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News for policy and program decision-makers

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In This Issue...

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NAATP members work to support staff during changes of pandemic

Members of the National Association of Addiction Treatment Providers (NAATP) — treatment programs both inpatient and outpatient — are still open for business. In fact, business is booming, NAATP told *ADAW* last week. This is good for patients, and good for providers, but at the same time, it's stressful for staff. Employers are working to combat this stress by helping to obtain personal protective equipment (PPE) — masks and gloves — for staff. In addition, they are trying to ramp up with telehealth, provide supports for staff and keep paying attention to the needs of patients. Demand for treatment is increasing, as drinking is going up as well.

Bottom Line...
NAATP members — private treatment programs, both inpatient and outpatient — are responding to challenges facing staff (and patients) during the COVID-19 pandemic.

In an interview with Peter Thomas, director of quality assurance; Nikki Soda, membership development officer; and Annie Peters, Ph.D., director of research and education, *ADAW* found out more about what this essential element of the health care field is doing to help staff during the COVID-19 pandemic.

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Doctors' exemplary treatment success occurs absent high use of buprenorphine

Physicians experience some of the most noteworthy recovery success rates among professional groups, largely because of the presence of physician health programs (PHPs) that offer a treatment-focused alternative to discipline while still protecting public safety. For physicians with an opioid use disorder (OUD), the treatment plan that is mapped out under the PHP's supervision ironically appears to rarely include the medication that most have considered revolutionary in OUD treatment.

Although no guidelines specifically prohibit physicians in recovery from receiving buprenorphine as they return to practice, it is more likely that extended-release (XR) naltrexone will be part of the continuing-care plan for a physician with OUD, reports a PHP national leader.

"XR naltrexone has historically been the treatment of choice for health professionals with OUD that we see coming out of treatment," Chris Bundy, M.D., president of the

Bottom Line...
A physician in recovery from an opioid use disorder is historically less likely to receive buprenorphine treatment when returning to practice.

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"PPE has been a big issue," said Thomas. "But I'm hearing less and less about it — channels are opening up." This is partly a result, most likely, of the Office of National Drug Control Policy's announcement that substance use disorder (SUD) workers are essential health care workers who need PPE (see story, p. 6).

NAATP has also been adding key resources to the NAATP webpage, including about PPE, to keep both management and staff informed, said Thomas. "We want to make sure members see this the moment it comes out," he said.

State issues

To find out more about how programs are faring, NAATP has been holding "virtual state discussions," said Soda. Because so much with the pandemic seems to depend on when states are opening up, this makes sense. NAATP started with Florida — the first and only one so far, conducted April 29. "The majority of responses were that they have not had to furlough or lay off any employees," Soda told *ADAW*. From this pool of responses, there was also no change in census, and programs "are getting quality calls for admission," she said. "There has not been a financial impact," at least not among the respondents in that discussion.

This is only to be expected, in many ways, because addiction is a disease of isolation. COVID-19 is likely to increase demand for addiction treatment, not to decrease it.

"People are online, looking for treatment," said Peters. "Alcohol use in general is way up, and a lot of people are using more, drinking more and online more." There's also a lot of online marketing, which is how people are finding treatment now, she added.

The question is whether patients are willing to expose themselves to possible exposure by leaving their homes. In addition, it's up to the patients to figure out if a program is quality, unless it is a NAATP member — this is not just a self-serving statement from the organization, but also a measure of the rigorous reviews it takes for ethics and clinical quality for members.

For residential treatment, patients are still willing to go, at least in Florida. Discussions with NAATP members in Colorado, California, Texas and Illinois will be conducted later this month.

"There's a huge variance based on the location and the type of services provided," said Thomas. "The services with inpatient or residential care are less affected, but outpatient services, especially in places where there are strict stay-in-place orders, are affected."

Some programs "have huge outlays in transferring services onto telehealth," said Thomas. "There has also been a huge outlay for PPE."

Outpatient and telehealth

Staff in outpatient programs are most likely to be affected because of the possible declines in enrollment and the costs of building up telehealth. In fact, the majority of patients in general access treatment through outpatient services, at least in the beginning, said Peters. They may step up to inpatient, if necessary. Currently, initial access is done online.

NAATP has been conducting regular webinars since the shutdown, and the second one for COVID-19 highlighted one of the members who has been doing telehealth for the last two years (https://www.gotostage.com/channel/b06896b2b73d45c4bc24e6ef8beffa45/recording/3e59ca84a0c04f2ba07f95828e0dc4ab/watch?source=CHANNEL). Virtual programs are on the increase among NAATP members, which does mean that staff need to be ready to do counseling via telehealth.

"It's a completely different program — residential and outpatient counseling," said Peters. Some counselors do both. "It's not a different skill set," she said. But the outpatient counselors will need to adjust to

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telehealth. "Clinicians who have to work in a residential setting have to know more about how to manage a milieu," she added.

There are problems with telehealth — not the least of which is that there is no proof telehealth works for addiction treatment, said Peters.

"I know a lot of clinicians who have said 'I can't do another Zoom session,'" said Peters. "They don't feel connected to their patients." This has taken an emotional toll on both outpatient and residential staff, she said. But for outpatient counselors, conducting sessions in people's homes via telehealth has been more traumatic than usual. "Outpatient therapists are seeing things they wish they hadn't seen," said Peters. "They're seeing how patients interact with their families; there are worries about child abuse, about domestic violence, about what their homes look like, how well patients are taking care of themselves." Counselors do want to help, but there's only so much that can be done. "There's so much need," said Peters.

NAATP just held a webinar on secondary trauma and burnout — always an issue for addiction counselors, and a major contributor to the historically high turnover rate in the field. The presenter recommended having support groups for counselors.

Extra work: Screening patients

Many centers are providing support groups for staff, said Peters. "Some are trying to be flexible with hours and understanding people's needs for time off," she said. In addition, workload is up, because residential or any in-person program requires COVID-19 screening (asking questions, taking temperatures). "People are working a lot harder," said Peters, adding that some programs have added more staff coverage to adjust to this. "Screening is happening all the time — multiple times a day," she said. Sometimes new patients have to be quarantined as a result, and only one staff member interacts with that them.

"Outpatient therapists are seeing things they wish they hadn't seen. They're seeing how patients interact with their families; there are worries about child abuse, about domestic violence, about what their homes look like, how well patients are taking care of themselves.... There's so much need."

Annie Peters, Ph.D.

This is why the NAATP website is so important as a communication tool, said Thomas. "We are recognizing that our members are essential services, that our patients need help now," he said. NAATP's role is "supporting our members and staff," he said. "Supporting the patients is more the role of the members."

Caring for staff

But it's hard to assuage the anxiety everyone feels about the possibility of losing their job — or their health. "I've heard some ancillary things that are going on," said Soda. "We've had members who have brought in food trucks for the staff, converted break rooms to a more nurturing rest spa-like area, made every day casual day," she said. "They're really trying to let the staff know how much they're appreciated, and find ways of showing support for them," she said. There are also more self-care virtual options, with centers offering yoga, breath work and more to their staff, she said.

"Alcoholism and addiction are diseases of isolation," said Peters. "And we're now isolated from each other. Our form of self-care is depleted."

Even the professional conferences were a form of self-care. "The option for me to participate in a virtual conference is not as appealing as the opportunity to have the face-to-face interactions," said Peters. "From my perspective, the traumatic impact on this whole system of addiction treatment and the workforce and all the people is not adequately followed." There are plenty of COVID-19 impact surveys for patients, but not any for the workforce, she said. "I wonder what emotional toll this is taking on them. They've let up on their self-care, which they know they're not supposed to do but they do anyway. They have fears they have for their own families. Are they going to get ill? Are they going to lose their jobs? And then they're hearing the traumatic stories. Anxiety is the biggest problem, and it's all being absorbed by the clinicians themselves."

The long-term results of this can increase burnout and reduce the workforce, and at the same time there will be more patients needing treatment because of their own stresses and turning to drugs and alcohol for help, said Peters.

She is collecting data on how patients and alumni are doing during the pandemic, including on feedback to telehealth. "We don't know much about it for addiction services, but we want to know what is the impact of COVID-19 on their recovery?" she said. Questions such as how many meetings patients were going to before the shutdown and how many they are going to now, as well as how many they want to go to now, are key. "The long-term consequences of the stay-at-home orders are people are drinking more," she said. "People have lost their jobs, have financial problems, and all of these things lead to needing more treatment."

Thomas, Peters and Soda spoke on behalf of NAATP. NAATP CEO-Marvin Ventrell was unavailable on the day of this interview, as he is recovering from COVID-19 himself. •

NAMA and AATOD warn Senators not to raise cap

Last week, Mark W. Parrino, president of the American Association for the Treatment of Opioid Dependence (AATOD), and Zachary Talbott, president of the National Alliance for Medication Assisted Recovery (NAMA Recovery), wrote a letter to Congress warning against raising the DATA 2000 (buprenorphine prescribing) patient cap from 275 to 500 during the pandemic. The letter to Senators Ed Markey (D-Mass.), Jeanne Shaheen (D-N.H.), Maggie Hassan (D-N.H.), Elizabeth Warren (D-Mass.) and Dianne Feinstein (D-Calif.) was in response to an April 17 letter from the senators to Health and Human Services Secretary Alex Azar and Assistant Secretary Elinore McCance-Katz urging them to increase the cap.

NAMA Recovery represents the interests of all medication-assisted treatment (MAT) patients, both those who are enrolled in opioid treatment programs (OTPs) as well as those who receive treatment in office-based settings, constituting a total of 700,000 patients in the United States. AATOD represents 1,100 OTPs. Patients of both OTPs as well as OBOTs (office-based opioid treatment programs) serve on the NAMA Recovery board of directors.

The debate has implications for the role of counseling and counselors in treating opioid use disorder.

"We understand the intent of your letter and your interest in increasing treatment capacity for the treatment of opioid use disorder at the time of the double epidemics of opioid use and COVID-19," Parrino and Talbott wrote. However, they say that increasing capacity without caring for quality could be harmful.

The main reason is the lack of psychosocial services that would be required with such a large patient load. In fact, there is little in the way of psychosocial services already for OBOT patients, they wrote. This is a distinction not between methadone, which is only offered in OTPs, and buprenorphine, which is offered in both OTPs and OBOTs, but between the two treatment settings. OTPs provide comprehensive services, regardless of what medication the patient is on. OBOTs need only provide a prescription. "Simply prescribing medication alone is not medication assisted treatment," Parrino and Talbott wrote.

They added that "most individuals currently receive little or no counseling or other recovery support services," which has "led to lower patient retention and questionable clinical outcomes."

And because no one really knows what kind of care such patients receive when utilizing buprenorphine through OBOTs, it's not possible to understand how policy changes should be made.

"At the present time, SAMHSA [Substance Abuse and Mental Health Services Administration] has approved more than 75,000, waived medical practitioners to prescribe buprenorphine in DATA 2000 practices," Parrino and Talbott noted. "Unfortunately, only 50% of these waived practitioners are active prescribers. There are a number of reasons for this, including insurance related barriers, lack of access to integrated clinical support services, and stigma against individuals who have an opioid use disorder."

There is plenty of capability to train (the waiver requires an eight-hour course), Talbott and Parrino wrote, adding that the American Academy of Addiction Psychiatry (AAAP) has experienced a 400% increase in training DATA 2000–waived practitioners between 2018 and 2019. "In addition, AAAP and the other medical associations/societies have the capacity to respond to increased opioid training needs through such online courses," they wrote. The AAAP also offers a professional mentoring program through Providers Clinical Support Services, with options for free online discussion forums, individual questions and one-one-one mentoring.

Counseling is always the sticking point, even if the word isn't mentioned. It is what is left out when all patients get is a prescription. "We do understand that it is not the intent of your correspondence to suggest that counseling is not necessary, but we are concerned that this could be an unintended consequence," Parrino and Talbott wrote. "We recognize that this recommendation is made to increase treatment capacity during this terrible epidemic." •

"We do understand that it is not the intent of your correspondence to suggest that counseling is not necessary, but we are concerned that this could be an unintended consequence."

Mark W. Parrino and Zachary Talbott

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NAADAC: William White research scholarship announced

Many people may not think of counselors as being involved in addiction research, but they are. Many just need help financing their education. Last month, NAADAC, the Association for Addiction Professionals, announced the availability of the William White Scholarship, created to promote student addiction studies research, as well as to develop the importance of student research projects.

The research would be in National Addiction Studies Accreditation Commission–accredited programs, NAADAC-approved programs in higher education or an accredited addiction studies higher education program acknowledged by the Higher Learning Commission that provides research or education to the addiction profession.

The William White Scholarship will be awarded annually to one graduate NAADAC student member and one undergraduate NAADAC student member with the best student addiction research paper on the assigned topic in that year. The funding will be applied directly to the students' educational debt.

Applications for the 2020 scholarships will be accepted up to May 31, 2020.

The scholarship will consist of $1,000 for one undergraduate student and $2,000 for one graduate student. Recipients will be recognized at the NAADAC Annual Conference.

To be eligible, students must have at least one full year (fall and spring semester) of coursework remaining, have a grade-point average of B (2.7–3.0) or higher and be a current NAADAC student member.

Applicants must complete the application form, provide an academic transcript, provide three letters of recommendation (two from faculty and one from an active NAADAC member) and provide an APA-formatted research paper on one of these five themes: "Recruitment of Young Professionals in the Addiction Profession," "Community Mobilization/Development for Substance Use Disorders," "Reducing Stigma and/or Discriminations," "Social Justice and Substance Use Disorders" or "Current Trends of Psychotherapeutic Approaches with Addiction."

Graduate students must submit a 10–12-page (exclusive of title page, abstract and references), double-spaced research paper. Undergraduate students must submit a five-to-seven-page (exclusive of title page, abstract and references), double-spaced research paper. It is strongly suggested that a faculty advisor review the paper before it is submitted.

Scholarship awards will be presented at the NAADAC 2020 Annual Conference and Hill Day Sept. 30. •

For more information, contact NAADAC Student Committee Chair Jeff Schnoor at jeff@spiritwolftherapeutic.org.

For the application, go to https://www.naadac.org/assets/2416/naadac_william_white_student_scholarship_applicationrubric_2019.pdf.

FDA warns companies not to promote CBD for opioid addiction

The U.S. Food and Drug Administration is warning companies for illegally selling cannabidiol (CBD) by claiming that the product can treat opioid addiction or be used as an alternative to opioids. These claims violate the law, and the warning letters are a continuation of the FDA's efforts to pursue companies that illegally market CBD products with claims that they can treat medical conditions.

"The opioid crisis continues to be a serious problem in the United States, and we will continue to crack down on companies that attempt to benefit from selling products with unfounded treatment claims," said FDA Principal Deputy Commissioner Amy Abernethy, M.D., Ph.D., in sending the warning letters in late April. "CBD has not been shown to treat opioid addiction. Opioid addiction is a real problem in our country, and those who are addicted need to seek out proper treatment from a health care provider. There are many unanswered questions about the science, safety, effectiveness and quality of unapproved products containing CBD, and we will continue to work to protect the health and safety of American consumers from products that are being marketed in violation of the law."

The two warning letters were issued to:

- BIOTA Biosciences LLC of Washington state for marketing and distributing injectable CBD products as well as an injectable curcumin product. These products are marketed for serious diseases and as an alternative to opioids. BIOTA Biosciences markets private-label CBD and wholesale CBD extracts, and their products include beverages, bulk CBD extracts, and water-soluble CBD, as well as injectable curcumin.
- Homero Corp DBA Natures CBD Oil Distribution of New Hampshire for marketing and distributing CBD products as a treatment for opioid addiction as well as other serious diseases. The firm is an own-label distributor for CBD products, as well as a retailer for Green Roads CBD products.

Unlike drugs approved by the FDA, these unapproved products have not gone through any FDA evaluation of whether they are

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effective for their intended use, what the proper dosage might be, how they could interact with FDA-approved drugs, or whether they have dangerous side effects or other safety concerns, the agency said. In addition, the manufacturing process of unapproved CBD drug products has not been subject to FDA review as part of the human or animal drug approval processes. Consumers may also put off getting important medical care, such as proper diagnosis, treatment, and supportive care, due to unsubstantiated claims associated with CBD products. For that reason, it's important that consumers talk to a health care professional about the best way to treat diseases or conditions with existing, approved treatment options.

In March, the FDA provided updates on its work related to CBD products, with a focus on protecting public health and providing market clarity. The FDA continues to be concerned that some people wrongly think that the myriad of CBD products on the market have been evaluated by the FDA and determined to be safe, or that using CBD "can't hurt."

Under the Federal Food, Drug, and Cosmetic Act , any product intended to treat a disease or otherwise have a therapeutic or medical use, and any product (other than a food) that is intended to affect the structure or function of the body of humans or animals, is a drug. The FDA has not approved any CBD products other than Epidiolex, which the FDA approved in 2018 to treat rare, severe forms of epilepsy (see *CPU*, August 2018).

This action by the FDA doesn't even begin to address the many products touted to contain CBD that you can find in health food stores, supermarkets, and so on — some quite expensive, and none approved for medical use or any other use. •

For more information, go to www.fda.gov.

ONDCP: SUD treatment providers need PPE

Last month, the Office of National Drug Control Policy (ONDCP) issued a "Dear Colleagues" letter calling on personal protective equipment (PPE) suppliers to honor requests from substance use disorder (SUD) treatment providers. "Treatment providers and all others associated with maintaining this vital sector of healthcare serve in a critical capacity and will require personal protective equipment (PPE) during unavoidable face-to-face patient interactions," wrote James W. Carroll, ONDCP director, in the April 23 letter.

"In line with guidance previously issued, President Trump's position is that the treatment of SUD is an essential medical service, and PPE ordered and requested by facilities treating SUD is for a legitimate need and purpose," he wrote. "The Trump Administration applauds those who are serving these patients on the front line; their dedication is overwhelmingly heartening. I trust that this letter serves as my endorsement that they too need to be protected during these trying times."

Carroll noted that there have been exemptions to increase access to treatment and the use of telemedicine in SUD treatment during the pandemic, but added that "we know that in-person patient/provider interactions will inevitably occur."

Mark Parrino, president of the American Association for the Treatment of Opioid Dependence (AATOD), told *ADAW* that he had not received any concrete information about how opioid treatment programs (OTPs) have been accessing PPE following the ONDCP letter, "but I do understand that materials are beginning to get shipped to OTPs." We heard that once programs send suppliers the ONDCP letter, response is swift. •

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Federation of State Physician Health Programs and executive medical director of the Washington Physicians Health Program, told *ADAW*.

The details around how these treatment decisions are made reflect both the complex factors influencing recovery within the physician workforce and the structure of a system that protects participant confidentiality but can leave decisions open to mass second-guessing.

"It's good that physicians are getting such privacy protections, but that makes it hard to tell if any are getting buprenorphine if they try to go back to work," Peter Grinspoon, M.D., a primary care physician in recovery who once worked in the Massachusetts physician health system, told *ADAW*. "Very few PHPs will say, 'We're not providing buprenorphine,' but are physicians actually receiving it?"

Washington's experience

How physicians typically encounter the PHP process in Bundy's home state of Washington offers an instructive look at a system that operates largely out of the public eye but has a strong track record of returning doctors to work and limiting relapse.

Bundy explains that most of the cases of individuals referred to a PHP are not known to a state's medical board at the time of referral. It is more common that a struggling physician will self-refer to the confidential option for assistance, or be referred by a concerned employer, peer, or loved one. "In Washington, 10 to 11% of our referrals come from the medical board, when there is a concern," Bundy said.

The PHP is not the provider of treatment, and consults with

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specialized evaluation centers (in Washington, these are treatment experts from out of state) that recommend an individualized course of treatment. Factors to consider in shaping a treatment plan include the scope of a physician's job responsibilities, such as whether he/she engages more in hands-on procedures or cognitive roles with patients, Bundy said.

"An important consideration for health care professionals, different from the general population, is that they are in a safety-sensitive occupation, like pilots and others whose work directly impacts the safety of others," he said. All PHPs adhere to an abstinence-based program of recovery that prohibits use of alcohol, he said.

Intensive residential care is typically recommended for physicians so that a rapid return to work is conceivable, Bundy said. For some medical specialists who carry significant overhead to maintain their practices, being out of work for many months while in an extended program would prove financially devastating, he said.

As part of continuing care, PHPs have historically embraced medication-assisted treatment (MAT) for both OUD and alcohol use disorder, which in no way conflicts with an abstinence-based philosophy, Bundy said. "It has been a mainstay of safe return to practice," he said of MAT.

However, for OUD, "We don't get a lot of doctors being recommended for Suboxone by the treatment program," Bundy said. He says there is a general consensus that buprenorphine and extended-release naltrexone have comparable effectiveness, but there are particular advantages to the monthly naltrexone injection for physicians, in terms of ease of use and a more successful induction rate for naltrexone than what is seen in the general population.

Others believe, however, that the PHPs and those that influence them, including treatment programs and state medical boards, harbor concerns about whether physicians can safely practice while on buprenorphine. Louis E. Baxter, M.D., president and CEO of the Professional Assistance Program of New Jersey, told *ADAW* that he believes any such concerns fly in the face of strong evidence that buprenorphine and even methadone result in no cognitive or motor impairment when appropriately dosed. (The restrictions around how methadone is dispensed generally make it a poor fit as part of a continuing-care plan for doctors in recovery.)

"If the state medical boards have a good relationship with the PHP, that increases the likelihood that they will allow the use of MAT. In some other states, there is tension between the two, a lack of coordination and education."

Louis E. Baxter, M.D.

"I have treated professionals with medication-assisted treatment and they have done very well without any difficulty," said Baxter, an internist who considers his work with substance use disorder patients to have been the most gratifying part of his medical career.

Bundy says he does not see a particular bias in the system against using buprenorphine for physicians but adds there is some divergence within the research regarding the drug's cognitive effects.

If the respective drugs' safety profile slightly favors extended-release naltrexone but efficacy results point more toward buprenorphine, balancing these factors may be what needs to take place in individualized treatment planning for physicians with OUD.

Role of medical boards

While the state medical boards have embraced the PHP as a vehicle for early intervention that can address problems before they morph into crises, the boards' central role is to protect the public's safety. Under typical circumstances, a PHP will not divulge details of a physician's treatment plan to the medical board, but in cases where an individual falls out of compliance, reporting to the board will be mandatory in the name of preserving safety, Bundy said.

Baxter believes physician outcomes are enhanced when the PHPs and the medical boards see their relationship less at cross-purposes. "In New Jersey, we have worked closely with our medical licensing board since 1994," he said. "What it took was education. We gave them data," including that in the Substance Abuse and Mental Health Services Administration's Treatment Improvement Protocols addressing MAT.

"If the state medical boards have a good relationship with the PHP, that increases the likelihood that they will allow the use of MAT," Baxter said. "In some other states, there is tension between the two, a lack of coordination and education."

Grinspoon, whose early recovery in the mid-2000s occurred when MAT had not yet attained the gold standard status it now carries (see "Risks of anesthesiology: Addiction and job loss — or recovery," *ADAW*, Dec. 17, 2018; https://onlinelibrary.wiley.com/doi/10.1002/adaw.32201), says the impression he received when he worked in physician health in Massachusetts in the mid-2010s was that none of the major players saw buprenorphine as a viable option for recovering physicians.

"My position is that a lot of this came from the medical board," Grinspoon said. "They just wanted

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everything packaged up in a different way." Less familiarity with the behavioral health specialty, combined with wanting to avoid unflattering newspaper headlines if a particular doctor's case went awry, made it easier for the board simply to advocate a blanket approach against MAT, Grinspoon said.

Other fields have found, however, that moves to restrict access to MAT can result in legal liability. Courts recently have ruled in favor, for example, of individuals in the criminal justice system who were denied access to evidence-based medication treatment. Sally Friedman, vice president of legal advocacy at the Legal Action Center, told *ADAW* that the topic of physicians' rights in matters such as this has not come up in her organization very often, although the subject comes to the group's attention more with the nursing profession. Friedman added, however, that any blanket policy against a treatment option without making individual determinations of need would be in violation of the Americans with Disabilities Act (ADA).

"Any employer or licensing agency that outright denies people an opportunity because they are taking a medication for OUD would violate the ADA," Friedman said.

Grinspoon adds that doctors who may have believed they did not receive the optimal treatment for their illness may be unlikely to vocalize their concern for fear of jeopardizing their license status. "These physicians are in hot water. They don't want to create waves," said Grinspoon, who believes physicians should have a pathway to appeal treatment decisions made on their behalf.

But Bundy points out that treatment success rates for physicians remain exemplary, showing that the rapid response and treatment-focused approach of the PHPs is saving lives and putting doctors back to productive work that benefits the community. "We have the best long-term outcomes for OUD," he said. •

Coming up...

Cancelled: The leadership conference of the **National Association of Addiction Treatment Providers** will be held **May 16–18** in **San Diego**. For more information, go to **https://www.naatp.org/training/national-addiction-leadership-conference**.

Cancelled: The annual meeting of the **College on Problems of Drug Dependence** will be held **June 20-24** in **Hollywood, Florida**. For more information, go to **https://cpdd.org/**.

Cancelled: The annual meeting of the **Research Society on Alcoholism** will be held **June 20-24** in **New Orleans**. For more information, go to **http://www.rsoa.org/**.

The annual meeting of the **National Association of State Alcohol and Drug Abuse Directors** will be held **June 22-24** in **Bethesda, Maryland**. For more information go to **http://www.cvent.com/events/samhsa-and-nasadad-annual-meetings-public/event-summary-7078b893cc1e4a438695497f26e4c6a9.aspx**.

Stay tuned, as other changes will probably be forthcoming.

In case you haven't heard...

If you read the recent interview Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA), did with Kaiser Health News (https://www.healthleadersmedia.com/clinical-care/vaping-opioid-addiction-accelerate-coronavirus-risks-says-nida-director), you may have been surprised to see that she said, "Methadone clinics are closing. If they're not closing, they're unable to process the same number of patients — because the staff is getting sick...." We contacted the NIDA press office to find out where she got this information. The "senior media manager (contractor)" sent this response: "We wish that we had more concrete information to share. As you might expect, data and aggregated, hard numbers on what is happening in communities is difficult to come by these days. We are hearing anecdotal reports, which Nora has mentioned in recent interviews. A good source to contact might be the American Association for the Treatment of Opioid Dependence — they may have a better sense of how things are playing out, or be able to speak to that more directly." Mark Parrino, president of AATOD, did not have more information, however. "I have not heard about program closings, with the exception of those two programs in Virginia about four weeks ago. They reopened after 14 days. There may be other programs that have closed due to COVID-19, but I have not heard about them. I do not know what Dr. Volkow is referencing. Is she talking about programs that are temporarily closing due to COVID-19 infection? In reading through the article, this would appear to be the case. Or is she referencing program closing as a trend? When Nora says things like this, I generally check with Jack Stein, who is the chief of staff at NIDA. He is quite sharp and may be able to provide some background." We subsequently emailed Stein to follow up, but he did not respond.