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

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Alison Knopf, Editor

WINNER 2013 APEX® AWARDS FOR PUBLICATION EXCELLENCE
NEWSLETTER WRITING

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SBIRT failure: 'S' works, 'BI' for low-risk only, 'RT' unknown

The recent study by Richard Saitz, M.D., and colleagues finding that screening, brief intervention, and referral to treatment (SBIRT) by primary care providers did not reduce drug use and is therefore a failure (see *ADAW*, August 11) has meant some serious soul searching for the field, which has been told that this innovation would reduce and prevent less severe substance use disorders (SUDs) and lead more serious cases to treatment providers. We asked three top experts to comment on next steps. The main consensus is that screening — the "S" — should continue to be performed, and that little is known about the "RT." The "BI" may need to be beefed up by actual substance use disorder treatment providers, and may need more of a stress on "intervention" and less on "brief."

Bottom Line...
Follow-up on SBIRT failure study: Screening works, but brief intervention only works for the least affected patients, and referral to treatment hasn't even been adequately studied.

Separate the S, the BI and the RT

"I don't think that anyone is saying that doctors shouldn't screen," said Kim Johnson, director of NIATx. "There is plenty of evidence that screening works to identify people

See **SBIRT** page 2

The Business of Treatment

Insurance leader foresees centers assuming greater risk with changes

Smart purchases of liability insurance coverage for addiction treatment centers certainly require a careful read of policy terms by an in-house staffer or outside consultant. But facility administrators must remain mindful that no words on the page of an insurance policy will protect centers from all the adverse consequences of a highly publicized event caused by absent or poorly enforced standards of conduct or internal controls.

In an interview with *ADAW* last week, the program director of a leading insurer that includes behavioral health facilities among its areas of specialization related the circumstances around a $500,000 settlement it recently negotiated on behalf of a California residential program. Richard Willetts of NSM Insurance Group said that two house

Bottom Line...
A stronger presence of medical professionals in addiction treatment systems likely will mean greater insurance liability concerns for specialty treatment centers, according to a program director with NSM Insurance Group.

See **Insurance** page 5

SBIRT from page 1

with a drinking or drug problem, and the only purpose of screening is to identify," she told *ADAW*. Brief intervention (BI) does work for risky drinking in people who do not yet have a diagnosable alcohol use disorder (AUD), but there isn't any evidence that it works for drug use, or for people with a diagnosable AUD, she said. And that makes sense, she added. "You wouldn't expect a single conversation about appropriate levels of alcohol consumption to reduce use for someone with a substance use disorder after all the research that indicates that length of time in treatment is the only indicator of positive outcomes," she said.

As for referral to treatment (RT) — that hasn't been researched much at all, said Johnson. "What would be the outcome measure for a study on referral to treatment? I think all you could study would be whether or not a referral was made or whether or not people went to treatment, because that would be the purpose of a referral, to send them to a specialist," she said. Anecdotally, however, physicians "get irritated with the complications of the referral process to addiction treatment and the lack of information that comes back to them and the low level of follow-through by their patients," she said.

Johnson said she would like researchers to "take apart the letters in SBIRT and use each element in the way it is intended and for the people for whom it might have an effect, instead of making it a package that we call an evidence-based practice that then mistakenly gets applied to everyone."

Greater role for specialty treatment

"The fact that recent research calls into question the efficacy of using SBIRT with drug users is useful information," said Jim Aiello, project associate with the Institute for Research, Education and Training in Addictions (IRETA), the ATTC that has SBIRT as its main initiative. Aiello, like Johnson, questions whether a brief intervention can help someone who uses drugs. "It appears that the complex matrix of biological, lifestyle and other factors that support a person's drug use may prove beyond the influence of a brief intervention," he said.

However, brief intervention does work with risky drinkers, who are able to cut back or stop, so Aiello said a different public health approach is needed that "mirrors the effectiveness of SBIRT with alcohol users."

Aiello also pointed out that SBIRT has actually been used on a limited basis. "Hopefully, as research and discussions continue, we won't stop emphasizing the importance of screening and talking to patients about their alcohol and drug use and its effect on their health," he said. "We really have an obligation to make patients aware of this information." As Saitz points out, even if brief interventions do not reduce illicit drug use, there are other reasons to continue having these types of conversations in medical settings, such as better understanding a patient's overall health, making appropriate diagnoses, and certainly to help guide appropriate prescribing, added Aiello. "Longer-term counseling and treatment options" may be needed for intervening with drug use disorders, he said.

Aiello also urged that the "warm handoff" approach to referral to treatment include good communication between the primary care provider, the patient and the specialty treatment provider. "All providers need to be truly familiar with the types of treatment that are available, spend some time with patients encouraging them to seek treatment, and even facilitate the referral by helping the patient make an appointment when necessary," he said.

Keep screening

Tom McLellan, Ph.D., outgoing CEO of the Treatment Research In-

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'You wouldn't expect a single conversation about appropriate levels of alcohol consumption to reduce use for someone with a substance use disorder after all the research that indicates that length of time in treatment is the only indicator of positive outcomes.'

Kim Johnson

stitute, said that most of the findings judging SBIRT effective have been "overinterpreted." He agrees with Johnson — that the S, the BI and the RT are three separate interventions, and that screening is the best proven and should continue. "Every single study has shown a 20 to 30 percent prevalence rate in any medical setting" of risky substance use, he said. "Even if we had no brief interventions at all, we know that the use of alcohol, cocaine, marijuana, opioids, and other drugs is going to interfere with the rest of the patient's medical care," he said. "So screening is fine."

Brief intervention doesn't work as well with more complicated, more severely affected patients, said McLellan. But they didn't work, according to the Saitz paper, with anyone. "What that means is that we should be trying different kinds of brief interventions," he said. "Maybe there are new medications for early intervention. Maybe there are new incentives." Maybe even repeated screening is the answer, for now. "If you had a growth and the doctor wasn't sure what to do, you repeat the screen again and again, to monitor it," said McLellan, drawing the analogy to medical care. "Screening won't produce any harm."

Referral to treatment never really got off the ground because specialty treatment for substance use disorders isn't part of mainstream health care, said McLellan. "If I have a button on my computer and I make a referral down the hall, that makes it easy," he said. Primary care doctors can do that with other specialists, but not with SUD treatment providers, he said, noting that many SUD treatment providers still aren't part of the same billing system as the primary care provider. "We need the systemic connections" for the RT to work, said McLellan.

Aiello of IRETA urged the field not to be disillusioned just because research has failed to support a hoped-for hypothesis. "It just means we have to work harder to find solutions that work better," he said. •

Drug courts should target most severe cases: NADCP

The first rule of drug courts is that they should be targeting high-risk, high-needs offenders — those with a high probability of failure in treatment, and with severe addiction or co-occurring mental illness. "That's your population — that's who you should be treating," Douglas B. Marlowe, Ph.D., chief of science, policy and law for the National Association of Drug Court Professionals (NADCP), told *ADAW*. This is the "targeting standard" — standard number one in the guidelines promulgated by the NADCP.

These standards also include a clear statement that a drug court participant should not be incarcerated simply due to a relapse, which is a health problem and not a crime.

But the NADCP, while the preeminent national membership organization for drug courts, can't enforce these standards—administrative court offices at the state and federal level do that, if they choose (12 states have adopted the NADCP standards so far).

Low-level offenders only, at first

In general, prosecutors are the ones who resist the idea of treating more severe cases, instead opting for those who are least likely to re-offend, and therefore leading to the analysis that drug courts are ineffective. If a one-time marijuana user is put in drug court, that's a waste of space, because that user is not likely to re-offend anyway, said Marlowe.

The idea of concentrating low-level users in drug courts started because it was the only way prosecutors would agree to drug courts, Marlowe said. When drug courts started 25 years ago, the criminal justice system was steeped in retribution and determinant sentencing, with little attention paid to the idea of rehabilitation. "Three strikes and you're out — that was the dominant philosophy," said Marlowe. "Drug courts were trying to challenge that."

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Prosecutors wouldn't agree to give treatment instead of jail to drug offenders. Finally, they agreed to do so as long as the cases were the ones with the least risk to public safety, so the earliest drug courts were for first-time possession cases.

But as research began coming in, it became clear that "effect sizes" were higher if only more serious cases went to drug court. For the heroin-addicted individual who had been arrested five times, the "effect size" of drug court diversion from incarceration was much higher than for the person arrested for the first time for marijuana possession, said Marlowe. "The earliest studies were in 2005, and since then the continuous finding, over and over again, is that the more severely addicted and criminologically involved the client, the better they do in drug court in terms of the effect size."

Convincing prosecutors

But it's still a matter of convincing prosecutors to allow the severest cases to receive treatment instead of incarceration, and, in many cases, the judges who listen to the prosecutors, said Marlowe. "These are courts of law," he said. "All we can do is enforce the best practice standards, so that a state who has adopted them can say whether or not a drug court is out of compliance."

The NADCP published the first installment of its practice standards more than a year ago, but now it's up to each state's administrative office of the courts to decide how to respond if a drug court is out of compliance, said Marlowe.

Still, prosecutors have constitutionally protected discretion. "You can try to enlighten the judge — the judge doesn't have to go along" with the prosecutor's recommendation, said Marlowe. "But these people are lawyers — you can't tell them what to do. You can say what is the standard of care, and you can try to change their hearts and minds."

But perhaps most important, the NADCP standards can "give them cover," said Marlowe, who is a lawyer. "Right now, many of them are afraid of something going wrong," he said. But if they have adopted the standards, and a drug court participant ends up killing someone in a driving accident while on drugs, for example, the prosecutor can say that he or she was "following the recognized practice of matching people to drug court by risk and need."

> **'The treatment provider should be talking to the defense lawyer to make a stronger case.'**
>
> Douglas B. Marlowe, Ph.D.

That's why it's important for everyone — prosecutors, judges, corrections, probation, treatment providers — to agree ahead of time when there isn't a case before them about what works, said Marlowe, noting that the NADCP hosted a White House–funded conference gathering all stakeholders on the drug court issue.

Treatment providers and defense attorneys

Marlowe also hopes that treatment providers and defense attorneys can play a stronger role, bringing the NADCP standards into court to help avoid incarceration. In the case of a drug court participant who relapses, for example, the treatment provider should "make the argument that this person needs a higher level of care, needs medication," said Marlowe. "The treatment provider should be talking to the defense lawyer to make a stronger case." And ultimately, the defense attorney should go to the judge and say, "I have here in my hands the national standards that our state Administrative Office of the Courts has endorsed, and you're not supposed to be putting this person away."

Despite repeated emails with Treatment Alternatives for Safe Communities (TASC), which focuses on diversion and drug offenses, nobody from the Chicago, Illinois–based organization was available for an interview for this article. •

For the NADCP best practice standards, go to www.nadcp.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf.

Editor's note: Drug courts are different from Law Enforcement Assisted Diversion (LEAD), an innovation funded by the Open Society Institute, which is having success in King County, Washington. Under LEAD, low-level offenders identified by police officers are not arrested, but referred to treatment providers.

New CEO for TRI; private investment to take bigger role

The Treatment Research Institute (TRI) is moving toward more funding from private investment, *ADAW* has learned. On August 14, the Philadelphia-based organization announced that David R. Gastfriend, M.D., will take over from A. Thomas McLellan, Ph.D., as CEO starting on September 1. Both men told *ADAW* in separate interviews that one of the major new initiatives will be relying on more private investment, a move that began with a TRI-funded conference of investors last year. It has become clear that with the Affordable Care Act and the promise of parity, treatment for substance use disorders (SUDs) is worth the

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investment.

"It's not sufficient to simply rely on the government to fund grants to generate studies and publish papers," Gastfriend told *ADAW*. "We need solutions, and other entities ought to be participating in funding those solutions." TRI is seeking funding from investors as well as insurance companies and hospital networks, among others. In the investment world, in particular, there is "considerable interest in providing services and generating profits from addressing the unmet need" for SUD treatment.

TRI has worked with the Wharton School at the University of Pennsylvania, and with others, including the Legal Action Center and Washington, D.C.–based lobby firm Capitol Decisions, said Gastfriend, adding that "we want to bring in all potential players." Currently TRI is "working with a number of investment houses which in the aggregate could conceivably put as much or more money into upgrading services in our field than the federal government," he said.

Starting in a one-car garage

McLellan, who will become chair of the TRI board of directors, told *ADAW* that one of his favorite memories was when co-founder Charles O'Brien, M.D., wrote a check for $12,000 to start TRI in a single-car garage in 1991. "We had three employees and no money," McLellan recalled. His TRI career was marked by one short-lived departure for the Office of National Drug Control Policy (ONDCP). Asked what his worst memory was, he responded, "Any meeting at ONDCP — including the pre-meetings before we were supposed to have a meeting. It's all paralyzing."

Now, McLellan is exhilarated about the future, saying, "our field is going to bloom." "The technology is there, the new investment is there — we're working with investment groups that are putting money in like I've never seen," he said. And, he added, the political will is there due to opioid problems.

Divided field

One of the biggest problems facing the field comes from within itself — "it's divided ideologically," he said. "People are making a living and trying to do the best they can, but it hasn't been working in a manner that parents want and that insurance companies want."

Gastfriend said that he has learned, through family members in recovery and in caring for patients over more than 20 years, that "the fellowship of AA" and "what we call the gift of recovery" are crucial to sustaining long-term health. "I've been to enough AA meetings myself, as a guest, to understand the suffering that's often required to bring one to accept the disease and the capacity for coping with pain that is the hallmark of health recovery," he said. "And as a scientist, I want TRI to integrate those experiences and truths with the truths that come from research." The internal conflicts between physicians and administrators who espouse medication-assisted treatment and those who don't have largely eluded Gastfriend. "I grew up as part of the newer generation of addiction physicians who appreciated both sides and didn't have artificial boundaries between them," he said. "I see how medications facilitate the start of recovery, but also how they do not represent the solution or transition into health," added Gastfriend, who was vice president for scientific communications at Alkermes, which makes Vivitrol, before joining TRI (see *ADAW*, February 20).

Before joining Alkermes, where he worked for 10 years on the development of Vivitrol, Gastfriend was director of the Addiction Research Program at Massachusetts General Hospital at Harvard Medical School. He is also a leading expert on the ASAM criteria software. •

'It's not sufficient to simply rely on the government to fund grants to generate studies and publish papers.'

David Gastfriend, M.D.

Insurance from page 1

managers at the facility decided to climb fully clothed into the beds of two same-sex sleeping residents to see how they would react when they awakened to find someone lying next to them; the staffers saw this as akin to a "hazing" ritual. When the patients complained to management about the incidents, their concerns were brushed off.

Legal action was taken on behalf of the residents, who said the behavior of the staff members had triggered traumatic stress reactions. A $2 million lawsuit was settled for $500,000, but the cost to a program's reputation in cases such as this could prove much greater, Willetts said. What arguably puzzled him most about the incidents was the cavalier approach administrators took even after they were facing a legal battle, he said.

"Reputational risk is huge, especially for the high-end private-pay centers," he said. Recounting this incident led Willetts to state, "You'd be surprised" when discussing how common these kinds of scenarios can become in the treatment industry.

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Insurance needs

Willetts explained that all addiction treatment centers experience exposure to claims in the areas of general liability, professional liability and physical and sexual abuse/misconduct. Their insurance needs generally don't differ a great deal from those of mental health treatment facilities or general health facilities, he believes, unless a center offers an unusual and/or highly specialized program as part of its operation.

"We have a client that does wolf therapy," Willetts said by way of example. "Most policies exclude nondomesticated animals." The same level of concern likely would not apply in the case of the more commonly used equine therapy, he said.

Willetts does believe that the global changes occurring in the health care market are bound to increase addiction treatment facilities' potential exposure. While he adds that he has not yet seen evidence of a pattern of claims stemming from physicians' greater involvement in addiction treatment, this remains an area worth monitoring.

"Medical professionals and psychiatrists owe the highest duty of care," said Willetts. "The more medical professionals you have, the greater the professional liability."

If general health services for a specialty addiction treatment center are provided under a contractual partnership with a separate entity, those terms must be examined carefully. "How are the contracts structured?" Willetts said. "Are you held harmless for their work?"

In general, Willetts believes that as care becomes more comprehensive and integrated, "there will be more potential for errors" in treatment facilities.

Sometimes a facility that is seeking effective insurance options might become a victim of issues beyond its control. Willetts recently spoke at a Florida Alcohol and Drug Abuse Association (FADAA) conference and expressed concern about a Palm Beach County treatment market "that appears to be a Wild West environment," he said, with a proliferation of centers that have engaged in questionable business practices and/or have lax controls on residents' activity.

Particularly in the area of residential treatment in Palm Beach County, "We've had to take a hands-off approach for a while — some of these facilities are becoming uninsurable," Willetts said. "There is a poison in this venue toward the treatment centers." NSM is pursuing little new business in this region at this time, he said, at least on the residential side.

> **'The more medical professionals you have, the greater the professional liability.'**
>
> Richard Willetts

Elements of success

Willetts says that in many smaller treatment centers, the CEO carries the responsibility for insurance-related decision-making. In larger organizations, that task may fall to a chief financial officer or chief operating officer, or could be entrusted to a human resources department. He added, "Very few facilities employ an in-house risk manager," although some have a contractual arrangement with one.

NSM provides training for its clients on topics ranging from driving safety for facilities' van drivers to measures to avoid incidents of physical or sexual abuse through the enactment and enforcement of strong policies. The key message there is one of zero tolerance, Willetts said.

"When is it OK to touch the clients? Never," he said. "You have to reinforce boundaries. Even joking around is not OK."

He also advises facilities to work with an insurance broker who understands the specifics of the industry. "My strong preference is to work with ones who can spell behavioral health," Willetts said. Also, facility administrators should review their insurance program at least annually, he said.

He believes the next trend for addiction treatment facilities will involve purchasing coverage specifically designed to offset any potential losses from breaches of confidentiality; he says this is not yet on many facilities' radar when purchasing insurance, but will need to be. •

Voices on the death of Robin Williams

On August 11, 63-year-old actor and comedian Robin Williams died, following years dealing with depression and alcoholism. Below are some voices that we found particularly appropriate for *ADAW* readers on this sad news.

Russell Brand

"He spoke candidly about his mental illness and addiction, how he felt often on a precipice of self-destruction, whether through substance misuse or some act of more certain finality. I thought that this articulate acknowledgement amounted to a kind of vaccine against the return of such diseased thinking, which has proven to be hopelessly naive.

"When someone gets to 63 I imagined, hoped, I suppose, that maturity would grant an immunity to adolescent notions of suicide but today I read that suicide isn't exclusively a young man's game. Robin Williams at 63 still hadn't come to terms with being Robin Williams."

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www.theguardian.com/commentisfree/2014/aug/12/russell-brand-robin-williams-divine-madness-broken-world.

CBS Minnesota

"Williams' death comes less than two months after he posed for a picture with an employee at a Dairy Queen in Lindstrom, Minn.

"Williams was in Minnesota at the time, according to his publicist, for rehab at the Hazelden Addiction Treatment Center in Lindstrom at the time to focus on his sobriety. Williams had planned the visit as a respite to recharge after more than 18 straight months of work.

"Williams had been open about the challenges of maintaining sobriety. He sought treatment in 2006 when he relapsed and returned to drinking after 20 years."

http://minnesota.cbslocal.com/2014/08/12/robin-williams-had-recently-visited-hazelden.

Dr. 24hours

"There's a lot of outrage online right now that apparently some newsrag or another published a photo of Robin Williams at an AA meeting. And yeah, that's kind of classless. And I'm appreciative that people who don't really understand AA or alcoholism are reflexively protective of the anonymity we need to do our work. It would be better if that photo had not been made public. But I can't find myself too angry about it. I'm not outraged. Time will pass. Memory will fade. People will forget the faces in that picture. And we'll go on doing what we do.

"I don't really need anonymity anymore. I've been sober long enough that if I were exposed, I can stand on my time, because people who don't get it think it's about time. And that's ok. I can talk to my boss or my human resources manager and describe my life and my sobriety in vague terms, and casually mention phrases like "Americans with Disabilities Act" and I'll be just fine. I'm not ashamed. But my life is easier if I don't have to go through that. And so I value my own anonymity, even if I don't need it.

"But I stay anonymous for others. And Robin Williams stayed anonymous for others, I feel confident saying, though I never knew he was sober until two days ago. We do it so that the starkly terrified newcomer will see that it can be done. That recovery is possible. That alcoholics in recovery can go on to live ordinary lives. They think their shame is permanent; they want to feel it can be protected. And it can. Until it doesn't need to be. Because we learn being an alcoholic isn't shameful."

http://infactorium.com/2014/08/13/celebrity-and-alcoholics-anonymous.

Robin Williams

Finally, here is a link to the *Guardian* interview in 2010 in which Williams discussed his alcoholism: www.theguardian.com/film/2010/sep/20/robin-williams-worlds-greatest-dad-alcohol-drugs. •

Two different marijuana reports from Colorado

This month two reports came out of Colorado on the impact of marijuana legalization in the state. One, funded by the federal government, which opposes legalization, found that the impact is adverse, with an increase in drug use, emergency room visits, exposure to infants, and more. The other, funded by the state, which obviously supports legalization, noted that past-month use by high school seniors did not go up from 2011 to 2013 — it's still about one in four students.

The Colorado marijuana impact report issued last week by the Rocky Mountain High Intensity Drug Trafficking Area (HIDTA) program shows a 100 percent increase in traffic fatalities involving drivers testing positive for marijuana from 2007 to 2012. The report also found a 57-percent increase in marijuana-related emergency room visits from 2011 to 2013, an 82-percent increase in hospitalizations related to marijuana from 2008 to 2013, and a 268 percent increase in marijuana related exposures to children ages 0 to 5 from the 2006-2009 time period and the 2010-2014 time period. The HIDTA program is run by the federal Office of National Drug Control Policy.

However, on August 8, the state Department of Public Health and Environment issued its 2013 Healthy Kids Colorado Survey showing that from 2011 to 2013, past-30-day marijuana use among high school seniors dropped from 22 percent to 20 percent. Pro-legalization advocates — which include the state of Colorado — argued that the survey shows that legalization is not having a harmful effect on underage use, which is illegal in Colorado. The state is still planning a prevention campaign to warn young people about the damage marijuana could inflict on their brains, according to the state announcement.

The Colorado survey did not refer to daily use by high school seniors, which was found to be increasing by the Monitoring the Future study conducted by the National Institute on Drug Abuse (see *ADAW*, December 23, 2013). For the past two surveys, 6.5 percent of high school seniors across the country reported smoking marijuana daily — the most dangerous type of use. Researchers with the Monitoring the Future study expect the perception of risk to be lowest in states where marijuana is legal. The lower the perception of risk, the higher the use.

Briefly Noted

Regular marijuana use harmful for teens' brains: APA

The American Psychological Association announced at its annual meeting that frequent marijuana use significantly adversely affects the brains of teenagers and young adults. "It needs to be emphasized that regular cannabis use, which we consider once a week, is not safe and may result in addiction and neurocognitive damage, especially in youth," said Krista Lisdahl, Ph.D., director of the brain imaging and neuropsychology lab at the University of Wisconsin-Milwaukee, in a statement released August 9. With 6.5 percent of high school seniors smoking marijuana daily, and 31 percent of adults ages 18 to 25 smoking it within the last month, added to the perception of safety that the legalization movement is bringing, clinicians are increasingly concerned about the adverse effects. For example, young people who are addicted to marijuana can lose six IQ points by adulthood. In addition, brain imaging studies have shown abnormalities in gray matter in 16-to-19-year-olds who increased their use of marijuana in the past year — findings that remain even after controlling for medical conditions, prenatal drug exposure, developmental delays and learning disabilities. "When considering legalization, policymakers need to address ways to prevent easy access to marijuana and provide additional treatment funding for adolescent and young adult users," said Lisdahl.

SAMHSA study predicts slowdown in funding

An article published in the current issue of *Health Affairs* predicts that funding for substance use and mental disorders will be slower than funding for the rest of health care in the years leading to 2020. The study was paid for by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted by SAMHSA contractor Truven Analytics. We asked SAMHSA why it funded the study. The response was that the report was supported "to provide policymakers and the public with a general understanding of funding patterns in the nation's behavioral health care system," according to SAMHSA press officer Brad Stone. "In the near future, SAMHSA will release the full report, which will provide a detailed analysis of the behavioral health spending projections and the factors contributing to slower growth in behavioral health treatment spending compared with spending for overall health," he told *ADAW*. For the *Health Affairs* article, go to http://content.healthaffairs.org/content/33/8/1407.abstract.

FDA approves new sleeping aid; DEA scheduling decision not made

On August 13 the Food and Drug Administration (FDA) approved Belsomra, a new sleeping aid. The drug cannot be made available yet because the FDA recommended that it be placed on the Controlled Substances Act, but the Drug Enforcement Administration (DEA) has not made a final decision about which schedule it will be on. Earlier this year, the DEA recommended that Belsomra (suvorexant) be placed on Schedule IV. It is recommended that the medication be taken within 30 minutes of going to be, with at least 7 hours remaining before awakening.

Coming up...

The **National Conference on Addiction Disorders** will be held **August 22–26** in **St. Louis, Missouri**. For more information, go to **www.addictionpro.com/ncad-conference/national-conference-addiction-disorders**.

The **Cape Cod Symposium on Addictive Disorders** will be held **September 11–14** in **Hyannis, Massachusetts**. Go to **www.ccsad.com** for more information.

Alcoholism & Drug Abuse Weekly welcomes letters to the editor from its readers on any topic in the addiction field. Letters should be no longer than 350 words. Submit letters to:

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e-mail: adawnewsletter@gmail.com

Letters may be edited for space or style.

In case you haven't heard...

It takes what my Catholic mother calls "chutzpah" to fight the Pope — but who better than Robert G. Newman, M.D., on the topic of methadone maintenance treatment. Pope Francis recently declared that "The problem of drug use is not solved with drugs! … Substitute drugs are not an adequate therapy, but rather a veiled means of surrendering to the phenomenon." On August 8, Newman's op-ed in the Baltimore Sun called the Pope's comments "an unfortunate, categorical rejection of 'maintenance' treatment of opioid addiction with medications such as methadone." While ceding that there's room for disagreement on how substance use disorders are treated, Newman said that nevertheless everyone should agree that people who need medical treatment should "receive not only our compassion but also treatment known to save lives." For Newman's full commentary, go to http://articles.baltimoresun.com/2014-08-08/news/bs-ed-pope-addiction-20140809_1_pope-francis-drug-addiction-drug-use. We'll wait to see if there are any changes of opinion from Vatican City.