

ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

Volume 37 Number 34
September 1, 2025
Online ISSN 1556-7591

IN THIS ISSUE...

Our lead stories this week look at the chilling effect of ICE and Medicaid on SUD treatment, and difficulties getting buprenorphine prescriptions from the pharmacy via telemedicine.
... See stories, this page

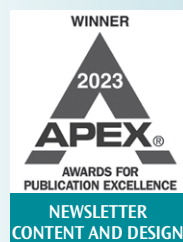
FROM THE FIELD...

Is the opposite of connection a biased AI Chatbot?
... See page 5

FROM THE FIELD...

Checking boxes is not enough
... See page 7

There will be no September 8 issue of ADAW published. Your next issue will be September 15.



2019 recipient of Henrick J. Harwood and Robert E. Anderson Award in Recognition of an Individual's Distinguished Service in the Field of Addiction Research, Training, and Evaluation.



Honorable Mention Spot News 2016



2016 Michael Q. Ford Journalism Award

FIND US ON

facebook

adawnewsletter

FOLLOW US ON

twitter

ADAWnews

© 2024 Wiley Periodicals LLC
View this newsletter online at wileyonlinelibrary.com

Patients, providers hurt by double whammy of ICE and Medicaid directive

A years-long crackdown by the U.S. Immigration and Customs Enforcement (ICE) agency against immigrants, and this month's new directive by the federal Center for Medicaid and Medicare Services (CMS) requiring states to ensure patients on Medicaid are eligible in terms of immigration status, has had a chilling effect on care. Patients, even those who are documented, are less likely to seek help due to fear of being detained and deported, and providers report a decreased numbers of people. It doesn't take immigration status to make someone afraid to seek

Bottom Line...

First, immigration enforcement scared patients from showing up for treatment, then just last month new Medicaid eligibility documentation requirements created a new barrier to care.

medical care: it can even be just skin color.

"We have heard from the provider community that this is a concern, and some current patients have expressed worries about if it's safe to access care," said Emily Duhovny Silverberg, legislative

See [ICE AND MEDICAID](#) page 2

Study: Buprenorphine fill problems in telemedicine are multifaceted

Despite longstanding recommendations across the industry to expand ease of access to buprenorphine treatment for opioid use disorder (OUD) via telehealth, a newly published survey suggests that many patients in these programs experience obstacles in getting their prescriptions filled at the pharmacy.

The survey of patients in a telemedicine practice covering five states found that around one-third of these patients have had to go without

buprenorphine over an inability to fill a prescription at their pharmacy, with pharmacist hesitancy to fill cited as one of the most common reasons for this problem. Results of the study were published online Aug. 18 in *JAMA Network Open*.

Among the research team's recommendations for overcoming these barriers to buprenorphine treatment via telemedicine are enhanced education of pharmacists and policy changes that would require community pharmacies to stock a minimum quantity of buprenorphine.

"There remains a critical need for greater efforts to reduce treatment interruption and disinformation related to buprenorphine use, address concerns about the validity of telemedicine treatment platforms and implement system-level interventions

See [BUPRENORPHINE](#) page 7

Bottom Line...

No location appears immune to obstacles when a patient receiving treatment for opioid use disorder via telemedicine seeks to fill a buprenorphine prescription at a pharmacy, results of a new survey suggest.

ICE AND MEDICAID from page 1

director and deputy chief of staff for Rep. Paul D. Tonko (D-New York). “We have heard that the recent directives have significantly shaken service providers, especially those who serve a high number of people who may be concerned about ICE,” she told *ADAW* last week. “

We heard from one provider that they are staying focused on providing care, reminding patients that they are not part of law enforcement and won’t turn people over and will continue to use lifesaving harm reduction efforts,” she added. “They [providers] also are talking to patients about how to keep themselves safe.”

The Legal Action Center has released a set of guidelines to help substance use disorder (SUD) treatment providers deal with ICE and welcome patients and protect the rights of patients and providers (see end of article).

CMS directive

On August 19, CMS ordered states to remove ineligible Medicaid enrollees and to uphold citizenship requirements. There is a new “verification process” which is designed to make sure everyone on Medicaid is a U.S. citizen, a U.S. national, or has a “satisfactory immigration status,” according to CMS.

The process also applies to individuals enrolled in the Children’s Health Insurance Program (CHIP).

Scripts can also help staff de-escalate interactions with immigration enforcement while following the law and program policy.

Legal Action Center

“CMS will begin providing states with monthly enrollment reports identifying individuals whose citizenship or immigration status could not be confirmed through federal databases, including the Department of Homeland Security’s Systematic Alien Verification for Entitlements (SAVE) program.

CMS will monitor states’ response.

‘Everything is in the dark’

More than half of the Medicaid population in opioid treatment programs (OTPs) in Rhode Island attend treatment at CODAC Behavioral Health Care, said president and CEO Linda Hurley. “So we’re very vulnerable.”

In the last year, CODAC hasn’t seen one person coming to care who is undocumented, said Hurley. The reason is not because

undocumented immigrants don’t need treatment. “It’s because they’re afraid,” said Hurley. “That’s not an assumption. We work closely with entities that work with undocumented people,” she said. “People are afraid to bring their children to doctor appointments they need to go back to school.” They’re afraid to go to school, too. Ever since President Trump rescinded the Biden rule that churches, schools, and hospitals are not safe sanctuaries, everyone, not just the undocumented, has been afraid, she said.

Patients with established citizenship may have a relative who is living with them. “It’s a zeitgeist of anxiety everywhere,” said Hurley. “Everyone is frightened.”

CODAC hasn’t had a drop in census because there are so many patients who need treatment, but the waiting list isn’t growing, either. “Everything has gone static,” said Hurley.

But Rhode Island is prepared, just in case. There are two options:

“If you come to treatment and you’re not documented, we have navigators who can help, so that your status is legal,” said Hurley. Or, there is a fund, not federal funds, out of which Rhode Island pays the OTP to see people who aren’t documented.

But the fact is that nobody really knows how many patients are missing out on treatment because



Editor Alison Knopf
Contributing Editor Gary Enos
Production Editor Nicole Estep
Publishing Editor Valerie Canady
Publishing Director Lisa Dionne Lento

Alcoholism & Drug Abuse Weekly (Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit

treatment agencies. Published every week except for the first Monday in April, the second Monday in July, the second Monday in September, and the first and last Mondays in December. The yearly subscription rates for *Alcoholism & Drug Abuse Weekly* are: Online only: \$672 (personal, U.S./Can./Mex.), £348 (personal, U.K.), €438 (personal, Europe), \$672 (personal, rest of world), \$8717 (institutional, U.S./Can./Mex.), £4451 (institutional, U.K.), €5627 (institutional, Europe), \$8717 (institutional, rest of world). *Alcoholism & Drug Abuse Weekly* accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Customer Service at +1 877 762 2974; email: cs-journals@wiley.com. © 2024 Wiley Periodicals LLC. All rights reserved. Reproduction in any form without the consent of the publisher is strictly forbidden.

Alcoholism & Drug Abuse Weekly is indexed in: Academic Search (EBSCO), Academic Search Elite (EBSCO), Academic Search Premier (EBSCO), Current Abstracts (EBSCO), EBSCO Masterfile Elite (EBSCO), EBSCO Masterfile Select (EBSCO), Expanded Academic ASAP (Thomson Gale), Health Source Nursing/Academic, InfoTrac, Proquest 5000 (ProQuest), Proquest Discovery (ProQuest), Proquest Health & Medical, Complete (ProQuest), Proquest Platinum (ProQuest), Proquest Research Library (ProQuest), Student Resource Center College, Student Resource Center Gold and Student Resource Center Silver.

Business/Editorial Offices: Wiley Periodicals LLC, 111 River Street, Hoboken, NJ 07030-5774; Alison Knopf, email: adawnewsletter@gmail.com; +1 914 715 1724.

To renew your subscription, contact Customer Service at +1 877 762 2974; email: cs-journals@wiley.com.



they are undocumented. There are no numbers, for example, of patients in emergency departments who are undocumented, said Hurley. “Everything is in the dark,” she said. “Honestly, I think that was the overall plan.”

Advice from Legal Action Center

The Legal Action Center (LAC) issued guidelines to help SUD treatment programs respond to immigration enforcement. The guidelines were issued in response to the “fear and uncertainty” within programs after healthcare settings were included by President Trump as places where immigration enforcement could take place.

“The U.S. Constitution prohibits immigration enforcement agents from entering non-public spaces without consent or a valid search or arrest warrant; a valid warrant must be issued by a judge based on probable cause and name a specific individual,” according to the LAC. “Immigration agents can enter public spaces without a warrant, but anyone questioned by immigration agents in a public area of a healthcare facility has the right to remain silent.”

If there is a mix of public and non-public spaces within a program treating people who use drugs and people with SUDs, LAC notes the following:

“A program’s waiting room may be considered “public” because anyone can walk in, but it may be possible to create a “non-public” waiting room by restricting it to patients and the people accompanying them. Other non-public spaces may include offices, meeting spaces for group sessions, and medical records areas. Whether any given space is considered “non-public” is fact-specific and depends on whether there is a “reasonable expectation of privacy.”

Door hanger from CODAC

One Stop Shop for all your Healthcare Needs!

Treatment for substance use
Recovery support!
Assistance with Insurance
Social Services/Basic Needs
Brand new facility!
Friendly, caring staff
Walk-ins welcome!

45 Royal Little Drive Providence

Visit our website
 codacinc.org
 401-808-6693

Your Partner in Recovery and Wellbeing Since 1971!

Privacy

In addition the privacy protections of the Constitution, many providers must follow strict protections under 42 CFR Part 2 of their treatment records, noted the LAC. These protections apply to inquiries by all, including immigration enforcement officials, absent a court order or patient consent. “It is unlikely that immigration enforcement officials will have patient consent or a Part 2-court order authorizing the use or disclosure of Part 2 records,” the LAC stated.

“When determining whether there is “good cause” to authorize the disclosure of Part 2 records, the court must find that:

- Other ways of obtaining the information are not available or would not be effective; and

- The public interest and need for the use or disclosure outweigh the potential injury to the patient, the physician-patient relationship, and the treatment services.”

Treatment providers can explain to law enforcement, including immigration enforcement according to the LAC: “Federal law prohibits me from disclosing any information without a Part 2-specific court order or the individual’s written consent.”

Staff must be prepared to

- evaluate the officials’ authority to enter any non-public space within the program, and
- maintain confidentiality of their patients’ identities and records, without interfering with the lawful execution of a valid judicial warrant.

“Staff should be clear that they are not consenting to immigration enforcement entering or conducting a search or arrest that is not authorized by a valid warrant,” the LAC states.

“There is risk that immigration enforcement officials may threaten staff with arrest for impeding an investigation or obstruction of justice. Staff should not assist patients in escaping or hiding. Staff may tell patients that they have a right to remain silent, but not direct patients not to answer questions. Staff should document all interactions with immigration enforcement officials, including their names and badge numbers. Note also that Immigration and Customs Enforcement (ICE) has recently deputized members of various federal agencies to carry out immigration arrests, who may not be clearly identified as ICE. This guidance document applies equally to any federal or local law enforcement conducting immigration enforcement.”

Practical steps:

- Do not request or record data about immigration status, unless required by law.

Continues on page 4

Continued from page 3

- Avoid asking for patients' immigration status if not required. If you are not required to collect immigration status-related information and a patient self-discloses their own or anyone else's immigration status, avoid including it in the patient's electronic health record or billing record.
- Evaluate waiting room protocols and public areas.
- Consider ways to minimize patients' time spent in the program's public areas. For example, invite patients to wait for their provider in an office, rather than in the waiting room. Or move waiting areas behind closed doors, which can only be entered upon authorization by designated staff.
- Clearly mark non-public areas within the Part 2 program. For example, mark doors "private." Make sure staff and patients understand the significance of public and nonpublic spaces within the program. Immigration enforcement officials cannot access nonpublic areas of the Part 2 program without a judicial warrant – unless an authorized person allows them to enter.
- Support frontline staff with protocols, scripts, and resources. Programs should have a clear protocol for responding to immigration enforcement; New York Lawyers for the Public Interest's model policies for non-profits are a helpful starting point. Scripts can also help staff de-escalate interactions with immigration enforcement while following the law and program policy.
- Refresh staff training on standard confidentiality measures. Training ensures that staff know how to assert legal rights – their own and patients'.

“We have heard that the recent directives have significantly shaken service providers, especially those who serve a high number of people who may be concerned about ICE.”

Legislative director, U.S. Rep.
Paul D. Tonko

- No patient-identifying information should be in “plain view,” such as files and computer screens that are visible from a public space, and staff should never discuss identifying information within earshot of non-Part 2 program staff.
- Designate an authorized person to review warrants, subpoenas, and court orders. There are legally significant differences between subpoenas, warrants, and court orders. Designating an authorized person to review these documents relieves the immediate pressure on front-desk staff and makes it more likely the program will respond lawfully without violating patient confidentiality.
- Direct patients to resources. Consider making available know-your-rights materials for patients to use, take home, and share with their communities. For example, the Immigrant Legal Resource Center's Red Cards can help people assert their rights while remaining silent. In addition to all the resources cited here, check with local non-profits offering free immigration legal services for good sources of accurate, reputable information and resources.

Sample scenarios and scripts

From the LAC:

Agents say they are investigating a crime and need the program's help identifying an individual. I understand you are looking for an individual as part of your investigation. This program is covered by the federal privacy law for addiction treatment records, which prohibits me from sharing any information without a special court order or an individual's written consent. This letter from the Legal Action Center explains the federal privacy protections in more detail. Please leave your contact information or wait here while I contact my supervisor. [The supervisor can confirm that the program cannot share any patient-identifying information without a Part 2 court order or the individual's written consent.]

Agents seek to enter a non-public area of the program because they are looking for a named individual. This is a private area, and I do not consent to you entering without a valid judicial warrant. If you have a warrant, please share it with me and wait in the lobby/other public area while I notify my supervisor. [Once the supervisor evaluates the warrant, they can follow script #3 or #4 below.]

ICE agents present a valid warrant to arrest a patient at the Part 2 program and ask staff to identify the patient. I understand you have a valid warrant authorizing you to enter the program and arrest [name]. We will cooperate and we are not interfering with the warrant, but we are still prohibited under federal law from sharing any information without a 42 CFR Part 2-specific court order or an

Continues on page 6

Is the opposite of connection a biased AI Chatbot?

By William Stauffer

Artificial Intelligence (AI) is our newest societal panacea. Like many other advancements, we overestimate its potential benefits and underestimate its probable downsides. Unlike prior innovations, AI magnifies our errors in judgements and biases in ways that have the potential to erode our society and make those challenges less visible to us even as it causes us harm. There is perhaps no greater example of this truth than in respect to how AI may be harnessed to support our understanding and amelioration of substance use conditions.

AI is like sugar. Sugar tastes good, but it is empty calories. So is AI. It makes you feel connected as it isolates you. We live in a society where authentic human connection is significantly eroded in ways that humanity has never experienced before. Connection is a form of nourishment as we do not get enough of it. Last year I wrote [Societal Hikikomori and the Importance of Bridging Community Capital](#) to not just focus on this challenge, but to identify potential solutions focused on community building.

Beyond its tendency to further isolate us, AI magnifies all of our biases.

A recent study, examined AI, published in the INFORMS journal Manufacturing & Service Operations Management, [A Manager and an AI Walk into a Bar: Does ChatGPT Make Biased Decisions Like We Do?](#) It ran ChatGPT through 18 different bias tests and found many errors. The study found examples of:

- **Overconfidence bias** – A cognitive bias in which a person overestimates their own knowledge, abilities, and precision, leading to a skewed and unrealistic self-perception. This can influence decision-making and cause individuals to take unnecessary risks.
- **Ambiguity aversion bias** – Where people have been found to be more likely to prefer familiar options with known outcomes over those with unknown or uncertain probabilities, even if the latter might be more rational or beneficial.
- **Conjunction fallacy bias** – In this bias, people assume that a specific combination of events (a “conjunction”) is more probable than a single, more general event when the actual likelihood of two events occurring together is always less than or equal to the likelihood of either event occurring alone.
- **Poor judgment** - The study found that AI does not do well with judgment calls. It excels at logical and probability-based problems but stumbles when decisions require subjective reasoning.

- **Not just an early version bug** – Although the newer GPT-4 model is more analytically accurate than its predecessor, the study found that in some instances it displayed *stronger biases* in judgment-based tasks.

We are seeing the adaptation of AI technology to replace crisis call center staff and therapists. We see [Chatbots being used to for people to confide suicide plans](#), there are instances in which AI is [telling individuals to use meth](#), or [kill people and engage in devil worship](#), or as the study above found, to [magnifying existent delusions](#). As a recent article in Forbes discussed, there is a concept called GIGO or garbage in, garbage out and it is magnified by AI. The article, [Garbage In, Garbage Out? Trust In The Data Behind AI Is Vanishing](#), found an increasing loss of trust across industry on the accuracy of the data being generated through AI processes. We should not be surprised that in areas in which there systemic negative perceptions and false beliefs, the deployment of AI would lead to the robots feeding us back falsehoods.

Addiction and AI bias

We should anticipate, that when studies like [Stigma, social inequality and alcohol and drug use](#) (2005) found that addiction is the most stigmatized condition in the world, there is a staggering amount of poor information out on the world wide web about substances use conditions, there origins and their resolution. AI magnifies all those negative perceptions because most all of our data is soaking in it.

We should ask, who is watching the store? Who is asking the questions we need to address? Should AI be used to answer suicide hotline calls? Should people use AI in lieu of therapy or recovery support? Who decides in respect to the risks and potential benefits of its use in our arena? What are the factual and contextual errors of AI record transcribing in patient records? What are the potential impacts to client care? What privacy protections exist from client and other information being out in the world through all the apps and databases? Who owns the errors when biased information is used in ways that cause real harm to people? With the federal government and states using AI to make predictions and decisions in respect to people with substance use conditions, what is being done to protect us from AI bias? What impact can a bias machine on steroids have on efforts to normalize that addiction is not a moral failing but that recovery is a probable outcome when people get what they need to heal?

[Continues on next page](#)

Continued from previous page

Tangentially, in April of 2024, I had the distinct honor of being asked by William White author and thought leader of the new recovery advocacy movement to present his words as the keynote to open up the first annual NIDA Consortium on Addiction Recovery Science (CoARS) conference. The paper was titled *Frontiers of Recovery Research*. Since then, I have begun to interview key researchers and thought leaders in our field about our future opportunities to expand research on addiction recovery here in the US and beyond. A few weeks back, I completed an interview with Dr David Best *Social Transmission of Recovery as a Helix of Connectivity, not a Service Checklist*. As he notes in detail in his interview, one of our greatest opportunity for building social connection and community rests in a focus on community level recovery capital development. This is the antithesis of using AI to support solutions. In my estimation there would be a much more effective use of our time and resources. But we tend to go for tech over people every time.

As Dr Best noted, as we were talking about support recovery community building, “we have these linear models in both the UK and the US, and they fail to consider what we could be developing by focusing on the science of social networks and community level recovery capital. These (treatment-centric) systems operate like sausage machines and see people as broken at the beginning, and then they go through the menus of services and supports and emerge whole beings on the other end of the grinder. People are not sausage meat, and we treat them like they have no talent or value and that the specialists are the change agents, which is not even close to the potential that ROSC has in respect to dramatically magnifying the capacity for the transmission of recovery within a recovery-oriented system grounded in community, building on the talents and capabilities of individuals and groups.” AI puts those sausage machines into overdrive. •

William (Bill) Stauffer is executive director of PRO-A in Harrisburg, Pennsylvania

Sources

- Chen, Y., Kirshner, S. N., Ovchinnikov, A., Meena Andiappan, & Jenkin, T. (2025). A Manager and an AI Walk into a Bar: Does ChatGPT Make Biased Decisions Like We Do? *Manufacturing & Service Operations Management*. <https://doi.org/10.1287/msom.2023.0279>
- Kooli, C., Kooli, Y., & Kooli, E. (2025). Generative artificial intelligence addiction syndrome: A new behavioral disorder? *Asian Journal of Psychiatry*, 107, 104476. <https://doi.org/10.1016/j.ajp.2025.104476>
- McKendrick, J. (2025, April 22). Garbage In, Garbage Out? Trust In The Data Behind AI Is Vanishing. *Forbes*. <https://www.forbes.com/sites/joemckendrick/2025/04/22/garbage-in-garbage-out-trust-in-the-data-behind-ai-is-vanishing/>
- Reiley, L. (2025, August 18). Opinion | What My Daughter Told ChatGPT Before She Took Her Life. *The New York Times*. <https://www.nytimes.com/2025/08/18/opinion/chat-gpt-mental-health-suicide.html>
- Shroff, L. (2025, July 24). ChatGPT Gave Instructions for Murder, Self-Mutilation, and Devil Worship. *The Atlantic*. <https://www.theatlantic.com/technology/archive/2025/07/chatgpt-ai-self-mutilation-satanism/683649/>
- Room R. Stigma, social inequality and alcohol and drug use. *Drug Alcohol Rev.* 2005 Mar;24(2):143-55. doi: 10.1080/09595230500102434. PMID: 16076584. <https://pubmed.ncbi.nlm.nih.gov/16076584/>
- Stauffer, W. (2024, November 9). Societal Hikikomori and the Importance of Bridging Community Capital. *Recovery Review*. <https://recoveryreview.blog/2024/11/09/societal-hikikomori-and-the-importance-of-bridging-community-capital/>
- Stauffer, W. (2025, August 23). Social Transmission of Recovery as a Helix of Connectivity, not a Service Checklist: A Conversation with Dr David Best. *Recovery Review*. <https://recoveryreview.blog/2025/08/23/social-transmission-of-recovery-as-a-helix-of-connectivity-not-a-service-checklist-a-conversation-with-dr-david-best/>
- Turner, B. (2025, June 5). “Meth is what makes you able to do your job”: AI can push you to relapse if you’re struggling with addiction, study finds. *Live Science*. <https://www.livescience.com/technology/artificial-intelligence/meth-is-what-makes-you-able-to-do-your-job-ai-can-push-you-to-relapse-if-youre-struggling-with-addiction-study-finds>
- White, W. (2024). *Frontiers of Recovery Research*. Keynote Address, Consortium on Addiction Recovery Science, NIDA, April 24-25, 2024. <https://deriu82xba141.cloudfront.net/file/2471/2024%20Frontiers%20of%20Recovery%20Research.pdf>
- Why Is AI-Associated Psychosis Happening and Who’s at Risk? (2025). *Psychology Today*. <https://www.psychologytoday.com/us/blog/psych-unseen/202508/why-is-ai-associated-psychosis-happening-and-whos-at-risk>

Continued from page 4

individual’s written consent. This letter from the Legal Action Center explains the federal privacy protections in more detail. Please wait in the lobby/other public area while I notify my supervisor. [The supervisor can assess the best way for the agents to execute the warrant, while taking steps to protect the confidentiality of other patients.]

ICE agents present an invalid warrant (e.g., signed by an immigration officer, not a judge or magistrate). Based on our review, this warrant does not authorize you to enter and we do not consent to you entering. I cannot answer any questions. Please leave your contact information.

What RI OTP is doing to cope

CODAC rents space to a program which manages 87% of the Medicaid population in Rhode Island, Neighborhood Health Care. “I’m thrilled that they trusted us,” Hurley said.

In addition, CODAC has created door hangers (see image, page 3) which are being placed on homes which give information on insurance. People can telephone anonymously, or come to a group meeting to ask questions. The door hangers tell people that if there’s anything they have questions about, any changes in insurance, and as recredentialing in Medicaid proceeds, so will the information. This program will continue for three years, said Hurley.

Rhode Island OTPs met with the State Opioid Treatment Authority (SOTA) last week and the immigration issue was top on the agenda. Out of 7,000 people in treatment in all of the OTPs, only seven are undocumented. Of course, this begs the question of whether people who are undocumented don’t want to seek treatment. Another finding from that meeting: treatment numbers have not grown. •

BUPRENORPHINE from page 1

to expand access to buprenorphine,” wrote study authors led by Lauren E. Hendy, Ph.D., a research analyst at Workit Health.

Workit Health operates an online therapy platform that includes medication treatment, therapist-led and mutual support groups, and a number of interactive courses for individuals in treatment. The new study, based on survey responses from Workit Health program participants, was funded by a grant from the Health Resources and Services Administration.

There has been a strong research basis for initiating buprenorphine treatment via telemedicine. A study based on 2019-2020 Medicaid data in Ohio and Kentucky reported that starting buprenorphine via virtual contact was associated with a greater likelihood of treatment retention compared with in-person initiation of the medication (see “NIDA-funded study supports telehealth buprenorphine,” *ADAW*, Oct. 23, 2023; <https://doi.org/10.1002/adaw.33922>).

Still, many barriers to prescribing through telehealth remain, including pharmacist distrust in instances where there is a considerable geographic distance between the patient and the prescriber.

Stock shortages were cited in the survey as the most common reason for patients’ problem in getting a prescription filled, a finding that points to the issue of access to treatment not being about telehealth alone, said study co-author Marlene C. Lira, M.P.H., director of research at Workit Health. Stigma also can be a contributing factor to stock shortages, “but a lot of the time the pharmacy requests greater stock but is told by its distributors that it has reached its limit,” Lira told *ADAW*.

Survey details

The research team surveyed 601 adult patients receiving OUD treatment in a telemedicine practice covering the states of Florida, Michigan, New Jersey, Ohio and Texas in August and September of last year.

Checking boxes is not enough

By Rob Kent, Esq.

“The value of experience is not in seeing much, but in seeing wisely.”

— William Osler

For almost 20 years, I have been blessed to work on drug policy! This work has allowed me to meet a lot of amazing people, including many who are in recovery from addiction. Their insights and understanding richly inform the work when we listen to them, when we allow them to meaningfully take part in the process.

During my time at NYS OASAS listening to them, allowing them to take part, helped us create the Certified Recovery Peer Advocate and to expand the number of Recovery Community Centers from 3 to more than 30. I value their work because, while I am not in recovery, I know what it means to be written off, to be treated as a lesser human! You never forget and some are motivated to not have others feel that way. I have listened to them because they are colleagues, and way more than just colleagues in recovery.

I have also seen that some employers simply value having folks in recovery on their staff as they can check that box!

I have also seen that we put folks in recovery in positions where they are set up to fail! They are given jobs that they are unfamiliar with, not supported to learn how to do the work and have it taken away when they do not do it as their superiors expect. Instead of mentoring and teaching them, we shut them out and then expect them to learn on their own or to fail and leave. Too often, we view them only as a person in recovery and not also as a colleague who, like everyone, needs mentoring to fit in and perform. They, like every one of us, struggle with their confidence. I have worked hard, but certainly without perfection, to show those I have worked with who are in recovery how I wanted the work done and why I made changes to their work. I have tried to give them the opportunity to succeed, not the silence which leads to failure.

When we mentor folks in recovery like every other employee, we set them up for success. We make it possible for them to help others. I passionately believe that when we pay it forward, we create the possibility for developing better drug policy because it is informed by individuals who best understand the impact of our work! •

Rob Kent, Esq., is president of Kent Strategic Advisors. He is former general counsel for the White House Office of National Drug Control Policy, and former general counsel for the New York Office of Addiction Services and Supports. Reach him at www.Kentstrategicadvisors.com

The online survey instrument asked participants about the number of days they went without buprenorphine because of pharmacy-related barriers, the frequency of buprenorphine fill problems, the type of fill problem, whether fill problems were resolved and whether they’d

be interested in receiving buprenorphine delivery by mail. The researchers examined differences in responses based on age, sex, race/ethnicity, education, time in OUD treatment and the presence of other substance use disorders.

[Continues on page 8](#)

Continued from page 7

The survey sample had a mean age of 41.4 years and 60.4% were women. The group was evenly split between rural and non-rural residents. More than 80% of respondents had been in OUD treatment for at least 6 months, and comorbid depression and/or anxiety was common in the overall group.

Just under 32% of the overall sample reported having to go without buprenorphine over an inability to fill a prescription at their pharmacy, with similar percentages between rural and non-rural dwellers. Among these individuals, 25% said the fill problem caused them to go at least a week without access to the medication.

The most commonly reported reason for a fill problem was that the pharmacy needed to order buprenorphine. Insurance barriers and pharmacist hesitancy to fill a prescription were the next most commonly cited causes.

Lira said the designers of the survey intentionally recruited both rural and non-rural residents in the states to explore the question of whether those in rural communities experienced greater problems. However, “pharmacy barriers were prevalent everywhere,” she said.

More than 85% of those who experienced a fill problem reported that it ultimately was resolved, and the vast majority of survey respondents expressed satisfaction with their prescription experiences overall. However, more than half of respondents did say they would be interested in mail delivery in the future.

The researchers also found considerable variation in the rate of fill problems by state, with a high of 45.5% in Florida and a low of 22% in Ohio – the latter being the state where individuals were least likely to report going without the medication.

Policy moves for combating the problem

Given that supply shortages at the pharmacy was cited in the survey as the most common reason for a

Coming up...

The **Cape Cod Symposium** on Addictive Disorders will be held **September 4-7**. For more information, go to <https://www.hmpglobalevents.com/symposia-addictive-disorders>

The 2025 **conference of the American Association for the Treatment of Opioid Dependence (AATOD)** will be held **October 4-8** in Philadelphia. For more information, go to <https://aatod2025.eventscribe.net/index.asp>

The 2025 annual meeting of the **American Academy of Addiction Psychiatry** will be held **November 6-9** in San Francisco. For more information, go to <https://www.aaap.org/training-events/annual-meeting/2025-annual-meeting-and-scientific-symposium/>

patient going without the medication, a key recommendation from study authors suggests state and local policy initiatives to require minimum supply levels at pharmacies.

Lira said some states and localities have adopted or are considering imposing minimum stock requirements for pharmacies. An enacted ordinance in San Francisco requires pharmacies to have enough buprenorphine in stock to be able to fill all active prescriptions and two additional prescriptions at any one time, she said. The quantity for an extra prescription is defined as 24 mg per day for one week.

Similar proposed state legislation in New Mexico failed to win passage this year, but Lira said supporters are working on refining the proposal with an intent to reintroduce it, and they are currently gathering input from pharmacists.

Lira said other possible strategies to combat barriers to prescribing include expanded education for pharmacists, some of whom attended school before the effects of the overdose crisis began to be felt. Also, states could renegotiate opioid settlement agreements that have triggered expanded monitoring of buprenorphine distribution, and the federal government could remove buprenorphine from the Suspicious Orders Report System, she said.

The survey instrument used for the study was developed by University of Pittsburgh Professor of Medicine Erin Winstanley, Ph.D., who last year co-authored a *JAMA Psychiatry* commentary suggesting several of the same measures to improve access to buprenorphine at pharmacies (see “Researchers call for fix to pharmacy-level barriers to buprenorphine,” *ADAW*, Dec. 16, 2024; <https://doi.org/10.1002/adaw.34350>). •

In case you haven't heard...

“Addiction is not a crime - it's a public health crisis. Addressing it requires compassion, coordination, and unwavering commitment,” said Sheriff Carl Ritchie of Charleston County, South Carolina. “We pause to remember the lives lost to overdose, lives full of potential, a purpose, and the people who matter deeply to their loved ones and to our community.” Ritchie was speaking to an ABC News reporter last week. The department will soon launch its “Leave Behind” program, where deputies will carry harm reduction kits, including Narcan and information on treatment and support services. Deputies will be able to leave these kits on the scene of an overdose, or hand them out to community members. The program will be funded by \$242,000 from the South Carolina Opioid Recovery Fund. For the full story, go to <https://abcnews4.com/newsletter-daily/addiction-is-not-a-crime-charleston-county-sheriff-recognizes-overdose-awareness-week-wciv-abc-news-4-charleston-sc-south-carolina> •