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In This Issue...

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Szalavitz's harm-reduction history a must-read for the field

Maia Szalavitz is often viewed as an enemy of treatment. Her frequent outspoken criticism of substance use disorder (SUD) treatment, mainly on social media, make the field cautious about her. But in fact, her solid reporting and journalism make *Undoing Drugs*, her new book on the history of harm reduction and the connection to addiction, essential reading, especially for treatment providers. At a time when books about SUDs, especially about opioids and especially by people who previously had opioid use disorder (OUD), are flooding the market, it's a pleasure to read one that is so well informed.

Bottom Line...
The new — and first — book about the history of harm reduction and its intersection with addiction is out, and worth a read.

We talked to Szalavitz last week about the book, which was released July 27.

"I thought about this for many years, and in fact, I was afraid of doing it because there's so much about writing about a political movement that's really hard," said Szalavitz, who herself is in recovery from OUD, and was in treatment

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Retirement of a longtime leader triggers a soul-searching process

Any planned departure of an organization's top administrator generates a healthy amount of anxiety among staff, and often the community served as well. When the exiting leader has been at the helm for decades and has shepherded a successful organizational transformation, the level of concern about the future can rise exponentially.

The team at Fall River, Massachusetts–based SSTAR (Stanley Street Treatment and Resources) is experiencing the full range of emotions as longtime CEO Nancy Paull plans to leave the organization next January. The carefully designed components of its search for a new chief executive can offer guidance to other addiction treatment organizations that soon will face the retirement of top leaders from a baby boomer generation that largely built the substance use treatment industry from the ground up.

Bottom Line...
As SSTAR searches for a new chief executive, it is emphasizing the importance of engaging its existing staff and remaining true to its integrated care mission.

Using the term "addiction treatment organization" to describe SSTAR is something of a misnomer, actually. Paull's decision to pursue a fully integrated behavioral health and primary care model, at a time when most saw only insurmountable hurdles to such a move, transformed SSTAR into a federally qualified health center (FQHC) operation

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with methadone in her 20s. "You have to decide who to put in and who to leave out, and that's hard for me as a human being," she told *ADAW*. "There were several other people I thought might [write this book] who didn't, and I realized that people's memories go."

With so much money being added to the SUD pie — in prevention, treatment, recovery and now harm reduction — there is "always the danger of co-option," said Szalavitz, responding to our question about how formerly grassroots organizations would handle new grants. "This can be very difficult, especially when you have people who have no experience managing" these grants, she said. The biggest danger is that "co-option takes the spirit out of" the harm-reduction movement, she said.

However, staying grassroots means staying less effective than harm reduction could be, some say. "Every movement wants to go mainstream," said Szalavitz. "But as Monique Tula [executive director of the Harm Reduction Coalition] said, the goal is to challenge the mainstream and bring them along toward your position."

That said, Szalavitz acknowledged that there is "always a sadness" when co-option takes place, but "at least it shows that you're getting somewhere."

And, as Szalavitz stresses in *Undoing Drugs*, there's a difference between being a service provider and being a radical on the street. Both are part of harm reduction.

She also looks at the harm-reduction origins, when it comes to syringe exchange, in HIV and AIDS. The HIV-AIDS activists like ACT UP were out in force, professional and accomplished a lot; why hasn't the drug-using community been able to do the same? "I don't think it's surprising that we haven't seen that kind of activism" by drug users, people in recovery and their advocates, she said. "By the time the AIDS epidemic happened, gay people were less criminalized" than they had been, or than drug users are now. Also, many people in recovery "just want to get on with their lives; some are devoting their energy to becoming counselors," she said.

On treatment

Of people in recovery, Szalavitz told *ADAW* that "if they do end up being advocates, it's for the treatment industry." (This comment was not in passing; if she hadn't said this many times during our interview, we wouldn't have included it.)

"You have a different interest when you're making money from something," said Szalavitz. This is one of the risks that harm reduction is facing via co-option as well.

For treatment, Szalavitz promoted "evidence-based treatment that appropriately cares for patients." As for 12-Step modalities, she doesn't think there is any basis for its incorporation in treatment. "It's fine to recommend 12-Step, but to teach people that they are powerless over alcohol interferes with what we know, which is that the idea of powerlessness can make people relapse more badly."

Another reason Szalavitz opposes incorporating 12-Step groups into treatment is that "you can get that for free elsewhere." Her bottom line: "Treatment should be treatment; self-help should be self-help."

However, she thinks the 12 Steps hold benefits for everyone. "I believe that every human being could benefit from taking a moral inventory," she said, referring to Step 4. "But you cannot give someone a sense of meaning and purpose — that has to come from within."

Actual SUD treatment should consist of cognitive behavioral therapy, relapse prevention, motivational interviewing and other tools "that have been tested," said Szalavitz.

And for OUD, the best treatment

ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

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is medication, something harm reduction brings to the table, according to Szalavitz. "You can use medication as part of abstinence, in the sense that they are just taking that medication, not taking any additional drugs, getting on with their lives, all that good stuff," she told *ADAW*. "Or you can use it so that people are maybe using fentanyl just two days a week."

With alcohol use disorders, she admits, the scenario is very different. There are medications, but they don't work for everyone.

Next steps

Asked about her next steps, Szalavitz said, "I'm not 100% sure — I want to make sure this book gets enough attention and people know it's out there." The many interviews in the book are fodder for an online archive, if she can get permission, because there was — as always with such a huge endeavor — so much she couldn't use. "I'm also just trying to get back to my regular journalism in the area," she said.

In general, she also wants to see "better drugs journalism in general." For harm reduction, she has concerns about coverage. "Harm reduction seems like an obvious thing, but people don't realize it has a history," she told *ADAW*. "Everybody needs to work very hard against a backlash. I love the radicals, but it's also the case that trying to change drug policy" requires some diplomacy. "There's a great young generation of harm reductionists coming up now," she said. "I'm also hopeful about young medical students who say 'We are going to treat this like a disease' instead of 'Get Out of My Emergency Room,'" she said. "They are a force for good."

"I'm also hopeful about young medical students who say 'We are going to treat this like a disease' instead of 'Get Out of My Emergency Room.'"

Maia Szalavitz

Many think Szalavitz is more advocate than journalist, but her book is not a polemic (despite her quotes to us such as "AA was based on rich white men"). The book is full of anecdotes but also has a solid index, footnotes and a well-organized structure that allows reading chapter by chapter, so you don't need to read it start to finish. But unlike purely scholarly authors, Szalavitz has the credentials of past drug use, a close affiliation with the pain and drug-using community and the trust of both official authorities and harm reductionists. That's a big burden, but one Szalavitz is ready for.

Harm reduction is here to stay, and Szalavitz's book won't be the last one to cover it. But it's a great start. •

Undoing Drugs: The Untold Story of Harm Reduction and the Future of Addiction, is published by Hachette. For ordering information, go to https://www.hachettebookgroup.com/titles/maia-szalavitz/undoing-drugs/9780738285764/.

Meeting: Make OUD medications available in jails and prisons

In *Medications for Opioid Use Disorder in Jails and Prisons: Moving Toward Universal Access*, a report summarizing a meeting April 20 led by the Johns Hopkins Bloomberg School of Public Health and updated last week, medical and public health experts from across the country call for making methadone and buprenorphine universally available in jails and prisons.

Funding for the report came from Bloomberg Philanthropies and Arnold Ventures.

The update notes that there are five key areas where there are currently significant barriers, but also opportunities for change:

- methadone and buprenorphine regulation,
- low-threshold treatment,
- collaboration between security and medical staff,
- harm reduction and
- reentry services and Medicaid enrollment.

Everyone in a jail or prison should have access to all forms of pharmacotherapy for opioid use disorder (OUD) — and there are currently three approved by the Food and Drug Administration: naltrexone, methadone and buprenorphine. The barriers to treatment with methadone and buprenorphine are laid out clearly in the report.

Barriers to treatment with methadone or buprenorphine include the fact that only opioid treatment programs (OTPs) can provide the medication for the treatment of OUDs.

- Few jails and prisons have successfully obtained licensure to operate as OTPs so that they can dispense methadone for OUD treatment on-site, the report notes. "The few licensed OTPs operating out of jail or prison settings report the process took years, which is too long given the urgency of the overdose crisis," the report notes. There are also requirements imposed requiring counseling. Instead, the

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report recommends that methadone be available on a "medication-first approach," which the authors define as "an approach to providing MOUD [medication for opioid use disorder]without pre-conditions." There is also the need for security by OTPs, which do not account for already existing security systems within jails and prisons.

- While partnering with a community OTP is technically an option, most jails and prisons would find it "logistically challenging or financially infeasible" for such an arrangement to deliver daily methadone dosing. The report notes, however, that the new mobile methadone regulations (see "Mobile methadone now approved for licensed OTPs," *ADAW* July 4, https://onlinelibrary.wiley.com/doi/10.1002/adaw.33120) do create this possibility, so that existing OTPs could deliver methadone to jails and prisons.
- The 72-hour rule allowing the prescription of methadone or buprenorphine without a license could be used by jails with high volumes of people cycling through for short, multiday periods, but the Drug Enforcement Administration (DEA) has provided unclear guidance on whether this can be done without an OTP license or an X-waiver, according to the report. Even during reentry, when people are leaving jails and prisons, coordinating take-home doses is a "major challenge" requiring coordination with community providers.
- Caps on the number of patients to which a single clinician can prescribe buprenorphine constrain the number of incarcerated people with OUD that carceral medical staff can treat.

Consensus values of the meeting include that the programs treating OUD in prisons and jails follow these principles:

The authors noted that jail and prison security and medical staff who work with methadone and buprenorphine must collaborate for such programs to be successful and support recovery.

- *Patient-centered care.* The cornerstone of any substance use treatment program — including those in jails and prisons — must be individual patient choice. Individuals should have rights to choose whether to receive treatment, and should be able to engage in shared decision-making with their clinician about how best to realize their goals.
- *Racial equity,* Black, Latinx and American Indian/Alaska Native/Native Hawaiian people are disproportionately incarcerated, which shapes their access to evidence-based treatment services. In this report, the authors refer to the combination of discriminatory policies and institutional practices that has led to unfair treatment of minority populations as structural racism. Programs treating OUD in jails and prisons must develop specific plans to address discrimination and bias that could lead to unequal treatment in carceral settings.
- *Commitment to evidence.* Treating opioid use disorder with MOUD is an evidence-based practice. The evidence about how to scale-up programs and optimally help patients under real-world conditions is evolving. The practices described in the report are informed by existing evidence about what works for OUD, and further research should guide the implementation of programs in real-world settings.
- *Holistic attention to health.* People with OUD often have health needs other than substance use. Substance use services in correctional settings should holistically address patient health through offering other services, including harm-reduction and mental health services, and these services should also be based on the principles of individual choice. Holistic attention to health also recognizes the importance of integrated and continuous care with community providers after release from incarceration.

The authors recommend that existing regulations be revised, or that regulatory language be clarified, to reduce barriers to dispensing methadone and prescribing buprenorphine in prisons and jails. One solution would be for the DEA and the Substance Abuse and Mental Health Services Administration to work with the National Commission on Correctional Health Care to create more flexible requirements for OTPs located in jails and prisons, according to the report.

Security

The authors noted that jail and prison security and medical staff who work with methadone and buprenorphine must collaborate for such programs to be successful and support recovery. All staff should be trained. One problem, however, is that stigma toward people with OUD is a barrier to such coordination. In jails and prisons, this stigma is magnified by the "disparate goals" of correctional staff, who view their role as preventing contraband and diversion in the

facility, and medical staff, who dispense medications that have historically been smuggled into facilities, mainly so that people can relieve withdrawal symptoms.

Challenges in this arena are significant, according to the report:

- Staff may not understand OUD and MOUD due to lack of education and misperceptions. For example, security staff are familiar with buprenorphine as commonly smuggled contraband and are concerned that it will be diverted if dispensed in the facility. This view of MOUD may lead to tensions between the security and medical staff.
- Changing the culture of the carceral system is difficult. Nonmedication treatment is the norm in most facilities, and security staff is more familiar with keeping buprenorphine out of a facility than with the process of dispensing it.
- Individuals with OUD in the carceral system often encounter stigma due to factors that may include incarceration, substance use and structural racism.
- The use of medication itself can be stigmatized by staff and residents as not producing "true recovery."

Solutions include:

- educating and training existing staff on the topics of addiction, OUD and MOUD, and ensuring that new staff are educated on these topics from the beginning of their career (education and training should work to combat stigma associated with these topics and emphasize medication treatment as the standard of care for OUD);
- implementing peer education from correctional staff at other facilities that have implemented MOUD to help make the case that programs reduce diversion, illicit substance use and behavioral disruptions, improving the safety environment of facilities;
- finding a champion in leadership who understands OUD and advocates for MOUD and is willing to be persistent in changing the culture of the facility;
- changing language and vocabulary throughout the facility when discussing substance use, such as using nonstigmatizing, science-based and person-first terms; and
- reviewing policies that impact individuals with OUD, along with education and training, which will work to reduce stigma and discrimination toward individuals with OUD.

Harm reduction

Harm reduction itself may be anathema to many of the jail and prison staffers, even though it "is a holistic and humane approach to addressing the health needs of people who use drugs," according to the report. Providing access to clean syringes — a lynchpin of harm reduction — is not likely to happen soon in jails and prisons, but that doesn't stop the group from recommending that these policies be more widely adopted. However, these challenges seem insurmountable:

- Stigma against drug use in the criminal justice system has deep roots.
- Attitudes around drug use in the criminal legal system (CLS) have historically centered on abstinence as a primary goal. Even existing substance use treatment services in the CLS rarely allow for continued drug use, despite other health benefits of engaging nonabstinent patients in treatment and other health services.
- Many jurisdictions continue to outlaw certain harm-reduction strategies such as sterile syringe possession that further criminalize harm-reduction efforts. Thus, efforts to integrate harm reduction in the CLS would have to address the entire spectrum of law enforcement, including laws related to drug paraphernalia and the policies and practices of community supervision agencies.

Not surprisingly, there are few good examples of alliances between the CLS and harm reduction, the report notes. One beachhead for such practices could be expanding efforts to offer naloxone, which rescues people from opioid overdoses, prior to release from incarceration, the report notes. Another could be creating partnerships between criminal legal system entities, community-based treatment programs and harm-reduction providers. Increasing awareness and stigma reduction, involving peers and eliminating abstinence as a requirement of parole supervision are also suggested.

Medicaid

Linking people to health insurance at the time of release is essential if they are to receive treatment. Since Medicaid is not allowed for people in prisons and jails, helping these people get enrolled before they leave the facility is something that should be required, certainly if they are to continue to receive medication when they leave. Community-based treatment providers should be able to connect with their prospective patients before release, including having access to medical records.

Abolishing the federal "inmate exclusion" policy would be a step toward keeping people in prisons and jails covered during incarceration, but implementation varies widely by state and county.

Specific recommendations include:

- States should implement streamlined Medicaid documentation requirements and automated data-sharing processes to make it easier to complete applications. They should also implement specific outreach and enrollment efforts and resources dedicated to people who are incarcerated, including using carceral staff to help process applications and peers to help

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educate people on health coverage and, where applicable, MCO [managed care organization] selection.

- State policies, such as those in Ohio, New Mexico, Louisiana and Arizona, that require MCOs to provide in-reach services prior to release can also facilitate continuity of care.
- Additional investments should be made in specialized reentry providers, such as the Transitions Clinics Network. The use of telemedicine and peer navigators and access to carceral medical records can facilitate continuity of care for people who are reentering.
- Facilities with effective Medicaid enrollment programs should also distribute naloxone immediately after release and can bill Medicaid for these services.
- Anticipated SUPPORT Act guidance offers an opportunity for Medicaid-funded services to be provided 30 days prior to release. However, implementation of this guidance, particularly for jails where a release date is often unknown, may be challenging.
- Legislation to eliminate the "inmate exclusion" from Medicaid would remove the need for suspension and termination, and the gaps in coverage it causes. An important first step in easing the inmate exclusion would be the passage of the Medicaid Reentry Act, which would allow for Medicaid coverage in the 30 days prior to release.
- States should assess whether there is an adequate network of providers to accept people undergoing reentry. For example, programs that are required to report "infractions" to parole/probation do not fit a low-threshold paradigm, and may interfere with adequate access to treatment post-release. •

JOURNAL WATCH

Recovery-informed theory: Make room for experience

In "Interdisciplinary Expansions: Applying Recovery-Informed Theory to Interdisciplinary Areas of Recovery Science Research," Jessica M. McDaniel and colleagues write that recovery science needs to be expanded to understand how people with substance use disorders (SUDs) get better.

Rarely are the experiences of people with SUDs included in research, and this accounts for the dismissal of subjective experiences of recovery, according to the article, which was published in *Alcoholism Treatment Quarterly* in late 2020. Various aspects of recovery could be investigated by using recovery-informed theory (RIT), which in turn could lead to new approaches in clinical, professional and community contexts.

The three preliminary areas of RIT application are reviewed in the article: recovery measurement, identity processes and systems engagement.

Finding out how individuals recover from SUDs has been, for many, the holy grail of how to treat this disorder. Many people recover without any treatment at all, but how? •

For the study, go to https://www.tandfonline.com/doi/abs/10.1080/07347324.2019.1701598.

States make $26 billion opioid deal with major drug companies

Late last month, a bipartisan group of state attorneys general announced a deal that would give them — before lawyer and other fees, of course — $26 billion, and in turn would release drug maker Johnson & Johnson and the drug distributors Cardinal Health, AmerisourceBergen and McKesson from civil liability in the opioid epidemic. The deal, reported by Jan Hoffman in *The New York Times* July 22, comes after almost two years of battling and will, if finalized, give money to local governments as well as states, all of whom would promise not to bring future lawsuits.

"The urgency of the problem continues," said Attorney General Herbert H. Slatery III of Tennessee at the news conference announcing the deal. "It's just relentless." Tennessee would receive more than $500 million.

In an emailed statement, Michael Ullmann, executive vice president and general counsel of Johnson & Johnson, said, "We recognize the opioid crisis is a tremendously complex public health issue, and we have deep sympathy for everyone affected. This settlement will directly support state and local efforts to make meaningful progress in addressing the opioid crisis in the United States."

In a joint statement, the three distributors said, "While the companies strongly dispute the allegations made in these lawsuits, they believe the proposed settlement agreement and settlement process it establishes are important steps toward achieving broad resolution of governmental opioid claims and delivering meaningful relief to communities across the United States."

Still being negotiated: a separate deal between the companies and Native American tribes.

Not over yet

The agreement doesn't address the

thousands of other lawsuits against other defendants, who include pharmaceutical manufacturers, drugstore chains and distributors.

Purdue Pharma and the Sackler family are negotiating a separate settlement with plaintiffs — probably for more than $4.5 billion — as part of bankruptcy restructuring.

Before any checks actually go out, the agreement must be formally approved by the states and all their municipalities, who have 30 days to review the offer and structure.

If the states don't agree, the companies could walk away from the deal and negotiations would have to start anew. Some states were already refusing to sign.

"The settlement is, to be blunt, not nearly good enough for Washington," said Bob Ferguson, Washington's attorney general, in the Times. "It stretches woefully insufficient funds into small payments over nearly 20 years." He added, "We are looking forward to walking into a Washington state courtroom to hold these companies accountable for their conduct. Washington families devastated by the opioid epidemic deserve their day in court."

States must also persuade localities, even those who did not file lawsuits, to agree to the deal.

"The lawyers will do a lot of the strong-arming of their clients, the localities, into agreeing to the settlements, because if the deal doesn't go through, the lawyers won't get paid," Elizabeth Burch, a law professor at the University of Georgia, told the *Times*.

More than $2 billion of the $26 billion agreement would go to private lawyers representing thousands of counties and municipalities, as well as some states, in the opioid litigation.

According to one negotiator on the committee, some states would have to pass laws locking in how the opioid settlement money would be used and precluding future litigation. But this negotiator, Joe Rice, did emphasize that the payments had been intended to be used almost exclusively to address the opioid epidemic. Rice, who also helped negotiate the tobacco settlements, conceded that much of that money had been diverted to balance state budgets rather than go to treat smoking issues. "Notably, the settlement funds are not intended to compensate families of the victims of the two-decade-long opioid crisis," according to the *Times*. •

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and shaped a broader community-focused mission going forward. An important factor in the organization's executive search has been an insistence that this mission will not change under new leadership.

A written document from Ford Webb Associates, the Massachusetts-based executive search firm the SSTAR board of directors has chosen to conduct the search for a new CEO, states that while bureaucracy and funding continue to challenge the integrated care organization's efforts to respond nimbly to emerging community needs, "this methodology has become a national model and we are resolved to carry it forward to the next level. We are committed to continuing on this pathway, and to empowering our next CEO to introduce whatever improvements and reforms are needed to do so."

"What I have found among the staff is a consistent message about the mission and the values, and the desire to maintain them," Victor Capoccia, a longtime addiction treatment executive whom the SSTAR board has brought on to engage staff during the search process, told *ADAW*.

Needs of today's workplace

Adding another layer of complexity to the search for new leadership in the field is the frank national discussion of what today's workplaces should look like, as issues around diversity and work-life balance have come to the forefront.

"As the composition of our population evolves, if we want these organizations to remain relevant, the leadership and staff need to reflect the population," said Capoccia, a colleague of Paull when he served as the top administrator at CAB Health and Recovery Services in Massachusetts. Racial and language diversity will be a must in organizational leadership, he believes.

For her part, Paull also sees many female executives soon to be making the same life decision she is (Paull turns 70 next year), and she hopes the new generation of leaders will maintain some of the areas of focus she and her colleagues have prioritized. "I hope there is a focus on special populations," she told *ADAW* last week.

The SSTAR board brought on Capoccia to work in concert with Ford Webb Associates during the search process; he is focusing on making sure the staff is fully engaged in the process and that its questions and concerns are addressed. "The engagement of the staff is critical to the selection of the right person," Capoccia said.

To that end, the search firm released a written document that is as much geared to the staff as it is to prospective CEO candidates. The document reinforces the organization's commitment to the team that has been instrumental in SSTAR's successes. "The devotion, flexibility and innovation our staff has brought to this work is precious," the document reads. "Our commitment to them is to find an experienced leader and manager who can help them grow professionally, grow the organization, and continue our innovative and devoted service to our clients and community."

A more striking component of the document written by the search firm leaves the door open to SSTAR hiring an individual from outside the treatment field as CEO. "While subject matter expertise in this field is a plus, we are also open to individuals

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with experience in other fields who have the core skills and values outlined in this document, and who can motivate and lead a strong professional team," the document states.

Ford Webb Associates principal Ted Ford Webb told *ADAW* that in theory, hiring someone from outside the field and having that person work closely with a team of clinical experts could appeal to younger employees, who prefer less of a top-down management approach in today's work environments.

Paull, who is not highly involved in the search process, confirmed that SSTAR is considering candidates from both within and outside the organization, SSTAR has 424 employees and an annual budget of over $29 million. She hopes to have the opportunity to work with her successor for a few months before she retires.

Webb says the four-page background document describing SSTAR and the open CEO position is designed to convey that this is not a typical executive search, in that it will involve a hard look "behind the curtain" of where the organization is and where it needs to go. "Recruiting is often a one-dimensional process, a fairly sterile exercise. I think that's a huge mistake," he said.

SSTAR well-positioned

Webb said SSTAR is operating from a fairly stable position as it searches for a new leader, though it will have to develop more management expertise to make up for the void in institutional memory Paull will leave.

Paull said SSTAR's status as an FQHC has positioned it well during the pandemic, allowing it, for example, to conduct 40,000 COVID-19 tests in the community. "SSTAR stepped to the forefront," she said. But the daily pressure involved in that convinced her that maybe the time was right for her to set a retirement date, after she had been contemplating the move for a while.

Her desire to pursue an integrated health model stemmed from the experiences HIV patients were encountering in the early years of that epidemic. "Nobody wanted to touch those people at the time. These were our patients," she said.

In its more recent history, SSTAR initiated an open-access model of service, with an opioid triage component that involves participation from medical professionals, master's-level clinicians and recovery coaches. Reflecting its broad community focus, SSTAR has seen only a minority of those served being referred to ongoing treatment in the organization. "We look at our patients, see what they need and deliver," Paull said.

Capoccia recalls that Paull was unafraid to confront challenges when she decided in the early 1990s that she wanted to develop a community health center. "I told her, 'You'll find opposition from the state's health centers' about dividing the pie. She said, 'We'll deal with that.'"on." •

Coming up...

Virtual: The annual conference of the **American Psychological Association** will be held **August 12-14**. For more information, go to **https://convention.apa.org/**

Virtual: The **National Prevention Network** conference will be held **August 24-26**. For more information, go to **https://npnconference.org/**

The **Cape Cod Symposium on Addictive Disorders (CCSAD)** will be held **Sept. 8-12** in Hyannis, Mass. For more information, go to **https://www.ccsad.com/**

Virtual: The **International Society of Addiction Journal Editors** annual meeting will be held **September 12-13**. For more information, go to **https://www.isaje.net/annual-meeting.html**

Virtual and in-person: The **European College of Neuropsychopharmacology Congress** will be held **Oct. 2-5** in Lisbon, Portugal. For more information, go to **https://www.ecnp.eu/ecnpcongress/congresses**

Virtual and in-person: The 2021 conference of the **International Network on Health and Hepatitis in Substance Users** will be held **Oct. 13-15**. For more information, go to **https://inhsu.org/2021-conference/**

Virtual: The **Addiction Health Services Research Conference** will be held **Oct. 13-15**. For more information, go to **https://www.ahsrconference.org/**

In case you haven't heard...

It's probably not unusual for patients to seek help for kratom addiction, but we don't hear about it very often. Still, "I got in trouble with kratom — I was getting it online; could I have some of that buprenorphine?" is not an unprecedented question for physicians to hear. Recently a case in which such treatment was successful was posted in a medical journal. For the case study, go to https://journals.sagepub.com/doi/full/10.1177/20503245211021193. This was, as Peter Grinspoon, M.D., observed, quite a large dose of kratom the patient was taking, and trying to withdraw on her own by using kratom tea probably would not have been effective. The episode occurred during the pandemic, when it would have been very difficult to find other treatment, and patients self-treating all kinds of problems were falling between the cracks as COVID-19 took precedence.

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