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News for policy and program decision-makers



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## In This Issue...

Why do some patients need to keep going back to treatment before they finally recover, with no more relapses? Federal officials, researchers, and treatment providers have different answers — not enough use of medications, too much reliance on medications, treatment doesn't last long enough, 12 steps aren't stressed. But the basic problem seems to be one of continuing care: if addiction were treated like another chronic disease, diabetes, there would be followup after a treatment episode.
. . . *See top story, this page*



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# Multiple relapses and SUD treatment: What's going wrong?

In the treatment field, it's well known that patients relapse. Some patients need to go to treatment many times before they recover. *ADAW* asked leaders in the field to comment on this phenomenon and got a surprisingly diverse set of answers to the question: "What's going wrong?"

Because addiction is a chronic disease, a relapse is not a treatment failure, according to the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

A. Thomas McLellan, Ph.D., CEO and co-founder of the Treatment Research Institute (TRI), said diabetes is a perfect example. He cited the massive Look AHEAD study funded by the National Institutes of Health that found that 40 percent of morbidly obese patients with hypertension and diabetes for whom insulin and other medications weren't working were able to reverse their diabetes by walking 30 minutes a day and losing 15 pounds.

**Bottom Line...**
*Treatment providers need to use all the tools at their disposal — behavioral therapies, medications, and long-term care management — if they are going to provide optimal care to substance use disorder patients. Even then, there will be relapses.*

See **Relapse** page 2

## *The Business of Treatment*

# When entering a new market, don't take success for granted

B$T

As with stocks and bonds, past business performance in the addiction treatment market doesn't guarantee future returns. A treatment center that expects its name alone to bring forth success in a new geographic location might encounter some harsh realities about differing payer relationships, unfamiliar community needs and unforeseen competitive pressures.

Compounding the issue for many addiction treatment organizations that seek to expand to a new location is a relative lack of sound data for reliable market research.

"It's more challenging in substance abuse treatment to locate new facilities," Ann Bray, vice president of strategic initiatives at Hazelden, told *ADAW*. "The databases are more mature in acute care because of Medicare. In acute care you know the market share of your competitors."

Bray explained, "Things are not

**Bottom Line...**
*Identifying community needs and building relationships with local leaders are among the challenges that even the most prominent treatment facilities encounter when they seek success in a new geographic market.*

See **Location** page 5

**Relapse** from page 1

"Radical lifestyle change is what they called it," McLellan told *ADAW*. It was done with case managers, personal counselors, and family and patient support. "It sounds like recovery to me," McLellan said.

## Continuing management

While counseling an obese person to lose weight and exercise sounds like common sense, the medical system is structured around medication and surgery — or it used to be, said McLellan. The Affordable Care Act is changing that. "All of medicine is rethinking its approach to illness, especially chronic illness," he said.

Meanwhile, in the substance use disorder (SUD) field, addiction was not originally recognized as a chronic illness, and there was little formal medicine or medications, he said. "We applied the tools we knew about — behavioral change through counseling, behavioral change in families, behavioral change in working with groups of peers who have the same illness."

And in reality, although everyone pays lip service to the chronic disease notion, most treatment programs still treat it like an acute illness, said Phil Herschman, Ph.D., chief clinical officer for CRC Health Group. "We're treating it like a broken leg, not like a chronic disease," he told ADAW. "You walk in the door for treatment and when you walk out the door, you should be abstinent and everything's fine," he said. "We measure you six months later, and you're not fine."

In diabetes, there are disease management concepts so that patients are monitored after an episode of care. "If they stopped their treatment, of course they'd have a treatment failure," said Herschman. "With a chronic disease, there can't be just an episode of care; there has to be lifestyle management."

At CRC facility Sierra Tucson, a new experiment based on chronic disease management was launched this month. "This is a paradigm shift," said Herschman. "Now when people get admitted, they're not just coming in for a 30- or 35-day episode of care; they're coming in for that and for one year of case management. We're not providing treatment; we're providing case management." Each patient will be discharged with a continuing care plan that will include contacting the follow-up providers wherever the patient lives. Research shows that participating in this case management means patients are 90 percent more likely to be abstinent a year later, compared to a 40 percent chance if they do not, said Herschman.

If the Sierra Tucson experiment works, CRC will expand it to other programs. So far, the biggest problem has been convincing insurance companies to pay for it, said Herschman. "When I talk to the payers, especially the medical directors, nobody argues with the concept, but nobody understands how to pay for it yet," he told *ADAW*. "When you think about healthcare reform, it's really a push for this kind of treatment. Addiction is defined as a chronic disease, and the benefit that's written into healthcare reform is an outpatient benefit."

## A menu of treatments

Raye Litten, Ph.D., associate director of the NIAAA Division of Treatment and Recovery Research, said that alcoholism isn't a single disease, so there isn't a single treatment that will work for everyone. "It's a heterogeneous disease, and because of that we're going to have to come up with a menu, or perhaps a combination," he said. "To be honest, even if a treatment facility could use all of the medications that look promising, and had all the behavioral therapies that have shown effectiveness, there are still some people who wouldn't respond."

So far, there are four medications approved for the treatment of alcoholism: oral naltrexone, injectable naltrexone (Vivitrol), acampro-

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sate and disulfiram. While these do not work for everyone, when they do work, "it's dramatic," said Litten. "It takes away craving and the urge to drink."

An important area of NIAAA research for the next 10 years is "personalized medicine," which enables clinicians to identify patients who will respond to certain types of treatment, said Litten. For example, Bankole Johnson, M.D., is looking at ondansetron, a now off-patent medication for the treatment of nausea, which certain alcoholics respond to based on their genetic variance, said Litten. Research is still in the early stages, but it appears that 34 percent of alcohol-dependent patients respond to ondansetron, Litten said.

## Opposition to medications

Lack of medication use is an endemic problem in treatment programs; it was actually major news last year when Hazelden announced that it would start using buprenorphine — cautiously (see *ADAW*, November 12).

In fact, many treatment centers don't use medications, and Burning Tree Recovery Ranch, which bases its reputation on treatment of hard cases including frequent relapsers, completely eschews them, and blames lack of spirituality and AA for the relapses.

"On a basic level, what I believe and what the treatment centers I work for believe is that most failures are a result of a client or an individual not having actually worked all 12 steps, and having a spiritual experience as a result of working all 12 steps," said Heidi V. Smith, clinical director of the Kaufman, Texas-based program. "We believe that's what's missing, especially in the shorter-term programs where it's impossible to complete all 12 steps."

The Betty Ford Center doesn't use medications either but does strongly support better training and long-term treatment. John Schwarzlose, CEO of the Betty Ford Center, attributes the problem to lack of trained staff. "Numerous programs, large and small, have unqualified staff working in important positions," he said. "It is simply crazy, and who suffers is the alcoholic/addict and their loved ones seeking help." The field needs to "raise the bar and clearly state what is required to be a frontline counselor," he said. "How much education and training?" A physician working in a treatment center should be certified in addiction medicine, and nurses should be trained in addiction, he said. "Some of the best-known programs in the United States have hired their own patients within six to 18 months of sobriety to be counselors or technicians. This is unacceptable," Schwarzlose said.

**'To be honest, even if a treatment facility could use all of the medications that look promising, and had all the behavioral therapies that have shown effectiveness, there are still some people who wouldn't respond.'**

Raye Litten, Ph.D.

## Lack of information

Litten sympathizes with the need to get better information out to patients about treatment options. "You can see the frustration," he told *ADAW*. "One person called me who was a former state trooper, and said he couldn't stop drinking, had tried AA and all sorts of things. I asked him if he tried naltrexone, and he didn't know anything about it." The man went to his physician, who told him he wouldn't prescribe it because he didn't think it would work. He called Litten back, who was outraged and told him he would find someone to prescribe it for him if necessary. "The man found someone and it worked — he called me saying he was a changed man," said Litten.

McLellan related the story of a man who has spent at least $100,000 on five different treatments for his son, who is addicted to opioids. "The kid always did well while in treatment but relapsed in days to weeks after he got out," said McLellan. The man — a university professor — had not heard of naltrexone, said McLellan. "Not one of those programs had told him about it," he said.

If the son had had AIDS, the father would have known whom to call for information. "But he didn't know where to get help for this," said McLellan, noting that the man called him not because of some paper he had written, but because of the "strange underground of people who have lost their children to addiction." (McLellan's son Beau died of an overdose in 2009.) "I'm not saying he should have been on Vivitrol. I'm saying we have a lot of tools and we need a comprehensive approach by educated people so that a patient could actually get access to some of this treatment and get it applied under a chronic care approach," he said.

McLellan said everyone's responses to our question were "partly right." And there were two areas that everyone completely agreed on, including McLellan: that the longer an episode of care is, the better a patient does, and that if insurance would reimburse SUD care management the way it reimburses diabetes care management, this model would be more likely to take hold. •


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# ASAM Criteria: New edition about much more than placement

Twelve years in the making, the third edition of the American Society of Addiction Medicine (ASAM) guidelines for determining what kind of treatment patients need will be out in October, and there are several changes. The title is new: no longer will they be called the "ASAM Patient Placement Criteria," but just the "ASAM Criteria."

"That's what everyone calls them anyway," said Michael M. Miller, M.D., past president of ASAM and medical director of the Herrington Recovery Center at Rogers Memorial Hospital in Oconomowoc, Wisconsin. "And it's about much more than placement," he said.

Originally developed by the National Association of Addiction Treatment Providers (NAATP) and given to ASAM in 1991, the criteria have been revised with the help of David Mee-Lee, M.D., who is senior vice president for The Change Companies. The first edition was published in 1991 and the second in 1996; the second was revised in 2001.

Miller talked to *ADAW* about the new edition last week after presenting it at the annual meeting of the National Association of Addiction Treatment Providers (NAATP) in San Antonio.

## Other changes

In addition to the name change, there are many other changes in the new edition:

- ***No separate adolescent criteria:*** Since the first edition was published in 1991, there have always been two set of criteria — one for adults and one for adolescents. The new edition will have only one set of criteria, with points included that reference adolescents where necessary. "Twenty years ago the thinking was that adolescents would need residential treatment more often than adults," said Miller. "Kids are particularly vulnerable — neurologically vulnerable.They often have problems with social skills; they don't live independently," he said. But the recovery environment for adolescents has changed, he said.
- ***"Dual diagnosis" changed to "co-occurring":*** This reflects the fact that there can be co-occurring medical as well as psychiatric conditions, along with addiction, said Miller. "Addiction care was stuck in behavioral health when the carve-out phenomenon began," he said. "Dual diagnosis is an inside baseball term. As we move more toward integration, we're going to need to talk more the language of general medicine."
- ***"Detoxification" changed to "withdrawal management":*** The new criteria recognize and

## Florida Experts condemn Florida task force approach to drug-exposed newborns

Earlier this month four leading experts in law, medicine, and addiction treatment, Robert G. Newman, M.D., Lynn M. Paltrow, Sharon Stancliff, M.D., and Mishka Terplan, M.D., released their analysis of the final report issued by the Florida Statewide Task Force on Prescription Drug Abuse and Newborns. The analysis urges the state "to give greater attention to existing well-established medical protocols and to address the needs of pregnant women," including the need for greater access to medication-assisted treatment that isn't linked to child welfare investigations and other punitive interventions. "We are very concerned that this report — one that will influence policy in Florida and that may be relied upon by other states — uses language and makes findings that perpetuate misinformation about NAS, pregnant women, and opiate use," said Newman, adding "the report contains views on treatment for pregnant women and newborns with NAS that do not reflect known, medically tested treatment protocols." The report from Florida has several problems, including the "conflation of drug-exposed newborns with those actually diagnosed with NAS," according to the Newman group. In addition, the task force report acknowledges but fails to address barriers to care and treatment; suggests public awareness campaigns that stigmatize pregnant women and use inaccurate language; and is based on work done by people who are not experts in opioid dependence. For the Florida task force report, go to http://myfloridalegal.com/webfiles.nsf/WF/RMAS-94LJPF/$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf. For the Newman group's full analysis, go to http://advocatesforpregnantwomen.org/main/publications/articles_and_reports/florida_statewide_task_force_on_prescription_drug_abuse_newborns_february_2013_final_report_an_inadequate_assessment_of_the_needs_of_women_children_and_families.php. In a related matter, Newman and more than 40 others released an open letter calling on the media to stop referring to drug-exposed newborns as "addicted." Pregnant women who are taking opioids — either because they are in methadone treatment or are being treated for pain — may deliver babies with neonatal abstinence syndrome, which is treatable, and that withdrawal would be harmful or lethal to the fetus. For that letter, go to http://idhdp.com/media/32950/rnewmanopenexpertletter_-_3.11.13.pdf. Also see *ADAW*, May 7, 2012.

 

describe ways that detoxification can be done safely on an inpatient basis. "We should always look at the patient first," said Miller. "Patients can do well with outpatient treatment."

- ***Roman numerals to Arabic:*** Instead of denoting the levels of care by Roman numerals, Arabic numbers will be used so there can be subdivisions that are more readable.
- ***Four special populations:*** There will be four special populations with their own sections: (1) older adults, (2) people such as physicians in safety-sensitive occupations, (3) parents with children and pregnant women, and (4) people in the criminal justice system. "We recognize that the monitoring programs who work with physicians, and sometimes law enforcement personnel, have more intensive levels of care," said Miller. For example, intensive outpatient treatment may be recommended for someone who is not a physician, but a physician with the same clinical presentation would probably be required to go to inpatient treatment, and be monitored for an extended period of time.

Additional changes include:

- real examples of how to apply the criteria;
- detailed information on gambling and tobacco disorders; and
- "opioid maintenance therapy" changed to "opioid treatment services."

## User-friendly

The ASAM Criteria have always been an "expert consensus document," with a field review process, said Miller. The group that Mee-Lee started in 1992 — the Coalition for National Clinical Criteria — along with ASAM, solicited field reviewers and met with employers, managed care and the public sector, said Miller. "The vision has always been to have a set of criteria that was consensus-based on a national basis so that many people would adopt this," he said. But the vision of universal adoption has yet to be realized, he said. Many payers use their own criteria or the InterQual criteria from McKesson.

**'As we move more toward integration, we're going to need to talk more the language of general medicine.'**

Michael M. Miller, M.D.

That may change with the arrival, at last, of software for use of the ASAM Criteria, said Miller. The software, which will be released in October as well, will allow providers "to do a structured interview and have it produce a report that includes an assessment of a patient along the six dimensions, and spit out a diagnosis that aligns with DSM," he said. The report can be transmitted electronically as well, to become part of an integrated electronic health record. The Substance Abuse and Mental Health Services Administration supported the software development, which will be open source, said Miller.

In addition, the release of the new criteria is timed to be available when healthcare reform goes into effect, including the implementation of parity.

The Change Companies is going to work with provider systems, managed care systems and public-sector systems on bulk purchasing.

Because of ASAM's partnership with The Change Companies, the new edition will also have "lots of user-friendly interfaces," said Miller. "We think the users are going to find it a much more useable document with a better flow."

The final piece of readying the manuscript for publication is under way: a careful review of the glossary. "ASAM's descriptive and diagnostic group wants to make sure that it's up to date, including terminology like 'recovery' and 'relapse,'" said Miller. "This is an official publication of ASAM, and there are ongoing issues of language." For example, ASAM welcomes the deletion of "abuse" and "dependence" from *DSM-5* because these terms were "confusing," said Miller. But ASAM's definition of addiction doesn't align with *DSM-5's*, which is mostly "observational," he said. The new ASAM Criteria will reference the ASAM definition of addiction.

"We recognize that language issues are going to remain in this field," he said. •

For more on the ASAM Criteria, go to www.asam.org/publications/the-asam-criteria. The pre-order purchase price is $95, $85 for ASAM members.

**Location** from page 1

as well defined in substance abuse. There are more black holes in the reporting."

*ADAW* interviewed Bray and officials with two other treatment organizations that have sought to extend their brand to new geographic markets. Their comments on the challenges involved with duplicating historical success in a different location point to the hard work involved in broadening one's geographic reach, even for some of the most recognizable names in the treatment community.

## Building a continuum

Hazelden, which operates in divergent locations from New York to Florida to Oregon in addition to its long-standing home base in Minnesota, conducted its most recent ex-

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pansion last November when it acquired an addiction medicine clinic in Beaverton, Oregon, and proceeded to expand outpatient service capacity at the location.

The business move reflected an effort to build a more extensive continuum of care in locations where Hazelden has a presence; the Beaverton site is not far from the Hazelden Springbrook adult residential program in Newberg, Oregon.

"We want to avoid the need for handoffs where possible," Bray explained.

The acquisition of the medical clinic that formerly had operated as HealthWorks NW also dovetailed with the Hazelden organization's overall move toward incorporating medication-assisted treatment for addictions where clinically indicated, according to company officials.

Attempting to assess community need in a targeted geographic location usually serves as a good starting point in the decision-making process, Bray said. A market assessment usually will be informed by a variety of sources, she said, including state data, Substance Abuse and Mental Health Services Administration (SAMHSA) data, and information from local agencies and associations.

Overall, Hazelden is being guided by a goal it established in early 2010: to double the number of people it served at that time by the end of 2016. This applies not only to its treatment operations, but also to its education and publishing divisions. It likely will have to explore both expansions in existing markets and ventures in new markets in order to reach that objective.

Bray said that in any new venture, Hazelden cannot take any aspects of its past track record for granted.

"Because we don't have an enormous marketing budget, we always have to restate our value in any community," she said. "With our 60-year presence in the Midwest, we have more alumni there who know who we are, but we have fewer alumni elsewhere."

The factors that Bray says Hazelden tries to emphasize when seeking to make inroads in a new location include its focus on managing a chronic illness across the lifespan and the importance of establishing a continuum of care.

Another challenge with expansion, Bray believes, involves increased pressure for each individual business entity to carry its weight financially. "To be sustainable, every location should be financially viable," she said. "It's harder and harder with healthcare to cost-shift. And unlike a hospital, we can't take high-margin orthopedics and cardiac care to support a women and children's program."

**'When the customers know this facility is connected in a joint venture with an American organization, they see that they are dealing with a good-quality program.'**

Aloysius Joseph

## Developing relationships at Caron

Caron Treatment Centers offers another example of a nationally known addiction treatment facility that has embraced a geographic expansion strategy. Its most recent example of ground-up expansion occurred when it launched the Caron Texas facility near Dallas in 2010. Executive Vice President and Chief Marketing Officer John Henry told *ADAW* that it was important at the time for Caron to establish key ties with leaders in the local community.

"As a nonprofit, we knew we could not begin to establish our brand regionally without an advisory board comprising key individuals from the Dallas community and members of various professional communities," Henry said.

He added that Caron also prioritized the scheduling of community events and the use of mainstream and social media to help create local awareness of the organization's individualized and family-centered approach to care. But Henry does believe that Caron's national brand identity also served as an asset to the expansion process.

"We were able to attract top talent and prominent board members, and make immediate inroads with referents," he said.

Henry agrees that no facility can take its approach to treatment in one location and superimpose it with no changes onto another. And in fact, he emphasizes that such an approach doesn't even really work at the patient-to-patient level.

## Going global at Daytop

For the New York City-based Daytop Village treatment organization, the past year has been a tumultuous time punctuated by a Chapter 11 bankruptcy filing and related program consolidations and asset sales (see *ADAW*, Dec. 3 and May 14, 2012). Yet the organization also has looked to continue to extend the reach of its brand in some cases, including entering into an agreement late last year to place the Daytop name on a former medical model treatment center in Brazil.

While Daytop has facilitated the establishment of numerous therapeutic community (TC) model programs around the world, those

 

operations have not traditionally ended up formally carrying the Daytop name. "We wanted to form a real partnership with the program in Brazil," Aloysius Joseph, vice president of Daytop International, told *ADAW*.

Daytop does not directly operate the Daytop Rio program, but it offered training to staff in the TC model and has continued to make ongoing consulting services available.

Joseph said the Daytop name has made the program more attractive to families struggling with the effects of a 1990s crack epidemic in a country with little formal training and certification for substance abuse treatment professionals.

"When the customers know this facility is connected in a joint venture with an American organization, they see that they are dealing with a good-quality program," Joseph said.

On May 23, the bankruptcy judge approved Daytop's restructuring plan, effectively taking it out of Chapter 11, Daytop officials told *ADAW* hours after the decision was handed down. •

# NIDA, CDC support onsite HIV testing without counseling

Citing the extra costs of 30 minutes of risk-reduction counseling compared to 5 minutes of counseling about the test itself, with no extra benefit, federal researchers are recommending that substance use disorder (SUD) treatment providers offer onsite HIV testing with no risk reduction counseling.

Patients who are offered onsite HIV testing by SUD treatment providers are four times more likely to be tested than patients who are referred offsite, according to National Institute on Drug Abuse (NIDA) results from its Clinical Trials Network (CTN).

In addition, the Centers for Disease Control and Prevention (CDC) recommended that healthcare facilities serving all high-risk populations offer onsite HIV testing, and also recommended that pretest risk-reduction counseling be omitted.

The NIDA clinical trial found that those who received 30 minutes of risk-reduction counseling were no more likely than those who received 5 minutes of information about the procedure to accept the test. Both groups also reported similar levels of sexual risk behavior during the six months after the test offer.

## Clinical trial

Twelve CTN treatment centers participated in the trial, which was co-led by Grant Colfax, M.D., of the San Francisco Department of Public Health (now director of the White House Office of National AIDS Policy) and Lisa Metsch, Ph.D., of Columbia University's Mailman School of Public Health and the University of Miami Miller School of Medicine. The 12 centers provide inpatient, outpatient and opioid replacement therapies.

In the trial, staff were offered onsite or referral to offsite HIV testing to all patients who had not been tested in the past 12 months, who thought they were HIV-negative or who didn't know. Out of 1,281 patients in the randomized trial, one-third were selected for offsite referral, one-third for an offer of onsite testing with 30 minutes of risk-reduction counseling and one-third for an offer of onsite testing with 5 minutes of discussion describing the procedure.

Risk-reduction counseling included an explanation of the routes of HIV transmission, a personalized risk assessment and motivating participants to accept the test.

Of those who were referred offsite, 18 percent learned their HIV status, compared to 79 percent of those tested onsite with counseling and 84 percent of those tested onsite without counseling, based on interviews conducted one month after the test offers.

There were similar rates of unprotected vaginal and anal sex across all three groups, based on interviews conducted six months after the HIV tests.

## Cost-effectiveness

The researchers concluded that the intervention of choice is onsite HIV testing without counseling. "With less expenditure of staff time and resources, it yielded rates of test completion and sexual risk reduction that were equal to those obtained with counseling and an offer of onsite testing, and greater than those obtained with offsite referral," according to NIDA. In addition, it "resulted in a beneficial cost-effectiveness ratio for the CTN study population." The costs of HIV medications and other medical treatment were included in the cost-benefit analysis.

Researchers used the "Cost Effectiveness of Preventing AIDS Complications" computer simulation model to project life expectancy, lifetime costs and quality-adjusted life years (QALYs) for the HIV-infected individuals. The results showed that onsite testing extended life expectancy for HIV-infected people by an average of 3.7 years per person compared to no offer of onsite or offsite testing. Taking into account the cost of testing and medical costs associated with longer survival, results showed a cost-effectiveness ratio of $60,300 per QALY. The usual figure used to gauge cost-effectiveness is $100,000 per QALY.

The study was published last year in the American Journal of Public Health and discussed as a broad-based concept in the April 29 issue of NIDA Notes. The Department of Health and Human Services, which NIDA and the CDC are part of, has been focusing on HIV testing as a preventive measure, to prevent additional transmission. Whether these patients receive HIV medication was not discussed. •

## Briefly Noted

**Free course for counselors interested in primary care career**

A free five-hour online course for addiction treatment professionals who are interested in career opportunities in primary care has been developed by the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) in collaboration with the Addiction Technology Transfer Center (ATTC) Network and the Morehouse School of Medicine National Center for Primary Care. The course is self-paced and will help professionals decide whether they are interested in working in primary care. It is expected that the Affordable Care Act will bring many new patients into primary care, and that many of those patients will have substance use needs. By expanding their workforce to include addiction treatment professionals, primary care providers can be better prepared to care for their patients. NAADAC, the Association for Addiction Professionals and the National Board for Certified Counselors (NBCC) offer five continuing education credits (CECs) for this course for a fee ($25.00 to earn 5.00 NAADAC CECs and 5.00 NBCC clock hours). To sign up, go to https://www.thedatabank.com/dpg/423/donate.asp?formid=meetb&c=939837. Note that unlike many other offerings from CIHS, this one is for addiction only, not "behavioral" health.

## Names in the News

The Substance Abuse and Mental Health Services Administration (SAMHSA) has hired its first chief medical officer. Effective June 3, **Elinore F. McCance-Katz, M.D., Ph.D.**, will begin in her role of "providing medical-scientific expertise to SAMHSA's major behavioral health efforts including those promoting the prevention of mental illnesses and substance use disorders, as well as the treatment and recovery of people from these conditions." McCance-Katz is an expert in addiction — in particular, buprenorphine treatment for opioid addiction. In her post, she will also "ensure that SAMHSA is advancing the most effective, state-of-the-art, evidence-based approaches to promoting the nation's behavioral health services." And she will represent SAMHSA in groups where medical and clinical expertise are required. She is board-certified in psychiatry and addiction psychiatry, and is a distinguished fellow of the American Academy of Addiction Psychiatry. She was formerly state medical director for the California Department of Alcohol and Drug Programs (ADP), which Governor Brown has ordered to shut down at the end of next month. According to SAMHSA, McCance-Katz is interested in the care of co-occurring disorders — in particular, "those with substance use and mental disorders, chronic pain, addiction, and mental illness, and HIV disease complicated by substance abuse and mental disorders." She has studied drug-drug interactions and was on SAMHSA's expert panel looking at these interactions. "As SAMHSA's chief medical officer, Ellie will greatly enhance SAMHSA's ability to bring the best available medical science and clinical perspective to bear in promoting all aspects of the nation's behavioral health," said SAMHSA Administrator Pamela Hyde in announcing the new position and McCance-Katz's appointment on May 20. "Her widely respected expertise, extensive experience and passion for applying science to help people make her the perfect choice to start this new, critically important position at SAMHSA."

## Coming up...

The annual meeting of the **College of Problems on Drug Dependence** will be held **June 15–20** in **San Diego**. Go to **www.cpdd.vcu.edu/Pages/Meetings/FutureMeet.html** for more information.

The **National Association of State Alcohol and Drug Abuse Directors (NASADAD)** will hold its annual meeting **June 18–19** in **Bethesda, Maryland**. For more information, go to **http://nasadad.org/annual-meeting**.

The **NIATx Summit** and **SAAS** annual conference, "Innovation, Integration, Implementation — The Business of Behavioral Healthcare," will be held **July 14–16** in **San Diego**. Go to **www.saasniatx.net/Content/Home.aspx** for more information.

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

Congratulations to SAMHSA administrator Pamela Hyde in holding up so well before a Congressional hearing that frequently followed a hostile line of questioning. On May 22 members of the House of Representatives Subcommittee on Oversight and Investigations grilled her about SAMHSA programs. Many questions clearly came from star witness E. Fuller Torrey, M.D., a longtime critic of SAMHSA who was the lead witness after Hyde. Unfortunately, instead of addressing serious problems such as a focus on "mental health promotion" in SAMHSA messaging, instead of prevention of drug abuse and treatment of serious mental illness and addiction, the hearing ended up seeming more like a circus, replete with the old stories about the painting and the play. It was not a slow news day, so nobody even picked up on the story, and mental health advocates across the country issued press releases in support of SAMHSA programs in response. Torrey's valid points got lost in the process.