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might behave, including their threatening clinicians for prescriptions. These are problems to be mitigated or solved, but not by eluding the needs of the patient we are serving.

I will not discuss naltrexone (Vivitrol) here, another effective, FDA approved medication, preferring to focus on the two agents that can save the most lives in the next year.

Naloxone

Naloxone is first and foremost a life-saver. EMTs, police and (increasingly) friends and families of people using opioids should have ready access to naloxone nasal spray in the event of an opioid overdose. The nasal spray avoids the "needle barrier", fears many have about the use of syringes, even auto-injection syringes. Countless lives have already been saved by naloxone.

Naloxone acts immediately and effectively, reversing respiratory arrest and loss of consciousness. It is like the AED (automatic defibrillator) of the world of opioid addiction.

Most states permit pharmacies to dispense naloxone without a prescription. But it can be pricey for individuals and families without insurance or facing a high co-payment (I paid $40 for a 2-vial package). Having naloxone available at no cost is essential if we are to save more lives in the foreseeable future. No one recovers from opioid addiction if they die from an overdose.

I do not mean to suggest that medications alone are the best approach to treating opioid use disorder. Like any complex and persistent condition, a combination of medication, therapy, motivational approaches, family engagement and mind-body interventions (like exercise, nutrition, yoga, meditation) are more likely to achieve enduring results. That said, buprenorphine and naloxone remain our most immediate and effective interventions to keep people with OUD alive, so they can live long enough to enter recovery.

Opioid use and dependence are of epidemic proportions in this country. But we have beaten back many an epidemic. Think of smallpox, polio and cholera; of how we have reduced morbidity and mortality from driving deaths and tobacco; and how, with a groundswell of public support, we beat back the AIDS epidemic.

Effective solutions to the opioid epidemic exist. Mental health clinicians need to join in this effort. After all, many people using and dependent on opioids are in our mental health centers day after day – even if we imagine they are not.

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Dr. Sederer is the 2019 recipient of the Doctor of the Year award from The National Council on Behavioral Health. He is a Co-Founder of SessionTogether. He recently created and now directs Columbia Psychiatry Media.

His new book, now in paperback, is The Addiction Solution: Treating Our Dependence on Opioids and Other Drugs (Scribner, 2018). Look for his next book in 2020.

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prescribing practices, preventing opioid diversion, using I-Stop, etc., but none of these address the root causes and issues that people with Opioid Use Disorders are confronted by. We can't simply enforce our way out of this epidemic, since pharmaceutical companies and prescribers do not control the supply of available opioids. With easy access to heroin, and the widespread presence of Fentanyl in the illegal drug supply, many people may simply turn to alternative opioids that it's now virtually impossible to use without being at risk for overdose death.

We are all now familiar with the term Medication Assisted Treatment, or MAT, often applied to buprenorphine and other addiction-specific medications. But I would ask: What is the Treatment that the Medication is supposedly Assisting? Often, there is none.

The psychological component in addiction is too often overlooked. Evidence for this lies in the frequency of relapse, even after withdrawal has been achieved and even when MAT is in place. There are frequently underlying psychological conditions that the individual is attempting to medicate with a substance; until that psychological condition is addressed, relapse is a risk. Although no single treatment intervention should be mandatory, effective evidence-based treatment should be offered, including counseling with licensed mental health providers who are substance use experts or licensed substance use disorder programs that include individual, group and family therapies, and include treatment for co-occurring disorders. These are treatments that operate from a person-centered, harm-reducing framework as opposed to treatments that merely operate at the level of the drug itself.

Why not require that health care providers provide referrals to substance use treatment for opioid overdose survivors and patients coming out of emergency department visits, rehabilitation and detoxification facilities? (That's one of our recommendations).

Why not ask prescribers who are checking I-Stop and are concerned about a possible addiction to make a referral to an appropriately trained clinician for an addiction risk assessment? The decision to prescribe or not prescribe is important, but why not take the opportunity to try to address the broader issues presented by a patient who won't get all of the help they need, whatever the prescriber ultimately decides.

We believe that a solution to the opioid epidemic is attainable. We look forward to working with our colleagues in government, healthcare, education, law enforcement and other arenas to create a comprehensive approach that reduces the frequency of opiate overdose and death in New York State and serves as a model that other states can benefit from.

Dr. Juman is a Past-President of NYSPA and a member of the NYSPA Division on Addictions Executive Board.

NYSPA White Paper Recommendations

1: Provide evidence-based training and education about substance misuse for medical and mental health professionals and students.

2: Require prescriber and patient education about the risks of opioid-based pain medications.

3: Require health care providers to provide referrals to substance use treatment for opioid overdose survivors and patients coming out of emergency department visits, rehabilitation and detoxification facilities.

4: Integrate medical, psychological services and social interventions.

5: Offer referrals for non-pharmaceutical, evidence-based interventions for pain management.

6: Address opioid use in individuals in, and transitioning out, of the criminal justice system.

7: Respect the importance of a harm reduction framework for the entire continuum of care.

8: Require health care providers to offer to prescribe buprenorphine, naltrexone and or naloxone to overdose patients and those coming out of rehabilitation and detox facilities.

9: Provide access to Medication Assisted Treatment to all persons struggling with opioid use disorders, regardless of income or insurance

10: Mandate adequate insurance coverage for evidence-based, non-opioid pain management interventions.