

ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

Volume 21 Number 18

May 4, 2009

Print ISSN 1042-1394

Online ISSN 1556-7591

HIGHLIGHTS...

How the parity law is written into regulation will determine whether it helps patients access addiction treatment or not. As veteran lobbyist Carol McDaid puts it, this is where the rubber meets the road. The federal government last week asked for comments, due by May 28, on how parity should really look. Both quantity and quality count, so ... comment! *See story, top of this page.*

Treatment organizations can now assess how well they are doing by benchmarking. A collaboration between Behavioral Pathway Systems, NIATx and SAAS, the program includes a year of data collection. The initiative will be focused on measures that are associated with improved outcomes. *See story, bottom of this page.*

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Published online in Wiley InterScience
(www.interscience.wiley.com) DOI: 10.1002/adaw.20184

Federal government calls for comments by May 28 on implementing parity

Last week the federal government began the process that will result in regulations to implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 — the parity law signed last year.

In issuing an RFI (request for information) in the April 28 *Federal Register*, the three agencies responsible for developing the regulation called for clarifications, definitions, and information from the field. The comment period is short — 30 days — with comments due by May 28.

Congress' intent

A complicating factor in developing the regulations is the lack of a conference report from Congress, a document that usually serves as a guide for agencies drafting regula-

tions. Although both the House of Representatives and the Senate passed the final bill last fall (see *ADAW*, Oct. 13, 2008), there had been significant differences at first between the House version, which was supported by addiction treatment, and the Senate version, which was supported by mental health, employers, and insurance companies.

"How the law gets interpreted is where the rubber meets the road," said Carol McDaid, principal with Capitol Decisions, a government relations firm active in lobbying on behalf of treatment. "What matters is that the compromise bill passed both chambers," she told *ADAW*. "But regulators will have some questions and some lack of clarity about what the law meant."

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Organizations partner to offer national benchmarks for SA providers

Building on a culture of organizational performance improvement that has been reinforced through the many projects of the Network for the Improvement of Addiction Treatment, NIATx is partnering with two other entities to conduct what could become a groundbreaking effort to offer treatment agencies comparative performance data.

NIATx, the State Associations of Addiction Services (SAAS) and consulting firm Behavioral Pathway Systems are establishing a national benchmarking initiative designed to help addiction treatment agencies achieve organizational excellence. Unlike some other benchmarking projects in behavioral health care, this initiative will be designed by in-

dividuals with addiction treatment expertise and will be tailored to the service and organizational issues that specifically matter to the addiction treatment community.

"Addiction providers have always felt like a minority in the behavioral health continuum," Paul M. Lefkowitz, Ph.D., president of Behavioral Pathway Systems, told *ADAW*. "This will be targeted for metrics that are relevant to addiction, and providers will be compared only to other addiction providers."

Lefkowitz said he hopes at least 75 to 100 treatment agencies will enroll in the program, to give a sufficient sample size for making relevant comparisons among agencies.

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For example, how insurance companies determine medical necessity and impose utilization reviews are supposed to be the same for mental health and substance abuse as they are for other medical and surgical conditions, under the law. “Regulators should interpret the law according to both the letter and the spirit,” said McDaid. “If they don’t interpret it that way, Congress will have worked for 12 years on a piece of legislation that will have no benefit to the consumer.”

The agencies don’t want that to happen — and they don’t want to write a rule that would allow for “subterfuge” by the insurance plans, a federal official working on the rule told *ADAW*. For this reason, the comments from addiction treatment professionals are essential to making the regulation serve consumers who need treatment. Comments will be incorporated into the preamble of the interim final rule, and all comments will be available to the public.

Both quality and quantity count when it comes to the comments, said McDaid, noting that in coming days there will be a model response on the Faces and Voices of Recovery website (www.facesandvoicesofrecovery.org).

Administrative code — the language of the RFI (which refers to the parity law as the MHPAEA) — is not

easy to read, noted Daniel Guarnera, government relations director for the National Association of Addiction Treatment Providers (NAATP) and NAADAC, the Association for Addiction Professionals (NAADAC). “We are encouraging our members to be direct, clear and precise with their comments,” he said. “They can leave the legalese to the lawyers.”

Medical necessity

One key issue for the addiction treatment field — the misuse of “medical necessity” as an arbitrary way to deny treatment — in particular cries out for comment as parity goes forward.

The issue of “fail-first” techniques — in addiction treatment, the requirement imposed by many payers that patients fail at lower levels of care before being admitted to higher levels — is an important area to comment on. “If you use utilization review techniques on the behavioral side that you’re not using on the surgical side, you would not be in compliance,” said McDaid. But the law uses the word “predominant” to gauge whether parity is present.

In the 1996 mental health parity law, predominant was defined to mean two thirds. This would mean that if “fail-first” isn’t used in two thirds of medical-surgical conditions, it can’t be used for substance abuse treatment, said McDaid. “We

also need to clarify that the full scope of services be included,” said McDaid. Otherwise, a plan could end up offering outpatient only, and that might be considered as meeting the criteria.

Another way insurance companies discriminate against addiction treatment is by limiting the types of providers they cover, said McDaid. “They’ll say they won’t pay for clinical licensed social workers, or for certified addiction counselors,” she said. “Just in NAADAC, there are 80,000 counselors. If you’re going to block out that whole group, you are blocking out a large section of our workforce.”

The parity law doesn’t require plans to include mental health and substance abuse benefits at all — it just says that if they do, they must offer them at the same level as other medical and surgical benefits. However, that raises questions about what kind of treatment is offered when a patient gets an antidepressant medication from the patient’s internist — a common practice. “Does that constitute that they’ve offered a benefit and have to be in full compliance?” asked McDaid. If the answer is yes — and it should be — that would make it more difficult for a plan to say it doesn’t have to comply because it doesn’t offer any mental health or substance abuse treatment at all.

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

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Alcoholism & Drug Abuse Weekly (Print ISSN 1042-1394; Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the first Monday in July, the first Monday in September, the last Monday in November and the last Monday in December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Electronic only: \$699 (individual), \$3950 (institutional); Print and electronic: \$769 (individual, U.S./Can./Mex.), \$913 (individual, all other), \$4345 (institutional, U.S.), \$4489 (institutional, Can./Mex.) and \$4537 (institutional, all other). **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Subscription Distribution US, c/o John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774; (201) 748-6645; e-mail: subinfo@wiley.com. © 2009 Wiley Periodicals, Inc., a Wiley Company. All rights reserved. Reproduction in any form without the consent of the publisher is strictly forbidden. For reprint permission, call (201) 748-6011.

Alcoholism & Drug Abuse Weekly is indexed in CINAHL: Cumulative Index to Nursing & Allied Health Literature (EBSCO).

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Health care reform

For purposes of the parity law, the focus is on parity and private insurance via employer-sponsored plans. The public sector would more likely fall under the rubric of health care reform proposals currently being debated in Congress. Under health care reform — which would most likely affect the uninsured population — it's likely that there will be provisions for addiction treatment as well, according to McDaid.

"I feel positive about the fact that care for people with addictive disorders will be included in the House bill that's being drafted," she told *ADAW*. "The devil is always in the details," she admitted. The issue dominating the headlines is whether or not there will be a public plan — something that is an important issue for the poor. The field is likely going to insist that any public plan that is developed include substance abuse and mental health parity as defined by the law.

Interim final rule

The parity regulations will not be developed according to a standard rulemaking process. Instead, there will be an interim final rule issued sometime before Oct. 3, the day the law takes effect. Then, the federal agencies will take additional comments based on that rule, and issue a final rule sometime afterward. So now is the only real chance for the field to make a difference in the regulations before they take effect.

The agencies governing the reg-

Questions the RFI asks

Among the questions regulators ask in the request for information (RFI) published last week:

- How do plans currently apply financial requirements or treatment limitations to: 1) medical and surgical benefits and 2) mental health and substance use disorder benefits? Are these requirements or limitations applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?
- What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?
- What information, if any, regarding the criteria for medical necessity determinations made under the plan (or coverage) with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?
- What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?
- To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical and surgical benefits?

ulation are: Internal Revenue Service (Department of the Treasury), Employee Benefits Security Administration (Department of Labor), and the Centers for Medicare & Medicaid

Services (Department of Health and Human Services). Only send a comment to one department — all comments will be shared with all departments, according to the RFI. •

For a copy of the RFI, which includes the process for submitting comments, go to <http://edocket.access.gpo.gov/2009/pdf/E9-9629.pdf>.

N.Y. outpatient system will combine methadone, other modalities

In the future there will be "one system of recovery" in New York, Karen M. Carpenter-Palumbo, Commissioner of the Office of Alcoholism and Substance Abuse Services (OASAS) announced last week at the annual conference of the American Association of the Treatment for Opioid Dependence (AATOD). A patient will be able to walk into any program and get methadone, buprenor-

phine, drug-free treatment, or whatever he or she needs.

Currently, if a patient walks into an opioid treatment program (OTP) in New York, the only treatment they can get is methadone, said Carpenter-Palumbo. That is going to change in the very near future — OTPs will become addiction recovery centers, able to offer counseling and other treatment for all kinds of

addictions, she said. Ultimately, what will take place in the state is a streamlined outpatient system.

"My vision is that someone can walk into any one of our 1,500 outpatient facilities, wanting to break the cycle of addiction, and that we will help them with what they need," Carpenter-Palumbo told *ADAW*. "There must be one door to recovery."

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It doesn't make any sense to separate the methadone treatment system from the rest of the outpatient treatment system, said Carpenter-Palumbo in an interview with *ADAW*. Combining them would go far toward removing the stigma from methadone, as well, she said.

"We have too long had them as separate units," she said, adding that there are barriers to a unified system within society that go back decades.

An emphatic supporter of methadone as an addiction treatment, Carpenter-Palumbo stressed that transformation will improve conditions for the consumer and the OTPs. "I chose the AATOD meeting [to make the announcement] because I wanted to make sure everyone clearly understood that medication assisted treatment is a respected form of an outpatient system of care."

Historically, heroin addicts were "not considered in the same culture or class as alcoholics," said Carpenter-Palumbo. "As we tried to deal with heroin addiction, using methadone was seen as the supplying of another drug." That was partly due to stigma, but partly to the regulations which require close supervision of methadone patients — almost to the point of "criminalizing" the medication, she said. "We're going to give it to you, but watch you very closely because we don't trust you," she said. "That was the message that was given."

One regulation

OASAS has already taken the first step in the transformation process by revising the methadone regulation (known as 828) and the outpatient regulation (known as 822) under one 822 regulation. The combined regulation, to be issued later this year, will have a separate section for methadone, but sets the stage for future discussions on merging the entire outpatient system of care.

The changes don't mean all programs will be immediately re-

'There must be one door to recovery.'

Karen Carpenter-Palumbo

quired to dispense methadone or that OTPs will be required to offer non-methadone services, Carpenter-Palumbo told *ADAW*. "We will have a transparent discussion with everyone sitting around the table talking about this," she said.

"There has always been some discord in the field as to whether methadone is truly treatment, and whether someone on methadone is in recovery," said Carpenter-Palumbo. "My belief is that it is, and they are." The treatment must be tailored to the person, however.

Report cards

There are changes in the methadone system itself that must be made in order to show better "respect for the consumer," said Carpenter-Palumbo. "I've stood in line on a Saturday morning with people lining up for methadone," she said. "It's not normal for everybody to go at 10 a.m. in the morning and wait in line. I don't know too many other diseases where people wait in line to get their medication."

There will be "report cards" for OTPs in the future, she said. "This is not a punishment, but an empowerment," Carpenter-Palumbo told the

AATOD attendees. "This is so we can spread best practices and outcomes."

There are problems with the current system, which is "archaic," agreed Ira J. Marion, executive director of the Committee of Methadone Program Administrator, which represents OTPs in the state and which supports the transformation.

The current methadone system creates programs that "are silos for community rage and patient disgrace," he said. "One of the things we need to do is get stabilized people out of the waiting rooms with people who used crack cocaine an hour ago." This means expanding medical maintenance — having stabilized patients go to an addiction psychiatrist, who prescribes a month's worth of methadone, and sends the patient to the pharmacy to pick it up.

"Programs have to get out of these situations where 800 people are coming to a single building every day," Marion told *ADAW*. Even if only 10 of these people are loitering outside, and the other 790 are doing well, the program suffers, he said.

Eventually, OTPs need to move toward providing "drug-free chemical dependency programs," he said. "We need to be doing business differently. This is the only way we're going to survive down the road: OTPs need to become addiction recovery centers, to work toward erasing the stigma." •

Billing transformation in New York

The next step in methadone transformation will be to consolidate the billing under the state's behavioral Medicaid transformation, which OASAS and the state Office of Mental Health (OMH) are developing (see *ADAW*, Jan. 19). Under the plan, treatment with methadone, which is currently paid for at the weekly rate of \$138 by OASAS, will be merged with other outpatient treatment, currently paid for by Medicaid at a visit rate ranging from \$62 to \$127.

Programs will be paid based on the intensity of the services they provide. Instead of being paid the flat \$138 for a methadone patient per week, regardless of whether that patient has been in treatment for 10 years and gets take-homes, or requires three group and one individual outpatient therapy a week, Medicaid will pay based on new codes.

National education standards vital for addiction professionals

By Patricia M. Greer and Donovan Kuehn

The development of national standards in the addictions academic programs throughout the United States is vital. Without a nationally recognized standard of skills and standardized content, the addiction profession will continue to be questioned as a professional group. Standardization of the academic content will more clearly define the educational process which will lead to professional recognition, reciprocity between states and higher compensation for addiction counseling services. This recognition is critical to the survival of a distinct profession of alcohol and drug counseling.

Historically, the field of alcohol and drug counseling has been slow in developing standards and competencies for the practice of alcohol and drug counseling. Throughout most of the addiction profession's history, the work of addiction (alcohol and drug) counseling has been provided by people in recovery from their own alcohol and drug addictions. Until recently, colleges and universities have had minimal course preparation specifically in addictions. Certification in alcohol and drug counseling has slowly pushed academic programs to develop. As the client population that addiction professionals serve have become more complex, the need for higher education has become more important.

NAADAC has established an Addiction Studies and Standards Committee to:

1. Develop a standardized curriculum for academic levels — from a one year addiction certificate to a Master's level degree.
2. Organize and implement a conference for addiction-focused educators to review and refine any curriculum, and
3. Integrate the knowledge and content already established through earlier work through the Addiction Technology Transfer Centers (ATTC), NASADAD, NAATP and other key stake holders.

Key to this process will be educators and professionals who will develop the skill standards

and content for each academic level. This process will be reviewed with key stake holders for refinement and investment to ensure that students receive a consistent, reliable and quality learning experience that is applicable to their careers and advances their understanding of addiction-related issues.

Scope of Practice

Who is an addiction professional and what key skills does he or she need to have? How can you assess if a professional has had successful outcomes? How can you determine if a professional deserves a raise and praise or needs additional training? How do you know what it takes to advance your career?

Currently, there is no generally accepted ways to measure the skills of addiction professionals. NAADAC is committed to developing a clear scope of practice and career ladder, so people can assess where they currently fit, and what skills and attributes they need to advance their careers.

As it currently stands, each state determines the criteria that people must fulfill to become an addiction counselor. This system ensures that there is a mishmash of rules and doesn't provide clarity for those in the profession, for those looking to move to another state or for people looking at starting a career.

One of NAADAC's goals for 2009 is to build a clear scope of practice and career ladder. This scope of practice and career ladder will incorporate the principles of professional development and life-long learning, utilizing technology and the demonstration of high ethical standards.

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Although SAAS is one of the partners in the initiative, provider agencies do not have to belong to one of the SAAS member state provider associations to be eligible to enroll.

Also, Lefkovitz said, the project is in theory open to both public-sec-

tor and private-sector agencies, although it is expected that it will attract more of the public-sector community-based agencies highly represented in SAAS's membership. Lefkovitz pointed out that the National Association of Addiction Treatment Providers (NAATP) al-

ready offers a members-only benchmarking project that involves many of the nationally prominent private-sector providers.

Improvement mindset

Provider agencies that have par-

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ticipated in some of NIATx's process improvement initiatives over the past several years report that the experience tends to affect their entire decision-making apparatus. One such provider sees the new benchmarking initiative as a logical extension of NIATx projects that have helped agencies with the basics of improving clients' access to and engagement in treatment.

"We'd like to be benchmarking outcomes, but we're aware of the cost of collecting that data outside of the structure of a formal research project," Michael Boyle, president and chief executive of the addiction and mental health treatment organization Fayette Companies in Peoria, Ill., told *ADAW*. "In the absence of our being able to do follow-up surveys for abstinence, criminal justice outcomes and quality of life, we often ask about the actions that research shows are associated with improved outcomes."

Boyle said he already has had discussions with Lefkowitz about how the benchmarking initiative could be structured. Boyle believes it will be important to focus on performance measures closely associated with improving client outcome, as well as measures that can be efficiently collected by provider agencies and therefore do not impose an undue administrative burden.

"I also think it will be important to resist the temptation to have too many measures," Boyle said. "When this happens, you don't know what areas to focus on."

Indeed, a brochure that has been drawn up for the benchmarking initiative states that in the selection of benchmarking dimensions, "Heavy emphasis will be placed on selecting items that are already being measured to minimize potential burden."

Boyle and Fayette Companies' vice president of quality improvement, David Moore, said their organization's board members have been a driving force behind the

Nation gets first board-certified addiction physicians

The American Board of Addiction Medicine (ABAM), a new independent medical specialty board, presented its first certifications at the American Society of Addiction Medicine (ASAM) conference this weekend.

This medical specialty, drawn from all areas of medicine, is dedicated to treating addiction.

"Physicians are often at a loss for what to do about substance use and addiction issues, and may even misdiagnose the problem," said Kevin B. Kunz, M.D., ABAM president, in a statement. "We hope to change this by creating a cadre of thousands of specialized physicians across medical specialties."

Addiction prevention, screening, intervention and treatment should become "routine aspects of medical care, available virtually any place health care is provided," Kunz said.

Certificates were to be presented May 1 in New Orleans at the ASAM Medical-Scientific Conference, by Nora D. Volkow, M.D., director of the National Institute on Drug Abuse. "Given the proper training, tools, and resources, physicians can be the first line of defense against substance abuse and addiction — identifying drug use early, preventing its escalation to abuse and addiction, and referring patients in need to treatment," said Volkow in a statement.

"The American Board of Addiction Medicine will provide assurance to the American public that addiction medicine physicians have the knowledge and skills to prevent, recognize and treat addiction," said Kunz. "ABAM-certified physicians will also be able to address common medical or psychiatric conditions related to the use of addictive substances."

Kunz said that the parity law helped pave the way for physician treatment of addictions, noting that insurance policies discriminated against people who needed these services. "Now that this barrier has been eliminated, we want to make sure that evidence-based addiction treatment is available to all who need it," said Kunz.

The ABAM was created in 2007 with the assistance of ASAM. For more information, go to www.asam.org/ABAM.html.

agency's search for more comparative data, consistently asking administrators how they know that what is being done in the agency is working. One board executive recently asked a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) surveyor about whether data existed to back the statement that the organization was faring well vis-à-vis similar provider agencies, Moore said.

Boyle said a benchmarking process also assists in arriving at much-needed common operational definitions for various areas of performance. In his state, it is impossi-

ble to compare provider agency reports on customer satisfaction because agencies do not maintain a uniform way of asking clients about this, he said.

Moore said his agency's participation in NIATx projects has changed the language of how staff members think about improvements. "When we're talking about system issues now, we look at piloting an effort, rather than trying to engineer the whole bridge," he said.

Boyle added, "Whenever we're making changes, we ask, 'How do we know that a change is an improvement?'"

Mechanics of initiative

A steering committee made up of SAAS and NIATx representatives will select the benchmark areas to be examined in the initiative. Although Lefkovitz said it is difficult to predict what will come out of discussions in this user-directed selection process, he believes it is likely that the areas to be measured will cover clinical, operational and financial aspects of agency performance.

The regular annual subscription fee for participating treatment agencies will be \$1,000, with a discounted fee of \$900 available to agencies that enroll by June 30. The fee covers a full year of data submission and report generation activity. The

reports will compare an organization's measured performance to that of other treatment agencies around the country; statewide norms will be available when there are enough participating providers to allow this.

The brochure adds that a "community of mutual support and shared learning underscores the mission of this initiative." Lefkovitz said that monthly audioconferences and a monthly newsletter available to participants will assist in identifying top-performing agencies in certain areas and giving these high scorers an opportunity to share with others what's working for them.

The leaders at Fayette Companies say a similar process in an Illinois benchmarking initiative involv-

ing Behavioral Pathway Systems has been extremely meaningful in identifying best practices for various areas of performance.

Lefkovitz said benchmarking helps agencies to prioritize the areas they should be working on, a factor that should not be underemphasized in today's difficult financial times. "This is a vital barometer for agencies to determine if they are operating as efficiently as they could," he said. "This can allow them to get through the turbulent times we're in and come out the other side."

SAAS is distributing information about the initiative to its members. Information about benchmarking and this addiction-focused project is also available at www.bpsys.org. •

State Budget Watch

Level funding in Michigan jeopardized by rising deficit



Addiction treatment funding in Michigan is low, and has stayed low for more than a decade. But at least there haven't been cuts — until now.

And last week the news was particularly dire. The deficit was reported to be \$1.32 billion, ballooning at a rate of more than \$100 million a month. That means the state will need to use more stimulus money than planned or make even deeper cuts. It also means that a \$15 million increase the field fought for will not take place, treatment advocates said.

"We are expecting instead that there will be at least a 5 percent cut to substance abuse treatment, because our economy is so bad," said Michael F. Reagan, president of the Michigan Association of Licensed Substance Abuse Organizations.

Gov. Jennifer M. Granholm proposed a 5 percent cut, which was restored by the House. However, in light of the current dire economy, the cut is likely to return, said Reagan.

One the bright side, there is an additional \$4.5 million added to prisoner re-entry for treatment. This money goes to the Department of Corrections, which currently funds

\$20 million for substance abuse testing and treatment. The state contracts out to providers for these treatment services.

Block grant

The addiction treatment field in Michigan has not had any increase from the state budget in 12 years, during which time demand has increased significantly, said Reagan.

Ironically, the fact that the treatment line-item — \$29 million, \$27 million of which is the state's share of the block grant — is so small may be what protects it. If the state needs to find \$1.32 billion, then will it really look for it in the \$29 million for substance abuse treatment? "There's not enough in our line item to make a difference," said Reagan. "The only reason we're held relatively harmless is that there's so little there."

The block grant — \$84.9 million, most of which comes from the federal government — funds the majority of the substance abuse prevention and treatment block grant, and this is where the majority of the state's treatment funding comes

from, said Reagan. Of this, only \$27 million is from the state general fund. "It's not a 50-50 match, and it doesn't have to be," said Reagan. Michigan kept the block grant "match" at a minimum.

Medicaid

There is the possibility of another funding source: Medicaid. "We have to do a better job of penetrating into the Medicaid-eligible population," said Reagan. Unlike the block grant, Medicaid isn't capped. "As enrollments go up, the allocation of dollars goes up too."

In Michigan, the Department of Community Health administers all Medicaid, and includes the Office of Drug Control Policy, which administers the block grant.

Asked what treatment providers can do to improve their funding, Reagan said they are already as "efficient as possible." In terms of advocacy, it's crucial to "demonstrate that what we do makes a difference in the lives of people," said Reagan. "We need to show that we contribute to an improved quality of life, both economically and socially, in our state." •

BRIEFLY NOTED

Supreme Court hears case on strip search of Arizona student

The Supreme Court last month heard the case of *Safford School District vs. Redding*, in which Savana Redding, 13 years old at the time, was asked to undress to her underwear and bra after school officials were told she possessed prescription strength ibuprofen. The Redding's lawyer said the court should require stronger cause to justify strip searches. But the justices appeared reluctant to limit a school's authority to search students. "How is a school administrator supposed to know?" asked Chief Justice John G. Roberts, Jr. "He sees a white pill and doesn't know if it's something terribly harmful..." A ruling is expected in June.

Experimental compound "erases" drug-associated memories

In a rodent study published April 15 in *Biological Psychiatry*, M. Foster Olive, Ph.D., and colleagues write, "The perseverance of the motivational salience of drug-associated memories is an obstacle to the successful treatment of drug addiction and is often a causative factor in triggering relapse." The researchers found that an experimental compound called CDPPB (an mGluR5 agonist) decreased rats' preference for a cocaine-associated environment. They believe this finding may support the development of therapeutic treatments to be used in conjunction with exposure therapy.

STATE NEWS

N.C. website details substance abuse problems by county

A new website, "Substance Abuse among North Carolina Adolescents" will simplify the process of assessing community need, according to Elizabeth Gifford of Duke's Center for Child and Fami-

Coming up...

The **National Association of Addiction Treatment Providers (NAATP)** will hold its 2009 Addiction Treatment Leadership Conference on **May 17-20** in **West Palm Beach, Fla.** Visit www.naatp.org for more information.

The **University of Wisconsin-Stout** will host the 25th annual National Rural Institute on Alcohol and Drug Abuse on **May 31-June 4** in **Menomonie, Wis.** For more information, visit www.uwstout.edu/outreach/conf/nri.

The **National Association of State Alcohol/Drug Abuse Directors (NASADAD)** will hold its annual meeting **June 3-7** in **Syracuse, N.Y.** Visit www.nasadad.org for more information.

The **National Association of Drug Court Professionals (NADCP)** 15th Annual Training Conference will take place **June 10-13** in **Anaheim, Calif.** For more information, visit www.nadcp.org/annual.html.

ly Policy. The site provides policy-makers and practitioners with substance abuse information organized by individual county. Visit <http://substanceabuse.ssri.duke.edu>.

Connecticut to target prescription drug 'doctor shoppers'

Connecticut Gov. M. Jodi Rell announced April 22 she will apply for more than \$620,000 in federal stimulus grants to add an investigational unit at the state Department of Consumer Protection (DCP), for surveillance of "doctor shoppers" — prescription drug abusers who fill multiple prescriptions through different doctors. The Drug Control Division of the DCP estimates over 3,000 patients receiving controlled substance prescriptions are potential "doctor shoppers." The unit would investigate roughly 200 such individuals during the two-year pro-

gram. In a "novel approach" to combating abuse and addiction, the program will "(identify) these individuals early and (offer) rehabilitation instead of criminal prosecution," said Rell.

NAMES IN THE NEWS

The National Association of Addiction Treatment Providers (NAATP) and Caron Treatment Centers reported April 10 that four individuals who are board members at three organizations will receive the second annual award named for the late Dr. Jasper G. Chen See, M.D., who served on Caron's Board of Directors for more than 20 years: **Thomas Furst** of Rosecrance Health Network, **James D. Simpson III** of Hazelden Foundation, and **Mary Jane Hanley** and **Jack Hanley** of The Hanley Center.

In case you haven't heard...

Television personality and star of the "Jackass" films Steve-O says that he filmed years of over-the-top footage of himself using drugs and alcohol without a specific goal in mind. He did not suspect that his friends would ultimately stage an intervention, that he'd end up in a psychiatric ward, and that he would find a practical use for his video footage. The MTV documentary "Steve-O: Demise and Rise" aired last night, recording Steve-O's darkest hours on drugs followed by his journey toward sobriety. In an April 28 interview with MTV, Steve-O said he originally conceived of the documentary as another shot at fame — as the "heroic recovery guy." Sober now for over 13 months, he now says he's concerned that the fame generated by this film may actually "jeopardize" his recovery.