

ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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BHOs to monitor providers in first step toward New York Medicaid carveout

In a move that was unthinkable a few years ago, managed care for substance abuse treatment is now a reality in New York. However, providers' concerns have been taken into account, and the process has been transparent, with a two-year learning period built into the process, according to providers and state officials.

Late last month New York awarded contracts to four behavioral health organizations (BHOs) to monitor substance abuse and mental health providers receiving fee-for-service Medicaid. The process was competitive, with the Request for Proposals (RFP) issued last summer. Two years from now, the providers who are selected to be in their region's BHO network will no longer be paid on a

fee-for-service basis, but will share risk with the managed care company.

The Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) were authorized to contract with the BHOs through an accelerated procurement and contract process. The selected vendors were announced last month. They are, along with the budget range per year:

- OptumHealth (New York City Region) — \$5,400,000 to \$7,200,000;
- Community Care Behavioral Health (Hudson River Region) — \$2,100,000 to \$2,800,000;
- Magellan Behavioral Health (Central Region) — \$1,050,000 to \$1,400,000; and

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Treatment Program Profile

Recovery home joins care continuum through merger with Easter Seals



by Gary Enos, Contributing Editor

A recovery residence that in a few short years became a fixture of New Hampshire's recovery community through the commitment of a small group of leaders suddenly can foresee significant growth opportunities through a merger.

Webster Place Recovery Center has announced a merger with Easter Seals New Hampshire, though the basic structure of Webster Place's four-member governing board will not change for the time being. The merger means that the 42-bed recovery residence just north of Concord becomes part of a continuum

of care with Easter Seals' primary residential and intensive outpatient treatment centers in the state. Easter Seals New Hampshire oversees 60 human services programs overall in the state and also has a management role in Easter Seals chapters throughout New England.

Webster Place board member and former board chairman Paul Lavalley told *ADAW* that while the recovery residence had succeeded on its own in building a self-sustaining operation not dependent on government or philanthropic support, the merger will enhance treatment opportunities for residents as well as

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- New York Care Coordination Program (Western Region) — \$1,300,000 to \$1,700,000

The vendor for the Long Island Region is still to be determined; the budget is \$1,650,000 to \$2,200,000.

Gov. Andrew Cuomo's Medicaid Redesign Team (MRT) recommended that BHOs be used as carve-outs last winter to manage Medicaid, in a move that is supported by the field, which played a role in the development of the recommendations (see *ADAW*, March 21). The BHOs will manage addiction and mental health services not already covered by the state's Medicaid managed care plans. The federal block grant is not included in this project; funding will be kept separate, and used for prevention and uncompensated care.

Alcoholism & Drug Abuse Weekly

welcomes letters to the editor from its readers on any topic in the addiction field. Letters no longer than 350 words should be submitted to:

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Reduction of unnecessary inpatient care is one of the main goals of the behavioral health group MRT, targeting overuse of detox by patients who are not connected to follow-up care.

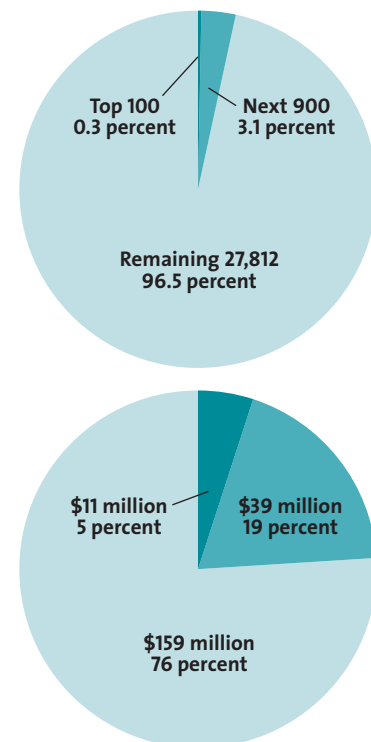
Detox targeted

Care in the current system is fragmented, with patients not getting continuing care for addiction, something that has long been recognized a best practice. Most notorious on the substance abuse side is the handling of detoxification, with patients getting detoxifications in costly hospital beds and no follow-up care at all, something which has troubled OASAS for years but which it has not been able to control.

In 2010, one person had 73 detox admissions, 291 detox days, 15 detox providers, and cost Medicaid more than \$300,000. For a view of how a small percentage of people use the most dollars in multiple detoxes, see graph, right.

Savings which accrue from the BHO efforts are expected to be \$5.5 million per year for OASAS and OMH combined. The savings will go towards areas such as housing and family support. There will be expanded access to outpatient services; according to OASAS, utilization management will not typically be used for these services.

Detox top 1000 users: 2010



Source: OHM/OASAS

Discharge plans

There will be two phases of the BHOs; the first phase will last for two years and will involve only monitoring by the BHOs. The second phase, to start in two years, will be true carveouts, in which the regional BHOs will receive premiums

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from the state and manage all Medicaid claims for mental health and substance abuse.

During the first phase, inpatient providers can expect their regional BHO to contact them after two days of detoxification, and prior to 21 days of non-hospital inpatient care, about a discharge plan. For mental health hospital admissions, there must be a discharge plan after five days.

“Enhanced engagement efforts” to make sure the patients get appropriate treatment will be used for any patients who are readmitted within 30 days for mental health or 45 days for substance abuse, and for patients with three or more detox admissions in a 12-month period.

At this point, the contracts are renewable on a year by year basis, up to five years. “We’ll be moving to a more managed system in 2013,” Rob Kent, OASAS counsel, told *ADAW* last week. “We don’t know yet if we will rebid this,” said Kent, adding that the first phase is mainly to help provider prepare for the second phase. “We’re going to learn from this process.”

Provider profiles

Also during the first phase, the BHOs will profile providers. The profile done by the BHO will include information about interactions between the provider and the BHO, statistics from concurrent reviews, characteristics, timeliness, and completion of discharge plans.

OMH and OASAS will profile providers based on inpatient length of stay, readmission rates, and patient engagement with follow-up care (including psychotropic medication fills).

Concern about access

“The first good news is there’s a concentration on behavioral health,” said Karen Carpenter-Palumbo, former commissioner of OASAS. But looking ahead to when the carve-outs will pay providers, she is concerned about access to care. “Man-

aged care hones in on the network, and may result in fewer providers,” she said. “That doesn’t help with access.” She also said that for providers, whether they are for profit or nonprofit, managed care ends up in fee cuts because the provider is at risk, especially if the company doesn’t approve admission or a longer length of stay. “What happens then is that the provider, who has an obligation to not turn people away, ends up providing uncompensated care.”

But she is strongly behind the move to alter detox. “I’ve always believed that 50 percent of the cases that are being managed in the hos-

The “revolving door” detox hospital beds are in general hospitals, said Hartigan, who is also treasurer of the National Association of Addiction Treatment Programs. “The Department of Health did a study and found that in our facilities, well above 85 percent who come into the detox units go on to rehabilitation,” he said. “In contrast, most of those patients they get hospital detox never get the other levels of service.”

Also, the New York programs predate managed care and have learned how to deal with it, said Hartigan. “At Arms Acres in Carmel and Conifer Park, we have a very good relationship with managed

‘A lot of our providers spoke very clearly during the whole MRT process about needing time to move to a more fully managed system.’

Rob Kent

pital for detox could be managed better in the community, from a clinical and financial perspective.”

Providers ‘comfortable’

William Hartigan, president and CEO of Liberty Behavioral Management Corporation, which owns treatment programs Arms Acres and Conifer Park, as well as a 130-bed psychiatric hospital, in New York, said he is not concerned about the BHO utilization management. “I am very comfortable about how this will be handled,” said Hartigan, who has been in the field for 46 years and who saw the demise of many programs after managed care entered the marketplace in the late 1980s. “The choices and the options that are there and the guidelines that are being given to the managed care organizations are less onerous than they have been historically,” Hartigan told *ADAW*.

Also, Liberty’s programs include a full continuum of care, he said.

care companies,” he said. “We survived the late 80s and the 90s, and figured out how to create cost-effective programs, and how to be sensitive to the length of stay.”

During phase 1, the BHOs won’t be “pushing patients out,” said Hartigan. “They’re not going to be denying care, they’re just going to be monitoring.” How should staff respond when they hear from the BHO after two days of detox? “If I get that call at Conifer Park or Arms Acres, my clinical staff will say, ‘My patient is in detox, and here’s the reason we need to go beyond two days.’” In all cases, though the plan is for the patient to get into rehab after detox, he said. “I’m not worried. The people who are going to have trouble with this are the revolving door detoxes that don’t plan anything for the patient, except to detox him for five to seven days. That’s an expensive proposition.”

Kent said that OASAS is talking

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to the Department of Health about the problem of general hospital beds — as against OASAS-licensed beds — being used for detoxification.

Also, OASAS is working closely

with providers. “A lot of our providers spoke very clearly during the whole MRT process about needing time to move to a more fully managed system,” said Kent. “Ultimately this is intended to begin to prepare

the fields for what’s coming, to get used to the lengths of stay.’ •

For the RFP, which describes how the contracts will be implemented, go to <http://bit.ly/rUOvGC>.

Buprenorphine works, but only if patients stay on it: Study

Last week researchers reported that nine out of 10 patients in short-term treatment with buprenorphine relapsed, results even more dismal than were expected, according to principal investigator Roger D. Weiss, M.D. There were 653 patients in the study, published online November 7 in the *Archives of General Psychiatry*.

“We were surprised that it was that high,” said Weiss of the relapse rates, which were 93.4 percent for patients on the 30-day treatment (detoxification) and 50.8 percent for patients in three-month treatment (followed by tapering to detoxification) which rose to 91.4 percent eight weeks after the taper. “I’m not sure why it was as high as it was,” he told *ADAW*. “We were expecting somewhat better numbers.”

During 30-day treatment, 43 of 653 (6.6 percent) patients had successful outcomes.

During 12-week treatment, 177 of 360 (49.2 percent) patients had successful outcomes. This dropped to only 31 of the 360 (8.6 percent) eight weeks after the taper, however.

The researchers chose to test short-term treatment, even though they knew it would have a high relapse rate, because it is a common model used in office-based treatment by physicians, said Weiss. “Detox was at that time and is still in many places the usual treatment,” he said. “We did a survey about what typical practices were with buprenorphine, and a 30-day detox was very common.” Many patients also request the short-term detox instead of long-term maintenance, he said.

“Also, I think there was a belief that prescription opioid patients might be different than heroin users.

If you look at our population, a lot of them are employed. Many are seeking treatment for the first time,” said Weiss, who is chief of the Alcohol and Drug Abuse Treatment Program at McLean Hospital in Belmont, Massachusetts and professor of psychiatry at Harvard. Weiss and his colleagues are looking at the data to see what could have led to the successful outcomes in the few people who did not relapse.

The news was expected; although he had not been allowed to give press interviews about the study until it was published, Weiss had discussed findings with colleagues and at conferences. Even when the study was first announced, experts predicted an 80-percent relapse rate (see *ADAW*, May 7, 2007).

oids, not heroin. The researchers hypothesized that they would do better on short-term treatment than heroin-dependent patients because they were more likely to be employed and had more stable lives in general. Maintenance treatment, not detoxification, has been shown to be better for heroin-dependent patients.

Asked whether Vivitrol is an option for these patients, Weiss said that this “is a work in progress” — there is another clinical trial sponsored by NIDA that has not begun yet which he hopes to participate in which would compare Vivitrol and buprenorphine. Vivitrol wasn’t approved for treatment of opioid dependence when the buprenorphine trial was designed. Weiss also noted that it “could present problems for

‘We did a survey about what typical practices were with buprenorphine, and a 30-day detox was very common.’

Roger D. Weiss, M.D.

Methods

There were two phases in the study: Phase 1 included two weeks of buprenorphine stabilization followed by a two-week taper and an eight-week post-medication follow up. People who did well left the study, people who did not do well entered Phase 2, which included 12 weeks of treatment with buprenorphine, a four-week taper, and an eight-week follow up.

All of the patients in the study were dependent on prescription opi-

people with pain,” because the naloxone would block all effects of opioids. Forty percent of the people in the Weiss study had chronic pain.

Length of maintenance

Maintenance treatment is better for patients dependent on prescription opioids, as well. However, the next question is how long that maintenance needs to be, given that people in the 12-week treatment phase had much better outcomes.

For example, Medicaid in Maine

last month said it could no longer afford to pay for Suboxone for unlimited time periods, and would taper patients off it after two years (see *ADAW*, November 7). Asked whether two years would give patients a better chance of good outcomes than three months, or if nine out of 10 would still relapse after the taper, Weiss said he didn't know.

"Nobody knows whether the results we got would be different after a longer period of time as opposed to three months," he said. "I would imagine that there would be fewer relapses," he said, because patients had two years to get their lives stabilized, but the physical effects of going off the buprenorphine would still result in a "considerable number of patients to relapse."

All of the patients received medication management, which was 45-60 minutes a week in phase 1 and 30-60 minutes a week in phase 2. Patients were also randomly assigned to receive drug counseling, delivered by substance abuse or mental health professionals, once a week. Individual drug counseling did not improve outcomes, but if it had been more frequent than once a week, the outcomes might have been better, according to the article. The authors conclude that the fact that the drug counseling didn't affect outcomes supports the trend toward treatment in an office-based practice.

Studies of methadone maintenance treatment have shown that patients in treatment for a year or more have better outcomes. However, it's not known whether this would apply to treatment with buprenorphine, the article says.

The financial disclosures of all authors are listed at the end of the article: Weiss is a consultant to Titan Pharmaceuticals, which is making a buprenorphine implant called Probu-phine. Other authors' disclosures include: Titan, American Pain Society, Pinney Associates, Reckitt Benckiser, Alkermes, Catalyst Partners Pharmaceuticals, Forest Laboratories, Hythiam, and U.S. Worldmeds. •

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initiate growth on campus. Webster Place is situated at the former Daniel Webster homestead, but it presently uses only one of several existing buildings at the site.

Lavallee said of the Webster Place leadership group's mission during merger deliberations, "We wanted to preserve the independent nature of the place, and to maintain the integrity of the mission."

'Sometimes when someone arrives here, we ask ourselves later on, "Do they really need something more than what we have to offer?"'

Paul Lavallee

History

The property on which Webster Place sits once served as an orphanage for children of the Civil War, then later housed a convent before falling into disrepair. The site eventually would be purchased by Alex Ray, owner of the Common Man chain of restaurants in New Hampshire, who envisioned a plan to allow for the formation of a nonprofit entity dedicated to helping individuals in recovery. Webster Place operators lease the property.

A quartet of leaders in the recovery community joined forces to establish a residence run completely by individuals in recovery. A loan from Ray helped to establish the facility, and that money already has been paid back through revenues from the operation, Lavallee said.

Lavallee said that while the facility does not offer primary treatment, it has been an entry point for services for many of its resi-

dents since 2008. "Sometimes they show up intoxicated at our door," he said.

Men and women live on separate floors in the campus building operated by Webster Place. The program has a strong 12-Step orientation, with 12-Step study and group meetings during the day and a detailed schedule that includes house chores. Family-style meals are a focal point of the day, with some of the food grown on farmland located on the property.

The private-pay program also offers a gym facility, a music room, and a number of mind-body therapies, said Lavallee. Residents stay for an average of two months, he said.

The seeds of a merger were sown when the Webster Place board launched a search for a new executive director last year. Struggling to find the ideal candidate with a professional background and a recovery history, the board enlisted the aid of Easter Seals and its senior director of substance abuse services, Cheryl Wilkie, Psy.D.

"The four people running the board were essentially running the company," said Lavallee. "It was hard to find somebody good." Eventually, the thought became, why not Easter Seals and Wilkie?

Wilkie also manages The Farnum Center for Easter Seals; it has a residential treatment component in Manchester and an intensive outpatient program in Hartford. Lavallee sees the partnership as paying dividends in terms of continuity of care and in addressing payment issues.

"It will be good to have a full continuum of care from detox to aftercare," Lavallee said. "Sometimes when someone arrives here, we ask ourselves later on, 'Do they really need something more than what we have to offer?'"

Also, because Webster Place never has accepted insurance payment, it has had limited options as an unaffiliated agency for referring individuals who need to access their

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insurance coverage. Conversely, Lavallee said, when Farnum Center is full and a prospective client has financial resources, Webster Place now could become a viable option for that person.

Lavallee said that program options such as Webster Place were considerably more prevalent in New Hampshire when insurance coverage was less restrictive. Easter Seals New Hampshire president and CEO Larry Gammon said in a statement, "There is a critical need for alcohol and substance abuse treatment services that are accessible, inclusive, and sustainable."

Future plans

Lavallee said that the merger with Easter Seals will open up a

Webster Place Recovery Center

Location: Franklin, New Hampshire

Founded: 2008

Services: 42-bed peer-run recovery support residence for adult men and women

Number of Employees: 14

Payer Mix: Entirely self-pay, with some scholarships offered. Cost is \$6,400 for first month and \$4,000 to \$4,500 in subsequent months

number of growth opportunities for Webster Place. While Easter Seals plans to double the treatment capacity of Farnum Center by acquiring a motel property, Lavallee foresees Webster Place being able to occupy a second building on its campus by next year.

That will allow the program to relocate 18 women to the new building site and to keep male residents in the original location. "This will establish the first gender-specific programs in the state," he said.

Current Webster Place board chairman Charles Clarkson summarized his organization's hopes for the future by saying in a statement, "Easter Seals [New Hampshire] has a strong track record of successful partnerships in New Hampshire and this collaboration is the next step in our evolution of developing to our full potential." •

For more information on addiction and substance abuse, visit www.wiley.com

SAMHSA places 10 regional administrators across the country

In a move that hasn't been done in the history of the Substance Abuse and Mental Health Services Administration (SAMHSA) — or its predecessor agency, for that matter — agency officials have been hired to work in Health and Human Services regional offices across the country.

Eric Broderick, D.D.S., M.P.H., then-deputy administrator of SAMHSA and acting director of the Office of Policy, Planning & Innovation (and now retired) said earlier this year that there would be no new positions involved (see *ADAW*, Jan. 10). He also said the regional administrators would be the "eyes and ears of the administrator" (Pam Hyde).

The appointments were made in what seemed to be an overnight process. There was no press release, but the field was advised on November 7, with Center for Mental Health Services (CMHS) managers told several days earlier. One of the regional administrators is CMHS director Kathryn Power, who will be heading the Boston region.

In another interesting appointment, David Dickinson, SSA for Washington who recently cut all adult substance abuse treatment in the state (see *ADAW*, October 17), has been appointed regional SAMHSA administrator for that region. Another SSA, Charles Smith of Colorado, will

also be a regional administrator.

In an email sent to field leaders last week, SAMHSA administrator Pam Hyde said that the "this new configuration of SAMHSA staff will help ensure that a voice for behavioral health is present in the regions along with all of the other HHS operating divisions."

The regional administrators will report to Anne Herron, Director of the Division of Regional and National Policy Liaison in the Office of Policy, Planning and Innovation.

The other regional administrators are Dennis O. Romero, currently Acting Director of SAMHSA's Office of Indian Alcohol and Substance Abuse (New York); Jean Bennett, currently Senior Advisor to the HHS Assistant Secretary for Administration and previous Disaster Coordinator in an HHS Regional Office (Philadelphia); Stephanie McCladdie, currently Director of Prevention Services for the Alabama Department of Mental Health (Atlanta); Jeffrey Coady, currently national behavioral health consultant for the Centers for Medicare and Medicaid

'[T]his new configuration of SAMHSA staff will help ensure that a voice for behavioral health is present in the regions along with all of the other HHS operating divisions.'

Pam Hyde

Services, Medicaid Integrity Group (Chicago); Michael Duffy, former Deputy Assistant Secretary for the Office for Addictive Disorders for the State of Louisiana (Dallas); Laura Howard, former Deputy Secretary with the Kansas Department of Social and Rehabilitation Services (Kansas City); and Jon Perez, currently national behavioral health consultant for the Indian Health Service (San Francisco).

About \$1.7 million has been budgeted to hire 10 regional administrators along with one regional coordinator, a SAMHSA spokeswoman told *ADAW* in an email last week. The funding “will be available from a combination of Program Management funds (to become Health Surveillance and Program Support) and technical assistance funds available from the SA and MH Block Grant Set-Aside for Administration,” the spokeswoman added. This would barely cover salary and benefits for a year for the 11 people, so other money to do their work would have to come from someplace else.

Also, this is fiscal 2012 money. However, the Continuing Resolution is about to expire, and the fiscal year budget is still very much up in the air, with the supercommittee reportedly stuck and huge cuts due to take effect. Nevertheless, the regional administrators have been hired, given their resignations at their previous jobs, and the welcoming party already set at SAMHSA headquarters for November 28.

The Senate appropriations committee with oversight over SAMHSA is looking into whether spending the funds is allowable. •

BRIEFLY NOTED

CADCA launches VetCorps to help returning veterans and families

Last week Community Anti-Drug Coalitions of America (CADCA) launched a VetCorps program, which uses the group’s infrastructure to help returning veterans and

Breaking News Exclusive

NAATP CEO Carpenter-Palumbo resigns to pursue consulting

After only seven months as president and CEO of the National Association of Addiction Treatment Programs (NAATP), Karen Carpenter-Palumbo is stepping down. “It’s time for me to leave,” Carpenter-Palumbo told *ADAW* last week. “I offered to do consulting with NAATP, it’s a good organization,” she said. “We just got to the point where consulting would be a better role.” Her resignation took effect November 4.

“It’s disappointing and sad, but we’re really grateful for the things she’s done for us,” said Kermit Dahlen, NAATP board chairperson. “It’s just one of the things that sometimes happens.” Dahlen confirmed that she was pursuing a consulting career in the field. “We wish her well.”

The new president and CEO is Dennis Gilhousen, who was interim CEO after the 2010 termination of longtime president Ron Hunsicker for misappropriation of NAATP funds (see *ADAW*, April 12, May 17, May 24, all 2010) until the appointment of Carpenter-Palumbo (see *ADAW*, March 28).

“What’s really important is that Dennis is not acting or interim, he is our CEO, and he will be with us for a while,” said Dahlen. “He’ll continue to pick up where Karen left off and move us into the future.”

Gilhousen is in the process of getting back into the job. “This was very sudden,” he told *ADAW* last week. Of course, it was sudden last time too. “At least this time I’m coming into it with some knowledge about where the organization is,” he said. “But I’ve been out of this for six months.”

Gilhousen told *ADAW* that NAATP will “do what we can to keep the organization going on behalf of our members and particularly on behalf of our members’ patients.”

Carpenter-Palumbo will stay in the addiction field, she said. “I adore the field,” she said. “I’m going to see what the next best step is.”

Correction

In the November 7 issue, an article about credentialing and IC&RC contained an error. Faces & Voices of Recovery is not doing any credentialing, is not working in the prevention field, and is not focusing on facilities. Here’s what Faces & Voices is doing, according to executive director Pat Taylor: “We are developing a process for accreditation of recovery support organizations to ensure that peer practitioners and the organizations that house peer services and other programming are qualified, recovery-oriented and legally and ethically sound.”

We regret the error.

families access support ranging from substance abuse prevention and treatment to employment and housing assistance. “The program is aimed at National Guard and Reserve veterans who don’t typically have access to the same type of supports that enlisted personnel do,” said Natalia Martinez Duncan, spokeswoman for CADCA. The Na-

tional Guard Bureau and the Corporation for National Community Service joined CADCA in presenting the program November 10. VetCorps will recruit veterans who will volunteer, following the Americorps model, to be placed in a CADCA community coalition, to provide support to veterans and military families.

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CDC links Rx opioid OD deaths to increased prescribing

Fatal overdoses involving opioid analgesics are linked to increases in prescribing in the November 4 issue of the *Morbidity and Mortality Weekly Report (MMWR)* from the Centers for Disease Control and Prevention. These deaths have increased, according to the report, which analyzes rates of overdoses, nonmedical use, sales, and treatment admissions. In 2008, drug overdoses in the United States were the cause of 36,450 deaths, of which 20,044 were prescription drug overdose deaths. Of these, 14,800 were prescription opioid deaths. The states with the lowest death rates had lower rates of sales and lower rates of abuse. The huge variations in states could not be explained by demographic differences, but were linked to similar variations in opiate prescribing. For the report, go to <http://1.usa.gov/vzU1V3>.

IN THE STATES

\$5.8 million in cuts to family programs in Hawaii

Budget cuts in Hawaii have targeted programs that help parents who have lost custody of their children due to substance abuse work toward reunification, Maui Weekly reported November 3. The state-funded programs in Maui were cut by Department of Human Services' cuts to Child Welfare Services contracts, with terminations and reductions of funding amounting to \$5.8 million. Other related cuts were to emergency shelter care, interstate child placements, and training and home studies for prospective foster families.

PHARMA NEWS

Nalmefene poised for marketing as alcoholism drug in EU

H. Lundbeck A/S is planning to market nalmefene for alcoholism

Coming up...

The **American Academy of Addiction Psychiatry** will hold its 22nd annual meeting and symposium **December 8-11 in Scottsdale, Arizona**. For more information, go to <http://www2.aaap.org/meetings-and-events/annual-meeting>.

next year, and considering forming a partnership to do so. The sales force for the manufacturer, based in Denmark, may not be big enough to take advantage of the huge market for the drug, the company's chief financial officer told Bloomberg News last week. The company expects to make more than \$460 million a year selling the drug in Europe. It is not approved for the treatment of alcoholism in the United States. And the company is not seeking approval because it would get patent protection for only five years, compared to 10 years in Europe.

NAMES IN THE NEWS

Kenneth E. Leonard, Ph.D., has been named director of the University at Buffalo's Research Institute on Addictions (RIA) in New York, succeeding Gerard J. Connors, Ph.D.,

who stepped down to return to full-time research work at RIA. Connors, whose research is funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), is working on mindfulness-based stress reduction in alcoholism treatment, the role of stress as a factor in relapse, and the importance of the therapeutic alliance in alcoholism treatment. Leonard is currently vice chair for research, and director of the Division of Psychology, and a research professor in the Department of Psychiatry in the UB School of Medicine and Biomedical Sciences. Leonard is studying the role of drinking problems in young married couples and predictors of alcohol-related violence among young adults. He has a MERIT award from the NIAAA.

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In case you haven't heard...

Bloomberg's November 2 article on food addiction begins with a quote by Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA). "The data is so overwhelming the field has to accept it," she said. "We are finding tremendous overlap between drugs in the brain and food in the brain." The article then goes on to cite research, including Volkow's own brain scan research and NIDA-funded research, on the science of food addiction, and shows how this is threatening the fatty and sugary foods favored by so many overweight and obese Americans. Comparing the food industry today to the tobacco industry a generation ago, the article shows how researchers are pitted against the food company lobby, and how addiction is at the heart of both problems. If people like Volkow are able to show now that food is addictive, it could put legal pressure on food companies to make it less so. "People knew for a long time cigarettes were killing people, but it was only later they learned about nicotine and the intentional manipulation of it," said Kelly Brownell, director of Yale University's Rudd Center for Food Policy & Obesity. Moderate obesity reduces life expectancy by two to four years. It's not the sugars and the fats that are bad, the article noted, but the modern processing and refining that creates such concentrated levels without any fiber or nutrients. And these unnatural levels are re-programming the brain to crave more. Exercise addiction, anyone?