ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

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In This Issue...

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CADCA
Celebrating 20 Years Building Drug-Free Communities

Alison Knopf, Editor, winner of CADCA Newsmaker Award

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MAT, especially Vivitrol, gets a foothold in the criminal justice system

Bottom Line...
Gradually, the criminal justice world is looking at medications instead of detoxification as a treatment for opioid addiction.

The past month has been intense — in a good way — for medication-assisted treatment (MAT) and criminal justice. Due to the opioid addiction and overdose epidemic, Congress and the White House are showing interest in MAT with methadone, buprenorphine and naltrexone. This goes against the traditional view of the courts and corrections of opioid addiction: the best treatment is detoxification, even if it is just coerced by incarceration.

One of the emerging storylines, however, is that naltrexone — Vivitrol — seems to be edging out the other two medications in the criminal justice arena, probably because it requires detoxification first, and itself is not addictive. This is in direct opposition from the trend in treatment and the physician office world, which has largely rejected Vivitrol in favor of buprenorphine and, for opioid treatment programs (OTPs), methadone.

Senators speak out

On April 10, 16 U.S. senators signed a letter to Attorney General Eric Holder calling for all branches in the Department of Justice to use

See **MAT** page 2

The Business of Treatment

Interventionists should be open and transparent with programs

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Bottom Line...
Some leading interventionists believe treatment centers should accept referrals only from interventionists who are credentialed, have visited the center and have achieved transparency with the provider and the patient's family.

As in any relationship, a commitment of time and a vow to be open and honest can serve as some of the key ingredients for successful relations between an addiction treatment facility and an interventionist. *ADAW* last week spoke with two intervention professionals who stand among the strongest voices for professionalism in the intervention community, and they agreed that the treatment center and the interventionist bear equal responsibility for assessing whether and when they can work well together while benefiting patients and their families.

In part, this means that both parties have to understand that the interventionist's referral of a patient to the center marks not the end of the professional relationship, but the beginning.

"We're moving farther and far-

See **Intervention** page 4

MAT from page 1

medications to treat opioid addiction in combination with counseling. The letter makes it clear the prescription opioid and heroin addiction are "expressions of the same disease," reflecting the fact that the medications work equally well for prescription opioids and heroin.

The letter, which attracted the immediate support of the American Association for the Treatment of Opioid Dependence (AATOD), called on the Justice Department to "initiate a multi-state program utilizing anti-addiction medications to support successful reentry into society of opioid addicted offenders from various correctional settings." In an email to the field, AATOD President Mark Parrino notes that the criminal justice field has long had a "misunderstanding" about MAT, with drug court judges extremely reluctant to refer people to anything but drug-free treatment.

AATOD has been working for more than 15 years to increase access to MAT in the criminal justice setting, along with the Legal Action Center, which in 2011 published a paper on the legal problems of denying access to MAT in the criminal justice setting.

Vivitrol

Then, Senators Rob Portman (D-Ohio) and Sheldon Whitehouse (D-R.I.) on April 19 led a symposium on Capitol Hill on addiction and criminal justice. Presenters focused on opioid addiction, and included Gov. Peter Shumlin of Vermont, where the hub-and-spoke system for methadone and buprenorphine is helping to deal with the opioid epidemic there.

But at the symposium, only one pharmaceutical company was represented. Richard Pops, CEO of Alkermes, which makes Vivitrol, was a presenter. There were no presenters from the American Society of Addiction Medicine or AATOD. There were presenters from the criminal justice field.

Over the past few years, it has become clear that the criminal justice community, in general, prefers naltrexone, which is an antagonist that blocks the effect of opioids, to methadone or buprenorphine.

Andrew Kolodny, M.D., chief medical officer of Phoenix House, attributes the rise of Vivitrol in the criminal justice system to lobbying and marketing by Alkermes, which had a hard time selling the product to the intended market — treatment programs. "What you have is the drug company has not been able to get many doctors or treatment programs interested in prescribing Vivitrol, so now they are sending their sales force out to drug courts," Kolodny told *ADAW*. An outspoken critic of opioid overprescribing — and of Zohydro, a controversial new painkiller that is owned by Alkermes — Kolodny pointed out that drug courts "like the idea of a drug that's not an opioid." Methadone or buprenorphine should be the first-line treatment for patients with opioid addiction, said Kolodny, who is particularly concerned about patients on Vivitrol who don't come back for their second injection. "Maybe Vivitrol would be good for a young adult who hasn't been addicted for very long, and is living with Mom and Dad," he said. "But it's being used in drug courts with a population who you would predict would be very bad candidates."

"We go through cycles," AATOD's Parrino told *ADAW*. "We've always had a problem with methadone in the court system." Frequently, patients who are on methadone in an OTP are told by a court that they have to leave treatment. There was hope, when buprenorphine came out, that courts would like it better than methadone, said Parrino. But

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those hopes are not panning out in most places, because buprenorphine is still abusable, and can be diverted. "You can't divert Vivitrol — it stays in your body for a month," said Parrino. AATOD supports MAT with methadone, buprenorphine and Vivitrol.

Educating criminal justice

The criminal justice system does not embrace the idea of addiction as a disease, which itself is a problem, said Parrino. "If you don't see addiction as a chronic relapsing illness, why would you give access to any medication?" said Parrino. Half of the drug courts do not make referrals to buprenorphine. "As one jail administrator told me the other day, 'I've got to deal with these people, I've got to keep them there as long as the court says, I've got to prevent them from hurting each other, and I've got to do the best I can to maintain order — you tell me I have an added responsibility to provide mental health and addiction treatment to them? Why?'" Parrino's response: 93 percent of that administrator's inmates will be released back into the community. That gives the jail the opportunity to initiate treatment.

'We've always had a problem with methadone in the court system.'

Mark Parrino

The jail administrator's response was typical: that by the time the inmates leave, they are no longer using drugs, so they don't need treatment. Of course, inmates with money can get drugs in jail, and inmates who can't are far more likely to relapse than not when they are released. Many corrections professionals don't like the idea of initiating treatment with an addictive medication like methadone or buprenorphine in a person who is currently drug-free.

Other news

Also last month, the Substance Abuse and Mental Health Services Administration (SAMHSA) released its report on the use of MAT in the criminal justice system. Based on meetings conducted during the last quarter of 2011, the report highlights methadone, OTPs (which SAMHSA regulates) and buprenorphine.

Part of what's happening includes the Affordable Care Act, which, by expanding Medicaid to include single men, has made it possible for many people who are incarcerated to have access to health care — in other words, jails and prisons can now charge Medicaid for treatment, instead of having to pay for it out of their own budgets — something that many simply did not do. Also last month, the Justice & Health Collaborative issued a resource guide showing how criminal justice personnel can connect individuals to benefits in Illinois. It includes strategies that can be used elsewhere. •

For the Legal Action Center report on the legality of denying access to MAT in the criminal justice setting, go to www.lac.org/doc_library/lac/publications/MAT_Report_FINAL_12-1-2011.pdf.

For the SAMHSA report, go to www.samhsa.gov/traumajustice/pdf/Final%20MAT_031014.pdf.

TRI reports on shortfalls of adolescent treatment

The Treatment Research Institute (TRI) has released a report it says will improve the quality of treatment of substance use disorders (SUDs) in adolescents. The report, "Paving the Way to Change: Advancing Quality Interventions for Adolescents Who Use, Abuse or Are Dependent Upon Alcohol and Other Drugs," was released May 7 by the Philadelphia-based organization.

"Research has clearly shown that adolescence is the 'at risk' period for developing the disease of addiction, and the current system to treat adolescents and young adults is simply unacceptable," said Kathy Meyers, Ph.D., senior scientist at TRI, in a press statement. "A redesign of the adolescent and young adult treatment system is necessary and must include a variety of stakeholders, including policy-makers, purchasers, parents and consumers."

The Affordable Care Act and the parity law have made many of these changes possible, but system change has been slow, according to the report.

"There is so much evidence out there about what needs to be done to improve the state of adolescent and young adult treatment in this country, but this evidence has never been presented in a manner that informs and compels the necessary system changes," said Nancy Marcus Newman, president of The Bridge Foundation, a charitable organization that funded the report. "Now is the time for our community to join together, as advocates, to push forward the change that is needed to improve adolescent care."

Prevention first

The report makes it clear that society has become more tolerant of the use of substances like alcohol and marijuana, that these are harmful to young people, and that these two facts compound the difficulty and importance of prevention and early intervention. Treatment is available for young people, but it fails them — and adults — by focusing only on "emergent symptoms" and not on the full continuum, which starts with prevention and ends with

Continues on next page

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continuing care. The report also criticizes programs for not using evidence-based treatments, and noted that there aren't enough programs specifically devoted to adolescents and young adults. The problem — as TRI CEO A. Thomas McLellan, Ph.D., says repeatedly — is that SUDs are being treated like an acute disease and not a chronic disease.

Throughout the report, a comparison to obesity and diabetes in young people is made. If the same approach were taken to SUDs as is taken to diabetes prevention and treatment, there would be better outcomes for adolescents with SUDs, the report says. "There is no other chronic disease where such an ill-fated approach to prevention and treatment is standard practice," according to the report.

Problems with treatment

Programs shouldn't group high-level users with low-level users, or younger teens with older teens, the report said, noting that these issues prevent parents from sending their children to treatment, contributing to underutilization of treatment in some cases.

Evidence-based practices that should be used include family-based therapy, cognitive behavioral therapy, motivational enhancement therapy and pharmacotherapies, according to the report, which includes a list of evidence-based practices in an appendix.

"The adolescent SAT approach is akin to ignoring warning signs, treating only the acute expression of chronic disease, and failing to provide any follow-up monitoring or care," according to the report. "This treatment approach would never be tolerated in physical medicine and it should never be tolerated in the treatment of substance use disorders — particularly adolescent substance use disorders."

School-based screening

The report states that treatment should start with screening, including screening in schools in school-based health centers (something that TRI just got a $3 million grant to do in New York City — see *ADAW*, Jan. 27). A large part of the report focuses on this option, and notes that early-intervention services may eventually be paid for by the federal Substance Abuse Prevention and Treatment block grant, currently used to pay for treatment for the uninsured but a pot of money that many are hoping can be used for other services once everyone has sufficient services paid for by Medicaid and health insurance. Early-intervention services would be prompted by school-based screening.

Just one page is given to financing, although the report notes that an entire paper could be written on that topic. TRI recommends that states and advocates undergo a process called "financial mapping," in which they can identify all public funds that are spent on SUD-related issues over the course of a year. "With leadership, legislative and judicial support, and trust and buy-in from all agencies involved, financial mapping has the ability to not only improve access and expand service capacity but to also address gaps in the continuum of services," the report states. "If done well, it can simplify the contracting process, improve accountability, promote common outcomes, and reduce duplication of services." •

'A redesign of the adolescent and young adult treatment system is necessary and must include a variety of stakeholders, including policy-makers, purchasers, parents and consumers.'

Kathy Meyers, Ph.D.

For the report, which is available online and meant to be copied and shared, go to http://issuu.com/tri_solutions/docs/tri_report_singlepages_highres.

Intervention from page 1
ther away from the model of the 'surprise' intervention where the interventionist goes in and out quickly and then just goes back to their career," said Phil Scherer, a certified addiction counselor and board-registered interventionist who also serves as administrative director at the Illinois Institute for Addiction Recovery, a treatment program. "More of us are trying to establish ongoing relationships with families. I refer to myself as the family's advocate, the go-between for the family that knows virtually nothing about treatment."

That means that from the treatment center's perspective, it is serving the interventionist's — as well as the family's — best interest if it maintains regularly scheduled communication with the interventionist while the patient progresses through treatment.

"We want to manufacture a new environment for the patient to go back to, so I want to have a progress update so that I can go back to the family," said David Brown, a licensed counselor and a certified and board-registered interventionist who also

 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

directs the treatment and intervention organization Avenues to Recovery in Olathe, Kansas. "My expectation is that I and the treatment center should communicate once a week."

Brown relates his recent experience of hearing from the elderly mother of a woman in long-term treatment; the patient had become increasingly angry in conversations with her mother, telling her that she needed money and that she wanted to leave treatment early. A subsequent conversation between Brown and the patient's counselor allowed him to put the situation in perspective and offer useful advice to the distressed mother, he said.

Building familiarity

Also, as in other relationships, it can become difficult for a treatment center leader and an interventionist to work well together if they never arrange to meet face-to-face. Brown believes interventionists should adopt a policy of never referring to a program that they haven't visited.

For the facilities to which he refers clients regularly — for example, Hazelden and Promises Austin — Brown pays regular visits for professional seminars and other events. He says the interventionist's attitude toward assessing the capabilities of a treatment center to assist his/her client becomes one of "Don't tell me, show me."

He adds that treatment centers should work with interventionists who share similar perspectives about what works in treatment, in terms of length of stay and clinical approach. They should be up front about what they do well and where they lack expertise, because they will ultimately be responsible for fulfilling the client's and family's expectations, he said.

"What the treatment centers I work with assure me of is incredible service," Brown said. "They give me the feeling that they're dropping everything to make this possible for me."

Scherer added in regard to treatment centers, "If you're not equipped to handle a certain area, be forthright about it, even if it may mean forgoing a payment. In the long run it's about getting the proper treatment for the patient."

Importance of credential

The intervention landscape often gets described as a "Wild West" because there have been few widely held standards governing interventionists' roles and qualifications. Practically anyone can call oneself an interventionist, and there isn't even a broad consensus in the field as to whether an interventionist's duties require having a clinical background.

'I refer to myself as the family's advocate, the go-between for the family that knows virtually nothing about treatment.'

Phil Scherer

Scherer, who serves as board president for the Association of Intervention Specialists (AIS), believes treatment centers should assist in the effort to separate qualified interventionists from opportunists by boosting the value of the year-old Certified Intervention Professional (CIP) credential managed by the Pennsylvania Certification Board.

"Treatment centers can help a great deal by insisting that the interventionists they work with be certified interventionists, if we see that as the pinnacle of best practice," Scherer said.

NAADAC's National Certification Commission for Addiction Professionals has stated that credential holders should have at least five years of clinical practice experience. But while interventionists such as Brown and Scherer are seasoned clinicians and work in treatment facilities, some interventionists believe that their work within family systems requires different skills that a direct clinical background does not necessarily nurture.

Another dilemma that the treatment and intervention communities have faced over the years involves the issue of who is paying for the interventionist's services. In some extreme cases, it has even been found that interventionists are receiving payment from both parties. Brown believes that any arrangement predicated on the interventionist sending an agreed-upon number of clients to a particular treatment center is "almost like selling beds," and he and Scherer advocate a matching process that is more patient-centered than facility-centered.

Scherer said that if the interventionist works directly for a treatment facility, that information should be available to the family. Moreover, his employer, the Illinois Institute, knows that he will refer to whatever facility the family needs most, based on clinical, financial or other factors. The Illinois Institute knows that he moonlights as an interventionist, that the families pay him for interventions and that some of his intervention clients may end up going to the Illinois Institute — but some may not.

Scherer believes that the intervention community is starting to mature in the way the primary treatment field did after managed care stepped in, ostensibly to correct excesses of the past. "There are more eyes watching folks now," he said. •

Project Synergy: DEA raids synthetic drug purveyors

The Drug Enforcement Administration (DEA) raided gas stations, head shops, and other retailers on May 7 as the culmination of Phase II of its "Project Synergy," targeting synthetic drugs like "bath salts," "Spice," and "K2." These are plant products with chemicals sprayed on them to resemble the effects of marijuana and other drugs.

Joined by Customs and Border Protection, Immigration and Customs Enforcement of Homeland Security Investigations, the Federal Bureau of Investigation, the Internal Revenue Service and other federal, state, and local partners, the DEA has been working since January on the nationwide raid.

More than 45 DEA offices served almost 200 search warrants, arresting more than 150 individuals and seizing hundreds of thousands of individually packaged, ready to sell drugs, as well as the raw synthetic materials used to make these products. In addition, more than $20 million in cash and assets were seized.

This is an emerging area of drug enforcement. Synthetic drugs aren't even called drugs most of the time — they may be sold as incense, jewelry cleaner, or plant food. According to the DEA, there are more than 200 new designer drugs from eight different structural classes, and most are made in China. These drugs can cause vomiting, anxiety, agitation, elevated blood pressure, irritability, seizures, loss of consciousness, organ damage and overdose.

"Many who manufacture, distribute and sell these dangerous synthetic drugs found out first hand today that DEA will target, find and prosecute those who have committed these crimes," said DEA Administrator Michele M. Leonhart in announcing the raids. "The success of Project Synergy II could not have been possible without the assistance of our state, local and foreign law enforcement partners. We stand united in our commitment to aggressively pursue criminals who are all too willing to experiment on our children and young adults."

The head of border control, R. Gil Kerlikowske, said that the raids will help "keep synthetic drugs out of the country, off the streets, and out of our communities." Border control officers and scientists "play a vital role in contributing to the seizure and identification of these potentially deadly substances at the border."

Phase I of Project Synergy started in December of 2012 and ended last June. It resulted in the seizure of 9,445 kilograms of individually packaged, ready-to-sell synthetic drugs, 299 kilograms of cathinone drugs (the falsely labeled "bath salts"), 1,252 kilograms of synthetic cannabinoid drugs (used to make the so-called "fake pot" or herbal incense products), and 783 kilograms of treated plant material.

These products are sold in 'head shops,' over the internet, and in a variety of retail outlets. They have not been approved for human consumption.

Circumventing the law

The DEA's office of forensic science relied on its chemists to identify the products that were designed to circumvent the Controlled Substances Act, which explicit defines which drugs are illegal.

Designer drugs are marketed as legal — they are smokeable herbal blends that provide a marijuana-like sensation, but are more dangerous, according to the DEA. They are particularly popular among teens. They are purposely mislabeled to mask their intended use.

The number of emergency room visits involving a synthetic cannabinoid increased 2.5 times between 2011 and 2012, to 28,531, according to the Substance Abuse and Mental Health Services Administration.

The products are marketed under names such as "Purple Wave," "Bliss" and "Vanilla Sky" and mimic cocaine, LSD, MDMA, and/or methamphetamine, according to the DEA. Users have reported impaired perception, reduced motor control, disorientation, extreme paranoia, and violent episodes. The American Association of Poison Control Centers reported 2,656 calls related to synthetic cathinone ("bath salts") exposures in 2012.

These products are sold in "head shops," over the internet, and in a variety of retail outlets. They have not been approved for human consumption.

Although these substances are not specifically prohibited under the Controlled Substances Act, they fall under the Controlled Substance Analogue Enforcement Act of 1986 if they can be shown to be chemically and/or pharmacologically similar to a Schedule I or Schedule II substance. In addition, the DEA has used its emergency scheduling authority to temporarily place substances on Schedule I; Congress also permanently placed 26 substances on Schedule I in 2012.

Placing substances on the Controlled Substances Act allows the DEA to prosecute manufacturers and distributors. •

For more information on designer drugs from the DEA, go to www.deadiversion.usdoj.gov/drug_chem_info/index.html.

 Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

CRC resolves Medicaid fraud allegations with $9.2 million sum

The Department of Justice announced on April 16 that CRC Health Group has agreed to pay $9.25 million to the federal government and the state of Tennessee to settle allegations that it submitted false claims by providing substandard treatment to Medicaid patients at its facility in Burns, Tennessee. "Medicaid patients who enter residential treatment programs for alcohol and drug addiction deserve to have treatment provided by qualified personnel according to the appropriate standard of care," said Assistant Attorney General for the Justice Department's Civil Division Stuart F. Delery. "We will not tolerate health care providers who prioritize profit margins over the needs of their patients." The Burns facility, called New Life Lodge, was purchased by CRC in 2006. According to the government, between 2006 and 2012, New Life Lodge billed the Tennessee Medicaid program (TennCare) for treatment that was not provided or was provided by therapists who were not licensed by Tennessee.

"Substance abuse of varying levels is rampant here and across the country," said U.S. Attorney for the Middle District of Tennessee David Rivera. "Fortunately, when needed, Medicaid or TennCare covers substance abuse treatment and certain mental health assistance. When those services are required, the government will ensure that the treatment is provided with the highest possible quality of care to those patients. Anything less is unacceptable."

The allegations that led to the settlement came from Angie Cederoth, previously employed by New Life Lodge, under the whistleblower protections of the False Claims Act. Cederoth will receive $1.5 million from the settlement, according to the Justice Department.

For the past five years, the Justice Department and the Department of Health and Human Services (HHS) have focused on reducing Medicaid and Medicare fraud.

New Life Lodge no longer accepts Medicaid.

"Providers of health care services must not place profits above patients," said Derrick L. Jackson, special agent in charge of the U.S. Department of Health and Human Services' Office of Inspector General in Atlanta. "This was a vulnerable population of individuals who were seeking treatment for their substance abuse problems. We will pursue these cases in order to ensure proper treatment is afforded to those seeking treatment."

'We dispute the validity of the allegations in the lawsuit, but to avoid the distraction that a protracted legal process would provide, we have agreed to settle this suit.'

CRC Health Group

CRC responds

"Nothing in this suit is related to the care of patients who have received care" since 2012, according to a statement provided to *ADAW* by the CRC counsel's office. "As part of the settlement, all parties agreed that allegations in the lawsuit have been neither proven nor disproven. We dispute the validity of the allegations in the lawsuit, but to avoid the distraction that a protracted legal process would provide, we have agreed to settle this suit."

CRC "cooperated fully with the government's investigation" and is "pleased" that the investigation is over. "Our priority, today and always, is to provide superior, compassionate treatment to our patients suffering from the chronic disease of addiction …. People seeking treatment for addiction, their families and the professionals who refer patients to us can feel confident that the treatment at New Life Lodge includes the clinical practices that science tells us lead to the best outcomes." •

Briefly Noted

Study recommends 'mindfulness therapy' to prevent relapse

A new study found that "mindfulness-based relapse prevention" is as effective as cognitive behavioral therapy for continuing care following treatment for substance use disorders, but that the effects of mindfulness therapy are more enduring than those of CBT. The study, published online March 19 in *JAMA Psychiatry*, found that mindfulness therapy incorporates many of the tools in CBT, including helping patients identify and avoid triggers. But it goes beyond that, including teaching patients how to be aware of their own emotional or physical states that could lead to relapse, according to lead author Sarah Bowen, Ph.D., an assistant professor of psychiatry and behavioral sciences at the University of Washington. Mindfulness training can also help patients determine what may be driving their craving, such as a need for comfort. For the study, 286 people who have completed treatment for

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SUDs were randomized to "treatment as usual" (a 12-step program or psychoeducation), CBT, or mindfulness training. At the three-month followup, there were no differences between the groups. At the six-month followup, both the CBT and the mindfulness groups had significant reductions in relapse and fewer heavy drinking days compared to the treatment-as-usual group. At the 12-month followup, the mindfulness group showed even less heavy drinking days and relapse than the CBT group. The study was funded by the National Institutes of Health.

Congress asks FQHCs about buprenorphine

On April 23, Sen. Edward Markey (D-Mass.) sent a letter to Administrator Mary Wakefield of the Health Resources and Services Administration (HRSA) including questions about whether federally qualified health centers (FQHCs) have waivered physicians who can dispense and prescribe buprenorphine. HRSA has a critical role in expanding access to treatment for people with substance use disorders (SUDs), and Senator Markey wants to understand better what that role is, particularly in terms of providing medication-assisted treatment. Specifically, Senator Markey wants to know about the prevalence of opioid addiction among FQHC patients, the existence of naloxone, and the number of waivered physicians under DATA 2000. He also requested information about the barriers faced by FQHCs.

Coming up...

The 2014 Annual Leadership Conference of the **National Association of Addiction Treatment Providers** will be held **May 17–20** in **Charlotte, North Carolina**. For more information, go to **www.naatp.org/events/annual-conference**.

The **National Association of State Alcohol/Drug Abuse Directors** will hold its annual meeting **June 3–5** in **Omaha, Nebraska**. Go to **www.nasadad.org** for more information.

State News

De Blasio's daughter receives HHS award for speaking out on recovery

Chiara de Blasio, 19-year-old daughter of New York City Mayor Bill de Blasio, received an award last week from the U.S. Department of Health and Human Services for her recovery from addiction and depression, *The Associated Press* reported May 7. The award was for National Children's Mental Health Awareness Day. She was in treatment last year and says it's a miracle that she is sober and healthy now. "Some people believe that it is impossible for people who come from backgrounds like mine to suffer from the diseases of depression and addiction. I am here to tell you that that is not true," said Chiara de Blasio. "Mental illness does not discriminate. However, that does not mean that there isn't hope for each and every one of us." And HHS outgoing secretary Kathleen Sebelius said: "Chiara and the other young people sharing their experiences today are taking a brave step in raising understanding about the reality of recovery from mental and substance use disorders. Their message needs to reach individuals, families and communities across our nation so that many more Americans can return to healthy, fulfilled lives."

Drug-testing company employee allegedly accepts bribe to fix results

An employee of a drug-testing company in Texas has been fired after he was arrested for seeking a bribe to "fix" a probation client's urine test, *The Associated Press* reported May 8. The employee is free on bond after being charged with tampering with a government record. The test was being performed for the Brazos County Adult Probation Office, which suspended testing following the arrest May 6 of 30-year-old Jesus Armando Ordonez, who allegedly accepted $100 to change the results. The man who gave the bribe contacted authorities, according to officials. The CEO of Recovery Healthcare Corp., Larry Vanderwoude, said the company, which provides treatment and monitoring to corrections organizations in Texas, Louisiana and Oklahoma, is cooperating with law enforcement.

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:

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Letters may be edited for space or style.

In case you haven't heard...

Insurers are balking at paying for medical marijuana, *The Associated Press* reported May 8. The treatment can cost as much as $1,000 a month, and the drug in plant form is still illegal in most states and federally. But what really adds up to "medically unnecessary" in insurance parlance is the fact that the Food and Drug Administration (FDA) hasn't approved it. There are medical products that have been approved containing synthetic THC, the main ingredient of marijuana, with others in the pipeline. Meanwhile, it's next to impossible to conduct research with marijuana itself, as long as it is illegal, a problem that even the American Medical Association wants to have changed.

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