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In This Issue...

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Health Reform Update

Getting ready for 2014: Integrate with medicine and get a mix of payers

In three years, health reform will be fully operational, and many providers are working on adapting to the new law, which will result in an increase in access to treatment and in the number of people coming into treatment. Medicaid and private payer reimbursements are also going to increase as a result of health reform, and providers who are used to a smaller comfort zone — fee-for-service from the state agency — will have to adapt to that. Related to this is the need to integrate with general medicine.

The "big picture" of health reform is the 20 million plus people who need addiction treatment and aren't getting it, said Victor Capoccia, senior scientist with NIATx. "Health reform changes provide the opportunity to reach these people," he said.

"It's easy to say that because people are going to have Medicaid and health insurance, providers need to know how to bill," said Capoccia. "But learning to bill is a mechanical and do-able process." Just focusing on that, and not understanding why the change has occurred, won't by itself be helpful, he told *ADAW*. "They need to understand clinically who they're serving and what they're offering them," he said. "Otherwise they'll bill and get claims rejected."

Focus on the patient

Stanley Street Treatment and Resources (SSTAR) in Fall River, Massachusetts began to adapt more than 30 years ago, by following one basic tenet, said CEO Nancy E.

See **Reform** on page 2

Faces & Voices seeks to strengthen recovery community's role in election

As the recovery movement grows in states across the nation, organizers expect to see individuals in recovery asserting a stronger presence in many aspects of civic life, including election campaigns. If the 2008 version of Faces & Voices of Recovery's Recovery Voices Count campaign was largely about registering voters from the recovery community, then 2010 is about making sure these voices are heard at the polls on Election Day.

With important mid-term elections coming up this fall, the recovery community is pressing candidates to respond, and encouraging its own grassroots supporters to do so.

"The campaign activities in the local communities largely reflect what the people involved are comfortable doing and have the capacity to do," Recovery Voices Count campaign coordinator Naomi Long told *ADAW*. "My job is to stretch them a little bit."

As it did in 2008, Faces & Voices will focus its campaign efforts this year in 12 states, encompassing a diversity of recovery community organizations. The campaign is positioned as an effort to build the advocacy movement by supporting recovering individuals' "nonpartisan civic engagement in local, state and

See **Election** on page 5

Reform from page 1

Paull: listening to the consumer. That led the provider quickly into wraparound services and health care integration.

"When we first opened in 1977 we had male alcoholics, and wondered why women weren't coming in," she told *ADAW*. It turned out that the women needed child care, so SSTAR developed it, and when the women did come in, it turned out they had domestic violence, mental health, and drug abuse issues as well, so SSTAR added relevant programs.

General medicine integration started out of necessity in the 1980s, when the HIV crisis erupted — the program had its first HIV-positive patient in 1983 — SSTAR needed to send patients to medical specialists. "This was a huge problem," recalled Paull, because many physicians didn't want these patients. "We tried to work with other providers, and they said, 'You can send one or two patients, but I don't want them taking over our practice.'" So in 1990, SSTAR opened its own health center. "We lost our shirts the first year, but now we have more than 60,000 patient visits a year."

Today, starting a community health center is too expensive and complex without "a lot of support," said Paull. "But you can do what we're doing now — talking to primary care doctors one-on-one in the community," she said. "We see the medical homes coming, and primary care doctors are going to need a place to refer patients to that is cost-effective."

> **'The health care system doesn't operate on the block grant, it operates on third party payments.'**
>
> Victor Capoccia

SBIRT

Screening for substance abuse, brief intervention, and referral to treatment (SBIRT), conducted in the primary care setting, has emerged as a key prevention focus of health reform. But the big question for substance abuse treatment providers is how to link up with the "referral to treatment" phase. That involves a lot more than sitting in a treatment program waiting for referrals to come in, Paull explained.

With a grant from the Robert Wood Johnson Foundation, SSTAR is conducting a small pilot project working with two primary care practices. "They have agreed to do CAGE screenings," said Paull. "We developed a hotline for their staff, which goes directly to one of our case managers." If someone screens positive, and the physician doesn't feel comfortable or doesn't know how to pursue the discussion with the patient, "they can just dial that hot line number and speak to the case manager," she said. Then, the case manager will help guide the physician, who might ask for help in how to proceed. "We're there to help them and do what they want," said Paull.

More Medicaid

When health reform takes full effect in 2014, the rule of many states will change — and for the first time, men as well as women and children will be eligible for Medicaid — which will be available for everyone up to 133% of poverty level. Chestnut Health Systems, based in Bloomington, Ill., is already adept at billing for Medicaid. Chestnut also does extensive billing every month to private insurance companies, said CFO Karen Rettick.

"We're very diligent in trying to

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get them to pay before we switch to a public funder," she told *ADAW*. "But it's very difficult." Private payers require authorization prior to treatment, she noted. Chestnut has a managed care area that does the preauthorization and billing, she said.

Billing in medicine means coding, and private payers use standard CPT codes, said Rettick. For public payers — Medicaid and, in Illinois, what's called "non-Medicaid" (block grant, general revenue fund, some other small grants) -- there is a specific billing system that does not use CPT codes.

Having more patients covered by private payers, under the insurance exchanges, may be financially better than having more patients covered by Medicaid — but it's too soon to say for sure. The public system already has a rate system that is "outdated by 30 years," said Chestnut CFO Alan Sender. "The theory is that the private payer would pay much better."

Block grant

The field "loves the block grant," said Capoccia. "Who wouldn't love it? It's a guaranteed source of revenue and it's not hard to access." But the block grant as a system is completely different from medicine, he said. "The health care system doesn't operate on the block grant, it operates on third party payments." Organizations that have "vision and are committed to serving the most people will use the block grant to complement other funding sources."

But that doesn't mean the block grant will disappear, he said. "I know some people say it will go away — that's scary, foolish talk." The block grant is essential for three reasons: 1) the insurance exchanges won't go into effect fully until 2014; 2) even in 2014, reform covers 32 million out of an estimated more than 45 million — that's still more than 13 million people who will lack health insurance, and many of them will have addiction problems; and 3) the block grant funds more than medically defined treatment, and also covers social supports.

But providers do have to change. "The worst step we could take would be to say the block grant has to keep doing what it's doing," said Capoccia. "That's in effect saying we want to continue this easy road, we don't want to do the hard work of improving the system." •

When is it time to stop medication-assisted opioid treatment?

"Terminable or interminable?" — referring to medication-assisted treatment for opioid addiction — was the title of one of the most popular workshops sponsored by the National Institute on Drug Abuse (NIDA) at the American Psychiatric Association annual conference in New Orleans last week. "There were people waiting outside the room," Ivan Montoya, M.D., Medical Officer with NIDA's Division of Pharmacotherapies and Medical Consequences of Drug Abuse and moderator of the workshop, told *ADAW*.

The answer is that the treatment can have an end, but there is no protocol for doing it — e.g., who should be tapered off the medication, and how well they will do — Montoya said. "This is a question everybody has on their mind, but it doesn't have a research-based, evidence-based answer."

Because addiction is a chronic disease, treatment should continue until the disease is "under control," just as with other chronic diseases like diabetes or hypertension, said Montoya. The same approach can be applied to opioid addiction, he said. "Treatment continues until the patient feels that he or she doesn't need the medication any more."

Hard detox from bupe

But the people attending the workshop — most of whom were prescribing buprenorphine, with only a handful working in methadone clinics — were asking for the parameters that determine when a person doesn't need medication anymore.

> **'Treatment continues until the patient feels that he or she doesn't need the medication any more.'**
>
> Ivan Montoya, M.D.

This is a poignant question, because withdrawal from buprenorphine is difficult — much more difficult than withdrawal from methadone, said Montoya, a psychiatrist who used to work in a large methadone program in Baltimore. "Many people feel opiate withdrawal, and they relapse, and that is the biggest fear about ending treatment," he said. "The counselor and the physician must make the patient aware that there is a chance for withdrawal symptoms and for relapse."

Buprenorphine binds strongly to the receptor site — "it's very hard to get it off the receptor," said Montoya. "And it has an effect that produces a feeling of comfort." Patients who go through buprenorphine withdrawal have more dysphoria and more discomfort than patients who go through methadone withdrawal, he said.

"We don't have the research on

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detoxification from buprenorphine," said Montoya. "Most of this research is on methadone." And while many methadone patients do stay on the medication for years, with no plan for withdrawal, it's not at all clear that buprenorphine is being used in the same way as a long-term maintenance drug.

Buprenorphine has two significant advantages over methadone, noted Montoya — it has a good safety profile (it's very difficult to overdose on buprenorphine alone) and it is less sedating.

How to withdraw

From research with methadone, it's known that if a patient does want to withdraw from the medication, the typical time frame is 21 days. This is probably true for buprenorphine as well, said Montoya. "I am hearing reports of seven-day detoxifications, but that would be very fast. We just don't know much about long-term treatment with buprenorphine, and we don't know about how to detoxify from buprenorphine."

The best way to tell when a patient is ready to be detoxified is when the patient says: "I think I'm fine, I don't want to be on this any more, please take my dose down," said Montoya. The provider has to respect this and develop a detoxification plan for the patient, he said.

There should be good clinical monitoring, good nurse support, and medication to accompany withdrawal from methadone, said Montoya. "Right now NIDA is investigating lofexidine," he said. "If approved, we are hoping patients can be detoxified using lofexidine, and then tapered off that slowly." The protocol will involve initiating lofexidine as quickly as possible, and increasing it while decreasing the methadone dose, he said. Lofexidine is not addictive, he said.

It's also important for patients to know there could be "protracted" withdrawal symptoms, occurring weeks or even months after detoxification, said Montoya. "The patients could feel muscle aches, goose bumps, diarrhea," he said. So they should have a prescription for the lofexidine, which would help with the withdrawal symptoms, he said.

Benzodiazepines can also be used on a short-term — no more than a week, because they are addictive — basis to help with anxiety caused by the withdrawal from methadone, said Montoya.

Administrative discharge

Another discussion during the workshop concerned the "administrative termination" of treatment — a euphemism for discharging a patient for disciplinary reasons. "The field is somewhat divided on this," said Montoya. "Some programs are flexible — they don't discharge anyone, and anyone can do what they want. Others are so strict, with so many rules, that patients are discharged for a variety of non-clinical reasons. For example, some programs discharge patients for dealing drugs at the clinic, being aggressive or violent, or even coming in intoxicated, he said.

Montoya cited evidence showing that people in treatment do better than people outside treatment. "That's a very powerful finding," he said. "It says that if you discharge someone as punishment, you are condemning that person to doing worse." •

NIH proposes rules to avoid big pharma bias

"The public may not always understand the intricacies of rigorous science, but most individuals quickly grasp the concept of bias," wrote Francis S. Collins, M.D., Ph.D., director of the National Institutes of Health (NIH), in last week's online edition of the Journal of the American Medical Association. "Plain and simple, Americans do not want financial conflicts of interest (FCOI) to influence the federally funded research they hope will yield better ways to fight disease and improve health."

In the commentary, Collins outlined the reasons for the rulemaking currently underway that would set stricter conflict-of-interest rules for NIH-funded research. Noting that partnerships and industry are essential, Collins said that nevertheless these partnerships can "compromise — or appear to compromise — the integrity of research supported by the NIH."

The proposed rulemaking, published in the Federal Register May 21, lowers the threshold for who must comply (it includes small grants to small businesses) and requires transparency, with researchers required to disclose their connections above $5,000 with any company related to their research.

ADAW asked some prominent researchers, as well as the National Institute on Drug Abuse (NIDA) and the National Institute on Alcoholism and Alcohol Abuse (NIAAA), for a perspective on how the new rules will affect research in the field.

"I support Dr. Collins," said Charles P. O'Brien, M.D., Ph.D., professor of psychiatry at the University of Pennsylvania. He noted that conflict of interest is a "very minor problem for addiction studies," because it is only an issue when there is a "potential for huge profits." Unfortunately, he said, the addiction field "has had little pharmaceutical interest" and this has limited potential for conflicts — and limited the availability of medications.

"I don't think there are many conflicts of interest in substance abuse research," agreed Frank Vocci, Ph.D., director of the Friends Research Institute in Baltimore, which conducts research into the medica-

tion-assisted treatment of addictions. Vocci, who until last year was director of NIDA's medications development division, also agreed that "big pharma" is reluctant to engage in substance abuse research.

Not just medications

"NIDA, as well as all other institutes at NIH, has the right to demand that any research they fund be published and accessible to the scientific community and even the lay public," said Vocci. He said it's a "major misperception" that NIDA funds only medication-related research. "You hear a lot about the medication, but it's only 10 percent of NIDA's research portfolio," he told *ADAW*. "NIDA has a large behavioral therapy portfolio and a large health services portfolio and funds research on the response to treatment of substance abuse disorders from the standpoint of the individual being treated, the substance abuse disorder being treated, the type and duration of treatment, the delivery of such services within the treatment system, and the cost-benefit and cost-effectiveness of treatment."

The movement toward transparency, said Vocci, has been moving along for some time, with journals requiring authors to disclose consultant agreements and other possible conflict of interest issues.

Huge alcohol market

At NIAAA, there has been more interest from larger pharmaceutical companies, particularly over the last two years, said Raye Z. Litten, Ph.D., chief of the Treatment Research Branch. "We always try to encourage them to get involved in alcohol trials," he said. "There's a huge market out there." About 18 million adults suffer from alcohol use disorders, and twice that many are high-risk drinkers, Litten said.

Still, there are only four drugs approved by the Food and Drug Administration for the treatment of alcoholism — and for the most part, people aren't even using these. "It's an attractive population for drug companies, but it hasn't actualized itself yet," he said. NIAAA has funded some grants to find out why people aren't using alcohol treatment medications, and one of the main reasons, researchers found, is poor marketing of the drugs. "They need to market beyond specialized treatment centers, to physicians," he said.

'If everybody did it the right way, we wouldn't have to worry about conflict of interest.'

Raye Z. Litten, Ph.D.

A perfect example is oral naltrexone, approved in 1994 for the treatment of alcoholism. "DuPont didn't understand the marketing issues, and it was about to go off patent," he said. "Now, if you ask primary care physicians, probably 98 percent haven't even heard of oral naltrexone for alcohol disorders."

Like Collins, Litten said there must be collaboration with pharmaceutical companies if NIAAA is to get medications out to the public. "We don't have the money to get something through the FDA," he said. "If everybody did it the right way, we wouldn't have to worry about conflict of interest. But when you have people who abuse the system, then that one bad apple ruins it for everybody." •

Election from page 1

national elections," as stated on Faces & Voices' website. Long emphasizes that people should not assume that people in recovery will vote as a bloc or carry the same opinions on policy issues.

"They are all over the map; they represent the entire spectrum on issues," Long said. "At the end of the day, the point is that we're educating voters on issues that are important to them and getting them out to vote."

The states on which Faces and Voices is focusing the campaign's efforts this election cycle are Colorado, Connecticut, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, Ohio, Pennsylvania, South Carolina and Virginia. Most of these states were also heavily involved in the effort around the 2008 presidential election year. Long said that while it might be considered more challenging to energize participants in a non-presidential election year, the acrimony that has characterized the national policy debate in recent months probably changes that.

"People recognize that these midterm elections are going to shape the political landscape for some time," Long said.

Restoring rights

In a couple of states, the election-year issue for the recovery community is even more basic than getting people to the polls — it involves giving many people the right to go to the polls at all.

Kentucky and Virginia remain the states with the most restrictive prohibitions on voting for individu-

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'At the end of the day, the point is that we're educating voters on issues that are important to them and getting them out to vote.'

Naomi Long

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als with felony records. In Kentucky, anyone with a felony conviction loses the right to vote for life unless a partial pardon from the governor is issued, explained Mike Barry, a former television broadcaster who is chief executive of the Kentucky organization People Advocating Recovery.

Barry told *ADAW* that his organization has been working on an effort to restore voting rights for felony offenders for the past four years. More than 100,000 people in the state are affected by the prohibition, and those whose convictions involved a drug offense are predominant in the group, he said.

"When you've paid your debt to society, you're told to go forth and do well, but they're still going to consider you a second-class citizen," Barry said.

Changing the law in Kentucky would require a constitutional amendment that would go to the state's voters. "We want to take it out of the governor's hands," said Barry, as the issuing of pardons is now subject to the whims of whoever happens to be in the governor's office at the time.

Proposals to place the question on the state ballot have sailed through the House in recent years but have stalled in the Senate, Barry said. Members of the recovery community organization have responded by conducting numerous rallies, including several in the home district of a particularly strong Senate opponent of changing the law.

In addition, the group stepped up its effort during this month's state primary campaign in Kentucky by organizing a massive phone bank in which individuals with felony records urged other residents to do what they cannot do, and go to the polls to cast a vote in the primary, Barry said.

He added that this initiative has enabled members of People Advocating Recovery to partner with other groups, such as the American Civil Liberties Union (ACLU) and the social justice group Kentuckians for the Commonwealth. "It has given an opportunity for people in long-term recovery to start interacting with other organizations and letting them know who we are," Barry said.

Candidate forums

Contrast the situation in Kentucky with that of Vermont, where nearly all convicts can continue to vote while incarcerated and where a national victory on parity legislation fails to impress advocates because the state has had a stronger parity law on the books for years. There, a recovery organization has shown it has little trouble attracting candidates for office to a discussion where addiction and recovery issues are likely to become prominent.

The recovery center Turning Point Center of Chittenden County is organizing a June 23 forum that nearly all of the candidates in a crowded field to become Vermont's next governor have committed to attend. Center director Mickey Wiles told *ADAW* that all of the five Democrats who will face off in an August primary are expected to participate, and several of these individuals have been strong supporters of addiction treatment issues and have even visited his recovery center in the past.

"I expect to hear many re-affirming messages at this forum," Patty McCarthy, executive director of Friends of Recovery-Vermont,

Anchorage moves to non-sober housing to fight homeless-alcoholism problems

The alcoholism problem in Anchorage, Alaska is inextricably tied to the city's homeless problem, but only recently have leaders there moved to create housing projects. Triggered by a spate of outdoor deaths of street alcoholics, some in their teens, there have been calls for housing for the hard-core homeless, with — maybe — treatment to follow.

The "housing first" concept has worked in many cities in the United States, and started in Seattle (see *ADAW*, April 6, 2009). Anchorage, with a population of 277,000, usually has 10 outdoor deaths a year, but it has had 21 in the past 12 months. The point of housing first is to get alcoholics indoors, with a stable place to live. They can continue to drink and get drunk. In the Seattle Housing First project, officials were pleasantly surprised to find that residents decreased their drinking and some even stopped, once they had a place to live.

Currently, the only options for homeless alcoholics are detox, a sobering-up station, jail, or — only if they are sober — a city shelter. Homeless encampments are illegal, and the city has been ordering them broken up on short notice. In Anchorage, the temperature can drop below freezing at night even in the spring, which contributes to the deaths of homeless people.

Anchorage officials believe there are about 400 "homeless inebriates" among the 3,000 homeless people living there, the Seattle Times reported recently. And now Anchorage has a full-time coordinator for homeless issues — for the first time — and that also elevates the importance of housing.

Finding the housing is the next step. There is a hotel, the Red Rose Inn, that could be turned into a housing complex that would take people who are drunk or still drinking. Opposition from neighbors is strong, however, with a large sign up across the street that reads: "No Red Nose Inn in Fairview."

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told *ADAW*. "We will work with folks prior to the forum, about coming up with questions related to substance abuse and recovery. There will be questions on candidates' positions on things such as treatment vs. incarceration."

As part of Recovery Voices Count's national effort, Faces & Voices has listed three position questions that the recovery community should ask candidates for office. The questions seek specifics on candidates' positions on:

- Whether they agree with the Office of National Drug Control Policy's (ONDCP) current push for a new drug-fighting approach emphasizing treatment.
- Whether laws that restrict some people in recovery from voting, obtaining a driver's license or pursuing education and a good job should be repealed.
- Whether they support efforts to repeal the newly adopted health reform law, particularly as it pertains to provisions mandating parity coverage for addiction care.

Wiles said that at his center's forum it also will be important to gauge the gubernatorial candidates' thoughts about the recovery movement in general, as reflected in the emergence of recovery centers that some Vermonters see as an important support element that has been missing in the past (see *ADAW*, May 10).

"I'm a real believer in the recovery center concept," Wiles said. "This is an area where we can reduce people's cycling through treatment."

Linkages to treatment community

Faces & Voices executive director Pat Taylor indicated that the intensifying activity around civic issues also gives members of the recovery community opportunities to establish linkages with treatment centers. In recent years many treatment centers have gotten more involved with encouraging civic participation through efforts such as voter registration drives.

Taylor agreed that the recovery community does not speak with one voice on all policy stances. "Individuals in the recovery community are like the rest of America; they have a broad swath of perspectives," she told *ADAW*. "We want them to be active in civic life, regardless of their political persuasion."

On June 3 at 1 p.m. Eastern time, Recovery Voices Count will hold an hourlong teleconference that will detail elements of the campaign and will feature comments from participants during the 2008 election cycle. •

Those interested in participating in the free event are required to register at www.facesandvoicesofrecovery.org.

Buffalo audit finds lack of financial controls in treatment program

Andrew A. SanFilippo, comptroller of Buffalo, N.Y., has found that three city-run clinics had lax handling of finances, with cash left unguarded and a theft of $585 from one clinic's front desk, the Buffalo News reported last week. The findings came at a time when the city is trying to close the three clinics it runs and transfer operations to the county or private operators.

There are no arrests, and no employee has been disciplined, but one person who complained to the police suspected someone "in-house" had taken the money. Apparently, fees were not deposited in a timely fashion, and clinics didn't have safes. The comptroller also found that there was poor tracking of receipts and payments, and poor training of employees.

"To expect drug counselors and clinical nurses to be handling money and be responsible for the depositing, protection and security of those funds leaves a lot to be desired," said SanFilippo. Since the investigation, the city has helped the clinics develop better practices, officials said.

"The Division of Substance Abuse Services has made tremendous strides to enhance fiscal integrity," said Community Services Commissioner Tanya Perrin-Johnson, in a report based on her review of the audit. "Staff training and development will become a cornerstone as we continue to address the needs of this vulnerable population." Earlier this month, however, city officials began to phase out all clinic operations, beginning with closing one clinic this year. This move was blocked by the city's Common Council, however. Council President David Francyk did read the audit and still wants to keep the clinics open. "If there are problems, they should be corrected," Franczyk said. "But you don't throw the baby out with the bath water."

Briefly Noted

Web-based self-help program works

A web-based, interactive, anonymous self-help program can help adult problem drinkers cut back on their alcohol consumption, according to a Heleen Riper and colleagues in the Netherlands. For the study, reported by the Research Society on Alcoholism, the intervention (Drinking Less, or DL), already found ef-

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fective in a randomized controlled trial, was assessed to see if the results were generalizable to a naturalistic setting. Researchers surveyed 378 of the 1,625 people who used DL in a real world setting, and found that 18 percent of the risky drinkers were low risk 6 months after the intervention. Risky drinking was defined as an average of more than 21 (for a man) or more than 14 (for a woman) drinks a week. The researchers concluded that the results from the randomized trial do translate to the real world, and that web-based self-help with no therapeutic guidance is an effective way to curb adult problem drinking.

Alcohol companies use new media to market to young people, report charges

A report issued earlier this month week by the Center for Digital Democracy sharply criticized alcohol companies for using new media — cell phones, social networking sites, YouTube and so on — to reach young people. The authors are asking the Federal Trade Commission and state attorneys general to investigate whether youth are protected from alcohol marketing in the digital era. "Youth are at the center of an exploding digital culture," said Kathyrn Montgomery, professor of Public communication at American University, who with co-author Jeff Chester, executive director of the Center for Digital Democracy, released the report, "Alcohol Marketing in the Digital Age," via teleconference May 18. "This is all about data collection for personalized, targeted marketing in order to better understand a user's attitude, their interests, their online behavior," Chester said. "Most of the data collection is covert. Users have no idea what's happening to the data." For example, a video promoting its alcoholic ice tea went "viral" and had 600,000 hits in just 10 days, Chester said. As of last fall, 5 million people had viewed it.

Coming up...

The **National Association of State Alcohol/Drug Abuse Directors (NASADAD)** will hold its 2010 Annual Meeting, "Fostering Success in an Evolving Health Care Environment," on **June 2-5** in **Norfolk, Virginia**. Visit www.nasadad.org for more information.

C4 Recovery Solutions, Inc., will hold the first annual West Coast Symposium on Addictive Disorders (WCSAD) on **June 3-5** in **La Quinta, Calif.** The symposium will take place in partnership with RecoveryView.com. For more information, visit www.wcsad.com.

The **College on Problems of Drug Dependence (CPDD)** will hold its 72nd Annual Meeting on **June 12-17** in **Scottsdale, Arizona**. Visit **www.cpdd.vcu.edu** for more information.

The 2010 **State Associations of Addiction Services (SAAS)** National Conference and NIATx Summit will take place **July 11-14** in **Cincinnati, Ohio**. For more information, visit www.saasniatx.net.

The **Substance Abuse and Mental Health Services Administration (SAMHSA)** in partnership with **Treatment Alternatives for a Safe Community (TASC)** will hold the 4th National Conference on Women, Addiction and Recovery: Thriving in Changing Times, on **July 26-28** in **Chicago**. For more information, visit www.SAMHSAWomensConference.org.

Names in the News

Michelle Dirst is the new director of public policy for the National Association of State Alcohol and Drug Abuse Directors (NASADAD). As a staffer for the Senate Committee on Health, Education, Labor, and Pensions, Dirst worked on the STOP Underage Drinking Act, reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA), and other initiatives. She then worked in SAMHSA's Office of Legislation, and most recently was deputy director of government affairs at the American Psychiatric Association, where she worked on health reform. Her email is mdirst@nasadad.org.

In case you haven't heard...

A now-deleted Facebook group called "Did you know this alcoholic Indian" reflected a violation of federal privacy rules by Tri-City hospital workers in Chicago who used the page to discuss a patient, even posting photos and making fun of him, according to a report by CNN. While the field waits to see what the federal government will do about confidentiality regulations (42 CFR Part 2) requiring patients to consent before substance abuse treatment information can be disclosed, in the larger world it's been made very clear that the public is much more concerned about privacy than anyone thought. Facebook is having to completely revamp its sharing of information with advertisers as a result of public opposition. What are the chances that the public will regard substance abuse treatment as an innocuous piece of information to be shared with other health care providers?