Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

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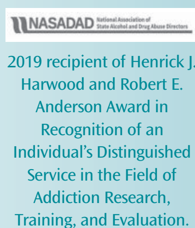

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Drugs for diabetes first, then weight loss, now maybe AUD

Semaglutide (Ozempic, Wegovy), a medication for type 2 diabetes that has also been popular with people trying to lose weight because it decreases appetite, has been shown to reduce the desire to drink, which has raised interest in the use of the drug to treat alcohol use disorder (AUD). A recent study, "Associations of semaglutide with incidence and recurrence of alcohol use disorder in real-world population," based on 83,825 patients with obesity, has found that these patients reduced their risk of AUD incidence or recurrence by 50%-56%. The study, published in the May issue of *Nature Communications*, found that consistent reductions were seen for a 12-month period. The findings provide evidence of the potential benefit of these drugs, now commonly called weight-loss drugs, to treat AUD, and the researchers (lead author William Wang, second author Nora D. Volkow, M.D., director of the National Institute on Drug Abuse) have called for clinical trials.

Bottom Line...

It didn't take long for the idea of losing weight by taking a pill or getting an injection to catch on…next up, reduce drinking the same way.

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National drug strategy addresses themes that include social factors

Last month's release of the 2024 National Drug Control Strategy appears to have created barely a murmur so far in the policy community — there isn't even a formal media announcement about the strategy's availability on the Office of National Drug Control Policy (ONDCP) website. Besides its usual focus on past progress and future priorities in interdiction, prevention, treatment, harm reduction and data collection, the newly published strategy addresses the broader social initiatives that can have an impact on the trajectory of addiction and recovery, from housing policy reform to job creation.

Bottom Line...

The messages conveyed in the 2024 National Drug Control Strategy align with a whole-person approach to addressing the nation's addiction and overdose crisis.

Amid a still volatile overdose crisis, the strategy seeks to foreshadow a future "with greater access to prevention, treatment, harm reduction and recovery support services; with a focus on equity and equal justice; with support for incarcerated individuals, as well as post-incarceration reentry assistance; with a [substance use disorder] and health care workforce that meets our nation's needs; with a payment system that sufficiently funds care; and with a concerted transnational effort to hold drug traffickers, their enablers, and facilitators accountable," the report states.

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AUD from page 1

Comparison drugs in the trials were topiramate (which has also been studied to treat AUD) and naltrexone; both to treat obesity.

Another medication, tirzepatide (Zepbound) was approved by the Food and Drug Administration (FDA) last fall to manage weight. Patients who were given this drug (on an experimental off-label basis) in the study also showed a reduction in AUD.

There are only three medications approved by the FDA to treat AUD, which causes more than 80,000 deaths a year in the United States. The medications are acamprosate, naltrexone, and disulfiram.

Many reports of patients who were prescribed semaglutide having a reduced desire to drink are anecdotal, so the benefits of the drug for AUD prevention and treatment in the real world have a limited evidence base. The researchers for this study used a large database of patient electronic health records (EHRs) to conduct a nationwide multicenter retrospective cohort study to assess the association of semaglutide, with both the incidence and recurrence of AUD in individuals with obesity, and with and without a prior history of AUD.

Then, the researchers assessed the reproducibility of the findings in a separate cohort of patients with type 2 diabetes from non-overlapping time periods. They also compared patients who suffered from obesity who had type 2 diabetes (33%) and those who did not (67%), as well as patients with type 2 diabetes who had obesity (40%) and those who did not (60%). The purpose was to evaluate whether there were interactions on the effects of semaglutide in patients with the two comorbid conditions — type 2 diabetes, and obesity.

Results

No prior AUD: This study population consisted of 83,825 patients with obesity who had no prior diagnosis of AUD and were for the first time prescribed semaglutide or anti-obesity medications including naltrexone or topiramate in 2021–2022. The semaglutide cohort (n=45,797) compared with the anti-obesity medications cohort (n=38,028) was older, had a higher prevalence of severe obesity and obesity-associated comorbidities, including type 2 diabetes, and lower prevalence of mental disorders, and tobacco use disorder. Matched cohorts were followed for 12 months, and compared to other anti-obesity medications, semaglutide was associated with a significantly lower risk of AUD diagnosis (0.37% for semaglutide, compared to 0.73%). These results were consistent across gender, age group and race. Compared to naltrexone or topiramate, semaglutide was associated with a significantly lower risk of incident AUD diagnosis.

Prior AUD: This study looked at 4,254 patients with obesity who had a prior diagnosis of AUD and were for the first time prescribed semaglutide or other anti-obesity medications including naltrexone or topiramate 2021–2022. The semaglutide cohort (n=1,470) compared with the other anti-obesity medications cohort (n=2,784) was older, included more women, had a higher prevalence of severe obesity and obesity-associated comorbidities, including type 2 diabetes, and lower prevalence of adverse socioeconomic determinants of health, mental disorders, and substance use disorders.

Implications

The findings of a beneficial effect of semaglutide on both the incidence and recurrence of AUD were replicated in two separate populations, with different characteristics, no-overlapping periods, and non-overlapping patients prescribed semaglutide: one with obesity and the other with type 2 diabetes. "These beneficial effects are consistent with anecdotal reports that patients prescribed semaglutide describe reduced desire to drink alcohol while on the medication and with recent clinical reports; one documenting reduced alcohol drinking with semaglutide or tirzepatide based on analyses of social media texts and follow-up of selected par-

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ticipants, and another of decreased symptoms of AUD in a case series of patients treated with semaglutide," the researchers wrote. They noted that a clinical trial of exenatide, which is, like semaglutide and tirzepatide, a GLP-1RA [glucagon-like peptide-1 receptor agonist] drug, reduced heavy drinking days and total alcohol intake in patients with obesity.

"The underlying mechanisms have not been fully delineated but are likely to involve modulation of the brain dopamine reward system via GLP-1 receptors," the researchers wrote. These receptors are present in the part of the brain where dopamine neurons are located, and in the nucleus accumbens (the brain's "pleasure center").

"The involvement of the dopamine reward pathway in modulating food and alcohol consumption could explain why semaglutide is beneficial in reducing food consumption and in animal models reducing alcohol and other drug consumption," the researchers wrote. They add that semaglutide binds to the nucleus accumbens "where it has been shown to attenuate alcohol-induced dopamine increases in alcohol-drinking rats." Modulating the dopamine reward system can be a key to overeating, which is driven by pleasure, just as the rewarding effects of alcohol drive alcohol consumption.

Another mechanism by which semaglutide could "buffer stress-related overeating and alcohol consumption" is the way it mediates stress response in general. The part of the brain involved in the negative reinforcement in obesity and in substance use disorders is responsive to semaglutide. In addition, semaglutide and other GLP1-RA medications have anti-inflammatory actions.

There is a disconnect for many: While the pleasure of eating food could be linked to the need to survive (energy), why is there pleasure in drinking? The researchers suggested that alcohol, like food, is a source of energy.

"Though there are no reports on semaglutide's effects on alcohol absorption and pharmacokinetics, it is likely that since it decreases gastric emptying it would also likely decrease alcohol's absorption," the researchers added. "Because the rate of alcohol absorption influences its rewarding effects, delayed absorption could make alcohol less rewarding. Delayed absorption could also increase alcohol's metabolism in the stomach into acetaldehyde, which would enhance its aversive effects."

So far there has been only one randomized clinical trial evaluating the effects of a GLP-1RA exenatide in patients with AUD: This trial showed a significant attenuation of brain activation to alcohol cues (although no reductions in heavy alcohol drinking days). But in a secondary analysis, the investigators found a significant reduction in heavy drinking days and total alcohol intake in AUD patients with obesity. The researchers in the *Nature* study found that the benefits of semaglutide were observed in patients with obesity and in patients with type 2 diabetes, many of whom also had obesity.

Do not use off-label to treat AUD…yet

"In summary, our study provides real-world evidence supporting the therapeutic benefits of semaglutide for AUD," the researchers concluded. "It is important to clarify that our findings of lower risk of AUD incidence and relapse in patients taking semaglutide cannot be interpreted to indicate that semaglutide reduced AUD symptomatology and are insufficient to justify clinicians' use of semaglutide off-label to treat AUD," the researchers warned. "For this to happen, data from randomized clinical trials are necessary."

Another warning: suicidality. There are five registered clinical trials to evaluate the effect of semaglutide in AUD, and some are already recruiting subjects. "Since individuals with AUD are at higher risk for mood disorders and suicidality, and there have been concerns that semaglutide could increase these, though recent evidence suggests it decreases them, it will be important for future clinical trials to assess semaglutide's effects in mood and suicidal ideation," the researchers wrote. "Future studies should also evaluate interactions with alcohol and with medications for AUD."

Limitations

The study has several limitations, according to the authors, who wrote:

- It is a retrospective observational study, so no causal inferences can be drawn.
- Study populations came from those who had medical encounters with health care systems contributing to the TriNetX Platform.
- There are limitations inherent in retrospective observational studies including unmeasured or uncontrolled confounders, self-selection, reverse causality and other biases.
- The follow-up time for the main analyses was eight months. However, future studies are necessary to evaluate longer-term associations of semaglutide with AUD in patients with obesity.
- The weekly higher dose format of 2.4 mg semaglutide (marketed as Wegovy) was approved for weight management, and the lower dose format of 0.5–1 mg semaglutide (marketed as Ozempic) was approved for treating type 2 diabetes. There was a stronger association of semaglutide with recurrent AUD in patients with obesity than in patients with type 2 diabetes, which could suggest a potential dosage effect.

"While these findings provide preliminary evidence of the potential benefit of semaglutide in AUD in real-world populations, further randomized clinical trials are needed to support its use clinically for AUD," the researchers concluded. •

Witness overdoses in order to reduce deaths: Study

In "Evaluation of Strategies to Enhance Community-Based Naloxone Distribution Supported by an Opioid Settlement," researchers found that witnessing overdoses (instead of rescuing them after the fact) can reduce deaths by 37% (compared to 9% without that increase). The simulation study by Xiao Zang, Ph.D., and colleagues supports the concept of overdose prevention centers (OPCs) where drug users can go to use drugs, under the observation of people equipped with naloxone. Witnessing overdoses maximizes the use of naloxone purchases with opioid settlement money, according to the study, which is published in the May 30 issue of *JAMA Network Open*.

Using opioid settlement money to purchase naloxone can greatly increase distribution, but how can this impact be helped by witnessing overdoses, is the question the researchers wanted to answer. They used a simulated model, including a simulated population in Rhode Island at risk for opioid overdose. Distributing more naloxone with opioid settlement money was projected to reduce annual opioid overdose deaths by up to 9%; increasing witnessed overdoses by 60% could further reduce the annual deaths, by 37%, the researchers found.

That's a huge difference. The problem with solitary drug use is that if the drug user overdoses, there is no one there to provide a rescue. The researchers used PROFOUND (Prevention and Rescue of Fentanyl and Other Opioid Overdoses Using Optimized Naloxone Distribution Strategies), a previously published simulation model, to forecast overdose deaths.

The study modeled expanded naloxone distribution supported by opioid settlement funds in Rhode Island (50,000 naloxone nasal spray kits each year), and evaluated two approaches: One based on historical spatial patterns of naloxone distribution (supply-based approach), and one based on the spatial distribution of individuals at risk (demand-based approach). In addition, hypothetical interventions to enhance the likelihood of witnessed overdoses in private or semiprivate settings were considered.

Results

Increasing witnessed overdoses by 20% to 60% demonstrated greater potential for reducing overdose deaths, ranging from 8.5% to 24.1%. Synergistic associations were observed when combining both interventions: Increased naloxone distribution with the two approaches and a 60% increase in witnessed overdoses could reduce overdose deaths in 2025 by 33.5% and 37.4%.

"Although low-barrier access to naloxone is essential for preventing fatal opioid overdose, naloxone is only effective when someone is present to administer it," the researchers wrote. "Unfortunately, only one-third of fatal overdoses in the US occurred with a bystander present, defined as someone being physically present during or shortly preceding a drug overdose who potentially had the opportunity to intervene and respond. Some recent interventions to address solitary drug use — and thus increase the likelihood that naloxone is administered in the event of an overdose — include peer support programs, overdose prevention centers (OPCs, sometimes referred to as supervised consumption sites, which are places where people can consume pre-obtained drugs in a monitored setting where staff can immediately intervene in the event of an overdose), telephone hotlines, mobile apps, stationary wired or wireless devices (such as passive motion detection system and button alert system), and wearable biosensors."

This study was the first to look at the synergistic effects of expanding naloxone distribution and interventions to reduce solitary drug use.

Implications

One of the major challenges in addressing opioid overdose deaths is the high prevalence of solitary drug use, the researchers wrote, noting that individuals who use drugs alone are less likely to receive timely medical intervention (including naloxone administration) when an overdose occurs. "Qualitative studies have suggested several variables associated with solitary drug use, including concerns for withdrawal symptom management, preference for privacy, safety concerns, stigma, not wanting to share drugs with others, and convenience." A cross-sectional study among people attending a substance use disorder treatment program found a significant association among anticipated stigma, polysubstance use, and use in a new setting with using opioids alone. And even when there are bystanders, they don't often respond, partly because they don't know that the individual was using drugs and don't know the signs of an overdose.

"Our study findings highlight the need for interventions that increase the possibility of a bystander witnessing an overdose, along with greater naloxone distribution," the researchers wrote. Additionally, there are several interventions currently being piloted or launched to prevent opioid overdose deaths, and the researchers cite OPCs in particular, calling them "an evidence-based, harm-reduction intervention that provide a space where people can consume drugs under staff supervision so that they can intervene immediately in the event of an overdose."

Going on about OPCs, the researchers wrote, "they are associated with reduced overdose deaths, substance use–related harms, and transmission of infectious diseases and increased treatment engagement and were found to be cost-effective," and they noted that two of the first were in Providence, Rhode Island, and in New York City.

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Limitations

According to the authors, study limitations include:

- There was no explicit inclusion of status for medications for opioid use disorders and other less common drug use patterns (e.g., fentanyl-contaminated benzodiazepines);
- The model was not able to capture the full complexity of evolving drug use patterns and heterogeneity of overdose risk among people who use drugs, such as the increasing use of xylazine;
- Given the dearth of other reliable data on the prevalence of stimulant use, the researchers used the prevalence estimates from the National Survey on Drug Use and Health, despite previous research indicating a propensity for National Survey on Drug Use and Health estimates to be underestimated;
- In contrast to the limited observed surveillance data used as calibration targets, many model parameters were unobservable or had substantial uncertainty, leading to non-identifiability for a subset of parameters during calibration;
- In calibrating the model to account for the increase in opioid overdose deaths during the COVID-19 pandemic, the researchers considered only changes to fentanyl exposure among people who exclusively use stimulants. They did not include other potential underlying factors, such as unexpected changes in the unregulated drug supply, interruptions to medications for opioid use disorders and emergency medical services, and increased solitary drug use, due to a lack of evidence, evidence that the services were not significantly affected during the pandemic in Rhode Island, or interruptions being temporary. Although they conducted sensitivity analysis on the potential reduction in overdose witnessing during the COVID-19 pandemic, they plan to incorporate the manifold effects of COVID-19 more comprehensively in future research as more evidence emerges; and
- The researchers focused solely on the expansion of naloxone availability in programs from the opioid settlement and did not consider other potential influences in the 2023 to 2025 period, such as the availability of over-the-counter naloxone in pharmacies, changes in the availability of medications for opioid use disorders due to removal of federal restrictions on practitioners (X-waivers), or shifts in the capacity of the harm reduction workforce to sustain community outreach and naloxone distribution efforts. If access to these services is enhanced, the estimates regarding the effectiveness of naloxone distribution and interventions to improve witnessed overdoses may reflect a more optimistic outlook.

Although increased naloxone provision supported by opioid settlements (and other major sources of funding) can offer significant public health benefits, combining expanded naloxone distribution with efforts to increase witnessed overdoses could result in a greater reduction in opioid overdose deaths, the researchers wrote. "There are other gaps in the literature that need to be addressed to strengthen future simulation models, including the role of new naloxone formulations, changes in naloxone pricing as a result of over-the-counter status, effectiveness of new overdose prevention interventions, and the impact of targeted naloxone distribution efforts," they added. "Because of its focus on a single small state with well-established naloxone distribution programs, this study may not be generalizable to other jurisdictions with lower coverage of naloxone distribution. Nonetheless, as we delved into solitary drug use, a widespread but understudied issue nationally, this study suggests that interventions that increase the likelihood of overdoses being witnessed, and naloxone administration may become critical components of a comprehensive strategy to maximize the impact of naloxone distribution and effectively use opioid settlement funds."

The study was funded by the National Institute on Drug Abuse. •

Hunter Biden gun trial highlights hypocrisy among advocates

In 2012, when an obviously disturbed young man walked into an elementary school in Newtown, Connecticut, and killed 20 children and 6 adults, there was widespread outrage among advocates when policymakers talked about banning guns for people with mental illness. And rightfully so. Not only are people with mental illness more likely to be victims than perpetrators of gun violence, but there are so many of them that vast numbers of people would be denied privacy and 2nd Amendment rights.. And most importantly, there is no proof that just because someone has a mental illness, that means they would be violent, or shouldn't own a gun.

But over the last couple of weeks, the country watched while the personal substance use problem of Hunter Biden, who is President Biden's son, was exposed in court, with testimony by his friends and family. Prosecutors were trying to prove that Hunter lied when he checked the box asking about substance use "no" in his application for a firearm license. To do so, they sought all of the lurid

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details they could, producing a spectacle designed to shame and humiliate the Biden family, and underscoring every myth about drugs. There was no praise for Hunter's having sought — and obtained — recovery. There was no discussion about whether, in fact, someone should even have to answer such a question.

What happened? Why did almost every advocate *ADAW* contacted, including the Legal Action Center, which has a long history of defending confidentiality of substance use treatment records, refuse to comment on this?

"I was not in the courtroom, nor on the jury, so I cannot comment on the outcome of the trial from that perspective," said Rob Kent, JD, president of Kent Strategic Advisors and former legal counsel to the White House Office of National Drug Control Policy. "However, as somebody who works with folks to convince them to seek recovery, the whole prosecution bothered me tremendously," he said. "When they see cases like this and how Hunter has been treated, it makes it harder to convince them to seek recovery. Furthermore, someone is in recovery when they believe they are in recovery. It is also infuriating to me that they put his daughter and the rest of his family through this. I wish them peace and I wish Hunter a long life in recovery."

People who need treatment are even less likely to admit that, after what Hunter was put through, which was clearly designed to shame — a hallmark of addiction.

Bill Stauffer, executive director of the Pennsylvania Recovery Organization Alliance (PRO-A) said the reporting on the trial "sets back efforts significantly," adding that "I have not watched it all, but it is cringe-worthy."

He added that "the vast majority of persons who own guns and have an SUD check off the 'no' box and do so without a second thought, even ones who have had treatment." The reason is simple: "This is, after all, a condition that people convince themselves that they do not have."

Now they have even more reason for that denial.

Where is the outrage? Field groups we contacted simply did not respond; to its credit, the Legal Action Center did, but only to say they are not gun rights experts and so would not comment. On what form will such a question next appear? When the only accurate and right answer should be "none of your business. •

Down memory lane with Bob Weiner: Methadone and more

When we were starting out as a drugs journalist, one of our first sources was Bob Weiner, then press person for the House of Representatives Select Committee on Narcotics, headed by Charles Rangel (D-NY). Much later, Weiner was press person for Barry McCaffrey, a consultant to an opioid treatment program (OTP) chain who did much good work for methadone treatment promotion. We checked in with Weiner last week, and he sent us some reminiscences.

"You may know that before I worked for Rangel at the Narcotics Committee, I worked for House Aging Committee Chairman Claude Pepper (as the committee's Chief of Staff, we abolished mandatory retirement 359-2 in House and 89-10 in the Senate, and President Carter signed the bill.) Even before that I was Rep. Ed Koch's (D-NY), (later Mayor of New York City) legislative assistant in the House.

"We [Koch and I] were close friends for the rest of his life even after I took other jobs. We co-wrote some op-eds together, and Pat (Weiner's wife) and I had dinner with him at Sardi's under his Mayor caricature on the wall. As a past Koch staffer and close friend I was invited to Koch's funeral and was seated next to Rupert Murdoch, whose endorsement of Koch was instrumental in his later becoming elected three times as Mayor of New York City.

"Also at the funeral as an ex-Mayor was Rudolph Giuliani [former Mayor of New York City, who tried to eliminate OTPs], and I said hi to him, told him I was Koch's legislative assistant, but also that I was Barry McCaffrey's communications director. I got a warm smile from Giuliani with the Koch reference, but then a scowl and look down at the floor when I mentioned McCaffrey.

"I asked Gen. McCaffrey when I got back what was that all about. Gen. McCaffrey reminded me what we did to Giuliani!! I was a piece of that too by the way. Giuliani hated methadone and was part of the uneducated cohort believing "just another drug" so should not be treatment for heroin and opioids. So McCaffrey got the [New York] City's Health Department Chief and Police Chief to agree with us and say that methadone was a super treatment and would greatly reduce the crime from heroin addiction strategies to buy, sell and use it. and of course, reduce heroin use and addiction itself, and had a massive history of scientifically proven success.

"Then we called Chris Wren of *The New York Times* and he put the whole story on the front page — the endorsements of methadone by the top NYC health and law officials, McCaffrey's speaking at the Parrino [Mark Parrino, president of AATOD] press conference and the Giuliani-attempted block of methadone.

"Giuliani's opposition to methadone disappeared. But he never forgave McCaffrey."

[*Editor's note: Giuliani was mayor during the 1990s; McCaffrey was also director of the White House Office of National Drug Control Policy.*]

Weiner is president of Robert Weiner Associates News and Public Affairs, based in Washington, DC. •

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Strategy from page 1

The strategy makes frequent mention of efforts that have sought to have a productive impact on the social determinants of health, citing as examples a reduction in housing eviction filings following a provision in the American Rescue Plan Act, as well as the Bipartisan Infrastructure Law's funding to create high-paying jobs that "have downstream effects that help stop drug use and support people seeking recovery."

Regina LaBelle, J.D., formerly a deputy director and acting director at ONDCP and now director of the Addiction and Public Policy Initiative at The O'Neill Institute at Georgetown University, told *ADAW*, "I think the strategy reflects a continuation of the policy priorities we released in 2022. The Administration has made significant strides in a short time — from reducing barriers to buprenorphine and methadone treatment to expanding access to care for at-risk populations. At the same time, there's a lot more that has to be done and the strategy reflects that."

Section on treatment

The strategy's chapter titled "Expanding Access to Evidence-Based Treatment" lists progress areas that focus largely on medications for opioid use disorder (MOUD). These include the elimination of the X-waiver for prescribing buprenorphine and the Department of Veterans Affairs' efforts to expand access to medication treatment in a variety of primary and specialty care settings.

The strategy states that the 2021 lifting of a moratorium on mobile units for the delivery of MOUD has resulted in a 64.5% increase in units certified by the Drug Enforcement Administration, with 29 new units having received the certification since the action was taken. The chapter cites as a success story the efforts of opioid treatment program (OTP) provider CODAC Behavioral Healthcare in Rhode Island, which became the first agency to advance mobile treatment services after new federal regulations went into effect. The document states that "the mobile clinic is parked near an encampment where unhoused people live, providing access to care for an underserved and marginalized population. The mobile clinic also serves working professionals who receive methadone and then go to work. It offers walk-up services so treatment can start when a patient is ready, truly meeting people where they are and providing low-barrier access."

The chapter on treatment lists these as areas where more work is necessary, all with an eye toward expanding SUD treatment access "so every American who needs it can access it by 2025":

- ***Implementing a national case-finding initiative.*** ONDCP believes a "cascade of care" model that begins with more effective identification of persons in need of treatment and continues with a warm handoff to the proper treatment professional is essential to addressing the drug crisis. "Case finding has no utility without successful linkage to evidence-based care," the strategy states. "As part of this initiative, it is essential that pediatricians and providers who offer SUD treatment to adolescents 16 and older begin offering extended-release naltrexone or buprenorphine."
- ***Exploring motivational incentives and digital therapeutics.*** The strategy cites the inclusion of evidence-based incentive levels for contingency management in Section 1115 Medicaid waiver projects in California and Washington. It states that until private insurers also begin to establish billing for incentive-based contingency management approaches, it will be difficult for many individuals to access evidence-based treatment for stimulant use disorders.
- ***Reviewing and updating OTP regulations.*** Following the recent effort to reduce barriers to methadone treatment by extending take-home dosing options, ONDCP pledges to continue to work with interagency partners to explore other approaches to expand access to methadone.
- ***Updating withdrawal management programs and policies.*** "Guidelines regarding withdrawal practices, such as the Federal Guidelines for Opioid Treatment Programs, which includes policies like involuntary withdrawal for non-compliance, should be updated to incorporate harm reduction approaches and require ongoing care after discontinuation of methadone or buprenorphine for any reason," the strategy states. "Withdrawal is even more complicated where illicitly manufactured fentanyl is adulterated with other substances such as xylazine; protocol development for this emerging threat is in its infancy."
- ***Building capacity in the treatment workforce.*** Broad-based efforts in this area must occur in early medical school curricula, in psychologist training in substance use issues comorbid with affective disorders, and in initiatives targeting nurses and social workers.

Section on harm reduction

The strategy's chapter titled "Expanding Access to Evidence-Based Harm Reduction Strategies" touts several initiatives to advance harm reduction approaches, including a proposed $459 million fiscal 2025 budget appropriation for harm reduction activities to "improve federal efforts for states and localities to support organizations providing legally authorized harm reduction services." The strategy also cites progress made since release of the

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2022 national strategy in expanding access to naloxone, such as through over-the-counter sales of naloxone nasal spray.

The chapter states that the Department of Housing and Urban Development has awarded a total of $486 million to 62 communities across the country to address homelessness through a Housing First approach, with grantees allowed to partner with harm reduction organizations on these projects.

The chapter cites as a success story the Washington, D.C., Department of Behavioral Health's use of State Opioid Response grant funding to establish overdose response teams made up of a paramedic and a community outreach specialist. The team members distribute naloxone kits and treatment and recovery resource information to an individual who has been rescued from an overdose but has declined to be transported to a hospital. The program has distributed more than 1,400 naloxone kits since November 2022.

The chapter on harm reduction lists these as areas where more work is necessary:

- Redoubling the focus on naloxone access while also expanding access to drug checking, syringe services programs and buprenorphine treatment at harm reduction sites. Among the areas that should be prioritized to expand access to naloxone further, there is a great need for insurance coverage for over-the-counter products. ONDCP and federal partners also "will continue working with state and local officials to convey the importance of collaboration with harm reduction stakeholders to better allocate federal dollars to the allowable harm reduction activities that the Administration has highlighted throughout notices of funding opportunities."
- Identifying opportunities to expand Medicaid coverage for harm reduction. The document mentions that New York remains the only state that has included harm reduction programs as qualified providers under Medicaid. Among the typical harm reduction program activities that can be authorized under Medicaid are community-based prevention and individual health education, screening for blood-borne illnesses, wound care to treat infections from drug use, individual and group counseling and peer support services.
- Supporting harm reduction training and education for the treatment workforce. Federal agencies intend to work toward ensuring that service providers deliver care "through an equitable approach that respects the autonomy of individuals to determine their goals related to their drug use."
- Expanding state and local harm reduction funding. The strategy states that while recent efforts to fund evidence-based harm reduction represented an important first step, ONDCP plans to work on an improved mechanism for budget requests for community-based organizations that serve persons who use drugs or individuals with SUD.
- Planning for new translational research to supplement current evidence. Ongoing efforts in this area include a program under the National Institutes of Health's Helping to End Addiction Long-Term initiative to support projects to improve the effectiveness, implementation and impact of existing and also new harm reduction practices.

The O'Neill Institute's LaBelle also cited the importance of the strategy's attention to timely data collection and said that "this remains a priority but this takes funding and coordination across all agencies." •

Coming up...

The annual meeting of the **Research Society on Alcoholism** (RSA) will be held **June 22-26** in Minneapolis. For more information, go to **https://researchsocietyonalcohol.org/**

The **National Prevention Network** annual conference will be held **August 13-15** in Phoenix, Arizona. For more information, go to **https://npnconference.org/**

The **Cape Cod Symposium on Addictive Disorders** annual conference will be held **September 5-8**. For more information, go to **https://www.hmpglobalevents.com/cape-cod-symposium**

The **Addiction Health Services Research Conference** will be held **October 16-18** in San Francisco. For more information, go to **https://www.ahsrconference.org/2024/**

The **NAADAC Annual Conference and Hill Day** will be held **October 18-23** in Washington, DC. For more information, go to **https://www.naadac.org/annualconference**

In case you haven't heard...

You can only go so far, even in Canada. Two drug user advocates have been charged with drug trafficking after police raids on their Drug User Liberation Front office and their homes last October. The two founders of the group had spoken about distributing heroin, cocaine and methamphetamine. In a report in the *Vancouver Sun* on June 7, it was disclosed that the two had received $200,000 in public funding in 2021–2022.

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