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News for policy and program decision-makers

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Our page one stories this week look at some of the unsavory aspects of addiction treatment when money comes first. In the top lead, we look at how a Florida rehab uses a marketer in Illinois to skim off the best-insured patients — and refers other people to various other programs, but never to MAT.
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Illinois residents with good insurance targeted by Florida provider

It's not a new story: in states where treatment capacity is limited and waiting lists predominate, Florida — where treatment providers are plentiful — has become the end destination for families desperate to get their loved ones into recovery. In this article, we focus on one such provider — Banyan Treatment Center — and its marketing methods, which are not unusual for the field.

Banyan has a residential treatment center in Pompano Beach and a detoxification facility in Stewart, and it recently opened an intensive outpatient program (IOP) in Naperville, Illinois. According to Eric Oakes, executive director, 95 percent of the patients in Florida have out-of-network insurance coverage. The other 5 percent are self-pay. "We don't take Medicaid, we don't have in-network contracts," said Oakes, noting that very few Florida providers are in-network with insurance companies.

See **Banyan** page 2

Bottom Line...

A mix of a forceful speaker-marketer, family members uninformed about appropriate treatment and a for-profit Florida rehab is an example of the out-of-network business model at work.

Jockey's treatment highlights pressures in sport without consistent protocols

Last week's news that jockey Kent Desormeaux had entered treatment for alcohol problems, not long before he was scheduled to ride the expected favorite in the June 11 Belmont Stakes, raised a spotlight on some of the complicating factors in treatment and recovery support for prominent athletes.

Events surrounding Desormeaux in recent days invited much speculation and commentary, in that his first-ever pursuit of treatment for long-standing issues was timed so close to one of the biggest races of any top-level jockey's year, and also that he was placing great emphasis on the anticipated presence of a sober companion for the 20 days following his eight-day treatment stay.

News about Desormeaux already was noteworthy in that he openly released information about the facility where he received treatment (Cirque Lodge in Utah) and the individual who would be serving as his sober companion post-treatment (Kevin McLaughlin). He said in an article on the website of *The Blood-Horse* racing publication that McLaughlin has 15 years of professional training and 15 years of sobriety.

"He will fly with me to New

See **Desormeaux** page 7

Bottom Line...

The recent treatment stay of nationally prominent jockey Kent Desormeaux calls attention to the precarious position of jockeys in a physically demanding sport with significant pressure to return to work rapidly.

Banyan from page 1

The vast majority of patients go to Banyan with a primary diagnosis of opioid use disorder.

Insurance first

The fact that virtually all Banyan patients have out-of-network insurance is by design — out-of-network insurance is the best kind from the provider's point of view, as there are no cost limitations based on contracts. The main referral source is in Illinois, where Tim Ryan operates as Banyan's Midwest regional outreach coordinator, a full-time salaried position. Ryan told us that he refers people with good insurance to Banyan, because that's his job. And in fact, this is an age-old marketing job for treatment programs — getting beds filled.

Some patients are referred to Florida, and some to the new IOP in Naperville, said Ryan. The IOP is a partial hospitalization program (PHP) that ultimately could treat up to 90 people but currently only has 20 housing beds, he said. "Some people don't want to leave the state or are still living with Mom and Dad." Only patients with "good policies" are referred to Banyan, he said. "It has to be PPO or cash pay," he said.

PPO plans — which allow treatment out of network but frequently only pay a portion of that care as a way of encouraging patients to use in-network providers — are viewed as a kind of out-of-network plan. Treatment programs that do not collect the patient portion of the PPO coverage are subject to fraud charges.

Art VanDivier, executive director of La Hacienda in Texas, questioned Banyan's business model of taking only out-of-network patients. "If you don't have a contract, most insurance companies will say they'll pay 50 percent of your rate," VanDivier told *ADAW*. "Suddenly the rates become very high, and 50 percent of out-of-network is higher than an in-network contractor gets and the provider doesn't even want to be in-network," he said. "Insurance is cracking down on this because it's an obvious abuse." This is a "shaky business plan," said VanDivier. "Is it illegal? Not technically. Is it unethical? You're gouging the insurance company."

It's not unusual for a treatment provider to have a patient whose insurance doesn't contract with the provider. "We all have those situations," said VanDivier. "But to create a business that's based on it? If I were an investor in that company, that would be scaring me to death, because managed care is going to come down on it. They're keeping stats, and they know there's money hemorrhaging."

The vast majority of patients Ryan, who has no clinical credentials, refers to treatment have no insurance. He has a not-for-profit that, according to Banyan and Ryan, is independent of his work for Banyan, called the Man in Recovery Foundation. Through this, he attracts people who need treatment. "I put 300 people a month into treatment, but 98 percent have no insurance or have state insurance," Ryan told *ADAW*. "I know how to maneuver the system whenever even if someone has state insurance, they can get treatment," he said. "I know exactly where the beds are." But, we pointed out, there are waiting lists all over the state. "I know when beds are opening up," said Ryan.

Ryan, a former heroin addict who lost his 20-year-old son to a heroin overdose, just got out of prison two years ago. He does not refer patients to medication-assisted treatment (MAT) with methadone, and buprenorphine is only used in Banyan facilities for detoxification, said Oakes. The Naperville facility has Vivitrol, said Ryan.

Edward-Elmhurst Health, which has a substance abuse treatment program in Naperville, declined to be interviewed for this article.

The Florida Department of Children and Families (DCF) licenses and regulates substance abuse treat-

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ment facilities in the state. But the DCF "has no authority regarding provider marketing practices in Chapter 397, Florida Statutes," said Jessica K. Sims, DCF communications director. The Office of the Attorney General (Pam Bondi) is responsible for enforcing the Florida Deceptive and Unfair Trade Practices Act and the civil provisions of the Racketeer Influenced and Corrupt Organizations Act, she told *ADAW* last week. "The State Attorney has enforcement authority over criminal cases," she said.

Lack of MAT

The fact that the first-line recommended treatment for opioid use disorders includes medications — methadone, buprenorphine or naltrexone — is ignored in this Banyan philosophy — as it is in many rehabs, partly because of patient ignorance and mistrust. All counties in Illinois are experiencing a gap in capacity for treatment with buprenorphine or methadone, said Kathie Kane-Willis, director of the Illinois Consortium on Drug Policy at Roosevelt University. Methadone is still not covered under Medicaid in the state, she noted, adding that in 2017, it will be covered just as buprenorphine and Vivitrol now are. But there aren't enough buprenorphine providers to meet the demand.

In addition, Illinois lost 50 percent of its publicly funded treatment capacity between 2007 and 2012, before the budget impasse in the state even started, noted Kane-Willis.

Of particular concern is the stigma against methadone and buprenorphine. "I just spoke to a mom who had lost her child to an overdose," she said. The mother said she would never have allowed her child to be on buprenorphine. "I think this speaks volumes," said Kane-Willis, who said Ryan is contributing to the attitude that buprenorphine and methadone aren't really treatment, but just "trading one addiction for another." This stigma has become worse, not better, over time — ironically during the same period in which the opioid epidemic itself has become worse. And family members are prey for rehabs that avoid these medications, like Banyan.

"Since folks really don't understand what treatment is and their only frame of reference is *Intervention* and Dr. Drew, they tend to look for inpatient programs because they feel that that is what treatment looks like," she said. "We are working hard to make simple videos to reduce the stigma related to these life-saving medications," she said. "People tend not to believe the science, which demonstrates the efficacy of these medications," she said.

However, people are more likely to believe those with lived experience, said Kane-Willis. "I know this because of my own experience," she said. "I can quote the science until I am blue in the face. However, when I mention my own lived experience, the conversation changes completely. When we were working on the override of the governor's veto on the heroin crisis bill, I was talking about methadone, and the general consensus from the advocates was 'We don't like that.' When I told them that I had used it in my recovery, the conversation changed, completely."

"We really need more people to come out regarding their positive experiences with these medicines," said Kane-Willis, although she sympathizes with the fact that stigma makes this difficult. "People are doing well and are stable living their lives — no one would know that they were once heroin users," she said. "But I really do hope people do start sharing their stories, as we know that these medications are the most effective treatments for opioid use disorders."

'Predatory' tactics

Because of the bias against MAT in many treatment programs, however, it is the "rehab" that is the focus of the Ryan-Banyan arrangement. Gerald "Jud" E. DeLoss, outside legal counsel for the Illinois Alcoholism and Drug Dependence Association (IADDA), shared his views on the arrangement between Ryan and Banyan with *ADAW*.

"First, state and federal consumer protection laws govern paid endorsers or references," he said. "If an individual is paid by a third party to provide an endorsement of a particular product or service, then that individual should disclose the financial relationship/incentive to potential consumers because the payment impacts the credibility of the endorsement."

Robert Ryberg, managing partner with Peak Consulting Partners, an addiction treatment consulting company based in Colorado and Arizona, agreed. "I feel very strongly that someone's integrity is in question when they don't make their financial situation known to the client," Ryberg told *ADAW*. "Tim and the entire group of Banyan folks, contract or not, are notorious for doing that," he said. "I've had a lot of words with them about this." Ryberg grew up in the area of Chicago where Ryan is operating, and got sober there. He has heard about the Man in Recovery Foundation's "outpatient groups," which are used as recruiting mechanisms for patients. "In no way, shape or form does the job they do resemble a typical clinical outreach representative in the industry," he said. "They're not clinical, and they're not sending clients to the appropriate level of care based on need. This is predatory."

The involvement of the not-for-profit Man in Recovery Foundation also concerned IADDA's lawyer. DeLoss questioned "whether a not-for-profit foundation can legally or ethically refer business to a for-profit treatment center that employs the foundation's leader," he said. "It's possible, but there are a whole host of tax-exempt issues that must be addressed."

"These are predatory marketing tactics," said Peter Palanca, executive vice president and chief operating

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officer of TASC, based in Chicago. "I don't think there's any question about that," he told *ADAW*. "To prey on families who are scared to death, grasping at straws, terrified about their son or daughter dying" is wrong, he said. Ryan "has the credibility that a microphone gives someone," said Palanca, who is on the board of the National Association of Addiction Treatment Providers (NAATP). "Large crowds are showing up for these presentations," he said. Palanca recalls the days when he spoke about adolescent issues in the 1980s, and people would show up looking for care for their children — but the audiences were much smaller. And he was at the time linked to a specific program and identified himself as such. "I ran the first intensive adolescent outpatient program in Illinois," he said. "We focused on kids who needed addiction treatment, and we were at that point in time where we would put every kid who came to us into IOP because there wasn't anything else," he said. "We quickly realized that it wasn't the way to go." Now, however, that is the scenario repeating itself.

DeLoss, who also represents treatment programs in Illinois and other states, also questioned the licensure, training or certification of Ryan. "There would likely be ethical if not legal restrictions on the use of a position of trust to refer clients to a specific treatment center," he said.

In Illinois, treatment providers are already having difficulties contracting with certain health plans to become in-network, said DeLoss. "We believe that the limitations imposed by the plans may be violations of federal and state parity laws that prohibit plans from treating mental health/substance use disorder providers differently than medical/surgical providers," he said. To the extent that there are waiting lists, it's likely the fault of plans failing to contract with in-state providers to ensure sufficient coverage of areas of the state where there is a lack of capacity, he said.

"Finally, I am aware of treatment centers utilizing separate not-for-profit foundations to fund the travel of clients to out-of-state treatment facilities," said DeLoss. These foundations are supported by the treatment centers, which pay for the transportation of patients, so the costs of treatment itself are similar to what they would be if treatment were delivered in Illinois. These arrangements would be prohibited if the patient has Medicare or Medicaid, under the anti-kickback law. State laws impose similar restrictions on private insurance, said DeLoss. "It is possible to structure such an arrangement legally but it is complex and an unsettled area of the law," he said.

'My dad used to say, "Let's check with the Better Business Bureau." Now, I would tell consumers, go to the NAATP website and check the program out. Are they licensed? Are they accredited?'

Phil Eaton

'Switching hats'

"I have no problem with an individual being compensated [for marketing] as long as they are transparent," said Bob Ferguson, founder of Jaywalker Lodge in Colorado. He said the transparency issue is paramount. "I am very careful when I walk into a room that people understand I am a full-time employee of Jaywalker Lodge, that I represent Jaywalker Lodge, that I'm not a licensed or trained counselor in any way, that I am not trained or equipped to make clinical recommendations, and that I do serve on the board of directors of nonprofits, including one called A Way Out, which provides treatment scholarships — and that those scholarships don't go to Jaywalker," he said. When a marketer is working for a program, that person "can't switch hats," he said. "I have no problem with anyone being employed for an organization as long as they represent themselves as such," he said.

But "switching hats" is exactly what Ryan is doing — he is taking some patients for Banyan. Others — those without good insurance — are referred to other programs, to mutual support groups and to the Salvation Army.

Rosecrance comments

"I'm not familiar with what Banyan is doing or their business practices, and I've never met Tim Ryan," said Rosecrance President and CEO Phil Eaton. But he recalled how the Rockford-based treatment program, which started more than 100 years ago as a mental health provider, began marketing addiction treatment in the 1980s. "We advertised in the Yellow Pages and trade magazines," he told *ADAW*. "We had marketing staff who would talk to clinicians and hospitals that were in our catchment area — traditional, transparent relationship marketing."

Now, however, treatment organizations around the country "overpromise and underdeliver," he said. "There are SEOs and outfits that are middle men brokering referrals," he said, noting that some organizations steal Rosecrance's website and put their own 800 number on it.

Compared to the internet scams, having a real person like Ryan who has a commitment to recovery and tries to get people into treatment may be a step up. Banyan is a real treatment program, with its own

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website and Ryan clearly listed as a staff member.

Rosecrance has just survived a NIMBY (Not in My Back Yard) battle over a licensed 24-hour staffed recovery home (see *ADAW*, Feb. 8, Oct. 26, 2015). And Eaton is concerned about "getting lumped into the sober living effort where some guy has a house and no oversight," he said.

Eaton is also concerned about the offers of Florida programs to fly patients there for free, and if the patient goes, the treatment program will forgive the copay (questionable legally, as DeLoss said). "We're very concerned about the high costs of urine drug screens as well," he said.

The National Association of Addiction Treatment Providers is working aggressively to rid the industry of these abuses in order to protect the integrity of the industry. "My concern is that consumers are getting swept up by these programs," said Eaton, who has served on the NAATP board. "These are often organizations that are not accredited by the Joint Commission or CARF, that are unlicensed, that have skirted around zoning requirements and are often not accepted in the communities where they are."

Uneducated, panic-stricken consumers

"The sad thing is, someone sees a TV show [Ryan was recently on *Steve Harvey*] or a video [Ryan has several], and they make that call," said VanDivier. "It's an uninformed panic-stricken consumer out there, and that's what these guys take advantage of."

John Lehman, president of the Florida Association of Recovery Residences, told *ADAW* that lack of education among patients and family members is the systemic problem. "They go Google, and boom, they make a decision," he said. "As an industry of ethical operators across the country, we should be building an infrastructure that supplants their SEO methods and gets them to a site that educates them on the levels of care, on the appropriate care for the individual, how you go about choosing a program," he said.

"My dad used to say, 'Let's check with the Better Business Bureau,'" recalled Eaton. "Now, I would tell consumers, go to the NAATP website and check the program out. Are they licensed? Are they accredited?"

Meanwhile, back at Banyan, Oakes defended Ryan and the arrangement. "He is primarily an ambassador for recovery," he said. "He's not a treatment broker. He runs the Man in Recovery Foundation, he speaks publicly and privately about trying to save lives from addiction, and if someone needs a treatment program and is willing to come to Banyan, that's an option," said Oakes. "If he can get someone clean in the rooms, that's his primary goal," he said. "If he can get someone to talk to him and put down the needle, he's fine with that. His primary goal is not to serve Banyan."

Banyan is not a member of NAATP. •

SUD treatment coverage inadequate despite ACA requirements

A new report confirms what many treatment providers know: states are ignoring federal requirements that they cover addiction treatment services. The report, "Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans," released June 7 by the National Center on Addiction and Substance Abuse (CASA), shows that the benchmark plans in the Affordable Care Act (ACA) marketplace fall short of covering addiction treatment as an essential health benefit, and that more than two-thirds violate the ACA.

"Our findings reveal that people with addiction may not be receiving effective treatment because insurance plans aren't covering the full range of evidence-based care," said Lindsey Vuolo, associate director of health law and policy at CASA and lead author of the report. "For example, our review did not find a single state that covers all of the approved medications used to treat opioid addiction."

Benchmark plans determine what specific benefits are available to the 12.7 million people who have ACA plans. The ACA also requires that the plans be provided at parity.

But it's up to the states to choose their own benchmark plans, which in turn determine the addiction treatment (and other) services in that state. When the federal Department of Health and Human Services decided more than four years ago to let states define what a minimal health benefit is under the ACA, addiction treatment providers knew this was bad news (see *ADAW*, Jan. 9, 2012; Feb. 13, 2012). That flexibility was strenuously opposed by the Coalition for Whole Health.

Coverage for addiction has been inadequate; this isn't new. But the promise of parity and the ACA isn't being fulfilled, and CASA says a lot of the blame for the current opioid crisis is due to the inability to access adequate treatment with medications for opioid use disorders.

All three opioid use disorder medications

The report noted that treatment with medications is a critical component of the treatment of substance use disorders (SUDs), and particularly opioid use disorders. According to the Essential Health Benefit (EHB) requirement, at least one drug in each category of the United States Pharmacopeia category and class must be required. This requirement is "insufficient for SUD treatment," the report states. Not only is methadone not even included in the guidelines used to determine categories

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and classes, but the drugs in each class used to treat opioid use disorders are not interchangeable. Methadone, buprenorphine and naltrexone are the only three medications approved for the treatment of opioid use disorders, and these three drugs are completely different. Not only does each medication work differently, with different protocols for administration, but they are typically prescribed or dispensed in completely different health care settings.

Patients and their physicians need to be able to choose which medication — and treatment setting — is best for them. "To ensure proper treatment, patients must have access to all of these medications and the settings in which they are administered, so they can take the one that is most effective for them," said the report. "All FDA-approved medications designed to treat and manage addiction should be covered by the EHB-benchmark plans. Benefits should include all clinical services required for patients to access these medications, such as physician visits for medical management of pharmaceutical therapies as well as coverage for treatment at licensed Opioid Treatment Programs when required for access to a medication modality (e.g., methadone to treat addiction involving opioids)."

Insurance barriers

In addition, insurance companies are still using tools to discourage appropriate treatment, such as prior authorization, level of care exclusions, reimbursement only for short-term or acute treatment, and limits based on past treatment response.

The report found that the adequacy of SUD treatment coverage based on EHB benchmark plans was impossible to determine in Maine, Massachusetts, Virginia and Arizona. In all other states, SUD treatment coverage was found to be inadequate.

"We are still a long way from treating addiction like a disease," said Samuel A. Ball, Ph.D., president and CEO of CASA, in a statement accompanying the release of the report. "Insurers are still not providing the same level of benefits for addiction treatment and services as they do for medical or surgical care. The absence of sufficient coverage for medication-assisted treatment for opioid addiction is particularly alarming given the number of people dying or suffering on a daily basis. This kind of health care discrimination would never be tolerated during an epidemic for any other life-threatening disease."

> **'We are still a long way from treating addiction like a disease.'**
>
> Samuel A. Ball, Ph.D.

Other key findings and highlights from the report include:

- Over two-thirds of the plans contain language that violates ACA requirements for addiction benefits.
- Eighteen percent of the plans do not comply with parity requirements.
- None of the plans provide comprehensive coverage for addiction by covering the full array of critical benefits without harmful treatment limitations.
- Eighty-eight percent of the plan documents lack sufficient detail to fully evaluate parity compliance and/or the adequacy of addiction benefits. •

For the full report, go to www.centeronaddiction.org/addiction-research/reports.

CASA report author on problems of using small group plans as benchmarks

Lindsey Vuolo, associate director of health law and policy at The National Center on Addiction and Substance Abuse and author of the report on parity, told *ADAW* that the cost of implementing what the report calls for — parity as required under the Affordable Care Act (ACA) — wasn't a part of the study. "But we do know that providing ineffective treatment is costly for the plans," she said last week. "If they're just paying for detox or just paying for emergency room visits, that's far more expensive than providing real care."

One of the problems with the benchmark approach the Department of Health and Human Services (HHS) developed in setting the minimum benefits for plans is that it included small groups — the plans that were the least generous in the first place. "Because these were all small group plans, there may have been vestiges of poor coverage," she said. And she noted that the plan documents themselves do not do a good job of defining benefits, so plan members don't always know what they're getting — or not getting. "We want to see better coverage," said Vuolo. Instead, the poor coverage that was there before is, in many cases, still there.

HHS first decided to let states make decisions about benefits. Add to this the fact that many states are opposed to implementing any part of the ACA, and it's not at all surprising.

Still, with the attention given recently by the White House to parity problems (see Names in the News on page 8), it's possible that there may be more focus on actual insurance coverage for SUDs — once it can be documented that claims show patients are not getting parity-based care. "We're hoping that this report may spark interest in doing additional research," said Vuolo. "We'd like to be able to look at what people are actually getting, but for that we'd need claims data, which is hard to get."

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Desormeaux from page 1

York (where the Belmont Stakes is held); he will sleep in my room; he will follow me back to Los Angeles," Desormeaux was quoted as saying. "The program will not stop when I finish the [Cirque Lodge] program."

A former member of the women's professional tennis tour who now counsels current and former athletes in her South Florida–based outpatient practice says sober companions/coaches are becoming significantly more prominent but should be subject to greater scrutiny.

"I know one big name who was recently flown to Canada and is being paid $1,500 a day, basically to be a babysitter," Sally Greer, founder of 1 on 1 Addictions Counseling for Athletes, told *ADAW*.

"I'm not a big fan of sober coaches — there's no real certification for it," Greer said. "It's not well guarded or looked over."

Professional considerations

There is little consistency in protocols for jockeys who experience problems with substances because there is no overall governing body for all thoroughbred and quarter-horse racing in the country. Therefore, there are essentially 38 different sets of rules in the government jurisdictions that host horse racing, said Mindy Coleman, in-house counsel for the 1,150-member Jockeys' Guild, based in Lexington, Ky.

Alcohol and drug testing procedures in the states vary considerably. In some states, Coleman told *ADAW*, alcohol testing is conducted on a random basis, while in New York every jockey is breath-tested at the start of every day's racing program.

The extent of drug testing in the states varies even more, and essentially "depends on funding [from the state racing commissions], unfortunately," Coleman said.

In some states, a first positive drug test triggers an automatic 30-day license suspension for the jockey. Because a jockey's income is not guaranteed and depends on the quality of the mounts he/she continues to be assigned, the pressure to return to work quickly can be great, Coleman said.

These pressures, combined with the toll that riding takes on jockeys' bodies over time, have intensified or at least called greater attention to problems with pain medication use in the profession, Coleman indicated. Some physicians are telling jockeys that they can take these medications and continue to ride an 1,100-pound animal, even though they are saying at the same time that they should refrain from driving a car, she said.

'As the organization representing the vast majority of jockeys, we have a strong concern about jockeys who suffer from drug and alcohol addictions, as they are not only a risk to themselves, but also those that they are riding against.'

Mindy Coleman

"As the organization representing the vast majority of jockeys, we have a strong concern about jockeys who suffer from drug and alcohol addictions, as they are not only a risk to themselves, but also those that they are riding against," Coleman said. She cited organizations such as The Healing Place in Louisville, Ky., and The Racetrack Chaplaincy among those that the guild works with to try to determine the best available services for the affected individual.

Dangerous balancing act

Desormeaux, who has battled alcohol problems for years but has been one of the most successful jockeys of his era, has openly talked about not having let his personal struggles affect his track performance. He said in the *Blood-Horse* article, "I probably have one of the best in-the-money percentages of any jockey and I am mandated to take a breathalyzer test every day. The fans who put their money on Kent Desormeaux can rest assured that I'm ready and good to go when I show up for work."

But news reports have stated that Desormeaux failed breath tests administered at racetracks in 2010 and 2012. He also was fined last year for being under the influence of alcohol during a racing program in California.

Greer, who said she was not familiar with the specifics around Desormeaux's situation, nevertheless expressed some concern about comments from the jockey and people in his circle about his past ability to compartmentalize.

"People need to be fully engulfed in their recovery," Greer said. "If you put anything before that, you're going to lose it."

She added that this can prove to be particularly challenging for athletes and for their influencers. The mentality often is one of "Let's give them a pill and put them back in [the competition]," Greer said. "There's a tremendous amount of pressure on any athlete."

Although she has not counseled a jockey in the past, Greer suspects that the pressure to maintain weight in the sport also can increase the susceptibility to substance use issues and process addictions.

Greer credits Desormeaux for being open about what he has gone through in recent weeks; he has said

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that his wife and a close friend encouraged him to seek formal treatment (he had attended Alcoholics Anonymous meetings at times in the past).

"He's not hiding it," Greer said. "Maybe in his mind this makes him accountable; it makes him feel that he's really got to follow through with it."

She emphasizes that she does not see sober coaching/companionship as an effective long-term strategy in general. "But if the plan is to get him back into rehab, that doesn't seem like a bad idea," Greer said.

While Desormeaux has emphasized that the sober companion is not directly linked to the treatment program that admitted him, it is unclear whether Cirque Lodge recommended that follow-up plan for Desormeaux. Even though numerous media outlets last week reported that Cirque Lodge was the site of Desormeaux's treatment stay, Cirque Lodge CEO Gary Fisher did not respond to requests from *ADAW* to discuss issues around treatment of individuals in the public eye — with which the facility has much experience. •

Coming up...

Innovations in Behavioral Healthcare will be held **June 20–21** in **Nashville**. Go to **http://foundationsevents.com/innovations-in-behavioral-healthcare** for more information.

The **Addiction Professional Summit: Addressing Opioid Dependence Treatment, Pain Management, and Recovery** will be held **June 23–24** in **Pittsburgh**. Go to **www.addictionpro.com/ap-summit/addiction-professional-summit-pittsburgh** for more information.

The **National Conference on Addiction Disorders** will be held **August 18–21** in **Denver**. For more information, go to **www.addictionpro.com/ncad-conference/national-conference-addiction-disorders**.

Names in the News

Frank leaving HHS, heading back to Harvard

Richard G. Frank, Ph.D., is going back to Harvard Medical School to teach. Since 2009, Frank has been with the federal Department of Health and Human Services (HHS), since 2013 as Assistant Secretary for Planning and Evaluation (ASPE). He's been leading the regulatory functions around the budget and congressional hearings on addiction, especially within the increasing opioid epidemic. He has been an articulate and erudite resource, for lawmakers and stakeholders, balancing many perspectives but with an immediate grasp of the hard realities of working with Congress and various stakeholder groups. Our favorite quote from him was his one-sentence answer to a congressional panel that was grilling him about medication-assisted treatment and wanted to know the downside of methadone: "It's prone to stigma," he said (see *ADAW*, Oct. 12, 2015). The professor of health economics is returning to academe, where he will contribute to another generation of erudite experts who can help guide policy where it needs to go. He wasn't a hardened bureaucrat, and he gave interviews without minders. We'll miss him. His last day at HHS was June 3; his final words as ASPE were published in a June 7 blog post in which he stressed that much work is still needed on parity for mental health and substance use disorders (www.hhs.gov/blog/2016/06/07/progress-mental-health-and-substance-use-disorder-parity.html). President Obama created a parity task force in March. For more information, go to http://hhs.gov/parity. Kathryn Martin is now the acting ASPE.

Alcoholism & Drug Abuse Weekly welcomes letters to the editor from its readers on any topic in the addiction field. Letters no longer than 350 words should be submitted to:

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Email: adawnewsletter@gmail.com

Letters may be edited for space or style.

In case you haven't heard...

Of course, everyone has heard by now that the singer Prince died from an overdose of fentanyl. But what is not known — and may never be — is whether that was pharmaceutical fentanyl, illicit fentanyl, a fentanyl analog, what kind of fentanyl analog, what other drugs were involved, whether he was addicted, whether he sought treatment, whether he was tolerant to opioids, whether he was in pain or where he obtained the fentanyl — although that last piece will be the subject of criminal investigations, if current tactics are any guide. Whoever provided it to him will be charged with a crime. Sen. Kelly Ayotte (R-N.H.), who has done so much to shepherd the Comprehensive Addiction and Recovery Act through Congress, last week proposed a poorly thought out bill that would require a mandatory minimum sentence of five years for possessing even small amounts of fentanyl. This would most likely hurt users, repeating the mistakes of mandatory minimums for cocaine just as reforms have recognized the unintended consequences of such laws. Treatment was near Prince's home if he wanted it — Hazelden Betty Ford and the Alltyr Clinic, to name two. Treatment could have saved him. Incarcerating whoever provided him the fentanyl would not.