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

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Our lead stories this week look at a demand by Congress that SAMHSA account for financing on Office of Recovery, and at how one SSP is engaging patients in buprenorphine treatment.
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Congress scrutinizes SAMHSA on Office of Recovery, SMI, 988

On April 4, the House Committee on Energy and Commerce sent a letter, a copy of which was obtained by *ADAW*, to Miriam E. Delphin-Rittmon, Ph.D., director of the Substance Abuse and Mental Health Services Administration (SAMHSA), seeking "a full accounting … for the influx of funds provided through COVID-19 supplemental relief, and more particularly, details on SAMHSA's performance in launching the 988 suicide prevention hotline, the extent of SAMHSA's support for providing clinical treatment for patients with serious mental illness, and SAMHSA's Office of Recovery." The Office of Recovery includes recovery from SUD (substance use disorder) and mental illness (https://onlinelibrary.wiley.com/doi/10.1002/adaw.33460).

Bottom Line...
The House Energy and Commerce Committee this month sent SAMHSA a letter demanding a response to questions about the Office of Recovery.

"They promised oversight — this is it," said one insider. And indeed, the scrutiny is political, with the now Republican-controlled House of Representatives choosing to pick on agencies under a Democratic administration. On the other hand, there are serious policy questions which may come up about funding.

What the letter focuses on is part of the funding that was freed up under COVID-19 for some of SAMHSA's programs. Many of the programs

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Harm reduction approach at Miami SSP engages users in medication treatment

Results of a new study suggest that a sufficiently resourced syringe services program (SSP) could become an ideal venue for improving buprenorphine initiation and retention in patients with opioid use disorder (OUD). Researchers for the study's pilot program at a Miami-based SSP credit the removal of common barriers to care for the successes of the initiative's harm reduction-focused approach.

Bottom Line...
A syringe services program's intervention heavy on peer and patient input resulted in buprenorphine treatment retention rates comparable to those for office-based medication treatment services.

Published online March 1 in the *Annals of Medicine*, the study of the pilot effort at the IDEA Miami SSP reported a 58.7% rate of retention on buprenorphine treatment at three months, a rate comparable to that of office-based buprenorphine programs. The investigators found that seeing a provider via telehealth and receiving an escalating dose of buprenorphine post-baseline were both associated with higher odds of three-month retention.

Under the "tele-harm reduction" (THR) approach tested in the pilot,

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are in the mental health arena, but one — for the Office of Recovery — focuses on substance use. Specifically: SAMHSA's budget authority in FY 2021 was $5.8 billion, but SAMHSA received more than $7.8 billion through the COVID-19 supplemental funds.

Here are specific questions that the committee wants answered. SAMHSA is directed to respond by April 18. (*ADAW* did not publish an issue on April 10 due to the holiday break, so we could not write about this until now.)

1. How much funding was provided to SAMHSA from COVID-19 supplemental funding? What accomplishments would SAMHSA attribute strictly because of the supplemental funding?
2. How much of this supplemental funding has been obligated?
3. How much of this supplemental funding has been expended? What was the supplemental funding spent on?
4. How much of this supplemental funding was provided to the states? Please provide information for each state to include dollar amounts of funding on a state-by-state basis.
5. Provide information about how SAMHSA tracks state expenditures of SAMHSA funds. What did the states spend the supplemental funding on?
6. In April 2022, SAMHSA awarded nearly $105 million in grants to states and territories for the transition to 988 and to support call centers. In addition, in December 2021, SAMHSA announced $177 million to support strengthening and expanding the National Suicide Prevention Lifeline network operations and infrastructure. Notwithstanding this total of $282 million funding for 988 during the last fiscal year, the nationwide suicide hotline crashed late last year.
   - 6a. Regarding 988, why did SAMHSA seek an increase in funding to further expand 988 after having spent $105 million to expand 988 in December 2021?
   - 6b. Why was there a 988 outage after all of the financial support?
7. Given the intensity of SAMHSA's focus on implementing 988, we are concerned about the adequacy of SAMHSA's efforts to provide support for clinical treatment to patients with serious mental illness (SMI). How much money has SAMHSA invested in clinical treatments to patients with SMI?
8. What progress in providing clinical treatments to patients with SMI was made with these investments?
9. We note that in September 2021, SAMHSA launched the Office of Recovery. It is unclear to us what the underlying authority was for establishing this office. What authority was used by SAMHSA to launch the Office of Recovery?
10. What funds are used to support the Office of Recovery? What were the sources of the funding and how much funding was contributed from each source?
11. What staff are involved in the Office of Recovery? Please indicate which SAMHSA offices were the sources of the staff, and the number of staff from each SAMHSA office transferred to the Office of Recovery.
    - 11a. Have staff (both permanent and detailed staff)/programs from the authorized Centers been transitioned to this Office? How many total staff were transitioned to the Office of Recovery? How many permanent staff were transitioned to the Office of Recovery? What SAMHSA offices had reductions in staff and what were the reductions because of transitioned staff to the Office of Recovery? What SAMHSA programs

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or resources were transitioned to the Office of Recovery? Please identify the sources of staffing and funding for the Office of Recovery that were not the result of SAMHSA or programs being transitioned?

About the Office of Recovery

Last fall, SAMHSA announced that Dona Dmitrovic, M.H.S., would be director of the Office of Recovery, launched less than a year ago (https://onlinelibrary.wiley.com/doi/10.1002/adaw.33460). The Office of Recovery provides no grants or funding of any kind, Dmitrovic told *ADAW*, adding that she hopes states will pick up on this role.

Among her previous roles, Dmitrovic was director of the national office of consumer affairs for Optum Behavioral Health, part of United Healthcare.

Last fall, Dmitrovic told *ADAW* that the Office of Recovery would focus on the role of "peers" and on the continued push for SAMHSA's definition of recovery, which hasn't changed since 2010 (https://onlinelibrary.wiley.com/doi/epdf/10.1002/adaw.20252). That definition is:

> *"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."*

In 2012, however, SAMHSA changed the definition of recovery to include abstinence (https://onlinelibrary.wiley.com/doi/epdf/10.1002/adaw.20324). That inclusion has quietly disappeared since, and the old definition has come back.

"Back in 2010, SAMHSA brought stakeholders together and came to a consensus" about the definition of recovery, Dmitrovic told *ADAW* last year. "That's the definition that has been used over the years, by many states and communities."

"The recovery-oriented system of care includes prevention, intervention, treatment and recovery for people who have an SUD," said Dmitrovic. "Now we're looking at inclusion of mental illness as well as mental health promotion."

Many in the SUD field take a dim view of diluting "recovery," which had been focused on SUDs, with mental illness recovery, and even mental health promotion. Everyone uses the word. It would be nice to know what SAMHSA's Office of Recovery says it is.

Here is a link to SAMHSA's Office of Recovery page. https://www.samhsa.gov/find-help/recovery.

Stay tuned for SAMHSA responses to the letter. *ADAW* asked the SAMHSA press office for a response, and received an acknowledgement of our question, but not an answer by press time. •

ONDCP at Rx Summit: Hydrazine an emerging health threat

This year's Rx and Illicit Drug Summit drew 4,000 participants to the Georgia World Congress Center in Atlanta last week; there were 100 exhibitors, and the pparticipants included ounselors, social workers, therapists, psychologists, and interventionists; physicians, psychiatrists, nurses, pharmacists, and dentists; advocates, families, and people in recovery; law enforcement and other first responders; state and federal lawmakers; and public health and prevention professionals. *ADAW* was able to pick up many new stories and meet with old friends and colleagues. The conference was also the setting for an announcement about a new emerging threat — fentanyl combined with xylazine (https://onlinelibrary.wiley.com/doi/10.1002/adaw.33205).

At the conference, Rahul Gupta, M.D., director of the Office of National Drug Control Policy (ONDCP) discussed his April 12 announcement officially designating "fentanyl adulterated or associated with xylazine as an emerging threat to the United States." Xylazine is not an opioid; it is a veterinary tranquilizer that can make fentanyl cheaper to make and extend its effects. It also causes terrible wounds.

"As a physician, I am deeply troubled about the devastating impact of the fentanyl-xylazine combination, and as President Biden's drug policy advisor, I am immensely concerned about what this threat means for the nation," said Gupta. "By declaring xylazine combined with fentanyl as an emerging threat, we are being proactive in our approach to save lives and creating new tools for public health and public safety officials and communities."

According to the Drug Enforcement Administration (DEA), the rapid increase in negative health outcomes and geographic distribution meet the emerging threats criteria used by ONDCP.

Here are some facts about hydrazine:

- Between 2020 and 2021, forensic laboratory identifications of xylazine rose in all four U.S. census regions, most notably in the South (193%) and the West (112%).
- Xylazine-positive overdose deaths increased by 1,127% in the South, 750% in the West, more than 500% in the Midwest, and more than 100% in the Northeast.

"Xylazine is not safe for human consumption," Gupta said at the April 12 plenary session. It has produced some of the "worst flesh wounds I have ever seen, some requiring amputation." This week, a plan will be published by ONDCP involving a plan to deal with xylazine. This plan will focus on:

- Testing: Improving a point-of-care xylazine test;
- Data: Finding out where xylazine is being used;
- Treatment: Bringing together experts for treatment;
- Supply routes and methods: Helping law enforcement;

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- Scheduling: Working with Congress to develop scheduling plans; and
- Pharmacology: Working on an antidote.

Gupta noted that President Biden has called on the nation to expand access to treatment for opioid use disorder (OUD) in his State of the Union last year.

Thanks to eliminating the X-waiver for buprenorphine, the country would go from about 129,000 prescribers to about 2 million, said Gupta. (Whether this will happen is unclear.)

Another plus cited by Gupta: The federal Food and Drug Administration's approval of naloxone (Narcan) for over-the-counter access, which should be on the shelves later this summer, he said.

New telehealth rules will also make it possible for more people to access treatment, he said.

Improving treatment for people in prison also is encouraged, said Gupta, who met with an inmate who had been abusing Percocet for many years, but wasn't diagnosed until the day he entered jail just over a year ago. He was screened by officials at the Camden County Correctional Facility in Camden, New Jersey, and immediately given treatment. Gupta congratulated the Warden, Karen Taylor, who was present in the audience and received applause.

He also thanked DFC (Drug-Free Communities) coalitions for helping to prevent youth substance abuse.

Law enforcement

Gupta said he thinks of addiction as a "heads and tails" strategy: "Heads, because addiction is a disease of the brain, and tails, because drug traffickers need to watch theirs." The audience applauded, as they did when he said later that "drug addicts need treatment, traffickers need justice."

In terms of drug traffickers, "We're going after them," said Gupta, including going after the financial methods that keep them operating. Thanks to the work of the federal High Intensity Drug Trafficking Areas (HIDTA) program, traffickers are "on notice."

ONDCP is convening an interagency working group to inform the development of the national response plan. The response will include work on xylazine testing, treatment and supportive care protocols, comprehensive data systems (including information on drug sourcing and supply), strategies to reduce illicit supply of xylazine, and rapid research (such as work on the interactions between xylazine and fentanyl).

The only complaint about the *conference ADAW* heard was, as always, there was too much information, too many great sessions going on at the same time. For more information on HMP meetings focused on addiction, go to https://symposiaonaddictivedisorders.com/. •

OUD treatment providers criticize DEA telehealth proposal

It sounded reasonable to many — patients can be started on buprenorphine without seeing a physician first, but must see that physician within 30 days. "Aren't people supposed to see their doctors anymore?" one Washington insider asked *ADAW*. That was what the Drug Enforcement Administration (DEA) proposed last month (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33712). This is a diversion from what providers got used to during the public health emergency of COVID-19, when telehealth rules were lenient, mainly in order to prevent transmission of the virus. Now, those leniencies are being viewed as having an additional benefit: To make it easier for patients to get treatment for opioid use disorder (OUD) and offer a chance to reduce overdoses and deaths.

However, the public health emergency, and with it the exemptions for both buprenorphine and methadone, end next month. And treatment providers are chafing at the DEA's proposal, saying that it will limit access to treatment. *ADAW* talked to one last week, surprised, as were many, that doctors don't want to see their patients.

What we learned is that under the current system, doctors do indeed make sure their patients are seen, just not necessarily by them. There aren't enough prescribers, especially in rural areas, and there aren't enough doctors. Even without the X-waiver requirement, which was abolished in December (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33651), there are barriers to buprenorphine prescribing — and not all pharmacies want to dispense it.

"So you can just call a doctor and say you need buprenorphine, get it called in to a pharmacy, and pick it up? For 28 days? Sight unseen? Refills too?" The answer is no to that simplistic question — although it might actually be possible. But it's not the way clinicians are practicing.

Steve Straubing, M.D., medical director of the opioid treatment program (OTP) at Meridian Behavioral Healthcare in Gainesville, Florida, told us how his practice works.

Initially, even if a patient is seen in person, the prescription is rarely for 28 days, said Straubing "One to two weeks is standard in our practice." Refills — even if a patient is seen in person — are never given, he said. Even though, legally, refills would be allowed, because buprenorphine is Schedule III, Meridian doesn't do it, he said.

Middle of the road

Straubing may represent a middle of the road, between those who want over-the-counter buprenorphine ("I'm not in favor of that, of course," he said), and those who want the old rules. "You might say

that our standard may be the reason that some say access is too onerous," he said.

"I'm really concerned about the telehealth ruling if it affects buprenorphine," said Straubing, a devoted clinician who normally is not politically active. "Ideally a patient will see a doctor in person, but there are rural communities here and elsewhere which are not ideal. If all of those people have to go to the doctor after 30 days, a lot will just not go and head to the streets."

Here's what happens now at Meridian, which is located in a rural area of Florida where there are outlying clinics. Under the public health emergency:

The new patient goes to an outlying office, has a urine drug screen, and a counselor conducts an extensive biopsychosocial evaluation. Then the patient is seen via video link by the provider (prescriber), where a history is taken, the patient is counseled, informed about medications (methadone and buprenorphine), and, if appropriate, prescribed buprenorphine. The starting dose is dependent on multiple factors, said Straubing, so it varies.

The prescription is sent to the pharmacy electronically. "Some patients are on a grant which pays for MAT (medication-assisted treatment)," said Straubing. Others have insurance, and some pay out of pocket.

"Our dosing has been consistent, averaging 16-20 mg, with many patients on 24 mg," said Straubing. "I have only one patient on 32 mg for concurrent chronic pain, but it was a bureaucratic nightmare to get a pharmacy to dispense at that dose. I had to show them articles supporting supra 24 mg dosing for pain."

"The only difference between the video visit and a face-to-face is that the patient isn't physically present in your office," said Straubing.

He noted that the urine drug screen is not a legal or regulatory requirement, but that Meridian does it to help avoid diversion and show compliance.

Visit frequency is based on demonstrated stability and compliance, he said. Refills are prescribed based on those as well.

Back to the DEA proposal. There are still questions about whether the proposed rule would allow a patient to go in person to an outlying office of a health care chain, where there is no physician present, but speak to a physician at a larger facility via telehealth, as is done at Meridian.

Finally, Straubing and many other providers of methadone maintenance treatment have noted that an increasing number of patients turn to methadone as their first choice, especially if they use illicit fentanyl. "I think that some of them choose methadone because they have experienced precipitated withdrawal before when they have used buprenorphine in the face of fentanyl — even up to a week after the last use."

Straubing cited the case report in *JAMA* on a patient who used naloxone at home under telehealth supervision and started buprenorphine an hour later (*ADAW* covered this in https://onlinelibrary.wiley.com/doi/10.1002/adaw.33605).

But other patients have been in treatment with buprenorphine and "just haven't felt it suppressed their cravings adequately." •

EXCLUSIVE

Beloved Rob Kent leaves ONDCP for private consulting

Rob Kent, formerly general counsel of New York's Office of Addiction Services and Supports (OASAS), and since 2021 general counsel of the Office of National Drug Control Policy (ONDCP) has left the federal office as of April 14 for private practice, *ADAW* has learned. We talked to him in Atlanta last week, and as always, he was confident and articulate about the way to move forward. "I want to focus on providers," he said. Since going to ONDCP, he has regularly heard from addiction treatment providers across the country about how to handle various issues. He's a lawyer and knows the field from a legal perspective better than anyone.

One of the issues is how to use the federal opioid settlement funds. These funds go to the states, and then to municipalities, but what about providers? "I also know that providers are left to rely on their state regulators for legal advice and I want to fill that role."

ADAW asked Kent why he decided to leave ONDCP. "I'm leaving because we've laid the foundation to make fundamental changes in how we treat addiction" on a federal level, he said. "But work needs to happen on the state level. I hear frequently from providers that things aren't happening in their state. I bring a unique perspective. I bring a law license. I know the laws; I know the regulations and I know how to solve problems."

And he doesn't want to see all the work that has been done at ONDCP under Rahul Gupta, M.D., to be for naught. There has to be a way that states can be required to help providers treat patients well. Kent has always been concerned about patients first — drug users, also, even if they are not patients.

Kent already has work lined up. His new company is called "Kent Strategic Advisors."

NIDA and NIAAA call for information on use of 'preaddiction'

The lead federal agencies on substance use disorder (SUD) research are calling for input on how to identify and intervene in the mild or early stages of the disease. Last month, the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) issued a request for information (RFI) inviting feedback on the use of a term like "preaddiction."

From the RFI:

Recently, the term "preaddiction" has been proposed as a way to: raise public awareness about potentially harmful patterns of substance use; spur greater utilization of screening and brief intervention in clinical settings; prevent overdose; and promote the development of new interventions for potentially clinically significant substance misuse and/or early-stage SUD. Although not always clinically well-defined, "addiction" to drugs or alcohol is well understood by the public as a serious yet preventable condition. In this context, addiction is like other serious health conditions for which behavioral factors are understood to play a role and for which early screening or intervention may prevent adverse health outcomes. Since substance misuse is easier to modify through voluntary behavioral change or brief interventions before it progresses to addiction, this window is a promising target for early intervention if both patients and clinicians can be made aware of the potential health and safety implications of substance misuse. Conversely, applying a term like "preaddiction" to clinically significant substance misuse and/or early-stage SUD could have unintended negative consequences, such as further stigmatizing people who use substances. Thus, information is needed to ascertain the benefits and potential drawbacks of adopting a term like "preaddiction" when used for screening in healthcare settings.

Information Requested:

This RFI seeks input from people with lived experience of substance use, medical and scientific research communities, and other interested parties regarding the use of a term like "preaddiction" for identifying and intervening in potentially clinically significant substance misuse and/or early-stage SUD within health care settings. Input is sought both on the terminology to describe this concept and the concept itself. For simplicity, the concept is referred to as "preaddiction," though input on the use of that specific term and its potential resonance with diverse patient populations is sought.

The NIH seeks comments on any of the following topics:

- How and whether to define preaddiction (or a similar term) across different classes of substances and across different age groups;
- The potential impact, both positive and negative, of a concept like preaddiction on different populations and on treatment seeking and use of harm reduction services;
- The potential impact of the use of a term like preaddiction in clinical practice (e.g., screening, brief intervention, referral, and treatment);
- Other terminology that may resonate with patients to describe potentially clinically significant substance misuse and/or early-stage SUD and motivate interventions;
- Whether a term like preaddiction should be applied to mild SUD per the *DSM-5* and/or to moderate SUD per the *DSM-5*;
- Whether a term like preaddiction should be applied to any problematic substance use prior to meeting criteria for SUD per the *DSM-5*, such as substance use by adolescents, driving under the influence of drugs, or other potentially risky behaviors;
- Optimal interventions and outcomes for people with preaddiction; and
- Barriers to the adoption of the concept of preaddiction in health care, research, the advocacy community, and general public.

NIH is also seeking input on research that could be conducted to evaluate the utility of a term like preaddiction, and, if appropriate, facilitate its adoption in health care settings, including research on:

- Development and validation of criteria for preaddiction;
- The natural history of people who meet those criteria;
- The proportion of people with preaddiction who self-correct vs. escalate to more severe SUD;
- The impact of social determinants of health on trajectories for people with preaddiction;
- The impact of co-occurring mental health conditions on trajectories for people with preaddiction;
- Appropriate screening tools to identify preaddiction and frequency of screening; and
- The development and testing of interventions for people meeting preaddiction criteria, including:
- Interventions to prevent substance use escalation;
- Interventions to prevent overdose;
- Guidelines for providers on how to intervene with patients who meet criteria for preaddiction (primary care physicians, emergency physicians, dentists, etc.);
- The impact of a term like preaddiction on the utilization of prevention services; and
- The impact of a term like preaddiction on substance use outcomes, including:

- Treatment seeking;
- Referral to treatment;
- SUD progression;
- Overdose;
- Use of harm reduction services;
- Ways to effectively integrate preaddiction screening and intervention into routine medical care, e.g., as part of annual primary care visits or during visits for medical concerns not specifically related to substance use; and
- Evidence needed to support insurance reimbursement of preaddiction screening and interventions. •

Responses to this RFI must be submitted electronically via: PreaddictionRFIFeedback@nida.nih.gov.

Responses must be received by: April 27, 2023.

Inquiries should go to PreaddictionRFIFeedback@nida.nih.gov. •

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"people can walk into the SSP and get connected to a provider and started on treatment essentially on-demand, during business hours," study co-author David P. Serota, M.D., assistant professor of clinical medicine at the University of Miami Miller School of Medicine, told *ADAW*. "When people feel the urge — sometimes brief urge — to make a positive change, we are there to facilitate it."

Serota contrasted that scenario with what many patients who visit substance use treatment programs in the community encounter. In those settings, "they feel stigma, they have lots of rules, require frequent visits, require abstinence from non-opioid meds, etc.," he said.

The seven-year-old IDEA Miami SSP received State Opioid Response (SOR) grant funding in 2021 to launch a buprenorphine clinic. A study co-author told *ADAW* that other SSPs would require similar funding support to be able to deliver the comprehensive services required for a successful program.

"I think the peers help the patients feel more trusting of the physicians, of whom they may be initially skeptical."

David P. Serota, M.D.

"The majority of SSPs in the U.S. remain extremely under-resourced and underfunded, limiting their capacity to implement more complex and comprehensive interventions like THR," said Tyler Bartholomew, Ph.D., assistant professor at the Miller School of Medicine's Division of Health Services Research and Policy and principal investigator at the IDEA Lab. "Our hope through our research is to show that our THR intervention delivered within an SSP venue should be the standard of care."

Key findings of study

The Miami SSP's adaptation of the THR approach emphasized significant input from clients in their treatment plan. To initiate services, an on-site peer specialist at the Miami SSP connected injection drug users with a medical provider and a psychologist via telehealth, possibly leading to a diagnosis of an OUD.

"Recognizing [people who inject drugs] as the true experts in their own health, via shared decision-making, individualized plans for [medications for opioid use disorder] were mutually agreed upon, including choosing a specific sublingual buprenorphine dose and formulation," the study's authors wrote in their paper.

As Serota explained, "if someone has prior experience with buprenorphine, I ask them what dose they think is best for them, I ask if they'd prefer buprenorphine tablets or buprenorphine-naloxone films, and I ask if they want to take their entire-month supply or if they'd like us to hold onto it in our pill lockers and give them [a dose equivalent to] a few days or weeks at a time."

He said that in the Miami area, those who try to access buprenorphine in the community, even when they have a script in hand, often find it inaccessible at many pharmacies.

The THR intervention also used a menu of wraparound support services for participants, including peer-facilitated telehealth follow-up sessions with providers and linkage to housing services. The program's peers are supervised by the SSP's on-site psychologist.

"Our peer-led approach is key to building trust," Serota said. "I think the peers help the patients feel more trusting of the physicians, of whom they may be initially skeptical."

The study of the pilot consisted of a retrospective chart review of individuals who accessed care between February 2021 and May 2022 and were prescribed buprenorphine. The primary outcome was three consecutive months of buprenorphine prescriptions picked up at the pharmacy post-enrollment.

In a study sample of 109 participants who were mostly male, uninsured and unstably housed (with a median age of 38), two-thirds received an initial daily dose of 16 mg of buprenorphine. The overall three-month retention rate was 58.7%.

Engaging with a provider through telehealth and receiving an escalating dose of buprenorphine at a follow-up visit increased the likelihood of three-month retention, while a self-report or positive

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drug screen for a stimulant was associated with a decreased likelihood of three-month retention.

"The program successfully initiated 109 patients on buprenorphine over 16 months, most of whom had no other access to therapy within the underserved local [substance use disorder] treatment environment," the study's authors wrote. "These data highlight the critical role of SSPs and other harm reduction organizations as an access point for lifesaving medical interventions for vulnerable and stigmatized populations, who are often avoidant of traditional health care institutions."

Critical funding

The research team stressed the importance of the SOR grant that the SSP received to implement the program. That money was used to provide buprenorphine at no cost to uninsured individuals, cover copayments for insured participants, and cover the full cost of participation for those whose insurers did not authorize the treatment.

Besides offering rapid service and ongoing support, the pilot did not require participants to attend mutual support meetings or psychiatric counseling. The study's authors wrote that "THR has an auspicious future as an adaptable intervention that sets aside the traditional, highly stigmatizing health care system to bring quality health services to [people who inject drugs] that they prioritize."

Serota also emphasized the broad-based nature of the services offered at the Miami SSP, including a free clinic to address wound care and other urgent-care needs.

Bartholomew said future research will seek to build a strong evidence base for this type of intervention. One upcoming trial will test the efficacy of the HIV prevention drug, PrEP, in promoting buprenorphine initiation among injection drug users at risk of HIV. Also, enrollment has begun for a randomized controlled trial that will compare the THR intervention with standard care for initiation of antiretroviral therapy and viral suppression in injection users who are living with HIV, he said. •

Coming up...

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**

The National Association of Addiction Treatment Providers (NAATP) **Annual Leadership Conference** will be held **May 21-23** in Washington, DC. For more information, go to **https://www.naatp.org/**

The **College on Drug Dependence conference** will be held **June 17-21** in Denver, Colorado. For more information, go to **https://cpdd.org/meetings/current-meeting/**

Briefly Noted

NIH study supports non-medication approach for NOWS

The National Institutes of Health (NIH) has just released research — soon to be published, according to director Lawrence Tabak, D.D.S., Ph.D. last week — that shows using the "eat, sleep, console" approach for neonatal opioid withdrawal syndrome (NOWS) is better than the traditional method of giving the babies opioids, such as morphine, methadone, or buprenorphine. This has been known for years in terms of pregnant methadone patients who deliver babies with withdrawal symptoms: Simply letting the baby breastfeed, live in the same room with the mother instead of being in the neonatal ICU, and get a lot of cuddling and swaddling eliminates the need for medication and reduces the hospital length of stay. Using the NIH HEAL Initiative's Advancing Clinical Trials program, one study evaluated the eat, sleep, console approach compared to usual care in 26 hospitals, said Tabak, speaking at last week's Rx and Illicit Drug Summit in Atlanta. The eat, sleep, console approach "substantially decreased the time until infants were medically ready for discharge, did not affect safety outcomes through three months of age, and provides strong support," said Tabak, adding that it should be the standard care for NOWS. •

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In case you haven't heard...

You need to be on your toes these days to keep up with our country's top federal agency on addiction prevention and treatment. On March 27, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a proposal on peer qualifications. The deadline for comment was April 10 — two weeks, plus a weekend. *ADAW* did not publish on April 10 due to the holiday, so we did not see the proposal, but in fact it was very quietly released. Here it is: https://www.samhsa.gov/about-us/who-we-are/offices-centers/or/model-standards. Then, on April 11, SAMHSA requested public comment on its strategic plan for 2023–2026. Here it is. https://www.samhsa.gov/about-us/strategic-plan/public-comment-form Comments are due on April 27.