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In This Issue...

Baclofen, a generic indicated for the treatment of muscle spasticity, is being used off-label to treat alcoholism, but so far, clinical trials have failed to arrive at a conclusive dose that is effective. In Europe, high doses are being promoted, but federal researchers are concerned about safety and the side effect profile at high doses. In the meantime, commercial drug developers are looking at versions of baclofen that may have fewer side effects but have no safety data yet.
. . . *See top story, this page*

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Baclofen: Hope for alcoholism treatment, but more trials needed

There is a need to discover new medications for alcoholism, because there is not just one kind of alcoholism, according to researchers at the National Institute on Alcohol Abuse and Alcoholism (NIAAA). While disulfiram, acamprosate and naltrexone, the three medications approved for the treatment of alcoholism, are effective for some people, they aren't for everyone. Identifying new treatment is one of NIAAA's "top priorities," said Lorenzo Leggio, M.D., Ph.D., chief of the section on clinical psychoneuroendocrinology and neuropsychopharmacology, a joint NIAAA-National Institute on Drug Abuse division.

And baclofen, approved for the treatment of muscle spasticity, is at the top of the list of Leggio's candidates.

Bottom Line...
In the hunt for more effective medications to treat alcoholism, NIH researchers are honing in on baclofen, a generic, while commercial interests look at patentable versions.

Leggio knows about baclofen; he studied it in 2002 in Italy with Giovanni Addolorato in Italy ("my first scientific father"), and together they published the first small pilot showing that baclofen was more effective than placebo in treating alco-

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The Business of Treatment

Centers push ahead to market on Web, despite ethics concerns

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Some addiction treatment executives may occasionally long to return to a time before phrases such as "pay per click" and "search engine optimization" became integral features of the industry's marketing playbook. But despite often being left cringing at some of the abuses of Internet marketing practices that have become too common in the treatment community, facility marketing leaders realize they need to maintain a strong presence in the area where most of their potential patients and a growing number of referring professionals feel most at ease in searching for information.

Bottom Line...
With more families and more referring professionals turning to the Internet to access information, marketing professionals at treatment programs say they must seek the kind of Web presence that distinguishes them from those facilities that engage in questionable Internet practices.

"Whether we like it or not, more and more people are becoming increasingly comfortable having most of their communications online," Ramona Cruz-Peters, senior director of marketing and communications at Austin Recovery and The Council on

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holism.

"Then we had an idea that was unique," said Leggio. The two looked at whether they could use baclofen to treat not only alcoholics, but alcoholics with severe liver disease. This is an unusual approach, because alcoholics with liver disease are excluded from trials in which cirrhosis is a concern — disulfiram is toxic to the liver. And naltrexone, which is approved for alcoholism, has potential for hepatotixicity and has a black-box warning that it can't be prescribed for patients with liver problems.

Patients with cirrhosis

"Our idea was that baclofen is safe, and is only 10 to 15 percent metabolized by the liver," said Leggio. So a trial was done with patients with alcoholism, with cirrhosis as an inclusion criterion. "The public health implication of this trial was huge — it was the only study done with this population," said Leggio. With fewer than 100 patients, the study was published in *The Lancet*, and afterward baclofen started being used with patients with liver disease. Then another study came out from another researcher, James C. Garbutt, M.D., at the University of North Carolina, which found that baclofen did no better than placebo.

Garbutt, whose study was funded by NIAAA, told *ADAW* in 2008 that perhaps his study used doses that were too low (see *ADAW*, December 15, 2008). At the time, baclofen was popular in the press because Dr. Olivier Ameisen, a French physician who had cured himself of alcoholism by taking high doses of baclofen and become an activist for the medication.

Garbutt and Leggio, who had conflicting results, have been collaborating. "You have to have an open mind," Leggio told *ADAW*. So in 2010, the three researchers — Addolorato, Garbutt and Leggio — wrote a review summarizing the literature and giving indications of why their data were so conflicting. One of the reasons was that the Italian population in the *Lancet* study was so ill with liver disease; Garbutt's study excluded liver disease.

Anxiety

Another possible reason for the conflicting results was that baclofen, a muscle relaxant, has some anxiolytic effects. "We thought maybe baclofen would work better in those patients with severe dependence, because they are also more likely to have anxiety," Leggio told *ADAW*.

In 2006, Leggio and Addolorato had published a study that showed that baclofen reduces the acute symptoms of alcohol withdrawal; a key symptom of alcohol withdrawal is anxiety. Importantly, the researchers have no data about the use of baclofen and the seizures and delirium tremens associated with withdrawal, said Leggio.

Leggio is now recruiting alcoholic subjects with high anxiety for a National Institutes of Health–funded study on baclofen. This study, which will be double-blind placebo controlled, will help researchers understand who best responds to baclofen, said Leggio.

'Rumors' from Ameisen

In 2008, as studies of baclofen were ongoing, Ameisen published his book, *The Last Glass*, which resulted in "a lot of rumor," said Leggio. "Dr. Ameisen's observation is interesting — he had high anxiety levels, he was not responding to low doses of baclofen and he then responded to high doses," said Leggio. "So people started to think that high doses are the solution. But it's not that easy. The higher the dose, the more likely you will have side effects, including sedation, headache and nausea," he said. "If you start using a high dose, the red flag for safety concerns becomes more important."

Ameisen died last year but has a devoted following among people who want to recover from alcohol-

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ism using baclofen. However, there have also been reports of people overdosing on baclofen.

The most important question for researchers is whether, in fact, there is any truth behind the idea that higher doses are more effective than lower doses, said Leggio. It is simply not correct to say that if something doesn't work at a low dose, it is more likely to work at a higher dose. One study, for example, found that aripiprazole for alcoholism worked better at medium than high doses.

"If you don't have a randomized trial, you can't know about efficacy," said Leggio.

Safety concerns

Like Ameisen, Leggio is passionate about baclofen, but he insists on scientific rigor. "Baclofen is one of my loves; it was my dissertation. I've been dedicating 12 years to it," he said. "By now there are a lot of studies, and there is not a strong rationale to say we should use higher doses." Many studies have shown that 30 milligrams were effective, he said.

According to the Food and Drug Administration, up to 80 milligrams can be prescribed. In Europe, in general, this is up to 100 milligrams. The dose recommended by Ameisen — 300 milligrams — is still three times the highest dose that is recommended anywhere, said Leggio.

New compound

One company, Addex Therapeutics, based in Switzerland, is developing a proprietary compound that it hopes to sell. The compound, a positive allosteric modulator (PAM) of the *y*-aminobutyric acid receptor B (GABA[B]) called ADX71441, will have the advantage of having fewer side effects, Addex officials told *ADAW*. Still in an early phase of development, this compound may end up in a completely different area from alcoholism, such as smoking cessation or cocaine addiction, or maybe an entirely different application.

In January, a paper published in *Psychopharmacology* showed ADX71441 was effective compared to naltrexone in reducing alcohol consumption by laboratory animals.

"Baclofen is safe, and we are building on that," said Sonia Maria Poli, Ph.D., vice president for translational science at Addex and a co-author of the *Psychopharmacology* paper, told *ADAW*. "Our molecule is targeting the same receptor" as baclofen, she said. "Although it is safe, the tolerability of baclofen is not great; you have to slowly and progressively increase the dose and the number of doses per day to achieve the desired efficacy," she said. "We can use a low dose and cover the receptor for the whole day." The Addex compound is "building on the same pharmacology" as baclofen, she said. "With baclofen, you need a relatively high dose to get efficacy," she said. "We are using a safer and more natural mode of activating the receptor."

'The higher the dose, the more likely you will have side effects, including sedation, headache and nausea.'

Lorenzo Leggio, M.D., Ph.D.

"Baclofen has been used in many investor-led trials," said Tim Dyer, chief executive officer of Addex. "It's the differentiated pharmacology that would afford us a better tolerability and safety profile," he told *ADAW*. Noting that pharmaceutical and biotechnology companies "have historically shied away from tackling" alcoholism, Dyer pointed out the clinical trials are costly.

"We have a testing agreement in place with NIDA to evaluate both our GABA(B) compound and another compound we have, for nicotine and cocaine," said Dyer.

Another issue is that baclofen is generic. There is no patent for it, so there is no financial motive for private companies to run clinical trials. "That's why NIAAA exists," said Dyer. "You need a place like NIAAA to fill the gaps" in research, "and [baclofen] is a great example."

Addex has a worldwide patent on its molecule.

Pros and cons of new compound

The work by Addex is important, because it looks at a GABA(B) positive allosteric modulator, said Leggio. "Baclofen itself has a very narrow window — you give it in a certain dose to have effects on drinking, but at higher doses the side effects are too generic," said Leggio, citing the work of Colombo, who pioneered animal studies of baclofen and alcoholism. "The rat stops drinking mainly because of sedation." In other words, animal models are difficult, because at high doses of baclofen, the animal just stops drinking because he's too tired. The beauty of the GABA(B) positive allosteric modulators is that they don't just work on the receptor but on a different site, and induce conformational change in the structure of the receptor, said Leggio, resulting in fewer side effects than with baclofen. "From a pharmacological perspective, these compounds are, pharmacologically speaking, quite interesting," he said.

Baclofen is a pure agonist of the GABA(B) receptor — a classical ligand that blocks the receptor. The positive allosteric modulators do not block or activate the receptor itself, but rather change the structure, so that the signal coming from the receptor remains open. This is "more natural" than baclofen, said Leggio. But until it has been tested, safety in humans can't be known.

That's the down side of the compound — it's new, said Leggio.

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"Baclofen is something we can use; we have 40 years of experience with it," he said. And, he said, the toxicology data for the GABA(B) allosteric modulators can't be translated to humans yet. "When you develop a drug that is wonderful in your animal model, you also need toxicology data you can bring to the clinical setting so you can test it in humans," said Leggio. "That's a key issue, at least for me — I need to have a goal, and my final goal is to have a drug tested in humans."

Garbutt is now running trials on baclofen at 30 and 90 milligrams. And Leggio, before coming to NIAAA, did a study on alcoholic smokers and baclofen, which is now under review. Most clinical trials funded by NIAAA include both craving and alcohol consumption as outcomes, said Leggio.

Europe and high doses

Meanwhile, the situation in Europe is different.

On March 14, the French version of the Food and Drug Administration granted a "temporary recommendation to use" baclofen for alcoholism, meaning that in that country its use on a case-by-case basis for alcoholism is not off-label. There is no similar category in the United States.

The French recommendation is for an initial daily dosage of 15 milligrams with a gradual increase until there is a clinical response. There are special rules for daily doses that go about 120 milligrams a day. The recommendation covers up to 300 milligrams of baclofen a day.

There are ongoing clinical trials in France with baclofen, and a researcher in the Netherlands received an anonymous donation to run a high-dose clinical trial, said Leggio. "I try to be open-minded, but I have my own reservations about using a high dose because of safety," he said. "My point is that we need a rigorous scientific basis in order to prove safety and efficacy — that's the bottom line."

It's too soon to say whether baclofen, with its proven safety (at a low dose), or a new compound, which will be years and years in development, will come out first as a hope for alcoholism treatment. But it is clear that researchers in the United States, including those without a vested interest in a money-making proprietary medication, are focused on finding better treatments for alcoholism that will work for different patients. •

How ONDCP changed course on naloxone: Harm reduction

Naloxone, a medication that safely reverses opioid overdoses, is championed by the Office of National Drug Control Policy (ONDCP); former ONDCP director Gil Kerlikowske has traveled across the country promoting it, saying that all first responders should have it, and also promoting Good Samaritan laws that allow people to call 911 without fear of being reported for illegal drug use.

But this is a drastic change, newer than the Affordable Care Act. Only four years ago, the federal government had two approaches to handling the prescription opioid overdose epidemic: disposing of medications or locking them up. The best way to prevent overdoses, the ONDCP said then, was to prevent drug use in the first place — only the Harm Reduction Coalition and the Drug Policy Alliance promoted the widespread availability of naloxone (see *ADAW*, March 15, 2010).

Now, however, the ONDCP is on the front lines promoting naloxone. Last week, we talked to some of the same people we talked to for the 2010 story to find out what has changed, and why.

Local law enforcement and the ONDCP

Michael Botticelli, now the director of the ONDCP, was director of the Massachusetts Bureau of Substance Abuse Services when the first national drug strategy endorsing the use of naloxone by first responders was released. "I was profoundly moved," he recalled in an interview with *ADAW* last week. State and local officials knew, of course, that overdoses were a problem that wasn't going to go away. "The solution to the opioid abuse issue is to have a comprehensive strategy" that includes prescriber education, safe disposal and increasing access to treatment, he said. But the naloxone promotion was "an acknowledgment that we had to pay attention to the skyrocketing rate of both prescription drug and heroin overdoses."

> **'We need to keep people from dying.'**
>
> Michael Botticelli

Today, it is known that naloxone is easy to administer and has no down side, said Botticelli. "To my knowledge, there were no barriers that had to be overcome," he said. "One of the things that moved the conversation is law enforcement, usually the first responders on the scene," he said. "Many come from communities where they see their neighbors overdosing." There has been a rapid uptake of the Good Samaritan laws, he said, and "every day we get a report on a new local or state law enforcement agency that is adopting naloxone," he said. "We are heartened by the changes that are happening."

The ONDCP has had an important role because of its status among law enforcement, added Botticelli. "There is tremendous influence

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when the White House comes out and says 'We've been leading the charge, and the efforts are paying off,'" said Botticelli. What is unique about the ONDCP is its institutional ties with both national and state law enforcement entities, which confers a sense of authority on the naloxone issue in this case.

DPA 'radically excited'

"It's incredibly rare when people who work in harm reduction can talk about how radically excited they are," said Meghan Ralston, harm reduction manager for the Drug Policy Alliance. Four years ago, she told *ADAW* about how hard it was to get messages to young people about overdoses. Now, not only is the federal government "on board," she said, "but in a high-profile advocacy way."

Saying that the ONDCP and the Obama administration have "done some substantial growth over the past four years," Ralston noted there has been a carryover effect, with a significant number of law enforcement agencies advocating that all police officers carry naloxone in their cruisers. "And we're seeing legislatures trying to push bills through quickly to allow EMTs to carry naloxone," she said.

Ralston gives credit to the harm reduction and public health workers who behind the scenes have been working to advance the use of naloxone to reverse overdoses. In addition, she cited the outcome of the Food and Drug Administration (FDA) hearing two years ago that resulted in a focus on the need for naloxone (see *ADAW*, August 27, 2012). "The FDA has the gravitas when it convenes a meeting of the top thinkers on overdose and naloxone and suggests that naloxone could be made available over the counter — that made a lot of people sit up and take notice," said Ralston.

Still problems

However, not everyone espouses naloxone. There is Gov. Paul LePage of Maine, who is opposed to naloxone because, he said, it would encourage drug use. "If there's any kind of argument that we often see around naloxone, that's the one," said Botticelli. His response to that kind of argument is simple: "We need to keep people from dying." And there is no evidence that naloxone perpetuates drug use, he said. "What we hear is that naloxone can be a pivotal point in someone's life — to show them that they need treatment," he said. "We need to keep people alive — that should be our compassionate and humane response."

Overdoses often take place in the context of relapse — people have been in treatment but are relapsing and take too much and overdose, noted Botticelli.

Another area that the ONDCP wants to focus on is the extent to which emergency departments can be used as intervention opportunities, so that after someone is rescued by naloxone, they can have appropriate access to treatment, said Botticelli.

There are still some "major gaping holes" in overdose prevention policy, said Ralston. "Number one, we're not doing a good job of saying that if you are going to do opioids, you shouldn't mix them with benzodiazepines or alcohol," she said. "We need to acknowledge that young people may experiment with drugs, and that if they do, 'Here's how to recognize an overdose in progress.'"

Ralston noted that young people are frightened. "Can you imagine being 18, at a frat party, away from your mom and dad for the first time, all the pressure on whether you should call 911, maybe get your friends arrested?" Ralston asked.

Finally, naloxone needs to be made more widely available, said Ralston. "Some states are being proactive," she said, citing New Mexico, where naloxone can be purchased without a prescription from pharmacies. •

FDA approves naloxone auto-injector

On April 3, the Food and Drug Administration (FDA) approved a naloxone handheld auto-injector that can be used by nonmedical people to reverse opioid overdoses. This is the first approved naloxone treatment specifically for "family members or caregivers," according to the press release announcing the approval. "It is intended for the emergency treatment of known or suspected opioid overdose, characterized by decreased breathing or heart rates, or loss of consciousness." The auto-injector is a major advance, because it means no longer will people have to wait for a first responder with a syringe to administer the naloxone.

"Overdose and death resulting from misuse and abuse of both prescription and illicit opioids has become a major public health concern in the United States," said Bob Rappaport, M.D., director of the Division of Anesthesia, Analgesia, and Addiction Products in the FDA's Center for Drug Evaluation and Research, in announcing the approval. The product will be called Evzio; cost information was not released.

"Evzio is the first combination drug-device product designed to deliver a dose of naloxone for administration outside of a health care setting," said Rappaport. "Making this product available could save lives by facilitating earlier use of the drug in emergency situations."

Evzio is injected into the muscle (intramuscular) or under the skin (subcutaneous). Once turned on, the device provides verbal instruction to the user describing how to deliver the medication.

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Alcohol and Drugs Houston, told *ADAW*. "That's going to be the way that people will feel comfortable engaging with an organization."

ADAW last week interviewed two of the presenters who will participate in a May 18 panel discussion on best practices in addiction treatment facility marketing at the annual conference of the National Association of Addiction Treatment Providers (NAATP) in Charlotte, N.C. Cruz-Peters and Lisa Nickerson Bucklin, director of marketing at Father Martin's Ashley in Maryland, both acknowledged the challenges of rising above the fray on a Web whose first two W's could just as accurately stand for "Wild West" as "World Wide."

Bucklin related an experience Father Martin's Ashley had less than a year ago — one to which numerous facilities unfortunately can identify. An online "treatment center finder" site seemed on the surface to list addiction treatment facilities in what would be interpreted as the results of a global search — except that it turned out that every facility mentioned and described on the site, including Father Martin's Ashley, had the same contact phone number listed for it.

In essence, the true operator of the "finder" site was steering every caller, no matter what the presenting issue, to its treatment services and no one else's, Bucklin said. Father Martin's Ashley found out that its information was being improperly used only after a caller contacted it to express anger over having tried to reach the Maryland center without success. "This organization is pretending to be you," Bucklin recalls the person saying.

She said her organization was able to have its information removed from the site. But the site still operates, listing other treatment facilities that either don't know about it or have chosen not to respond.

Bucklin likens the process of trying to police such Web activity to a Whack-a-Mole game: "You find one today, and three more pop up tomorrow," she said.

But this can hardly dissuade a facility from operating in the online marketing world, Bucklin said. "You want to stand out [from the others] because of your transparency," she said.

Constantly assessing strategy

Cruz-Peters said her organization consistently examines its call volume to identify patterns and to determine where it should be focusing its marketing efforts. She said it will prioritize around half a dozen areas for its marketing efforts each year, although these may be altered somewhat as the year progresses.

> **'The Internet has been our number-one referral source by far.'**
>
> Ramona Cruz-Peters

In the past few years, "The Internet has been our number-one referral source by far," Cruz-Peters said. Search engine optimization has constituted Austin Recovery's primary strategy online, executed mainly by building strong content on the organization's website, she said.

The organization experimented with the pay-per-click approach for directing traffic to its website around a year and a half ago but tried it for a long enough period to be able to conclude that "it really didn't pay off for us," Cruz-Peters said.

"It generated more traffic to our site," an increase of less than 10 percent, "but it was not translating to admission calls," she said.

Social media also has become an increasingly important component of marketing efforts at Austin Recovery and The Council on Alcohol and Drugs Houston. "Our Web traffic from social media sites has increased a lot," Cruz-Peters said. Facebook is significantly the number-one source on social media, she said, but Pinterest is now consistently outperforming Twitter for her organization.

Some referring treatment professionals may remain reluctant to access social media in a professional context for fear of violating client boundaries, but social media also can have other uses in the overall marketing effort, Cruz-Peters believes. "It is a way to connect to former clients, who can become great brand advocates for us," she said.

Both Cruz-Peters and Bucklin see a great deal of potential in sound Internet marketing in the addiction treatment field, notwithstanding the stereotype that addiction professionals lag behind other fields in their understanding and embrace of technology. Bucklin emphasizes the critical importance of conveying trust in everything a facility does, including its online activity.

"Our message is that someone isn't choosing to send a family member to treatment like they're buying a used car," she said. "Just because you pick a good keyword doesn't say anything about your services — and it actually might make you suspect."

She added, "Bait and switch has no place in our marketplace. It may be OK to do that when you're in a field that is not about life and death."

Role of conferences

Another important area of facility marketing that Bucklin sees as highly volatile involves national conferences, and the growing number of options for using one's marketing dollars through meeting exhibits and related activity.

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"What we see emerging now is the development of conferences as money-making businesses," she said. "The dilemma is that this creates an ever-fragmented audience," which can pose a challenge for a facility such as Father Martin's that has diverse program offerings and therefore must remain in front of multiple audiences.

Bucklin says the decision over where to allocate resources in the conference space often hinges on developments with the facility's service mix, such as was the case when the establishment of a Pain Recovery Program at Father Martin's suddenly required it to reach out to referral sources with which it was unfamiliar.

Cruz-Peters said the high cost of national conferences for treatment organizations results in her organization's focusing mainly on having a consistent presence at regional and state conferences serving Texas professionals. •

Decoding quality: Medication-assisted treatment and choices

When shopping for treatment for opioid addiction, people have several choices: abstinence (drug-free), methadone, buprenorphine or naltrexone (oral or injectable Vivitrol). Both drug-free and naltrexone methods require detoxification first, so opioids are no longer present in the body. But how are family members and friends supposed to decide on a method? Some treatment providers are surprised that patients come in with their own preferences, while others say it's important for the patient to "buy in" to a certain kind of treatment. Two experts we spoke to agreed that there needs to be a choice, and that any treatment provider who offers only one method is probably not the best choice for anyone.

"I think when an affected individual or their family faces the question of whether they need treatment and which treatment to buy, it's very much like the funeral industry," said A. Thomas McLellan, Ph.D., CEO and co-founder of the Treatment Research Institute in Philadelphia. "It's an emotionally charged time, with very little information available." Noting that it's easier to buy a refrigerator, using quality and price indicators that have been examined by *Consumer Reports*, McLellan said that the important thing is for consumers to have a choice. "If you go in for diabetes treatment, they don't just give you insulin," said McLellan. "They evaluate you, they monitor you, they figure out the least intrusive kind of care and what fits you best, and they don't let you fail."

Good experience with buprenorphine

George Kolodner, M.D., medical director of the Kolmac Clinic, an addiction treatment program with facilities in the Washington, D.C., area, was referred to us by the American Society of Addiction Medicine as a source on the quality of medication-assisted treatment. "Patients are being targeted by all kinds of misinformation," Kolodner told *ADAW*. "It would be great if there were some independent person who didn't have a vested interest in one thing or another" who could provide an evaluation of what kind of treatment would be best, he said.

'There are certainly some doctors who take out prime time advertisements telling people all they need are the pills. I cringe when I see that.'

George Kolodner, M.D.

Kolodner, an addiction psychiatrist, is a good example. He doesn't have opioid treatment programs and so can't offer methadone. "Years ago, if I could have offered methadone, I would have," he said. Instead, he offers opioid addicts buprenorphine. "I see buprenorphine having so many advantages medically over methadone that I tend to favor it," he said (acknowledging that even if he wanted to give methadone, he couldn't). "I do think that people have biases based on various situations, so that they don't always offer patients a good alternative."

Why naltrexone fails

Kolodner has his own biases. For years and years, he used oral naltrexone for opioid addicts — they had to come to the clinic for observed dosing, so there was no compliance problem. "But we still had little success" with naltrexone, he said. "When buprenorphine came out, patients did so much better." Patients are still offered the option of naltrexone, but buprenorphine is "superior," he said. This is mainly because in early recovery, patients are still struggling with their rewired brain chemistry — still going through craving and extended withdrawal symptoms that the naltrexone doesn't assuage, he said.

In early recovery, patients "need an anesthetic for a period of time" so they can be receptive to rehabilitation, said Kolodner. "Buprenorphine is to addiction treatment as

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anesthesia is to surgery," he said. "Naltrexone was like going in for surgery without the anesthesia," he said. "You can't use, but you are so tied up with the withdrawal symptoms that you can't benefit from the rehabilitation — you're too uncomfortable."

Ask about medications

Kolodner recommends that family members and prospective patients ask providers which medications they use, why they use them or why they don't, and in general "get what their thought process is." Kolodner would have grave concerns about any addiction treatment provider who used no medications at all.

Hazelden, one of the last holdouts against medications, started using buprenorphine in 2012, mainly because their patients were overdosing (see *ADAW*, November 12, 2012). "To their credit, they said, 'We've got to change this,'" said Kolodner. "But even they were holding their nose while they did it."

Meanwhile, there are many office-based physicians who are still not understanding the need for rehabilitation in addition to medication, said Kolodner. "It's a mixed bag out there," he said. "There are certainly some doctors who take out prime time advertisements telling people all they need are the pills," he said. "I cringe when I see that."

The 'never-ending debate'

One of the most damaging effects of "this stupid never-ending debate about harm reduction, abstinence and medication" is that patients never find out what their best option is, said McLellan, who strongly believes that every patient with opioid addiction be given the option of medication. "I can't tell you how many people I talk to every day who have spent a lot of money on residential treatment programs for their kids only to find rapid relapse to injection drug use," he said. "They have never even been told about medications."

And McLellan is optimistic about treatment in general. "My opinion is full recovery is now an expectable outcome of good addiction treatment," he said. "We have enough outcomes, enough science, to make an expectable result be full recovery, which I define as reduction of symptoms to a point where it's not a problem." This recovery could be abstinence-oriented or medication-assisted, he added.

The point is that either way, the patient should be offered a choice, said McLellan. "I'm about at the end my career, and the thing I see as most frustrating and divisive is this never-ending war between ideological and financial factions that stake out territory."

Even for adolescents, McLellan is not opposed to medications. "It would not be a bad idea to try an adolescent on a medication, as long as you monitor it very carefully to see if there are problems," he said. "There should be a strategy for transitioning them off medications in a safe manner when appropriate," he said. "My objection is to the single-decision way of management." •

Coming up...

The **American Society of Addiction Medicine** will hold its 45th annual medical-scientific conference **April 10–13** in **Orlando**. For more information, go to **www.asam.org/education/annual-medical-scientific-conference**.

The 2014 **National Rx Drug Abuse Summit** will be held **April 22–24** in **Atlanta**. For more information, go to **http://nationalrxdrugabusesummit.org/event**.

The **National Council for Behavioral Health** will hold its annual conference **May 5–7** in **Washington, D.C.** For more information, go to **www.thenationalcouncil.org/events-and-training/conference**.

The 2014 Annual Leadership Conference of the **National Association of Addiction Treatment Providers (NAATP)** will be held **May 17–20** in **Charlotte, N.C.** For more information, go to **www.naatp.org/events/annual-conference**.

The **National Association of State Alcohol/Drug Abuse Directors (NASADAD)** will hold its annual meeting **June 3–5** in **Omaha, Nebraska**. For more information, go to **www.nasadad.org**.

In case you haven't heard...

The *News Tribune* in Washington state editorialized April 3 that while there are fewer adult smokers, there are not fewer young smokers. "While we're doing a better job of protecting children from adults' smoking habits, we're falling behind in preventing teenagers from becoming adult smokers," according to the editorial, which traces the problem to the "scarcity of tobacco-prevention money going to county health departments anymore." While Washington state used to give out about $28 million a year from cigarette taxes and the settlement fund, that money is now being spent elsewhere. And if the state's rate of illegal sales to minors goes over 20 percent — it's currently more than 16 percent in some counties — the state stands to lose about $13.5 million a year in federal tobacco-prevention funds.

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