Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

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In This Issue...

Perils of eliminating the x-waiver: Comments from former CSAT official

A highly unusual meeting took place in 2014—a group of experts, including federal officials, and top legislators – namely, former senators Carl Levin (D-Michigan) and Orrin Hatch (R-Utah) met in June of that year to discuss changing the Drug Addiction Treatment Act of 2000 (DATA 2000), which regulated buprenorphine prescribing up until it was eviscerated in the spending bill last month (see https://onlinelibrary.wiley.com/doi/epdf/10.1002/adaw.20431). The lawmakers wanted to raise the maximum number of patients one physician could have (at the time, it was 30 under DATA 2000, and 100 under the 2006 amendment; since then it has been raised further).

Federal officials warned of buprenorphine "pill mills." These officials included H. Westley Clark, M.D., J.D., then director of the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services, which along with the states and the federal Drug Enforcement Administration regulates buprenorphine prescribing for opioid use disorder (OUD), Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA), Elinore McCance-Katz, M.D., then chief medical officer of SAMHSA, and Michael Botticelli,

See X-WAIVER page 2

Bottom Line...

H. Westley Clark, M.D., J.D., takes down the language from last month's spending bill, now law, which removes the x-waiver requirement for prescribing buprenorphine.

NIH ups its commitment to study harm reduction approaches

The National Institutes of Health (NIH) last month announced the grant awardees for its new initiative representing its largest funding commitment yet to evaluating harm reduction approaches to reducing fatal overdoses. Among the concepts to be tested as part of NIH's harm reduction research network are mobile van-delivered naloxone, contingency management strategies and "secondary distribution" of harm reduction supplies from one drug user to another.

Among the ideas not included in the awarded projects are safe consumption spaces, listed in NIH's original description of the research initiative as an "emerging" policy. Last month's announcement also made it clear that no NIH funding is being used for the purchase of pipes, syringes, or needles — a fact that could lead proponents of more aggressive harm reduction strategies

See HARM REDUCTION page 7

Bottom Line...

A point of emphasis for several of the newly announced projects in the National Institutes of Health's harm reduction research network involves expanding access to harm reduction services via mobile van, mail or virtual outreach.

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then acting director of the White House Office of National Drug Control Policy (ONDCP).

The x-waiver was a requirement that all physicians prescribing buprenorphine for OUD take an 8-hour training course under the supervision of SAMHSA.

The new law requires that, with limited exceptions, any clinician applying for a new or a renewed DEA license take a once in a lifetime 8-hour course with respect to the treatment and management of patients with opioid and other substance use disorders. Such a course could completely minimize OUD by focusing on stimulants, alcohol, smoking, marijuana or novel substances. In short, as written, there is no actual requirement to be trained primarily in the treatment and management of an opioid use disorder.

All of these federal agencies now support elimination of the x-waiver entirely, meaning that anybody can now prescribe buprenorphine for OUD with no special training or certifications, until they need to renew their DEA license.

Also present at that horseshoe meeting, named for the shape of the table the participants were sitting around, were advocates of getting rid of buprenorphine regulations, including the American Society of Addiction Medicine (ASAM).

One of the main elements that exists today, which did not in 2014, is the number of deadly overdoses due to illicit fentanyl. Advocates and lawmakers now use this tragedy as the rationale for increasing access to treatment. Will increased access to buprenorphine result in fewer overdoses? Will removing the x-waiver result in more physicians prescribing buprenorphine? These are questions we need to focus on in the future. But for now, the question is, what next?

"For ASAM to be talking about obstacles to buprenorphine without talking about prescriber attitudes misses the mark."

H. Westley Clark, M.D., J.D.

'Floodgates are opened'

In 2014, what Botticelli wanted to lay out for all present was what could happen if the "floodgates are opened," as he put it.

Well, the floodgates are now open. We asked Clark, now in retirement after a long post-government career at Santa Clara University, what could happen.

"For ASAM to be talking about obstacles to buprenorphine without talking about prescriber attitudes misses the mark," Clark told *ADAW* last week. "First, the 8-hour training requirement is still there, but now you don't actually need to know anything about OUD to treat it with buprenorphine or any other Schedule III, IV, or V drug."

Clark also noted that ASPE (Assistant Secretary [of HHS] for Planning and Evaluation) study which found that although requirements were suspended for those who saw less than 30 patients under the 2021 Biden buprenorphine guidelines, there was no increase in the number of patients seen (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33643). He also cited the impact of stigma and discrimination on the willingness of practitioners to see patients with substance use disorders. Neither the MAT and the MATE Acts, both incorporated into the spending law, account for stigma and discrimination against people with OUDs, he said.

In addition, neither the MAT nor MATE Acts account for justice and equity issues, said Clark. These include:

- cost of buprenorphine
- lack of pharmacy stocking of buprenorphine

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

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- pharmacy deserts
- the 12 states that do not have Medicaid expansion
- maldistribution of prescribers, especially prescribers of color and prescribers in rural communities.

Pill mills

Clark is also concerned about "the prospect of buprenorphine clinics becoming pill mills, given the lack of requirement for much training or behavioral health services, even as a referral." (The labeling for buprenorphine-naloxone requires physicians be able to provide or refer patients to counseling.) "This means that co-occurring disorders such as PTSD, depression, suicidality, psychosis, etc. will be further ignored in this new paradigm," said Clark. "I'm not saying that the often-amended DATA 2000 adequately addressed the co-morbidity issues, but at least it deferred to the significance of these themes." Now, the complete elimination of the requirements does mean that OUD could be treated with just a pill.

(Many say that this is enough, and some even say that diversion isn't a problem because buprenorphine used in the streets is used for the intended purpose – treatment of withdrawal – although that isn't its purpose, its purpose is treatment of OUD).

The treatment organizations, including ASAM, the American Psychiatric Association, the American Medical Association, and others, will have to "redouble their efforts to meet people suffering from OUD where they are by dealing with co-occurring mental health issues, homelessness, unemployment and other issues," said Clark. "Otherwise, it will appear that it is only the drug dealers and the DEA who focus on demand or demand reduction. Drug dealers have shown a fluidity and flexibility characteristic of a agile vendors in the marketplace, while organized medicine complained about the same 8 hours of training that the MATE Act requires and the free X-waiver which only showed intent to treat OUD ."

8 hour course

The 8 hour course – the x-waiver – has been cited as the barrier to buprenorphine prescribing. But Clark contests this. The education that MATE requires is "vague and nonspecific," said Clark. "Any CME vendor approved by ACCME can put together an online course focusing on any substance. The complexity of SUD/OUD will have to be speed-reviewed in the only once in a lifetime education that MATE requires. However, once practitioners of good faith understand the complexity of it

Continues on page 4

Evidence for counseling

Below are articles which assert that psychosocial counseling is at least beneficial, and some say it's essential, to treatment of OUD.

- Schottenfeld RS, Chawarski MC, Mazlan M. Behavioral counseling and abstinence-contingent take-home buprenorphine in general practitioners' offices in Malaysia: a randomized, open-label clinical trial. Addiction. 2021 Aug;116(8):2135-2149. doi: 10.1111/add.15399. Epub 2021 Jan 21. PMID: 33404150.
- Berry ARW, Finlayson TL, Mellis LM, Urada LA. Association between Participation in Counseling and Retention in a Buprenorphine-Assisted Treatment Program for People Experiencing Homelessness with Opioid Use Disorder. Int J Environ Res Public Health. 2021 Oct 21;18(21):11072. doi: 10.3390/ijerph182111072. PMID: 34769591; PMCID: PMC8582897.
- McHugh RK, Hilton BT, Chase AM, Griffin ML, Weiss RD. Do people with opioid use disorder and posttraumatic stress disorder benefit from adding Individual opioid Drug Counseling to buprenorphine? Drug Alcohol Depend. 2021 Nov 1;228:109084. doi: 10.1016/j.drugalcdep.2021.109084. Epub 2021 Sep 20. PMID: 34607194; PMCID: PMC8595708.
- Meshberg-Cohen S, Black AC, DeViva JC, Petrakis IL, Rosen MI. Trauma treatment for veterans in buprenorphine maintenance treatment for opioid use disorder. Addict Behav. 2019 Feb;89:29-34. doi: 10.1016/j.addbeh.2018.09.010. Epub 2018 Sep 12. PMID: 30243036.
- Levin JS, Landis RK, Sorbero M, Dick AW, Saloner B, Stein BD. Differences in buprenorphine treatment quality across physician provider specialties. Drug Alcohol Depend. 2022 Aug 1;237:109510. doi: 10.1016/j.drugalcdep.2022.109510. Epub 2022 May 23. PMID: 35753279.
- Lin LA, Lofwall MR, Walsh SL, Knudsen HK. Perceived need and availability of psychosocial interventions across buprenorphine prescriber specialties. Addict Behav. 2019 Jun;93:72-77. doi: 10.1016/j.addbeh.2019.01.023. Epub 2019 Jan 16. PMID: 30690416; PMCID: PMC6488400.

Continued from page 3

all, I wonder if there will be a flood of practitioners to ensue now that the so-called barriers of the X-waiver are down."

According to the ASPE study, there were between 114,000 and 115,000 DATA waived prescribers. "With the removal of the X-waiver, there should be a larger number of the over 1 million practitioners potentially prescribing buprenorphine, unless, of course, they don't want to treat people with SUDs," said Clark.

One of the unfortunate aspects of the change is that SAMHSA will no longer be able to directly track buprenorphine prescribers, said Clark. Buprenorphine data will have to come from IQVIA, DEA, PDMPs, claims data and surveys of willing practitioners.

But the other side of the story will come from the Centers for Disease Control and Prevention in terms of overdoses, and SAMHSA's National Survey on Drug Use and Health in terms of who is using what.

"I suppose what the Congress has done is to challenge the health care delivery system to step up and to prescribe buprenorphine more ubiquitously," said Clark, who has a long experience treating OUD with the VA, and with opioid treatment programs (OTPs). The next step will be a big challenge to OTPs, who may be pressed to alter their business models with methadone.

Indeed. If that 2014 horseshoe meeting were to be held today, another bill much more drastic would be under discussion: the OTAA, which would allow all physicians with training in addiction to prescribe methadone, and would essentially eliminate OTPs altogether. That is unlikely to happen, with a huge OTP reform proposal already in rulemaking which makes methadone through OTPs easier to access (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33643). But we aren't making any predictions. •

More on the funding additions for SUD treatment and prevention

The "omnibus" spending bill, passed by Congress and signed by President Biden last month (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33651), has too many important additions for substance use disorder (SUD) prevention and treatment to occupy even a few issues, so we will be shedding more light on what the law contains in coming weeks. The Substance Abuse and Mental Health Services Administration (SAMHSA) will be undergoing bigger changes than it has in more than two decades.

Notably, as covered last week in the Preview issue, the X-waiver is gone from buprenorphine prescribing for opioid use disorder (OUD). See our story on page 1 for a commentary on that.

Below are some of the additions to the spending law, with language from the Labor, Health and Human Services, Education, and Related Agencies appropriations committee that includes final directives from Congress to SAMHSA on how certain funds should be spent.

Building Communities of Recovery. The agreement provides an increase for enhanced long-term recovery support principally governed by people in recovery from SUDs. The agreement encourages SAMHSA to continue supporting recovery support programs principally governed by people in recovery from SUDs, including peer support networks.

First Responder Training. The agreement urges SAMHSA to take steps to encourage and support the use of First Responder Training funds for opioid safety education and training, including initiatives that improve access for licensed health care professionals, along with paramedics, to emergency devices that are used to rapidly reverse the effects of opioid overdoses. Within the increase, the agreement provides $10.5 million to make awards to rural public and non-profit fire and emergency medical services agencies as authorized in the Supporting and Improving Rural Emergency Medical Service's Needs (SIREN) Act (P.L. 115-334). The agreement again encourages SAMHSA to allow the purchase of equipment, including naloxone, and to continue to fund grants with award amounts lower than the maximum amount allowable.

Medication-Assisted Treatment for Prescription Drug and Opioid Addiction. The agreement directs SAMHSA to ensure that these grants include as an allowable use the support of medication-assisted treatment and other clinically appropriate services to achieve and maintain abstinence from all opioids, including programs that offer low-barrier or same-day treatment options. Within the amount provided, the agreement includes $14.5 million for grants to Indian Tribes and Tribal Organizations.

Opioid Use in Rural Communities. The agreement encourages SAMHSA to support initiatives to advance opioid use prevention, treatment, and recovery objectives, including by improving access through telehealth. SAMHSA is encouraged to focus on addressing the needs of individuals with SUDs in rural and medically underserved areas. In addition, the agreement encourages SAMHSA to consider early interventions, such as co-prescription of overdose medications with opioids, as a way to reduce overdose deaths in rural areas.

Opioid Use Disorder Relapse. The agreement recognizes SAMHSA's efforts to address OUD relapse within federal grant programs by emphasizing that opioid detoxification should be followed by medication to prevent relapse to

opioid dependence. The agreement encourages SAMHSA to continue these efforts.

Pregnant and Postpartum Women. The agreement provides an increase, and again encourages SAMHSA to fund an additional cohort of states under the pilot program authorized by the Comprehensive Addiction and Recovery Act (P.L. 114-198).

Recovery Housing. In order to increase the availability of high quality recovery housing, the agreement encourages SAMHSA to examine opportunities to provide direct technical assistance to communities in multiple states and promote the development of recovery ecosystems that incorporate evidence-based recovery housing for SUD intervention. SAMHSA is encouraged to explore the establishment of a Center of Excellence with a non-profit, in collaboration with a college of public health, that has expertise and experience in providing technical assistance and research in recovery housing and focuses on homeless and justice-involved individuals utilizing blended funding and an intervention model with demonstrated outcomes.

Treatment Assistance for Localities. The agreement again recognizes the use of peer recovery specialists and mutual aid recovery programs that support medication-assisted treatment. The agreement directs SAMHSA to support evidence-based, self-empowering, mutual aid recovery support programs that expressly support medication-assisted treatment in its grant programs.

Areas of concern

There was concern about the way SAMHSA established its "Office of Prevention Innovation" (OPI) without public notice, and without including it in the fiscal year (FY) 2023 budget request. "Further, the agreement is concerned that the work conducted by the OPI may be outside of the authorized scope of the federal Center for Substance Abuse Prevention (CSAP)," notes the appropriations committee's report. "The agreement requests an update from SAMHSA on OPI and its activities within 120 days of enactment of this Act" [the omnibus bill that was enacted on Dec. 28, 2022].

Prevention is another area of concern about funding from CSAP. It involves "efforts to reduce the risks associated with drug use, including efforts to avoid drug overdose deaths and the spread of diseases such as HIV and hepatitis." The appropriations committee supports these programs, but stresses that they should be funded by [Center for Substance Abuse Treatment] CSAT and not CSAP, because they are not preventing drug use, but rather treating people who already have SUDs. •

Study finds consistent increase in cannabis edible exposures in children

A study published in *Pediatrics* last week found an alarming increase in exposures to cannabis edibles by children under six years old. Using a retrospective analysis of the National Poison Data System, the researchers found there were 207 cases in 2017 and 3,054 cases in 2021. The vast majority occurred in a home. In 70% of the cases, there was central nervous system depression, a serious condition in which a person's breathing and heart can stop, and death can ensue. In 22.7% of the cases, the children were admitted to the hospital. In 8.1% of the cases, the patients were admitted to critical care units. There has been a consistent increase in pediatric edible cannabis exposures over the past five years, with the potential for significant toxicity, warned researchers from the Department of Emergency Medicine at Southern Illinois University School of Medicine. They added that it is important for providers to be aware of this in their practice as it presents an important opportunity for education and prevention. Cannabis edibles look like candy or cookies or cakes, and it's easy to see how young children could find them appealing.

Below is a chart showing the clinical effects on the children. •

Top 30 Clinical Effects for all Cases Followed to a Known Outcome (*n* = 4,827)

Organ System	Clinical Effects	Number of Cases (%)
Neurologic	CNS depression	3381 (70.0)
	Ataxia	359 (7.4)
	Agitation	342 (7.1)
	Confusion	294 (6.1)
	Tremor	98 (2.0)
	Dizziness/vertigo	91 (1.9)
	Seizure (any amount)	79 (1.6)
	Hallucinations/ delusions	47 (1.0)
	Slurred speech	*45 (0.9)*
	Headache	18 (0.4)
Cardiovascular	Tachycardia	548 (11.4)
	Hypotension	123 (2.5)
	Bradycardia	68 (1.4)
	Hypertension	43 (0.9)
Gastrointestinal	Vomiting	458 (9.5)
	Nausea	75 (1.6)
	Abdominal pain	49 (1.0)
Ocular	Mydriasis	284 (5.9)
	Red eye/ conjunctivitis	111 (2.3)
	Nystagmus	51 (1.1)
	Miosis	24 (0.5)
Respiratory	Respiratory depression	148 (3.1)
	Hyperventilation/ tachypnea	30 (0.6)
Other	Pallor	65 (1.3)
	Fever/ hyperthermia	49 (1.0)
	Acidosis	39 (0.8)
	Muscle weakness	38 (0.8)
	Hypothermia	38 (0.8)
	Urinary retention	35 (0.7)
	Electrolyte abnormality	32 (0.7)

Source: Pediatrics

Hopes and fears for 2023, reflections on 2022

As is traditional, with the new year, we asked stakeholders for their reflections on the past year and their hopes and fears for the new year. Here are some responses so far. (If you haven't submitted yours yet, please do: adaunewsletter@gmail.com).

Two bright spots of 2022 were the greater focus by [Office of National Drug Control Policy] ONDCP and [U.S. Department of Health and Human Services] HHS on the relaxation of regulations for individuals with opioid use disorder receiving treatment in opioid treatment programs and the use of contingency management (CM) for individuals with stimulant use disorder. Both initiatives will expand treatment capacity in a measured and evidence-based manner. Our hope for the coming year is that legislation to broaden methadone access beyond what has been done through the regulatory revisions will be put on hold in favor of tracking outcomes related to safety, access, and quality under the new rubric; and, that we see more concrete policy and training guidance on CM to avoid improper implementations that could result in CM falling short of its promise. With the year closing with new proposed rules from CMS that include provisions to improve SUD coverage, we are extremely happy with the [Biden] administration's efforts this year to keep access to substance use disorder treatment front and center!

—Sarah Wattenberg, director of quality and addiction services, National Association for Behavioral Healthcare

My offering is not a warning, prediction or threat assessment. Rather it's a wish. I wish that in 2023 our field could find a mechanism to bring together, face-to-face the leaders of our various networks, factions and organization to talk on a regular basis. We used to but have lost that capability.

In the 1990s I was fortunate to be employed by organizations that allowed me to be in Washington, D.C. fairly often. A highlight of these trips was to attend a once- or twice-a-year gathering of leaders and leadership organizations called the Forum. Orchestrated by the now defunct Johnson Institute and the National Council on Alcohol and Drug Dependence (also defunct), the event was held at the National Press Club and often had thought leaders as speakers.

The Forum led to the development of something called The Alliance Project which led directly to the eventual formation of Faces and Voices of Recovery (FAVOR). An organization committed to mobilizing the 23 million Americans in recovery. It was partly these meetings that fostered the collaboration necessary to birth FAVOR, which just celebrated a 20-year anniversary.

At some point [Substance Abuse and Mental Health Services Administration] SAMSHA decided that their national recovery month campaign could be greatly augmented by regularly convening a gathering of the tribes held twice-a-year called the National Recovery Month Planning Partners with a rollout in September that also usually brought us to the National Press Club, as well as a high concept luncheon, and again, the opportunity to meet, greet and collaborate.

During the previous administration, SAMHSA killed funding for convening the planning partners, although the annual event continues in the virtual world thanks to Faces and Voices of Recovery.

The benefits of face-to-face interaction are important enough for us to try and find a way to create an annual leadership gathering/summit.

—John de Miranda, independent consultant

My hope for 2023 is that the new Congress will recognize that the addiction crisis has worsened during COVID and that evidence-informed legislation is needed to combat it.

—Keith Humphreys, Ph.D., Esther Ting Memorial Professor Psychiatry and Behavioral Sciences, Stanford University

Acuity. Density. Equity. Workforce. Parity. For [National Association of Addiction Treatment Providers] NAATP and the addiction treatment profession, these words describe our universe, our challenge, and our opportunity. 2022, and the several years preceding it, have stretched treatment providers to their limits. A more difficult period of operation is beyond recall. Examples:

- Sufferers are sicker than ever before;
- A greater density of the population suffers from substance use disorders than at any other time in American history;
- We are finally awakened to our obligation to address the inequity of our system;
- Our workforce is exhausted, depleted and reimagined; and
- Insurance reimbursement remains grossly inadequate.

There is one more word: Community. Our community has held. There is no quit in this population. Through community, we are standing strong and building an endemic system that will treat our population for decades.

When COVID hit, there was more uncertainty than certainty. Nearly three years in, most providers are recovered or entering recovery, and the environment, while not entirely predictable, allows for strategic and operational forecasting. Operations have evolved to accommodate an altered population. Among the adjustments is managing greater acuity in our

patients combined with co-occurring disorders that reflect a society with deteriorating mental health.

As a professional society and trade association, NAATP has emerged from this period stronger than before. NAATP's membership did not decrease but grew at a greater rate and to the highest population in our history. Our members need the collective that NAATP is, notably as it concerns public policy advocacy. Maintaining good care and a strong workforce requires fair compensation for the health care we provide and that will only be a reality when Congress enforces the law of parity as it was intended. On this we will speak with an unabashed and united voice. Power concedes nothing without a demand. It never did and it never will.

That phrase belongs to Frederick Douglas, which brings me to NAATP's commitment to address inequitable access to and quality of addiction treatment for the [Black, Indigenous and people of color] BIPOC community particularly. None of our work will be sound until we do it with all of our populations in mind. It is both just to do so and a quality imperative if we are to fully understand and treat addiction, and we are determined to do so.

—Marvin Ventrell, CEO, National Association of Addiction Treatment Providers •

Harm reduction from page 1

to brand the NIH initiative as what consultant and advocate John de Miranda has referred to as "harm reduction lite" (see "Harm reduction innovation: Abstinence, move over," *ADAW*, Oct. 31, 2022; https://doi.org/10.1002/adaw.33600).

Funded through the National Institute on Drug Abuse (NIDA) under NIH's Helping to End Addiction Long-term (HEAL) initiative, the effort will involve an estimated $36 million in research awards over five years. Nine research projects and a coordination center at the Research Triangle Institute are being funded; applications for the grants were due last March.

"Getting people into treatment for substance use disorders is critical, but first, people need to survive to have that choice," NIDA Director Nora Volkow, M.D., said in a news release announcing the grantees. "Harm reduction services acknowledge this reality by aiming to meet people where they are to improve health, prevent overdoses, save lives and provide treatment options to individuals. Research to better understand how different harm reduction models may work in communities across the country is therefore crucial to address the overdose crisis strategically and effectively."

NIH has announced that each research project will have a community advisory board and/or people with lived experience in paid positions to support the project.

Summaries of projects

These are the nine research institutions with a project being funded under NIH's new initiative:

- **Johns Hopkins University** will study the effect of van-delivered supplies such as naloxone, fentanyl test strips and basic necessities on overdoses among women in Baltimore. Program operators will also offer individuals referrals to more intensive services.
- **New York University School of Medicine** will study the effects of mobile van delivery of services, targeting Black and Latino/Latina individuals in the Bronx and in New Haven, Connecticut. A community-based care coordinator will seek to link recipients to a variety of needed services.
- **Oregon Health and Science University** will evaluate a pair of rural interventions emphasizing contingency management and the identification of personal harm reduction goals under the guidance of a peer worker, with the effort targeting methamphetamine users.
- **Research Triangle Institute** will assess the implementation and maintenance of harm reduction services in San Francisco to inform government leaders and community-based organizations about optimal strategies.
- **The University of Chicago** will study ways to implement effective harm reduction strategies in remote areas of Illinois, including secondary distribution of supplies from an individual who has been served by a harm reduction program to someone who has not had access to a program.
- **The University of Nevada-Reno** will test ways to identify and support drug users who respond to an overdose by one of their drug-using peers in an effort to broaden the use of naloxone.
- **The University of Pittsburgh** will evaluate a peer-driven intervention aimed at Black individuals who visit a hospital emergency department, with strategies that include distribution of take-home naloxone.
- **The University of Wisconsin** will develop and test an intervention involving multiple internet- and smartphone-based tools to improve access to harm reduction services.
- **Weill Medical College of Cornell University** will evaluate

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optimal approaches for removing barriers to mail delivery of harm reduction supplies taking into account the preferences of users.

Besides hosting one of the research projects, Research Triangle Institute also will house the coordination center that will offer support to all of the projects.

An NIH spokesperson told *ADAW* that each project will have its own defined evaluation measures tied to its overall goals. The original request for applications for the initiative stated, "Given the variable state of the science related to different harm reduction strategies, applicants are not required to have preliminary data." However, those without such data were required to justify why the lack of data would not impede them from answering key questions in their research.

The application documents also stated, "To maximize the acceptability, feasibility, scalability and sustainability of the harm reduction interventions being studied, applicants must engage stakeholders, such as persons with lived experience, service providers, payors, policymakers, advocacy groups and community-based organizations, in developing and carrying out their research studies."

Does it go far enough?

De Miranda said he sees a dichotomy in current thinking nationally about harm reduction, with federal leaders embracing the concept as long as it focuses mainly on naloxone and other non-controversial components to reduce opioid overdose.

"The other half of harm reduction is meeting people where they're at, handing out clean needles," de Miranda told *ADAW*.

He said it has been difficult to collect any meaningful information on whether the Substance Abuse and Mental Health Services Administration's new technical assistance center on harm reduction is actually acting on any requests from the field. He said he also worries that a party change in the White House after the next national election could function to wipe away any gains that have been made during the current administration.

"The politics are still pretty treacherous," de Miranda said.

NIH's HEAL initiative was launched in 2018 as a multi-institute effort to improve opioid addiction treatment and prevention strategies and to enhance pain management. "The opioid and overdose crisis continues to evolve in dangerous and unpredictable ways, but scientific solutions that embrace innovative research and community connections offer the best hope for saving lives across America," said HEAL Initiative Director Rebecca G. Baker, Ph.D. •

Coming up...

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.cadca.org/forum2023**

The 2023 **Rx and Illicit Drug Summit** will be held **April 10-13** in Atlanta, Georgia. For more information, go to **https://www.rx-summit.com/**

The 2023 **ASAM conference** will be held **April 13-16** in Washington, DC. For more information, go to **https://annualconference.asam.org/**

The 2023 **American Psychiatric Association conference** will be held **May 20-24** in San Francisco, California. For more information, go to **https://www.psychiatry.org/psychiatrists/meetings/annual-meeting**

In case you haven't heard...

Last month — although it could have been any time over the past few decades because her view has been consistent — Maia Szalavitz wrote an opinion piece in *The New York Times* recommending a revamping of "our entire drug policy," but focusing on marijuana and scheduling it as a legal drug instead of keeping it on Schedule I, where it is now. *ADAW* obtained and is printing the response from Smart Approaches to Marijuana that President and CEO Kevin Sabet, Ph.D. wrote as a letter to the editor, but the *Times* did not print. "Ms. Szalavitz is misguided in her understanding of drug scheduling and her downplaying of the harms of today's marijuana, which greatly increases the risk for psychosis, schizophrenia, IQ loss, and other consequences. Drug scheduling is not a harm index. Though heroin causes more overdose deaths than marijuana, their shared Schedule 1 status is not incongruent. Schedule 1 drugs are defined as having a high potential for abuse and no accepted medical benefit, a position the Obama administration upheld for marijuana in 2015. It does not mean heroin and marijuana are equally dangerous. Her column rightly expresses concern about the consolidation of the marijuana industry by the pharmaceutical, alcohol, and tobacco industries — they have already invested billions in marijuana. Yet, rescheduling marijuana as a Schedule VI drug, as she suggested, would result in a similar outcome at the state level. Today's marijuana is much more harmful, and legalizing allows mass commercialization. No matter how marijuana is scheduled, well-funded interests will work to consolidate their market share and grow profits. Society should discourage use, not downplay dangers."