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News for policy and program decision-makers

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In This Issue...

OIG for first time endorses more than $75 a year for contingency management

Last month, the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) moved forward on showing that it does not oppose sums larger than $75 a year for contingency management (CM), a form of treatment for substance use disorders (SUDs) in which patients are given material rewards for negative drug tests. And while many think of CM as only for stimulant use disorders, the Feb. 25 OIG opinion to DynamiCare Health, a copy of which was obtained by *ADAW*, shows that HHS is balking unnecessarily by not allowing more liberalized CM policies to go forward (see "HHS OIG doubles down on constraints against contingency management," *ADAW* Aug. 24, 2020; https://onlinelibrary.wiley.com/doi/10.1002/adaw.32812, "CM for stimulant use disorder: No limit imposed by OIG," Nov. 8, 2021; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33255; "SAMHSA keeps $75/$15 CM limits despite methamphetamine epidemic, OIG ruling," Nov. 14, 2021; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33258).

Bottom Line...
For the first time, the HHS OIG has said a treatment provider can go above the $75 cap for contingency management, and for all substances.

See **CM** page 2

Overdose death data suggests Z-drugs, gabapentinoids not without risks

The percentage of overdose deaths involving non-benzodiazepine sedative-hypnotics ("Z-drugs") and gabapentinoids more than tripled between 2000 and 2018, according to a new analysis of U.S. health data published in *The Lancet Regional Health — Americas*. The study found that deaths in which these drugs were accompanied by the presence of benzodiazepines or opioids also increased at times during the same period, suggesting in some cases that patients engage in concurrent use of the drugs that Z-drugs and gabapentinoids are often meant to replace.

A study co-author told *ADAW* that the results highlight the need for closer patient monitoring and better coordination of care, as Z-drugs and gabapentinoids are not risk-free. This is especially true when these medications are used in combination with other drugs, which is relatively common, said Silvia S. Martins, Ph.D., director of the Substance Use Epidemiology Unit at the Columbia University Mailman School of Public Health.

Asked why she suspects these drugs often are used in combination

Bottom Line...
Risk of overdose is exacerbated when Z-drugs or gabapentinoids are used in combination with benzodiazepines or opioids, and national data suggests these types of concurrent uses of medication remain common.

See **Z-drugs** page 7

CM from page 1

Even though the opinion only refers to DynamiCare's program and is not generic, it is an important step for CM advocates. Even the OIG, which sees itself as the law enforcement arm of HHS, says it's OK to spend $599 — well above the $75 limit HHS still imposes — a year on CM.

The opinion is a rebuke to HHS, which has refused to increase the amount from $75. Last year, shortly after the OIG wrote that CM payments could be higher than $75, the Substance Abuse and Mental Health Services Administration, which funds treatment for SUDs, refused to abide by the OIG ruling, and said it would stick to the $75 maximum per year. Nevertheless, California, where the stimulant epidemic started, was able through a 1115 Waiver to get Medicaid funding for CM in which patients would receive up to $599 a year (see "California is first state to establish Medicaid waiver for CM," *ADAW* Jan. 10; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33305). The $599 was in order to stay under the $600 IRS reporting threshold, but CM experts say that even higher amounts, such as $1,000, would be better.

The request

DynamiCare, based in Boston, asked the OIG whether a system in which patients would be treated with digital CM (gift cards) funded by treatment providers or suppliers would be considered to be illegal under the federal anti-kickback statute and the Beneficiary Inducements Civil Monetary Penalty (CMP) provisions of the law. Years ago, the OIG did say that anything more than $75 a year to reward individuals for not using drugs could be considered an "inducement" to enter treatment and noted that paying patients to go to a treatment program is a kickback. However, paying patients as a reward for negative urine tests is one of the only methods of treating stimulant use disorders that works (see "CM, only effective treatment for stimulants, on the ropes as methamphetamine surges," *ADAW* June 8, 2020; https://onlinelibrary.wiley.com/doi/10.1002/adaw.32742).

As the nation is poised on the brink of a methamphetamine and cocaine epidemic, the OIG became convinced that it should not prohibit such treatment and started making these concessions last year (see "CM for stimulant use disorder: No limit imposed by OIG," Nov. 8, 2021; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33255).

Unlike opioids, stimulants do not have any medications for treatment that are approved by the Food and Drug Administration (FDA). This is another reason for embracing CM.

The OIG response to DynamiCare also went further, saying that CM could be used for SUDs, not limiting it to stimulant use disorders. In fact, experts say it works for other substances as well, including alcohol, and that it also works for some behaviors.

The OIG advisory has guardrails similar to those set up in California, which are designed to accommodate concerns about fraud, waste and abuse. It limits the incentives to $599 a year. DynamiCare's technology blocks use of the gift cards at bars and liquor stores, and for cash withdrawals.

Under the DynamiCare protocol, 70% of the incentives for negative results would be for random breath and saliva tests directly observed via "selfie" videos. The DynamiCare technology also logs each incentive delivery and negative test.

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"Fees include the costs of the application, any substance testing equipment that is shipped to the [patient], test monitoring, medication self-administration monitoring, appointment attendance monitoring, recovery coaching, and CM incentives."

OIG

The National Council for Mental Well-being worked with DynamiCare on the request to the OIG. The National Council has been a partner with DynamiCare throughout the process.

How DynamiCare works

The DynamiCare program uses smartphone and smart debit card technology for SUDs, mainly for opioids, stimulants, alcohol and nicotine. According to DynamiCare, SUDs "impair the brain reward mechanisms responsible for healthy motivations," the OIG advisory, which is footnoted by references to the DynamiCare descriptions, states. CM can "motivate and sustain behavioral health efforts in people who suffer from substance use disorders," a treatment approach that "addresses the brain's reward response in ways that conventional counseling and medications often cannot," according to the OIG advisory.

DynamiCare contracts with health plans, addiction treatment providers, employee assistance programs, research institutions and other treatment providers.

Before patients sign up with DynamiCare Health, they are screened via interview to see if they have an SUD. An "enrollment specialist" obtains "information that enables a branching algorithm to determine if the interviewee: has a substance use disorder; requires treatment, and if so, for which priority substance(s); and requires a specific level of care." The program uses the American Society of Addiction Medicine Continuum Triage Tool for assessments.

Under the guidance of a licensed clinical supervisor, the enrollment specialist then determines what type of services — e.g., alcohol, drug or nicotine testing, or medication administration reminders — are required, and what the frequency should be for recovery coaching. All is determined by algorithm. Random tests are conducted, with additional "for cause" tests added by the recovery coach.

Services are set based on a 12-month period, divided into three four-month phases:

- the anchor phase, which has frequent testing and incentives;
- the build phase, during which the substance testing frequency decreases and incentives begin phasing out; and
- the maintenance phase, during which behavioral health goals are reinforced through non-incentive community reinforcers, such as employment and relationships.

Every DynamiCare patients receives:

- automated appointment reminders, with both GPS (for in-person) and electronic (for virtual) attendance verification;
- medication reminders and self-administration verification via self-video;
- saliva drug testing, breathalyzer alcohol testing, Smokerlyzer CO testing for tobacco and saliva cotinine testing for e-cigarettes, all verified via self-video;
- cognitive behavioral therapy, which includes 90 modules on a variety of topics, each two to five minutes in length, with effort validation through exercises;
- comprehension questions and detection of actual reading duration;
- various surveys and assessments;
- certified recovery coaching offered weekly via video link or telephone call plus unlimited texting during business hours, with addiction specialist expert clinical supervision;
- certified family partners for significant others and family members, with Community Reinforcement and Family Training, which consists of video training in an evidence-based support model; and
- daily virtual support groups moderated by certified recovery coaches (for members) or certified family partners (for support persons).

There are no in-person elements in the DynamiCare program.

However, incentives may be tied to attending an in-person treatment session, verified by GPS, or a virtual session, verified electronically.

Most of DynamiCare's current customers don't bill federal health care programs, but potentially, they may do so, in particular for services such as group therapy sessions.

The smart debit card is monitored, which allows coaches and providers to see if an intervention is needed by a purchase being blocked at a liquor store, for example.

Payment is made to DynamiCare by its customers, although patients and their families can also self-refer and pay the program directly. These fees are for far more than the contingency management cards themselves, which will be for $599 total.

According to the OIG, "fees vary based on the service configurations being purchased and the intensity of behavioral targets that are planned" for each patient. "Fees include the costs of the application, any substance testing equipment that is shipped to the [patient], test

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monitoring, medication self-administration monitoring, appointment attendance monitoring, recovery coaching, and CM incentives," the OIG stated. Fees may vary based on whether the patient is low risk or high risk, and whether they are in treatment or not.

For example, a CM Incentive might start at $2.00 per successful breathalyzer test for five tests per week and potentially reach $3.50 per successful test for three tests per week later in the program. Similarly, for drug saliva testing, a CM Incentive may start at $5.00 per successful test for two tests per week and progress to $10.50 per test once a week.

Kickbacks and inducements

There's a widespread assumption that any objections to CM are based on the idea that it's wrong to pay people not to use drugs. That's not the reason for the OIG objection, although that rationale can be heard from people not familiar with the research showing that it works. The reason the OIG opposed it, originally, and is still concerned about abuses, is that the federal anti-kickback statute "makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce, or in return for, the referral of an individual to a person for the furnishing of, or arranging for the furnishing of, any item or service reimbursable under a federal health care program."

Violation of the statute constitutes a felony punishable by a maximum fine of $100,000, imprisonment up to 10 years or both. Conviction also will lead to exclusion from federal health care programs, including Medicare and Medicaid.

The advisory from the OIG states that the "Beneficiary Inducements CMP provides for the imposition of civil monetary penalties against any person who offers or transfers remuneration to a Medicare or state health care program beneficiary that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier for the order or receipt of any item or service for which payment may be made, in whole or in part, by Medicare or a state health care program."

In responding to DynamiCare's request, the OIG said it would not impose administrative sanctions for its proposed program.

Eric E. Gastfriend, CEO of DynamiCare (and son of David, who developed Vivitrol while at Alkermes and is now chief medical officer at DynamiCare), told *ADAW* that DynamiCare Health works mainly with stimulants, opioids, alcohol, smoking and vaping. DynamiCare has "published clinical studies in each of these five areas, showing two to three times increases in quit rates," said Gastfriend. "In addition to substance use disorders, we also address alcohol moderation."

Funding comes from various sources, said Gastfriend, "including payer pilots and contracts in both commercial and Medicaid, grants (including four from the National Institutes of Health), treatment systems and accountable care organizations, and families paying out of pocket (direct-to-consumer)." Last month, DynamiCare received FDA approval for its digital technology to reduce smoking during pregnancy (http://www.prweb.com/releases/2022/2/prweb18504522.htm). •

Biden supports treatment, recovery and prevention

President Biden's first State of the Union (SOTU) message last week held promise for treatment, including support of the workforce, and hope and support for patients in recovery.

"There is so much we can do. Increase funding for prevention, treatment, harm reduction and recovery," said President Biden in his March 1 SOTU speech. "I believe in recovery and I celebrate the 23 million people in recovery," he said.

The speech focused intently on the "unprecedented mental health crisis among people of all ages."

He also gave his approval to removing barriers to treatment for opioid use disorder, presumably referring to buprenorphine and methadone, saying, "Get rid of outdated rules that stop doctors from prescribing treatments." There wasn't anything else in the speech about that, except for that one line.

He also supported people who need treatment, saying, "If you're suffering from addiction, know you are not alone."

Most of the President's planned remarks, as detailed below, concentrated on mental and substance use disorder (SUD). He ended up, however, focusing on the problems of the day, mainly the Russian invasion of Ukraine. Still, his planned speech reveals the administration's focus on improving access to treatment.

One of the biggest problems is a shortage of treatment providers, he said. He focused on mental health provider shortages but included SUD in this. "We must dramatically expand the supply, diversity and cultural competency of our mental health and substance use disorder workforce — from psychiatrists to psychologists, peers to paraprofessionals — and increase both opportunity and incentive for them to practice in areas of highest need," he said.

Specifics from the speech include:

- *Invest in proven programs that bring providers into behavioral health*. The president's FY23 budget will invest $700 million in programs — like the National Health Service Corps, Behavioral Health Workforce Education and Training

Program and the Minority Fellowship Program — that provide training, access to scholarships and loan repayment to mental health and SUD clinicians committed to practicing in rural and other underserved communities. These major new investments will both expand the pipeline of behavioral health providers and improve their geographic distribution to target areas with the greatest unmet need.

- *Pilot new approaches to train a diverse group of paraprofessionals.* Doctors, nurses and other clinicians cannot do this work alone. In the fall of 2022, the Department of Health and Human Services (HHS) expects to award over $225 million in training programs to increase the number of community health workers and other health support workers providing services, including behavioral health support, in underserved communities. The president's FY23 budget will also propose major new multiyear funding to develop provider capacity and support mental health transformation.
- *Build a national certification program for peer specialists.* The Biden administration will convene stakeholders, launch development and support implementation of a national certified peer specialist certification program, which will accelerate universal adoption, recognition and integration of the peer mental health workforce across all elements of the health care system.
- *Promote the mental well-being of our front-line health workforce.* The administration has already dedicated $103 million in American Rescue Plan funding to address burnout and strengthen resiliency among health care workers. The president will strengthen this commitment by signing the bipartisan Dr. Lorna Breen Health Care Provider Protection Act into law, which will invest $135 million over three years into training health care providers on suicide prevention and behavioral health while launching an awareness campaign to address stigmatization and promote help-seeking and self-care among this workforce. In addition, HHS will continue grant programs to support health systems and provider groups to prevent burnout, relieve workplace stressors, administer stress first aid and increase access to high-quality mental health care for the front-line health care workforce.
- *Launch the 988 crisis response line and strengthen community-based crisis response.* Through the American Rescue Plan, the administration has provided $180 million to support local capacity to answer crisis calls and establish more community-based mobile crisis response and crisis stabilizing facilities to minimize unnecessary emergency department visits. The president's FY23 budget will build on this investment with an additional nearly $700 million to staff up and shore up local crisis centers while also building out the broader crisis care continuum: someone to call, someone to respond and somewhere for every American in crisis to go.
- *Expand the availability of evidence-based community mental health services.* The American Rescue Plan invested millions of dollars to expand Certified Community Behavioral Health Clinics (CCBHCs), a proven model of care that has been shown to improve health outcomes while lowering costs, by delivering 24/7 mental health and substance use care to millions of Americans, no matter who they are or whether they're able to pay. The president's FY23 budget will build on this down payment, by proposing to make this program permanent while granting states funding to expand CCBHCs for the communities that need them most. The president's budget will also permanently extend funding for Community Mental Health Centers, which provide essential mental health services to vulnerable communities that would otherwise lack access.
- *Invest in research on new practice models.* New scientific and technological innovation has the opportunity to expand our capacity to meet Americans' mental health needs, but there is a pressing need for research to validate what works and build a robust evidence base. The president's FY23 budget will call for investing $5 million in research into promising

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"In addition, HHS will continue grant programs to support health systems and provider groups to prevent burnout, relieve workplace stressors, administer stress first aid and increase access to high-quality mental health care for the front-line health care workforce."

President Biden

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models for treating mental health conditions.

- *Expand and strengthen parity.* The 2008 Mental Health Parity and Addiction Equity Act called for mental health care benefits to be covered at the same level as physical health care benefits. The president's fiscal year 2023 budget will propose that all health plans cover robust behavioral health services with an adequate network of providers, including three behavioral health visits each year without cost-sharing.
- *Integrate mental health and substance use treatment into primary care settings.* Equipping primary care providers with the tools to identify, treat and manage behavioral health conditions is a proven approach for delivering quality mental health and substance use care, particularly for individuals with depression.
- *Expand access to tele- and virtual mental health care options.* The use of telehealth to address mental health and substance use needs rose dramatically during the height of the pandemic and has remained above pre-pandemic levels even where COVID has waned. To maintain continuity of access, the administration will work with Congress to ensure coverage of tele-behavioral health across health plans, and support appropriate delivery of telemedicine across state lines. At the same time, HHS will create a learning collaborative with state insurance departments to identify and address state-based barriers, like telehealth limitations, to behavioral health access. And the United States Office of Personnel Management will facilitate widespread, confidential and easy access to telehealth services, in part by strongly encouraging Federal Employees Health Benefits Program carriers to sufficiently reimburse providers for telehealth services, and to eliminate or reduce co-payments for consumers seeking tele-mental service.
- *Expand access to mental health support in schools and colleges and universities.* The president has committed to doubling the number of school-based mental health professionals. The Department of Education will continue to support states, school districts, colleges and universities, in using relief funds — including the more than $160 billion invested by the American Rescue Plan in the Elementary and Secondary School Emergency Relief and Higher Education Emergency Relief Fund — to address the mental health needs of students, including by training, recruiting and retaining more school- and college- and university-based mental health professionals.
- *Embed and co-locate mental health and substance use providers into community-based settings.* Expanding pathways to care also means creating new, low-barrier access points, in settings where Americans already live, work and play. To that end, the president's FY23 budget will include $50 million to pilot models that embed and co-locate mental health services into nontraditional settings like libraries, community centers, schools and homeless shelters.
- *Increase behavioral health navigation resources.* Finding the right care or an available provider can be a frustrating experience. We need to make it easier for Americans to both find help and receive it. To meet this need, the administration will build new easy-to-access, user-friendly online treatment locator tools — starting with a redesigned and refurbished mentalhealth.gov — so Americans can find care when they need it, where they need it, with the click of a button. The Department of Defense will also create a one-stop online resource for service members and their families to access mental health information and locate mental health providers.

"The existing SUD workforce is highly trained, but their numbers are too few to address the size of the current and future challenge."

Mark Attanasi

The mental health and substance use "crisis is not a medical one, but a societal one," said President Biden, noting the "social determinants" in many cases of SUDs.

Comments from the field

"We applaud President Biden's call to intensify efforts to address the opioid epidemic in last night's State of the Union," said Rob Morrison, executive director of the National Association of State Alcohol and Drug Abuse Directors. "He appropriately called for increased funding across the continuum," Morrison told *ADAW* last week. "I also thought he offered a powerful and probably historic moment when he said, 'I believe in recovery and I celebrate the 23 million people in recovery.'"

Morrison also said he appreciates "the president's call for full implementation of the Mental Health Parity and Addiction Equity Act," adding

"we are hopeful this translates into support for the enforcement side."

President Biden's commitment to tackling SUDs and overdoses "can begin with addressing the dire shortage of trained professionals to help those struggling with addiction and mental health challenges," according to Mark Attanasi, CEO of the International Certification & Reciprocity Consortium, an organization that credentials prevention, addiction treatment and recovery professionals. "The existing SUD workforce is highly trained, but their numbers are too few to address the size of the current and future challenge," he said.

The FY23 budget from the White House will include $50 million to pilot models that embed and co-locate services into nontraditional settings like libraries, community centers, schools and homeless shelters, noted Attanasi, saying this will help increase access to care "in settings where Americans already live, work and play."

"These investments will require a robust workforce," said Attanasi, noting that only 10% of those in need of care for SUDs can access it, "in large part due to the dearth of qualified professionals." Despite the shifts in the perception of people who use drugs and in policy to treat addiction as a disease rather than a crime, "we have failed to elevate SUD professionals to the level of nurses or social workers, though the standards of their profession are just as high as these other trained clinicians," said Attanasi. "Addiction and substance use disorder services are reimbursed at far lower rates than other health services, making recruitment and retention for the profession a harsh challenge."

"The increase in demand for mental health and substance use treatment has exacerbated the workforce shortage," agreed Chuck Ingoglia, president of the National Council for Mental Wellbeing. "The workforce shortage that organizations providing mental health and substance use treatment services face today represents one of the greatest threats to our collective well-being," he said. "Recruiting and retaining employees is an immense barrier, with 97% of National Council members saying it has been difficult to recruit employees and 78% of them describing it as 'very difficult.'"

Ingoglia is also concerned about the overdose crisis, calling for "a much better job of making the overdose-reversal drug available." He added support for fentanyl test strips, another harm-reduction option that is funded by the federal government." With so many people dying from overdoses and falling victim to a polluted drug supply, ignoring those resources is no longer an option." •

Z-DRUGS from page 1

with the higher-risk drugs they largely have been meant to supplant, Martins said, "People have access to them, and there is not much monitoring. They can go to multiple providers.… We need better education of patients and providers."

Martins emphasized that the flurry of prescribing of the Z-drugs zolpidem, zopiclone and zaleplon and the gabapentinoids pregabalin and gabapentin resulted at least in part from a perception of relative danger that may have underestimated their own risk of adverse effects and abuse potential.

"Effects such as dizziness and drowsiness can be enhanced when Z-drugs are used with benzodiazepines or opioids," Martins said. But she added, "In and of themselves these drugs can also produce concern."

"Effects such as dizziness and drowsiness can be enhanced when Z-drugs are used with benzodiazepines or opioids…In and of themselves these drugs can also produce concern."

Silvia S. Martins, Ph.D.

Details of study

The research team sought to capture trends from 2000 to 2018 in the proportion of overdose deaths involving Z-drugs, which are approved for the short-term treatment of insomnia, and gabapentinoids, which are approved for the treatment of some forms of epilepsy and pain disorders. The study, published online Jan. 24, used cause-of-death data from the National Center for Health Statistics.

The researchers looked at a subset of individuals whose death certificates were marked with International Classification of Diseases (ICD) codes T42.6 and T42.7, representing poisoning by, adverse effect of and underdosing of other or unspecified antiepileptic and sedative-hypnotic drugs. They also looked at trends in the prevalence of deaths with both a T42.6/T42.7 code and a code for opioids, benzodiazepines or alcohol.

During the study period, more than 788,000 people had an overdose ICD code as the underlying cause of death. Just over 21,000 people had a T code for Z-drugs and gabapentinoids listed among multiple causes of death. Around 57% of this latter group were women, 93% were white and 41.8% had reached a higher-education level of schooling.

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Rises in the proportion of deaths with a T42.6/T42.7 code were identified for the periods between 2000 and 2006 and between 2006 and 2015. These periods coincided with times in which there were steep increases in the prescribing of Z-drugs and gabapentinoids nationally. Among all overdose deaths with a T code, the percentage of deaths with a T42.6/T42.7 code had increased from 1.46% in 2000 to 4.97% by 2018.

The researchers found that the proportion of deaths involving both a Z-drug/gabapentinoid and an opioid increased in the 2015–2018 period, and the proportion of deaths involving both a Z-drug/gabapentinoid and a benzodiazepine rose in the 2000–2015 period. Between 2008 and 2018, the proportion of deaths involving both a Z-drug/gabapentinoid and alcohol actually declined significantly.

The study's authors cited research published in 2020 that concluded that combining a Z-drug and a prescription opioid increases overdose risk as much as combining a benzodiazepine and an opioid. They added that gabapentinoids also can become lethal, especially when used with opioids and sedatives.

The researchers wrote in regard to their findings on overdose risk in women, "it is notable that despite the FDA's 2013 recommendation that women should be prescribed low doses of zolpidem to start, in 2012, only 5% of women were prescribed low doses."

Drugs used concurrently

"Despite the introduction of Z-drugs and gabapentinoids aiming to replace benzodiazepines and opioids as safer alternatives to treat insomnia and pain, there exists sufficient evidence that users of one often intake the intended replacement as well, a dangerous and often fatal practice," the study's authors wrote.

This mirrors the long-standing concerns regarding concurrent use of opioids and benzodiazepines. A study published in 2016 in the *American Journal of Public Health* documented a quadrupling of overdose deaths involving benzodiazepines between 1996 and 2010, with around 75% of benzodiazepine overdoses also involving an opioid (see "Fatal benzodiazepine ODs quadrupled from 1996–2013," *ADAW*, Feb. 22, 2016; https://onlinelibrary.wiley.com/doi/10.1002/adaw.30483). Study author Marcus A. Bachhuber, M.D., of the Division of General Internal Medicine at Montefiore Medical Center/Albert Einstein College of Medicine, remarked at the time that in most cases, it is the combination of opioids and benzodiazepines that caused the fatal overdose, as this occurs rarely with benzodiazepine use alone.

Martins said readers of the latest study shouldn't conclude that Z-drugs and gabapentinoids shouldn't be used, as it would be harmful to have these medications subject to the same backlash opioids have. However, "I think the main takeaway message is that providers need to monitor these drugs carefully," she said.

Providers need more education, she said, which then can translate to more effective conversations with patients about the dangers of using these drugs in combination with certain other medications, or the risk of overusing medications with sedative properties.

"And we need all providers to be asking, 'What else are you taking?'" Martins said. "Providers need to have an open relationship with their patients, and they need time." •

Coming up...

The **American Society of Addiction Medicine (ASAM)** 2022 will hold its annual conference **March 31 - April 3, 2022** in Hollywood, Florida. For more information, go to **https://www.eventscribe.net/2022/ASAM/**

RX Drug Abuse and Heroin Summit, **April 18-21**, Atlanta, Georgia. "Live and in person." For more information, go to **https://www.rx-summit.com/**

CPDD Annual Scientific Meeting, **June 11-15**, Minneapolis, Minnesota. For more information, go to **https://cpdd.org/meetings/current-meeting/**

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

Note: Conferences are now starting to be live, with requirements for proof of vaccination.

In case you haven't heard...

There is no methadone or buprenorphine in Russia. Ever since 2014, when Putin invaded Crimea, there is no methadone there either — and there were formerly opioid treatment programs. Now, people in Ukraine will probably, if they haven't already, lose their medications for opioid use disorder. In fact, Putin, in one of his false accusations against the Ukrainian people last week to go along with his military attack on the country, called them "drug addicts." As we reported, Russia has the to-be-expected HIV and HPV problems associated with lack of treatment (see "Trump, Russia and opioid treatment: What lies ahead for the U.S.?" *ADAW* Jan. 16, 2017; https://onlinelibrary.wiley.com/doi/10.1002/adaw.30820). If this invasion spreads, the pain of untreated addiction will spread as well. Perhaps the negotiators could bring up the need for treatment as a demand?

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