Autumn 2010 Volume 25, Number 8

ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

Remember to cast your ballot in ASAM's election of officers by November 30th!

WWW.ASAM.ORG

ASAM MRO Course to Meet in Washington, DC

ASAM's Comprehensive MRO Course: Toxicology Testing and the Physician's Role in the Prevention and Treatment of Substance Abuse, will meet December 10-12, 2010, at the Capitol Hilton Hotel in Washington, DC.

The course, which has been approved for up to 21 Category 1 CME credits, presents scientific information, guidelines, and practical tips for MROs. Through interactive lectures and panel discussions, participants have an opportunity to interact with experts in the field. To view the course program, go to HTTP://WWW.ASAM.ORG/PDF/CONFERENCES/2010%20MRO%20BROCHURE.PDF

The MRO Course and the MROCC Examination work in tandem to help physicians already involved in MRO practice, as well as those new to the field, maintain the highest standards of knowledge, practice, certification, and regulatory compliance. Federal regulations require specialized training for MROs, as well as retraining every three years. For the convenience of course participants, ASAM and MROCC have coordinated their schedules to offer consecutive training and examination at selected locations.

To register for the MRO course online, go to: HTTP://WWW.ASAM.ORG/ESERIES/SOURCE/MEETINGS/CMEETINGFUNCTIONDETAIL.CFM?SECTION=UNKNOWN&PRODUCT_MAJOR=MRODEC2010&FUNCTIONSTARTDISPLAYROW=1. If you have questions, contact ASAM's Meetings Department at 301-656-3920.

ASAM President Advises FDA on New Medication

In a decision announced October 12th, the U.S. Food and Drug Administration approved the use of Vivitrol® in the treatment of opioid addiction. Manufactured by Alkermes, Inc., Vivitrol is an extended-release formulation of naltrexone that is administered by intramuscular injection once a month.

As a member of the expert panel advising FDA on the matter, ASAM President Louis E. Baxter, Sr., M.D., FASAM, played a pivotal role in winning approval of the new indication (Vivitrol initially was approved for the treatment of alcohol dependence in 2006). Vivitrol was recommended for approval by Dr. Baxter and his fellow panel members based on findings from research conducted with heroin-addicted patients in Russia. Those studies showed that the drug is effective in blocking opioid receptors in the brain, thus making it useful in treating addiction to heroin and prescription opioids such as morphine. The National Institute on Drug Abuse is planning further studies of Vivitrol in the U.S.

In announcing approval of the new indication, Janet Woodcock, M.D., director of the FDA's Center for Drug Evaluation and Research, said: "Addiction is a serious problem in this country, and can have devastating effects on individuals who are drug-dependent, and on their family members and society. This drug approval represents a significant advancement in addiction treatment."

The FDA's full announcement on Vivitrol can be accessed at HTTP://WWW.FDA.GOV/NEWEVENTS/NEWSROOM/PRESSANNOUNCEMENTS/UCM229109.HTM.

Penny S. Mills, M.B.A.

ASAM Focuses on Medical Education

Penny S. Mills, M.B.A.

October marked several successful ventures in medical education for ASAM and addiction medicine. On October 14-16, ASAM welcomed nearly 700 physicians to its biennial Review Course in Addiction Medicine (the California course also had record attendance). As you know, the purpose of the courses is to review the core content of addiction medicine, and it was exciting to see so many physicians eager to join or move ahead in our field. This year's course not only exceeded all previous course attendance figures, but the evaluations are outstanding. Congratulations are due the co-chairs, Paul H. Earley, M.D., FASAM, and Edwin A. Salsitz, M.D., FASAM, as well as the entire program committee for this successful offering.

On October 30th, ASAM partnered with the National Institute on Drug Abuse to offer a course on Best Practices in Buprenorphine Treatment for Opioid Dependence in Buffalo, New York. We look forward to more such partnerships in the future, and thank Drs. Daniel Alford and Elizabeth Howell for their leadership of the course.

Earlier in October, ASAM participated in a meeting hosted by Mary K. Wakefield, Ph.D., R.N., Administrator of the Health Resources and Services Administration. HRSA is the Federal agency with primary responsibility for improving access to health care services for persons who are uninsured, isolated or medically vulnerable. Among its many responsibilities, HRSA is the agency responsible for the Nation's network of Federally Qualified Health Centers (FQHCs).

The meeting focused on two topics: how addiction field organizations can help HRSA educate primary care physicians in FQHCs to help them integrate addiction care into their practices; and how HRSA can help to support the development of addiction medicine residency training.

I was pleased to attend the meeting with ASAM President Louis E. Baxter, Sr., M.D., FASAM, and Immediate Past President Michael M. Miller, M.D., FASAM. We were joined by representatives of the Office of National Drug Control Policy (ONDCP), the National Institute on Drug Abuse (NIDA), the American Board of Addiction Medicine (ABAM), the American Academy of Addiction Psychiatry (AAAP), and the Association for Medical Education and Research in Substance Abuse (AMERSA). To prepare for the meeting, the groups collaborated on a briefing paper, titled "Joining Forces."

We are very hopeful that HRSA's support will accelerate the development of training programs so that even more patients will have the substance use disorders diagnosed earlier and those who need it will have better access to specialized addiction care.

Participating in the meeting were (from left): Dr. Timothy Condon of NIDA; June Sivili of ONDCP; Dr. Michael Miller, representing ABAM; David Mineta of ONDCP; Dr. Shelly Greenfield, representing AAAP; Dr. Louis Baxter of ASAM; Dr. Mary Wakefield, HRSA Administrator; Dr. Kevin Kunz and Dr. Hoover Adger, representing ABAM; Dr. Joseph Liberto representing AAAP; Penny Mills of ASAM; Dr. James Callahan of ABAM; Dr. Patrick O'Connor of AMERSA; Dr. Jim McRae, Deputy Administrator of HRSA, and Kathryn Cates-Wessel of AMERSA.

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ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by those illnesses.

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ELECTION 2010: ALCOHOL MEASURES MIXED, MARIJUANA INITIATIVES FAIL

Election 2010 delivered decided mixed results for the alcohol and other drug initiatives on State ballots.

Marijuana Legalization and Medical Marijuana. California's efforts to legalize marijuana through Proposition 19 fell short of passage, with 56% of voters rejecting the measure (which was opposed by the current and past Directors of the Office of National Drug Control Policy).

Initiatives in South Dakota and Oregon related to medical marijuana also failed. South Dakota's Measure 13 lost, with only 37% of voters giving their support. Oregon's Measure 74 didn't fare much better, with "yes" votes at only 42%. On the other hand, with only Maricopa County left to count — and less than a 4,000 vote margin — Arizona voters appear to have approved Proposition 203, which would allow medical use of marijuana.

Alcohol Taxes, Privatization, and "Charge for Harm." Massachusetts voters repealed a 6.25% alcohol tax, while voters in Washington State blocked at least one measure seeking to end State liquor stores and privatize liquor distribution. Meanwhile, California approved Proposition 26, possibly negating efforts to require the alcohol industry, among others, to pay for the harm caused by their products.

Massachusetts voters narrowly approved Question 1, which would exempt alcohol purchases from State sales tax. In 2009, Massachusetts overturned a 6.25% sales tax exemption on beer, wine, and liquor, but passage of Question 1 restores the exemption. The beverage alcohol industry outspent the "No On 1 Campaign" by a 15 to 1 margin.

Washington State voters overwhelmingly struck down Initiative 1105, which would have privatized liquor distribution, removed liquor taxes, and forced retailers to purchase from distributors, with 63% voting against the initiative.

California's Proposition 26 passed with about 54% of the votes. The measure, which was heavily funded by the beverage alcohol industry, requires two-thirds of the votes rather than a simple majority to pass future State or local "mitigation" fees that recoup some of the damage caused by alcohol products.

Smoking Ban. South Dakota voters passed Referred Law 12, which bans smoking in bars, restaurants and casinos, with 65% of the votes. The bans were scheduled to go into effect November 10th.

Course Materials Available for Purchase

If you weren't able to attend the ASAM Review Course, we invite you to purchase the Course Syllabus and Study Guide. The print book and CD-Rom contain copies of the speakers' slides and recent articles related to the various topics, as well as an outline of each presentation and practice questions from the Exam Committee. The cost of the book plus CD-Rom set is $125 for ASAM members and $150 for non-members (prices include shipping and handling). To order, contact ASAM at 1-800-844-8948 or visit the ASAM website at www.asam.org.

Widely Used Analgesics Pulled From Market

Analgesics containing propoxyphene were pulled from the market November 20th at the request of the FDA. The agency noted that it has received new data suggesting that the drugs can cause fatal cardiac arrhythmias.

Physicians should immediately stop prescribing any product containing propoxyphene (both the monoproduct, such as Darvon, and the combination with acetaminophen, as in Darvocet), the FDA said. Patients taking propoxyphene should contact their physicians to discuss switching to another medication. *See the November **ASAM e-News** for more information on the FDA action and available options.*

President Obama Signs Safe Drug Disposal Act

President Obama signed the Safe and Secure Drug Disposal Act (S.B. 3397) into law October 12th. The law is intended to allow individuals to more easily and safely dispose of controlled substances while reducing opportunities for diversion.

Under the law, a patient who has been prescribed or otherwise lawfully obtained a controlled substance can deliver unused medications to a designated entity (such as a pharmacy or police agency) for destruction. The law thus addresses a longstanding problem, in that patients were not allowed to return drugs to a pharmacy or other DEA registrant because such a return could be considered outside the "closed chain of distribution" established by the Controlled Substances Act. The new law grants the Drug Enforcement Administration authority to promulgate regulations to facilitate such returns but does not authorize DEA to require such disposal programs.

Underage Drinking Act Referred to Committee

In a demonstration of bipartisanship, Congress members Lucille Roybal-Allard (D-CA), Rosa DeLauro (D-CT), Zach Wamp (R-TN) and Frank Wolf (R-VA) have introduced H.R. 6241, the Sober Truth on Preventing (STOP) Underage Drinking Act, to ensure the continuation of this legislation, initially enacted in 2006. The STOP Act reauthorization would build on the success of the original Act by continuing all the authorities in the bill until FY 2015. It:

- Authorizes an additional $4 million, for a total of $9 million for the Community Based Coalition Enhancement grants to current and past Drug Free Community grantees;
- Doubles the original investment in a multi-media campaign to educate parents and communities about the dangers of underage drinking to $2 million;
- Calls for an Institute of Medicine report on the literature regarding the influence of drinking alcohol on the development of the adolescent brain;
- Establishes grants to train pediatric health care providers in how best to screen and treat children and teens who have had alcohol exposures; and
- Maintains funding for critical underage drinking research. Introduced by Rep. Roybal-Allard and 21 co-sponsors, the act was referred to the House Committee on Energy and Commerce, where it was awaiting action as of November 12th.

Louis E. Baxter, Sr., M.D., FASAM

ASAM Board Acts on Drug Testing, Other Issues

Louis E. Baxter, Sr., M.D., FASAM

ASAM's Board of Directors held its Fall meeting the weekend of October 22-24th. It was the first full meeting attended by ASAM's new Executive Vice President, Penny S. Mills, M.B.A.

Issues addressed in the meeting included Public Policy and Advocacy, Membership and Chapters, Publications, and Finance and Operations.

Public Policy and Advocacy

In response to a report that the Centers for Medicare & Medicaid Services (CMS) has changed its policy on payments for some laboratory services, including urine drug testing, the Board approved the creation of a Drug Testing Action Group, to be chaired by John Femino, M.D. The Board charged Dr. Femino with representing ASAM at an upcoming meeting with representatives of CMS. Members who are interested in work with the new Action Group should contact ASAM's Director of Government Relations, Alexis Geier-Horan, at AGEIER@ASAM.ORG.

The Board also approved updates to the Society's Public Policy Statement on drug testing (see the summary below). A full copy of the updated policy is posted on ASAM's website (WWW.ASAM.ORG)

The Board approved the work plan of the Data Definition and Taxonomy (DDTAG) Action Group, which reported that it expects to have a definition of addiction ready to presented to the Board at its April 2011 meeting.

The Board discussed creating an action group to address issues related to performance measures, particularly as they relate to maintenance of certification (MOC) and Part IV of ABAM's MOC program. Further work on this will be examined at a future Board meeting.

Membership and Chapters

The Board approved the creation of the Northern New England chapter of ASAM, which is to include New Hampshire, Vermont, and Maine. The Board also approved the re-activation of the Texas chapter, under the leadership of new chapter President Terry Rustin, M.D., FASAM.

The Board approved creation of a small work group to develop recommendations as to how ASAM can work more collaboratively with the International Society of Addiction Medicine (ISAM). ISAM leaders have been invited to attend the April 2011 meeting of the ASAM Board.

Publications

The Board approved the appointment of Lori Karan, M.D., FASAM, as Chair of ASAM's Publications Council, succeeding Penelope Ziegler, M.D., FASAM. Dr. Karan was charged with recruiting new members to the Council and setting out priorities for ASAM publications in the coming year.

The Board approved two new publications that will begin in 2011: (1) a weekly online news brief that will provide news about ASAM's legislative advocacy and other ASAM activities, programs and products, and a summary of key news and science articles; and (2) an on-site newspaper for Med-Sci to provide daily news and information for attendees and electronic content for members unable to attend Med-Sci.

The Board asked the EVP to review ASAM's website needs and to submit recommendations to the Board at its January meeting.

Finance and Operations

The Board approved ASAM's budget for FY 2011 and the results of the 2009 audit. It also reviewed the 2011 Strategic Framework document that integrates ASAM's budget with its strategic plan and includes metrics for individual strategies and activities. Finally, the Board approved a process for reviewing the new EVP's performance.

Excerpts from: ASAM Public Policy Statement on Drug Testing (Revised 2010)

The collection and analysis of body fluids, especially urine samples, for the detection of alcohol, nicotine, other drugs, or their metabolites, is a common feature of many addiction treatment services….In some instances, effective medical treatment cannot proceed without laboratory testing of this type….

When physicians conduct diagnostic examinations to rule in/rule out a substance use disorder, the use of drug testing can be just as essential a component of the diagnostic process as are the laboratory and radiographic evaluations that are components of diagnostic assessments for metabolic disorders. Drug testing is also an important diagnostic procedure in the assessment of psychiatric conditions, in which aberrant behavior, perceptions, thought processes, or affective States could be attributable to either a primary psychiatric condition or to the effects of a psychoactive substance….

The American Society of Addiction Medicine recognizes that the high prevalence of unrecognized substance use disorders represents a major public health problem that requires evidenced-based interventions. Arbitrary restrictions on drug testing jeopardize these efforts and create a barrier to engaging patients into cost effective and beneficial treatment….

It is the policy of ASAM that:

1. Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and in monitoring of the ongoing status of a person who has been treated for addiction. As such, it is a part of medical care, and should not face undue restrictions.
2. Urine drug testing, compounds tested for, and the composition of testing panels ordered by the physician should be determined by the ordering physician to deliver quality patient care based on the unique clinical presentation of the patient.
3. Arbitrary limits on reimbursements and restrictions on the number of tests; number of analytes; panel composition and type; frequency of testing; or methodology of testing interfere with the physician's judgment and represent a discriminatory action prohibited by Federal mental health and addiction parity legislation, which States that any limitations on addiction care may not be substantially different from limitations in any other area of health care.

Note: The full text of this policy Statement is posted on ASAM's website. ASAM also has a Public Policy Statement addressing "Drug Testing in Workplace Settings."

HHS, FDA Launch Anti-Smoking Initiatives

Cigarette smoking and exposure to secondhand smoke kill an estimated 443,000 people in the U.S. each year. For every smoker who dies from a smoking-attributable disease, another 20 live with a serious smoking-related disease. Smoking costs the U.S. $96 billion in health care costs and $97 billion in lost productivity annually. Despite progress in reducing tobacco use, one in five U.S. high school students and adults still smoke.

Accordingly, reducing the rate of tobacco use — and preventing youth and adults from starting in the first place — is a top public health priority. To describe how it proposes to reduce smoking rates, the U.S. Department of Health and Human Services on November 10th released a new strategy document, "Ending the Tobacco Epidemic." The strategic plan proposes a comprehensive approach composed of what HHS describes as "proven, pragmatic, achievable interventions that can be aggressively implemented not only at the Federal level, but also within States and communities." Its goal is to enable the U.S. to meet the *Healthy People* objective of reducing the adult smoking rate to 12% by 2020. The strategic plan is built around the following four strategies, each supported by specific steps:

Strategy 1. Strengthen the implementation of evidence-based tobacco control interventions and policies in States and communities. Implementation steps include:

- ★ Expand evidence-based comprehensive tobacco control programs.
- ★ Enhance comprehensive cessation services in the States.
- ★ Reduce tobacco-related disparities through targeted interventions in locations serving high-risk populations (e.g., public housing, substance abuse facilities, mental health facilities, correctional institutions, community health centers, Ryan White clinics, rural health clinics, critical access hospitals).
- ★ Accelerate adoption of comprehensive smoke-free laws in every State.
- ★ Increase local, State, and tribal enforcement of tobacco regulations.

Strategy 2. Change social norms around tobacco use. Implementation steps include:

- ★ Conduct a mass media campaign designed to prevent initiation among youth, promote cessation among adults, and inform the public about the health consequences and toll of tobacco.
- ★ Promote reductions in youth exposure to on-screen smoking.

Strategy 3. Leverage HHS systems and resources to create a society free of tobacco-related disease and death. Implementation steps include:

- ★ Expand Medicaid and Medicare health insurance coverage to include comprehensive, evidence-based tobacco cessation treatment.
- ★ Ensure that all HHS health care delivery sites implement evidence-based, system-wide changes that prompt the identification of and clinical intervention with all tobacco users.
- ★ Enhance health care professionals' knowledge and adoption of effective tobacco cessation treatments through HHS provider education programs.
- ★ Enhance health care providers' incentives to promote tobacco cessation treatment.

Strategy 4. Accelerate research to expand the science base and monitor progress. Implementation steps include:

- ★ Develop and implement a Department-wide research plan to support FDA's regulatory authority over tobacco.
- ★ Develop innovative, rapid-response surveillance systems for assessing quickly evolving changes in products, exposure, tobacco industry practices, and public perception.
- ★ Expand research and surveillance related to high-risk populations to identify effective approaches to tobacco use prevention and cessation.
- ★ Expand research and surveillance to assess the effectiveness of both population-based and individual cessation interventions and tobacco addiction treatments.

Success in implementing the strategic plan is to be assessed in annual progress reports. To read the full strategy document and related materials, go to HTTP://WWW.HHS.GOV/ASH/INITIATIVES/TOBACCO/TOBACCOSTRATEGICPLAN2010.PDF.

NEW IMAGES FOR CIGARETTE PACKS

Health warnings for U.S. Food adn Drug Administration proposed regulation. "Required Warnings for Cigarette Packages andf Advertisements."

Also on November 10th, the Food and Drug Administration unveiled a proposed series of graphic images and warning messages for cigarette packs. On the assumption that existing warnings have lost their impact on smokers, some of the proposed images are deliberately startling.

The public has an opportunity to comment on the 36 proposed images through January 9, 2011. FDA will select the final nine graphics and warning Statements in mid-2011, following a comprehensive review of the relevant scientific literature, the public comments, and results from an 18,000-person survey. By October 22, 2012, manufacturers, importers, distributors and retailers will not be allowed to advertise or distribute cigarettes in the U.S. without the new health warnings.

To view all the images under consideration for cigarette packs, go to HTTP://WWW.FDA.GOV/DOWNLOADS/TOBACCOPRODUCTS/LABELING/CIGARETTEPRODUCTWARNINGLABELS/UCM232425.PDF.

How Will Recent Legislation Change Addiction Medicine?

A. Kenison Roy III, M.D., FASAM, DFAPA

With the passage and initial implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (Parity Act), the practice of Addiction Medicine has begun to change. Even more changes can be expected to accompany implementation of health care reform under the Patient Protection and Affordable Care Act, which will force radical changes in the delivery of addiction care. These landmark laws present a great opportunity to guide such changes in ways that will lead to a more comprehensive delivery system for addiction care, if addiction specialists are willing to seize the opportunity.

Addiction medicine practitioners have always said that we wanted our patients to be treated like the patients of our colleagues in other areas of medicine. Now we have our wish, as both the parity act and health care reform impose similar rules and benefits for addiction and general medical care. Now we in addiction medicine share with our colleagues in other fields of practice the burden of utilization management and other practices by third-party payers. However you may feel about the impact of managed care, and the future impact of health care reform, and to whatever extent our colleagues are burdened, we will be also.

As we move forward, we will be well served if we hearken to our roots and make use of ASAM's Public Policy Compendium and our other publications, such as the ASAM Patient Placement Criteria. In 1993, during President Clinton's effort to achieve health care reform, ASAM's Board adopted a Public Policy Statement on the "Core Benefit for Primary Care and Specialty Treatment and Treatment and Prevention of Alcohol, Nicotine and Other Drug Abuse and Dependence." This is an amazing document and, like the best of ASAM's policy Statements, rather timeless. The Statement provides language, concepts and clear thinking that was helpful recently in developing comments on the "Final Interim Rules" to implement the Parity Act.

Interim Final Rules on Parity

The piece of this that will require the attention of practicing addiction specialists is a decidedly vague reference in the Interim Final Rules to the issue of medical necessity criteria. ASAM's 1993 Public Policy Statement recommends that "the need for and level

A. Kenison Roy III, M.D., FASAM, DFAPA

of treatment must be a clinical judgment based on objective guidelines derived from research literature and clinical consensus, such as the guidelines in the ASAM Patient Placement Criteria For The Treatment of Substance-Related Disorders: Second Edition (ASAM PPC-2)." However, the Interim Final Rules allow each individual insurer to adopt its own medical necessity criteria.

Unfortunately, many insurers misread "medical" in medical necessity criteria as meaning something other than the predictors of relapse identified in Dimensions 4, 5 and 6 of the ASAM Patient Placement Criteria: readiness to change (Dimension 4), potential for relapse or continued use (Dimension 5), and recovery environment (Dimension 6). Those outside the addiction field, and particularly third-party payers, tend to view the PPC Dimensions from moralistic and judgmental perspectives. In contrast, addiction specialists view the Dimensions as reflecting the biology of addiction. The assessment dimensions of the ASAM Criteria are clearly validated by the research, but it will require the diligence of addiction specialists to insist that all six Dimensions of the criteria be considered by third-party payers.

If the availability of addiction services is based only on the first three of the six assessment dimensions — intoxication/withdrawal (Dimension 1), comorbid biomedical conditions (Dimension 2) or co-occurring psychiatric conditions (Dimension 3) — treatment will be unsuccessful, patients again will have "revolving-door" care, and pressures could mount to reverse the gains represented by the Parity Act and health care reform. We need the ASAM Criteria as a rational basis for decisions about when, where and how much care patients require.

Health Care Reform

Health care reform also promises to lead to revolutionary changes in how and where we practice addiction medicine. In the past, 80% of all treatment was funded by the Federal government, the States, and other government agencies. Physicians in these public systems often were marginalized, being brought in only to treat "medical" complications and comorbidities. In even cases where a physician served as medical director as part of a multidisciplinary team, he or she was not the leader of the team. Instead, a program director or other non-physician clinical supervisor was the leader. Even in private sector addiction treatment programs where a physician is the nominal team leader, the ownership and direction of program often has been non-medical and financially-focused.

In the new medical model of addiction care afforded by health care reform, physicians will have the opportunity to function in all the different ways our colleagues in mainstream medicine function, and to do that across all the levels of care described in the ASAM Patient Placement Criteria. We can join large multispecialty groups and respond to consultation requests. We will be able to see patients in a Level I general medical setting, we can associate with or form our own Level II programs, or we can join Level III or IV programs as medical directors (or form our own residential services). Many more patients will have insurance benefits for treatment at all levels of care and the availability of compensation will drive the development of services.

Most important, the most underserved patient with addiction — the employed patient with a strong work ethic and an intact family — will have insurance that allows him or her to afford treatment at whatever level of care is deemed medically necessary. As more of America's health care delivery is moved into multidisciplinary team-based patient-centered medical homes, we can rely on ASAM's Public Policy Statement on patient-centered medical homes to guide us as we move into those medical homes with them.

Addictionists Should Guide Changes

As the core group of addiction medicine specialists, ASAM members have an opportunity

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RECENT LEGISLATION

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to nurture and guide these changes in a way that ensures successful treatment for our patients. Such an opportunity requires that we review and acknowledge our core beliefs, as reflected in multiple ASAM Public Policy Statements: that addiction is a biological disease of the brain, that the disease affects the whole person and his or her support system, that recovery requires changes in addition to discontinuation of use, and that recovery requires time. We can do this most effectively if we work within the research-validated parameters of the ASAM Patient Placement Criteria.

A key step for ASAM is to work with the Parity Implementation Coalition to record evidence of non-adherence to the provisions of the Parity Act. If you have evidence that insurers or managed care firms are applying "non-quantitative limitations" on your addiction patients, or attempting to impose processes upon ASAM members that are not "substantially equal" to the processes in medical-surgical care, you should report this to one of the three Federal departments charged with assuring compliance and penalizing violators of the Act. ASAM's Legislative Advocacy Committee and Parity Action Group, working through our Government Relations Department (AGEIER@ASAM.ORG), can assist ASAM members in reporting concerns about non-conformance with the new law.

I wish to express my gratitude to Michael M. Miller, M.D., DFAPA, FASAM, Immediate Past President of ASAM, for editorial review and substantive contributions to content.

Health Reform Benefit Design Can Increase Access to Addiction Treatment

An estimated 23.5 million Americans currently need treatment for alcohol and drug addiction. However, Federal data show that only one in 10 (2.6 million) receive the treatment they need, leaving a treatment gap of more than 20 million Americans. Lack of insurance, inadequate insurance coverage and insufficient public funds are the primary reasons for the treatment gap, according to a new report from the group Closing the Treatment Gap, an initiative of the Baltimore-based Open Society Foundation.

While asserting that enactment of health reform means millions more Americans will have insurance coverage for addiction treatment as part of their basic benefit package, the report cautions that Federal and State regulators still have to translate and implement the vision by defining what will be included in the addiction treatment benefit for both public and private insurance.

Elements of a Meaningful Treatment Benefit

When health reform is fully implemented, almost all individual and small group plans — both within and outside the future health insurance exchanges — will be required to cover addiction treatment services at "parity" with other covered medical and surgical care. In addition, basic addiction treatment benefit and parity requirements will extend to the millions of newly eligible adult Medicaid beneficiaries. In its report, Closing the Treatment Gap articulates four principles that it says should guide the design of these benefits:

1. ***Provide equitable coverage for a full continuum of addiction services***. In order to be meaningful, the full range of addiction services — including prevention and screening, early and brief interventions, treatment, and support services — must be fully covered and available to both the patient and the patient's family members.
2. ***Ensure full access to health care benefits, including the entire range of addiction treatment benefits, to all those in need.*** Qualified treatment professionals — not insurance companies — should decide what treatment options and levels of care are appropriate. Insurance companies must not use bureaucratic hurdles such as preauthorization or preferred provider networks to deny coverage or care that treatment professionals deem necessary.
3. ***Promote and support the provision of high-quality addiction prevention, treatment, and support services and practices***. Health care reform should: (a) recognize that there is no single treatment that is effective for all individuals, which makes access to a full continuum of care critically important; (b) enhance financing for publicly funded safety net programs dealing with addiction; (c) support research on evidence-based addiction prevention and treatment services; and (d) create incentives for providers to implement evidence-based practices, including the use of appropriate medications.
4. ***Allow access to the full array of services appropriate for long-term health***. Successful management of addiction, like other chronic diseases, must include ongoing support such as appropriate housing, transportation, education and employment. Accordingly, a full continuum of services, including case management, outreach and other enhanced services should be made available.

The report echoes calls by ASAM and other field organizations for experts on addiction treatment to be involved in benefit design at the Federal and State levels.

Treatment Gap Narrowed But Not Closed

Finally, the report points to a number of areas in which the 2010 health reform legislation leaves holes in the network of services for persons with addiction. As examples, it points to the following:

- Large employers are not required to provide addiction treatment coverage. Their employees, therefore, may not have coverage for services they need.
- Medicaid coverage of addiction treatment for traditionally eligible individuals is not offered in every State, and services vary among States that do provide a treatment benefit.
- Systemic and societal obstacles continue to prevent many people from seeking addiction treatment. A number of current government policies result in discrimination — in housing, education, health care and employment — against those who disclose a history of addiction. These barriers can hinder the long-term health of those seeking treatment.

According to Victor Capoccia, director of Closing the Addiction Treatment Gap, the group will work with other field organizations to ensure that individuals receive the services and intervention they need, regardless of whether they are covered by health care reform, are unable to afford even subsidized insurance coverage, or do not have coverage that meets their treatment needs. Mr. Capoccia adds: "If this disease had any other name, Americans would never tolerate their family members and friends going without care."

CONFIDENCE IN CONFIDENTIALITY

Stuart Gitlow, M.D., M.P.H., M.B.A.

Stuart Gitlow, M.D., M.P.H., M.B.A.

The Health Insurance Portability and Account ability Act of 1996, generally referred to as HIPAA, was a landmark act that eliminated much of the protection that previously existed with respect to patient information held by a treating clinician.

The Privacy Rule, a component of HIPAA, allows the treating clinician to disclose otherwise protected health information without any authorization or permission by the patient in 12 specific instances. Patient information can be released freely under this provision to employers upon request for information concerning a work-related illness or injury. It can be released under a wide variety of local statutes, regulations, and court orders. It can be released to governmental authorities where victims of abuse, neglect, or domestic violence are involved. It can be released in response to a law enforcement official's request for information about a victim or suspected victim of a crime. It can be released when a clinician believes that protected health information is evidence of a crime that occurred on its premises.

That is but a small sampling of the wide range of disclosures that are permitted under HIPAA, again with absolutely no permission required from the patient. Can you imagine? Under HIPAA, if a clinician feels that a patient might have given a controlled substance to another patient while on the premises, thereby committing a crime, the clinician could comfortably turn both patients in to law enforcement officials. Similarly, an eager new law enforcement agent suspecting such behavior among your methadone program patients could request your records and under HIPAA fully expect that you would deliver these records at once.

Protections Under 42 CFR Part 2

Thankfully, we have Federal confidentiality regulations at 42 CFR Part 2, commonly called simply Part 2, that take precedence and protect our patients. Part 2 applies to all medical information about any person who has applied for or been given a diagnosis or treatment for substance use disorders at a Federally assisted program. Within Part 2 is protection for all such information, because Part 2 forbids disclosure to any third party, independent of those allowed within HIPAA, without specific approval by the patient.

In June 2010, SAMHSA released additional information as to how to apply these confidentiality regulations. In the past, Part 2 generally was interpreted to apply only to Federally assisted programs such as a licensed drug/alcohol treatment center. The newly released interpretation indicates that a private physician registered with the DEA to dispense a controlled substance used in the treatment of alcohol or drug abuse (such as buprenorphine) would also be included in Part 2 protections. Clinicians who use benzodiazepines for alcohol detoxification "require a Federal DEA registration and become subject to Part 2 through the DEA license," according to the new guidelines.

I find it difficult to imagine a scenario in which a clinician or program treats substance use disorders but would not fall under Part 2. The information protected by Part 2 is any information identifying an individual as having a current or past drug problem, or as being a participant in a Part 2 program. The latter sentence is fascinating: those of us with a DEA registration now represent a Part 2 program, and if we cannot release information indicating that individuals are patients, we cannot release any information about the patient. Note that this holds true even for purposes of payment except under certain specific conditions. Also to be taken into consideration are the specific elements required for patient consent to release of information. There are nine such elements, all of which must be in writing and which are fully described at 42 CFR § 2.31. The complete SAMHSA guidance is available at HTTP://WWW.SAMHSA.GOV/NEWSROOM/ADVISORIES/1006165837.ASPX

Debate within Addiction Medicine

The new guidance from SAMHSA has given rise to much debate within the field of addiction medicine. On one side are individuals who feel that HIPAA has left patient privacy tattered and torn, who are proud that our patients have very reasonable privacy provisions in place, and who believe that Part 2's protections should be expanded to cover all patients in any medical setting.

On the other side are individuals who have a deep concern that separating addiction patients in this way will cause further disdain for the diagnosis of a substance use disorder in patients for whom it may be applicable, resulting in a deterioration of availability of addiction treatment despite the obvious great need. These latter individuals have a further concern that as electronic health records (EHRs) become more prevalent under health reform, the privacy requirement applying to addiction patients could result in information about their treatment not reaching other treating clinicians. Imagine if a patient on methadone is admitted for surgery; the surgeon checks the available medical information and finds everything except that the patient is an opioid addict now maintained on 170mg of methadone per day. That could turn out to be a critical point of information.

However, under HIPAA alone, our methadone patient could find his employer knowing all about his past opioid addiction and current methadone maintenance simply as a result of an inquiry about a recent workplace accident that had nothing to do with the addiction history or treatment.

Is there a middle ground that would better serve our patients? It was simple in the good old days, when treating clinicians shared all the information about any given patient with one another but with no one outside the health care treatment boundaries. Is it possible to return to those days, yet still have the benefits possible in terms of public health and public safety that we could gain through further sharing of information?

What are your thoughts? Should Part 2 be kept as strong as it is, or is the wide-open lack of confidentiality inherent in HIPAA the way of the future? Please send me your solutions at DRGITLOW@AOL.COM.

This article has been adapted, with permission of the publisher, from the October 2010 issue of Counselor magazine, for which Dr. Gitlow writes the regular column "From the Addiction Physician."

EXCERPTS FROM:
Confidentiality of Patient Records and Protections Against Discrimination

A joint statement on confidentiality of patient records has been adopted by ASAM, the American Academy of Addiction Psychiatry (AAAP), the American Osteopathic Academy of Addiction Medicine (AOAAM), and the Association for Medical Education and Research in Substance Abuse (AMERSA). Excerpts from the statement follow.

The patient-physician relationship is the foundation of medical care and is often considered a sacred trust. The uniqueness of this relationship derives from the mutual understanding that the encounter is confidential; that what is said by each party is kept private from all others except for a lifting of confidentiality specifically approved by the patient. Confidentiality is required by professional ethical standards, by medical practice acts, and by Federal and State law….

The privacy of medical records documenting addiction treatment is especially important. Confidentiality is the fundamental requirement for the establishment of trust when the most private details of a person's life are revealed. Activities of addiction treatment providers are addressed by laws which recognize that these special therapeutic relationships should be protected by the strictest expectations of confidentiality. Chapter 42 of the Code of Federal Regulations, Part 2 (42 CFR Part 2) is the statute in Federal law that requires that documents of addiction treatment be held to higher standards of confidentiality than even psychiatric records, and far higher than records of general medical encounters….

Increasingly, health care providers and health delivery systems rely on electronic health records (EHR) and electronic exchange of health information to facilitate the sharing of vital health information among different providers, treatment settings and insurers. Within an EHR, physicians and other professionals from a range of disciplines can coordinate their efforts, reduce duplication of services through pulling together all data into a single repository, and thus allow for reduction in medical errors and an overall improvement in quality of services and in clinical outcomes. However, the advent of EHR presents new challenges to addiction professionals who both want the best overall care for their patients and the utmost of privacy from those who would discriminate against them based on their health condition.

Therefore, the above named organizations recommend the following general principles of confidentiality applicable to health records of patients receiving addiction treatment:

Recommendations

1. In general, the patient's personal health information should be available to parties providing health care services to the patient, and not to other parties; but, within the health care delivery system, free exchange of basic health information, including via sharing of electronic health records or via the placement of basic health information into an electronic health information exchange, should be permitted by the patient's initial consent for treatment….
2. An additional basic principle of confidentiality is that personal health information should not be released outside of the health care system without the explicit written consent of the patient….
3. Any access to health information obtained in the course of facility inspections and quality assurance activities should be handled only by individuals and entities that agree in writing to avoid any secondary release of this information, and to store and analyze data from health records of patients only after patient identifiers have been removed from the files. Health information used for research purposes should not be subject to secondary release of personally identifiable data except as allowable under Federal research regulations….
4. Information submitted to prescription drug monitoring programs should be accessible by pharmacists, physicians, and other licensed independent health care providers with prescribing authority, as well as by public health officials, but not by persons outside the health care or public health systems….
5. Penalties for unauthorized release and use of confidential medical information should be severe….
6. Health care professionals are bound by ethical standards to not discriminate against patients and to offer care equally to all. Health care professionals, including physicians, pharmacists, and others who receive basic health information through a health information exchange or a shared electronic health record, should not use this information to discriminate against patients regarding their quality and access to care. Professionals who discriminate against patients or prospective patients on the basis of such personal health information should be subject to professional and legal sanctions….
7. Health insurers should not deny payment of claims for health services based on knowledge of a patient's health conditions such as substance use and addiction, mental disorders, genetic conditions, and information about infectious diseases such as hepatitis, human immunodeficiency virus infection, and sexually transmitted diseases….

For the full text of the statement, go to WWW.ASAM.ORG.

Implantable Buprenorphine Shows Promise

Limitations of existing pharmacologic treatments for opioid dependence include low adherence, medication diversion, and emergence of withdrawal symptoms, so development of new medications is a high priority. A study reported in the *Journal of the American Medical Association* shows promising findings for an implantable formulation of buprenorphine (Probuphine), which delivers a low, steady dose of the medication for up to six months.

For the study, a randomized, placebo-controlled, six-month trial was conducted at 18 sites across the U.S. between April 2007 and June 2008. Of 163 adults aged 18 to 65 years who had been diagnosed with opioid dependence, 108 were randomized to receive buprenorphine implants and 55 to receive placebo implants. After induction with sublingual buprenorphine-naloxone tablets, patients received either 4 buprenorphine implants (80 mg per implant) or 4 placebo implants. A fifth implant was available if a threshold for rescue use of sublingual buprenorphine-naloxone treatment was exceeded. Standardized individual drug counseling was provided to all patients.

A total of 71 of 108 patients (65.7%) who received buprenorphine implants completed the study, compared to 17 of 55 (30.9%) who received placebo implants (P < .001). Outcomes were assessed according to the percentage of urine samples that were negative for illicit opioids for weeks 1 through 16 and for weeks 17 through 24. The buprenorphine implant group had significantly more urine samples negative for illicit opioids during weeks 1 through 16 (P = .04). Those who received buprenorphine implants had fewer clinician-rated (P <.001) and patient-rated (P = .004) withdrawal symptoms, had lower patient ratings of craving (P <.001), and experienced a greater change on clinician global ratings of severity of opioid dependence (P<.001) and on the clinician global ratings of improvement (P < .001) than those who received placebo implants. Minor implant site reactions were the most common adverse events, affecting 61 patients (56.5%) in the buprenorphine group and 29 (52.7%) in the placebo group.

The researchers concluded that, among persons with opioid dependence, the use of buprenorphine implants compared with placebo resulted in less opioid use over 16 weeks as assessed by urine samples.

Source: Ling W, Casadonte P, Bigelow G, Kampman KM, Patkar A, Bailey GL, Rosenthal RN, Beebe KL. Buprenorphine implants for treatment of opioid dependence: A randomized controlled trial. JAMA. 2010 Oct 13;304(14):1576-83.

Mental Health Problems Increase with Exposure to Second-Hand Smoke

A new study has confirmed that mental health problems such as depression and anxiety increase along with exposure to second-hand smoke. In the study, Dr. Mark Hamer of University College London and colleagues combined measurements of tobacco exposure (using salivary cotinine level as a circulating biochemical marker) with interviews focused on mental health issues. They found that nonsmokers exposed to tobacco smoke were more likely to experience psychiatric distress than those were were not so exposed, and that the severity of the mental health issues increased in tandem with the tobacco exposure. They also found that, as with smokers, persons exposed to second-hand smoke were more likely to be admitted to a hospital for a psychiatric illness than were persons who were not exposed to tobacco smoke.

Specifically, psychological distress was apparent in 14.5% of the sample. In logistic regression analyses of the cross-sectional data, after adjustments for a range of covariates, high levels of exposure to second-hand smoke among nonsmokers was associated with higher odds of psychological distress (odds ratio = 1.49; 95% confidence interval, 1.13-1.97) . In prospective analyses, risk of a psychiatric hospital admission was related to high levels of exposure to second-hand smoke (multivariate adjusted hazard ratio = 2.84; 95% confidence interval, 1.07-7.59), as well as active smoking (multivariate adjusted hazard ratio = 3.74; 95% confidence interval, 1.55-8.98).

Dr. Hamer and colleagues commented that these concordant findings, using two different research designs, emphasize the importance of reducing exposure to second-hand smoke at a population level, not only for physical health but also for mental health.

Source: Hamer M, Stamatakis E & Batty GD. Objectively assessed secondhand smoke exposure and mental health in adults: cross-sectional and prospective evidence from the Scottish Health Survey. Archives of General Psychiatry 2010 Aug;67(8):850-55.

Twin Study Supports Simpler Method of Identifying Genetic Influence on Alcohol Consumption

While previous twin studies have consistently shown the importance of genetic influences on various measures of alcohol consumption, a full diagnostic assessment can be complicated and costly. This has led some researchers to ask: To what extent do measures of alcohol consumption accurately assess the genetic risk for alcohol dependence? According to Kenneth S. Kendler, M.D., Banks Professor of Psychiatry at the Virginia Commonwealth University School of Medicine, the results of a new study indicate that four relatively simple measures of alcohol consumption are able to capture all of the genetic risk for alcohol dependence in women, and a very large proportion of the genetic risk in men.

For the study, Dr. Kendler and colleagues assessed the lifetime history of alcohol dependence in 5,073 same-sex adult twins (2,090 complete pairs and 893 twins whose co-twins did not participate) from the Virginia Twin Registry, using DSM-IV criteria, and compared that information to four measures of alcohol consumption at the time of heaviest drinking: drinking frequency, regular quantity, maximum quantity, and drunk frequency. They found that these relatively simple measures of alcohol consumption were able to capture all or nearly all of the genetic risk for the DSM-IV diagnosis of alcohol dependence,

"This research has both theoretical and practical implications," Dr. Kendler noted, adding that relatively simple measures of drinking behavior can make the process of risk identification easier and faster for everyone.

Source: Kendler KS et al., Alcoholism: Clinical & Experimental Research, 2010 June [Epub ahead of print] and Addiction Science Made Easy, a project of the Addiction Technology Transfer Center National Office, with support from the Center for Substance Abuse Treatment of SAMHSA.

Maternal Age Matters in Prenatal Alcohol Exposure

Previous studies have shown that the presence and severity of Fetal Alcohol Spectrum Disorders (FASD) are influenced by factors beyond alcohol consumption. A new study finds that maternal age appears to be a significant factor.

The study examined the effects of alcohol use during pregnancy by mothers age 30 and older, as compared to women age 29 or younger. The study assessed measures of attention in 462 children (231 boys, 231 girls) born to inner-city women who were recruited during pregnancy at a university antenatal clinic. Investigators examined binge drinking, smoking, and the use of cocaine, marijuana and opiates among the mothers. At seven years of age, the children completed a Continuous Performance Test and their teachers completed the Achenbach Teacher Report Form.

Dr. Lisa Chiodo, an assistant professor in the college of nursing at Wayne State University and lead author of the study, says the study found that children born to older drinking mothers have more alcohol-related attention deficits than children born to younger drinking women. Noting that the finding is consistent with prior studies, Dr. Chiodo added that it "may be due to older moms drinking for longer periods, greater alcohol tolerance, and having more alcohol-related health problems — all leading to higher levels of alcohol in their fetuses."

Dr. Chiodo cautions that "it is important for women and clinicians to understand that although previous children born to one woman following pregnancy drinking might not have been affected by the alcohol, this may not be true for subsequent pregnancies, or for other women. Children of older women appear to be particularly vulnerable to the effects of prenatal alcohol exposure."

Source: Chiodo LM, Da Costa DE, Hannigan JH, Covington CY, Sokol RJ, Janisse J, Greenwald M, Ager J & Delaney-Black V. The impact of maternal age on the effects of prenatal alcohol exposure on attention. Alcoholism: Clinical & Experimental Research (ACER). 2010 Oct; 34(10):1813-1821.

Outcomes Worse for Alcoholic Liver Disease Than Other Liver Disease

A new study of the prognosis for patients hospitalized for liver diseases between 1969 and 2006 examined differences in mortality and complications between patients with alcoholic and non-alcoholic liver diseases. For the study, investigators used data from the Swedish Hospital Discharge Register and Cause of Death Register between 1969 and 2006 to both identify and follow up a cohort of 36,462 patients hospitalized with alcoholic liver diseases and 95,842 patients hospitalized with non-alcoholic liver diseases.

Their main finding was that mortality risk was significantly higher in alcohol- versus non-alcohol-related liver disease. Dr. Knut Stokkeland, an instructor in the department of medicine at Visby Hospital in Sweden and corresponding author for the study, explained that the key difference between alcoholic and non-alcoholic liver disease is that alcohol dependence "increases the risks of social problems, being a smoker, and severe psychiatric diseases," adding that "it also inhibits staying sober, which may stop disease progression."

Dr. Johan Franck, a professor of clinical addiction research at Karolinska Institutet in Sweden, noted that the implications of the study are that "patients with alcohol-induced liver diseases should receive more attention, and they should routinely be offered treatment for their alcohol-use disorder." Dr. Franck added: "Given that alcohol doubles the risk of having a serious liver disease, efforts to reduce alcohol drinking will likely have a positive impact on the diseases' outcome."

Source: Stokkeland K, Ebrahim F & Ekbom A. Increased risk of esophageal varices, liver cancer, and death in patients with alcoholic liver disease. Alcoholism: Clinical & Experimental Research (ACER). 2010 Nov; 34(11): 1993–1999.

How Fast Does Alcohol Dependence Develop?

About 1 in 7 adults who have been diagnosed with alcohol dependence developed it less than a year after having their first drink, according to unpublished data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationwide survey of U.S. adults aged 18 or older. Another 24% developed alcohol dependence less than 2 years after their first drink, about a third in less than 3 years, and about half in less than 5 years.

In the U.S., most people have their first drink by the time they leave high school.

In the U.S., most people have their first drink by the time they leave high school. This fact, combined with the relatively rapid onset of dependence in many drinkers, helps to explain why alcohol dependence is most often found among young adults. About 1 in 9 persons aged 18–24 have alcohol dependence — more than twice the proportion of any other age group.

Source: National Institute on Alcohol Abuse and Alcoholism, 2010.

LEVAMISOLE PROBLEM GROWING

Experts estimate that 60% to 90% of the cocaine sold in North America (both powder and crack) is being cut with a potentially dangerous but inexpensive additive called Levamisole. As reported in the Autumn 2009 issue of ASAM News, levamisole is a veterinary medicine used to de-worm livestock

Federal officials believe levamisole is added to cocaine at the point of manufacture outside the U.S. Anecdotal reports suggest that some users believe levamisole enhances the euphoric effects of cocaine.

What is clear is that levamisole severely weakens the immune system, suppressing the white cell count. The resulting condition, termed agranulocytosis, affects individuals who snort, smoke, or inject crack or powder cocaine contaminated by levamisole. All are at risk for overwhelming, rapidly developing, life-threatening infections.

The Canadian Harm Reduction Coalition has created a website, HTTP://WWW.LEVAMICOKE.INFO, to warn users about the dangers of levamisole-contaminated cocaine.

SAMHDA
SUBSTANCE ABUSE & MENTAL HEALTH DATA ARCHIVE
The data you need and the tools to analyze them

Are you interested in determining the average age at which men begin smoking compared to women? What if you need to know about differences in marijuana use based on age, gender, education, or race? These and countless other questions can be answered by studies in the Substance Abuse and Mental Health Data Archive (SAMHDA) data holdings.

An initiative of the Substance Abuse and Mental Health Services Administration, SAMHDA provide a single point of access to many important data sets, such as the National Surveys on Drug Use and Health (NSDUH) and the Treatment Episode Data Set (TEDS).

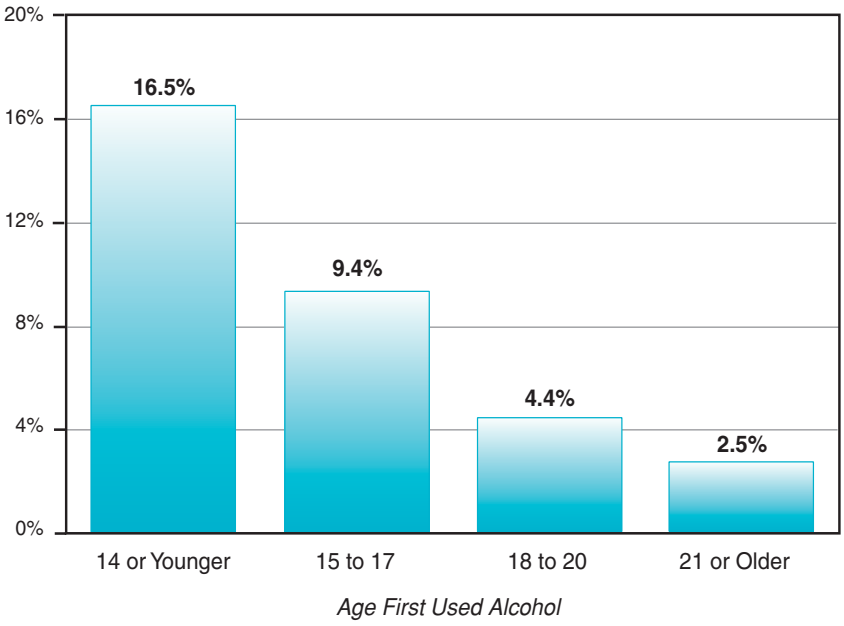
SAMHDA is based at the Inter-university Consortium for Political and Social Research at the University of Michigan, where it can be accessed at HTTP://WWW.ICPSR.UMICH.EDU/ICPSRWEB/SAMHDA/.

Early Alcohol Use Increases Risk of Abuse or Dependence

Early onset of alcohol use is associated with a greater likelihood of developing alcohol abuse or dependence at a later age, according to data from the National Survey on Drug Use and Health (NSDUH).

Individuals whose first use of alcohol occurs at or before age of 14 were nearly four times more likely to meet the criteria for past year alcohol abuse or dependence than those who started using alcohol between the ages of 18 and 20 (16.5% vs. 4.4%) and more than six times more likely than those who started using alcohol at or after age 21 (16.5% vs. 2.5%).

PERCENTAGE OF PERSONS AGE 21 OR OLDER WHO ABUSED OR WERE DEPENDENT ON ALCOHOL IN THE PAST YEAR, BY AGE OF FIRST ALCOHOL USE, 2009



NOTE: Abuse or dependence is defined using DSM-IV criteria.

Source: Office of Applied Studies, Results from the 2009 National Survey on Drug Use and Health: Detailed Tables, 2010. Rockville, MD: Substance Abuse and Mental Health Services Administration. [Available online at http://oas.samhsa.gov/WebOnly.htm#NSDUHtabs]

Buprenorphine Shortens Hospital Stay for Opiate-Exposed Neonates

A newly published study compared two treatments for neonatal abstinence syndrome (NAS) by dividing full-term infants with NAS into two groups: one given oral morphine, the current standard of treatment, and the other given buprenorphine to treat their symptoms.

Preliminary findings showed the treatment with buprenorphine to be safe and effective. In fact, infants in the buprenorphine group required fewer days of treatment (23 compared to 38 for the morphine group) and shorter hospital stays (32 days compared to 42 for the morphine group).

The study suggests that buprenorphine is a viable option for treating NAS in infants and may be more advantageous than morphine by allowing shorter hospital stays. However, the investigators caution that more research is needed before firm comparative conclusions can be drawn.

Source: Kraft et al. Revised dose schema of sublingual buprenorphine in the treatment of the neonatal opioid abstinence syndrome." Addiction 2010 Oct. 10 [Epub ahead of print].

HAART Therapy Reduces New HIV Cases in Injection Drug Users

Highly active antiretroviral therapy (HAART), currently known for its therapeutic benefits against HIV, also reduced the spread of the virus among persons with a history of injection drug use, according to a population-based study funded by the National Institute on Drug Abuse.

For the study, researchers analyzed information from two databases that provide information on HAART use, examining viral load, new HIV diagnoses, and HIV and viral load testing information in British Columbia, where residents are provided free access to HIV care. During three distinct time periods, they observed that the number of individuals actively receiving HAART had a strong impact on viral load and new diagnoses in the community. As HAART coverage increased sharply, new HIV diagnoses decreased sharply. As HAART coverage stabilized, so did viral load and new HIV diagnoses. "Our results clearly demonstrate that there is a connection between treatment and prevention not just among the general population, but among injection drug users as well," said Dr. Julio Montaner, the study's lead author and director of the BC Centre for Excellence in HIV/AIDS. "Expanding HAART coverage within current medical guidelines will prevent disease progression and decrease new HIV infections."

"This study strengthens the evidence that maximizing HAART coverage within current medical guidelines will help to curb the spread of HIV," said NIDA Director Dr. Nora D. Volkow. "These findings are especially important since new HIV cases have remained stubbornly steady in the United States at a rate of about 56,000 per year for the past 10 years." Worldwide, there were 2.7 million new HIV infections in 2008. In the United States, more than 1 million people live with diagnosed or undiagnosed HIV/AIDS.

Source: Montaner JS, Lima VD, Barrios R, Yip B, Wood E, Kerr T, Shannon K, Harrigan PR, Hogg RS, Daly P, Kendall P. Association of highly active antiretroviral therapy coverage, population viral load, and yearly new HIV diagnoses in British Columbia, Canada: a population-based study. Lancet. 2010 Aug 14;376(9740):532-29.

SAMHSA Publishes New Treatment Advisory on Protracted Withdrawal

SAMHSA's "Protracted Withdrawal," Substance Abuse Treatment Advisory, Volume 9, Issue 1, promises to help addiction specialists and other treatment professionals manage patients' protracted withdrawal . The Advisory differentiates acute from protracted withdrawal and provides an overview of the signs and symptoms of protracted withdrawal. It also provides guidance on differentiating between protracted withdrawal (which resolves over time) and a co-occurring mental disorder.

Exhibit 1. Acute Withdrawal Timeframes for Specific Substances

Substance	Acute Withdrawal Timeframe
Alcohol[6, 7]	5–7 days
Benzodiazepines[8, 9]	1–4 weeks; 3–5 weeks with tapering (i.e., reducing dosage gradually)
Cannabis[10]	5 days
Nicotine[11]	2–4 weeks
Opioids[12]	4–10 days (methadone withdrawal may last 14–21 days)
Stimulants (e.g., amphetamines, methamphetamine, cocaine)[13]	1–2 weeks

The Advisory can be viewed online and downloaded at no cost from www.samhsa.gov. Print copies can be ordered from SAMHSA at http://store.samhsa.gov or by phoning 1-877-SAMHSA-7 (1-877-726-4727). Request publication number (SMA) 10-4554.

Renew Your ASAM Membership Online

ASAM members can renew their memberships online or by telephone under a system implemented this year. Paper renewal notices will not be mailed out. Instead, renewal notices were emailed to members in October. Memberships can be renewed online through the Members Only section of the ASAM website (www.asam.org) or by phoning the national office at 301-656-3920 or 1-800-844-8948.

Members who renew before January 1, 2011, will be automatically entered in a drawing for a free registration for the 2012 Med-Sci Conference or a complimentary one-year membership renewal. Winners will be announced during ASAM's 2011 Med-Sci Conference in Washington, DC.

Don't miss out on your membership benefits, including **ASAM News**. If you have not already renewed your ASAM membership for 2011, please do so today!

Ruth Fox Memorial Endowment Fund

Dr. Ruth Fox

Dear Colleague:

At ASAM's Annual Med-Sci Conferences, we honor a group of physicians-in-training who have been chosen to receive Ruth Fox Scholarships. These scholarships are an important component of ASAM's educational mission, because they allow an outstanding group of physicians-in-training to attend the Medical-Scientific Conference and the Ruth Fox Course for Physicians. The scholarships cover travel, hotel and registration expenses, as well as one year's membership in ASAM.

The scholarships are but one example of the work supported by the Ruth Fox Memorial Endowment Fund, which was established to assure ASAM's continued ability to provide ongoing leadership in newly emerging areas of addiction medicine, to continue its commitment to educating physicians, to increasing access to care and to improving the quality of care.

With your participation and continued support, the Fund will continue to fulfill its mission. If you have not already pledged or donated to the Endowment Fund, please do so now. For information about making a pledge, contribution, bequest, memorial tribute, or to discuss other types of gifts in confidence, please contact Claire Osman by phone at **1-800/257-6776** or **1-718/275-7766**, or email Claire at ASAMCLAIRE@AOL.COM. She welcomes your calls. All contributions to the Endowment Fund are tax-deductible to the full extent allowed by law.

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Federal Agencies Move Against Alcohol-Based "Energy Drinks"

In letters released November 17th, the U.S. Food and Drug Administration warned six manufacturers of alcohol energy drinks that their products are not safe for human consumption and must either be reformulated or taken off the market. The letters gave manufacturers 15 days to come into compliance. If they do not, the Federal government could seize the drinks and sue the companies responsible for them. The warning letters were sent to Phusion Projects, Inc., maker of Four Loko, as well as Charge Beverages Corp., which makes the Core High Gravity line of alcohol energy drinks; New Century Brewing Co., LLC, which produces Moonshot; and United Brands Company Inc., which manufactures Joose and Max. Major beverage alcohol producers such as Anheuser-Busch and MillerCoors bowed out of the alcohol energy drink business last year, voluntarily removing Tilt, Sparks, and Bud Extra from the market.

Simultaneously, Treasury Department officials announced that, based on the FDA's conclusion, the companies would be told that the products had been mislabled and thus are illegal to ship. Also, the Federal Trade Commission informed the firms that marketing their products risked violating Federal law.

The FDA warning came over objections from Phusion that their drinks are safe and that other alcohol and caffeine combinations, such as Irish coffee and rum-and-coke, have gone unquestioned. Joshua M. Sharfstein, M.D., FDA Principal Deputy Commissioner, rejected that argument, noting in a press release that accompanied the letters, "To the contrary, there is evidence that the combinations of caffeine and alcohol in these products pose a public health concern."

The FDA letter came after a year-long investigation into the safety of drinks that mix large amounts of alcohol and caffeine. Four Loko, which features a variety of fruit flavors, combines a 12% alcohol content (equivalent to about four cans of beer) with three times the amount of caffeine in a regular cup of coffee, all in a 23.5-ounce can that sells for as little as $2.75. Four Loko earned an estimated $200 million in 2009 sales for its manufacturer, Phusion Projects, Inc.

Alcohol-laced energy drinks began to receive national scrutiny after an October 2010 party in Washington State that resulted in the hospitalization of nine university students with blood-alcohol levels ranging from 0.12 percent to 0.35 percent. A female student nearly died. All the hospitalized students, who ranged in age from 17 to 19, were inexperienced drinkers. Toxicology results showed no drugs in their bloodstreams. Their drink of choice, Four Loko, came to be known as "blackout in a can" and subsequently was banned in Washington State, Massachusetts, Michigan, Utah, and California, as well as on many college campuses.

As early as October 2008, a group of 100 scientists and physicians sent a petition to the FDA urging the agency to increase regulation of all energy drinks. The experts warned the FDA that the wide disparity in caffeine and alcohol content in various brands of energy drinks is not properly noted on the labels, increasing the risk of caffeine intoxication and alcohol-related injuries.

As if fulfilling their predictions, the FDA's action followed by a week the death of 21- year-old Courtney Spurry of St. Michaels, Maryland, who perished in a traffic crash after drinking two cans of Four Loko at a party. It also followed the filing of a wrongful death suit against Phusion Projects by the family of Florida college student Jason Keiran, 20, who committed suicide after consuming Four Loko.

In anticipation of the FDA's action, Phusion Projects announced November 16th that it would reformulate its product to remove the caffeine and taurine. The FDA acknowledged that Phusion's announcement would be a positive step, but said it had not been officially notified by the company that it intends to do so. Also, experts cautioned that a very high-alcohol drink with the caffeine taken out remains a dangerously high-alcohol drink.

ASAM Conference Calendar

ASAM EVENTS

December 10-12, 2010
ASAM's Comprehensive MRO Course: Toxicology Testing and the Physician's Role in the Prevention and Treatment of Substance Abuse
Capitol Hilton Hotel, Washington, DC
Approved for up to 21 Category 1 CME credits

April 14, 2011
Ruth Fox Course for Physicians
Capitol Hilton Hotel, Washington, DC
Approved for up to 8 Category 1 CME credits

April 14, 2011
Common Threads:
Pain and Addiction
Capitol Hilton Hotel, Washington, DC
Approved for up to 8 Category 1 CME credits

April 14-17, 2011
ASAM's 42nd Annual Medical-Scientific Conference
Capitol Hilton Hotel, Washington, DC
Approved for up to 21 Category 1 CME credits

OTHER EVENTS OF NOTE

December 2-5, 2010
American Academy of Addiction Psychiatry (AAAP)
21st Annual Meeting and Symposium
Boca Raton Resort & Club,
Boca Raton, Florida
[For more information or to register, go to WWW.AAAP.ORG or phone 401-524-3076]

January 14-16, 2011
Illinois Society of Addiction Medicine (ISAM)
Conference on Authority and Leadership in Chicago, Illinois
[For more information, contact ISAM at www.isam-asam.org
Or Dr. Jeffrey Roth at WWW.JROTHMD@GMAIL.COM]

April 29-30, 2011
Addiction Medicine 2011 Conference
Ashville, North Carolina
Sponsored by the North Carolina Society of Addiction Medicine
and the Governor's Institute on Alcohol & Substance Abuse
[For more information or to register, go to SA4DOCS.ORG]

Except where otherwise indicated, additional information is available on the ASAM website (WWW.ASAM.ORG) or from the ASAM Department of Meetings and Conferences at 4601 No. Park Ave., Suite 101 Upper Arcade, Chevy Chase, MD 20815-4520; phone 301/656-3920; fax 301/656-3815; email EMAIL@ASAM.ORG.

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