

# ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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## Addiction psychiatry: A voice for comprehensive treatment of SUDs

The American Academy of Addiction Psychiatry (AAAP), a subspecialty of the American Psychiatric Association, consists of about 1,500 members who are committed to treating substance use disorders (SUDs) along with mental disorders. In particular, the AAAP is concerned that with the public awareness of opioid use disorders and a focus on medication-assisted treatment, the need for additional psychosocial treatment will be lost. Last week, *ADAW* spoke with two of the organization's officials about the role of addiction psychiatry in treatment of SUDs.

"It's clear that the best treatment is usually a combination of medication and psychosocial therapies,"

### Bottom Line...

*Addiction psychiatry is a specialty that focuses on the mental and substance use needs of patients — a dual service that for years many people have said is essential.*

said Laurence M. Westreich, M.D., president of the Rhode Island-based association. "I prescribe buprenorphine and provide psychotherapy," said Westreich, who practices in New York and New Jersey with Park West Associates, and is also a consultant to Major League Baseball on behavioral health and addiction. "Some patients are fine with just bu-

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## The Business of Treatment

## Long-term view of care enhances partnerships with interventionists **B\$T**

A treatment center CEO with an intervention background and a licensed clinician who now does only interventions both see significant opportunities ahead for more productive partnerships between addiction treatment facilities and interventionists, as the field embraces a longer-term view of care. That can happen as long as both communities give accurate and thorough information to families seeking extended support, they say.

*ADAW* interviewed Rebecca Flood, CEO of California-based New Directions for Women, and Heather Hayes, an Atlanta-based interventionist who helped found the Net-

### Bottom Line...

*Addiction treatment centers can and should cultivate closer relationships with interventionists, as long as these ties emphasize ethical practice and accurate matching of services to families' needs.*

work of Independent Interventionists; both were in Palm Beach, Fla., last week for the Foundations Recovery Network's annual Moments of Change conference. Hayes participated on a conference panel on intervention that in part zoned in on ethical problems that are hurting the

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prenorphine, but they are in a minority,” he said. “There are lifestyle changes that have to be made, relationship changes, and these changes don’t come from any pill.”

The best model for the failure of a pill only is the widespread use of antidepressants by primary care, which was hoped to eliminate depression. It didn’t. “People with depression have been done a disservice by the notion that you can just prescribe and cure,” said Westreich. “The data are very clear — the best treatment is medication combined with psychosocial therapy.”

Many physicians don’t understand that there is an overlap between addiction and mental disorders, said John A. Renner Jr., M.D., president-elect of the AAAP. “There’s a blind spot in awareness of this,” he said. “People who do well in addiction treatment still require additional psychiatric care.”

**Need for psychosocial services**

Opioid use disorders are the only SUDs that have clearly effective medications — methadone and buprenorphine — but even these medications require complementary psychosocial treatment, said Renner, who is a professor of psychiatry at the Boston University School of Medicine, a clin-

ical instructor in psychiatry at Harvard Medical School, and the associate chief of psychiatry at the VA Boston Healthcare System. “When we look at people who are doing well with opioid use disorders where we have successful medications, the people who do well are people who combine medications with other components of care,” he said.

It’s important to conduct a full evaluation of patients in the early days of treatment, said Renner. “When people are in opioid with-

drawal, you don’t know whether you’re seeing the withdrawal or depression,” he said. “Once they’re stabilized, you need to have another evaluation, because some of the symptoms will disappear — you can do a much better assessment.”

The comprehensive evaluation is also needed because some patients need detoxification or inpatient treatment, said Westreich. “If they don’t need it, it’s foolish to send

them,” he said.

Addiction psychiatrists use drug testing as a part of treatment, said Westreich. “But it has to be framed the right way.” For example, he doesn’t think parents should do drug testing. “They get mad,” he said. “If someone tests positive in my office, I don’t get mad — I know what to say, what to do.”

**Buprenorphine cap**


The AAAP is opposed to lifting the patient cap for buprenorphine.

**‘There are lifestyle changes that have to be made, relationship changes, and these changes don’t come from any pill.’**

Laurence M. Westreich, M.D.

“People need comprehensive care,” said Renner, noting that the AAAP does want there to be increased access to buprenorphine. “Everyone would be better served if there were more physicians who could prescribe, and more who could integrate this into their primary care or psychiatric practices — that would be ideal, and that was the goal when buprenorphine was authorized.”

Looking at how opioid treatment



News for policy and program decision-makers

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programs (OTPs) have provided methadone and been monitored for the last 40 years, it's clear that the ancillary services that are included are important, said Renner, who has run an OTP. But it's not known whether the physicians who prescribe buprenorphine under DATA 2000 or DATA 2003 are providing any counseling or drug testing, he said.

"Unfortunately, the way you make money in this business is you provide medication, and you skimp on other services," said Renner. The Substance Abuse and Mental Health Services Administration (SAMHSA), which provides the waivers allowing physicians to prescribe buprenorphine, has not provided information on what the prescribers are doing. But most physicians with waivers are not, in fact, prescribing at all. "We only have anecdotal reports about why," said Renner. "We've had

discussions with SAMHSA, and there are hopes that there will be more rigorous assessments."

Lifting the patient caps is "one of those solutions that are obvious and simple and probably wrong," said Westreich. "If you think about the greatest good for the greatest number, in the short term, then yes, more people will get buprenorphine. But they will not be getting good treatment." Westreich also worries about buprenorphine diversion, and about side effects.

Renner and Westreich think that one of the reasons physicians aren't prescribing buprenorphine, even though they can, is that they don't want the inspections by the Drug Enforcement Administration (DEA). "I hear that frequently," he said. "One of the suggestions we made to SAMHSA is that they eliminate the DEA inspections for providers who

have small practices." Except for OTPs, most providers don't have DEA inspections on a regular basis, said Renner.

The American Society of Addiction Medicine (ASAM) is at the forefront of advocating for lifting the cap, creating conflicts between it and the AAAP as well as the American Association for the Treatment of Opioid Dependence. And many AAAP members are ASAM members. "We treat the same patients," Westreich said.

Furthermore, Westreich thinks that primary care physicians can do a good job of treating SUDs and other mental disorders — "there's certainly too much substance abuse out there for addiction psychiatrists to treat," he said.

There are about 1,500 AAAP members, many of whom are in academic settings, but who also have private practices. •

## Brief ED intervention for drinking teens shows promise

Is screening and brief intervention for risky drinking in teens in the emergency department (ED) effective? Yes, researchers who wanted the answer to this question found out — it reduces drinking and alcohol-related consequences in coming months. Led by Rebecca Cunningham, M.D., researchers studied the efficacy of brief interventions in the ED, comparing those delivered by a computer to those delivered by a therapist, and those with and without a follow-up session.

With 16 percent of teens aged 15–16 and 19 percent of those aged 17–18 reporting binge drinking, it's important to intervene early, public health experts say. In addition to increasing the risk for developing an alcohol use disorder, binge drinking by teens includes other risks, such as drunk driving, with 15 percent of young people ages 18–20 reporting

driving while under the influence of alcohol.

Most SBIRT (screening, brief intervention, and referral to treatment) alcohol approaches have only been tested in the ED among adults, and results have not shown any decrease in alcohol consumption but have shown decreases in alcohol-related consequences.

The American Academy of Pediatrics and the American College of Emergency Physicians support SBIRT for youth in the ED, as does the federal government, but in practice, there are problems with staff time and training. So instead of therapists, the possibility of using computerized SBIRT has been suggested, although there is no evidence-based intervention currently available for adolescents and alcohol SBIRT in the ED.

For this study, researchers used Project U-Connect, an alcohol brief intervention (not full SBIRT since there is no referral to treatment) that can be delivered by either a thera-

pist or a computer.

This study, "Alcohol Interventions Among Underage Drinkers in the ED: A Randomized Controlled Trial," was published in the October issue of *Pediatrics*.

### Study details

For the study, ED patients ages 14–20 who screened positive for risky alcohol use were randomized to brief intervention by a computer (277 teens) or a therapist (278), or to a control group (281). After the three-month follow-up, all participants, including those who did not receive an intervention in the ED, were then randomized to either a brief intervention session or control. The brief interventions incorporated motivational interviewing, focusing on alcohol consumption and consequences such as drunk driving and injuries, and other drug use. The computerized brief intervention was offline, styled like Facebook.

Recruitment took place seven

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days a week between 2 p.m. and 2 a.m. from 2010 to 2013. Patients were identified for screening by electronic medical record reviews. Those who could not be stabilized in the ED were enrolled on inpatient floors within 72 hours. Screening was done by a self-administered 20-minute survey (the Alcohol Use Disorders Identification Test — Consumption [AUDIT-C]) via touchscreen. Those who screened positive were selected for the randomized controlled trial.

Follow-up assessments at three, six and 12 months were self-administered online. Participants received remuneration for the assessments (\$35–\$45 each).

In addition to questions about alcohol consumption, participants were asked about alcohol-related consequences and illicit drug use, including prescription drug abuse.

Both the computerized and the therapist interventions incorporated principles of motivational interviewing, although modes of delivery differed. Sections included: (1) reasons to avoid drinking and drugs, including prescription drugs; (2) benefits of drinking less or not drinking; (3) better things to do; (4) risky situations; (5) protective behavioral strategies; (6) handling negative affect; and (7) avoiding DUIs. Therapists elicited “change talk” about alcohol and drugs and reasons to avoid or reduce use.

Participants in the control group received “enhanced usual care” consisting of reviewing a brochure listing resources with a staff member; the intervention participants received the same brochure.

For the post-ED session at three months — the booster session — the youth received a brief intervention delivered by a therapist who was blinded to the original type of brief intervention, or no intervention at all (control). The brief intervention was based on motivational interviewing; sessions were audiotaped and coded.

## Results

Of the 4,389 patients screened, 1,054 (24 percent) patients reported risky drinking; 836 were enrolled in the randomized controlled trial. Both interventions — computer and therapist — significantly reduced alcohol consumption at three months, and consequences at three and 12 months. The computer reduced DUI at 12 months, and the therapist reduced alcohol-related injury at 12 months. Finally, even the single brief intervention conducted at three months post-discharge reduced alcohol consequences at six months, even for those who did not receive a brief intervention in the emergency department.

Half of the patients were male, most were white, about two-thirds had a medical complaint, fewer than half lived with their parents and most were discharged from the ED.

Both the computer and therapist brief interventions conducted in the ED significantly decreased the alcohol consumption and alcohol consequences scores. At six and 12 months, however, the benefit of either ED intervention disappeared for alcohol consumption but remained for alcohol consequences. The main effect of the post-ED session was also only for alcohol consequences, not consumption.

## Implications

Any form of brief intervention — computer or therapist — shows promise for teen drinkers, the researchers concluded. Because of the ease of use, they said that the most appealing findings are for the fully automated computerized version. Using technology to streamline delivery makes it possible to reach more people.

The results show that brief, single-session alcohol interventions decrease alcohol consumption in the short run and alcohol consequences over time, and also reduce DUIs. By the 12-month following, the youth who received a brief intervention — either computer or therapist — in

the ED had a 10 percent reduction in consequences such as arguments or physical or mental health problems due to drinking. These findings are modest, the authors acknowledged, but still clinically significant considering that alcohol-related injury and DUI are leading causes of death. There were also reductions in prescription drug abuse as a result of the brief intervention, which is significant because of the problem of combining alcohol and prescription drugs.

There were some differences in the interventions. The computerized version contained a video clip of a teen describing financial and legal stresses after a DUI charge. Therapists, by contrast, had the discretion to elicit possible problems caused by drinking.

The benefit of the computerized version is that no staff is needed, the researchers wrote. They added that administration of the intervention is preferable to administration post-discharge, for staff reasons as well. However, “staff-free boosters” could be given online.

If the computerized brief intervention is chosen, there would still be costs, the researchers noted, adding that future examination of what these costs would be would be important before making decisions about what kind of intervention to use.

The study was funded by the National Institute on Alcohol Abuse and Alcoholism. •

### **Alcoholism & Drug Abuse Weekly**

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Letters may be edited for space or style.

## New ICD-10 codes distinguish between use, abuse, dependence

Effective October 1, there are new diagnosis codes for all diseases, with some major changes for substance use disorders. The new codes, which are listed in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), have broken out use, abuse and dependence for “mental and behavioral disorders due to psychoactive substance use.”

The addition of “use” diagnosis codes makes it possible for clinicians to denote, for example, when a patient merely uses alcohol. This does not necessarily indicate a pathological condition. In addition, for the first time, there is a diagnosis code for cannabis “use” — in ICD-9, there was only cannabis abuse or dependence.

The categories are further broken down between use, abuse and dependence, allowing for great specificity in the patient’s condition.

ICD coding is strictly hierarchical. For example, many patients have multiple substance use diagnoses. So multiple diagnosis codes can be used, but the first one should be the “most important single substance (or class of substances),” according to the guidelines. That would usually be the drug or type of drug responsible for whatever disorder the patient is presenting with. “When in doubt, code the drug or type of drug most frequently misused, particularly in those cases involving continuous or daily use,” the guidelines state.

The psychoactive substance use codes are part of the mental disorders section of the ICD-10, and all begin with the letter “F.” The first two digits after the letter F indicate the substance involved, and the fourth and fifth characters indicate the clinical state.

There is one code — F19.xxx — for disorders resulting from multiple drug use, but do not use this except for “in cases in which patterns of psychoactive substance taking are chaotic and indiscriminate, or in

which the contributions of different drugs are inextricably mixed,” the guidelines state.

The clinician may use patient self-report, a lab test, clinical signs and symptoms, reports from third parties or other information to make the substance use diagnosis. “It is always advisable to seek corroboration from more than one source of evidence relating to substance use,” according to ICD-10 guidelines. “Objective analyses provide the most compelling evidence of present or recent use, though these data have limitations with regard to past use and current levels of use.”

**‘If the coder doesn’t know, and the documentation just says that the patient drinks, the coder couldn’t code higher than use.’**

Melanie Endicott

For patients who misuse other substances that are not psychoactive, such as laxatives, use code F55.xxx (abuse of non-dependence-producing substances).

### Use vs. abuse

“It can be a bit tricky to define the difference between use and abuse,” said Melanie Endicott, senior director for health information management practice excellence at the American Health Information Management Association, which credentials diagnosis coders. “It all comes down to the physician documentation,” she told *ADAW*. “If the coder doesn’t know, and the documentation just says that the patient drinks,

the coder couldn’t code higher than use. Abuse would be drinking too much, but that would have to be defined by the physician.”

For diagnosis coding, always default to the least severe level when in doubt, said Endicott.

Adding the “use” diagnosis allows clinicians to collect all information, instead of labeling the patient, said Endicott. “You can capture the fact that they are using narcotics, without giving them the stigma of saying they are abusing it,” she said.

For drug testing when you don’t know what drug a patient is using, you would go to Chapter 21 for a drug screening code that doesn’t assign a diagnosis, said Endicott. “We use those in the lab setting,” she said.

### Getting paid

Diagnosis codes and procedure codes are used together, and payers decide how much — and whether — to pay based on these. It’s likely that an office visit or counseling session accompanied only by a “use” diagnosis would be rejected, although this depends on the individual policy. Why have the code, then? Because ICD is actually a project of the World Health Organization, which uses it to track disease; it was never meant to be a payment document.

ICD-10, with its explosion of added codes due to increased specificity, has been delayed for several years, so coders and health care providers have had a long time to prepare. “I don’t think everybody is ready, but most people are,” Endicott told *ADAW* September 30. “A lot of people were waiting or hoping it would be delayed, and they’ve been scrambling, because tomorrow is the big day. If you’re not ready, you’ll find out, because you’ll start getting denials.”

In fact, there is always a three-month grace period when the new

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diagnosis codes are added every October, and even insurance companies don't load all the new codes in time. •

For the guidelines, go to [www.cdc.gov/nchs/data/icd/10cmguide](http://www.cdc.gov/nchs/data/icd/10cmguide)

[lines\\_2016\\_Final.pdf](#).

For the actual codes, go to [https://www.cms.gov/medicare/coding/icd10/downloads/6\\_i10tab2010.pdf](https://www.cms.gov/medicare/coding/icd10/downloads/6_i10tab2010.pdf), and then to page 231 for mental and behavioral disorders due to psychoactive substance use (F10–F19).

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## Article details policy reactions to opioid epidemic

Policies aimed at treating the prescription opioid epidemic have had some success, but also had unintended consequences, including an increase in the use of heroin, according to an article published in the current issue of the *Journal of Addictive Diseases*. While both prescription opioid and heroin use disorders should mean an increase in treatment with evidence-based practices, policies have instead set up barriers.

The article, “Challenges and Opportunities for the Use of Medications to Treat Opioid Addiction in the United States and Other Nations of the World” by Mark Parrino, president of the American Association for the Treatment of Opioid Dependence and others, including Paul N. Samuels, director and president of the Legal Action Center, discusses three “policy reaction” phases.

First, states began developing prescription drug monitoring programs. Many physicians changed their prescribing practices as a result. The consequence, which was intended, is that fewer opioid prescriptions are being made. “This has partially resolved one problem, but created a different, unforeseen problem,” the authors write. This was the

unintended consequence of the use of heroin.

The Mexican and Colombian drug cartels were ready for the decrease in prescription opioid supply: they “increased their production of purer heroin and shipped it through to the United States so that rural and suburban areas now had access to a supply of heroin, in addition to the urban centers,” the article states.

The phase two policy response came in response to overdoses, and the federal government worked to increase the availability of the rescue drug naloxone. But naloxone only treats overdose — it doesn't treat addiction.

Phase three is having a harder time getting off the ground — it is in response to opioid addiction, and it involves the use of medications — methadone, buprenorphine and naltrexone/Vivitrol. “From the point of view of most American families that have individuals who are suffering with opioid addiction, they want a solution so that their loved ones will be able to access treatment,” the article states.

However, there are barriers to access to treatment, coming from state government as well as insurance companies.

Maine has decreased access to treatment for opioid use disorders. Mississippi's policies have limited access to only one opioid treatment program in the state. In many other states, Medicaid doesn't pay for treatment in OTPs at all. North Dakota is working to site its first-ever OTPs, as a result of so many people going to work there in the fracking boom.

The criminal justice system also denies medication-assisted treatment to inmates, as documented in the groundbreaking paper by the Legal Action Center in 2011.

The paper doesn't specifically mention lifting the patient cap for buprenorphine but does stress the importance of comprehensive treatment. In conclusion, the authors wrote: “In considering the medical field, doctors need to be educated in medical schools and universities, but also epidemiologists, policy makers, politicians, and families about the effectiveness of a correct agonist opioid treatment and, in response to those who say they believe only in harm reduction strategies, it can be said with confidence that the best harm reduction of all is that achieved by a comprehensive agonist opioid treatment.” •

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reputations of both primary treatment centers and the intervention community.

“Kickbacks in the industry are one of the most disgusting, deplorable things going on in the field,” Hayes said during the panel discus-

sion, referring to the commonly heard practice of some interventionists seeking payments from treatment centers for referring a patient to the facility.

Both Hayes and Flood told *ADAW* that treatment centers can serve as resources for families, and

can reinforce the need for long-term support for the addict and the family, if they help connect them to interventionists that offer a good match to the family's needs.

“As a treatment provider, we love working with interventionists,” Alina Lodge CEO Michael Hornstein

said during the panel discussion at the conference. “The families are usually sicker than the clients by the time we get them into long-term treatment.”

**Proper boundaries**

As an independent interventionist, Hayes maintains no financial ties with any treatment center. Like most interventionists, she tends to refer most often to a select number of facilities. “I have my go-to places,” she said.

While it may be more common for a family to find an interventionist before they locate a treatment facility for a loved one, it is also true that families will contact primary treatment centers to seek basic guidance. In those instances, the facility can help families ask the right questions about a potential interventionist’s credentials, Hayes said. Families should be advised to ask about an interventionist’s duration of service, training background and professional certifications (mainly that of Certified Intervention Professional), among other factors, she said.

“There is a problem with people practicing outside of their scope of practice,” Hayes said, in areas such as conducting psychiatrically focused interventions without holding a master’s degree.

What was also evident from the composition of the audience at the Moments of Change conference is that many addiction treatment facilities are run by executives who also have conducted interventions at some point in their career. Hayes believes in general that if these individuals continue to perform interventions, they should not refer to their own facility. But Flood says transparency in such situations is what matters.

Flood, a longtime leader in the Association of Intervention Specialists, said she has conducted around a dozen interventions in the 11-plus years that she has run New Directions, and only one of those patients ended up attending her facility. “It’s

about living up to your ethics code,” she said. “Potential conflicts exist at every stage of living.”

Flood said her facility’s work with interventionists always starts with making sure they are certified. Also, “We don’t pay, or share fees,” she said. The interventionist’s paying client is the family. If a family contacts New Directions seeking general help, Flood likes to be able to refer family members to a few potential interventionists. “We don’t say, ‘Call this particular person,’” she said.

It is also important for treatment facility staff to understand the nuances of each interventionist’s services, both in terms of the populations with which they are most comfortable and the basic structure of their work. For instance, an interventionist who traditionally con-

**‘... the money aspect of it should always be second.’**  
 Rebecca Flood

ducts surprise interventions would not be a good match for a person with a serious trauma history, for whom such an event might serve as a dangerous trigger, Hayes said. She uses the term “trauma-informed interventions” to describe processes that won’t serve to retraumatize individuals.

**Ongoing communication**

Hayes said treatment centers need to see interventionists as a friend to their process of helping patients and families heal. “We don’t want to micromanage,” she said. “We can help centers with support.”

She generally wants to hear at least weekly from a treatment center that is treating a patient from a family with which she is working. “If they give a patient an aftercare plan that I don’t think is going to work, it

will be my mess to clean up,” she explained.

Another point of emphasis in last week’s conference panel involved some treatment facilities’ tendency not to involve families while their loved one is receiving primary services. For other serious illnesses, parents maintain constant vigil over their child, while in addiction treatment they’re often advised to stay out of the process. “Things a facility can do to upset a family are not to ask for the family’s participation, and to give no explanation of what the family can expect in treatment,” Hayes said.

With most interventionists seeking to contract with families for at least a year, and in some cases significantly more, interventionists can serve to reinforce with families a longer-term view of support that also can benefit the treatment center’s relationship with its clients (in reinforcing the need for continuing care or support from the facility after primary treatment ends). “We always suggest that longer is better,” said Flood.

She believes partnerships between treatment centers and interventionists can continue to grow, and that intervention can continue to advance in the continuum of support, but adds that “the money aspect of it should always be second.” •

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**BRIEFLY NOTED**

**First 13 grants awarded in NIDA-NIAAA teen study**

Last week, the National Institutes of Health awarded the first 13 grants as part of the prospective study of the effects of adolescent substance use on the brain. The ABCD (Adolescent Brain Cognitive [Continues on next page](#)

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Development) study, first announced almost two years ago as the Collaborative Research on Addiction at NIH (see *ADAW*, Dec. 23, 2013) and then refined by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) last year (see *ADAW*, May 26, 2014), will look at 10,000 adolescents starting at age 9 or 10. “Adolescents have access to high potency marijuana and greater varieties of nicotine delivery devices than previous generations,” said NIDA Director Nora D. Volkow, M.D., in a statement. “We want to know how that and other trends affect the trajectory of the developing brain.” NIAAA Director George Koob, Ph.D., added that the study “is an important opportunity to closely examine, in humans, the hypothesized link between adolescent alcohol abuse and long-term harmful effects on brain development and function.” For the full announcement, including the list of grantees, go to [www.nih.gov/news/health/sep2015/nida-25.htm](http://www.nih.gov/news/health/sep2015/nida-25.htm).

## STATE NEWS

### Drug courts in N.Y. must allow methadone and buprenorphine

Last month, Gov. Andrew Cuomo signed a law requiring diversion programs, also called drug courts, to allow participants to be on medications such as methadone and buprenorphine. “This was a common sense, bipartisan initiative,” said State Senator Terrence Murphy, who authored the bill. “By expanding those who qualify for this lifesaving program, New York no longer denies this opportunity to those relying on maintenance medications as part of their recovery.” New York drug courts have had more than 85,000 participants, with a success rate of almost 50 percent, according to Murphy. The Coalition of Medication-Assisted Treatment Providers and Advocates, Alcoholism and Sub-

## Coming up...

**NAADAC, the Association for Addiction Professionals** will hold its 2015 annual conference and Hill Day **October 9–13** in **Washington, D.C.** For more information, go to [www.naadac.org/annualconference](http://www.naadac.org/annualconference).

The annual educational conference of the **International Nurses Society on Addictions** will be held **October 21–24** in **Charlotte, North Carolina.** Go to [www.intnsa.org/conference](http://www.intnsa.org/conference) for more information.

The **Association for Medical Education and Research in Substance Abuse** will hold its 39th annual national conference **November 5–7** in **Washington, D.C.** For more information, go to [www.amersa.org](http://www.amersa.org).

The **National Prevention Network Conference** will be held **November 17–19** in **Seattle.** Go to [www.npnconference.org](http://www.npnconference.org) for more information.

The **American Academy of Addiction Psychiatry** will hold its 26th annual meeting and symposium **December 3–6** in **Huntington Beach, California.** For more information, go to [www.cvent.com/events/aaap-26th-annual-meeting-and-symposium/event-summary-92c1c0c52b0a4cd0853e93c45ef952d4.aspx](http://www.cvent.com/events/aaap-26th-annual-meeting-and-symposium/event-summary-92c1c0c52b0a4cd0853e93c45ef952d4.aspx).

The **Addiction Executives Industry Summit** will be held **January 31–February 3, 2016**, in **Naples, Florida.** Go to [www.axisummit.com](http://www.axisummit.com) for more information.

stance Abuse Providers of New York State and the Coalition of Behavioral Health Agencies all support the measure, as do the Drug Policy Alliance and Vocal New York. The law is a result of the case of Robert Lepolszki, who died from a heroin overdose at the age of 28. He had been in treatment with methadone but was forced by Judge Frank Gulotta Jr., a drug court judge on Long Island, to taper off the medication. He had a choice between stopping taking methadone or going to prison. While on methadone, he had a job and was in recovery but, because of a previous offense occurring before treatment started, had ended up in drug court. More than 80 percent of people who taper off methadone re-

lapse. The judge had called methadone a “crutch.”

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

After candidate Hillary Clinton's announcement that she would put \$10 billion into fighting drug addiction with public health approaches (see *ADAW*, Sept. 14), other candidates are stepping up their attention to the issue. The pressure is coming from the voters, especially in early voting states like New Hampshire, The Associated Press reported September 30. Republican Jeb Bush last week listened as hospital leaders, recovering addicts and law enforcement discussed the 100 overdoses — and 10 deaths — that occurred in Manchester alone in the last 30 days.