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News for policy and program decision-makers

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There will be no April 25 issue of *ADAW*. Your next issue will be Monday, May 2.



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SAMHSA requires two-year block grant application

Unified MH-SA application among suggested changes

Last week the Substance Abuse and Mental Health Services Administration (SAMHSA) announced a proposal to require states to submit an application merging 2012 and 2013 for the Substance Abuse Prevention and Treatment Block Grant, instead of a one-year application. The notice, published in the April 11 Federal Register, also gives states the option of combining — or “unifying” — the application for the Community Mental Health Services Block Grant and the substance abuse

block grant. The two-year application would also be required for the mental health block grant.

“The unified application would make it easier for states to plan,” said Pamela Hyde, SAMHSA administrator, in an interview with *ADAW* last week. But it is not required — such a requirement would have to be made by Congress.

Throughout the announcement there is a fine line between what is required — the two-year merged application — and what SAMHSA would like — the unified application. But there are no repercussions

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Treatment Program Profile

CeDAR staff sees optimal treatment as a blend of the old and the new



by Gary Enos, Contributing Editor

What struck the founders of the Center for Dependency, Addiction and Rehabilitation (CeDAR) at the University of Colorado Hospital when they established their treatment facility more than five years ago was the single-minded approach most centers had been taking to their treatment philosophy.

“We felt that to do good treatment, you had to combine new data on clinical work and pharmacology with the historical work of the 12-Step philosophy,” CeDAR executive director Frank Lisnow, M.Ed., told *ADAW*. “The programs out there were either lost in the past and not integrating new information, or were using all new and forgetting from where the field came.”

CeDAR officials say their more blended approach truly becomes apparent when the center is addressing the needs of patients with comorbid psychiatric conditions. The organization’s leaders have a strong belief that individuals with even serious mental illness diagnoses can be helped in their residential facility with contemporary treatments that don’t alter the program’s 12-Step underpinnings.

“What is most important is that patients’ dual diagnoses such as schizophrenia, bipolar disorder and depression do exist and the 12-Step model is able to help them with both their chemical dependency and their mental illness,” CeDAR director of operations Anne M. Felton, R.N., told *ADAW*.

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for states that do not have the joint application, said Hyde. “Our whole approach to the states is not a hammer,” she said. “To the extent that they are unable to do some of the things that we are strongly encouraging them to do, we’re going to try to identify states that are having trouble, and help them.”

States could also use funds for co-occurring substance abuse and mental illness, “but the dollars would have to be tracked,” said Hyde, adding that there is no “co-occurring block grant.”

Whether states do a unified block grant application or not, SAMHSA is encouraging the mental health and substance abuse sides to “jointly

- 1) To fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage.
- 2) To fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance offered through the exchanges and that demonstrate success in improving outcomes and/or supporting recovery.
- 3) To fund universal, selective and targeted prevention activities and services.
- 4) To collect performance and outcome data to determine the ongoing effectiveness of behavioral health prevention, treatment and recovery support services and to plan the implementation of new services on a nationwide basis.

‘We’re trying to say that in 2011 things are a lot different than they were 15 years ago, than they were even two years ago.’

Pamela Hyde

The unified application does not allow states to pool the funds from the block grants, said Hyde, although signals from SAMHSA over the past year have indicated that it would like states to have this flexibility. Congress would have to change the law for this to happen. The funds in the substance abuse block grant would have to be used for substance abuse treatment, and those in the mental health block grant for mental health treatment.

“The states must report separately about the dollars for each of the two separate grants,” said Hyde.

plan” on their use of their respective block grants, said Hyde. “When we do population-based surveys around co-occurring, it is 50 percent or higher,” she said. For treatment-based surveys, it is much lower, something Hyde attributes to the fact that some treatment programs don’t capture co-occurring diagnoses.

Health care reform

In the Federal Register notice, SAMHSA proposes that block grants be directed to the following four purposes, beginning with the 2012-2013 two-year application:

SAMHSA is now trying to identify how many dollars are spent on what, and how this will shift under health care reform, said Hyde. “We’re trying to say that in 2011 things are a lot different than they were 15 years ago, than they were even two years ago,” said Hyde.

Asked if there are backup plans for the block grant if health care reform does not take effect in 2014, Hyde said no — health care reform “is the law of the land.” Each state

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should consider what might still need to be covered, how the state would move forward, and how more evidence-based practices could be used “regardless of who will pay for it in the future, and whether or not a lot of new people come on Medicaid in 2014,” said Hyde.

Under the Patient Protection and Affordable Care Act (PPACA), by 2014 much of the treatment paid for by the block grant now will be paid for by Medicaid and private insurance, freeing up some block grant funds to be used for recovery support services. SAMHSA will help states prepare for this, and the unified block grant application is a part of that planning. “We’ve taken an approach that says these are the things that would need to happen for a good and modern system,” said Hyde. “It would be irresponsible to wait.”

In addition, much of the PPACA is already being implemented in the states, said Hyde. “Each state has to go through its own process, and we want our behavioral health folks out there to be thinking about the role they play as the states make those decisions.”

Tribes

One significant new requirement in the block grant application is that tribes in the state be consulted about how the funding should be used. “What we consistently hear from tribes throughout the country is that states use the number of tribal members as part of the justification for getting certain dollars, and yet they feel pretty strongly that they are neither consulted with nor are their needs addressed when the state gets the dollars,” said Hyde. “The tribal members will frequently have higher needs in things like men’s drinking, or higher poverty numbers or access to care issues,” she said.

The federal government has a unique legal relationship with tribes, and is required to provide them with health care, she said, noting that the complaint about their needs not be-

FY 2011 continuing resolution cuts SAMHSA \$35 million

The Substance Abuse and Mental Health Services Administration (SAMHSA) was relatively spared in the fiscal year 2011 continuing resolution (H.R. 1473) considered by Congress last week. This bill would fund the government until September 30, 2011. This is a 1.5 percent cut, and about \$52.6 million less than the fiscal year 2010 level of \$3,431,24,000.

Included in that \$52.6 million are \$14.5 million in special projects or earmarks — eliminated in a previous short-term continuing resolution — and \$2 million in funding for the National All Schedules Prescription Electronic Reporting (NASPER) program. Congress gives SAMHSA the flexibility to decide how to distribute the remaining \$35 million in cuts.

Much more severely hit were Department of Justice programs, with a 17-percent cut to juvenile justice programs, enforcing underage drinking laws, residential substance abuse treatment, and other programs affecting substance abuse treatment.

Also see *ADAW*, February 11, March 14.

ing met runs through the Department of Health and Human Services, not just SAMHSA. There are 565 tribes in 33 states.

Steps

Under the new block grant application, states will have to follow these steps:

Step One: Assess the strengths and needs of the service system to address the specific populations. This will include a description of the organization of the current public system, the roles of the state, county, and localities in the provision of service and the ability of the system to address diverse needs.

Step Two: Identify the unmet service needs and critical gaps within the current system. Included in this step is the identification of data sources used to determine the needs and gaps for the populations identified as a priority.

Step Three: Prioritize State planning activities. Given the information in Step 2, the States will prioritize the target populations as appropriate for each Block Grant as well as other priority populations as determined by the State.

Step Four: Develop goals, strate-

gies and performance indicators. For each of the priorities identified in Step 3, the state will identify at least one goal, strategies to reach that goal, and the performance indicators to be examined over the next two years.

States will also have to create “dashboards” that show key outcome and performance measures, which will be developed by SAMHSA this year. Block grant funds, under the changes, would be used to measure the performance of states with these dashboards.

Finally, under the mental health block grant, states are required to have a state advisory council. There is no such requirement for the substance abuse block grant, but SAMHSA is encouraging states to “expand and use the same council” used by mental health block grant authorities for substance abuse.

Even though SAMHSA said the possibility of reducing four block grants to one means less paperwork, there are more requirements. “Some of our core concerns include paperwork burden, increasing flexibility, and reducing the number of directives that would predetermine how

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states allocate SAPT block grant funds,” said Rob Morrison, executive director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). “We’ve always proposed that the application be streamlined,” he said.

“We believe it’s best to set out the goals that we all want to achieve in terms of improving outcomes and services,” he said. “We are encour-

aging states to learn from each other on needs assessment,” he said. NASADAD is consulting with the states and will comment on the proposal, he said. “NASADAD wholeheartedly supports SAMHSA’s emphasis on the fact that the SAPT block grant represents a critical

source of dollars for recovery services. However, as federal and state dollars become more scarce, our members note that the current block grant allocations they receive are not enough to meet the diverse demands they see in their own jurisdictions.” •

Go to www.gpo.gov/fdsys/pkg/FR-2011-04-11/html/2011-8520.htm for the Federal Register notice. There is a 60-day comment period ending June 9.

House subcommittee looks at prescription drug abuse diversion

Last week Rep. Mary Bono Mack (R-Calif.) held a hearing on prescription drug abuse, focused on diversion of prescription opioids. Chairwoman of the Commerce, Manufacturing and Trade Subcommittee of the House Energy and Commerce Committee, Representative Bono Mack grilled witnesses about the dangers of Oxycontin in particular — she is the sponsor of proposed legislation to regulate the medication. The hearing covered prescription drug monitoring programs (PDMPs), law enforcement, drug disposal, and education of patients regarding diversion of controlled substances.

The April 14 hearing, which was webcast live, presaged a bigger announcement expected on Tuesday outlining the Obama Administration’s response to prescription drug abuse. Gil Kerlikowske, director of the Office of National Drug Control Policy (ONDCP), told the subcommittee that a separate plan is needed because the problem of prescription drugs doesn’t receive enough attention. The administration’s prescription drug abuse response plan will include education, prescription drug monitoring programs (PDMPs), and medication disposal programs, he said.

Michele M. Leonhart, administrator of the Drug Enforcement Administration (DEA), pointed to pain clinics — especially in Florida — as the “major source of controlled sub-

stances for non-legitimate purposes.” She cited the agency’s recent “Operation Pill Nation” for successfully shutting down pain clinics, arresting physicians, and obtaining surrenders of DEA licenses in Florida this winter. The DEA also has 37 “tactical diversion squads” throughout the country which are “dedicated solely to investigating, disrupting, and dismantling diversion schemes,” she told the subcommittee.

The DEA is also working to promulgate disposal regulations — current law requires that the end user (patient) only give unused controlled substances to law enforcement officers. New regulations would make “takeback” operations easier. In addition, the DEA is holding its second nationwide takeback initiative throughout the country April 30.

Florida

Some states have PDMPs, which enable physicians and pharmacies to see if patients are doctor-shopping or going from pharmacy to pharmacy, and the DEA and ONDCP both favor these, which can be funded by grants from the federal Department of Justice. Florida, however, has no PDMP, and Gov. Rick Scott, who admitted that his state is “ground zero” for prescription drug abuse, told the subcommittee that he plans to approach the problem differently.

Because he is concerned about patient privacy, Governor Scott is

said he wants “to find a law enforcement solution that starts at the top of a distribution chain, not the bottom.” So instead of looking at what patients are being prescribed, Florida will “target the sources of these drugs before they hit the streets.” Local law enforcement will investigate medical and pharmaceutical distribution chains, going after “unscrupulous doctors and pain clinics,” he told the subcommittee.

Representative Bono Mack asked Governor Scott if he was going to accept the \$1 million from Purdue Pharma (maker of OxyContin) for a PDMP; he said he would not, and she praised him for his decision. There will also be new rules in Florida that do not allow physicians to dispense medication or to own pharmacies, he said.

Gov. Steve Beshear of Kentucky said the state’s PDMP, called KASPER, was created more than a decade ago and is a national model (in fact, NASPER, the prescription drug monitoring program run by the Substance Abuse and Mental Health Services Administration but not adequately funded, was modeled after it). However, people from Kentucky are able to go to Florida to obtain prescription medicines from pill mills there, where there is no PDMP. “Our efforts have not been enough, because illicit drug users have found supplies in other states with looser regulations, and we’re

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Recovery and electronic health records: Two cautionary tales

by John de Miranda

The passage of the Patient Protection and Affordable Care Act and the increasing importance of electronic health records (EHR) has generated a robust discussion within the addiction and recovery community about the tension between integrating addiction treatment and recovery information into personal electronic health care records, and the importance of protecting the privacy of those who have received treatment and/or who are in recovery.

A 2010 position paper from Faces and Voices of Recovery states:

Current privacy protections should not be viewed as a barrier to integrating care for addiction with the rest of the health care system. As the Legal Action Center has pointed out, the tools exist to facilitate communication between these systems. The federal law and regulations allow for the disclosure of health information by an alcohol and drug program with an individual's voluntary, prior informed consent, and also allow for disclosure without their patients' prior consent in a number of circumstances, such as in a medical emergency or when there is a signed Qualified Service Organization/Business Associate Agreement in place between an addiction treatment program and another organization involved in providing or coordinating health care or other services to the program's patients.

With the implementation of health information technology, there is an opportunity to increase communication and collaboration between health care professionals including those providing care for people with substance use disorders, while maintaining critical privacy protections. Faces & Voices goal is to get effective care to more people and coordinate their care while protecting them from discrimination.

A panel discussion at the Eleventh Annual Behavioral Health Information Management Conference and Exposition presented information about how access to EHRs can both harm and help people in recovery who require urgent or emergency health care. A member of the audience volunteered that when she was involved in a serious automobile accident, the paramedics onsite learned that she had a history of depression including a suicide attempt. Despite protestations from the victim, the emergency service protocol required that she be transported to a hospital in four point restraints. "I felt so humiliated to be treated in a manner determined by my history. It was a terrible experience," she reported.

Tracey Lee, an addiction recovery advocate and member of the panel reported a very different type of experience resulting from a similar accident. She credits access to her full health record as "being instrumental in keeping me on my recovery journey". In 2006 she was involved in an automobile accident that resulted in rib and spinal fractures. After three weeks in an intensive care unit and multiple surgeries, she left the hospital providing care and was transferred back to her health home Kaiser Permanente Northern California. Many years earlier she had received treatment for addiction to methamphetamine at Kaiser and at that time of the accident was more than 7 years clean and sober.

At my first follow-up visit with the Kaiser surgeon he greeted me with the statement, "So I see that you are a drug addict?" I was initially upset at his manner, but also relieved that his understanding of my past would help guide my rehabilitation, especially since I needed significant doses of pain medication during those early weeks and months. Ultimately, he learned from me about addiction recovery and I learned about managing my care from him. If he did not have that information at the start, I'm not sure he would have heard it from me. My electronic health record contained my recovery voice.

The Faces and Voices statement recommends:

...the establishment of a deliberative process that would examine opportunities to improve the quality of care for people seeking recovery and encourage others to seek help. The stakeholders should include federal agencies led by the Substance Abuse and Mental Health Services Administration (SAMHSA), people in long-term recovery and their family members, state agencies, service providers, legal and health information technology experts and others. Their charge should be to develop recommendations for the promotion of efficient and clear communication between all health care systems without jeopardizing the underlying statute (42CFR Part 2) that is the backbone of privacy rights for individuals seeking and sustaining their recovery from addiction.

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not equipped to stop that,” Governor Beshear told the subcommittee. “What is needed is an aggressive national response.”

In fact, Kerlikowske, in response to a question from the subcommittee about what could be done to stem the problem of prescription drug abuse diversion, specifically recommended reauthorizing NASPER.

“No state is an island,” said Gov-

ernor Beshear. Tennessee and Kentucky have PDMPs, but Florida and Georgia don't. And the DEA's Leon-

‘No state is an island.’

Gov. Steve Beshear

hart said that after the pill mills were shut down in Florida, they started showing up in Georgia.

Other witnesses at the hearing included parents who had lost children to drug overdoses, a person in recovery from prescription drug addiction, representatives of the pharmaceutical industry, prevention experts, and researchers specializing in adolescent and young adult drug abuse. •

Go to <http://1.usa.gov/e2Hjsa> for prepared testimony submitted by the witnesses.

ASAM-NIDA service offers free mentor advice to PCPs

Last week the National Institute on Drug Abuse (NIDA) and the American Society of Addiction Medicine (ASAM) launched a free nationwide service to help primary care providers identify and advise patients who abuse alcohol or drugs. ASAM received \$100 million from NIDA for its Physician Clinical Support System for Primary Care (PCSS-P), which offers health care providers mentorship and resources on how to incorporate screening and follow-up into patient care.

ASAM's other peer support systems for health care providers — PCSS-M (methadone) and PCSS-B (buprenorphine) — are funded by the Substance Abuse and Mental Health Services Administration.

For the PCSS-P service, health care providers register and get the

contact information for a specialist in screening, brief intervention, treatment, and referral. Providers can then contact their mentor via telephone or e-mail, with questions about individual clinical situations involving alcohol, drugs, and tobacco. Called a “warm line,” because the response is in 24 hours rather than the immediate response of a “hot line,” PCSS-P is designed to help primary care providers on specific cases.

The service grew out of NIDAMED, an initiative to help health care professionals screen patients for tobacco, alcohol and drugs (see *ADAW*, May 25, 2009).

Also last week NIDA announced its “Quick Screen,” an online interactive single-question screen that asks: “In the past year, how many times have you used the following:

alcohol (more than 4 or 5 drinks in a day for women or men, respectively); tobacco products; prescription drugs for nonmedical reasons; and illegal drugs?” A positive response gives the physician the option of conducting further screening.

“Our NIDAMED screening tool is a user-friendly, interactive means to help providers quickly screen their patients for drug abuse,” said NIDA director Nora Volkow, M.D. “PCSS-P goes a step further, providing peer-to-peer mentorship in the use of these resources.” •

NIDAMED resources, including the Quick Screen, can be found at www.nida.nih.gov/nidamed.

To register for PCSS-P, health care providers can call 877-630-8812, or go to www.PCSSmentor.org.

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She added, “Where we need to go now is to this realization — the treatment of medical-based illnesses needs to learn from us. The two can co-exist and when they do, patients with comorbid psychiatric and/or medical problems also benefit.”

Diverse backgrounds

The professional backgrounds of CeDAR's founders tell a great deal about the multi-tool approach that has been adopted at the center. Lisnow had worked in both residential

treatment and mental health center settings in his career. Felton had served as a psychiatric adviser in an

Center for Dependency, Addiction and Rehabilitation (CeDAR)

Bed Capacity: 50

Average Length of Stay: 27.5 days

Patients Served per Year: 240

Treatment Fee: \$22,500 for 30 days, including medical care and medications

Payer Mix: Private pay, with 10 percent scholarships

emergency medical services setting. The late Robert Harmon, M.D., who was instrumental in building CeDAR's clinical vision, was an addiction psychiatrist with a heavy 12-Step orientation (“He sponsored a lot of people,” Lisnow said).

CeDAR considers a team approach to treatment and the use of multiple assessments as critical factors to making a blended approach to treatment work. “The doctors and the rest of the clinical team, not just the physicians themselves, need to be on the same page,” Fel-

ton said. As for assessment, CeDAR administrators say the most complete and accurate diagnostic picture often is not possible to achieve until the patient has progressed through detox and treatment for some time. So assessment becomes a frequent and ongoing process in the organization.

Lisnow said that CeDAR eagerly uses pharmacological tools that it considers to be not inconsistent with the 12-Step model. While it adopts the 12-Step approach of many other centers in using the opiate dependence medication Suboxone (buprenorphine/naloxone) for opiate detox only and not for long-term treatment, CeDAR does consider somewhat longer-term use of Suboxone beyond detox for patients who have a history of frequent relapses.

Felton said CeDAR also incorporates the anti-alcohol medications naltrexone and acamprosate into its treatment regimen when appropriate; she added that no more than about 35 percent of CeDAR's patients are taking these medications at any one time.

"There are very few [medications] that we're afraid of," Felton remarked.

One challenge CeDAR officials say they consistently face in implementing a blended approach to treatment lies in the fragmented training they see taking place in the field overall. Holistic treatment in

behavioral health remains a fairly new concept, Felton said, and even those individuals who might have received both addiction- and mental health-focused training prior to working at CeDAR tended to do so in a fashion that remained disconnected between the two disciplines.

Lisnow said CeDAR has taken to keeping on many of its interns into permanent positions in the organization. "They become integrated in our system," he explained. "They see how well it works."

'We do what we do without fear of interfering with integral 12-Step work.'

Anne M. Felton

He added in reference to identifying ideal staff members, "We look for how they're spiritually connected with their work." The rest of the essentials can be achieved through training and how CeDAR sets up its program, he said.

A blended modality

An example of a blended approach that CeDAR cites frequently is its integration of Dialectical Behavior

Therapy (DBT) with the 12 Steps. Two CeDAR staff members, clinical nurse specialist Bari K. Platter, R.N., and clinical coordinator for residential extended care Osvaldo Cabral, have become popular presenters on their concept of "DBT Meets the 12 Steps" at field training sessions.

Platter and Cabral see DBT, originally developed for women with borderline personality disorder, and the 12 Steps as complementary in that both can be used to help the individual achieve balance in their life. Platter and Cabral demonstrate that core principles of DBT as established by founder Marsha Linehan, including mindfulness and essential skills for distress tolerance, mirror descriptions that are found in the language of Alcoholics Anonymous's (AA's) Big Book, in areas such as serving others in order to help oneself.

For the past four years, CeDAR has integrated DBT techniques into its program through weekly skills groups for its primary treatment patients. The lessons of DBT and 12-Step treatment essentially reinforce each other, CeDAR staff believes.

"We see the dilemma of separating the two worlds," Felton said of the medical and 12-Step models. "It is a collaborative effort that benefits the patient. We do what we do without fear of interfering with integral 12-Step work. The two can co-exist seamlessly." •

BRIEFLY NOTED

Genetic link suggested between alcoholism and the insula

There is a genetic link between alcoholism, impulsive behavior, and the insula, a part of the cerebral cortex involved with craving and anxiety, researchers at the University of Michigan Health System reported last week. In an article published online April 12 in *Molecular Psychiatry*, Margit Burmeister, Ph.D. and colleagues report that variations in

the GABRA2 gene contribute to the risk for alcoholism. "Scientists often find a statistical association between behaviors and various genes, but the mechanism that's at work frequently remains unclear," said Burmeister, who is research professor at U-M's Molecular and Behavioral Neuroscience Institute. "Here we took some steps toward explaining how specific genetic risk factors are influencing behavior and the brain." The study included 449 people from 173 families, 129 of whom had at least one member diagnosed with

alcohol dependence or abuse. Subjects with certain variations in the GABRA2 gene were more likely to have alcohol dependence symptoms and to have higher measures of impulsiveness in response to distress. The link was stronger in women. "This wouldn't be a surprise to an alcohol researcher," Burmeister said. "Men and women tend to have different pathways to alcoholism. Drinking to relieve anxiety and distress is seen more in women." Insula's connection to addiction has al-

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ready been demonstrated: a study published in *Science* in 2007 found that smokers with insula damage due to stroke could more easily give up cigarettes. “We believe these results suggest GABRA2 exerts an influence on an underlying neural system that impacts early risk factors and, later, alcohol dependency,” said Burmeister, also a professor of psychiatry and human genetics at the U-M Medical School. “In the future, we hope to further examine the effects of family environment and other behavioral and environmental factors.” The research was supported by grants from the National Institutes of Health.

Nicotine linked to diabetes

Nicotine may be the leading cause of elevated levels of hemoglobin A1c, a measure of blood sugar control, in smokers who have diabetes, according to new research presented at the annual meeting of the American Chemical Society. “If you have diabetes and if you are a smoker, you should be concerned about this,” said Xiao-Chuan Liu, Ph.D., a researcher at California State Polytechnic University in Pomona, who spoke about his findings at a news conference at the meeting. Lui also found that the A1c levels were higher if the nicotine dose was higher. High blood sugar levels increase the risk of serious complications from diabetes.

IN THE STATES

CASACs permanently exempt from new N.Y. licensure requirements

If you are a CASAC (Credentialed Alcoholism and Substance Abuse Counselor) or a CASAC Trainee, you are unique in that you are the only behavioral health worker category in New York exempt from new Office of Alcoholism and Substance Abuse Services (OASAS) rules due to take effect on July 1, 2013. Since 2002, the OASAS

Coming up...

The **National Council for Community Behavioral Healthcare** national conference and expo will be held **May 2-4** in **San Diego**. Go to www.thenationalcouncil.org for more information.

The **17th National Treatment Accountability for Safer Communities (TASC)** Conference on Drugs & Crime will be held **May 4-6** in **Denver**. For more information, go to www.nationaltasc.org/conference.php.

The **National Association of Addiction Treatment Providers (NAATP)** will hold its annual meeting **May 14-17** in **Chandler, Arizona**. Go to www.naatp.org for more information.

The annual meeting of the **American Psychiatric Association** will be held **May 14-18** in **Honolulu**. For more information, go to www.psych.org.

The annual meeting of the **National Association of State Alcohol and Drug Abuse Directors** will be held **June 7-10** in **Indianapolis**. For more information, go to <http://nasadad.org/annual-meeting>.

The annual meeting of the **College on Problems of Drug Dependence** will be held **June 18-23** in **Hollywood, Florida**. For more information, go to www.cpdd.vcu.edu.

The **NIATx Summit and SAAS National Conference** will be held **July 10-13** in **Boston**. Go to www.saasniatx.net/Content/Home.aspx for more information.

system has been exempt from legislation that requires that only licensed professionals (social workers, marriage and family therapists, mental health counselors, psychoanalysts, creative arts therapists or psychologists) be permitted to perform certain restricted functions, including assessment, diagnose, treatment planning, or treatment. On July 1, 2013, this exemption will “sunset,” resulting in restrictions on the activities that unlicensed, non-credentialed staff can perform. However, Credentialed Alcoholism and Substance Abuse Counselors (CASACs) and CASAC Trainees are permanently exempt from this legislation and may continue to prac-

tice as counselors beyond July 2013.

Texas treatment programs face losing \$19 million

State legislators working on a budget in Texas are considering an 8.4 percent cut to funding for substance abuse treatment in the criminal justice system, resulting in fewer beds. According to Linda Oyer with the East Texas Council on Alcoholism and Drug Abuse, most taxpayer funded social services programs have substance abuse as “the root cause.” Losing licensed detoxification beds in East Texas means that emergency rooms will have to take care of these patients.

In case you haven't heard...

Remember Prometa, the proprietary treatment from Hythiam? Hythiam is no more — last month it changed its name to Catasys — which offers behavioral health managed services to health plans, employers, and unions — and changed its stock ticker too. Catasys will also promote Prometa. A call to the investor relations person was not returned, but according to a Catasys announcement, the company will use the Prometa treatment program, and Prometa is still available at treatment centers that are licensed (by Catasys) to provide it.