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In This Issue...

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Study shows that basing coverage on drug costs alone may not be cost-effective

Research published in the *American Journal of Managed Care* this month comparing patients started on treatment for opioid addiction with different medications showed that insurance companies should not look just at the cost of the medications when determining what to cover. They should also look at the medical costs that these medications may be offsetting.

The study, funded by Vivitrol sponsor Alkermes, looked at five years of retrospective claims data for 14 million patients, focusing on those with opioid dependence diagnoses who initiated treatment with methadone (1,916), buprenorphine (7,596), oral naltrexone (845), Vivitrol (156), or no medication (6,658). Those who received no medication clearly had higher medical costs than those who received medication. From there, the study compared the medical costs of patients on the different medications.

The study found that overall medical costs over six months were twice as high for patients on methadone as for patients on Vivitrol.

The study looked at total medical claims (pharmacy, inpatient, and outpatient) for these patients, and found that patients treated with methadone averaged $16,752 in medical costs within the six months following treatment, compared to $10,049 for buprenorphine, $8,903 for oral naltrexone, and $8,502 for Vivitrol. Vivitrol is by far the most costly drug, at more than $1,000 a

See **Vivitrol** page 2

Treatment Program Profile

TC's venture in supportive housing seeks to build continuum of care

by Gary Enos, Contributing Editor

With client monitoring an ever-present challenge in outpatient treatment, a publicly funded program in New Jersey has established its first-ever supportive housing site geared to serving mothers in recovery, just two doors down from the location that delivers their outpatient care.

Newark-based Integrity House, known for its residential care based on the therapeutic community (TC) model but also delivering a continuum of other treatment services, opened its supportive housing program in March. The organization completed $3.5 million in renovations to a Victorian-style building on Martin Luther King Boulevard in Newark, with most of the project supported through a multi-year fundraising effort.

The director of the women's housing program at Integrity House told *ADAW* that prior to the availability of the supportive housing on the same block with the outpatient center, it was more difficult to maintain a positive relationship with outpatient clients.

"It was difficult to have clients go home to bad neighborhoods," said Nicole J. Drake. "As a clinician, this gives me peace of mind."

See **Housing** page 6

VIVITROL from page 1

month. More than half of the patients in the study dropped out of treatment after two months, so the total pharmacy costs for Vivitrol averaged $2,842, compared to $311 for methadone. Some dropped out before the two month average point, some after. Vivitrol was the most cost-effective drug, based on the numbers.

The authors concede that the study requires a close scrutiny of selection bias They accounted for this using two statistical tools: propensity score (which according to the reference can eliminate "up to 85 percent" of selection bias, and instrumental variable analysis, which eliminates some unobserved variables.

Selection bias

But the selection bias issue was too troubling for methadone advocates to swallow. "Is it possible to draw any conclusions or to make any extrapolation whatever from this sample to the broader universe? My expectation is the answer is no," Robert G. Newman M.D., director of the Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center told *ADAW*. "How were these 156 people on Vivitrol selected for receiving a treatment under conditions which private insurance generally will not cover? Is it possible that they were reviewed and assessed and considered to have a great prognosis?"

Newman also asks how the patients treated with oral naltrexone were similar to people in the general population who might be candidates for oral naltrexone, and has the same question for buprenorphine. Finally, he asked how many insurance companies will agree to provide even buprenorphine treatment, when the medication alone is about $12 a day. "What we do know is that most people on methadone have no insurance, not even Medicaid," he said. The sample was just "too unusual" to draw any conclusions.

The methadone patients were all covered by commercial insurance — a rare occurence, according to David R. Gastfriend, M.D., Alkermes vice president for medical affairs and corresponding author for the study. It is not even known whether the methadone patients were treated in an opioid treatment program (OTP), in a physician office, or in another location, he said. Secondly, the patients treated with Vivitrol were being treated off label, since the drug wasn't approved for opioid dependence until last fall (see *ADAW*, Oct. 18, 2010).

Insurance companies generally do not cover medications for an off-label use, and for the 156 patients in the study, the physicians obviously did the extra work involved in appealing insurance denials, said Gastfriend. "The physician can appeal the rejection by arguing that the patient is prone to higher medical costs if they don't get the treatment," he said. "A meaningful number of physicians were able to get off-label approval."

Conflict of interest

We asked Gastfriend to account for his involvement in the research, as he is listed as providing contributions to the article.

"I'm glad you asked," Gastfriend told *ADAW*. Alkermes has a policy against ghost writing," he said. That means that any time an Alkermes employee or consultant is involved in research, that person must be listed as an author.

For the two papers published in the *American Journal of Managed Care*, Gastfriend conceived of the research, contracted with Onur Baser, Ph.D., the University of Michigan economist who is lead author, to the other authors involved, coordinated the conference calls, obtained the funding to purchase the data, coordinated email exchanges back and forth, and is the corresponding author. "I didn't write the whole paper," he said.

Additionally, Alkermes did not know what to expect from the study,

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he said. "We contracted this not knowing what the outcomes would be," said Gastfriend. "The only thing we knew was how many patients they had in their database who received Vivitrol."

Conflicts of interest do not necessarily mean that the research is suspect, said Charles P. O'Brien, M.D., Ph.D., Kenneth Appel Professor with the Department of Psychiatry at the University of Pennsylvania. "I've seen the Vivitrol data and I believe it's very solid," he said of the clinical trials conducted in Russia that led to the approval of the medication to treat opioid addiction. "When I talk about the studies, I can say they were supported by Alkermes." That disclosure is what is important, he said. "I can only tell you that conflicts of interest can be conscious or unconscious, and that studies can be slanted," he said.

Drop outs

Patients dropping out of treatment — referred to as a lack of "medication persistence" in the articles — may also skew the data. Gastfriend said that one problem among opioid addicts is "cycling" in and out of treatment. "A lot of people go on these medications to get out of going to jail, to drop their tolerance," said Gastfriend, noting that patients dropped out of Vivitrol treatment as well as other treatments.

The main issue is to what degree addiction medicine is part of mainstream health care, said coauthor Mady Chalk, Ph.D., director of the Center for Performance-Based Policy at the Treatment Research Institute. "All of these medications are effective, and we have more than enough information about the efficacy of methadone and buprenorphine," she said. "So now the question is that when doctors use buprenorphine, most are using it as a short-term medication. But people like Fiellin said it needs to be used over a sustained period of time." Health care providers — and insurance companies — need to come to grips with the maintenance concept, she said. "We have a medication, it works, let's use it."

The claims data is insufficient when it comes to finding out what is happening in the life of the patient, conceded Chalk. "I would be careful about drawing too early a conclusion about the cost comparison of these medications to suggest that we now have a definitive reference," she said. "There's an inevitable desire, especially by the newest company manufacturing something, that they have the best and most cost-effective drug to treat this disease."

So why did methadone patients have such higher medical costs? Was it the patients who dropped out who incurred the costs? The answer is not in the data, said Gastfriend. The biggest factor in the medical costs for methadone patients were hospital admissions for conditions like cellulitis and endocarditis, said Gastfriend. "We don't know if this is because of the kind of patient they are, or because of the use of hospitals in the places where they live, or because of other things," he said. While it's true that the methadone patients were sicker than other patients, "we did control for comorbidity in the propensity score and instrumental variable analysis," he said.

The study should not be viewed as showing that it's better to place patients on Vivitrol than on other medications, said Gastfriend. "Whatever comes out positive for Vivitrol should not in any way diminish the commitment to provide access to other treatments," he said. "But this is the world that the insurers are dealing with — what to pay for."

"This is a retrospective analysis, not a head-to-head analysis," said Gastfriend. "Furthermore, we know that the people who seek methadone are not going to seek Vivitrol. It's a different population. All this shows is that the people who are using Vivitrol, over a six-month period, during most of which they are not continuing the Vivitrol, are expending less hospital dollars than people on the other medications. It's saying that Vivitrol is not the most costly medicine in terms of total health care. And it's saying you shouldn't offer benefits for coverage based on drug cost alone."

'All this shows is that the people who are using Vivitrol, over a six-month period, during most of which they are not continuing the Vivitrol, are expending less hospital dollars than people on the other medications.'

David R. Gastfriend, M.D.

Vivitrol vs. no medication

When we talked to O'Brien last week, he noted that there are other benefits to Vivitrol besides cost offsets — it can save lives. He mentioned a study he is conducting for Alkermes randomizing people on probation and parole to either Vivitrol or no medication. "We have 155 patients in the study, and for those randomized to the control group, three have already died, two because of opioid overdose," he said. This is because when people have been off opioids during incarceration and are then released, they go back to their old dose of opioids. Not being tolerant any more, they overdose.

So far there had not been one overdose among the patients ran-

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domized to Vivitrol, he said, adding "knock on wood." O'Brien's study has medication for six months, and a follow-up for 18 months. "I wish we could keep them on it for years," he told *ADAW*. "What I'm afraid of is after we stop it, a lot will go back to using."

The article in the *American Journal of Managed Care* is called "Cost and Utilization Outcomes of Opioid-Dependence Treatments." A companion article, also by Basur, is called "Alcohol Dependence Treatments: Comprehensive Healthcare Costs, Utilization Outcomes, and Pharmacotherapy Persistence" and it also found Vivitrol surpassed other medications in cost offsets despite the cost of the medication. •

State Budget Watch

Health reform in Massachusetts: Lessons learned so far

Healthcare reform has worked well in Massachusetts, in particular for people who need detoxification and outpatient treatment for substance use disorders, Michael Botticelli, director of the state's Bureau of Substance Abuse Services (BSAS), tells everyone who will listen. Still, 16 percent of people with substance use disorders are uninsured, compared to fewer than 2 percent of the population in general.

Less than 2 percent of the population in Massachusetts is uninsured, compared to more than 17 percent nationally, he said. However, people with addictive disorders are more likely to be uninsured: 16 percent of Step Down Services or Transitional Support Services patients surveyed in 2009. The biggest age group that is uninsured is the younger adult population — ages 19 — 25. Also troubling for the state is the fact that heroin is rapidly approaching alcohol and the main substance of abuse.

It's important to heed the experience of Massachusetts, which instituted an insurance mandate and Medicaid expansion five years ago, because the state is now viewed as a testing ground for national health care reform due to take effect in 2014. Botticelli presented the results of the Massachusetts experience at the NIATx/SAAS conference held in Boston last week.

Copays for detox

There are some lessons to be learned — in particular the need to eliminate copays for detoxification, which has not been accomplished in Massachusetts, said Botticelli. The Health Connector — the state authority that governs health insurance in Massachusetts — denied an appeal by BSAS to eliminate these fees, which may be deterring patients from seeking treatment.

Notably, health care reform has not simplified insurance coverage. There are variations in the copays for detoxification — one plan has a $60 copay, another has a $250 copay. "We suspect that with some clients, even modest copays might be a barrier to accessing treatment," said Botticelli. Treatment providers are not able to waive these copays because they operate with such thin financial margins in the first place, he said.

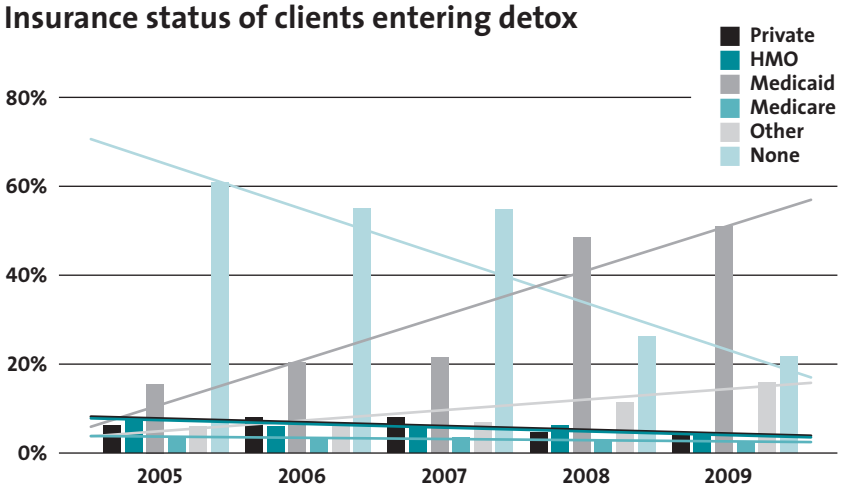
Providers who are under contract with the state receive $222 a day for a five-day detox. Waiving the $250 copay for patient would mean they would lose 25 percent of the reimbursement. "Many providers do a significant amount of free care work already."

Health care reform has also not made insurance affordable. A family of four, with an income of $68,000 or more, must pay for health insurance — the least expensive of which is $1,400 a month, with a $4,000 deductible and a hospital copay of 20 percent.

Uncompensated care

There is some money to reimburse treatment providers for patients without insurance, but not much, at least not anymore, said Botticelli. Even before health care reform, Massachusetts had an uncompensated care pool. A significant source of dollars for health care reform came from the uncompensated care pool, and these dollars are no longer available for uncompensated care for the people with substance use disorders who are uninsured.

Insurance status of clients entering detox



Source: Massachusetts Department of Health, Bureau of Substance Abuse Services

State-funded admissions themselves have declined over the past 10 years, by about 12 percent. This is a result of health care reform, but also a result of deep cuts in 2003. Also, as providers across the country know well from their experiences with managed care in the early 1990s, during which many programs had to close due to lack of patients, insurance coverage doesn't guarantee access. Insurance companies in Massachusetts require preauthorization for treatment services, Botticelli said.

Patients with substance abuse have to go through an authorization process, said Botticelli. "Insurance is largely driven by medical necessity criteria," he said. "While we might understand residential services to be clinically important, insurance reimburses on medical necessity." Parity has not been helpful to residential treatment, because all it did was say that diseases of the brain couldn't be treated to diseases of the body, he said. "There used to be more dollar limits for substance abuse treatment," he said. "What parity said was you can't have those differential requirements, you can't have differential copays."

The uninsured

"Churning" and disenrollment are two significant problems that are related to commercial insurance. "One of the issues that we've heard with substance use disorder clients is that for whatever reason someone gets enrolled, and then drops it," said Botticelli. "Or their employment changes, and they are disenrolled." The phenomenon of churning takes place when income status changes, making the person no longer eligible for a certain plan. They re-enroll in another plan, but in between there are periods when they are uninsured.

"We have a picture of who is uninsured, and what we want to do is get a better understanding of why they're uninsured when they're coming in for treatment," said Botticelli. It may be because their substance use disorder itself makes it impossible for them to do something as organized as sign up for health insurance. "Clients with substance use disorders are not known for self-care behavior," he said. "Someone in the throes of addiction can't even think about health insurance."

> **'Someone in the throes of addiction can't even think about health insurance'**
>
> Michael Botticelli

"I think both the federal block grant funds and state appropriations are still critically needed in a health care reform environment to pay for those medically necessary services for clients who remain uninsured at time of admission," said Botticelli. Additionally, however, he thinks the block grant and state dollars have to be used for "other services." These include residential services, which are not reimbursed by Medicaid or private insurance.

Currently, 70 percent of federal and state dollars are used to support services not reimbursed by Medicaid or private insurance, said Botticelli. This includes the prevention dollars, which constituted 20 percent of the block grant.

Medication-assisted treatment

Massachusetts provides generous coverage for medication-assisted treatment: methadone, buprenorphine, and naltrexone, including Vivitrol. "We're fortunate in Massachusetts that we have a robust Medicaid benefit," said Botticelli. Buprenorphine is the number two drug on the formulary. Because of the benefits for people with Medicaid, the experience with the block grant in Massachusetts "may not be 100 percent applicable" to other states, he said. "But I still think that what is happening in Massachusetts can happen around the country."

The state is now focusing more on prevention and early intervention, and on recovery support after or instead of treatment, said Botticelli. •

Interview

CRC's Herschman on choosing MAT for opioid addiction

Patients addicted to opioids, in the real world, have a choice of methadone treatment in an opioid treatment program, monthly Vivitrol injections, or buprenorphine prescriptions. At CRC Health Group, the largest substance abuse treatment provider chain in the country, patients have a choice as well. And nobody is better than Philip L. Herschman, Ph.D., returned to his position as chief clinical officer by new CEO Andy Eckert this spring, to talk about how patients are matched to medication-assisted treatment (MAT) for opioid addiction.

"There's not a simple answer," Herschman told *ADAW* last week. "In terms of real management of opioid dependency, the medication for either detox or maintenance would be methadone, buprenorphine, or Vivitrol."

The most-used medication is methadone, he said. "This is by dramatic orders of magnitude. It's still the least expensive form of treatment. You can get a month's worth of treatment in an OTP, which includes counseling and seeing a physician, for half of what buprenorphine medication alone costs and

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for a third of the cost of Vivitrol."

But economics aren't the only way the choice is made. "If you put on your clinical hat and talk about which medication might be more appropriate for which population, you would say that methadone is more appropriate for the longer-term heavier user of opioids, and buprenorphine is more effective with the younger population that hasn't been using for very long and whose dosage isn't high." Buprenorphine is also used for detoxification, he said.

CRC last spring launched a program, now called Provita, in which patients are hospitalized for two weeks for detoxification, and then administered their first shot of Vivitrol (see *ADAW*, February 28). "At this point, you can see that Vivitrol is useful for the physicians, lawyers, and other diversion populations," he said. Because it's an antagonist, with no abuse potential, naltrexone (oral or Vivitrol) is preferred for many professionals, especially those with access to medications. However, that doesn't necessarily mean it wouldn't be equally efficacious in other populations, he said. "Vivitrol is still sort of an unknown in terms of which populations it's best for," he said. "But the research on it looks really good."

Every kind of MAT has pluses and minuses from the patient viewpoint, as well, he said. "The down side of methadone is that you have to walk into a clinic every day. You can get a prescription for buprenorphine from a doctor, but the down side is that all too often there isn't much counseling. Vivitrol is attractive because you only have to think about it once a month, but the same concern is there — there is not as much counseling going on as there should be."

If a patient goes to a CRC clinic, they would be given the option of buprenorphine or methadone, but buprenorphine is usually rejected because of the cost, said Herschman. A typical dose for an opioid dependent patient costs about $500 a month. CRC currently treats 26,000 patients in OTPs, and about 500 of them are maintained on buprenorphine instead of methadone. About 500 injections of Vivitrol were given last month, some for alcohol, but most for opioid dependence. "We were using it for alcohol before we rolled out Provita," said Herschman.

Herschman said Vivitrol will probably be most useful for higher-functioning patients who are going back to strong support systems, have jobs and families, and — this is key — has insurance that covers the medication. •

Housing from page 1

With many policy leaders across the country seeing outpatient services coupled with transitional housing as perhaps offering a cost-effective alternative to traditional residential care, Integrity House's venture into supportive housing probably could not have been better timed. Yet Integrity House's president emphasizes that he sees the facility's latest project as an integral part of the continuum of care — not as a substitute for residential treatment.

"There's no way that someone who has been living for 20 years on the edge won't need long-term residential," Integrity House president David H. Kerr told *ADAW*. He added that for some of the chronically ill people that his agency traditionally serves, "Housing without treatment equals a shooting gallery."

Housing procedures

Integrity's supportive housing site contains eight units of shared housing, with four apartments designated for single women and four for women and children. In all, up to 22 women and 24 children can reside in the facility at one time.

Integrity House

Location: *Newark, New Jersey*
Founded: *1968*
Services: *Residential, halfway house and outpatient treatment, financed primarily by block grant funds*
Staff: *200 employees*
Clients Served: *1,500 a year*

Drake said the women generally arrive at the facility from a residential treatment stay, though not necessarily one at Integrity House. "We try not to take individuals with no treatment experience; we like to see them have some recovery under their belt first," she said.

The women pay rent to live at the apartments, with amounts based on a scale according to ability to pay. Rental subsidies are available from Integrity House. In general, the women residing in the supportive housing either are working part-time or are going to school; they have either employment income or some form of public assistance that can contribute to the cost of their housing.

Prior to the opening of the supportive housing program, the closest Integrity House could find to a sober-living environment for its outpatient clients was a nearby shelter operated by the local Urban Renewal Corporation, Drake said. "But the women had to be welfare-eligible to go there," she said.

A full-time housing case manager is assigned to the supportive housing site during business hours, and both that person and Drake are also available to respond to emergencies during off-hours. During evenings and weekends, residents who have made significant progress in their recovery are assigned as "apartment captains."

"We wanted these women to feel that they were gaining some independence," Drake said in explaining the staffing pattern.

She said each resident's status is reviewed once a month, and the general intent is for residents to stay in the housing for about 6 to 15 months. The case manager works with each

 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

individual to identify permanent housing options after their stay.

Drake does see the program as a possible alternative to residential treatment for some women, particularly given that many residential programs that are equipped to serve women with children have lengthy waiting lists. Integrity House itself presently carries a waiting list of about 100 for its overall residential programming.

Drake said she already has seen noteworthy progress in several cases, saying she is currently working with a client who two weeks after arriving in the program was reunited with a daughter who had been taken from her at age 6 months.

Financial support

Integrity House conducted a five-year fundraising drive to support an initiative to bolster services for women coming through treatment. "Most of the cases we had been seeing in Essex County where kids had been removed from the home were because of substance abuse," said Drake.

The facility in 2009 opened an outpatient program equipped to serve 100 women a year. The supportive housing program now expands Integrity House's ability to serve these women effectively, according to facility leaders.

Integrity House was able to make significant strides in its fundraising effort. Perhaps the highlight was the surprise announcement in the winter of 2009 that the facility would be one of five recipients of donations to Newark nonprofit organizations from the Oprah Winfrey Foundation. Kerr received a $500,000 check from the foundation just days after learning of the award.

Kerr believes the availability of the supportive housing will help communicate to women that they have a viable sober-living option after primary treatment.

"We mess everything up by telling the women after they complete treatment that the housing [decision] is on them," Kerr said. "The women make two big mistakes: They'll choose housing that is cheap, and they'll team up with a man, who is usually a recovering person also. They should never get back into the same old relationship."

The supportive housing allows the women to slow things down as they progress in their recovery, Kerr said. In addition, if they slip while in the housing program, Integrity House is immediately available and equipped to offer them a "tune-up" in their treatment, he said.

"These women need long-term recovery support, coaching, structure, encouragement, and supervision," Kerr said. He added, "Some other programs out there don't have the obsession with urine tests that we have." •

2011 drug strategy released

Last week the 2011 National Drug Control Strategy was quietly released in Ohio by Gil Kerlikowske, director of the Office of National Drug Control Policy. The strategy focuses on community-based drug prevention, integrating substance abuse treatment into health care, and for the first time includes a focus on three specific populations: active duty military and veterans, college students, and women and their children.

About 60 percent of the 140,000 veterans in federal and state prisons have a substance use disorder, and an estimated 375,000 patients in Veterans Administration facilities had a substance use disorder diagnosis in 2007. Substance abuse also affect many of the 75,6000 veterans who are homeless.

About 44 percent of full-time college students report binge-drinking the past 30 days, and 20 percent report past-month use of illegal drugs.

"Drug use affects every sector of society that is vital to a strong America, straining our economy, our healthcare and criminal justice systems, and endangering the futures of our young people," said Kerlikowske in releasing the policy. "This roadmap to reducing drug use and its consequences will require teamwork and collaboration that draws on the strengths of the prevention, treatment, law enforcement, criminal justice, and recovery communities, as well as parents all across America."

Go to www.whitehousedrugpolicy.gov/strategy for a full copy of the 2011 strategy.

Betty Ford's legacy

Betty Ford, who founded the Betty Ford Center after her recovery from alcoholism, died July 8 at the age of 93. Below is printed from the program distributed to guests at the July 12 "Celebration of the Life of Betty Ford" at St. Margaret's Episcopal Church in Palm Desert, California, a copy of which was obtained by ADAW. *The service was attended by Michelle Obama, Hillary Clinton, Nancy Reagan, Rosalind Carter, and President George W. Bush.*

Elizabeth Ann Bloomer was born in Chicago, Illinois on April 8, 1918, and was raised in Grand Rapids, Michigan. She was the daughter of Hortense Neahr and William Stephenson Bloomer and the sister of Robert Bloomer and William Bloomer. A youthful passion for dance took her to New York and led to a long, cherished friendship with

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Continued from previous page

the legendary Martha Graham. Returning to Grand Rapids, Betty Bloomer formed a dance group and taught rhythm and movement to handicapped children.

In 1947, she met a young Navy lieutenant named Gerald Ford. Their Ocober 15, 1948 wedding took place just two weeks before the bridgegroom's election to the U.S. House of Representatives. During her husband's thirteen terms in Congress, the Fords lived in Alexandria, Virginia. The family grew to include four children — Mike, Jack, Steve, and Susan. A newspaper profile of this period depicted Betty Ford as a classic suburban mom and Sunday school teacher and noted her taste for "quiet suites" and "slightly more talkative hats."

In 1973, when her husband suddenly was appointed to the Vice Presidency of the United States, Betty Ford found herself in the national and international spotlight. She also found her voice. Having long been an advocate for women's issues, she now had a platform rom which to champion those issues. Her advocacy became even more forceful when less than a year later her husband became the 38th President of the United States.

Within weeks of moving into the White House, the new First Lady was diagnosed with breast cancer. Following a successful mastectomy, she discovered a strength and an infuence that she utilized unceasingly to assist others. "Lying in the hospital, thinking of all those women going for cancer checkups because of me," Betty Ford would later say, "I'd come to realize more clearly the power of the woman in the White House — not my power, but the power of the position, a power which could be used to help."

It was a power and conviction she would use for the rest of her life. As First Lady, Betty Ford shone a national spotlight on the arts and served brilliantly as the Nation's hostess during America's Bicentennial. But it was as a pioneering advocate of women's rights and health initiatives that she made her greatest contribution. Her support of the Equal Rights Amendment and her plain-spoken approach to life and all its challenges earned her millions of admirers — and not a little controversy. Yet, by the 1976 presidential campaign, buttons had sprouted across the land declaring, "Betty's Husband for President!"

After leaving the White House, her personal recovery from addiction to alcohol and prescription drugs opened the doors on another health issue that was previously mentioned only in hushed tones, especially for women. Her courageous and forthright public discussions of her recovery encouraged tens of thousands of women and men to find their own recovery and ultimately resulted in the founding of the Betty Ford Center. The Center is at the international forefront in innovative treatment methods and was the focus of Betty Ford's devotion from the day its doors opened until her death.

In 1991, President George H.W. Bush, presented Betty Ford with the Presidential Medal of Freedom, the Nation's highest civilian award. The citation spoke for all Americans: "Her courage and candor have inspired millions of Americans to restore their health, protect their dignity, and shape full lives for themselves."

For her years of service as America's First Lady and for her courageous leadership in health issues of women and men in the years that followed, Betty Ford will forever have the respect and admiration of a grateful nation. She will long be remembered as a beloved wife and mother and as a treasured friend for her unconditional love, her unceasing joy in life and her readiness to lend and ear and a hand. But she will most love being remembered simply as Grandma. •

Coming up...

The annual meeting of **International Doctors in Alcoholics Anonymous** will be held **August 3-7** in **Tucson, Arizona**. Go to **www.idaa.org/2011** for more information.

Children and Family Futures will present "Putting the Pieces Together for Children and Families: The National Conference on Substance Abuse, Child Welfare, and the Courts" on **Sept. 14-16** in **National Harbor, Maryland**. For more information, go to **www.cffutures.org/conference2011**.

In case you haven't heard...

By July 8 when Mark Weber, spokesman for the Substance Abuse and Mental Health Services Administration (SAMHSA), blogged about "SAMHSA's Changing Role," the news was pretty old. SAMHSA has been changing drastically ever since Pam Hyde was confirmed as Administrator. But Weber introduced a new concept: the "random dot autostereogram." This, he explains, is a picture that "depicts a 3D image but is hidden in a repeated pattern of random dots. In order to see the picture a person has to step back and look at the image in its entirety and not focus on one or two specific dots." Some of the dots, it turns out, are "fund source" and "type of funding." SAMHSA is now going to focus on all treatment funding, including commercial and public insurance (Medicaid and Medicare). Other dots are specific diseases (like mental illness and addiction). SAMHSA is now going to be focusing on the whole person. So, there you have it. Stand back and stop looking so closely at the block grant and addiction, folks. The big picture at SAMHSA is how to be all things to all people.