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In This Issue...

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Medical marijuana dispensary: An on-site view

Bottom Line...
A visit by ADAW to a medical marijuana dispensary in Massachusetts revealed much about the benefits — and ongoing shortcomings — of the model.

It was a beautiful Saturday morning in early June in Chestnut Hill, Massachusetts, where we were heading from the CED Clinic to Revolutionary Clinics, a medical marijuana dispensary, in nearby Somerville. On the way, we passed a recreational marijuana dispensary — pointed out to us by our guide, Benjamin Caplan, M.D., founder of the CED Clinic. Caplan is a family medicine doctor who sees patients at his clinic and is an expert on medical marijuana. Also guiding us on the tour: Peter Grinspoon, M.D., a primary care physician with Massachusetts General Hospital who advocates for marijuana legalization and is the author of the memoir, *Free Refills: A Doctor Confronts His Addiction*.

We wanted to visit a dispensary because medical marijuana has been legal in some states for decades, and because physicians have many questions about it, and we wanted to visit one in Massachusetts because the state has its own system — now there is legal recreational marijuana in the state as well — which was set up based on a close watch of what's happened in other states, pitfalls to avoid and so on.

In other words, regardless of how you feel about the policy,

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Advocates highlight greater significance of congressional resolution on counselors

Bottom Line...
Clinical leaders in addiction treatment see a U.S. House resolution on the impact of counselors as a steppingstone to greater acknowledgment in legislation of front-line workers' needs.

A proposed U.S. House resolution of a few paragraphs likely won't steal the spotlight from a bitter congressional divide or a simmering presidential campaign this summer, but advocates in the substance use treatment community hope it will lay the foundation for a greater recognition of the addiction counseling profession's needs via a number of legislative vehicles.

House Resolution 419, introduced earlier this month by lead sponsor Rep. Dave Joyce (R-Ohio), states that the addiction professional workforce represents more than 100,000 counselors, educators and other addiction-focused health professionals who are addressing the full range of substance use disorders in a variety of settings, "including in the face of the current opioid crisis." The resolution concludes with:

"Resolved, That the House of Representatives supports the delivery of evidence-based care for

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medical marijuana is legal (and so, in many states, is recreational marijuana).

Under Massachusetts regulation, there must be separate access for medical and recreational marijuana. "You don't want an elderly person with arthritis to wait behind 100 college students just wanting to party," Grinspoon explained in our pre-tour meeting at the CED offices — spacious and well-lit. "People who are sick should have priority access." There are only two recreational marijuana dispensaries in the state at this time, and they are staffed with customer service agents who lack medical expertise.

Caplan has about 8,000 patients. The average age is 54, up from 52 a few years ago. Marijuana holds a lot of promise for aging patients who have various issues and don't want to take opioids. In fact, this is probably the biggest untapped market, despite the outcry against use by young people. In regions where there is access to medical cannabis, some of the lowest underage consumption is actually taking place, said Caplan.

Patients, in order to buy medical marijuana, must have a card obtained from the state. This can take time — as long as two weeks, said Caplan. "One of my projects is to whittle that time down," he said. "It is maddening that patients, some of whom have precious little time, are compelled to wait for access to medicine while they are suffering."

Getting the medical card is a two-step process in Massachusetts. First, the patient must have a bona fide relationship with his or her doctor, which means having a traditional doctor-patient relationship, with face-to-face visits at least once a year. In order to become a medical cannabis doctor who can refer a patient to the state for card access, you must pass some basic tests. Currently, there are about 250 such physicians in the state.

Physician support

Beyond that, there is little to impede Massachusetts residents from getting medical marijuana, except, of course, for money. Insurance doesn't cover it. They need to pay out of pocket.

However, as a board-certified family physician, Caplan can obtain insurance coverage for his patients' medical consultation visits. Still, insurance has yet to develop reimbursement for the cannabis product, which remains federally forbidden.

As legalization takes off in the state — driving across the border, one of the first things we noted were huge billboards for marijuana — physicians who are interested in medical marijuana are increasing their support. According to Caplan, more than 98% of physicians in the state support it. "We're seeing a reaction from doctors over the last year which is completely different from what I've seen in years gone by," he said. This despite the fact that the American Medical Association insists on more research before it can offer support (see "Medical cannabis needs tweaks to get full AMA support," *ADAW*, April 12).

Caplan and Grinspoon referred to the "entourage effect" when comparing marijuana to synthetic THC (dronabinol), approved by the Food and Drug Administration decades ago. Unlike synthetic THC, the plant contains more than 100 cannabinoids, they explained. "The

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Alison Knopf, Editor
Alcoholism & Drug Abuse Weekly
111 River Street
Hoboken, NJ 07030-5774
Email: adawnewsletter@gmail.com

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sum is greater than the parts," they said. And when it comes to treating pain using opioids, marijuana has the benefit of lacking disabling side effects, the doctors said. While tolerance to opioids can lead to harm, tolerance of cannabis lacks similar risks, they explained.

The role of medicine

Physicians may be uncomfortable with the concept of sending their patients to a marijuana dispensary, where the patients will be sold items by a salesperson (budtender). The budtenders are often very experienced, personally, with cannabis, but they have limited familiar with medical patients, and rarely have any formal medical education, said Caplan. However, the dynamic of medical oversight is shifting, partly due to cannabis. "Given its status as a largely safe treatment option for most medical conditions, cannabis medicine is about the doctor stepping back into a role of education, guidance, and support for patients."

Caplan knows this from his own patients. "The internet is bringing paternalistic medicine to its knees," he said. "Most of my patients are eager to learn how to help themselves and regain a sense of control over their circumstances. As my patients succeed with cannabis therapies, I would much rather that they look back on their achievements as their own, rather than merely hoping that they have found the right clinician, received the appropriate diagnosis, and are getting a suitable treatment."

Marijuana also helps with opioid withdrawal symptoms, Caplan and Grinspoon said. Opioid treatment programs have known this for decades, and it's one reason they don't test for it unless required by state regulation (ironically, Massachusetts does require this testing). It's not a treatment for opioid use disorder — as Gov. Andrew Cuomo of New York wanted it to be before the massive pushback — but it can help, especially in the early stages of treatment when the proper methadone dose is being titrated up. "Anybody with personal experience knows it helps withdrawal symptoms," said Grinspoon, who is himself in recovery from opioid addiction.

"Although budtenders are counseled not to give medical advice, it may not be clear to a patient that the information they're receiving across the counter is not filtered through the medical system we have come to know and trust."

Benjamin Caplan, M.D.

Grinspoon admitted there is only limited data that supports using cannabis as a treatment for opioid use disorder. "If I had a patient who was addicted to opioids, I wouldn't put him on cannabis as a first-line treatment," he said. "I wouldn't use it instead of methadone or buprenorphine." But the fact is that many drug users do use it that way. "I wouldn't be surprised if methadone and buprenorphine are supplemented with cannabis" by patients, he said. He would be a lot more worried about a patient using illicit fentanyl — which can be deadly — because the methadone or buprenorphine weren't adequate than about the patient using marijuana.

Both Caplan and Grinspoon report that on a nearly daily basis, they see cannabis reducing the amount of opioids being consumed and abused. Also, there are no contraindications to taking medical cannabis or marijuana with methadone or buprenorphine, they said.

There are no contraindications to taking medical cannabis or marijuana with methadone or buprenorphine, Grinspoon and Caplan stated.

One of the problems with the dispensary system is the absence of doctors on-site, Caplan and Grinspoon agree. Some physicians review a dispensary manual online and make recommendations to their patients. Caplan mentioned that some patients got information from dispensaries that was inaccurate. "It's not uncommon for me to hear from patients that budtenders are giving medical advice," said Caplan. "It's person to person. Patients are often confused and overwhelmed by many new choices, and they ask the person in front of them for help. Although budtenders are counseled not to give medical advice, it may not be clear to a patient that the information they're receiving across the counter is not filtered through the medical system we have come to know and trust." But in fact, if a patient has medical conditions and is on other medications, it's vital that there be medical involvement. For recreational, which is more like alcohol and liquor stores, the context is different. For medical, the patient is seeking a medication, and naturally expects a certain quality of care.

For example, sometimes physicians specifically don't want their patients to smoke. For patients who are new to marijuana in any way, the recommendation is to "start low and go slow." They are encouraged to keep a log book, recording what they eat and at what time they consumed the cannabis. Edibles, gummies and chocolate bars are popular. Caplan and Grinspoon educate patients on the differences in effects and action of various forms of cannabis, but under current national laws, the doctors are

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discouraged from writing specific doses of specific medicines, which in the case of cannabis would be construed as a formal prescription of a federally illegal substance.

Ethics rules

"This is why it's important to team up with the doctors," said Judy Gosselin, proprietor of Revolutionary Clinics. Grinspoon believes that budtenders should be required to have minimal training, and both Caplan and Grinspoon are already beginning to offer education to dispensaries in Massachusetts and beyond. Meanwhile, at Revolutionary Clinics, management is looking at the option of hiring physicians who "want to make the transition out of health care into the dispensary," said Gosselin.

However, one of the many rules is that dispensaries are not allowed to have physician offices on-site. "We're trying to have doctors come in and do education," she said. "We have to be very careful."

Caplan is going to be one of the physicians providing education there. But he won't be paid for it. Part of the regulation states that physicians can't benefit from dispensaries to avoid ethical conflicts of interest. Massachusetts law currently limits the benefits that certifying providers may receive from dispensaries.

Caplan is looking at alternative strategies for physicians to be more directly involved with distribution of cannabis to patients. "With cannabis medicine, complex medical care is often entangled with sophisticated chemistry and nuanced physiology," he said. "Ideally, patients should have a team managing their care that includes a knowledgeable physician."

In the meantime, there are so many rules. For example, patients are not allowed to bring their medical cannabis to the hospital with them, because the hospital — in almost all cases — gets federal funding. And marijuana is still illegal under federal regulation.

At Revolutionary Clinics

The clinic, which opened in September 2017, is an unassuming building in a residential neighborhood with plenty of parking. Gosselin greeted *ADAW* and our guides outside. We went into the building, which is set up like a living room, with a sophisticated sales office in one area; a fireplace and a screen showing a movie of baby jungle animals, with comfortable chairs around it; and a consultation room with a waterfall. We sat in the consultation room and chatted.

Revolutionary Clinics has more than 9,000 patients, most of whom are repeat customers. There is a veterans' discount — many veterans use marijuana for pain, insomnia, depression and post-traumatic stress disorder (PTSD).

For the patients who are age 50 and up, most of the reasons for buying marijuana involve pain management and insomnia.

The opioid crisis has fueled the need for medical marijuana. "With the cutback in opioid prescribing, the demand for pain treatment goes up," said Gosselin. "All of a sudden, they're cut off and frustrated."

In Massachusetts, the supply of opioids for pain is limited to seven days. That's all patients can get.

But with cannabis, patients feel as if they have more control of their lives than they did while taking opioids for pain.

Smoking is not the recommended route of administration for medical cannabis, and there is quite a bit of education going on at Revolutionary Clinics about the benefits of edibles. There is also the problem with the time lag to get a medical card — if a patient is in acute withdrawal because he or she was cut off from opioid painkillers, two weeks is too long. Caplan and the CED Clinic try to help with this.

Growing the plant

The marijuana sold at Revolutionary Clinics is grown in Fitchburg, on 250,000 acres. "Because it is at the pharmaceutical grade level, we do everything," Gosselin said. "We test for pesticides, metals, fungus, everything." In some places, the product was so potent that it had to be retested. The state has stopped allowing Revolutionary Clinics to do tours at the grow site.

It takes about four to six months to grow plants to bring to market, she said. Revolutionary Clinics began growing in January 2017.

The Fitchburg site only delivers to Revolutionary Clinics dispensaries. There is now a call by recreational stories for their marijuana, but it can't be shipped in the same vehicle with medical. Revolutionary Clinics has applied for a permit to sell recreational marijuana.

"We do a lot of wholesale," said Gosselin. "We also sell to commercial."

Interestingly, there was no police presence at or near the clinic. In fact, at an outdoor community event, the booth for Revolutionary Clinics was next to the police booth. And throughout the day, the police were asking questions about medical marijuana — which they can't take until they are retired. "But they would love to get access to it then," said Gosselin. "They have a lot of PTSD."

Revolutionary Clinics is one of only seven in the state that can deliver. "A lot of patients can't leave home," said Gosselin. "We have to have a special vehicle" for the delivery.

How did Gosselin come to be involved in the dispensary? She was a caregiver for 18 years. A close relative was being overmedicated with three medications at a large hospital. "We started giving her 2.5 milligrams of Marinol (synthetic THC), and when she couldn't get that because her insurance company cut her off, we gave her

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a little bit of a gummy," she said. She got better.

But the bottom line, as with everything in medicine, is trust. "No matter whether you're pro or con, you have to not be dismissive or condescending as a doctor, or patients won't tell you what they want — or what they're doing," said Grinspoon. "Doctors by their demeanor actively discourage patients from communicating." For example, "You don't take marijuana, do you?" is not likely to elicit an honest response.

"I have learned in my life that if you do the right thing, good things follow," said Caplan. "A lot of people enjoy face-to-face visits with their doctor." That, after all, is what medicine is supposed to be about, especially when patients are suffering — which is why most of us go to doctors. •

Prenatal use of cannabis associated with preterm birth

Self-reported cannabis use by pregnant women was associated with a significant increase in the rate of preterm birth, even after adjustment for confounding, researchers reported in the *Journal of the American Medical Association*.

In the study, "Association Between Self-reported Prenatal Cannabis Use and Maternal, Perinatal, and Neonatal Outcomes," published online June 18, Daniel J. Corsi, Ph.D., and colleagues sought to determine whether there is any association between prenatal cannabis exposure and maternal, perinatal and neonatal outcomes.

The retrospective study included 661,617 pregnancies, in which there were 9,427 self-reported cannabis users. The rate of preterm birth among cannabis users was 12%, compared to 6% among nonusers, after adjusting for confounders.

Study details

The study covered live births and stillbirths in Ontario, Canada, between April 2012 and December 2017. Self-reported cannabis use was ascertained through routine perinatal care.

The primary outcome measured was birth before 37 weeks' gestation. There were 10 secondary outcomes, including small for gestational age, placental abruption, transfer to neonatal intensive care and five-minute Apgar score.

The mean gestational age in the entire cohort was 39.3 weeks. The mean age of the mother was 30.4 years. Of the mothers, 9,427 (1.4%) reported cannabis use during pregnancy.

NIDA comments

In a research letter accompanying the publication of the article, Nora D. Volkow, M.D., director of the National Institute on Drug Abuse, and colleagues report on what is known about pregnancy and cannabis use from the National Survey on Drug Use and Health (NSDUH). Data from the 2002–17 survey was included. While it is known that cannabis use increased among pregnant women in the United States from 2002 to 2014, little is known about use and frequency of use by trimester.

For the NSDUH, sociodemographic characteristics, current pregnancy status, past-month cannabis use, past-month number of days of use and daily/near-daily use information were collected. Starting in 2013, respondents who reported past-year and past-month cannabis use were also asked if any cannabis use was recommended by health care professionals, and then such use was categorized as either "nonmedical-only" or "medical-only."

Based on 467,100 respondents overall between 2002 and 2017, the prevalence of cannabis use was higher for the first trimester than for the second and third trimesters. Between 2002-2003 and 2016-2017, past-month cannabis use among pregnant women overall increased from 3.4% to 7.0% and from 5.7% to 12.1% during the first trimester.

The research letter then discussed the clinical ramifications of this information. For example, cannabis effects on fetal growth can include low birth weight and may be more pronounced in women who consume cannabis frequently. These effects are more pronounced in the first and second trimesters.

In many states, cannabis is approved for treating nausea and vomiting, including in pregnancy. However, the American College of Obstetricians and Gynecologists recommends that pregnant women discontinue cannabis use.

It's likely that for the NSDUH, there is recall bias, and also women may not want to disclose that they are using cannabis. On the other hand, it's also likely that some women use cannabis before they know they are pregnant.

"This study highlights the importance of screening and interventions for cannabis use among all pregnant women," Volkow concluded. •

"This study highlights the importance of screening and interventions for cannabis use among all pregnant women."

Nora D. Volkow, M.D., et. al.

Gut bacteria can treat alcohol-associated liver disease

Almost half of all liver disease deaths in the United States are related to alcohol use. With alcohol-associated liver disease (AALD) now the leading cause of liver transplantation due to chronic liver disease, replacing hepatitis C, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) is calling for effective interventions for AALD.

A promising strategy is aimed at changes in the gut microbiota that are caused by chronic alcohol misuse. A new NIAAA-funded study has found that an underlying mechanism for these changes may contribute to AALD.

Ultimately, engineering gut bacteria could provide a new treatment for AALD, according to the research team, led by Bernd Schnabl, M.D., and colleagues of the University of California, San Diego.

Schnabl's team had previously found that chronic alcohol consumption reduces regenerating family member 3 gamma (REG3G), an antimicrobial protein, in the intestines. In mouse studies, the researchers showed that an increased level of REG3G in the intestine protects against alcohol-induced liver injury.

In addition, REG3G gene expression is regulated by interleukin 22 (IL-22), an immune system molecule that regulates inflammation, called a cytokine. Schnabl's team then investigated the effects of alcohol-induced microbiota changes in the gut on IL-22 production, and the role in AALD.

Using an animal model of AALD developed at NIAAA, the researchers found that alcohol disrupts gut microbiota, lowering the levels of indole-3-acetic acid (IAA), a product of gut microbes, and thereby reducing production of IL-22 in the intestines. Administering IAA to the mice in food increased the expression of IL-22 and the REG3G gene, and reduced the severity of alcoholic steatohepatitis, a type of liver disease characterized by liver inflammation and fat accumulation in the liver cells.

The researchers then engineered a common gut bacterial strain to produce IL-22, fed the bacteria to mice using the same animal model of AALD, and restored levels of IL-22 and REG3G gene expression in the gut, reducing the severity of alcoholic steatohepatitis.

The findings suggest that IL-22 could be a potential treatment for AALD, using manipulated gut bacteria.

The study, "Bacteria engineered to produce IL-22 in intestine induce expression of REG3G to reduce ethanol-induced liver disease in mice" is in press in *Gut*, and first appeared in the *NIAAA Spectrum*. •

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LETTER TO THE EDITOR

Instead of deregulating bupe, encourage more prescribing

*In last week's issue (*ADAW*, June 17, https://onlinelibrary.wiley.com/doi/10.1002/adaw.32403), we wrote about the hesitation on the part of the American Society of Addiction Medicine (ASAM) to comment on a bill that would deregulate buprenorphine treatment (H.R. 2482). Below is a letter to the editor we received in response:*

I can understand ASAM's difficulty to formally state a position on H.R. 2482 — those who drafted the legislation certainly have the right intentions, but the requirements to be able to prescribe buprenorphine certainly don't seem arbitrary, I would assume that they are designed with patient safety in mind. We never question the need for specialty training for other complex medical and public health issues, so there is no rational reason why this should be any different. The difference is the stigma associated with persons with SUDs.

The issue is not that the hands of medical providers need to be unbound. A more reasonable solution is to encourage many of those physicians already waivered to prescribe actually do so. The stigma of treating SUDs or the simple irrational fear that having SUD patients in one's practice will make the other patients uncomfortable need to be addressed. Increasing access so that we can work toward the ideal of treatment-on-demand is certainly needed, but let's not call training requirements arbitrary — that increases the stigma associated with having an SUD.

Jeffrey Quamme, MS
Executive Director
Connecticut Certification Board

CARE Act backed by medical experts at House hearing

At a hearing by the House of Representatives Committee on Oversight and Reform last week, medical experts backed the Comprehensive Addiction Resources Emergency (CARE) Act (H.R. 2569). The legislation, introduced by Committee Chair Rep. Elijah E. Cummings (D-Maryland) and Sen. Elizabeth Warren (D-Massachusetts), is modeled on the bipartisan Ryan White Comprehensive AIDS Resources Emergency (CARE) Act passed three decades ago to combat the HIV/AIDS epidemic.

The proposed legislation would provide $100 billion over the next decade to combat addiction.

Supporters of the CARE Act include the American Medical Association, the American Society of Addiction Medicine (ASAM), the American Psychological Association and many others.

"I'm honored that these medical experts who are on the front lines of combating this generational epidemic have endorsed my bill," said Representative Cummings on June 19, just before the hearing began. "These experts know better than anyone how this crisis is ravaging communities in blue states, red states and purple states. I look forward to hearing their testimony at today's hearing."

"Communities need additional resources to create systems of care and social services that give every individual the opportunity to achieve and sustain recovery."

Yngvild Olsen, M.D.

Paying for treatment is "just the beginning," said Yngvild Olsen, M.D., ASAM vice president, testifying before the committee. "Communities need additional resources to create systems of care and social services that give every individual the opportunity to achieve and sustain recovery," she said.

The Ryan White CARE Act is a "terrific model" that made ending HIV a national goal, said Olsen. "We need a similar investment so that we can one day achieve the national goal of ending our addiction and overdose crisis. That's why ASAM supports the CARE Act," she said. •

For a link to the hearing, including witness testimony, go to https://oversight.house.gov/legislation/hearings/medical-experts-inadequate-federal-approach-to-opioid-treatment-and-the-need-to.

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substance use disorder by acknowledging the contributions of addiction professionals and encouraging that recognized credentials reflect the requisite knowledge, training, and competencies for delivering quality, effective substance use disorder counseling."

Cynthia Moreno Tuohy, executive director of NAADAC, the Association for Addiction Professionals, was directly involved in the writing of the resolution's language. (Rep. Joyce was named NAADAC's Legislator of the Year in 2018.) Tuohy tells *ADAW* that the proposal serves a dual purpose of rallying national and local political support behind the needs of addiction counselors and helping to lay the groundwork for recognizing the needs of frontline clinical professionals in comprehensive addiction-focused legislation.

The ultimate goal among many advocates remains one of moving incrementally toward a nationally recognized scope of practice and a national professional credential for the addiction counselor (see *ADAW*, May 13).

"We never have had a resolution recognizing the good work of the profession. So this in itself is a statement that this is important."

Cynthia Moreno Tuohy

"We will use the resolution as a platform to continue the conversation and build on the conversation," Tuohy said. "We never have had a resolution recognizing the good work of the profession. So this in itself is a statement that this is important."

She continued, "Who is doing the good work of combating the opioid crisis?... We see so many stories of people being taken advantage of," through unethical activities such as patient brokering. "We need to show the other side," she said.

Need to build the workforce

The national call for a substance use disorder treatment workforce characterized by higher educational attainment and greater core competencies has grown stronger in recent years among policymakers, but not always with the funding support behind it. "Some of our counselors are

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lower-paid than people who work at McDonald's," Tuohy said.

The federal SUPPORT for Patients and Communities Act (H.R. 6) that was signed into law last fall begins to recognize the need for funding to support bachelor's-level counselor attainment, as a necessary step toward the more advanced education and training that has become a high-priority talking point for policy leaders, Tuohy said.

She said she has spoken to officials at the Health Resources and Services Administration for years about the need to support would-be bachelor's-level professionals, but the federal agency has had to follow the directives of congressional language that until recently offered little support for this.

She said NAADAC will follow up on the introduction of the resolution by issuing a call to action to encourage other members of Congress to sign on. Among the current co-sponsors is Ohio Democrat and presidential candidate Tim Ryan.

At the more local level, "We want states to recognize the importance of addiction counselors and their role in society," Tuohy said. Beyond the opioid crisis, Tuohy speaks frequently of what she sees as an incoming "marijuana tsunami," and she says family members need to be made aware that there are professionals qualified to address substance use disorders regardless of the form they take.

The long-term public policy goal remains one of seeking a nationally recognized credential and scope of practice for the counseling profession, moving beyond the alphabet soup of credentials that puts the addiction treatment community in an unneviably unique position. Establishing a national credential would do a great deal to take care of some of the narrower details addiction professionals have been pursuing, such as erasing disparities in Medicaid reimbursement for addiction counselors compared with mental health counselors, Tuohy said.

More patient-centric

Jeff Quamme, executive director of the Connecticut Certification Board, agrees that many of the addiction professionals who work in nonprofit facilities are significantly undercompensated, and find themselves in organizations that increasingly struggle to cope with skyrocketing costs. The kinds of training these professionals need often become the first items to be cut from a struggling nonprofit's discretionary budget, Quamme said.

At the same time, he believes professionals' training needs to be more geared to meeting clients where they are and individualizing treatment. "We still expect clients to meet the program's needs," Quamme said.

There has been so much attention paid recently to clinician self-care that Quamme fears this may be taking time away from learning strategies to do one's job better. Even at professional events for the field, the presence of recovery meetings and other self-focused activities can send a mixed message to outsiders. "This is still looked at as a field where we care more about ourselves," he said.

Quamme relates the recent experience in Connecticut in which counselors' scope of practice was expanded to incorporate treatment for co-occurring disorders, but without requiring any documentation of experience or proficiency in working with this population. State counselor and provider associations supported the legislation that allowed for this, but Quamme says no one spoke on clients' behalf.

"I will continue to fight that fight," he said, supporting an effort to require counselors to be able to demonstrate through master's-level examination that they can effectively serve the dually diagnosed population.

He said the perception of outsiders toward the addiction professional continues to be characterized by a "two steps forward and one step back" scenario of progress. Quamme said it is largely up to the professional community itself to erase any lingering notion that the field is largely composed of people who took care of their own issues, and who continue to be more oriented to that common bond. •

Coming up...

The annual meeting of the **Research Society on Alcoholism** will be held **June 22–26** in **Minneapolis**. For more information, go to **http://www.rsoa.org/2019meeting**.

The **National Conference on Addiction Disorders** will be held **Aug. 15–18** in **Baltimore**. For more information, go to **https://east.theaddictionconference.com/**.

In case you haven't heard...

Last week, the College on Problems of Drug Dependence held its annual meeting in San Antonio, Texas. Always a hotbed of new ideas and, in particular, posters, the meeting highlights — and, in some cases, intimate personal experiences — were detailed on Twitter, with the hashtag #CPDD19. One of our favorites came from Richard Saitz, M.D., professor in the Boston University Schools of Medicine and Public Health and chair of the Department of Community Health Sciences in the Boston University School of Public Health. "Just met a guy in the lobby of the CPDD19 conference. Him: What does CPDD stand for? Me: I tell him. Him: my son died of a fentanyl overdose. Thank you for the good work you are doing. Me: (tears)."