

The Psychiatric Society of Virginia VIRGINIA NEWS

SPRING

A District Branch of the American Psychiatric Association

2005

Yaacov S. Pushkin, MD, DFAPA



From the President of PSV

As I conclude my tenure as President of the PSV, I extend a hearty thanks to the many who have kept the PSV active over the past year. On behalf of PSV, I extend to our Executive Director, Sandra Peterson, our warmest appreciation for shepherding all aspects of PSV activities including fiscal oversight, planning and execution of semi-annual meetings, monitoring of membership activities, production and distribution of our newsletter, maintenance of our website, and ensuring that we adhere to APA protocol in our gatherings. Indeed, it is hard to think of an area where Sandra is not involved. I am pleased to report that one of my goals this year was to secure a raise for her, which was approved by the Board for the upcoming budget year. This recognition was richly deserved. Sandra, we are all indebted to you for your devotion, consistency, and competence.

Our organization is also deeply grateful for the ongoing relationship with our Governmental Relations Consultant, Cal Whitehead. Cal, we offer you thanks for your many efforts on our behalf including parity, the PDL carve-out, protection of patient records, addressing of the Legislative Black Caucus, access to mental health for minority and youth population, advocacy updates and for keeping us apprised of and in position to effect various legislation. Your establishment

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and the subsequent growth of Psych-MD PAC has been a critical addition to our body, and will no doubt facilitate the reception of our voice on important issues.

To my friend and Immediate Past President, Greg Fisher, I thank you for your wealth of knowledge and sage advice as we contemplated decisions of meaning to our body. I also express appreciation to our Board of Directors, a stalwart group, wherein lies passion, wisdom, and a layering of mentorship that promoted thought, action, and collegiality. I am grateful to John Shemo and Ram Shenoy, our APA Assembly Reps, and to all of those who served on our various committees and to those who shared in the academic and social exchange at our semi-annual meetings. Also, I extend thanks to Jerry Morewitz, Joel Silverman, and Jim Levenson for allowing me to allocate a portion of my workdays to serve PSV.

In a recap, I was pleased to have been involved in a number of PSV efforts. We enjoyed two academically stimulating meetings, which I was proud to help arrange. As a body, we spoke out on a number of issues: the prescriptive authority challenge in Louisiana, Medicaid formulary restriction in Virginia, the adolescent death penalty, to name a few. We commented on the status of the surrendering of custody of children in order to access mental health care in Virginia. We supported the Legislative Black Caucus in providing a forum on Mental Health in the African-American Community. We contributed support

to the DMHMRSAS in providing sponsorship of the Governor's Mental Health Conference. We have promoted a forum for further discussion relating to Virginia's psychiatric bed crisis and the simultaneous need for community reinvestment. We continued to speak out on the issue of mental disorders as medical conditions in our quest for parity. We provided financial support to a number of mental health advocacy groups. We have continued to work on ethics cases to ensure the proper monitoring and practice of our members.

Where do we go from here? I hope that we will continue to support our Psych-MD PAC, in my view the most practical way to effect matters of meaning to us and our constituents. We should aspire to resolve the state bed crisis while lending support to the vision of reinvestment. We should continue to support our medical schools as they nurture the psychiatrists of tomorrow. We must continue to lobby for the expending of state resources for the mentally ill. We should strive to and enhance our membership as well continue promoting scientific and social forums and the destigmatization of brain disease. We must continue to be vigilant and proactive regarding prescriptive authority. As I prepare to pass the baton of Presidency to Ed Goldenberg, I plan once again to make a plea for PAC donations. I ask for your support.

Finally, I submit to those hesitant of being involved in PSV that one need not hold a title to make contribution, and that title holders need not and cannot be obliged to carry the matters of PSV independently without support from the greater corpus. It is incumbent upon all of us to make a contribution to PSV, be it financial or of one's personal energy. I plan to continue to serve this body whether I have a title or not. I see it as a shared responsibility.

In closing, I thank you all for the honor of representing PSV.

Sincerely,

A handwritten signature in dark ink that reads "Yaacov R. Pushkin". The signature is written in a cursive, flowing style.

Yaacov R. Pushkin, M.D.

Working Yourself Out of Your Job

Perhaps it is because I may soon be unemployed when the current administration changes, the phrase “working myself out of a job” came to mind recently. In the case of many state agency heads, including the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), one doesn’t need to work at it. The unemployment status is usually a given, and expected, when the Commonwealth’s one-term governor is replaced by their successor.

However, there have been other times in my career when I have wondered whether I have been truly “working myself out of a job.” For example, when I took over as the facility director/CEO of Catawba Hospital, (a state operated adult and geriatric facility) in the mid-1990’s it became clear that there were a number of individuals that were receiving “custodial care” in a hospital setting. The talented staff with the leadership of some exceptional physicians at Catawba helped educate co-workers, family members, private providers, and the individuals we served and were able to re-integrate many people in more appropriate settings in the community – often back in their own homes or with willing family members.

The census dropped. Catawba hospital went from a census of over 200 to a census of under 100 in about a year or two. Staff began to look at me and ask, “Are we working ourselves out of a job? Will Catawba be at risk of closing?” As their fearless leader, I stared right back, and in a firm tone, responded bravely, “I’m . . . I’m not sure.”

It turns out Catawba Hospital is alive and well and life goes on there with a census of 110. Looking back, though, I should have given a better answer to the question, “Are we working ourselves out of our jobs?” I should have responded, “I certainly hope so!”

Working oneself out of a job may seem like a dumb thing to do. Many of us have serious financial commitments and we have serious dependents – as well as creditors - who don’t want to see us in the unemployment line. But the phrase is getting used more and more. For fun, I punched the phrase into a Google search and got over 500 references. From job coaches to tips on parenting, advising people to act like they were working themselves out of their job is becoming more and more popular.



yourself. Your primary job is to direct other people toward superior performance. Do you have enough energy to never send a reporter away empty-handed. If asked, ‘Got a minute?’ then have one. You can get a lot done in 120 seconds. Many make themselves unapproachable, by exuding stress and busyness. You can’t teach people if they won’t come near you. Make the effort, always.”

Perhaps the other reason this phrase came to mind is that a provocative and disturbing new book was mailed to me by the publisher entitled, “Destructive Trends in Mental Health: The Well-Intentioned Path to Harm.” Scanning the table of contents and briefly skimming a couple of chapters - which is all I thought the book deserved – did make me resolve more clearly to make sure that those around me knew I was more interested in working myself out of a job rather than be seen as having a death grip on my desk chair. You have heard the criticism of our profession reflected in some of the chapter titles in this book. Two examples:

Chapter 5 - Expanding a Shrinking Economic base: The Right Way, the Wrong Way, and the Mental Health Way (where the author proposes that the economic pinch of too many practitioners has led to artificial and harmful methods of expanding a diminishing revenue.)

Chapter 11 – The Diseaseing of America’s Children: The Politics of Diagnosis

We have heard the criticism. We also know there is plenty of work to go around. There are so many needs in the field of Psychiatry. Much of that entails promoting concepts of empowerment, self-determination, and resiliency in our work. Much of that is helping to teach the next generation of Psychiatrists. None of that, in my opinion, should even have the appearance of making more work, protecting our guild, or protecting our work. Are you working yourself out of your job?

VIRGINIA NEWS

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*We welcome letters to the editor
and editorial contributions.*

*“Many make themselves
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exuding stress and busyness.*

*You can’t teach people
if they won’t come near you.*

Make the effort, always.”

Here is something I found browsing the web for the phrase. An interesting journalist and writing coach who died of cancer in 2001 at the age of 61, named Foster Davis wrote, “Work yourself out of your job. This means you must think constantly of showing people how to do something, rather than doing it

2005 General Assembly Review

The General Assembly adjourned one day late this year after agreeing on a \$63 billion budget. Attention was focused on transportation funding, social policy, and "campaign" bills but the medical community had some high profile measures to address. Below are summaries of bills and initiatives impacting physicians and patients.

Medical Malpractice Insurance and Tort Reform

The centerpiece of tort reform, a \$250,000 cap on pain and suffering damages, failed to make it into the Omnibus Medical Malpractice Reform Bills HB 2659 (patroned by Delegates Kilgore, McDonnell and Albo) and SB 1173 (patroned by Senators Newman and Stolle). Despite grassroots support from physicians, legislators were not convinced that Virginia is facing a medical malpractice insurance crisis. The General Assembly did support the following reforms:

- Certification of expert witness opinion at time of service of process
- Admissibility of expressions of sympathy protected (I'm sorry language)
- Competency evaluations of certain practitioners
- Medical malpractice claims data reported to insurance commissioner—closed claims
- Allowing a physician to testify about his patient for the defense
- Expanding the definition of medical malpractice to include contract claims regarding patient care

Assignment of Benefits (AOB) and Health Insurance Reform

A growing movement to require insurance companies to pay out-of-network physicians directly led to Senator Tommy Norment's introduction of SB 904. In its original form, this bill would have ensured prompt, direct pay for physicians who chose not to be in-network

and would have outlawed a tool used by Anthem-Wellpoint to force doctors into networks. Anthem-Wellpoint and the Virginia Association of Health Plans (VAHP) vehemently opposed the legislation and enlisted the help of the Chamber of Commerce and other business interests. Insurers acknowledged that by not honoring patient assignment to out-of-network physicians, they keep networks together because medical practices cannot collect from patients efficiently or completely. As passed, SB 904 will require insurers to include instructions for payment, along with the out-of-network physicians' address, with an explanation of benefits (EOB). Physicians are encouraged to report collection problems and unfair negotiating tactics to the Medical Society of Virginia and their local or specialty society.

The Fair Business Practices Act was amended to increase the carrier's obligation to disclose all bundling and coding practices

Continued on page 4

Measure the benefits from your practice's insurance agency.



Other agencies



MSVIC

As a wholly owned subsidiary of **The Medical Society of Virginia**, our insurance agency profits go to MSV to help serve the Virginia Physician Community.

The purpose of the Medical Society of Virginia Insurance Center is twofold. First, to provide Virginia physicians with a one-stop-shop where they can receive expert guidance from insurance specialists about important coverages such as professional liability insurance, health insurance, employee benefits, and property and casualty coverages.

Second, the MSVIC serves the Medical Society of Virginia as a source of non-dues revenue. As the insurance agent for many physicians, the MSVIC receives commissions from the insurance companies where business is placed. These commissions lead to profits, which are sent by MSVIC to the Medical Society of Virginia to support the Virginia physician community.

Contact us to find out just how much more we have to offer your practice and the entire Virginia Physician Community.



4198 Cox Road, Suite 114
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Access sample cover letters and curriculum vitae, career development articles, salary surveys, interview worksheets and other tools on the APA Job Bank.



Visit the Psychiatric Society of Virginia website at www.psva.org and click on the APA Job Bank logo on the home page

Review continued from page 3

in their contracts or posted on their websites. The act also establishes that changes to provider contracts cannot be effective without 60 calendar days notice to the provider. In addition, physicians now have 30 calendar days, rather than 15 business days to notify the carrier of acceptance or denial of the changes. Finally, all carriers must now establish written claims payment dispute mechanisms and make this information available.

Medicaid Fee Increase

The state budget does include increases in Medicaid reimbursements for some physicians; however, it is not an across-the-board increase as the MSV had sought. The increase breaks down to a 3% increase for ER physicians; 2.5% for obstetricians; 1% for pediatricians, and 5% for primary care physicians. The MSV was charged by the legislature to find new revenue to support a Medicaid reimbursement increase and it did so through two tobacco bills: HB 2919 (patroned by Del. Clarke Hogan) and SB1332 (patroned by Sen. Phil Puckett). While these bills go into effect July 1, 2005, it will be April 2006 before the state receives the additional funding. Hence, the increase in reimbursements will be effective May 1, 2006.

Psychiatric and Mental Health Care Issues

The General Assembly passed a budget that includes language and funding to exempt anti-anxiety and anti-depressant medications from the Medicaid Preferred Drug List (PDL) prior authorization process. Budget language also modifies the composition of the

Medicaid Pharmacy and Therapeutics Committee to ensure at least one-half of the Committee is composed of professionals who provide services to Medicaid recipients.

The Legislature's budget provides \$3,850,000 for crisis stabilization units to provide acute and intensive services in Northern Virginia, the Shenandoah Valley, the Upper Peninsula of Hampton Roads and the Tidewater area. The location of three additional units shall be designated by the Commissioner. These units have proven effective in assisting consumers in crisis and providing needed stabilization and treatment, averting more costly hospital placements.

PSV-WPS amended HB 2037 (Hamilton, R-Newport News) to include itself among the groups represented on the Interagency Civil Admissions Advisory Council which will study issues related to the provisions of Virginia law regarding the emergency custody, temporary detention, admission, and involuntary inpatient and outpatient treatment of persons with mental illness, propose recommendations and provide advice addressing those issues, and improve the coordination and effectiveness of the implementation of those recommendations. Please contact PSV or WPS if you are interested being recommended for this Gubernatorial appointment.

PSV-WPS assisted the Joint Commission on Health Care with revisions to Virginia law that are consistent with federal HIPAA protections and requirements. Those bills, which deal with access to medical records and disclosure requirements, have passed the General Assembly. Delegate John O'Bannon (R-Henrico), a neurologist, patroned most of these measures.

HB 2245 (Bell, R-Albemarle) requires the Board of Juvenile Justice, after consultation with

the Board of Mental Health, Mental Retardation, and Substance Abuse Services and other related agencies, to promulgate regulations for the planning and provision of mental health, substance abuse or other therapeutic treatment services for persons returning to the community following commitment to a juvenile correctional center or postdispositional detention. PSV-WPS worked with representatives of DMHMRSAS, the Alzheimer's Association, Delegate Brian Moran (D-Alexandria) to address concerns about the treatment of detained Alzheimer's patients. Delegate Moran's HB 2551 would have excluded Alzheimer's from definition of mental illness. Interested parties agreed that this would have unintended consequences and create obstacles to care. A group will work with Delegate Moran to find alternative solutions.

2005 Elections

On November 8, Virginians will choose our next Governor, Lieutenant Governor, and Attorney General. The 100 members of the House of Delegates face re-election campaigns. The Virginia Senate is not up for re-election. For information on candidates, campaigns, and contributions please visit the Virginia Public Access Project (VPAP) website www.vpap.org/cands/index.cfm. As always, an election year is the best opportunity to engage and support candidates. Please contact me if you would like to get involved in a House or Statewide campaign.

For more information on any of these issues or to raise other concerns, please contact Cal Whitehead at cwhitehead@whiteheadconsulting.net.

Psychiatrists for Rural Virginia Child & Adolescent Psychiatry Practice

Rural Virginia child and adolescent psychiatry practice, 25 years old and thriving is available in June 2006.

It has not been true that there has been no psychiatric care in this rural area or that a non-physician is needed here.

Interested child and adolescent psychiatrists can call for an appointment to visit the location and discuss with me the opportunity to continue an incredibly rewarding practice and to experience a personal fulfillment. The community needs us.

Shenandoah County is growing fast and there may be work for 2 psychiatrists in the practice next year.

Call Eloise C. Haun, M.D. at 540-459-1271 for an appointment to visit the location

You have just been subpoenaed. *Do you know how to respond?*



If you have your malpractice insurance through The Psychiatrists' Program you can rest assured. With a simple toll-free call, a risk manager can assist you with the immediate steps you need to take to protect your practice.

As a Program participant, you can call the **Risk Management Consultation Service (RMCS)** to obtain advice and guidance on risk management issues encountered in psychiatric practice. Staffed by experienced professionals with both legal and clinical backgrounds, the RMCS can help prevent potential professional liability incidents and lawsuits.

If you are not currently insured with The Program, we invite you to learn more about the many psychiatric-specific benefits of participation. **Call today to receive more information and a complimentary copy of "Six Things You Can Do Now to Avoid Being Successfully Sued Later"**

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PSV IN THE NEWS

Your '05-'06 directory was sent to you in February. Hopefully you have received it. But if you did not please contact Sandra at the PSV office and she will get another one to you. (Directories are mailed to all PSV members except for Members-in-Training.)

Spring and Fall Meeting Update

Jointly Sponsored by the American Psychiatric Association
and the Psychiatric Society of Virginia

The Psychiatric Society of Virginia's Annual Spring Meeting

Survivor: Psychiatry

Saturday, April 16, 2005

Richmond Marriott West

4240 Dominion Boulevard, Glen Allen, Virginia

THE PROGRAM ON SATURDAY INCLUDES:

8:25 am • **Yaacov R. Pushkin, MD, President**
Welcome

8:30–9:30 am • **Norman Camp, MD, Director Resident
Psychotherapy Training, MCV/VCU; Private Practice of
Psychiatry and Psychoanalysis, Richmond Virginia**
Survival of Psychotherapy in Psychiatry

9:30 am–10:30 am • **Joel Silverman, MD, Chair, Dept.
of Psychiatry, MCV/VCU, Richmond, Virginia**
Survival of Academic Psychiatry

10:30 am–11:00 am • **Break with Exhibitors**

11:00 am–12 noon • **James Reinhard, MD,
Commissioner, DMHMRSAS, Richmond, Virginia**
Survival of Public Sector Psychiatry

12 noon–1 pm • **Lunch and Business Meeting**

1:15–2:15 pm • **Harold Eist, MD, Private Practice,
Bethesda, Maryland & Past President of the APA**
Survival of Private Practice Psychiatry

2:30 pm–4:00 pm • **Roundtable Discussion, Q&A**

**Deadline for room reservations is Friday, March 25,
2005 by 5:00 pm. 804-965-9500 Rate for single/double
is \$85.00 (plus taxes)**

Brochures are in the mail!

**Mark the Date
for the PSV Fall Meeting
Friday & Saturday, October 14 & 15
Marriott Norfolk Waterside
Norfolk, Virginia**

Congratulations to our new APA Distinguished Fellow and APA Fellows



Distinguished Fellows:

Rochelle L. Klinger
Kathleen M. Stack



Fellows:

Roger C. Burket
Alice N. Jesudian
Yad M. Jabbarpour

Corrections to the Directory

Please make these corrections in your copy:

Page 7

Ashai, Shaista *add BC before GM*

Ashman, Stuart *replace O with H in front of address and change LF to DLF*

Page 17

Evans, James *change e-mail address to:*

james.evans@co.dmbmrsas.virginia.gov

Page 18

Fernbach, Lousie *deceased 2/05*

Page 22

Hedberg, Ann *change last digit in phone number to a 5 (540-387-3105)*

Page 24

Jackson, Rochelle *remove – moved to Washington, DC*

Page 31

McNeil, Stephen *remove – no longer a member*

Page 35

Pizzani, Mimi Koller *change e-mail to mimikpizzani@comcast.net*

Posadas, Luis *change address to Behavioral Medicine Institute, 606*

Denbigh Blvd., #100, Newport News, VA 23608 Phone 757-872-8303

Page 39

Shemo, John *change e-mail to jsbemomd@hotmail.com*

Page 51

Peele, Roger *change address to P.O. Box 1040, Rockville, MD 20849*

Are You Eligible... For DISTINGUISHED FELLOWSHIP?



APA Distinguished Fellowship is a national honor awarded by the APA to psychiatrists who have made and continue to make significant contributions to the profession and the community.

The APA Membership Department annually sends to each District Branch a list of its members who have been APA General Members or Fellows for a combination of at least eight years. Those eligible will apply through their local District Branch and PSV will supply the application and instructions.

The following criteria must be met:

- ✚ *Not less than eight years as a General Member or Fellow of APA* ✚
- ✚ *Primary identification must be psychiatry for those in combined fields (e.g., psychiatry and pediatrics).* ✚
- ✚ *The District Branch should not resubmit the names of members who were nominated but not approved the preceding year. The purpose of this requirement is to allow time for members being re-nominated to improve their qualifications in areas where previously they did not show adequate strength. While a waiver of the two-year requirement is possible, there must be compelling reasons adequately documented by the branch.* ✚
- ✚ *The General Member or Fellow should be an outstanding psychiatrist who has made and continues to make significant contributions in at least five of the areas listed below. Excellence, not mere competence, is the hallmark of a Distinguished Fellow.* ✚
- ✚ *Certification by the American Board of Psychiatry and Neurology, the Royal College of Physicians and Surgeons of Canada, or equivalent certifying board.* ✚
- ✚ *Involvement in the work of the District Branch or other components of the APA.* ✚
- ✚ *Involvement in other medical and professional organizations.* ✚
- ✚ *Participation in non-compensated mental health and medical activities of social significance.* ✚
- ✚ *Participation in community activities unrelated to income-producing activities.* ✚
- ✚ *Clinical contributions.* ✚
- ✚ *Administrative contributions.* ✚
- ✚ *Teaching contributions.* ✚
- ✚ *Scientific and scholarly publications.* ✚
- ✚ *At least three of the letters must be from Distinguished Fellows of the APA. The District Branch Distinguished Fellowship Chairperson shall forward nominations to the APA Membership Committee by the 1st of July.* ✚

.....Or for FELLOWSHIP?



If you have been an APA General Member for five consecutive years, the APA will notify you that you may apply for nomination to Fellow. You will apply directly to the APA; they will provide the form and instructions.

You must meet the following additional criteria:

- ✚ *ABPN, RCPS®, or AOA certification.* ✚
- ✚ *Three letters of recommendation from APA Fellows or Distinguished Fellows.* ✚
- ✚ *Approval by the PSV.* ✚

Contact Sandra Peterson at the PSV office if you are interested and eligible for either Fellow at 804-754-1200 or e-mail at spetersonpsv@comcast.net.

A New Arrow in the Quiver: *Using Suboxone® to Treat Opioid Dependence*

As psychiatrists, you see it in your practice. Each year, millions of ordinary Americans who are properly treated for pain become dependent on prescription opioid painkillers when the need for medication has outlasted the need for pain relief. Millions others abuse heroin. Such opioid dependence is a chronic, relapsing brain disease that involves physical, psychological, and behavioral elements.

A sizeable proportion of individuals who seek your help for psychiatric conditions are likely to be already suffering from opioid dependence, whether from Rx painkillers or heroin. Among patients who seek treatment for opioid dependence, 47% have documented psychiatric co-morbidities. Many of these patients, with complicated dual or triple diagnoses, may have already experienced difficulty accessing the medical community and are avoided or referred by the medical professionals from whom they initially had sought treatment.

The statistics are compelling as to the need for psychiatrists to screen within their practices for opioid dependence:

- Opioid users have a significantly higher rate of depression (15.8%) compared with non-opioid users (5.7%)—and depression affects approximately 5% of the adult US population, about 19 million people.
- Patients with anxiety disorders are 2.4 to 4.8 times more likely to have a drug dependence problem than the general population.
- Nearly 50% of people with schizophrenia have a lifetime substance abuse disorder, a rate at least 3 times that of the general population.

Heroin abuse remains relatively constant at around 1.5 million individuals. Rx opioid painkiller dependence, however, is skyrocketing—according to the *2003 National Survey on Drug Use and Health*, approximately 4.7 million teenagers and adults currently use prescription painkillers for nonmedical

purposes, and approximately 31.2 million report having used Rx opioids for nonmedical purposes at least once in their lives.

Given the reasonably high probability that your present patients as well as new patients with whom you have initial diagnostic sessions are among the millions with opioid dependence, it is key to screen for opioid dependence and know how to treat it medically when it presents.

*... it is key to screen for
opioid dependence and
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medically when it presents.*

A Treatable Brain Disease

Opioid dependence is classified by the World Health Organization as a chronic, relapsing brain disease. Much like several other major psychiatric illnesses—bi-polar disorder, schizophrenia, autism, and depression—it is a medical condition that creates havoc in people's lives, often causing grave financial, social, and medical burdens for patients and their families, friends and employers. Because opioid dependence is extremely stigmatized, patients may hesitate to seek treatment, creating delays that only exacerbate their condition. Excessive or prolonged use of opioids can lead to physiological changes in the brain's function and chemistry, and with long-term use, these changes can persist even after the patient has stopped using the drug, setting the stage for relapse of this chronic disease.

Despite the rapid growth in opioid dependence, there is now a therapeutic option that offers hope to many of these patients. A

medical treatment is now available to treat such dependence—office-based opioid treatment (OBOT) with Suboxone® (buprenorphine/naloxone), the first medication approved by the FDA under the Drug Addiction Treatment Act (DATA) of 2000 for in-office opioid medical withdrawal and take-home maintenance prescriptions.

Benefits of Suboxone's Mechanism of Action: Partial Opioid Agonist

Suboxone is unique among opioid dependence treatments in that it is a partial opioid agonist. The buprenorphine molecule in Suboxone binds tightly to opioid receptors in the brain, thereby occupying receptors that are otherwise available to full agonist opioid painkillers or heroin. There are multiple patient benefits to this mechanism of action:

- Patients being properly treated with Suboxone derive limited additional reinforcement if they attempt to use other opioids, such as Rx opioid painkillers or heroin;
- Suboxone effectively suppresses withdrawal symptoms, and patients also report that Suboxone greatly reduces or eliminates their drug cravings;
- Because of Suboxone's characteristic slow dissociation from the receptors, ceiling effect, and lower intrinsic activity, it is thought to be easier for patients to withdraw from Suboxone and so become opioid-free than is the case with full agonists such as opioid painkillers, heroin or methadone;
- Suboxone's pharmacological characteristic as a partial agonist means that patients are likely to have fewer objective and subjective signs and symptoms of withdrawal following chronic dosing than is true with full agonists; and
- Because it is a partial agonist, Suboxone by itself does not lower respiration to the same extent as a full opioid agonist.

Continued on page 9

A New Arrow continued from page 8

However, as with all opioids, when Suboxone is abused intravenously or in combination with other Central Nervous System depressants, serious adverse events have been reported.

A New Weapon for Mental Health Professionals

For your opioid-dependent patients, Suboxone may be a valuable adjunctive therapy to psychosocial counseling. Patients and their therapists report that treatment with Suboxone can be beneficial to many other types of intervention, helping patients remain in treatment and thereby allowing them to focus on other aspects of their recovery, undistracted by opioid withdrawal symptoms or cravings.

Opioid prescription painkillers play a critical role in the treatment of acute and chronic pain. But they also can pose a grave risk to a certain percentage of patients who, perhaps for genetic reasons, become dependent. These victims are people at all socioeconomic and demographic levels—it can happen to anyone. Psychiatrists and other mental health professionals, on the front lines of mental health treatment, have the opportunity and the responsibility to help identify and treat patients with this chronic brain disease. Doing so will help these patients gain control over their dependence so that they can better focus on rebuilding their lives.

How to Become a Suboxone Prescriber

You can become certified to use Suboxone to treat patients in the privacy of your own office. Psychiatrists holding a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties and addiction specialists holding either an addiction certification from the American Society of Addiction Medicine or a subspecialty board certification in addiction medicine from the American Osteopathic Association are qualified to prescribe Suboxone. To begin prescribing, they simply must notify SAMHSA of their intent to treat opioid dependent patients with Suboxone prior to initiating treatment (typically

this is done by submitting a Notification of Intent [NOI] form to SAMHSA.) Additionally—and with truly huge implications for patient access to treatment—any doctor may become certified to treat opioid dependence after 8 hours of CME training and submission of an NOI form to SAMHSA. Under any circumstance, once the review of the NOI is complete, the physician receives a confirmation of the

— — — — —
*As a new treatment
modality, in-office
treatment with Suboxone
brings the promise of
discreet, private, and
respectful medical help to
an underserved patient
population on an
unprecedented scale.*
— — — — —

waiver and a DATA 2000 prescribing number.

As a new treatment modality, in-office treatment with Suboxone brings the promise of discreet, private, and respectful medical help to an underserved patient population on an unprecedented scale. To register for a training course near you, please visit www.DocOptIn.com. For more information on treating opioid dependence with Suboxone, see www.suboxone.com, www.opioiddependence.com, or www.buprenorphine.samhsa.gov.

In the U.S., the primary formulation of buprenorphine is Suboxone, a combination of buprenorphine and naloxone, an opioid antagonist that causes severe withdrawal if Suboxone is injected intravenously by an opioid-dependent person. There is also a buprenorphine formulation called Subutex®, which does not contain naloxone; Subutex is

primarily used for initial “induction” to buprenorphine (detoxification) under a doctor’s direct supervision. Subutex is not routinely prescribed for at-home maintenance therapy in the U.S.

Statement of Fair Balance

Suboxone® or Subutex® are controlled substances that should only be used as prescribed by a doctor who knows about the patient’s medical history and all other medications the patient is taking, especially CNS depressants, such as tranquilizers and sedatives. Some of the most common side effects that may occur when taking Suboxone and Subutex include: headache, pain, asthenia, constipation, nausea, anxiety, depression, runny nose, sweating, and withdrawal symptoms. For more information, please see the complete prescribing information.

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VIRGINIA NEWS

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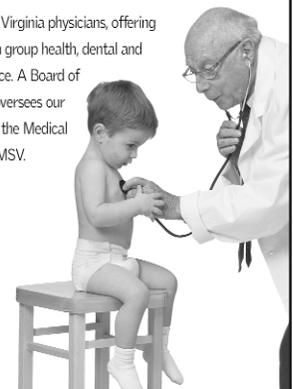
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