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News for policy and program decision-makers

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In This Issue...

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DEA final rule says in-person medical evaluation required before bupe induction

Upholding the interim final rule implementing the Ryan Haight Act from 2009, the federal Drug Enforcement Administration (DEA) has reiterated its requirement that an in-person medical evaluation be conducted prior to induction with buprenorphine.

(The exemption based on the pandemic emergency, which allows telephone inductions is still in force, however.)

The Ryan Haight Act makes it illegal under federal law to "deliver, distribute, or dispense a controlled substance by means of the internet, except as authorized by" the Controlled Substances Act (CSA). It is mainly focused on internet drugs, which makes the entire physical exam requirement confusing. It also applies to all controlled substances, while those who want buprenorphine — Schedule III — made available without a physical exam are restricting their comments to that medication.

Bottom Line...
The DEA's recent reiteration of the rule requiring an in-person exam before prescribing buprenorphine (or any controlled substance) renews calls to make the medication more accessible, especially when the telephonic inductions end.

But after more than a decade of commentary, both official and

See Ryan Haight page 2

With SAMHSA out of picture, advocates hope to identify Recovery Month funder

Having overcome poor communication around the Substance Abuse and Mental Health Services Administration's (SAMHSA's) decision to step away from coordinating annual Recovery Month activity (see "After 30 years, SAMHSA walks away from Recovery Month," *ADAW*, July 13, https://onlinelibrary.wiley.com/doi/full/10.1002/adaw.32770), leaders in the recovery community are taking stock of their first effort to oversee Recovery Month, surmising it won't be their last.

Faces & Voices of Recovery Executive Director Patty McCarthy Metcalf described the recovery community's assuming of the coordinating role for the 2020 events as a "smooth transition." SAMHSA turned over all materials that had been created for last month's events to Faces & Voices, which now hosts the new Recovery Month website (accessible at https://rm.facesandvoicesofrecovery.org). SAMHSA also coordinated four webinars over the course of the last month, and results of the latest National Survey on Drug Use and Health were released in a video presentation in keeping with the timing of past releases that

Bottom Line...
Last month's transition to a Recovery Month without federal agency coordination turned out relatively smooth, but a reliable funding source will be needed to maintain momentum in future years.

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unofficial, the DEA has issued, basically, the same requirement.

From the final rule, published in the *Federal Register* Sept. 30:

> One of the primary ways in which the Act combats the use of the internet to facilitate illegal sales of pharmaceutical controlled substances is by mandating, with limited exceptions, that the dispensing of controlled substances by means of the internet be predicated on a valid prescription issued by a practitioner who has conducted at least one in-person medical evaluation of the patient. While the lack of an in-person medical evaluation has always been viewed as highly probative evidence that a prescription has been issued outside of the usual course of professional practice and for other than a legitimate medical purpose, the Act makes it unambiguous that it is a per se violation of the CSA for a practitioner to issue a prescription for a controlled substance by means of the internet without having conducted at least one in-person medical evaluation, except in certain specified circumstances.

Furthermore, the DEA makes it clear that even conducting that in-person medical evaluation does not guarantee that the prescription will pass muster. From the final rule:

> [T]he mere fact that the prescribing practitioner conducted one in-person medical evaluation does not demonstrate that the prescription was issued for a legitimate medical purpose within the usual course of professional practice. Even where the prescribing practitioner has complied with the requirement of at least one in-person medical evaluation, a prescription for a controlled substance must still satisfy the longstanding requirement of federal law that it must be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice.

The final rule takes effect Oct. 30.

Congress passed the Ryan Haight Act because of "the increasing use of prescription controlled substances by adolescents and others for nonmedical purposes, which [had] been exacerbated by drug trafficking on the internet." A lot of time has gone by since then, but the DEA is still concerned about "rogue websites" selling controlled substances.

Ryan Haight was an 18-year-old who died after taking Vicodin he had purchased on the internet. Ironically, today he would have been held up as a reason that easy access to buprenorphine is needed.

As Corey S. Davis, an attorney who has long supported easier access to buprenorphine, puts it, "The general rule is that laws named after people who have died are generally well-intentioned and also generally bad," adding "In my mind, Ryan Haight follows that pattern."

But the DEA is tied to the statute. And while Davis commends the DEA for being "reasonable, for once" in allowing telephone inductions of buprenorphine during the pandemic, this isn't guaranteed to continue. "That's 100% the DEA using its enforcement discretion," he told *ADAW*. "They could change that at any time."

Asked for clarification about how long the telephone inductions might last or how the final rule applies, the DEA press office only referred us to its COVID-19 website: https://www.deadiversion.usdoj.gov/coronavirus.html.

"Neither the statute nor the regulations give them [the DEA] the authority to permit telephone prescribing," said Davis. So whenever the emergency regulations end, the regulations go back to the requirement for an in-person examination before prescribing.

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Buprenorphine is a controlled substance, but one designed to treat opioid use disorder.

In addition to the requirement for in-person medical evaluations, the Ryan Haight Act requires that online pharmacies obtain express authorization from the DEA for online controlled substance sales.

From the final rule:

> The Act's definition of "online pharmacy" encompasses more than merely legitimate pharmacies that may obtain a modification of their DEA registrations allowing them to dispense controlled substances by means of the internet. As explained below, the definition of "online pharmacy" includes, among others, those persons who operate the types of rogue websites that the Act was designed to eliminate. Consistent with the longstanding structure of the CSA (since it was enacted in 1970), the Act prohibits all controlled substance activities by "online pharmacies" except those expressly authorized by the Act. Again, only DEA-registered pharmacies may obtain a modification of their registration authorizing them to operate as online pharmacies. In addition, a pharmacy that has obtained such a modification of its registration may not operate as an online pharmacy unless it has notified DEA of its intent to do so and its website contains certain declarations designed to provide clear assurance that it is operating legitimately and in conformity with the Act.

New criminal offenses

Finally, the final rule upholds the two new criminal offenses the Ryan Haight Act — and the interim final rule — added to the CSA. The first makes it unlawful "to knowingly or intentionally dispense, distribute, or deliver a controlled substance by means of the internet or to aid and abet such actions, except as authorized by the CSA." The second prohibits the use of the internet "to knowingly or intentionally advertise illegal transactions of controlled substances that are not authorized by the CSA."

Over the past decade, there have been many objections to the in-person evaluation requirement for buprenorphine. The controversy highlights the different view people have of opioid analgesics — few have suggested no physical exams before these are prescribed — and buprenorphine, which is a Schedule III opioid for the treatment of opioid use disorder. When the Ryan Haight Act was passed, prescription opioids were the main focus.

In the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, signed into law in 2018, barriers to telehealth services for substance use disorder are addressed, including eliminating the requirement in the Ryan Haight Act that patients prescribed buprenorphine (or other controlled substances) have a face-to-face visit first (see *ADAW*, Dec. 10, 2018).

Medical concerns

"It's important to keep in mind that the generally applicable rules still apply," including for telephone inductions, said Davis. "The prescription still must be issued for a legitimate medical purpose," he said. "It needs to be prescribed to a patient based on a bona fide determination by the prescriber that it's appropriate for the patient."

But H. Westley Clark, M.D. (and also a lawyer), says it's not possible to tell what's appropriate without a physical exam. "I think you need the exam because you want to make sure the person doesn't have other problems," said Clark, former director of the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment, and a key federal policymaker when buprenorphine was going through the regulatory process. The DEA is concerned about diversion, but Clark is concerned about the patient. "The physical allows you to actually verify certain things," he said. "There might be other issues like hypertension, stigmata, fever, cardiac problems, respiratory problems," he said. "The purpose of the in-person exam is not just to document withdrawal. Is that all you care about as a physician? No. And this may be the first time the person had contact with a physician for a while. I know nothing about this patient. Are we interested in the person, or just the symptom?"

Clark is a proponent of the "If it can be abused, it will be" school. The harm reductionists, however, are more concerned about people dying from illicit fentanyl bought on the street, and don't even worry about diverted buprenorphine, as even if it is taken to excess, it is unlikely to result in overdose (unless combined with another central nervous suppressant). "We got into this problem due to complex behaviors," said Clark.

"The decision to prescribe any medication is ultimately one that should be left to the judgment of the prescribing professional and their patient," said Rob Kent, former counsel for the New York Office of Addiction Services and Supports. "The current federal relaxation of the rules to allow prescribers to start a patient on buprenorphine through a telephonic visit has, undoubtedly, assisted many patients. It has also likely mitigated overdoses as we have seen a spike across the nation."

Kent blames SAMHSA for not seeking a permanent relaxation of the rules. "Ultimately, rules that treat folks with a substance use disorder differently further perpetuate the stigma, reduce access to care and ignore the fact that we can actually trust prescribers and their patients," he said. •

$20 billion includes addiction and mental health, from HHS

Providers are scrambling to get applications in for $20 billion in new grant money from the federal Department of Health and Human Services (HHS). The funding, announced Oct. 1, specifically includes organizations that provide mental health and addiction recovery treatment and services. It's an allocation under the third stimulus bill.

Eligible organizations are those that have already received Provider Relief Fund payments but need additional funding because of financial losses and changes in operating expenses caused by the COVID-19 pandemic. The only organizations that aren't required to bill Medicare and Medicaid that are eligible for the new funding are behavioral health providers.

"We applaud HHS's recognition of the increased need and immense financial strain faced by mental health and addiction recovery organizations as a result of this brutal pandemic," said Chuck Ingoglia, president and CEO of the National Council for Behavioral Health, which spearheaded lobbying for the funds, in a statement after the HHS announcement. "The administration's announcement of an additional $20 billion in relief funds gives much-needed support at a time when demand for mental health and substance use treatment has skyrocketed due to increased isolation, unemployment and other difficulties Americans face during this crisis."

Ingoglia also credited Elinore McCance-Katz, M.D., Ph.D., HHS assistant secretary and head of the Substance Abuse and Mental Health Services Administration, for championing the initiative.

The health care provider relief funding from Stimulus 3 (and 3.5) is still being doled out, Ingoglia told *ADAW* last week. First, it went to Medicare providers and then to Medicaid providers, and the way it was done was very confusing, he said. In general, the money is for "any provider type that billed Medicare and Medicaid and had not already received 2% of patient revenue," he said. "It was not specific to behavioral health."

This new funding is for behavioral health organizations, and it adds those who were not eligible previously: those who bill private insurance and those who are cash-only, said Ingoglia.

Also, behavioral health organizations that had previously applied for and received the 2% are now eligible for supplemental payments, said Ingoglia, "although it's not very clear at this point how much those supplemental payments will be."

The Oct. 1 announcement is the first time in all of the Provider Relief Fund releases that behavioral health has been specifically mentioned, said Ingoglia. It's also the first time HHS is allowing providers that don't bill Medicare or Medicaid to receive funding.

Paying rent

We ask everyone how they are handling rent and mortgage payments during the pandemic, when most people are working at home. "I would like not to pay rent, but my landlord has a different opinion about that," said Ingoglia of National Council offices. "I have a lease, and for most organizations, they either own their own buildings or have leases," he said. "So right now, working at home really isn't less expensive."

Treatment organizations, he added, have incurred many unanticipated expenses due to the need for technology upgrades for telehealth.

Details of applying

All eligible providers will be considered for payment against the below criteria, according to HHS:

- All provider submissions will be reviewed to confirm they have received a Provider Relief Fund payment equal to approximately 2% of patient care revenue from prior general distributions. Applicants that have not yet received Relief Fund payments of 2% of patient care revenue will receive a payment that, when combined with prior payments (if any), equals 2% of patient care revenue.
- With the remaining balance of the $20 billion budget, the Health Resources and Services Administration will then calculate an equitable add-on payment that considers the following:
- a provider's change in operating revenues from patient care;
- a provider's change in operating expenses from patient care, including expenses incurred related to COVID-19; and
- payments already received through prior Provider Relief Fund distributions.

"We know providers want to receive payments shortly after submitting their information," said HHS. "However, this distribution requires cooperation on the part of all applicants. Again, HHS is urging all eligible providers to apply early; do not wait until the last day or week of the application period. Applying early will help to expedite HHS's review process and payment calculations, and ultimately accelerate the distribution of all payments."

All payment recipients will be required to attest to receiving the Phase 3 General Distribution payment and accept the associated terms and conditions.

Providers will have until Nov. 6 to apply for Phase 3 General Distribution funding. HHS's top priority is ensuring as many providers as possible have an opportunity to apply. HHS will continue to host webinars to assist providers through the application process, and the call center is also available to address questions.

Funding for this Phase 3 General Distribution came from the bipartisan Coronavirus Aid, Relief, and Economic Security Act and the Paycheck Protection Program and Health Care Enhancement Act, which allocated $175 billion in relief funds to hospitals and other health care providers. •

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SUD facilities billed $845 million fraudulently, says DOJ

More than 100 doctors, nurses and other licensed medical professionals were charged last month by the federal Department of Justice (DOJ) for submitting more than $6 billion in false and fraudulent claims to Medicare, Medicaid and private insurance companies. This included more than $845 million connected to "sober homes." The enforcement action, announced Sept. 30, involved 345 defendants across 51 federal districts, and was led by the DOJ's Criminal Division. Prosecution will be by U.S. attorneys and the DOJ's Criminal Division's Fraud Section. The cases are connected to telemedicine, which has taken off since the COVID-19 pandemic. "Telemedicine can foster efficient, high-quality care when practiced appropriately and lawfully," said Acting Assistant Attorney General Brian C. Rabbitt. "Unfortunately, bad actors attempt to abuse telemedicine services and leverage aggressive marketing techniques to mislead beneficiaries about their health care needs and bill the government for illegitimate services," said Department of Health and Human Services Deputy Inspector General Gary Cantrell. "Unfortunately, audacious schemes such as these are prevalent and often harmful. Therefore, collaboration is critical in our fight against health care fraud." Rabbitt said the enforcement action will "send a clear deterrent message and should leave no doubt about the department's ongoing commitment to ensuring the safety of patients and the integrity of health care benefit programs, even amid a national health emergency."

The "sober homes" cases include patient recruiters, often referred to as "body brokers," who get paid for luring patients with certain insurance to treatment facilities, which pay kickbacks and bribes illegally. "These individuals are alleged to have participated in schemes involving the payment of illegal kickbacks and bribes for the referral of scores of patients to substance abuse treatment facilities; those patients were subjected to medically unnecessary drug testing — often billing thousands of dollars for a single test — and therapy sessions that were frequently not provided, and which resulted in millions of dollars of false and fraudulent claims being submitted to private insurers," according to the DOJ. "Medical professionals also allegedly prescribed medically unnecessary controlled substances and other medications to these patients, sometimes to entice them to stay at the facility. The patients were then often discharged and admitted to other treatment facilities, or referred to other laboratories and clinics, in exchange for more kickbacks." •

For more information, go to:

- https://www.justice.gov/opa/pr/national-health-care-fraud-and-opioid-takedown-results-charges-against-345-defendants
- https://www.justice.gov/criminal-fraud/hcf-2020-takedown/graphics-images-resources

13 Reasons Why: Evidence is in

Substance use disorder (SUD) treatment providers well know that many of their young patients are also suidical. So they are interested in the research on the Netflix series *13 Reasons Why*, which dramatizes a book of the same name in which a girl who committed suicide leaves a tape giving the 13 reasons why she did. The research shows that the program's release is correlated with an increase in what is known as "copycat" suicides and suicidal behavior.

Among its most obvious and predictable and completely wrong messages is the one that people can leave a history after they commit suicide, getting retribution and at the same time justifying their act. Once you are dead, there is no retribution; you have lost your life and future, your loved ones have lost you, and then they mourn and eventually recover. But this false message romanticizing suicide, and suggesting that suicide will "teach them a lesson" — is promoted in the book and the Netflix show. And tragically, the message got through; suicides went up.

"This must result in a call to action to the entertainment industry to become better informed, educated, and advised of the role that they play in suicide, suicide prevention, and, as in the case of *13 Reasons Why*, the tragic risk of harm to others when they present dangerous messages and depictions to their audience," the authors of a study published in the current issue of *Journal of the American Academy of Child and Adolescent Psychiatry* write. "There should be accountability for use of depictions and storylines that do not follow best practices and/or consultation with experts, as was the case with Netflix and organizations. We therefore advocate for a bold new dialogue with the entertainment industry that builds on work that has been done in the past."

It's already known that news media reporting on suicide needs to be "safe, balanced, and responsible" for public health reasons, the authors write. "When news media follow recommendations for safe reporting, the risk of copycat suicide

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decreases." And indeed, the Recommendations for Media Reporting on Suicide were developed by leading experts in suicide prevention and in collaboration with several international suicide prevention and public health organizations, schools of journalism, media organizations, and key journalists, as well as internet safety experts (www.reportingonsuicide.org).

Study author Thomas Niederkrotenthaler and others have examined suicide-related media portrayals focused on messages of hope, recovery, or mastery over a crisis, and shown that following these portrayals, people who are exposed to them have "a decrease in suicidal ideation, diminished distress, and an increased sense of hope," according to the article, which he authored. Furthermore, fewer suicides are observed.

Both suicide and resilience are "contagious." One thing the release of *13 Reasons Why* did do was provide an opportunity to study the phenomenon of media exposure and suicides.

It should be noted that there was plenty of opposition from suicide prevention and mental health experts to the release, noting that copycat behaviors could follow. In this publication, we detailed some of the comments.

The 2019 NIMH-funded study

A study published in the *Journal of the American Academy of Child and Adolescent Psychiatry* last year (Bridge et al., 2019) found that the show was associated with a 28.9% increase in suicide rates among U.S. youth ages 10–17.

The increase occurred in April 2017, the month following the show's release. The findings highlight the necessity of using best practices when portraying suicide in popular entertainment and in the media, according to the National Institute of Mental Health (NIMH), which funded the study.

The number of deaths by suicide recorded in April 2017 was greater than the number seen in any single month during the five-year period examined by the researchers. The increase in the suicide rate was driven by increases in suicide in male youths.

"The results of this study should raise awareness that young people are particularly vulnerable to the media," said study author Lisa Horowitz, Ph.D., M.P.H., a clinical scientist in the NIMH Intramural Research Program, when the study was released. "All disciplines, including the media, need to take good care to be constructive and thoughtful about topics that intersect with public health crises."

To better understand the impact of *13 Reasons Why* on suicide rates, researchers analyzed annual and monthly data on deaths due to suicide sourced from the Centers for Disease Control and Prevention's web-based Wide-ranging Online Data for Epidemiologic Research (https://wonder.cdc.gov/). These data included information about the deaths of individuals between the ages of 10 and 64 that occurred between Jan. 1, 2013, and Dec. 31, 2017, a timespan that encompassed the period before and after the release of the series.

The researchers examined whether the rates of suicide for the period after the release of *13 Reasons Why* were greater than would be expected based on suicide counts and trends observed in previous years. The researchers found that the rates of suicide for 10- to 17-year-olds were significantly higher in the months of April, June, and December 2017 than were expected based on past data. This increase translated into an additional estimated 195 suicide deaths between April 1, 2017, and Dec. 31, 2017.

The observed suicide rate for March 2017 — the month prior to the release of *13 Reasons Why* — was also higher than forecast. The researchers note that the show was highly promoted during the month of March, exposing audiences to the show's premise and content through trailers. The researchers did not find any significant trends in suicide rates in people 18 to 64 years of age.

Suicidal thoughts or actions (even in very young children) are a sign of extreme distress and should not be ignored, the NIMH noted.

Two years later

Now, the data are in. No, it's not possible to make a causal interpretation; the correlation between increased suicidal behaviors and suicides coinciding with the release of the Netflix series is just that, a correlation. But, the researchers write, "there can be little doubt that the release of *13 Reasons Why* Season 1 was a significant contributing factor in online search-related behaviors, new and increased suicidal ideation, suicide attempts, and tragically, deaths by suicide."

Some studies — based on online surveys — did find some viewers may have benefited from watching *13 Reasons Why*, but many did not — especially those who were vulnerable to suicide.

"The sensationalized and repetitive suicide-related content portrayed over 13 hours in the first season of the series was likely an important contributing factor to the increased risk for some viewers," the researchers write.

"For example, the series opened with the main character and narrator (Hannah) telling viewers that she was deceased and that she had died by suicide. The series also opens with her locker being adorned with flowers, cards, etc., and this is shown throughout Season 1, which only adds to the memorializing of her suicide. Subsequently, she explains at length how common stressful life events in youth, including mistreatment by her peers, were the 'reasons' for her suicide. Hannah's efforts to seek help for her distress and suicidal ideation are presented as futile, even counter-productive, and lead to the hopelessness that

precede[s] the unnecessary graphic portrayal of her suicide."

There are safe ways to incorporate suicide content into an entertainment production — it's not a taboo subject. However, just as in news media reporting on suicide, the way it is done is what counts in terms of copycat suicides.

"The narrative of *13 Reasons Why* sends numerous dangerous messages to adolescents who may identify with the character and/or face struggles similar to those portrayed in the series," the researchers write. "It is therefore no surprise that, as predicted by experts, the totality of the research in the area suggests clear and substantial net harms. However, it is also not surprising that some studies, including research sponsored by Netflix, identified beneficial effects in certain viewers, such as a reported greater knowledge of suicide risk factors in youths who watched the series. There will always be differing reactions to fictional media such as a TV series. However, the risk of copycat suicides clearly applies to those audiences with increased preexisting vulnerability and high identification with the characters and how the depictions of suicide-related content are presented."

"There is no reason that any young person should die by suicide, and we hope that, in the future, those in the entertainment industry will support this message rather than contradict it," the researchers write. "At a minimum, information and resources for the public must accompany productions similar to those created for Season 2."

In advance of the release of Season 2, SAVE (Suicide Awareness Voices of Education) brought together a group of experts in mental health, suicide prevention, and education, as well as health care professionals, to develop tools to help encourage positive responses to the series. This group developed a toolkit providing practical guidance and reliable resources (www.13reasonswhytoolkit.org).

"Tools such as these can be used by professionals in their work with youths and families," the researchers conclude. "Messages of hope, resiliency, recovery, and bereavement following a depicted suicide are all areas that the entertainment industry must begin to address in future productions to prevent further tragedies like those observed following *13 Reasons Why*, season 1." •

Editor's note: Season 2 was released in 2018, Season 3 in 2019, and Season 4 in June this year. All four seasons are available for streaming.

The authors have reported no funding for this work, "13 Reasons Why: The evidence is in and cannot be ignored," and no conflicts of interest.

Recovery Month from page 1

took place during a Recovery Month luncheon (which this year was conducted virtually), McCarthy Metcalf told *ADAW*.

What will be needed to sustain a September of high-profile events in future years will be a commitment of ongoing funding, she said, in an environment in which SAMHSA has offered no clear explanation for its decision to hand over Recovery Month and no indication that it will reverse course.

"Support for recovery has been dwindling at SAMHSA," McCarthy Metcalf said. She cited as another example of this trend the agency's recent decision not to continue the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS), an initiative established in 2011 to assist programs and governments in implementing recovery services and supports. SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services jointly administered BRSS TACS.

Legislative proposal offers hope

A recovery community that traditionally lacks the advocacy resources of the treatment sector could receive a major boost in the effort to maintain the Recovery Month presence under legislation newly introduced in Congress by Rep. David Trone (D-Md.).

The Honoring National Recovery Month Act, co-sponsored by Rep. Denver Riggleman (R-Va.), would authorize $1 million a year for SAMHSA to develop materials, distribute best practices and lead activities for Recovery Month. If SAMHSA chose not to assume this role, the proposed legislation states that it could enter into an agreement with a national organization (such as Faces & Voices) to use the authorized funding for Recovery Month activity.

A summary from Trone's office reads, "Maintaining federal support for Recovery Month is critical to show that celebrating those in recovery and educating the public about recovery from substance use disorders and mental illness is a government priority. While Recovery Month is an important celebration every year, this bill is especially needed given the increased challenges posed by COVID-19 to people in recovery.… Now is not the time to stop supporting individuals in recovery."

McCarthy Metcalf also invoked COVID-19 in her comments about Recovery Month, which this year had a theme of "Join the Voices for Recovery: Celebrating Connections." Who would have known ahead of time, she pointed out, that this theme would resonate to such a degree at a time when all communities suddenly are trying to figure out how to support individuals and families in a more virtual environment?

She believes $1 million in annual support would be sufficient to fund all of the publication work, video services and other efforts that make for a successful Recovery Month. It is difficult to determine exactly what SAMHSA had been spending on Recovery Month because a specific

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line item devoted to it did not exist in the agency's budget, she said.

McCarthy Metcalf emphasized that there is "an amazing coalition of people" (not just Faces & Voices) that can muster the human resources needed to maintain Recovery Month's impact. As for SAMHSA, "I can't see them reversing their decision," she said of its move to step away.

SAMHSA officials did not reply by press time to *ADAW*'s request for comment for this article.

Precedent for involvement

Former CSAT Director H. Westley Clark, M.D., J.D., considered a champion for recovery-oriented services while with the agency, characterizes Recovery Month as "a very inexpensive activity" that provides an important opportunity for stakeholders to link recovery with treatment and prevention as a critical component of a trio. Without the recovery piece, Clark told *ADAW*, policymakers don't receive the consistent message that recovery is possible and treatment and prevention are therefore worthwhile to support.

It's a bit like the situation with COVID-19, which some people can tend to dismiss if it isn't hitting close to home. "They can say, 'I don't see it,' and behave accordingly," said Clark, Dean's Executive Professor at Santa Clara University. "Then the disease spreads."

He added, "The American public needs to see that recovery is possible."

Numerous other federal agencies, including the National Institute on Drug Abuse (NIDA) and the Centers for Disease Control and Prevention, continue to see stakeholder outreach efforts as relevant to their mission, Clark said. "For me, Recovery Month is an important thing," he said. "This is a public service issue. Previous administrations have endorsed it as an enhancement of the government's relationship with the people it serves."

Seeking language change

This year's Recovery Month did not include a national hub event because of a lack of resources. "We hope we can do it next year," said McCarthy Metcalf. A virtual luncheon event did attract around 500 attendees.

Along with their desire to see SAMHSA recommit to Recovery Month, recovery advocates are again pushing for a name change for that agency, NIDA and others that include the word "abuse" in their title. McCarthy Metcalf said Faces & Voices and the Recovery Research Institute have launched a petition drive with a goal of 1 million signatures, asking congressional leaders to support a name change.

"Exposure to the terms substance 'abuse' and substance 'abuser' has been shown to increase stigmatizing and discriminatory attitudes toward individuals suffering from drug and alcohol problems both in the general population and among clinicians," states a letter to Senate and House leaders that individuals are invited to sign. As of the morning of Oct. 6, just under 1,200 people had signed on. •

See "After 30 years, SAMHSA walks away from Recovery Month" (*ADAW*, July 13, https://onlinelibrary.wiley.com/doi/10.1002/adaw.32770) and "Recovery Month will take place: Faces & Voices of Recovery will run it" (*ADAW*, July 20, https://onlinelibrary.wiley.com/doi/10.1002/adaw.32780).

Coming up...

Onsite cancelled, virtual only: The annual meeting of the **American Public Health Association** will be held **October 24-28** in **San Francisco**. For more information, go to **https://www.apha.org/annualmeeting**.

Onsite cancelled, virtual only: The annual meeting of **AMERSA (the Association for Multidisciplinary Education and Research in Substance Use and Addiction)** will be held **November 12-14** in **Boston**. For more information, go to **https://amersa.org/conference/conference-at-a-glance/**.

Stay tuned, as other changes will probably be forthcoming.

In case you haven't heard...

The federal government has ordered a licensed alcohol and drug counselor to pay $230,000 to settle false claims allegations. John H. Durham, U.S. attorney for the District of Connecticut, announced Oct. 1 that Hector B. Chukwuemeka Okwuosa, LADC, and his business, My Father My Son Rehabilitation and Counseling Center LLC, will settle allegations of violations of the federal and state False Claims Acts for $230,000. My Father My Son, now dissolved, provided in-home mental health and substance abuse counseling in the greater New Haven, Hartford and Bridgeport communities. Okwuosa is enrolled as a Licensed Behavioral Health Clinician in Independent Practice in the Connecticut Medical Assistance Program, which includes the state's Medicaid program. Okwuosa and My Father My Son billed Medicaid for behavioral health services as if a licensed individual had provided the services, when in fact an unlicensed individual rendered the services, according to the allegations. The case stems from a larger investigation into fraudulent activity in the area of behavioral health services, which has been jointly conducted by the Office of the Inspector General of the U.S. Department of Health and Human Services, the Medicaid Fraud Control Unit of the Chief State's Attorney's Office and the Connecticut Office of the Attorney General, with support from the Connecticut Department of Social Services.