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News for policy and program decision-makers

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In This Issue...

CDC: Dramatic increase in OD deaths from smoking opioids/stimulants

In a *Morbidity and Mortality Weekly Report* (MMWR) released last week, the federal Centers for Disease Control and Prevention (CDC) reported that overdose (OD) deaths from smoking illegally manufactured fentanyls and fentanyl analogs have increased dramatically, from 13.3% to 232.1% from 2020 to 2022. The study, "Routes of drug use among drug overdose deaths — United States, 2020-2022" is by Lauren J. Tanz, ScD, and colleagues at the CDC and the Oak Ridge Institute for Science and Education.

Drug overdose deaths from injection decreased from 22.7% to 16.1% during the same period. Also, the number of deaths with evidence of smoking drugs increased by 109%, and by 2022, smoking drugs was the most commonly documented route of administration by evidence in OD deaths.

There were more than 109,000 drug overdose deaths in the United States in 2022, with almost 70% due to illicit fentanyl, the CDC noted.

Routes of drug administration have implications for overdose

See **Smoking** page 2

Bottom Line...

It's time to retire "safe injection sites" from the lexicon; the majority of drug overdose deaths now are from smoking, not injection.

Current wave of opioid crisis run by fentanyl combinations

The fourth wave of the opioid crisis continues to grow increasingly complex, dominated by "fentanyl plus" combinations of drugs that, in some cases, predictably follow historical patterns, and in others, turn logic on its ear. A leading national researcher on drug-using behavior told *ADAW* that unlike fentanyl's original imposition into the drug supply, many of the combinations that have emerged since then appear to be demand-driven, though the "why" of the demand is often hard to pinpoint.

"My own read is that the majority is being driven by intentional co-use, not by contamination, not that I'm saying contamination doesn't happen," said Daniel Ciccarone, M.D., M.P.H., professor at the University of California, San Francisco (UCSF).

Researchers such as Ciccarone seek to determine the motivations for co-use of fentanyl and another substance; co-use with a stimulant being somewhat more understandable based on mechanisms of action than co-use with xylazine or a benzodiazepine. The way fentanyl infiltrated the drug supply created

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Bottom Line...

Numerous combinations of fentanyl and other drugs complicate communities' drug-fighting response, in part because the sources and motivations for these combined uses often remain unclear.

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risk, infectious disease transmission, other comorbidities and harm reduction services.

How the study was done

For the study, data came from death certificates, post-mortem toxicology testing, and medical examiner or coroner reports that were entered into the CDC's SUDORS (State Unintentional Drug Overdose Reporting System). Scene investigations, witness reports and autopsy data were used to categories deaths into ingestion, injection, smoking, and snorting. Transdermal routes were not included in the study because they are so small.

The CDC looked at regional as well as overall trends, but in general, there was consistency. Smoking-related deaths increased:

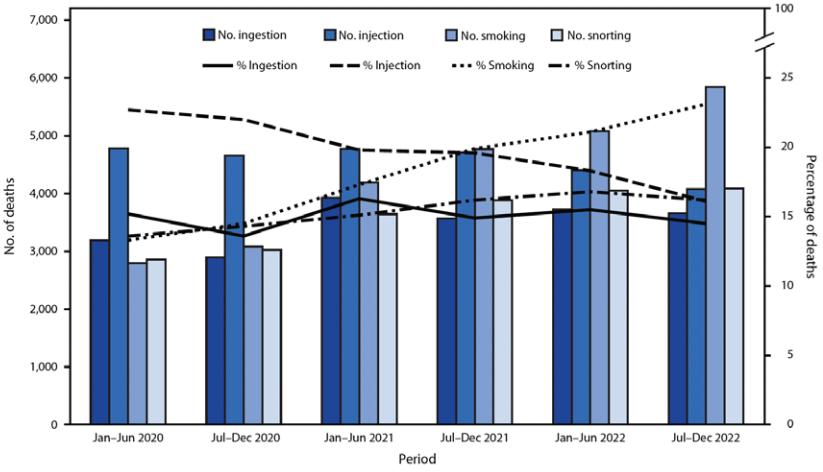
- 91% in the Northeast;
- 75% in the Midwest;
- 48% in the South; and
- 69% in the West.

Evidence of injection decreased:

- 21% in the Northeast
- 36% in the Midwest
- 28% in the South, and
- 34% in the West.

In the period of July 2022 to December 2022, smoking was the most common route of drug administration in overdose deaths in the Midwest (22%) and West (42%); injection and smoking were the most common routes in the Northeast (17% and 17%, respectively) and in the South (19% and 18%, respectively).

Number and percentage of drug overdose deaths with evidence of selected routes of drug use, by 6-month period of death



(N = 139,740) — State Unintentional Drug Overdose Reporting System, 28 jurisdictions, January 2020–December 2022

Source: CDC

The drugs

Overdose deaths with only illicit fentanyl use constituted 9.6% of all deaths. Illicit fentanyl combined with stimulants were detected in 43% of deaths. Stimulants only were detected in 6.2% of all deaths. In 7.8% of deaths, there was no evidence of either stimulants or illicit fentanyl.

The pattern was that smoking was strongly connected with deaths from illicit fentanyl alone, and also connected with the combination of illicit fentanyl and stimulants.

Counterfeit pills frequently contain illicit fentanyl and are often smoked, the report noted.

Why smoking?

Motivations for switching from injection to smoking, according to the report, include:

- Fewer abscesses and other adverse health effects;
- Reduced cost and stigma;
- More control over drug quantity consumed; and
- Perception of reduced OD risk.

There is no logic to the perception of reduced OD risk connected with smoking, when one looks at the data: Smoking illicit fentanyl

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has increased, and so have OD deaths related to the drug and the route of administration.

This would be a helpful message for harm reduction advocates and others who work with drug users to get across. The CDC noted that "compared with ingestion [oral], smoking can intensify drug effects and increase overdose risk." This is due to the rapid drug absorption by this method.

Harm reduction

In the majority of OD deaths (80%) related to smoking drugs, there was no evidence of injection at all. These drug users therefore would not even be likely to use syringe services programs, the researchers wrote. "In response, some jurisdictions have adapted harm reduction services to provide safer smoking supplies or established health hubs to expand reach to persons using drugs through non-injection routes."

The CDC suggests that peer outreach, providing fentanyl test strips, and other harm reduction services should link top health care delivery (emergency rooms, for example) and public safety (such as diversion) settings.

Limitations and recommendations

Study limitations include:

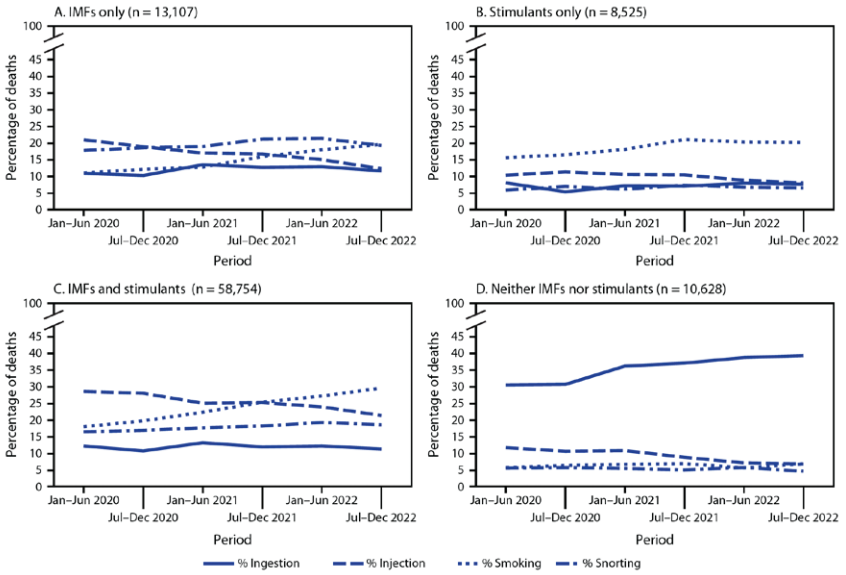
- Only 28 jurisdictions were counted;
- For half of deaths, there was no evidence of route of administration;
- Percentages of non-injection routes are likely to be underestimated because it's easier to identify injection route; and
- Routes could not be linked to a specific drug unless only one drug class was detected.

Still, the study underestimates, if anything, the number and percentage of drug OD deaths tied to smoking.

The authors recommended:

- Expanded messaging emphasizing OD risk associated with smoking and other routes;
- Continued and expanded support for syringe services programs to provide comprehensive, integrated health services; and
- Enhanced outreach and harm reduction services across multiple settings for people using drugs by smoking and other routes. •

Percentage of drug overdose deaths with evidence of selected routes of drug use, by drugs detected, and 6-month period of death — State Unintentional Drug Overdose Reporting System, 28 jurisdictions, January 2020–December 2022



Source: CDC

High MME use by mother linked to increase in preterm births

Women who use prescription opioids for pain during pregnancy are more likely to deliver their babies prematurely, a study by Sarah S. Osmundson, M.D., and colleagues at Vanderbilt University has found. The study, "Prescription Opioid Exposure During Pregnancy and Risk of Spontaneous Preterm Delivery," was published Feb. 5 in *JAMA Network Open*.

There was a continuous link between total opioid exposure during mid-pregnancy and spontaneous preterm birth – a 4% increase in odds for each doubling of morphine milligram equivalent (MME) compared with no opioid exposure.

Common one-time prescriptions are usually in the 150-225 MME range, so that is not as much of a concern as the multiple, higher strength opioids, the researchers wrote. In their study, there were 1,573 pregnancies filled for 900 MMEs or greater; these were associated with 21% increased odds for spontaneous preterm birth.

However, the researchers do not encourage any opioid use during pregnancy. "We also caution against the conclusion that lower doses especially those below 100 MME are safe; the confidence bands over the low-dose range still include odds ratios that are consistent with meaningful harm," they wrote. "More research would be required to determine confidently that lower dose

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opioid prescribing is not associated significantly with spontaneous preterm birth."

The study only looked at prescription opioids for pain – not at methadone or buprenorphine, which are used for opioid use disorder. It is known that abrupt withdrawal from any opioid, if there is dependence, is bad for the fetus.

Causal or confounders

However, opioids do cross the placenta, and could be linked to fetal growth restriction, abruption and hypertensive disorders of pregnancy, researchers have found.

"An association with preterm birth has been reported among those studies; however, it remains uncertain whether this association is causal or related to confounding exposures," the Vanderbilt University researchers wrote. Tobacco use is common among patients who used opioids and is also associated with preterm birth. Yet, accurately measuring tobacco use during pregnancy using claims data can be challenging. In a population-based study from Ontario limited to patients without opioid use disorder, the authors found that the association between opioid use and preterm birth was attenuated, but not eliminated, by addressing multiple potential sources of confounding. They also found that increasing cumulative opioid dose, as estimated by the number of days supplied in pregnancy, was associated with an increased risk of preterm birth. Other investigators have questioned whether this observed association could be due to the conditions leading to opioid use (ie, pain) rather than opioids themselves.

This is the first study that directly addresses whether prenatal prescription opioid exposure is associated with spontaneous labor, the researchers wrote, adding that "our finding of a continuous association with opioid dose as measured by opioid MME and spontaneous preterm birth suggests a dose-response relationship."

Their study is a nested case-control study, so it cannot prove this association, the researchers wrote; however, "it does bolster the hypothesis of a causal relationship between opioid exposure and spontaneous preterm birth," they added. "We did not identify a statistically significant association between specific opioids and spontaneous preterm birth after accounting for opioid MME, suggesting that MME dose impacts spontaneous preterm birth more than opioid type.

Below are the drugs and dosages studied (MME, fills, number of pills)

- 50 (one fill hydrocodone 5mg, 10 tablets);
- 150 (one fill hydrocodone 5mg, 30 tablets);
- 225 (one fill oxycodone 5mg, 30 tablet);
- 300 (two fills hydrocodone 5mg, 30 tablets);
- 450 (one fill oxycodone 10mg, 30 tablet);
- 550 (two fills oxycodone 5mg, 30 tablets); and
- 900 (two fills oxycodone 10mg, 30 tablets).

Other opioids included hydrocodeine, fentanyl, hydromorphine, meperidine, morphine, nalbuphine, oxymorphine, propoxyphene, tramadol and butorphanol.

Characteristics of Case Patients and Matched Control Patients

Characteristics	Patients, No. (%) Case (n = 25 391)	Brand Name(s) Control (n = 225 696)
Maternal age, median (IQR), y	23 (20-28)	23 (20-27)
Nulliparity		
Yes	8909 (35.3)	87 678 (39.0)
No	16 333 (64.3)	137 367 (60.9)
Missing	149 (0.6)	651 (0.3)
Previous preterm birth	2690 (10.6)	9162 (4.1)b
High school education or less	17 597 (69.6)	145 573 (64.7)
Missing	90 (0.4)	566 (0.3)
Prepregnancy BMI, median (IQR)	24 (21-30)	26 (22-31)
Missing	583 (2.3)	4655 (2.1)
Race and ethnicity		
African American or Black	9820 (38.7))	89 819 (39.8)
Asian	127 (0.5)	229 (0.1)
Hispanic or Latinx	664 (2.6)	3590 (1.6)
Non-Hispanic White	14 748 (58.1)	132 002 (58.5)
Not categorized	32 (<0.1)	56 (<0.1)
Depression	1639 (6.5)	9044 (4.0)
Chronic hypertension	714 (2.8)	5116 (2.3)
Preexisting diabetes	478 (1.9)	2186 (1.0)
Pain conditions	4801 (18.9)	30 529 (13.5)
Abdominal	4503 (17.7)	29 158 (12.9)
Myalgia	161 (0.6)	1073 (0.5)
Dental	1 (<0.1)	21 (<0.1)
Trauma and accidents	56 (0.2)	456 (0.2)
Sickle cell disease	50 (0.2)	121 (0.1)
Malignant neoplasm	1 (<0.1)	0
Kidney stones	60 (0.2)	153 (0.1)
Inflammatory arthritis	33 (0.1)	66 (<0.1)
Colitis	46 (0.2)	118 (0.1)
Chronic pain	68 (0.3)	265 (0.1)
Acute pain	56 (0.2)	442 (0.2)

Source: JAMA Network Open

Strengths of study

Because detailed prescription data was available, the researchers were able to precisely quantify the amount of opioid dispensed during specific time periods, they wrote. "While we did not define exposures by trimester as has been done in other studies, our study design ensured that all patients had exposures assessed during the same gestational age window during pregnancy minimizing the effect of pregnancy development and exposure timing on the outcome. We also enriched our data, using detailed information from birth certificates, including smoking, maternal weight, and other covariates that are often difficult to ascertain using other data sources. We limited our population to patients without opioid use disorder to reduce confounding and we also adjusted for multiple conditions related to pain to mitigate the impact of confounding by indication."

"Our findings support guidance to prescribe the lowest dose necessary to manage pain."

Limitations

Still, the researchers could only describe how many opioids were dispensed to patients, not how much patients actually used. They also had no data on nonprescription analgesics used in pregnancy. "Although opioid use may be triggered by early initiation of labor and introduce potential protopathic concerns, our planned sensitivity analyses demonstrated that our findings were not affected by that potential phenomenon. We also acknowledge that we only examined births occurring at 24 weeks or greater, which limits our understanding of first trimester exposures and early pregnancy loss. In addition, our observations come from individuals enrolled in a Medicaid program, and our findings may not be generalizable to our populations or settings. Finally, we implemented a matched case-control study design in order to align the gestational age of exposure assessment for all comparisons, but residual confounding remains a concern. A case-control design requires that we report measures of association as an odds ratio (OR) rather than relative risk, which is known to inflate the degree of association."

The summary, however — a positive association between total prescription opioid MME dose exposure and the odds of spontaneous preterm birth — was clear. "Our findings support guidance to prescribe the lowest dose necessary to manage pain," the researchers concluded. •

NIDA on dramatic increase of mushroom seizures

From 2017 – 2022, law enforcement seizures across the United States of mushrooms containing psilocybin increased dramatically, according to a new study funded by the National Institute on Drug Abuse (NIDA). The number of law enforcement seizures increased from 402 seizures in 2017 to 1,396 in 2022. In addition, the total weight of psilocybin mushrooms seized by law enforcement increased from 226 kg (498 lbs.) seized in 2017 compared with 844 kg (1,861 lbs.) in 2022. This analysis, published in *Drug and Alcohol Dependence*, was led by researchers at New York University (NYU) Langone Health in New York City, and the University of Florida, Gainesville. The data used for the analysis were collected through the High Intensity Drug Trafficking Areas (HIDTA) program, a grant program aimed at reducing drug trafficking and misuse administered by the Office of National Drug Control Policy. Though law enforcement seizures do not necessarily reflect prevalence of use, they represent an indicator of the availability of illicit drugs. "We are in the middle of a rapidly evolving cultural, media, and legal landscape when it comes to psychedelics, and we need data to help shape informed and appropriate public health strategies," said NIDA Director Nora D. Volkow, M.D., in announcing the research publication last week. "Moving forward, we must continue to track data on the availability of psychedelics, patterns in use, and associated health effects to guide efforts in promoting accurate education and reducing potential harms among people who do plan to use psychedelic drugs." Adverse effects of psilocybin mushrooms, such as "bad trips," are marked by "distorted thinking, perceptual changes, putting oneself in physical danger, and intense feelings of fear, anxiety, and confusion," according to NIDA. "People who take psychedelic drugs like psilocybin may also experience short-term side effects such as raised blood pressure and heart rate, agitation, confusion, vomiting, or nausea, which may be severe and require medical attention." Joseph J. Palamar, Ph.D., M.P.H., associate professor at the NYU Grossman School of Medicine, co-investigator on the NIDA-funded National Drug Early Warning System (NDEWS), and lead author on the paper, said "Research studies suggesting its effectiveness in treating mental health issues and extensive positive media coverage may lead some people to seek 'shrooms' outside of medical contexts. People who use psilocybin outside of medical supervision need to be educated about risks associated with use." •

Federal grant opportunities in prevention, recovery

Below are two recent grant announcements from the federal government.

Prevention

The Centers for Disease Control and Prevention (CDC) recently announced a new funding opportunity for the fiscal year (FY) 2024 Drug-Free Communities (DFC) Support Program - NEW (Year 1). The DFC Support Program is designed to strengthen collaboration among community coalitions working to prevent youth substance use and build safe, healthy, and drug-free communities. In statute, the DFC Support Program has two primary goals:

- Establish and strengthen collaboration among communities, public and private non-profit agencies, as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance abuse among youth (individuals 18 years of age and younger).
- Reduce substance abuse among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse.

CDC will provide up to 100 awards of up to $125,000 per award, per year for up to 10 years for total program funding of $62,500,000. Applications are due April 17, 2024.

Additional details on eligibility and how to apply can be found here.

The DFC Support Program Notice of Funding Opportunity (NOFO) can be found under "Related Documents," here.

Recovery

SAMHSA announced the "Building Communities of Recovery" grant program last week.

The purpose of this program is to mobilize and connect a broad array of community-based resources to increase the availability and quality of long-term recovery support for persons with substance use disorders (SUD) and co-occurring substance use and mental disorders (COD). Recipients will be expected to support the development, enhancement, expansion, and delivery of recovery support services (RSS) directly to individuals as well as advance the promotion of, and education about, recovery at a community level.

Eligibility is limited to Recovery Community Organizations (RCOs), defined as independent, non-profit organizations wholly or principally governed by people in recovery from substance use disorders and/or co-occurring substance use and mental disorders who reflect the community being served.

- Anticipated Total Available Funding: $6,000,000
- Anticipated Number of Awards: 20
- Anticipated Award Amount: Up to $300,000 per year
- Length of Project: Up to 3 years
- Cost Sharing/Match Required?: Yes

Proposed budgets cannot exceed $300,000 in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award. •

For more information, go to https://www.samhsa.gov/grants/grant-announcements/ti-24-003

NIAAA reports primary care checkups "plus" SBIRT works

As the name suggests, screening, brief intervention, and referral to treatment (SBIRT) for alcohol can both identify people who are at risk for, or who have alcohol-related problems, and for those who need treatment, provide connections, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) reported last week. But more is needed, and a recent study showed that primary care follow-ups and checkups can work for alcohol use disorder (AUD).

Alcohol misuse is commonly seen—although maybe not consciously—in primary care, recent studies have shown. This is what happens: patients are screened, but there is no brief intervention for problematic drinking and certainly no referral to treatment for AUD, according to NIAAA. Even for those who do receive treatment, sustaining recovery and preventing relapse are still major concerns.

A new study funded by NIAAA and published in the journal *Alcohol: Clinical and Experimental Research*, reported that combining SBIRT with recovery management in primary care settings increases the likelihood that patients receive treatment for alcohol and other substance use disorders (SUD) and reduces substance use over a 12-month period. In the study, researchers with Chestnut Health Systems' Lighthouse Institute conducted a randomized controlled trial to evaluate the effectiveness of SBIRT plus recovery management checkups for primary care compared with SBIRT only.

"The recovery management checkups (RMC) intervention directly links patients to treatment, ensures they engage in treatment, and promotes recovery through regular checkups and early interventions that detect relapse early

and reduce the time to re-entry of treatment," NIAAA noted. "A previous pilot study examining the efficacy of RMC for patients who had received SBIRT in primary care demonstrated higher rates of SUD treatment entry and more days of receiving treatment compared to SBIRT only."

In the Chestnut study, researchers followed 266 participants at four primary care sites (federally qualified health centers) to evaluate treatment and substance use outcomes over a 12-month period.

Participants in the SBIRT plus recovery management checkups for primary care (RMC-PC) group received quarterly checkups, and participants in both the SBIRT plus RMC-PC and the SBIRT-only groups were assessed quarterly.

The findings showed that participants who engaged in the combined approach were nearly four times more likely to start treatment for AUD and other SUDs and achieve sustained recovery.

In addition, participants who received SBIRT plus RMC-PC reported a significant increase in the number of days that they received treatment during the year.

Participants in the SBIRT plus RMC-PC also reported a decrease in the number of days that they used alcohol or cannabis as well as an increase in the number of days that they abstained from alcohol and other substances.

"The study findings reinforce the critical role of primary care in identifying and intervening with alcohol and other substance-related problems, and in providing continuous support to improve treatment and recovery outcomes," according to NIAAA.

SBIRT was a federally funded concept from more than a decade ago, and from the beginning, the "RT" part of the equation was left out; even the "BI" was ignored. All they did was screening. Maybe that will change. •

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a lasting narrative around contamination and unintentional use, but today's reality is more nuanced, Ciccarone said.

Assessing the combinations

Ciccarone, the Justine Miner Endowed Professor of Addiction Medicine in UCSF's Department of Family and Community Medicine, discussed several of the most prominent "fentanyl plus" trends that have emerged. News of overdose deaths in which both fentanyl and cocaine are present has become commonplace at this point, though toxicology reports cannot discern whether these drugs were in the same substance used or in separate substances, with the latter suggesting intentional co-use.

Co-use of fentanyl and methamphetamine was somewhat more surprising when it gained prominence, Ciccarone said, because methamphetamine generally overpowers any other drug with which it might be used. That's not the case with fentanyl, with theories on co-use ranging from methamphetamine boosting fentanyl's effects to methamphetamine allowing users to skip a dose of fentanyl and get things done in the short term while on meth, he said.

Ciccarone offered several examples of potential contributing factors to the combination phenomenon.

Co-use of xylazine and fentanyl has become an issue of great concern, prompting federal officials last summer to launch a coordinated response effort after having called the combination an emerging drug threat earlier in the year (see "ONDCP calls for all-government response to xylazine-fentanyl," *ADAW*, July 17, 2023; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33837). Ciccarone said the evidence suggests that xylazine is being used almost exclusively in combination with fentanyl.

He admited to wavering a bit on why he thinks this co-use is happening. It would not seem to make sense that users would want to take these two "downers" together, he said. However, it became apparent during recent research he conducted in Philadelphia that there was indeed a component of choice here, as users could easily cross the state border into Camden, New Jersey, to get fentanyl without xylazine but were choosing not to. "I sometimes like to fight that notion that they are simply victims and say that people still have agency," Ciccarone said.

In Canada, he said, there have been recent reports of co-use of fentanyl with benzodiazepines and fentanyl with caffeine, the former being harder to explain. "Caffeine has always been a component of the opioid supply," Ciccarone said, with theories that it made smokable forms of heroin more usable and that it takes the edge off the drowsiness that opioids cause.

Ciccarone offered several examples of potential contributing factors to the "fentanyl plus" phenomenon. As tolerance grows, is fentanyl no longer producing the effect it once did and a second drug is being used to counteract that? This would constitute the standard explanation, but other factors also could be at work.

There is a paradox in that fentanyl has become desired among some drug users but is not

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necessarily a likable drug, Ciccarone said, so some users become fascinated with the next trend to emerge (as with xylazine). "Or it could be a self-preservation issue," given the dangers of fentanyl, he said. "If they're taking something else, they're consuming less fentanyl." In research, "Some meth users said this. They feel that they're 'high enough' and don't need fentanyl," he said.

Ciccarone said he often finds himself at odds with conventional wisdom about features of the drug supply. He said he and members of San Diego's harm reduction community have had to agree to disagree about the methamphetamine supply (they have said that all of the meth out there has fentanyl in it; Ciccarone has said that's not the case).

Treatment, harm reduction

Ciccarone also reflected on the status of two other topics that *ADAW* has discussed in detail with him over the years: the dearth of widely used treatments for stimulant addiction and the current standing of harm reduction in the continuum of care (see "Latest iteration of the opioid crisis may be the toughest yet to combat," *ADAW*, June 7, 2021; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33087).

There is not much new to pin hopes on in terms of medication treatment discoveries for stimulant use disorder, he said. A recently issued guideline from the American Society of Addiction Medicine, for which Ciccarone served on an expert panel, suggests that the field needs to make better use of the unapproved but available medications already out there.

However, research-based contingency management (CM) strategies for treatment of stimulant addiction remain severely underutilized, Ciccarone said. "If CM were a drug, it would be approved by now," he said. "It's that good."

Ciccarone suggested that a creative use of opioid settlement dollars would involve building on contingency management approaches in substance use treatment.

As for harm reduction, Ciccarone said he sees it being "increasingly maligned," and unfairly so. Observers see more prominent harm reduction approaches in communities, then look at the latest numbers showing a rise in overdose deaths and adopt "the false notion that harm reduction is causing it," he said. "This is not data driven."

He said he believes nothing else that is done along the continuum of support engages the typical drug user more than harm reduction. That's why he would like to see more coordinated efforts between harm reduction and treatment — something that both camps bear some blame for not nurturing. Ciccarone said examples of such cooperation are much more easily found in Europe, where as a result harm reductionists are not as embattled as they are in the U.S. •

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/**

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In case you haven't heard...

ADAW asked representatives of the press offices of the Substance Abuse and Mental Health Services Administration and its parent agency, the Department of Health and Human Services, to respond to our question: Why did they weaken the privacy and not strengthen the anti-discrimination provisions of 42 CFR Part 2 in their final rule issued last month? Congress required this to be done in the 2020 CARES Act. Neither office responded to our question. *ADAW* asked again this week, as promised. Still no response. We will continue to push for an answer. This time, we're also asking what they're going to do about it. Patients lose confidentiality for the rest of their lives with the first consent to release substance use disorder treatment information. And it can go to anyone, anywhere, anytime if they do consent. It's not only patients who don't like this; treatment providers don't either, because patients aren't going to want to go to treatment if this will happen. Still no response.