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News for policy and program decision-makers



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# SAMHSA issues final rule allowing OTPs to dispense take-home buprenorphine

Opioid treatment programs (OTPs) will soon be able to dispense a month's supply of buprenorphine to patients under a long-awaited final rule issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). Currently, patients must wait one year before they can have a two-week take-home supply of methadone. Under the new rule, the same restrictions apply to methadone, but newly admitted and current patients can initiate or switch to take-home buprenorphine as soon as the rule takes effect, which will be 30 days after it is published in the Federal Register, expected within the next few days.

"These types of requirements impart a burden on patients and may affect their adherence to treatment," SAMHSA said in supplementary information to the final rule, referring to take-home limitations. Daily dosing is required with both methadone and buprenorphine; no take-homes mean the patients must come to the clinic every day, which is beneficial for patients who need additional support but an inconvenience and sometimes a deterrent to treatment for those who do not.

Mark Parrino, president of the American Association for the Treatment of Opioid Dependence (AATOD), was clearly thrilled that, at last, the final rule has been issued. "We've been writing in support of this for more than seven years," he told *ADAW*.

Philip L. Herschman, Ph.D., chief clinical officer of CRC Health Group, which has many OTPs throughout

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## *Treatment Program Profile*

# Vt. hospital program manages planned and unexpected growth

A hospital-based addiction and psychiatric treatment program with roots dating to the 1830s has seen explosive growth over the past three years, with its total staffing jumping from around 500 to nearly 750 employees. Numerous program expansions and new initiatives have fueled some of the growth at Brattleboro Retreat in Vermont, and the devastating flooding that crippled the state in the summer of 2011 played a major part as well.

Brattleboro Retreat is now poised to be one of the three permanent sites for Vermont's state psychiatric hospital patients, in developments that have been in the works since the 2011 floods forced what would eventually become the permanent closure of the Vermont State Hospital complex. Brattleboro Retreat President and Chief Executive Officer Robert Simpson explains that the challenge of managing a high-need patient population amid the organization's other tasks has been an ordeal at times but ultimately a valuable effort for the organization.

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the country, said the change is welcome. "We've already been building the buprenorphine product business, both with Suboxone and generic buprenorphine," he said (generic buprenorphine is buprenorphine without the naloxone). "This just adds to that growth." At CRC, some patients are already starting to switch to generic buprenorphine from methadone, said Herschman.

## Counseling and other services

Citing buprenorphine's safety profile, as well as the experience of OTPs in treating challenging patients, SAMHSA is giving OTPs flexibility in take-homes of buprenorphine only. "The added flexibility will also benefit patients, who should be able to report to the OTP less frequently, while still benefitting from the counseling, medical, recovery and other services OTPs provide."

Nicholas Reuter, senior public health analyst with SAMHSA's Center for Substance Abuse Treatment and the author of the final rule, told *ADAW* that the lack of drug testing, counseling and other services provided by office-based physicians may be one reason for the increased abuse and diversion of buprenorphine. "OTPs take a very, very careful approach," he said.

Under the final rule, OTPs are still required to assess patients before dispensing take-homes, and still required to provide counseling. Office-based physicians who prescribe buprenorphine do not have to do either, the rule noted, suggesting that this was the reason OTPs do not have the 100-patient cap that office-based physicians have.

While there may be an increased risk of diversion and abuse, the Department of Health and Human Services (HHS) said the "benefits of increased flexibility and increased access to care in OTP settings outweighs these possible risks."

> **'OTPs take a very, very careful approach.'**
>
> Nicholas Reuter

In fact, fears of diversion are likely what held up the final rule. Ironically, the delay made it possible to show that diversion — which is increasing and very worrying to officials — existed before OTPs even were approved to dispense buprenorphine. This proved that the office-based system, called office-based opioid treatment (OBOT), led to diversion in the absence of counseling and supportive treatment. Claims that OTP patients would divert buprenorphine take-homes were spurious, said Parrino.

## Methadone vs. buprenorphine

Walter Ginter, project director of the Medication Assisted Recovery Support (MARS) project at the National Alliance for Medication Assisted Recovery, told *ADAW* he is concerned that patients will want to switch to buprenorphine to get the take-homes. "We have already seen this in places where methadone is available through a clinic, and buprenorphine is available through a doctor's private practice," he said. "Some patients switch to buprenorphine and relapse."

Ginter comes from the perspective of having been maintained on both medications. He is currently on a high dose of methadone, and has been for many years. But in the 1990s he participated as a patient in the studies of buprenorphine. He liked it but preferred methadone, reflecting the fact that different medications work better for different patients.

OTPs won't dispense take-homes of buprenorphine — or methadone — unless a patient is ready, said Herschman. Regardless of what a patient "wants," if the patient isn't ready for take-homes, he or she won't get them, he said.

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According to Tim Baxter, M.D., global clinical director of Reckitt Benckiser, which makes Suboxone, there is no "segmentation" of patients in terms of buprenorphine and methadone. "That's a myth," he said. "There is no difference in efficacy." Baxter thinks buprenorphine should be the drug of first choice, and if patients fail on that, they can then move to methadone or some other kind of treatment.

Baxter said that patients do experience a subjective difference. "What we hear almost universally is when patients switch from methadone, they describe it as coming out from underwater," he told *ADAW*. "They say they have a lot more clarity. Some people don't like it and go straight back to methadone."

However, Parrino and Ginter disagreed strongly with Baxter on the patient reaction issue. "It is completely and clinically inappropriate for anyone to suggest that patients should start with buprenorphine," said Parrino. "And while some patients have said they have a subjective preference for buprenorphine, as they switch, because they don't feel a sedated effect, others have not made that claim."

There is a protocol for switching (see SAMHSA's *TIP 40*, pp. 53-55, http://1.usa.gov/TdFMij), but in general, it will be difficult unless patients are on low doses of methadone — about 65 milligrams of methadone is the highest dose someone could be maintained at before switching, said Parrino.

## Growth

Herschman said it was impossible to predict how many additional patients will come to OTPs as a result of the available of immediate take-home medication, and stressed that they can't assume they will be able to get it.

"I would be surprised if patients stream into OTPs for buprenorphine and they all get 30-day take-homes," said Parrino. First, the rule requires that OTPs assess patients for appropriateness of take-home medication. In addition, there are other impediments to real-world adoption — notably, state regulations.

"SAMHSA had to issue this Federal Register notice as the first step," said Parrino. "Now the states will have to follow." In addition, many states do have Medicaid reimbursement for buprenorphine prescribed by office-based physicians, but that doesn't necessarily mean they will reimburse it in an OTP, said Parrino. Suboxone is very costly, especially now that it is available only in film (see *ADAW*, October 1).

"The real step will be to allow people to use methadone in a clinic the same way," said Herschman. "Requiring a patient to come in every day is absurd."

OTPs, like office-based physicians, also have the option to use generic buprenorphine, which does not contain naloxone, said Reuter, although CSAT "encourages" the combination product. Naloxone is what makes it impossible for people to get high by melting down and injecting the buprenorphine.

The publication of the final rule also signifies a rapprochement between OTPs and Reckitt Benckiser, between whom a tension has existed since the early days of the development of buprenorphine, under federal auspices, in the 1990s. The OTPs and Reckitt, the sponsor of the medication, each saw the other as a competitor, trying to keep business or take away business from the other. "This has been a long and winding process, and even my patience has been sorely tested," said Parrino.

"Clearly this is something that we welcome, because it increases access to patients," said Baxter. "We don't know at this stage what the demand will be," he said. "We're not in the methadone business. We're not in competition with methadone." •

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The final rule was signed by SAMHSA Administrator Pamela S. Hyde on February 23, and by HHS Secretary Kathleen Sebelius on March 8, after which it went to the Office of Management and Budget for review. It was submitted to the Office of the Federal Register on November 30 and takes effect 30 days after publication in the Federal Register. For the text of the final rule, go to http://1.usa.gov/12nG4XY.

# Program to screen staff for relapse risk after DUI tragedy

In the wake of a terrible tragedy, David Lisonbee, president and CEO of Twin Town Treatment Centers, is going to start asking all of his employees to fill out a questionnaire aimed at detecting the risk of relapse. The tragedy ended with one death, one employee in jail, and, for Lisonbee, a soul-searching quest for the most responsible next step.

On November 25, the world changed for Lisonbee and for two other people — Sherri Lynn Wilkins, a substance abuse counselor at the agency, and Phillip Moreno, who was killed when Wilkins' car allegedly ran into him (see *ADAW*, Dec. 3). She ended up driving with Moreno pinned to the windshield for two miles. Wilkins, whom Lisonbee had thought was in recovery for 11 years, was charged with driving while intoxicated and ultimately with murder. The incident occurred when the outpatient program was closed and on Wilkins' day off. The victim was not affiliated with the program.

The story is one that can easily trigger fears in treatment programs, where many staffers and officials are in recovery. Lisonbee, whose program is based in Los Alamitos, California, reached out to other treatment providers on a LinkedIn group, looking for information about a standard-

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ized tool to identify relapse risk. The interchange, which Lisonbee shared with *ADAW*, reflects a degree of respect and support that sometimes seems missing in the field, he said. "I often think of the addiction treatment field as needing some collegiality and cohesiveness," he told *ADAW*.

## LinkedIn responses

One of the responses included a recommendation to use the *AWARE* (*A*dvance *WA*rning of *RE*lapse) *Questionnaire* by Miller and Harris, adapted from Gorski and Miller, and this is the questionnaire that Lisonbee will use. The National Institute on Alcohol Abuse and Alcoholism funded its development, and it is in the public domain (go to http://bit.ly/ZlI1VY).

The *AWARE Questionnaire* was designed as a measure of the warning signs of relapse, as described by Terence Gorski (Gorski and Miller, 1982). It was revised from 37 to 28 items in 2000 (Miller and Harris).

Other responses highlighted the fact that treatment program administrators — like all employers — do not have total control of everything, even if they wish they did. One said: "Forecast relapse? What would you do if someone scored as a high risk for relapse? Sew his mouth shut? Lock him in a room?"

And Lisonbee's response honed in on the fact that employers can't control people outside the workplace. "As told in the 'Big Book,' as practicing alcoholics we wanted to be the directors of the show; when things ran against our wishes, we couldn't handle the reality that we aren't in fact in control of the show or its actors. The freedom of recovery is in part accepting such realities. We don't live under external controls, thank God, and freedom is what we in recovery have worked so hard to achieve. Tragically, in some situations, freedom comes with some risk."

## Supervision

Another important approach is clinical supervision, said Michael Flaherty, Ph.D., a clinical psychologist in Pittsburgh who ran the St. Francis Medical Center's Institute for Psychiatry and Addictions for 26 years. "I loved my staff who were in recovery," he told *ADAW*. "They — and my nurses — were the backbone of our treatment." However, all staffers were kept under "close clinical supervision," he said. Supervisors "made sure they were never emotionally overwhelmed by the numbers of people or issues they dealt with."

Unfortunately, clinical supervision is grossly inadequate today because it is not reimbursed, said Flaherty. However, it was worth it, and when staffers did show that they needed a break, they were moved temporarily to a less stressful position, not working directly with patients, he said. The program also required that people be in recovery for two years before being hired, and that they remain in a documented recovery program, he said.

**'I think that many in the field are sophisticated to the behavioral cues and successfully disguise relapse and denial.'**

David Lisonbee

"Creating workplaces where employees know that self-care is a priority is very challenging," said Pat Taylor, executive director with Faces and Voices of Recovery. She said what happened was a tragedy. "We mourn this tragic loss of life," Taylor said.

## Hiding cues

If someone wants to hide the fact that he or she is relapsing, nobody is better equipped to do this than a trained substance abuse counselor who knows what not to do.

What Flaherty recommends — a period of recovery and clinical supervision — is Twin Towns' policy, said Lisonbee. "Wilkins allegedly had 11 years sober, and burnout or other signs of relapse weren't detected by any of her closely affiliated co-workers and supervisors," he told *ADAW*. "I think that many in the field are sophisticated to the behavioral cues and successfully disguise relapse and denial."

"We all always recognized the illness was chronic in nature and without sufficient safeguards could return at anytime," said Flaherty. "We also saw and valued the unique value of those in recovery to others seeking to find it. We need to respect that and do what is necessary both for the healer and for those seeking to be well."

Lisonbee plans to use the *AWARE Questionnaire* "at hire and periodically throughout counselor employment," he said. "If nothing else, it may provide each individual a chance at contemplation and consideration." •

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"The state rewarded us with money to renovate our unit for these patients," Simpson told ADAW. He recalled, "The state hospital people called us that August, and at 9 at night I'm on a bus with 18 [state hospital] patients, handing out chocolate chip cookies and moving them to our site."

Partnerships have been at the heart of much of Brattleboro Retreat's overall expansion in recent years, in efforts ranging from alliances with local insurers to development of a specialized program for uniformed service personnel.

Simpson also credits the work that his leadership team is doing with the help of Massachusetts-based consultant Linkage, Inc. Under this effort, Brattleboro Retreat vice presidents, physicians and nursing staff are be-

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FROM THE FIELD

# Where recovery residences fit in health care reform

**By Beth Fisher**

Recovery residences have become a vital component in the addiction services spectrum, particularly as addiction recovery services have evolved from a short-term acute-care model to one that promotes sustained recovery management over extended time. With the advent of implementation of the parity law and the Affordable Care Act (ACA), there will be greater access to services through the healthcare system, longer-term monitoring and maintenance strategies, and efforts toward teaching and promoting self-care. Recovery residences are perfectly suited to accommodate these changes; quality recovery residences provide a safe, healthy, cost-effective and community-based opportunity for facilitating recovery at all stages of the recovery process.

Recovery residence is a broad term that encompasses a full spectrum of housing ranging from the democratically operated "sober home" to the clinically overseen "extended care." Recovery residences at all levels provide a viable setting for initiating and sustaining long-term recovery. They are desirable in their (1) emphasis on structure and community in a recovery setting, (2) service provision over a longer period of time and (3) cost-effectiveness. It is noteworthy that these attributes are also key elements of the healthcare reform initiative.

Significant changes regarding the nature of services available to persons with substance abuse disorders are expected as a result of parity and the ACA. There will be greater access to services through the healthcare system, as well as longer-term monitoring and maintenance strategies. Additionally, there will be efforts toward education, self-care and innovative utilization of community services, all of which complement recovery residences. Quality recovery residences offer affordable choices that support outpatient and other forms of community-based treatment and recovery services.

Most recovery residences are self-funded through resident contributions; recovery residences with higher levels of support, such as those that provide a range of clinical services as part of the residential modality, can receive other forms of federal, state and private funding. However, services of a medical or clinical nature are most often referred out or contracted by recovery residences. Effective recovery residences are adept at identifying and partnering with appropriate collateral resources for their residents in terms of recovery and medical services.

Two key mandates of the ACA are to (1) introduce new innovations that bring down (healthcare) costs and (2) encourage integrated health systems. Recovery residences have long utilized an integrated approach and community model for service provision. Until recently there has been limited documentation about recovery residences, and the model is only just now emerging as an accepted component in the professional continuum of recovery services. For this reason, it may seem a "new innovation" in the behavioral health spectrum.

Another ACA mandate is to increase access to affordable care. Recovery residences are benefiting from this through collaboration with two impactful recovery resources. Recovery coaches are increasingly used in recovery residences, particularly as Medicaid has broadened its base of reimbursable services to include recovery coaches in many states as a result of the ACA. Recovery coach services are highly compatible with all levels of recovery residences, and are a valuable resource for support and accessing community resources.

Another effective implementation of the ACA is the pairing of a recovery residence with outpatient treatment services. Outpatient centers are an increasingly funded modality in behavioral health due to their cost-effectiveness and sustainability of services over a longer period of time. Nonclinical recovery residences will have greater access to outpatient treatment services as ACA implementation progresses.

It will be important for all recovery residence providers to begin implementing outcome studies into their protocol of operations. ACA-funded programs must demonstrate data collection pertaining to outcomes and demographics of those served. While most levels of recovery residences are not presently at the table for funding consideration through the ACA, if it is ever to be a reality, there must be demonstrated program efficacy. Studies on recovery residences, in particular Oxford Houses, have shown promising results indicating a wide variety of persons benefitting from recovery residences. These studies must be expanded on by all levels of recovery residences.

*Beth Fisher is the current President of the National Association of Recovery Residences, www.narronline.com. She is also the founder and executive director of Hope Homes, Inc. a level 3, supervised recovery residence organization in Atlanta, Ga., Charlotte, N.C., and Greenville, S.C. (www.hopehomesrecovery.org). Contact her at beth.fisher@hopehomesrecovery.org.*

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ing trained in nine core skill sets designed to help them become better leaders to shepherd their staffs through organizational change.

"Without this, I don't think we could have handled the growth," Simpson said.

## Diversity of services

Brattleboro Retreat was originally established as a psychiatric facility in the 1800s after its benefactor left $10,000 in her will for an organization to take care of individuals with mental illness. Simpson said that substance abuse services have been a major part of the organization's service mix for about 30 years, and now most people refer to Brattleboro Retreat as a regional tertiary care hospital for addictions and mental illness.

Some of the organization's addiction services are centered around a 21-bed dual-diagnosis unit. Much emphasis is placed throughout the organization on integrated behavioral healthcare, as well as on integrating behavioral health and primary care services. The latter approach has led to one of Brattleboro's most recently finalized partnerships, with Blue Cross and Blue Shield of Vermont.

Under the Vermont Collaborative Care initiative, which was announced last summer, Brattleboro Retreat is assisting in managing the behavioral health needs of Blue Cross plan members. This builds on other existing initiatives at Brattleboro Retreat, which also has served as a management services organization for another insurer in the state.

Simpson says he is a firm believer in the whole-health approach to delivering services. "We do put our heads on top of the rest of our bodies each morning," he joked. "You have to think always about the whole person."

In another Brattleboro Retreat initiative that has captured a great deal of attention in recent months, the organization built on longstanding experience in serving members of the military and first responders by establishing a formal Uniformed Service Program. The initiative is headed by a former member of a police SWAT team.

### *Brattleboro Retreat*

***Location:*** *Brattleboro, Vermont*
***Founded:*** *1834 (originally established as psychiatric facility)*
***Services:*** *149-bed licensed hospital, including 21-bed dual-diagnosis unit; outpatient services include buprenorphine services for opiate addiction*
***Employees:*** *740*
***Revenue Mix:*** *About 55 percent Medicare/Medicaid and about 45 percent private insurance/self-pay*

"The Retreat has been treating service members since the Civil War," Simpson said. "Our program is really a partial hospital program, although some of the patients may need to start in inpatient care for detox. We purchased a mountaintop inn in Brattleboro and use it to house patients."

> **'You have to think always about the whole person.'**
>
> Robert Simpson

The Uniformed Service Program emphasizes helping patients learn skills to cope with traumatic experiences. It employs the cognitively based Acceptance and Commitment Therapy (ACT) approach that has become widely used in veterans' programming, Simpson said.

Also last summer, the Verizon Foundation gave a boost to this program's ability to deliver ongoing support by offering $15,000 to launch a mobile aftercare pilot project. This involves giving Uniformed Service Program participants access to an online portal, through the Retreat's website and use of a mobile app, in order to receive information on wellness strategies and on mindfulness techniques for stress management.

The Retreat also reports that it has seen success in helping to combat the state's opiate addiction problem through use of buprenorphine treatment and psychosocial support over the past several years. Simpson said the organization has sought to partner with community-based providers in an effort to make buprenorphine treatment more widely available to individuals across Vermont and from out of state.

## Moving parts

Seeing about 10,000 patients a year in a variety of inpatient and outpatient programs, Brattleboro Retreat certainly has become used to juggling priorities over the years. That process intensified last year when the state came calling for sites to house displaced Vermont State Hospital patients.

Simpson explained that in order to accommodate the state hospital population in the short term, the organization opened up space in its unit for LGBT patients, moving these patients to scattered sites across the hospital campus. It then gradually worked through the process of renovating the former LGBT unit to meet the needs of the seriously mentally ill population.

"We've admitted over 270 patients since the Vermont State Hospital closed," Simpson said. "We've played a significant role in helping the state."

Flexibility has been crucial to these efforts, and Simpson said the organization is trying to take a similar approach to the uncertainties surrounding the impacts of Affordable Care Act (ACA) implementation and state reform efforts. It is working with other large healthcare entities in the region for the establishment of accountable care organizations and other reform-friendly initiatives, Simpson said. •

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# Bill White 'retiring' but will continue work in the field

The legendary William L. (Bill) White, senior research consultant at Chestnut Health Systems, is retiring — but being who he is, he will stay involved in the field, supporting it financially. White's body of research has helped move the field to a focus on recovery, instead of just on treatment.

"I am retiring to a research associate emeritus position at Lighthouse Institute, the research division of Chestnut Health Systems, as of January 14, 2013," he wrote *ADAW* in a December 10 email. "The unpaid emeritus position will provide continued research assistant and tech support that will allow me to continue selected recovery research projects and my recovery advocacy writing without the pressure for income generation of a full-time position."

This "retirement" will allow White to "continue selected contracts while diverting some of the fees for this work to Faces and Voices of Recovery and other recovery advocacy organizations," he said. "I think of this as a way of tithing time to the recovery advocacy movement."

Encomiums from many people in the field poured in to Chestnut, which was putting them together for a December 12 retirement reception. Meanwhile, *ADAW* contacted experts for exclusive quotes as well.

Alexandre Laudet, Ph.D., senior staff with National Development and Research Institutes in New York City, wrote to *ADAW* that White "single-handedly put recovery on the map of addiction services discourse and, subsequently, services." White, she said, "had the vision, the courage and the dedication to build on his own experience and training to inspire and lead what has become a national grassroots movement and a key stakeholder group in policy discussions." She added that his writing has "chronicled and guided the recovery movement and will continue to do so."

Michael T. Flaherty, Ph.D., a clinical psychologist who founded the Institute for Research, Education, and Training in the Addictions, wrote in his official comment: "Simply put, no one mortal person has meant more to those who suffer or suffered addiction than you — period." Citing White's "transformational work as a historian, researcher, speaker and courageous fellow human being has brought the understanding and acceptance of this illness and the pathways of recovery from it to many more in this country and around the globe," Flaherty said that he can't wait for "new steps"

Continues on next page

## Study: Binge eating in teens associated with initiating drug use

Adolescents and young adults who binge eat may also be more likely to start using marijuana and other drugs, according to a study published December 10 Online First in the *Archives of Pediatrics & Adolescent Medicine*.

In the current (*DSM-IV*) edition of the *Diagnostic and Statistical Manual of Mental Disorders*, binge eating is defined as eating more food than most people would eat and feeling a lack of control during the binge. With overeating, there is no loss of control.

For the study, Kendrin R. Sonneville, Sc.D., R.D., of Boston Children's Hospital, and colleagues looked at the association between overeating and binge eating, and various adverse outcomes such as being overweight/obese, depressive symptoms, binge drinking, and marijuana use and other drug use.

The researchers found that 29 percent of adolescents who were binge eaters or overeaters used marijuana later, compared to 17 percent of adolescents who never went on eating binges.

The researchers aren't sure why the association is there. It's possible that whatever impulse leads them to binge eat also leads them to try marijuana, but it's only a theory, Sonneville told National Public Radio December 11. "There's something that may have even preceded the binge eating episode," she said. "We don't know if the binge eating is the start of the chain." The loss of control is "terribly distressing," Sonneville said. Binge eating isn't like eating too much of something delicious — the feeling is so unpleasant because the person wants to stop eating but can't.

Binge eating isn't diagnosed unless it occurs frequently and regularly.

The three-way relationship between binge eating, drug use and depression needs more research, said Sonneville. But she pointed out that in addition to focusing on the eating habits of obese children, it's important to watch for the more nuanced problems of binge eating.

The study was based on the *Growing Up Today Study*, which looked at 16,882 boys and girls who were 9 to 15 years old in 1996 and given questionnaires every 12 to 24 months between 1996 and 2005.

The study found that 2.3 to 3.1 percent of females reported binge eating between the ages of 16 and 24, compared to 0.3 to 1 percent of males.

The researchers found that any overeating, with or without loss of control, predicted the onset of drug use. They also found that binge eating, but not overeating, predicted the onset of being overweight/obese and worsening depressive symptoms.

Neither overeating nor binge eating was associated with initiating regular binge drinking.

Continued from previous page
White will take.

In his comments, prepared for the Chestnut document and directed at White, Flaherty wrote, "Thank you mostly for many, many others whose faces and names you will never know but whose lives have been salvaged by your work — and that silent gratitude is without any doubt the highest gratitude a man can earn."

Pat Taylor, executive director of Faces and Voices of Recovery, saluted White's "passion for building the growing recovery advocacy movement" and credited his "groundbreaking contributions to understanding the reality of recovery."

And Mark D. Godley, Ph.D., director of research and development at Chestnut Health Systems, in an email to *ADAW*, wrote that in addition to his work at Chestnut, which he joined in 1973, White "has been a creative researcher in the addictions field and a prolific author." He encouraged *ADAW* readers to go to www.williamwhitepapers.com to view White's work.

White hopes to keep generating recovery-focused research and writing and to "gracefully disengage from the field before I become too decrepit to make further contributions," he said. "This may sound like a strange retirement, but I have loved my work in this field and look forward to my continued involvement in this new role."

So do we. •

## Resources

### NSDUH data now available for public use

Data from the National Survey on Drug Use and Health (NSDUH) are now available for online analysis from the Substance Abuse and Mental Health Services Administration (SAMHSA) using the Restricted-Use Data Analysis System (R-DAS). Users can obtain two-year estimates for 2002 to 2003, 2004 to 2005, 2005 to 2006, 2006 to 2007, 2008 to 2009, and 2010 to 2011 using this system. Available variables include: state codes to allow for state-level analyses, detailed race/ethnicity, country of birth and age of first use. Four- and eight-year estimates are available as well. For a FAQ on how to correctly generate estimates, go to http://bit.ly/VEKpA9.

Go to the Substance Abuse and Mental Health Data Archive (SAMHDA) at http://bit.ly/Te1uTl for the two-year R-DAS study home page. SAMHDA is sponsored by SAMHSA's Center for Behavioral Health Statistics and Quality.

## Coming up...

The 9th Annual Medical-Scientific Conference of the **New York Society of Addiction Medicine** will be held **February 1-2, 2013** in **New York City**. For more information, go to **www.nysam-asam.org**.

The **Community Anti-Drug Coalitions of America** 2013 Leadership Forum will be held **February 4-7, 2013** in **National Harbor, Maryland**. For more information, go to **www.cadca.org/events/detail/2013-national-leadership-forum**.

The **Evolution of Addiction Treatment** Conference will be held **February 7-10, 2013** in **Los Angeles**. For more information, go to **www.theevolutionofaddictiontreatment.com**.

## Obituary

### Alcoholism treatment pioneer Riley Regan dies

**Riley Regan** died December 7 at the age of 77. The cause was liver cancer. A hero to the alcoholism recovery movement, his list of contributions to the field is extensive. He was founding director of the New Jersey Division of Alcoholism; helped to decriminalize public drunkenness; was executive director of the New Jersey Governor's Council on Alcoholism and Drug Abuse; was on the faculty of the Rutgers University Center for Alcohol Studies; served as deputy state director of the Maryland Alcoholism Control Administration, deputy director of the National Center for Alcohol Education, president of the National Association of State Alcoholism and Drug Abuse Directors, a member of the National Institute on Alcohol Abuse and Alcoholism's National Advisory Council and director of the New Hampshire Division of Alcohol and Drug Abuse Prevention and Recovery; and was the "professor and profound pundit in the field of alcoholism prevention and treatment for decades," said David H. Kerr, Integrity House president. Regan's "unflappable spirit, collegiality and charisma caused the critical, and at the time, unlikely, merging of the fields of alcohol and drug treatment in the state of New Jersey," Kerr said.



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

From the "boggles the mind" department: The latest fashion from Mary-Kate and Ashley Olsen: a backpack made out of black patent crocodile skin and appliqued with various multicolored prescription pills. Only 12 will be made. They will cost $55,000 each. On the bright side, some of the proceeds will go to UNICEF.