Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

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State Budget Watch

New Jersey drug court expansion: A question of timing and scale

When Gov. Chris Christie proposed mandatory drug court for all nonviolent drug offenders in New Jersey — and proposed to pay for it with $2.5 million he put in his budget — questions were raised about whether the funding would be adequate, and the legislature continued pursuing its own proposal for a program that was smaller in scale but more expensive (see *ADAW*, April 16). With less than three weeks left in the budget process, it's still unclear whether the governor and the legislature will agree on next steps.

There is no disagreement between the legislature and the governor on the value of drug courts: instead of incarcerating people with addictions at a high cost, the state could treat them at a lower cost. "This bill is about spending our corrections budget smarter and putting the focus on addiction recovery rather than blind incarceration for offenders who are motivated by substance abuse," said Sen. Raymond J. Lesniak, one of the bill's two sponsors, after the bill, S881, passed the Senate by a 33-2 vote May 31.

S881 would cost more than $5 million and be a pilot in two of the state's 21 counties. "Our current criminal justice system fails individuals who are addicted to drugs," said Sen. Nicholas Scutari, the other sponsor of S881. "One of the popu-

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Treatment Program Profile

Experience in justice leads TC to work with other populations

The therapeutic community (TC) based agency Center Point, Inc. is seeing its work with military veterans as a relatively new line of business with significant growth potential, but its leaders believe they never would have been in a position to work with this group had they not had a history of assisting another special population.

"We had an understanding of substance abuse and mental health issues, domestic violence, sexual trauma, and community reintegration because of our work in prisons," Center Point president and CEO Sushma D. Taylor, Ph.D., told *ADAW*. "There is a parallel between prison and veteran populations. Both groups have been very directed, in terms of the scope of their decision-making. They have been told what they're supposed to be doing, wearing, eating."

Therefore, each population faces significant community reintegration issues when exiting their highly controlled environment. Center Point in recent years has tailored its veterans programs, particularly in Texas, to the specific needs of returning female veterans, many of whom have faced harassment while in the military and then encounter a male-centric service system when return-

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lar definitions of insanity is doing the same thing over and over again and expecting different results. In the case of drug-addicted criminal offenders, if we think for a minute that the current vicious cycle of incarceration, release, criminal offense and incarceration will eventually yield rehabilitated individuals, then we're certainly inviting questions about the efficacy of the state's criminal justice system, let alone our own mental health and well-being."

And at his March announcement at the Rescue Mission calling for mandatory drug court for all nonviolent drug offenders in the state, Governor Christie, saying he had experienced addiction in his own family, called for the drug court participation to be mandatory because he didn't think people would come forward voluntarily for help (see *ADAW*, March 19). Both Senators Lesniak and Scutari think the mandatory measure is worth studying but they want the governor's support for their bill.

The question on everyone's mind about Governor Christie's proposal is how to pay for it. Of the $2.5 million in new money for drug courts in his proposed budget, $1.5 million would be used for drug court administration, leaving $1 million in additional new money for treatment. The budget was released February 21. His vision — mandatory drug court for every nonviolent drug offender in the state — wasn't made clear until the Rescue Mission press conference March 1.

A spokeswoman for the Department of Human Services' Division of Mental Health and Addiction Services, which would be responsible for getting treatment to the drug court participants, did not have any officials available to comment on this story but said "the department is closely monitoring the budget process in this regard."

'An evolution'

So we turned to providers and lobbyists for the story. "There's been an evolution" in the governor's thinking, said Debra L. Wentz, Ph.D., CEO of the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA). First, the budget called for $2.5 million to establish a statewide mandatory drug court program. Then, at the press conference at the Rescue Mission in March, the governor was asked about the adequacy of the funding. "That's where the disconnect is," Wentz told *ADAW*.

At the Rescue Mission press conference, the governor made clear that his approach was to use the money for the 1,500 currently sentenced nonviolent offenders who would voluntarily go through drug court. "It was brought up at the press conference that this money wouldn't treat 1,500 people," said Wentz. "His thinking was that not everyone would voluntarily go into drug court, and this would give them time to get legislation in place first for a pilot and then to roll out the program." Asked why an addict would not volunteer for drug court instead of incarceration, Wentz said she didn't know. But she did say that the governor's assumption was that not all 1,500 would volunteer.

Money from corrections?

Providers communicated to the governor that with only $1 million in treatment dollars, the state would have to build addiction capacity, said Wentz. "The governor said that he would go to the legislature for an additional appropriation," she said.

As for where the money would come from — it's unlikely that the legislature would appropriate new dollars — Wentz said it should come from the Department of Corrections, which would save money in incarcerations. "This could get changed in the budget process," she said, admitting that there is no agreement to transfer funds. But further in the future, there could be a memorandum of understanding, she said.

The National Council on Alco-

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holism and Drug Dependence–New Jersey (NCADD-NJ) agreed. On March 17, the NCADD-NJ wrote a letter supporting the governor's proposal to the legislature's budget committee, calling for $46 million to be reallocated for drug courts from the savings from incarceration. "The $2.5 million is simply not sufficient to even cover those that request to participate in Drug Court, let alone those that do not want it and are mandated into it," the NCADD-NJ said. "Money must also be set aside to evaluate the effectiveness of mandatory Drug Court, whether it is implemented statewide as proposed by the Governor or as a pilot in two counties as proposed by S881."

According to the state's October 2010 drug court report, drug court graduates' re-arrest rate is 16 percent, and the reconviction rate is 8 percent. Drug offenders released from prison have re-arrest rates of 54 percent, with reconviction rates of 43 percent. And the report says an average institution cost per inmate is $38,900, compared to $11,379 for an active drug court participant.

'Just the beginning'

Wentz views S881 and the governor's proposal as "complementary, not antithetical."

Whether the governor will support S881 as it goes to the Assembly is not clear. But he has been clear in his ultimate direction — expanding the program to cover the entire state. "This is just the beginning," said Wentz.

> **'He's obviously very committed and wants to see this happen, whether it's fast-tracked or a slow rollout.'**
>
> Debra L. Wentz, Ph.D.

She believes that, ultimately, the state will approve mandatory drug court for nonviolent offenders and fund it adequately, "because the cost of incarceration is huge." The trend is nationwide, she said. "Treating addicts instead of incarcerating them saves money in the long term and it's excellent public policy."

Another reason that Wentz is optimistic about the measure is Governor Christie's commitment to it. "Regardless of the economy and budgets, in any state, and that would be true in our state, whatever the governor's priority is, that is what gets funded." Governor Christie said at the Rescue Mission in March that he wants drug courts to be his legacy, she noted. "He's obviously very committed and wants to see this happen, whether it's fast-tracked or a slow rollout," Wentz said.

In some states, there is more of a thirst for locking people up than treating them, but that doesn't seem to be true in New Jersey, said Wentz. Nevertheless, Governor Christie, a Republican with political ambitions, is taking a "courageous position because he's saying that addictions are treatable diseases and people should not be criminalized because of a disease," said Wentz. •

For the NCADD-NJ letter to the legislature's budget committee, go to http://bit.ly/Ly2jPP.

For more information on addiction and substance abuse, visit
www.wiley.com

GAO report finds plans still exclude treatments for SUDs

Since the enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), there has been an increase in a broad array of exclusions for treatment for substance abuse, according to a report released May 31 by the Government Accountability Office (GAO). Diagnoses including tobacco dependence and places of service including residential come in for exclusions based on the GAO's review of plans.

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The report was a follow-up to a report the GAO released last fall, which called the parity law a success because only 2 percent of employers discontinued coverage for mental health and substance abuse as a result of the 2008 law (see *ADAW*, December 12, 2011). That report was based on 168 plans. Congress requested more detail about those plans, and this report is a response to that request. Only 24 percent of the plans responded to the GAO's request for additional information.

The report was prepared for Rep. George Miller (D-California), member of the Committee on Education and the Workforce. Last fall's report was written to fulfill a mandate in the parity law requiring the GAO to look at trends in coverage. More information about treatment exclusions requested by Representative Miller was based on survey data collected during the plan year in effect at the time of the survey (either 2010 or 2011) and in 2008. The survey was fielded between May 18 and July 1, 2011, to 707 employers, stratified to include small, medium and large employers.

The results are not generalizable because of the small response rate, said John Dicken, director of health care for the GAO.

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The language for the exclusions was taken directly from the plans, Dicken told *ADAW*. "Unfortunately, the only information we had was how they worded the exclusions," Dicken said.

Reasons for exclusions

Below are the reasons given by the plans for exclusions for different diagnoses and places of service, for the 2008 plan year and the 2010 or 2011 plan year.

Alcoholism

2008 plan year:

- Alcohol and/or substance abuse treatments are not considered mental health benefits
- Services or supplies furnished for diagnosis or treatment of alcoholism, controlled substance abuse, chemical dependency, tobacco addiction or codependency treatment for any of the above, except as provided in the Schedule of Benefits
- For acute care, rehabilitative care, or diagnostic testing or evaluation of mental or nervous conditions, alcoholism, substance abuse or addiction, or for pain rehabilitation, except as specified as a covered service in this plan

2010 or 2011 plan year:

- Alcohol and/or substance abuse treatments are not considered mental health benefits
- Services or supplies furnished for diagnosis or treatment of alcoholism, controlled substance abuse, chemical dependency, tobacco addiction or codependency treatment for any of the above, except as provided in the Schedule of Benefits

Court-ordered treatments

2008 plan year:

- Court-mandated treatment or treatment that is a condition of parole or probation or in lieu of sentencing
- Any court-ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, or custody or visitation evaluations unless medically necessary and otherwise covered under this policy or agreement
- Charges for services, treatment or care of any kind of chemical dependency if the participant is convicted in any court of law and is required by the court, or arranges in lieu of conviction, to undergo care or treatment as an alternative to, or in addition to, a fine or imprisonment
- Court-ordered psychiatric or substance abuse treatment except when certified by (the plan) as medically necessary
- Counseling, studies, services or confinements ordered by a court or law enforcement officer that are not determined to be medically necessary by the plan administrator or its designee
- Court-ordered behavioral health services.
- Court-ordered psychiatric or substance abuse treatment except when certified by (the plan) as medically necessary
- Court-ordered behavioral health services
- Court-ordered examinations and treatment, unless medically necessary
- Court-ordered testing and/or evaluation

2010 or 2011 plan year:

- Court-ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy
- Any court-ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, or custody or visitation evaluations unless medically necessary and otherwise covered under this policy or agreement

Residential treatment facility

2008 plan year:

- Residential treatment services
- Covered expenses for residential treatment provided in a residential treatment facility when the total phase of treatment has not been completed by you

2010 or 2011 plan year:

- Covered services in a residential treatment facility, provided in a residential treatment facility, when the member fails to complete that phase of treatment
- Residential care by a residential treatment facility
- Necessary services such as vocational programs or employment counseling residential treatment program
- Covered expense does not include charges for inpatient or outpatient services rendered in a residential treatment facility

For smoking cessation, many plans simply did not cover it at all.

Below are the number of times and the percentages of exclusions that pertain to treatment for substance use disorders (SUDs):

- Court-ordered treatments: ex-

'We are glad to see the GAO report confirm what patients and providers are experiencing.'

Carol McDaid

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cluded nine times by 33.3 percent of plans in 2008, eleven times by 28.2 percent of plans in 2010 or 2011

- Treatment in a residential facility: excluded three times by 11.1 percent of plans in 2008, six times by 15.4 percent of plans in 2010 or 2011
- Smoking cessation or tobacco addiction: excluded twice by 7.4 percent of plans in 2008, eight times by 20.5 percent of plans in 2010 or 2011

"We are glad to see the GAO report confirm what patients and providers are experiencing," said Carol McDaid, principal with Capitol Decisions. "Among many other exclusions, they reported the reduction in access to intermediate levels of care."

"I can't speak to how the report will be used, whether by Congress or the Department of Labor or employers or policymakers," Dicken told *ADAW*. "As a broader effort, you can see that there are still areas where employers are making decisions as to what they cover." •

To view the full report, go to http://1.usa.gov/KKPvLM.

New York moves to eliminate 'stop-and-frisk' marijuana arrests

After last month's ruling by a federal district court judge granting class-action status to a lawsuit challenging the New York City Police Department's policy of stopping young people and asking them to empty their pockets, and then arresting them if they possessed small amounts of marijuana, Gov. Andrew Cuomo has proposed decriminalizing marijuana possession in the state. The governor's proposal came on June 4 and was supported by New York City's Mayor Michael Bloomberg and Police Commissioner Raymond Kelly.

At first, it seemed as if the city would continue to make the stop-and-frisk stops. A spokeswoman for the city's law department told the New York Times last month that the city disagreed with the decision and was reviewing options, including a possible appeal.

But when Governor Cuomo proposed reducing the penalty for possession in public view to a violation, charging the police department with being overzealous, the city's mayor and police commissioner supported him.

"There's a blatant inconsistency," said Governor Cuomo in announcing his proposal, which was sent to the legislature. "If you possess marijuana privately, it's a violation. If you show it in public, it's a crime," Cuomo said. "It's incongruous. It's inconsistent the way it's been enforced. There have been additional complications in relation to the stop-and-frisk policy where there's claims young people could have a small amount of marijuana in their pocket, where they're stopped and frisked. The police officer says, 'Turn out your pockets.' The marijuana is now in public view. It just went from a violation to a crime."

'There's a blatant inconsistency. If you possess marijuana privately, it's a violation. If you show it in public, it's a crime.'

Gov. Andrew Cuomo

The governor's move came after Judge Shira A. Sheindlin on May 16 cited the city's "deeply troubling apathy towards New Yorkers' most fundamental constitutional rights." Police do not have the right, under the Fourth Amendment of the Constitution, to search people without reasonable suspicion. Judge Sheindlin said in her decision that the majority of New Yorkers who are stopped unlawfully — without any suspicion — would never bring suit.

The police department made more than 200,000 "stop-and-frisk" stops in the first three months of 2012. Last year, the city's police department arrested 50,000 people for possessing small amounts of marijuana based on these stops.

Critics of stop-and-frisk have charged that blacks and Hispanics — about 85 percent of people stopped — are singled out for these stops and arrests. In addition, only 10 percent of people stopped are issued summonses or arrested.

Saying that "suspicionless stops should never occur," Judge Sheindlin called the city's attitude "cavalier."

Possession of small amounts (25 grams or less) of marijuana was decriminalized in New York state in 1977. Possession "in public view" was made a misdemeanor, with a fine of $500 and a three-month jail term. But arrests continued; 94 percent of the 12,000 teenagers arrested in the city last year for marijuana possession had no prior convictions, and half have never been arrested before.

The class-action status case was filed more than four years ago by the Center for Constitutional Rights on behalf of four plaintiffs.

Penalties for smoking marijuana in public are not changed by the bill. •

For Governor Cuomo's press release, go to http://bit.ly/KYeFU6.

For Judge Sheindlin's ruling, go to http://bit.ly/KY195A.

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Rx database law signed in Tennessee

Tennessee is one of the first states to enact a law requiring physicians to check a drug monitoring database before prescribing pain medication. The new law, the Prescription Safety Act, was signed May 11 by Gov. Bill Haslam. It gives state officials the ability to see which physicians prescribe the most opioids, and, if an investigation is already under way, allows law enforcement access to the database without a warrant. The legislation was crafted by the state's Department of Safety and Homeland Security. The purpose of the law is to fight what Governor Haslam called the "scourge" and "epidemic" of prescription drug abuse in the state.

Methadone rules amended

Ironically, Tennessee tried to institute a policy of requiring all methadone patients to withdraw from the medication, and all new methadone patients to plan for discharge upon admission (see *ADAW*, February 6). The Tennessee Department of Mental Health (DMH) said that it favors a treatment regimen of abstinence only. However, those rules are being changed, Grant Lawrence, DMH communications director, told *ADAW* in a June 5 email. "Late last year, the department held a public hearing to hear from stakeholders and welcomed any responses to the rules in writing as well. We have received these responses and have responded accordingly. We are currently in the process of amending the rules." How the rules will be amended is not yet known, but the American Association for the Treatment of Opioid Dependence (AATOD) sent a letter May 25 to DMH commissioner E. Douglas Varney, calling for public policy to be "based on the evidence and not a philosophy or belief." The letter, a copy of which was obtained by *ADAW* and not released by DMH, cites the evidence for methadone maintenance.

Focus on physicians

The prescription drug abuse focus in the state is now on physicians who prescribe opioids for pain. Officials considered going farther, giving law enforcement free access without a warrant to scrutinize the database. There would have been a fight from the Tennessee Medical Association if this had been proposed.

As it is, physicians in Tennessee — as in other states — say there is an unfair burden put on most physicians, who prescribe properly, instead of the few who are overprescribing.

The Tennessee Medical Association had wanted exceptions for checking the database, for hospice and surgical patients. Physicians say that it takes too much uncompensated time to check the database, given the few minutes they have per patient. Finally, some patients need more pain medication than others, and a physician who specializes in pain management should be expected to write more opioid prescriptions than other kinds of physicians, state officials say. The state plans to hire an epidemiologist who will help benchmark appropriate prescribing amounts.

The law allows state and federal agents to pull information from the database without a warrant, if they are already working on an investigation. Tommy Farmer, assistant special agent in charge of the Tennessee Bureau of Investigation drug investigation division, told the Chattanooga Times Free Press that the law tells doctors that the state is watching. "We are looking for you and we will be coming after you," Farmer said.

Treatment providers, including methadone clinics, expect to see more patients with opioid dependence or addiction as a result of the prescribing restrictions.

The law goes into effect April 2013. •

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ing home.

"A lot of veterans facilities are not friendly to females — you can't take your children there, for instance," Geri Penn, a program manager overseeing Center Point's veterans programs in Texas, told *ADAW*.

Diversifying its operations to encompass needed services for special populations has become a critical goal for an agency that depends largely on government funding (and in cash-strapped states such as its home base of California) and that must pursue any and all available grants for the most current programming needs. Taylor said that the agency's work with female veterans in Texas grew out of a project designed by the Texas Veterans Commission.

Veterans services in Texas are carried out on an outpatient basis, and this represents another way in which Center Point has diversified from its 1970s-era TC roots. Much as has been the case for other TC programs around the country, residential treatment has represented a shrinking portion of Center Point's overall services.

Residential care now accounts for less than 10 percent of Center Point's business and is dwarfed by the size of the agency's correctional and case management services, said Taylor, who is also president of the national association Treatment Communities of America (TCA).

Veterans helping veterans

Most of the staff working in Center Point's Austin, Texas-based program for women veterans are veter-

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ans themselves; Penn served in the Air Force during the Vietnam era. "In the 1970s we didn't even use the term 'sexual harassment,'" she said.

The program offers services such as counseling, case management, and emergency financial assistance, and also helps troubleshoot problems for women veterans in areas such as accessing benefits. "We don't do it for them; we show them how to do it," said Penn.

She added in regard to the barriers these women face, "The military is only 15 percent female, and women are not always encouraged to pursue the proper channels."

Penn's staff currently is serving an overall caseload of about 45 female veterans from an eight-county area surrounding Austin. "We have women veterans from the Vietnam era who are coming in because they've never had access before," Penn said.

Taylor said she sees significant growth potential in veterans services for both women and men, especially given some of the dissatisfaction that veterans can experience when trying to access services through the Department of Veterans Affairs (VA) at remote sites or in the face of bureaucratic delays.

Developing partnerships

Much of Center Point's business depends on the building of relationships, whether with correctional agencies, insurance companies, or other treatment providers. Taylor said the agency is about to grow through a newly forged affiliation agreement with the Drug Abuse Alternative Center in Sonoma County, Calif., though she added that corporate affiliations have not been a primary goal of her agency.

"We've turned more people down than we have accepted, because of differences in philosophy and culture," Taylor said. "In this case, we've known them for a long time and their longtime CEO was retiring, and their situation will be helped by our national focus."

Center Point, Inc.

Founded: *1971*
Services: *Residential treatment, outpatient care, specialized programs for offenders and veterans, and transitional housing in California, Texas, Oklahoma and Louisiana*
Clients Served: *Close to 10,000 in a typical year*
Number of Employees: *Just over 200*
Payer Mix: *Less than 15 percent insurance and private pay; the majority of revenue is from state contracts and block grant funds*

Although private insurance still represents a relatively small portion of Center Point's revenue, the agency made its residential program more insurance-friendly as far back as the early 1980s. Taylor said that at a time when many of her colleagues were increasing lengths of stay, she was converting Center Point's core TC program from a one-year residential program to a six-month stay.

Since then, the agency has continued to experiment with variable lengths of stay ranging from 30 days to six months, she said. "Many of our people don't really need all of that support in a residential environment," she said. "They can do it in continuing care and with transitional housing."

Taylor believes that Center Point's work in correctional institutions and with veterans is likely to grow. "We're bound to look different in three to five years," she said. "We'll serve more people, but I'm not sure it'll be in residential treatment."

She adds that she does not believe the much-anticipated outcome of the legal challenge to the Affordable Care Act (ACA) will have a significant short-term impact on her agency ("The implementation is in the infancy stage," she said). Of more concern at the moment is California's fiscal crisis, which for an agency such as Center Point simply indicates the need for maximum diversification of operations — and funders. •

'We have women veterans from the Vietnam era who are coming in because they've never had access before.'

Geri Penn

Briefly Noted

People with high-risk gene for smoking may need Rx to quit

Whether someone needs medication to quit smoking or can do it on his own may depend on genetics, according to research published in the *American Journal of Psychiatry* May 30. The study, funded by the National Institute on Drug Abuse (NIDA) and other components of the National Institutes of Health, may lead to the use of medications for people most at risk for nicotine dependence, but not for people who are at low risk and able to quit on their own. "This study builds on our knowledge of genetic vulnerability to nicotine dependence, and will help us tailor smoking cessation strategies accordingly," said NIDA Director Nora D. Volkow, M.D. "It also highlights the potential value of genetic screening in helping to identify individuals early on and reduce their risk for tobacco addiction and its

Continues on next page

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related negative health consequences." For the study, researchers, led by Li-Shiun Chen, M.D., of the Washington University School of Medicine, St. Louis, focused on the nicotinic receptor gene cluster CHRNA5-CHRNA3-CHRNB4. People carrying the high-risk form of this gene cluster, which previous studies have shown contributes to heavy smoking, took two years longer to quit than those with low-risk genes. The researchers found that people with high-risk genes were less likely to succeed at their attempts to quit than people with low-risk genes when treated with placebo. When treated with medications, however, the likelihood of quitting increased for both groups. "If smokers have the risk genes, they don't quit easily on their own and will benefit greatly from the medications," said lead author Chen. "If smokers don't have the risk genes, they are likely to quit successfully without the help of medications such as nicotine replacement or bupropion." For the article, go to http://bit.ly/KZKDOp.

Coming up...

The 2012 **State Associations of Addiction Services (SAAS)** National Conference and **NIATx** Summit will be held **June 19-22** in **New Orleans**. For more information, go to **www.saasniatx.net**.

The annual meeting of the **National Association of State Alcohol/Drug Abuse Directors** will be held **June 26-28** in **Savannah**. Go to **www.nasadad.org** for more information.

The National Conference on Behavioral Health for Women and Girls sponsored by the **Substance Abuse and Mental Health Services Administration** will be held **July 17-19** in **San Diego**. Go to **http://samhsawomensconference.org** for more information.

State News

Pro-alcohol beverage law signed in Alaska

Instead of being regulated by the Department of Public Safety, alcohol beverages now fall under the Department of Commerce, Community & Economic Development, the Juneau Empire reported June 5. The bill, signed into law by Governor Sean Parnell June 1, is supported by the alcohol industry and opposed by treatment and prevention groups. With the Alcoholic Beverage Control Board now in the business-friendly commerce department, there will be a more collaborative arrangement between the government and the industry, said supporters, including Rep. Mike Hawker (R-Anchorage) and Dale Fox of the Cabaret, Hotel, Restaurant and Retailers Association. The ABC Board, which is made up of public and private members, said alcohol is not like other industries because of problems drinking causes in Alaska. And Matt Felix of the National Council on Alcoholism and Drug Dependence said what little power the ABC Board has now would be further eroded by moving it to the commerce department. "To dumb down the board at this point would be somewhat ludicrous," he said. The law, which takes effect July 1, was signed by the governor with no announcement or press release.

Names in the News

Walter Ginter and others to be honored

A reception will be held in Washington, D.C., on June 27 for **Walter Ginter**, project director of the Medication-Assisted Recovery Services (MARS) Project, and other recipients of the the Vernon Johnson Award from Faces & Voices of Recovery and Hazelden's Center for Public Advocacy. Other honorees are the **Massachusetts Organization for Addiction Recovery**, **Robert McGinley Seymour, Jr.** of Real Urban Ministry in Texas and **Rosemary Tisch** of Prevention Partnership International in California. **Jeff Blodgett**, a founder of Faces & Voices, will receive the Lisa Mojer-Torres Award. The reception will be hosted by reporter and anchor Pat O'Brien.

For more information, e-mail info@facesandvoicesofrecovery.org, go to http://bit.ly/Kf6XbW or call (202) 737-0690. Co-hosts are former Congressman Patrick Kennedy and Carol McDaid of Capitol Decisions.

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: Alison Knopf, Editor, Alcoholism & Drug Abuse Weekly, 111 River Street, Hoboken, NJ 07030-5774; e-mail: aknopf@bestweb.net. Letters may be edited for space or style.

In case you haven't heard...

What a difference a chamber makes. The Prescription Drug Abuse Prevention and Treatment Act, which would provide grants for education on opioid abuse and establishing training requirements for prescribers, has been referred to the Senate Committee on Health, Education, Labor and Pensions (S. 507, sponsored by Sen. Jay Rockefeller). The companion bill in the House of Representatives is in the Subcommittee on Crime, Terrorism, and Homeland Security (H.R. 1925, sponsored by Rep. Nick Rahall). Both sponsors are Democrats from West Virginia.