Opiate Use and Addiction in Ohio: The Basics
May 2, 2016

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Prescription Opioids in Ohio
Prescription Opioid Doses per Capita
Ohio’s Automated Rx Reporting System - 2014

Legend
- ADAMHS Board
- Doses Per Capita
  - 22.5 - 61.2
  - 61.3 - 84.0
  - 84.1 - 113.0

Map Information:
This map displays per capita prescription opioid consumption. In 2014, the statewide average per capita dosage rate was 61.2 doses for every man, woman and child. Counties with the highest per capita rates were Jackson (113.0), Vinton (102.7) and Perry (96.9). Counties with the lowest per capita dosage rates were Holmes (22.5), Mercer (36.7) and Geauga (38.4). Per capita rates are based on oral solids and transdermal patches. All opioid solutions and most buprenorphine combinations are excluded from the analyses except for Butrans, which is primarily used for pain management and not medication-assisted treatment.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data adapted by OhioMHAS from The Ohio State Board of Pharmacy
Map produced June 2015
Morphine Milligram Equivalents per Script
Ohio's Automated Rx Reporting System - 2014

Legend
- ADAMHS Board
- MME per Script (mg)
  - 34.0 - 47.2
  - 47.3 - 54.2
  - 54.3 - 54.5

Map Information:
This map examines morphine milligram equivalents (MMEs) per script in 2014. Most prescription analgesics in the OARRS system (>97%) have a morphine equivalence as established by the Centers for Disease Control. On average, each prescription contained the 43.4 MME during this time. Counties with the highest MMEs per script were Trumbull (54.3 mg), Ashtabula (49.9 mg) and Mahoning (47.6 mg). Counties with the lowest MMEs per script were Shelby (34.0 mg) and Allen, Harrison, and Auglaize (all with 35.8 mg).

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data adapted by OhioMHAS from
The Ohio State Board of Pharmacy
Map produced June 2015
Prescription Opioids per Capita and Milligram Morphine Equivalents (MME) per Script, Ohio, 2010 - 2014

†Calculations are only based on oral solids and transdermal patches. All opioid solutions and most buprenorphine combinations are excluded from the analyses except for Butrans, which is primarily used for pain management. Rates are likely underestimated because data from drugs dispensed at physician offices and the Veteran’s administration are not included in the calculations.
Unintentional Drug Overdose Deaths
State Rank in the Age-adjusted Rate of Unintentional Drug Overdose Deaths, Ohio, 2000 - 2014

Source: CDC WONDER, codes X40-X44
†Results are unreliable for 2003
Epidemics of unintentional drug overdoses in Ohio, 1979 - 2014\textsuperscript{1,2,3}

Number of Unintentional Drug Overdoses Involving Selected Drugs by Year, Ohio, 2000 - 2014

Source: ODH Vital Statistics
Percentage of all Unintentional Drug Overdose Deaths Involving Selected Drug by Year, Ohio, 2010 - 2014

Source: ODH Vital Statistics: ***No specific drug was identified
Average Unintentional Drug Overdose Death Rate by Age Group, Ohio, 2002-2014

Source: ODH Vital Statistics
Fentanyl-related Overdoses, Ohio, 2012 - 2014

Source: ODH Vital Statistics: 12014 drug overdose data is based on information listed on death certificates, including for Ohioans who died in other states.
Treatment Admissions
Percentage of AOD Clients with an Opiate Diagnosis, Ohio, SFY 2001 - SFY 2014

Source: Multi-agency Community Services Information System (Claims)
Unduplicated Admissions for Opiate Abuse and Dependence
Ohio MACSIS Data - State Fiscal Year (SFY) 2001

Legend
- ADAMHS Board
- Opiate Addicts (%)
  - 0.0% - 3.0%
  - 3.1% - 6.7%
  - 6.8% - 14.3%

Map Information:
This map represents the percentage of clients in treatment with an opiate-related diagnosis (heroin and prescription opioid). On average, 6.6 percent of client admissions statewide were associated with a primary diagnosis of opiate abuse or dependence in SFY 2001. The highest concentrations of opiate admissions were in Cuyahoga (14.3%), Montgomery (12.5%) and Mahoning (12.2%) counties. Noble, Paulding, Putnam and Wyandot counties did not have residents with any opiate-related admissions in the public behavioral health system.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data from Multi Agency Community Information Systems (MACSIS)
Map produced March 2014
Unduplicated Admissions for Opiate Abuse and Dependence
Ohio MACSIS Data - State Fiscal Year (SFY) 2003

Legend
- ADAMHS Board
- Opiate Addicts (%)
  - 0.0% - 3.0%
  - 3.1% - 6.7%
  - 6.8% - 16.3%

Map Information:
This map represents the percentage of clients in treatment with an opiate-related diagnosis (heroin and prescription opioid). On average, 8.6 percent of client admissions statewide were associated with a primary diagnosis of opiate abuse or dependence in SFY 2003. The highest concentrations of opiate admissions were in Cuyahoga (16.3%), Mahoning (15.8%) and Montgomery (14.9%) counties. Paulding, Putnam and Wyandot counties did not have residents with any opiate-related admissions in the public behavioral health system.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data from Multi Agency Community Information Systems (MACSIS)
Map produced March 2014
Unduplicated Admissions for Opiate Abuse and Dependence
Ohio MACSIS Data - State Fiscal Year (SFY) 2005

Legend

- ADAMHS Board

Opiate Addicts (%)
- 1.0% - 3.0%
- 3.1% - 6.7%
- 6.8% - 34.4%

Map Information:
This map represents the percentage of clients in treatment with an opiate-related diagnosis (heroin and prescription opioid). On average, 10.6 percent of client admissions statewide were associated with a primary diagnosis of opiate abuse or dependence in SFY 2005. The highest concentrations of opiate admissions were in Scioto (34.4%), Clark (21.1%) and Jackson (20.9%) counties. The counties with the lowest concentrations of opiate-related admissions were Holmes (1.0%), Morgan (1.0%) and Henry (1.1%).

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data from Multi Agency Community Information Systems (MACSIS)
Map produced March 2014
Unduplicated Admissions for Opiate Abuse and Dependence
Ohio MACSIS Data - State Fiscal Year (SFY) 2007

Legend
- ADAMHS Board
- Opiate Addicts (%)
  - 0.0% - 3.0%
  - 3.1% - 6.7%
  - 6.8% - 31.4%

Map Information:
This map represents the percentage of clients in treatment with an opiate-related diagnosis (heroin and prescription opioid). On average, 11.2 percent of client admissions statewide were associated with a primary diagnosis of opiate abuse or dependence in SFY 2007. The highest concentrations of opiate admissions were in Jackson (31.4%), Scioto (30.8%) and Lawrence (22.7%) counties. The counties with the lowest concentrations of opiate-related admissions were Putnam (0.0%), Coshocton (1.9%) and Holmes (2.0%).

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data from Multi Agency Community Information Systems (MACSIS)
Map produced March 2014
Unduplicated Admissions for Opiate Abuse and Dependence
Ohio MACSIS Data - State Fiscal Year (SFY) 2009

Legend
- ADAMHS Board

Opiate Addicts (%)
- 2.3% - 3.0%
- 3.1% - 6.7%
- 6.8% - 64.1%

Map Information:
This map represents the percentage of clients in treatment with an opiate-related diagnosis (heroin and prescription opioid). On average, 15.4 percent of client admissions statewide were associated with a primary diagnosis of opiate abuse or dependence in SFY 2009. The highest concentrations of opiate admissions were in Scioto (64.1%), Lawrence (49.5%) and Jackson (35.7%) counties. The counties with the lowest concentrations of opiate-related admissions were Allen (2.3%), Coshocton (2.4%) and Carroll (3.5%).

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data from Multi Agency Community Information Systems (MACSIS)
Map produced March 2014
Unduplicated Admissions for Opiate Abuse and Dependence
Ohio MACSIS Data - State Fiscal Year (SFY) 2011

Legend
- ADAMHS Board
- Opiate Addicts (%)
  - 3.1% - 6.7%
  - 6.8% - 70.2%

Map Information:
This map represents the percentage of clients in treatment with an opiate-related diagnosis (heroin and prescription opioid). On average, 21.3 percent of client admissions statewide were associated with a primary diagnosis of opiate abuse or dependence in SFY 2011. The highest concentrations of opiate admissions were in Scioto (70.2%), Lawrence (56.2%) and Athens (41.9%) counties. The counties with the lowest concentrations of opiate-related admissions were Morgan (3.1%), Holmes (4.4%) and Tuscarawas (5.5%).

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data from Multi Agency Community Information Systems (MACSIS)
Map produced March 2014
Unduplicated Admissions for Opiate Abuse and Dependence
Ohio MACSIS Data - State Fiscal Year (SFY) 2013

Legend
- ADAMHS Board
- Opiate Addicts (%)
  - 10.3% - 75.3%
  - < 25 cases

Map Information:
This map represents the percentage of clients in treatment with an opiate-related diagnosis (heroin and prescription opioid). On average, 30.4 percent of client admissions statewide were associated with a primary diagnosis of opiate abuse or dependence in SFY 2013. The highest concentrations of opiate admissions were in Scioto (75.3%), Lawrence (73.8%) and Gallia (61.8%) counties. The counties with the lowest concentrations of opiate-related admissions were Tuscarawas (10.3%), Coshocton (12.0%) and Darke (13.0%). Percentages are not displayed for counties with fewer than 25 admissions.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data from Multi Agency Community Information Systems (MACSIS)
Map produced January 2015
Unduplicated Admissions for Opiate Abuse and Dependence
Ohio MACSIS Data - State Fiscal Year (SFY) 2014

Legend
- ADAMHS Board
- Opiate Addicts (%)
  - 13.1% - 71.6%
  - < 25 cases

Map Information:
This map represents the percentage of clients in treatment with an opiate-related diagnosis (heroin and prescription opioid). On average, 37.0 percent of clients admitted statewide were associated with a primary diagnosis of opiate abuse or dependence in SFY 2014. The highest concentrations of opiate admissions were in Marion (71.6%), Scioto (68.8%) and Vinton (68.5%) counties. The counties with the lowest concentrations of opiate-related admissions were Tuscarawas (13.1%), Coshocton (14.7%) and Henry (15.8%). Percentages are not displayed for counties with fewer than 25 admissions.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data from Multi Agency Community Information Systems (MACSIS)
Map produced November 2015
Hospital Admissions
Number of Admissions for Opiate Abuse, Dependence or Poisoning to Emergency Rooms, Ohio, 2004 - 2013

Source: Ohio Hospital Association
Thanks to:

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What is addiction?
What can we do about it?

Mark Hurst, M.D., Medical Director
Ohio Department of Mental Health and Addiction Services
Alcohol kills 3.3 million worldwide annually.
350,000 die due to illicit drugs (WHO, 2015).
Alcohol and other drug-related conditions number 1 public health concern in US and unintentional overdoses are now the leading cause of accidental death (CASA, 2011; Warner et al., 2011)
Addiction (Substance Use Disorder) Is a Major Contributor to Death and Disability

• 23 million individuals with substance use disorder in the US
• Cost of SUD in US is estimated at $600 Billion annually due to:
  • lost productivity
  • health care expenditures
  • criminal justice involvement
• Despite high prevalence and about 14,000 treatment facilities and 100,000 self-help groups meeting weekly in US, only 10% receive some form of help
• A main barrier to seeking and receiving help is stigma (but not the only one)
Definition of Addiction

- Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

(American Society of Addiction Medicine, 2010)
What is a disease?

All diseases should have:

1. Characteristic symptoms (things that a person complains of)
2. Characteristic signs (things that can be seen)
3. Predictable course
4. Outcomes should be able to be defined
5. Defined etiology (what causes it)
6. Treatments
Characterized by:

- Compulsive Behavior/craving
- Continued abuse of drugs despite negative consequences
- Persistent changes in the brain’s structure and function
Diagnostic Criteria for Substance Use Disorders (1)

- Taking the substance in larger amounts or for longer than the you meant to
- Wanting to cut down or stop using the substance but not managing to
- Spending a lot of time getting, using, or recovering from use of the substance
- Cravings and urges to use the substance
- Not managing to do what you should at work, home or school, because of substance use
- Continuing to use, even when it causes problems in relationships
- Giving up important social, occupational or recreational activities because of substance use
Diagnostic Criteria for Substance Use Disorders (2)

- Using substances again and again, even when it puts the you in danger
- Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance
- Needing more of the substance to get the effect you want (tolerance)
- Development of withdrawal symptoms, which can be relieved by taking more of the substance.

2-3 “mild” SUD, 4-5 “moderate SUD, > 6 “Severe” SUD
But there are substantial moral overtones relating to Substance Use Disorders…….
Diagnostic Criteria for Substance Use Disorders (1)

- Taking the substance in larger amounts or for longer than you meant to **WEAK-WILLED, BAD JUDGEMENT**
- Wanting to cut down or stop using the substance but not managing to **WEAK WILLED**
- Spending a lot of time getting, using, or recovering from use of the substance **IRRESPONSIBLE**
- Cravings and urges to use the substance
- Not managing to do what you should at work, home or school, because of substance use **IRRESPONSIBLE**
- Continuing to use, even when it causes problems in relationships **UNFEELING**

*with moral judgments added*
Diagnostic Criteria for Substance Use Disorders (2)

- Giving up important social, occupational or recreational activities because of substance use **IRRESPONSIBLE**
- Using substances again and again, even when it puts the **RECKLESS, IRRESPONSIBLE**
- Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance **IRRESPONSIBLE**
- Needing more of the substance to get the effect you want (tolerance)
- Development of withdrawal symptoms, which can be relieved by taking more of the substance.
How and why to diminish stigma
What Factors Influence Stigma?
Cause, Controllability and Safety

• Cause: “It IS their fault”
• Controllability: They CAN help it”
• Safety: “They ARE dangerous”

Result:
Punishment over treatment

• Cause: “It’s NOT their fault”
• Controllability: “They CAN’T help it”
• Safety: “They AREN’T dangerous”

Result: Treatment over punishment
Addictive drugs: fundamentals

- All addictive drugs work on our natural neurotransmitter systems and mimic their activities in some manner.
- All addictive drugs have effects on our biological reward centers, which gives them their reinforcing effects.
- These reward centers are the same areas that are activated when we perform activities that are required for our survival or survival of species.
- Drugs of abuse “trick” some of us in to believing their use is necessary for survival (and nothing is farther from the truth).
Addiction is a brain disease

Characterized by:
• Compulsive Behavior/craving
• Continued abuse of drugs despite negative consequences
• Persistent changes in the brain’s structure and function
DRUGS OF ABUSE TARGET THE BRAIN’S PLEASURE CENTER

Brain reward (dopamine) pathways

These brain circuits are important for natural rewards such as food, music, and sex.

Drugs of abuse increase dopamine

Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.
SUDS are brain diseases...and more
Addiction is similar to other chronic illnesses because...

• It has biological and behavioral components, both of which must be addressed during treatment
• Recovery from it--protracted abstinence and restored functioning--is often a long-term process requiring repeated episodes of treatment
• Relapses can occur during or after treatment, and signal a need for treatment adjustment or reinstatement
• Participation in support programs during and following treatment can be helpful in sustaining long-term recovery

Recovery can occur with appropriate treatment and supports
Treatment for drug addiction is as effective as treatment for other chronic illnesses

McLellan et al., JAMA, 2000.
Project Match

Treatment Type

<table>
<thead>
<tr>
<th>MET</th>
<th>CBT</th>
<th>12-Step</th>
</tr>
</thead>
</table>

Post Treatment Evaluations

<table>
<thead>
<tr>
<th>Time</th>
<th>MET 45%</th>
<th>CBT 38%</th>
<th>12-Step 27%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td></td>
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<tr>
<td>12</td>
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<tr>
<td>39</td>
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</tbody>
</table>
ALLHAT
Pre-Specified Criteria – Adjustment Oriented

Start
27% Control

DURING Treatment Evaluations

Diuretic
CCB
ACE

42%
55%
64%
Project Match

Treatment Type | Post Treatment Evaluations
--- | ---
MET | 45% | 38% | 27%
CBT | | | |
12-Step | | | |
Treating a bio-behavioral disorder like addiction must treat the whole patient.

We Need to Treat the Whole Person!

Pharmacological Treatments (Medications)

Behavioral Therapies

Medical Services

Social Services

In Social Context
Treatment of Opioid Addicted Patients

- Assessment
- Detoxification
- Counseling
- Support Groups
- Medication
Why Medication Assisted Therapy?

- The risk of relapse among individuals with Opioid addiction is exceedingly high (up to 90%) over the course of a year without MAT
- Cravings and preoccupation decreases capacity to learn coping skills and change lifestyle
- Medication Assisted Therapy (MAT) can appreciably decrease risk of relapse and associated morbidity and mortality
- MAT alone is not adequate treatment
# MATs improve abstinence rates

<table>
<thead>
<tr>
<th>Medication</th>
<th>With MAT (% Opioid Free)</th>
<th>Without MAT (% Opioid Free)</th>
<th>NNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naltrexone ER</td>
<td>36 %</td>
<td>23 %</td>
<td>7.7</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>20-50 %</td>
<td>6%</td>
<td>7.1-2.3</td>
</tr>
<tr>
<td>Methadone</td>
<td>60 %</td>
<td>30 %</td>
<td>3.3</td>
</tr>
</tbody>
</table>

**NOTES:**
- COMPARATIVE CONCLUSIONS CANNOT BE DRAWN FROM THIS
- ALL MAT WAS PROVIDED ALONG WITH RELAPSE PREVENTION COUNSELING

## MAT Comparisons: Prescribing Considerations

<table>
<thead>
<tr>
<th></th>
<th>Extended-Release Injectable Naltrexone</th>
<th>Buprenorphine</th>
<th>Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of Administration</strong></td>
<td>Monthly</td>
<td>Daily</td>
<td>Daily</td>
</tr>
<tr>
<td><strong>Route of Administration</strong></td>
<td>Intramuscular injection in the gluteal muscle by healthcare professional.</td>
<td>Oral tablet or film is dissolved under the tongue. Can be taken at a physician's office or at home.</td>
<td>Oral (liquid) consumption usually witnessed at an OTP, until the patient receives take-home doses.</td>
</tr>
<tr>
<td><strong>Restrictions on Prescribing or Dispensing</strong></td>
<td>Any individual who is licensed to prescribe medicine (e.g., physician, physician assistant, nurse practitioner) may prescribe and order; administration by qualified staff.</td>
<td>Only licensed physicians who are DEA registered and either work at an OTP or have obtained a waiver to prescribe buprenorphine may do so.</td>
<td>Only licensed physicians who are DEA registered and who work at an OTP can order methadone for dispensing at the OTP.</td>
</tr>
<tr>
<td><strong>Abuse and Diversion Potential</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Additional Requirements</strong></td>
<td>None; any pharmacy can fill the prescription.</td>
<td>Physicians must complete limited special training to qualify for the DEA prescribing waiver. Any pharmacy can fill the prescription.</td>
<td>For opioid dependence treatment purposes, methadone can only be purchased by and dispensed at certified OTPs or hospitals</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Improved social functioning; may reduce criminal activity more than other drugs; very high dropout rate</td>
<td>Improved social functioning; good drug for client retention at adequate doses; suppresses illicit opiate use at adequate doses</td>
<td>Improved social functioning; best drug for client retention; suppresses illicit opiate use</td>
</tr>
</tbody>
</table>

Source: Center for Substance Abuse Treatment
Naloxone

- Opioid antagonist that blocks effects of opioid analgesics and reverses the effects of overdose
- No abuse potential
- Can be administered in both healthcare settings and in community
- Project DAWN (Deaths avoided with naloxone)
- **Outcomes:** Demonstrated to decrease mortality, not cause dose escalation and increase eventual entry into treatment
Heroin Related Deaths in San Francisco Decreased with Broad Availability of Naloxone
In Treating Addiction... We Need to Keep Our Eye on the Real Targets!

Abstinence

Functionality in Family, Work and Community
Extended Abstinence is Predictive of Sustained Recovery

It takes a year of abstinence before less than half relapse.

After 5 years – if you are sober, you probably will stay that way.

Dennis et al, Eval Rev, 2007
Aspects of dealing with an epidemic

• Prevention
  – Start Talking
  – Prescribing guidelines

• Early intervention
  – SBIRT

• Treatment
  – Psychosocial and MAT

• Life-saving measures
  – Naloxone
Summary

• Opioid addiction is rampant in Ohio
• Addiction is a chronic, biobehavioral disease
• *Chronic diseases* require *chronic biobehavioral treatment*
• Appropriate identification and treatment success requires addressing the biological, *and* social aspects of the disease in a comprehensive manner and generally require both non-medication and medication treatments
Treatment Resources

• Local treatment resources:
  – https://prod.ada.ohio.gov/directory/
  – Listing by county of licensed/certified treatment resources, with specific services provided
  – Specific insurance plan information through their websites