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News for policy and program decision-makers

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In This Issue...

WINNER 2013 APEX® AWARDS FOR PUBLICATION EXCELLENCE NEWSLETTER WRITING

CADCA Celebrating 20 Years Building Drug-Free Communities

Alison Knopf, Editor, winner of CADCA Newsmaker Award

A reminder to our readers...

There will be no December 2 issue of *ADAW*. The next issue will be December 9. We wish you all a Happy Thanksgiving.

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Annapolis Coalition: Workforce needs beefing up by primary care and others

Stating that the specialty substance abuse treatment workforce is beset by many problems, the Annapolis Coalition in a report published in the November issue of Health Affairs recommends that other health care providers be trained in providing substance abuse treatment. Among the problems with the substance abuse workforce: "shortages, high turnover, a lack of diversity, and concerns about its effectiveness."

The study cited a report from the Substance Abuse and Mental Health Services Administration (SAMHSA) projecting that every 10 percent increase in demand for treatment would result in a need for 6,800 additional counselors for substance abuse. The authors then criticize the federal government for having "funded multiple workforce assessments and plans" but never having "adopted or implemented a comprehensive plan."

The report drew the keen attention of Andrew Kessler, whose Slingshot Solutions lobbying firm represents IC&RC, which credentials

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Bottom Line...

Substance abuse counselors are slighted as lacking training, diversity, and quality in a report from the Annapolis Coalition on beefing up the workforce.

The Business of Treatment

Unproven treatments seen as meaningful, if not lucrative

B$T

Suncoast Rehabilitation Center, a five-year-old nonprofit addiction treatment facility in Florida that last week was touting its fourth consecutive award of a 100-percent performance rating from the state Department of Children and Families, freely acknowledges that it engages in some clinical practices that fall under no one's definition of "evidence-based." The Gulf Coast facility's administrators also admit that despite the high post-inspection ratings they have received from the state regulatory authority, they make their business task somewhat more difficult by enthusiastically embracing approaches such as sauna detoxification and aggressive nutritional supplementation.

"I think honestly that if we were a straight-up conventional program we'd probably be making more money, because those approaches are what's accepted," Suncoast Executive Director Tammy Strickling told *ADAW*.

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Bottom Line...

Some addiction treatment programs do not adhere to a strict evidence-based standard when evaluating potential practices, even though they acknowledge that this strategy probably compromises their bottom line.

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substance abuse counselors. "The article talks about training more professionals in evidence-based treatment," he told *ADAW*. "Evidence based treatment is the cornerstone of all substance abuse treatment provided by trained, educated professionals," he said. "The addiction workforce is well-trained — the counselors I represent are trained in thousands of hours of evidence based practices," he said. IC&RC has under their purview at least 45,000 credentialed counselors.

Upset by this attack on the substance abuse workforce, Kessler asked for concrete solutions. "In this fiscal environment where budgetary shortfalls dominate the entire healthcare landscape, it's not useful to say, 'Hey, you need to be doing more.'" Federal agencies' budgets are being decimated, he said. "If we ask them to do more, they can say, 'With what money?'"

Lead author calls for SBI

More can be done with screening and brief intervention (SBI) in non-specialist offices, according to Michael A. Hoge, Ph.D., lead author of the report. "We believe we need more specialty providers in substance abuse and mental health, but we also need expanded efforts to train other providers such as primary care providers to be able to treat these conditions," Hoge told *ADAW*.

"We do know that people quite frequently and more often than not, go to an internist, a primary care doctor, or are seen in the ER" instead of seen by a substance abuse provider, added Hoge, who is also professor and director of clinical training in psychology in the Department of Psychiatry at Yale University School of Medicine. "There will always be the need for specialists to care for the people who have the most serious disorders, I don't disagree with that at all."

'The field needs to be paid what it's worth.'

Andrew Kessler

The report concludes with four recommendations: 1) to advocate for resources from the administration and Congress to address the workforce crisis; 2) to allocate more of federal agencies' resources and energies to workforce development; 3) to create a robust national technical assistance infrastructure to disseminate information on recruitment, retention, and training; and 4) to facilitate coordinated activity by federal agencies and stakeholders on workforce development.

The Health Resources and Services Administration (HRSA) has been taking some role in the substance abuse workforce. When we pointed out that SAMHSA removed workforce from its strategic initiatives (see *ADAW*, October 11, 2010), Hoge responded: "My understanding is that SAMHSA would like to see HRSA play a major role if not the lead role around workforce."

Unified approach

Michael Flaherty, Ph.D. and Eric Goplerud, Ph.D. were the two substance abuse experts brought in by Hoge to work on the paper. Flaherty, a psychologist with an active practice in the addictions, emailed comments to *ADAW* but stressed that he was speaking for himself, not the Annapolis Coalition. "We all need to address the illness and its recovery with a more unified and collaborative understanding of how prevention, intervention, treatment and recovery work," said Flaherty, adding that "no one should grow more in all this than the addictions profession and the peers related to it."

The Annapolis Coalition has been addressing mental health and substance abuse workforce develop-

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ment for more than 10 years, noted Flaherty. "The workforce has been dwindling in its stamina and numbers for too many years," he said. Under parity and health care reform the crisis will only get worse "unless we all look at the needs for a broader, more collaborative, competent and capable unified workforce," he said.

Better pay

Kessler, who is present at stakeholder meetings in Washington and a lobbyist on Capitol Hill, has two remedies for the substance abuse workforce problems that the Annapolis Coalition refers to (turnover and shortages): help with student loans, and better salaries. "The field needs to be paid what it's worth," he said. The main reason for high turnover — and even for people leaving the field — is low pay. And this is a key issue which is, in fact, being worked on, he said. "If the Annapolis Coalition thinks this issue isn't being worked on, they can call me, and you can print my number," he said. "Nobody talked to IC&RC, the nation's largest credentialing organization for substance abuse counselors."

Flaherty agreed with Kessler's assessment of counselor pay. "Our workers shouldn't be paid at a level eligible for food stamps while working," he said. "But our disciplines need to open up to the strength of integration to understand and treat an illness, as opposed to girding their guilds."

This also means recognizing the peer and other community support staff "who will not replace professionals but support them and the outcomes they jointly seek," Flaherty said. "Let's hope the article takes our collective heads out of the sand and within limited resources connects the dots of this critical need to our simultaneous national and economic need for new workers and jobs."

Health Affairs originally asked for a study of the mental health workforce, but Hoge insisted that substance abuse be included, he said. None of the authors received any compensation for work on the article, he said. •

For the report, go to http://content.healthaffairs.org/content/32/11/2005.full?ijkey=bxIjREWJCgGtk&keytype=ref&siteid=healthaff.

Electronic cigarettes: It's about the nicotine… and more

Nicotine is the reason that people become addicted to smoking cigarettes, and get lung, head and neck cancers as a result, but the nicotine in electronic cigarettes is also considered addictive, according to the National Institute on Drug Abuse (NIDA). Addiction, characterized by compulsive drug seeking in the face of negative health consequences, is felt by smokers who try to quit — of the almost 35 million who try to quit smoking every year, more than 85 percent relapse, usually within a week, according to NIDA.

Research has shown that nicotine increases dopamine levels in the reward circuits of the brain, according to NIDA. Cigarette smoking rapidly distributes nicotine to the brain, with levels peaking within 10 seconds and dissipating quickly, resulting in the need to keep smoking. But less is known about the delivery of nicotine via electronic cigarettes, in which the nicotine vapors are inhaled without any of the tobacco smoke.

For more information about electronic cigarettes, NIDA recommended that we talk to Thomas Eissenberg, Ph.D., professor of psychology and co-director of the Center for the Study of Tobacco Products at Virginia Commonwealth University in Richmond.

'Based on data I have seen, I think there is little doubt that at least some e-cigarettes marketed in the U.S. today can support nicotine dependence in some users.'

Thomas Eissenberg, Ph.D.

Concerns about youth

Nicotine affects the brain by "binding to acetylcholine receptors," said Eissenberg. A mild psychomotor stimulant, nicotine "continually bathes receptors, resulting in cellular changes that lead to dependence, meaning that the drug is now necessary for normal function to occur," he said. "There are major concerns about youth becoming nicotine-dependent via electronic cigarettes," he said. "First of all, do we want nicotine-dependent kids?" There also may be risks involved with the daily electronic cigarette use that would accompany dependence, he said.

So far, while it is possible that someone could transition from electronic cigarettes to tobacco cigarettes, there is not much information about whether this is happening or not, said Eissenberg. It is also possible that young people could use electronic cigarettes as a way to use other drugs — for example, dripping hashish oil on the heater.

Question about delivery

Nicotine causes physical dependence, and electronic cigarettes

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have the potential to cause physical dependence if they contain nicotine, he said. "Of course, if they do not deliver any of the nicotine they contain to their users, then that potential cannot be realized." Eissenberg and Andrea Rae Vansickel, Ph.D., in a paper published in Nicotine & Tobacco Researchin January, showed that if electronic cigarettes do deliver nicotine, then they can cause physical dependence.

"Based on data I have seen, I think there is little doubt that at least some e-cigarettes marketed in the U.S. today can support nicotine dependence in some users," Eissenberg told *ADAW*. "We have demonstrated beyond any doubt that some experienced e-cigarette users receive cigarette-like nicotine doses when they use these products."

Not approved as quitting tool

The Food and Drug Administration (FDA) has not approved any claims by electronic cigarettes that they can be used as a therapeutic smoking-cessation product, like nicotine gum or patches. This kind of therapeutic use "may apply to e-cigarettes, or it may not," said Eissenberg.

That's because there is more in the electronic cigarettes than nicotine, and what goes into the lungs, he said. "The difference between FDA-approved nicotine-containing tobacco-cessation pharmacotherapies and e-cigarettes is that e-cigarettes involve delivering more than nicotine by itself, and that what is delivered that is not nicotine is likely delivered to the human lung with unknown health consequences," said Eissenberg. The "vehicle" for the nicotine delivery with electronic cigarettes is propylene glycol or vegetable glycerine, in which the nicotine is dissolved, as well as a variety of other chemicals used for flavor, said Eissenberg. There may also be "other chemicals of unknown purpose," he said, noting that manufacturers are not required to report the contents of the liquid that goes in the electronic cigarette cartridge to be vaporized when heated.

Eissenberg is very concerned about saying electronic cigarettes are safe when so little is known about them. "What is the influence of inhaling these substances into the human lung, hour after hour, day after day? Do they cause cancer in humans when inhaled daily for several years? Do they cause lung disease in humans when inhaled daily for several years? Do they cause any other diseases in humans when inhaled daily for several years? I am not sure anyone has the answers to these questions."

Eissenberg added there is no data that show that electronic cigarettes reduce cancer.

Finally, there are some electronic cigarette companies that, trying to evade future regulation by the FDA as a tobacco product, claim that their nicotine comes from other plants. Electronic cigarettes are legally defined as tobacco products if the nicotine comes from tobacco, said Eissenberg. But no matter where the nicotine came from, it is still addictive, he said. "Nicotine is nicotine, regardless of the source," he said. •

Employee illicit drug use is declining, but Rx drug use is rising

This year's annual report from Quest Diagnostics found that drug use among workers is continuing to decline, although positive tests for opioids are rising. The report, called the Drug Testing Index, was released November 18 to coincide with the 25th anniversary of the passage of the Drug-Free Workplace Act in 1988.

"Today's Quest Diagnostics Drug Testing Index provides the best evidence to date that the Drug-Free Workplace Act and the public and private initiatives it helped to spur have led to steep declines in drug use among much of the American workforce," said Laura Shelton, executive director of the Drug and Alcohol Testing Industry Association (DATIA), when the report was released. "While more needs to be done to reduce illicit drug use by workers, we should take heart from the tremendous progress employers have made to create safer workplaces for millions of Americans."

For this year's Drug Testing Index, Quest looked at more than 125 million of the urine drug tests it performed for government and private employers between 1988 and 2012. The analysis looked at test results for employees in federally regulated safety-sensitive positions, such as truck drivers, railroad operators, airline employees and nuclear plant workers; private-sector workers not mandated to be tested; and at both groups together.

Key findings:

- The positive rate for the combined workforce declined 74 percent, from 13.6 percent in 1988 to 3.5 percent in 2012.
- The positive rate for the federally mandated safety-sensitive workforce declined by 38 percent, from 2.6 percent in 1992 to 1.6 percent in 2012.
- The positive rate for the general workforce (not including federally mandated) dropped by 60 percent, from 10.3 percent in 1992 to 4.1 percent in 2012.

Increase in amphetamines, opioids

However, positive rates for amphetamines have tripled in the combined workforce, to the highest level since 1997. The positive rate for amphetamines themselves — which are prescription medications usually prescribed for ADHD — more than doubled in the past 10 years.

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Positive rates for prescription opioids have also increased steadily, more than doubling for hydrocodone and hydromorphone over the past decade.

According to the Quest report, positive rates in the workforce mirror drug-use developments nationwide in general.

"While this 'Silver Anniversary' Drug Testing Index underscores the nation's progress in reducing the prevalence of drug use in our country's work environments, there is a danger in becoming complacent in response to this good news," said Barry Sample, Ph.D., director of science and technology for Quest Diagnostics Employer Solutions, a business of Quest Diagnostics. "Our data shows that an increasing number of workers are testing positive for certain prescription drugs, such as opiates and stimulants, reflecting the increased use, and potentially abuse, of prescription medications in the U.S. We also know from other research that the steep declines in our data's overall drug positivity rates would likely not be observed in workplaces that do not have workplace drug testing programs."

Out of control?

"Some industries such as the restaurant industry have adopted an attitude that drug use in their industry is something they cannot control. The fact remains that drugs in the workforce contribute to industrial and other accidents, not to mention employer costs and liability," said Mary Brown-Ybos, director of compliance for DISA Global Solutions, Inc., and president of the Substance Abuse Program Administrators Association (SAPAA). "The Drug-Free Workplace Act was an important step in fostering safer workplaces, but we have more work ahead of us to foster truly drug-free work environments."

'Our data shows that an increasing number of workers are testing positive for certain prescription drugs, such as opiates and stimulants, reflecting the increased use, and potentially abuse, of prescription medications in the U.S.'

Barry Sample, Ph.D.

Under the Drug-Free Workplace Act of 1988, federal contractors and grantees must provide drug-free workplaces. The law itself did not mandate drug testing, but federal agencies required it for safety-sensitive employees and other federal employees. Subsequently, many private employers created similar policies. Union lawsuits helped ensure that testing was done using the highest degree of scientific accuracy to reduce the possibility of false-positive tests.

"The Drug Testing Index is more than an established barometer of workplace drug-use trends. Quest's DTI demonstrates the power of diagnostic insights to reveal opportunities to create a healthier and safer world," said Harvey Kaufman, M.D., senior medical director for Quest Diagnostics. "Our goal for this seminal DTI report is to reveal both the huge progress made to date to deter the use of drugs by workers, but also to show that vigilance is required by employers seeking to create safe, healthy environments for their employees."

The fact that there are still employees who test positive shows the need for continued access to treatment. •

Times' buprenorphine series gets it wrong

A two-part series published last week in *The New York Times* with the headlines "Addiction Treatment with a Dark Side" and "At Clinics, Tumultuous Lives and Turbulent Care" presented buprenorphine as a medication that is diverted and sold by unscrupulous doctors. The story managed to dig up one former addict who is running a buprenorphine clinic in Pittsburgh, ironically running the week after 1,500 opioid treatment experts gathered in Philadelphia for the meeting of the American Association for the Treatment of Opioid Dependence (see *ADAW*, November 18).

The series did capture the essence of the truth in one brief quotation from Stuart Gitlow, M.D., president of the American Society of Addiction Medicine. "The benefits are high, the risk is low and it is worth it on a population-wide basis," he said in the *Times* article. "But beyond that limited quote, people are now thinking that buprenorphine treatment programs are no different from pill mills," Gitlow told *ADAW* after the series ran.

Limited providers

The problem, said Gitlow, is that there aren't enough providers to prescribe buprenorphine. "We in the addiction treatment community have enormous demand that is legiti-

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viduals in my practice, almost everybody who comes in, has been on a waiting list for a long time," he said. They have indeed been getting buprenorphine on the street to stave off withdrawal while they wait for real treatment, he said.

Noting that under federal regulations no physician can have more than 100 patients in buprenorphine treatment for addiction — and that for many patients, this is a maintenance, long-term treatment — Gitlow questioned the value of that cap. "It seems very odd that the very drug that would be used to treat opioid dependence is limited with the cap while the drugs that are causing it are not," he said.

If the cap were lifted, there would be increased diversion at first, said Gitlow. "But as patients find that they are legitimately able to find the drug, that diversion would decrease," he said.

Self-treatment

As an indication of the fact that many patients first got buprenorphine on the street, Gitlow said there is no induction anymore. "Ninety-eight percent of my new patients are already on" buprenorphine when they come in, he said.

> **'But beyond that limited quote, people are now thinking that buprenorphine treatment programs are no different from pill mills.'**
>
> Stuart Gitlow, Ph.D.

The substance abuse treatment field is still polarized between the older abstinence-based model and harm reduction, such as needle exchange, said Gitlow. "Buprenorphine isn't abstinence-based, and it's not harm reduction," he said. But many treatment programs don't understand that, he said. "They don't want to maintain patients on buprenorphine; they use it as a detoxification approach, a temporary measure." The problem of what happens to the patients when they are discharged into the community is key, however. "What is the availability of long-term care?" he said.

When buprenorphine does cross over into harm reduction, however, it is typically in the self-treatment seen when addicts buy it on the street because they can't get into treatment, he said.

Gitlow, like most substance abuse treatment providers, is well acquainted with stigma and not surprised by articles like those in the *Times*. "We have to face up to the fact that the news tried to find controversy and report on it, because if there's no controversy, there's no news," he said.

Gitlow is also medical director of Orexo, which makes buprenorphine product Zubsolv. •

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Suncoast is a Narconon, Scientology-affiliated facility.

But while Strickling and other administrators whose programs incorporate some of the less conventional treatments for addictions say their approaches can be met with a jaded eye by insurers and policymakers, they still consider it essential to maintain these practices because they are producing results for individuals who often have failed in other programs.

"We'll do whatever it takes to get patients the outcome they are looking for," Kent Runyon, executive director of Florida-based Novus Medical Detox, told *ADAW*. Novus uses standard medical detoxification protocols but also incorporates its own recipe of supplements that won't traditionally appear on any of the insurance company invoices it processes. Patients pay out of pocket for the proprietary vitamins, for example.

"It is the ancillary services that make us stand apart," Runyon said.

Many programs that provide such ancillary services and don't get reimbursed by insurance typically charge patients, who pay out of pocket.

An evolving concept

Among the many questions with which the addiction treatment community is grappling as the Affordable Care Act (ACA), insurance parity and other big-picture changes take hold is the matter of whether fewer clinical practices will be acceptable and reimbursable going forward.

In reality, says A. Thomas McLellan, Ph.D., CEO and founder of the Treatment Research Institute (TRI), there are numerous practices that meet the criteria for being evidence-based, from medication-assisted treatments to at least a dozen behavioral therapies to a number of community-based preventive interventions. There are even numerous official lists of evidence-based practices, from the well-known national registry maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA) to a state-based list in Oregon, McLellan said.

But the addiction field is in no better position to judge definitively which practices will work best for which individuals than are many other medical specialties, such as internists or cardiologists who go in uncertain as to which medication or which diet might best control an individual patient's hypertension, McLellan said.

In addiction treatment, "It is

 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

good news that there are so many things available, but bad news that so few are being tried," McLellan said.

Few believe that interventions that lack a formal evidence basis, such as many of the experiential and holistic therapies, are going to disappear from the addiction treatment landscape anytime soon. Yet it remains the case that facilities incorporating such practices cannot expect reimbursement for them in an increasingly insurance-driven service system.

In reality, McLellan believes the entire evidence-based concept is largely lost on payers. "It is my experience that it is difficult to get insurers to buy into any kind of evidence-based approach that's going to cost them five cents more than what they are paying," he said.

TRI's toolkit

Of course, it is also true that TRI is primarily in the business of helping treatment programs understand what the research is saying about effective treatment and how that can be applied to programs' everyday work with clients. Earlier this month, New Jersey–based Seabrook House announced that it has begun using TRI multimedia toolkits on 12-Step participation and relapse prevention to improve client engagement in processes seen as enhancing long-term outcomes.

Jason Gerner, Seabrook's clinical outreach representative, told *ADAW* that his facility is the first residential treatment center to employ TRI's Open Doorways toolkit to emphasize to clients the importance and positive impact of 12-Step involvement post-treatment.

While Gerner said Seabrook considers itself a progressive organization that will at least look at any promising practice, he added, "Anytime we implement anything, we've looked at the research." He added, "You need to implement proven practices."

For McLellan, the standard he embraces for evidence-based practice generally comes from the Food and Drug Administration's (FDA's) reliance on two randomized controlled trials or one large field study of the medications and devices it considers for approval. The criteria that he believes the addiction field must consider in evaluating a specific practice, much like other branches of medicine, are symptom reduction and improvement of social and personal function.

Under that measure, he said, there are certainly numerous interventions that might make the case for effectiveness but do not currently appear on anyone's evidence-based practices list, from acupuncture to deep tissue massage to equine-assisted psychotherapy. But to make a more solid argument for them, "I want to see the evidence," McLellan said.

Outcomes over evidence

Norman G. Hoffmann, Ph.D., is president of Evince Clinical Assessments and an adjunct professor of psychology at Western Carolina University, and an outspoken critic of several practices that have earned the "evidence-based" imprimatur, including the widespread use of an Addiction Severity Index (ASI) instrument that he sees as highly flawed. Hoffmann believes "outcomes-based treatment" rather than evidence-based treatment should serve as the concept for the treatment field to embrace.

"If a program can document that it's achieving good results at a reasonable rate, that should suffice," Hoffmann told *ADAW*. He added that a clinician's own buy-in to the treatment approach being used, and the rapport he/she can build with an individual client, appears to prove far more important to a positive outcome than the actual modality selected.

'If a program can document that it's achieving good results at a reasonable rate, that should suffice.'

Norman G. Hoffmann, Ph.D.

That resembles the perspective shared by facilities such as Suncoast and Novus, In Suncoast's case, it does not adhere to a disease model of addiction treatment and shuns medication-assisted approaches altogether, but does fully embrace CBT. In several cases, that will mean ceding a self-paying or insured patient to another facility.

"We evaluate each person on a case-by-case basis," said Strickling. "Drug treatments are appropriate for some people, but it's not what we do." •

Briefly Noted

Hospital achieves 95 percent 30-day retention rates in outpatient opioid program

The opioid treatment program at Kings County Hospital Center, part of the New York City Health and Hospitals Corporation, won the Substance Abuse and Mental Health Services Administration's Science and Service Award for its retention rates. The hospital achieved a 95 percent retention rate for its 30-day treatment program by reducing waiting times for admission, assigning patient navigators and offering peer support. "Remaining in treat-

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ment for an adequate period of time is critical and it requires a strong commitment by the patient," said Susan Whitley, M.D., director of chemical dependency services at the hospital. "When patients abandon treatment early, it becomes almost impossible to recover from their addiction." The hospital's opioid dependency treatment program has the capacity to treat up to 650 patients at a time. Last year, about 240 new patients entered the program. In addition to increasing same-day admissions, the program established a welcome committee of staff who explain the roles of each team member; helped resolve barriers to treatment such as housing, transportation and childcare; designated an outreach worker to help re-engage the patient in treatment after a missed visit; and introduced a peer-led orientation on the day of admission. The hospital is located in Brooklyn, New York.

In the States

Hepatitis C outbreak in Wyoming blamed on intravenous drug use

A doubling of new hepatitis C infections in Park County, Wyoming, from 2011 to 2012, when there were 56 such reports, is probably due to intravenous drug use, according to health officials in the state, the *Powell Tribune* reported November 20. The reports are seen especially in young people between the ages of 20 and 34, according to Wyoming Department of Health Viral Hepatitis Prevention Coordinator Ashley Grajczyk. About 39 percent of the cases in 2012 came from Powell, and the remaining 61 percent came from Cody, she said. She said that it's possible that some of the new reports are from people who don't live in the area but come there for substance abuse treatment, she said, noting that the county's rate has been rising since 2008. "We're talking about hepatitis C here, but in reality it is at-risk kids, 15 to 30, who are doing all kinds of things that maybe we don't want to acknowledge, or we know about but don't know what to do about," said Park County Public Health Nurse Manager Bill Crampton. Crampton and Grajczyk spoke at a meeting this month of the Park County Health Coalition in Powell, looking for ideas on how to stop the continued spread of the disease and how to help those already infected. "Hepatitis C is for life," said Crampton. "You can put it into remission. You can live with it. You can live a full and healthy life." Hepatitis C attacks the liver, but initially there are no symptoms. When it progresses to the chronic stage, permanent liver damage or cancer can result. The medications to treat it are also costly, which is why the state is focusing on prevention of new infections. One way to do that is to encourage sterilizing of drug-injecting equipment. "We may not be able to modify them and get them to stop injecting, but if they clean their equipment with bleach, you know, at least we're making another step," Crampton said. "Does that mean we're promoting the idea? No, we're not promoting the idea, but there's just some folks that aren't going to listen to us. We can at least break the chain at some point."

Coming up...

The 24th annual meeting of the **American Academy of Addiction Psychiatry** will be held **December 5–8** in **Scottsdale, Arizona**. For more information, go to **www.aaap.org/meetings-and-events/2013-annual-meeting**.

Community Anti-Drug Coalitions of America (CADCA) will hold its annual leadership forum **February 3–6, 2014** in **National Harbor, Maryland**. For more information, go to **www.cadca.org/events/detail/forum2014**.

Names in the news

New CEO, new direction for CASA

The National Center on Addiction and Substance Abuse (CASA) has a new president and chief executive officer: **Samuel A. Ball, Ph.D.**, professor of psychiatry at the Yale University School of Medicine. Ball will remain at Yale but oversee a newly structured CASA, which is located at Columbia University. CASA has now brought all addictive behaviors, including eating disorders, sex addiction, and problem gambling, into its portfolio, according to a press release from Yale University. Ball is research and scientific director of Yale's APT Foundation, which provides substance abuse treatment.

Visit our website:
www.alcoholismdrugabuseweekly.com

In case you haven't heard...

Zohydro ER, the first hydrocodone product without acetaminophen and the only extended release hydrocodone product, became a part of Alkermes' stable of products when the company, which is known for Vivitrol, acquired Elan in 2011. Zohydro was in Elan's pipeline, and Alkermes assumed contractual liabilities for it. But when the FDA approved Zohydro ER this fall (see *ADAW*, November 4), some hackles were raised. In a November 15 article in *The New York Times*, Andrew Kolodny, M.D., chief medical officer of Phoenix House, was attributed as saying that the American Society of Addiction Medicine should not take money from Alkermes any more, and also that Alkermes officials were "not welcome" at Phoenix House.