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News for policy and program decision-makers

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Physicians are playing a bigger role in treatment than ever before, judging by the influence of the American Society of Addiction Medicine (ASAM), which met last week and wants to have all players in the field working together. How the more traditional providers will work with the ASAM physicians will have a bearing on the face of addiction treatment in coming years. . . . *See bottom story of this page*

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Best treatments for young people with heroin addiction: No rule book

With anecdotal reports across the country soaring about young people switching from prescription opioid addiction to heroin, *ADAW* looked into what special treatments are recommended for heroin addiction for people under 25. Experts say that there is no cookie-cutter approach: The treatment must be geared to the individual, just as it is for someone of any age addicted to heroin.

Of the four medications approved for treating opioid addiction — methadone, buprenorphine, naltrexone (oral) and Vivitrol (injectable) — which is best suited for young people?

"The choice of treatment has to be individualized to their risk factors and the overall conditions as they enter treatment," said Melinda Campopiano, M.D., medical director for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. But she stressed that medications can't be the only form of treatment. "The behavioral therapy also

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Bottom Line...
While there is no protocol dictating what medications are best for young people addicted to heroin, sources told ADAW *they would first try naltrexone, then buprenorphine, and only as a "last resource," methadone. For people under 18, there are no FDA-approved medications for opioid dependence.*

The Business of Treatment

Physicians' presence in centers reflects business transformation

The physician members of the American Society of Addiction Medicine (ASAM) gathered in Chicago last week for the association's 44th annual Medical-Scientific Conference at a time of unprecedented influence for physicians in freestanding addiction treatment facilities. While physicians' obvious presence in many specialty treatment centers by no means occurred overnight, what has surfaced more recently is the public acknowledgement among these centers that a prominent role for M.D.s in their organizations positions them best for the future of service delivery.

"When our physicians do grand rounds with other physicians, and our nurse interfaces with other nurses in the field, the medical community begins to see us not so much as a social service agency, but as a

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Bottom Line...
American Society of Addiction Medicine (ASAM) member physicians are exerting significant influence in many freestanding treatment centers, while the society as a whole reaches out in search of common ground with other addiction-focused organizations.

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needs to be tailored to the individual," she told *ADAW*.

Whether the person was using prescription opioids or heroin is not the most important factor in choosing the type of treatment, said Campopiano. "You have to look at how much medical harm they've experienced, at the route of administration, and the length of time of the addiction," she said. "There is no formal guidance" on the best treatment protocol for heroin addiction, regardless of age, she said. "A treatment decision needs to be based on what information is available."

"It's a gray area — there's not much out there in terms of research" on treating young people with heroin addiction, said Philip Herschman, Ph.D., chief clinical officer for CRC Health Group. Nevertheless, Herschman said the same thing that Campopiano did — the characteristics of the user are more important than the age alone. "It's not a matter of whether they're using heroin or a prescription opiate — to me, they're using opiates," Herschman told *ADAW*.

Methadone for long-term addiction

That said, however, younger patients are more likely by definition to have had a shorter period of addiction. "Generally, the younger the person, and the shorter the addiction, I might try one kind of treatment," he said. "The older the patient and the greater the amount of drug use, I might try a different kind." CRC has opioid treatment programs that provide methadone and buprenorphine treatment, uses buprenorphine and Vivitrol in inpatient and outpatient programs, and provides drug-free treatment, so is not vested in only one type of treatment.

> **'Generally, the younger the person, and the shorter the addiction, I might try one kind of treatment.'**
>
> Philip Herschman, Ph.D.

Another issue for Herschman is whether the maintenance medication will be given on an open-ended basis, or for only one year. "If you're younger and have been addicted for a shorter period of time, and you're more likely not to need a maintenance drug for the rest of your life, and I'm more likely to start you on a buprenorphine product instead of methadone," said Herschman. "I can't point you to any paper, but we've seen that the younger addict using for a shorter period of time has a much better chance of getting into that drug-free lifestyle at some point down the road." For example, a 22 year old who is using Vicodin may need "a couple of years of treatment — one year is the minimum — and then may not need the buprenorphine anymore."

Even if the young person were using heroin, methadone would not be his first choice, he said. "If it turns out that they fail on the buprenorphine — either they're not taking it, or they are taking it and it's not working, then my suggestion would be to try methadone," he said.

There are no FDA-approved medications for heroin addiction in people younger than 18 years of age, said Ivan Montoya, M.D., deputy director of the division of pharmacotherapies and medical consequences of drug abuse at the National Institute on Drug Abuse (NIDA). "So, for them, the only option is counseling," he told *ADAW*. "For ages 18 to 25, there are no evidence-based recommendations," he said. "However, as a clinician, if I have a patient in that age group, I

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would start with depot naltrexone [Vivitrol], and if he or she does not respond, I would try buprenorphine," he said. "I'd leave methadone as the last resource."

However, Montoya said that maintenance with buprenorphine or methadone can help patients, including young patients — even those who plan to go off them eventually. "There is no indication that maintenance is not appropriate for young heroin addicts," he told *ADAW*. "In fact, quite the contrary. Research indicates that in some cases maintenance is beneficial, at least to help the patient to get ready for detoxification."

Herschman speculated that the physiological changes to the brain caused by opioid abuse are less likely to be permanent for people who have abused the drugs for three to four years, compared to someone who has been addicted for decades.

"I don't think we know what the neurochemistry is, whether it's reversible or not reversible," said Campopiano. "But it is true that when you have been misusing a substance — of whatever type — for longer, it is more of a struggle to overcome your use."

Short-acting opioids

Heroin is notable in that it is short-acting, compared to buprenorphine, methadone and — when properly used and not crushed and snorted — OxyContin. But most prescription opioids are short-acting as well, which is what makes them so highly reinforcing and addictive, said Campopiano. "The short acting supplies a more intense, rapid-onset experience," she said. "The long acting is slow to work, and doesn't provide the same euphoria."

Herschman agreed, noting that anyone who is addicted to opioids — prescription or heroin — is using multiple times a day.

Herschman stressed that the value of the maintenance medications — buprenorphine and methadone — is not that they cure the disease. "The medication stabilizes the patient so that the rest of the treatment can be provided."

Finally, there is Vivitrol — which unlike buprenorphine and methadone is not an opioid, but rather prevents opioids from having any effect. "I love Vivitrol," said Herschman. "We're using it a lot now in our residential setting, and working on some papers with Penn State. What we see in our residential facility is that people get their first injection while they're in treatment, and the number who complete treatment is up by 50 percent, with the number of AMA discharges down by 60 percent." Patients don't, however, start on Vivitrol. Rather, they start on buprenorphine, then taper off it and start on Vivitrol. "When you get to the taper point, that's the perfect patient for Vivitrol," he said.

Herschman said CRC is seeing an uptick in heroin use, but not only in the young adult populations. "There's greater pressure from the Feds on pill mills, and also, it's gotten to the point where heroin on the street is cheaper than OxyContin on the street. Heroin really is dangerous." •

Parents' 'lax attitudes' blamed for rise in ADHD meds abuse

Citing "lax attitudes and beliefs of parents," the Partnership at Drugfree.org and MetLife Foundation last week released a report showing that misuse or abuse of prescription drugs by teens has gone up 33 percent in the past five years. The report, the *Partnership Attitude Tracking Study (PATS)*, found that one in four teens has used a prescription drug when it was not prescribed for them at least once in their lifetime.

The report focused on abuse of ADHD medications like Ritalin and Adderall — nearly one-third of parents think these drugs can improve academic performance even if the child does not have ADHD. And, in fact, 13 percent of teens have used ADHD medications without a prescription at least once in their lives.

While abuse of prescription opioids is leveling off, according to the report, abuse of stimulants — those medications used to treat ADHD — is rising. In 2008, 4 percent of teens had used Ritalin or Adderall without a prescription within the past month, which increased to 6 percent in the current survey. Nine percent of teens have misused or abused Ritalin or Adderall in the past year. One in four teens thinks these drugs can be used as a "study aid," according to the report.

"We need to make sure that children and adolescents receive a thorough assessment before being placed on stimulant medications, and that if medication is prescribed to a child, it should only be as one component of a comprehensive ADHD management plan," said Alain Joffe, M.D., director of the Student Health and Wellness Center at Johns Hopkins University and former chairman of the American Academy of Pediatrics Committee on Substance Abuse. "We don't really know what long-term effects these ADHD medications will have on the still-developing brains of adolescents who do not have ADHD. We do know they can have significant side effects, which is why they are limited to use with a prescription."

Parents don't care

Twenty-three percent of teens say their parents don't care if they use prescription drugs without a prescription, although their parents would care if they used illicit drugs.

The increases seem to be leveling off: in 2011, 24 percent of teens reported misusing or abusing prescription drugs at least once (it was 25 percent in this year's survey),

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compared to 18 percent in 2008.

Twenty-seven percent of the teens think that misusing and abusing prescription drugs is not as dangerous as using illicit "street" drugs. And 33 percent of teens think it's okay to use prescription drugs that weren't prescribed for them to treat their own injury or pain.

"These data make it very clear: the problem is real, the threat immediate, and the situation is not poised to get better," said Steve Pasierb, president and CEO of the Partnership at Drugfree.org. "Parents fear drugs like cocaine or heroin and want to protect their kids. But the truth is that when misused and abused, medicines — especially stimulants and opioids — can be every bit as dangerous and harmful as those illicit street drugs."

But even though most parents talk to their children about marijuana, use of that drug still remains high. What's going wrong? The answer is that if parents didn't talk to their teens about marijuana, even more would use the drug, said Bonni Hopkins, Ph.D., director of research and evaluation at the Partnership. "The data tells us that kids who learn about the risks of substance abuse from their parents are significantly more likely to not abuse drugs (including prescriptions), compared to those who do not learn the risks of substance abuse from their parents. So what we stress is that parents should talk more often to their kids about the dangers of prescription drug abuse, since there is a relationship between these behaviors."

Opioids leveling off

Teen abuse of opioids like Vicodin and OxyContin has leveled off since 2011, with 16 percent of teens abusing or misusing these medications at least once in their lifetime, and 10 percent abusing or misusing a prescription "painkiller" at least once in the past year.

The report cited access to these medications in the home as well as "parent permissiveness."

Only 16 percent of teens said that their parents discussed prescription pain relievers during the most recent substance abuse discussion. However, 81 percent had discussed the risks of marijuana use, 80 percent have discussed alcohol and 30 percent have discussed cocaine.

About half of the parents said their medicine cabinet is accessible to anyone in the home. Forty-two percent of the teens who misused or abused a prescription drug obtained it from the home medicine cabinet, and 49 percent obtained it from a friend.

'We don't really know what long-term effects these ADHD medications will have on the still-developing brains of adolescents who do not have ADHD.'

Alain Joffe, M.D.

It's important to note that 20 percent of the parents have given their teen a prescription drug that was not prescribed for the teen.

The medications that parents give to their children — without a prescription for the child — are not necessarily abusable, it turns out. They could even be antibiotics. "We cannot definitively say if parents give painkillers, stimulants, antidepressants, or other types of prescriptions to their children," Hopkins told *ADAW*. The survey used the word "misuse" to apply to someone using a prescription drug without a prescription for some reason other than to "get high," she said. In other words, the parents might be giving the medication to treat an injury or illness. The specific question on the survey is: "Please indicate the extent to which you agree or disagree with each statement: I have never given my child/teen a prescription medicine that was not prescribed for him or her."

"This new data is not about blaming parents," said Pasierb. "It's about missed opportunities to protect their kids by having direct conversations with them about the health risks of misusing and abusing medicines — and to then moving to safeguard the medicines in their own home."

"Parents need to be very clear in the messages they send their kids about the misuse and abuse of prescription medications," said Dennis White, president and CEO of the MetLife Foundation. "It is important for parents and caregivers to set a good example in their own families. This includes using their own medicines properly, safeguarding medications in their own homes and properly disposing of unused medicines so teens won't have easy access to them." •

Editor's note: The survey also noted that one in four teens has used marijuana within the past month. The increase in marijuana use in teenagers is troubling, as the National Institute on Drug Abuse (NIDA) Monitoring the Future survey revealed last year (see *ADAW*, December 24, 2012).

The *PATS* tracked 3,884 teens in grades 9–12 and 817 parents. It is nationally projectable, with a ±2.1 percent margin of error for the teen sample and ±3.4 percent for the parent sample. GfK Roper Public Affairs & Corporate Communications conducted the survey; the teen survey was administered in private, public and parochial schools, while the parent survey was conducted through in-home interviews by deKadt Marketing and Research, Inc.

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FROM THE FIELD

Information technology, healthcare reform and recovery aids

By John de Miranda

Presentations at the Thirteenth Annual Behavioral Health Information Management Conference (April 3–4) in San Diego had some intriguing insights into how information technology can improve addiction and mental health treatment and recovery. The conference design included scholarships to enable consumers' attendance to provide a client-centered "voice" as well as enable those individuals to return to their recovery community organizations with information to assist those agencies in preparation for future opportunities. The event was hosted by the California Institute for Mental Health.

Tom Trabin, Ph.D., from Behavioral Health Informatics was the conference chair. His greeting called for increasing attention to information management issues, particularly in light of the looming full implementation of the Affordable Care Act. Two continuing themes throughout the event were (1) how to serve people through technology and (2) how to create technological solutions that improve treatment and recovery outcomes.

Dale Jarvis, a health policy consultant with a focus on underserved mental health and substance use disorder clients, gave an overview of the importance of Accountable Care Organizations (ACOs) in the healthcare reform landscape. Jarvis encouraged all addiction and mental health providers to seek out collaborations with ACOs, which are heavily oriented to primary care institutions.

David Gustafson, Ph.D., director of the Center for Health Enhancement Support Systems at the University of Wisconsin, reported on research about the use of smartphones to support an individual's recovery from addiction. The A-CHESS system provides a variety of information aids, including: monitoring and alerts, medication reminders, a panic button, autonomous motivation, locations tracking, contact with professionals, and assistance with care coordination and even relaxation.

Field tests of the A-CHESS system demonstrate dramatic reductions in heavy drinking days, increases in 12-Step attendance and reduced treatment readmissions. Smartphone reminders and pre-programmed actions such as automatically contacting a sponsor when the GPS (global positioning system) function places the individual in a high-risk location (bar, illicit drug marketplace) essentially act as a person's conscience. One conference participant referred to A-CHESS as "superego in a phone." A-CHESS will be commercially released later this year.

42 CFR Part 2

Continuing controversy surrounds how to accommodate the tough confidentiality restrictions embedded in 42 CFR Part 2 for clients receiving addiction treatment services. Linda Garrett, a partner in Risk Management Services, a firm that provides consultation services to 45 of California's counties, described these restrictions as a "vault" in which information is stored about a person's treatment. The vault can only be opened by affirmative actions of the individual, or because of imminent threats to health and safety, she said.

With the increasingly widespread use of electronic health records (EHRs) and the importance of participating in ACOs and health information exchanges (HIEs), the addiction treatment and recovery field is wrestling with a vexing dilemma. Should we give up keeping treatment records in the vault and continue to be seen as marginal players by primary care organizations or should the vault be opened so that addiction providers can get into the game and be seen as true partners?

At issue, of course, is the fact that widespread discrimination continues against people with histories of substance use disorder both among the general public and in the healthcare professions. Recent investigations of insurers' compliance with the Mental Health Parity and Addiction Equity Act of 2008 indicate that while the law of the land has changed, many insurers' discriminatory practices have not.

There was much positive rhetoric at the conference about the benefits of interoperability and client information exchange. Organizations such as Kaiser Permanente were lauded for having fully integrated (primary care and behavioral health) electronic records and the care coordination benefits that accrue to members. Patient information breaches are rare when integrated records exist under a singular provider organization. The potential problems metastasize when information is ported into an exchange or ACO because of the exponentially greater complexity of software, number of individuals/organizations accessing data, and potential threats to maintaining the integrity of the addiction treatment vault.

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Effects of Rx take-back day unclear; overall approach working

The sixth annual National Prescription Drug Take-Back Day, planned for April 27, 2013, hopes, like the previous five events, to reduce prescription drug overdoses and diversion, according to Drug Enforcement Administration (DEA) press officer Dawn Dearden. The DEA sponsors the annual event, which is an opportunity for people to safely and anonymously dispose of medications — all prescription medications, not just controlled substances.

However, nobody knows what amount of the more than 2 million pounds of prescription medications that previous take-back events brought in were actually controlled substances, Dearden told *ADAW*, "We don't look at whether it was opioids, benzodiazepines, antibiotics or other medications," she said. "The whole point of this is for it to be anonymous, for people to feel they could turn in their medications" without the information on the label being looked at.

"Proper disposal is just one of the four elements of the Administration's approach to combat this epidemic — but an important one," said Rafael Lemaitre, press officer for the Office of National Drug Control Policy (ONDCP). "There's no silver bullet when it comes to combating prescription drug abuse — we have to do everything we can, including proper disposal."

Meanwhile, the DEA doesn't have the data that can specifically connect take-back events to reduced prescription drug abuse. "It's difficult to say," said Dearden, "but we do know that turning the drugs in take them out of the illicit market." Still, knowing whether those drugs are the ones that someone would abuse is "difficult" to predict, she said. Still, "it's what we hope for."

Lemaitre noted that for the first time in 10 years prescription drug abuse has declined among young adults aged –25. "That's progress," he said. "We think a comprehensive approach is working."

In any event, the organized take-back days do present an opportunity to educate the public about the dangers of prescription drug abuse, and to protect the water supply which can be adversely affected if people flush the pills.

Finally, drug take-back day DEA-style avoids the ridicule that the Bush Administration brought upon itself when it recommended disposing the medications in kitty litter or coffee grounds. At the time, a SAMHSA spokesman suggested to a Reuters reporter that if someone didn't have a cat, ferret litter would do. This resulted in the American Ferret Association announcing: "Ferret Poop Has a Purpose: The U.S. government declares ferret poop to be an effective weapon against drug abuse" on its web page (see *ADAW*, December 10, 2007). In 2010, the Obama Administration declared that the personal garbage disposal method was no longer valid, and instead would be taken over by official take-back days. •

National drug strategy focuses again on move toward public health

The National Drug Control Strategy, released April 24 by the Office of National Drug Control Policy (ONDCP), urges — as it has in recent years — that the system take a more balanced approach to substance use disorders (SUDs). The focus should be on public health as well as criminal justice, the strategy says.

"Science, research, and evidence" are cited as key to the Obama administration's approach to drug policy. In keeping with the administration's overall approach, the strategy discusses the importance of prevention as the most cost-effective way to reduce drug use. The strategy supports the Drug-Free Communities support program, expansion Screening, Brief Intervention, and Referral to Treatment (SBIRT), and education of health care professionals in safe prescribing practices for opiate pain relievers.

The strategy also endorses the expansion of naloxone kits to reverse overdoses, something that ONDCP director Gil Kerlikowske strongly supports (see *ADAW*, August 27, 2012).

The strategy relies on the Affordable Care Act (ACA) and the parity law to expand access to treatment for addiction.

It also targets stigma by working with the recovery community to look at laws and regulations that target people with SUDs and impede their recovery — including restrictions to housing, employment, student loans, and driving licenses.

"President Obama believes in the pursuit of an America built to last — a nation with an educated, skilled workforce that has the knowledge, energy, and expertise to succeed in a highly competitive global marketplace," said Kerlikowske. "For too many Americans, this future is clouded by drug use and substance use disorders, which inhibit the ability of our citizens to remain healthy and safe and to achieve their full potential. This plan represents a smarter approach to drug policy in America — one based on the premise that addiction is a disease that can be prevented and treated."

Instead of incarcerating people with SUDs, the strategy encourages innovative criminal justice reforms, including drug courts and diversion of non-violent drug offenders to community-based treatment instead of prison or jail.

For the strategy, go to www.wh.gov/drugpolicyreform.

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medical affiliate," Mary Lynn Ulrey, CEO of the Drug Abuse Comprehensive Coordinating Office (DACCO), a nonprofit addiction treatment agency in Tampa, Fla., told *ADAW*.

Ulrey's facility is one of two nationally that is receiving top honors from the quality improvement collaborative NIATx in its annual iAward competition this year, and the presence of physician support serves was an important element in NIATx's decision to recognize DACCO's opiate treatment services for pregnant and postpartum women.

Not only has the oversight of DACCO medical services manager Jason Fields, M.D. (an ASAM member) and a team of physicians led to an agencywide acceptance of medication-assisted treatment (in this case, methadone for the largely Medicaid-covered population), these physicians' presence also has paved the way for important linkages with area hospitals that often serve as the first point of contact for opiate-dependent pregnant women.

In essence, Ulrey believes that referrals of these patients to her facility from the medical community likely would not be happening absent DACCO's medical staff presence. "This has definitely improved our readiness for healthcare reform," she said.

Where members practice

Data furnished to *ADAW* by ASAM on the eve of its conference indicate that the society has about 3,000 members (there are an estimated 5,000 addiction physicians in the country overall). Around 31 percent of ASAM members work in solo private practice; in total, just under half work in practice settings. By contrast, only about 15 percent are believed to work in specialty addiction treatment facilities.

But ASAM president and Rhode Island physician Stuart Gitlow, M.D., says the data remain difficult to interpret because many ASAM members' work crosses over into more than one type of setting. He cites his own experience: While he maintains a very traditional office practice, he also contracts with a local clinic for what amounts to medical director-like oversight.

And while it remains likely that it is the largest and most prominent of the freestanding addiction treatment facilities that will have the resources to employ a full-time medical director who is an ASAM member and is board-certified in addictions, ASAM clearly is making an effort to reach out to numerous associations representing a cross-section of organizations and professionals in the treatment and recovery communities.

Gitlow said after last week's board meeting preceding the annual conference that this was the first ASAM board gathering at which a board member of the National Council on Alcoholism and Drug Dependence, Inc. (NCADD) also participated. "We want everybody to be at the table," he said.

> **'We want everybody to be at the table.'**
>
> Stuart Gitlow, M.D.

A key player in this regard would clearly have to be the National Association of Addiction Treatment Providers (NAATP), an organization whose members include prominent centers with leading voices in the addiction medicine community (many of whom are ASAM members as well). Those voices don't always sing from the same sheet of music on key issues affecting practice, particularly on the use of medication-assisted treatment.

In recent months, some prominent leaders in NAATP went public with concerns that ASAM's agenda had become too tied to medication interests, as evidenced in their view of a conference agenda that they said had become dominated by medication research presentations.

But NAATP president and CEO Michael Walsh told *ADAW* last week that most recently, a group of physicians active in NAATP has moved toward trying to get more active in ASAM as well, in order to make sure its perspectives are included — as opposed to simply criticizing from afar. Walsh said physicians led by Kenneth Thompson, M.D., medical director of Caron Treatment Centers, and Chapman Sledge, M.D., chief medical officer of Cumberland Heights, have had productive meetings with ASAM leaders.

"We hope to be much more aligned with ASAM going forward," said Walsh. He added that in a recent addition to the agenda for NAATP's annual conference last month, ASAM's 2013 award honoree Michael M. Miller, M.D., medical director of Rogers Memorial Hospital's Herrington Recovery Center, will conduct a session outlining this year's revised edition of ASAM's Patient Placement Criteria.

Walsh considers the dichotomy that is often presented between those who see medication-assisted treatment as the standard of the future and those who adhere to an abstinence-based model somewhat misleading because most NAATP member facilities offer some form of medication as part of the treatment and recovery process.

"Many say they don't believe in medication-assisted treatment, but if they're doing detox properly, they're using medications to assist things," he said. More widespread specialty services for co-occurring disorders also have brought medications into the mix to a greater extent, he said.

Gitlow acknowledges that ASAM has received some pushback from those who contend it has become too medication-focused, but he says what has happened in recent years simply reflects where the direction of research has taken the field. Yet he also believes that individualized treatment approaches that are open

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to all potentially effective interventions make the most sense.

"The moment I say I'm going to do it this way all the time or that way all the time, I'm dooming a certain percentage of the population," Gitlow said.

DACCO's success

Fields, DACCO's medical services manager, entered the medical field in pediatrics, but says a personal experience with addiction took him both to Florida and to the desire to work with addicts. He now serves on the board of directors of the Florida Society of Addiction Medicine, as well as being an ASAM member.

His early knowledge of treatment had been in abstinence-based services, but he added, "I really believe in medication-assisted treatment. I had to learn a lot about it, but I've seen it transform people's lives."

DACCO's comprehensive care model for pregnant and postpartum women addicted to opiates, which Fields launched, has methadone treatment at its core but also emphasizes the efforts of an in-house treatment team that includes addiction medicine fellows representing several disciplines, as well as linkages with general medical and pediatric support in the community.

Ulrey, who previously had worked as a nurse practitioner before joining DACCO more than a decade ago, said the strong presence of physicians has helped to transform the culture of her organization. No longer do clinicians dismiss the idea of methadone treatment for the clients they see in group just because one might be experiencing complications in achieving the optimal dose, she said.

She added, "Now our biggest hurdles with [acceptance of] medication-assisted treatment are in the community, with judges and the child welfare system. The case managers in child welfare want the women off [methadone] before they get their child back."

No one knows for sure about the degree to which medication advances might truly transform addiction treatment outcomes in the future — most doubt that one compound can possibly help enough of a critical mass of people to play that transformative role. But Fields hopes his organization can play its own role in arriving at some of the answers. "As busy as we are, I'd love to see us participate in some of the research," he said. •

Coming up…

The **Global Addiction and EUROPAD Conference** will be held **May 7–10** in **Pisa, Italy**. Go to **www.globalladdiction.org** for more information.

The annual conference on **Treatment Accountability for Safer Communities (TASC)**, with a focus on reentry, will be held **May 9–10** in **Columbus, Ohio**. For more information, go to **www.nationaltasc.org/index.php**.

Visit our website:
www.alcoholismdrugabuseweekly.com

In case you haven't heard…

A Phoenix House administrative assistant in Yorktown used thousands of dollars in taxpayer money to buy alcohol, cigarettes and weight loss supplements, according to the New York State Comptroller's Office, the Journal News reported April 24. But that's not the least of the problems. Funding from the state Office of Alcoholism and Substance Abuse Services (OASAS) that was supposed to be used for gambling and addiction treatment also went to "inappropriate perks" such as executive bonuses, vehicle leases and other fringe benefits. A total of $223,000 was misused, mostly for inappropriate fringe benefits, according to the audit. "This was money intended to treat people struggling with substance and gambling addiction, not to subsidize unwarranted perks for high-salaried executives," comptroller Thomas DiNapoli said in a statement. Bonuses paid to upper managers were paid from state funds and totaled more than $91,000. The audit also cited Phoenix House for not reporting $290,000 in Medicaid revenue. That money would have reduced the OASAS payment to Phoenix House. "The Phoenix House takes this audit seriously and started addressing the specific findings months ago," Phoenix House spokeswoman Karen Sodomick said in a statement. "Phoenix House has had a strong relationship with New York State over the last 46 years that has resulted in helping tens of thousands of people dealing with substance abuse issues. We will continue working with all of the authorities including the Office of Alcoholism and Substance Abuse Services to address these issues and bring this matter to a close."

Briefly Noted

FDA nixes generic OxyContin

The Food and Drug Administration (FDA) announced on April 16 that generic OxyContin would not be approved, because it is not abuse-resistant. Purdue Pharma stopped selling the old, crushable form of its OxyContin opioid pain medication in 2010 and instead is only selling its patented tamper-proof version. Purdue benefits from the decision, which gives it patent protection on OxyContin, a medication valued by pain specialists because it provides long-term pain relief without hills and valleys — and, in the new version, without the euphoria that people could obtain by crushing and snorting it. For the announcement, go to www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm347857.htm.