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Sharply divided field awaits rulemaking on revising 42 CFR Part 2

Bottom Line...
A divided field, with patients on one side and providers and vendors on the other, looks forward to forthcoming rulemaking on 42 CFR Part 2.

With information technology vendors and office-based addiction physicians on one side and patient advocates and methadone clinics on the other, anxiety over changes to the federal confidentiality law is mounting. Changes could take place in the form of a regulatory revision that may turn out to be more palatable than some of the legislative proposals, which call for drastic changes in privacy of treatment for substance use disorders (SUDs).

The long process of revising 42 CFR Part 2, the 41-year-old regulation protecting the confidentiality of SUD treatment records in most programs, began more than five years ago (see *ADAW*, Jan. 25, 2010) and is now nearing its endstage. The Substance Abuse and Mental Health Services Administration (SAMHSA), which promulgates the regulation, has drafted the Notice of Proposed Rulemaking and sent it to the Office of Management and Budget (OMB) for review, *ADAW* has learned. How long it will be held by the OMB is not known, but when it is released, stakeholders will comment.

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The Business of Treatment

As peer certification hits stride, who should steer the process?

Bottom Line...
The varying interpretations of the state of Virginia's developing process for certification of peer support specialists illustrate the complexities involved in integrating peers into a traditional care system.

Virginia officials are in the early stages of implementing a statewide peer support specialist certification system that could facilitate a stronger presence of peer support staff in the state's addiction treatment centers. But at least one prominent Virginia-based recovery community organization believes that in designing its system, the state is missing out on an opportunity to tap into some of its most seasoned local expertise in the delivery of peer-based support.

The concerns of the McShin Foundation, co-founded by John M. Shinholser and his wife, national addiction field lobbyist Carol McDaid, bring up some basic questions about the role of peer support services in the continuum of care, such as: Should states establish separate or integrated peer support certifications for substance abuse and mental health? And, to what degree should certification be driven by existing bureaucracies, or feature more

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Some are already commenting, however. On October 6, Mental Health America (MHA) and Netsmart, a vendor of electronic health records (EHRs), jointly released a statement calling for changes. Netsmart, in the release, supported proposed legislation by Sen. Chris Murphy (D-Connecticut) and Rep. Tim Murphy (R-Pennsylvania) that would drastically revise the current regulation. Under the proposed legislation, which MHA has not endorsed because of other provisions, consent would be "streamlined," according to the press release.

"You can't treat the 'whole person' with half the data," said Paul Gionfriddo, president and CEO of MHA, in the press release. "It's critical that these regulations be updated to permit the sharing of addiction treatment medical records, with patient consent, in new integrated care settings like Health Information Exchanges (HIEs), Accountable Care Organizations (ACOs), and Medicaid Health Homes."

Individualized consent

The key sticking point is the individualized consent provision of the regulation, which requires SUD treatment programs that do any business with the government — including accepting federal funds or taking Medicaid or Medicare — to obtain written consent from the patient to disclose any identifying information about that patient. That consent must also indicate the individual who will be receiving the information. For more than 35 years, this simple paper form was used. The statute authorizing 42 CFR Part 2, as well as the regulation itself, calls for written consent, Kate Tipping, a SAMHSA public health advisor, told *ADAW* this spring (see *ADAW*, May 25).

Then came EHRs and the HIE, in which patient records are freely available to any provider treating a patient. The main point of such sharing is to facilitate quality care, and according to proponents of revising 42 CFR Part 2, this information sharing is necessary in the event of SUD treatment as well.

'Burdensome'

But mainly, it's a technical problem. It's "burdensome" to segment out SUD data, said Kevin Scalia, Netsmart executive vice president of corporate development. The proposed legislation would "modernize 42 CFR Part 2 to say a consumer consent for one year, and it allows their consent to work in an ACO health home, or other care-coordination-type bodies," he told *ADAW*. "We have tons of opioid treatment providers who are for changing these rules," he said. "If you have an opioid addiction and you want to get the same quality of care, then you want doctors should share your medical records."

Scalia insists that providers, including OTPs, want to be able to share information. "I've had multiple meetings with SAMHSA, and with ONC [the Office of the National Coordinator for Health Information Technology], and I think there's universal demand from the provider side" to change 42 CFR Part 2.

"Think of the administrative burden of data segmentation on a provider," said Scalia. "I'm going to share these three fields with this doctor, and this with that doctor. How many different fields will you share with whom?"

Stigma

But H. Westley Clark, M.D., former director of SAMHSA's Center for Substance Abuse Treatment (CSAT), who presided over much of the 42 CFR Part 2 discussion in the federal government before abruptly resigning a year ago, says that SUDs and treatment are still too stigmatized to make patient information a part of the EHR and HIE.

"I suppose in a world where there are no criminal sanctions, no civil penalties and no discrimination, the privacy issue would not

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matter," Clark told *ADAW* last week. "However, we have to keep in mind that we are not in that world."

In addition, SUD treatment is already difficult to access, said Clark, noting that 17 states have not even expanded Medicaid, so that "poor people, especially people of color, cannot get basic SUD, health or mental health services." There is also data from the National Survey on Drug Use and Health showing that almost everyone who meets the criteria for SUD treatment isn't in treatment; only 2 million people go to specialty treatment who need it — 19 million do not.

"If you were one of those 19 million people with an SUD that you recognized, and you knew that your employer, your ex-spouse or law enforcement could have access to your records, would you even acknowledge your substance use?" asked Clark. "I think not."

Even Scalia agrees that there is discrimination against people with SUDs. "I'm not minimizing the problems with stigma in the U.S.," he said. "But my frustration is of trying to get equal rights for people with SUDs. If you don't want to share data, then opt out of the HIE."

'Tweaks'

Becky Vaughn, vice president for addictions at the National Council for Behavioral Health, said that there is still a need for 42 CFR Part 2. "We know after this much time there will probably be some tweaks, trying to address things with EHRs," Vaughn told *ADAW*. "And we feel we are moving away from stigma and discrimination, but we're not there yet." For providers who are "whining that they can't communicate, that it's too hard to communicate with addiction providers," Vaughn said they should just obtain the individualized consent from the patient. "It's not that hard," she said.

"I understand that it would be easier if all they had to do was follow the HIPAA regulations, but there are reasons why the regulations are stronger" for SUDs, she said.

There are strategies that could facilitate both treatment and privacy, such as the data segmentation for privacy initiative (DS4P) (see *ADAW*, May 25), which was initiated by Clark when he was at CSAT (see *ADAW*, Sept. 24, 2012). Under DS4P, patients could separate their SUD records and have individualized consent for release.

Netsmart's Scalia, who said he has been part of the DS4P experiments, would not be opposed to such a rule, but would want all other EHR vendors to be subject to the same rules.

As he has been saying for years, Clark told *ADAW* that it comes down to what is convenient for the big providers — of treatment and of EHRs — versus what protects the patients. "It seems that it is comfortable to sacrifice the most vulnerable," he said.

'I suppose in a world where there are no criminal sanctions, no civil penalties and no discrimination, the privacy issue would not matter.'

H. Westley Clark, M.D.

AATOD and Legal Action Center

The positions of the American Association for the Treatment of Opioid Dependence (AATOD), a membership organization of opioid treatment programs (OTPs), and the Legal Action Center, which more than 40 years ago helped draft the 42 CFR Part 2 regulations, and has worked on them ever since, have not changed. Both organizations oppose changing the regulation.

"We don't want to get out ahead of SAMHSA," said Anita Marton, deputy director and vice president of the Legal Action Center. "We know that SAMHSA is looking at how to modify the regulation, allowing for information flow yet protecting patients' rights," she said. "But our position has not changed. We still think it's premature for any legislation to be enacted."

"I suspect that there is a potential so-called negotiated approach, which is that if OTPs have to share information, it has to be sealed in such a way that only certain entities can get access to it, and that law enforcement can't," AATOD President Mark Parrino told *ADAW*. "I'm not comfortable with that. Once the safeguards end, there is a different problem, like patients not wanting to come into treatment, or stable patients leaving treatment for fear of being found out."

Patients are capable of telling their physicians about their SUD status. Consider the statement of Walter Ginter, project director at Medication-Assisted Recovery Services and a methadone patient, made at a public meeting on 42 CFR Part 2 five years ago at which physicians, particularly those prescribing buprenorphine, wanted to have access to OTP patient records (see *ADAW*, Aug. 9, 2010): "Is there a sudden epidemic of patients being given medications around the country because we don't have access to those records now? Like most patients, I carry a little card. I'm someone who takes a medication that might be contraindicated if I were in an emergency environment, and I carry a little card in my wallet that says do not give Walter certain medications because of that reason. I think medical people making the assumption that we're all too stupid to take care of our own medical conditions is insulting, to say the least."

The Americans with Disabilities Act (ADA) does not protect current

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illicit drug users, Clark noted. "If they can't change the ADA, if they can't change the criminal justice system in states, if they can't change the child welfare system in many states, if they can't change employers' attitudes, if they can't keep sensitive information protected, then recognize the unique role that SUD has in the mindset of America and behave accordingly," said Clark. "A computer fix and patient consent would solve the information problem. However, it seems that the system believes that it is cheaper to shift the risk and the harm to the poor." •

Video of jail drug-withdrawal death leads to FBI inquiry

Video of the death throes of a jail inmate in withdrawal from his prescribed opioids and benzodiazepines went viral last month. The family has sued Macomb County in Michigan, and the Federal Bureau of Investigation (FBI) instituted an inquiry last month, the *Detroit Free Press* reported September 29.

The inmate, David Stojcevski, died June 27, 2014, in Macomb County Jail at the age of 32. He was serving a 30-day sentence for failing to appear in court for a traffic ticket for careless driving. After 16 days, he was rushed to a hospital, where he died less than two hours later, according to the *Detroit Free Press*.

Stojcevski, who was in jail for two weeks, lost 50 pounds and died from prescription medication withdrawal, according to a lawsuit filed by the family, quoting from the autopsy. Sheriff Anthony Wickersham confirmed that the Detroit office of the FBI is asking for information about the death.

The sheriff said he encouraged the FBI to meet, and gave the agency the results of the internal investigation, as well as 240 hours of in-cell video.

"I promote transparency within my office and look forward to the findings of the FBI," Wickersham said in a September 29 press release after meeting with the FBI. "Any death that occurs in the Macomb County Jail is tragic; not only to the family of the deceased, but to the men and women of the Sheriff's Office who oversee the care and custody of our 1,200 inmates daily." Because of the current lawsuit, Wickersham said he could not comment further on the case.

The county had already conducted an internal investigation and found that nothing was amiss, Michigan Radio reported October 13.

Benzos, opioids

The lawyer representing the Stojcevski family, Robert Ihrie, is glad the FBI is involved. The lawsuit was filed in March in U.S. District Court in Detroit and claims that the county, Correct Care Solutions (which provides health care at the jail) and others allowed Stojcevski to go through withdrawal from prescription medications, causing suffering and death. The prescriptions were for benziodiazepines and opioids, but it was most likely the benzodiazepine withdrawal that was fatal. Both opioid and benzodiazepine withdrawal are painful.

> **'They need to be punished for everything what they do (to) my son. Shame on them!'**
>
> Dafinka Stojcevski

The video was posted by a Detroit NBC TV station September 24. Since then, the family has protested outside the jail. For Dafinka Stojcevski, David's mother, the anger is still raw. She is seeking justice for her son.

"They need to be punished for everything what they do (to) my son," said Dafinka Stojcevski at an October 10 protest. "Shame on them!"

The death certificate listed the cause of death as "acute withdrawal from chronic benzodiazepine, methadone and opiate medications," according to the lawsuit. The autopsy report also reflected dehydration and seizures — the seizures can be seen on the video, in which Stojcevski is naked and monitored around the clock in a "mental health cell."

Stojcevski's brother, Vladimir Stojcevski, was jailed at the same time, also for failing to appear in court on a traffic charge. He filed the lawsuit, which seeks more than $75,000 in damages. David had owed $772 in traffic fines, according to Michigan Radio.

County blames lawyer

On October 2, Macomb County Executive Mark Hackel called the Stojcevskis' lawyer "irresponsible," *The Detroit News* reported. "We've got an attorney out of St. Clair Shores who's trying to strong-arm us out of $25–30 million," Hackel said during a press conference with Wickersham and other officials.

The lawyer, Ihrie, had asked for the multimillion-dollar settlement before filing the lawsuit in March, said Hackel. "He said, 'This is going to be a media spectacle,'" Hackel said of Ihrie's offer. "Obviously, he made good on his promise."

Ihrie denied that he had made any official money offers. "All I can say is that I did my best to try and have a meaningful discussion about this case before it was filed, and I never got a response," he told *The Detroit News*.

Ihrie released the video footage — all 240 hours — and did not edit or cut it. He said the family hopes there will be changes made. "If there's

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a silver lining, it's that the visual component of this case, hopefully, will highlight the issue with respect to how jails and prisons are equipped and how medical care is managed for the sick and addicted," said Ihrie.

Now the problem of access to medications in jail is an important topic, but it's not often that people can see the consequences of withdrawal on a live video. Furthermore, if that video hadn't gone viral, the FBI might not have become involved, and the county's internal investigation — which it still stands behind — would have been the last word. •

For the video, go to www.metrotimes.com/Blogs/archives/2015/09/24/video-of-man-dying-in-macomb-county-jail-emerges.

Methadone in jail

When people on medications for medical problems go to jail, they may not get their medications even if they ask for them — with fatal results some of the time. For methadone, this is a particular problem, and although methadone and other opioid detoxification don't have the same medical risks as alcohol or benzodiazepine detoxification, methadone treatment is still hard to get in jail. "In larger jails, there is usually support for a medically managed detox from heroin or other opioids," said Pamela F. Rodriguez, president and CEO of Treatment Alternatives for Safe Communities (TASC), based in Chicago. "Often the Cook County Jail will send people to the Cook County Hospital for more complicated withdrawals — benzodiazepines and sometimes alcohol." For more rural jails, the situation may be different, she said.

As for methadone, the federal Drug Enforcement Administration requires that jails become opioid treatment programs in order to administer methadone, said Rodriguez. "This is a tall order," she said. "Pregnant women are usually maintained on methadone when the jail knows the woman is pregnant, which is not always the case," she said. Opioid detoxification can be fatal to the fetus.

Sleepy N.Y. county waking up to need for opioid treatment

Last July, Nancy Haggerty, a reporter for *The Journal News*, based in Putnam County, New York, interviewed John DeFonce as part of a story about former athletes from the area who had become addicted to heroin via prescription painkillers for sports injuries. At the time, DeFonce was in treatment at St. Christopher's Inn in Garrison and was not identified by last name in the story, which didn't run in print until October 1. Less than two weeks later, the paper had to report on his death. He was on a weekend pass from a halfway house owned by St. Christopher's. His parents found him unresponsive on a couch and called 911. The cause of his death is pending results of the autopsy.

Formerly a star high school football player in the area, DeFonce had first become addicted to prescription opioids.

DeFonce had been prescribed pain medications after a high school football injury, according to *The Journal News*, which reported that after his physician refused to give him more prescriptions, he began buying drugs on the street, and soon went to heroin. "I bounced from rehab to rehab," he said.

At one point he was arrested and accused of credit card fraud, and checked himself into a treatment program in Florida, which meant he had jumped bail. "My lowest point was sitting in that jail cell," he told *The Journal News*. "That's when I decided I wanted to change."

Putnam County, called "where the country begins" by many former New York City residents (and where the editor of *ADAW* lives), has a drug court, headed by Judge Jim Reitz, who believes in allowing offenders one chance at treatment.

St. Christopher's starts Vivitrol

Stephen Shapiro, M.D., medical director of St. Christopher's Inn, didn't want to talk about a "particular client for confidentiality reasons." However, he did say that Phase 1 of treatment involves a 30-day stay, with no one allowed out on passes. Phase 2 involves some privileges, but it's still "highly structured." By the time someone reaches Phase 3 — the phase DeFonce was in — "we're hoping they're out in the community more, out on weekend passes," he said. "Even when my own mother talked to me on the phone about this, she said, 'How could you let him go out on a weekend pass?'" But that is the position many treatment programs are in, after weeks and even months of treatment — they discharge patients who seem ready, and some patients relapse.

St. Christopher's uses buprenorphine, with a maximum dose of 8 milligrams, said Laurel McCullagh, director of nursing at St. Christopher's. "Ideally, we like to see people free of substances," she said. "But I'm more excited about Vivitrol."

The plan in the future is to taper patients off of buprenorphine, and then give them a Vivitrol injection when they leave, said Shapiro. "Then, they need to get another shot every month," he said.

The sales representative for Alkermes, Michael Peluso, has been "very proactive," said McCullagh. They have helped with getting prior authorization for Vivitrol, which is "very expensive," she said. "He is

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passionate about this, a wonderful guy." An email to Peluso was not returned by press time.

Patients also like being on Vivitrol, said Shapiro. "They feel no cravings," he said. Shapiro has given eight Vivitrol injections in the past two months, he said.

More than medication

But Vivitrol and buprenorphine "are not the total answer," said Shapiro. "They're part of a treatment program. I still believe that Twelve-Step programs are the bottom line to success. So you have to combine Vivitrol with AA and NA meetings."

Currently, St. Christopher's has 180 beds and is full. The waiting list is about two weeks long. An unusual program in one way, St. Christopher's also operates a shelter where patients can live while they are attending outpatient treatment at the program.

"We're 106 years old," said Shapiro of St. Christopher's. "For the first 100 years, alcohol was the primary drug of choice. Now, it's opioids."

And there aren't many resources in Putnam County. Arms Acres, in Carmel, is, like St. Christopher's Inn, always full. "When I first came here in 1998, there were 129 beds — now there are 162," said Patrice Wallace-Moore, CEO of Arms Acres and vice president of Liberty Management Group, which owns Arms Acres. "But there's still such a need," she told *ADAW*. "We're always trying to figure out how we can reach more people."

In New York state, managed care companies now know that they have to abide by parity rules, and must pay for detoxification, she said. "There was a time when it was considered not life-threatening, and people on opioids were not allowed in treatment programs," she said.

> **'We're always trying to figure out how we can reach more people.'**
>
> Patrice Wallace-Moore

Wallace-Moore credits many of the mothers who lost children to opioid overdoses for the attorney general's lawsuit enforcing parity (see *ADAW*, March 31, 2014).

NIMBY and methadone

Liberty would open methadone programs in Putnam County if there were community support, said Wallace-Moore. "The problem is that many people in the community do not agree," she said. "In order for an OTP to be allowed in a particular community or county, state regulations require that it receive community support. There is a lot more resistance in the community than there is in the treatment field."

Liberty just opened an OTP in Plattsburgh, where there was none. "We are attempting to put one in Troy, but met with widespread resistance from the community," said Wallace-Moore. Meanwhile, Arms Acres does use buprenorphine and Vivitrol, although problems with reimbursement for Vivitrol exist.

"The medications are going to be different for each individual, and the more options that you have, the better for the community," said Wallace-Moore. "But medication alone isn't good. The key word is treatment."

In the meantime, *The Journal News* published an editorial noting that the number of methadone programs was going down in the area, and calling for more support for treatment. It also published a story detailing social media responses to the death of DeFonce, many of which showed that local residents blame drug users for their own problems. Siting a new treatment program in Putnam County would probably include convincing the residents that their own friends and family members are the ones who would need it. •

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input from the growing ranks of recovery community organizers at the grassroots level?

"They're making a big mistake by not including us in the process," Shinholser told *ADAW* in reference to officials with Virginia's Department of Behavioral Health and Developmental Services (DBHDS). "They are discriminating against the real authentic movement."

Lengthy process

It took many months for Virginia to join the list of states with a process for certifying peer support specialists (often referred to as "recovery coaches"), a move driven largely across the country by the Medicaid requirement for billing purposes that peer specialists be certified by the state. A "Creating Opportunities" planning committee examining peer support looked at other states' processes as part of its work on a report of recommendations that it issued to the DBHDS in December 2013. The department formally initiated the state's certification process this year, with a one-year grandparenting period for existing peer support workers scheduled to expire next July.

Susan Pauley, behavioral health program consultant with the DBHDS, told *ADAW* that the state agency accepted most of the planning committee's core recommendations, including that there should be one certification process covering both mental health and substance use support. Ironically, when state officials first started looking into this, many other states had either opted for separate certifications or were ignoring the role of peer support in substance abuse altogether, Pauley said.

"Too many of our people who

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come through the doors [for treatment] have multiple problems," she said in explaining the attraction of a certification encompassing both disciplines. This does not suggest that each certified peer specialist must have lived experience in both domains, but that all certified workers should receive sufficient training in both substance abuse and mental health, she added.

The DBHDS also adopted the committee's recommendation that an entity outside of state government should implement the actual certification process. The organization chosen for that role is the Virginia Certification Board, the credentialing authority that is an affiliate of the International Certification & Reciprocity Consortium (IC&RC), Pauley said.

To Shinholser, the process that Virginia officials have created remains too bureaucracy-driven. "They want to make the recovery coach curriculum mental health primarily and substance abuse secondarily," he said, and he believes this is largely because of existing funding streams that have a mental health focus.

Training curriculum

The state is still in the process of designing a training curriculum that will need to be in place for the grandparenting period to end and the program for issuing new certifications to begin. The state is scheduled soon to issue a request for proposals from entities interested in designing the curriculum, Pauley said. Minimum requirements to become a certified recovery support specialist in Virginia will include at least 500 paid and/or volunteer hours of recovery-related activities, at least one year of demonstrated time in recovery prior to applying for certification and at least 90 hours of training in topics addressing both mental health and substance use disorders.

Some of the subjects that will be required to be addressed in the training will be crisis intervention, basic principles of health and wellness, stage-appropriate pathways in recovery support and ethics (with the latter covering boundaries, confidentiality, sexual harassment, self-care and other topics). Pauley said the state's standards for certification are more stringent than what the IC&RC calls for in its own peer support standards.

During the grandparenting period, the state is recognizing several existing training curricula for purposes of certifying current peer support workers. The McShin Foundation, which was training recovery coaches in the state well before state officials began the process of designing a certification system (it has certified around 500 individuals in Virginia alone under its own program, and is a NAADAC-approved education provider), was denied in its attempt to have its training curriculum recognized.

"They have chosen to fortify an antiquated system," Shinholser said of state officials. "It is too heavy toward mental health compliance. We are going to continue to be at odds with the state delivery system."

Pauley said that the McShin Foundation's curriculum failed to make the cut not because of a focus on substance abuse (most of the curricula that have been designed to this point have emphasized one discipline more than the other, she said), but because its total number of hours fell short of what the state was seeking for accepted curricula during the grandparenting period. She added that McShin will still have an opportunity to become a trainer of would-be state-certified specialists under the state's program.

Shinholser says many other state and local entities don't see things the same way as the DBHDS does about McShin's training resources. Several states, including Colorado, Florida and Montana, recognize his recovery community organization's training hours under their approved training curricula for peer support specialists, he said.

On the day he was interviewed by *ADAW*, Shinholser was traveling within his state to the community of Winchester, where he said leaders that include the chief of police and local hospital officials are seeking to establish a recovery-oriented system of care and want McShin to serve as their technical adviser. "They don't want the typical bureaucracies to do it," Shinholser said.

'They want to make the recovery coach curriculum mental health primarily and substance abuse secondarily.'

John M. Shinholser

Treatment community responding

Shinholser said traditional treatment organizations are beginning to tap into the growth in recovery community participation, with many centers now engaging in their own training of recovery coaches.

"The future will be a blend of acute-care and recovery support services," he said.

It is not known how many individuals in Virginia might eventually pursue certification as a recovery support specialist, but Pauley said the state "budgeted for hundreds" when setting aside funds for financial assistance for individuals who pursue certification during the grandparenting phase. The state has agreed to pay the majority of the $100 application fee for individuals during this phase, she said. •

Briefly Noted

Senate calls for OMB accounting on PR spending

On October 7, Sen. Michael B. Enzi (R-Wyoming) wrote Shaun Donovan, director of the Office of Management and Budget (OMB), requesting a detailed list of how the Substance Abuse and Mental Health Services Administration (SAMHSA) spends its money on "messaging." The letter was prompted by the September 28 "In case you haven't heard…" article in *Alcoholism & Drug Abuse Weekly* reporting on the outreach by Edelman to reporters on behalf of SAMHSA (see *ADAW*, Sept. 28). The *ADAW* article was picked up by *The Washington Post* (see https://www.washingtonpost.com/news/powerpost/wp/2015/10/05/federal-agency-pays-outside-pr-firm-to-ask-reporters-for-messaging-help). In the letter to the OMB, Senator Enzi, who chairs the Senate Budget Committee, warns that federal law prohibits the use of federal funds for "publicity or propaganda," and asks for (1) a copy of the Edelman contract; (2) a breakdown of all executive branch spending on advertising, media relations and public relations; and (3) a copy of written policies the administration has to prohibit the use of funds for propaganda or publicity. The letter requested a response by October 16.

NSDUH-based study shows no treatment increase from 2004–13

Despite the dramatic increase in opioid use disorders during the decade from 2004 to 2013, use of treatment did not increase, even after accounting for changing populations, according to a "Research Letter" published October 13 in the *Journal of the American Medical Association*. There were increases in different kinds of treatment settings — in particular, physician's offices and inpatient treatment. "Use of addiction treatment did not change among people with opioid use disorders during the decade we looked at," lead author Brendan Saloner, M.D., told *ADAW*. "However, among people who did get treated, they visited more types of settings on average. In particular, they were more likely to get treated in doctor's offices (a setting where buprenorphine is commonly administered)." The study, based on the National Survey on Drug Use and Health, was limited by the fact that this survey doesn't measure the use of medication-assisted treatment or the quality of care. Saloner told *ADAW* that "based on other data (not from this study), there is evidence that buprenorphine treatment did expand." There were no variables to measure this in his study.

Half of states don't enforce parity

Fewer than half of states are enforcing the Mental Health Parity and Addiction Equity Act, according to an October 7 report from The Kennedy Forum and the Thomas Scattergood Behavioral Health Foundation. Part of an ongoing ParityTrack initiative, the report found that since the law was signed by President Bush in 2008, only five states have taken disciplinary action against insurers for violating federal and state parity laws. "We have difficult work ahead to make parity a reality," said Patrick J. Kennedy, who wrote the parity law when a U.S. representative. "ParityTrack is designed to help individuals understand their rights to accessing care, and what they can do if those rights have been violated," said Joe Pyle, president of the Scattergood Foundation. "By completing the Parity Reports, we now understand what is working to implement parity as well as what gaps still need to be filled." Some positive actions include a bill passed in Illinois that would require the state's Department of Insurance to enforce federal and state parity laws, and the investigations by the New York state attorney general that led to five settlements with insurance companies for violating parity laws. ParityTrack was launched in June to promote efforts to implement mental health and substance use disorder parity laws. Using ParityTrack, individuals can access details of mental health and substance use disorder parity in their state and compare it to other states. ParityTrack works with the Treatment Research Institute, the Parity Implementation Coalition, the Legal Action Center, Community Catalyst, and Health Law Advocates to develop tailored resources for consumers. For more information, go to www.paritytrack.org.

Coming up…

The **Association for Medical Education and Research in Substance Abuse** will hold its 39th annual national conference **November 5–7** in **Washington, D.C.** For more information, go to **www.amersa.org**.

The **National Prevention Network Conference** will be held **November 17–19** in **Seattle**. Go to **www.npnconference.org** for more information.

In case you haven't heard…

Two marijuana users in Colorado, one a cancer patient, have sued a marijuana business, claiming that a toxic pesticide was used on the product, CNBC reported last week. The fungicide Eagle 20EW could also be harmful to humans if it is inhaled when burned, according to the article. The lawsuit claims that LiveWell, the marijuana company, used a pesticide that was not on the list of pesticides Colorado approves for food and tobacco crops. The Associated Press reported that LiveWell says its products are safe.