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should be sending them to people who are certified to treat gambling addiction," he said.

And many people will come up positive, because the prevalence rate for the two disorders to co-exist is high. While only 2 percent of the general population has a gambling problem, 30 percent of people with a substance abuse problem are problem gamblers, said Beck. Fifty percent of compulsive gamblers have an addiction problem, he added.

Co-occurring disorders expert Kenneth Minkoff, M.D., said addiction treatment programs should be able to integrate gambling issues into routine programming. "There are never going to be enough gambling specific programs," he told *ADAW* last week. "No, gambling isn't the same, and it helps to have some special attention paid to it, but it's not so different that it's a complete mystery," he said. "You don't want to get everybody so scared that they can't even talk about it or work with it."

An addiction counselor can be co-occurring capable without having a mental health credential, said Minkoff. So that addiction counselor could certainly be capable of dealing with gambling problems without having a gambling credential, he said. "There's a place for specialists, but everybody has to realize they can help people with gambling issues."

New York experience

In New York State, gambling has been under the auspices of the Office of Alcoholism and Substance Abuse Services (OASAS) for more than two years, and there are now 25 outpatient programs for gamblers statewide. "Problem gambling is a disease of addiction," said Karen Carpenter-Palumbo, OASAS Commissioner.

The recession and related job losses do lead to an increase in gambling, said Carpenter-Palumbo. "People think it's a quick fix," she said. Unfortunately, suicide is also linked to gambling. "We know that one out of five problem gamblers have either contemplated or succeeded at committing suicide," she told *ADAW*.

Buying a lottery ticket is not necessarily the same as being a problem gambler, said Carpenter Palumbo, who compared gambling to drinking alcohol. If it's out of control — if someone becomes agitated because they can't buy their daily lottery ticket — then it's a problem, she said.

New York has Indian casinos, which don't pay the taxes private casinos pay. But in Pennsylvania, the tax on private casinos is 55 percent. Even so, noted Flaherty, the casinos made a profit. Over the weekend of August 8, the new casino in Pittsburgh took in $13 million in wagering over a 15-hour period. Of that, $3 million in pure profits went to the casino, $1 million went to local government, and $1.6 million went to the state. These numbers, said Flaherty, reflect a state's ambivalence when it comes to balancing revenues from gambling with costs of gambling addiction. "There are hot lines," he said. But for people in recovery, the message that they should stay away from casinos is a quiet one, if it's being said at all. Flaherty hopes addiction treatment providers will help spread the word. •

State Budget Watch

Montana treatment system gets additional $3 million

Montana, at least for the fiscal biennium beginning July 1, is doing well. Tax collections are down only by $37 million (2 percent) for the fiscal year that just ended. One of the two states that isn't facing a budget shortfall — the other is North Dakota — Montana went into the new fiscal year with $400 million in reserves. But the state's treatment system isn't waiting for the recession to hit: it's getting prepared by utilizing the NIATx principles, which focus on access and efficiency.

However, for now, the state's financial situation is good news for addiction treatment, as well, which got an increase due to alcohol taxes that were earmarked for the field.

The funding for the current biennium for the Bureau of Chemical Dependency Services is $35.5 million, up from almost $32.8 million in the previous biennium, according to director Joan Cassidy, who noted the increase came entirely from the alcohol tax. "We're happy that there were no reductions," Cassidy told *ADAW*.

One of the best moves the department made took place long before the recession, said Cassidy — the state bought into the NIATx principles, which focus on increasing access and retention, improving results, and satisfying the consumer — all without raising costs. "Now we have 15 of our 20 providers trained in NIATx," Cassidy said. "It's very exciting, and this is my kind of project."

> **'Providers have begun to look at their business practices.'**
>
> Joan Cassidy

The state's treatment providers have a strong clinical history, but are weaker on "the business side," said Cassidy. The NIATx project has changed that dramatically. "Providers have begun to look at their business practices," she said.

For example, if a patient doesn't show up in group, that empty chair costs the program money. "NIATx

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has really allowed providers to make sure that chair is full," she said. Programs have learned to follow up on appointments, to remind people to come to group, she said. "They've changed the way they conduct intake and orientation to engage patients."

And the state has responded as well, creating a new payment for patients who are not yet in treatment due to space limitations, but who are in a "pre-treatment" mode. "We've built this pre-treatment into contracts," said Cassidy.

The NIATx contract, combined with a small contract for an outside coach, costs the state only $6,000, said Cassidy. With admissions running at over 8,000 a year, about 700 of which are inpatient, this is a very affordable sum, she said.

Some states participate in NIATx via a grant, but Montana made the small investment, and it pays off, Cassidy said, adding that treatment providers will have to continue to follow these principles, which work to treat more people with less money.

"Although the picture looks good today, what happens in the future is very questionable," said Cassidy. That's because the impact of job losses that may take place on tax receipts won't be felt until next year, she said. Already, the state administration is taking a conservative route. "State employees are on a wage freeze, and travel has been restricted," said Cassidy. When the recession comes to Montana, she wants to be prepared, not only clinically, but financially. •

Methadone induction death raises questions

The county coroner of Lake County, Ill. is under investigation in the Dec., 2008 death of a patient at the Green Dragonfly methadone clinic. Richard Keller, M.D., the coroner, is also the medical director of the clinic.

Steve Vaughn, 30 years old, died on the second day of methadone treatment after he had been given a 70-milligram dose. He was given 40 milligrams the first day (10 more than is allowed by federal regulations).

Vaughn told Keller that he had taken Xanax three days earlier, but there is no record of a urine test. He died from a combination of Xanax and methadone, but not from an overdose of either, according to Keller (the coroner's) report.

Keller, who did not return a phone call from *ADAW*, told the Chicago Tribune that there was no conflict of interest in his signing of the death certificate. "It's like any other doctor who signs a death certificate for his patient, which happens all the time."

In fact, the federal government doesn't require that urine tests be done before someone is given methadone, according to Nicholas Reuter, Senior Public Health Advisor, Division of Pharmacologic Therapies, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. "Our regulations specify that there be at least eight random drug tests a year," Reuter told *ADAW*. "But our regulations do not require an initial point of collection test." Still, he said, every program as a "standard of practice" collects a drug test specimen on admission — although the results of that test aren't always available prior to administration of methadone.

> **'We have said that the induction period, which lasts 14 days, give or take, is the most dangerous phase.'**
>
> Nicholas Reuter

If there were no opioids in the patient's system, it might be expected that the program would give less methadone than the maximum allowable 30 milligrams for the first dose, but this isn't required, said Reuter. "Under our regulations, a patient does not have to be currently dependent to be admitted."

But, Reuter said, it would be expected that the program physician would monitor new patients very carefully. "We have said that the induction period, which lasts 14 days, give or take, is the most dangerous phase," said Reuter. The maximum initial daily dose of 30 milligrams is a rule that has been in place for 25 years, he said. "We remind programs that we have this regulation in place, and we remind them that you have to individualize the dose to each patient — not every patient should receive 30 milligrams. We're very direct on that, and very clear."

Vaughn was found at home by his mother, dead, hours after he received the second-day dose of 70 milligrams of methadone.

State's attorney Michael Waller told *ADAW* that the family, weeks after Vaughn died, went to the coroner to ask for an investigation into the death. They didn't know that the coroner was the same person as the medical director of the clinic, Waller said.

The family said that Keller was addicted to Xanax, not opiates, but he lied about this to the methadone treatment program, because he

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