

# ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

Volume 19 Number 06

February 5, 2007

Print ISSN 1042-1394

Online ISSN 1556-7591

## HIGHLIGHTS...

Because of an alarming increase in methadone overdose deaths, West Virginia legislators are clamping down on methadone maintenance treatment. Ironically, though, the increase in overdoses is most likely caused by an increase in prescribing the medication for pain relief. The federal government and West Virginia officials are mounting an education campaign aimed at physicians and the public to help deal with the problem. *See story, top of this page.*

A new program in Alabama is using substance abuse treatment funds to provide 16 group home beds for women with co-occurring disorders. The women are to be discharged from the Searcy state mental health facility into the group homes, which are aimed at providing substance abuse treatment. The funding is all coming from the state, not the block grant, in this microcosm of how to divvy up mental health and substance abuse resources. *See story, bottom of this page.*

## INSIDE THIS ISSUE...

Utah governor requests new facilities, drug court expansion  
... *See page 4*

SA seen as common thread in repeat emergency patients... *See page 6*

© 2007 Wiley Periodicals, Inc.  
Published online in Wiley InterScience  
(www.interscience.wiley.com) DOI: 10.1002/adaw.20076

## Methadone overdose deaths lead to restrictive bills in West Virginia

### *Situation mirrors national misconceptions*

Methadone maintenance treatment is under fire in West Virginia because of an increase in overdose deaths (99 in 2004, with West Virginia having more methadone overdoses than any other state). Ironically, there is no data that shows whether these deaths were due to methadone maintenance treatment, methadone prescribed for pain, or diverted methadone.

According to addiction officials in West Virginia and the federal government, the increase in methadone mortality is not related to methadone maintenance treatment, but rather is due to misused pain medication, according to West Virginia and federal addiction officials.

But this hasn't stopped what seems to be a press-politician juggernaut against methadone maintenance. Due to widespread public misconceptions about methadone, it is the addiction treatment that is being targeted for local restriction.

In West Virginia, legislation prohibiting any new for-profit methadone programs was introduced January 26, and additional legislation was being considered that might limit methadone treatment to 12 months. Other regulatory measures are being looked at as well. Of the eight methadone maintenance programs in West Virginia, seven are owned by addiction treatment giant CRC Health Group. All are for profit.

Phillip Herschman, M.D., president of CRC's Opiate Treatment Program  
[See METHADONE on page 2](#)

### *Trends in co-occurring disorder funding*

## Alabama using SA treatment funds for patients discharged from mental facility

It's a festering issue for the field — who will pay for treatment for people with co-occurring mental and addictive disorders. In Alabama, where substance abuse, mental illness, and mental retardation are all under the same umbrella, a state pilot project is taking \$640,000 of addiction treatment money and putting it in two group homes for women being discharged from the state mental hospital.

The program will fund 16 beds — eight in each of the group homes — and funding is for the current fiscal year, ending in September 2007. It is from state, not SAPT block grant, dollars. The programs are Emma's

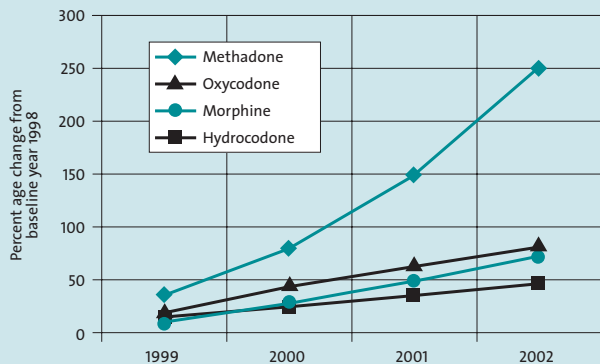
Harvest Home, and Second Choice, Inc. They are both group homes for addicted women, and the funding comes from the Division of Substance Abuse Services.

### **\$325 vs. \$83 per diem**

The figures tell the story: a day in Searcy, the state mental facility in Mobile, costs \$325. In a group home, it's \$83.

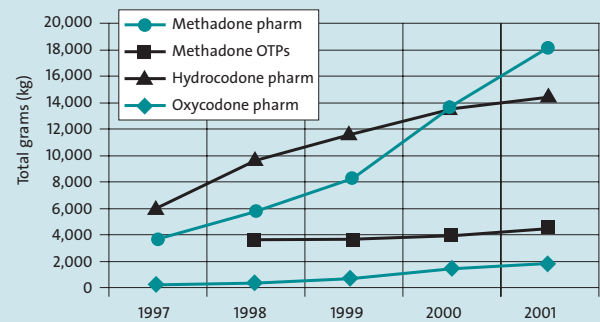
But beyond the cost savings, the group homes will also improve recovery rates, according to John Ziegler, Ph.D., spokesman for the Department of Mental Health and Mental Retardation (the division of  
[See ALABAMA on page 6](#)

**Percent change in distribution of methadone and three comparison drugs, from baseline year 1998-2002**



Source: Data from IMS Health, National Prescription Audit Plus, courtesy of Laura A. Governale, PharmD.

**Distribution of methadone through optional treatment programs (OTPs) and pharmacies, compared**



Source: Data derived from DEA ARCOS-2; methadone pharmacy 2000 data are an interpolated estimate.

**METHADONE from page 1**

gram, was in West Virginia last week enlightening lawmakers about methadone maintenance treatment. It was an uphill battle. “We tried to educate politicians, brought them into clinics, and until this point they believed the anecdotal stuff about overdoses,” he told *ADAW*. “We were able to show them that this methadone came from prescriptions, not clinics,” he said.

This was the state where the newspaper series “Killer Cure” about methadone ran last year (see *ADAW* June 26, 2006), and where press coverage about methadone overdoses has not let up. It’s also a certificate-of-need state, which

means CRC must apply to develop any new clinics. It has one such application in, and that has brought the situation to a head.

“We wanted to develop a clinic in Mercer County, because we had too many patients driving two hours to other counties,” Herschman told *ADAW*. But at the hearing late last year, there was no support except for from licensing authorities. While he’s used to some resistance, what surprised him was the “depth of the emotional response.” Opposition came from police, district attorneys, the Chamber of Commerce, and finally got the attention of politicians. The result was two bills — one in the House of Delegates (H.B. 2572),

one in the Senate (S. 193) — which would prohibit any new methadone treatment programs in the state except for those that are not for profit. If the bills became law, the ban would take effect July 1, 2007.

**Time limits an issue**

Both bills are as much anti-CRC as they are anti-methadone. They are only opposed to for-profit methadone programs. Substance Abuse and Mental Health Services Administration (SAMHSA) official Robert Lubran, who has decades of experience working with methadone programs, gave us some insight as to why. “There is a view among some that a for-profit pro-

**ALCOHOLISM DRUG ABUSE WEEKLY**  
News for policy and program decision-makers



**Executive Editor** Karienne Stovell  
**Editor** Alison Knopf  
**Contributing Editor** Gary Enos  
**Associate Editor** Sarah Merrill  
**Art Director** Douglas C. Devaux  
**Publisher** Sue Lewis  
**Wiley Bicentennial Logo** Richard J. Pacifico

**Alcoholism & Drug Abuse Weekly** (Print ISSN 1042-1394; Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the first Monday in July, the first Monday in September, the last Monday in November and the last Monday in December. The yearly subscription rate for **Alcoholism & Drug Abuse Weekly** is \$699. **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Subscription Distribution US, c/o John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774; (201) 748-6645; e-mail: subinfo@wiley.com. © 2007 Wiley Periodicals, Inc., a Wiley Company. All rights reserved. Reproduction in any form without the consent of the publisher is strictly forbidden. For reprint permission, call (201) 748-6011.

To renew your subscription, contact Subscription Distribution US, c/o John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774; (201) 748-6645; e-mail: subinfo@wiley.com.

**Business and Editorial Offices:** John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774; Alison Knopf, e-mail: insinger@bestweb.net; (845) 225-2935.

gram has an added incentive to retain somebody in treatment for a long period of time," he told *ADAW*. "The presumption is once someone is stable, they become a profitable patient, don't demand much service, can have take-homes, and still have a fee," said Lubran, who is director of the division of pharmacologic therapies at the Center for Substance Abuse Treatment (CSAT). "There might be a view that these programs are profiteering off people who are addicted, instead of helping them get off methadone."

This is not SAMHSA's view. "The issue of how long someone stays on methadone should be up to a physician and patient," Lubran told *ADAW*. "It's like Lipitor. You don't hear legislators saying, 'Two years on Lipitor, and you're out of there,'" he said. "But if a patient and doctor together decide to try diet instead, that is up to them." Other restrictions being looked at in West Virginia include a 12-month limit on methadone.

"Some people can be tapered off methadone, but everyone is different," said Timothy P. Condon, Ph.D., deputy director of the National Institute on Drug Abuse (NIDA). But there is absolutely no scientific evidence to back up limiting methadone treatment to 12 months, he said. "Some people need to be maintained on methadone for the rest of their lives," Condon told *ADAW*. "We really do stigmatize methadone. If someone needs to be on insulin we don't think twice about it."

As addiction treatment continues to move toward evidence-based medicine, he said, it will be increasingly difficult to make non-scientific directives about how it should be delivered.

### Counselors to educate in WV

In West Virginia, state officials are working to educate the public, said Merritt Moore, NCC, CCAC, LPC, adult treatment services coordinator for the West Virginia division

## Medical examiners and methadone death data

"Before we determine whether a blood narcotic level represents a valid cause of death or merely represents an incidental finding in someone who is tolerant to that medication, we perform a full autopsy," James Kaplan, M.D., chief medical examiner for West Virginia, told *ADAW*. "We check for metabolites that might suggest long-term use."

About 80-90 percent of methadone overdose deaths also show the presence of other addictive medications — benzodiazepines or other opiates — he said. This doesn't indicate whether someone was abusing drugs or not, and further, routine review of medical records may not give any clues as to whether the person was in a methadone maintenance treatment program or not.

"We get board of pharmacy records, and doctors do prescribe methadone and diazepam" as well as other combinations, said Kaplan. "We cobble together records, board of pharmacy records, and in association with a scene investigation, sometimes we can determine whether the person is in a methadone maintenance program, sometimes not." It would help if the medical examiner's office could reliably obtain records of decedents who are in methadone maintenance treatment, but some interpret that these are protected by federal confidentiality regulations.

The medical examiner's office hasn't been able to distinguish among those 99 methadone deaths in 2004 in terms of whether they were caused by methadone maintenance, pain, diverted medication, or other causes. "We've tried very hard, but we haven't been able to reliably distinguish between those three," said Kaplan.

on alcoholism and drug abuse. "This includes educating physicians about pain medication," said Moore, who is also the state methadone authority. He noted that most patients in methadone addiction treatment in West Virginia had been addicted to OxyContin, not heroin.

"We're providing funding for six trainings to physicians about prescription drug abuse in general," said Moore. The West Virginia Alcohol and Drug Abuse Counselors Association will provide the training, he said.

According to Moore, approximately 20 percent of patients who go to a methadone clinic will need it "ongoing."

As for the profit/not-for-profit controversy, Moore says sometimes for-profits can hire better staff because they have more money. "I don't believe that non profit is a synonym for quality, or that profit is a synonym for lack of quality," he told *ADAW*. "But I know that programs in West Virginia are working to get all their counselors certified

and licensed. And good credentials ensure competent staff."

Another faction of the legislature is coming up with a different bill, which would not be anti-profit. Obviously, this faction is the one CRC's Herschman was working closely with. "The good news is, the 12-month limit won't happen," Herschman predicted.

The bad news is there will likely be some restrictions. For example, House delegate Don Carruth plans to sponsor different legislation that would have a moratorium on new clinics until the issue can be studied. More onerous is a provision expected to be included that would require a patient be discharged from treatment after a certain number of positive urine drug screens. "I don't like this, but I can live with it," said Herschman. Also, however, clinics would be open on Sunday. And there would be no time limit.

Medical examiners have no simple way of distinguishing between

[Continues on next page](#)

[Continued from previous page](#)

treatment-program methadone and analgesic methadone: it's the same medication, and the toxicology is the same, according to James Kraner, Ph.D., chief toxicologist for the Medical Examiner's office in West Virginia. "The drug we see in the bloodstream is the same," he told *ADAW*. "The investigation may find out more, there may be pharmacy records." (See *Medical examiners and methadone death data* on page 3).

### CSAT report

The most important report to date on methadone mortality came out of CSAT in February of 2004 ([http://dpt.samhsa.gov/reports/CSAT1\\_REV.pdf](http://dpt.samhsa.gov/reports/CSAT1_REV.pdf)). The report ("Methadone-Associated Mortality: Report of a National Assessment") was the result of a meeting of stakeholders convened because of an increase in methadone deaths. It called for the

"immediate need for professional organizations and regulatory agencies to present scientific evidence and credible data to counter misinformation about methadone and 'methadone clinics' (OTPs) presented in the mass media."

But three years later, the White Paper this assessment promised has still not materialized.

However, *ADAW* has learned that SAMHSA is going to convene another meeting this summer on methadone mortality. It will be a repeat of the 2003 meeting, with per-

haps some new recommendations, Lubran said.

SAMHSA is also working on a uniform case definition for medical examiners. "By the end of this year, we'll have good data on what other factors medical examiners need to look at," Lubran told *ADAW*. "It's important to have this data to better understand how methadone contributes to an overdose death. We need to know whether the source of methadone was an opioid clinic or a prescription or medication that was diverted." •

Deaths related to methadone that is prescribed for pain are usually due to misuse. Methadone has a slow onset, so if someone doesn't immediately get a response, they may be tempted to take another dose. By the time the first dose reaches its peak level, the second dose is taking effect. Whether taken by a pain patient or a teenager experimenting with the pills in the medicine cabinet, the effect is central nervous system depression and possibly death.

## Utah governor requests new facilities, drug court expansion

### *Methamphetamine epidemic drives need*

Responding to a surge in treatment demand and admissions caused by methamphetamine addiction, Utah Gov. Jon Huntsman Jr. has filed legislation that requests \$2.5 million to expand treatment services for women and \$1.7 million to expand drug courts in the state.

Between 1991 and 2006, the state has witnessed a 170 percent increase in the number of women entering the public treatment system, while the number of men entering the system during this time declined by 5 percent. Methamphetamine is the drug of choice for 41 percent of women in treatment between the ages of 18 and 35.

Overall, methamphetamine is the number one drug of choice for people between the ages of 26 and 35 who are entering the public treatment system. While typically ranked in the lower echelon in sur-

veys of drug use in states, Utah has invariably ranked between third and 16th in surveys of methamphetamine use, Brent Kelsey, assistant director of the Utah Division of Substance Abuse and Mental Health, told *ADAW*.

About 100,000 Utah residents are in need of treatment services and the state has the capacity to treat about 19,000. Kelsey said the state's first priority is to increase treatment capacity for women. "The demographic of the population we're serving is changing," he said. "We've really needed to expand treatment capacity for women."

The governor's request of \$2.5 million ongoing state general funds to expand treatment services for women includes \$900,000 to create two new residential facilities for women and dependent children and \$1.6 million that would be allocated to local authorities to develop a full continuum of services ranging from long-term residential to stan-

dard outpatient treatments. Services for both allotments will include screening and assessment, group therapy, individual therapy, parenting classes, life skills classes, employment training, housing assistance, and medical assistance.

Kelsey called drug courts the state's most successful treatment model. Governor Huntsman is requesting \$1.7 million to expand drug court services in the state. The expansion would provide additional treatment, supervision/case management, and drug testing.

Utah drug courts have graduated over 6,300 residents. Of those who enroll in drug court, 67 percent graduate, 78 percent report a decrease in drug use, and 84 percent report zero arrests while enrolled in drug court.

"Drug courts are one of the only strategies we have that retains users in treatment for a long enough period of time and it also breaks down

[Continues on page 6](#)

## Counseling key to buprenorphine treatment

By Deborah H. Lombardi, LCSW, CASAC

*In the January 8 issue of ADAW, an article on the lifting of the physician cap from 30 to 100 patients on buprenorphine pointed out that there is no requirement that physicians provide counseling. Physicians must have the ability to refer to counseling, but do not have to actually refer or provide the counseling itself. Deborah H. Lombardi, LCSW, CASAC is concerned to hear that treatment with buprenorphine could ever be done without counseling, especially in the early stages of treatment, and wanted to share her experience with readers.*

At West Midtown Medical Group, our buprenorphine program requires therapy services in conjunction with buprenorphine medication. We have structured a therapy program including individual, group, and family counseling with a minimum of two sessions weekly for the first 90 days. We monitor progress and titrate therapy based on the patient's success in meeting goals. The definition of success is different for each patient, but one thing we have definitely found is that those who receive our recommended counseling/therapy in conjunction with buprenorphine treatment fare better in their recovery from opiates, suffer less relapse and proceed toward their life and treatment goals.

One of the benefits of buprenorphine treatment is also creating a dilemma — the medication may be prescribed by qualified physicians in private practice. The benefit is that more patients can get buprenorphine this way. The problem is this eliminates the requirement of licensed treatment facilities to provide supportive counseling and other needed services to imbed long term recovery from opiate dependency.

Buprenorphine blocks the effects of other opiates. This eliminates the major motivation for opiate abuse by preventing withdrawal symptoms such as pain, chills, nausea, and opiate cravings.

It is established in the literature that counseling helps outcomes. In a study by Thomas McLellan and colleagues entitled "The effects of psychosocial services in substance abuse treatment" and published in the 1993 *Journal of the American Medical Association* [269(15):1953-1959], researchers found that supportive counseling in conjunction with medication yielded far better results. At West Midtown Medical we have also found the same results.

According to our preliminary findings, these

factors are associated with better outcomes in buprenorphine treatment:

- reducing barriers to entry into the program,
- optimal dosing by our physicians,
- high quality medical and psychosocial services through our various counseling teams,
- orientation towards social rehabilitation via peer support,
- sufficient duration of treatment, and
- long term maintenance of willing, well stabilized patients with established abstinence from all classes of illicit drug use and movement toward life goals.

Our patients have maintained stable housing, returned to school, obtained jobs, have become reconciled with their families and are emotionally productive in many life areas.

Since we offer counseling, psychiatric services, and family programming as well as full medical care including methadone and buprenorphine we are the "mother ship" (in the words of Judith Martin, M.D. quoted in the Jan. 8 ADAW) of service delivery.

For patients, the psychosocial support of receiving group, individual, and family services assists patients in stabilizing their cravings while on medications plus they don't have to do it alone. They get peer support from others in the same "boat." They compare stories and discuss the various differences buprenorphine and therapy have made in their lives. They form community and that assists in their recovery from opioids or pain medication.

We concurrently provide our staff the supervision and training that Cynthia Moreno Tuohy of NAADAC referenced in the ADAW article. This training includes information on all types of medication assisted therapies. Staff then educate their patients. This assists in a smooth transition sometimes from methadone to buprenorphine — and sometimes back to methadone.

*Lombardi is currently the Administrator of the Out Patient Services ASAS Program at West Midtown Medical Group, 311 West 35th Street, 4th floor, New York, NY 10001 (212) 736-5900 x109. She is also in private practice and an educator at various facilities in New York City. West Midtown Medical Group provides methadone maintenance and other medication-assisted treatment, as well as drug-free addiction treatment and general medical care.*

## Continued from page 4

completion of the program into small meaningful steps, and those two factors are critical to success,” said Kelsey.

Kelsey said that Governor Huntsman has made addressing the methamphetamine epidemic a priority for his administration. “He

pulled together a task force of all the executive branch agencies and the Utah Association of Counties and brought everyone to the table and said ‘okay, what are we going to do about this problem.’”

The funding recommendations came out of that task force process, according to Kelsey. “There’s been a

lot of positive publicity about the problem and a lot of leadership provided by the governor,” he said, adding that there is support for the governor’s proposals in the state legislature. “The challenge will be competing against all the other priorities in state government,” he said. “There are limited dollars.” •

## SA seen as common thread in repeat emergency patients

A study of frequent visitors to a hospital emergency room in a rural community has found that while the profile of these individuals differs from the typical recurrent emergency patient in urban areas, a prevalence of substance abuse problems is seen in both populations.

This finding illustrates the urgency of offering services to individuals who screen positive for substance use in the emergency setting, with the challenge remaining one of whether patients will follow up with recommended services in the community once they are released from the hospital.

The study, published in the January issue of the *Archives of Surgery*, assessed 15,370 injury patients visiting an eastern North Carolina hospital’s emergency department between 1994 and 2002. The 3.4 percent of this total population that was admitted more than once during this period exhibited different characteristics from one-time visitors, with alcohol and illegal drug use rates considerably higher in the recidivist population.

Researchers led by Eric A. Toschlog, M.D., of The Brody School of Medicine at East Carolina University, found that while 39.9 percent of one-time visitors had positive blood alcohol screening results during their visit, 58.7 percent of repeat visitors had positive blood alcohol screenings. Recidivist visitors also had higher average blood ethanol levels than one-time visitors, according to the study.

Cocaine use rates also were higher in the repeat visitor population (6.4 percent vs. 4.1 percent in the one-time visitor group).

Substance use appears to constitute the one common element in rural and urban populations that visit hospital emergency rooms frequently for treatment of injuries. While the repeat visitor in urban communities tends to be young, male and a victim of violent trauma, the repeat visitor in rural areas tends to be an older female injured in a fall.

Toschlog told *ADAW* that one patient in his University Health Systems of Eastern North Carolina system had visited the trauma center

five times for separate injuries during the study period, while a number of others had four visits. “The joke here is that we recycle the same 1,000 patients,” he said. “Rural trauma patients have been an underserved and underrecognized population.”

Toschlog’s facility has established a structured intervention under which anyone who screens positive for substance use in the emergency setting must receive counseling services. He believes the hospital has established a good support system for these individuals, but that is not necessarily matched by the level of support seen in many of the low-income communities that make up part of the hospital’s service area.

“We can’t mandate the interventions post-discharge,” Toschlog said. “We schedule follow-up with a provider such as a clinic or a social worker,” often not affiliated with the hospital system. University Health Systems is located in Greenville and serves an eastern North Carolina area that houses five of the nation’s poorest counties, Toschlog said. •

## ALABAMA from page 1

substance abuse is within this department). “Many times these patients are discharged from hospitals and try to cope with their symptoms on their own,” Ziegler told *ADAW*. “They get off their medications, and then find that temporarily their addictive substances will treat their symptoms. But then, they become newly addicted.”

The staff of the two group homes specialize in treating addiction, but have had additional training to treat mental illness, said Ziegler. “This is the first time we’ve done this in the state.”

The fledgling model seems to be one in which the mental illness is stabilized in the mental hospital, and the addiction is treated in the group home later. The mental hos-

pital staff are adequately trained to treat the addiction while the person is there, according to Ziegler, who added that the longer the treatment for the mental illness, the more effective it is.

“But the issue is that individuals now have personal rights, and once they’re psychiatrically stabilized and in recovery from psychiatric side of their illness, we must release them,”

he said. "We can't keep them against their will. Once they're no longer a danger to themselves or others, we're bound to release them." The average length of stay in Searcy is 35-45 days. The women are expected to stay in the group homes for 16 weeks, he said. From there, they will go home.

### 'Dwindling pot'

Importantly, the funding is coming from state dollars, and not from the block grant. The federal block grant can be used for co-occurring disorders, but states must have an accounting measure in place that shows that substance abuse block grant dollars go only to the substance abuse part of treatment, not to the mental health side.

Field advocates are aware of the concern that co-occurring treatment not rob addiction treatment to pay for mental illness, but in this case, they say the group homes actually are providing substance abuse treatment. "Most of our advocates would

look at this as being addiction treatment," said N. William Layfield, president of Alabama Voices for Recovery. "These patients have been in the state mental hospital working on mental health problems, and then reached a point where they're ready to go home except for facing up to their substance abuse. It really is substance abuse treatment, not mental health treatment, that they'll be getting in the homes."

Yet Layfield, who is on the state mental health board and the substance abuse coordinating subcommittee there, is keenly aware of the lack of funds for addiction treatment all over the state. "There are 300,000 people in the state who need treatment each year, and only 19,000 get it," he said. "Of that 19,000, about 64 percent are referred by the courts."

The fact that mental illness, mental retardation, and substance abuse are all in one department has not worked well for the addiction treatment side, said Layfield. And a

focus on co-occurring disorders is raising questions everywhere about whether the mental illness or substance abuse side gets more money. Rather than mental health and addiction treatment all fighting for the same thing, it comes down to people fighting over the "dwindling pot" of money, said Layfield. "It's the state's fault, our representatives' fault, because they're the ones allocating this money."

But there was no decrease in capacity on the substance abuse side, according to Ziegler. "This is not taking it out of one pot and putting it in another." How could that be, since the money came specifically from substance abuse treatment services? The department received a "small increase from the legislature," he responded, adding that this is a program that has been planned for a number of years. For the future, the administration factored the program into their budget request for 2008 and 2009, Ziegler said. "It's obviously cost-efficient for the state." •

## BRIEFLY NOTED

### Damage to specific brain region "disrupts urge to smoke"

Researchers have linked addiction to a specific area of the brain. In preliminary research, lead study author Anthony Bechara of the University of Southern California found that individuals with damage to the insula were "overwhelmingly more likely" than those with damage to other brain regions to "experience a true disruption of the urge to smoke." The National Institute of Drug Abuse (NIDA), which funded the study, announced January 25 that among 19 smokers with brain damage to the insula, 13 quit smoking and all but one quit within one day of injury. Among 50 smokers whose brain injuries did not include the insula, only 19 quit smoking and only four of these quit right away. NIDA Director Nora Volkow, M.D.

suggested that identifying a way to alter the function of the insula could have "major implications" for smoking and other addictions.

### Alcoholism responsible for only fraction of heavy drinking

A study published in the February 2007 issue of *Alcoholism: Clinical & Experimental Research* found that although 16.5 percent of 4,761 New Mexico adults surveyed in 2002 were considered "excessive drinkers," only 1.8 percent met the criteria for alcohol dependence, while over 14 percent binge drank. Corresponding study author and alcohol epidemiologist Jim Roeber said that excessive drinking has historically been categorized as alcoholism. He added that prevention resources have not been adequately directed toward "more prevalent forms" of heavy drinking like binge drinking and alcohol-impaired driving. Tim Naimi of the

Centers for Disease Control & Prevention said that "focusing exclusively on alcoholism will identify only a small percentage of those at risk of causing or incurring alcohol-related harms."

### California kicks off meth awareness campaign

Responding to climbing treatment admissions for methamphetamine, California and the Partnership for a Drug-Free America are producing state's first broadcast campaign to educate the public and encourage users to seek treatment. Last year, the state approved \$10 million to combat methamphetamine use; in addition to radio and television public service advertisements, the campaign will include community outreach programs. State substance abuse officials hope the effort will spur more action at the local, community level.

[Continues on next page](#)

Continued from previous page

## RESOURCES

**NIDA establishes addiction Centers of Excellence**

The National Institute on Drug Abuse (NIDA) is reaching out to help physicians better understand how to treat addiction. In collaboration with the American Medical Association's Research Consortium, NIDA has established four Centers of Excellence (COEs) for Physician Information to "serve as national models to support the advancement of addiction awareness, prevention, and treatment in primary care practices." The COEs are geared toward physicians-in-training, in an attempt to address any knowledge gaps related to drug addiction. The centers, to be located at major universities around the country, will educate physicians on topics including prescription drug abuse, meth abuse and addiction, and comorbid substance abuse and mental illness. NIDA announced the COEs January 25.

## NAMES IN THE NEWS

**Angela Cornelius** has been appointed director of the Ohio Department of Alcohol and Drug Addiction Services, effective March 5. Since 1988, Cornelius has served as the executive director of Project Linden, Inc., a private non-profit outpatient alcohol and drug treatment and prevention services center.

## CALL FOR APPLICATIONS

**NIAAA grants: impact of drinking on adolescent brain**

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has issued a call for applications for grants of up to \$350,000 to "propose and test the feasibility of research-

## Coming up...

**The Community Anti-Drug Coalitions of America (CADCA)** will hold its National Leadership Forum XVII, the nation's largest training conference for community drug prevention leaders, treatment professionals and researchers, on **February 12-15 in Washington, D.C.** For more information, visit [www.cadca.org](http://www.cadca.org).

**NAADAC, the Association for Addiction Professionals** will hold its annual advocacy meeting on **March 4-6 in Arlington, Va.** For more information, visit <http://naadac.org>.

**The National Institutes of Health (NIH), the National Institute on Drug Abuse (NIDA) and the American Medical Association** will sponsor a joint meeting, "Pain, Opioids and Addiction: An Urgent Problem for Doctors and Patients" on **March 5-6** at the Natcher Auditorium, NIH in **Bethesda, Maryland.** For more information, visit <http://conferences.masimax.com/opioid>.

study designs" addressing the long- and short-term effects of alcohol exposure to the developing brain, as well as to explore the effects of timing, doses and duration of alcohol exposure. Applications from non-profits, for-profit companies, schools and governments are due March 29, 2007. For more information, visit [www.grants.gov/applicants/search\\_opportunities.jsp](http://www.grants.gov/applicants/search_opportunities.jsp).

**SAMHSA: CSAT grants for peer-to-peer recovery**

The Substance Abuse and Men-

tal Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) has announced the availability of an estimated 8 grants for up to \$350,000 to "deliver peer-to-peer recovery support services that help prevent relapse and promote sustained recovery from alcohol and drug use disorders." Domestic public and private nonprofit entities are eligible. The deadline to apply is February 28, 2007. Visit [www.grants.gov/applicants/search\\_opportunities.jsp](http://www.grants.gov/applicants/search_opportunities.jsp) for more information.

## In case you haven't heard...

*The fact that the federally funded Second Chance program used a combination of saunas (5 hours a day), confrontation, and nutritional detoxification in its substance abuse treatment program, and that it was based on the precepts of L. Ron Hubbard of Scientology (Narconon) fame, was perhaps not newsworthy by itself. But when last month the Wall Street Journal featured a history of the program's short but thus far lucrative life in New Mexico treating criminal justice referrals, it became clear that someone needs to be minding the store when it comes to giving out these grants. Judge William Lang, chief district judge in the area that includes Albuquerque and a recovering alcoholic, has told his fellow judges not to send addicts to the program. His predecessor on the bench and adversary in recent years, W. John Brennan, who lost his seat in 2004 after pleading guilty to drunk driving and cocaine possession, has been hired by Second Chance to persuade judges to refer offenders (50 have been sent for 6-month stints since the program opened there in September). Second Chance received more than \$347,000 as an "earmark" in ATR funding in 2004. An earmark means a legislator from mandated that the money be given; SAMHSA had no choice in the matter. Now Second Chance's Rick Pendery, who started the program in 1995 with his own money, is asking New Mexico for more than \$3 million to continue it. The earmark, according to the Journal, came from Rep. Anna Crook (R-New Mexico).*