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

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In This Issue...

In this issue, we look at some of the developments that are taking place in the blossoming addiction treatment field.

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ADAW *Exclusive*

Seabrook sues Elements, Recovery Brands for trademark infringement

This summer, Seabrook House quietly sued Elements Behavioral Health and Recovery Brands, which operates Rehabs.com, for trademark infringement and unfair competition. In the complaint, filed August 26 in the U.S. District Court for the District of New Jersey, Seabrook House asks for a full accounting from both Recovery Brands and Elements of the money they received as a result of people searching for Seabrook or Seabrook House and any subsequent call center on any of the Recovery Brands websites. In addition, Seabrook asks for an award of damages in an amount to be determined at trial of an amount greater than three times the profits of Elements and Recovery Brands or three times the damages sustained by Seabrook. Seabrook also asks for attorney's costs and lost profits.

Bottom Line...
Internet marketing and call center referral scheme cost Seabrook business because of trademark infringement and unfair competition, center claims in lawsuit.

The complaint is remarkable in that it brings out in the open what is

See **Complaint** page 2

The Business of Treatment

Interventionist buys mansion, will offer 'spiritual' care

B$T

Early next year, nationally prominent addiction interventionist Brad Lamm will introduce to Detroit a treatment alternative for substance use disorders (SUDs) that integrates day treatment with "spiritual healing" and that appears more insurance-friendly than standard residential care. The Breathe Life Healing Centers program in Detroit will resemble a pioneering program that Lamm founded under the same name in Los Angeles.

Bottom Line...
Brad Lamm's Breathe Life Healing Centers concept combines an intensive outpatient level of treatment with an extended period residing in a "spiritual healing" center, thereby skirting the problem of seeking insurance reimbursement for a residential level of care.

Under the anticipated payment model, around 80 percent of clients will have their outpatient treatment services covered by insurance, billed under a partial hospitalization/intensive outpatient level of care. They will receive these services off-site from the "spiritual retreat" that will serve as their home for around 90 days, with a base cost of $1,500 a month charged according to their

See **Retreat** page 7

Complaint from page 1

very common practice, as the complaint itself notes: that the program's name is used in marketing and promotion, with other programs — and the website — getting the benefit of the prospective patient. Here's what happens: a desperate person looks for a treatment program online, probably Googling "addiction" or "rehab." The person lands on a website featuring a searchable directory, finds treatment programs that may be of interest and calls the website's 800 number. This is actually a call center that determines whether the patient has good insurance (out-of-network is the best), and then funnels the caller to a treatment program that may or may not have paid for the privilege of getting patients. Recovery Brands claims on its website that programs on Rehabs.com do not pay for patients.

In fact, Rehabs.com does use the trademarks and website links for many treatment programs, but the links are, at least in some cases, to the programs' actual websites and to those programs' actual phone numbers, based on research we conducted last week. Seabrook House is no longer listed on Rehabs.com.

Elements' alleged role

In the case of Seabrook House, however, the complaint goes farther, saying that Elements worked with Rehabs.com to pay for advertisements on the website, and to match search results to a call center that leads directly to an Elements call center, which diverts the prospective patient to an Elements facility — even if the patient wanted Seabrook House.

"Defendants' rendering of this web of deceptive and misleading advertisements using the valuable 'SEABROOK HOUSE' and 'SEABROOK' trademarks (and many other third-party competitor trademarks) for their own related and/or identical services has, and is likely to continue to cause confusion and to deceive consumers and the public regarding their source," the complaint said.

Along with the complaint, Seabrook filed a 34-page list of exhibits — screen shots and more — detailing the Elements connections.

Matthew Wolf, vice president for business operations of Seabrook House; David Sack, M.D., president and CEO of Elements; and Abhilash Patel, co-founder of Recovery Brands, all responded to our request for comments by saying they had been advised by counsel not to discuss the pending litigation. In addition, Sack and Patel declared that their companies had committed no wrongdoing.

"My client denies the complaint, and we will defend it if necessary," said Jessie Beeber, Esq., from Venable in New York City, who represents Recovery Brands. Seabrook is represented by Christopher D. Olszyk Jr. of Fox Rothschild in Philadelphia; Olszyk did not respond to a request for an interview.

We talked to David Lisonbee, president and CEO of Twin Town Treatment Centers in California, and Beth Ann Middlebrook, Esq., lawyer for The Watershed Treatment Programs in Florida, about the case.

Settlement likely

"It's unfair competition because they're competing by using Seabrook's own name," said Middlebrook. "This is just one example of how the proliferation of treatment providers throughout the country is leading to this type of marketing," she said. "If I go online and find a number and I think I'm calling a particular program, but instead I'm calling a referral center, they're going to refer me to a treatment provider based upon whatever private contractual arrangement they have, unbeknownst to me," she said. "This is a consumer problem."

When treatment providers become aware of this, they take action, at least with a cease and desist order on behalf of themselves, she said. "If Seabrook has instituted this lawsuit,

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I'm sure there's a good deal of damages at stake," she said. Seabrook, like The Watershed and Twin Town, is just one program. It doesn't have a network of programs throughout the country that people can be referred to. So those geographically isolated programs are likely to suffer the most in an Internet-call-center-type marketing scheme.

"Any defendant in a lawsuit like this is going to deny wrongdoing," said Middlebrook. "They will settle this, because Elements and Recovery Brands can't afford to go to trial — they would lose, and it would cost them and tarnish their reputations." The settlement agreement will include a statement by both defendants denying any wrongdoing, she added. "That's just par for the course," she said.

Internet marketing not bad per se

This makes treatment marketing look terrible, we said. "You're right," said Middlebrook. But she added that just because treatment providers participate in such referral schemes doesn't necessarily mean that they are bad treatment providers, clinically. And she doesn't think the practice is so prevalent that treatment providers feel pressured to participate. She added that The Watershed does not participate in such schemes. Based on her reading of the Seabrook complaint, in which Elements advertisements popped up when people searched for Seabrook, she said that situation is "egregious." But, she said, "there's nothing wrong per se to effectively market yourself via the Internet."

Lisonbee could not comment on the specifics of the Seabrook complaint. But he is known as an icon of ethics in the treatment field, and said that "it's pretty clear that patients are being purchased as collateral" on the Internet and through call centers. "Unfortunately, the treatment field is not able to self-regulate and we're begging the authorities to step in and parent us," he said.

'If Seabrook has instituted this lawsuit, I'm sure there's a good deal of damages at stake.'

Beth Ann Middlebrook

'Payola' and call centers

"They're all looking for patients who have out-of-network coverage," said Lisonbee of treatment programs participating in call centers. If a provider is in network, the patient's HMO or PPO will decide what kind of treatment you can provide. "So it's popular to go for the out-of-network PPOP patient," he said. Out-of-network PPOs can also bill for the medically unnecessary and exorbitant drug testing, he said.

Twin Town does not work with call centers, said Lisonbee. "Most of the call centers are working on a payola basis," he said. "It's like dealing with a cattle auction. These people aren't in it to help; they're in it for the money."

Lisonbee pointed out that many treatment center websites give no indication of where the program is located. He found his own program listed on his mobile phone. He called the number, and it went to a call center in Florida. It wasn't just a coexisting ad that popped up. He threatened them and they stopped doing it. "But first I called them 20 times to run up their bill, because every time you do that they have to pay for the click," he said.

Middlebrook said that treatment programs, when they find their trademarks are being misappropriated by call centers, "just want it to stop; they want the injunctive relief, they don't want the whole hassle of a lawsuit." What Seabrook is doing in filing this suit may help other treatment providers to contact websites asking them to stop.

Recovery Brands, which owns the website Substance.com and has ventured into providing content to news outlets, is one of the more respected websites in the field. *ADAW* learned of the complaint when a reader forwarded it, after we ran a positive article about Recovery Brands (see *ADAW*, October 6). Elements is also highly respected as a treatment provider. Stay tuned: all parties have agreed to comment when the case is resolved. •

ATTC Network launches integration initiative aimed at SUDs

The Addiction Technology Transfer Center (ATTC) Network is promoting the integration of substance use disorder (SUD) services and health care, beginning with the release Oct. 21 of an issue brief that explains why this integration is important. One of the main reasons is that the SUD workforce is inadequate to treat the many more people who now have access to insurance coverage through the Affordable Care Act (ACA), and will now be able to get help. As one example, the ATTC Network cites an April 2014 study that showed that only one of 58 master of social work programs required a course in substance abuse.

"Healthcare that ignores the fundamental interrelatedness of health, mental health and substance use is poor quality care," said Paul Sacco, Ph.D., assistant professor at the University of Maryland School of Social Work and an ATTC network advisor,

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in a press statement included in the issue brief release. "Behavioral health integration, including services for substance use disorders, holds great promise in improving the health and ultimately the quality of life for all Americans."

Problems with specialty treatment

While most clinical treatment of SUDs has occurred in specialty settings, the environment of health care has been "drastically changed" by the ACA and the parity law, the issue brief states.

"The role of non-specialty providers is increasing in importance" and "the role of specialty SUD providers is decreasing as providers consolidate to take advantage of the move from a grant/contract-based funding system to a fee-for-service payment system," the issue brief states. "Larger, better-operated providers are creating efficiencies that are causing small organizations to close." Pharmacological interventions and more "medicalization" of SUD treatment is encouraged by the use of evidence-based practices and the requirement that physicians direct most outpatient Medicaid treatment, it states.

The issue brief states that evidence-based practices "are not widely incorporated into routine clinical practice and are rarely administered with fidelity."

Barriers to integration of SUD services include "defining and developing appropriate services; training the SUD, mental health and medical workforce; creating strategies for implementing change; and uniting the currently bifurcated SUD and mental health care systems," the report says. In addition, while health care settings are incorporating mental health services, "the inclusion of similar care for people who have, or who are at risk of developing, SUDs is not receiving adequate attention."

SAMHSA message

The issue brief has the message, promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA) from the early days of the ACA, that the block grant will not be needed, that insurance reforms under the ACA combined with parity have made treatment and coverage accessible to all, and that electronic health records and consolidation are essential. This message may be overly optimistic. For example, the issue brief says that the ACA "ends insurance abuses," which is overly optimistic: there have been many problems with nonquantitative treatment limitations such as onerous utilization review, and refusals to pay for the pharmacological therapies. And it says that the block grant is shifting focus because "most people will now be covered through other means."

'We have invited leadership from national organizations with an interest in the topic.'

Laurie Krom

Screening, brief intervention and referral to treatment (SBIRT), which has been debunked in several recent research articles (see *ADAW*, Aug. 11, Aug. 18, Aug. 25, Sept. 15), is also touted as one of the evidence-based practices that will be used by primary care. Also a SAMHSA favorite, SBIRT still has its defenders. Most recently, H. Westley Clark, M.D., who has since retired as director of SAMHSA's Center for Substance Abuse Treatment, told *ADAW* that SBIRT is effective for mild SUDs, and that the referral to treatment only includes the referral, not the treatment (see *ADAW*, Sept. 25).

Other evidence-based practices that primary care can use to treat SUDs, according to the issue brief: medication-assisted treatment, technology-assisted care, motivational interviewing, motivational incentives, trauma-informed care and cognitive behavioral therapy.

'Invite-only forum'

An "invite-only forum" will be held next month, including the following speakers: Mady Chalk, Ph.D., of the Treatment Research Institute; Redonna K. Chandler, Ph.D., of the National Institute on Drug Abuse; Glenda Wrenn, M.D., of the Satcher Health Leadership Institute at the Morehouse School of Medicine; A. Seiji Hayashi, M.D., of the federal Health Resources and Services Administration (HRSA); and Christopher D. Carroll of SAMHSA, which funds the ATTC Network.

"We have invited leadership from national organizations with an interest in the topic," said the ATTC Network's Laurie Krom in an email to *ADAW*. In particular, she said NAADAC, the Association of Addiction Professionals; IC&RC; the American Society of Addiction Medicine; the National Council for Behavioral Health; and the Treatment Research Institute were invited. "We also have a number of physicians and health care professionals who were recommended to us through our ATTC colleagues," she said. In addition, federal officials from HRSA, the National Institutes of Health, and SAMHSA were invited. "We are near capacity for the space we have available for the meeting," which will be held in Baltimore, said Krom. "I would encourage people who want to be a part of this conversation to join the 'Advancing Integration' forum on the ATTC/NIATx Network of Practice website (http://networkofpractice.org)."

After the forum, the ATTCs will

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produce three papers on the topic of integrating SUD services: "Health Reform and the Integration of Addiction and Health Care Services," "Enhancing the Pre-Service Non-Specialty and Substance Use Disorders Specialty Workforce: Preparing Students to Work in Integrated Health Care Systems," and "Workforce Development through Clinical Supervision: A Promising Approach for Facilitating the Adoption and Implementation of Evidence-Based Practices for SUDs in Health Care Settings."

The ATTC Network has for the past 20 years been one of SAMHSA's flagship workforce development programs and is now focusing on addressing the gap between SUD treatment, to make sure that SUD services are included in all integration efforts. •

For the issue brief, go to www.attcnetwork.org/advancingintegration/final_issue_brief.pdf.

National Council leadership: Merger respects SUD concerns

Last week, the semiannual board meeting of the National Council for Behavioral Health concentrated on the final details completing the merger with the former State Associations of Addiction Services (SAAS), with the new board members from SAAS being incorporated into the National Council board. Those new members are Connie Peters from Massachusetts, Arthur Schut from Colorado, Mark Fontaine from Florida and Sara Howe from Illinois. A new committee focused on addictions was also created, which is chaired by Peters.

"We wanted to hear from everybody to find out what they would like us to accomplish," said Jeffrey Walter, chairman of the board of directors, in an October 30 interview with *ADAW*. "My take on it is that we had a really positive meeting." Concerns about the merger were expressed, he said. "A lot of people said they came into the merger to have a voice for the issues and needs of people who have substance use disorders first and foremost," he said. "They don't want to get lost in behavioral health and mental health agendas that won't help their cause."

There is agreement at the National Council there, said Walter. "The National Council wants to advocate together for issues that we have in common," he said. Two big issues — the unique role of residential treatment for substance use disorders (SUDs), and the importance of 42 CFR Part 2, the confidentiality regulation that applies to SUDs — came up, he said, noting that 42 CFR Part 2 champion Paul Samuels of the Legal Action Center was at the meeting as well.

However, it's clear that the residential issue is going to be approached in terms of the IMD (Institutions for Mental Disease) exclusion, which applies to Medicaid and residential care. "The committee is going to work hard on this issue," said Walter.

As for 42 CFR Part 2, the National Council has not formed any policy — pro or con — yet. That could be worrisome for SUD treatment providers for whom protecting confidentiality is seen as very important. "We didn't talk in the meeting about a particular position," said Walter. "We'll have monthly meetings and phone conferences, and a short list in terms of dialoguing," he said. While 42 CFR Part 2 is on that list, "it's a very complicated issue," he said. When the Substance Abuse and Mental Health Services Administration issues its notice of proposed rulemaking in the *Federal Register*, the National Council will be ready to comment, he said. "It's on our agenda," he said. •

> **'They don't want to get lost in behavioral health and mental health agendas that won't help their cause.'**
>
> Jeffrey Walter

CRC acquired by Acadia for $1.18 billion

Acadia Healthcare Company has made its biggest acquisition in the substance use disorder treatment field yet: on October 29, CRC Health Group announced that it has entered into a definitive agreement to be acquired by Acadia Healthcare Company. CRC Health Group has more than 140 programs treating 44,000 patients per day. The combined company will be one of the largest in the behavioral health care field. Acadia specializes in inpatient treatment; CRC Health Group has many facilities offering a comprehensive array of treatment services, including opioid treatment programs. CRC was previously owned by Bain Capital, which was rumored to be preparing to sell last winter

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(see *ADAW*, March 17).

"We are very excited about this acquisition and the opportunity it affords both Acadia and CRC," CRC CEO Jerry Rhodes told *ADAW* in an October 30 email. "This combined company will offer an unprecedented platform of programs and services in behavioral health care and addiction services," he said. "This will also enhance our company's ability to promote the opportunities under the Affordable Care Act and the Mental Health Parity and Addiction Equity Act."

'This combined company will offer an unprecedented platform of programs and services in behavioral health care and addiction services.'

Jerry Rhodes

"We expect our combination with CRC to be a great transaction for both Acadia and CRC," said Joey Jacobs, chairman and chief executive officer of Acadia, in an official statement. "We believe the addiction treatment markets that CRC serves represent a very meaningful and accretive growth opportunity. As a well-established market leader, CRC will provide Acadia with an outstanding platform for growth in this fragmented market. We further expect to support CRC in taking advantage of additional growth opportunities through both our access to capital and the expertise evident in the successful long-term growth record of Acadia's management team."

Under the terms of the deal, which is expected to be finalized by early next year, pending regulatory approval, CRC Health's owners will receive about 6.3 million Acadia shares, according to Acadia, which said it will also assume CRC Health's debt.

Acadia has acquired 27 facilities and more than 1,500 beds in the last year.

Closing treatment gap

Weiner said that Acadia, as a behavioral health care provider, is even more likely than Bain to put money into its facilities. "If Acadia smartly expands patient care and facilities, they will continue to go a long way to addressing the nation's 20-plus-million treatment gap," said Bob Weiner, former spokesman for CRC Health Group. "CRC has led the field in successful development from one to 140-plus facilities over the past 15 years at a time of economic downturn because of the innovations and financial wizardry of founder Barry Karlin and co-organizer/final CEO Jerry Rhodes, who knows the national health and treatment field cold," added Weiner, who is also former spokesman for the White House Office of National Drug Control Policy. "Let's hope Acadia maintains the comprehensive science-based model for patients and understands that 100-percent success is not an option, but help for the vast majority of clients can remain a reality," he told *ADAW*. "Then they can remain and expand on CRC's legacy of having become the world's largest provider of behavioral treatment services."

Weiner noted that Karlin put in about $20 million for CRC, sold to Bain for about $700 million, and now Rhodes, McCaffrey, other board members and Bain "get their piece of $1.18 billion."

According to Acadia, CRC facilities are expected to generate $450 million this year, with an adjusted earnings of $115 million. Acadia has 76 facilities and 5,800 licensed beds.

Publicly traded Acadia gained 2.1 percent on October 29; the stock has increased 34 percent in the past year. •

42 CFR Part 2, buprenorphine cap: SAMHSA still deliberating

There's no news yet from the Substance Abuse and Mental Health Services Administration (SAMHSA) on two current decisions officials are considering, both of which will have far-ranging effects on substance use disorder (SUD) patients and providers: raising the buprenorphine cap and watering down the regulations protecting the confidentiality of SUD patient records.

Under pressure to raise the buprenorphine cap, currently 100 patients, SAMHSA has held meetings on the issue; the decision will ultimately be that of the Department of Health and Human Services (HHS). SAMHSA has provided advice to HHS Secretary Sylvia Mathews Burwell and will be implementing whatever she decides. There are currently 7,800 physicians certified to treat up to 100 patients with buprenorphine; SAMHSA doesn't know how many patients are being treated by which physicians.

With the backdrop of waiting lists for treatment and opioid overdose deaths, many providers, backed by the American Society of Addiction Medicine (ASAM) say raising or removing the cap is essential. There is also concern, however, that the treatment will end up being medication only, with no comprehensive care such as is provided in

opioid treatment programs (OTPs), which dispense methadone and are much more tightly regulated than physicians who dispense and prescribe buprenorphine. (Also see *ADAW* June 23, July 21, August 11, September 29.)

Mark Parrino, president of the American Association for the Treatment of Opioid Dependence (AATOD), a membership organization of OTPs, told *ADAW* that he believes HHS will be comprehensive and deliberative in arriving at a conclusion related to the buprenorphine cap. He was impressed by a letter he received from Secretary Burwell last week that suggested the HHS response is "going to be thoughtful and not reactive." The tone and content of the letter reflected the feeling that it is important to balance risk assessment with the need to increase access to treatment, he said.

SAMHSA has already stated that it does not need Congressional authority to raise the cap; there is also proposed legislation that would eliminate it completely.

42 CFR Part 2

For 42 CFR Part 2, the regulation requiring that SUD patients give consent for their records to be released each time, in writing, the path is not clear either. H. Westley Clark, M.D., former director of SAMHSA's Center for Substance Abuse Treatment (CSAT), had fought hard to retain those protections. His sudden retirement last month signaled that perhaps SAMHSA was heading in another direction, on both 42 CFR Part 2 and lifting the buprenorphine cap, about which he had reservations (see *ADAW*, October 6).

SAMHSA administrator Pam Hyde said last year that 42 CFR Part 2 is "getting in our way" (see *ADAW* September 23, 2013).

If changes are made to 42 CFR Part 2, they will be announced in the *Federal Register* in a Notice of Proposed Rulemaking, said Karla Lopez, staff attorney with the Legal Action Center, a nonprofit law firm that fights discrimination against people with histories of addiction and others. "Then there would be a period for stakeholders to comment on the proposed rule before SAMHSA could issue an interim final rule and then, ultimately, a final rule," she told *ADAW*. Anyone can comment on a proposed rule.

With 42 CFR Part 2, much of the pressure is coming from other agencies outside SAMHSA, because of the focus on an integrated electronic health record and on enhancement of prescription drug monitoring programs (PDMP). Clark as CSAT director told OTPs that they should not report patients to the PDMP, because that would violate 42 CFR Part 2 (see *ADAW* October 24, 2011). Patients in OTPs fear disclosing their status as methadone patients to PDMPs, which in most states are run by law enforcement agencies, would jeopardize their privacy; advocates fear that this threat would discourage patients from seeking methadone treatment. •

Retreat from page 1

ability to pay.

The retreat center will be housed in a 15-bedroom mansion that Lamm purchased last summer for $1.6 million in the historic Palmer Woods section of Detroit; Lamm plans to make the home his own primary residence and to house around 20 men and women there.

"The days of reliance on residential treatment centers are over," Lamm told *ADAW*. "And 30 days [of treatment] isn't enough."

He emphasized that the businesses in Los Angeles and Detroit (and one in New York City that has not yet fulfilled his vision because of a bogged-down licensing process) are not directly linked to the intervention work for which he is best known. Lamm says he has not referred any of his intervention clients this year to Breathe Life because those individuals generally need a more intensive level of care than what the Breathe Life concept is geared to provide.

'The work we do is very 'out, loud and proud' spiritual development.'

Brad Lamm

Typical schedule

Clients living at a Breathe Life retreat generally are off the property by 7 a.m. each day to attend 12-Step meetings followed by their day treatment. Lamm says the most prominent techniques used in the daily treatment include cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), eye movement desensitization and reprocessing (EMDR), and psychodrama. Equine therapy is offered up to two times a week, and clients regularly visit a gym before returning home at day's end for dinner and for evening groups in spiritual development.

Each Breathe Life center is structured to have a campus pastor; in the Detroit program, that role will be filled by Lamm's brother, who is a minister. Lamm, the son of a minister, who also has another brother in the ministry, says his personal background shaped his vision for a program that would seek to "reignite the flame" spiritually for persons with substance or process addictions.

"The campus is ministerial, as individuals connect with their inner life and issues of faith and spirituality," Lamm said. "For some, all of that

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is a concrete notion, while for others it's a real conflict," particularly if their past experience with religion has not been a welcoming one.

"The work we do is very 'out, loud and proud' spiritual development," he said. On the clinical side, Tian Dayton, Ph.D., serves as Breathe Life's director of clinical programming.

Lamm's vision involves having clients stay for around 90 days before moving to a sober living environment. The 26,000-square-foot mansion where the Detroit program's clients will live will offer the kind of serenity Lamm believes all treatment clients deserve.

"If you're in middle-class treatment that's insurance-driven, it's often not in the nicest place," he said. "If you have the creature comforts — a nice bed, good hygiene, good lighting — it's easier to stay if you're in a place where you feel safe."

Because Breathe Life is not seeking a residential treatment use for the house and essentially will be operating as a spiritual center, it will not have to clear any regulatory hurdles before opening in the first quarter of next year. Winning over local neighbors may take longer.

"They're not thrilled that I'm there," said Lamm, who added, "We'll be fine there — we hope time will help some people identify us as a good neighbor."

Dual roles

It is not uncommon for an interventionist also to have a role in a primary treatment program or in some other segment of the continuum of care. Phil Scherer, who chairs the board of the Association of Intervention Specialists (AIS), offers an example of this: He conducts interventions and is also administrative director of the Illinois Institute for Addiction Recovery. He says while there are still a number of completely independent interventionists practicing, around half of AIS members serve some other role in the treatment field.

Like Lamm, who is also an AIS board member, Scherer has avoided referring his intervention clients to the treatment programs where he has worked. "There has been a movement in AIS that if you work in a center and also do interventions, there is an inherent conflict of interest," he told *ADAW*. "The perception is there. One guy said to me once, 'You can't tell me that if on Monday morning your program's census is low, you're not getting pressured to refer.' I said to him, 'I don't look at the census when I do an intervention.'"

Scherer added that in his intervention work with individuals and families, he always fully discloses his philosophy about intervention and all of his professional affiliations.

Lamm believes the Detroit program will serve an important need in a state where residential centers are operating above capacity and many individuals' insurance coverage will not allow an out-of-state placement. As he sees with his intervention clients, about eight of ten people needing treatment face payment barriers that he believes Breathe Life can avoid. •

Coming up...

The **Association for Medical Education and Research in Substance Abuse** will hold its 38th Annual National Conference **November 6–8** in **San Francisco**. Go to **www.amersa.org** for more information.

The **American Public Health Association** 142nd Annual Meeting and Exposition will be held **November 15–19** in **New Orleans**. For more information, go to **www.apha.org/events-and-meetings/annual**.

The Annual Meeting of the **American Academy of Addiction Psychiatry** will be held **December 4–7** in **Aventura, Florida**. Go to **www.aaap.org/annual-meeting** for more information.

In case you haven't heard...

Bates College in Lewiston, Maine, banned the annual "Trick or Drink" pre-Halloween tradition this year. The event, in which students go to off-campus student houses in costume and consume a lot of alcohol, "strained relations" with people who lived near the houses, according to *Inside Higher Ed*. During Trick or Drink, hundreds of students paraded through neighborhoods interspersed with student housing and homes that had nothing to do with the school. Seniors, who can live off-campus, decorate their houses and sell tickets to the underclassmen, who can have a different drink at each house. Seniors were unhappy about the cancellation, because they didn't have any input into the decision, according to the October 29 article. "We kind of felt left out of the decision, and the timing of it, right before our break, seemed manipulative," said Sean Murphy, a senior at Bates. He started an online petition, signed by 600 students, who said they would withhold their senior gift until the administration changed its new policy — enforcing a ban on alcohol use on campus. The culture of drinking is alive and well at Bates College, where presumably most of the students are under the age of 21.