

# ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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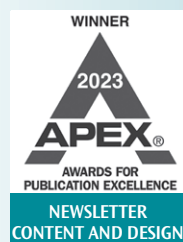
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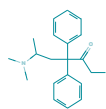
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## OPIOID TREATMENT PROGRAMS

### New York announces first mobile methadone van

Operated by VIP Community Services, an opioid treatment program (OTP) in the Bronx, a "ribbon cutting" was held last month for the first mobile methadone van in New York state. The state's Office of Addiction Services and Supports (OASAS). The mobile unit will provide a wide range of addiction services and other medical care in the New York City area.

The program is supported with \$550,000 in federal funding under the Substance Abuse Prevention and Treatment Supplemental Grant, administered by OASAS.

"This new mobile medication unit will serve a vital role in supporting our vision to meet people wherever they are, by allowing

#### Bottom Line...

*The first mobile methadone van to operate in New York was launched last month at a ribbon-cutting ceremony hosted by OTP VIP Community Services.*

providers to bring services to those in need, in their communities, and addressing barriers that keep people from receiving treatment," said OASAS Commissioner Chinazo Cunningham, M.D., in announcing the launch on July 20. "It will allow more people to access medication for addiction, which is a proven, effective, and safe treatment, and will support their long-term health."

See **MOBILE METHADONE** page 2

### Partner in planned Rhode Island OPC expanding comprehensive SUD care

As Rhode Island edges closer to the planned opening of what is expected to be the nation's first state-regulated overdose prevention center (OPC), one of that project's partners is preparing for an earlier launch of a comprehensive treatment and support site that ultimately could benefit many of the OPC's visitors.

#### Bottom Line...

*Rhode Island's nationally prominent opioid treatment program operator is developing an innovative "one-stop shop" site as it also prepares for the launch of the first state-sanctioned and state-regulated overdose prevention center.*

CODAC Behavioral Health-care expects this fall to open a 22,000-square-foot facility in Providence that will offer substance use disorder (SUD) treatment, mental health services, primary care and social services ranging from housing assistance to career training. Amid a flurry of construction, renovation and relocation activity that will affect three CODAC locations in Rhode Island, CODAC President and CEO Linda Hurley sees all of it as representing progress toward a goal of whole-person, humane care.

Hurley told *ADAW* last month during our visit to CODAC's offices, regarding plans for the OPC (for

See **CODAC** page 7

### MOBILE METHADONE from page 1

OASAS refers to the van as a mobile medication unit, or MMU. The initiative is designed to help bring services to underserved areas and reach people who may face issues accessing treatment by bringing services directly to them.

“We are grateful to OASAS for its ongoing support of our work, and for awarding VIP a grant to establish a mobile medication unit,” says Debbian Fletcher-Blake, president and CEO of VIP Community Services. “MMU services are crucial to address the staggeringly high number of overdose-related deaths and align with VIP’s mission to provide access to equitable care to communities in need.”

VIP Community Services will provide prevention, treatment, harm reduction and recovery services, as well as connections to other addiction and primary health care services in high-need areas of New York City.

OASAS has awarded more than \$6 million to support the development of these programs across the state.

MMUs offer services that include admission assessments and medication induction, medication administration and observation, toxicology tests and other medical services. The development of MMUs is made possible by a federal Drug Enforcement Administration (DEA)



VIP Community Services

rule change, allowing them to be operated by existing opioid treatment program (OTP) providers (see <https://onlinelibrary.wiley.com/doi/10.1002/adaw.33120>).

VIP Community Services is an OTP that operates in the Bronx. The “ribbon cutting” was held July 21, but services by the van are not yet officially being provided.

Those who attended the ribbon cutting on July 20 include:

- New York state Assemblymember Karines Reyes (District 87);
- New York state OASAS Commissioner Chinazo Cunningham, M.D.;
- Nanette Alvarado, district director, Office of Congressman Ritchie Torres (District 15);

- Ritchard Ewings, Office of Senator Luis Sepúlveda, District 32
- Debbian Fletcher-Blake, President and CEO, VIP Community Services
- Justin Mitchell, chief program officer, VIP Community Services

VIP Community Services is a non-profit partner to the Bronx community offering integrated medical, behavioral health, housing, and wrap-around services to improve the health and well-being of the Bronx and greater New York City communities. It is a member of the Coalition of Medication-Assisted Treatment Providers and Advocates (COMPACT).

For a list of the criteria for funding from OASAS for MMUs, see page 3.

# ALCOHOLISM & DRUG ABUSE WEEKLY

News for policy and program decision-makers

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# WILEY

## OASAS rules for funding for MMUs

### *Is it necessary to be a methadone provider to apply?*

Response: Yes. As noted on page 5 of the RFA, eligible bidders are voluntary agencies or other not-for-profit organizations that currently operate OASAS-certified OTPs.

### *Are proposals expected to give methadone on the MMU vs. suboxone?*

Response: Mobile medication units (MMUs) are permitted to administer or dispense OASAS-approved medication for the purpose of maintenance or detoxification treatment for substance use disorder, including Schedule II-V controlled substances. For this RFA, at a minimum, MMUs are expected to dispense methadone and buprenorphine.

### *Can an agency bill for services provided as part of the MMU?*

Response: Providers should bill for services provided on the mobile medication unit as they would at a brick-and-mortar location.

### *Do you have to serve the entire service area (would you have to serve all five boroughs of New York City)?*

Response: OASAS expects MMUs to provide services in areas of greatest need within an economic development zone (EDZ) and reserves the right to determine these areas. Some EDZs will require servicing the entire service area due to the large need and logistical possibilities, while others require servicing only specific pockets of the EDZ. At a minimum, providers should take into consideration the following factors: (1) the ability of the MMU to return to the opioid treatment program at the end of each operational day (unless the OTP intends on obtaining a separate waiver from the [Drug Enforcement Administration] DEA that enables the MMU to waive this requirement); (2) areas with gaps in OTP services; (3) areas with a high patient (and potential patient) population; (4) areas of great opioid burden; (5) locations where the MMU can be safely parked to provide services; and (6) locations where the MMU can be accessible by patients.

### *What level of service (number of clients) does OASAS expect for each funded project?*

Response: The projected number of clients served per mobile medication unit is dependent on the service area(s) and should consider the needs justification of that economic development zone. While there are logistical and geographical differences within each economic development zone, each MMU is expected to



VIP Community Services

be in operation for a minimum of three hours per day, six days per week. Note that operating hours do not include any travel or prep time.

### *How many locations do you have to serve in a given service area?*

Response: The number of locations, or “stops,” of each mobile medication unit will differ depending on the needs of that specific economic development zone, as well as the main patient population served by the MMU. As an example, an MMU serving only long-term care facilities, congregate care settings, or correctional facilities will have different locations and numbers of locations as compared to another MMU serving the public. Opioid treatment programs should aim to identify the locations and/or numbers of locations depending on the need justification for that economic development zone. OASAS urges providers to determine a set schedule for where and when an MMU will be deployed to a said location.

### *What is involved in obtaining DEA approval to operate an MMU?*

Response: Upon successfully obtaining New York state’s approval, the opioid treatment program must notify the local DEA office, in writing, of its intent to operate a mobile medication unit. The OTP must then await the receipt of explicit, written approval from the DEA before beginning operations. Full details on this process can be found on the DEA’s final rule on “Registration Requirements for Narcotic Treatment Programs with Mobile Components” at <https://www.federalregister.gov/documents/2021/06/28/2021-13519/registrationrequirements-for-narcotic-treatment-programs-with-mobile-components>.

There was no bidder’s conference, and all grants have been awarded.

Also see story, page 1.



## New naloxone spray approved for reversing overdoses

On July 28, the Food and Drug Administration (FDA) approved the second over-the-counter naloxone nasal spray product. So it's not just "Narcan" anymore.

On July 28, the FDA approved RiVive, a 3 milligram (mg) naloxone hydrochloride nasal spray for over-the-counter (OTC), nonprescription use for the emergency treatment of known or suspected opioid overdose. This is the second nonprescription naloxone product the agency has approved, helping increase consumer access to naloxone without a prescription. The timeline for availability and the price of this nonprescription product will be determined by the manufacturer.

Drug overdose persists as a major public health issue in the United States. In the 12-month period ending in February 2023, more than 105,000 reported fatal overdoses occurred which were primarily driven by synthetic opioids like illicit fentanyl. Naloxone is a medication that rapidly reverses the effects of opioid overdose and is the standard treatment for opioid overdose.

"We know naloxone is a powerful tool to help quickly reverse the effects of opioids during an overdose. Ensuring naloxone is widely available, especially as an approved OTC product, makes a critical tool available to help protect public health," said FDA Commissioner Robert M. Califf, M.D. "The agency has long prioritized access to naloxone products, and we welcome manufacturers of other naloxone products to discuss potential nonprescription development programs with the FDA."

The approval of RiVive nasal spray for nonprescription use was supported by data from a study submitted by the manufacturer which showed that similar levels of RiVive reach the bloodstream as an approved prescription naloxone product. The drug has been demonstrated to be safe

and effective for use as directed in its labeling. The manufacturer also provided data that showed consumers can understand how to use the drug safely and effectively without the supervision of a health care professional.

**"Ensuring naloxone is widely available, especially as an approved OTC product, makes a critical tool available to help protect public health."**

Robert M. Califf, M.D.

The use of RiVive nasal spray in individuals who are dependent on opioids may result in severe opioid withdrawal characterized by body aches, diarrhea, increased heart rate (tachycardia), fever, runny nose, sneezing, goose bumps, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness and increased blood pressure.

The FDA has taken a series of steps to help facilitate access to opioid overdose reversal products and to decrease unnecessary exposure to opioids and prevent new cases of addiction. The agency approved the first nonprescription naloxone nasal spray product in March 2023, the first generic nonprescription naloxone nasal spray product in July 2023, and over the last year has undertaken new efforts to expand opioid disposal options in an effort to reduce opportunities for nonmedical use, accidental exposure and overdose.

Through the FDA Overdose Prevention Framework, the agency remains focused on responding to all facets of substance use, misuse, substance use disorders, overdose and death in the U.S. The framework's priorities include supporting primary prevention by eliminating unnecessary initial prescription drug exposure and inappropriate prolonged prescribing; encouraging harm reduction through innovation and education; advancing development of evidence-based treatments for substance use disorders; and protecting the public from unapproved, diverted or counterfeit drugs that present overdose risks.

The FDA granted the nonprescription approval of RiVive to Harm Reduction Therapeutics.

### How to use naloxone

Anyone can save a life during an opioid overdose with naloxone, a front-line defense in the nation's overdose crisis. Naloxone is a life-saving drug that, when sprayed into the nose or injected, quickly reverses the powerful effects of opioids during an overdose.

Everyone who overdoses with opioids, whether with a prescribed medicine or an illicit drug, can use naloxone, including nasal sprays and injections. Examples of opioids include heroin, fentanyl, oxycodone, hydrocodone, codeine and morphine.

Naloxone products approved by the FDA are an important tool to reverse overdose in health care and community settings. That's one of many reasons the FDA is working to help increase [access to naloxone](#).

"Without the administration of naloxone, there is a high risk of fatality from an opioid overdose," said Marta Sokolowska, Ph.D., deputy center director for substance use and behavioral health at the FDA's Center for Drug Evaluation and Research. "This is the

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## Alcohol is killing many more Americans, and we simply are not paying attention

By William Stauffer

Stop for a moment and consider how our society would react if cancer-related deaths jumped 25% in one year and 10% in the next. Over a 30% increase in two years. Is there any question that we would declare a national emergency and devote moon-shot-level resources into reversing the trend? Task forces would be deployed. Early interventional strategies identified and put into every health care setting in the nation. Cancer is not stigmatized. We treat people who get it as valued members of our society, worthy of help.

These numbers are not hypothetical, these are the current trends in alcohol-related mortality. Earlier this month, *The Washington Post* reported that between 2018 and 2021 the rate of Americans dying from alcoholic cirrhosis of the liver grew by 42%, while deaths stemming from alcohol dependence or harmful use disorders increased by 54%. Because it is alcohol and not cancer, we don't do much at all. If you quizzed the average person on the street about which drug was killing people at these dramatically increased rates, they would probably say heroin or fentanyl. Alcohol is normalized as a harmless substance despite it killing thousands of our community members.

In the year 2021, just under 30,000 more people died from alcohol-related causes than in 2019. The total number of people who died in 2021 from alcohol-related causes is greater than the number of people who live in my hometown, Allentown, Pennsylvania, the third largest city in the state. These figures are likely underreported. Falls, illnesses and accidents are often attributed to other causes because alcoholism is still stigmatized in 2023.

People are drinking themselves to death, a trend associated with the [depths of despair](#). Medical complications from heavy drinking that are commonly associated with drinkers in their 50s [are surging in young adults](#). We normalize heavy alcohol use as something that people do, often in situations in which doing so is ill advised. The “[wine mom](#)” phenomenon comes to mind. You can buy single-serve shots while getting gas at the convenience store. Yet few people can access help as easily as alcohol. Alcohol-related deaths are [the fourth](#)

[leading preventable cause of death in America](#), yet only around [6% of persons that meet the criteria for alcohol use disorder get treatment](#).

Society moralizes substance misuse as a way to distance itself from the consequences. We can rationalize broad misuse of substances by seeing people who experience severe problems as fundamentally different from us. Stigma is as much about protecting ourselves from examining our own use as anything else. We look the other way for a while when a person is getting into trouble with a substance, including alcohol. Then they cross some invisible line. When this happens, they become one of those people that society sees as hopeless and beyond help.

A recent study found that only [around 15% of patients hospitalized for alcohol-related liver disease received alcohol and other drug \(AOD\) treatment](#). To complete the cancer analogy, that would be like sending less than one in five patients with cancer for chemotherapy. A recent survey (with which I was involved) on the [health care-associated substance use and recovery stigma](#) found that only around one in three health care providers said they think a person who currently uses drugs or alcohol problematically can maintain recovery. As a person in long-term recovery for several decades, I can attest that recovery is highly probable if people get what they need to heal, although that does not occur nearly as often as it should.

We have not even properly enforced our own laws, intended to help people to heal. Consider the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. It was intended to give people a fair shot at getting help. It simply has not been enforced, as a [2022 report to Congress](#) from the U.S. Department of Labor found minimal compliance. Not until 2021, 13 years later, did [Congress require employers](#) to evaluate compliance. Not something we would tolerate if it were any condition other than alcoholism or substance use dependence.

We have normalized death, not healing. We must face the truth. Alcohol addiction is commonplace. Fortunately, so is recovery. If a medical professional

[Continues on next page](#)

Continued from previous page

spotted cancer growth and did not address it, we would view it as malpractice, because cancer is a no-fault condition. The same is true with alcoholism, yet our practices have not caught up with reality. It's time that they do.

*William Stauffer is the executive director of the Pennsylvania Recovery Organizations Alliance and has over 35 years of experience working in the substance use service system. He has testified in front of the U.S. Senate on older adults and opioid use, and a number of times, in the Pennsylvania General Assembly. He is an adjunct faculty member at Misericordia University in Dallas, Pennsylvania, and recipient of the America Honors Recovery 2019 Individual Recovery Advocate of the year award.*

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reason it is very important that anyone witnessing an opioid overdose has access to naloxone and feels confident using it during an emergency.”

### How to recognize an OD

Opioids are medications that can be used to treat certain kinds of pain or opioid use disorder. Some illicit or non-prescribed substances, such as heroin, are also opioids. Signs of an opioid overdose may include:

- Unconsciousness or unresponsiveness (doesn't wake up when shaken or called);
- Shallow breathing;
- Limpness;
- Blue lips, gums, or fingertips; and
- Slow or irregular heartbeat or pulse.

“Anyone — including family members, caregivers, or other people who may have to use naloxone in an opioid overdose — should be taught to recognize the signs of an

opioid overdose and to administer naloxone,” Sokolowska said.

Naloxone is very powerful and works quickly. When administered soon after someone starts experiencing an overdose, the person will usually wake up within one to three minutes. Repeat administration of naloxone may be necessary.

But naloxone is a temporary treatment, and its effects do not last long, thus it is extremely important to still call 911. After giving someone naloxone and calling 911, stay with the person, even if they are conscious, until emergency medical help arrives. The person could lapse back into unconsciousness and might need another dose of naloxone. Keep trying to wake them up and keep them breathing. Also, lay the person on their side to prevent them from choking if they are unconscious.

### When getting an opioid prescription

Some naloxone products are safe and effective for nonprescription

OTC use, while some other products may require a prescription.

Many states allow “standing orders,” which means consumers can get naloxone directly from a pharmacist, without a prescription. This allows access to naloxone for anyone who thinks they might need it, either for themselves or for someone else who might be at risk for an overdose.

“Naloxone should be available to anyone taking opioids and to anyone who may be around people who are taking opioids,” Sokolowska said. “This medicine is safe and very effective. It is also important to know that naloxone is not addictive.”

To reduce the risk of death from opioid overdose, the FDA recommends that these people carry naloxone:

- People who are prescribed opioid pain relievers.
- People who are prescribed medicines to treat opioid use disorder.
- People who are at increased



risk of opioid overdose, such as people who also use alcohol or other drugs such as benzodiazepines.

- Caregivers of people who are at risk of an opioid overdose.

“We want naloxone in the hands of the friends, family members, and caregivers of people taking opioids,” Sokolowska added.

### Harmless

If someone is having a medical emergency other than an opioid overdose, such as a diabetic coma or cardiac arrest, giving them naloxone will generally not have any effect or cause them additional harm.

Naloxone can be administered to people of all ages, so it can also be used for suspected overdose in

infants, children and the elderly.

“Don’t hesitate to administer naloxone in an emergency even if you’re not sure if the person is experiencing an opioid overdose,” Sokolowska said. “Giving someone naloxone who does not have opioids in their system shouldn’t hurt them, but it could help them and save their life.”•

### CODAC from page 1

which a CODAC-operated hub for medical support will be co-located), “This is real recovery. We are respecting people’s autonomy.”

Plans are for the OPC, which will be housed in a Providence industrial area where CODAC currently operates opioid treatment program (OTP) services, to begin operations in early 2024. The harm reduction and recovery services organization, Project Weber/RENEW, will run the OPC under a partnership with CODAC. By that time, it’s expected that CODAC will already have completed several months of operation at the comprehensive care center, at a different location in Providence.

Hurley and her colleagues consistently refer to the comprehensive care center as a “one-stop shopping” site; among the entities that have accepted or have been invited to occupy space in the large facility are Brown University researchers, a local community health organization, and a provider of pharmacy services.

### Moving parts

Activities affecting the three locations will take place simultaneously over the next several months. Hurley and her leadership team will vacate their administrative offices in Cranston for the new comprehensive care site in Providence; the Cranston location will then house an expanded CODAC day treatment and intensive outpatient program.

The new comprehensive care site, being developed in an area with prime transportation access

**Hurley and her colleagues consistently refer to the comprehensive care center as a “one-stop shopping” site; among the entities that have accepted or have been invited to occupy space in the large facility are Brown University researchers, a local community health organization, and a provider of pharmacy services.**

near Interstate 95, is expected to open in November. Two congressional earmarks totaling around \$1.6 million, secured with the help of Rhode Island’s two U.S. senators, have supported the site acquisition and construction. Sen. Sheldon Whitehouse said at a news conference held in June at the construction site that those who will be served at the facility “are entitled to first-class care.”

Hurley described the conversion of part of the other Providence site for OPC use as “not a complex build-out,” but, in at least one respect, it carries the biggest challenges. The proverbial elephant in the room regarding OPCs remains whether the federal government could ultimately take steps to block their operation, given the planned on-site injection and inhalation of illegal drugs that will take place there.

Much of that could hinge on whether the current administration in Washington, D.C. decides to take a firm position on OPCs, which are currently in operation only in New York City (see “OPCs supported by

and working with OTPs,” *ADAW*, April 24, 2023; <https://onlinelibrary.wiley.com/doi/10.1002/adaw.33750>). A potential change in administration after the 2024 election would add more uncertainties, with at least some presidential contenders likely to be vehemently opposed to at least some harm reduction approaches.

The opposite of this uncertainty reigns in Rhode Island, where state legislators overwhelmingly approved the establishment of an OPC pilot and state officials have established implementing regulations that Hurley said are not overly prescriptive. The pilot regulations, which will sunset in 2026, essentially emphasize the core principles that these operations should be “effective, efficient and safe,” Hurley said.

She credits state Sen. Joshua Miller for being the driving force behind Rhode Island pioneering this concept at the state level. More than \$2 million in opioid settlement funding to Rhode Island is supporting the launch of the OPC.

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Project Weber/RENEW will still need several additional state-level approvals before it can open the peer-run OPC. “We will need to apply for, and receive, a license from the department of health for this usage,” Annajane Yolken, Project Weber/RENEW’s director of strategy, told *ADAW*. “Other medical services on-site will also need to receive proper authorization. Additionally, per our state law, we will need municipal approval via the Providence City Council to approve the specific location.”

CODAC plans to provide a medical hub in the building that will house the OPC, and it also intends to maintain a satellite OTP office there. “What I’m interested in measuring is the effect of having a medical hub on-site at all times, as opposed to referring, taking someone somewhere, or having someone sitting in a waiting room somewhere for hours,” Hurley said. “This will be a site where providers are trusted.”

At the same time, the mindset won’t be one of forcing anyone to engage in services for which they aren’t ready. The focus will be on safe use and meeting basic human needs such as food and hygiene, “to safely get through today and then get to tomorrow,” Hurley said.

She said the Rhode Island OPC will be modeled a great deal after the two sites that the organization OnPoint is operating in New York City. There will be areas for safe injection and safe inhalation, with the latter requiring special ventilation equipment.

## Other areas of growth

*ADAW* last month also took a tour of the second van that CODAC will be using to offer mobile OTP services, once the Drug Enforcement Administration signs off on the plans for securing medication within the operation (see “First methadone van approved under new DEA rules,” *ADAW*, July 25, 2022;

## Coming up...

The **National Prevention Network conference** will be held **August 15-17** in Birmingham, Alabama. For more information, go to <http://nnpconference.org/>

The **California Society for Addiction Medicine (CSAM) State of the Art Addiction Medicine Conference** will be held **August 30 - September 2** in San Diego, California. For more information, go to <https://csam-asam.org/>

The **Contemporary Drug Problems Conference** will be held **September 6-8** in Paris, France. For more information, go to <https://www.latrobe.edu.au/arcshs/events/contemporary-drug-problems-conference>

The **Cape Cod Symposium on Addictive Disorders** will be held **September 7-10** in Hyannis, Massachusetts. For more information, go to <https://www.capecodsymposium.com/>

The **NAADAC annual conference** will be held **October 6-12** in Denver, Colorado. For more information, go to <https://www.naadac.org/annualconference>

<https://onlinelibrary.wiley.com/doi/10.1002/adaw.33507>). Foundation grants have supported the purchase and refurbishing of the RVs. The newer of the two vehicles has distinct spaces for methadone dosing, counseling and medical support.

Hurley told us that she intends to pursue funding to double the size of the mobile methadone fleet in order to achieve statewide coverage across areas of Rhode Island where residents need a more convenient option for receiving their medication.

Once a new comprehensive care facility, an OPC and full-capacity mobile services are in place, Hurley

said she will have one more key priority on which to focus: improving lagging payment rates for SUD services in Rhode Island. The current numbers make little sense to a treatment organization with nearly 90% of its clients eligible for Medicaid, Hurley said. The state has the nation’s eighth highest overdose rate but the fourth lowest Medicaid payment rate for substance use treatment, she said. •



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## In case you haven’t heard...

A study lead by the Addiction Policy Forum found that people with “lived experience of [substance use disorder] SUD” found certain images not only stigmatizing, but also able to trigger a possible relapse. The study, published in the current issue of the journal, *Health & Justice*, also found that the individuals suggested alternative images. “Stigma is a major barrier to treatment and recovery for individuals with SUD, with intersecting stigma experiences for those who are also justice-involved,” said Jessica Hulseley, the study’s lead author and the executive director of the Addiction Policy Forum. “Much of the imagery currently used to depict addiction in the news, social media, television and in publications can be both triggering and stigmatizing for those in recovery from SUD. We hope the findings can be helpful in informing the selection of less harmful imagery to represent substance use disorders.” Among the alternative suggestions for images: molecular structures. This keeps it “science-based,” the people interviewed for this qualitative study said. For the study, go to <https://healthandjusticejournal.biomedcentral.com/articles/10.1186/s40352-023-00229-6>.