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PERSPECTIVES

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Urgency of opiate crisis comes to the fore in budget testimony

Members of the Senate Budget Committee listen to testimony on the dire need for expanded treatment and recovery supports.

This year's spate of budget hearings had particular focus on a health issue as pressing as any in recent memory: New Jersey's opiate crisis. With the many opiate-related deaths and the attention they have generated, state lawmakers now confront an unprecedented level of addiction and its too often fatal fallout. Testimony given at the hearings, held at the State House and around the state, recounted the toll of addiction but also emphasized the possibility of reclaiming lives with treatment and recovery support services.

During the hearings, lawmakers were credited for having put in place some measures to address the heroin and prescription opiate problem. But for the most part, these steps were limited in scope or geography.

Among the more promising recent initiatives has been providing widespread access to naloxone, which reverses the effects of an overdose. A recent push seeks to refer people revived from an overdose into treatment by having recovery coaches meet with them as soon as is medically safe. The state has seen marked success with this link to treatment in pilot programs in Ocean and Passaic counties.

In his budget proposal, Gov. Chris Christie included $1.7 million to expand the number of recovery coaches. The Governor's budget also included a combined federal/state expenditure of $127 million to increase reimbursement rates for treatment providers; historically, the state has ranked near the bottom nationally in its rates. Christie's budget also allocates $2 million to convert a former correctional facility into a lock-up for many inmates in need of addiction treatment.

Some of those giving testimony were themselves in recovery from addiction; others were family members. Either way, the travail of addiction was clear, not just for the affected person but for their families and extending to their communities.

One witness providing testimony at the State House was Kaisha Carson, who like many to address the Budget Committee is a National Council on Alcoholism and Drug Dependence-NJ Advocacy Leader. Arrested for possession, she faced a five-year prison sentence. Had she served that sentence, her life might have been set on the cycle of drug use, arrest, sentence, prison, release, repeat.

Carson, however, was admitted to drug court, the statewide initiative offering treatment in place of prison for non-violent offenders. During her stint in drug court, Carson received inpatient and outpatient treatment. Not only that, she entered vocational training and services that helped her become gainfully employed, find stable housing, and have her children returned to her care. She is currently pursuing a graduate degree. Carson credits all of those positive elements to drug court.

Carson's story offers a shining example of what investing in a health approach to addiction can produce. As is apparent with her case, Carson told the committee, "Recovery is real for many individuals in New Jersey, just as it is real for me and my family." She cited statistics illustrating how much money the state can save by providing a way out of addiction: 81 percent of incarcerated people have a drug problem; treatment can reduce criminal activity by 80 percent.

Another witness,

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Back on the road - advocates ready for Road to Recovery, pt. 2

NCADD-NJ's Road to Recovery campaign is a grassroots effort to highlight public policies that help individuals overcome addiction through life-saving intervention, education, and treatment, as well as remove common barriers to living healthy lives in recovery.

NCADD-NJ successfully launched its Road to Recovery campaign in 2015, which had a victory in its first year when A.471 was signed into law permitting automatic expungement for individuals completing drug court. This victory, along with the Overdose Prevention Act, Opportunity to Compete Act, and recent legislative enactments for recovery high schools and collegiate recovery programs, is due to the endless support of grassroots advocates working with decision makers.

Addiction is a disease that touches many lives in New Jersey. Taking a comprehensive public health approach to this growing problem is urgent.

NCADD-NJ has identified new legislation that, with your grassroots support, can save lives and encourage those struggling with addiction to get well and become, like many in recovery, productive members of our communities. Finding and sustaining recovery can be hard, so focusing on public policies that make the recovery process easier is a cause worth fighting for.

The following bills are a priority for NCADD-NJ advocates in the 2016-2017:

Educate Early for Young People

The opiate epidemic in New Jersey is preventable. Many of the individuals that are most severely struggling are young people. Age-appropriate, evidence-based education for young people is crucial in preventing addiction.

A.2292/S.372 mandates substance misuse instruction developed in the state Department of Education for the core curriculum.

Continued Naloxone (Narcan) Expansion

New Jersey has made strides in making Naloxone, a drug that reverses overdose, more readily available for first responders and family members. We can continue to work together to get this life saving drug into as many hands as possible to get more individuals on the **Road to Recovery** by advocating for these bills.

A.2334/S.295 allows anyone to get Naloxone without a prescription.

S.1051 requires insurance payers to cover the costs of Naloxone and Buprenophine

Addiction as a Health Issue for the Incarcerated

NCADD-NJ has identified bills that address addiction and introduce recovery in institutional care. New Jersey prisons are filled with non-violent drug offenders, many of whom suffer from untreated addiction. NCADD-NJ believes that addressing addiction as a health issue can be the beginning of anyone's **Road to Recovery**, regardless of their environment

S.383 trains certain doctors in jails and prison on dealing with people with addictions

S.384 requires jails and prisons to supply medications to inmates for chronic illnesses

Remove Barriers to Sustain Recovery

Once an individual is on the **Road to Recovery**, there are many obstacles. NCADD-NJ has identified bills that will help remove some of these common barriers in addition to establishing community environments where the recovery community can thrive.

A.3684 facilitates the establishment of four new peer-to-peer Recovery Community Centers in New Jersey

S.1687 provides for issuance of certificate of rehabilitation to certain offenders with substance abuse disorders.

Opiate crisis spurs summit touting alternative pain care

Three members of New Jersey's Congressional delegation convened a summit at a Paterson hospital focusing on the state's –and the nation's – opiate problem. The event stressed the need to dramatically decrease overprescribing opiate pain medication and touched on broad federal legislation designed to promote addiction and recovery.

The summit took place on March 28 at Paterson's St. Joseph's Regional Hospital, which recently introduced a program that breaks with conventional methods for treating pain. Its pilot project uses alternatives to opiates, an innovation in response to the widespread surge in opiate misuse. The event at the hospital featured speeches on the opiate crisis by Sen. Robert Menendez, Sen. Cory Booker, and Rep. William Pascrell, all Democrats who represent the state in Washington. They were joined by a host of state and local officials, and medical personnel, all of whom touted the new initiative, known as the Alternatives to Opiates Program (ALTO for short).

Under ALTO, which began in January, three in four people admitted to the hospital will have their pain treated with non-opiate medications and holistic methods. The program has treated more than 300 patients with non-opiate medications; in other medical settings, these patients, whose ailments ranged from back pain to broken bones, would have been treated with opiates such as Vicodin or Oxycontin.

Senator Cory Booker (standing) discusses federal legislation to address the country's opiate crisis. Seated are (from left) Senator Robert Menendez, Congressman William Pascrell, and NJTV's Steve Adubato.

"Rather than covering up pain with opioids, we actually treat where the pain is coming from," said Mark Rosenberg, the hospital's chairman of emergency medicine. There has been something of a divide in the medical community on this issue. Many cite an excess of prescribing very strong and potentially addictive opiates, while others argue that doctors are well equipped to made decisions on treating pain. Medical schools, generally speaking, allot only a handful of hours to the practice of pain medicine.

Booker noted, "Heroin addiction and opioid abuse have reached epidemic levels in the United States, and it is tearing individuals, families and communities apart. Last year, opioids including heroin killed over 28,000 people in the U.S., which is greater than any year on record. I was pleased to have this important, substantive conversation with legislators, advocates, and other community leaders today, which has strengthened my commitment to fighting for federal resources that support law enforcement efforts as well as education and treatment funding so that, together, we can tackle this crisis head on."

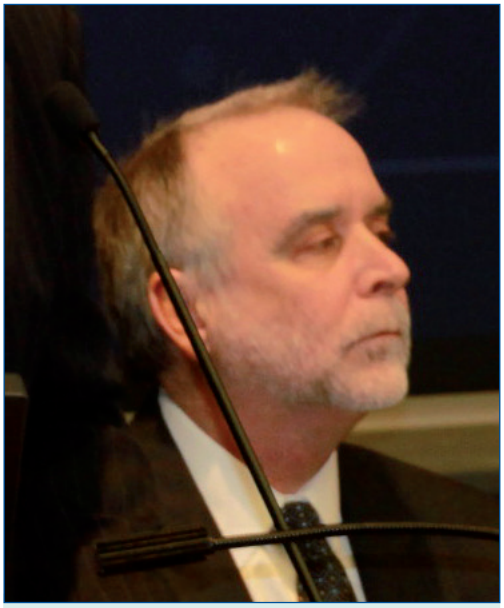
Participants in the roundtable also mentioned the federal Comprehensive Addiction and Recovery Act, which was co-sponsored by Booker. The broad measure, which authorizes expanded treatment and recovery resources, passed the Senate, but an amendment to fund critical expanded services was defeated.

The fallout of over-prescribed opiates has been a dramatic increase in heroin addiction and overdoses. Rosenberg said that the weekend before the event at St. Joseph's, eight people were revived by emergency personnel using naloxone. So strong was the heroin that the naloxone dose had to be increased, the doctor said.

One constituency conspicuous by its absence was the pharmaceutical industry, which Rep. Pascrell took note of. The congressman said, "We need the pharmaceutical companies here because they're shoving drugs down our throats.''

Menendez said the issue demands input from all quarters: "We need an 'all hands on deck' approach, including physicians, nurses, patients, families, law enforcement and communities. Successfully addressing our nation's, and our state's, opioid addiction crisis requires us to be creative, to think outside the box, about how to not only serve those individuals battling an addiction, but to effectively prevent addictions in the first place."

Care integration bogged down by regs, Seton Hall study finds



John Jacobi of Seton Hall School of Law and director of the Center for Health & Pharmaceutical Law & Policy.

Seton Hall University School of Law has issued a new report strengthening the case that integrating primary and behavioral care produces better health outcomes at a lower cost. The study, "Integration of Behavioral and Physical Healthcare: Licensing and Reimbursement Barriers and Opportunities in New Jersey," reinforces established evidence about the effectiveness of "whole person" care, but also addresses a host of policy and regulatory obstacles the state needs to remove before this model can thrive.

The study noted that a movement towards integrated care models is under way in New Jersey and nationwide. In the state, however, the effort has been forestalled by byzantine policies and practices, which the report identifies and presents solutions to.

As with previous reports on this issue, the Seton Hall findings illustrate the considerable savings that intergrated care would produce with what are known as "super-utilizers," people who run up enormous costs to the public sector through repeated emergency room visits. There is also the often cited statistic of the human cost to patients with serious mental illness, whose life-span is 25 years less than the average person's.

Newark-based Nicholson Foundation funded a team led by John Jacobi at the Seton Hall University School of Law to examine New Jersey's regulations and payment obstacles and then work with state agencies and healthcare stakeholders to implement solutions. The study is an extension of Nicholson's pilot projects attempting to integrate care in Trenton and Lakewood. Those sites encountered the obstacles the study identifies and seeks to eliminate.

Jacobi, the Dorothea Dix Professor of Health Law & Policy and director of the Center for Health & Pharmaceutical Law & Policy, was optimistic that the state can make the changes necessary to promote integration. "Too often, New Jersey's regulations continue to reflect a previous era of separation, and create significant barriers to enacting current clinical norms. Our report shows that there is a clear path forward, and the open engagement of representatives of state agencies demonstrates both leadership and cooperation on the part of the state."

The problem's roots partly lie in the fact that different state departments have oversight of the physical care and behavioral health realms. The Department of Health has authority over hospitals, health clinics, while the Department of Human Services oversees care for addiction and mental health.

Carolyn Beauchamp, executive director of the New Jersey Mental Health Association, said in an NJ Spotlight article, "You've got two competing departments … and there have been ongoing concerns about why it has to be this way. The system has to move and it has to change."

Further complications arise from the state's licensure and reimbursement standards. Jacobi noted that payment problems arise due to a burdensome funding stream. In the case of Medicaid clients, there is an intermediary between patient and provider. It may be a managed care entity, an administrative services organization, etc.. But whatever it is, Jacobi said that if the entity does not provide for prompt and proper payments, the patient will suffer.

In a webinar, Dr. Kemi Alli of Henry J. Austin Health Center in Trenton provided the perspective of primary care providers on the ground seeking to integrate behavioral health into their work. Alli described the frequent occurrence of non-compliant patients. The example she gave was of a patient diagnosed with diabetes who does not modify her or his diet or become more active despite being told of the serious complications they faced by not doing so.

Alli said in many cases, an underlying behavioral health problem, which may go back to childhood, is at the root of this non-compliance. She cited a study by the Kaiser Foundation on the lasting effects of Adverse Childhood Events, traumatic occurrences of abuse that prevent the person from acting rationally.

Despite the challenge of such systems change, Jacobi was encouraged by early signs of progress. He noted the importance of having had a close collaboration with government officials in the creation of the report. Jacobi said, "As a result, key decision-makers became increasingly aware of the problems – and solutions. In October of 2015, the DHS and DOH announced the joint creation of a 'Shared Space Waiver,' which would allow providers to offer both behavioral and primary care in the same facility. The departments' movement in creating the waiver is consistent with our recommendations in this report, and demonstrates that they are interested in continuing regulatory advances to accommodate integrated care."

Bill lifting assistance benefit ban clears vote and goes to Christie

Both houses of the New Jersey Legislature have approved a measure revising the requirements for receiving general assistance benefits under the Work First New Jersey program. With the Assembly's April 7 vote for the proposal, it goes to Gov. Chris Christie.

The legislation would remove the lifetime ban on eligibility for general assistance benefits for individuals who have been convicted of offenses involving distribution of a controlled dangerous substance. These individuals would be subject to the same requirements for drug treatment as individuals with convictions related to drug possession or use.

Currently, only people convicted of offenses involving the use or possession of a controlled dangerous substance must enroll in or complete a licensed residential drug treatment program in order to be eligible to receive general assistance benefits. The measure expands on the present statute to allow applicants with distribution charges. It also allows for outpatient care to satisfy the treatment requirement.

> ***"By removing these restrictions, we can give individuals in our state the ability to get back on their feet and reestablish themselves. We need to recognize the need to assist individuals who have paid their debt to society and are struggling to reenter as productive citizens."***
>
> ***Senator Sandra Cunningham***

One of the Senate sponsors, Sen. Sandra Cunningham (D-Hudson), said, "The Work First New Jersey program can go a long way in terms of helping individuals who have just gotten out of prison to pay for shelter stays or to qualify to enroll in rental assistance programs around the state, which helps keep people off the streets and under a roof. By removing these restrictions that are placed on drug offenders, we can give individuals in our state the ability to get back on their feet and reestablish themselves. We need to recognize the need to assist individuals who have paid their debt to society and are struggling to reenter as productive citizens."

The bill would also clarify that an individual who has a past drug conviction may receive general assistance benefits without enrolling in or completing a drug treatment program if either the treatment is not available, or the person is excused from enrolling in a treatment program for good cause.

"This bill will expand opportunities for people, and give them comfort and relief to know that this assistance will be available to them, despite their backgrounds and regardless of their pasts," said Sen. Joseph Vitale (D-Middlesex), the other prime sponsor. "This bill looks to bring fairness to those who are trying to rebuild their lives and be productive citizens."

The Work First New Jersey general assistance program provides an essential lifeline for those most in need. Eligible New Jersey residents are provided a small cash subsidy of approximately $140 per month for single, childless adults, or more if the recipient is permanently disabled.

Prior to 1997, New Jersey's general assistance program did not deny benefits based on an individual's drug convictions. In 1996, however, federal legislation was enacted disqualifying individuals with drug convictions from Temporary Aid to Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). While states were given the option to opt out of this disqualification through legislation, New Jersey expanded it with the creation of the Work First New Jersey program, which disqualified individuals with drug convictions from receiving general assistance as well.

In 2010, recognizing the need to assist individuals who have paid their debt to society and are struggling to reenter as productive citizens, New Jersey passed the "Women and Families Strengthening Act," repealing the drug conviction ban for SNAP and TANF benefits. This repeal, however, did not apply to general assistance under the Work First New Jersey program. Currently, of the 28 states with general assistance programs, New Jersey is one of only four that deny benefits to individuals with drug convictions.

In their testimonies before the Legislature on the bill, Ed Martone, NCADD-NJ's policy analyst, and Steve Leder, senior counsel for the Community Health Law Project, pointed out that the state will benefit along with the general assistance recipient. Martone noted that more people being eligible for financial help also means more individuals being referred in to drug treatment programs when a person's availability for work is hampered by addictions.

In a projected fiscal impact statement, Mr. Leder testified that the initial increase in outlays to additional recipients will lead to an almost immediate savings in the costs to the judiciary, corrections, prosecutors, public defenders, police and homelessness programs, among others.

CARA advocacy push in House

In a near-unanimous vote, the U.S. Senate on March 10 approved the Comprehensive Addictions and Recovery Act (S.524), the first stand-alone bill to pass the Senate in years. Known as CARA, the legislation authorizes much-needed funding for evidence-based prevention, treatment and recovery programs to help Americans struggling with addiction to heroin or other opioids. The bill passed the Senate with a bipartisan vote of 94-1 and a push is now under way in the House of Representatives.

CARA took three years to develop and is the only legislation in Congress that addresses all four corners of an effective response to addiction: prevention, treatment, recovery and law enforcement. CARA will provide resources for recovery community organizations to develop, expand and enhance recovery services, advocate for individuals in recovery, reduce stigma, conduct public education and outreach, and strengthen the network of community support for individuals in recovery.

Faces & Voices of Recovery is working to build support for CARA in the House of Representatives. It recently launched an initiative reach 50 new co-sponsors before the Memorial Day recess. CARA currently has 112 co-sponsors (77D, 35R).

Linda Rosenberg, president and CEO of the National Council for Behavioral Health, said, “Let’s not kid ourselves: addictions to painkillers, heroin and alcohol are chronic diseases just like diabetes or heart disease. We’re talking about a health crisis that dwarfs the Ebola outbreak. It’s physically and emotionally crippling, wrecks families, jobs and local economies, and it takes millions of lives.” She added, “The only way to attack a crisis of this magnitude is for the government, health care and law enforcement communities to attack the problem with adequate prevention, treatment and recovery services. Such an effort takes time, commitment, patience and yes, money. We are so gratified that the Senate has come to their aid.”

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Katie Calvacca of Sussex County, recounted her addiction and that of a close friend. Their bond was broken in 2010, when that friend, Mandy, died of an overdose, leaving Calvacca to mourn and tell the story of how their lives diverged.

With the surge in addiction and overdose deaths such as Mandy’s, New Jersey has responded with making widely available the overdose antidote naloxone, also known by the brand name Narcan. Narcan’s life-saving capacity was part of testimony provided by Judith Linscott of Belmar. She told the committee that her niece overdosed in her driveway. Because the person with her knew of the state’s Good Samaritan Initiative, they called for help rather than flee for fear of arrest. Police administered Narcan and thereby saved her niece’s life. Linscott encouraged the committee members to support the Governor’s proposal to expand the recovery coaching program that helps place overdose victims in treatment.

Marie Bruno of Flemington told the Assembly Budget Committee about her son’s four-year addiction, a time she said was filled with “fear and horror.” Her son, who will soon turn 20, has been free of drugs for six months, prompting Bruno to proclaim, “Recovery is real.”

Real though it is, in Bruno’s case it came at a great emotional and financial cost to the family. Her son twice went to Utah for wilderness therapy, the bill for which was more than $200,000. That, Bruno said, was before her son was 17 years old. It was an arrest within the past year that frightened him to the point of wanting to go for long-term treatment.

In one sentence, Bruno summed up the issue of addiction and its consequences: “Addiction is a mental health disease that robs our communities of time, talent, and treasure.”

NCADD-NJ Advocacy Leader Tonia Ahern has years of experience testifying on the budget, and each time she finds herself disappointed in the shortage of treatment for those with limited or no insurance. She said, “Private organizations are opening treatment facilities across the state but most of the people I work with are underinsured or not insured so these programs will not help them.”

Ahern lamented the absence of stable housing for people in a Medication Assisted Treatment Program or who are in “evidence-based outpatient treatment.” Those treatments, she said, are effective, but the people awaiting such care often reside in volatile areas, putting them at greater risk. She contrasted the scarce substance abuse housing with the relatively abundant residences for those receiving mental health care.

She added that peers are a critical piece of the puzzle. But she noted that “peers need to be educated in how they use their experiences to support others and they need to be included as a (reimbursable) fee for service.” Stressing the monetary argument, Ahern said that paying for certified peer specialists and housing for different levels of care will lower state treatment costs and save lives

In his testimony, Ed Martone, policy analyst for NCADD-NJ, credited some of the measures outlined by Christie in his Budget Address. Among these are the federal/state outlay of $127 million to increase Medicaid reimbursement rates, $1.7 million for recovery coaches and patient navigators, and funding to turn a correctional facility into an inmate treatment

Martone said the above measures need to be bolstered with opening more state-funded recovery centers (it currently funds two), establishing a certificate of recovery, and supporting a host of measures to improve therapies, including expanding the use of medications such as buprenorphine in treating opiate addiction.

One way to reduce the many societal costs tied to addiction is to prevent its onset. A recent report revealed that many youths were arrested for criminal offenses had a drug problem early on. Their drug use was the precursor to their criminal activity. A screening instrument, whose full name is Screening, Brief Intervention and Referral to Treatment (SBIRT), would help address this problem but has been little used in the state, particularly with youth. NCADD-NJ and New Jersey Citizen Action are working to broaden the use of SBIRT to stem the cases of full-blown addiction.

NJAMHAA report outlines fiscal benefits of BH community care

The economic benefits to the state outlined in a new report on community-based addiction and mental health services came strikingly to life through the story of James Morris, who was saved by those very services. Less than two years before the March 29 press conference at which he recounted his journey to recovery, Morris was in the throes of addiction and contemplating suicide. With the help and hope offered by the Trenton Rescue Mission, all that changed.

New Jersey Association of Mental Health and Addiction Agencies Executive Director Debra Wentz and James Morris, a former client and now employed at the Trenton Rescue Mission, speak at a press conference on the financial and human benefits to the state of behavioral health community care facilities.

The new report, "*The Economic Contribution of the Mental Health and Substance Abuse Services Industry to the New Jersey Economy,"* was released by New Jersey Association of Mental Health and Addiction Agencies. The report, which was produced by Rutgers University's Edward J. Bloustein School of Planning and Public Policy, illustrates the tremendous direct and indirect savings to the state seen through the thousands of lives who, like Morris, underwent treatment in a community setting and now add revenue and make other societal contributions.

At a recent press conference in Trenton, Debra Wentz, NJAMHAA's CEO and president, said the intent of the report was to take "a point in time snapshot to see the impact, and it is substantial, even by these conservative estimates. Wentz said what is often invisible "is the cost to the health care system." She noted that people with serious addiction and mental health problems are so-called "superutilizers" of the health care system, consuming more than 50 percent of Medicaid dollars. These individuals regularly rely on expensive emergency room visits for health care.

Describing the benefits, both human and fiscal of community-based care, Wentz recalled a troubled little girl who "has blossomed" into a social young lady. Another example she offered was a veteran who had been in the depths of post traumatic stress syndrome, but who is now gainfully employed. And there are the many young people who lost their way for time in drug addiction and who are now "thriving in schools, jobs and their communities." All of those examples translate into people who had been a cost to the state now contributing to its economic health.

The comments by Wentz were reinforced by James Cooney, CEO of Ocean Mental Health Services. He noted the reduction in patients being treated in the state's psychiatric hospitals. Those patients now number only 1,700, though one each costs the state approximately a quarter of a million dollars a year. The large majority of mental health patients are now cared for by the community-based mental health centers, producing a savings of many millions of dollars.

When asked if sufficient drug treatment were available, Cooney acknowledged there was a shortfall. Ocean County, he said, has a severe need for outpatient care (Ocean has been among the hardest hit counties of the opiate crisis).

The issue of the new Medicaid reimbursement rates came up during the press conference. Wentz and Cooney said that, while the new rates are certainly an overall improvement and very good for some care and services, in other areas they still fall woefully short. The new addiction rates will take effect on July 1, and the mental health increases will begin in January.

When care is provided, the results are evident. Morris' story offers a remarkable instance of a life in dire circumstances taking a nearly miraculous turn. After treatment helped Morris enter recovery, he completed his GED and went on to be admitted to an entrepreneur program at the University of Pennsylvania.

Beyond his professional growth, his recovery means that he can now pay visits to his ailing mother in North Carolina. That was not something he did 21 months ago. And as with so many in recovery, Morris has a deep commitment to giving back, which he does by assisting at the Rescue Mission's Housing Program.

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Extended-release naltrexone cuts ex-offender relapse

New research funded by the National Institute on Drug Abuse (NIDA) revealed that the initial relapse rates among opioid-dependent adults in the criminal justice system was lower for participants receiving extended-release naltrexone than for those receiving treatment as usual (brief counseling and referrals for community treatment programs). Administered as a monthly injection, naltrexone is an FDA-approved sustained-release, opioid antagonist for the prevention of relapse to opioid dependence.

This study is the first large randomized trial of extended-release naltrexone versus usual care conditions among criminal justice involved adults. The findings showed that 24 weeks (six monthly injections) of extended-release naltrexone resulted in a significantly lower opioid relapse rate (43 percent vs. 64 percent) among the two groups. Additionally, while there were no overdoses observed in the extended-release naltrexone group, there were seven in the usual care group, with three resulting in fatalities.

For a copy of the abstract, "Extended-Release Naltrexone to Prevent Opioid Relapse in Ex-Offenders," published in The New England Journal of Medicine, go to http://www.nejm.org/doi/10.1056/NEJMoa1505409.

Campus addiction program in Vermont

The University of Vermont is pioneering a program that integrates residential and curricular elements to address substance abuse, according to NBC News.

The program's participants are 120 freshmen who live in a substance-free dorm. They receive a Fitbit, gym passes and nutrition coaching. They take a neuroscience course, "Healthy Brains, Healthy Bodies." The class begins with meditation, and covers research on the benefits of clean living, the article notes.

The program, called Wellness Environment, was founded by Dr. James Hudziak, Chief of Child Psychiatry at the College of Medicine and the University of Vermont Medical Center. The program has four pillars of health: exercise, nutrition, mindfulness and mentorship.

"It's about behavior change," Hudziak said. "When armed with science, young people can make better decisions." The program will expand next year to 500 students, including 320 new freshman, as well as currently enrolled students and transfers.

Hudziak explained the human brain does not fully mature until about age 25. "There is no such thing as a bad kid, just bad ideas taking place in the brain during construction," he said. Young minds are especially vulnerable when exposed to high-risk substances, he noted.

He told NBC News there is "some evidence" the program is working, and data is being collected to assess its effectiveness.

Doctors regularly overprescribe opiates

Almost all physicians who write prescriptions for opioid painkillers exceed the federally recommended three-day dosage limit, according to a survey by the National Safety Council.

The survey found 99 percent of doctors exceed the three-day limit. Almost one-quarter of doctors prescribe opioids for a month, HealthDay reports.

"Opioids do not kill pain. They kill people," Dr. Donald Teater, a medical advisor at the National Safety Council said in a news release. "Doctors are well-intentioned and want to help their patients, but these findings are further proof that we need more education and training if we want to treat pain most effectively."

While almost 85 percent of doctors screen for signs of prior opioid painkiller abuse, only one-third asks about a family history of addiction, the survey found. When signs of abuse are uncovered, only 5 percent offer direct help and only 38 percent refer these patients for treatment elsewhere.

The survey found 74 percent of doctors said they believe pain relief is best achieved through one of two opioids: morphine or oxycodone. The National Safety Council said over-the-counter pain relievers, such as ibuprofen and acetaminophen, are more effective in providing short-term pain relief.

Earlier this month the Centers for Disease Control and Prevention (CDC) issued guidelines that recommend primary care providers avoid prescribing opioid painkillers for patients with chronic pain. The risks from opioids greatly outweigh the benefits for most people, the CDC says.

Primary care providers write nearly half of all opioid prescriptions, according to the CDC. The new guidelines are designed for primary care doctors who treat adult patients for chronic pain in outpatient settings. They are not meant for guiding treatment of patients in active cancer treatment, palliative care, or end-of-life care, the agency said.

Doctors who determine that opioid painkillers are needed should prescribe the lowest possible dose for the shortest amount of time, the guidelines state.

Recovery houses lacking in oversight

The opioid epidemic is leading to an increase in the number of "sober homes," a form of housing where people in recovery live together in a supervised, substance-free setting. Most of these homes have little or no government oversight, the Associated Press reports.

Sober homes are rarely run by credentialed professionals, according to the AP. They often are run by people in recovery themselves who have remained clean after going through rehab.

At least five states have passed or are considering legislation to improve rules on the operation of these facilities. Some measures would require sober homes to be inspected and certified, and be subject to consumer protections and ethical codes. Some sober homes have been accused of insurance fraud and tolerating drug use.

"The ones that are good are fantastic," said Pam Rodriguez, CEO of Treatment Alternatives for Safe Communities, an Illinois nonprofit that works to reduce prison time for nonviolent drug offenders. She noted the field also includes "people exploiting the vulnerability of the population and their desperation to find a safe place to live."

Sober homes originally were designed as halfway houses for people in recovery from alcoholism. Now many sober homes cater to people trying to recover from opiate addiction. Some sober homes are single-family houses in residential neighborhoods, while others are in apartment complexes.

AMA reacts to opiate guidelines urging need to strike a balance

In response to the Centers for Disease Control and Prevention new opiate guidelines, the American Medical Association noted its shared goal of reducing harm from opioid abuse and seeking solutions to end this public health epidemic and applauds the agency for making the issue a high priority.

"While we are largely supportive of the guidelines, we remain concerned about the evidence base informing some of the recommendations, conflicts with existing state laws and product labeling, and possible unintended consequences associated with implementation, which includes access and insurance coverage limitations for non-pharmacologic treatments, especially comprehensive care, and the potential effects of strict dosage and duration limits on patient care," said Dr. Patrice A. Harris, the AMA board chair-elect and chair of the AMA Task Force to Reduce Opioid Abuse.

> ***"We know this is a difficult issue and doesn't have easy solutions and if these guidelines help reduce the deaths resulting from opioids, they will prove to be valuable. If they produce unintended consequences, we will need to mitigate them."***
>
> ***Dr. Patrice A. Harris, AMA chair, Task Force to Reduce Opioid Abuse***

Harris went on to say, "We know this is a difficult issue and doesn't have easy solutions and if these guidelines help reduce the deaths resulting from opioids, they will prove to be valuable. If they produce unintended consequences, we will need to mitigate them. They are not the final word. More needs to be done, and we plan to continue working at the state and federal level to engage policy makers to take steps that will help end this epidemic.

"While prescription opioids can be part of pain management, they have serious risks. The new guideline aims to improve the safety of prescribing and curtail the harms associated with opioid use, including opioid use disorder and overdose. The guideline also focuses on increasing the use of other effective treatments available for chronic pain, such as non-opioid medications or non-pharmacologic therapies.

"By using the guideline, primary care physicians can determine if and when to start opioids to treat chronic pain. The guideline also offers specific information on medication selection, dosage, duration, and when and how to reassess progress and discontinue medication if needed. Using this guideline, providers and patients can work together to assess the benefits and risks of opioid use."

Recovery coach training in June

NCADD-NJ will start offering Recovery Coach training in 2016. The CCAR Recovery Coach Academy© is a seven-day intensive training academy focusing on providing individuals with the skills need to guide, mentor and support anyone who would like to enter into or sustain long-term recovery from an addiction to alcohol or other drugs.

This training will be held at the NCADD-NJ Training Center (330 Corporate Boulevard, Robbinsville NJ) on Monday, June 20 through Sunday, June 26. (Monday-Friday 6 p.m.-9 p.m. and Saturday-Sunday 9 a.m.-5p.m.) This training costs $500 per person and includes the CCAR training manual and lunch on Saturday and Sunday. Trainers will be Aaron Kucharski and Mariel Harrison. For more information about the RCA or to register, contact Mariel Harrison at mharrison@ncaddnj.org.

Study notes use link in youth incarceration

New research funded by the National Institute on Drug Abuse revealed that of previously incarcerated youths, more than 90 percent of males and nearly 80 percent of females had a substance use disorder at some point in their lifetime. The longitudinal study randomly sampled 1,829 youth -- ages 10-18 years who entered detention in Cook County, Illinois, from 1995-1998 -- and examined how lifetime and past-year prevalence of substance use disorders differed by sex, race/ethnicity and substances abused as the group grew to young adulthood. The participants were re-interviewed up to nine times over 16 years and were assessed for substance-use disorders involving alcohol, marijuana, cocaine, hallucinogen/PCP, opiate, amphetamine, inhalant, sedative and other unspecified drugs.

For a copy of the abstract, "Health Disparities in Drug and Alcohol Use Disorder: A 12-Year Longitudinal Study of Youths After Detention," published in the American Journal of Public Health, go to http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2015.303032.

Commentary

Affordable Care Act's key role in treating adult children

By Dana Connolly

More young people between 18 and 34 years of age are now living with their parents. The dearth of jobs, high cost of living, and postponement of marriage and children are several factors contributing to the trend. For some families, the arrangement is mutually beneficial and financially advantageous. For others, the arrangement can put a strain on parents' finances.

Another major trend affecting families today are mental illness and substance use disorders. While behavioral health care has been shown to be effective, only a small fraction of those suffering receive professional treatment. Changes in health care insurance with the passage of the Affordable Care Act has left many parents wondering how to get their grown children covered and into treatment.

Many Americans qualify for health coverage under the ACA and don't know it. No one can be denied care because of pre-existing mental illness or substance use disorders. This means that the majority of those who need addiction treatment should be able to receive it under the Mental Health Parity and Addiction Equity Act of 2008, and both the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, which together comprise the ACA.

Basically, the MHPAEA requires insurance companies to cover mental illness and addiction treatment just as they cover physical disease. To increase access to behavioral health care and addiction treatment, the MHPAEA and ACA combined and, as a result, beginning on July 1, 2014, approximately 87 percent of Americans became eligible for free or affordable rehabilitation for mental and behavioral disorders in addition to substance use disorders, including smoking. Furthermore, parents can keep their children on their policy up to age 26.

Amid overwhelming alcohol and drug use statistics, rates of depression, anxiety and other mental illnesses continue to grow. Suicide rates have risen to new heights as a leading cause of death in Americans under the age of 50.

Relatively few of those who need help actually receive it, and there was an average delay of eight to 10 years between onset of symptoms and intervention before the ACA.

With 16.4 million newly insured out of 319 million Americans, we should expect to see more people seeking help as a result of the ACA. Yet several other barriers to care remain. These include pervasive social stigma and insurance-related issues such as:

•Many remain unaware of their eligibility.

•Physically healthy young Americans elect not to pay premiums, so they lack mental health insurance that they need.

•Millions of Americans and undocumented immigrants are still without coverage.

•There is a lack of mental health services and substance abuse counselors in relationship to need, particularly in rural areas.

•Insurance companies make payments and reimbursements a challenge despite laws.

In addition, various policymakers and presidential candidates have postulated that the ACA should be repealed. It is estimated that such a repeal would result in 24 million uninsured by the year 2025, many young adults and those with pre-existing conditions.

These barriers to care can be overcome, but much is left to the policymakers. In the meantime, families can become proactive by holding insurance companies accountable for covered reimbursement. Refusals to pay, endless forms, difficulty reaching a representative and other obstructionist behavior can be exasperating to families already under tremendous stress. Here are a few tips to cope with uncooperative insurance companies:

•Distribute tasks among family members and supportive others.

•Don't get upset when a bill arrives because providers generally bill faster than insurance companies pay. Keep your provider updated throughout the process.

•Appeal unfavorable decisions immediately; denials can be appealed in an expedited manner under the ACA.

•Keep all documentation and paperwork.

•Be persistent.

•Seek assistance from state, local and community agencies, organizations and mutual support groups.

•Stay calm and practice good health habits.

Recent legislation now makes treatment available to most Americans suffering from substance use disorders. As more people become aware that affordable coverage and treatment are available to Americans in all socioeconomic brackets, we should begin to see a reduction in the current mental health crisis. Though barriers to care still remain, the ACA has allowed many families to obtain coverage and gain access to addiction treatment for their loved ones.

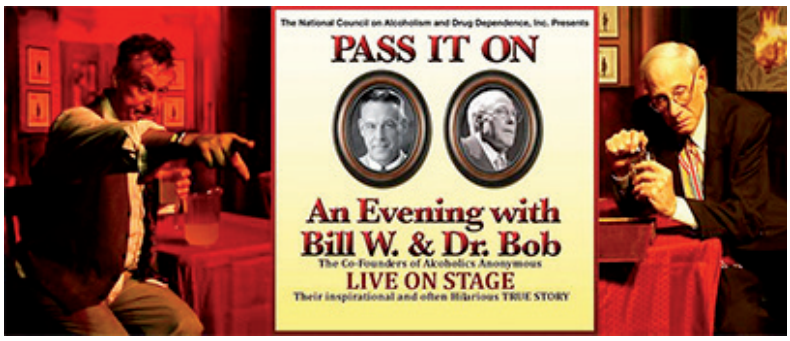
To learn more about the ACA, visit its official website, www.healthcare.gov. For more information about getting treatment for your child with a drug or alcohol problem, read the Treatment eBook.

Dana Connolly, is a senior staff writer for the Sovereign Health Group.

'Pass It On', play on AA's origins, launches its national tour in NJ

Tabor House recently brought "PASS IT ON: An Evening with Bill W. & Dr. Bob" to New Jersey for a one-night benefit performance. The moving and inspirational theatrical performance was presented by Tabor House, along with the National Council on Alcoholism and Drug Dependence-NJ (NCADD), at the Bordentown Regional High School Performing Arts Center in Bordentown, NJ on Saturday, April 23, 2016, 7 pm.

The April presentation coincided with NCADD's National Alcohol Awareness Month. It was presented with the generous support of event sponsor, New Hope Foundation, and in collaboration with the high school's Peer Awareness of Nicotine, Drugs & Alcohol Club. A special ceremony will also be held to mark NCADD's 30th annual commemoration of Alcohol Awareness Month.



PASS IT ON is both inspirational and hilarious in telling the story of the co-founders of Alcoholics Anonymous stumbling onto the discovery of 12 Step Recovery, which has transformed the lives of millions around the globe since 1935. This unique celebration of sobriety delivers the message of hope, help and the miracle of recovery - serving as the centerpiece for the National Recovery Education Campaign.

This live stage production was created to raise awareness about the solution to America's number one public health concern – alcoholism and drug addiction. Its message of hope, help, and the healing miracle of recovery is especially touching amidst the tremendous suffering and tragic losses being experienced nationally and in New Jersey due to the heroin epidemic as well as opiate overdose deaths.

PASS IT ON has created excitement among audiences and recovery communities in dozens of cities across the United States and Canada. This dynamic two man show features nationally acclaimed professional actors Gary Kimble and John Schile who both have personal stories of recovery and share 40 years of sobriety between them.

The one-night benefit performance in Bordentown launched this production's fourth year of touring North America – offering audiences an unforgettable evening of theater, enhancing recovery.

Proceeds benefited Tabor House.

A journal on ADDICTION RESEARCH & PUBLIC POLICY
PERSPECTIVES

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CDC responds to opiate crisis with issuance of new guidelines

As part of the federal government's urgent response to the epidemic of overdose deaths, the Centers for Disease Control and Prevention on March 15 issued new recommendations for prescribing opioid medications for chronic pain, excluding cancer, palliative, and end-of-life care. The CDC Guideline for Prescribing Opioids for Chronic Pain, United States, 2016 will help primary care providers ensure the safest and most effective treatment for their patients.

The United States is currently experiencing an epidemic of prescription opioid overdose. Increased prescribing and sales of opioids—a quadrupling since 1999— helped create and fuel this epidemic. In New Jersey, an effort by the Legislature to require physicians to discuss the potential for addiction of pain opiates has been frustrated by Assemblyman Herb Conaway (D-Burlington). Conaway, a physician, opposes having lawmakers impose restrictions on how doctors practice medicine.

"More than 40 Americans die each day from prescription opioid overdoses, we must act now," said CDC Director Dr. Tom Frieden. "Overprescribing opioids—largely for chronic pain—is a key driver of America's drug-overdose epidemic. The guideline will give physicians and patients the information they need to make more informed decisions about treatment."

The guideline provides recommendations on the use of opioids in treating chronic pain (that is, pain lasting longer than three months or past the time of normal tissue healing). Chronic pain is a public health concern in the United States, and patients with chronic pain deserve safe and effective pain management. This new guideline is for primary care providers—who account for prescribing nearly half of all opioid prescriptions—treating adult patients for chronic pain in outpatient settings. It is not intended for guiding treatment of patients in active cancer treatment, palliative care, or end-of-life care.

Among the 12 recommendations in the guideline, three principles are key to improving patient care:

- Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
- When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
- Providers should always exercise caution when prescribing opioids and monitor all patients closely.

"Doctors want to help patients in pain and are worried about opioid misuse and addiction," said Dr. Debra Houry, director of CDC's National Center for Injury Prevention and Control. "This guideline will help equip them with the knowledge and guidance needed to talk with their patients about how to manage pain in the safest, most effective manner."

In developing the guideline, CDC followed a rigorous scientific process using the best available scientific evidence, consulting with experts, and listening to comments from the public and partner organizations. CDC is dedicated to working with partners to improve the evidence base and will refine the recommendations as new research becomes available.

CDC developed user-friendly materials to assist providers with implementing the recommendations, including a decision checklist. These materials, as well as information for patients, are available at www.cdc.gov/drugoverdose/prescribing/guideline.html.

CDC will continue to work with states, communities, and prescribers to prevent opioid misuse and overdose by tracking and monitoring the epidemic and helping states scale up effective prevention and treatment programs. CDC also continues to improve patient safety by equipping health care providers with data, tools, and guidance so they can make informed treatment decisions.

Health and Human Services Secretary Sylvia Burwell has made addressing opioid misuse, dependence, and overdose a priority. Other work on this important issue is underway within HHS. The evidence-based HHS-wide opioid initiative focuses on three priority areas: informing opioid prescribing practices, increasing the use of naloxone (a rescue medication that can prevent death from overdose), and expanding access to and the use of Medication-Assisted Treatment to treat opioid use disorder.

These efforts build on work that began in 2010, when the President released his first National Drug Control Strategy, which emphasized the need for action to address opioid misuse and overdose, while ensuring that individuals with pain receive safe, effective treatment. Also in 2010, the Affordable Care Act improved access to substance use disorder treatment options by requiring coverage of substance use disorder services in the Health Insurance Marketplace and establishing important parity protections to ensure that substance use disorder coverage is comparable to medical and surgical care coverage. The next year, the White House released its national Prescription Drug Abuse Prevention Plan to outline goals for addressing prescription drug misuse and overdose. Since then, the Administration has supported and expanded community-based efforts to prevent drug use and pursue "smart on crime" approaches to drug enforcement, as well as efforts to improve prescribing practices for pain medication and increase access to treatment, to reduce overdose deaths and support the millions of Americans in recovery.

The American Medical Society had a somewhat ambivalent response to the issuance of guidelines, noting that opiates have their place in treating pain. "Dr. Patrice A. Harris, the AMA board chair-elect and chair of the AMA Task Force to Reduce Opioid Abuse, said, "While we are largely supportive of the guidelines, we remain concerned about the evidence base informing some of the recommendations, conflicts with existing state laws and product labeling, and possible unintended consequences associated with implementation, which includes access and insurance coverage limitations for non-pharmacologic treatments, especially comprehensive care, and the potential effects of strict dosage and duration limits on patient care."