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

Volume 24 Number 2
January 9, 2012
Print ISSN 1042-1394
Online ISSN 1556-7591

In This Issue...

DOI: 10.1002/adaw.20312

HHS gives states flexibility in implementing health care reform

Last month, the U.S. Department of Health and Human Services (HHS) issued a bulletin that gives states more flexibility in implementing the Affordable Care Act (ACA), including possibly allowing substitutions of services. This makes it essential for substance abuse treatment providers to make sure that their services will be covered. HHS asked for public input, which is due Jan. 31.

All health plans, including those operating within and without state-run exchanges, must offer the essential health benefits by 2014.

According to Paul Samuels, director of the Legal Action Center, the bulletin's recognition of the Mental Health Parity and Addiction Equity Act (MHPAEA) will help safeguard the treatment needs of substance use disorder (SUD) patients. "The HHS bulletin firmly establishes the requirements of parity, so that SUD and MH coverage is required for all types of services where other medical/surgical care is covered," he said in an email to *ADAW* after the bulletin was released last month.

Substitutions

However, HHS, in a press release accompanying the December 16 bulletin, says that "Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage." Anten-

See **Benefits** page 2

Treatment Program Profile

Center sees affiliation responding to managed care, client needs

With their corporate headquarters only a mile apart but their addiction services more complementary than competitive, two New York City-based treatment organizations have entered into a strategic affiliation that they believe will offer an attractive continuum of care to payers and families.

Kathleen Riddle, president and CEO of Outreach, which has served the region since 1980, considers the newly announced partnership with Samaritan Village as a proactive step that too many addiction treatment centers neglect to take. "I think it's unfortunate in our field that people wait until it's too late and an agency is in trouble, and then they really can't compete," Riddle told *ADAW*.

Riddle said the alliance with Samaritan Village, which has been in business for about 50 years, maximizes the strengths of both agencies and does not represent a case of one healthy agency seeking to prop up a weaker one. For that reason, she said, the two not-for-profit organizations never seriously considered an outright merger since launching discussions of an affiliation about a year ago.

"Both agencies are very well-known, with brands that are already established," Riddle said. "This will build on our strengths."

Service mix

The partnership, which took effect in December, formalizes what

See **Affiliation** page 7

Benefits from page 1

nae of interest groups in all 10 benefit categories (see sidebar, next page) shot up at this, but SUD and MH treatment are among the most vulnerable.

Does this mean that within the SUD and MH category, coverage could be limited if it is strengthened in other categories? We asked the Substance Abuse and Mental Health Services Administration (SAMHSA), where John O'Brien, senior advisor for health finance, has been shepherding the SUD and MH aspects of essential health benefits through the HHS process for almost two years. O'Brien, who is leaving SAMHSA in March, demurred, directing us to HHS.

The December 16 bulletin is the "intended approach," according to Erin Shields, HHS director of communications for health care. "The bulletin outlines a comprehensive, affordable and flexible proposal and informs the public about the approach that HHS intends to pursue in rulemaking to define essential health benefits," she said in an email to *ADAW* last week. "More specifics will be detailed in the notice of proposed rulemaking, which will be the Department's next step in this process. The bulletin also solicits public comment on the approach, including comments on balance within and across categories."

'The HHS bulletin firmly establishes the requirements of parity, so that SUD and MH coverage is required for all types of services where other medical/surgical care is covered.'

Paul Samuels

The bulletin clearly lays out what HHS is considering — allowing states to take away from one category and give to another, asking whether such a practice would need to be scrutinized. "We are considering permitting substitutions that may occur only within each of the 10 categories specified by the Affordable Care Act. However, we are also considering whether to allow substitution across the benefit categories. If such flexibility is permitted, we seek input on whether substitution across categories should be subject to a higher level of scrutiny in order to mitigate the potential for eliminating important services or benefits in particular categories."

Samuels, who has been closely involved in the process as co-chair of the Coalition for Whole Health (with co-chair Ron Manderscheid), doesn't think the category of SUD and MH can be chipped away at. "It is our understanding that SUD and MH services will not be subject to actuarial adjustment, so coverage cannot be shifted from SUD/MH to any other categories," Samuels told *ADAW*. "We will of course be staying on top of this issue, including staying in close touch with HHS, as implementation and enforcement of parity are critical to ensuring that people with substance use and mental disorders receive the life-saving — and cost-efficient — services they need."

The Coalition for Whole Health posted its recommendations for a minimum essential benefits package for mental health and substance use disorder services last summer (see *ADAW*, Sept. 15, 2011).

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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 April, the second Monday in July, the first Monday in September, the last Monday in November and the last Monday in December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Print only: $699 (individual, U.S./Can./Mex.), $843 (individual, rest of world), $5125 (institutional, U.S.), $5269 (institutional, Can./Mex.), $5317 (institutional, rest of world); Print & electronic: $769 (individual, U.S./Can./Mex.), $913 (individual, rest of the world), $5897 (institutional, U.S.), $6041 (institutional, Can./Mex.), $6089 (institutional, rest of the world); Electronic only: $559 (individual, worldwide), $5125 (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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Affordability

The bulletin was developed with input from the public, the Department of Labor, the Institute of Medicine (IOM), and other HHS researchers, according to HHS. The IOM, commissioned by HHS to lay out paradigms (but not specific benefits) for the essential benefits package, last fall issued its report calling for the package to consider "affordability," not "comprehensiveness" as a primary factor (see *ADAW*, Oct. 17, 2011).

After the IOM's recommendations were released, HHS held meetings with "stakeholders, including consumers, providers, employers, plans, and State representatives," according to the Dec. 16 bulletin. Themes that emerged were similar to the those surrounding the ACA and parity: consumers and providers were concerned that there was too much emphasis on cost and not enough on having a comprehensive benefit, while employers and insurance companies agreed with the IOM conclusions.

Consumers and providers were also concerned about relying on small group plans as a model, instead of the "typical employer plan" required under the ACA. Again, employers and insurance companies favored having benefits based on small group plans, which are generally less generous in terms of benefits than large groups. Consumers and providers wanted HHS to specify what benefits should be included, while employers and insurance companies wanted more flexibility.

Finally, consumers and providers were concerned about discrimination against people with certain conditions, and employers and insurance companies countered with concerns about resources and asked for a moderate benefits package.

Whether employers and insurance companies, on the one hand, and providers and consumers, on the other, win their case is unclear. HHS is optimistically assuring people that both affordability and comprehensiveness will be reflected in the package.

"Under the Affordable Care Act, consumers and small businesses can be confident that the insurance plans they choose and purchase will cover a comprehensive and affordable set of health services," said HHS Secretary Kathleen Sebelius in releasing the bulletin. "Our approach will protect consumers and give states the flexibility to design coverage options that meet their unique needs."

'Benchmark' plan

Under the plan, states can select an existing health plan to set the benchmark for items and services included in the essential health benefits package. States would choose one of the following plans as a benchmark:

- One of the three largest small-group plans in the state.
- One of the three largest state employee health plans.
- One of the three largest federal employee health plan options.
- The largest HMO plan offered in the state's commercial market.

Whatever benefits and services are included in the health insurance plan selected by the state would be the essential health benefits package. Consistent with the ACA, the essential health benefits package must cover at least 10 categories of care, including SUDs and MH.

But mental health and SUD services do come in for special treatment in the bulletin, mainly because typical plans may not offer adequate benefits, the bulletin says, in an admission by HHS that many plans are not complying with the MHPAEA. "In general, the plans and products studied appear to cover inpatient and outpatient mental health and substance use disorder services; however, coverage in the small group market often has limits," the bulletin said.

The good news for MH/SUD providers and patients: there is no flexibility about complying with the MHPAEA. •

Go to http://bit.ly/sfgzym for the bulletin. Comments on the proposal are due by January 31 and should go to EssentialHealthBenefits@cms.hhs.gov.

Editor's note: There is no time frame for publishing the Notice of Proposed Rulemaking yet. Stay tuned.

The 10 benefit categories

Below are the 10 benefit categories defined by the ACA:

1) Ambulatory patient services;
2) Emergency services;
3) Hospitalization;
4) Maternity and newborn care;
5) Mental health and substance use disorder services, including behavioral health treatment;
6) Prescription drugs;
7) Rehabilitative and habilitative services and devices;
8) Laboratory services;
9) Preventive and wellness services and chronic disease management; and
10) Pediatric services, including oral and vision care.

More reflections from readers: Hopes and fears for 2012

We asked field leaders to send in their reflections on last year and their hopes and fears for this year. We printed some in last week's issue and will print the balance in next week's issue.

"I'm grateful for a season of reflection and anticipation. Services for prevention, treatment, and recovery are essential to individuals, families, and our communities. Health care and parity legislation has opened doors to opportunities offering hope for improved services and cost-based reimbursements, including appropriate salaries for our well-educated and skilled workforce. Change also brings fears associated with transition and implementation. Much more advocacy is needed as states begin to develop their plans. We must be vigilant to ensure that the goals of the original legislation don't disappear in a flurry of regulations based on shortsighted budgets instead of overall savings to healthcare and the wellness of our citizens."

— Becky Vaughn, CEO, State Associations of Addiction Services

"I remain thankful that drug policy continues to remain a non-partisan issue. Despite the divisions we have seen in Congress over the past year, Democrats and Republicans continue to work together on substance abuse issues that are important. My hope is that in 2012 we'll continue to make progress in addressing the nation's prescription drug epidemic in such a bipartisan way. I also predict that the recovery community will become stronger than ever, helping to lift the stigma of addiction and encourage more Americans to get the help they need to free themselves from the misery of addiction."

— Rafael Lemaitre, spokesman, Office of National Drug Control Policy (ONDCP)

"Right now many substance use disorder (SUD) treatment providers are not participating in health information exchanges (HIEs) due to their fears about the privacy and security of their clinical data as it relates to 42 CFR part 2. I would consider it a huge achievement if by the middle of 2012 we have a SUD treatment provider electronically connected to an HIE, with a functioning electronic consent management system that is deemed 42 CFR Part 2 compliant by SAMSHA so that other providers and other HIEs feel comfortable using that approach."

— Kevin Scalia, executive vice president, Netsmart

"With the enormous economic and political challenges facing the nation, our field successfully maintained its core funding for fiscal year 2012. This was accomplished by all of us working together to ensure that the substance abuse prevention and treatment programs in SAMHSA were preserved. CADCA also worked to ensure that the Drug- Free Communities program was funded at the highest possible level. Going forward, our entire field needs to be more data- and outcome-driven and strongly advocate for the entire continuum of care -- from prevention through recovery support."

— Sue Thau, Community Anti-Drug Coalitions of America (CADCA)

"2012 will be the year of decision. From the Supreme Court to the local treatment facilities and communities, decisions will be made. States, local government and managed care will play the directional roles. Resources, workforce development and community values will dictate within hard realities and limits. Providers will need to affiliate for efficiency and choose to be part of the growing generalist opportunity or remain in specialty care —both will survive. More people will be served, but demand will still exceed capacity and public health models will grow. Progress will be determined by improved access. But will we measure improved wellness and recovery? That would be evolution."

— Michael Flaherty, Ph.D., Founder, Institute for Research, Education and Training in Addictions (IRETA)

"As CEO of the country's largest substance abuse treatment provider, I've been most excited that my objective to help people is coming true. We treat 30,000 every day and the overwhelming majority live better as a result. At the same time, I've been saddened to see firsthand that the "treatment gap" is very real – as SAMHSA reports, over 23 million people need but do not receive alcohol or drug treatment. Neither we at CRC nor the entire field combined is more than the tip of the iceberg in reaching people who need professional help. We will keep innovating (as an example, we are aggressively incorporating Vivitrol as a monthly treatment option for opiate addiction) to draw more people to our programs. But clearly denial, access, and stigma all must be addressed to reach the millions of individuals and families in need."

— Andy Eckert, CEO, CRC Health Group

"It seems to me that the message attacks on the field are getting worse from all sides — by the NIMBY advocates, the legalizers, and the media emphasizing a few selected bad outcomes instead of the overwhelming successes. We have to counter the NIMBYs with the fact that drug treatment reduces

 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

FROM THE FIELD

The 'last' house on the block: Higher power or personal power?

by Sarah Myers

In 2008, I spent 30 days in a 12-step-oriented treatment facility in San Diego and began my journey in recovery. For me, this facility — and the program of recovery it offered — was the "last house on the block."

My caregivers urged me to do three things following discharge: first, attend 12-step meetings at least once a day for the first 90 days after my release; second, find a sponsor; and third, accept a "higher power" of my understanding. The final task proved arduous. While my 12-step peers insisted that any power greater than myself could fill this spiritual void, I feared that my inability to find a God would lead ultimately back to the subterranean exile of my disease. Worse, I was cautioned that without a God of some variety and working the 12-steps, I would slip from sobriety into dreaded "dryness" — a miserable Siberia of the mind where untreated alcoholism lays in wait for the demons of the disease to inevitably return.

Consequently, I went searching for God the way one might search for a lost sock — its mate in hand. I attended Buddhist services in Mandarin Chinese, danced in the streets with Hare Krishna monks and sang hymns at a Christian cathedral. I did not find God, but did maintain my sobriety. Nevertheless, I was repeatedly told that the 12 steps were the so-called "penicillin" in my treatment; while not the "cure", the 12 steps were my best shot at gaining and sustaining long- term recovery. By comparison, other recovery programs that side-stepped the spiritual component were only "Vitamin C."

At nearly four years sober and an active participant in 12-step programs, I embarked on courses at a local university, determined to pursue certification as an alcoholism and drug abuse counselor. My study of the history of addiction treatment suggests a more subtle and, at the same time, a more marvelous truth: the road to the miracle of sobriety can be ushered not only by angels, but also taught in a tongue matched to the language of client, so they can have the opportunity to understand the principles required to build a new life.

In this light, after a number of personal squalls, for me the conception of a higher power rests in the negative space — in the battle for meaning — irrespective of a benevolent or malevolent omnipresence. While I would have loved to discover my own spirituality in the pages of the Torah, the Bible, the Bhagavad-Gita or the Koran, I found myself more aligned with the language of existential philosophers Nietzsche and Sartre: "We are condemned to be free." I am, therefore, held philosophically accountable for my freedom, my choices and the meaning I derive in the face of my own mortality.

While I consider the 12-step fellowship my family and my personal path to recovery, it would appear my so-called "language" of recovery is not so dissimilar from the meaning embedded in the treatment philosophy of self-empowerment, rather than significant reliance on a higher power.

However, I can conceive of examples in which one embarking on recovery might cringe at the staunch request that a newcomer they must live a spiritual 12-step program or wither back into addiction. To suggest such a thing as a treatment professional may prove dangerous; allowing no alternative options to the 12 steps may very well lead a desperate client back out into the storm, uninformed of the true plethora of possible pathways to recovery. Furthermore, for those professionals that are also in their own personal recovery from addiction, what we hold true for ourselves in sobriety may not necessarily hold true for the client before us. I believe it is our ethical obligation as treatment professionals to continue to incorporate knowledgeable options into our recommendations for clients' continued care.

While I have no intention of changing my personal program of recovery, from these lessons I would argue with contention that any specific program may represent the so-called "last house on the block." There are many doors through which one can open a new life of health and recovery. Perhaps the goal of the treatment professional is to help find the key that unlocks the door in the life of each client.

Sarah Myers, Recovery Consultant at Stepping Stone of San Diego, can be reached at sarah@steppingstonesd.org.

crime locally and regionally. We need to defuse the legalizers (and their state referenda) by emphasizing the chaos and increased drug usage that would occur. We still have enormous work to do to remove biases against methadone and other medical approaches proven to work, and have to get the word out that these reduce addiction and restore productivity. And when media headlines a bad outcome-case, we all need to write and speak out about the overwhelming number of lives that treatment saves in a difficult population."

— Robert Weiner, former spokesman, White House ONDCP and U.S. House Narcotics Committee; president, Robert Weiner Associates Public Affairs •

SAMHSA's new recovery definition applies to MI and SUD

The Substance Abuse and Mental Health Services Administration (SAMHSA) last month released its new "working definition" of recovery. It's a blended definition – one that applies equally to substance abuse and mental illness. It's vague, and general, and doesn't stress abstinence. The addiction field hopes that it will be changed to denote that it is for mental illness and/or substance use disorders, and that it will stress abstinence for people in recovery from addiction.

Under the definition, which was released on Dec. 22 — just before the long holiday week — in the form of a blog, the four dimensions of recovery are the same as those revealed last year (see *ADAW*, May 16, 2011):

1) Health: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.
2) Home: a stable and safe place to live.
3) Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.
4) Community: relationships and social networks that provide support, friendship, love, and hope.

This is very different from the 2005 and still current definition from SAMHSA's Center for Substance Abuse Treatment: "Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life." In fact, abstinence is only mentioned in one non-committal sentence: "Abstinence is the safest approach for those with substance use disorders."

Recovery researcher Alexandre B. Laudet, Ph.D. said feedback from people in recovery from addictions or in the recovery field was negative. They feel that their definition of themselves and recovery has little in common with what SAMHSA has released so far, and that they do not have any more in common with someone who is in recovery from mental illness than they do with someone who is in recovery from, for example, diabetes.

> **'...there is still work to be done.'**
>
> Pat Taylor

Laudet, who is director of the Center for the Study of Addictions and Recovery at the National Development and Research Institutes, recounted what one person in recovery from addiction — a SAMHSA employee — told her last year: "If I have to be considered the same as someone in recovery from mental illness, I am going back underground." Of course, Laudet said, no one at SAMHSA can talk like this openly.

Pat Taylor, executive director of Faces and Voices of Recovery, said that her organization's comments on the recently released proposed definition were not taken into consideration by SAMHSA. "We said that the definition should be mental health and/or substance use disorders," Taylor told *ADAW* after the definition was released last month. "The 'and' is necessary because some people do have co-occurring. But we need to distinguish between the two. That comment was not taken into account and was not reflected in the definition SAMHSA came out with."

Taylor noted that SAMHSA is still calling the definition a "working" one. "We hope they mean that, because there is still work to be done," said Taylor.

In particular, the definition should focus on the principle of not using alcohol and other drugs, she said. "It's still buried in this document, and it needs to be high-profile," she said. And the definition should clearly be for mental health and/or substance use disorders, she stressed.

Faces and Voices of Recovery will be sending a letter to SAMHSA this month, said Taylor. •

For the blog and responses, go to http://bit.ly/wu4bzp.

Also see *ADAW*, May 9, 2011.

FY 2012 budget bill includes increases to SAPT block grant

After 10 months of uncertainty, beginning with the President's proposed budget for fiscal year 2012 (see *ADAW*, Feb. 21, 2011), the year ended on a bright note for substance abuse prevention and treatment providers, with the Congressional appropriations process making the final determination. While there are overall cuts to the Substance Abuse and Mental Health Services Administration (SAMHSA), the cuts could have been much deeper. And the Substance Abuse Prevention and Treatment block grant, thanks to Congress, received an increase of $20.9 million, for a total of more than $1.8 billion.

The FY 2012 appropriations bills included a $915 billion omnibus bill that included funding for the Departments of Labor, Health and Human Services, and Education. The bills were passed by both houses Dec. 17 and Dec. 18, too late to cover in *ADAW's* last issue of 2011.

- Cuts to SAMHSA were $27.1 million for a total of $3,383.9 million. The Center for Substance Abuse Treatment was

cut $4.8 million for a total of $400.8 million.
- The Center for Substance Abuse Prevention (CSAP) is level funded at $186 million.
- The National Institute on Drug Abuse (NIDA) receives a $2.9 million increase for a total of $1,053.4 million.
- The National Institute on Alcohol Abuse and Alcoholism (NIAAA) receives a $1.2 million increase for a total of $459.5 million

Rebuke to SAMHSA

In language that must have stung SAMHSA, the bill managers' report from the conferees of the House of Representatives and the Senate makes it clear that Congressional appropriators don't want the agency to make any changes without including "the specific funding increases, decreases and FTE changes being requested by program, project or activity, along with a detailed description of activities funded under each program." In addition, the budget requests must specify "the number of new and continuing grants made; the average grant size; and a State-by-State table for any formula-based funding."

Appropriators were furious at SAMHSA last year over its plans to revamp the agency, moving money from substance abuse prevention to mental health promotion and merging the block grants, among other things, without consulting with Congress (see *ADAW*, Oct. 3, 2011).

In the future, including the proposal for fiscal year 2013, the appropriations committees "expect that SAMHSA shall not make changes to any program, project, or activity as outlined by the budget tables included in this Statement of the Managers without prior notification to the House and Senate Committees on Appropriations." •

For the spending bill, go to http://bit.ly/tzQP2t.

Affiliation from page 1

was already a friendly relationship between the two neighboring treatment organizations; it likely will step up the pace of referrals between the two centers. Samaritan Village president and CEO Tino Hernandez had previously been a funder of Outreach when he served as New York City's commissioner of juvenile justice in between two stints working at Samaritan; Outreach's programs have focused primarily on the adolescent population, as well as women with children.

By contrast, Samaritan Village has been known mainly for adult care, as well as specialized services for veterans, medication-assisted treatment services, and more recently inroads into transitional and supportive housing and other support services.

"This affiliation made perfect sense for a continuum of care," said Riddle. "This will make it easier for marketing with the managed care entities. They want to go to one location to purchase everything."

Riddle added that she sees several potential synergies as a result of the strategic alliance. With Samaritan Village making significant progress in the treatment of veterans, for example (with 123 of its treatment beds specifically set aside for that population), Outreach will be poised to assist veterans' family members with the services they need, she said.

Outreach

Location: *New York City and Long Island*
Founded: *1980*
Services: *Specializes in residential and outpatient programs for adolescents and programs for women and children; also a leading trainer for would-be certified counselors*
Clients Served: *More than 3,000 annually*
Employees: *More than 250*
Payer Mix: *One-third Medicaid, one-third private insurance, one-third self-pay*

A news release announcing the partnership describes one mutually beneficial aspect as establishing "a stronger platform for expanding initiatives to address service gaps for special populations." This has been a priority for Outreach in recent years: It offers counseling in English, Spanish and Polish and has explored assisting other non-English speaking groups, and it also has been looking to expand services to the gay and lesbian population.

The affiliation also expands the organizations' overall geographic reach, with Samaritan Village having bases of operation in upstate New York and Outreach having a significant presence on Long Island.

"In this kind of environment, with health reform and the economic difficulties that exist, we feel it's best to join forces," Hernandez told *ADAW*. Yet he emphasized that both organizations alone are in sound financial condition, adding that Samaritan Village's budget has grown by about 50 percent over the past two years as it has diversified its service mix.

The two organizations also see opportunities in the area of staff training. Outreach operates New York's largest training program for addiction professionals who are pursuing the state's certified counselor credential, and Hernandez said the two organizations want to work on creating some advanced training programs for their respective staffs.

Riddle said arrangements such as this alliance could help establish more uniformity in staff training, which would prove advantageous to clinicians and agencies in a field

Continues on next page

Continued from previous page
with a great deal of job movement.

"Part of the problem for staff is that treatment is done differently from one agency to the next," she said. "As an agency, you end up investing so much in retraining your staff."

There is also the possibility that the two partners will identify some cost savings through increased purchasing power related to back-office operations, although this objective was not a driving force behind the partnership.

Future affiliations

Riddle said the arrangement as it currently stands does not preclude the organizations from considering future alliances with other treatment centers as well. "We're always open to new partnerships," she said, emphasizing the need to identify agencies that maintain similar standards of care.

In fact, Hernandez said that Samaritan Village might explore some outright merger arrangements if it can identify struggling agencies for which that type of match would make sense. He added that he believes more organizations in the region are beginning to talk about various forms of partnership.

He said the arrangement with Outreach is mainly about a more comprehensive approach to care. "We want to be able to treat the whole family, and we want to extend our geographic coverage," he said.

Riddle said the success of such ventures depends greatly on commitment from both top administrators and the rest of the organizations' staffs. "There's a trust factor that's very important," she said. •

Briefly Noted

West Virginia Quitline now run by First Choice Services

West Virginia Prescription Drug Abuse Quitline is no longer run by the West Virginia University School of Medicine, but rather by First Choice Services, which has run the Problem Gamblers Help Network for over a decade. Both helplines are staffed by mental health professionals, according to a First Choice press release. The West Virginia Prescription Drug Abuse Quitline was created in 2008 with funding obtained through a settlement with Purdue Pharma over marketing of OxyContin. The funding ended last June, with about $70,000 remaining, and First Choice is looking at other funding opportunities. It needs $300,000 a year, and will seek funding from the legislature and private sources. The WVU School of Medicine will stay involved in the quitline through data management and analysis, with the aim of improving services for the population that is affected by prescription drug abuse. For more information, go to www.wvrxabuse.org.

Tricare proposes lifting ban on methadone/buprenorphine

Tricare, the insurance company for active-duty military, is proposing to lift the decades-old prohibition on using addictive drugs to treat addiction. There are only two medications that currently fall in this category: methadone, which has been available for more than 50 years, and the much more recent buprenorphine. In a proposed rule published in the Federal Register Dec. 29, the Department of Defense proposes to remove the ban on "drug maintenance programs here a therapeutic drug with addictive potential is substituted for a drug of addiction." Saying that "medicine is constantly evolving including in the area of drug addiction treatments," the notice states that "in the past, there was not sufficient reliable evidence… to establish that the substitution of one addictive drug for another was an effective part of a drug treatment program." The proposed rule cites battlefield injuries requiring "long-term use of pain medications" that has put many troops "at risk for dependence." Comments are due by Feb. 27. To read the Federal Register notice, go to http://1.usa.gov/ubkYlK.

Coming up…

Community Anti-Drug Coalitions of America will hold its 2012 Leadership Forum **February 6-9** in **National Harbor, Maryland**. Go to **www.cadca.org** for more information.

The 18th Annual **National Treatment Accountability for Safer Communities (TASC)** Conference on Drugs and Crime will be held **March 21-23** in **Baltimore**. For more information, go to **www.nationaltasc.org/conference.php**.

The first National Rx Drug Abuse Summit will be held **April 10-12** in **Orlando**. Go to **http://nationalrxdrugabusesummit.org** for more information.

In case you haven't heard…

Liquor bottles aren't the best way to smuggle contraband through an airport, a man arriving at Newark Liberty International Airport on New Year's Eve discovered. Wilfer Bohorquez Rojo, 53, of Miami was arrested and charged after being found to be in possession of 25 pounds of heroin, with much of it hidden inside bottles of Scotch, MyCentralJersey.com reported January 4. Bohorquez Rojo's flight originated in Medellin, Colombia, according to U.S. Customs and Borders Protection officials. The value of the heroin was $700,000. The four bottles of Scotch were Chivas Royal Salute, which costs upwards of $150 a bottle.