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

Volume 25 Number 19
May 13, 2013
Print ISSN 1042-1394
Online ISSN 1556-7591

In This Issue...

View this newsletter online at wileyonlinelibrary.com
DOI: 10.1002/adaw.20377

Michigan requires addiction credentials for FQHC-SUD Medicaid services

In a win for the addiction workforce, Michigan is requiring that providers of substance use disorder (SUD) services paid for by Medicaid in a Federally Qualified Health Center (FQHC) must hold credentials showing they have specific experience and training in addiction. It will not be enough to be a psychologist, social worker, or professional mental health counselor, according to the policy, which was issued May 1 by the Michigan Department of Community Health (DCH).

Psychologists, social workers, and professional counselors providing SUD services must also possess specific Michigan Certification Board of Addiction Professionals (MCBAP) or International Certification and Reciprocity Consortium (IC&RC) credentials, according to the policy, which takes effect June 1.

"These are truly significant steps to enhance the protection of recipients of substance use disorder services in the state of Michigan," Kristie R. Schmiege, director of prevention and health promotion for the Genesee Health System in Flint, told *ADAW* last week. "There has been much emphasis from the federal and state levels toward integrated primary and behavioral health services, so

See Michigan page 2

Bottom Line...
Patients treated for SUDs in FQHCs in Michigan will be assured that their providers are credentialed in the treatment of addiction under a new policy from the state's Medicaid department.

The Business of Treatment

Funding is still elusive for treatment of offenders

B$T

Despite widely held beliefs about the cost-effectiveness of substance use treatment services for individuals in the criminal justice system, some addiction service programs continue to struggle to assume the kind of role they would like to have in serving offender populations. When an organization also rests somewhat outside the mainstream addiction treatment community, the challenge can become ever greater.

Take the experience of the McShin Foundation, the Virginia recovery community organization co-founded in 2004 by spouses John M. Shinholser and Carol McDaid. McShin and a nonprofit agency that spun off from it, Kingdom Life Min-

See Justice page 6

Bottom Line...
In many communities, data to document the cost-effectiveness of substance use treatment services for offenders remain in short supply, while programs that offer nontraditional services face an even steeper climb in their effort to gain funding support.

Michigan from page 1

it is wonderful to see the state requiring the same MCBAP/IC&RC certification standards for behavioral health staff working in Federally Qualified Health Centers as are currently required in publicly funded addiction treatment programs."

"SUD is a disease," said Deborah J. Hollis, director of the DCH Bureau of Substance Abuse and Addiction Services. 'To provide care requires training in addiction competency," she told *ADAW*. "We want qualified individuals to provide SUD services, whether its prevention, treatment or recovery. It's up to us, the field, to instill this value into private sector care."

Specifically, the required credentials for people working in FQHCs diagnosing or treating SUDs are:

- Certified Alcohol and Drug Counselor – Michigan (CADC-M).
- Certified Alcohol and Drug Counselor – IC&RC (CADC).
- Certified Advanced Alcohol and Drug Counselor – IC&RC (CAADC).
- Certified Criminal Justice Professional – IC&RC – Reciprocal (CCJP-R).
- Certified Co-Occurring Disorders Professional – IC&RC (CCDP).
- Certified Co-Occurring Disorders Professional Diplomat – IC&RC (CCDP-D).

'These are truly significant steps to enhance the protection of recipients of substance use disorder services in the state of Michigan.'

Kristie R. Schmiege

The most important credential is the CAADC — there are currently 2,090 (131 new since January 2012). The CCDP-D will be increasingly significant, although there are currently only 8 in the state (3 new since January 2012).

More than the degree

While Michigan has required Master's-prepared providers for some time, the credentialing addition is significant, because under the Affordable Care Act (ACA) many more people will be seeking care in FQHCs, said Karen Youngs Hartley, administrator of the MCBAP. They will be covered by Medicaid, and as care becomes more integrated they will be seeking SUD services in those FQHCs as well, she told *ADAW*. "The FQHCs typically provide all the primary care for low income people, and now they will be providing integrated care as well," she said. Nevertheless, FQHCs are not licensed substance abuse treatment providers, so the credentialing of the individuals providing SUD services there is key, said Hartley.

The same credentialing rule will apply to the FQHC "lookalikes" — health care providers who are similar to FQHCs but don't have the federal designation and don't get the same grants. "Typically these lookalikes are arising in order to integrate primary care services with other services such as mental health and SUD treatment," said Hartley. As long as Medicaid is paying, the person delivering the SUD services must have the addiction-specific credential.

It's important to make sure that providers working with people with SUDs have the ability to do so, she added. "The majority of people coming out of school with a Masters in professional counseling or social work or marriage and family therapy have zero hours in addiction," she said.

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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 second Monday in July, the second Monday in September, and the first and last Mondays in December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Print only: $695 (individual, U.S./Can./Mex.), $839 (individual, rest of world), $5433 (institutional, U.S.), $5577 (institutional, Can./Mex.), $5625 (institutional, rest of world); Print & electronic: $765 (individual, U.S./Can./Mex.), $909 (individual, rest of the world), $6251 (institutional, U.S.), $6395 (institutional, Can./Mex.), $6443 (institutional, rest of the world); Electronic only: $555 (individual, worldwide), $5433 (institutional, worldwide). **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.

Alcoholism & Drug Abuse Weekly is indexed in: Academic Search (EBSCO), Academic Search Elite (EBSCO), Academic Search Premier (EBSCO), Current Abstracts (EBSCO), EBSCO Masterfile Elite (EBSCO), EBSCO MasterFILE Select (EBSCO), Expanded Academic ASAP (Thomson Gale), Health Source Nursing/Academic, InfoTrac, Proquest 5000 (ProQuest), Proquest Discovery (ProQuest), ProQuest Health & Medical, Complete (ProQuest), Proquest Platinum (ProQuest), Proquest Research Library (ProQuest), Student Resource Center College, Student Resource Center Gold and Student Resource Center Silver.

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There are currently 35 FQHC organizations throughout Michigan, providing care for over 600,000 residents a year at more than 200 sites, according to Brad Barron, policy analyst with the DCH Medicaid Program Policy Division. Information on the number of SUD patients in the state is not "easily accessible," said Barron. In addition, he could not say how many social workers, psychologists, and professional counselors are in the state, but added that the Department of Licensing and Regulatory Affairs handles licensing for these professionals.

Professionals who work in SUD agencies are already required to have these credentials, Barron told *ADAW*. The new policy requires FQHCs to have the same credentialing requirements as a provider within a SUD agency "because these credentials provide validity to the services being provided," he said. "These individuals have, or will have, documented knowledge and training in treating SUDs."

Hartley noted that if someone does not yet have an addiction certification but is hired in a new SUD services position, that person can prepare a "development plan" with their employer and then register it with the MCBAP. That person would gain the credential within a specified period of time — typically one to three years, she said. "With an approved development plan, and proper supervision, they are allowed to work (be paid with public funds) under development plan status during the limited period of the plan."

More jobs

The FQHC-Medicaid policy expands job opportunities for people with the addiction credential, said Hartley. In the past, FQHCs have referred patients who need SUD services to another provider, but under the ACA and integrated "wholistic" care they are going to be providing the services themselves, said Hartley. So most of the jobs will be new.

However, Michigan is prepared, she said. There are already many Masters-prepared credentialed addiction professionals who are in Michigan and ready to work — they got laid off during the recession, and they "can come back as soon as positions are available," said Hartley.

Hartley credits people in state leadership, including Deborah Hollis, who is the single state authority over the substance abuse block grant, with supporting the policy. In particular, regional substance abuse coordinating agencies, including the one that Schmiege directs, manage the block grant, and have been working with the DCH "to make sure the transition to health care reform includes support for the credentialing process, especially as services get blended together," said Hartley. "There is a tendency for people to say, 'Oh well, we have lots of Masters-prepared people in our mental health center.'"

Quality assurance

MCBAP/IC&RC credentialing for professionals providing addiction-related prevention and treatment services is "fundamentally a quality assurance and public protection process," said Hartley. Through credentialing, there is a degree of proof that a professional serving a person with a SUD diagnosis has a demonstrated level of knowledge and expertise in the science and treatment of SUDs, she said.

"Since addiction studies are not a standard part of most Masters level counseling or social work academic programs, it is important that specialty credentials be achieved beyond the basic academic training and degree, so that accurate assessments and diagnoses can be provided, and effective treatment methods used."

Alcohol and drug addictions have "specific etiologies," said Hartley. "Harmful alcohol and drug use may precipitate or exacerbate other illnesses, may affect the use of prescribed medications, may contraindicate some medications or other medical procedures, and may block progress in medical or psychological treatments." Hartley and other advocates are hoping that private insurance companies institute similar rules for staff providing SUD services.

"The foray into private insurance companies has been on our radar with various pushes over the years here in Michigan," said Schmiege, who is also an IC&RC chair. "I hope that other health insurance carriers here in Michigan will follow suit, and I further hope that other states will also consider such policy decisions in both of these directions." •

For the policy bulletin, go to www.michigan.gov/documents/mdch/MSA_13-13_419426_7.pdf.

Probuphine rejection by FDA: Adequate dosing a key concern

When the Food and Drug Administration (FDA) rejected the New Drug Application (NDA) for buprenorphine implant Probuphine on April 30, there was surprise on Wall Street and among many in the treatment community. An FDA advisory committee had recommended weeks before that Probuphine be approved (see *ADAW*, April 1).

Despite the fact that clinical trials showed that only 8 percent of patients were opioid-free throughout the treatment, perhaps signaling problems with determining an adequate dosage, the expectation was that since it was more effective than placebo, Probuphine would be approved. Overall, 35 percent of the Probuphine patients and 72 percent of the placebo patients in the controlled trials did not complete the six-month treatment course. The

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most common reason in the placebo patients was "treatment failure," which was defined as needing additional sublingual buprenorphine beyond preset amounts. The trials did not define continued use of illicit substances as treatment failure.

One of the questions that came up at the March 21 hearing on Probuphine was whether the dose was high enough — why did patients supplement with illicit opioids or need additional buprenorphine? Advisory committee member Louis E. Baxter, Sr., M.D., executive medical director of the Professional Assistance Program of New Jersey, was very concerned about how an effective dose is determined. Insurance companies, he said, rely on FDA-approved language to determine how much of a medication to pay for. "In general practice, whatever we say here, the third-party insurers will try to hold us to," he said at the March 21 hearing on the NDA by the FDA's Psychopharmacologic Drugs Advisory Committee, a group that advises the FDA on approvals.

"It's been promoted here that the equivalent of 16 milligrams [of buprenorphine] is the effective dose" of Probuphine, said Baxter, referring to the recommended dose in the NDA for the Probuphine implant. "And it may be for many individuals. But in my clinical practice, I have individuals who are on the other formulation [sublingual buprenorphine] who require 24 or 32 milligrams. And I have had instances with the new product that recently came out [Suboxone film] where the effective dose is no longer what it initially was."

Baxter went on to say that physicians were told that with the film, 16 milligrams is the most effective dose. "That is what has been translated to the insurers, and so insurers have been trying to get us to knock some of our people who have been stable on 24 or 32 milligrams for years, got their lives back, to go back down to 16." As a result, "I've had people who have relapsed," said Baxter. "So it's important that we are sure when we say what the most effective dose is."

"The biggest problem was that the implant didn't give comparable blood levels to the 16-milligram sublingual," agrees Jana Burson, M.D., a North Carolina internist who treats opioid addiction with buprenorphine and also works in an opioid treatment program with methadone patients. "If you're going to have to supplement anyway, what's the advantage, if you're still going to be prescribing sublingual?"

Burson also thinks Probuphine will be a problem because of storage. "I'm not going to store it on the premises," she told *ADAW*. "And if I have a surgeon implant it someplace else, I'd have to watch it implanted and explanted, and I'm sure I wouldn't be reimbursed for that." Except for the big treatment centers that can afford to store it, Probuphine won't be widely used in the addiction treatment field, said Burson. "However, I see a real role for it in law enforcement, for people who are going to be incarcerated."

> **'In general practice, whatever we say here, the third-party insurers will try to hold us to.'**
>
> Louis E. Baxter, Sr., M.D.

Other FDA concerns are with the logistics of having physicians placing and removing the implant.

Public safety

The drug's sponsor was astonished by the rejection, thinking that efficacy had been established by the clinical trials and that the majority of the advisory committee had recommended approval. "Titan and our partner, Braeburn Pharmaceuticals, are extremely surprised and disappointed with the FDA's response," said Marc Rubin, M.D., executive chairman of Titan, after the FDA's decision. The benefit of Probuphine is that it can't be diverted and abused, or accidentally consumed by a child, since it is implanted under the skin. The formulation "is consistent with the recently issued FDA guidance supporting diversion- and abuse-resistant products," said Rubin, adding that the medication "has demonstrated both safety and efficacy in accordance with primary endpoints that were pre-agreed with the FDA."

Titan isn't giving up; company officials plan to meet with the FDA and plan next steps. "Given the nationally recognized, growing and devastating opioid dependence epidemic, there is critical need for new safe and effective treatments that reduce the likelihood of abuse, diversion and accidental pediatric exposure, and Titan and Braeburn remain committed to making Probuphine available for patients that need it."

The FDA told *ADAW* it is not allowed to talk about new drug applications or to share any information about rejections.

More information for FDA

According to Titan, the rejection letter from the FDA states that additional data is needed to support the efficacy of Probuphine, including:

- the ability of Probuphine to provide opioid blockade of relevant doses of agonists;
- the effect of higher doses of Probuphine, ideally doses more closely approximating the blood plasma levels associated with sublingual doses of buprenorphine of 12 to 16 milligrams a day; and
- human factors testing of the training associated with Probuphine's insertion and removal.

The FDA also wants changes in product labeling and the implementation of the Risk Evaluation and

 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

Mitigation Strategy (REMS).

Probuphine is an experimental implant that delivers continuous blood levels of buprenorphine for six months. Although compliance and retention have not been cited as specific problems with buprenorphine, the implant delivery method "simplifies" compliance and retention, according to Titan. It also reduces the possibility of diversion, which is a huge problem with buprenorphine taken orally.

Finances

The financial implications were immediate upon FDA rejection. The stock, which had been rising for years, plummeted. This suggested that Probuphine was hoped to replace much of the sublingual buprenorphine market, and that it would not necessarily be less expensive.

We asked Phil Skolnick, Ph.D., director of the Division of Pharmacotherapies and Medical Consequences of Drug Abuse at the National Institute on Drug Abuse in 2010 about Probuphine, then in development. He said that one of the advantages of an implant would mean that patients would not have to take a pill every day. But costs would not be an advantage, he said — it would probably cost no less than Suboxone (about $300 a month at the time). "Titan spent a lot of money developing this compound, and they would like to make a profit on it," Skolnick told *ADAW* then.

Titan received a two-year, $7.6 million grant from NIDA to fund half of its Phase III study in 2010 (see *ADAW*, August 16, 2010). NIDA and the Substance Abuse and Mental Health Services Administration supported the development of Suboxone, now off-patent in the sublingual tablet form. There are two generic buprenorphine-naloxone products on the market.

Titan is to receive $50 million from Braeburn for Probuphine distribution rights upon FDA approval. Titan holds the patent on Probuphine until 2023. •

For more on the FDA advisory meeting held March 21 that resulted in the initial recommendation to approve, go to www.fda.gov/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/PsychopharmacologicDrugsAdvisoryCommittee/ucm341479.htm.

State Budget Watch

N.H. advocates send senate video postcards in funding plea

Advocates for treatment and residents who have been through treatment are sending video postcards to New Hampshire state senators in a last-ditch attempt to increase funding for prevention and treatment, the New Hampshire Union-Leader reported May 6. New Futures, an advocacy group working with Media Power Youth, hopes the video postcards succeed in the Senate. The state's treatment system has a long history of being underfunded, despite what was hoped to be a fix more than ten years ago.

The state legislature established the Alcohol Abuse Prevention and Treatment Fund in 2001; the fund is administered by the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment. Funding is supposed to come 100 percent from 5 percent of gross profits of the State Liquor Commission. However, the legislature suspended the law, and since 2003 the account has not been fully funded.

For example, $18.3 million would have been allocated to the fund for fiscal year 2012–2013, because that would have been 5 percent of State Liquor Commission sales. However, only $3.2 million was allocated for both years combined. The budget for fiscal year 2014–2015 proposed by Gov. Maggie Hassan, and passed by the House, provides only level funding, at $1.5 million a year.

> **'The only state in this country where you are less likely to get treatment if you need it is Texas.'**
>
> Tym Rourke

"The only state in this country where you are less likely to get treatment if you need it is Texas," said Governor's Commission Chairman Tym Rourke, adding that New Hampshire leads the nation in youth drinking. "This is a problem that it is no longer in the state's economic best interest to avoid."

The funding level of $1.5 million is a 5-percent cut from the prior budget, said Rourke, adding that the previous budgets eliminated all of the prevention contacts and left only a minimum of treatment contacts. "There is a simple solution — fund the alcohol fund."

Linda Saunders Paquette, executive director of New Futures, said 113,000 residents need treatment, but only 6,000 can access it. "We know what happens to people who don't get these services," she said. "They end up in prisons, jails, hospitals, and

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Continued from previous page
they end up costing our businesses lost productivity." She said excessive consumption of alcohol alone costs the state $1.15 billion a year.

"We were disappointed not to see prevention dollars in the governor's budget or the House budget, but we're encouraged that the Senate may think differently and restore prevention funding in its budget," Saunders Paquette said.

"I know for a fact that treatment works," said Manchester small business owner Douglas Boisvert, who sent a video to his senator. "Treatment provides hope. I was one of the lucky ones. When I needed treatment it was there. It's not there anymore."

"I do not believe there is any family that's not affected on some level" by alcohol or drug abuse, said Susan McKeown of Child Health Services, a 40-year pediatric nurse practitioner, who sent a video postcard to her senator. "As a certified prevention specialist, I'm appalled the prevention funds were cut in the last budget," she said. •

So far, 125 video postcards have been sent to legislators by people who have received treatment or are working in treatment. The videos can be viewed at YouTube.com/NewFuturesNHMedia.

Self-medicating mood with alcohol linked to dependence

Self-medicating mood disorders with alcohol is associated with the onset and persistence of alcohol dependence, according to a recent analysis of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a fertile database of alcohol use disorders and related disabilities. Drawn from NESARC 1 (43,093 adults interviewed in 2001 and 2002) and NESARC 2 (34,653 re-interviewed in 2004 and 2005), the study found that self-medicating mood symptoms increases the odds of new-onset and persistence of alcohol dependence.

People who were self-medicating mood disorders — depression, bipolar disorder or dysthymia — were three times more likely to have new-onset alcohol dependence as a result, and three times more likely to still have alcohol dependence if they had ever had it before.

Mood disorders were measured based on past-year symptoms and assessed based on whether they were threshold (meeting the diagnostic criteria) or sub-threshold. Other substance use disorders, anxiety disorders and personality disorders were also assessed. The NESARC interviews were face-to-face.

About 12 percent of new cases of alcohol dependence, and 30 percent of persistent cases, were attributable to self-medication of mood disorders, according to the study, published online in *JAMA Psychiatry* on May 1.

This study is based on a NESARC sample of people with mood symptoms who were asked about self-medication with alcohol, had used alcohol anytime in their lifetime and were re-interviewed in wave 2 (5,768). For the analysis of new-onset alcohol dependence, anyone with current or lifetime alcohol dependence was excluded, leaving a sample of 4,221. For the analysis of persistence of dependence, only people with current or lifetime dependence at baseline were included, leaving a sample of 1,547. Persistent dependence was defined as meeting the criteria for alcohol dependence at both ends of the study.

The study did not find any relationship between self-medication and alcohol dependence that was linked with race/ethnicity, gender or age.

People who had been treated for a mood disorder were more likely to self-medicate with alcohol than people who had not been, according to the study. This may be because these people had more severe mood disorders, or symptoms that did not respond to treatment, according to the study. In addition, the study noted receiving treatment for a mood disorder does not preclude developing alcohol dependence as a result of self-medicating.

These patients need a "multimodal treatment strategy," according to the article. In addition, it would be helpful for patients in treatment for mood disorders to know the risks of using alcohol to self-medicate their symptoms. •

The study was supported by grants from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and from the National Institute on Drug Abuse. NESARC is a project of the NIAAA.

Justice from page 1
istries, had been offering peer-to-peer recovery support services in the city jail in Richmond, along with post-release services. But it would take a bit of a chance conversation between Shinholser and a state legislative assistant who was seeking a topic for her doctoral dissertation to give momentum to an effort to quantify the jail-based services' impacts in Richmond.

"I dug deep into a literature review, and for Virginia the research was very minimal," Sarah Scarbrough, Ph.D., the former Virginia Commonwealth University doctoral student who now directs the governor's mansion in Virginia, told *ADAW*. "For much of the data that was out there, it could be based on a sample of 10 individuals."

Shinholser says the research that Scarbrough conducted, which has not yet been published in a peer-reviewed journal, at least has helped

quantify and confirm what he says has been known for some time about what works with the offender population (the research documented an 18 percent decrease in recidivism for an offender group receiving peer-to-peer support services vis-à-vis a control group).

"Support services delivered by recovering people by far provide the best services," Shinholser, who serves as the McShin Foundation's president, told *ADAW*.

Critical elements

Scarbrough said her research into the jail-based programming operated by Kingdom Life Ministries, which combines faith-based principles with a behavior modification approach, pointed to the importance of peers' role in reaching out to incarcerated offenders. The offender population often is skeptical of what someone without an addiction history can accomplish, she said.

"The peer-based model provides the offender with hope," Scarbrough said. "It's kind of cutting-edge right now in Virginia — there's not too much of it out there."

She added that her research found that programming for offenders is most effective when it is available both when an individual is still incarcerated and then again upon release. "While they're incarcerated, you can capture their attention and help develop the fundamentals of recovery," she said, referring to areas of focus such as strategies to overcome an addictive personality, efforts to manage anger and skill-building in parenting.

"If this programming is available only when somebody gets out, it becomes harder to start living by the new rules then," Scarbrough said.

McShin's efforts with jail inmates in Richmond have resulted in offenders having access to peer support even before they are sentenced. But the recovery support services available to offenders in the Richmond area subsist largely on donations; Shinholser says his organization has never received funding from local government.

He has a regular presence in advocacy activity at the state legislative level, but the picture is not much brighter there. Shinholser says efforts to have the state allow unspent substance abuse treatment dollars at the end of a fiscal year to finance recovery support services have fallen short. He compares his request to have the recovery support community seated as an equal partner at the table to asking political leaders to undergo dental surgery without anesthesia.

And it's not that traditional primary treatment centers have it much easier, Shinholser says. He serves on the board of directors of Rubicon, Inc., a Richmond-based residential treatment program with more than 200 beds, a 40-year history in the community, numerous contracts with state corrections and recent financial struggles.

'If this programming is available only when somebody gets out, it becomes harder to start living by the new rules then.'

Sarah Scarbrough, Ph.D.

The home page of the Rubicon website proudly announces that the center, in conjunction with the state Department of Corrections' High Intensity Drug Trafficking Act (HIDTA) program, won an Outstanding Treatment Effort Award at the beginning of this year. In the most recent analysis of the HIDTA initiatives, it was found that only 28 percent of offenders who successfully completed substance abuse treatment were arrested in the year following treatment. Yet Shinholser said underfunding of Rubicon's offender services at the state level has contributed to persistent financial struggles for the organization.

Drug court success

Certainly there are some jurisdictions where policymakers probably can rattle off data about cost savings from offender treatment and support services, and where the funding prognosis appears more stable. State funds support nearly all of the $1.6 million annual budget of the nationally known Davidson County Drug Court program covering the Nashville, Tenn., area. Most legislators probably are very familiar with the $12 a day per individual difference between incarceration costs and housing an offender in the residential treatment program operated within the Davidson County Drug Court apparatus.

Judge Seth Norman and Drug Court Program Director Janet Hobson explained to *ADAW* that the program in Davidson County has several built-in advantages. It is the only drug court program in the state with a dedicated residential treatment operation. And these services are delivered by county staff, meaning that the court is able to maintain substantial oversight of both the offender population and the actual delivery of services.

Norman said that while he has worked successfully in the past with contract providers for some services to his population, the in-house aspect of the core program has contributed to the consistent support it receives at the state level. "I have absolute control over the people in my facility," he said. •

Briefly Noted

Program for women leases more space for child care

The National Council for Alcoholism and Drug Dependency's (NCADD's) Sacramento branch is moving to a bigger space in order to make room for child care, which is part of its treatment program for women, the Sacramento Business Journal reported April 25. The new building will have a backyard area where the children can play. "We've been growing so fast that we needed more floor space," said Barbara Thompson, the group's Sacramento executive director. "We'll fill it instantly." NCADD Sacramento has 20 staff members, several interns and "dozens of volunteers," according to the article.

State News

Physicians in California support tracking prescribing practices

The Medical Board of California is supporting legislation that would require coroners to report prescription drug overdose deaths to the board, which would be able to take away a physician's prescribing privileges, the Los Angeles Times reported April 27. The board voted to support the bill in an April 26 meeting, at which it also voted to develop guidelines for prescribing opioids. The board oversees more than 100,000 physicians, but its president says it doesn't have the authority to identify overprescribers because it can't use the Controlled Substance Utilization Review and Evaluation System, the state's prescription drug monitoring system. The Los Angeles Times reported last year that from 2006 to 2011, at least 30 patients died of accidental overdoses while their physicians were under investigation.

Coming up...

The annual **West Coast Symposium on Addictive Disorders** will be held **May 30 to June 2** in **La Quinta, California**. For more information, go to **www.wcsad.com**.

The annual meeting of the **College of Problems on Drug Dependence** will be held **June 15–20** in **San Diego**. For more information, go to **www.cpdd.vcu.edu/Pages/Meetings/FutureMeet.html**.

The **National Association of State Alcohol and Drug Abuse Directors (NASADAD)** will hold its annual meeting **June 18–19** in **Bethesda, Maryland**. For more information, go to **http://nasadad.org/annual-meeting**.

The **NIATx** Summit and **SAAS** National Conference, "Innovation, Integration, Implementation — The Business of Behavioral Healthcare," will be held **July 14–16** in **San Diego**. For more information, go to **www.saasniatx.net/Content/Home.aspx**.

Names in the News

Jerry Rhodes, chief operating officer for CRC Health Group, will receive the Nyswander-Dole Award for his outstanding contributions to the opioid treatment field in the fall at the American Association for the Treatment of Opioid Dependence (AATOD) Conference in Philadelphia. "We congratulate Jerry on this fantastic and well-deserved achievement that validates a career-long dedication to the treatment field," said CRC Health Group CEO R. Andrew Eckert. "His championing of medication-assisted treatment as one of the most effective means for overcoming opiate addiction has saved thousands of lives. He is a true leader in the field and a treasured member of the CRC Health team." The Nyswander-Dole Award, named for the founders of methadone treatment, was first presented in 1983 to recognize extraordinary work and service in the opioid treatment field. The award recipients are selected by peers from each region. Rhodes was selected by his peers within the Pennsylvania Association for the Treatment of Opioid Dependence (PATOD). Prior to joining CRC in 2003, he was the chief executive officer for Comprehensive Addictions Programs Inc. (CAP). "I am surprised and humbled by this award," said Rhodes. "Twenty-three million people need but do not receive substance abuse treatment, and I am proud that CRC is leading the effort to help them. The treatment field has made great strides, but we have a lot more work to do." The award will be presented by A. Thomas McLellan, Ph.D., CEO and co-founder of the Treatment Research Institute (TRI), and current Clinical Advisory Board member for CRC.

In case you haven't heard...

Production of "Alert Energy Caffeine Gum" is being halted, due to Food and Drug Administration concerns over the effect of caffeine on children and adolescents, Reuters reported May 8. Each stick contains 40 milligrams of caffeine — about the amount in half a cup of coffee. "After discussions with the FDA, we have a greater appreciation for its concern about the proliferation of caffeine in the nation's food supply," Wrigley North America President Casey Keller said in a statement, adding that industry and consumers need better guidance about the use of caffeinated products.