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News for policy and program decision-makers

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In This Issue...

Researchers call for caution in opioid tapers for pain patients

Tapering pain patients from prescribed opioids has been going on for the past 10 years and the results have been mixed. One recent report, however, shows that there should be fresh concern about what is happening to these patients.

On the one hand, by 2020, per capita prescription of opioids in the United States decreased to levels last seen in 1993. The purpose of this initiative, which was spearheaded by the federal government, was to reduce the rising tide of opioid overdose deaths. That hasn't happened and the deaths continue to rise. Perhaps they would have risen at an even higher rate without the mitigation produced by decreased prescribing. But nobody knows, according to the report, published in *JAMA Network Open* on June 13 and written by one of the country's top experts in pain and addiction, Stefan Kertesz, M.D.

Bottom Line...
Patients who are tapered from opioids they receive from pain are at risk of adverse events, including overdose from illicit fentanyl, and suicide and should be given informed consent before a taper, according to a study and accompanying editorial.

Kertesz is an outspoken supporter of pain patients and continued treatment for them, including with long-term opioids, if necessary. In his report, which is labeled an editorial, he noted that there are 8 to 10 million individuals in the

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Mindful of history, observers express guarded optimism on opioid spending

It will be many years and decision-making cycles before community leaders can draw firm conclusions on whether proceeds from litigation against opioid manufacturers, distributors and pharmacies prove to be a boon to substance use disorder (SUD) services. For the moment, observers have expressed cautious optimism that states are taking important steps to ensure no repeat of the empty promises that characterized the national tobacco settlement of the 1990s.

Bottom Line...
States appear at least to be using model legislation governing proceeds from opioid litigation as a guide to ensure that these dollars effectively support substance use disorder treatment and recovery goals.

As of the beginning of this month, 28 states had enacted laws (in most cases) or memoranda of understanding (a small handful of states, including Arizona) to govern the distribution of opioid litigation proceeds, according to the Legislative Analysis and Public Policy Association (LAPPA). The association last year released a model opioid litigation proceeds act, and its president told *ADAW* last week that many of the new state laws at least appear to have been inspired by the LAPPA model legislation.

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U.S. who may yet need long-term opioids for pain and had been prescribed them in the past.

"New research on prescription opioid dose reduction should cause us to look upon their situation with fresh eyes, and with concern," he wrote in the current issue of *JAMA Network Open*. "Reductions and stoppages in these patients' prescription regimens are likely to reflect varied motivations and understandings among physicians and other professionals who care for them." In fact, a lot of the reduced prescribing is not from specific rules and policies, but a chilling effect on physicians who are afraid of drug enforcement authorities (see Patients with chronic pain forced into opioid tapers by their prescribers, *ADAW* Jan. 15, 2018; https://onlinelibrary.wiley.com/doi/10.1002/adaw.31819). And there are also studies by Ajay Manhapra, M.D. and others that support tapering, finding that, in fact, patients do not need long-term opioids (see One physician's path to addiction medicine, *ADAW* May 13, 2019; https://onlinelibrary.wiley.com/doi/10.1002/adaw.32360).

"Some may reduce doses out of a belief that the dose reductions confer safety and well-being, a perspective reinforced by studies in which voluntary tapers are achievable or even salutary for some patients," Kertesz wrote in his report. "However, it is likely that many clinicians are reacting to a fraught public discourse and to external pressures as well, including measures that rate the quality of their work."

Insurance companies play a major role in deterring prescriptions as well. For example, Kertesz cites the metric issued by the National Committee for Quality Assurance, and taken up by most payers, in which patients taking a daily dose that is more than the equivalent of 90 milligrams of morphine "count as receiving poor care, regardless of their prior dose history." Clearly, these measures do incentivize either dose reduction or termination of the doctor-patient relationship.

Studies showing poor outcomes

In recent years, this has happened, with dose reductions and terminations becoming more common. The results, according to some retrospective studies, have been death by overdose, suicide or mental health crises. These studies compared patients who underwent such reduction with those who did not.

There is an important limitation to such reports. As Kertesz noted, people who underwent reduction could have differed in important ways from those who did not. The prescribers could have reduced their dose or terminated them because the patients were misusing the opioids or at risk for the very problems they ended up suffering.

"Differences in their risk could have spurred both the dose reduction and the outcome," wrote Kertesz. "For example, a patient with volatile behavior may be at risk for suicide, and that same volatile behavior could spur clinicians to alter prescriptions. Some may suggest that the dose reduction did not cause a subsequent suicide."

But this doesn't mean that all patients should be reduced, because the studies give "an unduly pessimistic portrait of the risk of harm resulting from prescription opioid reduction."

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Fenton study

A study in the same issue of *JAMA Network Open* in which the Kertesz editorial appears suggested that opioid tapering was associated with increased rates of overdose, withdrawal, and mental health crisis extending up to two years after taper initiation. In a cohort study by Joshua Fenton and colleagues, "Long-term Risk of Overdose or Mental Health Crisis After Opioid Dose Tapering," the data came from OptumLabs Data Warehouse, which included deidentified medical and pharmacy claims and enrollment records for commercial insurance and Medicare Advantage enrollees. Participants were U.S. adults who were tapered from opioids between 2008 and 2017 after a 12-month baseline period of stable daily dosing of 50 morphine milligram equivalents or higher. Opioid tapering was defined as a 15% or greater reduction in mean daily dose. The main outcomes and measures were emergency or hospital encounters for drug overdose or withdrawal, and mental health crisis (depression, anxiety, or suicide attempt). Outcome counts were assessed in pre-taper and post-induction periods (from 12 to 24 months after taper initiation).

There were 21,515 tapering events among 19,377 patients who had a mean of 9.1 months of post-induction (taper initiation) follow up per event. Somewhat confusingly, the Fenton paper defines taper initiation as post-induction.

Importantly, the Fenton study addresses the confounding issue of other studies, first by using an "exposure–crossover design," in which each patient is their own control in the assessment of event frequencies before and after the dose reduction; and secondly, with the attempt to mitigate time-limited volatility in the period before and after dose reduction by focusing on outcomes occurring a full year after the taper was initiated (which they term postinduction).

"If an elective change to care involves both potential benefit and risk of serious harm, including loss of life, the longstanding norms of ethical medical care call for informed consent. We see no reason to set these norms aside when discussing dose reductions."

Stefan Kertesz, M.D.

Compared with the period before dose reduction, the incidence of hospital or emergency department encounters was elevated by 57% for drug overdose or withdrawal, and by 52% for mental health crisis in the 12 to 24 months following reduction. The elevations in observed risk were greater for patients whose baseline opioid dose was greater than the equivalent of 300 milligrams of morphine daily.

Supplementary analyses in the Fenton paper that compared tapered patients with those not tapered were concordant: Patients at a stable dose remained at lowest risk, compared with patients whose doses were lower or higher.

"By our count, this is the tenth retrospective comparative study to document an adverse association between opioid dose reduction and patient safety, although a gain in safety was shown in one other study," Kertesz concluded. "We caution that the article by Fenton et al., despite its strengths, still cannot fully resolve potential bias from unmeasured factors, because many aspects of the clinical story remain outside of the researchers' database."

Confounders in retrospective studies

Evidence derived from retrospective analysis requires caution, according to Kertesz. But policymakers did not pay attention to that stricture, and Kertesz opined that "it is deeply regrettable that such caution was absent when many health systems, government agencies, and payers incentivized dose reduction on the basis of retrospective data that were subject to all the same limitations, and many more."

These days, in light of evolving and cautionary findings on opioid dose reduction, clinicians are faced with questions on how to respond. Not surprisingly, the answer is that the "opioid dose reduction is likely to offer benefit for some, while harming others," Kertesz wrote. "The harms may include worsening pain, distress, or death." Clinicians need to consider "this uncertain balance of harm and benefit," he wrote, adding, "it would be wise for health systems to stop promoting this change to care."

Available evidence does not support a policy of tapering all patients to doses lower than a specified threshold, Kertesz stated, calling for metrics that incentivize such treatment to be retired. "Indeed, experts who assisted the Centers for Disease Control and Prevention's 2016 guideline urged that it not be adopted in the first place," he wrote, adding the note, which all clinicians should consider, that care be individualized.

Informed consent and reversing the taper

And, Kertesz called for informed consent. Tapering opioids should come with the patient's knowledge of what could happen when their dose is reduced. "If an elective change to care involves both

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potential benefit and risk of serious harm, including loss of life, the longstanding norms of ethical medical care call for informed consent," he wrote. "We see no reason to set these norms aside when discussing dose reductions."

Clinicians should proceed with dose tapering only after informed consent, which, according to Kertesz, includes:

- Documenting evidence of harm,
- Offering a plan to mitigate harm from the reduction, and
- Telling the patient what criteria will be used to decide whether the taper has failed or succeeded.

"When tapers fail, as many do, then clinicians must be open to reversing them," said Kertesz. "For this reason, the longstanding adage that opioid tapers must not be reversed, most recently cited in a draft revision to the Centers for Disease Control and Prevention's opioid prescribing guideline, has been worn thin by studies such as this one and the many that precede it. To our view, that adage is not tethered to clear and compelling evidence. It should be set aside. Finally, whenever consent is sought, it should be in the context of a serious conversation grounded in mutual respect, rather than an attempt to convince the patient to embrace something they do not really believe in. This is because patients — it has been overlooked far too often — are the moral equals of the people writing the prescriptions." •

New York leading the way in methadone reform

A symposium held June 13 at the Albert Einstein College of Medicine/Montefiore Medical Center (Montefiore) showed the many ways in which New York State's Office of Addiction Services and Supports (OASAS) is leading the way in methadone reform. Including the focus on more flexible take-homes (see *ADAW* June 20), OASAS is focusing on methadone vans — both mobile and stationary (in clinic parking lots) — and on merging opioid treatment programs (OTPs) and other addiction programs. Getting rid of stigma is almost insurmountable, but the state is doing everything it can, with the help of OTPs.

COVID-19 forced rapid changes in the way methadone treatment works, beginning with more flexible take-homes, which did not result in any more overdose deaths, although OTPs at the symposium expressed concern that there was diversion.

Still, at Montefiore in the Bronx, which was an epicenter for both COVID-19 and opioid use disorder (OUD), the changes resulted in care being more patient-directed. The suspension of routine toxicology testing also, by definition, allowed more patients to get take-homes, and all possible services were expanded from in-person to telehealth. Montefiore officials who spoke at the symposium said this entire program worked well and should be continued. They were able to increase counseling time because more patients were getting take-homes via telehealth, with 11% more counseling visits in 2020, mostly by phone.

And as Allegra Schorr, M.S., president of the Coalition of Medication-Assisted Treatment Providers and Advocates (COMPA) explained, New York, early on, got a reimbursement structure which allowed the OTPs to be paid for the increased take-homes (see Where methadone is now in NY: Take-home flexibility, OTP concerns, *ADAW* June 20; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33465). "This was critical, and I have to thank the state, because they did approve that very quickly," she said.

Mobile vans

So far there are 10 methadone mobile vans in New York, with more on the horizon. The state paid $200,000 per van, which was not nearly enough, however. "We know we underfunded the vans," Chinazo Cunningham, M.D., OASAS director, told *ADAW*. This will be impoved in the future. One OTP director suggested the figure of $1 million would be more appropriate..

The U.S. Drug Enforcement Administration (DEA) has specifications for the safe in which the methadone is stored in the van. And security is important. "If a van is broken into and methadone or buprenorphine is stolen, this will be widely reported and have a chilling effect" on vans in the future, said Mark Parrino, president of the American Association for the Treatment of Opioid Dependence (AATOD).

The $20 million from OASAS for the 10 vans came from the Substance Abuse Prevention and Treatment (SAPT) block grant. This is the first money that the federal government has said could go to for-profits, meaning that the state can buy the vans from for-profit entities. Cunningham noted that the state will get the money that it invested in the vans back through patient payments for treatment. However, she acknowledged that that money will go to the state in general, and not to the block grant. New York is one of the few states, however, where Medicaid does cover OTP treatment in vans.

Integrating treatment and stigma

By integrating OTPs into the existing Part 822 outpatient programs, there will be more locations providing methadone treatment, said Cunningham. She said that for the past 20 years she worked in a federally qualified health center in mental health, providing buprenorphine for the treatment of OUD. She had

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no interaction with OASAS, she said, because she wasn't in that system. So it's important that the 750 employees of OASAS help her in her quest to reform methadone treatment.

One of her focuses is on opening new OTPs in regions with no prior OTP services.

Simply integrating OTPs with other outpatient addiction treatment programs would not solve the Nimby (not in my backyard) problem with methadone, and panelists at the symposium urged that education be conducted in communities where this integration will occur. "What message would you give the Nimby communities who are fighting against the opportunity to bring OTPs to their neighborhoods?" one audience member asked. Politicians, clergy, neighborhood group leaders, local media, all need to be involved in order to gain widespread support, said Patrick Seche, M.S., of the University of Rochester Medical Center. He did this with a community in upstate New York, where OTPs are sorely needed. "Every time there was an opioid overdose, the local media would write about it," he said. "Not just a number, so the community started to learn about the people involved, and I found that it changed the community's acceptance."

Another educational opportunity is training the community in naloxone reversal of overdoses, said Sara Lorenz Taki, M.D., medical director of Greenwich House methadone treatment center in New York City. "We went into the police precinct during community meetings," she said. "Once you start talking about CPR and people turning blue and dying, there's a lot of softening that happens."

Demystifying methadone

And Pat Lincourt, OASAS associate commissioner, pointed out that if methadone were more available and "less concentrated in clinics that were only for methadone, that would be a selling point." She added that this would help "demystify" methadone. Another way to do this is for people to hear individual stories.

"We're kidding ourselves if we think the patients will jump through 10 hoops to get to us."

Chinazo Cunningham, M.D.

But the bottom line is ignorance. Parrino told a story about working with a legislator on OTPs, who told him flatly that methadone is a "devil drug."

Cunningham said that bringing treatment to where the patients are, including integrating it into other parts of health care, is part of what she views as harm reduction. "We need to make sure the regulations allow us to do that," she said.

But it is not easy to get treatment in an OTP, or to open one. There are rules. And patients want something easy. This is a principle not only for OUD, but for all substance use disorders (SUDs). It's not like diabetes or epilepsy; it's not something people necessarily want to get rid of. So it needs to be simpler for the patients' sakes.

"We're kidding ourselves if we think the patients will jump through 10 hoops to get to us," said Cunningham. And she noted that other kinds of controlled substances, including methadone for pain, don't have the kind of regulations that methadone for OTPs does. "The idea that you have to fail treatment to get treatment seems backward."

Urge for caution

But Parrino noted that he has weekly discussions about changes in regulatory guidance with the Substance Abuse and Mental Health Services Administration (SAMHSA) which, along with the DEA, regulates OTPs. "They are taking a lot of COVID lessons to heart," said Parrino. And OTPs would like to see less regulation as well, including methadone induction by telehealth. "I think they're getting there," said Parrino. "The issue of the mobile vans is a game-changer."

There is a split between policymakers and clinical decision-making, said Parrino. "I came out of a program environment, so my knowledge is more clinically based and these experiences informed my policy perspectives," he told ADAW. The more senior leaders in the federal government understand this, he said. He recalled when the new COVID-19 take-home rules came out in March 2020, and he spoke with then-SAMHSA administrator Elinore McCance-Katz, M.D. about them. "She said, 'These are the take-home guidelines.' I reminded Dr. McCance-Katz that I fought tooth and nail with her predecessors several years ago when SAMHSA was mandating that every clinic be open 7 days a week and SAMHSA had no plan for how people were going to get to the clinics in suburban and rural areas of the country when public transportation was extremely limited on holidays and weekends. And now you advise that it's okay to give 14 days [of take-homes] to clinically unstable patients. It's not like you're changing the deck chairs on the Titanic, you're changing decks."

Parrino added: "Nowhere have I found that SAMHSA is going to hold programs harmless if there are improper clinical determinations being made, and it didn't come to that, thank God. But the split between public policy on one hand and clinical decision-making on the other is worrisome. We need greater access, but to what? And just to be clear, OTPs have greater opportunities to expand access to good care in opening vans and brick-and-mortar medication units; however, we are in the midst of a major workforce shortage so getting these newe treatment programs open with proper staffing presents a major challenge." •

NIAAA provides information in multiple languages

To extend its reach, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) is now providing resources in many different languages. This reflects the fact that people from other countries, not just the U.S., search the NIAAA website for information, according to the agency. It also reflects the Obama-era executive order, from 2000, that requires all federal agencies to provide access to their services to individuals with limited English proficiency. The U.S. Census Bureau and the National Institutes of Health have identified certain languages as being of greatest need.

In support of those policies, NIAAA offers some of its most popular fact sheets on alcohol and health in the following languages:

- Amharic,
- Arabic,
- Chinese (simplified),
- Chinese (traditional),
- Farsi,
- French,
- Haitian Creole,
- Italian,
- Japanese,
- Korean,
- Polish,
- Portuguese,
- Russian,
- Spanish,
- Tagalog, and
- Vietnamese.

The fact sheets that are now available in all of the above languages include:

- Alcohol Use Disorder: A Comparison Between *DSM-IV* and *DSM-5*,
- Hangovers,
- Interrupted Memories: Alcohol-Induced Blackouts,
- Understanding Alcohol Use Disorder, and
- Understanding the Dangers of Alcohol Overdose.

NIAAA announced the availability of these new publications last month. •

House passes H.R. 7666, setting stage for revamping SAMHSA

On June 22, the House of Representatives overwhelmingly passed H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act of 2022. The bill, if passed by the Senate and signed, will revamp many programs in the Substance Abuse and Mental Health Services Administration (SAMHSA). The 462-page bill includes many provisions fought for by the American Society of Addiction Medicine (ASAM) and others.

Energy and Commerce Chairman Frank Pallone, Jr. (D-New Jersey) said the legislation is needed now more than ever, with people reporting increased use of alcohol and other substances, suicide now the second-leading cause of death in children ages 10-14, and opioid overdose deaths continuing to rise.

"The Restoring Hope Act includes crucial provisions to meet the challenges of the nation's opioid epidemic—expanding and ensuring timely patient access to life-saving treatment for opioid use disorders through the elimination of barriers to treatment," said Pallone, noting that it includes the MAT Act, which eliminates the X-waiver for prescribing buprenorphine. The X-waiver, said Pallone, is "a burdensome registration requirement that establishes arbitrary caps on the number of patients a provider can treat for opioid use disorder using buprenorphine." The bill also establishes a one-time, eight-hour training requirement on treating and identifying substance use disorders that providers must complete before their first registration or renewal of a license to dispense controlled substances.

Some specifics from the bill:

- Subtitle E—Timely Treatment for Opioid Use Disorder
- Sec. 251. Study on exemptions for treatment of opioid use disorder through opioid treatment programs during the COVID–19 public health emergency
- Section 251 requires the Assistant Secretary for Mental Health and Substance Use to conduct a study and report within 180 days on the impact of treatment flexibilities allowed during the pandemic on an OTP's effectiveness and safety.
- Sec. 252. Changes to Federal opioid treatment standards
- Section 252 changes the federal opioid treatment standards to allow an OTP to operate one or more mobile units to dispense medications at locations other than the registrant's principal place of business or professional practice under the same registration. Previously, each mobile unit had to be separately registered. This section eliminates the requirement that an individual be addicted to opioids for at least one year before being admitted for treatment by an OTP. This section also requires the Secretary to establish criteria for OTP to allow certain patients to receive take home medications.
- Sec. 262. Eliminating additional requirements for dispensing narcotic drugs in schedule III, IV, and V for maintenance or detoxification treatment
- Section 262 eliminates the requirement for registered health care practitioners to apply for a separate waiver through the Drug Enforcement Administration to dispense certain narcotic drugs

(e.g., buprenorphine) for maintenance or detoxification treatment.
- Sec. 263. Requiring prescribers of controlled substances to complete training
- Section 263 requires health care providers, as a condition of receiving or renewing a registration to prescribe controlled substances, to meet a one-time eight-hour training requirement on treating patients with substance use disorders.

Also see "Mammoth bipartisan bill would revamp SAMHSA programs, *ADAW* May 16; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33428. •

Stay tuned for more on this bill next week.

Settlements from page 1

To LAPPA President Susan Weinstein, perhaps the most important component of a plan that will lead to success involves establishing an overseeing council or commission that includes diverse stakeholders, including individuals with lived experience with addiction.

Ideally, Weinstein said, that body also should have final approval authority over where funds are directed. In states such as New York, however, the panel will have an advisory role on spending, with the ultimate decisions remaining in the hands of state legislators (see NY opioid settlement money in danger of being co-opted by the state, *ADAW* May 30; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33443 and New York law paves way for distributing opioid settlement funds to treatment, *ADAW* July 11, 2021; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33127) In Oklahoma, the state attorney general is authorized to use proceeds from the state's fund to provide opioid-related grants.

Weinstein said she often hears those involved in the planning process vowing not to let the prevalent raids on tobacco settlement funding be repeated this time. "We as a field have to do everything we can to make assurances that this will not happen again," she said.

Slow start in New York

The New York advisory board convened by the state Office of Addiction Services and Supports (OASAS) held its first meeting last week; advocates had expected its work to start much sooner. Observers said they think the state is building in some important safeguards, such as delineating the categories of SUD-related spending that can be supported with the opioid litigation funds.

Still, as an advisory panel, the New York board could face the circumstances of having state legislators recommend different priorities during a particular budget cycle.

Christine Khaikin, senior health policy attorney at the Legal Action Center, is encouraged that state officials appear to be looking broadly at the kinds of initiatives these new dollars could support. LAPPA's model legislation encourages states to spell out that litigation funding should supplement and not supplant existing state funding streams.

"OASAS has [an] interest in spending in areas such as syringe exchange and other harm reduction programs, which I think is a really good thing, because right now we're having a death crisis," Khaikin said. This also would help to ensure that the supported initiatives simply don't duplicate what's been done in treatment, prevention and recovery for years.

Khaikin said that states are doing a somewhat better job this time in articulating that these funds should not be used for purposes unrelated to SUD. Over time, however, "We will just have to be vigilant," she said. "This is a lot of money over a long time."

"Directing opioid litigation proceeds to establish, sustain and expand substance use disorder abatement infrastructure, programs, services, supports and resources for prevention, treatment, recovery and harm reduction … will represent a critically important down payment on the work to be done."

LAPPA

Components of model law

"Addressing substance use disorders, overdoses and drug-related harms will require dedicated resources and many years," states the legislative findings section of LAPPA's model law. "Directing opioid litigation proceeds to establish, sustain and expand substance use disorder abatement infrastructure, programs, services, supports and resources for prevention, treatment, recovery and harm reduction … will represent a critically important down payment on the work to be done."

The model legislation includes these among its main areas of intent:
- That states establish a dedicated fund for SUD abatement, separate from the state general fund and with monies not allowed to be reverted

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to the general fund. Weinstein explained that having a dedicated fund does not suggest that no other monies can be used to support SUD initiatives, as these litigation funds are not meant to supplant existing funding streams for SUD.

- That "a council of geographically, racially, and ethnically diverse stakeholders" have wide discretion regarding the types of programs for which it would recommend or approve funding, with an emphasis on evidence-based and promising practices, but also potentially including "pilot programs reasonably expected to yield evidence of effectiveness." LAPPA recommends that the council have decision-making authority, an approach "intended to streamline the process and prevent undue delays in deciding how monies are distributed."
- That funded programs yield reductions in mortality and other improved outcomes and that the programs report to the state on these outcomes.
- That monies from the dedicated fund can be awarded to both public and nonprofit entities.

Weinstein said some of the enacted laws so far have listed the permissible purposes for the spending of funds, while others have opted for more general language. As an example of the former, North Carolina has listed a number of permissible activities that include service infrastructure, data collection and evaluation, and workforce development. The more general approach, however, could allow states to support SUD funding categories that might not yet be anticipated.

The history of the tobacco settlement does not set a high bar at all for use of the opioid funds. As explained in the LAPPA model act, as of 2019, no state in the country was funding tobacco cessation and prevention programs at levels recommended by the Centers for Disease Control and Prevention. In 2020, states spent less than 3% of tobacco settlement and tax revenues on tobacco cessation and youth tobacco prevention.

A commentary attached to the model law suggests that states can use opioid litigation proceeds to enact Medicaid expansions, perhaps through vehicles such as a partial expansion to cover SUD services for at-risk populations such as postpartum women. Another strategy might involve modeling the use of opioid litigation funds after the federal Ryan White HIV/AIDS Program, which targets uninsured and/or underserved populations. •

Coming up...

Annual RSoA Scientific Meeting, **June 25-29**, Orlando, Florida. For more information, go to **http://www.rsoa.org/**

The **East Coast Symposium** will be held in Baltimore **August 19-22**. For more information, go to **https://eastcoastsymposium.com/**

The **National Prevention Network** conference will be held online **August 23-25**. For more information, go to **http://npnconference.org/**

Briefly Noted

New study shows fathers are accused by family court when pregnant partners use substances

A new study has found that in some states fathers lose their parental rights, and legal orphans are created, when fathers are accused of allowing their pregnant partners to use alcohol or drugs. The worst offenders in terms of numbers of cases are New York and Texas, according to the report, issued June 17 by National Advocates for Pregnant Women (NAPW). "Harming Fathers: How the Family Court System Forces Men to Regulate Pregnancy," analyzes and documents dozens of cases across the country in which men have been labeled as abusive or neglectful for not controlling the behavior of their partners during pregnancy. The first analysis of this kind, the report identifies 56 cases in 14 states where a prospective father's inability to stop a pregnant partner from using alcohol or drugs has constituted civil child abuse or neglect on his part. The cases harken back to a time when women were considered the property of their husbands, the authors noted. For the report, go to https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2022/06/NAPW-Fathers-Report-Final-2022.pdf. •

In case you haven't heard...

Why are there for-profit opioid treatment programs (OTPs)? Simple answer. Most states won't pay for them or set them up. So private OTPs make up about 60% of the 1,900 OTPs in the country. Where are they going to get funding? If they don't get them from funders who want a return on their investment, financially, there won't be any and there won't be any expansion. And guess what else some states do? "They set up contracts with private entities, which have deliverables," explained Mark Parrino, president of the American Association for the Treatment of Opioid Dependence. "In other words, private entities do not get carte blanche. On the other hand, publicly funded entities have different requirements in getting grant submissions."