Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

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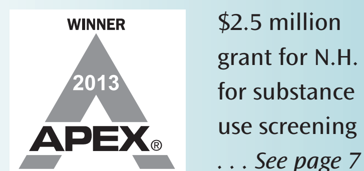

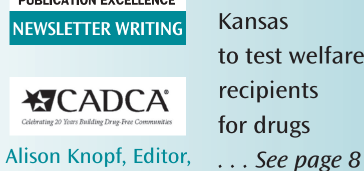

Alison Knopf, Editor, winner of CADCA Newsmaker Award

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The ACA one month out: Too soon to see any impact

For years, the Affordable Care Act (ACA) has been touted by supporters — led by the federal government — as the solution to treatment providers whose patients have no money for services. Put another way, the ACA, combined with parity, was supposed to help people who needed treatment but didn't have insurance for it and, ultimately, be a bright new funding stream for treatment providers who have seen nothing but cutbacks.

Bottom Line...

The ACA's implementation January 1 has had no discernible effect on treatment providers one month out.

But some cautious officials have been warning that the ACA would not miraculously mean new patients with Medicaid and private insurance would start streaming through the doors on January 1, 2014, and calls this past week have revealed that, in fact, it's far too early for anyone to know what effect the ACA is having on treatment demand.

The only information that the Centers for Medicare and Medicaid Services (CMS) could provide to *ADAW* was raw data on how many people have enrolled in the exchanges and Medicaid. There was no information on whether any of these people had tried to access any

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The Business of Treatment

Providers steer through complex process for inclusion in networks

Private insurance dollars still represent less than 10 percent of the overall revenues at Behavioral Health Services, Inc., a comprehensive substance abuse services organization covering much of Los Angeles County. But with public reimbursement levels flagging and more of the provider's patients expected to be enrolled in insurance in the months ahead, Behavioral Health Services continues to push a long-standing effort to be part of the provider networks of the leading insurers serving the Los Angeles County area.

Bottom Line...

Accreditation standards, billing and even the quality of insurance companies' own records are just some of the variables that can affect addiction treatment providers' success in joining and staying on private insurance panels.

"We want to be on as many panels as we can," Michael Ballue, Behavioral Health Services' chief strategy officer, told *ADAW*. "We're in-network with a lot of them."

Funders and organizers of the BHbusiness initiative, an online learning curriculum designed to prepare provider organizations for the dramatic changes occurring in the

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treatment, much less a specific kind of treatment.

Jerry Rhodes, president of the recovery division of CRC Health Group, the nation's largest chain of substance use disorder (SUD) treatment providers, told *ADAW* last week that any changes will take months — "maybe years" — to see. "We have not seen any wholesale change or increase in patients, and I expected that," said Rhodes, who, like virtually all treatment providers, strongly supported the ACA and parity. "This is going to be an evolution as these populations come into the exchanges," he said, referring to the private marketplaces where people can buy plans and get subsidies under the ACA.

"People thought it's a black-and-white thing — that you would flip the ACA switch and suddenly we're in nirvana," said Rhodes. "It doesn't work that way."

Parity is local

And the promise of parity, under which all treatment for SUDs and mental illness must be provided on the same basis as medical and surgical treatment, still has a long way to go. "I don't know that the exchanges fully comprehend what parity does or does not do," said Rhodes. "I think we're going to be in a period of several years before the dust settles."

Getting into the private networks is difficult for all providers, especially SUD treatment providers (see sidebar, page 3). "We've got to work harder as providers to start the dialogue in terms of getting access," said Rhodes, noting that this has to take place on a local, regional basis.

> **'People thought it's a black-and-white thing — that you would flip the ACA switch and suddenly we're in nirvana.'**
>
> Jerry Rhodes

"There's no national overview of this," he said. Networks are set up at county levels, and insurance companies, to keep the costs down — marketplace plans are relatively inexpensive — are limiting the number of providers.

Medicaid better than exchanges

Medicaid offers a better opportunity for treatment providers than the exchanges, said Rhodes. "That's a very viable population," he said, noting that of course this depends on the state. Some state Medicaid plans have very limited SUD treatment services — even with parity the law of the land — while others have generous benefits and have expanded under the ACA. "There's going to be a high degree of variability," he said.

Noting that no CRC program is in any marketplace network, Rhodes said that implementing parity is going to be essential, but that cultivating local relationships with plans and other providers is more practical at this point. "I would look at regional and local opportunities," he said. "But in the future, as this evolves, as exchanges see the necessity of implementing the parity act, I think there will be significant opportunities for reaching out on how to service this population." First, the exchange plans have to understand the costs overall of not treating SUDs — a lesson that seems to have to be relearned. "It's going to be months, maybe even longer, before there's any clarity on it," he said.

On the bright side, the ACA and parity have "clearly put SUD treatment front and center," said Rhodes. "There's a greater recognition by society, and that's important, that has

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Editor Alison Knopf
Contributing Editor Gary Enos
Copy Editor James Sigman
Production Editor Douglas Devaux
Executive Editor Patricia A. Rossi
Publisher Margaret A. Alexander

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elevated the status of treatment, that SUDs are analogous to a medical condition." That imposes equity in the healthcare system that didn't exist before, said Rhodes. But he noted that the healthcare system itself has insurance "issues," he said. "If people are thinking that with parity, there will suddenly be a significant advantage, that's not true," he said. "The healthcare system still has the same issues in terms of interactions with insurance and other payers. We're not going back to the old days."

But Rhodes conceded that there are flagrant violations of parity and the ACA imposed at the state level: some states refuse to allow Medicaid to pay for methadone or buprenorphine treatment, for example. Some states are still openly defying the ACA even as residents seek coverage. "There are some major policy issues that CMS needs to deal with," he said. •

Study shows parity for SUDs raised costs only $10 per enrollee per year

A study published in the current issue of the *American Journal of Managed Care* found that parity for SUD treatment is not resulting in an increase in costs. The study, conducted by researchers at Yale, obviously took place before full implementation of the ACA this January, and before implementation of the final rule on parity next year, but found that for those plans that did have to comply with the parity law, the increase in spending was only $10 per year per enrollee. What the study proved was that plans were unlikely to drop insurance coverage completely for SUDs as a result of increasing costs — something that the parity law would allow them to do.

New Hampshire providers push for Medicaid expansion

Treatment for substance use disorders (SUDs), chronically underfunded in New Hampshire — as are many public health services — has a chance to grow for the first time in decades, if the state legislature can agree on Medicaid expansion. Shut down by the Senate last session, Medicaid expansion — which would be paid for by the federal government under the Affordable Care Act — is under consideration again this year. Supported by the House and Gov. Maggie Hassan, Medicaid expansion would give thousands of residents of New Hampshire their first chance to get treatment for SUDs, according to Abigail Shockley, executive director of the NH Alcohol and Other Drug Service Providers Association.

Opposition comes from legislators who are up for reelection and who don't want to be associated with "Obamacare," said Shockley. "It's very much party politics at this point," she said.

And while there is a healthcare exchange — set up by the federal government — it's not helpful to people who earn too little to qualify. "We don't want to miss out on Medicaid expansion," Shockley told *ADAW*. The state exchange has only one insurance company: Anthem.

Block grant

Most of the SUD treatment providers in New Hampshire are funded by the federal block grant, said Shockley. "But the state is aware of the benefit of being able to bill insurance," she said. What treatment providers need is a reliable funding stream, so that they can be ready for the additional patients that Medicaid expansion — if it happens — will bring in. "The worry is that if we have a surge of folks who need treatment, will there be the capacity? The short answer is yes, but the long answer is that these folks are going to have to hire and expand, and they don't have the funds to pay for that up front," she said. "It will be a learning curve and there will be some growing pains."

'It's very much party politics at this point.'

Abigail Shockley

But those are pains Shockley would welcome. In New Hampshire, Medicaid doesn't pay for any SUD treatment, she said.

Work group

There is a work group that is very active in pushing for Medicaid expansion, and the SUD providers are a part of it. "All the big players are there — the advocacy groups, the trade associations, primary care, mental health, the legal aid centers," said Shockley. The coordinated effort makes sense, because the effect of untreated SUDs is seen in all parts of the public system, from health to criminal justice.

The state's insurance department supports Medicaid expansion as well.

Navigators who try to help people sign up with Anthem for insurance on the exchange report that many people are falling into the "coverage canyon," said Shockley. "The navigators are having to turn them away, telling them they're too poor."

Opioids, marijuana

New Hampshire's biggest SUD

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problem is prescription opioids, said Shockley. New Hampshire does allow methadone maintenance treatment but doesn't pay for it, so most of the clinics are for-profit and self-pay, she said. The state also does not pay for buprenorphine treatment.

Another big problem is marijuana dependence, said Shockley. Ironically, the legislature is seriously looking at marijuana legalization, she added, noting that her organization is fighting this, while at the same time fighting for Medicaid expansion. With too little capacity to treat the people already needing help, providers wonder how they will be able to treat additional patients with marijuana dependence, whose ranks are expected to grow with legalization.

Heroin is also taking over as the state's prescription drug monitoring program is successfully cutting back on prescription opioids on the street, said Shockley. "Law enforcement can't keep up with heroin on the streets," she said. "We had three overdoses last week — one fatal — and three more this week." •

For the NH Alcohol and Other Drug Service Providers Association position paper on Medicaid expansion, go to www.nhproviders.org/uploads/3/3/4/8/3348331/medicaid_expansion.pdf.

More research needed on underage drinking: NIAAA

While underage drinking and related traffic deaths have been going down, underage drinking itself is still an ongoing problem, according to research published by Ralph Hingson, Sc.D., and Aaron White, Ph.D., of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Research shows that laws including night driving restrictions and graduated licensing have contributed to the good news in traffic deaths, and additional studies show that individually oriented interventions are helpful as well. Strategies that were recommended by the Surgeon General in the 2007 Call to Action on alcohol (see *ADAW*, March 12, 2007), when put into practice, have been effective, according to the NIAAA report, which is a review of recent literature on the topic and published in the January issue of the *Journal of Studies on Alcohol and Drugs*. However, continued study is needed, the researchers concluded, particularly in the minimally studied areas of prospective studies of alcohol and brain development, "use and lose" laws, criminal "internal possession" laws, social-host liability and parent-family interactions.

> **'While progress has been made in addressing underage drinking, the consequences still remain unacceptably high.'**
>
> Ralph Hingson, Sc.D

"The downward trend in underage drinking and alcohol-related traffic deaths indicates that certain policies and programs put in place at the federal, state and local levels have had an impact," said NIAAA Acting Director Kenneth R. Warren, Ph.D. Since 2007, alcohol use and heavy drinking have gone down in middle and high school students.

The researchers' analysis of driving studies has found that certain laws — especially graduated licensing laws for underage drivers, including nighttime restrictions, and license suspension laws for alcohol violations — have been effective in reducing traffic deaths related to underage drinking. In states with the strongest of those laws, young people are half as likely to drive after drinking.

College campus interventions have also contributed to these successes, the researchers found.

In addition, brief motivational interventions are successful, but very few people under 21 are screened for alcohol use, the researchers found. Only 25 percent of 18- to 20-year-olds who saw a doctor in the past were asked about driving, and only 12 percent were advised of the health risks of drinking.

"An evaluation of the recommendations in the Call to Action reveals that certain strategies show promising results," said Hingson, director of NIAAA's Division of Epidemiology and Prevention Research. "While progress has been made in addressing underage drinking, the consequences still remain unacceptably high. We must continue research to develop new interventions and implement existing strategies that have been shown to be effective." •

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healthcare industry (see *ADAW*, Jan. 27), recently have been highlighting the importance of BHbusiness courses in third-party contract negotiations and third-party billing and compliance. Ballue's agency last year participated in BHbusiness' course in strategic business planning, which often serves as a good initial overview course for participants, but he says insurance contracting already has been a priority in his organization for several years now.

"Public reimbursements have

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been reduced since the recession hit," Ballue said. "There is no indication that there will be a large turnaround in this. We need new revenue streams to offset the changes in others."

Familiarity with market

With a $20 million budget and more than a dozen facility sites offering a continuum of detox, inpatient, residential and outpatient services across Los Angeles County, Behavioral Health Services sees its size and reach as placing it in an advantageous situation for inclusion in insurance networks. "Our size and diversity puts us in some geographic areas where there are not a lot of other providers," said Ballue.

In addition, Ballue said he and several other staff members at Behavioral Health Services have worked in the private-sector side of the field in the past, so many are already adept at speaking the language of insurance.

That doesn't mean challenges don't remain in working with various insurers. For example, Ballue said, his organization is CARF-accredited, but Aetna does not accept CARF accreditation in its review process. So that necessitated additional site visits from Aetna to Behavioral Health Services to assess the provider's compliance procedures, he said.

Ballue added that some of the keys to the organization's recent progress in the insurance arena have included designing a new benefit verification system for patient intake and contracting with an outside billing service to troubleshoot problems at the other end.

The benefit verification system features a centralized administration that allows numerous staff members to complete that function when the patient presents for treatment, depending on which staff member is available at that time. Ballue said the organization patterned this function after its information technology help desk.

"We started finding out that some patients who were in public programs also had insurance," Ballue said.

Based on the differences in billing procedures among the various insurers with which Behavioral Health Services wants to continue to do business, it contracted out with a national vendor for its billing. "It was the prudent way to go," Ballue said. "They deal with any rejections."

Ballue pointed out that his organization has not set a formal percentage goal for how much of its revenue it wants to see as coming from insurance.

"We expect this to be a volatile landscape," he said of the market. "We want to be able to serve our constituents regardless of how they're funded."

As working with insurance has become a more important component of an organization traditionally dependent on public dollars, Ballue said managers of the organization

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'We started finding out that some patients who were in public programs also had insurance.'

Michael Ballue

Wyoming bill would fund treatment and prevention with state alcohol revenues

Wyoming state Rep. Bunky Loucks, a Republican lawmaker from Casper, has proposed a bill that would fund substance abuse prevention and treatment with alcohol taxes. Under the bill, a copy of which was obtained by *ADAW*, 15 percent of all alcohol revenue collected by the state would be placed into a special account for substance abuse services. Last year, the state collected $13.6 million from taxes and profits generated by the Liquor Division: all of that money goes into the general fund, according to the *Wyoming Tribune-Eagle*. According to Loucks, this earmark makes sense. "I think all of us have had issues with someone struggling with alcohol abuse or substance abuse," he told the newspaper. "So I wanted to see if we couldn't give more money (for substance abuse treatment and prevention programs) without dipping into another account."

This is different from a direct alcohol tax: last year the legislature was looking at a plan to raise the 2 cents per gallon beer tax to 18 cents per gallon. That tax would have also given the state more money for substance abuse treatment. However, the proposal was defeated in committee, with Loucks among those opposed to raising the tax, which has stayed the same since 1935.

The state Department of Health spent $51.2 million in general fund dollars during 2007–2008 on mental health and substance abuse: that number was $113.5 million for 2013–2014. But providers say there still isn't enough funding for the growing need for substance use disorder services. The number-one drug of abuse in Wyoming is alcohol, according to the health department.

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have prioritized consistent communication and updates for staff. "You get staff buy-in if you bring them along at every stage," he said. "This is not something that should come out of left field for the staff."

Timely monitoring

LifePoint Solutions, a community behavioral health provider organization in Ohio that includes addiction treatment but is somewhat more focused on mental health services, participated last year in the BHbusiness course on third-party billing and compliance. Candy Gabriel, the organization's director of business services, told *ADAW* that in Ohio, individual providers in a treatment organization generally need to be licensed independent social workers to qualify for placement on insurance panels. But sometimes the question of whether a provider will qualify will depend more on how updated an insurer's panel is than on actual credentials, she said.

"A person can stay on a panel for years," Gabriel said. "The person can be dead and stay on — I see it. Then an insurer will tell us that there are already enough providers in the area."

She said that for her agency, the most important takeaway from the BHbusiness course was to highlight the need for frequent reporting within the organization to identify and respond to emerging trends.

"This has allowed me to have new reports created for me by our IT person, so I can monitor who hasn't been paid for," Gabriel said. "I want to know immediately."

Although there is often a significant lag time between delivering a service and paying for it, based on needing to ensure that a clean claim is being submitted, LifePoint Solutions is sending out insurance bills on a weekly basis in order to maximize cash flow, Gabriel said. •

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Program employees charged with blocking police access

In a case of federal confidentiality law versus law enforcement, two employees of Bridgeway Behavioral Health in St. Louis, Missouri, are charged with interfering with police officers who wanted to arrest a patient and had a search warrant, the *St. Louis Post-Dispatch* reported last December. The patient was wanted for a parole violation; he was on probation for resisting arrest, burglary and stealing, and his violation was not showing up for his meeting with his parole officer. The officers had gone to the home of the patient, where someone told them he was at Bridgeway. Two managers, Christine Marie Rupp and Stacy Lynn Glenn, would not produce the patient, even after the police officers returned with a search warrant, citing federal confidentiality rules (42 CFR Part 2). During this time, the patient climbed out of a window and ran away. He was found later that day after a manhunt that involved more than 10 officers.

Both employees have been charged with a misdemeanor and could be sentenced to six months in prison. The program manager, David Chernof, said that it was not the first time police had tried to arrest patients and been turned away, but it was the first time employees had been charged. "I'm not an attorney, but my opinion is that there's no basis for these charges," Chernof told the newspaper. "It would be a huge barrier for people if they thought their treatment was in jeopardy because the police were going to be able to walk in and arrest them." But the St. Charles County prosecutor, Tim Lohmar, disagreed. "We don't ever want to create a situation where people who are wanted by law enforcement can have asylum; that's what we're trying to guard against," said Lohmar. "This doesn't come up very often because we don't usually have people bold enough to refuse to honor a search warrant."

> **'The federal confidentiality regulations do not permit programs to confirm that the individual is a patient (e.g., by producing the patient or taking the police to him/her) unless the police have a court order issued under 42 CFR Part 2.'**
>
> Sally Friedman

Advice from the Legal Action Center

The Legal Action Center, the foremost legal authority on 42 CFR Part 2, the law that protects the confidentiality of patients in SUD treatment, stresses that it's essential for treatment providers to educate law enforcement, as well as to understand their own obligations under the federal law.

"These types of scenarios are rare, but I have seen them in the past," said Sally Friedman, legal di-

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rector for the Legal Action Center.

"The federal confidentiality regulations do not permit programs to confirm that the individual is a patient (e.g., by producing the patient or taking the police to him/her) unless the police have a court order issued under 42 CFR Part 2," Friedman told *ADAW*. "A search warrant in and of itself is not such a court order."

However, the regulations "do not require program personnel to prohibit the police from entering and searching on their own for the patient at issue," said Friedman. "This puts programs in a terrible bind."

So the Legal Action Center has the following recommendations:

- Work with law enforcement officials ahead of time to explain the requirements of 42 CFR Part 2.
- Produce a copy of 42 CFR Part 2 when the police present themselves at the program and explain that with a court order that complies with 42 CFR Part 2, the program could cooperate if the patient were there.
- Try to get time to contact a lawyer.
- Ask for the prosecuting attorney or commanding officer so that the program can repeat its arguments.
- If the police insist on entry, do not forcibly resist.

In a case in which the police are in hot pursuit of a patient, following the fleeing subject of the warrant into the program — which was not the case in the Bridgeway situation — then the individual's flight itself could constitute a crime that should be reported to the police, said Friedman. "But this is a very rare circumstance, and programs should consult counsel before so doing to ascertain whether by entering the program, the patient actually did commit a crime in that state," she said. •

This — and much more — is explained in the Legal Action Center's *Confidentiality and Communication: A Guide to the Federal Drug and Alcohol Confidentiality Law and HIPAA*, available at www.kintera.org/site/apps/ka/ec/product.asp?c=8hKNI3MIIjI0E&b=6343345&en=dmLPI6OPJcJYLgMSIbKUKiP9JqKZLgOZKjI0JnOaJAI&ProductID=1567519.

Briefly Noted

Researchers find food addiction linked to impulsive personality

Food addiction and substance use disorders (SUDs) are both reflections of impulsive personalities, according to research published in the current issue of *Appetite*. For the study, researchers at the University of Georgia used the Yale Food Addiction Scale and the UPPS-P Impulsive Behavior scale to determine the rates of food addiction and impulsive personalities among 233 participants. They then used body mass index (BMI) to determine obesity and found that impulsive behavior does not necessarily result in obesity. "The notion of food addiction is a very new one, and one that has generated a lot of interest," said James MacKillop, Ph.D., the study's principal investigator and an associate professor of psychology in UGA's Franklin College of Arts and Sciences. "My lab generally studies alcohol, nicotine and other forms of drug addiction, but we think it's possible to think about impulsivity, food addiction and obesity using some of the same techniques." The researchers found that an increase in certain impulsive behaviors is linked to food addiction, which may result in a higher BMI. "Our study shows that impulsive behavior was not necessarily associated with obesity, but impulsive behaviors can lead to food addiction," MacKillop said. The researchers plan to expand their research by looking at the brain activity of individuals while making decisions about food. "Modern neuroscience has helped us understand how substances like drugs and alcohol co-opt areas of the brain that evolved to release dopamine and create a sense of happiness or satisfaction," he said, noting that modern foods may have sugar, salt and flavors to enhance that sense of happiness. His research, funded mainly as obesity research, will focus on how "certain types of food also hijack these brain circuits and lay the foundation for compulsive eating habits that are similar to drug addiction."

Correction

In the January 27 issue, the article on appropriations should have stated Fiscal Year 2014.

We regret the error.

In the States

$2.5 million grant for N.H. for substance use screening

The Hilton Foundation has given New Hampshire a $2.25M grant that the New Hampshire Charitable Foundation will use to create a new substance abuse screening program for adolescents and young adults, The Associated Press reported January 26. Working with hospitals, primary care and community health centers, the program will screen 10,000 young people for substance use by 2017.

N.Y. counties report increased heroin ODs as users switch from prescription opioids

Like localities across the country, Long Island is seeing an increase in heroin overdoses as drug users switch from prescription opioids to the less expensive and more available heroin. *Newsday* reported January 25 that prescription pills are now costing $60 to $80 each, compared to $6 to $8 for a bag of heroin. In two Long Island counties (Nassau and Suffolk), heroin killed 121 peo-

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ple in 2012 and at least 120 last year — the two highest totals ever. Both counties are close to New York City, a known heroin hub. Even though intranasal naloxone is increasingly available, deaths are still going up. In Suffolk County alone, 563 people were successfully saved from overdoses from naloxone administered by police and paramedics last year. Nonfatal heroin overdoses are also going up. The trend toward heroin is occurring because of a crackdown on prescription opioids, according to county officials. The preliminary overdose count could increase by 10 percent in Nassau when the medical examiner's office completes investigations on all cases. "As bad as these numbers are, they're only the tip of the iceberg," said Jeffrey Reynolds, executive director of the Long Island Council on Alcoholism and Drug Dependence. "These numbers demonstrate that we have to redouble our efforts to crack down on those who deal heroin while providing needed treatment for those who are addicted," said state Sen. Phil Boyle, chairman of the Senate's Committee on Alcoholism and Drug Abuse. "This is an epidemic in the truest sense of the word."

Coming up...

Community Anti-Drug Coalitions of America (CADCA) will hold its annual leadership forum **February 3–6** in **National Harbor, Maryland**. For more information, go to **www.cadca.org/events/detail/forum2014**.

NAADAC, the Association for Addiction Professionals will holds its annual advocacy conference **March 2–4** in **Alexandria, Virginia**. For more information, go to **http://naadac.org/advocacyconference**.

The 45th annual medical-scientific conference of **The American Society of Addiction Medicine** will be held **April 10–13** in **Orlando**. For more information, go to **www.asam.org/education/annual-medical-scientific-conference**.

Kansas to test welfare recipients for drugs

Kansas is starting to test welfare recipients for drug use this year, and according to a report in the *Kansas City Star*, it will spend a lot of money to catch very few drug users. Last year, Missouri instituted drug tests, and after eight months and 636 tests, only 20 people tested positive. About 200 refused to be tested. Over the course of the eight months, about 32,000 people applied for welfare. The cost of the testing was $500,000. Rep. Stacey Newman from St. Louis called the program "a horrible waste of state resources." But Rep. Rick Brattin supported the program, saying people are "being held accountable for taking state aid." Critics of drug testing say it singles out poor people who are no more likely to use drugs than the general population. Last year North Dakota and Virginia rejected mandatory drug testing for welfare recipients, and Gov. Pat McCrory of North Carolina vetoed a drug testing bill (which the legislature overrode). In Florida, out of 4,086 tests conducted in 2011, 108 were positive. The program was ruled unconstitutional. Florida spent $115,000 on the program and had to reimburse those welfare recipients who lost their benefits $600,000. Out of 6,007 welfare recipients in Utah who were tested in 2012, only 14 tested positive, at a cost of $32,000 to the state. In Missouri, lawmakers who support the testing said the 200 people who refused to be tested constituted a savings to the test, because they were denied benefits for three years — and the refusal proved that they were drug users, these lawmakers said. But others say that simply refusing to take a test doesn't prove anything. Under the Kansas program, people who test positive lose their benefits but can get them back after completing a treatment program and job skills program. A second positive test means the recipient loses welfare benefits for a year; a third positive test means they lose them for life. A third party can apply for benefits on behalf of the children.

In case you haven't heard...

Marijuana stores are getting a taste of NIMBY. *The New York Times* reported January 26 that an increasing number of towns and counties are banning the sale of marijuana, fueled by the imminent opening of retail stores in Washington and the opening of such stores in Colorado. The tax revenues promised by the supporters of legalization — the main reason states supported legalization themselves — are now threatened by these local bans. "In some ways I think the best thing that could have happened to the anti-legalization movement was legalization, because I think it shows people the ugly side," Kevin A. Sabet, Ph.D., co-founder of Smart Approaches to Marijuana, told the *Times*. And he had advice for his opponents on the other side of the legalization debate: "If legalization advocates just took a little bit more time and were not so obsessed with doing this at a thousand miles per hour, it might be better. Instead, they are helping precipitate a backlash." He added, "This is not about the adult being able to smoke a joint. It's about widespread access, it's about changing the landscape of a neighborhood, it's about widespread promotion and advertising, and it's about youth access." Dave Ettl, a Yakima City Council member who favors a ban on legal marijuana in the Washington city, said he viewed the tax revenues from marijuana as tainted. "There's some money that's not worth getting," he told the *Times*.

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