

# ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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## Bias against agonist treatment for incarcerated people continues

When *CommonWealth* Magazine ran an article by Andrew Klein, Ph.D., on Jan. 4, our first question was “Why?” The main reason was to push back against an increasing demand for prisons and jails to offer agonists, Klein said. Despite the plethora of research showing agonists are effective treatment for opioid use disorder (OUD), including for incarcerated patients, Klein, a researcher, deviates from the mainstream of peer-reviewed literature and seems to side more with the criminal justice system. So we talked to both Klein and a physician in charge of a jail-based treatment system for this story.

The article, titled “Four reasons medication-assisted treatment may not help inmates,” with the subhead

### Bottom Line...

*Despite repeated data showing treating incarcerated people who have opioid use disorder with agonists results in reduced overdoses and deaths after release, bias persists.*

“It’s not clear providing opioid medications to prisoners is always the best course” (Klein says the publication, not him, bears the responsibility for the headline), opens with a description of a federal district court decision requiring an Essex County, Massachusetts, jail to provide methadone to an inmate, who had been taking the medication successfully for two years (see *ADAW*, Dec. 3, 2018). The jail operates a

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## Addiction consult services in hospitals show promise in facilitating ongoing care

Addiction medicine consulting teams in acute-care hospitals are beginning to show promise as an effective referral source to specialty treatment for opioid use disorders (OUDs). But inconsistencies in how these consult services are structured suggests much room for refinement, according to a newly published study.

### Bottom Line...

*Some hospitals are making inroads in identifying patients who can benefit from referral to community-based care for addictions, but a study concludes that the structure of many of the medical consulting arrangements could be improved.*

One of the critical gaps to this point is a lack of peer representation on many consulting teams, with a peer in place at only one of the nine addiction medicine consult (AMC) services that were examined as part of the latest research. Moreover, even at that one location with peer involvement, implementation challenges arose over issues such as the peer’s status as an unlicensed worker.

“Hospital staff unaffiliated with the AMC service were not used to having ‘fierce advocates’ at the bedside,” wrote study co-authors Kelsey Priest and Dennis McCarty, Ph.D., of Oregon Health & Science University (Priest is a fifth-year M.D./Ph.D.

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“sophisticated medical detox program, a model RSAT [residential substance abuse treatment] treatment program,” that does not include methadone, wrote Klein, who added that nevertheless the sheriff would comply with the federal order and not appeal “even if correctional officers had to drive him daily to a methadone clinic.”

We asked Jonathan Giftos, M.D., clinical director for substance use treatment with correctional health services at the New York City Health and Hospitals, to respond to Klein’s charges. Giftos oversees care for incarcerated patients with substance use disorders at Rikers Island, where he is medical director of the opioid treatment program (OTP) for the New York City jail system. This is the oldest jail-based OTP in the country.

The decision to taper an individual off of opioids — while far more humane than the “cold turkey” withdrawal espoused by some correctional facilities — is not clinically advisable, because by definition it increases their risk of death if they relapse, said Giftos. “Instead of worrying about maintaining people if they can’t guarantee they’ll link to continued treatment, we should be worried about forcing people to withdraw,” he said.

**Vivitrol**

“There’s a movement out there, when you look at public policy, to go from one extreme to the other,” Klein told *ADAW* last week, referring to the antagonist Vivitrol on the one hand and agonists and partial agonists on the other. Klein is senior scientist for criminal justice with Advocates for Human Potential (AHP), which is based in Sudbury, Massachusetts, and has RSAT Training and Technical Assistance (TTA) contracts with the federal Bureau of Justice Assistance (BJA). AHP has had the prison and jail RSAT TTA contracts for eight years; these run in three-year cycles, so next fall it goes out for bid again. (We were unable to confirm with the BJA because of the government shutdown.)

Indeed, Vivitrol is favored over agonists methadone and buprenorphine by many in the criminal justice system.

“We’ve been championing MAT [medication-assisted treatment] in prison and jail for years,” he added, although Vivitrol — not methadone or buprenorphine — appears to have been his main focus. “Five years ago, we did the first training video, going to the first three prisons training with this — these were all Vivitrol programs,” he said. “They were basically re-entry programs

where people got injected [with Vivitrol] right before they left.”

Multiple studies have shown that prescribing methadone or buprenorphine to people in jails and prisons reduces the overdose rate upon re-entry and at the same time reduces the pain of going through withdrawal, often untreated. Rhode Island is at the forefront of the move to make treatment for OUDs accessible to detainees (see *ADAW*, May 7, 2018; Oct. 1, 2018). And in a move showing the increasing connection between OTPs and corrections, Mark Parrino, president of the American Association for the Treatment of Opioid Dependence, made the opening speech at the annual conference of the National Commission on Correctional Health Care, which, in partnership with the National Sheriffs’ Association, had just released guidelines on MAT in jails (see *ADAW*, Oct. 29, 2018).

Nevertheless, bias persists, especially among sheriffs and custodial staffs in jails, and even in state prisons.

“The real issue is should jails and prisons provide opioid medications for those already on these medications or for those who request them to prevent relapse upon release?” asked Klein in his article, followed immediately by “The answer is not clear cut one way or the other.”

# ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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# WILEY

Among Klein's objections to agonists in prisons and jails:

- Methadone may not be available once people are released and go home.
- In states where Medicaid doesn't cover treatment with methadone or buprenorphine, people may not be able to afford it (the same, of course, is true for Vivitrol).
- People may not follow the rules. In the Essex County jail that was the subject of the lawsuit, for example, Klein said many people entering with prescriptions for methadone or buprenorphine also use benzodiazepines, alcohol or other drugs that are not prescribed.
- People without jobs, housing and family support can't follow a buprenorphine treatment regimen that "was not designed for individuals prone to criminal behavior."
- The few jails that do start people on methadone or buprenorphine find that most don't continue when they are released. "Their motivation to begin agonist medication understandably appears to be avoidance of the agony of withdrawal from opioids, not a commitment to long-term recovery after release," Klein wrote. "The retention rate for injectable naltrexone after release is also problematic, but stopping does not result in withdrawal."

"To discuss Vivitrol requires that we discuss a population of people who have been tapered or withdrawn from whatever agonist that they were taking," said Giftos (Vivitrol can't be started until the individual has been opioid-free for a week). So Vivitrol in a jail-based situation means giving it to the person at the end of their time incarcerated — upon re-entry. "So starting the conversation with the Vivitrol shot pre-release is pretty far down the line," he said. In addition, there is no

data that shows that pre-release naltrexone reduces mortality, he said.

The median length of stay in large jails is about two weeks, Giftos and Klein agree. But this is one reason Vivitrol is not a realistic treatment strategy for jails. "If that's all you offer, by definition you are forcing people off their medication," said Giftos.

### Community health

As for availability of methadone, this is an issue where regional variation exists, Giftos admitted. "We are lucky in New York City to have a lot of treatment access for people in correctional settings," he said. "But we need to think about correctional health as community health."

It's important for correctional settings — sheriffs and staff — to work with communities to build treatment continuums for people with OUD, said Giftos. "It takes a little bit of cooperation," he said. Although he's in the ideal position — a physician working for the health department within the jail — this doesn't happen everywhere. "The relationship between correctional health systems and public health offices varies a lot around the country," he admitted.

### Diversion

But Klein has a different view of people in jails and prisons. "We wrote the op-ed because the realities were being ignored," he told *ADAW*. "When SAMHSA [the Substance Abuse Mental Health Services Administration] approved buprenorphine, they agreed that it would not have to be dispensed through OTPs, but through doctor's offices, because at that time, people who went to doctors were people who had insurance," he said. "It was before Medicaid expansion. This was a different population than people in prison or jail." In fact, even people in OTPs were employed, had family supports and were stable — before buprenorphine existed. But Klein's perspective is different. "The model for buprenorphine was for a different

population than what we're dealing with in jails and prisons," he said.

Giftos disagreed. "The best medication for patients is the one that they're most motivated to continue taking," he said. Some patients struggle with the daily attendance required for methadone (at first) but do well with buprenorphine, which allows them more flexibility. Other patients Giftos has worked with were not able to stabilize on buprenorphine but did well on methadone. "We don't know who's going to respond to each therapy," said Giftos. "My general approach is to meet the person where they are, explore their preferences and give them a trial of that therapy," he said. "People who pass through jails are very heterogeneous."

In fact, Klein is not opposed to methadone, buprenorphine or naltrexone. "There are different constraints and challenges to all three," he said. "But the issues of diversion and compliance are real, and more is involved than just giving people medication."

But Klein is concerned that people newly released from jail who are given buprenorphine pills will "just sell them."

Giftos explained how he handles patients who are released on buprenorphine. "We stabilize them on a daily dose and give them a seven-day supply, and an appointment in the first week for continued follow-up," he said. Each month, 50 to 60 percent of these people link into continued treatment. "A big part of managing patients in the community is ensuring that they're taking their medications, so we monitor for diversion," he said. But in addition to buprenorphine, these individuals get flu shots, depression treatment, hepatitis C treatment — all of their medical needs are addressed. This helps motivate them to engage in treatment, he said.

He also counsels patients on the fact that buprenorphine reduces the effects of exogenous opioids (something that if they test out, they will

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find is true — and many do), and that it reduces cravings (which they know). “Patients may miss getting high, in which case they may stop taking their medication,” said Giftos. But most of the time, the reason patients stop is because they have lapses in insurance.

“There’s nothing magical I tell people,” said Giftos. “I tell them, ‘Your life matters, you deserve good health care, this is a medication that is evidence-based, it’s not something you should feel guilty for taking, it’s associated with reductions in heroin use, and if taken every day, people’s lives stabilize and get better,’” he

said. “We explore housing and other things that people need to have happy and productive lives.” •

For the Klein article, go to <https://commonwealthmagazine.org/opinion/four-reasons-medication-assisted-treatment-may-not-help-inmates/>.

## House changes parties, Senate plans oversight of STR/SOR

So now that we have a Democratic House of Representatives, has the landscape changed for substance use disorders (SUDs) on Capitol Hill?

Yes, at least in the House. First of all, the all-powerful House Energy and Commerce Committee, which last year focused on decimating 42 CFR Part 2, the confidentiality regulation applying to SUD treatment, is now headed by Rep. Frank Pallone (D-New Jersey), whose questions of witnesses during hearings on the regulation clearly showed what side he’s on: confidentiality and patients.

More to the point is the Affordable Care Act (ACA), which is threatened by a ruling in Texas. There are many interpretations of what could happen next, but Rep. Paul D. Tonko (D-New York), who sits on the House Energy and Commerce Committee, recently confirmed to field groups that initial hearings will be on protecting the ACA.

There are so many personnel changes in the House — committees and staff — that last fall, after the midterms, it was hard to find people to talk to. There was still a lame-duck session, after all.

In the Senate, however, there are virtually no changes. It’s still run by Republicans. And Sen. Lamar Alexander (R-Tennessee) was re-elected last week to chair the Senate Committee on Health, Education, Labor and Pensions. He announced that a “top priority is reducing the cost of health care,” adding that the National Academy of Medicine says “up to half of health care spending is unnecessary.” He added, “That is a massive tax on

American families, businesses, and state and federal budgets.”

Senator Alexander, in his Jan. 9 statement, also focused on oversight of opioid legislation, specifically on Cures (STR [State Targeted Response to the Opioid Crisis] and SOR [State Opioid Response] grants) and the SUPPORT for Patients and Communities Act. “The committee will conduct oversight on both of these new laws to make sure the Administration is carrying out the intent of Congress to help the American people,” he said.

### Oversight

What of the future of grants, such as STR, which originated from the 21st Century Cures Act passed by Congress and signed by President Obama in 2016, and SOR, both aimed at treating the opioid epidemic? Most insiders didn’t anticipate another large opioid bill after Cures, but it happened. “I’ve stopped predicting,” said Robert Morrison, executive director of the National Association of Alcohol and Drug Abuse Directors (NASADAD), whose members are responsible for distributing STR and SOR funding. Advocates “have to look at the budget and appropriations, and look at the variety of products funded in the Comprehensive Addiction and Recovery Act, Cures and SUPPORT,” he said, referring to the competition for funding in FY 2020 given the number of distinct new programs authorized by Congress over the past several years.

Morrison added that the new lawmakers — the “freshman class”

— want to “do something about the opioid crisis” as well.

The current debate regarding the shutdown, in which appropriations have been put on hold, is limiting prognostications about what Congress will do about SUDs in the near future. (The unfunded part of the government is heading into its fourth week of being shut down over President Trump’s demand for funding for a wall on the southern border).

But oversight will clearly be an issue. Traditionally, this has been the province of the House Energy and Commerce Committee. The federal government has pumped out the dollars, and Congress will want to know what they are getting for the investment. Still, with Senator Alexander and a Republican Congress grilling the administration side, the oversight might be gentler than it was when the Substance Abuse and Mental Health Services Administration under President Obama was called in to defend its very existence.

However, Morrison — and other advocates — stress that it’s time to move more money into other areas, instead of focusing only on opioids. “We say it all the time,” Morrison told *ADAW*. “And now, other leaders are beginning to say it — the answer is to allow states to target resources on what they are seeing as problems, not predetermine what states should do with dollars.” For this, expanding the Substance Abuse Prevention and Treatment (SAPT) block grant would make more sense. “We recommend transitioning to the block grant, which also benefits

## The protections of our privacy rights are under threat in Congress

By Bill Stauffer

As the executive director of the Pennsylvania Recovery Organizations Alliance, the statewide recovery community organization of Pennsylvania, I am alarmed by ongoing efforts occurring in Congress to erode our substance use disorder patient record privacy rights. There are sweeping changes being considered in Congress that would fundamentally erode our rights.

Moving forward, if such changes are enacted in the 116th Congress, it will have devastating consequences to persons with substance use conditions for a generation to come.

Versions I have seen in recent weeks that Congress was considering would:

- Allow our information to be used to discriminate against us by opening up access to all historic and future substance use disorder patient records.
- Open up our community to broad discrimination by creating ways to access our records that do not currently exist that could be used within criminal, judicial, legislative and administrative contexts.
- Provide empty protections that place the burden of proof that discrimination has occurred on the patient. Our community is often unable to assert our rights by the very nature of seeking help for illegal drug use. Additionally, it is also nearly impossible to determine who in the myriad of entities improperly protected or disclosed their information.
- Set up a future regulatory process that may well result in additional erosions of our critically important protections.
- Lead to fewer people seeking help for fear of what would happen to their records in the midst of an unprecedented addiction epidemic.

The regulations components of these privacy laws were updated two years ago to support improved

health care sharing abilities. The truth of the matter is that the largest barrier to sharing these records is how poorly understood they are by our medical care institutions. The current protections were set forth by Congress in 1972, and they are at least as relevant now as they were then. Medical record data breaches affect one in three Americans, a fact we should consider when opening up information even more widely for sharing. What Congress said back then was:

“The conferees wish to stress their conviction that the strictest adherence to the provisions of this section is absolutely essential to the success of all drug abuse prevention programs. Every patient and former patient must be assured that his right to privacy will be protected. Without that assurance, fear of public disclosure of drug abuse or of records that will discourage thousands from seeking the treatment they must have if this tragic national problem is to be overcome.”

We staunchly believe that sharing of addiction and recovery information is an individual choice to be made by the individual who retains control over how it is used.

Unfortunately, we know full well that this fight will resume in the coming weeks in the 116th session of Congress.

Treatment providers should consider that erosion of our substance use patient record privacy rights would open them up to significant liability and result in fewer patients seeking help for a substance use condition.

We need treatment providers to connect with their House and Senate members to protect these critically important privacy rights!

*Bill Stauffer, CADC, CCS, LSW, is executive director of the Pennsylvania Recovery Organizations Alliance.*

prevention specifically, given the prevention set-aside,” said Morrison, noting that prevention has been shortchanged.

The “first glimmer of hope and excitement came when the House provided an increase to the SAPT block grant of \$500 million last year,” said Morrison.

One question is whether that will hold with the change in party. Last year, one senator suggested in a hearing that the best solution was to expand the allowable use of SOR grant money drug by drug. This is the opposite of allowing state directors, who know their states best, to choose how to spend it.

Finally, it’s important to note that the Senate confirmed James Carroll as director of the Office of National Drug Control Policy, who has done well by the field. NASADAD is sending thank-you notes to both majority leader Sen. Mitch McConnell (R-Alabama) and minority leader Sen. Charles Schumer (D-New York). •

## New generation of harm-reduction workers: Helton's concerns

Tracey Helton has been running peer programs for a decade, and involved with harm-reduction work for two. Her “real” day job is working for San Francisco, a job that includes benefits and enables her to support her children. But it also allows her to run harm-reduction services “from my closet,” as she puts it. We called her because we wanted to learn more about how she views the field.

And Helton is a bit concerned about some of the trends she has seen. “Because of the huge increases in overdoses, there’s a new generation of people getting into harm-reduction work, work that has expanded out beyond traditional public health,” Helton told *ADAW* last week. “People get involved in this work because they believe in the cause, but a lot are not adequately prepared for the mental and physical health implications of the work,” she said.

Many of these workers are volunteers. Some are themselves current drug users. But what are the support systems for these workers, who see tragedy and near-tragedy on a daily basis? “In the Bay Area, when you’re doing outreach, you’re reviving people from overdoses, you’re calling ambulances,” said Helton. “These things can be very traumatic. What are the safeguards for these people?”

For starters, it would help for staff to be paid, said Helton. “But if it’s up to the individual agency that’s bringing in volunteers, there are still things you can do,” she said. “We have unprecedented levels of death now. We need to have debriefs of critical incidents, retreats for people to get together and unwind from some of these events.”

There are also online support groups, as well as training through the Harm Reduction Coalition, which has regional and national conferences and provides professional development, said Helton. It’s

also important to “mingle with people in the same field,” she said.

But the bottom line is something that will resonate with people who work in the addiction recovery movement: taking care of yourself. “Self-care is a radical act,” said Helton. “We have to make harm reduction safe and inclusive, so we can draw in other communities.”

For herself, Helton, who has been a methadone patient and who worked in a methadone clinic for five years, said support groups are critical. “I belong to two different Facebook groups for people who

are on methadone,” she said. “You see increasing numbers of people advocating for the needs of people on methadone, for changing federal regulations, for getting rid of the stigma,” she said.

Meanwhile, Helton’s job is her self-care. She has a good salary and benefits. This enables her to do the grassroots work she does as a city employee. She’s not interested in going back into the substance use disorder workforce, where the pay is very low. Instead, she’ll continue to do her harm-reduction work for free. •

### CONSULTS from page 1

student in the university’s School of Public Health, and McCarty is a university professor and a former state substance abuse director in Massachusetts).

With most hospital systems not addressing OUD-specific treatment and discharge planning needs within their populations, “The AMC services are an important advance in quality of care for persons with alcohol and drug use disorders, especially opioid use disorders,” McCarty told *ADAW*.

### Study findings

Published online Dec. 28 in the American Society of Addiction Medicine’s *Journal of Addiction Medicine*, the study involved data collection via telephone interviews with board-certified addiction medicine physicians affiliated with the Addiction Medicine Foundation’s Addiction Medicine Fellowship Programs. The represented hospitals were scattered across the country, with most located in Medicaid expansion states and all having access to buprenorphine and methadone treatment among the services available to OUD patients.

Here are some of the key findings gleaned from the interviews with the professionals, whom the researchers referred to as “informants”:

- Only one of the nine AMC services that were represented in the study offered in-person consults over the weekend, so these were largely weekday-only services. “The informants, in general, were frustrated with the limited AMC service availability because patients admitted or discharged over the weekend were not receiving life-saving addiction-related services,” the researchers wrote.
- Three of the nine AMC services provided consultations in the hospital’s emergency department. This was another component that informants increasingly considered to be an essential component of program design.
- The consulting teams generally consisted of a diverse mix of professionals. Physician representation was present on each, while four of the nine services included social workers and only two of the nine included alcohol and drug counselors.
- The common core services offered by the teams were substance use disorder and mental health assessments, psychological intervention, medical management of substance use disorders, medical management

of pain and linkage to care. The latter encompasses both referral to treatment and “bridge” services such as a prescription for buprenorphine to serve the patient until he/she has established care from a provider in the community.

- The service plays a broad educational role for the rest of the hospital staff in highlighting that addictions need to be treated in a medical context. One informant said in the interview that “it just raises the profile of addiction in general when there is a consult service identified with it.”
- The surveyed services generally struggled with acquiring the financial resources for operations, with most surviving on a patchwork of government, insurance and private funding. The analysis suggests that the Centers for Medicare & Medicaid Services could make a difference in this regard, by increasing reimbursement for hospital-based addiction treatment services.

### New York City’s effort

The study paper states that most of the existing AMC’s were recently established. One of the efforts that was not part of this study but should generate significant research findings in the future is taking place in New York City, which has plans in the works for a total of six Consult for Addiction Treatment and Care in Hospitals (CATCH) teams in areas hit hardest by the opioid epidemic.

Leaders with the NYC Health + Hospitals agency told *MH/W* that while these services are intended to address all addictions, OUD services will be the present focus given the magnitude of the opioid crisis. The effort is being funded in part with monies from the comprehensive Healing NYC initiative out of the New York City mayor’s office, with additional funding support from a National Institute on Drug Abuse grant.

Lynsey Avalone, associate director of NYC Health + Hospitals’ Office of Behavioral Health, said each of the consulting teams will include a prescriber (either a physician or a nurse practitioner), a counselor/social worker and a certified peer recovery advocate. The city has a more extensive history with integrating peer services (such as in mental health care) than many communities, and there are plans also to house peers in city hospital emergency rooms as part of a separate initiative.

Avalone said that at the inpatient level, the CATCH team’s efforts could range from a simple recommendation for a hospital staff physician on a medication treatment for addiction to assisting in care right through discharge from the hospital. The programs in New York City also include bridge clinic services for patients who might not have a provider for medication-assisted treatment immediately upon discharge. Avalone said bridge clinic services will operate in a fashion similar to an outpatient primary care clinic.

Two of the planned CATCH team sites, at NYC Health + Hospitals/Bellevue and Lincoln, went into full operation in the second half of 2018, with another two of the six planned sites already fully staffed.

With MAT and other treatment capacity at a higher level in New York City than in some communities, the consult services can help facilitate rapid referral to ongoing treatment for hospitalized patients with OUD, according to city leaders.

Study co-author Priest told *ADAW* that in a forthcoming paper, the researchers will describe how the level of availability of community-based services facilitates or deters the existence of AMC services. “The connection with community treatment services is critical,” Priest said.

### Efforts in Illinois hospitals

The CEO of Chicago-based Gateway Foundation told *ADAW* that his treatment organization is

working with nine hospitals to furnish round-the-clock access to a specialist (including on weekends) to meet with patients in emergency or hospital detox settings, in order to plan the transition to outpatient care.

Tom Britton said State Targeted Response to the Opioid Crisis monies have supported this effort, but he sees formalized partnerships between hospitals and community providers as a major business opportunity for the specialty treatment sector — given the high costs that hospitals bear even for very short-term treatment of patients with addictions. “We sell this service to hospitals,” he said.

Britton explained that patients in the hospitals with which Gateway works (located in a diversity of urban, suburban and rural communities) may be seen by either a clinician or a peer, under the supervision of an addiction medicine specialist. “We have been successful in building a network of [community] placement options to meet the needs of a 24/7 model,” he said.

Around 20 percent of Gateway’s typical patient base receives medication-assisted treatment, and Britton suspects that with the level of acuity high in the hospitalized population for which it is consulting, a good number of those individuals will be on medication when they are placed in community treatment.

Over the past year and a half, Gateway has seen 1,000 hospitalized patients in this capacity, Britton said. The placement rate for these individuals has been 90 percent, but only about 10 percent of that 90 percent have been referred to Gateway’s own programs. That speaks to the larger communitywide goal of this initiative, a factor Britton says could pose a challenge for some treatment programs.

“You have to do what’s best for the patient and what’s best for the hospital,” Britton said, and that is not necessarily always what’s best for one’s own program. •

## BRIEFLY NOTED

**Shatterproof continues 'report card' project**

A project that began a year ago (see *ADAW*, Jan. 15, 2018), Shatterproof's rating system of addiction treatment programs took another step last month when the nonprofit announced it would start out with a pilot, now that it has \$5 million. Saying the current addiction treatment system is broken, Shatterproof founder and CEO Gary Mendell said the project was made possible by funding from two foundations (the Laura and John Arnold Foundation and the Robert Wood Johnson Foundation) and a coalition of five insurance companies. "People who need help for addiction don't know what to look for or where to turn," said Sam Arsenault, director of national treatment quality initiatives at Shatterproof, in the Dec. 18 announcement of the project. "We are taking rating system best practices from health care and other business sectors and applying them to addiction treatment. This will not only provide critical information to individuals looking for care but also drive a long overdue transformation of the addiction treatment industry." The Shatterproof Rating System will utilize data from three sources: insurance claims, provider surveys and consumer experience, with collaboration from the National Quality Forum (NQF), a membership organization composed of payers. Initially, the program will begin with a pilot, with analysis done by RTI International. "Consumers can find information and accurate data on the quality of nursing homes, hospitals, physicians and most other types of providers," said Tami Mark, director of behavioral health financing and quality measurement at RTI International. "It's time that patients have reliable information on addiction treatment."

**NY announces grants for up to \$10 million for 40 new beds**

Up to \$10 million for 40 new substance use disorder (SUD) treatment beds will be available from the

**Coming up...**

The **New York Society of Addiction Medicine's annual conference** will be held **Feb. 1–2** in **New York City**. For more information, go to <http://nysam-asam.org>.

**CADCA's 29th annual National Leadership Forum and the Substance Abuse and Mental Health Services Administration's 15th Prevention Day** will be held **Feb. 4–7** in **National Harbor, Maryland**. For more information, go to <http://www.cadca.org/>.

The annual meeting of the **National Association for Behavioral Healthcare** will be held **March 18–20** in **Washington, D.C.** For more information, go to <https://www.nabh.org/2019-annual-meeting/>.

The annual meeting of the **National Council for Behavioral Health** will be held **March 25–27** in **Nashville, Tennessee**. For more information, go to <https://www.eventscribe.com/2019/NatCon19/>.

The **American Society of Addiction Medicine's annual conference** will be held **April 4–7** in **Orlando, Florida**. For more information, go to <https://www.asam.org/>.

The annual meeting of the **National Association of Addiction Treatment Providers** will be held **May 5–8** in **Washington, D.C.** For more information, go to <https://www.naatp.org/training/national-addiction-leadership-conference>.

New York State Office of Alcoholism and Substance Abuse Services, the state announced last week. The funding will be for "withdrawal and stabilization" or "residential treatment." The withdrawal and stabilization beds will be short-term, "designed to prepare people for and connect them to longer term treatment," according to the state. Residential services can include counseling, training and recreational programs, according to the state. The new beds are part of the state's efforts to provide a full continuum of residential care for addiction,

which include what the state calls three essential areas: stabilization, rehabilitation and reintegration. Priority for the money will go to areas where these services are not currently available. Selected applicants must develop and support from 16 to 40 bed facilities. There is no funding available for conversion of currently operating programs. Responses to the Request for Applications (RFA) are due by Feb. 19. For the RFA, go to <https://oasas.ny.gov/procurements/documents/RFA-2019-Rapid-Expansion-19100.pdf>.

**In case you haven't heard...**

Jane Goodall's work has rescued more than two dozen monkeys from nicotine addiction research, moving them from a lab in Arkansas to a primate sanctuary in Gainesville, Florida. The nicotine addiction study was run by the Food and Drug Administration (FDA), which suspended the research last year after four of the monkeys died, three from anesthesia-related complications and one from bloat. The story, reported by The Associated Press last month, said Goodall wrote to the FDA in September 2017, calling the study "cruel and unnecessary." To continue the experiments on monkeys when the results of smoking in humans are already well-known is "shameful," she said. The study involved placing devices inside young monkeys that would deliver nicotine directly to their bloodstreams. The animals were then restrained and taught to press levers to receive nicotine. The FDA promptly stopped the experiment and sent the monkeys, along with \$1 million for their care, to the sanctuary. In the meantime, the effects of vaping nicotine will continue to be measured in the real world of teenagers, who are viewed by researchers at the National Institute on Drug Abuse as "guinea pigs" in the vaping issue (see *ADAW*, Dec. 24, 2018).