ruary, he said.

Grants are essential to finding new innovations, said Vocci. "We do all this on our own time when it comes to pilot studies. We don't even get our expenses covered. Basically they say, 'If I get this grant, I can keep my lab open, and I won't take a salary.'" The pharmaceutical industry has stayed away from trying to develop medications for addiction "because they think it's not profitable," he said. That's why buprenorphine, which was developed with funding from the federal government — largely NIDA, when Vocci was there — and then resulted in great profits for Reckitt Benckiser as the owner of Suboxone, is a model, said Vocci. "The buprenorphine story is a good one," he said. "If we had something to treat cocaine, to treat alcohol use disorders, to treat methamphetamine — that would be a blockbuster."

However, when the blockbuster medications are found, payers balk at the price tag. And for addiction, they balk at the idea of lifetime maintenance as well. "If you have a chronic disorder, you're going to manage it, not cure it, and in the case of addiction, often therapy lasts for years," said Vocci. Exactly how long someone needs to be on medication is still an open question, he said. "The problem is that the relapse rate is really high," he said. "The people who do the best are those who stay on the medication for a long time." As for insurance companies not believing that addiction is a chronic disease, or believing that long-term medication is necessary, Vocci said simply: "Science is not a belief system — that's something the insurance companies have to understand." •

Rhode Island links naloxone rescues to treatment

People who overdosed on opioids and were rescued with naloxone are being connected to treatment in hospital emergency departments across the state of Rhode Island, thanks to a new program funded by the state's Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (DBHDDH). Recovery coaches are on call 24 hours a day, seven days a week, to help get the person into a treatment program. Rebecca Boss, deputy director of the DBHDDH, said the program stemmed from a meeting she had with emergency department (ED) physicians and others. "I asked, 'What happens in an ED when someone gets brought in with an overdose?' They said, 'We watch them for four hours and send them home,'" she said.

Boss had one immediate thought: "What a wasted opportunity. Four hours? What about an intervention in the ED?"

Recovery coaches

So Boss started a program a little over a year ago, in which recovery coaches go to the hospital to help get the patients into treatment. Based on the most recent data, 83 percent of the overdose patients who are seen by recovery coaches are now connected with treatment and recovery services, compared to fewer than 3 percent who were even referred before the program was implemented.

"The emergency rooms love it; they love having one number to call instead of figuring out which treatment center they should refer to," said Boss.

In the beginning, funding from an existing contract was used. Now, Boss can use some of the Substance Abuse Prevention and Treatment block grant money, because as a Medicaid expansion state, treatment itself is being paid for by Medicaid. The total cost is $600,000 a year, said Boss.

'What a wasted opportunity. Four hours? What about an intervention in the ED?'

Rebecca Boss

The program is called AnchorED, after the Anchor Recovery Community Center, based in Pawtucket, which is supplying the recovery coaches.

All recovery coaches who participated received specialized training and had to embrace medication-assisted treatment, said Boss. "You can't have someone who's abstinence-based," she said, because that doesn't work for patients with opioid use disorders.

Changing the ED culture

The recovery coach program has "changed the culture of the emergency rooms and the medical staff," said Boss. "We have heard from consumers who had multiple experiences in the same emergency department with an overdose situation that the attitude has changed, that they are much more empathetic than they were before." It's not only the recovery coaches who are making the referrals now, said Boss — the ED medical staff are doing it, too. She doesn't think the EDs have any more information about where to refer patients, but that the philosophical shift has made them more likely to do so.

Emergency departments, like many medical providers, have a history of viewing patients with substance use disorders as a nuisance — people who create their own problems — rather than as people

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who can be treated.

The type of treatment a patient gets is based on their choice, said Boss. The recovery coaches "have our resource list," she said.

Need for weekend admissions

Referring to treatment isn't the same as getting it, however. "One of the things this program highlights is that treatment on demand is not available," said Boss. "If they overdose on a Friday night but can't get into a methadone program until Wednesday, we will lose them." So Boss is telling treatment providers they need to "develop their capacity for weekend admissions."

In addition, initiation of buprenorphine treatment in the ED is another option, said Boss, noting that this has been found to be more effective than referrals (see *ADAW*, May 11). Why don't the EDs do this already? "They are reluctant; they are afraid to do what they don't know about," said Boss.

Currently, the 12 opioid treatment programs (OTPs) in the state could have enough capacity to meet demand, said Boss. "We don't have caps on our OTPs, so the capacity is only limited by the size of the program itself, the number of staff," she said.

The program started in May 2014 with only one hospital and now has grown to operate 24 hours a day, seven days a week, with nine of the 11 hospitals in the state on board. Recovery coaches are at the hospital within 20 minutes of being called.

Data based on November 2014 until June 2015 show that 230 patients were seen. Boss estimates that, overall, three times that number have been seen — about 700. With more than four-fifths of them engaging in treatment, this is a huge success story. In fact, the National Institute on Drug Abuse is so interested that it is studying the program, *ADAW* has learned. •

Equine from page 1
search on the benefits of using horses in treatment has focused on settings other than substance use treatment. But that may start to change. The journal *Addiction Science & Clinical Practice* has published a study from a hospital-based substance use treatment program in Norway, which found that substantially more patients who participated in an optional equine-assisted therapy program as part of their treatment overall remained for the full duration of their treatment program, when compared with individuals who chose not to participate in equine therapy.

While authors of that study could not definitively conclude whether it was the equine therapy or another factor that was mainly responsible for the improved engagement, they stated that the results make a strong case for further inquiry into the factors that make addiction patients responsive to equine therapy.

Experiences relate to addiction

At The Oxford Centre, other experiential therapies such as use of a ropes course also are integrated into treatment, but equine therapy is considered the centerpiece of its experiential therapy (especially in its young-adult program but also for its older patients). Because its campus is made up of 110 acres in the area of the Holly Springs National Forest,

'The horse is going to respond to your approach, so you want to be positive and calm, versus harsh and rushed.'

Clint Crawford

The Oxford Centre can offer all of its equine therapy on-site, with specialized therapists who are part of the center's staff.

Crawford says that while it is possible that therapy using other animals (such as dogs) could achieve similar results, he is partial to horses in part because their personality matches that of humans to a great degree. Therefore, the bond that is developed with a horse can be translated to how relationships grow — or crumble — in interactions with humans.

"The horse is going to respond to your approach, so you want to be positive and calm, versus harsh and rushed," Crawford said. "The last thing you want the horse to do is react — you want it to respond."

A patient riding a horse can become familiar with the tools needed to get the horse to respond effectively, and that can translate for the patient to an understanding of the tools he/she needs to stay grounded in recovery, from support meetings to daily meditations. Also, the "herd" dynamics that patients observe in how the horses interact with one another teach lessons about leading and following in life, Crawford said.

"Everything observed in the therapy is a tie-in to something else," he said.

The Oxford Centre campus includes a barn with 10 stalls, an arena, a smaller pen and numerous trails. Equine therapist Terry Timmons told *ADAW* that at a particular time, one group of patients may be

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