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In This Issue...

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SAMHSA document, made public in error, reveals changes planned for block grant

A contract solicitation from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) released — and then pulled — earlier this month indicates that the federal agency has been working on a plan that would drastically overhaul the Substance Abuse Prevention and Treatment Block Grant and the Mental Health Block Grant, *ADAW* has learned. The contract solicitation, no longer available on the web, details two significant changes:

- Using the prevention set-aside from the current substance abuse block grant, as well as discretionary substance abuse prevention funding, and forming a new Prevention Block Grant for use in both promoting mental health and preventing substance abuse.
- A proposal to create a uniform application for the mental health and the substance abuse block grant. Both would require states to use the block grant to purchase services that are necessary for recovery, such as housing, that are not paid for by Medicaid, Medicare, or private insurance. The solicitation indicates that this would take place starting in fiscal year 2012.

The solicitation asks the contractor to "identify SAMHSA's 'degrees of freedom' in making changes," referring specifically to authorizing legislation and regulations.

What makes the solicitation embarrassing for SAMHSA is not only that somehow, it got released as part of procurement — whether it was pulled because stakeholders were upset or because it was re-

See **SAMHSA** on page 2

NIH panel recommends replacing NIAAA and NIDA with new addictions institute

As reported under "breaking news" last week, the federal panel looking at a merger between the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) has recommended dissolving both institutes and creating a new institute on addictions (see *ADAW*, Sept. 20). This week we will cover the details of the recommendation, made by the Substance Use, Abuse, and Addiction (SUAA) Working Group to the Scientific Management Review Board (SMRB), established to look at reorganizing the National Institutes of Health (NIH).

"Merger" is a misnomer, because the new institute will not just be a sum of the NIDA and NIAAA portfolios. Some current NIDA and NIAAA grantees may have to go to other institutes to continue their research. And some researchers funded by other institutes — not NIDA or NIAAA — may find themselves writing grants for the new addictions institute.

Under the recommendation, "all relevant addiction research portfolios" from NIDA and NIAAA and other NIH institutes would be integrated into the new addictions institute. "Funding for existing research should not be supplanted or re-

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leased by accident was unclear – but that it appears to represent work done in secret.

Most remarkably, this proposal had not been discussed with Congressional staff, or with any stakeholders, or even been cleared through other government agencies. It applies to the fiscal year 2012 budget, which must first go through the Department of Health and Human Services (HHS) (SAMHSA's parent agency) and the Office of Management and Budget (OMB).

"This was a document that should not have been released," said John O'Brien, senior advisor on healthcare financing for SAMHSA. "Obviously we have to respect the budget process for 2012. That document does not reflect what HHS or OMB had approved for 2012."

He said the document was meant to "assist SAMHSA in their planning efforts," but is not the only planning effort. It did represent the thinking of SAMHSA in May, he said. "We've had conversations with our stakeholders," he said. "There's some anxiety out there." The contract solicitation is widely believed to be the framework for SAMHSA's fiscal year 2012 budget for the block grant.

SAMHSA is "going through the process now with HHS and with OMB," O'Brien told *ADAW*. "As soon as we get permission, we will have the conversation with our stakeholders."

The Office of National Drug Control Policy, which has budget authority for drug spending, refused to comment for this story.

Funders 'blindsided'

Congressional staffers were clearly not pleased with the situation. "We were blindsided," Senate Appropriations Committee staff told *ADAW*. "We need to figure out our own strategy."

'As soon as we get permission, we will have the conversation with our stakeholders.'

John O'Brien

There's a process by which the administration can make small changes without going through appropriations, but this proposal is "major," Senate staff told *ADAW*. Of particular concern was the fact that SAMHSA was seeking an outside contractor to find out what SAMHSA's "'degrees of freedom'" are. SAMHSA should have asked Congress, which authorizes it and appropriates funding. "This is something that usually is undertaken with input from stakeholders, with input from Congress," according to a staffer.

The Subcommittee on Labor, Health and Human Services, Education, and Related Agencies — part of the Committee on Appropriations — has been in contact with SAMHSA about this solicitation and what it means, according to staff. There is also concern about the apparent secrecy with which the proposal was developed — nobody knew about it. "Making major changes like this requires an open transparent process, consulting with all the stakeholders, not least of which is the authorizing and appropriating body," the staffer said.

Buying 'what people need'

Even though O'Brien would not talk on the record about the document, he did talk about "the overall gestalt of where we're going." Similar to the "modern addictions and mental health system" draft that circulated in June (see *ADAW*, June 14), the proposal details ways to "get prepared for 2014," and the full implementation of the ACA, he said. With more people having insurance coverage or Medicaid, there will be less need for the block grant to be used for treatment services, so the

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states will be able to use it for other services that people need to stay in recovery, he said. "Our thinking was let's not wait until 2014, let's start a little in 2011 or 2012."

As O'Brien told *ADAW* in June, SAMHSA wants the block grant to be used to purchase "what people need" — even if that is housing and vocational training, and not treatment — in order to have good outcomes. He also said at the time that there would be no "extended collective bargaining" and that SAMHSA intended to "charge forward" on its plan.

In addition to the draft of the modern plan, SAMHSA also detailed its plan for working with health reform in its 10 Strategic Initiatives (see *ADAW*, June 14). Both of those documents were released very quietly — no announcement at all was made.

Uniform application

SAMHSA is also looking at whether there need to be differences in the mental health and substance abuse block grant applications, said O'Brien. "We have already told the state directors that we're talking about a uniform application," he said.

SAMHSA is not proposing that the payments will be combined. "They'll still get separate payments," said O'Brien, referring to mental health and substance abuse. The purpose of the uniform application is to "get some consistency around what it is the states report on, so we can use that information for our own purposes."

Both proposals raise the specter of merging of the two block grants, something that is much more threatening to substance abuse treatment providers because the substance abuse block grant is much larger, and because they depend on it for funding. Mental health providers have much greater access to Medicaid funding.

And the Prevention Block Grant would result in a loss of funding for substance abuse prevention providers, because it would merge all prevention funding for both block grants — the lion's share of which comes from the substance abuse block grant. Then the Prevention Block Grant would use the money for both mental health promotion and substance abuse prevention.

With SAMHSA reauthorization still pending, the question of merging block grants brings up many concerns. The last time the SAMHSA reauthorization discussion was taking place, the idea of merging was extremely controversial, the staffer said. "Do you really want to start that again?" •

What the contractor would have done

Below is the "statement of work" listed in the contract solicitation, issued by the procurement office of the Department of Health and Human Services September 15 and pulled a week later, for a redesign of the mental health and substance abuse block grants.

This contract is to provide for the coordination and support to SAMHSA to make specific changes to the block grants to be consistent with the direction of the 10 Strategic Initiatives and the Affordable Care Act.

1. *Review the authorizing legislation and regulations for MHBG and SAPTBG to identify SAMHSA's 'degrees of freedom' in making changes in covered services, reimbursement strategies and reporting requirements.*
2. *Review the current array of block grant-funded services, provided by SAMHSA*
3. *Establish a SAMHSA steering group with representation from senior members of all three Centers to identify their future vision, or purchasing objectives, for block grant funds.*
4. *Conduct a gap analysis between the objectives outlined by the working group and what is covered by a typical Medicaid benefit package and what is expected coverage for benchmark plans under the Patient Protection and Affordable Care Act. This analysis will result in recommendations for specific services that could be purchased under the block grants. These services would meet the following criteria: 1) be complementary to services expected to be covered under health reform; 2) benefit individuals who will remain uninsured after health reform; 3) be evidence-based, promising, or emerging best practices; and 4) be valuable to integrated service delivery systems.*
5. *Establish a working group comprised of internal and external SAMHSA stakeholders (including NASADAD and NASMHPD) to identify possible reimbursement strategies for states to use to improve quality, incentivize access and outcomes and enhance accountability for patient-centered care.*
6. *Recommend performance and outcome measures that are linked to service intent and reinforce SAMHSA's purchasing objectives; recommended measures would be vetted in relationship to the National Outcome Measures (NOMs).*
7. *Develop a basic description of reporting requirements based on the measures selected by SAMHSA and create a draft Implementation Plan for State Mental Health Authorities and State Substance Abuse Agencies to use in implementing SAMHSA's revised block grant requirements.*
8. *Work with NASADAD and NASMHPD to equip them to deliver ongoing training and technical assistance to states for implementation.*

State Budget Watch

'Front door' to treatment in Texas endangered in budget process

While publicly financed addiction services in Texas were spared from a current-year budget-cutting process that trimmed 5 percent from overall state spending, the picture for the next biennium in the state looks murkier for the addiction field. A process to identify possible 10 percent cuts from each state agency's budget has placed an innovative outreach and referral program in the spotlight as a possible budget casualty.

The state's Outreach, Screening, Assessment and Referral (OSAR) program was established about five years ago to offer more effective statewide management of waiting lists for publicly funded residential addiction treatment. Entities that operate OSAR in various regions of the state help take waiting list management out of the hands of the treatment centers themselves, and have the ability to transport clients with no access to treatment in their community to an open bed elsewhere.

Yet the Texas Department of State Health Services included OSAR and its budget of nearly $4 million as an option for elimination if the state moves forward on plans to cut individual agencies' spending by 10 percent for the biennium that begins next Sept. 1. State lawmakers will begin considering plans for the 2012 and 2013 budget years when the legislative session convenes in January.

Members of the state's provider community consider OSAR an important initiative in client engagement as well as a useful tool in a state as large as Texas, where many remote communities lack any public treatment infrastructure.

"OSAR plays a pivotal role as an accessible front door," said Eric Niedermayer, director of the Recovery Resource Council, which performs OSAR functions in a multi-county area surrounding Dallas and Fort Worth. "Our clients don't do well waiting for treatment services," he told *ADAW*.

How program works

Niedermayer said that in his region of the state, the OSAR effort is identifying about 20 individuals a day who need treatment but lack an immediately accessible option. In some cases, his program can identify a location outside the client's home county and can arrange for transportation for the client, while in other situations the program may offer group counseling or other support services while a permanent placement is being sought.

> **'We can offer them counseling while they're waiting, allowing them to participate in groups prior to their admission.'**
>
> Eric Niedermayer

He cited as an example of a typical process the recent case of a woman residing in a community two counties to the north of Dallas. His agency located a residential bed for her in Fort Worth, but the provider wouldn't agree to hold the bed open for the couple of hours it would take to transport the patient to the center. Niedermayer's agency subsequently located another bed in Dallas and arranged bus transportation to the city for the client, who was picked up by the second center when she arrived in town.

State officials have indicated that they would hope treatment centers could re-assume management of the residential waiting lists if OSAR were to be eliminated, but Niedermayer believes that could be impractical as well as inefficient for the consumer. "They don't have the staffing patterns to handle people coming through," he said of the residential programs. "The treatment providers also won't look across the state for an available bed."

Cynthia Humphrey, executive director of the Association of Substance Abuse Programs, representing publicly supported treatment and prevention agencies in the state, emphasized the importance of OSAR's ability to reach individuals in remote counties where there may be no publicly financed providers. "They go out into the counties and do screenings and assessments," Humphrey told *ADAW*, with drug and alcohol councils usually performing these functions using licensed professionals.

Niedermayer said that in his agency, staff visits Denton County, where there is not one state-funded treatment program, once a week.

Humphrey considers OSAR a "warm hand" that can keep clients engaged while they wait for a placement. Added Niedermayer, "We are the facilitator of services. We can offer them counseling while they're waiting, allowing them to participate in groups prior to their admission."

Other budget options?

A spokesperson for the Department of State Health Services emphasized last week that the possible elimination of OSAR is not a done deal, and she acknowledged that state officials do consider the program important — one that could affect clients in its absence.

"We were trying to present options that would have the least direct impact on people," department spokesperson Carrie Williams

told *ADAW*.

Williams added that OSAR is the only substance-abuse related program that has been presented among the budget-cutting options that could achieve the 10 percent cut being sought for all departments. On the mental health side of the health services budget, by contrast, cuts to both state psychiatric hospitals and community-based mental health care have been suggested as part of the overall 10 percent target, she said.

Williams said that the department looked at all options for cuts it could recommend that legislators consider beginning next year. "It was impossible to leave certain programs untouched," she said. "We weren't interested in lopping off an entire area of an agency."

But Humphrey believes that with substance abuse services in the state not having received budget increases since the mid-1990s, the case can be made that any substantial cuts could serve to damage the state's public treatment infrastructure. "This may be the final blow," said Humphrey, whose organization represents more than 60 treatment and prevention agencies. "Our reimbursement rates have remained low."

She added that state officials need to look at compelling evidence that continued investment in treatment-related services saves state dollars elsewhere. Back in 2007, she said, the state was able to forestall the planned construction of a new prison facility as a direct result of an infusion of treatment dollars into the state's justice system.

At present, just under $25 million in general revenue funding in the state is devoted to substance abuse services, so the nearly $4 million that pays for OSAR represents a fairly large share of that. Any erosion of that base, say provider agency representatives, makes little sense when the state itself acknowledges that drug and alcohol abuse is third to only smoking and obesity as drivers of increased health care costs.

"On the plus side, in terms of the entire state budget $4 million is such a tiny amount of money that I wouldn't think people would get heartburn over putting it back in," Niedermayer said. "In the Texas state budget, $4 million is like 4 cents." •

Recovery researcher to focus on developing science of recovery

The biggest problem facing recovery researchers is lack of funding, explains Alexandre B. Laudet, Ph.D., who is back at the National Development and Research Institutes (NDRI) as director of the Center for the Study of Addictions and Recovery, where she will focus on "building the science of recovery." And that means finding out who is in recovery and how they got there.

Earlier this month the Office of National Drug Control Policy sponsored a recovery summit, where there were 175 people — advocates, providers, and top officials of SAMHSA and the ONDCP. "The White House is on board," she said.

But virtually every keynote speaker said that whatever is provided in terms of recovery services has to be "research-based and outcome-driven," said Laudet. For that, there needs to be research conducted on people in recovery. "And we don't have the research base. We know anecdotally that the majority of people recover without treatment, but it's very hard to get funding from NIH to look at recovery among folks who are not enrolled in something." The funding for research is designed using the treatment model, which is focused on services, said Laudet.

While it's known that only 10 percent of people who need treatment ever seek it, nobody knows that other number — how many people are in recovery and got no treatment. "We need to know how people get well, so we can build on this knowledge," she said. "Maybe it is housing. If it is, then the department of housing needs to get on board."

There is a small body of research on what is called "natural recovery," which means being in recovery without either 12-step or treatment programs. "The bulk of these individuals are usually not as severely dependent," said Laudet. In addition, this research is mainly focused on alcohol.

ROSC

There are "shining beacons of recovery" that are way ahead on implementing Recovery-Oriented Systems of Care (ROSC), such as early adopters Connecticut and Philadelphia. They are serving as role models and guides for other cities and states around the country, said Laudet.

"The transformation to ROSC is

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>
> Alexandre B. Laudet, Ph.D.

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an extremely messy and time-consuming process," she said. It involves more than just the substance abuse and behavioral health arenas, but integration with housing, legal services, and "all the areas and services that people who are actively using have impairments in."

"If people just say no to drugs and alcohol but experience no other improvements in their life they will relapse," said Laudet. She has done research with people in treatment and people in recovery, and they give the same answer to the question "What are your biggest challenges" whether they have been abstinent six months or five years, said Laudet. "They need housing, they want to get their children back, they need a job." These are the same things that everyone wants for their loved ones who are in recovery, she noted. "If they have their lives devastated by addiction, we would want them to have more than just not using," she said. "We would want them to have a better life."

Peer support is an important part of this transformation, said Laudet. "We need to cultivate a work force of people who are in recovery who are going to be peer supporters, who will work with professionals in the field," she said. "They are less expensive" than professionals, she said. Credentialing criteria need to be developed as well, so that peer support staff can be paid by Medicaid and insurance. And the peer support staff importantly will come from the recovering community — the people for whom being a peer supporter will be much more than just a job, but give meaning to their own recovery, she said.

There are between 20 and 40 million people in recovery in America, said Laudet. She wants to find out how they got there. •

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duced, but rather, relocated so that addiction-related programs are funded out of the addiction institute to achieve better integration and synergy across substance- and behavior-addiction research fields."

The reference to "behavior-addiction" is telling, because it signals that research into food, gambling, and other non-substance addictions would become part of the mission of the new institute.

"Those of us who work in the treatment community, especially as advocates, know there's a difference between substance abuse and addiction," said Andrew Kessler, principal with Slingshot Solutions, in an interview immediately after the SUAA vote. "The question I'm struggling with is: How closely does science have to be related to addiction to fall under this new institute?" (Kessler contributed a "From the Field" on the merger last year, see *ADAW*, Nov. 9, 2009.)

That is a question many researchers are asking, and it probably won't be answered until there is a new institute with new leadership, said Cindy Miner, Ph.D., deputy director of NIDA. "This is going to play out over time," she said, depending on whether NIH goes forward with the recommendations. Then it will depend on who the new leader of the new institute is, and how the portfolios of other institutes may change. "We won't know what the portfolio analysis will look like until then," she said.

> **'The status quo was toxic.'**
>
> Charles O'Brien, M.D., Ph.D.

Asked about the morale at NIDA, Miner said "change is difficult for some and not for others." In general, she said, people are "ready to roll up their sleeves and work on whatever is coming next."

Rationale for change

The question of merging NIDA and NIAAA was first raised by the National Academies in 2003, and the SMRB first met in April of 2009 to undertake this evaluation (see *ADAW*, Feb. 9, 2009,). Since then the SUAA has continued meeting and reporting to the SMRB (see *ADAW*, March 15).

The report, released when the SUAA Working Group met September 15-16, notes that researchers have found "unique genetic sites" that are "associated with risk for specific disorders related to alcohol and several drugs of abuse." Different receptors are involved depending on the type of drug, but in the case of addiction, the dopamine levels in the limbic system — the brain's reward system — are elevated. "Stimulation of this circuitry produces feelings of euphoria, motivates behaviors necessary for survival, and can result in a learned association between substance use and pleasure, which is believed to underpin repeated behaviors and addiction," the report states, citing testimony to the SUAA Working Group.

Charles O'Brien, M.D., Ph.D., whose research has been funded by both NIDA and NIAAA, strongly supports the change. "The status quo was toxic," he told *ADAW* last week. "It was splitting the field, retarding the field," said O'Brien, who is Kenneth Appel Professor in the Department of Psychiatry at the University of Pennsylvania. "The people who are focused on developing new treatments — which is why the taxpayers fund the NIH — have always been integrated," he said. "I have done as much research on alcohol as any other drug, but also done work on cocaine, heroin, and marijuana. The biology is that ad-

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diction is addiction, whether it's alcohol or cocaine."

Another justification for a focus on research into addiction is that in the case of poly-drug addiction, treating addiction to one drug can lead to higher relapse rates for another, the report states. In addition, there are "common pathways across multiple forms of compulsive behaviors" making it possible, in theory, to treat more than one addictive disorder with the same treatment. In addition, there are links between substance abuse and mental health disorders — for example, between alcohol and depression.

NIDA vs. NIAAA

Throughout the merger discussions, NIDA and NIAAA had "diametrically opposed opinions" regarding the merger. NIDA and the drug abuse research community were in favor of it; NIAAA and the alcohol research community were against it. Passions ran high, with Enoch Gordis, M.D., former longtime NIAAA director, writing the SUAA in closed testimony last December, "This is clearly not a time to bury the NIAAA… I ask this committee and the NIH: please don't take the sign off the door."

Last February, the NIAAA Advisory Council passed a resolution (14-0-1) strongly advising against any reorganization that eliminated NIAAA. In March, the NIDA Advisory Council unanimously passed a resolution (15 favored-0) supporting a single institute for drug use and addiction. These views reflect those of NIAAA and NIDA staff, grantees, and constituency groups, the report noted.

There is some fear that the NIDA portfolio, because it is so much larger than NIAAA's, could mean a merger would result in loss of funding for alcohol research. This issue was not directly addressed by the SUAA Working Group.

Behaviors

A new addictions institute will include portfolios from other centers, because addiction includes substances such as tobacco and behaviors such as gambling not traditionally part of NIDA or NIAAA portfolios, the report said. "The mission of the reorganized entity should reflect the diverse array of substances (e.g., alcohol, cocaine, tobacco, food) and behaviors (e.g., gambling, exercise, sex) that have demonstrated the potential for compulsive use and abuse, along with the range of behavioral stages that can lead to the prevention or facilitation of compulsive use (e.g., abstinence, abuse, addiction, etc.)," the report states.

The NIAAA through its press office would not participate in an interview, and referred *ADAW* to NIH for comments. "This consolidated new institute would also house addiction portfolios within other NIH institutes and centers, such as tobacco addiction-related research at the National Cancer Institute," the NIH press office stated last week. "Conversely, non-addiction research programs at NIDA and NIAAA would be transferred to other institutes and centers as deemed appropriate. For example, research on Fetal Alcohol Spectrum Disorders could move from NIAAA to the National Institute of Child Health and Human Development."

If the SMRB recommendations

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What was missing: NIDA, NIAAA perspectives

Both NIAAA and NIDA provided a list to the SUAA Working Group of research opportunities and needs that are not adequately addressed by either institute.

NIAAA's perspective:

- A compendium of the pharmacokinetic and pharmacodynamic interactions between alcohol and the therapeutics used to treat general medical and psychiatric conditions (e.g., hypertension, diabetes, epilepsy, depression, etc.);
- Research on the generation of novel metabolites resulting from the in situ interaction of alcohol with opiates, stimulants, hallucinogens, or inhalants (e.g. the production of coco-ethylene) and their pharmacokinetic and pharmacodynamic properties and toxicity;
- Mechanisms by which alcohol increases risk for certain cancers; and
- Encouragement of patients who are hesitant to seek treatment.

And NIDA's perspective:

- Lack of pharmaceutical industry interest in developing medications to treat addiction/alcoholism;
- Insufficient involvement of the medical community in preventing and treating drug addiction and alcoholism;
- Relatively low rates of treatment by individuals with substance abuse, despite available treatments; and
- A bottleneck in translating treatments for substance abuse from bench to bedside to the community.

In addition, the SUAA Working Group said research into substance use by adolescents and young adults also needs more attention. Specifically, the age of first use — for alcohol, or for other drugs — correlates with future abuse or addiction, suggesting "an urgent need to target effective prevention, intervention, and treatment strategies towards these populations."

Continued from previous page

are accepted, "the NIH Director would submit a proposal for the creation of the new institute, termination of NIDA and NIAAA, and reorganization of any other ICs, as necessary, to the HHS Secretary for approval," the NIH said. "If the Secretary approves the creation/termination/and reorganization proposal, the Secretary would notify Congress that the additional institute is necessary to carry out the proposed activities, and simultaneously notify Congress of the related IC terminations and reorganizations."

The reorganization would take effect 180 days after the notification to Congress, if Congress does not object, according to the NIH.

NIH director Francis Collins, M.D., will make a decision on the SMRB recommendation. •

Coming up...

The 2010 Annual Conference and Training Institute of the **Substance Abuse Program Administrators Association** will be held **October 17-21** in **Las Vegas**. Visit www.swiftpage6.com/CampResource/2YoRJSUNHVITLMSO/1/text.pdf for more inforamtion.

The **American Association for the Treatment of Opioid Dependence, Inc. (AATOD)** will hold its 2010 National Conference, "Building Partnerships: Advancing Treatment & Recovery," on **October 23-27** in **Chicago**. Visit www.aatod.org.

The **Association for Medical Education and Research in Substance Abuse** will hold its annual conference **November 4-6** in **Bethesda, Md.** For more information, visit www.amersa.org/conf.asp.

Therapeutic Communities of America will hold its national conference **November 7-10** in **Washington, D.C.** For more information, visit http://registration.sitesolutionsworldwide.com/synergy/v_1_/home/?id=267&info=1 or call Site Solutions Worldwide at (866) 374-6338.

Briefly Noted

Study finds that cue-induced tobacco cravings persist

Some tobacco cravings do not diminish over time, even long after withdrawal symtpoms have disappeared, a new study has found. Published online in *Biological Psychiatry* this month, the study, by Gillinder Bedi and colleagues, shows that cravings induced by "cues" increase with abstinence. Cravings that just occur spontaneously, however, and are not associated with cues — the "people, places, and things" that the person associates with smoking — do not increase. The findings may help patients cope with situations that induce craving. The study, funded by the National Institute on Drug Abuse, has treatment implications, showing that "incubation of drug craving" is a real phenomenon. For the study, 86 adult smokers were paid to abstain for 7, 14, or 35 days. They were given cue sessions on the final abstinence day. Cue-induced craving increased with abstinence on some measures. "Background" craving and withdrawal symptoms did not.

In case you haven't heard...

The press office at the Office of National Drug Control Policy (ONDCP) has been sloppy lately. First, the ONDCP broke the embargo on the NSDUH story (the story wasn't supposed to be published or aired until 9:30 a.m. September 16, but CBS, NPR and Associated Press released their stories — all interviews with ONDCP director Gil Kerlikowske — several hours in advance). A tongue-tied press officer at ONDCP was unable to explain this when we asked what happened. Then last week the ONDCP issued a press release with typos — "prescription" was misspelled twice, and Kerlikowske's name was misspelled. It may all be a coincidence, but the good news is Rafael Lemaitre, former press deputy at ONDCP and — until today — press officer at the Department of Homeland Security — is going back to ONDCP as director of public affairs. We asked Bob Weiner, who hired Lemaitre to work for him when he ran the press department at ONDCP, what he thinks. "I am thrilled for the office and the field," said Weiner, who said Lemaitre is "extremely effective," has the "aggressiveness" needed for the job, and is "knowledgeable on the issues facing the field and ONDCP."

In the States

Costly Montana Meth Project tactics not effective, study finds

Aggressive law enforcement, not the Montana Meth Project, was responsible for the decline in methamphetamine use in the state, according to a study by D. Mark Anderson of the University of Washington. Already, seven other states have copied the project: Arizona, Idaho, Illinois, Wyoming, Colorado, Hawaii, and Georgia, according to an article in the Chicago Tribune last week. The Montana Meth project, which relies on billboards and other advertisements that link methamphetamine abuse to crime, death, and teen prostitution, cost about $50 million so far, including $13 million in Montana, and was started by software billionaire Tom Siebel. Supporters of the project said the ad campaign reduced demand for the drug, while arrests of methampehtamine dealers did not increase. The study is published in the September issue of the *Journal of Health Economics*.