

# ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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## HIGHLIGHTS...

Insurance and employer support for the parity law appears waning now that the process of writing implementing regulations has begun. In comments to the Department of Labor, the business community has recommended that there be specific restrictions on behavioral treatment. Lobbyists for the treatment field and the business community are interviewed. *See story, top of this page.*

Drug czar R. Gil Kerlikowske told attendees at the NASADAD annual meeting last week that treatment and law enforcement need to have a better partnership. Instead of looking for a bigger piece of the budget, treatment providers should develop ways to work with criminal justice, he said. *See story, bottom of this page.*

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## Parity Update

### Business community supported parity law, but favors a different kind of regulation

Now that the public comments on implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) are in, it appears that the business community is no longer siding with the treatment field in supporting the original intent of the law, which was for addiction and mental health treatment to be covered on an equitable basis with medical and surgical treatment.

Employers and insurance plans had originally been supportive of the Senate version of the parity bill — the weaker version for addiction — and then dropped out when the House version predominated. Now, the business community, based on comments filed for the MHPAEA Request for Information (RFI) from the U.S.

Department of Labor, is specifically calling for extra restrictions on addiction and mental health treatment.

“The business community had said they were supportive, that they were going to go easy on this, that there wasn’t going to be a big dog fight,” Carol McDaid, principal with Capitol Solutions, which represented the Parity Implementation Coalition in its filing of its 44-page response to the RFI, told *ADAW*. “They said they weren’t going to be oppositional.”

The business response is virtually a “point counterpoint” with the Coalition’s response, said McDaid. “This was supposed to be very conciliatory,” she said. “Now it’s not.” The Parity Implementation Coalition consists

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### NASADAD conference: New ONDCP director urges stronger partnerships with police

New partnerships involving treatment organizations and law enforcement were a hot topic during the first day of last week’s annual meeting of the National Association of State Alcohol and Drug Abuse Directors (NASADAD) in Syracuse, N.Y.

Plenary speaker R. Gil Kerlikowske, the new director of the White House Office of National Drug Control Policy (ONDCP), said that in the city of Seattle, drug abuse and crime both declined during his nine-year tenure as chief of police there. “But it wasn’t because we put more cops on the street,” Kerlikowske said. “We can’t arrest our way out of the drug problem.”

Instead, Kerlikowske urged bet-

ter partnerships between treatment and law enforcement, saying that this has to happen on the local level. “I can’t name five treatment providers in Seattle,” he said. “I’m ashamed to say that. I should have been reaching out to treatment professionals.”

But it’s a two-way street, he added. “You need to be open to them,” Kerlikowske told the attendees, who numbered about 200. “And you need to go and knock on their door.”

When the treatment field needs funding, law enforcement can be “unexpected messengers” in local legislatures or even in Congress, Kerlikowske said. “When they show

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### PARITY from page 1

of treatment providers and patient advocates in both the substance abuse and mental health fields.

The American Benefits Council and the U.S. Chamber of Commerce, in a joint response sent May 28 to the Department of Labor's RFI, asked for language that would make it easier to discriminate against treatment for addiction or mental health problems.

The business community "supports the statute and its intent," said Kathryn Wilber, legal counsel with the American Benefits Council and author of the May 28 letter. "But our recommendations will make this a workable benefit, and will make it possible to offer the benefit."

The law does say that behavioral health benefits don't have to be offered at all, Wilber noted. This implicit threat wasn't stressed in the response to the RFI, however. "We don't want to go there," she told *ADAW*. "Our members want to be able to continue to offer this benefit."

But the benefit would be on different terms from what is envisioned by the field.

Below are some of the recommendations included in the letter from the American Benefits Council and the Chamber of Commerce:

- A non-enforcement policy for the first year,
- Language allowing group

health plans to "exclude coverage for a particular mental health or substance use condition",

- Language allowing group health plans to "exclude coverage for a particular inpatient or outpatient treatment or treatment setting with respect to a mental health or substance use condition that is otherwise covered so long as there are meaningful other treatments available for that mental health or substance use condition",
- Language allowing group health plans to "exclude coverage for treatment settings or providers where licensure requirements are not satisfied", and
- A request for guidance confirming that group health plans may use "medical necessity provisions, precertification requirements or other medical management tools for mental health or substance use disorder benefits and that such tools need not be the same as those used for medical and surgical benefits covered under the plan."

Employers and insurance plans want to be able to provide "any level of services including no services and still be in compliance," said McDaid. The Coalition's response, anticipat-

ing this stance from the business community, makes a clear point that the law requires not just benefits, but benefits with respect to services.

"We're not saying that the law mandates certain levels of treatment, but that it mandates the same levels that exist on the medical/surgical side," McDaid said.

### Medical management

And medical management is the "800-pound gorilla," said McDaid. Medical management takes place, for example, when insurance plans use their own medical necessity criteria to determine what level and amount of treatment they will pay for. The Coalition had the consultant Milliman analyze claims data so it could present proof that medical management is more restrictive by 15 to 20 percent on addiction and mental health treatment than on medical/surgical treatment, said McDaid. In addition, it polled providers to find out anecdotally what the differences were.

Unlike Act 106 in Pennsylvania (see story, page 3) — a state law that bans medical management — the federal parity law has a role for medical management.

Another key point is the definition of a "benefit," said McDaid. The law refers to benefits, but the regulations need to clarify that services must be offered in addition to the presence

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of a benefit. The law defines benefits as “benefits with respect to services” for mental health conditions or substance use disorders. This “explicit reference to services” is “strong evidence that Congress intended to include services within the definition of” a benefit, the Coalition’s comments on the RFI state.

Any other interpretation would not make sense, the Coalition noted. “If health plans were allowed to qualify as providing ‘benefits’ while not providing any services, it would severely undermine the statute passed by Congress,” it stated. For example, an employer could choose to cover depression, but not antidepressant drugs or psychotherapy.

If a plan does not provide treatment for a mental health or substance abuse condition that it covers, the regulatory language must clarify whether this would violate the treatment limitations section of the law, which does not allow any limitation to be more restrictive for a mental health or substance abuse problem than for a medical/surgical condition, the Coalition response to the RFI states.

### Plans want flexibility

Wilber, however, recommends that health plans and employers be given flexibility, when the statute allows that. And if something is allowed in medical and surgical benefits, it’s allowed in mental health and substance abuse benefits.

“Exclusions can be retained for medical benefits,” said Wilber. “Poli-

**‘Our members want to be able to continue to offer this benefit.’**

Kathryn Wilber

cies can exclude treatments that aren’t evidence-based. Some exclude maternity and cancers.”

In addition, there may be a “variety of treatments” for medical conditions as well as for substance abuse or mental health conditions, she said. “We are saying that we don’t have to cover the entire universe, as long as there is at least some meaningful treatment.”

The American Benefits Council also asserts that insurance companies and employers should be able to determine what kind of license a treatment provider should have. Insurance companies “accredit” providers — they approve them to participate in plans and be paid —and they want to determine who is qualified.

“There need to be some standards,” said Wilber. “This would probably be determined at the network or plan level.” This could mean, for example, that a payer would say only a licensed social worker or licensed psychologist (or a physician) could provide addiction treatment. Wouldn’t that leave

out the country’s 80,000 certified alcoholism and drug abuse counselors? “It might, depending on the plan,” said Wilber.

### Contact Congress

The rulemaking process will be internal in the Department of Labor, which will issue an interim final rule by October. The rule will be binding. Comments can still be made after the interim final rule is issued, but there is no guarantee that the final rule, which could be issued at any time in the near or distant future, would be any different from the interim final rule.

So it’s key for the treatment field to go to senators and representatives now and ask members to help ensure the implementing regulations are true to the original law, said McDaid.

“People need to engage the members of Congress who played such a critical role in shaping this legislation to make sure it isn’t undermined,” she said. “That’s what’s at stake here.”

Members of the Coalition are: American Society of Addiction Medicine, Betty Ford Center, Bradford Health Services, Faces and Voices of Recovery, Hazelden, Mental Health America, National Alliance on Mental Illness, National Council for Community Behavioral Healthcare, Watershed Addiction Treatment Programs, and Wellstone Action. •

Comments to the RFI will be posted on the Department of Labor’s website. Go to [www.dol.gov/ebsa/regs/commentsmain.html](http://www.dol.gov/ebsa/regs/commentsmain.html).

## Field wins in final legal battle against utilization review in Pa.

“I’m floating on the ceiling,” said Deb Beck, president of the Drug and Alcohol Service Providers Organization of Pennsylvania (DASPOP), after the state’s highest court sided with addiction treatment and the state on May 27.

In a legal challenge that has dragged on for years with no victories for insurers administering addic-

tion treatment coverage, the Pennsylvania Supreme Court has issued what appears to be the final affirmation that managed care may not apply utilization review to override a physician’s or psychologist’s judgment on appropriate treatment.

In the 4-2 ruling, the Supreme Court affirmed an earlier order of Pennsylvania’s Commonwealth Court

stating that the only statutory prerequisites to obtaining alcohol and drug abuse services in the state are certification and referral from either a licensed physician or a licensed psychologist (see *ADAW*, Aug. 6, 2007).

The action at the heart of the lawsuit, brought by the Insurance Federation of Pennsylvania and sev-

**Continues on next page**

Continued from previous page

eral other industry entities, was a 2003 notice from the state Insurance Department that clarified insurers' obligations under Act 106, a state law that the General Assembly adopted back in 1989. Act 106 mandates certain benefits for alcohol and drug dependency in group plans offering medical/surgical coverage, and gives physicians and psychologists the exclusive right to certify inpatient detoxification, non-hospital residential and outpatient addiction services.

The 2003 notice from the Insurance Department read in part, "The certification and referral in all instances controls both the nature and duration of treatment." It added that a state law passed nine years after Act 106's enactment, governing managed care responsibilities in health service delivery, did nothing to alter the Act 106 requirements, despite insurers' contentions.

Addiction treatment advocates have said for years that Pennsylvania insurers have violated the intent of Act 106 through restrictive utilization review practices. Beck, of DASPOP, told *ADAW* that for many years the state's providers and consumers were not even aware that the insurance mandate was on the books — mainly because they had gotten used to hearing insurers' denials and assumed this was within their rights. She added that similar insurance laws exist in other states and aren't being enforced.

"In the mid-1990s, the managed care industry said, 'We get to second-guess [the physicians]," Beck said. "We didn't realize we were going to be in for such a long fight."

## Court's argument

After the 2003 Insurance Department notice was issued, the Insurance Federation of Pennsylvania led the effort by several insurance groups, including managed behavioral health care companies Magellan Behavioral Health and ValueOptions, to challenge the state agency's

interpretation of the 1989 law. The insurers argued that state legislators in adopting Act 106 had intended that utilization review be incorporated into the law's framework.

Yet the state's Commonwealth Court concluded that it was not the legislature's intent to allow managed care entities the ability to overrule a physician or psychologist judgment. Insurers then appealed to the Supreme Court, which last month issued a ruling denying their claims.

The court's majority opinion states that Act 106 prohibits insurers from concluding, for example, that outpatient services could be substituted for residential treatment authorized by a physician. It added that Act 106 language is very similar to that of several other state statutes where coverage is mandated for

**'We didn't realize we were going to be in for such a long fight.'**

Deb Beck

certain health services, such as mammograms, annual gynecological exams and childhood immunizations.

In addressing the issue of whether blocking the application of utilization review violates the public interest, the Supreme Court opinion states that "we have resolved the question of the General Assembly's intent with regard to Act 106 based on the plain language of the statute; accordingly, it would be improper to stray into the arena of public policy in resolving this case, and we decline to do so."

## Worlds apart

Comments from Beck and from Sam Marshall, president of the Insurance Federation of Pennsylvania, about the effect of the state law illustrate how far the interests represented in this longstanding

dispute seem to be from a meeting of the minds.

Marshall told *ADAW* that it is puzzling why policy-makers would not want to have in place for addiction treatment the same utilization review that is applied to other areas of coverage. "We believe in the balance of having not only good treatment but affordable treatment," he said. "Utilization review is good for the patient."

He said the state's interpretation of Act 106 led to a dramatic increase in inpatient services for alcohol and drug issues, but there has been no documentation of better results for patients because of this.

He added, "I can understand a provider saying, 'I don't want to be questioned,' but I don't know if that's a good thing for the patient, or for people struggling with affording health insurance."

Beck counters that managed care's restrictions actually place treatment providers in the position of recommending against evidence-based practice. She said there is vast research evidence that length of stay has a major effect on improving outcomes, and that when there are fewer restrictions on service authorization, people get better and insurers end up saving money.

Beck added that in the early years after Act 106's enactment, advocates were receiving "complaints by the bucketful" about managed care denials that were having devastating consequences. "Quite frankly there were some deaths," said Beck, and this spurred advocates and some lawmakers to ensure that the law be strongly enforced.

Nils Frederiksen, deputy press secretary for the state Attorney General's office, which argued the case before the state Supreme Court, told *ADAW* that at times the matter has been "a very frustrating fight, especially for the family members."

Frederiksen said, "In our view, this [ruling] should put an end to it. We expect everybody to play by the rules." •

## State Budget Watch

# Across-the-board budget cuts of 50 percent possible in Illinois

As Illinois was facing a budget cut of 50 percent for the fiscal year beginning in three weeks, the best hope for the addiction treatment field to avoid catastrophic damage was an increase in income taxes and alcohol taxes, state officials and treatment providers told *ADAW* last week.



Gov. Pat Quinn had proposed an increase in the income tax to help close a \$12 billion hole in the state's fiscal year 2010 budget. Treatment advocates had spent most of the legislative session hoping this would go through, but in a last-minute session held on Sunday, May 31, the increase was defeated by 18 votes. That meant the alternate budget approved by both chambers if no budget was passed would go into effect — a budget that gave the state half of the money the governor proposed — for the entire year.

"We're holding out hope that the governor and the legislative leaders will be able to come up with some type of a compromise or consensus," Department of Human Services (DHS) spokesman Thomas Green told *ADAW* last week. "But since the General Assembly has not indicated that they plan to provide the other 50 percent, agencies are being instructed to look at that 50 percent as their budget."

Notifications are going out to funded agencies "in the near future" that will tell them they should anticipate getting only half-year funding for the full year, said Green. "This could result in a cut of about 65,000 treatment slots for alcohol and drug abuse," he said, adding, "It's very bleak."

### Income tax

Currently, the individual income tax rate is 3 percent, and the corporate income tax rate is 4.8 percent. The House proposal this session,

which failed, would have raised the individual tax to 4.5 percent and the corporate tax to 7.2 percent. The Senate version, which passed, would have raised both the individual and the corporate rate to 5 percent.

The leaders of both chambers are going to meet with the governor to see if they can come to an agreement; after June 1, a three-fifths majority is required for anything to pass. "The basic sentiment in Illinois is that the Republicans don't want to put more money into a corrupt government," said Sara Moscato Howe, CEO of the Illinois Alcoholism and Drug Dependence Association (IADDA). Illinois voters suspect politicians of selling themselves to the highest bidder, and the fallout from its disgraced former governor, Rod Blagojevich, impeached in January and facing federal corruption charges, continues.

The Division of Alcoholism and Substance Abuse (DASA) portion of DHS funding is \$161.4 million. If \$80 million is cut, then the federal government could cut the federal block grant match, said Howe. "We have made the case, as we did last year, that our federal dollars are dependent on state dollars, so they should prioritize any program that has a federal match," said Howe.

Between now and the end of June, treatment providers need to keep reaching out to their legislators, said Howe. This week — when they are not in session — is a good time to get on legislators' schedules, she said. "They should get them to meet clients, to put a human face on this."

### Last year

This seems like *déjà vu* for the addiction treatment field, but last year's battle may have had a beneficial effect. Last year, although the situation wasn't as dire for the state as a whole, the addiction treatment field was singled out for a \$55 million cut. "The field rose up and said 'We're not

going to be left behind; we're not going to be the forgotten stepchild,'" Howe said. And the funding was restored by the legislature in September (see *ADAW*, Sept. 29, 2008).

The governor (then Blagojevich) signed the measure in November. Contracts weren't amended until January, and people didn't start getting their jobs back until February. "They gave it all back to us in the end, but it was a good eight months late." This meant that a lot of the money couldn't even be used for treatment, because Illinois contracts are fee-for-service. "There were circumstances where DASA allowed one-time only grants, such as to upgrade computer systems or to get a new van to transport clients," said Howe.

Some treatment programs operated at 100 percent capacity and didn't do any layoffs. "They hedged their bets that the money would come eventually," said Howe. They did this by taking loans, something that "just about all" treatment providers in the state did, she said. Nobody can get those loans any more. "Most are at the end of their credit line," she said.

In addition, having state contracts is not good collateral any more, she said. "The lenders say, 'I've been reading the news, the state's broke. I'm not giving you a loan.'"

Now, just four months after they have restarted from last year's debacle, many providers are wondering if they are going to have to lay off staff again, said Howe. •

### Alcoholism & Drug Abuse Weekly

welcomes letters to the editor from its readers on any topic in the addiction field. Letters should be no longer than 350 words.

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## Field moving slowly toward electronic health record

The addiction treatment field better be prepared to contribute to and participate in an electronic health record (EHR) — a “virtual” place where all of a patient’s medical data will be stored — according to Ronald J. Hunsicker, president and CEO of the National Association of Addiction Treatment Providers (NAATP). Otherwise, he said, the field may find itself left out of health care reform.

“All of the details haven’t been worked out,” Hunsicker told *ADAW* last week, “but it’s pretty clear that if we don’t join that train, we’re not going to be in health care at all.”

Providers not part of the EHR will be treated as “something other than health care,” said Hunsicker.

It’s imperative for addiction and mental health treatment to be included in integrated health care, said Hunsicker. “Once you put all that stuff into one basket, including the funding and the paying for it, the cost offsets make a lot more sense.” Then, he said, policy makers will want to mandate at least a minimal level of services for addiction treatment on demand. “Everybody now understands we’re paying for not treating people,” Hunsicker said.

### Integrated addiction EHR

New York-based Netsmart Technologies provides EHR systems for public addiction treatment programs using its software called Avatar. Here’s how it would work under an integrated system, according to Kevin Scalia, executive vice president of corporate development.

For example, a patient is diagnosed with alcohol abuse and opioid dependence and treated in the public system. That patient also has a co-occurring mental disorder, and is released on medications. Some time later, the person forgets to take the medication and starts drinking, becomes totally “decompensated,” and ends up with the police taking him to the hospital emergency department. “In this new world, all the

emergency department needs to do is figure out who the person is,” Scalia told *ADAW*. “Then they can find out where they were treated before, what medications they were on, and what their treatment was.”

As emergency personnel stabilize the patient, they won’t give him a contraindicated medication. And instead of admitting the patient, the emergency department could call the addiction treatment provider that treated the patient previously, and say, “We want to refer him back to you so he’s treated someplace he’s familiar with,” Scalia said.

### EMR first

But before you have an EHR, you must have an electronic medical record (EMR) — an electronic instead of paper system — said Hunsicker.

“As a goal, it’s very important for the addiction field to become electronic as the rest of health care becomes electronic,” said Ronald W. Manderscheid, Ph.D., a former federal mental health official and now director of mental health and substance

wireless and PDAs, for example — that when Seabrook House finally went live with Sequest on April 23, 2008, the timing was right, said Wolf.

The initial costs of EMR — which the American Recovery and Reinvestment Act (ARRA) will not help with — are steep, said Wolf. “You’re going to spend a minimum of \$50,000 to \$100,000 on anything,” he said. “Start budgeting for it, or get a grant.”

Anecdotally, said Wolf, the EMR saves time. “All of us are going into the same record, looking at the same information,” he said. “Before, you would ask somebody 10 times — literally — for their name and address.”

### Help from government?

While ARRA provides \$40 billion in cash to providers in grants or incentives to help them roll out EHR (not EMR), addiction or mental health providers are not eligible under its provisions, said Scalia, who is Chair of the Software and Technology Vendors’ Association (SATVA). “The people who need it

**‘[I]t’s pretty clear that if we don’t join that train, we’re not going to be in health care at all.’**

Ronald J. Hunsicker

use programs at the consulting firm SRA International. “Otherwise, we will end up as a paper island in an electronic ocean.”

Matthew Wolf, vice president of business operations at Seabrook House in New Jersey, is one of the field’s acknowledged “techies” — and he took over 10 years to lock into an EMR. “I started researching in 1995,” he said. “We chose Sequest [as the vendor], but I didn’t sign until 2006,” he told *ADAW*. “I dragged my feet because I knew it would be a big project that took a lot of money.” As it turned out, so much happened in 10 years — the introduction of

most — in addiction and mental health — are the ones who aren’t getting it,” he said.

Unfortunately, much of the information about EMR and, now EHR, is coming from vendors, which leaves addiction treatment providers nowhere when it comes to knowing which to choose. Manderscheid, formerly with the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Mental Health Services, said the “federal government has to do more to help,” citing the need for SAMHSA to have the resources to do this. •

## Interventionists boost admissions at addiction treatment program

Using professional interventions — often with patients who are geographically far away — bolstered admissions for Mountainside Drug Rehab by 38 percent in the past year, the program announced last week.

“This is what’s going on in the field now,” said Matt Eakin, vice president of external affairs for the Canaan, Connecticut facility. “The interventionists know exactly the right fit for a program and patient,” he said.

The use of interventions is a trend that goes against the conventional wisdom that patients need to “hit bottom” before they go to treatment. The intervention works because reality is presented to the patient — with the participation of family and friends — in an acceptable way, said Eakin.

But it’s important to make sure the interventionist is board-certified, he said. There is a website for the Association of Intervention Specialists (AIS) (see end of story). In addition, Eakin goes to their conferences where he meets people individually — such as Paul Gallant, MC, LTC, BRI-II (the BRI is for Board Registered Interventionist).

Gallant visited Mountainside, and works with the program regularly, as well as with Caron, Hazelden, and the Betty Ford Center.

There is not a financial relationship between Gallant and Mountainside — and such a relationship would be improper and a violation of AIS certification. “The family pays for the treatment and for the intervention separately,” said Gallant, who is on the ethics committee of AIS. Because treatment providers rely on interventionists for some admissions, the risk of ethical violations is there, said Gallant.

When someone calls Mountainside seeking help getting treatment for a loved one, Eakin can get their information and then pass it on to an interventionist, if the family wants that. The interventionist then calls the family member and sets up the arrangements, including the fee, which is often on a sliding scale. If travel is involved, the family pays the interventionist’s expenses.

It’s important for the interventionist to make sure the recommen-

dation is clinically appropriate, said Gallant. For example, Mountainside would not be a good fit for a patient who is very impaired psychiatrically. “I must make the recommendation based on the clinical needs of the patient,” he said.

Occasionally, Gallant gets a call directly from someone who does not meet the criteria for residential treatment. “Once a mom called me because she found some marijuana in her 15-year-old’s room,” he said. “I told her to get the kid to a counselor, they didn’t need to ship him off to rehab.”

Almost three quarters of the admissions that resulted from professional interventions at Mountainside were from more than 500 miles away from the facility. Even considering the travel — Gallant has brought patients to Mountainside from as far away as Seattle — the price of treatment — \$7,400 — is low, which attracts families in the first place. Getting the addicted person to agree to go to treatment is, when an interventionist is required, the hard part. •

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For the Association of Intervention Specialists (AIS) website, go to [www.associationofinterventionspecialists.org](http://www.associationofinterventionspecialists.org).

### NASADAD from page 1

up in uniform with guns and badges, people take notice,” he said. “When they are the ones advocating for more treatment beds, people listen to them.”

Kerlikowske, who immediately said his department would no longer use the well-worn phrase “war on drugs” after his confirmation last month, instead favors a strategy that is “comprehensive and holistic.” And he asked for suggestions from the field. In the next eight months, ONDCP’s main goal will be to come up with a drug control strategy, and to submit it to President Obama for approval, he said. “I’ll need help crafting messages that resonate.”

The fact that addiction is a disease

is not in question. “The Obama administration understands that addiction is a disease,” said Kerlikowske. However, he at the same time defended his predecessor, John Walters, saying that the former drug czar told him to “make sure to continue the message that addiction is a disease.”

During a question and answer session, not one question was asked about the block grant — the crown jewel of NASADAD state directors — which did not get any increased funding in the president’s proposed budget. The only reference Kerlikowske made to it in his remarks was “I would be happy to talk about my support for the block grant.” As for the fiscal year 2010 budget, he said “this isn’t either/or — we’re not

going to take money away from law enforcement in order to fund more treatment.” Instead, he said, the best focus will be on partnerships.

Kerlikowske praised the nomination of addiction treatment research leader Thomas McLellan, Ph.D., as deputy director of ONDCP. He noted that McLellan, who is expected to be confirmed, will be the top treatment official in the office.

NASADAD president Flo Stein, the single state authority for North Carolina, introduced Kerlikowske to the conference audience by saying that she welcomes the new “tone” coming out of ONDCP. “Substance abuse leadership understands how treatment and prevention are linked to public safety,” she said. •

## BRIEFLY NOTED

**Study examines retention factors for women in alcohol treatment**

Women attend more treatment sessions if they are assigned to individual treatment, are older, had fewer symptoms or alcohol dependence, had spouses who drank, had more satisfying marital relationships, or had matched preference for a treatment condition, according to a new study the Center for Alcohol Studies at Rutgers University. The study, by Fiona S. Graff and colleagues, appears in the July issue of the *American Journal on Addictions*.

**ACMHA changes name to include substance abuse**

The American College of Mental Health Administration announced June 1 that it has changed its name to ACMHA: The College for Behavioral Health Leadership. The name change, which followed two years of consultation with the group's membership, reflects the organization's aspiration, which is "to be recognized as the premier forum for the exchange of new policy ideas that contribute to the improvement in the lives of people with mental health and substance use disorders and the systems that provide treatment and prevention services."

## STATE NEWS

**Rep. Sullivan of Oklahoma enters alcohol treatment**

U.S. Representative John Sullivan (R-Okla.) has entered the Betty Ford Center in California to receive treatment for his addiction to alcohol. On May 29, Representative Sullivan issued a statement, and said he "wanted to be open and honest about this tough situation," but requested privacy for he and his family as he gets "through this most challenging time in my life." Sullivan served in Oklahoma's state legislature before becoming a member of Congress.

## Coming up...

The **College on Problems of Drug Dependence** will hold its 71st Annual Meeting on **June 20-25** in **Reno/Sparks, Nev.** For more information, visit [www.cpdd.vcu.edu](http://www.cpdd.vcu.edu).

The **NIATx Summit** and the **State Association of Addiction Services (SAAS)** National Conference will take place **July 29-August 1** in **Tucson, Ariz.** Visit [www.saasniatx.net](http://www.saasniatx.net) for more information.

The **Florida Alcohol and Drug Abuse Association (FADAA)** will host its 2009 Annual Conference **August 12 - 14** at the Hilton in Walt Disney World in **Orlando, Fla.** For more information, visit <http://conference.fadaa.org>.

**NAADAC, the Association for Addiction Professionals**, in conjunction with co-hosts including the **Association of Utah Substance Abuse Professionals (AUSAP)** and **NALGAP, the Association for Lesbian, Gay, Bisexual, Transgender Addiction Professionals and their Allies**, will hold its 2009 "Sowing the Seeds for Recovery" Annual Conference on **August 19-22** in **Salt Lake City, Utah.** Visit [www.naadac.org](http://www.naadac.org) for more information.

## BUSINESS

**Vigabatrin fails in Phase II cocaine trials**

In what is being called a significant setback for Florida-based Catalyst Pharmaceutical Partners, Inc., Phase II clinical results for vigabatrin (or CPP-109) found the drug was not significantly more effective than placebo in helping patients remain cocaine-free in the last two weeks of a 12-week trial. The Associated Press reported May 29 that shares of Catalyst fell 53.3 percent to 98 cents. Catalyst has not said whether it will continue testing vigabatrin for cocaine addiction. The drug is also being studied for treating methamphetamine addiction.

## NAMES IN THE NEWS

**Edward Diehl**, President and CEO of Seabrook House, received the Outstanding Achievement Award from the American College of Addiction Treatment Administrators (ACATA), which recognizes administrators who have made "outstanding contributions in the field of addiction treatment administration and management." Diehl received the award May 19 during the National Association of Addiction Treatment Providers (NAATP) Annual Leadership Conference.

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## In case you haven't heard...

"... I am extremely susceptible ... me and millions of others," writes Jeff Vogel on May 26. Vogel is not talking about drugs or alcohol. His editorial for the *RPG Vault* explores the dangerous power of "addiction-based" video game design. The game designer describes the "grind-reward cycle," in which a system of constant positive reinforcement in the form of small rewards "can keep players coming back to one game — and the same content — for years." He warns players that games using a reward system have been specifically designed to take advantage of anyone who finds a sense of accomplishment to be addictive. "If you don't mind, that's cool, but you should understand it," he counsels.