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

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In This Issue...

Our cover stories in this issue look at opioid addiction and treatment from the perspective of a former researcher in the field who is now working as a counselor in the trenches, after being addicted himself; and at the use of alcohol testing to monitor compliance with treatment for alcoholism, and the challenges of such tests.
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Behavioral pharmacologist with addiction history now helps MAT patients

Sam Snodgrass, Ph.D., works as an "addiction specialist" — a title he gives himself because he said he has no title — at CATAR Clinic, a treatment program in Arkansas that provides both methadone in an opioid treatment program (OTP) setting and buprenorphine in a clinic setting — patients come in and choose either type of medication-assisted treatment (MAT). "It is patient choice; we try to give them the option," Snodgrass said. But many prefer buprenorphine because they don't have to come in six days a week to get their dose for the first 90 days, the way they do, by regulation, for methadone.

The OTP itself is more comprehensive and intensive in care, and many people with opioid use disorders don't need it, said Snodgrass. "These are family people who have jobs, are relatively stable, and just need something to control their addiction," he said. If they don't do well on buprenorphine, then they are switched to methadone in the OTP, he said. And clinically, switch-

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Bottom Line...
One treatment advocate's path from behavioral pharmacologist to treatment specialist in a methadone and buprenorphine program included his own addiction and treatment.

In testing for alcohol use, research is outpacing implementation

An expanding base of research knowledge about the alcohol metabolite ethyl glucuronide (EtG) offers a potent example of the challenges associated with seeing scientific findings translated into everyday addiction treatment practice. Although research that has been going on for several years is helping to identify the proper cutoffs to allow alcohol testing to detect recent use with minimal risk of generating a false positive, it remains difficult to find examples of mainstream treatment programs that incorporate EtG into their patient monitoring.

Use of the EtG biomarker in addiction treatment programs remains largely confined to mandated treatment settings where operators are seeking a thorough review of patient compliance, such as in drug court programs or programs for impaired professionals. A leading researcher on EtG believes sufficient data exist to justify wider use of the biomarker as a clinical monitoring tool, as well as potentially to evaluate during an assessment whether a patient might need more than the typical treatment interventions to

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Bottom Line...
Studies are shedding light on the cutoff levels that can result in the most effective application of the EtG alcohol metabolite as a tool to inform treatment.

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ing from buprenorphine to methadone is much easier than switching from methadone to buprenorphine.

Snodgrass has a lot of credibility: he was trained as a behavioral pharmacologist with one of the best researchers in the country, who was addicted to opioids himself. From 1992 to 2007, Snodgrass himself was a methadone patient in an OTP. He was eventually kicked out because he was using benzodiazepines. He went to detox and a six-month inpatient treatment program, and hasn't used drugs since 2011.

Now 59 years old, Snodgrass said his once-promising career as a behavioral pharmacologist was derailed when the director of the laboratory found out he was stealing drugs. Now, he is happy to be able to help patients who need treatment.

He spent some time discussing his current work and his history in a telephone interview with *ADAW* last week.

Benzodiazepines

Some patients who have been taking methadone since the program opened in 1994 still come in every day for their methadone doses, said Snodgrass. "They're not using other opioids," he said. But methadone, while it prevents any euphoria from opioids, doesn't affect euphoria from benzodiazepines.

Benzodiazepines are always a concern when patients are taking opioids, whether prescribed methadone or illicit opioids, because of the possibility of respiratory depression and overdose, said Snodgrass. There are also concerns about patients on buprenorphine taking benzodiazepines, but because of the ceiling effect of the buprenorphine, the risk of overdose is less. Benzodiazepines, when combined with opioids or alcohol, can be deadly, he pointed out.

Induction, Vivitrol

Another issue is access: unlike a single office-based physician, the CATAR buprenorphine program is a clinic, and if the program runs up against the 30- or 100-patient limit, the clinic can simply hire another doctor. It's better to do that than to put people on a waiting list, said Snodgrass.

Typically, patients at CATAR do home induction with buprenorphine, said Snodgrass. (Patients must be in some withdrawal before their first dose, so home induction is more convenient than telling the patient to return to the office when they are in withdrawal.) For the first week, patients are limited to two doses per day, with one dose being a standard 8 milligrams of buprenorphine. "Some people do need more than that," said Snodgrass. "I wish they would prescribe more than that, because we lose a lot in the first week." But if patients last through the first week, they can come back and get their dose adjusted, he said.

The same thing happens in OTPs, which under federal regulations aren't allowed to give more than 30 milligrams of methadone initially. Considering that most OTP patients are stabilized at more like 100–120 milligrams, this is clearly too low a dose as well, said Snodgrass. "It's insane," he said. "You start off giving them an ineffective dose, they go out and get more drugs because of the withdrawal." This is why the first two weeks of methadone induction are the most dangerous for methadone patients — not because they get too much methadone, but because they don't get enough, he said.

Snodgrass is opposed to extended-release naltrexone (Vivitrol).

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Editor Alison Knopf
Contributing Editor Gary Enos
Copy Editor James Sigman
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Executive Editor Patricia A. Rossi
Publisher Amanda Miller

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"We need a functioning opioid system, to be normal, and Vivitrol shuts that down," he said. "These people are obsessing about opioids, it does nothing to stop their cravings, and so people go to other drugs to try to find some way to feel normal." And unless they are required to get the shot every month or go to jail, the compliance rate is low, he said. "They don't come back, because Vivitrol doesn't do anything for the craving — they're miserable, they have trouble eating, they don't feel right, and they can't get good feelings that we're supposed to feel." Vivitrol blocks the effects of opioids but has no effect on benzodiazepines or, for most people, alcohol.

History

Snodgrass' drug use started in 1976 when, as a student at the University of Arkansas at Little Rock, he visited an apartment where people were injecting black tar heroin. He tried it, and for 15 years continued to use heroin only occasionally — twice a week at the most. He went on to get a Ph.D. in psychology, and to work with the highly respected drug researcher Donald E. McMillan, Ph.D., at the University of Arkansas for Medical Sciences. He would still use heroin occasionally, and one day saw a bottle of powdered methadone in the lab. He used it. "That methadone took me away. I was doing it every day, massive shots of it, but I thought, 'I have a Ph.D.; I'm not a loser junkie,'" he said. "I told myself, 'I can stop when I want to,' and I believed that up until I couldn't stop." He started stealing drugs from the safe, until the thefts were discovered, and then he had to buy drugs on the street. "My work went to hell, because I spent all my time and money getting drugs," he said. "One day McMillan called me in and shut the door, and said, 'Let's talk about your drug problem,'" he said. "That ended my career in behavioral pharmacology." McMillan and Snodgrass published several important articles together.

'… I thought, "I have a Ph.D.; I'm not a loser junkie … I can stop when I want to," and I believed that up until I couldn't stop.'

Sam Snodgrass, Ph.D.

When he was kicked out of the methadone program in 2007, he thought he could quit, but instead started injecting OxyContin. A friend had gotten him a job teaching in the psychology department, but by the spring of 2008, he couldn't teach. "I don't remember this, but apparently I was nodding out at my desk — that's how we are in active addiction." For the next three years he was what he calls a "street junkie" — homeless, living on the street and doing everything he could in terms of drugs to avoid being sick — "just to make it through the day without feeling like the guts were coming out of my body," he said.

During those three homeless years, he never could come up with the $200 required to enter an OTP. This was before the Affordable Care Act, so Medicaid wasn't available to men without dependent children.

He has been working at CATAR for almost two years. As for research and university, "that's over," he said. "I'll never get back to it, but I can do what I'm doing now, which is rewarding in itself." He helps tell patients about the brain and addiction, and he explains that "this is not a choice, not about willpower, and that they need to be on medication to control the symptoms," he said.

Snodgrass also works with Broken No More, an organization formed by families and friends of people with substance use disorders. •

Good Samaritan laws undercut by prosecutions

So-called "Good Samaritan" laws provide some immunity from criminal charges for individuals seeking help for themselves or others suffering an overdose. These laws are meant to save lives by eliminating the fear of arrest; someone who is with someone who overdoses can call 911 without fear of arrest — or at least, that was the hope and the promise. It isn't working out that way.

When Illinois adopted its Good Samaritan law in 2011, there was an exemption for "drug-induced homicide," so that prosecutors could still charge drug dealers. Allowing this exemption was the only way to get the Good Samaritan law past the legislature, said Kathie Kane-Willis, Ph.D., director of the Illinois Consortium on Drug Policy at Roosevelt University. "We had to do some serious negotiations around drug-induced homicide to say that the Good Samaritan immunity didn't apply," Kane-Willis told *ADAW* last week. "That was the concession we had to make, in our legislation it says specifically there is no immunity from prosecution for drug-induced homicide."

Dealers and users

The idea from the law enforcement people working on the Good Samaritan bill was clear, recalled Kane-Willis — "they wanted to go after the drug seller," she said. But the way drug-induced homicide investigations and prosecutions have

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gone since then have actually involved drug users — friends and relatives of the person who is overdosing. If the victim dies — even if the friend or relative called 911 — that person is being charged with drug-induced homicide.

Another problem is that law enforcement traditionally thinks of users and dealers with a bright line separating them, said Kane-Willis. That is just not true; many people sell drugs because they are supporting their own habit.

In Chicago, paramedics usually go to overdose 911 calls, not the police, said Kane-Willis. But it became clear that first one prosecutor and then more were interested in prosecuting drug users whose loved ones died from overdoses using the drug-induced homicide exemption from the Good Samaritan law. "We were really concerned about how this would impact overdose deaths," she said. "Also, I was afraid that this would be a wholesale problem across the country."

In one case in Madison County, a young woman — Angie Halliday — was charged with drug-induced homicide because she sold a drug in order to get the money to buy heroin for her boyfriend, who overdosed and died. "So she was charged with her boyfriend's death," said Kane-Willis. The only reason she wasn't convicted was that the drugs were purchased in Missouri, which has no drug-induced homicide law. Halliday pled guilty to a lesser charge, as do many people charged with drug-induced homicide, because the penalty is so high, said Kane-Willis.

"What makes it very complicated is the delivery-sales aspect," said Kane-Willis. "There doesn't need to be remuneration in order to be charged with delivering the drugs. If I'm in a using pair, and I go out and buy the drugs that we use together and he dies, I can be charged with homicide." Halliday had argued in her defense that both she and her boyfriend knew the risks, and knew they were "playing Russian Roulette."

And there can even be charges if the person who overdosed is rescued. In Illinois, "aggravated battery" now includes injection of any drug that results in "grievous bodily harm," said Kane-Willis. "So if you inject someone, and you call 911 and save their life, you can still be charged with aggravated battery."

'The Good Samaritan laws are not really providing immunity. It's hard to communicate the message that it's safe to call 911.'

Kathie Kane-Willis, Ph.D.

National problem

"I've been talking to our colleagues across the country, and the sad reality is we're not seeing the promise of these Good Samaritan laws materializing on the ground yet," said Daniel Raymond, policy director of the Harm Reduction Coalition. "The easy part is passing the laws; the hard part is implementing them."

Even the laws themselves are a "patchwork of carve-outs," said Raymond. "When we try to educate users about Good Samaritan laws, there are so many loopholes that we have to say, 'If the police want to arrest you, they will find a way.'"

Part of the legislative process for advocates like Kane-Willis and Raymond means educating lawmakers about taking a treatment and public health approach to opioid addiction. "We see all these law enforcement officials saying, 'We can't arrest our way out of the problem,' but there's still this sense that if there's an overdose, someone needs to be punished," said Raymond.

Because the drug prosecutions are in general not federal, it's not as if the attorney general can issue a memorandum saying "We're no longer going to prosecute around this," said Raymond. "But there is a sense that we need a higher level of leadership and some greater level of buy-in."

Police and treatment

It's clear that law enforcement is getting more involved with some of the health aspects of the opioid crisis, such as the Gloucester, Massachusetts, police initiative in which drug users are told they can be referred to treatment instead of arrested (see *ADAW*, July 27, 2015). But can drug users really trust the police? Raymond provided two perspectives on the issue. On the bright side, this could be a "transitional moment when there is a lot of confusion, not just about the laws but about the right responses," he said. "But my more cynical view — and I was concerned about this when we started training police in New York City about naloxone — is that law enforcement is taking an outsized share of responsibility for what should be a medical problem."

Raymond is also concerned that the Gloucester initiative, as we reported last year, focuses on out-of-state rehabs, instead of focusing on medication-assisted treatment. "Time and again, people go through detox and rehab, and a huge proportion

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end up relapsing and then overdosing," he said.

Raymond talked to us in the middle of a week spent on Capitol Hill talking to staffers about opioid addiction. "They told me that they are taking their cues from the police," said Raymond. "I asked them if they are talking to addiction counselors, to treatment experts, but they're more interested in the uniform," he said. "Many members of Congress are former prosecutors, who have always relied on the endorsement of the Patrolmen's Benevolent Association," he said. "They have a direct pipeline to law enforcement."

Families

Another factor in the prosecutions is the parents of young people who die from overdoses, many of whom support drug-induced homicide laws, said Kane-Willis. "It makes sense," she said, "because many of these parents are unaware of what drug use looks like. They really believe that the child just used once and overdosed, and they're so angry."

And Raymond agrees. When the parent says "I want whoever sold the drugs to rot in jail," prosecutors have a hard time turning this kind of plea down, he said. "Prosecutors see this as the old model of deterrence — that they can scare people out of using," he said. "They want to have a spectacular prosecution, make the evening news."

In many cases, these are communities that several years ago didn't have a heroin problem, and are "catching up to the reality," said Raymond. He learned a few years ago when the Harm Reduction Coalition when to northern Kentucky to organize a three-day training on overdose prevention and syringe access that communities do not want to adjust to the opioid epidemic — they want it to disappear. "I had to explain to my colleagues that this area has been overwhelmed by heroin; they think it's a nightmare they need to wake up from. They don't want to hear about needle exchanges; they just want to ride out the epidemic and have it end," he said. "It's just like people who think treatment is this magic thing, and they can put someone in rehab and in a month they'll come back to their old self."

'Culture change' needed

In the meantime, it's hard to create a public health infrastructure to reduce overdose as long as the using community is going to be afraid to call 911. "The Good Samaritan laws are not really providing immunity," said Kane-Willis. "It's hard to communicate the message that it's safe to call 911."

Perhaps the harm reduction community should have started by talking to prosecutors, Raymond acknowledged. "Now I'm at the point where I think it's going to take a culture change," he told *ADAW*. "The prosecutors are going to have to start telling police, 'Don't bring these cases to me; you're wasting my time.'" •

Editor's note: The National District Attorneys Association was not able to respond to a request for an interview by press time, but we will have their perspective in an upcoming issue.

How treatment can capitalize on media attention to opioids

For several years now, opioids have been in the headlines; President Obama even mentioned prescription drugs and heroin in his State of the Union address January 12, which resulted in a flurry of praise from treatment advocates. But he didn't mention any policy changes that would help improve availability of treatment — and most of the news articles don't talk about treatment, either. They talk about overdoses, prescribing behaviors and naloxone.

We talked to a treatment provider and a media expert familiar with the field.

"I would say that most of these news stories hook into the hopelessness of it all," said Joseph Garbely, M.D., medical director of Caron Treatment Centers, based in Wernersville, Pennsylvania. "I have the advantage of being in the front row watching recovery happen, and seeing people get well," he told *ADAW*. "My message is that treatment does work, and that while this news is bringing proper attention to an epidemic, it is focusing more on hopelessness."

Garbely is in favor of naloxone, the opioid overdose-reversal drug, but it's not treatment, he said. "It's preventing death by reversing the respiratory depression that happens in the medullary centers," he said. Naloxone is now available over the counter in Pennsylvania, something that Garbely applauds. "But we have to start sending a message that treatment does work, and that this is not a hopeless situation," he said.

Garbely is helping to get the word out about the success of treatment by giving grand rounds in health systems in the Philadelphia area. "They've started to knock on my door because I've been a physician in the Philadelphia area for many years, and I'm familiar with the head of health systems," he said. He helps teach young physicians

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about the dangers of overprescribing prescription opioids, and about the importance of treatment. "I'm educating them not just about medications like methadone and buprenorphine and Vivitrol, but about the therapy that those medications are meant to assist," he said.

Garbely is pleased that the young physicians do believe that there is a disease of addiction. "They are not skeptical at all, and they're hungry to know about it — I talk to them about research from the National Institute on Drug Abuse, and they can't get enough," he said.

Although he himself did an internal medicine residency and a psychiatry residency, Garbely said he got "next to no addiction training." Most psychiatric residencies find a way to include other rotations, such as psychiatry emergency, and count them as addiction training, he said. Garbely is certified by the American Board of Addiction Medicine.

The media expert

Robert S. Weiner, one of the few people we know who is an expert in publicity, media affairs, substance use disorders and politics, believes there is an "enormous positive opportunity for treatment" in the bigger picture. With the provisions of the Affordable Care Act and parity provisions that are now in place, the key is getting treatment providers to provide more and better treatment, Weiner told *ADAW* last week.

"The new visibility of heroin's resurgence creates an urgent need to act," he said. There is nothing new about the lack of an adequate capacity, he added. "We've had the waiting list issue literally for decades," he said.

'The new visibility of heroin's resurgence creates an urgent need to act.'

Robert S. Weiner

Even the Mexican drug lord El Chapo said the drug issue in the United States will continue unabated, just as every Mexican president has said, due to demand for drugs by Americans.

Weiner is a former spokesman for the Office of National Drug Control Policy and the House Select Committee on Narcotics Abuse and Control, and is a radio and television commentator. He is also working on training programs for young journalists. He noted that President Obama had to mention opioids, because these are major problems in most states.

Words or action?

And about President Obama's reference to prescription drugs and heroin in the SOTU, the fact is that this White House has gutted Access to Recovery, the $100-million-a-year treatment funding that went to states. Access to Recovery was first announced in the 2003 State of the Union by then President George W. Bush, who took everyone by surprise. Congress then made sure that the funding was well-used. Still the lobbyists and advocates who took to the Internet the morning after the Obama SOTU were right to point out that this topic was mentioned. It helps give what the treatment providers need just as much as the patients: hope. •

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make progress.

The practical question that researchers have been attempting to answer, says Michael McDonell, Ph.D., of Washington State University, is "Could we test two or three times a week and detect most use?" McDonell, associate professor in the university's Elson S. Floyd College of Medicine, says the results he and colleagues have seen in the past four years tell him that many programs have used too low a cutoff level to detect significant patterns of alcohol use.

"I worry at the forensic level that there are a lot of programs out there that miss a lot of drinking," McDonell told *ADAW*.

What is known

The EtG metabolite that is present in the body after exposure to alcohol is believed to be detectable in any tissue, so it can be tested for in alternative technologies to urine testing — though most of the existing EtG research has focused on urine tests.

The marker's very high sensitivity offers advantages and disadvantages, explains Kenneth R. Warren, Ph.D., senior advisor for science and operations at the National Institute on Alcohol Abuse and Alcoholism (NIAAA). It can identify alcohol use extending back for a longer period than Breathalyzer-type technology, but also can potentially yield a positive reading if a person has been exposed to common household products containing alcohol, such as hand sanitizer or mouthwash. And the window of detection is still relatively short, so a test performed at midweek won't identify heavy drinking that took place over the previous weekend, Warren told *ADAW*.

He said NIAAA does not have a specific policy statement regarding EtG testing. The Substance Abuse and Mental Health Services Administration has suggested in the past that an EtG result should not be used absent other considerations in order to justify imposing sanctions in a recovery program. But McDonell says recent research is shedding light on

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what cutoff levels should be used to achieve the most reliable results in testing.

A study of 121 adults with alcohol use disorders that McDonell led, published last month in *Drug and Alcohol Dependence*, compared cutoff levels of 100, 200 and 500 nanograms per milliliter (ng/mL) in detecting light and heavy drinking in patients who also submitted self-report data on their use. The study found that the 100 ng/mL cutoff was most effective in detecting heavy drinking for up to five days prior to the test, and in detecting any drinking over the two days before the test. Some programs that have traditionally used a 500 ng/mL cutoff are therefore missing what could prove to be problematic patterns of use, McDonell said.

McDonell's research largely has focused on use of EtG in treatment initiatives that use a contingency management strategy, rewarding patients for recovery-affirming outcomes.

> **'I worry at the forensic level that there are a lot of programs out there that miss a lot of drinking.'**
>
> Michael McDonell, Ph.D.

Use in aftercare

One treatment organization that examines EtG in an informative but not punitive way is Pennsylvania-based Caron Treatment Centers. Senior clinical director Chris O'Reilly told *ADAW* that participants in Caron's 12-month aftercare program called My First Year of Recovery typically are tested for alcohol use two to three times per month.

The participants receive an email or text with an authorization number, informing them that a test is to take place. They take that number to a lab that is convenient to their location, where the test takes place. "They know it's a randomized process, but our goal is not to overwhelm them," O'Reilly said. "These are people who have a lot going on in their day. They would have all of that day and the next day to get to the lab."

He sees the EtG testing as adding an important accountability component to the aftercare program, both for individuals who have primarily had alcohol problems and for those who simply may not take alcohol use seriously compared with illicit drug use. "They know that it will trigger an intervention on them if the test is positive, and that often deters them from even considering alcohol as an option," he said.

O'Reilly said Caron actually lowered its cutoff level for a positive recently, and has not had many instances of patients claiming a false positive. In any event, "Our primary goal is not to catch them," he said, but to help get patients stabilized in their early recovery. The EtG test is therefore not used punitively, but as an information tool that supplements self-report, updates from family members and other measures, he said.

Barriers to use

Why haven't more addiction treatment programs incorporated EtG into their monitoring? McDonell lists several factors, starting with cost. Adding alcohol to a typical testing panel can double the cost of each individual test. Purchasing one's own analyzer would cost around $40,000, said McDonell, who has these devices installed at several treatment clinics for research purposes.

In addition, the potential risk of a positive test in individuals who have not been drinking, even if there are safeguards against that, has probably raised concerns among some treatment providers. Finally, "In the history of the field, self-report has always been the gold standard," he said.

NIAAA's Warren said there is hope that other alcohol biomarkers will emerge as viable alternatives with advantages of their own. These include phosphatidylethanol, which has a much longer window than EtG (at least several weeks) but is detectable in blood and not urine. In addition, NIAAA is sponsoring projects that it hopes will lead to conveniently wearable technologies that could monitor individuals' alcohol use on an ongoing basis, he said. •

Briefly Noted

NIDA-CDC-FDA deny link between prescription opioid crackdown and heroin epidemic

The federal government, which years ago endorsed a reduction of opioid prescribing as a main tool in reducing opioid addiction and is stepping up such efforts, has just come out with a literature review showing these tools "have not directly led to the recent increases in heroin use across the nation," according to a January 13 National Institute on Drug Abuse (NIDA) press release announcing the study. The study is by NIDA Deputy Director Wilson M. Compton, M.D.; Christopher M. Jones, Pharm.D., senior advisor with the Office of Public Health Strategy and Analysis of the Food and Drug Administration; and Grant

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T. Baldwin, Ph.D., director of the Division of Unintentional Injury Prevention at the National Center for Injury Prevention and Control with the Centers for Disease Control and Prevention, and is published in the January 14 issue of *The New England Journal of Medicine*. The study said that the lower price and higher purity of heroin are the main drivers of the increase in heroin use and overdoses, which, they say, preceded the prescription opioid crackdown. "Although none of these studies can disprove a potential relationship between policies that are aimed at decreasing the availability of inappropriately prescribed opioids and the motivation for heroin use in some people, the results of these studies consistently suggest that the transition to heroin use was occurring before most of these policies were enacted, and such policies do not appear to have directly led to the overall increases in the rates of heroin use," the authors wrote. The study, "Relationship between Nonmedical Prescription-Opioid Use and Heroin Use," is available online free: go to www.nejm.org/doi/full/10.1056/NEJMra1508490.

Pew report touts Vivitrol

A three-part story published by the Pew Charitable Trusts gives an overview of the barriers to medication-assisted treatment (MAT). The second article in the series — the third had not yet been released at press time — is mainly about Vivitrol, profiling a jail-based program in Massachusetts where the medication is said, according to Pew, to reduce craving for opioids. Part 1 was about the bias against MAT in general and featured a section on Kevin Flattery, who died after overdosing shortly after he was discharged from drug-free rehab, and whose father is on a campaign to tell parents whose children have opioid addiction to seek MAT, not rehab (see *ADAW*, Sept. 28).

Coming up...

The **Addiction eXecutives Industry Summit** will be held **January 31–February 3** in **Naples, Florida**. Go to **www.axissummit.com** for more information.

The **Community Anti-Drug Coalitions of America** will hold its leadership forum **February 1–4** in **National Harbor, Maryland**. For more information, go to **www.cadca.org**.

The annual meeting of the **American Academy of Pain Medicine** will be held **February 18–21** in **Palm Springs, California**. Go to **www.painmed.org/annualmeeting/main.aspx** for more information.

The **National Council for Behavioral Health** will hold its annual meeting **March 7–9** in **Las Vegas, Nevada**. For more information, go to **www.thenationalcouncil.org/events-and-training/conference**.

The **2016 National Rx Drug Abuse & Heroin Summit** will be held **March 28–31** in **Atlanta, Georgia**. Go to **http://nationalrxdrugabusesummit.org** for more information.

Names in the News

Robert Lubran retired at the end of 2015 as the director of the Division of Pharmacologic Therapies at the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA). Melinda Campopiano, M.D., is acting as the director of that division, which is in charge of regulating opioid treatment programs (methadone clinics) and office-based opioid treatment (buprenorphine providers).

The job will be advertised "soon," a SAMHSA spokesman told *ADAW*. It's possible that Campopiano will be chosen for the permanent position, sources tell us.

In case you haven't heard...

On January 11, the public comment period on the draft guidelines for opioid prescribing from the Centers for Disease Control and Prevention (CDC) ended (see *ADAW*, Dec. 21), and some stakeholders were already weighing in on the side of the CDC — notably, the National Association of Addiction Treatment Providers and Facing Addiction, both of whom posted emails urging support of the guidelines. Of course, PROP (Physicians for Responsible Opioid Prescribing) and Andrew Kolodny, M.D., have long been in favor of such guidelines. Under the guidelines, which are voluntary and apply only to primary care physicians providing opioids for pain for a patient for three months or more, opioid addiction and dependence would be curtailed, these groups said. Meanwhile, the pain community continues to strongly criticize the CDC for unfairly limiting people to adequate pain treatment.