Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

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Our lead stories this week look at how one patient self-administered naloxone remotely to go from illicit fentanyl use to a maintenance dose of buprenorphine in 3 hours, and New Jersey's expansion of recovery therapy to include providers serving dual diagnosis patients.
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Self-administration of naloxone to induce withdrawal in buprenorphine initiation

It is possible to self-administer naloxone and transition to a therapeutic dose of buprenorphine shortly thereafter, according to a case report published in the *Journal of Addiction Medicine* on Sept. 23. In this report, the patient was able to start buprenorphine less than three hours after the last fentanyl administration.

The naloxone was not used to self-rescue from an overdose, but rather, to clear the receptors from opioids so that buprenorphine could be safely started instead of waiting for withdrawal to begin.

Taking buprenorphine if opioid-dependent, and while not in withdrawal, results in precipitated withdrawal and is a deterrent experience for patients.

That's not to say this was a pleasant experience, and many patients might find it easier to let opioids gradually wear off before taking the buprenorphine at the first sign of withdrawal. In this case, after the patient administered intranasal naloxone, there were 14 minutes of moderately severe withdrawal. Overall, the withdrawal took 31 minutes.

Patients who are worried about withdrawal are often hesitant about starting buprenorphine treatment,

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Bottom Line...

If a patient with OUD wants to transition quickly to buprenorphine instead of gradually being in withdrawal, he or she can self-administer naloxone, being sick for an hour but then feeling "perfectly fine," according to one case report.

N.J. providers serving dually diagnosed eligible for recovery-focused training

New Jersey provider agencies treating patients with co-occurring substance use and mental health disorders are among the target recipients in a training initiative to promote the use of recovery-oriented cognitive therapy. State officials' provision of $500,000 to conduct the training and ongoing mentoring of clinicians is designed to encourage wider use of a strengths-based treatment seen as particularly suited to individuals who hesitate to engage in treatment due to mistrust, a history of institutionalization or other common barriers.

The New Jersey Department of Human Services last month announced it has awarded $500,000 to the Foundation for Cognitive Therapy and Research to provide the training in a modality that goes by the acronym CT-R. Although CT-R is related to cognitive-behavioral therapy, it does not focus on reducing symptoms as a central goal but instead emphasizes identifying aspects of the patient's

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Bottom Line...

New Jersey providers participating in a training initiative in recovery-oriented cognitive therapy will be able to use funding to offer patients incentives for recovery-promoting behaviors.

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the researchers write. Micro-dosing protocols, with potential benefits and risks, have been suggested as another method of buprenorphine initiation.

The case report is "a novel approach for rapid outpatient" initiation of buprenorphine in which the patient chose to induce withdrawal with self-administration of naloxone, according to the study authors, who added that the patient reviewed this article, as well as provided written informed consent for publication.

What the researchers found

The patient was a 33-year-old man with two years of daily fentanyl use. He reported to a telehealth addiction program, saying he consumed 2–20 pressed fentanyl tablets a day, via crushing and inhaling. Sometimes he used marijuana, but said he had no other substance use, chronic medical or psychiatric conditions. In the past, he had been in treatment with Vivitrol for one month, on two separate occasions, but had not yet been in treatment with buprenorphine or methadone.

The patient met the criteria for severe opioid use disorder (OUD) and wanted to start buprenorphine maintenance. After learning of the options — including micro-dosing with various doses and rapid initiation — he opted for rapid initiation, mainly because he wanted to stop using fentanyl immediately.

> **""Best detox I have had in my life.... You will be sick for an hour and then you will be perfectly fine.'"**
>
> Patient in case report, *Journal of Addiction Medicine*

The entire buprenorphine visit was performed via telehealth; the patient and his wife were there, and the clinician was at a remote site. The patient wanted a clinician present even remotely "just in case," he said. Most of the time, home inductions of buprenorphine do not involve a physician present even remotely.

The patient's last use of two pressed fentanyl tablets was two hours before the appointment.

Using the Clinical Opioid Withdrawal Scale (COWS), the patient scored zero at the start of the appointment. He took 0.2 mg of oral clonidine and 600 mg of gabapentin to mitigate the anticipated precipitated withdrawal produced by the naloxone.

"Thirty-five minutes later, with his COWS score remaining zero, he self-administered a full dose of 4 mg intranasal naloxone," the researchers write. "Within two minutes, he developed withdrawal symptoms — two episodes of vomiting, three of dry heaving — and within 14 minutes, his COWS score was moderately severe at 28. He then self-administered 24–6 mg sublingual BUP-NX [24 milligrams of buprenorphine, 6 milligrams of naloxone]. Five minutes after the medication was fully absorbed, he felt well enough to request disconnection from the visit to take a nap. He was instructed to continue with sublingual 8–2 mg BUP-NX the following morning and follow-up."

The next day, the patient reported that he took a nap for an hour and woke up feeling normal. "Best detox I have had in my life," the researchers report the patient had said. His advice was: "You will be sick for an hour and then you will be perfectly fine.'"

Four weeks later, the patient continued to attend telehealth appointments and do well on 16–4 mg BUP-NX daily.

Two timeframes

The case highlights two timeframes for buprenorphine initiation. The first is the time since last use and the related degree of withdrawal;

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the second begins with the first dose of an initiation medication — intranasal naloxone in this case study, sublingual buprenorphine in other methods — until a therapeutic dose of buprenorphine is reached.

The case builds on what emergency medical services workers have found, and also lends support for a higher dose of buprenorphine when patients are transitioning from fentanyl.

"As with other approaches, rapid initiation has risks, but none that compare with ongoing use of lethal opioids," the researchers write.

A note about different protocols: "Standard buprenorphine initiations require patients to wait after their last full agonist use and experience significant withdrawal symptoms. Very low-dose buprenorphine transitions intentionally minimize withdrawal, but patients usually continue illicit opioid use while gradually increasing their daily buprenorphine dose over several days to weeks; a recent review found this transition to take a median of eight days (range, 3–120 days). Although very low-dose and low-dose transitions aim to avoid precipitated withdrawal, it can still occur. High-dose (defined as total dosing up to 32 mg) initiation has been done in emergency departments, but these protocols also require patients to wait at least 12 hours since their last use before taking a first buprenorphine dose. Outpatient use of the high-dose method has not yet been described."

And a note about terminology: Buprenorphine had naloxone added to it to prevent patients from injecting it; the naloxone would render the opioid ineffective. However, oral ingestion of the naloxone has no such effect. Usually, when writing about buprenorphine to treat OUD, we refer to just buprenorphine, without adding the extra word (buprenorphine-naloxone). There are times when only buprenorphine is recommended, without the naloxone. However, the presence of the naloxone in the buprenorphine is not what could cause precipitated withdrawal when opioid-dependent patients take it; rather, it is the buprenorphine, a partial agonist, itself.

"The described approach has potential for home or outpatient settings. It allows flexible timing as to a person's last use of fentanyl, provides more autonomy in starting BUP-NX, makes use of intranasal naloxone availability, and better aligns with the short time when beginning treatment is especially salient — paralleling "quick start" methods for contraception initiation," the researchers wrote. "In addition, the expedited timeline may appeal to patients with work, family, or other obligations. Depending on their preferences, patients could make this transition on their own, with a peer recovery specialist or other trusted person, or with a clinician. This specific case also demonstrates the utility of telehealth in supporting patients during BUP-NX initiation."

"In times of crisis — wounds in world wars, burns in mass casualties, and the HIV/AIDS epidemic — medical practice has had to respond in seemingly unconventional ways to save lives," the researchers concluded. "People suffering from OUD are pleading for the same intrepid focus to help them begin BUP-NX. We welcome further study, in a larger cohort of patients, of the unconventional but effective approach described in this case report." •

The study is by Adam Randall and colleagues.

Objective withdrawl signs help establish physical dependence

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last* 1/2 *hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past* 1/2 *hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Source: NIDA

CDC: 1 in 8 deaths among 20-64 year olds from alcohol use

One in eight deaths of Americans ages 20 to 64 is due to excessive alcohol consumption, according to a new study by the federal Centers for Disease Control and Prevention (CDC). The study, "Estimated Deaths Attributable to Excessive Alcohol Use Among U.S. Adults Aged 20 to 64 Years, 2015 to 2019," published in *JAMA Network Open* on Nov. 1, found that 12.9% of total deaths among adults ages 20 to 64, and 20.3% of deaths among those ages 20 to 49, are due to alcohol consumption.

The proportion of premature alcohol-related deaths could be reduced by alcohol policies such as taxes and brief intervention, according to the CDC.

Alcohol-related deaths, like opioid-related deaths, are preventable. One difference between deaths from alcohol and opioids, however, is that alcohol-related deaths can result after years of use, as in alcoholic liver disease, while opioid overdoses can kill immediately.

The study was population based, using the 2015-2019 Behavioral Risk Factor Surveillance System of the CDC, adjusted using per capital alcohol sales to correct for underreporting. There were 2,089,287 respondents to the system.

Causes of alcohol deaths - chronic

Chronic Causes	Overall
100% Alcohol-Attributable	
Alcohol abuse	3,735
Alcohol cardiomyopathy	559
Alcohol dependence syndrome	5,257
Alcohol polyneuropathy	7
Alcoholic gastritis	36
Alcoholic liver disease	22,472
Alcoholic myopathy	2
Alcoholic psychosis	991
Alcohol-induced acute pancreatitis	354
Alcohol-induced chronic pancreatitis	60
Degeneration of nervous system due to alcohol	177
Fetal alcohol syndrome	7
Fetus and newborn affected by maternal use of alcohol	2
100% Alcohol-Attributable Total	**33,658**
Cancer	
Cancer, breast (females only)	1,759
Cancer, colorectal	2,221
Cancer, esophageal *	1,058
Cancer, laryngeal	523
Cancer, liver	3,878
Cancer, oral cavity and pharyngeal	2,010
Cancer, pancreatic †	573
Cancer, prostate (males only)	454
Cancer, stomach †	150
Cancer Total	**12,627**
Heart Disease and Stroke	
Atrial fibrillation	984
Coronary heart disease	7,986
Hypertension	11,337
Stroke, hemorrhagic	2,391
Stroke, ischemic	1,658
Heart Disease and Stroke Total	**24,356**
Liver, Gallbladder, and Pancreas	
Esophageal varices	132
Gallbladder disease	0
Gastroesophageal hemorrhage	33
Liver cirrhosis, unspecified	10,497
Pancreatitis, acute	139
Pancreatitis, chronic	38
Portal hypertension	62
Liver, Gallbladder, and Pancreas Total	**10,901**
Other Chronic Causes	
Chronic hepatitis	4
Infant death, low birth weight **	4
Infant death, preterm birth **	92
Infant death, small for gestational age **	0
Pneumonia ‡	273
Unprovoked seizures, epilepsy, or seizure disorder	364
Other Chronic Causes Total	**737**
Chronic Causes Subtotal	**82,279**

Source: CDC

Chronic and acute

The researchers considered both chronic and acute deaths, and deaths in which alcohol was only one of the factors involved.

The CDC's Alcohol-Related Disease Impact (ARDI) application was used to define alcohol-attributable deaths for 58 causes (see chart to the left); mortality data were from the CDC's National Vital Statistics System.

The death rates might have been even higher, because death rates involving alcohol as an underlying or contributing cause of death increased during the first year of COVID-19 in 2020, the researchers reported. The study findings are still consistent with the epidemiology of excessive drinking, they added, noting that the prevalence of binge drinking is generally higher among younger adults.

Implications

From 2006 to 2010, an estimated 1 in 10 deaths among adults ages 20 to 64 was attributable to excessive alcohol consumption, according to a different study method that was partially based on self-reported mean daily consumption estimates. The ARDI methods used in this study provide estimates of deaths pertaining to excessive drinking rather than all levels of consumption.

Limitations of the study were mainly that fewer deaths attributed to excessive alcohol consumption were reported than actually occurred, because if alcohol was only a contributing cause of death, that was not included. Another limitation was that adults who formerly used alcohol — some of whom likely died from alcohol-related causes — were not included in the study. This is a weakness of the Behavioral Risk Factor Surveillance System when used to assess alcohol harms, because information on former alcohol consumption is not collected in that system.

Possible ways to reduce these premature deaths include increasing alcohol taxes and regulating alcohol outlet density, as well as using screening and brief intervention, the researchers concluded.

Asked to comment on the study, George F. Koob, Ph.D., director of the Naitonal Institute on Alcohol Abuse and Alcoholism, said: "The important thing to recognize is that the burden alcohol places on public health in the United States is very large, much larger than people tend to recognize. He added: "Over 14 million individuals suffer from alcohol use disorder and alcohol contributes to 200 different diseases and 5-6% of cancer in the United States."

"Earlier this year, NIAAA (White et al, 2022) published a study using data from death certificates to see whether alcohol-related deaths increased during the first year of the COVID-19 pandemic. After increasing by about 2.5% per year between

1999-2019, the rate of alcohol-involved deaths jumped 25% in 2020 to about 99,000 deaths. We know that death certificates underestimate the scope of the problem, typically because the person filling out the death certificate might not recognize the role that alcohol played. So using attributable fractions to recapture some of those alcohol related deaths makes sense." •

The authors, led by Marissa Esser, Ph.D., of the CDC's Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, declared funding from the CDC as a conflict of interest, but also said that the sponsor (CDC) had no role in the study.

FROM THE FIELD

Boo! The addiction treatment false binary

By Marvin Ventrell

Please forgive the abuse of the Halloween metaphor as I find myself spooked by the specter of an addiction treatment false binary in the op-ed in the innovations issue (see "Harm reduction innovation: Abstinence, move over," *ADAW* Oct. 31; https://onlinelibrary.wiley.com/doi/full/10.1002/adaw.33600).

Title aside, the piece is fairly balanced, particularly taken in the context of author John de Miranda's thoughtful piece published earlier this year titled "Treatment and Recovery Discover Harm Reduction: Now What?" (see *ADAW* July 18; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33500). (*Editor's note: We, not de Miranda, are responsible for the headline; apologies to all for any misunderstanding.*)

I'm haunted though, as we critique treatment modalities along the continuum of interventions, by our tendency once again to fall into the ideological inferno of "either or" by viewing treatment only through the mask of personal lived experiences. When we do that, we divide into warring factions that disregard a reality that seemingly contradictory concepts, if understood and applied with expertise, can coexist to the benefit of a population at large. Such is the case with harm reduction and abstinence.

Don't be frightened. Our lived experiences (mine, like those of so many, being 12-step abstinence recovery) are valuable and inform our work, as do evidence-based practices, practice-based evidence, and measurement-based care. Rather, abstinence need not and must not "move over" for harm reduction to find its place in the continuum. The word continuum, after all, suggests that adjacent elements appear very different when viewed in their extremes, but actually can exist in a sequence.

de Miranda suggests a dichotomy of origin, and presumably of value, in that he argues motivational interviewing is the product of a gradual, organic and bottom-up process, whereas harm reduction emanates from the top down through the innovation of federal agencies. Admittedly, the current administration is laser focused on harm reduction, but, like motivational interviewing, harm reduction in its many and varied types has clear and extensive evidence in years of bottom-up practices of reduction of disease, severity of consequences and mortality. It's not new or innovated from federal agencies.

It is true that simply staying alive on the one hand, and recovery as a process of transformation through which individuals reach their full potential on the other hand, are not the same thing. But, if our experience has taught us anything, it is that science, 12-step humility and motivational interviewing require that we take the client as the client presents, and disease as it is optimally treated. In so doing, we offer the lifesaving gift of that which can be grasped by the patient in a moment of time. It is too easy in a critique to grab at polar ends of a spectrum. It requires wisdom to find the nuance in complex matters. And that is the job of an experienced, educated and trained professional. As journalist and scholar H.L. Mencken once said (paraphrased), every complex problem has a solution which is simple, direct, plausible — and wrong.

Oh yes, back to Halloween. In ancient Western tradition, at this time of year the soul proceeds through a continuum called Allhollowtide by stepping first into All Souls' Eve, then All Hallows Eve (Halloween), until emerging forward in a better place called All Saints' Day. As addiction treatment professionals, we are not saints, but just like our patients, works in progress open to challenging new discoveries. More will be revealed.

Marvin Ventrell is the CEO of the National Association of Addiction Treatment Providers. Reach him at mventrell@naatp.org.

SBI use for AUDs in middle-income countries: Positive reports

Little is known about the use of screening and brief intervention (SBI) for alcohol use disorders (AUDs) in low-income countries. A new study of people in Brazil, China, and South Africa has found that at-risk drinkers are receiving SBI services.

For the study, "Screening and brief intervention for alcohol use disorder risk in three middle-income countries" published in *BMC Public Health* last week, researchers from the Pacific Institute for Research and Evaluation looked at whether drinkers in these middle-income countries are receiving SBI.

This study examined the prevalence of SBI for AUD risk and the extent to which meeting criteria for AUD risk was associated with SBI.

Survey measures included:

- Past-year alcohol use;
- The CAGE assessment for AUD risk;
- Talking to a health care professional in the past year;
- Alcohol use screening by a health care professional;
- Receiving advice about drinking from a health care professional; and
- Sociodemographic characteristics.

Talking to a health care professional is an important measure because it is an opportunity for the individual to receive SBI.

Screening and brief intervention are two separate functions; screening, if no AUD risk is found, is not followed by brief intervention. If a risk is found, the brief intervention occurs. In South Africa, 6.7% of individuals were screened and 4.6% received a brief intervention. Drinkers who talked to a health professional in the past year were more likely to have received SBI.

Although the overall prevalence of SBI among drinkers at risk for AUD is low in these three countries, drinkers are more likely to receive SBI than non-drinkers, the report found.

More than three million people die each year across the world from harmful use of alcohol, which is also the leading cause of premature mortality and disability among individuals ages 15 to 49.

Many evaluations of SBI have demonstrated positive results, but most studies have been conducted in high-income countries. •

AATOD conference features harm reduction session

The first in-person conference since COVID-19 of the American Association for the Treatment of Opioid Dependence (AATOD) held in Baltimore last week included sessions on harm reduction, including one that featured Chase Holleman as a speaker. Holleman is the new lead for harm reduction at the Substance Abuse and Mental Health Services Administration (SAMHSA). In recovery from opioid use disorder (OUD), Holleman is also a licensed clinical social worker and a licensed addiction specialist who helped found a harm reduction center in Greensboro, North Carolina with Louise Vincent of the Drug Users Union.

"I'm tired of burying the people I love," Holleman told attendees of the Oct. 31 pre-conference session, noting that after he lived through a handful of overdoses, quality addiction treatment changed his life.

Harm reduction isn't new, and to make it more acceptable, Holleman, like many proponents, used examples from everyday life:

- Syringe exchange;
- Life jackets;
- Crutches;
- Gloves;
- Age limits;
- gun locks;
- Childproof caps;
- Traffic laws;
- Cigarette filters; and
- Face masks.

Harm reduction approaches, said Holleman, should be

- Person-driven;
- "Just say know" — as against 'Just say no' from [former First Lady] Nancy Reagan's prevention approach;
- Low-threshold;
- Accepting of any positive change; and
- Centered on lived and living experiences — "living" referring to current drug use.

Specific services include:

- Syringe services programs;
- Opioid education and naloxone distribution hub;
- Navigation and case management; and
- Participant advocacy.

Entities should be:

- Led by people with lived experience;
- Community-based;
- Utilizing peer support and mutual aid;
- Based on grassroots origins; and
- "At the table" for policy discussion.

Treatment should:

- Use lowest-barrier strategies for entry;
- Meet patients where they are;
- Build rapport and trust;
- Be transparent and open;
- Celebrate any positive change;
- Respect privacy; and
- Make access and engagement easy.

A common theme of the conference was that treatment can be more difficult to obtain than illicit opioids, specifically illicit fentanyl which now can be contaminated with xylazine (see "Potent non-opioid xylazine emerges as overdose threat without antidote," *ADAW* Sept.

26; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33557).

"How can we warn people?" asked Holleman. "In harm reduction, treatment isn't necessarily encouraged or discouraged," he said. Having access to buprenorphine and methadone is very important, but sometimes harm reduction comes first, he said, citing the 2013 study which showed that people who participate in a syringe services program are five times more likely to enter treatment than people who don't (Editor's note: see Des Jarlais DC, Nugent A, Solberg A, Feelemyer J, Mermin J, Holtzman D. Syringe service programs for persons who inject drugs in urban, suburban, and rural areas — United States, 2013. *MMWR Morb Mortal Wkly Rep.* 2015;64(48):1337-1341. doi:10.15585/ mmwr.mm6448a3).

With SAMHSA now collaborating with the Office of National Drug Control Policy and the Centers for Disease Control and Prevention on harm reduction strategies, Holleman is optimistic about "how a very bureaucratic agency from the federal government can still engage with people," he said. The reach of syringe services programs, overdose education and naloxone distribution can help guide drug users into lifesaving methadone or buprenorphine treatment. •

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desired life and empowering the individual to realize these goals in the face of challenges.

CT-R is based on the cognitive model of the famed late psychiatrist Aaron Beck, M.D. — often referred to as the father of cognitive behavior therapy — and integrates that model with principles of the recovery movement. The Foundation for Cognitive Therapy and Research is housed within the Beck Institute in Pennsylvania. New Jersey officials said CT-R training will be offered to practitioners who serve patients with serious mental illness and those with co-occurring mental health and substance use disorders.

Federal mental health block grant funding will support the initiative. As a result, programs offering only substance use treatment services will not be able to participate in this training initiative, although CT-R is certainly applicable to substance use-only treatment and future initiatives for those providers are a possibility, state Division of Mental Health and Addiction Services Assistant Commissioner Valerie Mielke told *ADAW*.

Participating provider agencies will be allowed to offer patients incentives to encourage positive behaviors, not in the form of cash, but instead tied to something with personal meaning to the patient, such as tickets to a museum for an individual with an interest in the arts. Mielke said $150,000 is being made available for incentives under the program.

"CT-R is grounded in the premise that recovery is possible for all, no matter how long an individual has been experiencing these challenges or how difficult these challenges appear."

Beck Institute

Although this component of the program resembles the contingency management (CM) approach that is increasingly being seen in substance use treatment, New Jersey state officials have not referred to it specifically as CM. The state has supported a separate CM initiative involving treatment of patients affected by stimulant use disorder, Mielke said.

"Practitioners and providers who participate in this program will be able to implement a creative and engaging set of practices and

Continues on page 8

Correction

No office-based prescribing and pharmacy dispensing of methadone: We regret the mischaracterization of the views of the American Association for the Treatment of Opioid Dependence (AATOD) and the National Association for Behavioral Healthcare (NABH) in a recent story on a possible rulemaking from the Substance Abuse and Mental Health Services Administration on methadone take-homes (see "SAMHSA to ask for rulemaking on take-home methadone doses," *ADAW* Sept. 23; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33558. The problem was a three-clause sentence, and when misquoted out of context, the appearance was that AATOD and NABH might at some point change their position about office-based prescribing and pharmacy dispensing, which both organizations oppose. The context was in the third clause of the sentence: "as long as the OTPs [opioid treatment programs] retain clinical decision-making for methadone" as well as the first, "in some situations in the future." Neither organization supports office-based prescribing and pharmacy dispensing of methadone for opioid use disorder. We regret any misunderstanding. That sentence has been deleted from the online version of the article.

Continued from page 7

strategies to encourage and motivate their clients towards the life they want," Mielke said in a Department of Human Services news release.

Supported by research

"CT-R is grounded in the premise that recovery is possible for all, no matter how long an individual has been experiencing these challenges or how difficult these challenges appear," according to a summary of CT-R from the Beck Institute.

The summary cites results from several clinical trials that offer a strong evidence base for the treatment. A randomized trial published in 2012 in the *Archives of General Psychiatry* found that CT-R improved community participation, motivation and symptoms compared with usual care for patients with schizophrenia. A six-month follow-up study published in 2017 in *Psychiatric Services* found sustained improvements over that period.

The Beck Institute's description of CT-R states that it can be used in individual or group treatment settings, and in residential or community-based programs. Initially CT-R focuses on accessing the patient's "best self" through a shared activity such as listening to music or going for a walk. This process seeks to build a trusted connection between the patient and the clinician, and to avoid activating the negative beliefs that keep some patients from engaging with others.

The resulting positive beliefs and actions are referred to as the patient's "adaptive mode." Once the path to identifying that is clear, it can be reinforced through an array of activities, which engender more positive feelings about engaging with others, and repeating reinforcing behaviors.

In turn, "During trying times, the key is to maintain focus on that which is most valuable — one's aspirations, connections and their personal meanings," the summary from the Beck Institute states. "The cognitive model helps us to understand the negative beliefs that give rise to challenges, but also the positive beliefs that can help shift the focus back to the adaptive modes of living."

Mielke said the training initiative grew out of a pilot effort in the state that showed promising results. Citing an example of a patient who was helped, she said one patient expressed a life aspiration of opening a bakery. This became the starting point for conversations that helped create a rapport between the patient and the clinician, and the incentive for the patient came in the form of baking supplies that were used to bake goods that were shared with fellow patients in the program, Mielke said.

According to the institute, individuals who have experienced severe impacts from trauma and those who have difficulty accessing motivation are among those who can be helped most by CT-R's empowering approach.

Mielke said the provider trainings will use a hybrid model combining in-person and online instruction. The duration of training will depend on each provider organization's needs, with some training involving organizational leadership and some focused on direct-care staff that includes licensed clinicians and peers.

Evaluating success

Mielke said the foundation will be reaching out to provider agencies eligible for the training. "We want to make sure this gets out to as many provider agencies as possible," she said.

State officials said that besides looking at utilization outcomes, such as the number of providers trained, they also will be evaluating how CT-R and the use of incentives affects patient behavior change, and how this ultimately affects patient quality of life.

Mielke emphasized that CT-R can have as profound an effect on clinicians as it can on patients. "The provider is seeing dramatic changes in the person they're working with," she said. •

Coming up...

The **Liver Meeting** (American Association for the Study of Liver Disease) will be held **Nov. 4–8** in Washington, DC. For more information, go to **https://www.aasld.org/the-liver-meeting**

The **AMERSA** annual conference will be held in Boston **Nov. 10–12**. For more information, go to **https://amersa.org/2022-conference/**

The annual meeting of the **American Academy of Addiction Psychiatry** will be held **Dec. 8–11** in Naples, Florida. For more information, go to **https://www.aaap.org/training-events/annual-meeting/2022-annual-meeting/**

The CADCA 2023 **Leadership Forum and SAMHSA's Prevention Day** will be held **Jan. 30–Feb. 3** in Washington, D.C. For more information, go to **https://www.aaap.org/training-events/annual-meeting/2022-annual-meeting/**

In case you haven't heard...

Last week in Baltimore, in a hotel across the street from the conference center of the American Association for the Treatment of Opioid Dependence, a staffer shared some reflections on methadone with us. He said he knew too many people who were taking methadone in an OTP and supplementing with street drugs they bought for $1, and that he believed treating trauma and learning humility were equally important as the medication. He supported overdose prevention centers as safe places for drug users to go. And he credited Narcotics Anonymous for helping many people get to know themselves, and come out healthy. Just another view from the real world.