facility. "At least somebody thought this might be an issue."

It's quite likely, since the whole reason 42 CFR Part 2 was developed was because law enforcement officials were going into New York City-based OTPs looking for people with outstanding warrants for their arrest and demanding to see patient rosters. Bob Newman, then head of the city's most powerful OTPs and a vocal and eloquent proponent of methadone treatment, was having none of it, and got the confidentiality regulation put into implementation and enforcement. This was more than three decades ago.

Schorr also said that the underlying assumption by policymakers was that "you have HIPAA, so you don't need this." But in fact, privacy is being sacrificed across the board, as part of the "new electronic digital world," she said. "Privacy is a secondary concern now, taking a back seat to convenience and integrating data."

Educating patients

"At the end of the day, all you can really do is explain to people what their rights are and what's being disclosed and educate them," said Schorr of how to tell patients they are signing away their rights to privacy forever when they sign that initial consent.

Schorr recalled a webinar she participated in, in which one participant suggested that the consents to information release be put at the bottom of all forms, so people "won't know what they're signing." She said that is the "scary part." The idea is to make the treatment provider get the consent, and then push that consent through to the broader universe, with the treatment facility just providing the service.

H. Westley Clark, M.D., who has been one of the strongest proponents of privacy and confidentiality, always said that the change would come back to haunt treatment providers (Clark was not available for an interview). He told us often that the consent could be easily traced to the treatment provider, the only party that collected it. And if there were adverse consequences — custody or job loss, for example — it would be the treatment provider who would be sued.

"I hope it won't come to that," said Schorr.

Putting anti-discrimination provisions into the final rule would have gone a long way to preventing that.

Another issue that many treatment providers have to consider is the possibility of patients' private information becoming public may deter people from seeking treatment. As the National Association of Addiction Treatment Providers and the American Society of Addiction Medicine (but not the American Association for the Treatment of Opioid

Dependence) continued to support weakening confidentiality, they were thinking only of themselves as organizations, and not of their rank-and-file members, who in a plot twist are concerned about the unintended consequences of these changes. However, those organizations are also looking toward a future of integrated care, and they don't want to be left out if there are no more silos and primary care gets to take care of all the addicted patients.

Removing stigma?

There are some who say that if more people disclose their situation — being in treatment on methadone — over time, this will be accepted. Yes, indeed, this is a common argument, but never made by someone in treatment with methadone, rather, it's made by people in recovery, often abstinence-based.

"The better-off people are, the more likely they can disclose," said Schorr. "But a lot of the people in treatment are not well off at all."

Hurley, however, is not at all optimistic about stigma going away for methadone patients. "I've been doing this for 37 years," she told us. "I have not seen any deep cultural change in the level of stigma." Now, added to the mix, is marketplace competition (buprenorphine, office-based methadone) harm reductionists who, in varying degrees, want to eliminate OTPs; and other levels of stigma in various forms. "There has never been any letting up of the attack on methadone treatment from any one group or combination of groups," said Hurley.

Hurley testified this month before the Rhode Island legislature about the stigma the field experiences, and this is "only a small modicum of what our patients or people who come to us for care experience," she said. "This results in discrimination decade after decade. I'm extremely concerned about the underlying assumption that the stigma has disappeared."

That said, Hurley, like Schorr, knows that patients need to be told what their consent to information release means — that it will be shared. •

CDC: 23% increase in deaths from excessive drinking

There was a 23% increase in deaths from excessive alcohol use from 2018–2019 to 2020–2021, the federal Centers for Disease Control and Prevention reported in the Feb. 29 issue of the CDC's *Morbidity and Mortality Weekly Report*. This compares to a 5% increase that occurred from 2016–2017 to 2018–2019. The researchers attributed the increase to the availability of alcohol in many states during the pandemic, which at its peak saw policies that expanded alcohol carry-out and delivery to homes, and places that sold alcohol for off-premises consumption. The purpose of these policies was to limit transmission of the COVID-19 virus.

"From 2016–2017 to 2020–2021, the average annual number of U.S. deaths from excessive alcohol use increased by more than 40,000 (29%), from approximately 138,000 per year (2016–2017) to 178,000 per year (2020–2021)," the study noted. "This increase translates to an average of approximately 488 deaths each day from excessive drinking during 2020–2021. From 2016–2017 to 2020–2021, the average annual number of deaths from excessive alcohol use increased by more than 25,000 among males and more than 15,000 among females; however, the percentage increase in the number of deaths during this time was larger for females (approximately 35% increase) than for males (approximately 27%)."

Increases in deaths from excessive alcohol use during the study period took place across all age groups.

The deaths measured in this report do not include those caused by excessive alcohol consumption over time, such as cirrhosis. These deaths were solely those related to acute consumption, as the authors noted in the "limitations" sections of the report. "The findings in this report are subject to at least two limitations. First, population-attributable fractions were calculated based on data including only persons who currently drank alcohol. Because some persons who formerly drank alcohol might also die from alcohol-related causes, population-attributable fractions might underestimate alcohol-attributable deaths. Second, several conditions, e.g., HIV/AIDS and tuberculosis, for which excessive alcohol use is a substantial risk factor, were not included because relative risk estimates relevant to the U.S. population were not available for calculating the portion of these deaths attributable to drinking alcohol, further contributing to conservative death estimates in this report."

Another possible reason for the increase in deaths is "delays in seeking medical attention, including avoidance of emergency departments for alcohol-related conditions," the researchers wrote. In addition, an increase in alcohol consumption might have been driven by "stress, loneliness and social isolation" during lockdown, as well as "mental health conditions."

It should be concerning that some of the suggested reasons for the increased consumption are still present beyond the pandemic, notably the easier access to alcohol in the form of to-go beverages and other measures approved by states. In addition, patient fears of going to the emergency room for alcohol problems are likely still present.

The study, "Deaths from Excessive Alcohol Use — United States, 2016–2021," is by Marissa B. Esser, Ph.D. and colleagues. •

Attorney argues against SAMHSA overdose toolkit

In the February 26 issue, *ADAW* wrote about the "toolkit" on overdose prevention and rescue from the Substance Abuse and Mental Health Services Administration (SAMHSA) that calls for giving one dose (4 mg) of naloxone initially followed by a second dose two or three minutes later. The toolkit references studies that show increased doses of naloxone are not necessary in the fentanyl era. This is despite a study published in January from the U.S. Food and Drug Administration which found that 35% of overdose victims would die from that two-to-three-minute wait for the second dose.

The toolkit focused on "precipitated withdrawal," and warned that overdose victims could experience this if given too much (or any) naloxone. It did not discuss the risks, i.e., death, of not giving enough.

For example, in a list of rescue medications, the toolkit notes the following about Kloxxado, which is an 8 mg intramuscular dose of naloxone: "High dose compared to other products; may cause severe withdrawal symptoms in people with opioids in their body."

We asked Robert Kent, president of Kent Strategic Advisors and former general counsel for the federal Office of National Drug Control Policy, and before that general counsel for the New York State Office of Addiction Services and Supports, to comment on this. Below is what he said.

"As an attorney, I would have advised against including that information. The government should strenuously avoid doing or saying anything that could be perceived as supporting or questioning any product, especially one that has been approved by the FDA [as] safe and effective."

"Beyond that, their 'panel of experts' appears to represent only one segment of folks who use naloxone, those who work with folks who knowingly use fentanyl. There are many others who are unknowingly exposed to fentanyl where the use of any of the products is unlikely to produce significant withdrawal symptoms."

"I wish SAMHSA would use their time to force states to maximize the use of [state opioid response] SOR, and other SAMHSA grant funds to purchase as much naloxone as possible. Every state should issue competitive procurements to purchase naloxone to ensure that they are purchasing as much as possible. Every state should end these exclusive arrangements with one particular company."

Below is the chart of rescue medications from SAMHSA's toolkit. •

OORMS AVAILABLE TO THE PUBLIC*

OORM	Brand	Formulation	Dosage	Availability	Considerations
Naloxone	N/A	Adaptable Nasal Spray	2 mg/ml	Rx, community naloxone distribution, harm reduction organizations	Assembly required to attach nasal spray adapter to needle-less syringe. Not approved by FDA. Possible to titrate to meet the needs of the patient and facilitate a gentler overdose reversal with potential for less severe withdrawal in people with opioids in their body.
Naloxone	RiVive ™	Single-use Nasal Spray	3 mg	Rx, OTC, community naloxone distribution, harm reduction organizations	Lower dose can facilitate a gentler overdose reversal with less severe withdrawal in people with opioids in their body.
Naloxone	Narcan, generic	Single-use Nasal Spray	4 mg/ 0.1 ml	Rx, OTC, community naloxone distribution, harm reduction organizations	May cause withdrawal symptoms in people who have opioids in their body.
Naloxone	N/A	Single-dose Vial Intramuscular Injection; can also be given intravenously or subcutaneously	0.4 mg/ml	Rx, community naloxone distribution, harm reduction organizations	Has been studied and used in the real world to reverse overdoses for decades; cheapest naloxone available; easy to use.
Naloxone	Zimhi®	Intramuscular or subcutaneous Auto-Injection	5 mg/ml	Rx, community naloxone distribution, harm reduction organizations	Accessible product format that auto-injects the medication; high dose compared to other products; may cause severe withdrawal symptoms in people with opioids in their body.
Naloxone	Kloxxado®	Single-use Nasal Spray	8mg/0.1 ml	Rx, community naloxone distribution, harm reduction organizations	High dose compared to other products; may cause severe withdrawal symptoms in people with opioids in their body.
Naloxone	Opvee	Single-use Nasal Spray	2.7 mg/0.1 ml	Rx, community naloxone distribution, harm reduction organizations	Longer lasting than naloxone but may cause severe extended withdrawal in people with opioids in their body.

Source: SAMHSA

*Editor's note: This "Considerations" column of this chart has many incorrect assumptions, including that there having a "gentler reversal" is better than death or brain damage. See FDA' study: https://onlinelibrary.wiley.com/doi/10.1002/adaw.34010

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referring patients to ongoing care for OUD in the community.

"Both of our groups were working on getting MOUD implemented in the county. We had no prescribers," said Erin Cohen, executive director of prevention services at Prevention Resources Inc., referring to her organization and the group One Voice of Hunterdon Inc. The county, with a population of nearly 130,000, is located about an hour from Philadelphia and has several rural pockets. This has made transportation to an available MOUD provider outside of the county a challenging proposition.

Cohen and Lesley Gabel, executive director of One Voice of Hunterdon, said that while the aim of the CADCA-Indivior program was to help communities address challenges around the implementation of MOUD, Indivior did not directly influence the direction participating coalitions took on which medication treatment to advance and how. "That was not even a consideration," Gabel told *ADAW*.

Earlier this year, Cohen and Gabel co-presented a session titled "The Missing Piece: Solving the Gap to Address Opioid Overdoses" at CADCA's National Leadership Forum. The "missing piece" theme is depicted on the MOUD hats as a puzzle piece. Gabel said she now keeps a hat always visible inside the rear windshield of her car.

> **"Both of our groups were working on getting MOUD implemented in the county. We had no prescribers."**
>
> Erin Cohen

An open-door recovery community center is among Prevention Resources' programs. One Voice of Hunterdon focuses on reducing youth substance use, and also has a mental health awareness component.

Garnering support

CADCA Director of Business Development Mia Wallace told *ADAW* that a cohort of 20 coalitions from across the country participated in the project, which started in 2022 and ended last year. The coalitions were selected based on having demonstrated excellence in the field and having already worked on an opioid-related initiative in their home community, Wallace said.

The initiative offered the coalitions free online and in-person training, coaching and technical assistance, with Indivior and CADCA seeking to increase the availability of medication treatment and to reduce stigma around OUD. "Each coalition had an opportunity to manage the project their way," Wallace said. Indivior did not respond to an inquiry from *ADAW*.

In its "What's Trending?" infographic on MOUD, CADCA cites the clinical benefits of treatment with medications such as methadone, buprenorphine and naltrexone, and lists several potential activities that communities can engage in to encourage their use, such as outreach to faith leaders to develop recovery support groups for individuals receiving MOUD.

In Hunterdon County, coalition leaders seeking to bring MOUD into the community began by conducting a survey to gauge community readiness. "In our survey we found that the community was more ready for it than we thought," said Gabel, who with Cohen also worked with One Voice colleague Peggy Dowd and Prevention Resources' Renata Denlinger on the overall project. "The community was behind it."

Leaders said they did not see their coalitions' activity as straying from the organizations' mission, despite the notion that these groups are mainly prevention-focused not treatment-focused. "Coalitions have a great ability to bring people together on a community-wide issue," Gabel said. "Coalitions can look at where the

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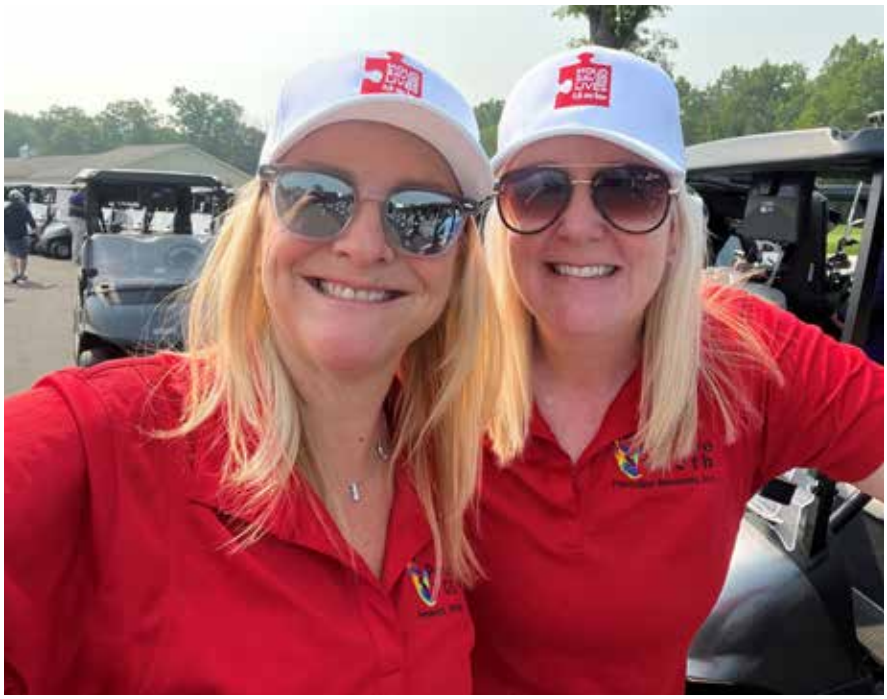

Lesley Gabel is on the left and Erin Cohen is on the right.

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gaps are and change lives in a community."

In their county, Cohen and Gabel said the main philosophical barrier to introducing MOUD wasn't the general public's sentiment, but the notion among some in the recovery community that MOUD simply caused a different type of dependence.

The coalitions' discussions with the health care community alerted leaders that although neighboring Somerset County was experiencing more overdose deaths in total, the smaller Hunterdon County actually has had a higher per-capita overdose death rate. At this time the coalitions were working on a variety of other initiatives to combat overdose, from placing naloxone in locations where automated external defibrillators (AEDs) were installed to using other grant funds to introduce a "RecoverWE" app to help connect individuals with services. But MOUD remained the missing piece.

Cohen and Gabel both said they emphasized in their CADCA forum session that this can be a lengthy and painstaking effort. "We didn't want them to think this was simple to do," Cohen said. "You're going to have roadblocks."

"We are not experts in providing a medication," Gabel said. "We brought in resources. We also were not recommending one medication over another."

They advised conference attendees to try to identify a local champion for MOUD — their version of the physician who stepped up at the Hunterdon Health Care System golf tournament and advanced the conversation.

Gabel gave great credit to former CADCA Vice President of Business Development, Raiko Mendoza, for originally connecting the Hunterdon County organizations to the project. Mendoza died of cancer in February.

Long-term effort

Although the project supported by CADCA and Indivior has officially ended, community leaders in Hunterdon County have said that their effort to build momentum for MOUD will continue. "Our job is only beginning," Gabel said.

While helping to educate the larger community, coalition leaders said they also learned a dose of patience from the medical professionals, who emphasized that they also had to put the proper staff training in place to prepare for the introduction of MOUD. "Our timeline in prevention is, 'We want it now,'" Gabel said. •

Coming up...

The **Rx and Illicit Drug Summit** will be held **April 1-4** in Atlanta. For more information, go to **https://www.hmpglobalevents.com/rx-summit/rates**

The **ASAM annual conference** will be held **April 4-7** in Grapevine, Texas. For more information, go to **https://annualconference.asam.org/**

The inaugural meeting of **The National Conference on Addiction Recovery** and Science will be held virtually **April 24-25**. For more information, go to **https://www.recoveryanswers.org/coarsconference/**

The **annual meeting of the American Psychiatric Association** will be held **May 4-8** in New York City. For more information, go to **https://www.psychiatry.org/psychiatrists/meetings/annual-meeting**

The **2024 AATOD conference** will be held **May 18-22** in Las Vegas. For more information, go to **https://aatod.eventscribe.net/**

The **annual leadership meeting of NAATP** will be held **May 19-21** in Denver. For more information, go to **https://naatpnational2024.eventscribe.net/**

In case you haven't heard...

Being in treatment on buprenorphine or methadone can get you in trouble. Yet another patient in recovery from opioid use disorder has had his treatment used against him. A young man who proudly passed the bar exam and had an employment contract with a law firm was told by Tennessee state authorities that they doubted his ability to practice law because he was taking buprenorphine, a medication that had helped him achieve what he called "normalcy." An excellent write-up aired by NBC News last week described the ordeal of Derek Scott, the first in his family to even go to high school, and then later, after struggling with opioid addiction and other problems, to have achieved recovery and enrolled in college at age 32. Sally Friedman of the Legal Action Center discussed the many violations of the Americans with Disabilities Act this case entails, with legal officials, of all people, in charge. The U.S. Department of Justice has been investigating such cases and is investigating Scott's. Stay tuned. For the story, go to https://www.nbcnews.com/news/us-news/tennessee-lawyer-opioid-addiction-medication-ada-discrimination-rcna126358.

Alcoholism & Drug Abuse Weekly welcomes letters to the editor from its readers on any topic in the addiction field. Letters no longer than 350 words should be submitted to:

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Letters may be edited for space or style.

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