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

Volume 29 Number 15
April 10, 2017
Print ISSN 1042-1394
Online ISSN 1556-7591

In This Issue...

Our lead story this week brings readers a ringside seat at last week's appropriations hearing on opioids. In the lineup: Vermont's hub-and-spoke system, faith-based treatment, and Medicaid.
. . . *See top story, this page*

CDC urges Medicaid to restrict access to methadone for pain
. . . *See page 3*

Examples of prevention programs that work . . . *See page 5*

Journalist at NatCon says Trump's family may be the way to reach him
. . . *See page 7*

Botticelli heads up new addiction center in Boston . . . *See page 8*

A reminder to our readers...
There will be no April 17 issue of *ADAW*. The next issue will be April 24.

SIPAwards
Honorable Mention Spot News 2016

NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS
2016 Michael Q. Ford Journalism Award

FIND US ON facebook
adawnewsletter

FOLLOW US ON twitter
ADAWnews

View this newsletter online at wileyonlinelibrary.com
DOI: 10.1002/adaw

House appropriations committee focuses on federal funding gaps in opioid crisis

Last week's hearing by the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies focused on the federal response to the opioid crisis. There were four witnesses, with Barbara Cimaglio, deputy commissioner of the Vermont Department of Health, presenting the case for the states. Cimaglio made a strong presentation for the need for federal funding for treatment and prevention, in both the Substance Abuse Prevention and Treatment (SAPT) block grant and the Medicaid expansion allowed under the Affordable Care Act (ACA).

Vermont actually expanded Medicaid before the ACA officially took effect, and about 80 percent of patients in medication-assisted treatment in the state are covered by Medicaid as a result, she told subcommittee member Rep. Rosa DeLauro (D-Connecticut), who had many questions about funding. What would be the effect on Vermont if the ACA is repealed? "It would be a challenge — a disaster," Cimaglio said. "If you have to interrupt treat-

See **Appropriations** page 2

Bottom Line...
An opioids focus in a House appropriations committee hearing looks at Medicaid, prevention and Vermont's hub-and-spoke system.

SAMHSA guide cites effective practices in transitional services for offenders

Planning for the transition into the community remains the least developed service in local jails, but some states and localities have made significant inroads in offering needed services and support to release-ready inmates with substance use and mental health disorders, according to a new report. The new implementation guide, published by the Substance Abuse and Mental Health Services Administration (SAMHSA), offers examples of the progress some corrections systems have made under the guidelines of an APIC (Assess, Plan, Identify, Coordinate) model.

Crucial to the success of these efforts, the report states, is effective coordination between behavioral health and correctional stakeholders in order to bring about universal screening, individualized assessment and treatment planning, continuity of services and sharing of data.

"Increasingly, but slowly, there has been cross-system recognition that improved outcomes for individuals, justice systems, and the community require comprehensive and

See **SAMHSA** page 6

Bottom Line...
A new report cites several local corrections systems for conducting exemplary assessment, treatment and follow-up efforts targeting justice-involved individuals with substance use and mental health disorders.

Appropriations from page 1

ment because of loss of health insurance, what does that mean?" asked DeLauro. "We don't want to see that happen," said Cimaglio. The state "would pick up what we could" through the SAPT block grant, she said. "The block grant is the foundation to our statewide system," she said. DeLauro pressed on, asking "So if we cut back dollars to Medicaid, yes or no, would this worsen your crisis in the state of Vermont?" "It definitely would affect it and worsen it," Cimaglio said. "Our approach has been very comprehensive," she said, adding "We appreciate the talk of flexibility so each state can do what it needs to do."

Indeed, Vermont's approach to the opioid epidemic has been the most comprehensive and pioneering in the country. In 2012, the state launched its "hub-and-spoke" system, in which opioid treatment programs (OTPs) were the hubs and office-based opioid treatment with buprenorphine served as the spokes (see *ADAW*, Oct. 29, 2012). This system, developed with ACA dollars, has become a model, with other states hoping to use Cures Act funding to follow it.

"We've worked very hard to get to where we are today," said Cimaglio. "We would not want to see it having to go backwards."

Operation UNITE

Nancy Hale, president and CEO of Operation UNITE, made a pitch for the national prescription drug abuse and heroin summit coming up later this month. Rep. Hal Rogers (R-Kentucky) even dropped in to promote the conference, which he helped to found seven years ago.

Operation UNITE has always had a strong law enforcement focus, but now is stressing prevention, said Hale. Rep. Tom Cole (R-Oklahoma), chair of the subcommittee, asked Hale for three initiatives that really matter in the opioid epidemic. "We started out with an emphasis on law enforcement, but over the years we have seen that we can't arrest our way out of the problem," said Hale. "We see that we need to move prevention to the forefront — we have to be proactive instead of reactive." Young people want good information, she said. "We have a whole generation of young people who need a K through 12 program," she said. "And we need to provide vouchers for treatment programs."

'We've worked very hard to get to where we are today. We would not want to see it having to go backwards.'

Barbara Cimaglio

When Rogers helped establish Operation UNITE, there were very few treatment programs in Kentucky, said Hale. "Now we have many," she said, citing the "angel initiatives" of police departments that help people access treatment. Operation UNITE is helping to provide vouchers to patients who get treatment through those initiatives, she said.

RAND

Rosalie Liccardo Pacula, senior economist and co-director of the Drug Policy Research Center of the RAND Corporation, stressed the importance of data collection. She blamed some of the data limitations on the inability of researchers to access patient information from the Centers for Medicare & Medicaid Services (CMS) on addiction due to 42 CFR Part 2 — restrictions that were lifted last year for researchers only (see *ADAW*, February 15, 2016). "A lot of work was stalled on the effectiveness of medication-assisted treatment because of redaction of patients in CMS data," she said. "We

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

Editor Alison Knopf
Contributing Editor Gary Enos
Copy Editor James Sigman
Production Editor Douglas Devaux
Managing Editor Donna Petrozzello
Publisher Lisa Dionne

Alcoholism & Drug Abuse Weekly (Print ISSN 1042-1394; Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the third Monday in April, the first Monday in September and the last Mondays in November and December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Print only: $695 (individual, U.S.), $716 (individual, Can./Mex.), $865 (individual, rest of world), $6504 (institutional, U.S.), $7056 (institutional, Can./Mex.), $7110 (institutional, rest of world); Print & electronic: $765 (individual, U.S.), $788 (individual, Can./Mex.), $937 (individual, rest of world), $7805 (institutional, U.S.), $8468 (institutional, Can./Mex.), $8532 (institutional, rest of world); Electronic only: $555 (individual, U.S.), $572 (individual, rest of world), $6504 (institutional, U.S.), $6895 Institutional, rest of world). **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Customer Service at (800) 835-6770; email: cs-journals@wiley.com.

Alcoholism & Drug Abuse Weekly is indexed in: Academic Search (EBSCO), Academic Search Elite (EBSCO), Academic Search Premier (EBSCO), Current Abstracts (EBSCO), EBSCO Masterfile Elite (EBSCO), EBSCO MasterFILE Select (EBSCO), Expanded Academic ASAP (Thomson Gale), Health Source Nursing/Academic, InfoTrac, Proquest 5000 (ProQuest), Proquest Discovery (ProQuest), ProQuest Health & Medical, Complete (ProQuest), Proquest Platinum (ProQuest), Proquest Research Library (ProQuest), Student Resource Center College, Student Resource Center Gold and Student Resource Center Silver.

Business/Editorial Offices: John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774; Alison Knopf, email: adawnewsletter@gmail.com; (845) 418-3961.

To renew your subscription, contact Customer Service at (800) 835-6770; email: cs-journals@wiley.com.

WILEY

couldn't get combined data sets until last year." Researchers were trying to show the effectiveness of primary care prevention on future substance use disorders, she said.

Lawmakers expressed concern about overprescribing of opioids for pain, something all witnesses concurred with. "You have to instill in the physician that other options are available, that there are alternative forms of pain management," she said. But she noted that limiting those options through insurance is not helpful. If there is only a certain number of physical therapy visits allowed, for example, the pain may not be alleviated.

Just say no

One committee member wants to resurrect "Just say no" as a strategy — and also thinks faith-based treatment isn't getting the credit it should. "We should say 'Just say no to drugs,'" said Rep. Andy Harris, M.D. (R-Maryland), adding that "now we have someone" in the White House "who says no." He added that marijuana is a gateway drug, and that "because of its interaction with the dopamine system, this makes sense." Not a supporter of marijuana legalization, Harris was particularly incensed by the idea that marijuana could be used to treat opioid addiction "with no scientific evidence." Finally, he upbraided Surgeon General Vivek Murthy for not including faith-based treatment in the *Report on Alcohol, Drugs and Health*. "What do you think about them?" he asked the witness panel. "Should we consider getting over the fact that it has the word 'faith'"?

Hale responded first, saying unequivocally that faith-based treatment programs should be included, citing the examples of her son, with nine years of recovery, and daughter-in-law, with 10 years of recovery. "They both went through an abstinence-based program," she said. "They say they know there is something between them and their next pill or drink — and that element is faith." There are many different roads that she could take back to Kentucky from Washington, D.C., she said. "If you block one because it was my choice, you're going to cause me to be frustrated," she said. "That's what we have done with the faith-based treatment programs. We've tried to vilify them."

Cimaglio responded that many people are involved in prevention programs that are faith-based. "We say there are many paths to recovery, and one size doesn't fit all," she said. "Whatever we do at a policy level, we need to be open to a variety of paths."

And Pacula said "there's research that suggests it does work." •

For links to speaker biographies and prepared testimony, go to http://appropriations.house.gov/calendar/eventsingle.aspx?EventID=394821.

CDC urges Medicaid to restrict access to methadone for pain

Methadone (prescribed for pain, not for addiction) accounted for one in four prescription opioid deaths in 2014, the federal Centers for Disease Control and Prevention (CDC) announced last week. Using utilization review and other tools to decrease prescriptions to Medicaid patients may help reduce overdoses, the CDC suggested.

Background

More than a decade ago, a series published in *The Charleston Gazette* in West Virginia about methadone treatment for addiction — called the Killer Cure — created a public relations nightmare for opioid treatment programs (OTPs) (see *ADAW*, June 26, 2006).

Because of its long half-life, methadone can lead first-time users to think it isn't working correctly if their pain doesn't go away immediately, and to take more before they should. Some people may inappropriately mix it with alcohol, other opioids or benzodiazepines. Compounding the problem for medical examiners was the fact that death certificates indicated "methadone" but not whether the substance had been a pill (for pain) or a liquid (for addiction).

Following a Food and Drug Administration (FDA) warning on methadone for pain (see *ADAW*, Dec. 4, 2006), and subsequent restrictive legislation in West Virginia (see *ADAW*, Feb. 5, 2007), the Substance and Mental Health Services Administration (SAMHSA) convened a meeting to defend methadone maintenance as a treatment modality (see *ADAW*, July 30, 2007).

Methadone deaths had been increasing over the past four years, but these were related to methadone prescribed for pain, and sometimes diverted, not to methadone that originated in an opioid treatment program and was then diverted. "We don't want methadone to be labeled a 'killer drug,'" said H. Westley Clark, M.D., then director of SAMHSA's Center for Substance Abuse Treatment, noting that the purpose of the meeting was to address "media distortion."

The pain community had relied on OxyContin, which like methadone had a long half-life, making it good for chronic pain. But when it became clear that people were abusing OxyContin, snorting it so they could get immediate euphoria, pain physicians switched to methadone.

A report from the Government Accountability Office showed that methadone for pain, not addiction, was responsible for the overdoses (see *ADAW*, April 6, 2009). And by 2010, a methadone mortality summit in Washington conclusively stated that pain prescribing, not addiction

Continues on next page

Continued from previous page
treatment, was responsible for the overdoses (see *ADAW*, Aug. 9, 2010). At that summit, Clark said that diversion of methadone from OTPs was not a problem. "That's not on anyone's radar screen," he said.

Ultimately, OTPs were completely exonerated of having anything to do with methadone overdoses, but the damage had been done — in some places, like West Virginia, the draconian steps taken in 2006 and 2007 (no take-homes, no new clinics) still persist to this day.

The pain problem

By 2012, the CDC had refocused methadone scrutiny to the pain community, telling the public that even though methadone was less expensive than other analgesics, it was not a good idea to use it for pain (see *ADAW*, Aug. 20, 2012).

Now the United States is in the midst of an illicit opioid epidemic (heroin and illicit fentanyl), with prescription opioid overdoses going down, largely as a result of fewer prescriptions being written. And now everyone understands that it is methadone for pain that was the culprit for overdose deaths — and in 2014, the most recent year for which the CDC has this information, it still was.

Study details

Methadone accounted for only 1 percent of all opioids prescribed for pain in 2014, but accounted for 23 percent of all prescription opioid deaths, according to the article "Methadone Prescribing and Overdose and the Association with Medicaid Preferred Drug List Policies — United States, 2007–2014," published in the CDC's *Morbidity and Mortality Weekly Report* of March 31.

"Because methadone might remain in a person's system long after the pain-relieving benefits have been exhausted, it can cause slow or shallow breathing and dangerous changes in heartbeat that might not be perceived by the patient," the CDC noted.

Utilization review helped cut methadone overdoses, according to the report, by Mark Faul, Ph.D., and colleagues. Between 2007 and 2014, large declines in methadone-related overdose deaths occurred, with prior authorization associated with lower rates of overdose.

The CDC used the National Vital Statistics System Multiple Cause of Death mortality files and U.S. Census data for the 1999 to 2014 period. They used Truven Health's MarketScan Commercial Claims and encounters and Medicaid databases for 2014 to assess whether methadone prescribing is higher among Medicaid enrollees, where researchers suspected the lower cost of the medication compared to other analgesics might make it more likely to be on formularies.

Restrictions for Medicaid patients

Some states use a preferred drug list (PDL), and if methadone is on that list, it can be prescribed or dispensed without prior authorization. For example, in 2013, Florida listed methadone as a preferred drug on its PDL.

From 1999 to 2014, the overall prescription opioid overdose death rate increased 300 percent, from 1.2 people per 100,000 in 1999 to 4.6 in 2014. During this time, the rate of methadone overdose deaths increased 600 percent, from 0.3 persons per 100,000 in 1999 to 1.8, in 2006; was stable in 2007; and then declined 39 percent to 1.1 in 2014.

The rates of fatal and nonfatal methadone overdose among Medicaid enrollees in Florida and North Carolina — which treated methadone as a preferred drug not requiring prior authorization were significantly higher than those in South Carolina, which did not include methadone as preferred.

Despite the decline in methadone overdose deaths, the medication still accounted for almost 25 percent of prescription opioid–related deaths in 2014. The CDC report noted that the peak was in 2007 shortly after the FDA's public health advisory on prescribing methadone, referring to respiratory depression and cardiac arrhythmias. "Although this study was not designed to assess causal inference," the authors wrote, that FDA advisory combined with the voluntary manufacturer restriction limiting the 40-milligram formulation — used only in OTPs, not for pain (see *ADAW*, Aug. 9, 2010) — in 2008 contributed to declines in methadone overdose death rates.

"Given that methadone prescribing rates are higher among persons enrolled in Medicaid, strategies to reduce methadone prescribing among persons in this population might further reduce injuries and deaths from methadone," the *MMWR* article concluded. "Focusing on the differences between state PDLs, a comparative exploratory analysis of states with different methadone drug utilization management policies found an association between a state's internal PDL policy and methadone overdose rates." If confirmed by other studies, states could use utilization management for Medicaid to reduce deaths associated with methadone, as well as pharmacy management such as prior authorization, quantity limits and retrospective utilization review.

The most recent CDC guidelines for prescribing opioids for chronic pain recommend that methadone should not be the first choice for long-acting opioids (see *ADAW*, Dec. 21, 2015). •

Editor's note: The CDC does not view the increase in heroin overdoses as related to the cutbacks in prescription opioids (see *ADAW*, May 4, 2015).

For the full article, go to https://www.cdc.gov/mmwr/volumes/66/wr/mm6612a2.htm.

 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

Examples of prevention programs that work

Last week, we wrote about the science of prevention, with sources from the Center for Substance Abuse Prevention (CSAP) at the Substance Abuse and Mental Health Services Administration, Community Anti-Drug Coalitions of America (CADCA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Here are some specific prevention programs from CSAP:

- **LifeSkills Training:** Research has shown that this training delayed early use of alcohol, tobacco and other substances and reduced rates of use of all substances up to five years after the intervention ended. Evaluation outcome: lower prevalence of weekly use of marijuana.
- **Keepin' it REAL:** Uses student-developed videos and narratives and has shown positive effects on substance use among Mexican-American youth in the southwestern United States. Evaluation outcomes: lower marijuana use, slower increase in marijuana use over time and greater use of program strategies to resist marijuana use.
- **Project Toward No Drug Abuse:** Designed for youth who are attending alternative high schools but can be delivered in traditional high schools as well. The 12 40-minute interactive sessions have shown positive effects on alcohol and drug misuse. Evaluation outcomes: reduction in 30-day marijuana use and lower level of marijuana use among males at two-year follow-up.
- **Project SUCCESS:** Designed for high school students and their families, this is a skills-based drug prevention curriculum for all students and individual or group counseling for students and families at greater risk. Evaluation outcomes: lower likelihood of having ever used marijuana, and, if used at baseline, reducing or stopping marijuana use.

Specific examples of a broader type of intervention include:

- **Strengthening Families:** A seven-session psychoeducational program offered separately to pre- and young adolescents and their parents. The program focuses on family communication, conflict and cohesion. Evaluation measures indicate that there is a lower initiation of marijuana (at grade 10) and slower overall growth in lifetime use of marijuana (at grade 12).
- **The Iowa Strengthening Families Program (ISFP):** Six two-hour concurrent parent and youth curricular sessions followed by a family skill-building segment. The ISFP seeks to promote these protective factors: positive future orientation, peer pressure resistance skills, prosocial peer relationships, positive management of emotions and empathy with parents. In 12th grade, and at ages 21, 22, 23 and 25, former intervention students had a lower lifetime prescription drug misuse rate than control students.
- **Positive Parenting Program:** The program includes five levels of parenting guidance based on family needs and preferences. Evaluation outcomes: children of parents who participated had significantly lower levels of disruptive behavior (based on parental reports), and parents expressed higher levels of competence.

Drug-Free Communities grants

Local coalitions apply for Drug-Free Communities grants; these coalitions are CADCA members. The Office of National Drug Control Policy administers these federal grants.

In order to be eligible for a DFC grant, a local coalition must:

- be in existence for six months prior to applying;
- have communitywide involvement of the following 12 sectors, which each commit to work together through the coalition, to reduce youth drug, alcohol and tobacco use — youth, parents, businesses, media, schools, youth-serving organizations, religious or fraternal organizations, law enforcement, civic and volunteer groups, health care professionals, state/local/tribal agencies and other organizations involved in reducing substance abuse;
- have communitywide data for planning, implementation and evaluation; and
- target the entire community with effective strategies.

SBI for alcohol

Screening and brief intervention (SBI) for alcohol problems is effective as well, said Ralph W. Hingson, director of the Division of Epidemiology and Prevention Research at NIAAA. SBI is more effective with at-risk drinking than heavy drinking, making it an ideal prevention — rather than intervention — tool.

It's particularly important to prevent underage drinking, said Hingson. "We know that the younger people are when they start to drink, the more likely they are to develop dependence at some time in their life," he said. "There are also a number of studies of family interventions, in which parents talk to their children about alcohol and set boundaries."

One of the problems with SBI is that few physicians use it, said Hingson. He conducted a national survey in 2012 using a probability sample

Continues on next page

Continued from previous page
of 18-to-39-year-olds. Two-thirds had seen a physician in the past year, but only 13 percent had been asked about drinking. "The people least likely to have been asked were the 18-to-24-year-olds — the people who could have benefited the most," he said. For another study he did, published in *JAMA Pediatrics*, about 80 percent of 16-year-olds had seen a physician in the past year. Half were asked about drinking and smoking. But of those who reported being intoxicated six or more times, only one in four were told that it would be a good idea to reduce their drinking, he said. "I don't know why they weren't being asked," said Hingson, noting that one research from Brown University has recommended that every single college student should be given a brief alcohol intervention. •

SAMHSA from page 1
integrated service planning that is implemented within the correctional setting and continued into the community with minimal disruption," states the implementation guide, *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison*.

The publication serves as a successor to 2013's *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison*, which was a collaboration between SAMHSA's GAINS Center and the Council of State Governments' Justice Center. The new guide cites the disparity in the prevalence of substance use disorders in corrections and in the general population (68 percent in local jails, 53 percent in state prisons and 8.5 percent in the general public). It adds that individuals with substance use or mental health disorders tend to experience longer jail stays and are more likely to be segregated during incarceration.

The guide, which was prepared by consultant Policy Research Associates, states that on the local level, effective models of service delivery for this population have been established in Allegheny County, Pennsylvania; Franklin County, Massachusetts; Gwinnett County, Georgia; Hampden County, Massachusetts; Hancock County, Ohio; Montgomery County, Maryland; and Pima County, Arizona. In addition, noteworthy statewide initiatives have been implemented in Hawaii, New York and North Carolina, according to the guide. The publication focuses on the general features of effective programs and does not offer specifics on the treatment modalities used.

Case example

The APIC model encompasses a total of 10 guidelines under the four domains of:

- Assessing the individual's clinical and social needs and public safety risk;
- Planning for the treatment and services required to address the individual's needs, both in custody and upon re-entry;
- Identifying required community and correctional programs responsible for post-release services; and
- Coordinating the transition plan to ensure implementation and avoid gaps in care with community-based services.

'We now make sure that those receiving Vivitrol are assigned to a counseling agency.'

Peter Babineau

The local jurisdictions cited in the guide have taken a variety of approaches to conducting screening early in the booking process. The universal screening in the Gwinnett County Jail identifies housing, education and employment needs as well as treatment-related requirements. In Montgomery County, any behavioral health issue identified by initial health care and corrections screeners leads to immediate referral to a team of on-site therapists for a comprehensive assessment.

The guide cites officials at the Hampden County Jail for adopting a "comprehensive approach to individualized treatment and service planning." In the Massachusetts jurisdiction, offenders with substance use disorders proceed through a four-phase protocol of supervision and care. "Noting that there is an optimal time frame for effecting meaningful behavioral change prior to reentry, discharge planning begins as early as possible during an individual's period of incarceration," the guide states.

After the first phase of institutional orientation, inmates in Hampden County participate in a four-week second phase that incorporates substance use education, health education, anger management, pre-employment training and other skill building. In phase three, an individualized service plan addressing addiction, mental health and criminogenic risk factors is designed. Initial services are broken down into crisis and noncrisis care depending on the severity of presenting issues.

Peter Babineau, a substance abuse educator/supervisor with the Hampden County Sheriff's Department, told *ADAW* that the department's outlook toward services for inmates began taking shape more than four decades ago, when a sheriff with a social work background presided. Babineau said the depart-

 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

ment has been an active proponent of medication-assisted treatment for some time, having piloted use of injectable naltrexone for its population about four years ago.

Under that effort, which has expanded across the department's correctional sites, inmates are screened before release and receive their first monthly injection of Vivitrol before leaving custody. That dose is paid for by the drug manufacturer, while subsequent doses in most cases are covered under the state's MassHealth program.

"The missing piece at the beginning was making sure that the individuals were also getting counseling," Babineau said. "We now make sure that those receiving Vivitrol are assigned to a counseling agency."

Each element of the program in Hampden County must be adhered to in order for the inmate to become eligible for lower security consideration. As an individual's release date approaches, meetings with a state-employed peer mentor are scheduled. The mentor introduces the inmate to services available through community organizations in the western Massachusetts region.

"Peer mentors follow discharged individuals into the community, transporting them to appointments and encouraging compliance with treatment plans," the SAMHSA guide states. Inmates for whom substance use is a significant issue and who are still under correctional jurisdiction might be transferred during phase four to the 182-bed minimum-security Western Massachusetts Recovery and Wellness Center (recently renamed from the Western Massachusetts Correctional Addictions Center), where they complete a 12-week residential treatment program.

The importance of reaching offenders with comprehensive services was made clear in a 2016 state report indicating that 56 percent of the fatal drug overdoses in the state the previous year involved individuals who had recently left corrections facilities, Babineau said.

Need for teamwork

The SAMHSA guide emphasizes the importance of correctional and behavioral health personnel working together at both the institutional and community level, with the need for substance use and mental health treatment professionals to understand public safety, criminogenic and correctional management concerns. Several of the cited programs in the guide have emphasized staff cross-training, including training of corrections staff in crisis intervention and trauma-informed care.

The final of the 10 guidelines under the APIC model calls for data collection and analysis to evaluate program performance and to plan for long-term sustainability. The guide cites an example of a jurisdiction that reported challenges with effective data collection. Franklin County, Massachusetts, officials acknowledged that a jail management information system that was designed to track movement within the facility was not translating well to the collection of post-release data, according to the report. •

Briefly Noted

Journalist at NatCon says Trump's family may be the way to reach him

Steve Clemons from *The Atlantic* gave a presentation on behavioral health under the Trump administration at the conference of the National Council for Behavioral Health last week. He was traveling in Africa at the time President Trump had his controversial phone conversation with the leader of Taiwan. "I was traveling with someone who was getting messages from Donald Trump directly — I saw it on his phone," he said. His friend had worked with people in Hong Kong, and told Clemons that the president realized he had messed up. "Donald Trump the man would not be reaching out across international lines" where communications were monitored, asking what he should do about this, unless he needed help. "I found this a remarkable moment, because it told me that our assumptions" about who Trump trusts were wrong. He was unlike other presidents, in that he trusted his family more than his official advisors. Dealing with his daughter, Ivanka, would probably be more effective than going through official channels, Clemons suggested. Attendees at his session, mental health experts, said that looking at Trump makes people wonder if he is OK. "I don't see purposeful malice," said one attendee. Clemons, not a mental health expert, noted that *The Atlantic* published a "highly speculative" story about Trump's mental state. "You'll find reams and reams of material about this," he said. "I've had three encounters with Donald Trump," said Clemons, adding that he felt that the president was processing information clearly, and that his strength is in being a "reader of people." For the National Council video, go to https://www.facebook.com/pg/TheNationalCouncil/videos/?ref=page_internal.

Small rehab forced to close due to pervasive insurance fraud

Tom Horvath, Ph.D., had two small residential treatment programs in California: one had six beds and one had four. The programs, called Practical Recovery, required abstinence while patients were there (Horvath is also president of Smart Recovery, which has mutual support groups around the country in which participants are not required to be abstinent). Charges ranged from $42,000 a month to $54,000 a month. "We had a number of clients who paid cash to do that," he told *ADAW* last month. "But we weren't in a mansion, like in Malibu, and a lot of folks are more interested in a mansion than in treatment." So Practical Recovery used out-of-network insurance policies as much as possible.

Continues on next page

Continued from previous page

Out-of-network covers nonparticipating treatment providers, but there is usually a copay. When patients heard they would have to write a check for thousands of dollars for their copay, they told the intake coordinator they had found another facility that would not only forgive the copay, but would send them a plane ticket. "This is insurance fraud; we don't do that," Horvath told us. Unable to compete with the providers that do this, he shut down his programs. He was not a member of the National Association of Addiction Treatment Providers, because "I couldn't join an organization that so explicitly endorsed the disease model as the way to treat this problem," he said. "And many of their members are part of the problem anyway." Horvath said the solution lies with the insurance companies. "They're the ones with the money; they set the rules," he said. If insurance companies made sure that patients paid copays, there would be less fraud. "I think that addiction is such a small piece of what insurance companies do, they don't pay attention to this," he said. Currently, Horvath is running an outpatient program with about 10 staffers. "I'm investigating other options," he told *ADAW*. "In the past I was out-of-network, but I'm going to look at being in-network as well."

Names in the News

Last month, **Michael Botticelli**, former director of the Office of National Drug Control Policy (ONDCP), was appointed the first executive director of the Grayken Center for Addiction Medicine, created at Boston Medical Center (BMC) earlier this month by a $25 million gift from John and Eilene Grayken to fight the opioid epidemic. "Michael embodies every item on the wish list of what we wanted in the ideal Director of the Grayken Center and he is the perfect fit for the Center and its ability to lead in this battle," said Boston Medical Center CEO Kate Walsh in a statement. "Michael was instrumental in getting the fight against addiction to the top of the national agenda. He fought for additional funding, and worked closely with groups across the country to develop and replicate clinical treatment programs that work. But he also led the way on shaping our country's understanding of addiction as a disease, not a moral failing or character flaw, and that patients with substance use disorder deserve treatment not punishment. He is a true leader in addiction medicine." Before going to the ONDCP, Botticelli had a long career as director of the Bureau of Substance Abuse Services at the Massachusetts Department of Public Health. Born in upstate New York, Botticelli is in long-term recovery. "I am excited and a bit in awe of the opportunity to work with this team to build the Grayken Center on the already strong foundation of great work in addiction medicine at BMC," said Botticelli, in a statement from BMC. "BMC's international leadership in research, teaching, and clinical programming on substance use disorders and their consequences is well known. And the Graykens' extraordinary gift makes it possible to spark innovation on new models of treatment and care that will have real impact." The Grayken Center will focus on research, treatment, and training and prevention. John Grayken is founder and president of private equity firm Lone Star Funds. His donations are usually private, but the Graykens wanted to be public to work to destigmatize addiction, according to BMC.

Coming up...

The **National Association of Addiction Treatment Providers** National Addiction Leadership Conference will be held **May 21–23** in **Austin, Texas**. For more information, go to **https://www.naatp.org/training/national-addiction-leadership-conference**.

The **National Association of State Alcohol and Drug Abuse Directors** annual conference will be held **May 24–26** in **Indianapolis**. For more information, go to **http://nasadad.org/annual-meeting**.

The **College on Problems of Drug Dependence** will meet **June 17–22** in **Montreal**. For more information, go to **http://cpdd.org/meetings/2017-meeting-information**.

In case you haven't heard...

"Obamacare, unfortunately, will explode," President Trump said in an interview after the Republican health care bill failed to muster enough votes (see *ADAW*, April 3). He said he would abandon his pledge to repeal the Affordable Care Act (ACA), adding that "it's going to have a very bad year," that premiums would increase and that Americans would blame Democrats. If the president wants the ACA to fail for political benefit, that would be — as he would put it — sad. But in fact, the loss of the repeal vote stung so badly that he almost immediately began working on a deal with ultra-conservative Republicans to eliminate the essential health benefits — including treatment for addiction — and to charge higher premiums for people who are older or sicker. As *ADAW* went to press April 6, there was talk of "invisible" risk pools to keep the sick out of the general population, and thus keep premiums down for healthy people. President Trump wanted action before Congress left for recess April 7. Meanwhile, an uncertain insurance industry waited, as do all Americans whose health care depends on the ACA.