

ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

Volume 19 Number 03

January 15, 2007

Print ISSN 1042-1394

Online ISSN 1556-7591

HIGHLIGHTS...

In California, a huge state with 58 counties, an ambitious outcomes measurement system is in the first year of operation, with 35 measures in addition to the 7 used for federal outcomes being reported. All counties agreed on all the measures, which took almost three years to develop. Kathryn Jett, director of the state's ADP and CalOMS, reassures treatment providers that there won't be strings tied to the measures, but that they will be used to help providers benchmark with other providers across the state. *See story, top of this page.*

A legislative audit in Maryland has found that the state failed to provide adequate monitoring of treatment programs; in particular, that it did not track the number of patients served. The problem was mainly a resource one, according to Peter Luongo, Ph.D., director of the state's ADAA, which is required to evaluate private programs as well as public ones. The auditor, meanwhile, is optimistic that problems will be rectified. Treatment programs, however, face the bad press coming from a local newspaper. *See story, bottom of this page.*

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Published online in Wiley InterScience
(www.interscience.com) DOI: 10.1002/adaw.20073

California outcome measurement forges ahead with all 58 counties on board

The California Outcomes Management System, or CalOMS, has entered a new phase: implementation. Three years in the making, CalOMS goes much farther than seven domains measured by NOMS, the National Outcome Measurement System run by the Substance Abuse and Mental Health Services (SAMHSA) in partnership with the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and includes 35 measures.

What is truly remarkable about CalOMS is its breadth, particularly in such a large state. All 58 counties participated in the development of the 35 statewide measures, and all agreed on them, said Kathryn P. Jett, director of the California de-

partment of Alcohol and Drug Programs (ADP). "To get that agreement was a huge accomplishment," she told *ADAW*.

In addition to agreeing to the measures, the counties had logistical issues to cope with. At the heart of outcomes measurement is the data, which must be recorded, standardized, and codified — all difficult tasks for substance abuse treatment. For some of the counties, the implementation of CalOMS means that for the first time they had to establish a localized data system, said Jett. For others, it meant they could adapt existing systems.

"We're coming up on our first year of reporting, and we're very ex-

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Maryland audit charges single state authority with accountability problems

The payer need for accountability means treatment providers — and the states that fund them — are being called upon to produce data showing not only that what they do works, but that they are doing what they are paid to do: treat patients. Even if there is no disagreement that providers are treating the right number of patients, states and providers need to be able to show this or face an adverse audit and a misled and misleading press.

A legislative audit by the Maryland General Assembly has found that the state's Alcohol and Drug Abuse Administration (ADAA) could not prove that treatment programs served the number of people they were funded to serve. The audit, issued quietly last month, does not say that ethical violations occurred or that any money was misused, but focuses on lack of documentation, saying that ADAA failed to "adequately monitor substance abuse treatment grants." The audit covered January 23, 2003 to March 9, 2006.

There were four areas of concern:

- 1) Lack of proof that the proper number of people were treated, which should have been done by comparing number of treatment slots with related grant awards. The auditor tested five of the grantees, and found no documentation of the verification process. "As a result, there was a lack of assurance that services provided by grantees were commensurate with the funding

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cited about the level of data analysis that we'll be able to run," said Jett.

As with NOMS, one of the concerns about CalOMS is that performance would be tied to funding. And as has been promised with NOMS, in which SAMHSA is relying on the measures for quality improvement, the ADP will use CalOMS only as a way to improve performance, said Jett. "You can't approach this type of system punitively," she said. "This system will provide counties with a way to measure themselves against other providers, and it will look at best practices and outcomes, but it's not intended to be punitive."

The way CalOMS will be used was a topic of "major discussion with counties and providers alike," Jett admitted. "Our NNA [negotiated net amount] contracts will say that the data is set up in such a way that it is used for program performance improvement."

CalOMS won't tie the client to a funding source — whether the program is funded by federal block grants or state grants won't be relevant. However, only the seven NOMS domains will be reported to the federal government, not the additional 35 state measures. Also, CalOMS will identify Proposition 36 clients.

Also, there will be a distinction between the kind of clients served,

California Drug Abuse Index

The California Drug Abuse Index is an ongoing exploratory project with the purpose of developing and testing outcome measures that accurately describe and predict California's alcohol and other drug abuse problems and the populations most affected.

The most severe outcome of alcohol and other drug abuse is death. The initial phase of the Drug Abuse Index project includes a report currently under departmental review that examines deaths between 1990 and 2004 related to drug abuse where drug abuse is defined as both the use of an illicit drug and the illicit use of a legal drug.

The drug abuse outcome measure of death as compiled by the Center of Health Statistics, California Department of Health Services was examined for number of deaths and death trends over time for the following categories:

- a. Demographic: age, race/ethnicity, marital status, education level, etc.
- b. Geographic: California was divided into 10 regions, all with populations exceeding 1.5 million.
- c. Drug level: type of death (accident, suicide, from chronic use); type of drug (heroin, cocaine, methamphetamine, all other), relationship with other drug use.
- d. Criminal Justice Statistics: arrests and automobile accidents by region.
- e. Hospital Discharges: discharge diagnoses with mention of drugs or drug-related conditions by region.

Source: Michael Males, Ph.D., Senior researcher for the Center on Juvenile and Criminal Justice, San Francisco, Consultant to the ADP on the drug abuse index

and outcomes expected. "You can't just look at broad numbers and expect them to tell the same story in every county," said Jett. "Higher income clientele coming out of Hollywood may have better outcomes

than clients in programs that are publicly funded, that may have just outpatient clients," she said. "You can't compare numbers without looking at that kind of detail. That's our major argument for not using



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Alcoholism & Drug Abuse Weekly (Print ISSN 1042-1394; Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the first Monday in July, the first Monday in September, the last Monday in November and the last Monday in December. The yearly subscription rate for **Alcoholism & Drug Abuse Weekly** is \$699. **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. © 2007 Wiley Periodicals, Inc., a Wiley Company. All rights reserved. Reproduction in any form without the consent of the publisher is strictly forbidden. For reprint permission, call (201) 748-6011.

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this data to make funding decisions.”

Safety mechanisms are also incorporated into the data, so that not everybody has access to it, said Jett. “You have to be an approved user.” The full data set will be at the department. The next step will allow each county to measure itself against others, she said.

Any time data is involved — whether it’s the federal TEDS system, or more local systems — from the administrator’s view, it’s a logistical challenge to assimilate it all. But CalOMS is one of the better systems, said Jett, because it is “decentralized,” allowing reporting from the provider level.

And data is a powerful advocacy tool. For example, it was the UCLA data on the Proposition 36 population (the treatment in lieu of incarceration initiative) that showed that methamphetamine addicts were faring as well in treatment as other drug addicts, said Jett. “We expect that the data will help answer questions that the legislature has, but before this it would have taken me years to answer,” she said.

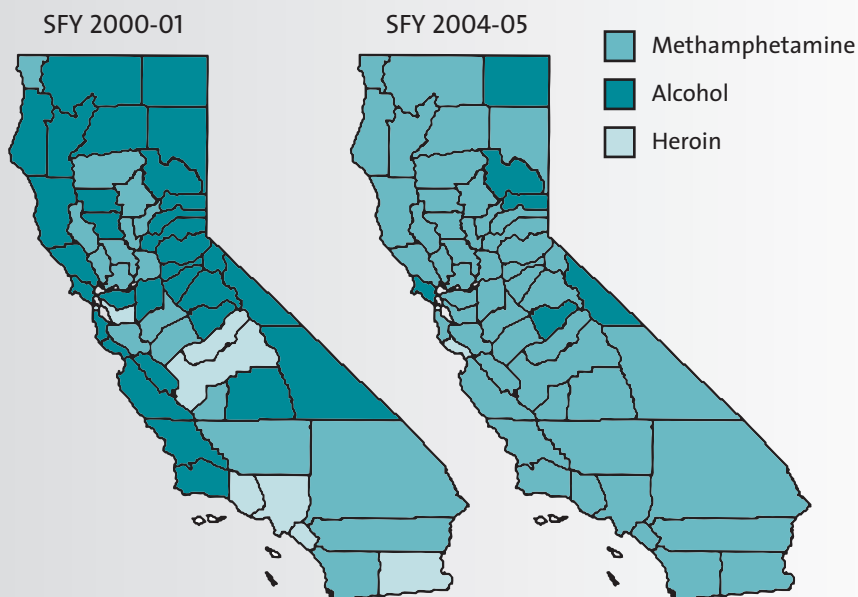
“We have a story that needs to be told not only to our state legislature, but to Congress, every year,” said Jett. Outcomes measures help give the taxpayer assurance “that we are striving for the best possible services,” she said. “And Congress is setting standards for the states as well.” Finally, there’s an expectation in the technology age that this information should be available.

Ultimately, if a provider is successful with their client, the measures will be reported on, and ADP will end up with a picture of what it takes to do good treatment for what kind of a client. “We’re trying to look at different service delivery models,” said Jett. “For example, we’re matching a sober living environment with intensive outpatient, and looking at their outcomes as compared to residential-only treatment.” This is a promising combination, she said. “People need to understand what works in addiction.” •

Methamphetamine is number-one for treatment admissions in California

With many drug abuse trends originating on the West Coast of the country and moving East, it’s particularly useful to track California data. For example, the state recently found that methamphetamine is responsible for more treatment admissions than any other single substance, including alcohol (see maps below).

Primary drug of abuse at admission



Source: California Department of Alcohol and Drug Programs

Governor’s budget proposal slashes Prop. 36 funding

The bad news is that if Gov. Arnold Schwarzenegger’s budget is approved, Prop. 36 treatment programs would be slashed. The budget proposal, released January 10, would give only \$120 million for Prop. 36-related programs, compared to \$145 approved by the legislature last year. The new proposal would divide the \$120 million into two programs: one, the fledgling fund called the Substance Abuse Offender Treatment program, which requires county matches.

According to a recent survey by the Coalition of Alcohol and Drug Associations, Prop. 36 needs at least \$209.3 million to “adequately address the treatment needs.” The Governor’s proposed funding for Prop. 36 falls almost \$90 million short of that target, which would allow counties to better meet the range of needs in treatment, support services and criminal justice supervision for the over 36,000 clients enrolling in Prop. 36 programs each year.

Texas county boosts capacity to treat probationers

The Bexar County, Texas Adult Probation agency and the offender population under its authority have become the beneficiaries of a justice system more likely than ever to embrace treatment-focused alternatives to incarceration. Support from a variety of state and county agencies has allowed probation officials to establish a 100-bed residential treatment facility that significantly boosts the county's capacity to improve long-term prospects for nonviolent offenders.

A Bexar County Adult Probation treatment facility with capacity for 50 male and 50 female residents began providing services in late 2006. Prior to the facility's opening, the county probation system had residential treatment bed capacity for only 10 women and fewer than 100 men, said David Abbott, director of clinical services for the adult probation agency.

Abbott told ADAW that drug offenders usually will arrive at the facility under one of two sets of circumstances: They could be recently arrestees sent to residential treatment as a condition of a newly imposed probation, or they could be existing probationers who begin testing positive for substance use and are returned to court. There are about 25,000 individuals total on probation in Bexar County, which includes the city of San Antonio.

Abbott believes the most impressive feature of the new treatment facility may be the interagency cooperation that helped make it possible, indicating how attitudes

throughout Texas about how to manage drug offenders are dramatically changing.

The probation department located a possible site for the facility on the grounds of a state psychiatric hospital in San Antonio, and was

'The reason the county is willing to help is I've promised them beds to help them reduce the county's jail population. We're all pulling together on this.'

David Abbott

able to receive a lease to occupy the building for \$1 a year. The state Criminal Justice Assistance Division is funding the treatment programs at the facility, and Bexar County leaders agreed to kick in funds for a \$200,000 installation of a needed sprinkler system, said Abbott.

"The reason the county is willing to help is I've promised them beds to help them reduce the county's jail population," he said. "We're all pulling together on this."

Abbott explained that services in the residential treatment facility generally adhere to a cognitive restructuring model, helping offenders move toward a more productive way of thinking that will lead to more prosocial behaviors. Once a resident leaves that level of care, he or she may attend 12-Step meetings or use anti-addiction medications to boost prospects for long-term recovery, but generally the focus during the residential treatment stay remains on cognitive issues, Abbott said.

"We keep them pretty busy while they're there," he said.

No violent offenders or sex offenders are allowed to be sent to the residential facility. Probationers who successfully complete residential treatment generally are moved to an aftercare track where they are connected with providers in the community. Under an interlocal agreement, the residential treatment services are provided by staff members working under the county behavioral health authority, Abbott said.

Abbott added that while Texas judges for a long time have had a great deal of flexibility to order non-violent drug offenders into treatment, they are presently more inclined to explore the alternative to jail than they ever have been before.

"We now have more validated, objective assessments," Abbott said. "And we're not only struggling with the jail population, but we're also struggling statewide with the prisons. Everybody is trying to find more treatment alternatives to incarceration." •

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and related grant awards."

- 2) Field visits were not conducted on all programs to verify the accuracy of data submitted by the programs.
- 3) The vendor responsible for the funds in Baltimore was not complying with the terms of its agreement that it would

conduct the site visits there, and the ADAA should have ensured that it did. As of April 2006, no reports had been submitted since December 2005, the audit says.

- 4) The ADAA did not verify that counties receiving Substance Abuse Treatment Outcomes Partnership funds made re-

quired matching contributions. State law allows these contributions to be waived, but the audit found that the ADAA had no documentation to support such a waiver in the case of three non-contributing counties.

The auditor's main recommendation was that ADAA document its

comparison of funded treatment slots to the treatment data submitted by programs. This was the same problem found in an audit done three years ago of ADAA.

But Bruce A. Myers, the auditor, said that now, the problems are being rectified. "We had some issues, but we're optimistic that there will be improvement," he told *ADAW*. And he laid the blame squarely at the feet of the ADAA, not the treatment programs. "The grantees are reporting the data monthly, but the ADAA was not documenting it, and in that case, it's the ADAA's fault," he said. "With \$125 million at stake, the taxpayers deserve better."

Treatment programs don't need to worry that they will have to return funds, said Myers. "If you're doing what you should be with the grant, you won't have to give back money."

Further reassurance came from Peter F. Luongo, Ph.D., director of the ADAA. "Nobody will be giving back any money," he told *ADAW*. "The money isn't being mismanaged." The problem, however, is lack of resources to do the monitoring, he said.

But in fact, the ADAA is mandated to evaluate all certified programs, whether they receive funding from the state or not. This requires the ADAA to "take scarce monitoring resources away from state-funded programs to evaluate programs that are not funded by the state," said Luongo. His department will seek relief from this mandate, "so ADAA resources can exclusively monitor state-funded programs," he said.

The ADAA falls under the Maryland Department of Health and Mental Hygiene (DHMH).

Press reports

Perhaps the biggest fallout of the report, which was published on December 28, occurred due to press reports. It began with a January 5 article in the *Baltimore Examiner*, which quoted an anonymous "former addictions counselor" who crit-

icized the state for claiming to treat people but not counting the numbers treated.

This was followed by a January 10 editorial, titled "Drunk at the wheel," about the ADAA. Then on January 11, the *Examiner* ran another story that was based on the report of a woman named "Pam" whose husband was detoxified at Father Martin's Ashley in Havre de Grace, and who needed to be transferred to a psychiatric facility. The woman claimed she sent a certified letter to the ADAA on December 14 complaining about this, but that her letter was misplaced. But what she wanted was her money back — the \$9,000 she had paid to the private treatment program as a downpayment.

The audit did not include private programs like Father Martin's Ashley, which are not funded by the ADAA.

Site visits

The problem with site visits in Baltimore rested with Baltimore Substance Abuse System, Inc. (BSAS), the quasi-governmental city substance abuse authority which

issues, we are number three, and that our MOU [memorandum of understanding] with ADAA is in good shape." Asked to comment on how the audit may affect treatment providers throughout the state, Brickner demurred. "I can't speak beyond BSAS," he said.

Luongo added that the ADAA did not in fact get a site report from every visit. But he also said that the audit itself miscounted the number of programs. "There are not 265 programs, there are 265 sites," he said. There are 163 programs, and all 163 were visited during the audit period.

"The auditors correctly stated that all clinics receiving state funds were not physically visited," Luongo conceded. These visits are important, auditor Myers told *ADAW*, because they allow ADAA to find out whether the grant funds are being properly used.

But Luongo, in defense of the ADAA, said that at the time of the audit the state had "written review procedures that utilize electronic data to monitor performance and identify anomalies in the data for further examination." The auditor

The auditor's main recommendation was that ADAA document its comparison of funded treatment slots to the treatment data submitted by programs. This was the same problem found in an audit done three years ago of ADAA.

contracts with the state to provide financial and program oversight for many state-funded programs in the city. "There was a miscommunication," BSAS president Adam Brickner told *ADAW*. "We had suspended the site visits for three months while we did a grant review, and I thought we had received authorization for this." Brickner has had a board meeting, and reassured his staff. "I told our staff that out of four

focused on site visits alone instead of on "automated business practice improvements," Luongo said.

In the coming months, the ADAA will submit "quality status reports" to the Office of Inspector General within the DHMH, said Luongo. The OIG will then conduct a follow-up review to assure implementation of corrections, he said, and report its findings to the Secretary of DHMH. •

Mass. agency to bring efficiencies to new outpatient services

Well aware that outpatient addiction treatment generally represents the most difficult level of care to sustain financially in today's environment, a Massachusetts provider agency is nonetheless eager to begin offering outpatient services on Cape Cod that a health care agency had abandoned last year.

Gosnold on Cape Cod is banking on the fact that process improvement functions that it established as one of the initial grantees under the national Network for the Improvement of Addiction Treatment will allow it to avoid significant losses in providing outpatient services on the Cape. The agency already

told *ADAW* that outpatient care in today's marketplace faces several challenges to its viability, including the need for highly skilled clinicians, prevalent rate pressures and bureaucratic requirements from managed care, and productivity losses caused by frequent client no-shows for appointments. It is in the latter area, however, where Gosnold has made significant organization-wide progress as a result of its process improvement activity over the past few years, Tamasi said.

Gosnold was one of the first treatment agencies in the country to benefit from an initiative started early this decade by the federal Cen-

ing staff — of the warning signs that a client is contemplating leaving a program prematurely.

It is with these simple kinds of tools to improve engagement and retention that Gosnold intends to overcome the main barriers to providing sound and cost-effective outpatient services on the Cape.

"We have tried to inculcate a culture of serving the customer," Tamasi said. "I use a lot of business metaphors here. The underlying principle is to understand that patients need to be communicated with, engaged, and 'sold' on recovery."

Tamasi believes the success of the newly assumed outpatient services largely will be measured on how quickly clients are able to get into treatment and how well they are retained, with no-shows ideally kept to a minimum. Gosnold operates generally on an abstinence-based model, although its programs have seen variations to the theme in recent years with more use of medication-assisted recovery, evidence-based practices, and services for co-occurring mental illness and trauma issues, Tamasi said.

About one-quarter of Gosnold's services throughout the organization are for clients on public assistance. Gosnold treats all clients regardless of ability to pay, Tamasi said, and he expects most of the outpatient clients on the Cape to have limited financial resources for treatment. A typical length of stay in outpatient care will be about six to nine months, he said. •

'We have tried to inculcate a culture of serving the customer. I use a lot of business metaphors here. The underlying principle is to understand that patients need to be communicated with, engaged, and 'sold' on recovery.'

Raymond Tamasi

has overcome hiring challenges in bringing on four new therapists to handle the added caseloads expected from assuming services formerly operated by Cape Cod Healthcare.

The Cape Cod Times reported that Cape Cod Healthcare, which owns two hospitals on the Cape, decided last summer to drop both its outpatient addiction counseling and driver alcohol education programs in order to focus more on mental health service provision. Gosnold, which operates a continuum of residential, rehabilitative and outpatient addiction services on Cape Cod and also operates clinics in other Massachusetts communities, has assumed operation of both programs vacated by Cape Cod Healthcare.

Gosnold CEO Raymond Tamasi

ter for Substance Abuse Treatment (CSAT) and the Robert Wood Johnson Foundation. The aim of the project was to improve agencies' administrative processes of care, rather than focusing on the clinical services themselves, in order to enhance access to and retention in treatment.

Being part of the Network for the Improvement of Addiction Treatment has significantly altered the way Gosnold does business, according to Tamasi. For example, the agency was able to eliminate several steps and redundancies in its intake processes in order to engage clients in treatment more quickly. On the retention side, Tamasi said, the agency broadened awareness among all staff members — from clinicians to dietitians to housekeep-

Attention...

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.

Submit letters to: Karienne Stovell, Executive Editor, *Alcoholism & Drug Abuse Weekly*, 111 River Street, Hoboken, NJ 07030-5774; e-mail: kstovell@wiley.com. Letters may be edited for space or style.

Addictive diseases chair funded at University of Florida

A gift of \$1.5 million from Donald and Irene Dizney of Windermere, Fla. has established the Donald R. Dizney Chair in Addiction Medicine at the University of Florida, the school announced last week. The announcement was made by Mark S. Gold, M.D., distinguished professor and chief of the division of addiction medicine in the College of Medicine. The gift will be used to address smoking, overeating, and smoking as well as drugs and alcohol, said Gold.

"This is an extremely important gift for our division, the College of Medicine and also the State of Florida," Gold said. "This gift means that research, treatment and prevention of the nation's top five causes of death will accelerate here at the University of Florida," he said, adding that it will help ensure that addiction remains "an integral part of the University of Florida's College of Medicine."

Gold has been at the forefront of research into new treatments for people who are addicted to food, cigarettes, and alcohol.

The gift is eligible for \$1.2 million in matching funds from the State of Florida's Major Gifts Trust Fund.

"This is the largest known endowment for a professorship chair in addiction medicine in the United States," said Gold, "and makes it possible for us to make investments in addiction research scientists and emerging technologies that will not only allow us to develop new treatments, but possibly reverse the effects of drugs of abuse on individual cells and systems within the brain."

"It is critically important to transform our medical centers from disease centers to health and prevention centers," said Dizney. "All too often we are quite good at treating cancers, cirrhosis or other problems caused in the first place by drug abuse and addictions. We hope to help to change this approach by understanding the progression of addictive disease in the

brain so we can identify and treat the cause rather than wait until we

need to treat the debilitating and often fatal consequences." •

Methamphetamine treatment admissions decline in Minnesota

In Minnesota, methamphetamine admissions went down in 2006, according to a research report from the Hazelden Foundation released January 11. Hospital emergency room cases related to methamphetamine, and the incidence of clandestine labs, went down as well. Deaths did not decrease, however.

"Collectively, these new findings suggest that the growth in methamphetamine abuse is slowing down, possibly reversing itself in the Twin Cities area," said Carol Falkowski, Hazelden's director of research communications and report author. "Whether this downward trend continues long-term remains to be seen, but these figures are very encouraging."

Highlights of the report include the following:

- A total of 806 patients treated at metro area addiction treatment programs reported methamphetamine as their primary substance problem. This represented 8.2 percent of total treatment admissions, compared to 12 percent (2,465 methamphetamine patients) in 2005.
- Methamphetamine-related hospital emergency department (ED) episodes in the Twin Cities also dropped significantly, to 251 in 2006 (first half) compared with 1,402 in 2005 (full year).
- The number of deaths remained stable; both Hennepin County and Ramsey County reported five accidental deaths involving methamphetamine in 2006 (through September) compared with seven in 2005 entire year).
- Statewide the number of methamphetamine labs also declined in 2006.

The report was prepared as part of an epidemiological drug abuse monitoring network based in 20 cities across the country. Falkowski has been the contributor for Twin Cities drug abuse trends since 1986.

The full report is available online at www.hazelden.org/research.

BRIEFLY NOTED

SAMHSA considering relief for methadone programs

Currently, when methadone programs dispense buprenorphine, they must do so under the same take-home restrictions that apply to methadone. Methadone programs have applied for regulatory relief from this rule, and according to Nicholas Reuter, M.P.H., senior public health advisor with the division of pharmacologic therapies at SAMHSA's Center for Substance Abuse Treatment, that relief is a real possibility.

"We are actively looking into that petition for relief," Reuter told *ADAW*. "It looks to be in very good shape." A regulatory process, including publication in the *Federal Register*, must take place first, however.

Treatment programs lacking for incarcerated women

According to the Women's Prison Association, the mandatory minimum sentencing law has had a "profound effect" on women, who now represent the fastest growing prison population nationwide for drug offenses. Meanwhile, there are

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only a dozen or so comprehensive treatment programs in place for incarcerated women. It's become a vicious cycle, said Malika Saada Saar with the Rebecca Project for Human Rights. "Many women say it's easier to wind up in prison than to get treatment," said Saar, since treatment programs are turning away women with children or those who are pregnant. And once in jail, women must contend with far greater stigma than male drug offenders, particularly if they are mothers.

Tobacco quitlines appear cost effective for states

In their study published online on December 20 in the *American Journal of Preventive Medicine*, Paula Keller, MPH and her colleagues write that tobacco quitlines are generally considered an effective, evidence-based strategy to deliver smoking cessation treatment. In one of the few studies to consider the financing of such "quitlines," Keller examined data from the 2004 North American Quitline Consortium Survey. Among the 38 states to report having a quitline in place in 2004, state governments funded over eighty percent of quitlines, with a "remarkably modest" annual median annual operating cost of \$0.14 per capita, or \$0.85 per adult smoker. States spent even less on various promotional strategies.

Some minorities less likely to seek alcohol treatment

While some studies have indicated that minority groups are overrepresented in treatment settings, Laura Schmidt published a report to the contrary in the January issue of *Alcoholism: Clinical and Experimental Research*. Schmidt and her colleagues from the Alcohol Research Group, Public Health Institute, Berkeley, Cal. suggest that at higher levels of alcohol problem severity, Hispanics and African Americans utilize treatment services at lower rates

Coming up...

The Community Anti-Drug Coalitions of America (CADCA) will hold its National Leadership Forum XVII, the nation's largest training conference for community drug prevention leaders, treatment professionals and researchers, on **February 12-15 in Washington, D.C.** For more information, visit www.cadca.org.

The Network for the Improvement of Addiction Treatment (NIATx) will hold its first annual summit, "Improving Access and Engagement in Addiction and Behavioral Health Treatment," on **April 23-25 in San Antonio, Texas**, in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment and The Robert Wood Johnson Foundation. For more information and to register, visit www.NIATx.net.

The National Rural Institute on Alcohol and Drug Abuse will hold its Twenty-third Annual Conference on **June 3-7** at the **University of Wisconsin-Stout**. For more information, visit www.uwstout.edu/outreach/conf/nri.

than comparable whites. Although Hispanics as a group report higher severity alcohol problems than whites, Schmidt wrote that financial issues and logistical issues like child-care appear to be barriers to care. The findings were based on data from the U.S. National Alcohol Surveys (1995, 2000).

CALL FOR APPLICATIONS

SAMHSA grants: Substance abuse/HIV treatment/outreach

The Substance Abuse and Mental Health Services Administration (SAMHSA) issued a call for applications on January 4 for a grant program to "enhance and expand sub-

stance abuse treatment and/or outreach and pretreatment services in conjunction with HIV/AIDS services in African American, Hispanic and other racial ethnic communities." Annual awards will be about \$500,000 for treatment services and \$400,000 for outreach and pretreatment, for up to 5 years. Applications are due February 28, 2007. For an application, call SAMHSA's Clearinghouse at 800-729-6686 or visit www.samhsa.gov. (Grant No. TI-07-004).

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In case you haven't heard...

Scarce — and expensive — hospital beds don't need to be used for people who just need to "sober up." That's the rationale behind a new program funded by Genesee County in Michigan, in which adults will have up to 23 hours to stay after being referred by a county hospital. The program will be run by New Paths in Flint, and have a capacity of 10-12 to start. It's expected to open up in the next month, and to relieve congestion in hospital emergency departments. It's not necessarily for alcoholics, according to a report in the Flint Journal. "We aren't saying you have to have a diagnosable substance abuse problem, just that you are drunk," said Kristie R. Schmiede, director of substance abuse services for Genesee County Community Mental Health. New Paths is a community corrections program for nonviolent men. It will provide the sobering-up clients with referrals to treatment.