Special Issue: Innovations

ALCOHOLISM & DRUG ABUSE WEEKLY

News for policy and program decision-makers

Volume 22 Number 41
October 25, 2010
Print ISSN 1042-1394
Online ISSN 1556-7591

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2010 APEX Awards for Publication Excellence — Health and Medical Writing

ASBPE American Society of Business Publication Editors — 2010 Newsletter General Excellence Bronze

ASBPE American Society of Business Publication Editors — 2010 Newsletter Editorial Award Winner

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DOI: 10.1002/adaw.20255

NIATx pushes treatment programs to operate more like medical businesses

Last week NIATx launched the second phase of it's "Accelerating Reform" initiative, in which it will help about 250 providers learn how to develop business practices that make them ready for health reform. Each provider in the collaborative will pay $1,500 and will receive coaching from NIATx staff. *ADAW* spoke to NIATx co-deputy directors, Kim Johnson and Todd Molfenter, about how the project will help bring the substance abuse treatment field into the coding and billing arena.

Billing and getting paid by insurance companies is hardly an innovation in general medical care, but it's a whole new world for substance abuse treatment providers, especially those in the public sector, according to Molfenter. Whatever health reform ends up looking like, there will be more private insurance, which means more managed care, he said. "Reliance on the block grant as a sole source of income is not wise."

When the project ends in July of 2011, there will be a report that can be shared with other providers, and in typical NIATx fashion the lessons learned will be spread. Health reform may be three years away, but many substance abuse treatment providers have far to go before they can bill insurance companies for their services.

Treatment providers complain about not being able to get paid,

See **NIATx** on page 2

Sierra Tucson enhancing assessment by using SPECT imaging technology

The medical director of the Sierra Tucson treatment facility in Arizona sees the addiction field moving toward an era of more precise diagnosis aided by technology. Of the technological options available, Robert R. Johnson, D.O., is clearly behind SPECT (single photon emission computed tomography) scans, which have received a somewhat lukewarm response from federal leaders but which Johnson says are part of a category of neuroimaging tools with substantial research support.

Johnson told *ADAW* in a wide-ranging interview that close to 1 in 4 people seen at Sierra Tucson are receiving a SPECT scan as part of the assessment process; the scans are offered as an option to individuals. While emphasizing that the scans contribute to accurate assessment but do not themselves produce a diagnosis, Johnson said he believes neuroimaging will be critical to moving away from diagnoses based on symptom clusters and toward a reliance on biological markers that will allow for more individualized treatment.

"I see us moving more to having diagnostic laboratories, providing SPECT, PET or fMRI scanning," said Johnson. He added, however, "It is important not to overreach. We don't use this to diagnose. It is one piece of the puzzle."

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but many of them don't have the ability to bill private insurance, said Johnson. The behavioral health benefit is there, parity is the law of the land, and in 44 states there is some sort of additional behavioral health mandate. "The missing link is that providers don't access the benefits," she told *ADAW*. "Or if they are billing, they're not doing it well — for many organizations, the collections rates are very low."

Many providers have gotten used to public funds coming in, without having to deal with private insurance system. There are standard codes, but every payer has its own rules, and programs need to know what those are, said Johnson.

NIATx is helping programs design billing systems, and focusing in particular on making those systems effective. Some programs have systems, but have collections rates of 20 to 40 percent, Johnson said. "They're doing all the billing work, but they're not earning the money for doing that work," she said. Most of the time, the reason for this is that nobody is following up on the claims, and pursuing the payer for the money.

Another step involves the contract with the insurance company, which should be beneficial for the treatment program. In general, larger behavioral health practices are better at contracting and collections, because they have the staff to do the work, get the prior authorization, the continuing stay authorization, and negotiating aggressively all along.

Programs don't need to have their own coding and billing staff. This is a service that can be purchased. When Johnson ran a small treatment program in Maine 10 years ago, she paid an outside company to do all of the billing and coding. "We didn't deal with that at all," she said. So a treatment agency needs to determine whether it has the capacity to do the billing and coding in-house, or whether it wants to contract out for it. Payment can be based on unit of revenue collected, she said. There are only a handful of codes that are used in substance abuse treatment, so it's not complicated, she said. A general coding and billing company can easily do the work.

'They're doing all the billing work, but they're not earning the money for doing that work.'

Kim Johnson

Johnson is concerned about states that are setting up their own coding systems. "They are setting their providers up for failure under health reform," she said. "It would be better to have universal codes, so that every state is using the same codes for the same services," she said, noting that this should apply to Medicaid as well as private insurance. Medicare already uses standardized codes.

Electronic health records

Programs working with NIATx recognize that even though health reform is three years away, they need to start planning for it now, explained Molfenter. "The changes that they're going to have to embark on are going to take a fair amount of infrastructure development, like electronic health records," he said.

Programs that don't have electronic health records (EHR) will have to spend a large amount of money to buy a system — Molfenter has heard fees that range from $50,000 to $2 or $3 million. And unless Congress provides additional HITECH money for behavioral health care, they will have to make this purchase with their existing resources. "We're finding that a number of organizations are going ahead

ALCOHOLISM & DRUG ABUSE WEEKLY
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ISBN 978-1-118-02054-8

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 first Monday in April, the first Monday in July, 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), $4835 (institutional, U.S.), $4979 (institutional, Can./Mex.), $5027 (institutional, rest of world); Print & electronic: $769 (individual, U.S./Can./Mex.), $913 (individual, rest of the world), $5563 (institutional, U.S.), $5707 (institutional, Can./Mex.), $5755 (institutional, rest of the world); Electronic only: $699 (individual, worldwide), $4835 (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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with EHR, because they see it as essential to their survival," he said.

NIATx is also tackling the confidentiality issues raised by 42 CFR Part 2, which are still not settled, said Molfenter. "We run across problems when we do the primary care integration," he said. The kickoff for the business practices collaborative this week was to feature tips for reducing the documentation required, said Molfenter.

It's also possible to partner with others by setting up an administrative service organization, so the treatment program can share an EHR system with another program or health care system, he said. And he cautions that the investment isn't only in the software and hardware. "The implementation process is very labor-intensive," he said.

Accelerating Reform is funded by the Substance Abuse and Mental Health Services Administration, and the Robert Wood Johnson Administration. •

Benefits of keeping mom on methadone outweigh risks to baby

Babies born to mothers in treatment with methadone or buprenorphine go through withdrawal at birth, but they are not "addicted," two experts in medication-assisted treatment and pregnancy explained in a joint interview with *ADAW* last week. The treatment for neonatal abstinence syndrome (NAS) does not alter normal development, said Karol Kaltenbach, Ph.D., director of Maternal Addiction Treatment, Education and Research at Jefferson Medical College in Philadelphia, and Hendree Jones, Ph.D., research director of the Center for Addiction and Pregnancy at Johns Hopkins Bayview Medical Center in Baltimore.

It's an important point, because mothers who are on methadone or buprenorphine are victims of the same stigma that affects other patients in medication-assisted treatment, only it's even worse because they are perceived as somehow being "bad" and harming their babies, the researchers said. The correct term for babies born with NAS is "prenatally exposed," not "addicted," said Kaltenbach. "They don't meet the diagnostic criteria for addiction."

When the mother is in treatment with methadone, the expectation is that she is also receiving good prenatal care, said Kaltenbach, noting that most babies born to mothers in treatment and given adequate doses of methadone or buprenorphine are full-term. "Mothers who are using heroin are subjecting the baby to repeated episodes of withdrawal in the womb, which nobody can see, and can often cause morbidity," she said. But babies whose mothers are on medication-assisted treatment are typically "normal and healthy in all ways except that they will have to be treated for NAS — a treatable condition that has no long-term sequelae."

Most hospitals use morphine for the treatment of NAS, said Jones. Morphine is a short-acting opioid that enables withdrawal to be controlled easily and quickly, she said. "We have good tools to assess NAS, and good protocols to treat it," she said. "There are no long-term negative impacts for these children — the most important thing is the environment they grow up in."

> **'There are no long-term negative impacts for these children — the most important thing is the environment they grow up in.'**
>
> Hendree Jones

The MOTHER study

Early evidence indicates that buprenorphine is better prenatally than methadone — at least, hospital stays for the baby are shorter. But the definitive study comparing the two medications — the MOTHER study funded by the National Institute on Drug Abuse — is not expected to be published until later this year. Kaltenbach and Jones are co-authors of that study, and can't discuss findings until it is published.

However, the reality is that many pregnant patients in methadone treatment can't afford buprenorphine, said Kaltenbach. "They are Medicaid-eligible, and many Medicaid formularies don't include buprenorphine."

More importantly, methadone is typically provided in the context of a comprehensive treatment program, while buprenorphine could be given in an office-based setting, noted Kaltenbach. "We have decades of experience indicating that women who are in treatment in methadone maintenance have better outcomes than women who don't receive treatment," she said. "But that doesn't mean it's the methadone that produces the results. It's the methadone combined with comprehensive services." If women get only the medication, then they won't be getting the services they need, she said.

If a pregnant woman were maintained on methadone and doing well, no one would recommend that she switch to buprenorphine, said Jones. "The point of any study is not to eliminate an effective medication, but to look at the complete risk benefit," she said. "The more medications we have, the better we can appropriately treat the patient."

Once the study is published,

Continues on next page

Continued from previous page

there will have to be a "long period of education," said Kaltenbach. "That's what happens any time a new study is published — it's only the beginning," she said. "The public has to be informed about what it means, what the implications are, and what options need to be presented to women."

Stigma in hospitals

Despite the success of treatment, Jones and Kaltenbach are both frustrated with the stigma faced by these women in the public eye and even in the hospitals where they give birth. The providers in the unit where the babies are treated tend to "punish" the mothers, said Jones. "sometimes the medical staff doesn't want the mother to be with the baby and will work to make sure they are separated," she said. "The mothers are making the best decisions they can, and they have a tremendous amount of guilt and sadness," said Jones. "I wish there were more of an emphasis on helping them parent, rather than on punishing them."

Most of these babies are cared for in neonatal intensive care units (NICUs), which Jones and Kaltenbach say is not an optimal for them. "They need quiet, they need skin-to-skin contact," said Jones. In a NICU, there are constantly buzzers and alarms, and babies are kept in isolettes. But nurses in the normal nursery may be resistant to care for them because of the added burden (the babies can be difficult to care for and they require assessment for NAS every four hours).

Breastfeeding

Mothers on methadone or buprenorphine should breastfeed, as long as there is no other contraindication, said Jones. The amount of either methadone or buprenorphine that is passed through in breast milk is very low, she said. What is really important is the act of breastfeeding, in which the baby is swaddled and bonds with the mother, she added.

But breastfeeding is another area in which some hospitals are not helpful, said Kaltenbach. "Some staff may not be well informed and they tell the mothers they can't breastfeed," she said. There are even situations in which child protective services have been called in and threatened to take the baby from the mother if she breastfeeds, she said.

"To put this in context, what other medications do we ask about and question the short and long term outcomes of prenatal exposure when babies are born?," asked Jones. "The scrutiny given to prenatal methadone and buprenorphine exposure is indicative of the need for on-going education about the illness of addiction and it underscores society's prejudicial bias as to whether drug-dependent women can be good mothers." •

How the Probuphine trial was done

The blinded study a buprenorphine implant (Probuphine), published earlier this month in the Journal of the American Medical Association (see *ADAW*, Oct. 18), showed promising results for the product, which is still years away from approval. Last week *ADAW* interviewed Katherine L. Beebe, Ph.D., vice president for clinical development of Titan Pharmaceuticals, which is developing Probuphine.

The study was designed so that subjects started with a dose of four implants, and if they had opioid cravings, they could have a sublingual buprenorphine, Beebe said. If they required above a certain level of rescue oral doses, they qualified for a fifth implant. If they needed more buprenorphine than five implants provided, they were deemed a treatment failure.

Interestingly, not all patients in the placebo group needed rescue buprenorphine. "That's probably because they were still using drugs," said Beebe, adding "I haven't looked up those five to see if they were still using." Urine samples were collected throughout the study, but all of the testing was done afterward, in order to maintain blinding.

For the study, all subjects received counseling, making it unclear whether the Probuphine would work without counseling — a major limitation cited by the researchers. "We included counseling because that's the standard of treatment for opioid addiction," Beebe told *ADAW*. "Any of the medical instructions, guidebooks, journals, that instruct how to provide services, indicate that counseling is important," she said. In addition, for ethical reasons, it was important to provide some kind of care because there was a placebo group, she said.

To have a single implant for one dose would have meant too large a size, so four implants were used, Beebe explained. The placebo implants looked a little different than the study implants. The research design provided for blinding by having the physicians who placed the implants be completely separate from the rest of the study staff, Beebe explained. •

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 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

CSAT to review ways to switch patients from opioids to Vivitrol

The Center for Substance Abuse Treatment (CSAT), which regulates both methadone and buprenorphine treatment for opioid addiction, is planning to convene an expert group to look at how to transfer these patients to Vivitrol (injectable naltrexone), *ADAW* has learned. Patients would need to be opioid-free, or the Vivitrol injection would produce withdrawal. Alkermes, which makes Vivitrol, referred us to CSAT for protocols on switching from the two agonist medications to the antagonist (naltrexone).

"It's a little premature for us to say at this point what is the correct protocol," said Bob Lubran, acting director for the division of services improvement at CSAT. "I think that in this case, we will work with the field and develop some protocols," he told *ADAW* last week. The Food and Drug Administration (FDA) just approved Vivitrol for the treatment of opioid dependence this month (see *ADAW*, Oct. 18). It has been approved for the treatment of alcoholism since 1996.

"We're already in touch with both NIAAA and NIDA about some plans that might be carried out over the next year or so," said Lubran. Ultimately, there will be a CSAT advisory to help inform and educate the field, but first, CSAT will meet with treatment experts.

The labeling says that patients must be opioid-free seven days before getting Vivitrol, but individual practitioners can make their own decisions, noted Lubran. "Our guidance is not necessarily rigidly adhering to the FDA label," he said. "We're not the FDA, and we have more flexibility to work with the field, to put out information regarding clinical practice." CSAT can't do that until there has been more experience with using Vivitrol for opioid addiction.

Vivitrol is expensive ($1,100 per injection), but it may be covered by insurance, said Lubran. And a Federally Qualified Health Center can obtain it for a lower cost due to "deep discount pricing," he said.

For many patients who are successfully maintained on methadone or buprenorphine, a switch to Vivitrol may not be a good idea. It costs more, and the transition could be a very dangerous time. But Lubran said that some patients might prefer to get one shot a month, instead of going to an opioid treatment program (OTP) to pick up methadone, on a daily basis during the first period of treatment. "Another question is whether OTPs would be interested in having Vivitrol as part of their approach," he said. But this raises the question of whether they would be interested in having oral naltrexone — which is only $3 a pill — as part of their approach as well, an idea that Lubran discounted.

Rather, CSAT is trying to move toward newer medications by educating providers. "As we learned from buprenorphine, the more consumers and practitioners and counselors learn about a pharmacotherapy, the better the adoption and implementation," said Lubran. "One of the major barriers to use is education."

Meanwhile, oral naltrexone for opioid dependence is "not dead from our standpoint," said Lubran. "Maybe the injectable will be seen as more effective than the oral. We have TIPs for oral naltrexone for both alcohol and opioids dependence." •

Massachusetts treatment chain to offer Vivitrol for opioid dependence

A week after the Food and Drug Administration approved Vivitrol for the treatment of opioid dependence, Punyamurtula S. Kishore, M.D., FASAM, founder and president of Preventive Medicine Associates, Inc. (PMAI), the largest outpatient substance abuse treatment provider in Massachusetts, announced that his 37 clinics would offer Vivitrol for the prevention of relapse to opioid dependence. He has been offering it for alcoholism since 2006.

Kishore recommends that all patients have Vivitrol for a year, so that they can get through all of the relapse triggers, many of which are related to seasons, holidays, or even the first anniversary of sobriety. And he orders his patients on Vivitrol to have at least three shots. However, 49 percent of the patients got only 1 shot — the first month. Only 30 percent got more than four shots. Asked why so many patients did not follow through on the treatments, Kishore said he wasn't sure. "Some people respond better than others." (Editor's note: Alkermes also offered a program giving the first shot free to eligible patients, which could explain this.)

It's even difficult to say whether the Vivitrol is being used for opioid dependence or for alcohol dependence in some cases, he said. For example, patients on long-term opioids for pain don't usually drink alcohol while they're on the medication. But when they are no longer on opioids, they find that they are drinking too much alcohol, perhaps as a way of dealing with the lack of opioids. Kishore has used Vivitrol for these patients, as well.

SPECT from page 1

While federal agencies such as the National Institute on Drug Abuse (NIDA) have been intrigued but cautious about the potential of neuroimaging in clinical services (saying that its clinical effectiveness remains unproven), a growing number of treatment centers are exploring scans' ability to uncover what might be important information for treatment and recovery efforts. As of August, all newly admitted patients at Hanley Center in Florida began receiving baseline SPECT scans to demonstrate how substances have affected their brains (see *ADAW*, June 21).

Hanley officials hope eventually to arrive at a point where scan images will contribute to a better understanding of which clients might fare best under certain treatments.

Sierra Tucson procedures

Johnson considers the greatest benefit from SPECT scan use to be the motivational factor for the client, who is able to see vividly how substance use has affected brain physiology and blood flow to the brain.

"There is nothing more powerful than showing a normal surface brain scan and showing theirs, and then posing the question, 'Which do you want?'" Johnson said.

The decision of whether to perform a scan on an individual is made in conjunction with the attending physician, who can determine whether information from a scan might have value for a particular patient. One group that Johnson considers good candidates for the SPECT scans are individuals who appear to have comorbid disorders ("tweeners," as he referred to them, who don't fit neatly into diagnostic categories). In these cases a scan might help reveal some information to give a clearer picture of the presenting problems.

"We want to get away from having 6 or 8 descriptive diagnoses for someone," Johnson said.

While SPECT information is only one data point and cannot be used in isolation to diagnose, Johnson said the information it reveals allows staff to ask better questions of the patient and to have more impactful conversations.

"It's amazing what you see when you look," Johnson said. "There might be things that the assessment hadn't hinted at. There may be a traumatic brain injury that the patient may have forgotten, or that he didn't think counted."

Sierra Tucson, which is a member of the CRC Health Group family of treatment centers across the country, has incorporated SPECT imaging as an option in its Assessment & Diagnostic Program (ADP), a service offered either as a four-and-a-half day inpatient service or a two-day outpatient service (depending on the complexity of the case). The imaging constitutes one element of a whole-person review under ADP that encompasses medical, psychological, family and other dynamics. A psychiatric evaluation always accompanies any use of SPECT technology.

Johnson said that most of the individuals who visit Sierra Tucson for ADP are found not to need inpatient treatment and are referred elsewhere; about 30 to 40 percent of those who require the most intensive services will end up staying at Sierra Tucson. The ADP service is often used by entities such as medical boards and employers to help evaluate an individual.

Johnson added that he is not aware of any other CRC facilities that have begun employing SPECT scans. A CRC spokesman told *ADAW* that the parent company is proud of Johnson's leadership in advancing knowledge on science-based tools.

Cost factors

The scans at Sierra Tucson cost $1,500, up from $1,000 when Sierra Tucson started using them about 18 months ago, Johnson reported. He explained that the cost of the isotope that is injected into the patient's bloodstream to produce the scan has soared, because of a worldwide shortage of the chemical element technetium.

The scans represent a direct-pay cost for patients who receive them. Johnson said Sierra Tucson provides itemized bills with diagnostic billing codes that might enhance the possibility that the patient's insurance plan will cover the cost of the scan. But he added that "we don't bill insurances directly, and certainly can't guarantee they will be reimbursed for the scan costs." He added that the cost Sierra Tucson imposes barely covers the facility's expenses.

Johnson said that Medicare for years has recognized SPECT as a billable service for indications such as stroke and epilepsy. Perhaps there will be a time when its ability to offer additional clues for addiction diagnosis and treatment will make it a widely billable service in the substance use treatment community as well.

Advantages to technology

Johnson believes SPECT carries some advantages over other neuroimaging technologies. Once a patient is injected, he/she can be scanned for up to four to six hours without the image changing. This means that a patient who experiences some anxiety before taking the test could receive medication or otherwise be eased through the process over a period of time, with no effect on the image produced.

Johnson added that the scanning machine is not as large or expensive as a functional magnetic resonance imaging (fMRI) scanner would be for a treatment facility.

It is common for patients with a substance abuse history to see prefrontal cortex abnormalities on their SPECT scan, and this can help start a conversation with the provider about how their ability to manage impulses that conflict with their recovery goals has been compromised, according to Sierra Tucson.

They will have a better understanding of why they struggle to make positive choices, and they may appreciate the need for extra assistance from professionals and the community to improve their recovery prospects, the center believes.

In other cases, a SPECT scan might reveal important auxiliary information. Johnson related the account of a patient who had endured extreme abuse in childhood; he had received a SPECT scan that showed increased blood flow in the temporal lobes, suggesting a propensity for irritability and related problems. He was prescribed the medication Lamictal and later showed improved mood and better quality of life. A subsequent scan showed a more stable temporal lobe region, Johnson said.

This subject might not have been explored without the finding that was achieved through neuroimaging technology, according to Johnson. He sees SPECT as being able to shift the conversation in assessment and treatment.

"We're moving away from the DSM symptom cluster to a neurobiological approach," he said. "We're also going from guilt and shame to a neurobiological explanation for the patient." •

Editor's note: See also "Neurofeedback: Fad or Fact" in *ADAW*, Sept. 6.

TRI issues roadmap for integrating substance abuse treatment with health care

The Treatment Research Institute (TRI) has published its recommendations on integrating substance abuse treatment with primary care and other health care services, based on its April 22 meeting with the TRI Forum on Integration, funded by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration.

Go to www.tresearch.org/centers/LessonsLearned.pdf for the report.

Collaborative/Integrated Care Continuum

Coordinated Care	Colocated Care	Integrated Care
Independent organizations, each with its own systems and culture.	Independent organizations, but may have some agreements related to sharing.	One organization; all providers use the same systems; behavioral health screening is routine.
Routine screening for behavioral health conditions may be conducted by the physician or other staff.	Behavioral health and medical services available in the same physical location.	May be located in the same or different physical locations.
Referral relationship between medical care setting and behavioral health care setting.	Referral relationship between medical care setting and behavioral health.	One treatment plan for the patient, including both medical and behavioral components.
Uses normal processes (although they may be standardized) and communication may be more frequent than in standard care.	Normal processes used for communication but may be enhanced due to proximity of providers.	Team working together to deliver care.
Primary physician or other health care provider may deliver brief behavioral interventions. Referral to community resources may be actively facilitated.	Enhanced communication increases the skills of each practitioner type.	Teams composed of a physician and some or all of the following: nurse, nurse practitioner, physicians assistant, case manager, family advocate, behavioral health therapist.

Source: Adapted from Blount (2003) as cited in Collins et al. (2010); and Doherty (1996).

Briefly Noted

Study under way to look at male sexual aggression and drinking

A new study will look at how drinking and sexually aggressive behavior are connected, from the male perspective. Most studies have been based on experiences of female victims. The study, to be conducted by Maria Testa, Ph.D., a senior research scientist at the University of Buffalo's Research Institute on Addictions, is expected to shed light on why young college men do what they do, said Testa. "Rates of sexual victimization and perpetration among college students are disturbingly high nationwide," she said. "In order to learn more about what is happening and why, we will talk to young college men." The study, funded by a $2 million award from the National Institute on Alcohol Abuse and Alcoholism, will recruit 1,800 college freshmen males who will be followed for their first five semesters. The study will use interactive voice response (IVR)

Continues on next page

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technology to determine whether sexually aggressive behavior occurs during or immediately after drinking. Testa will be looking at whether variables such as sex-related alcohol expectancies, hostile masculinity, and impersonal sexuality influence drinking and sexual aggression.

D.A.R.E. student turns in parents for marijuana

An 11-year-old student in Matthews, North Carolina turned in his parents for marijuana possession when he brought marijuana cigarettes to school and said they belonged to his parents. The boy did so as a result of a recent D.A.R.E. (Drug Abuse Resistance Education) presentation. The boys' parents were arrested on suspicion of marijuana possession. According to news reports, the father said it was "no one's business" how the boy obtained the marijuana, and said "I don't give drugs to my kids." Police Officer Stason Tyrrell told reporters that the boy did the right thing. "Even if it's happening in their own home with their own parents, they understand that's a dangerous situation because of what we're teaching them. That's what they're told to do, to make us aware."

Teen heavy drinking, drug use leads to mental deficits: Study

Heavy substance abuse during adolescence could have adverse effects on intellectual abilities into adulthood, a new study has found. Researchers at the University of New Mexico found lower scores across a wide range of tests for these teens, finding neuropsychological deficits were similar to those of adult alcoholics and addicts. "The worry is that kids who start drinking early, and drinking heavily, may be affected for their entire life," according to lead researcher Robert Thoma. While the study was small, it found that teens with an alcoholic parent also had deficits. It involved 48 teenagers, 19 of whom had substance abuse disorders. The teens who drank, spent 30 percent of the 90 survey days drinking heavily. Those who used marijuana spent 40 percent of that period smoking marijuana. The study was reported online October 19 in *Alcoholism: Clinical & Experimental Research*.

Coming up...

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

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

A conference on Substance Use Disorders: Understanding Prevention and Treatment Interventions with the Hispanic/Latino Family will be held November 18-19 in **New York City**. The conference is jointly sponsored by the **NYU Post-Graduate Medical School**, **Caribbean Basin and Hispanic ATTC** and **Northeast ATTC**, and is presented by the **Center for Latino Health (NYU Langone Medical Center)**. Go to http://ireta.org/ireta_main/confnyu2010_event.html for more information.

The **American Academy of Addiction Psychiatry** will hold its annual meeting **December 2-5** in **Boca Raton, Fla.** For more information, go to http://www2.aaap.org/meetings-and-events/annual-meeting.

State Watch

Latest prescription drug problem in Kentucky: Opana

Oxymorphone (Opana) is the latest prescription painkiller to be abused in Kentucky, according to law enforcement officials in that state, where Oxycontin was known as "hillbilly heroin" and was a major problem. Operation UNIT comes in an time release formula designed for around the clock pain relief. Dale Morton of Operation UNITE says Opana is stronger than Oxycontin. "A 40 milligram tablet is equal to 200 milligrams of Oxycontin," he told the Williamson Daily News. It costs the same, however, leading to concerns that there could be overdoses if drugs are mixed. Law enforcement officers with UNITE have made their first undercover buys of the drug this month.

In case you haven't heard...

Although Gil Kerlikowske, director of the Office of National Drug Control Policy, has been speaking out against the medical marijuana proposition in California, saying that Mexican drug cartels derive 60 percent of their revenue from marijuana was overreaching. The ONDCP retracted this in a quietly issued September 16 statement that that figure was "based on data from 1997" and derived from models that "may no longer apply." Then, on October 12, a 57-page RAND study showed that legalizing marijuana would only take about $1.5 to $2 billion a year from the cartels — a fraction of their earnings. The ONDCP responded that the RAND study proves its point: legalizing marijuana will not hurt the drug cartels. "This report shows that despite the millions spent on marketing the idea, legalized marijuana won't reduce the revenue or violence generated by Mexican drug-trafficking organizations," Kerlikowske said.