

ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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Our page 1 stories this week look at Damian Family Care's collocation of addiction treatment and FQHCs, and at the importance of coordinating family-centered care so that children and families don't suffer at the hands of the criminal justice and child welfare systems when a parent has a substance use disorder.

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Collocating FQHC and addiction treatment at Damian

When we visited Damian Family Care Centers' Wards Island facility in New York City, collocating addiction treatment services run by Odyssey House and a Federally Qualified Health Center (FQHC) run by Damian, all we could think was: "Why isn't this done everywhere?" Damian originated as a part of Samaritan Health Services but is now an independent not-for-profit corporation. It is run by people who are committed to addiction treatment and recovery. Peter Grisafi, CEO of Damian, and Henry Bartlett, vice president for government and community relations collectively have more than 75 years in the addiction treatment arena. Similarly, their colleagues at Odyssey House, Peter Provet, Ph.D., Odyssey House CEO, and John

Bottom Line...

Damian's Wards Island facility shows what a treatment program can be, in terms of both addiction and health care.

Tavolacci, Odyssey House COO, have long careers in the treatment field and embrace the Damian/Odyssey partnership as the right model for providing health care and substance use disorder treatment in an integrated setting. We visited on March 6.

The Wards Island program is, Tavolacci said, the "Taj Mahal" of publicly funded treatment centers. We have visited about 50 treatment centers and agree (see photos of the art studio,

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Family treatment can break cycle of child welfare involvement

If leaders of substance use treatment programs that work with at-risk children and families have often seen themselves at cross-purposes with child welfare and criminal justice agencies, there is growing evidence of greater cooperation. The director of an innovative women and children's treatment program at the University of North Carolina at Chapel Hill made a pitch for coordinated and family-centered care in a webinar

presentation last week, using her agency's experience as an example.

"Family-centered care is not easy to do, but when it is done well, it is incredibly rewarding, and incredibly fruitful [for families]," said Hendrée Jones, Ph.D., executive director of the Horizons Program, which operates residential and outpatient treatment for pregnant and/or parenting women and their children. The March 16 webinar, titled "From Policy to Practice: Comprehensive and Coordinated Family-Centered Treatment for Families," was sponsored by the Children's Bureau, the Quality Improvement Center and the Center for Children and Family Futures.

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Bottom Line...

More flexibility in funding is helping to create partnerships between substance use treatment and child welfare agencies to improve opportunities for at-risk families.

DAMIAN from page 1

below). There's a gym, art studio, bedrooms that rival any college dorm room we have seen, views, child care (including for babies) and on-site health care.

Damian had help: the New York State Office of Addiction Services and Supports contributed \$28 million to the construction of the Wards Island building. But that's where the help ended: The rest of it is smart people using New York's generous Medicaid program, the release of liability based on tort reform and the vision of people who have worked in the system long enough to know that if you don't treat a person's addiction, they won't get well in other ways either.

Damian Family Care is a network of 15 centers located in New York City and Long Island, and expanding into upstate New York. "We have a specialty in treating people who are going through recovery," Grisafi told *ADAW*. Often patients graduate from

addiction treatment but come back for health care — either at the collocated site or at one of the other sites (there are 12 sites with collocated addiction treatment and health care). Damian treats more than 12,000 patients a year, more than 6,000 of whom are in a collocated model where the FQHC partners with an addiction treatment program. There are referrals from site to site — for example, for optometry, neurology or pain management, which aren't at every site. Damian transports patients from site to site for services that aren't available.

The Wards Island facility is only for residents of Wards Island.

At Wards Island, primary care, OB-GYN and oral health (dental) services are offered.

Sliding scale

Treatment is available on a sliding scale. Anyone below 200% of the federal poverty level (FPL) is slid down to a reduced fee, and anyone

below 100% of the FPL gets the service for free. This includes prescriptions. "We know that people going through recovery have a high percentage of HIV and HCV," said Grisafi. "We treat more than 800 people a year with HIV or HCV." The medications for these conditions work but are expensive.

Odyssey House would have always paid for someone's medications for HIV or HCV, but now that an FQHC is involved, they don't have to do that, explained Grisafi. "They no longer have to pick up that tab," he said. "We pick up the tab."

Full retail for Gilead's hepatitis C medication is about \$60,000.

"We at Odyssey House have seen oral health as important to treating the whole person," said Tavolacci. After medical services, evidence-based addiction treatment and the whole process of recovery, if a patient goes to a job interview and has no teeth, the prospective employer wonders "How can this person represent our organization?" he said. That's why Provet is so committed to dental services. "Provet was the champion in creating the first dental clinic at Odyssey House," said Tavolacci.

Provet, who started Odyssey House 20 years ago, worked for Phoenix House before then. At the Yorktown Heights Phoenix House facility at the time — a beautiful



Alison Knopf



Alison Knopf

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Alison Knopf

Bartlett, Grisafi, and Tavolacci

campus at the time (200 acres) with houses — the program had a dental facility. “People looked at us like we were nuts,” said Provet. “At that time, medical care was barely given to clients.” But the dental chairs were made so that the clients could look out the window at the pasture. “Many visitors were stunned,” said Provet. “There was almost a feeling, even from some funders, like “These clients, they really have it good, these poor people who were living on the streets.” The driving force, said Provet, was to create an environment of dignity. (Damian is also a provider for Phoenix House — one of the collocated sites.)

TCs collocating with FQHCs

This was the model for the programs like Samaritan Village, Phoenix House and Daytop — the residential addiction treatment programs commonly known as therapeutic communities (TCs).

“This is the movement,” said Tavolacci. “We all had this vision of doing a biopsychosocial model.”

How is this financially viable? There are some grants from the

federal government. “We get the wraparound rate from Medicaid,” said Grisafi. The patient population is 85% Medicaid. “That’s our best payer,” he said. “That’s where the non-FQHC providers are — they don’t want Medicaid.” There are regulations the FQHC has to adhere to. For one thing, the board must be a majority of patients of current health centers; this must be demonstrated to the federal government — “not

just coming in for a flu shot,” said Grisafi. Finally, the government covers the FQHC in the Tort Claims Act. “We don’t have to buy malpractice insurance for our providers,” said Grisafi, noting that this cost is very high for OB-GYN. The government doesn’t buy health insurance for the FQHCs, but actually covers them. •

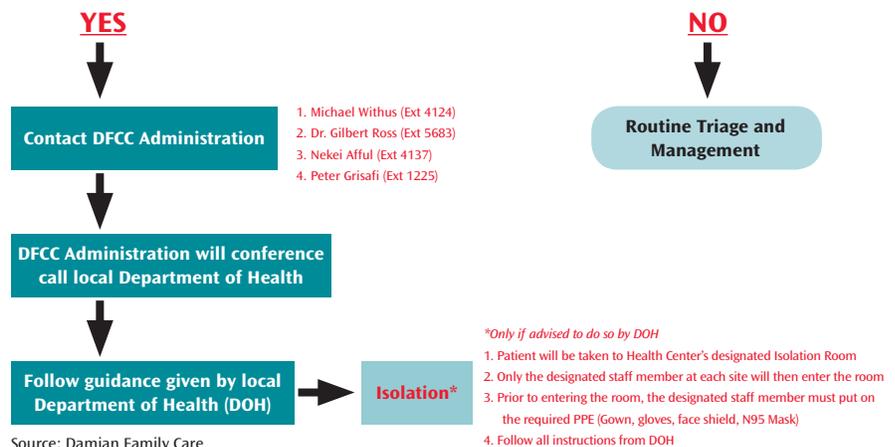
For more information, go to: <https://www.damian.org/>

Flowchart for COVID-19 procedures at Damian Family Care Centers

Below is the protocol at Damian Family Care Centers (DFCC) to be followed for COVID-19/coronavirus. The local department of health confers with DFCC on all suspected positive cases.

1. Identify	
Does the patient meet the following criteria?:(This question should be asked by front desk staff for a patient presenting to the Health Center, or by the staff member answering the phone for a telephone triage) If patient is coughing or showing other signs of communicable disease, a surgical mask may be offered to the patient in accordance with DFCC protocol.	
CLINICAL FEATURES	EPIDEMIOLOGIC RISK (WITHIN 14 DAYS OF SYMPTOM ONSET)
1. Fever ¹ <i>or</i> signs/symptoms of lower respiratory illness (LRI) (e.g. cough or shortness of breath)	AND Any person, including health care workers ⁵ , who had close contact ³ with a laboratory-confirmed ⁶ COVID-19 patient
OR	
2. Fever ¹ <i>and</i> LRI signs/symptoms requiring hospitalization	AND A history of travel from affected geographic areas ²
OR	
3. Fever ¹ <i>and</i> severe LRI (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza) ⁷	AND No source of exposure has been identified

* Affected geographic areas include; China, Iran, South Korea, Europe



Source: Damian Family Care

DEA, SAMHSA relax OTP/OBOT regulations due to COVID-19

Opioid treatment programs (OTPs) that dispense methadone got a fast and clear reprieve from federal authorities last week in the face of COVID-19. The Drug Enforcement Administration (DEA) and the

Substance Abuse and Mental Health Services Administration (SAMHSA) issued policies that give OTPs flexibility in take-homes, limiting the frequency of face-to-face contact and opportunities for transmission of

COVID-19. There is also greater flexibility for office-based opioid treatment (OBOT) with buprenorphine.

Specifically, SAMHSA said March 16 that all states with declared states

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of emergency may request blanket exemption (from SAMHSA) for all stable patients to receive 28 days of take-home doses of methadone. In addition, the state may request up to 14 days of take-homes for “patients who are less stable but who the OTP believes can safely handle” the take-homes.

For states without a declared emergency, each individual OTP may request a blanket exemption for its clinic for up to 28 days for stable patients and up to 15 days for less stable patients. The requests don’t have to be on a per-patient basis, and programs and states should use their clinical judgment and procedures to identify stable patients.

Make sure that enough medication is on hand, SAMHSA urges. An increased supply will accompany these requests. “Therefore, OTPs and states must ensure that there is enough medication ordered and on hand to meet patient needs,” said SAMHSA.

The American Association for the Treatment of Opioid Dependence (AATOD), the membership association of OTPs, is also working on draft field recommendations in dealing with COVID-19, which incorporate SAMHSA’s recommendations in addition to those of the Office of National Drug Control Policy (ONDCP) of the White House. *ADAW* obtained this document, which is awaiting a coordinated response by the State Opioid Treatment Authorities (SOTAs), after which AATOD will release it.

Many states have OTP regulations that are stricter than those of the federal government, and the point of the revisions is to make it easier, not harder, to get take-homes and minimize possible contagion via human contact. So it’s vital that the states work with the federal government, and that’s what happened here, AATOD President Mark Parrino told *ADAW* last week. “I do believe that SAMHSA’s coordination with SOTAs and our guidance is extremely helpful,” he said. “The fact that they are working on blanket

take-home guidance with the states and providers is demonstrating increasing and necessary flexibility.”

COVID-19 is scaring everyone, and it’s commendable that the federal authorities responded so quickly to the needs of the OTP population, so often ignored. “The DEA is also demonstrating greater flexibility in dealing with OTP policy,” Parrino said. “All of this is against the backdrop of a frightened population as governors, county executives and mayors enter a phase of quasi-quarantining.”

Patients maintained on methadone and buprenorphine need daily medication or they will go into withdrawal. With methadone, many patients need to go into the clinic on a daily or almost-daily basis due to federal (and, mostly, state) regulations. “People are getting understandably rattled as greater restrictions are imposed and as freedom of movement is increasingly limited,” said Parrino.

But the greatest number of complaints appears to be that the bars are closed, said Parrino. These complaints are from local officials in New York, he said.

As for the SAMHSA take-home changes, Zachary Talbott, chief clinical officer of ReVida Recovery Centers, president of the National Alliance for Medication Assisted Recovery, and president of the Alcohol and Drug Abuse Certification Board of Georgia, said they are “progressive.”

DEA and telemedicine

The DEA is also allowing for increased use of telemedicine and the internet in particular for office-based opioid treatment and buprenorphine, as well as for OTPs (which dispense buprenorphine and other medications as well as methadone — only OTPs can dispense methadone for opioid use disorder). The sticking point has been the initial evaluation, which had to be done face to face — until now. “While a prescription for a controlled substance issued by means of the Internet (including telemedicine) must

generally be predicated on an in-person medical evaluation (21 U.S.C. 829(e)), the Controlled Substances Act contains certain exceptions to this requirement,” the DEA states. “One such exception occurs when the Secretary of Health and Human Services has declared a public health emergency under 42 U.S.C. 247d (section 319 of the Public Health Service Act), as set forth in 21 U.S.C. 802(54)(D). Secretary Azar declared such a public health emergency with regard to COVID-19 on January 31, 2020 (<https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html>). For as long as the Secretary’s designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable Federal and State law.”

Note that if “the prescribing practitioner has previously conducted an in-person medical evaluation of the patient, the practitioner may issue a prescription for a controlled substance after having communicated with the patient via telemedicine, or any other means, regardless of whether a public health emergency has been declared by the Secretary of Health and Human Services, so long as the prescription is issued for a legitimate medical purpose and the practitioner is acting in the usual course of his/her professional practice,” the DEA wrote, adding however, that “for the prescription to be

valid, the practitioner must comply with any applicable State laws.”

Confidentiality

However, there may be some concerns going forward about confidentiality, already at risk as the federal government pushes to overhaul 42 CFR Part 2 and Congress considers eliminating it. The Department of Health and Human Services said on

March 17 that it would waive potential Health Insurance Portability and Accountability Act penalties “for good faith use of telehealth” during the COVID-19 crisis. “Enforcement discretion” is only for telehealth and not for in-person treatment; however, in-person treatment for anything is taking a back seat to COVID-19.

As *ADAW* was going to press, SAMHSA issued a new directive eliminating

42 CFR Part 2 confidentiality restrictions on SUD telehealth in the case of a medical emergency (<https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf>). More on this, and on how to define “stable,” next week. •

For more information, go to

• <https://www.samhsa.gov/medication-assisted-treatment>

Alcohol store closure in Pennsylvania: Withdrawals in future?

Last week, the Pennsylvania Liquor Control Board, which runs all liquor stores in the state (and employs all the workers), announced that the stores would be closed 24/7 to mitigate against the spread of COVID-19. The announcement came on March 16, with stores to close at 9:00 p.m. the next day (St. Patrick’s Day, a notorious drinking day).

“This was a tremendously difficult decision to make, and we understand the disruption our store closures will have on consumers and licensees across the commonwealth” of Pennsylvania, said Board Chairman Tim Holden in a press statement. “But in these uncertain and unprecedented times, the public health crisis and mitigation effort must take priority over the sale of wine and spirits, and the health and safety of our employees and communities is paramount.”

Asked about the possibility that alcohol-dependent people could go into withdrawal, board spokeswoman Elizabeth Brassell told *ADAW*, “There will be beer and wine in the grocery stores — they can go there.”

The Liquor Control Board has 600 stores across the state, and the closure will last “as far as we can see for the short term,” said Brassell.

“This decision was made in conjunction with officials at the health department,” she said. Asked which officials in the public health department participated in the decision, she refused to answer. The health department did not return our call. The

person who answered the phone in the press office at the health department did tell us that all calls should go to the Liquor Control Board.

“You’d need to buy three to eight times as much wine or beer to get the same alcohol content as liquor,” said John F. Kelly, Ph.D., Elizabeth R. Spallin Professor of Psychiatry at Harvard Medical School and Director of the MGH Recovery Research Institute. “But at least they can get alcohol that way, which will stave off withdrawal and mitigate or obviate adverse health events.” But Kelly said that the policy “could create an increase in adverse health events, including life-threatening withdrawal, seizures, and delirium, for those who are addicted to alcohol and who are unable to obtain it.”

“People who are desperately in need of alcohol will probably be able to find some,” said George Koob, Ph.D., director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). “If they have the means, they’re going to find ways of getting in enough alcohol to stave off severe withdrawal, but there will be exceptions — people who are really dependent.”

Physicians, including emergency care physicians, will know how to do a risk assessment, so people who are alcohol-dependent can call and ask how to handle the situation. “It should probably be done by phone in the current climate,” said Koob. “Most alcohol withdrawal treatment today is done on an ambulatory basis.”

There are also many homeless people who have alcohol dependence, and it’s going to be harder for them to find help, as always. Severe delirium tremens is rare, but it occurs. “They’re going to be having a high fever, delirium, seeing things, severe shakes, and I assume that if someone saw someone in that condition, the humanitarian thing would be to get them to an emergency room,” said Koob. There are established protocols for severe alcohol withdrawal, but there are people who are going to suffer, and as usual, people who are homeless will suffer the most.”

Koob starkly reminded us that “drinking is contraindicated for catching the coronavirus because it lowers the immune response.” Alcohol interacts with many conditions. “The silver lining is that this allows people to evaluate their relationship with alcohol,” said Koob of the Pennsylvania policy. “Everybody’s going to have a dry March whether they like it or not,” he said. “Hopefully we won’t lose too many people to alcohol withdrawal. This will be a triage situation. If the projected viral spread goes on to be the worst-case scenario, it’s going to be a very crowded emergency room.”

There is a lot treatment programs can do via virtual connections, “if they are up and running,” said Koob. And this will involve more than treating COVID-19. NIAAA’s Lorenzo Leggio, M.D., is from Italy, where COVID-19 is a full-blown crisis. And

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Leggio says that “there’s going to be a good deal of mental illness that follows the viral illness because of the loss of loved ones, because of trauma” — and because of a return, eventually, to heavy drinking to cope with these issues. “There could

be a drinking rebound, with a dry March and April, but a very wet June,” said Koob sadly.

NIAAA clinical research has stopped, and across the country many researchers have stopped recruiting, said Koob. “There will be a slowdown on research.”

Not only is COVID-19 a pandemic, but the cost to society, and the physical harm, is “enormous and continuing,” said Koob. “Fingers crossed that we get a treatment, we blunt its spread and we can get back to trying to solve the problems we are all trying to solve.” •

Kolodny counters Wakeman, but both agree on many points

It wasn’t a live debate as had been planned, with most presenters, including Sarah Wakeman, M.D., and Andrew Kolodny, M.D., presenting remotely like almost all of the speakers, with their slides and microphones, at the American College of Medical Toxicology (ACMT) opioids symposium March 12 in New York City.

In fact, Kolodny, who spoke after Wakeman, noted that there was “a lot of agreement” between them, which, he added, would “make for a less icy interaction.”

That was not what anybody who knows them both could have expected. There were no sparks, just back-to-back presentations, on which, indeed, there was much agreement.

And it shows that, perhaps, the field has been unfair to Kolodny, who has been blamed for being so anti-opioid that some in the pain community hold him personally responsible for the cutbacks in opioid pain medication.

OD deaths or addiction?

Wakeman had argued that restricting clinical decision-making in treating patients with opioid pain medications is a bad idea, and Kolodny agreed. He also agreed that people who have been on chronic opioid treatment for a long time can’t just be terminated, but he used language that went beyond Wakeman’s, calling them “victims of aggressive prescribing.” As Kolodny has told *ADAW* in the past, he told the gathered attendees, some there for the annual meeting, some just for the symposium, as well as the

large online audience, that many of these chronic opioid patients need treatment with buprenorphine — or to stay on the opioids for pain.

However, where they differed was in describing the problem, which Wakeman defined as an overdose crisis and Kolodny called an opioid addiction epidemic. “I wouldn’t focus so much on the deaths,” said Kolodny. “That would be like blaming AIDS deaths on PCP pneumonia, instead of on HIV infections.” The reason for the increase in neonatal abstinence syndrome and foster care is opioid addiction, not overdoses, he said.

That’s why he focuses on reducing opioid prescribing, which he said would reduce addiction. But would it also reduce deaths? Apparently not — and that’s what Wakeman’s presentation showed: We have reduced opioid prescribing, and deaths are going up, not from prescribed opioids but from heroin and illicit fentanyl.

Blaming the manufacturers

Kolodny went into his well-known — and, in many respects, true — litany of blaming the manufacturers for increasing prescribing.

Kolodny thanked the ACMT for its support in 2010 when Physicians for Responsible Opioid Prescribing put together education information on opioid prescribing, and looked for professional societies to co-brand with the notion that opioids are addictive and haven’t been safe and effective for long-term use. “The only professional society that was willing to co-brand was the American

College of Medical Toxicology,” he said. “It was almost taboo in 2010 to say that opioids are addictive.”

But Kolodny refused to accept that the increase in overdoses was due to the cutbacks in opioid prescribing — Wakeman’s main point, backed up by cited studies. “We keep hearing that reduced prescribing has made the opioid crisis worse by forcing people to switch from prescription opioids to heroin,” he said. “I can understand why people believe this.” However, he said that inner-city Washington and Baltimore, where many people are “victims of the 70s and heroin,” are where fentanyl overdoses are clustered. “These places are still struggling,” he said.

However, like Wakeman, he believes in liberalizing access to buprenorphine, and doesn’t think diversion would lead to an increase in overdoses. Asked whether buprenorphine could be dangerous when combined with other opioids, benzodiazepines or alcohol, he said that “obviously it’s dangerous and not recommended, but it’s much less dangerous for someone to combine buprenorphine (a partial agonist) with these than a full agonist (like methadone).”

Most presenters and half of the attendees participated remotely due to COVID-19 concerns. The March 12 symposium was supposed to precede the ACMT’s three-day annual meeting, but at 3:00 that day New York City Mayor Bill de Blasio announced new restrictions, and the association had to quickly shut down the in-person meeting. •

Online meetings for 12-Step and other support groups

The study showing that Alcoholics Anonymous as as effective, or more effective, than psychotherapy (see “Research: AA is better pathway to abstinence than psychotherapy,” *ADAW* March 16, <https://onlinelibrary.wiley.com/doi/full/10.1002/adaw.32655>) was published a few days before COVID-19 federal and state restrictions on group gatherings (“social distancing”) took effect, making AA and other meetings untenable. This seems like cruel timing. But John Kelly, Ph.D., one of the authors of the study, provided the below infographic to *ADAW* on other meetings. And Keith Humphreys, Ph.D., co-author, was quoted recently on ABC News saying that he is concerned about patients with extreme mental health issues such as addiction, for whom face-to-face contact is key.

“Those small actions -- the holding of hands, the hugs [and] the wiping away of tears -- those are very important,” he said. Also in the same article, the General Service Office of AA said that contingency plans for local meetings include “creating contact lists and keeping in touch by phone, email or social media,” and “meeting by phone or online.” (For the ABC News story, go to <https://abcnews.go.com/Health/therapists-face-challenges-coronavirus-limits-person/story?id=69625069>). Humphreys also urges friends and family members of people who are struggling to reach out and support them.

The infographic is a diamond-shaped graphic with four colored quadrants: teal (top-left), purple (top-right), yellow (bottom-left), and blue (bottom-right). A dark grey diamond in the center contains the text 'Online/Digital Recovery Support Resources'. Each quadrant lists a support group and its website. The teal quadrant features the Alcoholics Anonymous logo and lists 'Alcoholics Anonymous' with websites: aa-intergroup.org/directory.php, onlinegroupaa.org, and aaonlinemeeting.net. The purple quadrant features the Narcotics Anonymous logo and lists 'Narcotics Anonymous' with website: virtual-na.org and na.org/meetingsearch (with a note: *for country, select "Web"). The yellow quadrant features the SMART Recovery logo and lists 'SMART Recovery' with websites: smartrecovery.org/smart-recovery-toolbox/smart-recovery-online and smartrecovery.org/private-convenient-online-recovery-support. The blue quadrant lists 'Other Resources' with websites: addictioncampuses.com/alcohol/apps-for-recovery, sobergrid.com/howitworks, intherooms.com/home, and unityrecovery.zoom.us/my/allrecovery. A smartphone icon is at the bottom center of the blue quadrant.

Source: John Kelly, Ph.D.

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Some of this progress has been driven by bipartisan federal legislation that has enhanced opportunities for substance use treatment and child welfare agencies to work together. The Family First Prevention Services Act, signed by President Trump in early 2018, allows for use of federal Title IV-E foster care and adoption assistance dollars to reimburse states for substance use treatment and other behavioral health services to children at imminent risk of foster care placement. Families affected by the opioid epidemic make up a substantial share of the growth in cases that has overburdened many child welfare agencies.

Among its provisions, the act allows foster care payments to be given to a parent residing in a family-centered substance use treatment facility, as a strategy aimed at keeping children out of the protective services system.

Jones suggested that as collaborative care models evolve, housing support for women and children needs to become a high-priority component. “Housing, bar none, is the most significant challenge for the families I work with,” she said.

Emphasize strengths

Throughout her presentation, Jones reinforced that the women in treatment with whom she has worked have great resilience. “These are some of the strongest women I know,” she said.

Horizons, which operates both residential and outpatient levels of care, gives every woman the same foundational education in parenting. Jones said, however, “Every woman I’ve worked with has strengths in the parenting arena.”

Also, in family-centered treatment, every involved family member has his/her own treatment plan, Jones said.

Family-centered treatment for these women also needs to be trauma-informed, Jones explained. She said that among the women in the Horizons Program, 80% have

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experienced physical, sexual or emotional abuse in childhood or adulthood. Best practices for trauma-informed care include simple provisions such as giving women 48 hours' notice before a planned activation of a fire alarm, and using floor lighting that is not as harsh to the eye as traditional lighting. The program also hires individuals with lived experience, who can serve as role models for the women, Jones said.

She cited several effective interventions for trauma, adding that the clinical approach that gets the most rave reviews among Horizons staff is dialectical behavior therapy. However, "You can't pick just one strategy or program," she said. She also pointed out, "Sometimes we forget to engage the fathers and other family members."

The language of treatment also is critical in family-centered care, Jones said. "Please do not use the words 'clean' or 'dirty'" when referring to drug screen results, she said. "It's really not helpful."

Horizons' services include medical care, buprenorphine treatment for opioid use disorder, on-site psychiatric services twice a week, transportation services, day care and employment assistance, with the latter including help in compiling a job interest inventory and preparing a résumé. Trying to achieve stable housing remains the most significant obstacle to progress, with government assistance vouchers often taking months to years to secure, Jones said.

Interagency cooperation

Jones is proud of the strong relationships Horizons has built with child protective services and the justice system. About one-third of the program's patients come from incarceration. Staff from the correctional facility transport the women to the residential program, she said.

An important goal involves breaking the intergenerational cycle of child welfare involvement. Mentioned in the webinar was one state's data showing that 40% of women with children

Coming up...

Cancelled, going virtual: The annual conference of the **American Society of Addiction Medicine** will be held **April 2–5** in **Denver**. For more information, go to <https://www.eventscribe.com/2020/ASAM/>.

Cancelled: **NatCon 20** will be held **April 5–7** in **Austin, Texas**. For more information, go to <https://www.eventscribe.com/2020/NatCon20/>.

Postponed: The **Rx Drug Abuse and Heroin Summit** will be held **April 13–16** in **Nashville, Tennessee**. For more information, go to <https://www.rx-summit.com/>.

The leadership conference of the **National Association of Addiction Treatment Providers** will be held **May 16–18** in **San Diego**. For more information, go to <https://www.naatp.org/training/national-addiction-leadership-conference>.

The annual meeting of the **College on Problems of Drug Dependence** will be held **June 20–24** in **Hollywood, Florida**. For more information, go to <https://cpdd.org/>

The annual meeting of the **Research Society on Alcoholism** will be held **June 20–24** in **New Orleans**. For more information, go to <http://www.rsoa.org/>

The annual meeting of the **National Association of State Alcohol and Drug Abuse Directors** will be held **June 22–24** in **Bethesda, Maryland**. For more information, contact Fsimpson@nasadad.org

Stay tuned, as other changes will probably be forthcoming.

prenatally exposed to substances had been known to the child welfare system when they were children.

Challenges in coordinating care remain, in areas such as the changing landscape around confidentiality, Jones said. In the question-and-answer portion of the webinar, she also acknowledged the need for innovative reimbursement models,

after an attendee asked how value-based payment models under Medicaid might affect the integration of care. Already, "We spend a lot of nonbillable time," Jones said.

She also admitted she was not aware of any fidelity tools for providers to ensure they are delivering family-centered care, calling that "a great area for research." •

In case you haven't heard...

For several years, we have been writing about the \$1–2 billion infused into the substance use disorder (SUD) treatment and prevention system due to the opioid epidemic. In the past two weeks, the American taxpayer has been put on the hook for \$8 billion, then \$50 billion and now possibly \$1 trillion for COVID-19 — most recently to bail out hotels, airlines and businesses in general, not to mention giving checks to individual Americans. This virus needs to be combatted with everything science can offer, but can we really buy people into acceptance of financial losses while not funding treatment, public health and the safety net the way they always should have been funded? You can expect to see fewer headlines about opioids and more about viruses (in the mainstream media, not in *ADAW*, of course). As *ADAW* readers well know, addiction goes on. So does good news like recovery. So keep your eye on the ball and advocate for your patients. There must be something in that \$1 trillion for them. Your children's great-grandchildren will be paying for it.