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

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Pros and cons of eliminating buprenorphine patient cap

Raising the "cap" — or the number of patients a single physician is allowed to treat with buprenorphine — to "unlimited" was proposed by Sen. Edward Markey (D-Massachusetts) in a bill last month. This controversial issue has been discussed by legislators at a forum with stakeholders (see *ADAW*, June 23), but until Senator Markey's bill, it was the Substance Abuse and Mental Health Services Administration (SAMHSA) that was under pressure to raise the cap, which is currently 100. Numbers discussed had been 300, or sometimes 500, but never "unlimited." We asked Elinore McCance-Katz, M.D., chief medical officer for SAMHSA, about the pros and cons of raising the cap.

"The pros would be that we increase access to treatment," she said. "I think an unlimited cap could set up a situation where you could see pill mills mainly focusing on buprenorphine." That is why SAMHSA first created the cap — which was 30 under DATA 2000, and then increased to 100 when Congress amended DATA 2000 in 2003.

Bottom Line...
The debate about whether to lift the 100-patient limit on buprenorphine reached a new level last month when a bill was proposed in Congress to allow physicians to treat an "unlimited" number of patients.

No 'therapeutic' street use

One rationale for having more buprenorphine made available is that people are buying it on the street because they can't get it through a physician, and they are taking it for "therapeutic" purposes

See Markey page 2

The Business of Treatment

Centers say they would benefit from one integrated care measure

BST

As more addiction treatment facilities prioritize the integration of their specialty services with general medical care, their strategies for evaluating the success of integrated care efforts appear as diverse as the settings and models for coordinating the services.

Professionals interviewed last week by *ADAW* agree with the notion that they could benefit from a nationally accepted instrument for measuring the impact of integrated services. For now, most use a combination of metrics that largely focus on patient follow-up with recommended care and on patient and

Bottom Line...
Addiction treatment facilities that are integrating their services with primary medicine are generally using a patchwork of standards to evaluate the success of their efforts.

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Markey from page 1

— to ward off withdrawal. But McCance-Katz debunked this theory. "If your body requires opioids in order not to go through a painful withdrawal, and if you can find one through street lore that will last longer, you may prefer it," she said. "Is that therapeutic? I would say no. Buying buprenorphine on the street is not therapeutic."

SAMHSA is responsible for giving physicians waivers that allow them to prescribe buprenorphine for opioid addiction, following the completion of an eight-hour training course. But SAMHSA doesn't know what these physicians are doing in terms of comprehensive services. "We don't collect data on that," said McCance-Katz. "We know if a physician is waivered or not, but we don't know if they are referring patients for counseling." Noting that counseling is not required, McCance-Katz said that it nevertheless should be provided. "I personally believe that counseling must be a part of treatment, especially early in treatment," said McCance-Katz. She added that studies, because of their design, include many interventions even with the non-counseling arm that obscure the effectiveness of counseling.

"The physicians that like to do this are physicians who have experience in treating patients who have SUDs," said McCance-Katz. "I would fall into this category."

ASAM favors no limits

So would Stuart Gitlow, M.D., president of the American Society of Addiction Medicine (ASAM), which opposes any limitations placed on the number of patients who can be treated by properly trained and certified addiction specialists. "No other specialty of medicine has such constraints," Gitlow told *ADAW*. "An oncologist can treat any number of cancer patients, utilizing whatever modality of treatment is available and appropriate for the situation. A surgeon can perform surgery on any number of patients. Only in the case of opioid addiction are physicians limited to utilizing an approved treatment for a restricted number of individuals."

The average psychiatrist working in a community mental health center probably covers close to 1,000 individual patients, many of whom are treated with psychotropics and who require close case management, said Gitlow. "Somehow in this ongoing discussion, someone out there must think 100 patients represents a significant portion of the usual medical caseload. It doesn't," he said.

However, Gitlow said that without checks and balances, "some physicians who are not good might treat a large number of patients, and might do so indiscriminately and without appropriate overall care." That's true in any branch of medicine, he said. He did suggest that eight hours of training for non-addiction physicians is insufficient, and that Drug Enforcement Administration (DEA) certification without recurrent training is insufficient. "But punishing the patients by limiting their access to addiction certified physicians due to a ceiling on the number of patients we can treat makes no sense whatsoever," he said.

But Gitlow said that a buprenorphine expansion should be attracting physicians who like treating SUDs. "I'd rather not see people treat opioid addicts just because they have had eight hours of training and have received a DEA number," said Gitlow. "I want them to treat opioid addiction because they are actually interested in doing so and can provide quality care."

Challenges for SAMHSA

Meanwhile, SAMHSA is faced with the challenge of deciding whether to raise the cap, and if so, by how much. This is not something that Congress needs to authorize, according to Brian Altman, legislative director at SAMHSA, who said that the secretary of the Department

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> **'I think an unlimited cap could set up a situation where you could see pill mills mainly focusing on buprenorphine.'**
>
> Elinore McCance-Katz, M.D.

of Health and Human Services (HHS) has the discretion to change the number, according to the statute.

However, he said that SAMHSA, while it is "leading the policy discussions," will be working with the DEA, the Office of National Drug Control Policy, and others in the administration on the buprenorphine issue. "SAMHSA will not be acting unilaterally," he said. We asked if SAMHSA had a comment on the policy paper circulating from the American Association for the Treatment of Opioid Dependence (AATOD) that questions the unintended consequences that could come from liberal distribution of buprenorphine (see *ADAW*, July 21). "There are a lot of stakeholders in this issue," said Altman.

The next steps by SAMHSA will be determined by Sylvia Mathews Burwell, the new secretary of HHS. "Our timing has to be based on when or if the secretary is interested in this," said Altman. SAMHSA officials have been briefing her on the issue.

Safety concerns

Because opioid overdoses are one of the reasons for expanding access to treatment, buprenorphine's safety is also a consideration, in particular the ramifications of combining buprenorphine with other central nervous system (CNS) depressants. The safety profile of buprenorphine was established only using the single drug, mainly in those people who already have tolerance to opioids, said McCance-Katz. "We do know that there is an increased risk for adverse events in people who are using or abusing other CNS depressants, such as benzodiazepines and alcohol, among others," she said. "That introduces a whole new set of safety concerns."

And many treatment providers are appalled that there is any proposal to simply prescribe addictive medications as a remedy to addiction. "This will be harmful to patients," said Chapman Sledge, M.D., chief medical director at Cumberland Heights in Nashville, of the proposal to raise the cap. "We see significant abuse and diversion of buprenorphine in our practice every day," he said. "We are detoxing people from buprenorphine — it is not an innocuous drug."

Sledge told *ADAW* that many physicians who prescribe buprenorphine for opioid addiction are "reputable, knowledgeable and caring." But there are also physicians who are not adequately trained, said Sledge, adding that he doesn't think the eight-hour online course that is required is sufficient. "It's not unusual in our practice to have someone who has been prescribed buprenorphine and a benzodiazepine by the same physician," he said.

Sledge acknowledged that he doesn't see the patients who are doing well on buprenorphine, but only the ones who are not doing well. He also sees patients who get a prescription for buprenorphine but never take it — instead, they sell it to fund the opioid they prefer, reserving some in case they need it. And others sell it to fund completely different types of drugs. Sledge uses the prescription drug monitoring database in Tennessee, and recounted a recent experience in which a patient who was being admitted for methamphetamine addiction had a prescription for buprenorphine every month. "'I don't use that stuff; I sell it to buy meth,'" she told Sledge.

The controversy has had the result of creating a kind of agreement between AATOD, which represents methadone clinics, and SUD treatment providers that have traditionally been opposed to medication-assisted treatment, such as Cumberland Heights. Both AATOD and so-called "drug-free" treatment providers are opposed to raising the cap. •

For the AATOD policy paper, go to www.aatod.org/wp-content/uploads/2014/07/MAT-Policy-Paper-FINAL-070214-2.pdf.

For the Markey bill, go to www.markey.senate.gov/imo/media/doc/2014-07-23_TREATAct_text.pdf.

DPA says it hasn't left harm-reduction to promote marijuana

The Drug Policy Alliance (DPA) has traditionally been on the same side as most treatment providers in news stories: treatment instead of incarceration, the availability of clean needles, overdose rescue via naloxone, fighting racial disparity, sentencing reform, and, most significantly, Proposition 36 in California, which, until it failed, paid for treatment instead of incarceration. Recently, however, almost all of the press releases and social media messaging from the DPA has been focused on one goal: marijuana legalization, with cheerleading every time there is another win for recreational marijuana use. This has led the treatment field to believe the DPA has lost its credibility. We asked DPA Public Policy Director Stephen Gutwillig this week whether the DPA is abandoning the mission of

Continues on next page

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harm reduction for that of marijuana promotion.

"DPA has always had the same mission from its get-go — we are the leading organization working to end the war on drugs," said Gutwillig in an August 6 interview with *ADAW*. "Our primary focus has been on promoting alternatives to punitive responses to drugs, whether problematic or nonproblematic drug use."

Eliminating criminal justice role

The DPA wants to reduce, if not eliminate, the role that the criminal justice system plays in "making things worse," said Gutwillig. "Our primary impetus for writing and passing Proposition 36 was to move people universally caught up in the criminal justice system from incarceration into treatment," he said. However, when the five-year funding for treatment ran out, the skeleton of Proposition 36 remained on the books — people could no longer be incarcerated — but the money for treatment was gone. Gutwillig said the DPA should have written the law to include permanent funding.

Now, however, the DPA's primary focus is to radically reduce the role of criminal justice in treatment. That's why it doesn't support drug courts; according to Gutwillig, drug courts focus mainly on people who don't really need treatment. Still, he said the DPA isn't in favor of getting rid of them, because "they help many people."

The DPA is promoting this mission through the expansion of Law Enforcement Assisted Diversion (LEAD), a pre-booking diversion program that was inaugurated in Seattle. LEAD is not just a diversion away from prosecution, but it moves people into "wraparound services" including housing, said Gutwillig. "People won't be criminalized solely based on relapse, and will be moved to a healthy place and a functioning position within society," he said.

Decriminalization — not legalization — of all drugs is the goal of the DPA, said Gutwillig. People should not be prosecuted for possession of drugs, but instead get treatment, if they need it.

"We do not promote use of marijuana," said Gutwillig. "The potential for becoming dependent increases with underage uptake, and we agree that those are real issues, but that the best way to address that is through regulation and age controls."

HRC's view

The Harm Reduction Coalition (HRC), which shares many of the DPA's missions, such as overdose prevention, has no position on marijuana legalization. "I think of the DPA as being in the drug policy world, and we're more in the health world," HRC Policy Director Daniel Raymond told *ADAW*. "We do a lot of work on the federal level around overdose prevention."

> **'Our primary focus has been on promoting alternatives to punitive responses to drugs, whether problematic or nonproblematic drug use.'**
>
> Stephen Gutwillig

The HRC still works with the DPA on issues like overdose prevention, said Raymond. "They don't put out a lot of press releases on this, but they've been very supportive of states working to pass naloxone laws and Good Samaritan laws" allowing people to report overdoses without fear of arrest, he said.

The marijuana legalization issue is a "strategic calculation" the DPA made because it felt it had a good chance of being reality, said Raymond. The HRC has no position on marijuana legalization.

But Raymond agrees that there is racial disparity in arrests, and marijuana has been at the center of it. Public possession of marijuana was made a misdemeanor in New York City in the 1970s, which meant that it was not illegal for carrying it in your pocket. "But you would hear story after story of young black men saying the police stopped me, they frisked me, I had marijuana on my person, and as soon as I took it out I was charged with public possession," said Raymond, who lives in New York City. "Once these arrests are on the books, they affect all kinds of things in terms of employment, housing, and so on." The DPA made a major commitment to reforming these laws, he said.

Still, Raymond is concerned about legalization increasing marijuana use. "We need to talk about what we learned from alcohol, and what we learned from tobacco," said Raymond. "It's possible to say yes, marijuana can be addictive, yes, alcohol can be addictive, but still advocate for harm reduction." •

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provider satisfaction.

"If we were measuring the same things nationally, it would help with credibility," said Mary Ann Abate, who directs the public policy operation at Rosecrance Health Network in Rockford, Ill. Abate served as vice president of community mental health at Rosecrance at the time that the treatment organization began embedding a licensed clinical social worker at a federally qualified health center (FQHC) in the region.

Inquiry from managing entity

David Freedman, project director of the South Florida Behavioral Health Network Inc., last month

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posed a question to colleagues on a primary care/behavioral health integration listserv as he searched for accepted tools for measuring progress toward care integration. Freedman says he has received numerous helpful responses, but no clear picture of a widely accepted instrument for addiction treatment centers has emerged.

The network is one of many nonprofit managing entities in Florida that oversee regional spending of public dollars for substance use services (in this case, for Miami-Dade and Monroe Counties). It has received Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding for integrated care initiatives and has focused its efforts mainly on the provision of behavioral health at two FQHCs in the region.

He is seeking to identify an instrument sensitive enough to measure patient change over six months and a year. "I don't want to spend a lot of time punching data," he said. "If I can look online, that will help a lot, because I'm the only one in my agency [tracking] this."

Satisfaction metrics

At Rosecrance, leaders began embedding a licensed clinical social worker at the Crusader Clinic in Rockford in early 2012. The social worker and a physician will see an identified patient together when that person agrees to have a discussion with a professional about behavioral health issues, says Abate. "Compartmentalizing of a human really does not lead to recovery," she said.

She said the organization does not have any standard computerized metrics to evaluate its efforts; it relies heavily on patient and provider satisfaction data, as well as statistics related to patient follow-up. Nearly all "referrals" from the primary care physician to the embedded social worker are accepted, meaning that the organization is succeeding in moving toward whole-person care, she said.

'If we were measuring the same things nationally, it would help with credibility.'

Mary Ann Abate

More recently, the network received a foundation grant that it will use to encourage change in specialty addiction and mental health facilities. "The goal of the project is, through training, can we make these facilities better able to integrate care?" said Freedman.

The foundation awarding the grant has asked the network for a tool to measure movement toward integration, and this prompted Freedman's online inquiry. He has spoken with several respondents in the couple of weeks since he posted the question, and says he has discovered that much of what's available for evaluation appears to be primary care–centric.

"A lot of tools measure the ability of health care organizations to integrate behavioral health care," said Freedman. "The reverse was what I was looking for."

For the fiscal year ended June 30, a total of 2,010 primary care clinic patients were seen by the embedded behavioral health clinician, said Abate. "Most ended up being referred for some type of counseling at Rosecrance," she said. "We have priority status for these individuals. If they need immediate intervention, that happens on the same or next day."

Abate said that while it will be important for addiction treatment organizations to evaluate general health and substance use outcomes when evaluating their efforts, insurers already are observing a positive effect of integrated care when examining claims data.

All responsible for whole health

Tarzana Treatment Centers in California differs from many other addiction treatment organizations in that it is providing general medical services at its own sites rather than locating at medical clinic facilities. Its director of information technology, Jim Sorg, Ph.D., says he does not know of any concrete measures for evaluating the impact of integration, adding that much of Tarzana's focus remains on ensuring that all care professionals in the organization consider both behavioral health and general health indicators in their patients.

"Everyone is responsible for the whole health of the patient," Sorg said.

From the behavioral health clinician's perspective, this means collecting information from each patient with a chronic medical illness about follow-up care such as blood work and foot examinations for persons with diabetes. On the primary care side, it means an annual Screening, Brief Intervention and Referral to Treatment (SBIRT) completion, as well as attention to regular mental health screenings, Sorg said.

He added that while FQHCs are required to report SBIRT data, such reporting requirements have not been imposed on his facility to this point. Tarzana is currently pursuing Joint Commission accreditation as a behavioral health home, he added.

The payment picture for California addiction treatment organizations that are integrating other services has improved in recent months, Sorg said. Based on statutory changes that took effect in January, organizations such as Tarzana now can be reimbursed for psychiatric care provided to patients with mild to moderate mental health problems, he said. •

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SBI for drugs a failure, time to go 'back to the drawing board'

Screening and Brief Intervention (SBI) doesn't reduce unhealthy drug use, according to a study published in the August 6 issue of the *Journal of the American Medical Association* (*JAMA*). The conclusion was best summed up by the subhead of an accompanying editorial, "Back to the Drawing Board," written by Ralph Hingson of the National Institute on Alcohol Abuse and Alcoholism and Wilson Compton, M.D. of National Institute on Drug Abuse (NIDA). The study was funded by NIDA and the Substance Abuse and Mental Health Services Administration.

The federal government has committed years and millions of dollars to SBI, so the finding that it doesn't work for marijuana, cocaine, opioids, or prescription drug use was not good news. However, it's important to recognize that there was no referral to treatment in this study: the brief intervention was performed in a primary care setting.

SBI for alcohol misuse has been proven to work, and it is recommended by the US Preventive Services Task Force.

The study, called the Assessing Screening Plus Brief Intervention's Resulting Efficacy to Stop Drug Use (ASPIRE), was a randomized trial that tested two brief interventions for unhealthy drug use: a brief negotiated interview (BNI) and an adaption of motivational interviewing (MOTIV). Compared with no brief intervention, both the BNI and the MOTIV were associated with no reduction in drug use at the end of the study period.

Most of the patients (63 percent) reported marijuana use, and more than half of them said that use had adverse consequences. Therefore, the researchers thought that the consequences would contribute to the efficacy of the brief intervention. "On the other hand, such patients are already aware of consequences and have not changed on their own," they write, "so it isn't a given that counseling would be more successful for them."

The researchers suggested some possible reasons for differences in using SBI for alcohol compared to drugs. "Despite the potential for benefit with this approach, drug use differs from unhealthy alcohol use in that it is often illegal and socially unacceptable, and is diverse—from occasional marijuana use, which was illegal during this study, to numerous daily heroin injections," they write. "Prescription drug misuse is particularly complex, with diagnostic confusion between misuse for symptoms (eg, pain, anxiety), euphoria-seeking, and drug diversion. Brief counseling may simply be inadequate to address these complexities, even as an initial strategy."

"Based on the current literature and our findings, brief intervention for unhealthy drug use in primary care patients identified by screening appears unlikely to be effective for decreasing drug use or consequences," the researchers conclude. "Both clinicians and researchers should look beyond screening and brief intervention—and perhaps to lengthier and more complex longitudinal care management strategies—as the main solution to addressing illicit drug use and prescription drug misuse in primary care patients." •

The lead author is Richard Saitz, M.D., who is with Boston University School of Public Health. For the full article, go to http://jama.jamanetwork.com/article.aspx?articleid=1892250.

Recovery improves lives of vets and non-vets

A study comparing the addiction and recovery histories of veterans and non-veterans has found that veterans have significantly longer addiction phases, and significantly more financial and legal problems as a result. Nevertheless, the study, by veteran recovery researcher Alexandre Laudet, Ph.D., and colleagues, found dramatic improvements in functions across the board, once the individual got into recovery.

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The study was based on a national study of 3,208 people in recovery, 481 of whom were veterans.

Typically, veterans were in active addiction four years longer than nonveterans, and it took them seven more years to get into recovery. However, a greater percentage of veterans were in recovery for 20 years or more, since in general veterans were older than nonveterans in the study.

Large percentages of both veterans and nonveterans had negative experiences in all life domains, including financial and legal issues, health, employment, and family functioning. Veterans, however, had more financial problems, such as unpaid debts, and greater involvement with the criminal justice system than nonveterans.

Both groups documented dramatic improvements in recovery, compared to active addiction. In fact, once they were in recovery, most of the differences between the groups disappeared – and ones that remained were reflective of the improvements veterans made compared to their problems during active addiction.

For example, consistent with the findings that veterans had more debt during addiction, greater percentages of them repaid debts while

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in recovery. The same pattern exists in the legal area, where once in recovery greater percentages of veterans rectified legal problems.

Contributing factors

There are unique aspects of military culture that contribute to persistent addiction, the researchers noted. "During active duty, assuming a sick role is contrary to the military's warrior ethos and may predispose individuals to avoid seeking help for a substance use or psychological problem," they write. In addition, fear of loss of military status impedes help-seeking. "Unlike in civilian settings, where seeking help can be a private decision, military leadership may determine when a possible problem will be professionally evaluated to determine whether treatment is needed, when someone will receive help for a psychological or substance use problem, and when the service member can return to duty." Furthermore, utilizing SUD treatment, even if self-referred, is not necessarily confidential while in active duty.

Even treatment for alcohol use disorders "can have negative career ramifications" for soldiers, the researchers write. " In light of the high prevalence of substance use, especially alcohol, among active military personnel, it is important that military policies become more conducive to encouraging self-referral, referral from medical professionals, and confidential treatment before alcohol-related behaviors necessitate formal involvement of the soldier's commander."

One potential strategy to help with alcohol use disorders for active duty personnel and veterans is self-help, in particular internet-based interventions, the researchers write. These interventions are more anonymous, and therefore perceived as less likely to lead to exposure, they say. However, destigmatizing addiction and addiction treatment should be a priority to encourage earlier treatment and recovery.

The researchers were surprised to find that veterans consistently reported fewer mental health problems than nonveterans, both currently and over their lifetime. Other studies have found that veterans have a high prevalence of mental health issues, in particular depression, posttraumatic stress disorder, and traumatic brain injury. One possible reason is that the same stigma that operates in terms of treatment for SUDs is there for mental illness, the researchers wrote. However, they also suggested that the veterans in the study, once reaching middle age, were psychologically resilient, a resilience which helped them achieve recovery from SUDs. •

Funding for the study was provided by private donations to Faces & Voices of Recovery. The study, "Comparing life experiences in active addiction and recovery between veterans and non-veterans: A national study," is published in the current issue of the *Journal of Addictive Diseases*.

Massachusetts law focuses on treatment, Senator invites feds

A new law signed by Gov. Deval Patrick of Massachusetts requires insurance companies to pay for up to two weeks of inpatient treatment for substance use disorders (SUDs). Insurance companies are not allowed to require preauthorization for the treatment. Sen. Edward Markey (D-Massachusetts), who was on hand for the signing, is considering submitting a similar bill in Congress.

"When you invest in treatment for patients, in the long run, you save money in re-hospitalization, in readmission to prisons," said Senator Markey. "When we're discussing these issues with the insurance industry, we understand there's a reluctance up front, but over the long term there's much more money that is saved and much better outcome for patients as well." Senator Markey recently introduced a bill that would allow outpatient physicians to treat an unlimited number of buprenorphine patients (see page 1). The new law has the support of the treatment community, but advocates still note that two weeks doesn't pay for much more than detoxification and "step-down" from detoxification (see *ADAW*, May 19). In an unusual twist, many supporters of medication-assisted treatment sided with the insurance companies, who opposed the new law, mainly because they are concerned that patients who would be better suited to outpatient treatment with methadone or buprenorphine will instead go to drug-free treatment, only to relapse later. The new law also allows the state to classify a drug as dangerous; there have been efforts to do so with new painkiller Zohydro.

"This bill creates some new rules and new tools for us to use together to turn to our brothers and sisters who are dealing with these illnesses and addiction and help them help themselves," said Governor Patrick in signing the bill.

Convening federal officials

The same day the bill was signed, Senator Markey hosted top drug policy officials at Boston Medical Center, including Michael Botticelli, acting director of the Office of National Drug Control Policy, Nora Volkow, M.D., director of the National Institute on Drug Abuse; Pamela Hyde, administrator of the Substance Abuse and Mental Health Services Administration; and state and Boston officials. Senator Markey convened the meeting to develop a strategy for combatting the opioid epidemic, according to a press release. Joseph Rannazzisi, Deputy Administrator of the Office of Diver-

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sion Control of the Drug Enforcement Agency (DEA) was also there.

"Prescription drug and heroin addiction is a public health emergency as virulent as any microbe and as persistent as any physical enemy," said Senator Markey. "An issue as complex as opioid addiction requires a multi-pronged solution. Today, we brought together science, medicine, public health and law enforcement to develop a plan of action for how to comprehensively address an epidemic that is tearing apart our families and our neighborhoods. In the coming weeks, I will be releasing a comprehensive strategy for combating the prescription drug and heroin crisis, which will include an array of prevention, treatment and enforcement approaches that will help to reduce the harms of addiction now." •

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Briefly Noted

Bill sets sights on IMD exclusion

The decades-old Institutions for Mental Diseases (IMD) exclusion, which prohibits federal Medicaid dollars from paying for inpatient mental and substance use disorder treatment in specialized facilities that have more than 16 beds, is being targeted by treatment providers. The law was intended to make sure that states, and not the federal government, has the responsibility to treat inpatient psychiatric services. Part of the Medicaid program since Medicaid was enacted in 1965, the law needs to be changed, but how to do it is unclear. Last month Rep. Marcia Fudge (D-Ohio) introduced the Breaking Addiction Act of 2014, which would establish five-year demonstration grants, similar to ones currently under way for mental illness, that would allow states to use federal Medicaid dollars to pay for inpatient treatment for substance use disorders (SUDs) even in programs that have more than 16 beds. "Fatal drug overdoses now exceed motor vehicle crashes as the leading cause of accidental death in Ohio," said Representative Fudge in announcing the bill. "Heroin alone claims more lives in Cuyahoga County than homicides." Like the demonstration project for psychiatric hospitals, the bill directs the Secretary of Health and Human Services to prepare a report at the conclusion of the project to evaluate the impact of lifting the IMD exclusion. "By removing an outmoded barrier to funding for substance abuse treatment, we can go a long way toward reversing the heroin epidemic and saving lives," said Representative Fudge. "I am also confident that data collected from this demonstration project will show community treatment will lower the bill to taxpayers for overall health care and decrease law enforcement costs associated with opiate addiction."

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Letters may be edited for space or style.

Coming up...

The **National Conference on Addiction Disorders** will be held **August 22–26** in **St. Louis, Missouri**. For more information, go to **www.addictionpro.com/ncad-conference/national-conference-addiction-disorders**.

The **Cape Cod Symposium on Addictive Disorders** will be held **September 11–14** in **Hyannis, Massachusetts**. Go to **www.ccsad.com** for more information.

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In case you haven't heard...

Marvin Sundquist, a 43 year old massage therapist in Nebraska, had his license placed on probation and, as a condition of getting it back, had to attend Alcoholics Anonymous. He is now suing the state, saying his constitutional rights were violated, because AA is a religious organization, the *Associated Press* reported July 31. "AA is a religious organization," says Sundquist. "I do not believe the state should be telling anybody to go to them, and it cost me a career as a massage therapist because I didn't go." When Sundquist asked to go to a treatment provider who had a non-religious program, the Nebraska Department of Health and Human Services said no, he said. "They would not accept my alternative or provide any other alternatives," Sundquist said. "Their only option was to attend AA." Sundquist's lawsuit names the state, its Attorney General's Office, the state health department and several individual state employees with those agencies as defendants in the case. Sundquist is asking for $200,000, saying he lost his career because of the state's requirement. There was nothing in the records that indicated the reason for Sundquist's license suspension, according to *AP*.