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News for policy and program decision-makers

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Highlights...

Wyoming is rolling out a large SBIRT program designed to cut general healthcare costs by identifying people early in their addiction histories. The program also includes a referral component for people who do need treatment, and state officials are in the process of making it possible to track whether or not these people do show up for treatment. *See story, top of this page.*

Intensive case management is increasingly used as an adjunct to substance abuse treatment for people in the welfare system, and a recent study provides evidence that this works. Different from the recovery coach approach, case management includes helping the client navigate the legal, employment, and social services networks so they can obtain all the services they need. *See story, bottom of this page.*

Inside this issue...

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Wyoming moves to expand SBIRT to include follow-ups

Now well into the second month of a major expansion of its own SBIRT (screening, brief intervention, and referral to treatment) program, Wyoming is already planning changes that will result in sending more people to treatment.

As of Jan. 1, state Medicaid will pay physicians to conduct SBIRT (see *ADAW*, Jan. 12), but what's being added is a way to track whether the patients are referred to treatment, and ultimately whether they actually go.

The "RT" — the referral to treatment — is not specifically included in the codes, but is part of the Wyoming program. Referrals are done by handing the patient the contact information for the provider agency in the area.

The hard part is finding out whether anyone follows up on the referral, according to state officials in charge of the SBIRT program. "We're not tracking whether they actually go," says Marilyn Patton, M.S.W., community services coordinator for the Mental Health and Substance Abuse Services (MHSAS) division of the Wyoming Department of Health. "We have copies of the scores of the ASSIST screenings, but we don't have any way to go back and see whether referrals were made, or whether people showed up," she said. (The ASSIST is the screening tool developed by the World Health Organization which Wyoming is using for SBIRT.)

The Wyoming SBIRT program was designed with the hope of getting a grant from the Substance

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ICM study points to importance of long-term recovery supports

A recent study on intensive case management (ICM) for women published in the current *American Journal of Public Health* (see *ADAW*, Feb. 2) underscores the importance of a recovery-oriented system of care that focuses on what happens after formal treatment ends, experts told *ADAW* last week. Instead of providing treatment for an acute condition, recovery requires client contact for months and years, and includes helping the patient with other needs such as employment. The recent study drew attention from researchers and policymakers because it provided evidence of the need for long-term recovery support not only for abstinence but for better functioning.

This view of treatment also fits in well with the Obama administration's vision of a wellness-oriented health care system, according to H. Westley Clark, M.D., M.P.H., director of the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration (SAMHSA).

"This administration recognizes that without more of a systems approach, without looking at the full spectrum of problems, you can't achieve what you're trying to achieve," Clark told *ADAW*. "You want to improve outcomes, and you want sustained impact."

The *AJPH* study also fits well into the administration's focus on

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Abuse and Mental Health Services Administration (SAMHSA), so it went through the health department's Institutional Review Board (IRB) for the initial phase. "We did not ask to receive any identifying data," said Patton. "But now we are going back to the IRB to ask whether we can collect this data." If the IRB says it can, then there will be a way to know who gets referred to treatment and who goes.

The department will also ask whether it can screen people under 18, and will present a number of possible screening tools (the ASSIST is not validated for people under 18).

What the current SBIRT lacks is a really strong referral component, according to treatment providers. "In theory it should be great," said Mike Huston, executive director of the Central Wyoming Counseling Center in Casper. "But if we had a more formal referral process, so that the public health nurse would call the substance abuse treatment center, that might result in more referrals," he said. "People are given an option of going or not."

What Huston would like to see is a more thorough assessment using the Addiction Severity Index, and then the ASAM placement criteria. "If they really wanted to get serious in terms of getting primary care involved, we would make some staff resources available to really work hand in glove with those physician offices." In some counties, the treatment agency does send someone to the public nurse to help with the assessments, said Huston.

'...we don't have any way to go back and see whether referrals were made, or whether people showed up.'

Marilyn Patton

$400,000 from MHSAS

The MHSAS division has set aside $400,000 to pay the state's share of the Medicaid claims for conducting SBIRT, said deputy director Rodger McDaniel. "I think that's high," he said. In Wyoming, there is a state matching requirement for federal Medicaid payments.

Medicaid and MHSAS are both part of the health department, which helped the SBIRT collaboration, said McDaniel. In addition, Medicaid staff are embedded in MHSAS. "So we coordinate a great deal," he said. The SBIRT proposal was originally made by MHSAS to the health department, where the director is "big on prevention," he said. "That made this easier to happen." And the icing on the cake was the Washington study that showed a reduction in Medicaid claims due to SBIRT, he said.

Medicaid can also be used for direct treatment, and probably will be used for some of the SBIRT clients who are referred. "Our contracts require providers to maximize Medicaid funding," said McDaniel.

Wyoming has made a large investment in substance abuse treatment, with the block grant representing less than 10 percent of funding, said McDaniel.

Provider opposition

Many providers in Wyoming don't like SBIRT because they don't understand how it fits into the system of care, according to MHSAS. "The future of mental health and substance abuse is being integrated into a total health package," said Patton.

"They have not been supportive of SBIRT and have seen it as competitive with them," said McDaniel of anti-SBIRT providers. Most people screened will not have a problem, and most who do will be able to be managed with a brief intervention — they don't need the full-blown treatment assessment, exten-

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sive SBI research has shown. Less than 5 percent will need a referral to treatment, said McDaniel — and these people will be referred to treatment providers for an assessment. The missing link — whether they actually go — is hoped to be filled in by the tracking, once approved by the IRB.Each person assessed and referred under SBIRT could then be followed.

"There have been some problems," conceded Huston, asked about provider sentiment toward SBIRT. "The old model I was trained with, the AA model, said you have to hit bottom first. But we don't need to waste human resources letting things go that far."

Finally, SBIRT makes sense to the Wyoming culture, said Patton. "It goes along with with the philosophy here that you ought to take care of yourself as much as you can, and not depend on other people," she said. "So when you're in that middle territory of not yet having formed an addictive relationship with a substance, you can reduce your risk." •

Editor's note: This is the second in a series of stories looking at one state's use of screening and brief intervention and whether it actually does deliver patients to the treatment system.

State Budget Watch

Good news in Pennsylvania, but work still to be done

Treatment providers in Pennsylvania are fortunate to have Act 106, the insurance law mandating benefits. But this law only applies to commercial payers. So providers are eager to find out how the state budget for publicly funded treatment will affect them.

The news, so far, is good, said Mark Sarneso, chairman of the board of Drug and Alcohol Service Providers of Pennsylvania (DASPOP) and vice president for legislative affairs at CRC Health Group. "Historically, the Pennsylvania legislature and administration have been very supportive of funding drug and alcohol treatment and prevention," Sarneso told *ADAW*. "Act 106 is the strongest benefit law in the country."

Publicly-funded treatment is taking a $2 million cut in the fiscal year 2009-2010 budget proposed by Gov. Edward G. Rendell earlier this month. Driven mainly by the projected $2.3 billion project deficit in the state, the governor said in his budget message that there would be a "series of painful reductions in services, and in some cases we must eliminate programs altogether." However, he pointed to "critically needed drug and alcohol programs," saying "my intention is to restore funding as soon as our economy recovers and state revenues improve." In other cases, however, the cuts will be permanent, he said, "because they are outside of the essential business of the state."

Knowing that addiction treatment is considered part of the "essential business of the state" is reassuring, but the field is still going to fight to get the $2 million restored, said Sarneso. "What we would like is to get everything at least level-funded," he said. "Our research at DASPOP indicates that there are about 600,000 Pennsylvanians who need treatment and aren't getting it," he said. "As favorable as the legislature has been to us, we don't think there's enough money to treat all those people." But at least, there should be a restoration to last year's levels.

> **'What we would like is to get everything at least level-funded.'**
>
> Mark Sarneso

Since untreated addiction is a cost-driver, the benefit to the state of providing treatment funds is lower criminal justice costs, health care costs, and child welfare costs, said Sarneso. "We will be talking to the legislature about finding money that will help us stay at level funding."

Last year, treatment programs in Pennsylvania treated about 90,000 unduplicated clients, said Sarneso.

Diversified funding streams

Publicly funded treatment is paid for by different departments — the Pennsylvania Department of Health, which manages the SAPT block grant, the Department of Public Welfare, which manages the Behavioral Health Services Initiative (BHSI), and other programs. "We have diversified funding streams, because we don't want to put all our eggs in one basket," said Sarneso. The DPW amount went up $11 million – a program that is reserved for the working poor.

"These are people who are not eligible for Medicaid, but can't pay for treatment," said Sarneso. "This fund shows the commitment of the legislature to make sure people get treatment." The DPW funds are administered by single county authorities. About $6 million of the increase is for alcohol and drug treatment — the rest is for mental health.

The intergovernmental transfer money is being phase out with the start of the new fiscal year, but the cut is not as bad as it looks on the below chart. "We still get three months of this," said Sarneso, because the fiscal year for the state doesn't end until June.

One funding stream — under Medicaid — is Act 152 money, which is funded at $16 million for this year. This is money to be used

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for Medicaid-eligible patients in treatment who haven't officially been enrolled in Medicaid yet. "This helps payments for the lag time after someone applies for Medicaid," said Sarneso. "We're working with the state so that Act 152 money can be better used," he said. "Patient should be eligible for Medicaid on the day of admission. But that doesn't always happen because of the paperwork issues."

A pilot program currently under way is aimed at reducing the lag time between filing for Medicaid and enrollment, said Sarneso.

There had been some talk about moving all drug and alcohol issues into the Office of Mental Health and Substance Abuse Services, which is under the DPW. The treatment field was relieved that the governor did not include this proposal in his budget address.

In fact, there is a move to make the Bureau of Alcohol and Drug Programs a cabinet-level agency. Rep. Gene Di Girolamo (R-Bucks County) is one of the biggest supporters of treatment funding in the legislature, and last session he introduced a bill that would elevate the Bureau of Alcohol and Drug Programs, currently under the Department of Health. Currently, acting director Robin L. Rothermel oversees the $56 million block grant. The Di Girolamo bill passed by a 199-4 vote in the house, but got stalled in the senate. Rep. Di Girolamo is in the process of reintroducing it this session.

"We're three rungs removed from a seat at the table," said Sarneso. "Our belief is that the higher you are in state government, the better your chance of formulating public policy," said Sarneso. •

Pennsylvania drug and alcohol abuse prevention and addiction treatment budget (Dollar amounts in thousands)

Agency	2007-2008	2008-2009	2009-2010	Change
DOH-State Assistance	$42,602	$42,602	$41,750	–$825
DOH-Block grant [1]	$56,719	$57,041	$56,474	—
DOH-Liquor control board	$2,121	$2,121	$2,121	—
DPW-BHSI [2]	$45,300	$45,164	$56,126	+$10,962
DPW-Intergovernmental transfer [3]	$12,107	$12,107	0	–$12,107
Drug courts	$17,900	$17,574	$17,574	—

1 Federal runding projected by the state
2 Drug and alcohol portion equals an estimated 55 percent
3 This Federal Intergovernmental Transfer Program has been phased out

Source: DASPOP

Stimulus package: Contact your senators and representatives

Last week the House and Senate conferees on the American Recovery and Reinvestment Act of 2009 agreed on a $789 billion stimulus package — less than the House-passed package of $820 billion or the Senate version of $838 billion.

Below is a breakdown of some of the provisions included in the agreement — these numbers have not been confirmed, but were put together by the National Association of State Alcohol and Drug Abuse Diretors (NASADAD)in the hours after the conference:

- Public Health and Social Services Emergency Fund/Prevention and Wellness Fund: The conference agreement provides $1 billion for this, compared to $3 billion from the House and nothing from the Senate.
- FMAP for Medicaid Program: The Conference agreement provides an increase of $86.7 billion for the Federal Medical Assistance Percentage (FMAP) for the Medicaid Program.
- Medicaid Moratorium: Some Medicaid regulations have an extended moratorium under the conference agreement, costing about $100 million.
- Temporary Assistance for Needy Families (TANF): The conference agreement provides $3 billion for TANF.
- Health Information Technology: The conference agreement provides funding for health information technology, costing about $19 billion.

The bills were expected to be

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Update: Field coalition meeting 'positive'

There were over 40 stakeholders at a Feb. 5 meeting called by the Legal Action Center and focused on getting addiction issues into health care reform, and the results were "positive," said national public policy director Gabrielle de la Gueronniere (see *ADAW*, Feb. 9). "There were people from addiction prevention, treatment, and recovery, and from the mental health community," she told *ADAW*. There was a clear consensus that the group wants to work on ensuring that any kind of health care reform proposal includes "meaningful coverage for mental health and for addiction," she said.

Several people will be on a working group, to craft message points to get to Congress, she said.

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FROM THE FIELD...

Sexual health: A new ally in addiction treatment improvement

By Doug Braun-Harvey and John de Miranda

Men and women whose sexual behavior is inextricably linked with addiction to drugs and alcohol enter treatment centers ill-prepared to treat their sex/drug linked condition. Treatment centers typically address half of this potentially lethal combination; the substance dependency. Based upon an innovative and pioneering treatment program the drug and alcohol recovery industry now has an important new question to consider. When drug taking and sexual behaviors are linked and the client's sexual behavior is not concomitantly addressed is addiction treatment likely to fail?

Stepping Stone faces sex/drug linked treatment failure

In 2002 staff of Stepping Stone of San Diego, an addiction recovery program, were dissatisfied with their poor client retention and relapse rates among clients with significant sex/drug linked behavior. In the words of then Executive Director Cheryl Houk "People are dying, we can do better."

Ms. Houk's leadership, in consultation with Doug Braun-Harvey a local sexual health expert, Stepping Stone began the difficult but responsible course of facing the program's deficits in addressing client's sexual behavior. Three central issues emerged. First, sexuality was primarily addressed only when sex was a problem (i.e., HIV infection, sex between residents, masturbation activity, "sex addiction", and sexual activity away from the treatment center). Secondly, there was not a place, group or intervention that provided positive, affirming and factual sexuality information for residents. Lastly, Stepping Stone did not offer a proactive treatment intervention to explore, discuss and understand how sexual behavior linked with addiction often leads to relapse.

In 2003 The California Endowment funded a three-year project for Stepping Stone to develop, implement and measure treatment outcomes of a sexual health-based, harm reduction, relapse prevention program targeted at high sex/drug linked addiction. The goal was to positively and confidently create a residential drug and alcohol treatment program, seamlessly integrating client sexual behavior in all phases of treatment.

The pioneering nature of this sexual health relapse prevention intervention required the development of two new drug and alcohol treatment tools. Jim Zians, Ph.D created an assessment survey for determining level of relapse risk linked to sexual behavior as well as develop an evidence-based outcome evaluation process. Doug Braun-Harvey, MFT authored a psycho-educational curriculum as the framework for weekly sexual health in recovery groups. Stepping Stone began assessments and the "Discovering Sexual Health in Recovery" (DSHIR) psycho-educational group program before the end of the year.

From November 2003 to May 2007 more than 250 residents completed the initial sex/drug-linked relapse risk assessment survey. In the same time period more than 150 residents completed a second survey following three months of residential treatment and attending weekly DSHIR group sessions. Additional program components were one-on-one counseling sessions geared towards those residents assessed to be a high relapse risk due to sex/drug linked addiction patterns.

Outcome evaluation shows sexual shame is key to treatment success

The analysis of the evaluation data revealed several exciting and significant outcomes. 190 men, 69 women and 10 transgender residents participated in the program. In the three years prior to beginning the sexual health based relapse prevention program (1999 – 2002) more than 70% of residents did not complete the treatment program. Only about one in four Stepping Stone clients completed treatment. In the four years of the sexual health based relapse prevention grant program (2003 – 2007) treatment completion increased to over 50 percent. Client retention rates were doubled.

Of the six risk categories assessed in the client assessment survey, relapse risk due to sexual secrets and shame was closely linked with client retention and treatment completion. Upon entering treatment, Stepping Stone residents with high sex/drug linked relapse risk had double the levels of measured shame compared with low sex/drug linked residents. Three months later these same high shame/high relapse risk men and women had similar measured levels of shame to the shame levels of low sex/drug linked clients. The assessment results point the drug and alcohol field into a new direction for treatment improvement: sex/drug linked addiction and high levels of shame.

Treatment is only as effective if it accurately

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targets the symptoms associated with the distress.. The evidence strongly suggests that a sex positive treatment environment combined with a sexual health-based psycho-educational skill building curriculum will decrease sex/drug linked shame resulting in a treatment ready client population.

Doug Braun-Harvey, MFT, CGP, is the Director of The Sexual Dependency Institute of San Diego and author of "Sexual health in drug and alcohol treatment: A relapse prevention curriculum" to be published by Springer. He can be reached at www.sexualdependency.com or 619-528-8360.

John de Miranda, EdM, is the CEO of Stepping Stone of San Diego. He can be reached at johnd@steppingstonesd.org or 619-278-0777.

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brought to a vote in Congress Feb. 12, and President Obama was ready to sign the package.

However, the field is still calling for constituents to contact their legislature about the importance of adding certain items to the stimulus bill. Even if it's too late for this law, lobbyists say it's important for legislators to know that treatment and recovery funding is important to their constituents.

The Legal Action Center last week issued an alert to providers to ask their representatives and senators to "include language in the economic stimulus bill to ensure that funds can be used for drug and alcohol addiction, and mental health programming and professionals." •

Call the Capitol switchboard at 202-224-3121 to get the direct lines to your senators and representatives. You can also go to www.senate.gov and www.house.gov.

ICM from page 1
"greater sensitivity to not just acute intervention but to what happens in the long term," said Clark, who called the study an important step in creating an evidence base for ICM specifically aimed at substance abuse treatment.

'We have pretty good evidence that additional formal social services elevate long-term recovery outcomes.'

William L. White

Case management in general "plays a critical role in facilitating what a person needs in order to achieve recover, and to monitor that recovery process," said Clark. "So if a person needs transportation, or has legal issues or child welfare issues, housing issues or income issues, these need to be dealt with."

Vulnerable populations

While recovery support should be included in everyone's treatment and recovery plan, not everyone needs case management, said Clark. People with "mild to moderate" addiction problems, who still have family support, don't. Case managers from social services departments like welfare and child protection don't get involved unless the client is actually in those systems. But if the client's problems are "moderate to severe," case management is important, said Clark. If there's domestic violence, child abuse, housing loss, or job loss, case management becomes more important.

The *AJPH* study showed that ICM was better than standard case management in both helping women on welfare (Temporary Assistance for Needy Families, or TANF) get jobs, and helping them stay in recovery. Two years after treatment, there were twice as many women employed who had received ICM compared to women who had received standard case management.

The key focus of ICM was recovery, an important point of the study, said Clark. "I won't get you off welfare if I ignore the problem of addiction," he said. "The case manager has to facilitate that."

Relapse prevention plus ICM

Significant early work had been done on the use of case management in substance abuse treatment by the Case Management Enhancements project, a research project funded by the National Institute on Drug Abuse at the Center for Interventions, Treatment and Addictions Research (CITAR) at the Wright State University School of Medicine in Dayton, Ohio. For example, CITAR found that up to nine months of "strengths-based case management" led to improved retention in aftercare, reduced drug use, and less criminal justice involvement. The research into case management at CITAR led to early reports that case management could be a stand-alone treatment intervention, instead of just an adjunct to treatment.

By combining a "navigating the system" approach of traditional case management with the relapse-prevention approach of aftercare, CITAR found that helping clients

focus on their strengths improved their functioning and their recovery.

One of the foremost researchers in recovery, contacted about ICM, said that case management must be incorporated into treatment and recovery systems because of fragmentation of services for clients. William L. White, senior research consultant at Chestnut Health Systems in Bloomington, Ill., told *ADAW* that helping clients access services can help them sustain recovery, he said — but he made a distinction between case management and recovery support.

"We have pretty good evidence that additional formal social services elevate long-term recovery outcomes," White, whose recent writing, including a monograph in press, focuses on the importance of sustained recovery support and guidance, told *ADAW*. What's new is the use of case management in a recovery-specific context. "Traditionally, the case manager has been a resource connection person," he said. "The recovery coach is qualitatively different — they can help make linkages, but they are really more of a personal guide." A recovery coach, however, cannot necessarily help a client navigate the system.

Unlike recovery coaches, whose main role is to assist the client with recovery, case managers help clients navigate the system, said Clark. "A recovery coach can also be a case manager, but in order to do that, you need to remind them that they need to deal with a wide range of issues, not just abstinence."

What made the case management "intensive" in the *AJPH* study, which was conducted by Jon Morgenstern, Ph.D., and colleagues at CASA and in the New Jersey state government, was more frequent contact lasting longer. The long-term contact is "very important," said White.

Drug czar at last?

News reports indicate that the news director of the Office of National Drug Control Policy is Seattle Police Chief Gil Kerlikowske, who told his department managers the news last week. Kerlikowske reportedly wanted to be administrator of the Drug Enforcement Administration.

Kerlikowske, who has been police chief in Seattle for 8 years, formerly worked in the Justice Department during the Clinton administration as director of community-oriented policing. Before that, he was chief of police in Buffalo, N.Y. An advocate of gun control, he has a reputation as a progressive and intellectual, according to news reports.

"If selected (as reported) and confirmed, [Kerlikowske] will be an excellent with a combination of national law enforcement leadership plus sensitivity to what really does and does not matter in confronting the drug problem," Bob Weiner, former spokesman for the ONDCP, told *ADAW*.

Inter-agency agreements

"This study is an eye-opener," said David H. Kerr, founder and president of Integrity House in Newark, N.J., of the *AJPH* article. It confirms what researchers have known for years, he said, and it could have systemic implications for treatment and recovery systems. One of the problems is that researchers sometimes confuse "treatment" and "recovery," he said. Nobody needs five years of treatment —but everyone at Integrity House is recommended to receive five years of recovery support — which includes case management.

What is lacking in the current system is formal inter-agency agreements that allow different agencies — like substance abuse and TANF — to use case management to help clients get the services they need. For example, web-based databases are still in separate silos, with no "one easy link" to help coordinate the abilities of individual databases, said Kerr.

Finally, Kerr said the real reason why the women in the *AJPH* study are doing well after ICM is that they had more effective linkage with community agencies. And he said the personal one-on-one relationship with the same case manager over a long period of time is critical.

Post-treatment monitoring

According to White's research, recovery doesn't become stable until five years after treatment, at which point the likelihood of relapse drops below 15 percent. "With case management, we can have external monitoring and support for a year, but what then?" he said. "What it takes to sustain recovery is different than what it takes to initiate recovery."

White hopes that case management can be integrated with post-treatment monitoring and support. "We need to build long-term supports for recovery, instead of recycling people through extremely expensive episodes of care," he said. "Right now 64 percent of people in treatment have already been in treatment before, and 20 percent have been through five or more treatment episodes."

And the fact that people get recycled through treatment doesn't mean treatment isn't working — it means that the ongoing case management and recovery support isn't taking place. "It's like giving people antibiotics for bacterial infections, but giving them only half of what's needed," said White. "People will feel much better at first. But the infection returns." •

Briefly Noted

SAMHSA report tracks non-medical use of prescription pain relievers

A Substance Abuse and Mental Health Services Administration report released February 9 finds that non-medical use of prescription pain relievers among young adults (18-25) increased from 4.1 to 4.7 percent from 2002 to 2007. However, use decreased from 3.2 to 2.7 percent among youths aged 12 to 17. Among males only ages 12 and older, there was an increase from 2.0 percent to 2.6 percent. The SAMHSA report, "Trend s in Nonmedical Use of Prescription Pain Relievers: 2002-2007," is drawn from National Surveys on Drug Use and Health (NSDUH) and represents roughly 405,000 U.S. citizens. To view the full report visit http://oas.samhsa.gov/2k9/painRelievers/nonmedicalTrends.cfm.

State News

Pros, cons of heroin maintenance under discussion in Baltimore

A study of heroin maintenance programs has found moderately positive results, said drug policy expert Peter Reuter with the University of Maryland. Reuter believes that although such programs as found in countries like Switzerland and Vancouver are costly, Baltimore should consider this a plausible means to get more addicts into treatment and decrease crime. However, officials including City Health Commissioner Joshua Sharfstein cite insufficient evidence of efficacy. Several politicians say the idea is too controversial. The Abell Foundation commissioned the study.

Connecticut bill would consolidate regional action councils

The Connecticut legislature is considering a bill that would consolidate 14 regional action councils working to prevent substance abuse into five entities, the Record-Journal reported February 9. The Wallingford/Meriden service area would expand to include New Haven. The local group fears this will cost them private funding from area supporters. The bill was introduced by the state Department of Mental Health and Addiction Services, whose Deputy Commissioner Peter Rockholz said it will cut administrative costs. Some organizations supporting the Meridan/Wallingford program have said they will not fund programs outside the area.

Texas treatment centers see increase in clientele

A declining economy coupled with the end of an oil boom mean more clientele for Texas's substance abuse treatment facilities, reported the Midland Reporter-Telegram on January 30. According to Bruce Cooper, recovery manager for the Palmer Drug Abuse Program, some employees with substance problems are pushed into treatment without a guaranteed job to return to. Others who have lost their jobs and can no longer support their habit turn to treatment out of desperation. Texas ranks low for funding for drug treatment and prevention, according to the Kaiser Family Foundation.

Coming up...

Members of the **National Association of Addiction Treatment Providers (NAATP)** and **NAADAC, the Association for Addiction Professionals** will gather for the Advocacy Action Conference on **March 8-10** in **Arlington, Virginia**. Visit **www.naadac.org** for more information.

The **Alabama Department of Mental Health and Mental Retardation (DMH/MR)** is co-sponsoring the 29th annual Alabama School of Alcohol and Other Drug Studies annual conference, taking place **March 23-26** in **Tuscaloosa, Ala.** For more information, visit **http://asadsonline.com/conference.html**.

The **California Institute for Mental Health** will host the Ninth Annual National Information Management Conference and Exposition: Addressing the Needs of Mental Health, Alcohol and other Drug Programs on **April 22-23** in **Anaheim, Calif.** For more information, visit **http://elearning.networkofcare.org**.

The **American Association for the Treatment of Opioid Dependence (AATOD)** will hold its national conference **April 25-29** in **New York City**. For more information, visit **www.aatod.org** or call 856-423-3091.

In case you haven't heard...

Guinness beer lovers looking for an excuse to celebrate with a few extra pints may like to know that this year marks the 250th anniversary of Arthur Guinness's original lease on St. James' Gate Brewery in Dublin. They may even be interested to learn that it was Arthur's son who added barley to the recipe when taxes on malt go too steep (Sunday Times, Feb 9). However, Guinness drinkers may be considerably less interested in knowing exactly how many units of alcohol they are consuming in each pint they enjoy. Patrons across the United Kingdom (UK) will soon learn that a pint of Guinness contains 2.3 UK units of alcohol, as clearly indicated on their new glass created to "make it easier for people to stay within (UK) Government recommended guidelines on alcohol unit consumption," reported Brand Republic on February 9.