

ADDICTION TREATMENT

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#81 July 2003**How Much Is Really “Enough” Methadone?**

Heroin Addiction & Related Clinical Problems; received July 2003 -- In a review of 29 clinical studies examining methadone dosing for MMT, the authors conclude that there is no evidence of lower doses being adequate for the vast majority of patients and they leave the question “How much is enough?” open-ended.

In the most comprehensive examination of evidence to date, Icro Marenmani and colleagues describe clinical investigations comparing fixed methadone maintenance doses ranging from 0 mg/day (placebo) up to 250 mg/day, and in one clinical trial some patients were receiving 780 mg/day. In all trials, patients receiving the higher doses consistently exhibited superior outcomes compared with those at lower doses, in terms of such variables as opioid abstinence, retention in treatment, and psychosocial measures.

The authors quote Vincent Dole (a developer of MMT), who observed: “[T]here are no reasons for us to limit our prescriptions according to some upper dose threshold, thus using dosages that only provide partial improvement. As with antibiotics, cautiousness means to use dosages high enough to allow the best results to be achieved.”

Marenmani et al. note that the problem is not what the highest possible dosage is -- for it is far above 100 mg/day -- rather, the real problem is that of assessing the most adequate dose that can control the risk of relapse. They conclude that different patients thrive best at different dose levels, whether high or low. “On clinical grounds,” they write, “it is important to warn physicians that their therapeutic decisions should be made in full autonomy, and that they should act to prevent political pressures weighing upon clinical practice. High dosages can be useful, bringing special benefits to patients whose opiate use has proved to be particularly resistant to treatment.”

See: Marenmani I, Pacini M, Lubrano S, Lovrecic M. When “enough” is still not “enough”: effectiveness of high-dose methadone in the treatment of heroin addiction. *Heroin Add & Rel Clin Probl.* 2003;5(1):17-32.

[Unfortunately, even using terms like “high” or “low” dose with respect to methadone takes away from the more critical concept of a dose tailored to individual patient needs, no matter what that dose might be. As the authors of this article observe, “If methadone treatment was regarded in the same

way as any other medical or pharmacological approach, there would not be such concern about what methadone dosage is adequate....” In short, any preconceived notion of what is “enough” methadone for an individual patient is founded more on prejudice than science. -- Ed.]

Radio Ads Promoting Methadone Draw Static

Portland Press Herald; June 15, 2003 (David Hench) -- A state-sponsored advertising campaign to improve methadone’s public image drew fire from police who objected to the state’s advocacy of the drug and say the ads benefit for-profit clinics.

The State Office of Substance Abuse launched a six-week radio ad campaign intended to show the benefits methadone offers to addicts in recovery and alleviate the stigma associated with daily methadone treatments. The effort came after methadone was linked to a third of Portland’s record 28 overdose deaths last year. The surge in methadone-related deaths puzzled treatment professionals because it has not historically been thought of as a recreational drug, and yet non-patients were the ones dying from it.

“Stigma is such an important aspect of substance-abuse treatment,” said Kim Johnson, the State agency’s director. “It’s such a barrier for people getting into treatment, a barrier for people resuming their lives after treatment. It’s an incredibly important issue we have to address in order for people to get well.”

But some of those who are skeptical of the way methadone treatment has worked so far objected to the State’s publicity campaign. “I’m sure there are success stories, but there are horror stories too,” said Portland Police Chief Michael Chitwood. “Methadone is not a panacea for curing opiate addiction.”

Johnson said the outcry over the overdose deaths and the involvement of take-home methadone overshadowed the benefits of the program for the many people who use methadone responsibly. As a result, a State survey found that many in the public were unaware of the therapeutic benefits of methadone and believed only that it was a dangerous, and therefore bad, drug.

Grim Results of Life Without Methadone in Oregon

Associated Press; June 22, 2003 (Peter Zuckerman) -- Last March, 2,900 heroin addicts in Oregon were dropped from drug-treatment programs paid for by the state-funded medical insurance for people with low incomes or disabilities. Police and health statistics suggest that at least

some addicts who are cut off from methadone treatment return to illegal drugs and turn to crime to support their habits.

Since the funding was reduced in March, needle-exchange programs across the state have reported dramatic increases in the numbers of clean syringes they have given to injection-drug users to forestall the spread of diseases. Health experts say this suggests there has been an increase in the number of people who use syringes to inject themselves with drugs. Furthermore, substance-abuse help lines have been flooded with calls from people who no longer qualify for treatment.

Pat Gold, who runs the DELTA Outpatient Drug Rehabilitation Clinic, said one patient cut off from treatment committed suicide and two others were put in psychiatric wards. "I hate to turn them away from treatment when I know some of them are probably going to die" because they're not getting help, Gold said. "But there's no choice."

Study: Deaths Linked to Methadone Used for Pain, Not MMT

Reuters; July 1, 2003 -- New research suggests that an increase in methadone use in North Carolina for pain management may be associated with the significant jump in accidental deaths in that State linked to methadone overdoses.

According to the study by researchers at the Centers for Disease Control and Prevention, 198 North Carolina residents died from methadone overdoses between 1997 and 2001. However, only 4% of those who died were enrolled in methadone maintenance treatment (MMT) programs. During the same time period, the amount of methadone purchased by pharmacies and hospitals increased four-fold. The researchers said this reflects "the increased use of methadone for pain management."

In recent years, doctors have increasingly prescribed methadone to patients with chronic pain. These patients are more at risk of overdosing because the pain-killing effects of methadone wear off in 12 hours, but the drug remains in the body for many more hours, researchers said. The researchers said it is "unlikely" that people who overdosed on methadone had received the medication from [an MMT program] to treat opioid addiction.

See: Ballesteros MF, Budnitz DS, Sanford CP, Gilchrist J, Agyekum GA, Butts J. Increase in deaths due to methadone in North Carolina [research letter]. *JAMA*. 2003;290(1):40.

Hepatitis Alters Methadone Metabolism

Heroin Addiction & Related Clinical Problems; received July 2003 -- In a recently published letter to the editor, the authors lend support to the notion that hepatitis infection can alter methadone metabolism and require dose adjustments in infected patients.

According to most, but not all, prior clinical research, HCV-infected MMT (methadone maintenance treatment) patients may need increased daily doses of methadone. Ernesto De Bernardis and Lina Busa note that research first published in 1996 found a correlation between HCV and the *stimulation* of a liver enzyme responsible for metabolizing methadone (namely, CYP3A4), and this could account for infected patients suffering a *lowering* of methadone serum levels and opioid withdrawal symptoms. They further suggest that some of these patients may intuitively turn to using unauthorized drugs like marijuana or benzodiazepines in an attempt to slow methadone digestion and stave-off withdrawal.

The authors further observe, there has been some evidence from laboratory research to suggest that hepatitis B infection might *inhibit* another metabolic agent (P-glycoprotein), which would produce an *increase* of methadone levels in HBV-infected patients. However, this effect requires further clinical investigation and verification.

See: De Bernardis E, Rusa L. Liver cytochrome overexpression in human HCV infection. *Heroin Add & Rel Clin Probl*. 2003;5(1):47-48.

Sniffing, Snorting Drugs May Raise HCV Risk

Reuters Health; July 4, 2003 (Theresa Waldron) - People who snort or sniff heroin in combination with cocaine may be at increased risk of developing the liver infection hepatitis C, according to a new study.

Thomas Kresina, a spokesman for the National Institute on Drug Abuse in Bethesda, Maryland, which funded the study, said in an interview that any of the drugs might actually cause bleeding in the nose. HCV can be transmitted when objects such as straws used to sniff or snort drugs are shared. "Obviously, the more drugs you put in intranasally, the more you're going to irritate your (nasal) vascular wall, and that's going to result in a little bleeding in the nose," he explained. "Then that blood goes on the instrument you use (to sniff or snort), and you transfer that to the next person. That's where the risk occurs."

In the study of 276 people who had ever smoked crack or who sniffed or snorted cocaine or heroin, 4.7% were infected

with HCV. Participants who sniffed or snorted heroin and cocaine together were most likely to be infected with HCV. The reason for the increased risk of HCV infection among those participants may be related to the combined damaging effects of the drugs on the delicate nasal mucosal lining.

See: *Journal of Medical Virology*. 2003;70:387-390.

Naltrexone May Counter Alcohol's Damage in HCV Infection

PRNewswire; June 26, 2003 -- Immunology researchers have demonstrated that alcohol promotes the proliferation of hepatitis C virus (HCV) in human liver cells, and that naltrexone may block such harmful effects.

“It was already known that habitual alcohol drinkers have higher blood levels of hepatitis C virus, compared to infrequent drinkers, even when both are infected with the virus,” said Wen-Zhe Ho, MD, the director of retroviral research at The Children’s Hospital of Philadelphia, who led the research team. Their study appears in the July issue of *Hepatology*.

The researchers found that alcohol increases the activity of a protein (nuclear factor kappa B) that causes the HCV virus to produce multiple copies of itself. Furthermore, they found that alcohol interferes with the antiviral activity of interferon-alpha, a key therapy used for patients infected with HCV. Another finding that may eventually have implications for patient treatment was that naltrexone, a drug used to help patients with alcoholism avoid relapse, may also block the deleterious effects of alcohol in promoting HCV infection.

This stems from previous research, finding that morphine stimulates HCV in liver cells by the same mechanisms as those found with alcohol. Both alcohol and morphine activate opioid systems present in liver cells, according to Ho, which helps explain why naltrexone, which blocks opiates from binding to their receptors on cell membranes, reduced the harmful effects of alcohol on HCV in the current study. “Although further study is needed, our results suggest that naltrexone might supply additional benefits in reducing hepatitis C infection,” said Ho.

ADHD and Substance Abuse

Medscape Psychiatry & Mental Health; June 3, 2003 (Jay Giedd, MD) -- Increased use of stimulant medications for attention-deficit/hyperactivity disorder (ADHD) has sparked debates about whether more people are being appropriately recognized and treated or whether people are being

overmedicated. A particularly powerful issue in these debates is the relationship between ADHD and substance abuse.

Are people with ADHD more like to develop substance abuse? A plethora of epidemiologic data indicate that the diagnoses of ADHD and substance abuse occur together more frequently than expected by chance alone. Comorbidity of ADHD with bipolar or conduct disorder has a greater than additive effect on the risk of developing substance abuse. Furthermore, those with ADHD are at greater risk for earlier onset of substance abuse, and even a family history of ADHD is a risk factor for developing substance abuse.

Does using stimulant medication to treat ADHD lead to substance abuse? This was recently addressed in a meta-analysis of 6 ADHD studies that contained adolescence or adulthood substance abuse outcome data on people who were diagnosed with ADHD as children. The pooled results demonstrated that *untreated* ADHD subjects were about twice as likely as ADHD subjects treated with stimulant medications to develop substance abuse.

An interesting finding emerging from the meta-analysis was that stimulant treatment was far more likely to reduce substance abuse during adolescence (5.8-fold) than in adulthood (1.4-fold). Although the finding may be somewhat accounted for by adolescents not being fully through the age of substance abuse risk, it may, in fact, reflect a particular vulnerability of the adolescent brain to substance abuse.

Help For Depression Lacking, Studies Find

San Francisco Chronicle; June 18, 2003 (Katherine Seligman) -- As many as 14 million American adults have yearly episodes of major depression, but the majority of sufferers don’t get adequate treatment, according to a series of studies published in the June 18, 2003 edition of the *Journal of the American Medical Association*.

“This puts to rest the criticism that the high numbers [of people with depression] are overestimated,” said Ronald Kessler of Harvard Medical School, lead author of a two-year study that used new clinical definitions to measure depression on 9,090 adults around the country.

The *JAMA* studies call for clearer treatment goals and better training of physicians, who themselves suffer a disproportionately high death rate from suicide. Together, they underscore both the serious toll that depression takes and the fact that while much is known about how to relieve

symptoms, scientists still have a long way to go in figuring why the illness is so widespread.

Research has shown that a combination of medication and psychotherapy is effective in treating most cases of depression, Kessler said, but there is no one-size-fits-all treatment. Some people get inadequate doses of medication or they stop taking the pills or drop out of therapy as soon as they start to feel better. Some use unproven treatments such as Internet support groups and herbal supplements, he said.

Researchers See Stronger Genetic Links to Addiction

Independent Digital (UK); June 18, 2003 (John von Radowitz) -- Genetics may play a stronger role in substance abuse than previously believed, new research indicates.

Researchers from Oxford University studied more than 20,000 people and found that a particular version of the human serotonin-transporter gene is strongly related to anxious personalities. People with this gene variant may be more likely to find social interaction stressful and use alcohol and other drugs to calm their anxiety.

Further, scientists said that a weaker link exists between the dopamine D4 receptor gene and extroverted personality types -- the kinds of people who are novelty seekers and perhaps more likely to smoke, take drugs, gamble, or take other risks.

“Our study suggests that there’s a genetic basis to certain kinds of personality trait, which may be important in influencing whether people take up habits like smoking or whether they can subsequently give them up,” said lead researcher Marcus Munafò. “Understanding genetic influences on personality is important if we are to design health campaigns that are effective for the widest possible range of people.”

The study was published in the journal *Molecular Psychiatry* (2003;8[5]).

Heroin Addicts Suffer High Rates of Mental Illness

National Drug and Alcohol Research Centre (Australia); June 24, 2003 -- Data from an Australian research project reveal that large proportions of heroin-dependent people entering treatment are also suffering from mental health problems such as clinical depression (25%) and Post Traumatic Stress Disorder (41%). More than a third had also attempted suicide at some point in their lives and 13% had done so in the previous 12 months.

Project coordinator, Associate Professor Maree Teesson said “In addition to a high prevalence of mental health problems, polydrug use is the norm, with the average client using five different drug classes, in addition to heroin, in the month before they entered treatment. This included drugs such as cannabis, alcohol, tobacco, and benzodiazepines.” These figures highlight the complexity of patients entering treatment for drug problems, and the vast majority entering treatment had already been through treatment in the past.

“Commonly held perceptions in the community are that treatment for drug dependence is either ineffective or that it will fix the problem instantly. Both of these perceptions are incorrect,” said Cheryl Wilson, CEO of the Alcohol and other Drugs Council of Australia (ADCA). “Treatment for alcohol and other drug dependence is as successful as treatment for other chronic disorders, such as diabetes and asthma, but it is not a quick fix and people may need multiple treatment episodes in order to achieve sustainable change.”

Study: Doctors Disregard Alcohol-Treatment Guidelines

Associated Press; June 26, 2003 -- Many doctors are failing to follow recommended treatment guidelines for helping patients with alcohol addiction.

Elizabeth McGlynn, a researcher with the think tank Rand Corp., examined the medical records of 6,712 people in 12 cities. She reviewed how often doctors followed the latest treatment recommendations and guidelines for particular medical conditions, and found that individuals addicted to alcohol received the least standardized care of all the health conditions studied. The study found that doctors treating 280 alcoholics or possible alcoholics followed recommended procedures only 11% of the time. Doctors were especially lax in suggesting specific treatment programs, following this procedure less than 5% of the time.

See: McGlynn E, Asch S, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr E. The quality of health care delivered to adults in the United States. *NEJM*. 2003;348(26): 2635-2645.

Senate Nixes SAMHSA’s Addiction Treatment Voucher Program

JoinTogether Online; July 10, 2003 (Bob Curley [edited version]) -- The Substance Abuse and Mental Health Services Administration (SAMHSA) recently offered a first glimpse of what President Bush’s addiction-treatment

voucher program might look like in practice. But the Senate dealt the proposal a heavy blow when it refused to fund the program, citing tight budgets and concerns about implementation.

President Bush unveiled the \$600-million voucher program, newly named Access to Recovery, during his State of the Union address last January, and the administration proposed spending \$200 million in FY2004. The program would provide vouchers that clients with alcohol and other drug problems could redeem at their treatment center of choice, including faith-based programs. The Access to Recovery program also intends to increase overall treatment capacity by 100,000 clients annually and expand the variety of services available.

The budget plan approved by the House of Representatives' Appropriations Committee during the last week of June 2003 supported the voucher program and earmarked \$100 million for it in FY2004. However, the Senate took a dimmer view of the initiative, refusing to spend any money for treatment vouchers.

"...due to tight budget constraints the committee has not provided funding for the administration's initiative," the Senate Appropriations Committee said. "In addition, the Committee has concerns that many implementation issues have not been resolved, such as the role of professional assessment, certification requirements, and the administrative costs of setting up a voucher program for treatment."

The Senate's comments echo the concerns of addiction-treatment advocates, who worry that the voucher program could open up public funding to programs that don't meet current state certification and training standards, particularly faith-based programs. The House and Senate will now have to meet to work out the differences between the two funding measures.

#82 August 2003

Breast-Feeding Recommended During MMT

US Newswire; July 21, 2003 -- The American Osteopathic Association's (AOA) House of Delegates voted during their annual business meeting in Chicago to encourage all women on methadone maintenance and in stable recovery from drug and alcohol abuse to exclusively breast-feed their children.

The delegates concluded that the health benefits of exclusive breast-feeding for those infants whose mothers were in drug

and alcohol recovery were beneficial and that the low levels of methadone in breast milk did not have adverse effects on newborns. The AOA represents approximately 49,000 osteopathic physicians (DOs) and is the accrediting agency for all osteopathic medical schools and health care facilities.

Free Treatment Improves Entry Into MMT; Cocaine A Hindrance

Journal of Substance Abuse Treatment; June 2003 -- A study of 577 out-of-treatment drug injectors assessed predictors of entry into methadone maintenance treatment (MMT), including offering coupons for free treatment.

Participants were recruited through street outreach and randomly assigned to receive a coupon for 90 days of free treatment or required to pay for their treatment. Regardless of assignment, all subjects who desired treatment were provided transportation, rapid intake, and a waiver of the treatment entry fee. Overall, 33% entered treatment, including two-thirds of those who received a free coupon. Other factors associated with treatment entry included desire for treatment, heroin use, prior treatment experience, associating with fewer drug-using friends, and injecting with a previously used unsterile needle/syringe. Injecting cocaine and smoking crack reduced the probability of treatment entry.

Findings lend support to street outreach efforts designed to increase rates of treatment entry among chronic out-of-treatment drug injectors. Additional treatment options are required for those abusing cocaine.

See: Booth RE, Corsi KF, Mikulich SK. Improving entry to methadone maintenance among out-of-treatment injection drug users. *J Subst Abuse Treat.* 2003;24(4):305-311.

MMT In Primary Care Settings May Offer Benefits

Journal of Substance Abuse Treatment; June 2003 -- Few studies have investigated methadone treatment of opioid-dependent patients in primary health care settings. This study investigated outcomes at 1 and 2 years for 240 patients treated by either general practitioners or drug clinics at sites across England.

Mean daily methadone dose for both groups was 50 mg. Reductions in illicit drug use, injecting, sharing injecting equipment, psychological and physical health problems, and crime, were found in both groups at 1- and 2-year follow-up. Patients treated in general practitioner (GP) settings reported less frequent benzodiazepine and stimulant use, and fewer psychological health problems at follow-up. Alcohol use

outcomes were poor for both groups. Differences in treatment practices were found for GPs and clinics.

See: Gossop M, Stewart D, Browne N, Marsden J. Methadone treatment for opiate dependent patients in general practice and specialist clinic settings: Outcomes at 2-year follow-up. *J Subst Abuse Treat.* 2003;24(4):313-321.

[Methadone doses were probably subtherapeutic for many, if not most, patients, which might also have accounted for alcohol abuse as an attempt to cope with opioid-withdrawal symptoms. Other factors related to treatment setting, in lieu of adequate methadone doses, may have had greatest impact. -- Ed.]

Ohio's Methadone Policies Spur Black Market

Dayton Daily News; July 21, 2003 -- According to this report, Ohio's restrictive methadone policy causes wait lists at MMT clinics and fosters a black market for methadone.

Methadone maintenance treatment (MMT) clinic officials are saying, at the current funding levels, up to 2 years may be required for someone to reach the top of their waiting lists. Critics of Ohio's restrictive policy say this has led to the growth of black-market methadone sales and an increase in the potential for overdoses. Ohio's methadone policy has been considered one of the nation's most restrictive. State agency officials say they have been criticized for that, but as a department they stand by their standards. Researchers who study addiction say the lack of methadone at public clinics has led desperate users to pay street dealers \$50 or more for a dose of the substance, which costs about \$8 at clinics.

Puzzling Trend: Fewer Heroin Addicts Seeking MMT in Virginia

Hampton Roads Daily Press; July 14, 2003 -- Leaders of a Virginia clinic are unsure why fewer individuals addicted to heroin are seeking methadone treatment.

A year ago, 150 people received methadone treatment at the Hampton Roads Clinic and Support Services Center in Hampton Roads, with 50 more on a waiting list. This year, the demand has dropped 30%. "We have 140 clients and no waiting list," said Stephanie Savage, director at the clinic.

Savage is unsure why the demand for treatment has declined. She said some addicted individuals are dodging methadone treatment by obtaining pain medication from private physicians. "We require them to come every day and go for counseling, which some might consider inconvenient," she said.

Heroin Use Surges In Boston As Treatment Options Dwindle

Boston Globe; July 14, 2003 -- Social service agencies are desperate to decrease demand for heroin in South Boston, which they say costs as little as \$5 to \$10 a bag on street corners. Officials say people are losing their lives because they can't access treatment.

An estimated 600 addicted persons are still on the streets of South Boston, according to drug prevention workers. The state legislature and governor maintained funding levels for methadone treatment in the current budget, but other treatment options were either eliminated or curtailed. The nonprofit Mental Health and Substance Abuse Corporations of Massachusetts says funding for public supported substance abuse treatment declined by 25% over the past 4 years. The additional anticipated loss of \$26 million in Medicaid for the current fiscal year has already led to the closure of some treatment programs, while others are turning away persons with addictions. Last year at this time, 997 state-funded detoxification beds were available, today that figure has fallen to about 400. Advocates and stakeholders believe only a supplemental budget to support better and longer drug treatment could counter this trend.

HIV Among IV-Drug Users On The Rise

Morbidity & Mortality Weekly; July 11, 2003 -- A Centers for Disease Control and Prevention (CDC) study -- "HIV Diagnoses Among Injection-Drug Users in States with HIV Surveillance - 25 States, 1994-2000" -- found that HIV cases among intravenous-drug users increased in 2000 after five years of steady declines.

The CDC plans to conduct further research to determine whether HIV/AIDS is making a comeback among intravenous-drug users. People who inject drugs and their sex partners represent about one-third of all those who have been infected with HIV in the United States since 1981. As many as 30% of the estimated 850,000 to 950,000 people living with HIV in the United States do not know that they are infected. About 16,000 Americans die each year from AIDS, and another 40,000 become infected with HIV. CDC's strategy is to make HIV testing more common to increase the proportion of HIV-infected persons who are aware that they have the virus from 70% to 95% by 2005.

"It could be that some of the prevention messages have lost their fervor in the communities and the advances in antiretroviral drug treatment may have lulled some people into a false sense of security," said Tanya Sharpe, a

behavioral scientist and an AIDS expert with the CDC. A key focus of the CDC is to make AIDS testing more commonplace.

Addiction Relapse Similar To That Of Other Chronic Diseases

PRNewswire; July 14, 2003 -- Relapse following treatment for drug and alcohol addiction is common, predictable, and preventable, according to "Relapse & Recovery: Behavioral Strategies for Change," a research report by the Caron Foundation available at www.caron.org.

"Relapse should not be viewed as a failure; it is part of a learning process that eventually leads to recovery," says Susan Merle Gordon, PhD, author of the report. Relapse rates for addictive diseases do not differ significantly from rates for other chronic diseases; ranging from 50% for resumption of heavy use to 90% for a brief lapse.

The potential for relapse is part of chronic disease. As is the case with chemical addiction, patients with diseases such as diabetes, asthma, and hypertension frequently fail to comply with their treatments. Just as people with chronic diseases must adjust their lifestyles and assume responsibility for managing their own care, so do those with addictions to drugs and alcohol. Gender is an important factor in relapse. "Women are less likely to relapse than men, in part because they are more likely to seek treatment and engage in group counseling," according to Gordon.

Hepatitis C Treatment Not Cost Effective For All

Journal of the American Medical Association; July 9, 2003 (Salomon, et al.) -- People with hepatitis C (HCV) who do not have liver damage may not benefit from beginning treatment early because of the potentially severe side effects of the drugs, the "hefty cost" of treatment, and the chance that treatment could be ineffective, according to a study from the Harvard School of Public Health's Center for Risk Analysis.

There are 2.7 million people with chronic HCV in the United States, and 25,000 new cases are reported annually. Researchers examined U.S. health data for people with HCV and found that during a 30-year period the chance of developing cirrhosis, or inflammation of the liver, for men with HCV is between 13% and 46%, and female patients' chances range between 1% and 29%. Most patients do not develop liver damage before dying of other causes, the study claimed.

In addition, three injections per week of interferon and oral ribavirin cost \$20,000 per person for the 48-week course of treatment. HCV patients experienced treatment benefits "largely in the form of improvements in health-related quality of life," instead of prolonged life, according to the study. Therefore, although newer HCV treatments seem to be "reasonably cost-effective on average," the study's findings "vary widely" across different patient subgroups and "depend critically on quality-of-life assumptions," according to the authors. They concluded, "As the pool of persons eligible for treatment [for HCV] expands to the more general population, it will be imperative for patients and their physicians to consider these assumptions in making individual-level treatment decisions."

Addiction Among Seniors Called "Hidden Epidemic"

United Press International; July 16, 2003 -- Alcohol and other drug addiction among seniors is such a significant and growing problem that one treatment expert called it "America's hidden epidemic."

Carol Colleran, national director of older-adult services at Hanley-Hazelden treatment center in West Palm Beach, Florida, said at least 17% of Americans age 55 or older have either alcohol or drug problems, or both. However, she said, very few seniors are in treatment programs, because their physicians usually fail to diagnose the problem.

According to Colleran, in about two-thirds of older Americans with alcoholism the disease started before age 50. The remaining one-third developed late-onset addictions, often arising from life changes such as retirement or death or disability of a spouse. Often, these seniors are misdiagnosed as being depressed. But Colleran said, "Once we get them through detox, the alcohol-induced depression lifts and we can confirm that alcohol is the real problem."

Diagnosing drug addiction can be difficult because older Americans usually don't use street drugs, but rather abuse prescription medications. "The most common addiction is to benzodiazepines, tranquilizer drugs like Valium and Xanax," Colleran said. "Valium was developed as post-trauma medication to be used for 14 days. We have patients who have been taking it for 20 to 25 years."

Antidepressants: Staying the Course For Better Results

PRNewswire; July 22, 2003 -- A common problem for depressed patients is that they do not take antidepressant

drugs for a long enough time, and their physicians may be to blame.

Most guidelines suggest continuing for 4 to 6 months after symptoms in a first episode of depression improve, but more than half of patients quit sooner. The August issue of *Harvard Mental Health Letter* describes two new studies that explore the problem.

These studies conclude that most patients should probably stay on antidepressants even longer than 6 months -- and that they would be less likely to quit prematurely if physicians communicated better with them both before and during treatment. According to one of the featured studies, more than half of the physicians responding to a survey said they had told their patients to continue taking their antidepressants. But only one-third of the patients remembered hearing that advice -- and more than half said they had been given no instruction at all as to how long to continue taking the drug. Furthermore, those who said they hadn't been told were more likely to quit, as were those who visited their doctor less than 3 times after beginning treatment. And more than two-thirds who quit taking antidepressants did not consult their doctor first.

Genetics, Environment Have Little Impact On Drug Choice

American Journal of Psychiatry; 2003 (Kenneth Kendler, et al.) -- Drug abuse has a strong hereditary component; however, new research suggests genetics and shared environment have little impact when it comes to selecting a particular illegal drug.

Scientists interviewed nearly 1,200 male twin pairs about their history of use, abuse, and/or dependence on marijuana, sedatives, stimulants, cocaine, opiates, hallucinogens, inhalants, and over-the-counter medications. Subjects in the study ranged from 20 to 58 years old.

Upon analyzing data from the interviews the scientists could find no evidence that shared genetic or environmental factors increased the risk of abusing one specific drug over another. The decision to use and abuse a specific drug seemed to depend on unshared factors, such as ease of access. The findings suggest that the search for genetic variations that affect human drug abuse should focus on factors that increase or decrease the risk of abuse of all types of substances, not just a specific drug.

See: Kendler KS, Jacobson KC, Prescott CA, Neale MC. Specificity of genetic and environmental risk factors for use

and abuse/dependence of cannabis, cocaine, hallucinogens, sedatives, stimulants, and opiates in male twins. *Am J Psychiatry*. 2003;160(4):687-695.

CPDD Issues Statement On Opioid Abuse

Drug & Alcohol Dependence; 2003 (Vol. 69, pp. 215-232; James Zacny et al.) -- Nonmedical use of prescription opioids is increasing in the United States and a position statement from a task force of the College on Problems of Drug Dependence (CPDD) says programs to control and reduce such abuse must be balanced against the need for access to these drugs for legitimate medical purposes.

Opioid medications include morphine, codeine, hydrocodone, oxycodone, and methadone, to name a few. These often are prescribed to treat pain that is not alleviated by such nonopioid medications as acetaminophen; plus, in the case of methadone only, it also may be prescribed for treating opioid addiction. Results of surveys and other data collection sources show that use of prescription opioids appears to have risen dramatically in recent years.

Data from the federal government's Monitoring the Future survey show that use of prescription opioids over a 30-day period by high school students who reported taking these drugs without a physician telling them to do so increased by 173% between 1991 and 2001. Another study, the National Household Survey on Drug Abuse, tracks incidence and prevalence of drugs of abuse in Americans aged 12 and older. These survey results showed that the number of people using prescription opioids for nonmedical purposes for the first time increased by 400% between the mid-1980s and 2000 (from 400 thousand to 2 million). Prevalence of opioid abuse was higher in people aged 12-25 than in people aged 26 or more. The survey also showed that the prevalence of opioid abuse is similar to that of cocaine and heroin. Furthermore, the Drug Abuse Warning Network (DAWN) report, which collects information on drug-related visits to emergency departments (EDs), shows that the number of ED visits related to opioid analgesics and opioid analgesic combinations increased by 123% between 1994 and 2001.

The CPDD task force expressed the concern that an undue focus on opioid abuse, and the addiction that can result, may unwittingly lead to less use of opioids for treating pain [and, presumably, less use of methadone for addiction treatment]. Members recommend several steps be taken to improve the ability to make informed policy decisions on prescription opioid abuse. These include: further epidemiological research, laboratory testing of prescription opioids to

determine abuse liability, and clinical trials to determine the efficacy of different approaches to the prevention and treatment of prescription opioid abuse. A balanced approach is needed so programs developed to reduce and prevent such abuse do not deter physicians from prescribing these drugs for appropriate patients.

Merging NIDA, NIAAA Would Improve Science, Report Says

National Academy of Sciences; August 8, 2003 (Bob Curley) -- The influential National Academy of Sciences (NAS) has recommended merging the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), saying that research on alcohol and other drugs frequently overlaps and that arguments against a merger are “primarily nonscientific.”

The two leading addiction-research agencies “have overlapping missions... and would work more effectively together than apart,” according to a report from the NAS’s National Research Council. The committee’s report, “Enhancing the Vitality of the National Institutes of Health: Organizational Changes to Meet New Challenges,” suggests that Congress or the NIH launch an evaluation of the proposed NIDA/NIAAA merger and assess support for combining the institutes. A spokesperson for NIH said that the recommendation was under review, but that no action has yet been taken in response to the report.

“Prevention and treatment approaches are fundamentally similar for alcohol abuse and abuse of other substances,” the report said. The NAS also quoted a February 26, 2003 editorial in the *Journal of the American Medical Association* by current NIAAA Director T.K. Li and the then acting director of NIDA, Glen Hanson, discussing the overlap between alcohol and other drug research. “There is a strong association among the use of tobacco, illicit drugs, and the abuse of alcohol,” wrote Hanson and Li. “In addition, there is a similarity of biological and social-risk factors underlying vulnerability to all of these substances, including genetic and environmental factors. Lastly, there are overlapping mechanisms thought to underlie how these substances influence the brain. Hence, it would be desirable from a public-health perspective to address all substances of abuse when opportunities arise.”

While Li and the recently appointed director of NIDA, Nora Volkow, remain officially mum on the merger proposal, former NIDA Director Alan Leshner, PhD, said that, “On substantive grounds, it seems to make sense.” Leshner, now

the CEO of the American Association for the Advancement of Science, said he would like to see the agencies brought together as a National Institute on Addiction. “From the point of view of an individual suffering from obesity because of compulsive eating, I think those people have as much right to benefit from science as anyone else,” he said.

The NAS has had its say; now its up to Congress or the leadership of NIDA and NIAAA to decide if their recommendations bear further scrutiny. Standing in the way of further study of a merger will be opposition from members of Congress allied with the alcohol industry; resistance from inside the bureaucracy, where change to the status quo is rarely welcomed; and plain old inertia. “Nothing happens until somebody decides to recommend it as an action item,” said Leshner

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LAAM To Be Discontinued

Roxane Laboratories, Inc.; August 23, 2003 -- This sole U.S. manufacturer of ORLAAM[®] (Levomethadyl hydrochloride acetate [LAAM], oral Solution, 10 mg/mL) announced in a letter that it will be discontinuing the sale and distribution of LAAM after the current inventory is depleted, which was estimated to occur early in the first quarter of 2004.

Since the introduction of LAAM in 1995, there were increasing reports of severe cardiac-related adverse events, including QT interval prolongation (15), torsades de pointes (8) and cardiac arrest (6). Other cardiac-related adverse events have also been reported, including arrhythmias, syncope, and angina. These events led to the removal of LAAM from the European market in March 2001, and extensive changes (including additional warnings & contraindications) were made to the U.S. package insert in April 2001. Since these changes, the use of LAAM has decreased dramatically over the last two years. While there may be a very small number of patients who may benefit from LAAM, the manufacturer believes that the risks of continued distribution and use in the face of less toxic treatment alternatives no longer outweigh the overall benefits.

Due to the forecasted unavailability shortly after the beginning of 2004, no new patients should be initiated on LAAM therapy. For existing LAAM patients, it is extremely important for healthcare providers to transfer patients to alternative treatments as soon as possible prior to the product’s unavailability. Patients maintained on LAAM may

be transferred directly to methadone. Because of the difference between the two compounds' metabolites and their pharmacological half-lives, it is recommended that methadone be started on a daily dose at 80% of the LAAM dose being replaced; the initial methadone dose must be given no sooner than 48 hours after the last ORLAAM dose. Subsequent increases or decreases of 5 to 10 mg in the daily methadone dose may be given to control symptoms of withdrawal or, less likely, symptoms of excessive sedation, in accordance with clinical observations.

[LAAM and methadone should not be given concurrently during the transition, as some evidence indicates that they may pharmacologically interact to produce unexpected, and potentially unsafe, increases of LAAM metabolites and/or methadone.-- Ed.

For further reference, see:

Henderson GL, Weinberg JA, Hargreaves WA, et al. Accumulation of l-alpha acetylmethadol (LAAM) and active metabolites in plasma following chronic administration. *J Anal Toxicol.* 1977;1(1):1-5.

Henderson GL, Wilson BK, Lau DHM. Plasma l- α -acetylmethadol (LAAM) after acute and chronic administration. *Clin Pharmacol Ther.* 1977;21:16-25.

Lau DH, Henderson GL. Uptake metabolism and efflux of l-alpha-acetylmethadol (LAAM) by rat lung tissue. *J Pharmacol Exp Ther.* 1978;206(1):143-150.

Toro-Goyco E, Martin BR, Harris LS. Binding of l-alpha-acetylmethadol and its metabolites to blood constituents. *Biochem Pharmacol.* 1980;29:1897-1902.]

Expanded Methadone Treatment Considered In Ohio

Associated Press; August 22, 2003 (Jim Hannah) -- Ohio was reviewing reports of waiting lists of heroin addicts at methadone clinics to determine whether to expand treatment.

“One of the options may be the possibility of expansion,” said Stacey Frohnapfel Hasson, spokeswoman for the Ohio Department of Alcohol and Drug Addiction Services. “We're uncomfortable with these super-long waiting lists we're hearing about.” She said the agency sent teams to the state's 9 methadone clinics to evaluate the need.

In Columbus, there was a two-year waiting list for methadone treatment. Some addicts resorted to paying \$50 for a dose on the street; whereas, the cost at a clinic was about \$8 a day.

Buprenorphine Vs Methadone Cost Analysis

Drug and Alcohol Dependence; September 10, 2003 -- A randomized controlled trial conducted in two Australian cities assessed the safety, efficacy, and cost-effectiveness of buprenorphine versus methadone in the management of opioid dependence.

The trial used a flexible dosing regimen tailored to the clinical needs of the patients. A total of 405 subjects were randomized to a treatment at one of three outpatient drug treatment centers in Adelaide and Sydney, Australia. The perspective of the cost-effectiveness analysis was that of the service provider and included costs relevant to the provision of treatment. The primary outcome measure used in the economic analysis was change in heroin-free days from baseline to the sixth month of treatment.

Treatment with methadone was clinically found to be both less expensive and more effective than treatment with buprenorphine, which suggests methadone dominates buprenorphine. However, in terms of cost alone, the difference in Australia between methadone and buprenorphine treatments was not statistically significant.

See: Doran CM, Shanahana M, Mattick RP, Alia R, White J, Bell J. *Drug and Alcohol Dependence.* 2003;71(3):295-302.

Naltrexone May Help Primary Care Doctors Treat Alcoholism

AMNews; August 25, 2003 (Victoria Stagg Elliott) -- Office care and medication are found effective for treating addiction, but addiction specialists question what role primary care physicians should play. Now, a growing number of experts are suggesting that addictive disorders can indeed be treated in the primary care setting much like chronic conditions such as diabetes or hypertension.

A study in the July *Archives of Internal Medicine* (see below) suggested that primary care management combined with a prescription for naltrexone was as effective as a specialized addiction treatment setting approach that combined the drug with cognitive behavioral therapy.

“Primary care [doctors] to date have referred out and not managed these patients themselves. These data suggest that they could,” said Stephanie O'Malley, PhD, lead author on the paper and professor of psychiatry at Yale University School of Medicine.

“Primary care is the ideal setting for addiction care,” said Patrick G. O'Connor, MD, MPH, one of the paper's authors

and also a Yale professor of medicine. “Addiction problems fit the chronic disease model perfectly.”

But before treatment, the condition has to be diagnosed, and physicians long have struggled with this. Most experts say the reasons involve both the stigma associated with addiction as well as the time it takes to address such problems. Other experts caution that at a point it still is necessary for a patient to turn to a specialist for care.

The difficulty exists in determining where primary care should end and specialist care should begin. Most experts feel that generalists absolutely should be screening and diagnosing and even initiating treatment, but they're not so sure how much further involvement should go.

With regard to alcoholism, several experts were highly critical of the model suggested by the *Archives* study. They worried that patients in the primary care setting would miss the opportunity for the intensive treatment that some of them need and suggested flaws in the paper. For example, response to treatment was defined as no more than two days of heavy drinking in a 28-day period, rather than abstinence.

“One isn't a little sober any more than one is a little pregnant,” said Stuart Gitlow, MD, MPH, an addiction psychiatrist from Providence, R.I. “You're either sober or you're not.”

When it comes to treating addiction to opiates, concerns about the ability of generalists to prescribe buprenorphine persist. This drug requires special certification from the Substance Abuse and Mental Health Services Administration, and the 2,000 physicians currently authorized to do so are primarily specialists, although eventually its use may trickle down to primary care.

[For further information see: O'Malley SS, Rounsaville BJ, Farren C, et al. Initial and Maintenance Naltrexone Treatment for Alcohol Dependence Using Primary Care vs Specialty Care. A Nested Sequence of 3 Randomized Trials. Arch Intern Med. 2003;163:1695-1704.

Three trials were conducted. In the first, nearly 200 alcoholics received either primary care and naltrexone or the drug and cognitive behavioral therapy. Those who responded continued to one of two further trials. One approach compared the use of maintenance naltrexone versus placebo in a primary care setting. The other compared the drug to placebo in conjunction with cognitive behavioral therapy.

Patients receiving naltrexone in either the primary care setting or receiving cognitive behavioral therapy did equally well at avoiding persistent heavy drinking. During the maintenance period, naltrexone did better than placebo in the primary care setting. With cognitive behavioral therapy, patients did equally well on placebo or on the drug.

The authors concluded that naltrexone did equally well in both settings during initial treatment. During longer-term maintenance, the drug improved the efficacy of treatment in the primary care setting. --Ed.]

Alcoholism Treatments Neglected

Sydney Morning Herald (Australia); August 21, 2003 (Julie Robotham) -- Effective treatments for alcohol addiction are massively under-used in Australia, despite government subsidies for the medications.

Only 1 in 30 alcoholics is being treated with either acamprosate or naltrexone, available on the Pharmaceutical Benefits Scheme since 1999 to treat alcohol dependence, according to the health economists from the National Drug and Alcohol Research Centre, based at the University of NSW.

During 2001, 40,000 scripts were filled by about 13,500 users. “This is equivalent to a maximum of about 3% of alcohol-dependent individuals taking either drug,” wrote Christopher Doran and colleagues in the *Medical Journal of Australia*. “Although use of these medications is not necessarily appropriate for all dependent individuals, their low uptake raises serious concerns.” It was possible doctors were put off by a government requirement that the drugs be prescribed only within a vaguely defined, “comprehensive treatment program for alcohol dependence with the goal of maintaining abstinence.”

The head of drug health services at Royal Prince Alfred Hospital, Paul Haber, said: “A lot of people don't think alcohol problems should be treated with a tablet. They think it's a moral problem or a willpower problem.”

Why Do Addiction Docs Shun Naltrexone?

Drug and Alcohol Dependence; September 10, 2003 -- Naltrexone was approved for alcoholism by the U.S. Food and Drug Administration (FDA) in December 1994 and, although it is one of only two medications for alcohol rehabilitation approved in the U.S., naltrexone is not frequently prescribed.

To examine the factors limiting physicians' use of naltrexone, data were collected through a survey of U.S. physician members of two addiction medicine professional associations. On average, addiction medicine physicians prescribed naltrexone to 13% of their alcoholism patients. The two main self-reported reasons why they did not prescribe the medication to more patients were that patients refused to take the medication or comply with prescribing regimes (23%), and that patients could not afford the medication (21%). Furthermore, physician perceptions of naltrexone's effectiveness and safety were significantly associated with prescribing. Those who had more exposure to information about the product (e.g., by reading more journal articles about naltrexone or from other sources) were more likely to prescribe it.

See: Mark TL, Kranzler HR, Song X. *Drug and Alcohol Dependence*. 2003;71(3):219-228.

Short-term Addiction Treatment Success Predicts Long-Term Outcome

Drug and Alcohol Dependence; September 10, 2003 -- This study examined the relationship of 6-month treatment outcomes to abstinence at 5-years post-treatment, and whether the predictors of abstinence at 5 years were different for those who were or were not abstinent at 6 months.

The sample included 784 patients from an outpatient (day hospital and traditional outpatient) managed-care chemical-dependency program. Subjects were interviewed at baseline, 6 months, and 5 years. Abstinence at 6 months was an important predictor of abstinence at 5 years. Among those abstinent at 6 months, predictors of abstinence at 5 years were older age, being female, 12-step meeting attendance, and recovery-oriented social networks. Among those not abstinent at 6 months, being alcohol dependent rather than drug dependent, 12-step meeting attendance, treatment readmission, and recovery-oriented social networks predicted abstinence at 5 years.

The authors concluded that there was a clear association between short-term and long-term treatment success. In addition, these results strongly support the importance of recovery-oriented social networks for those with good short-term outcomes, and the beneficial impact of readmission for those not initially successful in treatment.

See: Weisner C, Ray GT, Mertens JR, Satria DD, Moore C. *Drug and Alcohol Dependence*. 2003;71(3):281-294.

Controversy Surrounds Medical Heroin

British Medical Journal; August 2003 -- A set of randomized controlled trials sought to determine whether supervised medical prescription of heroin could successfully treat addicts who do not sufficiently benefit from methadone maintenance treatment.

The trials included 549 heroin addicts in methadone maintenance programs in 6 cities in the Netherlands. Subjects were randomly assigned to receive either heroin, heroin-plus-methadone, or methadone alone. Psychosocial treatment was offered throughout.

Outcome data at 12 months was available for 94% of all randomized participants. According to the analysis, treatment with heroin-plus-methadone was more effective than treatment with methadone alone. Discontinuation of the co-prescribed heroin resulted in a rapid deterioration in 82% (94/115) of those who had responded to heroin-plus-methadone.

The authors concluded that supervised co-prescription of heroin is feasible, more effective, and probably as safe as methadone alone in reducing the many physical, mental, and social problems of treatment-resistant heroin addicts.

See: van den Brink W, Hendriks VM, Blanken P, Koeter MWJ, van Zwieten BJ, van Ree JM. Medical prescription of heroin to treatment resistant heroin addicts: two randomised controlled trials. *British Medical Journal*. 2003;327:310

[The authors' descriptions of methadone dosing were rather vague, other than to state the patients who had previously failed on methadone therapy ["treatment resistant"] received at least 50-60 mg/d and doses during the trial averaged from 57 to 71 mg/d. Hence, a great many subjects may have been undermedicated with methadone both before and during the trial.

In a followup letter to the journal (BMJ, August 19, 2003), John Caplehorn, MD noted that the data analysis was flawed and biased in favor of the heroin-plus-methadone condition, and that those receiving only methadone actually demonstrated superior objective performance in terms of treatment retention.

In reporting on the Netherlands research, BBC News noted on September 12, 2003 that doctors in the UK did not back plans to expand the prescription of heroin to addicts. Of the 200,000 heroin-addicted persons in the United Kingdom, about 40,000 are receiving methadone therapy. The UK is one of the few countries where doctors can prescribe heroin,

though few do so, with only 448 patients receiving therapeutic heroin.

A report from the Joseph Rowntree Foundation criticized the limited research to date on prescribing heroin, since there is no evidence regarding the impact of heroin prescribing on the community as a whole, and that the drug is more expensive to prescribe than methadone.

Clare Gerada, MD, spokeswoman on drugs for the Royal College of General Practitioners, said: "As we are still a long way from providing drug users with basic interventions such as methadone maintenance we need to see a greater investment in these services before committing to prescribing heroin on the NHS and creating addicts for life." --Ed.]

Narcotic Pain Meds Boost Drug-Related ER Visits

SAMHSA Press Release; August 26, 2003 -- The 2002 Drug Abuse Warning Network (DAWN) survey found a 20% increase in the number of emergency-room visits involving narcotic pain medications, according to the Substance Abuse & Mental Health Services Administration (SAMHSA).

The survey, which includes a sampling of 437 hospitals in 21 metropolitan areas nationwide, noted there were 119,185 narcotic pain-medication emergency visits in 2002, up from 99,317 in 2001 and a 45% increase from 2000. Overall, besides narcotic pain killers, the most frequently mentioned drugs in emergency-room visits in 2002 were alcohol in combination with another drug, cocaine, heroin, marijuana, and anti-anxiety drugs (benzodiazepines).

"We must educate the public about the dangers of misuse of prescription medications," said Health and Human Services Secretary Tommy G. Thompson. "We must continue to strengthen our prevention programs and build substance-abuse treatment capacity so that people don't abuse drugs and tax the medical and economic resources of our emergency departments."

The DAWN survey also shows that the number of hospital emergency-department visits related to drug misuse nationwide stayed about the same as 2001 at an estimated 670,307. However, emergency-room mentions of marijuana, which in the past had been included with other drugs, rose 45% from 2000 to 2002. "This report proves that marijuana is more harmful than many people think," said White House Director of National Drug Control Policy John Walters. "The rising levels of marijuana potency that we've seen over the last several years correspond with dramatic increases in

people seeking emergency medical care for marijuana-related incidents."

Drug Relapse Tied To Specific Brain Region

Rutgers University; August 20, 2003 -- In a study on laboratory rats, scientists discovered that certain nerve cells in a specific region of the brain play a key role in drug addiction relapse.

Individuals who recover from addiction often face environmental stimuli associated with drug use, such as hearing a particular song or walking through a certain neighborhood. These triggers could provoke a return to drug use. In studying how environmental stimuli cause relapses, researchers at Rutgers studied the nerve cells in the *nucleus accumbens*, a region deep in the brain found to be involved in the addictive effects of drugs.

"We've identified a part of the brain that appears to process these memories," said Mark West, a professor of psychology at Rutgers. "This might be one of the brain areas that a very skilled pharmacological approach could target."

For the study, rats were able to self-administer cocaine by pressing a lever. When the animals pressed the lever, a tone sounded, which they came to associate with the drug. At the end of three weeks, the cocaine and lever were removed. A month later, the researchers returned the lever but the rats ignored it until the tone sounded again. The researchers found that the nerve cells in the accumbens responded instantaneously when the tone was sounded.

"When we started to play the tone that had been paired with cocaine, the animals began to press the lever at a fairly high rate," said West. "It indicated that the animals had a persistent memory -- they remembered the significance of the tone. We interpreted the resumption of lever pressing as a behavioral relapse."

See: Ghitza U, Fabbriatore A, Prokopenko V, Pawlak A, West M. Persistent Cue-Evoked Activity of Accumbens Neurons after Prolonged Abstinence from Self-Administered Cocaine. *Journal of Neuroscience*. 2003;23(19):7239-7245.

New Survey Tallies Overlooked Drug Users

Reuters News; September 5, 2003 -- A new survey that uses enhanced methods to identify drug users overlooked in previous studies concluded that 19.5 million Americans, or 8.3% of the population age 12 and older, used illegal drugs in 2002.

The annual National Household Survey, renamed the National Survey on Drug Use and Health, also estimated that *22 million Americans are chronically addicted to alcohol and other drugs.*

In 2001, the report estimated that 15.9 million Americans used illegal drugs. But for the latest study, stricter questioning methods and a \$30 incentive payment resulted in more than 68,000 people participating in the research.

According to the report, about 14.6 million people used marijuana, 2 million were current cocaine users, and 1.2 million used hallucinogens, such as ecstasy. In addition, 54 million people were defined as binge drinkers and about 16 million as heavy drinkers.

The upsurge in heroin use continued. During the latter half of the 1990s, the annual number of heroin initiates rose to a level not reached since the late 1970s. In 1974, there were an estimated 246,000 heroin initiates. Between 1988 and 1994, the annual number of new users ranged from 28,000 to 80,000. However, between 1995 and 2001, the number of new heroin users was consistently greater than 100,000.

“The report highlights that 7.7 million people, 3.3% of the total population ages 12 and older, needed treatment for a diagnosable drug problem and 18.6 million, 7.9% of the population, needed treatment for a serious alcohol problem,” said SAMHSA. However, the study found that many addicted individuals are not obtaining the help they need. “Only 1.4 million received specialized substance-abuse treatment for an illicit drug problem and 1.5 million received treatment for alcohol problems,” according to the report.

See:

<http://www.samhsa.gov/oas/nhsda/2k2nsduh/Results/2k2Results.htm>

Ritalin Studied for Addiction Treatment

Neue Zurcher Zeitung, September 8, 2003 -- A study underway in Switzerland will test the effectiveness of using methylphenidate (Ritalin®) to treat individuals addicted to drugs.

Methylphenidate is generally prescribed to treat Attention-Deficit Hyperactivity Disorder (ADHD) in children. However, researchers want to study the drug's effect on individuals addicted to both cocaine and heroin.

“If we talk about street drug use, we don't see anyone who just consumes heroin anymore. The normal pattern today is the consumption of heroin and cocaine in the form of a

cocktail,” said Christopher Burki of Bern's Koda heroin prescription clinic. “Some studies have been done with Ritalin for cocaine addiction but it has never been done in this framework with patients in heroin-assisted treatment.” For the study, 60 heroin and cocaine users in Basel and Bern will be given methylphenidate over a three-month period.

“Cocaine and Ritalin are both stimulants and although they don't work in the same way, they function in similar regions of the brain,” said Burki. If methylphenidate shows positive results, the study would proceed to a second phase of treatment that includes group therapy.

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Adequate Methadone Dose Does Not Harm Newborns

Reuters Health; September 17, 2003 (Karla Gale) -- Treating heroin-addicted pregnant women with the most adequate dose of methadone does not increase their infants' symptoms of withdrawal after they are born, new study findings suggest. Instead, methadone appears to reduce risks to both mother and infant by preventing illicit drug use.

Many physicians believe that methadone doses should be kept no higher than 20 mg/day when women are pregnant, lead investigator Vincenzo Berghella, MD said. But effective doses for pregnant women range from 50 to 200 mg daily.

Therefore, his research group, based at Jefferson Medical College of Thomas Jefferson University in Philadelphia, examined the records of 100 mother-newborn pairs treated in their program for drug-addicted pregnant women. Methadone doses ranged from 20 to 200 mg/day. They also scored the newborns' withdrawal problems using an objective measure of clinical signs and symptoms, called the Newborn Abstinence Score (NAS).

Birth weight, highest NAS, presence of neonatal withdrawal, and average duration of treatment for withdrawal did not differ significantly between the higher doses and lower doses of methadone. “I was happily surprised when our data confirmed that using an effective dose is best for both the women and their babies,” Berghella said.

He added that prior research demonstrated that methadone has no long-term effects on the fetus, “just short-term withdrawal,” which occurred in 60% of the babies. “Effective maintenance prevents drug hunger and craving and blocks the euphoric effect of illicit drugs,” he noted. As a result, the fetus is not exposed to erratic maternal opioid

levels, protecting it from repeated episodes of withdrawal. Furthermore, “by preventing drug-seeking behavior, women are less likely to engage in prostitution or other behaviors that increase their risk of HIV, hepatitis infection, and other sexually transmitted diseases.”

Source: Berghella V, Lim PJ, Hill MK, et al. Maternal methadone dose and neonatal withdrawal. *Amer J Obstet Gyn.* 2003;189(2):312-317.

[In this retrospective study, women who received an average methadone dose of <80 mg (n = 50) had a trend toward a higher incidence of illicit drug abuse before delivery than women who received doses of 80 mg or more (n = 50). Newborns of women who received an average methadone dose of <80 mg had similar highest neonatal abstinence scores, need for neonatal treatment for withdrawal, and duration of withdrawal compared with those of women whose condition was maintained with dosages of 80 mg. For all cutoffs that were used for high versus low dose and for both the average and last methadone dosage analyses, neonatal withdrawal was similar. The authors concluded that the maternal methadone dosage does not correlate with neonatal withdrawal; therefore, adequate methadone dosing at optimum levels is not harmful to newborns. – Ed]

Continued Alcohol Abuse May Relate To Inadequate Methadone Dose

Journal of Substance Abuse Treatment; October 6, 2003 (Comments by Richard Hallinan, MD [Australia] on: Hillebrand J, Marsden J, Finch E, Strang J. Excessive alcohol consumption and drinking expectations among clients in methadone maintenance. *J Subst Abuse Treat.* 2001;21(3):155-160) -- Excessive alcohol consumption and related problems are common among patients in methadone maintenance treatment (MMT), yet relatively little is known about the psychological and social determinants of alcohol-related attitudes and behaviors during treatment. This study reports on the prevalence of alcohol dependence, patterns of alcohol consumption, and preliminary findings about patients' beliefs that they will change their drinking behavior in the future.

Data were gathered from personal interviews with 66 patients attending an MMT program in South London (some 80.5% of the eligible caseload). Forty-one percent of the overall sample met DSM-IV criteria for alcohol dependence in the past 12 months.

Study participants had been in treatment at least a month (mean 28.4 months), and were administered methadone at

community pharmacies with an average dose of 49 mg/day (SD 27 mg/d). There were high levels of recent use of heroin (62%), stimulants (47%), and benzodiazepines (32%). The researchers examined the functions that patients' perceived alcohol served and found that 84% used it to relax, 68% to relieve boredom, 66% to improve low mood, 64% to forget problems, 54% to help them sleep, 30% to increase the effect of methadone, 28% to get going in the morning, 24% to stop feeling sick in the morning, and 24% to calm down after using other drugs.

Most of the specific perceived functions of alcohol could be interpreted as self medication of abstinence symptoms. The average dose was lower than the minimum 60 mg daily recommended by the U.S. National Institutes of Health consensus panel guidelines, and 95% received doses less than 103 mg/day. Therefore, upward methadone dose titration might have provided the simplest alternative for resolving many of the patient-perceived functions of alcohol identified by the researchers.

More Addiction Specialists Accept Long-Term Methadone Use

Toledo Blade; September 22, 2003 -- Although lifelong methadone use remains controversial at some addiction-treatment facilities, many are adopting the approach because of its proven effectiveness.

Recently, Substance Abuse Services, Inc., in Toledo, Ohio, changed its strategy and began providing long-term methadone treatment to individuals addicted to heroin. Previously the facility gave methadone for only one year, using OxyContin and other opiates as maintenance treatment.

Ross Chaban, executive director of the facility, said statistics reflected a need for the change. According to Ohio treatment officials, the number of heroin-dependent individuals seeking help increased 42%. At the same time, drug misuse involving OxyContin and other opiates continues to increase throughout the state and nationwide.

“The leadership at the state was resistant to the concept of long-term methadone use,” said Ted Zigler, chief executive officer of the Community Health Center in Akron. “But, in fact, 45 years of research and science have demonstrated that methadone maintenance is the single most successful treatment of narcotic addiction on the face of the earth.”

Treatment For *Both* Drug & Alcohol Addiction Commonly Needed

SAMHSA Press Release; October 2, 2003 -- Nearly half of all 1.1 million people receiving treatment for addiction are being treated for both drug and alcohol abuse, according to the 2002 National Survey of Substance Abuse Treatment Services released by the Substance Abuse and Mental Health Services Administration (SAMHSA).

On a typical day in 2002, that there were 1,136,287 persons receiving substance abuse treatment. Of these, 8%, or 91,851, were under age 18. The lowest percentage, 21%, were in treatment for alcohol abuse alone, while 31% were being treated for only drug abuse and 48% were being treated for both.

The purpose of the annual National Survey of Substance Abuse Treatment Services (N-SSATS) is to collect data on the location, characteristics, and use of alcoholism and drug treatment facilities and services throughout the 50 States, the District of Columbia, and other U.S. jurisdictions. In 2002, a total of 13,720 facilities, 96% of those eligible, participated in the survey.

The N-SSATS survey found that outpatient treatment was the most widely available type of care with 74% of facilities offering this, and most patients in treatment on the survey date (90%) were enrolled in some type of outpatient care.

Opioid treatment programs were offered by only 8% of facilities and 19% of those patients received outpatient methadone/LAAM maintenance at these facilities.

Private non-profit facilities make up the bulk of the total treatment system (61%) with private for-profit accounting for another 25%. State or local governments own 11% of treatment facilities and the federal government owns 2%. Tribal governments own 1% of reporting facilities.

[According to SAMHSA Administrator Charles G. Curie, "This survey tells us where the substance abuse treatment system is going, to help us analyze system trends and forecast resource requirements." The survey also is used to update SAMHSA's Substance Abuse Treatment Facility Locator at <http://findtreatment.samhsa.gov>. However, this just-released survey was conducted on March 29, 2002, so the "new" data are about 18 months old. -- Ed]

Addiction Requires Chronic Disease Treatment Approach

Washington, DC; September 15, 2003; NAADAC annual meeting (Bob Curley reporting) -- Researcher Tom McLellan

has long contended that positive addiction-treatment outcomes shouldn't be about abstinence alone, but should factor in a broad range of improvements in areas such as family life, employment, and decreased involvement with law enforcement and the justice system.

Addiction treatment, he contends, should be held to the same standards of success used to judge treatment of other chronic diseases, such as diabetes, hypertension, and asthma, where relapse and noncompliance with therapy or medication are common. But addiction researchers have made the mistake of trying to evaluate treatment as if they were dealing with an acute disorder, not a chronic one, said McLellan, scientific director of the Treatment Research Institute at the University of Pennsylvania School of Medicine.

"Why does treatment seem so ineffective? ... We only look at the post-discharge results," said McLellan. "You can't possibly see a lasting effect if you don't have a cure for your illness. With a model that says you should have 'learned your lesson,' you will always see deterioration."

A disease-management model for addiction treatment would require that patient progress be measured in predefined steps, and that relapse result in an intermediate step back, not removal from the program and a return to square one. Frequent contact from program staff would be essential from both an outcomes and cost perspective, as experience in the care of other chronic illnesses demonstrates. "They [staff] care about you, but that's not why they're calling," said McLellan. "They're managing you because they want to keep you at the low end [of the continuum of care], not where it's expensive."

Report: 10% Addicted in Washington, DC

Washington Post; October 2, 2003 (Sewell Chan) -- About 60,000 District residents, more than one in 10, are addicted to illicit drugs or alcohol, and substance abuse costs the city \$1.2 billion each year in lost productivity, illness, premature death, and crime and incarceration, according to a study released by Mayor Anthony A. Williams.

The two-year study, which sought to measure the scope and effects of substance abuse, also found that half of all people arrested for violent crimes in Washington test positive for narcotics. A task force that Williams convened in May 2001 announced two goals to achieve by 2010: reducing the number of addicts from 60,000 to 25,000 and cutting the total cost of substance abuse from \$1.2 billion to \$300 million.

Officials billed the task force's study as a comprehensive, citywide substance abuse strategy and as the first-ever collaboration of 14 federal and city agencies, including DC Superior Court and the public schools, that deal with substance abuse and addiction. The task force panel concluded that funding for drug-related programs is spread across many agencies. Although an estimated \$356.1 million was spent on such programs in the last fiscal year, only \$53.3 million funded programs whose primary focus was on treatment, and of the smaller sum, only \$34.5 million went to the direct provision of drug treatment.

"Treatment beds lie empty, while people who want to get clean and sober are turned away from central intake and detox," said Robert H. Fleming, a community organizer who chairs an informal coalition of drug-treatment groups. "Right now, the best way to get into treatment is to commit a felony while under the influence of drugs and alcohol."

U.S. States End Drug War, Treat Addiction As Illness

Associated Press; September 17, 2003 -- Rather than following policies to harshly penalize drug offenders, more U.S. states are enacting alternatives that treat addiction as an illness.

According to a report by the Drug Policy Alliance, which supports alternatives to the drug war, 46 states have passed a total of 150 drug-reform laws. A number of states are turning away from the "get-tough" drug policies of the 1980s and 1990s, which treated addiction as a crime, and are instead passing laws that support individuals with drug problems. "There was a great deal of dissatisfaction with the way the war on drugs has been pursued, from conservatives and liberals," said Senator Adam Kline (D-Washington).

Panel Nixes Restrictions On Painkilling Drug – For Now

New York Times; September 11, 2003 -- Despite urging from Congress and drug-enforcement officials, a federal drug-advisory panel decided that OxyContin use should not be further restricted.

According to data presented to the panel, up to 1,000 deaths a year are attributed to OxyContin. Laura Nagel, deputy assistant administrator of the Drug Enforcement Administration's (DEA) office of diversion control, urged the panel to limit sales of OxyContin and similar medications to patients who suffer from severe pain. She also called on

the panel to ban family doctors and nonspecialists from prescribing the painkilling drug.

However, the panel voted against restricting OxyContin. "I'm uncomfortable with people with moderate pain having to beg for access to these drugs," said Steven Shafer, an anesthesiologist from North Carolina. The panel also rejected the proposal to restrict family physicians from prescribing drugs, saying that people in rural areas with limited access to specialists would be denied medicine.

However, the panel supported the Bush administration's proposal to require doctors to receive special training before prescribing the drug. "We should restrict the prescriptions of these drugs to the educated physicians," said Carol Rose, a panel member and an anesthesiologist from Presbyterian University Hospital in Pittsburgh.

Epilepsy Drug Could Treat Cocaine Addiction

NIDA Press Release; September 22, 2003 -- Preliminary results from a clinical trial show that gamma vinyl-GABA (GVG), a drug used to treat epilepsy, may be useful in treating cocaine addiction, according to the National Institute on Drug Abuse, which is funding the research.

The study, conducted in Mexico by researchers from New York University School of Medicine and Brookhaven National Laboratory in Upton, NY, involved 19 men and 1 woman who had used cocaine for at least three years. The researchers found that GVG reduced cocaine use among participants by eliminating the craving for the drug.

"GVG reduces levels of dopamine, the 'feel-good' chemical that floods the brains of cocaine users, providing the 'high' they crave," said Frank Vocci, PhD, director of the Division of Treatment Research and Development at NIDA. "Using GVG to temper the dopamine system may very effectively block the addiction-related effects of cocaine."

The study's results were published in the online version of the journal *Synapse*.

Cost Effectiveness: Buprenorphine vs Methadone

Drug & Alcohol Dependence; September 10, 2003 -- This article presents the cost-effectiveness results of a randomized controlled trial conducted in two Australian cities designed to assess the safety, efficacy, and cost-effectiveness of buprenorphine versus methadone in the management of opioid dependence.

The trial used a flexible dosing regimen that was tailored to the clinical needs of the patients, with high maximum doses

under double-blind conditions. A total of 405 subjects were randomized to a treatment at one of three specialist outpatient drug treatment centers in Adelaide and Sydney, Australia.

The perspective of the cost-effectiveness analysis was that of the service provider and included costs relevant to the provision of treatment. The primary outcome measure used in the economic analysis was change in heroin-free days from baseline to the sixth month of treatment.

Treatment with methadone was found to be both less expensive and more effective than treatment with buprenorphine, indicating methadone was superior. Although this was clinically important, the observed differences did not reach statistical significance. Therefore, the results of this study could suggest that for certain patients buprenorphine may provide a viable alternative to methadone in the treatment of opioid dependence.

See: Doran CM, Shanahan M, Mattick RP, Ali R, White J, Bell J. Buprenorphine versus methadone maintenance: a cost-effectiveness analysis. *Drug Alcohol Dependence*. 2003;71(3):295-302.

U.S. Physicians Find Barriers To Buprenorphine Use

Join Together (Boston University School of Public Health); October 9, 2003 -- A recent national poll of 415 doctors authorized to prescribe buprenorphine for opioid addiction found that many physicians are confronting obstacles to the use of this newly available medication. Inadequate access to the medication, poor awareness within the health community, costs, and federal limitations were among the most commonly cited hindrances.

There are currently several thousand doctors in the United States qualified to treat patients with buprenorphine, and the poll focused on those physicians listed in the online directory maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). Earlier this year, the SAMHSA Buprenorphine Physician Locator database included contact information for 863 doctors from across the country. However, the accuracy of those listing was questioned, as nearly 10% of the providers listed in the directory could not be reached for the poll, even with multiple attempts.

Of the responding physicians who had already treated or tried to treat patients with buprenorphine (66% of those polled), one-third reported experiencing problems with

access to the medication. A most common complaint was that doctors could not find a pharmacy willing to stock the drug.

Cost was another pressing issue of concern. Many doctors contended that lack of insurance coverage for buprenorphine treatment -- whether private, Medicaid, or Medicare -- is a substantial impediment. Physicians have found that patients discontinue use of the drug because they cannot afford the treatment without adequate insurance coverage. Several respondents said that the cost is so prohibitive that some patients are forced to cease treatment, and then they resume opiate use.

“ASAM Public Policy Days on Capitol Hill” Nov. 3-4, 2003

ASAM; September 26, 2003 – The American Society of Addiction Medicine has announced their First Annual Legislative Days set for November 3- 4, 2003, at the Washington Court Hotel in Washington, D.C. The topic is “Insurance Parity in Addiction Medicine today.”

This is an excellent opportunity for physicians, physician assistants, nurse practitioners, and other healthcare professionals to meet with elected officials and educate congressional representatives about addiction medicine and parity in substance abuse treatment benefits and insurance coverage. Registration for this event is available online at www.asam.org or by contacting Celso Puente, ASAM’s Membership and Chapter Development Manager at cpuen@asam.org.

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MMT Improves Thought Processing, Reduces Drug Abuse

Bal Harbour, Florida; CPDD; June 2003 (Gruber SA, et al. Methadone Maintenance Improves Cognitive Performance After Two Months of Treatment) -- Scientists reporting at last summer’s CPDD (College on Problems of Drug Dependency) 64th Annual Meeting noted that continuing participation in methadone maintenance treatment (MMT) improves patients’ thought processing (neurocognitive) skills.

A neurocognitive test battery was administered to 18 opioid-dependent subjects enrolled in an MMT program at baseline and following two months of treatment. Statistically significant improvements were noted on tasks designed to assess verbal learning and memory. Notable improvements

also were detected in other areas, including verbal fluency and visuospatial working memory. These increases in cognitive functioning were accompanied by a significant decrease in drug use between the two time points, which suggests that even short-term methadone treatment may be associated with improved cognitive function and decreased drug use.

MMT Patients Not Getting Treated For HCV

Bal Harbour, Florida; CPDD; June 2003 (Batki SL, et al. Hepatitis C Treatment Initiation Among Methadone Patients in Upstate New York: Preliminary analysis) -- in another presentation at the CPDD Annual Meeting, researchers concluded that better interventions are needed to help more HCV-positive MMT patients seek and receive treatment for this infection.

Interviews were conducted with 41 MMT patients with known HCV infection. Patients' mean age was about 44.3 and they were mostly male (68%) and Caucasian ((78%). Subjects had known of their HCV+ status for an average of 7.2 years and had been in MMT an average of 3.3 years. Practically all of them (97.6%) knew HCV could lead to liver failure and indicated that they would be willing to take medication that needed to be injected 1-3 times/week. Three quarters indicated they would start treatment even if there was a risk of flu like symptoms.

However, when it came to entry into HCV care, less than 20% had been offered HCV treatment by their primary care physicians or GI specialists and only 3 patients (7.3%) had completed such treatment. Of the 33 subjects not offered treatment, 15 (45.5%) had never consulted a physician and 14 (42.4%) reported that they were told their HCV infection was not severe enough. Only 6 (14.6%) subjects in the total sample had received Hepatitis B (HBV) vaccination.

While 83% of HCV-positive MMT patients in this sample were insured and nearly all knew about the dangers of HCV infection, many had not seen a physician and few had started HCV treatment. The vast majority had not received vaccination against HBV. Interventions are needed to close the gap between knowledge and action regarding initiation of HCV treatment by MMT patients.

Could Pending Heart Attack Mimic Methadone Undermedication?

Circulation; November 2003 (McSweeney JC, et al.) -- In a study titled "Women's Early Warning Symptoms of Acute Myocardial Infarction," the authors noted that unusual

fatigue and insomnia may be the primary indicators of pending heart attack in women, rather than chest pain.

At 5 medical centers, investigators retrospectively surveyed 515 women (ages 29-97 years) who had heart attacks. Almost all of the women (95%) experienced unusual symptoms as much as a month before they were stricken. The most commonly reported symptoms during that time period included unexplained or unusual fatigue (71%), sleeplessness (48%), and shortness of breath (42%). More than a third of the women (35%) experienced increased anxiety. Only about 30% said they had any sort of chest discomfort; a classic symptom of heart trouble in men.

[The authors of this study noted it was unclear to what degree the advance symptoms are predictive of future heart attack. However, these could be important during methadone maintenance treatment (MMT). Fatigue, insomnia, and anxiety also are symptoms of opioid withdrawal and suggestive of methadone undermedication. Therefore, while methadone dose adjustments still might be appropriate, an examination of cardiac risk factors also might be considered in female MMT patients of any age unexpectedly complaining of such symptoms. -- Ed.]

Beware Methadone, Metadate Name Confusion

Nursing 2003; November 10, 2003 -- healthcare personnel are being warned to be on guard for mix-ups between the extended-release nervous system stimulant Metadate CD (methylphenidate capsules) or Metadate ER (methylphenidate tablets) and methadone. Methylphenidate is typically prescribed for patients with attention deficit hyperactivity disorder (ADHD).

In a name-related mishap, a druggist accidentally substituted methadone for Ritalin (methylphenidate) prescribed for a 7-year-old boy in New Mexico. The methadone accumulated in the boy's system for 3 days before triggering signs of overdose requiring hospitalization. The boy survived, but in a similar case in 1999 the mix-up was fatal in an 8-year-old child. [Report from the *Chicago Tribune*, October 8, 2003.]

Addiction Treatment Meets Barriers in Doctors' Offices

New York Times; October 21, 2003 (Howard Markel) -- While progress has been made in combating alcoholism and drug addiction in the U.S., the medical establishment is still failing in large numbers to diagnose the disease in their patients, according to experts at a recent conference.

“Although doctors and nurses have the best opportunity to intervene with alcoholics and substance abusers, our research indicates they are woefully inadequate at even diagnosing someone with this disease,” said Joseph Califano Jr., the chairman and president of Columbia University’s National Center on Addiction and Substance Abuse (CASA) that sponsored the conference.

Surveys conducted by the center’s researchers found that 9 of 10 primary care doctors fail to diagnose substance abuse in patients who display classic symptoms of the problem. The researchers attributed these failures to insufficient training in the treatment of addiction, doctors’ frustration with afflicted patients, the common perception among doctors that treatment for substance abuse does not work, and a poor rate of insurance reimbursement for such services.

CASA policy makers made several recommendations to address these problems, including: increasing formal substance abuse training for medical students, residents, and physicians so they can recognize the symptoms and understand the treatment tools; expanding coverage provided by Medicare, Medicaid, private insurers, and managed care for treatment; and adding legal accountability for primary care doctors who fail to diagnose substance abuse or addiction and encourage their patients to seek help.

June E. Osborn, president of the Josiah Macy Jr. Foundation, which is concerned with the education of doctors, observed, “Most doctors want to be helpful as well as knowing exactly what they are doing,” Dr. Osborn said. “They are taught primarily about acute medical care. In clinical situations where they don’t know exactly what they are doing, doctors tend to walk away and adopt an attitude of blaming the patient. But there is no place for blame in health care.”

Doctors have a particularly hard time accepting that there are no easy cures for the chronic and often relapsing disease of addiction, unlike surgical problems that can be corrected by an operation or infections that can be conquered by antibiotics. Surprisingly, scant formal training on addiction and substance abuse is available in American medical schools. Currently, most of them offer only a few hours on these complex subjects and even less is offered during most residency or postgraduate programs.

Still, another major obstacle to effective treatment is the presumption among many doctors and patients that addiction is a matter of personal responsibility rather than a bona fide disease with treatments that can work. However, scientists

are steadily unlocking the critical biological secrets of addiction and the reasons that some people become addicted to specific substances but others do not.

Maine Crafts Model Strategy For Combatting Drug Overdose Deaths

Portland (Maine) Press Herald; October 23, 2003 -- The federal Center for Substance Abuse Treatment (CSAT) praised the state of Maine for creating a strategy to address a rise in drug overdose deaths; some of which were related to methadone.

In 2002, there were 126 overdose deaths in the state with about a quarter involving methadone. The state responded by gathering data on the problem; introducing an education program for medical providers, addicted individuals, and the public; enhancing oversight and monitoring of clinics; and creating a network of groups to address the issue. Additionally, the state legislature approved an electronic prescription-monitoring system, and the Portland Department of Health and Human Services created its own education and intervention program to curb overdose deaths.

A report issued by CSAT said that Maine’s Office of Substance Abuse “has led a campaign that appears to be a model strategy for responding to a public crisis and mobilizing partners in crafting a plan for response.” The first six months of this year show that there were 46 overdoses, 14 of them linked to methadone. Last year during the same time period, there were 75 overdoses, 28 involving methadone.

The CSAT report also recommended that Maine increase the availability of methadone treatment to avoid waiting lists at clinics and people having to drive long distances for treatment.

[It should be noted from other data that very few of the deaths were in persons attending methadone maintenance treatment programs. Most of the decedents obtained methadone via unspecified sources, presumably illegally. Also, in most cases associated with methadone the drug was combined with other opioids and/or alcohol and there was a high prevalence of both physical disorders and mental illness among the decedents. -- Ed.]

Researchers Explore Ways To Prevent Drug Relapse

San Diego Union-Tribune; October 22, 2003 -- Researchers are close to unlocking the code of addiction and crafting new

approaches to prevent drug relapse in persons recovering from addiction.

Treatment success may require a targeted approach. For instance, cocaine addiction could be treated with customized psychotropic drugs targeting specific areas of the brain. “Our objective is to revolutionize drug development and provide a completely new view of psychiatry,” said Hans Breiter, a psychiatrist and researcher at Massachusetts General Hospital in Boston.

Researchers are examining the links between psychiatric disease and addiction. “People with psychiatric disorders have a much higher propensity to use drugs,” said Bertha Madras, a professor and researcher who works with non-human primates at Harvard Medical School.

Since addictive drugs cause molecular changes in the reward circuitry of the brain, researchers also want to pinpoint which molecules have been altered by drug use and find ways to reverse the effects. “A major cause of relapse is the long-lasting adaptations that have occurred in the brain in response to drugs of abuse,” said Stanford University psychiatrist Robert Malenka. “What commonly happens is that someone who has a problem with addiction is abstinent, but will be exposed to some environment where they used the drug or some person they’ve used the substance with. Then, they get these overwhelming memories we call cravings that become so powerful they have to start using drugs again.”

Many Substance Abusers ‘Just Not Ready’ To Seek Treatment

Washington, DC, PRNewswire; November 7, 2003 -- A new report from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) shows that even when people recognize they are having problems with alcohol or drugs many do not seek treatment because they are “just not ready” to stop using. The report also found that many people do not believe they can financially afford to obtain treatment.

According to the report, there were about 6 million persons with illicit-drug dependence or abuse in 2002 who did not seek specialty treatment for their illicit drug use. There were an estimated 17 million persons in 2002 with alcohol dependence or abuse who did not receive specialty treatment. At the same time, only 6% of those with untreated illicit drug problems, and 4.5% of those with untreated alcohol problems, even perceived that they had a need for treatment.

Furthermore, the data show that among the 362,000 untreated persons who do recognize they are in need of treatment for their illicit-drug problems, 39% indicated that they were not ready to stop using illicit drugs and 37% perceived the cost of obtaining treatment as too high. For the 761,000 persons with untreated alcohol problems who recognized in the past year that they needed treatment, nearly half (49%) indicated that they simply were not ready to stop their alcohol use and 40% said that the cost of treatment contributed to their not receiving treatment.

The report, “Reasons for Not Receiving Substance Abuse Treatment” was developed from SAMHSA’s National Survey on Drug Use and Health, which was based on interviews with 68,126 respondents. It is available online at DrugAbuseStatistics.samhsa.gov.

Myriad of Health Problems Often Accompany Substance Abuse

Washington, DC, PRNewswire; November 10, 2003 -- Results of two new studies show that people with substance abuse disorders often have accompanying medical or psychiatric conditions that can include bone fractures, muscle injuries, pain disorders, depression, anxiety, and even psychoses.

In an *Archives of Internal Medicine* article, Jennifer Mertens and colleagues analyzed 12-month data from 747 people who entered the Kaiser Permanente substance abuse program, and 3,690 demographically matched control patients who were not diagnosed with substance abuse. They found that people undergoing treatment for substance abuse had a significantly higher prevalence of injuries (such as fractures, sprains, strains, and burns), depression, and anxiety disorders. Substance abuse patients also were more likely to require treatment for lower back pain, headache, and arthritis.

More than 25% of the substance abuse patients were diagnosed with injuries compared to only 12% of the controls. Also, 29% of the substance abuse patients were diagnosed with depression and 17% with anxiety disorders, versus only 3% and 2% of the control patients, respectively.

The second study, published in the *Archives of General Psychiatry*, highlights data from the Northwestern Juvenile Project. Karen Abram and colleagues interviewed 1,829 youth ages 10 to 18 at the Cook County [Illinois] Juvenile Temporary Detention Center. Overall, more than 10% of males and almost 14% of females had a substance abuse

disorder and a major mental disorder, such as psychosis, manic episode, or major depressive episode.

When the scientists examined data from a different subset of 874 youth with substance abuse disorders, they found that 30% of the females and 21.4% of the males also had a major mental disorder. The mental and drug abuse disorders developed within the same year for almost 67% of females and more than 54% of males.

“As members of the medical community, we need to be aware of the high prevalence of comorbidity with substance abuse and adjust our focus to include treating all of a person’s health problems,” said Nora Volkow, director, National Institute on Drug Abuse (NIDA), which helped fund the studies. “We need to recognize that these problems can be severe and can include physical injuries and serious mental disorders. Effectively addressing these concerns will be key to breaking the cycle of these disorders and substance abuse.”

For further information see:

Abram KM, et al. Comorbid psychiatric disorders in youth in juvenile detention. Arch Gen Psychiatry. 2003;60:1097-1108.

Mertens JR, et al. Medical and psychiatric conditions of alcohol and drug treatment patients in an HMO: comparison with matched controls. Arch Intern Med. 2003;163:2511-2517.

Study: Parity is Cheap, But Must Be Mandated and Enforced

Join Together; November 13, 2003 (Bob Curley) -- Requiring insurers to cover addiction and mental illness on par with other types of diseases raises insurance premiums just 0.2% annually, according to a new study of state parity laws.

Ensuring Solutions to Alcohol Problems, a research group based at the George Washington University Medical Center, reviewed 11 previously published studies by states that examined the impact of their own parity laws. Generally, the studies found that parity eases pressure on state budgets by cutting health, correctional, and welfare costs, and increases the number of people entering treatment. The cost of addiction and mental illnesses to individual business also declines sharply when all employers are required to provide parity coverage, the state studies found.

To date, 38 states have passed laws mandating some form of parity coverage for mental illness, and seven states nationally

require parity for addiction. Simply having a law in place does not guarantee equal coverage, however. A second Ensuring Solutions study, of 70 health plans in 36 states, found that at least 10 major health plans in five states -- Florida, Georgia, Nevada, New York, and West Virginia -- have failed to comply with state laws governing insurance coverage for addiction.

Advocates for parity point to a 2001 study by the National Center on Addiction and Substance Abuse (CASA), which estimates that every American pays \$227 in state taxes to deal with addiction-related problems. “The brunt of failure to prevent and treat substance abuse and the cost of coping with the wreckage of this problem falls most heavily on the backs of governors and state legislatures across America,” the CASA report stated.

Various state studies have concluded that improving access to addiction treatment by mandating parity would result in cost savings to taxpayers. Minnesota, for example, said in its parity report that 80% of costs were offset in the first year by decreased use of hospital, emergency-room, and detox services, as well as reduced arrests. California found that addiction treatment resulted in a 66% decline in criminal activity and 33% fewer hospitalizations.

Book Helps Drug-Addicted Mothers

November 2003 (AT Forum review) -- *The Mother’s Survival Guide to Recovery* has been in print for awhile, having first been published in 1996, but has unfortunately been largely overlooked.

Subtitled “All About Alcohol, Drug & Babies,” the 138-pages by health educator and parenting counselor Laurie Tanner provides thoughtful guidance for women who are pregnant or faced with caring for a newborn while at the same time struggling with substance-dependency and recovery issues. The comprehensive, yet easy-to-read, presentation of advice and authoritative facts also would be of importance for all healthcare workers -- addiction counselors, social workers, clinicians -- trying to assist drug-addicted mothers cope with everyday problems while seeking help for their drug and alcohol problems.

“Get help, don’t drink, and get on methadone if you’re a heroin addict” is an essential but hard-to-follow message of the book. Actually, all types of substance dependency are discussed and Tanner’s understanding and straightforward approach -- covering the many facets of addiction, addiction treatment, and parenting -- provides much hope for addicted mothers and their offspring. Often, she addresses the reader

like a caring friend: “If you are opiate addicted,” she writes, “methadone is a loving, responsible, humane thing to do for yourself and your baby.” This sort of sympathetic tone throughout the book is certain to be welcomed by women who are confused and fearful about recovery issues.

This is a unique (and very reasonably priced) book with much potential for helping pregnant drug-addicted women and those who care about them. To order *The Mother’s Survival Guide to Recovery* call 760-934-2499; visit <http://www.adicma.com/>; or e-mail to adicma@msn.com. Cost is \$5.00 + postage (indicate with the order that you are an *AT Forum* reader and receive free shipping).

SAMHSA Offers Video On Co-Occurring Disorders

Washington, DC; October 16, 2003 -- Drug and alcohol dependence in conjunction with mental disorders wreak havoc on the lives of millions. Learn more about co-occurring substance abuse and mental disorders as well as treatment practices in the SAMHSA-sponsored video, “When Addiction and Mental Disorders Co-Occur.”

This 57-minute presentation features discussion by a panel of experts, such as SAMHSA Administrator Charles G. Curie. Other participants include: Ivette Torres, Associate Director for Consumer Affairs, Center for Substance Abuse Treatment (CSAT); Michael M. Faenza, National Mental Health Association; Andrea Barnes, Outpatient Addiction Services (OAS) at Twinbrook; and Thomas A. Kirk, Jr., Department of Mental Health and Addiction Services, State of Connecticut.

The video is available for the specially reduced price of \$10 from SAMHSA’s National Clearinghouse for Alcohol & Drug Information at 1-800-729-6686. Ask for item VHS167. The program, which was Webcast March 5, 2003, also is available via Internet viewing at: <http://www.recoverymonth.gov/2003/multimedia/w.aspx?ID=178>.

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Canada Updates “Best Practices” Guidelines for MMT

Health Canada; November 14, 2003 -- This updated best practices document is intended to help improve the effectiveness of current methadone maintenance treatment (MMT) programs and encourage the establishment of new programs. It is an educational tool which synthesizes knowledge about best practices in MMT design and delivery.

Furthermore, it contributes to an ongoing process of knowledge development and education for policy makers and health and social services professionals responding to the issue of opioid dependence.

The document provides a summary of what current research and expert opinion -- from within Canada and abroad -- indicate are the best practices in the field of methadone maintenance treatment. It focuses on what a comprehensive approach to effective, accessible MMT should look like and how to achieve it.

A prior review of the literature (Health Canada, 2002) indicated that MMT is an effective means of reducing the use of other opioids, the use of other substances, criminal activity, and the rate of mortality. Methadone maintenance treatment has also been found to reduce injection-related risk behaviors, other risk behaviors for transmission of human immunodeficiency virus (HIV) and sexually transmitted diseases, and the transmission of HIV (and potentially the transmission of hepatitis C virus (HCV) and other blood-borne pathogens). MMT has also been found to increase retention in treatment for improving physical and mental health, social functioning, quality of life, and pregnancy outcomes.

For more complete information, see: http://www.hc-sc.gc.ca/hecs-sesc/cds/publications/methadone_treatment_best_practices/preface.htm

Driving Restrictions Unnecessary for MMT Patients; Study

Drug and Alcohol Dependence; December 2003 -- An Australian study found that persons stabilized on methadone, as well as other pharmacotherapy for opioid dependence, can perform driving tasks equally as well as any other persons.

Michael Lenne and colleagues from Monash University and Paul Dietze from Turning Point Alcohol and Drug Centre, Victoria, Australia studied 34 patients stabilized on methadone, LAAM, or buprenorphine for at least 3 months, compared with 21 non-drug using volunteers. Experimental sessions in a simulator assessed driving speed, lateral position, steering wheel angle, and response to a secondary task. Before one of the sessions participants drank ethanol to obtain a targeted blood alcohol level (BAL) of 0.05%.

Simulated driving performance did not differ among the opioid-treatment subjects or between them and control subjects. However, impairment was observed in all groups

after alcohol consumption and the effects of alcohol in producing diminished performance were equal in all groups. Results from this study question any need for imposing restricted driving standards on stabilized methadone, buprenorphine, and LAAM patients.

For more information on the study, contact Dr. Paul Dietze at: pauld@turningpoint.org.au

Interactions of HIV Treatments With Methadone & Other Drugs Studied

Eureka Alert; November 2003 -- How do multiple substances affect how HIV drugs work and how do HIV drugs, in turn, affect the other drugs a patient takes?

That question is at the heart of research being conducted by the University at Buffalo's Laboratory for Antiviral Research, where researchers are developing innovative new methods of testing the blood and cells of HIV patients for drug interactions. Daily medication regimens for some HIV/AIDS patients may include an antiretroviral drug for HIV, methadone for heroin addiction, a birth control pill, and an antidepressant. Others also take drugs to treat diabetes, opportunistic infections, and side effects of antiretrovirals. Some patients continue to abuse alcohol, cocaine, or heroin.

The decision to propose a comprehensive study on how antiretroviral drugs interact with other drugs HIV patients take grew out of a recent, multi-year clinical pharmacology study of interactions with methadone by Gene Morse, PharmD and psychiatrists at New York City's Montefiore Hospital. Morse, principal investigator for this new study, is professor and chair of the UB Department of Pharmacy Practice.

A big factor in treating HIV infection are those patients with concurrent substance addiction," according to Morse. "For example, some of the drugs patients take to treat HIV could actually put them into withdrawal from methadone." UB is the lead institution on the project, conducting laboratory-based studies to measure concentrations of drugs a patient is taking in blood and cells and to analyze the pharmacogenetic basis of different drugs, or how patients' genetic makeup may influence their response to the drugs.

During the study, blood samples will be collected from a total of 500 patients enrolled at four clinical sites: Montefiore Hospital in New York City, the University of Rochester, Case Western Reserve University and the University of Miami in Florida. Each site has had prior

clinical research collaborations with UB's Laboratory for Antiviral Research.

The study will be conducted and coordinated through the HIV ePharmacotherapy Network, a Web site developed by Morse and his colleagues in 1998 to coordinate HIV clinical pharmacology research. "Considerable variation exists among individuals as to how AIDS drugs are absorbed, distributed and metabolized," he said, "but right now are all prescribed as though 'one size fits all,' according to fixed-dose regimens."

For more information, see: <http://hiv.buffalo.edu/>.

[AT Forum has developed a new research report on "Methadone-Drug Interactions" scheduled for release next month (January 2004). This is the most comprehensive listing to date, including more than 100 drugs and other substances that interact with methadone to influence its effects. The report also will be available for download at www.atforum.com (in the "Addiction Resources" section). -- Ed.]

Oral Fluid Testing Effective in Detecting Opioids

Eureka Alert; December 11, 2003 -- A study published in the December issue of *Drug and Alcohol Dependence* indicated that the use of oral fluid analysis may be an effective alternative to urinalysis in detecting drug use in opioid-treatment settings.

Gerald A. Bennett and colleagues studied the use of rapid oral testing in 150 persons with known drug problems to assess accuracy in detecting drugs of abuse. Subjects were screened using 3 methods for the use of opioids, methadone, benzodiazepines, and amphetamines. Each subject submitted to a laboratory urinalysis, and rapid screenings of both oral fluids and urine.

The ease of administration of the oral fluid test makes it an attractive alternative to urinalysis, but it has several limitations. Substances in saliva are only detectable for 12 to 24 hours after consumption, a shorter time period than in urine. Results of the study showed that patients in a treatment setting could be administered an oral fluid analysis as an alternative to a urinalysis with similar accuracy in detecting opioid or methadone use; however, the oral screening was significantly less effective at detecting the presence of benzodiazepines than the urinalysis. Testing for other drugs of abuse, such as marijuana, was not evaluated.

For more information on the study, contact Dr. Gerald Bennett at: gerald.bennett@dorsethc-tr.swest.nhs.uk

Faces and Voices of Recovery Campaign Mobilizes for Action

Washington, DC; November 18, 2003 - Addiction recovery advocates have taken decisive steps to launch a new national campaign to organize and rally the families, friends, and allies of the millions of Americans in addiction recovery. Faces and Voices of Recovery, created to broaden social understanding and achieve a just response to addiction as a public health crisis, will work closely with local and regional advocates who have taken one of the many paths to recovery from alcohol and drug addiction.

At a November 7-8 meeting in Washington, DC, Faces and Voices created a governance structure that will be responsive to the recovery community. A 13-member Campaign Steering Committee, with representatives from around the country, will guide the organization. According to Steering Committee member Ron Williams, “We committed to a national recovery advocacy campaign, streamlining our governance. We are moving forward to support the important organizing work that is going on across the country.”

Faces and Voices, headquartered in Washington, encourages people in recovery to “be living proof that there are real solutions to addiction” and to advocate for public policies that support recovery.

For more information visit:

<http://www.facesandvoicesofrecovery.org>.

Employers Believe in Drug Rehab, But Won't Hire Recovering People

Hazelden Press Release; December 1, 2003 -- Nearly one in four human resources professionals surveyed reveal that their companies are less likely to hire a job candidate if the person is in recovery from drug or alcohol addiction – even though 89% believe treatment is effective in helping their employees fight addiction.

These findings are from a new “Workplace Addiction Survey” conducted by Minnesota-based Hazelden Foundation as part of the launch of its “Making Recovery America’s Business” corporate education campaign. The survey of 200 U.S. companies reveals that almost all (84%) of the HR professionals surveyed considered addiction a chronic illness/disease and more than 80% would recommend treatment for an addicted executive or a rank-and-file worker alike, rather than merely firing them.

Overall, 89% of respondents believe that addiction treatment programs are effective in helping employees beat addiction.

However, a number of stumbling blocks were noted. Although 60.5% of the HR professionals surveyed believed addiction significantly affects employees in their workplaces – citing absenteeism and reduced productivity – those same respondents highlighted barriers keeping them from suggesting chemical dependency treatment to employees. More than half (54%) reported a lack of experience or expertise in knowing how to identify addiction, and more than one-third (36%) reported a lack of experience or expertise in knowing how to get treatment. One-quarter (25%) reported a belief at their company that it is just easier in the long run to terminate an addicted employee rather than getting them treatment, noting that treatment is too expensive as one reason that.

Opioid Withdrawal Drug Could Become Available in U.S.

Wall Street Journal; November 18, 2003 -- By 2005, Britannia Pharmaceuticals Ltd. of Great Britain could have its drug lofexidine available in the U.S. to help medically withdraw [sometimes called, “detox”] individuals addicted to heroin and other opioids.

Currently, lofexidine is used in Britain to treat withdrawal symptoms such as vomiting and diarrhea. Britannia Pharmaceuticals has licensed U.S. rights for the drug to US WorldMeds LLC in Louisville, KY. A large trial of the drug is expected to begin next year, and the company hopes to receive U.S. FDA approval to market the drug by the end of 2005.

Depression, Stress, and Anxiety Account for Most Psychiatric Claims

Mental Health Weekly; December 8, 2003 -- According to an analysis of MetLife’s database of disability claims, depression and stress or anxiety account for most psychiatric claims.

Overall, psychiatric claims made up 7% of MetLife’s group short-term disability (STD) claims, with depression accounting for 55% of these claims and stress or anxiety accounting for 30%. Employees ages 35 to 44 were most likely to file psychiatric claims. The analysis also revealed that white-collar employees were more than twice as likely as the general employee population to submit an STD claim for psychiatric conditions and call center personnel were 4 times more likely to miss work for such conditions.

Ronald S. Leopold, M.D., national medical director and vice president of MetLife Disability noted that even when

employees are at work they may be unable to focus on the job due to stress or depression. Such “presenteeism” can result in more lost productivity than absenteeism, according to Leopold. Depression and stress or anxiety may cost U.S. employers an estimated \$344 billion annually in areas such as lost productivity and medical fees. Companies that have employee assistance services to help employees with life issues and mental health have 21% lower absenteeism and 14% higher productivity, according to the Substance Abuse and Mental Health Services Administration (SAMHSA).

Alcohol Can Shrink the Brain; Study

The Sun (Baltimore, MD); December 8, 2003 -- A new study says moderate alcohol use may reduce the size of your brain and, contrary to previous studies, may not reduce the risk of a stroke.

Researchers at Johns Hopkins University who studied 1,909 middle-aged and elderly people found moderate drinkers had smaller brains than those who abstained. The differences in brain sizes were small, so it was impossible to say if they affected cognitive abilities, said Jingzhong Ding, the lead author. But he said magnetic resonance imaging tests also found nothing to show that alcohol reduced the chances of stroke, which contradicts several previous studies.

“The study suggests that while we know moderate alcohol consumption may be beneficial in terms of coronary artery disease, the evidence of a benefit in terms of stroke risk is inconsistent,” he said. The results were published in *Stroke: Journal of the American Heart Association*.

Even Low Levels of Alcohol Can Impair Brain

HealthDay News; November 17, 2003 -- New animal research finds that even moderate drinking can impair motor coordination and memory and lower social inhibitions.

According to lead researchers at the University of California at Los Angeles, a blood-alcohol level of 0.01% can impair brain function. “This is the effect one or two drinks will have,” they said.

Researchers studied the effects on gamma aminobutyric acid (GABA) receptors in animal cells exposed to low levels of ethanol. They found that GABA receptors with a beta-3 subunit and a delta subunit responded to low levels of alcohol. They are now conducting similar studies on rats. “If we understand the action of alcohol at the cellular and molecular level, it is helpful in treating the bad effects that alcohol may have,” they said. “We may be able to develop antidotes or treatments for intoxication or overdoses and

coma and life-threatening effects as well as being able to understand and treat alcohol abuse.”

See: Wallner M, Hanchar HJ, Olsen RW. *Proceedings of the National Academy of Sciences*. December 9, 2003;100(25):15218-23.

Injectable Naltrexone Reduces Heavy Drinking in Male Patients

Business Wire; December 8, 2003 -- Statistically significant reductions in heavy drinking were demonstrated in male patients administered an injectable form of naltrexone; however, less successful outcomes were observed in female subjects.

Alkermes, Inc. announced preliminary results from its Phase III study of Vivitrex® (naltrexone for injectable suspension) at 24 treatment centers in a total of 624 male and female patients with alcohol dependence. This formulation of naltrexone uses extended-release technology that allows once monthly, rather than daily, administration of the drug.

Patients received psychosocial therapy and once-monthly injections of Vivitrex 380 mg, Vivitrex 190 mg, or placebo for a six-month period. The primary endpoint of the study was the rate of heavy drinking during the period, defined as 5 or more drinks per day for a man and 4 or more drinks per day for a woman.

Overall, patients treated with the higher dose of injectable naltrexone experienced approximately a 25% reduction in the rate of heavy drinking relative to placebo, which was statistically significant ($p < 0.03$). Gender played a dominant role in the study results, as males showed approximately a 48% reduction in the rate of heavy drinking relative to placebo, but females showed no significant difference from placebo. The lower dosage formulation produced less favorable results in male subjects and, as before, no significant improvements among females compared with placebo. The results have not yet been formally published.

Family Environment, As Well As Genetics, Influences Alcoholism

HealthDay News; December 9, 2003 -- A person’s likelihood of developing alcohol abuse disorders is influenced by genetics and family environment, says an American study in the December issue of the *Archives of General Psychiatry*.

Researchers from the Palo Alto Veterans Affairs Health Care System in Menlo Park, AZ, interviewed 1,213 identical and non-identical male twins (average age 50), 1,270 of the

twins' children (aged 12 to 26 years), and 862 mothers of those children.

Among the children, 276 had fathers with no alcohol abuse or alcohol dependence. The remainder of the children had either a father or uncle, or both, with alcohol abuse or alcohol dependence. Children of twins with a history of alcohol dependence were much more likely to exhibit alcohol abuse or dependence than children of nonalcoholic fathers, the study found.

Children of an alcohol-abusing identical twin whose co-twin also was alcohol-dependent were more likely to be alcohol-dependent than children of nonalcoholic twins. Meanwhile, children of an identical twin with no history of alcohol abuse or dependence, but whose co-twin was alcohol-dependent, were no more likely to be alcohol abusers or alcohol-dependent than the children of nonalcoholic twins.

“These findings support the hypothesis that family environment effects do make a difference in accounting for offspring outcomes, in particular, that a low-risk environment (ie, the absence of parental alcoholism) can moderate the impact of high genetic risk regarding offspring for the development of alcohol-use disorders,” the study authors wrote.

FDA & DEA Plans Will Address Opioid Painkiller Misuse

Wall Street Journal; December 3, 2003 -- The U.S. Food and Drug Administration (FDA) and the Drug Enforcement Administration (DEA) have unveiled plans aimed at reducing the growing misuse of prescription opioid painkillers.

The strategy would require pharmaceutical companies that market powerful painkillers to create programs to reduce the risk of misuse and addiction of their products. In addition, the FDA is revising labeling regulations to require more detailed information on prescribing. The DEA, in conjunction with state medical boards, also is planning to add a training component on opioid use to the continuing-education requirements for physicians, and is working with pain-related medical specialty groups to create educational initiatives. The federal agencies want the plan in place before drug companies introduce new narcotic painkillers.

Federal Grants Info Now Available Online

HHS Press Release; December 10, 2003 -- The Bush administration unveiled a new Internet site --

<http://Grants.gov> -- billed as a “one-stop shopping” resource for getting information and applying for all federal grants.

The initiative is part of Bush’s Electronic Government initiative. “For the first time, there will be a single, government-wide source for information about grant programs across the federal government,” said Tommy Thompson, secretary of the Department of Health and Human Services. “By putting relevant information in one place, we’re helping to level the playing field for organizations less familiar with federal grant programs so that they too can identify and apply for appropriate grants.”

The site will have information on more than 800 grant programs from 26 federal agencies, representing total annual awards of more than \$360 billion. About half of all federal grants are awarded by HHS. Site visitors will be able to search for, download, complete, and submit federal grant applications.

\$100 Million for Addiction Treatment Vouchers Approved

Join Together; December 5, 2003 (Bob Curley) -- A House-Senate conference committee has approved a budget plan that gives impressive increases to federal addiction treatment and prevention programs, including \$100 million for President Bush’s proposed treatment-voucher program. President Bush originally requested \$200 million for the voucher program in FY2004 and Congress approved half that amount.

As part of an omnibus appropriations bill, House and Senate conferees agreed to fund the voucher program -- previously rejected by House lawmakers -- and add \$36 million to the \$1.753 billion federal addiction block grant, the nation’s single largest source of addiction-related funding.

President Bush made the voucher plan a budget priority by touting it in his State of the Union speech and in official visits to treatment programs across the country. Despite fears that a conservative Congress and administration might turn away from demand-reduction strategies, treatment and prevention have become nonpartisan issues.

The Access to Recovery treatment-voucher plan is one of the biggest nonmilitary new programs in the FY2004 budget. While the addiction field embraced President Bush’s call for an investment in treatment, many have been wary about the types of programs that would be funded, particularly given the administration’s affection for faith-based interventions.

But lawmakers stressed that voucher money should only go to programs with a proven record of effectiveness.

“The conferees expect that the new voucher program will support evidence-based practice and will provide medically appropriate treatment for individuals needing care,” the House-Senate conference report said. “To this end, the conferees expect that states and providers receiving funds under this program will use assessment and placement criteria developed by national experts, such as the American Society of Addiction Medicine.”

Beyond the voucher program and the block grant, Congress gave increases of \$35 million and \$15 million, respectively, to the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). With the increase, NIDA stands on the brink of being a billion-dollar agency, with its 2004 budget set at \$997 million. If the spending plan is approved, NIAAA’s budget next year would be \$431 million.

Are Newer Drugs Always Better? Schizophrenia Drug in Question

Associated Press; November 25, 2003 -- A drug that has become one of the first-line treatments for schizophrenia since the mid-1990s is not much better than older and cheaper medications, a surprising new study found.

The study was paid for by the maker of the newer drug, olanzapine, sold as Zyprexa. Earlier, shorter studies showed it was less likely to cause the tremors associated with older drugs such as haloperidol. But some previous research compared Zyprexa against only haloperidol, which typically is combined with another drug, benztropine, to reduce the risk of tremors.

The latest study, conducted for a year at 17 veterans hospitals, tested Zyprexa against the two-drug combination and found that Zyprexa patients fared only slightly better on scores of restlessness and mental function but had about the same degree of tremors. At the same time, Zyprexa costs more than \$8 a day versus about 10 cents a day for the two-drug combination.

In the study, Zyprexa patients had \$3,000 to \$9,000 more in yearly expenses -- mostly because of higher drug costs and more hospital stays -- and the newer drug also caused substantial weight gain, a known side effect.

The study appeared in the *Journal of the American Medical Association*.

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Report: Methadone Deaths Not Linked To MMT Programs

SMHSA News Release; February 6, 2004 -- Methadone-associated deaths are not being caused primarily by methadone diverted from methadone treatment programs, a panel of experts convened by the Substance Abuse and Mental Health Services Administration (SAMHSA), reported.

The consensus report, “Methadone-Associated Mortality: Report of a National Assessment,” was released by SAMHSA’s Center for Substance Abuse Treatment (CSAT) director, H. Westley Clark, MD, JD, MPH, at the 6th International Conference on Pain and Chemical Dependency in New York City. It concludes that “although the data remain incomplete, National Assessment meeting participants concurred that methadone tablets and/or diskettes distributed through channels other than opioid treatment programs most likely are the central factor in methadone-associated mortality.”

SAMHSA had convened the panel of more than 70 experts in May 2003 to determine whether its methadone regulations were allowing diversion of methadone from clinics or whether the rise of methadone mentions in hospital emergency rooms and death reports were due to methadone coming from other sources. “The participants in the meeting reviewed data on methadone formulation, distribution, patterns of prescribing and dispensing, as well as relevant data on drug toxicology and drug-associated morbidity and mortality, before concluding that the cases of overdosing individuals were not generally linked to methadone derived from opioid treatment programs,” SAMHSA Administrator Charles Curie said.

“The Office of National Drug Control Policy (ONDCP) is pleased that the consensus report findings demonstrate that the controls on methadone are working,” Andrea Barthwell, MD, deputy director for Demand Reduction at the White House Office of National Drug Control Policy, said. “We applaud the diligence that the providers of methadone have shown in keeping this a safe modality for the patients they serve and the communities in which they reside.”

Data showed that the greatest growth in methadone distribution in recent years has been associated with its use as a prescription analgesic prescribed for pain, primarily in solid tablet or diskette form, and not in the liquid

formulations that are the mainstay of opioid treatment programs. “Methadone continues to be a safe, effective treatment for addiction to heroin or prescription painkillers,” Clark said. “While deaths involving methadone increased, experiences in several states show that addiction treatment programs are not the culprits.”

The panel recommended creation of case definitions that would make a distinction between deaths caused by methadone and deaths in which methadone is a contributing factor or merely present. Furthermore they want better training for health care professionals in both “the diagnosis and treatment of addiction and appropriate pharmacotherapies for pain.”

[It is expected that the full report will be available at SAMHSA’s Web site: <http://www.samhsa.gov>. For more information contact: Leah Young at 301-443-8956. Addiction Treatment Forum will feature an overview and commentary on the report in our Spring 2004 edition. -- Ed.]

MMT Poised for Growth in Vermont

Times Argus (Montpelier, VT) and WCAX-TV (Burlington, VT); February 3-4, 2004 -- The Vermont legislature appears poised to approve a bill allowing expansion of methadone maintenance treatment (MMT) in that state.

Vermont is a relative newcomer to the MMT scene, having opened its first clinic in late 2002, and was one of only a handful of states without such a program. However, there were severe restrictions placed on its operation, including a requirement that any MMT clinic must be located in a hospital setting and there was *no* allowance for take-home doses of the medication. Recently, the Vermont Senate approved a plan to expand the current single clinic located in Burlington by eliminating the hospital-location restriction and also allowing take-home doses. The bill, which had support from Governor James Douglas, Health Commissioner Paul Jarris, and Public Safety Commissioner Kerry Sleeper, moved on to the House for consideration.

In a related news item, it was noted that drug-related deaths in Vermont increased 50% last year, as 60 persons died of drug overdoses (out of a total state population of only about 617,000 persons). Methadone overdoses accounted for 10 deaths, while heroin killed 3 people. However, in view of the fact that MMT programs were not allowed to provide any take-home doses, this strongly supports the contention of the new CSAT “Methadone-Associated Mortality” report (see

item above) that methadone most typically comes from sources *other than* MMT clinics in such cases.

[Watch for our exclusive interview with Mark D. Green, MD, medical director of Vermont’s only current MMT clinic, in the upcoming Spring 2004 edition of AT Forum. -- Ed.]

SAMHSA Adds 6th MMT Accreditation Body

SAMHSA News Release; January 28, 2004 -- The Substance Abuse and Mental Health Services Administration (SAMHSA) announced the addition of the National Commission for Correctional Health Care as an approved accreditation body to conduct accreditation surveys for initiation, renewal, and continued accreditation of opioid treatment programs in jails and corrections facilities that provide methadone to patients addicted to heroin or prescription pain medications.

Other approved accreditation bodies include: The Commission on Accreditation of Rehabilitation Facilities (CARF); the Council on Accreditation for Children and Family Services; the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); Division of Alcohol and Substance Abuse, Washington Department of Social and Health Services; and the Division of Alcohol and Drug Abuse, State of Missouri Department of Mental Health.

Oversight of opioid treatment programs was transferred to SAMHSA from the Food and Drug Administration in May 2001. At that time, the SAMHSA accreditation process was created to require all treatment facilities that use methadone to withdraw or maintain patients addicted to opiates to become accredited. All facilities that treat with methadone or LAAM must be accredited, including stand-alone detoxification units and detoxification units in hospitals and residential facilities.

Tech Notes: New Discoveries About Methadone Pharmacology

Cytochrome 2B6 Strongly Involved in Methadone Metabolism

University of Colorado Health Sciences Center; January 2004 -- Methadone is well-known to be metabolized by cytochrome P450 (CYP) enzymes to inactive metabolites. Those enzymes previously described include CYP-1A2, -2C9, -2C19, -2D6, and -3A4. New research appears to confirm that CYP-2B6 also is involved.

The primary enzyme thought to be involved in methadone metabolism is CYP-3A4 and, secondarily, CYP-2D6. However, working with animal models, researchers led by John Gerber at the University of Colorado Health Sciences Center, Denver, found that CYP-2B6 plays an important role, possibly more so than CYP-3A4. They further observed that CYP-2C19 may be more significant in methadone metabolism than previously thought.

According to Gerber et al., their research helps to further explain why serum concentrations of methadone are so variable, and why drugs that induce CYP-2B6 -- such as nevirapine and efavirenz -- also increase methadone metabolism, while a CYP3A4 inducer like rifabutin has no effect on methadone serum levels.

[For more information see: Gerber JG, Rhodes RJ, Gal J. Stereoselective metabolism of methadone N-demethylation by cytochrome P4502B6 and 2C19. Chirality. 2004;16(1):36-44. An earlier report on this subject may be found at: Gerber JG. Interactions between methadone and antiretroviral medications. Paper presented at: 3rd International Workshop on Clinical Pharmacology of HIV Therapy [NIDA-sponsored]; April 13, 2002; Washington, DC. Available online at: <http://www.drugabuse.gov/MeetSum/CPHTWorkshop/Gerber.html>.

Also see -- the latest Addiction Treatment Forum research report on "Methadone-Drug Interactions," which lists more than 100 substances that may affect methadone metabolism and/or influence its effects. This is available online at: <http://www.atforum.com/methadonedruginteractions.shtml>. - Ed.]

P-glycoprotein Limits Methadone Entry Into The Brain

Medical University of South Carolina, January 2004 -- One of the factors explaining high variability of methadone serum concentrations is the action of P-glycoprotein (P-gp). This is a metabolic protein found in the intestine that functions like a pump, pushing methadone back into the gut and away from the circulatory system. Now, researchers have found that P-gp in tissues surrounding the brain may affect how much methadone ultimately reaches opioid receptors.

Working with specially bred mice, researchers at the Laboratory of Drug Disposition and Pharmacogenetics at the Medical University of South Carolina found that the amount

of P-gp in tissues of the blood-brain barrier greatly limits methadone's entry into central nervous system sites.

Therefore, differences between patients in the expression of P-gp in the blood-brain barrier is yet another factor that may influence individual response to methadone dose.

[Source: Wang JS, Ruan Y, Taylor RM, et al. Brain penetration of methadone (R)- and (S)-enantiomers is greatly increased by P-glycoprotein deficiency in the blood-brain barrier of Abcb1a gene knockout mice. Psychopharmacology (Berl). January 8, 2004; e-publication ahead of print.]

Marijuana Abuse During MMT Examined

Israel; January 2004 -- Researchers at an Israeli MMT clinic examined the influence of continued marijuana (cannabis) use on treatment outcomes.

MMT patients (n = 283) at the clinic underwent twice-weekly urine testing and completed various questionnaires and interviews. The researchers found that lifetime abuse of marijuana in these patients was 75% and use at intake was 25%, but this did not increase during a 1-year period of observation. Marijuana abusers were more often found to be polydrug abusers than other patients; however, they did not suffer more psychological distress or infectious diseases, nor did they engage in more HCV/HIV risk-taking behaviors or leave treatment earlier. The authors concluded that marijuana abusers should be treated just any other polydrug abusers and treatment policies should take the lack of specific harms associated with marijuana use into account.

[See: Weizman T, Gelkopf M, Melamed Y, et al. Cannabis abuse is not a risk factor for treatment outcome in methadone maintenance treatment: a 1-year prospective study in an Israeli clinic. Aust NZ J Psychiatry. 2004;38(1-2):42-46.]

MMT "Patient Dignity Project" Threatened

NAMA Press Release; January 14, 2004 -- The National Alliance of Methadone Advocates (NAMA) has been involved in a Methadone Emergency Database Project that would create a way to verify a patient's dose in the case of an emergency. However, that endeavor, which has been referred to as the "Patient Dignity Project," is apparently not going to receive further funding.

It is called the patient dignity project because it will allow patients to go to any methadone maintenance treatment (MMT) program and eventually any hospital and get their methadone in the event of an emergency. The project,

initially funded by the Center for Substance Abuse Treatment (CSAT), recently completed its report and was ready to advance to a demonstration project in the New York, New Jersey, and Connecticut areas. However, by not being funded, the project will be delayed indefinitely.

NAMA encourages all advocates, methadone patients, friends and family of methadone patients, and all concerned individuals to contact SAMHSA director Charles Curie (ccurie@samhsa.gov) and/or Westley Clark (wclark@samhsa.gov), director of CSAT, and encourage them to fund the Methadone Emergency Database Project. For more information from NAMA, contact Joycelyn Woods or Walter Ginter at 212-595-6262.

Resource Center Addresses Discrimination & Stigma

SAMHSA Announcement; February 2004 -- A new resource -- called the ADS Center -- will address discrimination and stigma associated with mental illness and drug addiction.

The Center will help individuals, organizations, and governments design and implement programs to reduce discrimination and stigma associated with mental illnesses in the community, workplace, and the media. The Center's Web site offers a wealth of useful information related to stigma and discrimination, describing what they are, what works to counter them, and what resources are available.

The ADS Center also provides hands-on assistance, helping to tailor campaigns and programs to the needs of states, local communities, healthcare providers, managed care organizations, advocates, family members, and mental health consumers. The Center is a program of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, and is operated by a contract with The Gallup Organization and the Mental Health Association of Southeastern Pennsylvania.

[For more information -- visit, <http://www.adscenter.org/>; e-mail, info@adscenter.org; or call, 1-800-540-0320. -- Ed.]

Study Finds Drug Misuse Surprisingly High Among Adults

Health Day News; January 13, 2004 -- A University of Michigan study found that more people in their mid-30s misuse alcohol and illegal drugs than previously believed.

The study of 7,541 people in their 30s found that more than 32% of the men drank heavily, which was defined as consuming 5 drinks or more at one time. In addition, 13% of the men and 7% of the women used marijuana. The study also showed that 8% of the women and 7% of the men misused prescription drugs.

"We found that substance abuse was surprisingly prevalent at the start of midlife. And we also found that it is not restricted to stereotypical drug users with low socioeconomic status," said study author Alicia Merline. For instance, the study found that professionals are just as likely to use marijuana as people in other job classifications.

The study was published in the January 2004 issue of the *American Journal of Public Health*.

Gene Linked to Alcoholism

San Antonio Express-News; January 15, 2004 -- A 15-year study has resulted in the identification of a specific gene that may increase the risk of alcohol dependence.

The \$65 million federally-funded Collaborative Study on the Genetics of Alcoholism (COGA) included 10,000 participants with a history of alcohol addiction. Scientists isolated a gene on chromosome 15 that appears to be connected to alcohol addiction.

The gene is involved in the regulation of gamma-aminobutyric acid (GABA), a chemical in the brain that helps send messages between neurons. Previous research showed that GABA alters behavior and is linked to psychiatric disorders.

"Stimulating GABA receptors will increase behavioral effects of alcohol, like motor coordination and reduction of anxiety," said Danielle Dick, a principal author of the study. The researchers expect to find several genes associated with alcohol dependence, which could lead to new avenues for medications.

Study findings appeared in the January 14, 2004 issue of the journal *Alcoholism: Clinical and Experimental Research*.

Animal Research Finds "Addiction Switch" in Brain

Nature Neuroscience; January 2004 -- A study on laboratory rats found that certain brain receptors may control the switch from an addicted to a non-addicted state.

Researchers at the University of Toronto discovered that the VTA (ventral tegmental area) region of the brain contains receptors that, when exposed to the enzyme GABA-A, may control the addiction process. In studies with rats, they found that when GABA-A is manipulated with medication, the

brain's switch to a non-addicted state takes only several hours. But without such intervention, the brain took weeks to switch back to a non-addicted state after a period of withdrawal from drugs. According to lead author Steven Laviolette. "[The findings] suggest we may be able to manipulate that switch pharmacologically to take drug addicts back to a non-addicted state in a relatively short period of time so they do not crave the drug."

The study's findings were published in the January 18, 2004 online edition of *Nature Neuroscience*.

NIAAA to Shelve Alcohol-Research Database

Join Together; January 13, 2004 (Bob Curley) -- The National Institute on Alcohol Abuse and Alcoholism (NIAAA) plans to discontinue its "ETOH Alcohol and Alcohol Problems Science Database," saying it is largely duplicative of other information repositories. But many researchers and librarians say that NIAAA's database is a unique resource that cannot be duplicated elsewhere.

A spokesperson said that while ETOH would no longer be updated, it would be archived as a historical resource for researchers. The bottom line, however, is that researchers will lose a "one-stop-shopping" database on alcohol, and some publications currently available through ETOH will no longer be available through Medline, NCADI, or other databases.

Pain Medication, Alcohol Don't Mix

Newswise; January 15, 2004 -- Despite warning labels, people who take narcotic pain relievers continue to consume alcohol, often heavily.

A University of Michigan Health System (UMHS) study examining the relationship between drinking and chronic back pain found that most users of narcotic pain relievers failed to heed drug manufacturers' warnings against mixing alcohol and narcotics.

"The combination of alcohol and narcotics increases the sedative effect of both, probably the desired effect amongst people with pain, but in significant quantities the combination could lead to respiratory depression," said study coauthor Ethan Booker, MD.

Andrew Haig, MD, another coauthor of the study noted that doctors are less likely to go beyond the general question about alcohol use to determine interactions between alcohol and physical disability in their patients. "Be careful if you're a heavy drinker with pain, because doctors don't seem to pay

attention to the interaction between alcohol and drugs," he stated.

The study was published in the December 2003 issue of the journal *Disability and Rehabilitation*.

Doctors Want Laws Hindering Drug Screening Repealed

American Medical News; January 5, 2004 -- The American Medical Association (AMA) is calling on states to repeal statutes that effectively prevent alcohol and drug screenings from being conducted on patients who come to emergency departments.

State laws based on a model law called the Uniform Accident and Sickness Policy Provision permit insurance companies to refuse coverage for treatment of intoxicated patients' injuries. Consequently, emergency departments "are less likely to screen for alcohol and drugs because visits won't be covered by patients' insurance," said Michael E. Migliori, MD, a delegate to the AMA's Interim Meeting. "Repealing the laws will hopefully reduce the recidivism and allow injuries to be covered."

According to data presented at the meeting, more than 40% of patients treated in hospital emergency rooms are either under the influence of alcohol or some other drug. However, less than 15% of patients are screened for drugs or referred to counseling. Physicians said the state laws create missed opportunities for helping patients through addiction intervention.

Leadership Workshop Launched For People in Recovery

Johnson Institute Press Release; February 5, 2004 -- More than 3,000 Americans recovering from alcoholism and drug addiction will receive leadership training in the "Recovery Ambassadors Program" announced by the Johnson Institute.

The training at 6 workshops around the country during 2004 will prepare them to advance public understanding and appropriate responses to chemical dependency, according to Johnny W. Allem, President of the Institute. The Johnson Institute is a non-profit think tank and support organization that advances addiction recovery and fights discrimination of anyone afflicted, affected, or in recovery from alcoholism and drug addiction.

For further information on Recovery Ambassador workshops, contact Ingrid Faust at 202-662-7108 or e-mail ingridfaust@johnsoninstitute.org.

Study Links Brain Injury, Drug Abuse

University of Washington at Seattle; February 4, 2004 -- New research shows a relationship between traumatic brain injury (TBI) and psychiatric illness, including alcohol and other drug misuse, depression, and anxiety.

Researchers analyzed 939 patients diagnosed with TBI to see if there was a link between their injuries and ensuing psychiatric illness. The review found that patients with mild TBI were 2.8 times more likely to experience psychiatric illness in the 6 months following the injury. Patients with moderate to severe TBI were 4 times more likely to experience psychiatric illness.

For more information, see:

http://thedaily.washington.edu/news.lasso?-database=DailyWebSQL&-table=Articles&-response=newspage.lasso&-keyField=__Record_ID__&-keyValue=8242&-search.

Panel Urges Purchasers to Demand Quality in Addiction Treatment

Boston, MA, Join Together; February 2004 -- A national panel of experts has called for a fundamental change in the payment system for treating drug and alcohol disorders.

The group, chaired by Jerome Jaffe, MD, the nation's first "drug czar," says that payment should be based on the results achieved. Treatment programs that do a better job helping their patients improve would be paid more, while programs with poor results would be paid less and might be forced to change or close.

Join Together, a project of the Boston University School of Public Health, convened the national, non-partisan panel to develop specific recommendations to improve the treatment of substance use disorders. Their recommendations urge employers, insurers, and others to embrace the concepts of quality and outcomes in treatment for substance use disorders in the same manner that quality is being encouraged throughout the health care system. Unless there are real and continuing incentives to provide quality treatment, quality will always take second place to treatment program survival or expansion," said Jaffe. "What is needed to drive quality improvement is a commitment by those who pay for treatment to reward good outcomes."

According to a new report released by the panel, policy-makers and those who purchase treatment services should demand information about results and reward those programs that succeed in delivering them. The report provides

guidance to payers and providers about the steps they should take to implement a results-based reimbursement system. Copies of "Rewarding Results: Improving the Quality of Treatment for People with Alcohol and Drug Problems" are available online at www.jointogether.org/quality, or in PDF format at

<http://www.jointogether.org/sa/files/pdf/quality.pdf>, or by calling (617) 437-1500.

Did You Know About AT Forum "Addiction-News Updates" Archives?

AT Forum [Addiction-News Updates](#) archives -- dating back to June 1996 -- contain more than 1,250 items on methadone maintenance treatment, addiction research, public policies, and other news topics of interest compiled from journals, news media, the Internet, and other sources worldwide. These are easily accessible at <http://www.atforum.com> (look under the "Addiction Resources" tab), or go directly to: http://www.atforum.com/SiteRoot/pages/addiction_resources/addiction_resources.shtml.

Addiction-News Updates, are organized by the month in which they appeared and contained in 8 Volumes in Microsoft® Word document format. Each Volume file can be conveniently downloaded and explored using the index at the beginning of each Volume or via the search function in MS Word.

For the most current, non-archived, Addiction-News Updates, go to...

http://www.atforum.com/SiteRoot/pages/news_updates/news_updates.shtml.

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Hepatitis C Screening Far From Universal in MMT Programs

Drug and Alcohol Dependence; March 8, 2004 -- Hepatitis C is a very common disorder in drug-abusing populations, yet not all treatment programs offer nor do all patients take advantage of screening for the disease.

Researchers compared the accessibility and patients' use of opportunities for HCV testing in 256 methadone maintenance treatment (MMT) and drug-free addiction treatment programs in the U.S. Almost all MMT programs and about 2/3 of drug-free programs provided HCV antibody screening to at least *some* patients during 2001. About 2/3 of MMT and close to 1/3 of drug-free programs offered the service to *all* patients; however, only about 60% of patients

actually provided specimens for testing. Unfortunately, some programs were planning to cut back on these services due to limited resources.

See: Strauss SM, Astone JM, Des Jarlais D, Hagan H. A comparison of HCV antibody testing in drug-free and methadone maintenance treatment programs in the United States. *Drug Alcohol Depend.* 2004;73(3):227-236.

Treating Anxiety in Methadone Patients; Buspirone Ineffective

American Journal on Addictions, March 2004 (Reporter: Andrew Byrne, MD; Australia) -- An investigation identified 130 of 297 methadone maintained patients (47%) who exhibited symptoms of anxiety, and of whom 62 met criteria for treatment with the non-benzodiazepine sedative buspirone (BuSpar). Groups were treated using average methadone doses between 85 and 103 mg daily (range 20-200mg). By randomizing subjects to receive either placebo or active drug (up to 60 mg buspirone daily) the investigators found no significant difference in outcomes in a 3 month trial period.

The connection between drug abuse and anxiety/depression is very complex. In some the symptoms may precede drug use while in others it may stem from the dependency and life situation. Benzodiazepines have major disadvantages that are now clearly spelled out by the drug manufacturers. Thus, some doctors are reluctant to prescribe benzodiazepines even when they might still be clinically indicated.

Some methadone patients appear to do well with maintenance diazepam, but this needs to be supervised. The total daily dose and degree of supervision depends on the individual but more research is needed to document whether such prescribing is safe and effective, and when it can safely be diminished. Methadone dose should always be optimized in such patients by considering post-dose examinations, serum methadone levels, dose adjustments, or even dose splitting.

See: McRae AL, Sonne SC, Brady KT, Durkalski V, Palesch Y. A Randomized, Placebo-controlled trial of Buspirone for the Treatment of Anxiety in Opioid-dependent Individuals. *American Journal on Addictions*. 2004;13(1):53-63.

Diverted Methadone a Minor Part of Opioid Abuse Problems

Program & Abstracts, 6th International Conference on Pain & Chemical Dependency; February 4-7, 2004; Brooklyn, NY (Irwin K, et al. Chronic Pain and Methadone Diversion

Among Active Users of Illicit Opiates. Poster/Abstract #23) -- A team of researchers from Yale University investigated illicit methadone use and chronic pain factors among 237 active users of illicit opioids recruited in Cumberland County, Maine (which includes the city of Portland). In total, respondents had taken 10,323 illicit opioid doses in the prior month.

However, methadone accounted for only 4.9% of those illicit opioid doses. Less than a quarter of the respondents had used any illicit methadone, and it was the most abused opioid by only 8% of respondents, compared with OxyContin®, heroin, and other opioid agents.

Although roughly 39% of all subjects indicated that chronic pain was a problem, this did not seem to influence the type or frequency of opioids abused. Those with chronic pain did report that their medical, psychological, social, and drug problems were worse than the other respondents (measured via the Addiction Severity Index).

The authors concluded that, "Contrary to media assertions, illicit methadone use does not appear to be widespread among illicit opiate users in the Portland metropolitan area, comprising only a small fraction of opiate misuse."

U.S. Drug Czar Criticizes Bill Limiting Methadone Clinics

The Roanoke Times (Virginia); March 12, 2004 (Laurence Hammack) -- A bill restricting methadone clinics in most urban areas of Virginia was criticized by national "drug czar" John Walters.

After speaking to a group of students at George Washington University, Walters was asked about a bill -- which has the Virginia General Assembly's approval and now goes to Governor Mark Warner -- that prohibits methadone clinics from opening within a half-mile of schools and day care centers. Walters, head of the Office of National Drug Control Policy, said: "If there are any reporters present, I want them to know that this is a bad law."

Andrea Barthwell, MD, deputy director for demand reduction in the drug czar's office, said a law restricting methadone treatment could have adverse effects for both drug addicts and the communities where they live. "It may in fact be eliminating the possibility of offering a beacon of hope to some of society's most disenfranchised," she said.

Critics of the legislation say it is based on fears of clinic-related crime that have no factual basis. Police in every Virginia jurisdiction that has a methadone clinic have said

the drug treatment centers do not cause major problems with crime. Studies have also shown that methadone treatment leads to reduced criminal activity among addicts.

Drug treatment advocates say the proposed law leaves so little room for methadone clinics, at least in urban areas, that it effectively denies treatment to drug addicts and could be subject to a legal challenge under the Americans with Disabilities Act.

If the bill becomes law, Barthwell said, it could have the unintended consequences of harming not just drug addicts who need treatment, but also the communities where they live. "This is not a problem of someone other than us," she said of drug addiction. "This is a problem that affects every American family, directly or indirectly."

Saquinavir/Ritonavir Combo Does Not Alter Methadone Effects

Journal of Clinical Pharmacology; March 2004 -- Once-daily saquinavir/ritonavir therapy in methadone-maintained subjects is safe and not associated with any clinically significant interaction with methadone during 14 days of concomitant administration.

Twelve methadone-maintained HIV-negative subjects were given saquinavir/ritonavir (1600 mg/100 mg) once daily for 14 days. Pharmacokinetic evaluations of total and unbound methadone were conducted before and after antiretroviral dosing.

Saquinavir/ritonavir was well tolerated, with no significant adverse events and no evidence of sedation. Pharmacokinetic parameters for methadone were unchanged, but the percent of unbound methadone concentrations were somewhat reduced. The unbound fraction is the portion available to freely cross the blood-brain barrier for therapeutic effect; however, the decreases in this did not result in any necessary increases in methadone dose. Similarly, saquinavir and ritonavir remained at therapeutic levels.

See: Shelton MJ, Cloen D, DiFrancesco R, et al. The effects of once-daily saquinavir/minidose ritonavir on the pharmacokinetics of methadone. *J Clin Pharmacol.* 2004 Mar;44(3):293-304.

[Other research has found that the lopinavir/ritonavir combination (Kaletra) decreases methadone effects; whereas, ritonavir alone does not have such an effect. For more information see the AT Forum special report "Methadone-Drug Interactions" available at:

<http://www.atforum.com/methadonedruginteractions.shtml>. - Ed.]

Doctors Hesitant About Buprenorphine

Los Angeles Times; February 16, 2004 -- Buprenorphine, considered by some as an important medicine for persons addicted to heroin, prescription painkillers, and other opioids, has not received an enthusiastic response from physicians.

The drug, which received federal approval for use in treating opioid addiction a year ago, differs from medications like methadone in that it can be dispensed in a doctor's office. It was believed that this convenience factor might encourage more addicted individuals to seek treatment.

But doctors have chosen not to prescribe the treatment, saying it is difficult to locate local pharmacies that will stock the drug or that they lack the resources to dispense narcotics to addicted persons. Others are not dispensing the treatment because most private insurers and state Medicaid programs are not covering it. Experts say buprenorphine is being given to only a few thousand addicted individuals nationwide; meanwhile, the National Institute on Drug Abuse estimates that there are more than 1 million individuals addicted to opioids.

"We're seeing less interest than we expected, especially among primary-care physicians," said Robert Lubran, director of the division of pharmacologic therapies at the U.S. Department of Health and Human Services.

New Congressional Caucus Focuses on Addiction, Recovery

News Release (Join Together and Legal Action Center); March 4, 2004 -- Congressional Representatives Jim Ramstad (R-Minn.) and Patrick Kennedy (D-R.I.) have formed a new Addiction, Treatment and Recovery Caucus in the U.S. House of Representatives. This is intended to enhance awareness of addiction and educate lawmakers about the challenges associated with accessing treatment and recovery services.

According to Ramstad, 3.5 million Americans who sought treatment last year were unable to access it. He is urging Congress to pass his Recovery and Treatment (HEART) Act of 2003, which is aimed at establishing parity for treatment services.

Trial Shows Pair of Drugs Can Treat Both HIV & HCV

Wall Street Journal; February 13, 2004 (Gautam Naik) -- In San Francisco, at the 11th Conference on Retroviruses and Opportunistic Infections, investigators said a trial of a two-drug combination for patients infected with HIV and hepatitis C (HCV) showed a marked benefit against viral levels.

The combination of the hepatitis C drug Pegasys[®] and the antiviral Copegus[®] produced a sustained 40% virological response in a trial of 868 patients with both infections. Similar viral reductions were achieved in only 20% of patients receiving only Pegasys, and in only 12% of participants receiving conventional interferon/ribavirin treatment.

In the trial, patients were treated for one year and followed for 6 months. At that point, 40% of Pegasys-Copegus patients showed no discernible sign of the hepatitis virus, demonstrating “that you can eradicate the virus,” said Francesca Torriani, lead investigator and an associate professor of medicine at the University of California, San Diego.

Improving treatments for co-infected HIV/HCV patients is vital. Now that antiretroviral drugs are prolonging the lives of many people with HIV, liver disease is emerging as one of the main causes of morbidity and mortality among such patients.

Bush’s Anti-Drug Strategy Targets Rx Medications

Associated Press; March 1, 2004 -- A national drug-control strategy announced by President Bush would focus in part on the misuse of prescription medication, including pain relievers, sedatives, and stimulants.

The aim is to curb the growing problem of prescription drug use for non-medical purposes among adults and young people. One key component of Bush’s plan is to assist states in developing monitoring systems to track patients’ use of prescription medicine and identify patterns of misuse.

Currently, 20 states have prescription-monitoring systems. John Walters, director of the White House Office of National Drug Control Policy, said federal funding would be used to develop systems in 11 more states next year. In addition, the Drug Enforcement Administration plans to target pharmacies that sell prescription drugs illegally over the Internet. The new campaign also includes physician training and education programs.

Some concerns over Bush’s plan were voiced by Drug Policy Alliance director Ethan Nadelmann, who said it could end up causing more pain and suffering. “The principal impact of this campaign when you step up the law-enforcement response is that doctors will err on the side of under-treating pain,” said Nadelmann. “So any time a doctor is dealing with a patient in pain, their first instinct is not to prescribe enough.”

Painkillers May Be Harder to Obtain; Patients Could Suffer

Washington Post; February 15, 2004 (Marc Kaufman, p. A03) -- The Drug Enforcement Administration is working to make the nation’s most widely prescribed analgesics more difficult for patients to obtain as part of its stepped-up offensive against the diversion and abuse of such painkillers.

Top DEA officials confirm that the agency is eager to change the official listing of the narcotic hydrocodone -- which was prescribed more than 100 million times last year -- to the highly restricted Schedule II category of the Controlled Substances Act. As a painkiller and cough suppressant -- sold as Lortab[®], Vicodin[®] and generic brands -- hydrocodone combined with other medications has long been available under the less stringent rules of Schedule III.

The DEA effort is part of a broad campaign to address the problem of prescription drug abuse, but the initiative has repeatedly pitted the agency against doctors, pharmacists, and pain sufferers, and it is doing so again with the hydrocodone proposal. Pain specialists and pharmacy representatives say that the new restrictions would be a burden on the millions of Americans who need the drug to treat serious pain from arthritis, AIDS, cancer, and chronic injuries, and that many sufferers are likely to be prescribed other, less effective drugs as a result.

The DEA effort comes as the agency is already embroiled in a dispute with many pain specialists over the use -- and alleged overprescribing -- of another powerful painkiller, OxyContin[®]. Scores of doctors have been arrested on felony charges of conspiracy, drug trafficking, and even murder in connection with their prescribing. Although the agency says the prosecutions are needed to shut down “pill mills” and stop unscrupulous doctors, many pain specialists say that the agency has become overzealous and that some doctors are refusing to prescribe needed painkillers because they fear DEA investigation.

Washington State Curbs Opioid Prescribing

Seattle Times; February 26, 2004 -- Citing a significant increase in the use of narcotic painkillers among workers, the Washington Department of Labor and Industries has urged physicians to limit prescriptions for powerful opiates like OxyContin[®] and methadone.

According to the department, since 1999 there have been a growing number of injured workers who have died after taking opioid painkillers or painkillers mixed with other drugs. Gary Franklin, MD, the department's medical director, also indicated a "dramatic shift" -- a 60% increase - - in prescriptions of more potent painkillers, such as OxyContin, rather than aspirin with codeine. His agency mailed a letter to doctors in the state warning them of "potentially serious problems that may arise" when non-cancer patients take long-acting opiates for chronic pain.

State Medicaid officials had already stopped paying for OxyContin and other expensive analgesics unless there was a medical reason why cheaper alternative could not be used. OxyContin cost the state \$5.06 for a dose equivalent to 60 mg of morphine, which cost \$2.36. Meanwhile, the equivalent dose of methadone cost only 25 cents.

Drug Pushers on the Internet

CASA (New York); February 2004 -- A new report from the National Center on Addiction and Substance Abuse at Columbia University (CASA) -- called "'You've Got Drugs!' Prescription Drug Pushers on the Internet" -- reports on the alarming ease of obtaining controlled, dangerous, and addictive prescription drugs with only a computer and a credit card.

The research, conducted by Beau Dietl & Associates, uncovered 157 sites selling controlled prescription drugs on the Internet during January 15-22, 2004. Of these, 90% did not require any prescription, 4% required that a prescription be faxed (which would allow the same prescription to be used at multiple sites), 2% required that a prescription be mailed, and 4% did not mention a prescription one way or the other.

Controlled prescription drugs available online included opioid analgesics, benzodiazepines, barbiturates, and various stimulants. There were no mechanisms in place to block children from purchasing these agents.

Among those sites that indicated origin of the drugs, 47% were coming from outside the U.S. and 25% were to be

shipped from a U.S. pharmacy. A quarter of the sites did not indicate where the drugs would originate.

[The CASA report is available for download at: http://www.casacolumbia.org/pdshopprov/files/you_ve_got_drugs.pdf. -- Ed.]

Teen Brain Wired to Seek Easy Rewards

Health Day News; February 26, 2004 -- Researchers say that the reward center in an adolescent's brain is not as fully developed or responsive as an adult's, which could explain why teens tend to engage in risky behaviors such as consuming alcohol, using drugs, or having unsafe sex.

Using magnetic resonance imaging (MRI), researchers scanned the brains of 12 teens aged 12 to 17 and 12 young adults aged 22 to 28. During the scan, participants played a game that involved monetary risk and reward.

In comparing the scans, the researchers found that the section of the brain known as the "reward center" (ventral striatum), showed increased activity as the reward increased for both groups. However, the portion of this brain center responsible for motivation showed more activation in adult participants than in the teens.

"That region of the brain controls how much an organism is willing to work to get a reward," researchers said. "The data show that adolescents are just as happy and excited at the prospect of winning as adults, but they differed in the expenditure of effort for that reward." The researchers concluded that adolescents are more likely to engage in risky behaviors, such as alcohol and other drug use, because they involve little effort but provide a greater reward in return.

The research also may explain why teens sometimes seem unmotivated. "Adults have readily active motivation in the brain," said study co-author James Bjork, a research fellow in the Laboratory of Clinical Studies at the National Institute on Alcohol Abuse and Alcoholism. "But it may take exceptionally strong incentives to get kids jazzed up."

The study's findings were published in the February 25, 2004 issue of the *Journal of Neuroscience*.

Disulfiram + Behavioral Therapy Effective for Cocaine Addiction

NIDA Press Release; March 1, 2004 -- Results of a study funded by the National Institute on Drug Abuse (NIDA) suggest that disulfiram, a medication used to treat alcohol addiction, is effective in combating cocaine abuse.

Combining disulfiram with behavioral therapy provides even more positive results.

In the study, 121 cocaine-dependent individuals randomly were assigned to receive disulfiram (also known as Antabuse®) or a placebo, in addition to undergoing one of two behavioral therapy interventions. Participants received either cognitive behavioral therapy (CBT) or interpersonal psychotherapy (IPT) in individual sessions during the 12-week project.

Results showed that participants given disulfiram reduced their cocaine use significantly compared with people given placebo. In addition, those who received disulfiram in combination with CBT reduced their cocaine use more, compared with those who received disulfiram in combination with IPT. Lead investigator Kathleen Carroll, of Yale University School of Medicine, and her colleagues also report that benefits seen with disulfiram and CBT were most pronounced for people who were not alcohol dependent or who abstained fully from alcohol during therapy.

“About 60% of people dependent on cocaine also abuse alcohol, so it was thought you could reduce cocaine abuse by targeting the accompanying codependence on alcohol,” says NIDA Director Nora D. Volkow. “But these results suggest that disulfiram exerts a direct effect on cocaine use, rather than reducing concurrent alcohol use.”

The research was published in the March 2004 issue of the *Archives of General Psychiatry*.

How Effective Are Antidepressants?

Cochrane Reviews; March 2004 -- Although there is a consensus that antidepressants are effective in depression, placebo effects are also thought to be substantial. During research trials, side effects of antidepressants may reveal the identity of the true medication to participants or investigators and thus bias the results. Therefore, trials using an ‘active placebo’ that mimics side effects of the medication could give a better comparison.

This systematic review of the literature examined trials that compared antidepressants with ‘active placebos.’ Nine studies involving 751 participants were identified. Only 2 of the studies produced effect sizes showing a consistent and statistically significant difference in favor of the antidepressant. The reviewers concluded that differences between antidepressants and active placebos were small in terms of mood improvements. Tricyclic antidepressants were only slightly better than active placebos.

See: Moncrieff J, Wessely S, Hardy R. Active placebos versus antidepressants for depression. *The Cochrane Database of Systematic Reviews* (Complete Reviews) 2004, Issue 1. DOI: 10.1002/14651858.CD003012.pub2.

Treatment System Instability Could Affect Quality of Care

Demand Treatment E-News; March 12, 2004 -- New research finds that the national treatment system for substance use disorders is in constant flux and drowning in data.

Within the 16 months prior to a national study of 175 treatment programs, 15% of programs had closed or had stopped providing services, and 29% had reorganized. In the year prior to the study, there was a 53% turnover among program directors and a similar rate among counselors.

Professional disciplines, apart from counselors, were rarely represented in treatment programs. Only 54% of programs had a part-time physician on staff, and less than 15% of programs other than methadone maintenance clinics employed a nurse.

In the study article, the authors said: “These findings are disturbing and call into question the ability of the national treatment system to meet the complex demands of both the patients that enter this system and the agencies that refer to it.”

See: Can the national addiction treatment infrastructure support the public’s demand for quality care? *Journal of Substance Abuse Treatment*. 2003;25:117-121. Also see, the report -- “Rewarding Results” -- from the national treatment quality improvement policy panel, available at: <http://www.jointogether.org/sa/files/pdf/quality.pdf>.

#90 April 2004

Methadone Maintenance Treatment (MMT) Turns 40

Opiate Addiction Rx; April 2004 -- This year marks an important milestone in methadone treatment history. Forty years ago, in 1964, Drs. Nyswander and Dole initiated methadone studies with 22 opioid-addicted “subjects” on a closed research unit at Rockefeller University.

Today, according to a report by INDRO e.V. Deputy Director Ralf Gerlach, Muenster, Germany, there are an estimated half-million patients treated for opioid addiction with this medication in 47 countries around the world, with more than 200,000 being treated in the U.S.

For details and information on international travel while on methadone, see: <http://www.indro-online.de/nia.htm>.

MMT Patients Suffer Sleep Disturbances

Journal of Substance Abuse Treatment; April 2004 -- This study examined the relationship of sleep disturbance and demographic, mental health, drug use, and other factors among 225 methadone-maintained individuals.

The cohort was 78% Caucasian and 54% male with a mean age of 41 years. Sleep disturbance was measured using the Pittsburgh Sleep Quality Index (PSQI) with a score >5 indicating poor global sleep quality.

Most subjects (84%) had PSQI scores of 6 or higher. Depressive symptoms, anxiety symptoms, greater nicotine dependence, body pain, and unemployment were significantly associated with poorer global sleep quality. The authors conclude that targeting modifiable psychological and medical risk factors that are most strongly associated with sleep disturbance may improve quality of life in drug MMT.

See: Stein MD, et al. Sleep disturbances among methadone maintained patients. *J Subst Abuse Treat.* 2004;26(3):175-180.

Disparities In Supplemental Services Used By MMT Patients

Journal of Substance Abuse Treatment; April 2004 -- This study of randomly selected male MMT patients examined associations between sociodemographic factors and supplemental service utilization.

The high prevalence of health and psychosocial needs among methadone treatment patients has prompted efforts to supplement MMT with additional services. Research has generally focused on linking supplemental service utilization to drug treatment outcomes, with fewer studies aimed at understanding supplemental service utilization itself.

Findings indicated that MMT patients who were African American, Latino, uninsured, or had less education were *less likely* to report any supplemental service utilization. Thus, there is a need to improve access to supplemental services for minority and disadvantaged MMT patients, and MMT programs may represent an important venue to address health disparities in general.

See: Wu E, et al. Sociodemographic disparities in supplemental service utilization among male methadone patients. *J Subst Abuse Treat.* 2004;26(3):197-202.

Disulfiram For Cocaine Use During MMT Cost-Justified

Journal of Substance Abuse Treatment; April 2004 -- Evidence suggests that disulfiram (Antabuse®) is a promising treatment for cocaine dependence. This study examined the cost-effectiveness of providing disulfiram to MMT patients.

The economic evaluation was based on a randomized, double-blind, 12-week clinical trial in which 67 cocaine-dependent MMT subjects were randomized to get the additional treatment of disulfiram or placebo. Outcome measures included the number of days of cocaine use and grams of cocaine per week. Cost measures included the cost of providing standard methadone treatment and the incremental cost of adding disulfiram.

Results implied that, even though disulfiram increases slightly the cost of MMT, its increase in effectiveness may be important enough to warrant its addition for treating cocaine dependence in methadone-maintained opiate addicts.

Jofre-Bonet M, et al. Cost effectiveness of disulfiram treating cocaine use in methadone-maintained patients. *J Subst Abuse Treat.* 2004;26(3):225-232.

[It could be important to also consider reductions in alcohol abuse among cocaine-abusing MMT patients as a result of disulfiram therapy, which would provide added cost justifications. -- Ed.]

Psychiatric Severity Increases Methadone Dose Requirement

Heroin Addiction & Related Clinical Problems; December 2003 -- Studies have shown that the presence and severity of psychiatric comorbidity in opioid addicts enrolled in methadone maintenance programs does not interfere with treatment outcomes, such as retention in treatment and heroin abstinence. The authors report here on a recent prospective study to further investigate the impact of psychiatric illness severity on several outcomes during MMT -- retention, craving, use of heroin and cocaine, and psychiatric status.

The results, obtained from 78 patients enrolled in the study, showed no significant differences in terms of retention in treatment or of heroin and cocaine use between patients with high and low psychiatric severity. Regarding mental status, almost all the psychopathological dimensions explored showed a significant reduction in symptoms during the course of MMT. Also, patients with more severe mental

illness in addition to their addiction demonstrated significantly greater improvement.

Methadone dose was higher, on average, in patients with greater psychiatric severity. The results of this study are consistent with those of previous ones showing that the severity of psychiatric comorbidity does not substantially alter the efficacy of MMT; however, patients with more severe mental illness require higher methadone doses.

Pani PP, et al. Psychiatric severity and treatment response in methadone maintenance treatment programmes: new evidence. *Heroin Add & ReI Clin Probl.* 2003;5(3):23-36.

Harm Reduction Approach Reduces HIV Risk During MMT

Journal of Substance Abuse Treatment; March 2004 -- MMT programs have the potential to play an important role in reducing HIV risk, given the appropriate type and level of ancillary treatments. This study investigated the efficacy of a 12-session harm reduction group intervention for injection drug users that focused on reducing both drug and sex risk.

Two hundred and twenty patients entering an MMT program were randomized to receive either standard care (SC) -- 2 hours of counseling per month and a single-session risk reduction intervention -- or SC plus the harm reduction group (HRG). Results showed that, during treatment, patients receiving HRG were more likely to be abstinent from cocaine and to report fewer unsafe sexual practices. Post-treatment, HRG patients scored more favorably on a sexual risk quiz and reported increased self-efficacy in high risk sexual situations.

Enhancing methadone maintenance with a weekly harm reduction group treatment was somewhat more expensive but brought about positive changes in behaviors and attitudes that are otherwise associated with the transmission of HIV.

See: Avants SK, et al. Targeting HIV-related outcomes with intravenous drug users maintained on methadone: A randomized clinical trial of a harm reduction group therapy. *J Subst Abuse Treat.* 2004;26(2):67-78.

WHO Paper Promotes MMT In Combatting HIV/AIDS

World Health Organization (WHO); April 2004 -- This paper from WHO, titled "WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention,"

emphasizes the importance and benefits of treating opioid addiction.

Opioid dependence is associated with a high risk of HIV infection and often requires long-term treatment and care. As no single treatment is effective for all individuals with opioid dependence, sufficiently diverse treatment options should be available.

According to the WHO paper, substitution maintenance therapy* -- primarily referring methadone maintenance -- is one of the most effective treatment options for opioid dependence. It can decrease the high cost of opioid dependence to individuals, their families, and society at large by reducing heroin use, associated deaths, HIV risk behaviors, and criminal activity. Substitution maintenance therapy is a critical component of community-based approaches in the management of opioid dependence and the prevention of HIV infection among injecting drug users (IDUs). Provision of substitution maintenance therapy -- guided by research evidence and supported by adequate evaluation, training and accreditation -- should be considered as an important treatment option in communities with a high prevalence of opioid dependence, particularly those in which opioid injection places IDUs at risk of transmission of HIV and other bloodborne viruses.

This paper is available for download at:

http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf.

*[*It is popular in Europe to use the phrase "substitution maintenance therapy" for the treatment of addiction with opioid agonists, such as methadone. This is an unfortunate choice of words and should not be interpreted as the stigmatizing notion of maintenance therapy substituting one addictive drug (methadone) for another (heroin). -- Ed.]*

Fast Saliva Test for HIV Gains Federal Approval

New York Times; March 27, 2004 (Donald G. McNeil Jr.) -- Secretary of Health and Human Services Tommy Thompson announced Food and Drug Administration (FDA) approval of the first HIV test that uses saliva rather than blood and delivers results in 20 minutes.

Health officials hope the new test will encourage wider and more frequent testing. The Centers for Disease Control (CDC) estimates that 25% of Americans with HIV do not know their serostatus. Globally, according to the World Health Organization, that figure may be as high as 95%.

According to Michael Gausling, president of Bethlehem, Pa.-based OraSure Technologies, the OraQuick HIV-1/2 Test is more than 99% accurate. Typical HIV tests require a vial of blood, and a lab returns results in 2 to 14 days. Two years ago, the FDA approved an OraSure test that uses blood from a finger prick and took only 20 minutes to give results. The new test delivers results as quickly but uses saliva, which is hundreds of times less infectious than blood and therefore less dangerous to the tester.

The test uses a plastic stick with a pad rubbed against the gums. The saliva sample is put in a vial of reagent solution. Within 20 minutes, two reddish-purple lines appear if the result is positive. The company said the test is for preliminary screening and must be confirmed with a more sophisticated test before treatment is begun.

OraSure expects to charge \$8 to \$20 per test and, for now, the test can be used only in certified laboratories. But Dr. Lester Crawford, acting FDA commissioner, “strongly urged” the company to apply for a waiver to let the test be used in simpler settings such as neighborhood clinics.

News Media Asked to Abandon Stigmatizing Terms

Alcoholism & Drug Abuse Weekly; March 15, 2004 -- Thirty medical doctors, scientists, and psychological researchers released a public letter calling on the media to stop using terms such as “crack baby,” “crack-addicted baby,” “ice babies,” and “meth babies.”

The letter states that these terms lack scientific validity and should not be used. It goes on to note that the researchers have not identified a recognizable condition, syndrome, or disorder that justifies the term “crack baby,” and that “crack-addicted baby” is also incorrect. The letter cites examples of the media’s use of these terms and explains how this stigmatizing language can be dangerous to the children to whom it is applied.

“Patient” Versus “Client” Debate Continues

European Addiction Research; April 2004 (Andrew Byrne, MD, report to *AT Forum*) -- In a survey of what drug addicts/users in treatment would like to be called, “patients” was the consensus.

The survey asked 150 mixed-drug dependency patients to rate various terms. ‘Service user’ was the least popular term, identified as the preferred term by only 5% of subjects. “Patient” was preferred by 66% of alcoholics, 52% of opioid users, but only 47% of smokers in treatment. “Client” was

only preferred by 24% of alcoholics, 46% of illicit drug users, and 41% of smokers in treatment.

The authors state: “Commonly used pejorative terms such as ‘alki’ or ‘junkie’ prejudice appropriate care and add to stigmatization.” While only a minority considered that they personally had a “mental illness” (38%), most considered that “substance misuse problems” formed a category of mental health illness (59%).

Thus the majority here preferred the term “patient,” going against current trends in addiction treatment services for use of the term “client.” The authors conclude: “In a culture of ‘user involvement’ in substance misuse, the results of this study should prompt reconsideration and revision of our verbal and written communications with patients.”

See: Keaney F, Strang J, et al. Does anyone care about names? How attendees at substance misuse services like to be addressed by health professionals. *European Addiction Research*. (2004) 10;2:75-79

[An earlier and larger survey by Addiction Treatment Forum -- Summer 2000, Vol. 9, No. 3 -- examined responses from 308 readers. Overall, 61% of respondents favored using the term “patient” for persons in MMT; including 71% of medical staff and 67% of patients. Non-medical staff (counselors, psychologists, etc.) were split 49% vs 51% between using “patient” or “client.” As noted in the AT Forum survey article, there is some question as to whether health insurers and/or legislators would or should be willing to pay for or fund addiction treatment programs that serve “clients” as opposed to those caring for “patients.” -- Ed.]

WHO Report Classifies Addiction as Brain Disorder

World Health Organization (WHO); March 2004 -- A new report from WHO, “The Neuroscience of Psychoactive Substance Use and Dependence,” concludes that addiction is as much a disorder of the brain as any other neurological or psychiatric illness.

The report -- the first of its kind produced by WHO -- found that psychosocial, environmental, biological, and genetic factors all play a major role in substance dependence. The report also showed that advances in neuroscience make addiction treatable through innovative diagnostic tools and behavioral and pharmacological treatments.

The WHO advocates policies, prevention, and treatment approaches and the development of interventions that do not stigmatize patients, are community-based, and cost-effective. “The health and social problems associated with use of and

dependence on tobacco, alcohol, and illicit substances require greater attention by the public health community and appropriate policy responses are needed to address these problems in different societies,” said WHO Director-General Dr. Lee Jong-Wook. “Many gaps remain to be filled, but this important report shows that we already know a great deal about the nature of these problems.”

The report is available online at:

http://www.who.int/substance_abuse/publications/psychoactives/en/.

FDA Calls for Suicide Warning on Antidepressants

FDA Public Health Advisory; March 22, 2004 -- Warning that some popular antidepressants may be linked to suicides, the Food and Drug Administration (FDA) is calling for a new warning on antidepressant labels.

Studies have not confirmed that the drugs actually lead to suicide; however, the FDA said stronger caution language should be added to labels for adults and children using antidepressants to treat depression. The FDA also issued a public-health advisory for doctors, patients, families, and other caregivers to be aware of growing signs of depression or suicidal thoughts at the onset of antidepressant therapy or whenever the dosage is changed.

Among the drugs included in the warning are: Prozac (fluoxetine); Zoloft (sertraline); Paxil (paroxetine); Luvox (fluvoxamine); Celexa (citalopram); Lexapro (escitalopram); Wellbutrin (bupropion); Effexor (venlafaxine); Serzone (nefazodone); and Remeron (mirtazapine).

Anxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, akathisia (severe restlessness), hypomania, and mania have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although the FDA has not concluded that these symptoms are a precursor to either worsening of depression or the emergence of suicidal impulses, there is concern that patients who experience one or more of these symptoms may be at increased risk for worsening depression or suicidality.

Therefore, therapy should be evaluated, and medications may need to be discontinued, when symptoms are severe, abrupt in onset, or were not part of the patient’s presenting symptoms. If a decision is made to discontinue treatment, some of the medications should be tapered rather than

stopped abruptly (see labeling for individual drug products for details).

Most Female Opioid Addicts Are Reliant On Rx Painkillers

Business Wire; March 22, 2004 -- According to The Waismann Institute’s 2004 Opiate Dependency Report, 86% of female patients seeking addiction treatment were battling a dependency to prescription painkillers.

The drug most commonly found to be a problem for women was OxyContin at 21%, while 60% sought treatment for dependency to various hydrocodone-based medications such as Vicodin, Lortab, Norco, and Percocet. Five percent sought treatment for methadone dependency. The findings are based on a survey conducted of patients receiving treatment for dependencies to various opiate-based drugs.

Of the female respondents, 51% indicated that a doctor’s prescription marked the beginning of the dependency, while another 18% said they were taking the drug to treat pain but they obtained it through a friend or family member. Only 10% reported taking it recreationally. Sixty-three percent of women with prescription drug dependencies did not seek help from the prescribing doctor after they realized they developed a physical dependency to the drug, and 88% said their doctors were not aware of their dependency.

Computer-Aided Rehabilitation Improves Treatment Outcomes

University of Buffalo news release; March 26, 2004 -- Computer-aided cognitive rehabilitation helps people in treatment for substance use disorders regain cognitive functioning and increase the amount of time spent in treatment.

While cognitive functioning gradually improves during treatment, computer-aided rehabilitation using exercises originally developed for the rehabilitation of head-injury patients accelerates the process.

The study included 120 patients randomly assigned to 3 treatment interventions. Those in the group that received computer-assisted cognitive rehabilitation plus standard treatment remained in a 6-month residential treatment program for an average of 200 days, significantly longer than other patients, and 38% “graduated” from treatment, compared to only 18% of those in control groups.

“This study shows the importance of cognitive rehabilitation for improved substance-abuse treatment,” said William Fals-

Stewart, a clinical psychologist and Research Institute on Addictions (RIA) senior research scientist. “Decreased lengths of stay in treatment and premature discharge have been linked with subsequent addiction-related problems. This treatment program provides a method to address at least some of the factors contributing to these problems.”

The research was reported in the Winter 2003 issue of the *Journal of Cognitive Rehabilitation*.

Addiction Caucus Aims to Educate Lawmakers

Minneapolis-St. Paul Star Tribune; March 21, 2004 -- By forming the “Addiction, Treatment and Recovery Caucus,” U.S. Reps. Jim Ramstad (R-MN) and Patrick Kennedy (D-RI) hope to bring a new understanding about addiction and clear up misperceptions that their fellow lawmakers may have.

“Believe it or not, there are still members of Congress who do not understand the disease nature of addiction or the cost-efficiency of treatment,” said Ramstad, a recovering alcoholic. The goal of the caucus, he said, is to “educate lawmakers on the problems of addiction and need for expanding treatment access. For all intents and purposes, Congress has failed to recognize addiction for what it is -- a serious health problem affecting Americans.”

Study: Alcohol as Damaging as Tobacco

CanWest News Service; April 8, 2004 -- A new World Health Organization (WHO) study concludes that alcohol use is just as damaging to individual health as tobacco use.

Study co-author Jurgen Rehm, an addiction specialist and a senior scientist at the Centre for Addiction and Mental Health at the University of Toronto, said alcohol’s risks have been understated because several studies have shown that a drink a day can reduce the risk of heart attacks. As a result, he said, the industry has been able to escape the harsh health warnings associated with cigarettes even though alcohol is an obvious public-health threat.

According to Rehm’s study, the health benefits of alcohol use are generally overstated, and they are virtually non-existent for young people. “Even small amounts of alcohol increase the risk of injury and boost the chances of developing about 60 diseases, including several cancers, liver cirrhosis, and neuropsychological disorders,” Rehm’s report said.

The WHO said the report’s findings should serve as a stepping-stone for an international debate about the need to

reduce global alcohol consumption. The study appeared in the April 8th issue of the journal *Nature*.