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News for policy and program decision-makers

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CADCA
Celebrating 20 Years Building Drug-Free Communities

Alison Knopf, Editor, winner of CADCA Newsmaker Award

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Addiction treatment provider continues expansion into mental health

In a new partnership aimed at improving care for patients with substance use disorders and mental illness — the latest in one program's bold expansion from being a substance use provider only to providing psychiatric services as well — Rosecrance Health Network is going to manage the inpatient mental health unit of SwedishAmerican Health System. In addition, Rosecrance purchased SwedishAmerican's outpatient behavioral health clinic, which will shut down on March 1 and be integrated with existing Rosecrance operations.

More than two years ago, Rosecrance made its first move: the venerable addiction treatment provider merged with the Janet Wattles Center, a mental health provider, and became the parent entity (see *ADAW*, December 6, 2010).

The new partnership between Rosecrance and SwedishAmerican, both based in Rockford, Illinois, has fast-forwarded the possibility of geo-

See **Rosecrance** page 2

Bottom Line...

Rosecrance is expanding into mental health and primary care by partnering with SwedishAmerican, a large healthcare system also located in northern Illinois. The project will help patients in the area as well as the program's payer mix.

Treatment Program Profile

Seabrook positions for changes with renewed outpatient emphasis

Seabrook House President Ed Diehl never has expressed shyness when discussing the ills he believes managed care has wrought on addiction treatment services. But while he continues to believe that fighting insurance battles will remain an integral component of his treatment organization's mission, Diehl indicates that recent business moves for his facility reflect an overall environment of improved communication between treatment and managed care.

After having closed all of its outpatient operations in 2001 during a stage in which managed care had become "absurdly restrictive," Diehl said, Seabrook House last fall announced the opening of new outpatient sites in Cherry Hill and Northfield, N.J., to serve the Philadelphia and southern New Jersey markets.

"In recent years, there's been a resurgence of interest among major insurance payers who have encouraged us to work with them on out-

See **Seabrook** page 5

Bottom Line...

Seabrook House believes that its expanded outpatient operations provide a more solid continuum of care while preparing the organization to serve a key role in insurance exchanges under health reform.

Rosecrance from page 1

graphic scope to Rosecrance, which was founded in 1916 as an orphanage. Prior to the partnership, Rosecrance had two inpatient addiction treatment facilities and the Ware Center (from the Wattles merger) for outpatient mental health services. SwedishAmerican is a large system. The partnership could go beyond one inpatient unit and one outpatient clinic.

Inpatient and outpatient

Under the agreement, which was announced January 31, nurses providing direct patient care will be employed by SwedishAmerican Hospital, and the psychiatrists and therapists will be employed by Rosecrance. The unit will be managed by a Rosecrance employee who will report to SwedishAmerican's vice president of nursing.

There will be no interruption of outpatient services at the outpatient mental health clinic, now located in Camelot Tower. Rosecrance affiliate Aspen Counseling & Consulting will take over the services at a new location to be announced.

The partnership will provide more comprehensive coverage for SwedishAmerican Hospital's Emergency Department, with additional case management alternatives, according to both organizations.

"Our partnership with Rosecrance will help us to more effectively bridge gaps in the current mental healthcare system, and ensure that patients receive the best possible care in the most appropriate setting, and in a timely fashion," said SwedishAmerican President and CEO Bill Gorski, M.D. "This is an excellent example of how two respected organizations are coming together to advance the continuity of mental healthcare in northern Illinois with creative solutions."

"'[I]t's not just doing more of the same and calling it behavioral health.'

Philip W. Eaton

"The goal is to connect the dots between the acute care system and community-based services, creating a seamless transition between levels of care within the same network," said Rosecrance President and CEO Philip W. Eaton.

SwedishAmerican has two hospitals, 30 clinics, a home health care agency and a foundation. It will open a new cancer center this fall.

Rosecrance is a comprehensive behavioral health network providing substance abuse and mental health treatment to more than 14,000 children, adolescents, adults and families each year. Rosecrance has facilities in northern Illinois and southern Wisconsin.

Major adjustments for SPMI

Integrating mental health programming into primarily addiction programs has to be "an intentional journey," Eaton told *ADAW*. For example, in Illinois, regulatory and certification implications required major adjustments. "It wasn't just hiring just a few more counselors," he said.

The experience of merging the Janet Wattles Center into Rosecrance in 2010 has been successful, and reinforced the fact that "it's not just doing more of the same and calling it behavioral health."

In particular, patients with serious and persistent mental illness (SPMI) "come to the table with very different needs than patients with substance use disorders," he said. "They come with primary healthcare needs, and longer-term case management." For substance use disorder (SUD) patients, the duration of treatment is days or weeks, said Eaton. "Aftercare could be

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months," he said, noting that the importance of aftercare to patients is sometimes missed in community mental health centers.

Support systems

"On the addiction side, we have this wonderful support system, anywhere in the world, for free — Alcoholics Anonymous and Narcotics Anonymous," said Eaton. "You just open up a phone book and find an AA or NA meeting." For people with SPMI, this system does not exist, said Eaton. "There is a movement of peer support specialists, but it's a different type of support," he said.

The community mental health field has developed two models — the clubhouse model and the living room model, he said. In the clubhouse model, people with SPMI could "drop in" and have psychosocial rehabilitation, skill building and confidence building.

State funds

The challenge in Illinois is the shutdown of state-owned psychiatric facilities due to lack of funding, as the state struggles to meet its pension liabilities first. "So it's hard for the state to say they're going to lead this wonderful integration, because they're not going to pay people for nine or ten months," he said.

That's why Rosecrance moved on its own to integrate, said Eaton. "Organizations are trying to work in this new era of health reform, and we're looking at how we can do this best locally," he said. "The national initiatives, even parity, still have a lot of issues that have to be worked out at the state level."

Another reason for the local focus is that providers need to respond to the varied needs of the population. Rockford is very different from Chicago, said Eaton. "We're an urban setting but still are surrounded by an enormous rural environment," he said. "In 5 minutes I can be in the middle of cornfields." In these areas, there are "40-bed hospitals that have no behavioral healthcare whatsoever," said Eaton.

Payer blend

On the business side, the partnership will "strengthen our private-pay insured commercial business, both for mental illness and substance abuse," said Eaton. "We know that the strength of our organization is having a good blend of payers," said Eaton, who has watched the programs, which are solely dependent on state funding, struggle over the past two years. "It's no secret that those organizations are being choked."

No wrong door

For several years the Substance Abuse and Mental Health Services Administration (SAMHSA) has endorsed a "no wrong door" policy, in which patients get the treatment they need, regardless of what type of provider they present at. Eaton noted that what Rosecrance is doing by integrating with mental health fits into that concept. The key point is improving the "handoff," so that when someone is referred to a different service, that person is engaged in it. In fact, often people who need treatment for substance abuse or mental illness have as their first contact their primary care provider (PCP), said Eaton. Most PCPs still have a very difficult time doing the handoff to a behavioral healthcare provider, he said. "We need to streamline that access," he said. "The goal is for the PCP to be able to refer."

Most PCPs do screen for substance abuse, but Eaton thinks that they are "terrified" that patients will screen positive. "They'll say, 'Yes, I drink two pints of vodka a day,' and the PCP won't know how to respond because there's no place to refer the patient to."

Ideally, the "embedding" concept works, because it facilitates the handoff, said Eaton. Rosecrance is embedded in a federally qualified health center. If a patient is screened by the PCP and answers "yes" to the substance abuse questions, that PCP "can say, 'I'm going to walk you right down the hall, and we have a staffer right here from Rosecrance who can see you,'" said Eaton.

Initially, Rosecrance is not embedded in all of the SwedishAmerican clinics. "We're in two community-based clinics," said Eaton. "This is a dialogue that we're going to work on, going forward." •

NIH responds to *Nature* article on duplicative grants

A recent news article published in *Nature* focused on the problem of duplicate grants, in which two agencies — such as the National Institute on Drug Abuse (NIDA) and the National Institute on Alcoholism and Alcohol Abuse (NIAAA) — fund the same grant. The *Nature* article, "Funding Agencies Urged to Check for Duplicate Grants," has some implications for the substance abuse field. As the merger process for NIDA and NIAAA showed, there are many similarities between the two institutes. One of the arguments for a merger was that such duplications would be avoided. However, the National Institutes of Health (NIH) is taking steps to make sure there won't be such duplications.

Asked for a response to the *Nature* article, NIH said it "takes the issue of duplicate funding of the same project very seriously."

Most recently, NIH instituted a new process, called "special review," to complement existing NIH policies that require monitoring all investigators' activities for overlapping support, and determining whether additional funds should be awarded to well-supported investigators. The re-

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viewers determine whether project proposals received from well-supported investigators are "promising and distinct" from other NIH-funded projects from that same investigator.

In fact, agencies may fund health research on the same general topic when the precise methods and focus of the work is different, reflecting the mission of the agency supporting it, according to information sent to *ADAW* by the NIH press office.

"NIH makes every effort to eliminate or amend overlap regardless of the funding source prior to the issuance of a Notice of Grant Award," a NIH spokeswoman told *ADAW*.

NIH has extensive policies, procedures and guidance to help NIH-funded institutions and staff monitor and manage potential overlap in grants.

Electronic preparation and submission has contributed to the overlap, according to the *Nature* article.

The article, which is a news article and not a study, opened with a description of a grant submitted by neuroscientist Steven McIntire of the University of California, San Francisco, for a five-year, $1.6-million grant NIH study, similar to a grant award by the U.S. Army for $1.2 million. Both grants were looking at how a worm responds to ethanol. The worm is used as a model to understand how alcohol affects humans. According to McIntire, who is no longer a researcher, the grants had different scientific aims. No wrongdoing is suggested in this story. But what is wrong, according to the *Nature* article, is the fact that NIH was unaware of the Army grant and only learned of it from McIntire himself.

Alexandre B. Laudet, Ph.D., director of the Center for the Study of Addictions and Recovery at National Development and Research Institutes, said that this kind of scrutiny is essential, especially given the limited amount of research funding available. "Lots of people have made big careers, and I mean big, doing the same project for NIDA and NIAAA," she told *ADAW*. "It is critical to do this," she said of the move to limit duplication. She would not give any names.

Laudet recalled a conversation she had with a program official last year "who made it clear to me that they have to look for duplication," she said. Laudet, who is a principal investigator on a NIDA grant to study the college-based recovery programs that help recovering students avoid relapse while pursuing academic goals (see *ADAW*, July 16, 2012), commends such rigorous review. But, she added, reviewers don't always have the same level of access to everything that an investigator not only has published, but has applied for.

> **'Lots of people have made big careers, and I mean big, doing the same project for NIDA and NIAAA.'**
>
> Alexandre B. Laudet, Ph.D.

The process

Here's how the NIH process works:

- **Receipt and Referral Stage:** Immediately after applications are submitted, they are reviewed against previous submissions to make sure it is "new," with "significant and substantial changes in content and scope rather than a resubmission of an earlier application." Overlap between two concurrently submitted applications is also assessed.
- **Peer Review:** At this stage, applications, grouped by scientific discipline and not by disease state, are checked by individual Scientific Review Groups. This facilitates identification of multiple applications for the same project.
- **Administrative Review:** If peer review results in a recommendation for funding, the next step for the application is administrative review. In this step, prospective grantees must provide "other support" — additional documentation — as part of what is called a "Just-In-Time" procedure, which includes all existing and pending financial support. This must include federal, non-federal, commercial or organization support of the individual's research, including research grants, cooperative agreements, contracts or awards, but not training awards, prizes or gifts. This is the step at which overlaps can be identified in terms of scientific aims. If there is overlap with other federal agencies, NIH staff may communicate through interagency coordinating committees or discussions with colleagues to determine duplication. NIH staff also looks at information disseminated at scientific conferences.
- **Post-award Phase:** Once a grant is awarded, grantees must submit annual progress reports that provide information about changes in other support since the last reporting period. For example, this would reflect termination of a previously active grant.
- **Special Council Review:** Recently, NIH instituted a new policy that requires institutes and centers to perform a special review of any investigator who receives $1 million or more in direct costs from NIH. This policy requires council members "to recommend consideration of funding for applications from an investigator

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that afford a unique opportunity to advance research which is both promising and distinct from other funded projects from that investigator."

Resources

The Division of Receipt and Referral at the Centers for Scientific Review maintains policies and procedures that address the evaluation of unallowable resubmission and overlapping application for consultation here: http://1.usa.gov/12251WV.

The NIH GPS has policies regarding Similar, Essentially Identical, or Identical Applications under Section 2.3.9.4: http://1.usa.gov/VZzPqU.

With regard to policy references, Just-In-Time procedures and Other Support are described extensively in the NIH Grants Policy Statement (10/12) in Section 2.5.1, Just-In-Time Procedures found here: http://1.usa.gov/11PWXxb.

For more information on NIH policies during the post-award phase, please consult the following sections in the Non-Competing Continuation Progress Report Instructions (PHS 2590): http://1.usa.gov/fUEmhD.

For the *Nature* article, go here: http://bit.ly/TXRgee. •

CSAT's Reuter retires, leaving a legacy for OTPs

Nicholas Reuter, with the federal government for some 37 years, retired quietly, effective January 31. He started with the Food and Drug Administration (FDA) and was recruited to the Substance Abuse and Mental Health Services Administration (SAMHSA) about 12 years ago, when oversight of opioid treatment programs (OTPs) went from the FDA to SAMHSA.

Reuter's crowning accomplishment as senior public health analyst at SAMHSA's Center for Substance Abuse Treatment (CSAT) was shepherding the rulemaking process for getting buprenorphine into OTPs (see *ADAW*, December 17, 2012). That rule, which allows OTPs to dispense buprenorphine without restrictive take-home restrictions, took effect January 7.

We are sorry we didn't get to do an "exit interview." We would have asked about the buprenorphine rulemaking, and whether he had held off on retiring until that was finished. "Maybe that was one of his goals — to wrap that up, to make sure that got out," Robert Lubran, director of CSAT's division of pharmacologic therapies, told *ADAW*. "He didn't say that. But you could think that he felt a sense of accomplishment."

We would also have asked Reuter about his plans for the future. "He's home now, and I don't know that he has any specific plans," said Lubran. "But he's a valuable piece of property for organizations that would like to have his skills and knowledge, so I wouldn't be surprised if he found another job."

Reuter knew the OTP regulations by heart; it will be hard to fill his place at CSAT. "Right now there are no definite plans for a replacement," said Lubran, who was Reuter's boss. There might be someone "acting" (i.e., temporary) in his position, said Lubran. Or several people might contribute to the duties of the position. "A lot of the work that he's done is going to be filtered down to a number of people," said Lubran. "What one person did could be done by seven or eight." Asked whether H. Westley Clark, M.D., J.D., director of CSAT, would be involved, Lubran said no. "Nick was more of an operations day-to-day kind of person," he said.

One of the projects that Reuter has been heavily involved in is updating the accreditation guidelines for OTPs. "We're looking to release them sometime within the next 90 days," Lubran told *ADAW* February 6. There will be an announcement in the Federal Register and a comment period. "Nick felt very committed to seeing that through as well, and it is pretty far along," said Lubran.

> **'…he's a valuable piece of property for organizations that would like to have his skills and knowledge, so I wouldn't be surprised if he found another job.'**
>
> Robert Lubran

"We hated to see him go," said Lubran. "He was the hardest-working person in government I ever met." Lubran said it was Reuter's preference to retire quietly. "He did not want any hoopla or fanfare," he said. •

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patient utilization," Diehl told *ADAW*. He says this has occurred in marked contrast to a scenario more than a decade ago when insurance did not fulfill its promise to make up for ratcheting down inpatient utilization by bolstering coverage within levels of care such as intensive outpatient and partial hospitalization.

Moreover, Diehl sees the addition of full-service outpatient operations to Seabrook's residential and

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transitional-living programs as positioning the organization for a critical role in the insurance structures that will emerge under Affordable Care Act (ACA) implementation. He said Seabrook House has been in communication with the large insurance companies and healthcare systems that are poised to form the insurance exchanges in its region.

"The big insurance players with large regional systems will be the exchanges," Diehl said. "It is incumbent upon providers such as Seabrook House to be a valued service within the range of services."

Outpatient sites

With the addition of the two outpatient operations to existing outpatient services at its main location, Seabrook House now is able to serve around 75 individuals at an outpatient level of care. It usually maintains a census of about 85 in detox and short-term residential treatment (average length of stay of three to four weeks) at its main campus, and it is typically serving around 25 patients at any one time at two long-term transitional-living sites, Diehl said.

The Cherry Hill and Northfield outpatient sites, which Diehl says are leased properties that Seabrook has renovated, are equipped with lecture and group meeting space and a café that serves as a central meeting place for individuals in early recovery. Diehl said the re-emergence of outpatient options for more of Seabrook House's inpatient and extended-care patients has allowed the organization to build what it believes is a more reliable continuum of care than what has been available in the community.

"We've been frustrated with our handoff to outpatient providers that were not operating at our level of consistency," said Diehl.

In some respects, establishing new outpatient operations means that Seabrook House is coming full circle, as at one time it operated four outpatient sites in southern New Jersey. Diehl believes the more comprehensive service mix that Seabrook now can offer will enhance opportunities for partnership activity with other entities.

"We see further cooperative service relationships with other providers, from large hospital systems to community mental health centers," Diehl said. "We have been approached quite a bit of late."

Yet he does not foresee the possibility of Seabrook House merging with another healthcare entity, saying he's never met a colleague in the addiction field who merged into a large hospital system in the 1990s and ultimately was pleased about having taken that step.

"Our interest is in being a valued partner — a service provider within a larger continuum," Diehl said. He added, "We do provide a specialty service that needs to remain that way.… The reason why places such as us, Betty Ford and Hazelden still do work is because we maintained our independence."

And Diehl remains fiercely independent, usually separating himself even from his colleagues, when it comes to speaking bluntly about managed care failings. He has helped rally colleagues in the National Association of Addiction Treatment Providers (NAATP) to try to combat managed care tendencies to see medication treatments as the standard of care over supervised residential stays. In New Jersey, he has worked to fight some insurers' insistence that adolescent opiate addicts work with a buprenorphine-prescribing doctor for a year before being allowed to receive residential treatment.

"We're in an environment where insurance companies wrongly follow misleading best-practice suggestions on medication treatment," said Diehl. "We're not against meds — we use meds to support detox and as anti-craving agents." But he added, "If we don't combine use of supporting medications with psychosocial interventions, patients don't get to abstinence."

Workforce needs

Other current priorities within Seabrook House include recognizing and responding to the challenging circumstances under which the addiction treatment workforce is expected to operate. Clinicians enter the profession with the hope of having sufficient time to build a counseling relationship with a patient, and instead find a compressed scenario, Diehl said. "Shorter lengths of stay don't make them happy," he said.

Seabrook House
Headquarters: *Seabrook, New Jersey*
Founded: *1974*
Services: *Detox and short-term residential at 110-bed main campus; three outpatient locations; two long-term transitional living programs*
Employees: *230*
Payer Mix: *75 percent insurance, 25 percent self-pay*

'We've been frustrated with our handoff to outpatient providers that were not operating at our level of consistency.'

Ed Diehl

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The organization's human resources staff will take on this issue this year by establishing a training institute that will formalize mentoring and coaching opportunities for young clinicians interested in growing in the profession. Growing young leaders in the organization has become essential in an aging field, says Diehl.

"If we're looking for a 55-year-old counselor to come in to apply here and work here for 10 years, that is a wrongheaded approach," Diehl said. •

Colo. officials worried about child welfare and substance abuse

Child welfare, law enforcement and healthcare experts testified at the Colorado Children's Caucus hearing last month. The hearing was meant to address the dangers of drug abuse to children in the wake of the recent legalization of marijuana in the state. However, as the Colorado Statesman reported February 1, the hearing ended up being a referendum on the state's fractured child welfare system.

A recent investigation found that of 175 children who died of abuse and neglect in the last six years, 72 were known to caseworkers. The Children's Caucus, a bipartisan group of state legislators concerned about children's issues, heard testimony from several experts about the lack of coordination among state agencies.

"There's no requirement that law enforcement and child protection services actually work together, collaborate and share data," said Sgt. Jim Gerhardt, with the Colorado Drug Investigators Association. "We were astonished to find what we were missing when we didn't actually work together."

Gerhardt noted that while abuse — "a broken bone, or a bruise, or a sex assault" — is not the same as neglect, which can be related to caregiver substance abuse. "What typically in law enforcement we miss are a lot of neglect factors, and neglect typically results in more child fatalities nationally than physical abuse," he said.

Gerhardt asked for a legislative solution so that incidents "can be caught before they turn really, really bad."

And Kathryn Wells, M.D., a child abuse pediatrician with Denver Health, said that the medical community should be more involved in child protection. But she stressed that the real solution lies in identifying substance abuse problems early on.

"I saw a lot of families affected by substance abuse, and I think we need to start having honest discussions about how can we identify these problems early on and hopefully get folks the help that they need," said Wells. "I would love to be out of a job as a child abuse pediatrician, and be able to help poor families in the way that we would like to, rather than have them destroyed by some of the horrific cases that I unfortunately see."

According to the Office of Colorado's Child Protection Ombudsman, 9.2 million children in the United States live in a home where someone uses illicit drugs. In 2008, it was estimated that 37,000 children ages 12–17 and 401,000 adults in Colorado were using drugs.

Eighty percent of the child protection system cases involve substance abuse, according to the ombudsman's office. "These are just the people we know; not all users report that they use drugs, and not all people are honest about that," said Associate Ombudsman Stacee Read. One problem is how to train child welfare system staffers to identify drug use, she said. "We don't know what to do with these," she said. "We don't know how to make that assessment."

However, some legislators thought it would be a bad idea to interfere more in families. Sen. Kevin Lundberg, co-chair of the caucus, is opposed to more government intervention. "I believe in limited gov-

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ADAW editor awarded CADCA 'National Newsmaker'

Alison Knopf, editor of *Alcoholism & Drug Abuse Weekly*, has been recognized in this year's Community Anti-Drug Coalitions of America (CADCA) National Leadership Awards with a National Newsmaker Award.

CADCA presents annual awards recognizing individuals and organizations that have made a major impact on the coalition field at their National Leadership Forum. This year's forum, "Coalitions: Science, Strategies and Solutions," convened on February 4 at the Gaylord National Hotel & Convention Center in National Harbor, Maryland. Knopf was honored along with other awardees on Thursday, February 7 at CADCA's National Leadership Awards Luncheon.

"We are tremendously proud of Alison's many years of excellent reporting in the substance abuse treatment field and congratulate her on receiving this well-deserved recognition from an important national advocacy organization," said Sue Lewis, publisher, Wiley Professional Development Subscription Content.

"I am honored by this award," said Knopf. "It's always inspiring to cover a field so committed to its goals."

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ernment; I believe that we get too involved in too many families too often," he said. "But I also believe in the best interest of children, and believe that we need to have the entire spectrum of discussion at the table when we deal with these most critical issues that really affect virtually everyone at some point in time, and some people all the time."

Michael Elliott, executive director of the Medical Marijuana Industry Group, said there are "very legitimate concerns about how best to protect kids, especially with the new law being passed." But, he said, his group will work with legislators on solutions. He noted that the rate of marijuana use by youth has fallen 3 percent.

The next meeting of the Children's Caucus is scheduled for February 11. •

Briefly Noted

Average number of relationships with alcoholics by Al-Anon members: 3

People who belong to Al-Anon are there not because they have a relationship with only one alcoholic family member or friend — most have more. According to the Al-Anon Family Groups membership survey released January 31, most people with an alcoholic in the family have had multiple relationships with other alcoholics. Sixty percent of those surveyed reported that they have two to four alcoholics in their lives, including one or both parents, a spouse or romantic partner, children, grandparents, siblings or friends. Twenty percent have had relationships with five to 11 alcoholics. Being raised by an alcoholic mother was associated with having the largest number of alcoholics in the lives of the Al-Anon members — 4.5, compared to 3 for the average Al-Anon member. "These numbers validate that alcoholism is a family illness, as many Al-Anon members have come to understand," said Pamela Walters, Al-Anon Family Groups information analyst. "Even people who do not think their lives have been affected by a problem drinker are surprised at what they learn in Al-Anon meetings. Al-Anon has conducted the survey every three years since 1984. More than 3,200 members participated in this survey, which was conducted last fall.

Coming up...

The annual meeting of the **National Association of Psychiatric Health Systems** will be held **March 11-13** in **Washington, D.C.** For more information, go to **www.naphs.org/annmeeting/index**.

State News

West Virginia legislator calls for money for treatment

If one legislator has his way, West Virginia, long besieged by prescription opioid addiction and lack of adequate treatment, may move toward beer and cigarettes to fund treatment. Gov. Earl Ray Tomblin's substance abuse task force recommended tax increases to pay for drug abuse treatment, but the governor has rejected this idea. Still, House of Delegates Health and Human Resources Committee Chairman Don Perdue said money is essential for treatment, and wants to use "sin taxes" to do so. Perdue proposed a one-cent increase in the tax on beer — a tax that has not gone up since 1965 — and an increase in the cigarette tax from 50 cents to $1. According to Perdue, there are 40,000 untreated addicts in West Virginia and only 300 long-term beds. "You can see the facilities we need to utilize to combat these problems are very minimal," Perdue said. "We have got to address the problem. We can't continue to assume that just by saying 'no new taxes' we are doing the right thing."

Correction

In the article "Opposing Voices on Essential Health Benefits: Insurers and Employers" in the February 4 issue, we incorrectly stated that nonquantitative treatment limitations (NQTLs) are banned in the interim final rule on parity. The regulations say that NQTLs must be applied comparably and no more stringently to mental health or substance use disorder services than they are applied to medical/surgical healthcare. We regret the error.

In case you haven't heard...

Could medical marijuana become the latest in medication for chronic pain, with none of the overdoses and at a profit to the government? In one state at least, this could be happening already. Michigan's medical marijuana program is providing a windfall: for every dollar spent on administering the program last year, the state took in three dollars. And at a time when pain medication is being limited by crackdowns on prescribing, the most common reason for qualifying for medical marijuana was "severe and chronic pain," according to the most recent annual report on the law, which requires a $100 fee from patients to register for the program. Patients are allowed to purchase and grow marijuana. Revenue to the state from the program last year was almost $9.9 million, with administration costs of $3.6 million. There are almost 125,000 patients in the state, and more than 50,000 caregivers, who must be approved by the state.