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In This Issue...

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NAATP outcomes project, IRB in hand, starts enrolling subjects

The National Association of Addiction Treatment Providers (NAATP) started the official phase of its outcomes research project last month when Institutional Review Board (IRB) approval was granted. And last week, the first patient participants were enrolled in the study.

This Outcomes Pilot Program is significant for NAATP, whose members comprise mainly residential treatment providers, and for the field. As NAATP Executive Director Marvin Ventrell said in announcing the IRB approval last month, "We have not done enough to authenticate our treatment outcomes and our value in general."

An IRB is a committee that has been designated to approve, monitor and review biomedical and behavioral human subjects research. It protects the rights and welfare of human subjects, and it also ensures fidelity of data, important to the credibility of any study.

"We really do see this as a historic study," Ventrell told *ADAW* last week. "The instrument itself is very progressive in its understanding of what treatment and recovery look like — it's not judgmental or ideological, and it neither undervalues

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Bottom Line...

The nine providers in NAATP's outcomes project started enrolling patients last week in what will be the field's most rigorous study of what works in residential addiction treatment.

Advocates ponder solutions as ill will toward sober homes intensifies

Recovery residence community leaders who seek to operate ethically and to shine a light on sober home operators who don't are continuing to find it difficult not to be painted with the same brush as the questionable businesses. Efforts in some states to distinguish high-quality operators through voluntary certification remain in an early stage of development, and some political leaders continue to resort to measures that would serve to make it difficult to site any recovery residence, regardless of its quality.

In the latest example of the latter on the political front, U.S. Rep. Darrell Issa (R-Calif.) this month led a regional panel discussion concurrent with his plan to introduce legislation to amend fair housing protections and allow government entities to restrict the number of homes in a particular neighborhood. While few observers envision widespread support for changing the Fair Housing

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Bottom Line...

Those who have advanced standards of high quality for recovery residences look for opportunities to support reasonable regulation that does not eviscerate fair housing protections for sober home residents and operators.

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nor overvalues abstinence as a measure." It's also significant that NAATP and not individual programs or payers are sponsoring the study. Finally, the study is rigorous, with IRB oversight.

Ventrell said there is some self-doubt in the profession. "They're asking themselves, 'Are we doing the right thing? Does this work?'" It's not that they go to work every day and question the value of their services, he said. "But it's deeply ingrained in us that we don't know the answers — it's not just our ability to articulate what the benefits of treatment are, but it's our ability to understand it."

There is no debate within the field that addiction is a chronic, not an acute, disorder, said Ventrell. It needs to be treated on a long-term, chronic basis, he said. "That doesn't mean that we don't get stuck in a moment of time," he said. "If somebody needs detox, that's acute treatment. You can even say that 28 days is an acute period."

But what needs to change is the question being asked. "Do people recover after 28 days of care?" is the wrong question, he said. "The question should be, 'Do people enter lifelong recovery after 28 days of care?'" Even the Big Book of Alcoholics Anonymous is confused on the definition, in one place calling people "recovered," and in another saying "it's a never-ending battle," noted Ventrell. But among NAATP providers there is no confusion: addiction is a chronic disorder requiring long-term attention.

How the study is set up

All nine organizations will use the same data-collection tools, and administer the three surveys in the same way using a common data-collection system. While each provider may be offering different kinds of care — some may offer opioid substitution medication and some may not, for example — those different types of treatment will also be measured.

The NAATP provider model has inpatient treatment in common, with inpatient treatment being measured from the date of intake at 30-day, 90-day, 6-month, 9-month and 1-year follow-ups. Main variations will be in the length of stay, explained Jessica Swan, outcomes manager for NAATP. Some patients will have the option of a longer length of stay, or may be recommended for a longer length of stay, she said. The baseline and the first 30 days will be similar across all nine programs, she said.

NAATP has also secured a Certificate of Confidentiality from the National Institutes of Health for the project, which gives an additional layer of confidentiality to the participating patients/subjects over and above 42 CFR Part 2. "This allows researchers to refuse to disclose names or identifiers," said Swan. Participants will also receive Target gift cards.

The pilot sites

There are nine NAATP members who are serving as the pilot sites: Addiction Recovery Resources (Metairie, Louisiana), Ashley Addiction Treatment (Havre de Grace, Maryland), Caron Treatment Centers (Wernersville, Pennsylvania), Hazelden Betty Ford Foundation (Center City, Minnesota), Jaywalker Lodge (Carbondale, Colorado), New Directions for Women (Costa Mesa, California), Seabrook House (Bridgeton, New Jersey), Sundown M Ranch (Selah, Washington) and Tully Hill Chemical Dependency Treatment Center (Tully, New York).

The project was first presented at the NAATP annual leadership meeting in 2015, and last fall about 20 sites had expressed interest in participating. NAATP narrowed the number down to 12, said Swan, "and when it came to contract, we got 9."

Now that the project is under way, many more members want to participate, said Ventrell. "There were organizations who stepped forward and saw the need for this, for the industry," he said. "These

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folks have a broader industry view, not just a purely provincial view." Since the launch, however, many more requests to participate have come in. "Now everybody wants to do this," he said.

Results

At the annual leadership meeting in Fort Lauderdale, Florida, this spring, a session on the outcomes project prompted some impatience from members, who want the results out as soon as possible (see *ADAW*, June 6).

Providers will be enrolling participants through the end of 2017. Then the OMNI Institute, an independent research firm, will analyze the data. NAATP hopes to publish the findings in a journal by mid-2018. "We plan to provide periodic reports on our progress, in terms of what's working, and to provide educational tools for our membership," said Swan.

"I wish we could get something out sooner, but there's nothing that's taking too long about this study," said Ventrell, noting that he made the outcomes project top priority as soon as he took the helm at NAATP. "What may have taken too long was for the study to be conceptualized," he said. "But the new NAATP administration had this project operational within six months of our taking over. Our time line was very fast."

The new NAATP

While NAATP and these centers know that treatment works, because they see it every day, they need to be able to demonstrate this value to the press, public, policymakers and health care industry at large, said Ventrell.

Some providers are worried that the data won't be good, and criticized NAATP for conducting research that could damage marketing efforts. But this is not a marketing study, said Ventrell. Rather, it is designed to evaluate service, and if the data show there are problems, NAATP and its members want to improve.

'There were organizations who stepped forward and saw the need for this, for the industry.'

Marvin Ventrell

This outcomes project is a centerpiece of the "new NAATP," which is represented by a completely new structure — and by Ventrell. Last spring, the organization released a 30-page strategic plan outlining the organization's vision for the next three years (see *ADAW*, May 16). The focus was clearly on ethics, outcomes and accountability.

This focus may not be welcome to some treatment providers who do not want to abide by transparency and ethics rules, and indeed, many of the treatment providers in the country are not members. But the view of the NAATP board and Ventrell is that these providers make a focus on quality even more important, because if profits are put before the welfare of patients, patients will suffer. But so, ultimately, will the industry if it can't prove that quality pays.

"As the industry evolves and as new players come in, we can't immediately determine what values an operator is using," he said. "There are good providers coming in, and there are providers who are only selfishly motivated coming in." The outcomes study will favor the good providers, he said. "If what you want is an anecdotal marketing study, this is not going to appeal to you. There are folks coming in who are probably not going to be here five years from now. NAATP is playing the long game, which is hard to do if you are losing the short game. But we are confident that this is a long-term process." The outcomes study will benefit providers "whether you are an altruistic thinker or a long-time capitalist." It won't benefit the get-rich-quick providers — and it isn't supposed to.

"We are interested in driving our industry," said Swan. "Rather than being reactive to marketing or selfish business practices, we want to drive the health and well-being of the patients we serve." •

For more information, go to https://www.naatp.org/resources/treatment-outcomes-surveys.

Study: Teens with bipolar disorder at increased risk for SUDs

Adolescents with bipolar disorder (BPD) are at increased risk for substance use disorders (SUDs), including cigarette smoking, according to a study published in the Aug. 30 *Journal of Clinical Psychiatry*. Studies of children with BPD have found high rates of psychiatric comorbidity, including attention-deficit hyperactivity disorder (ADHD), anxiety disorders and conduct disorder (CD). But one of the most worrisome comorbidities is the link with SUDs and cigarette smoking.

The link is bidirectional, emerging data indicate. There is also a suggestion that juvenile onset BPD may be a major risk factor for SUDs. However, adult studies have been retrospective, there has been a lack of controls and sample sizes have been small.

It's also difficult to disentangle the link between BPD and SUDs without looking at psychiatric comorbidity. Conduct disorder is

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known to be a risk factor for SUDs in youth, and some studies have suggested it is CD that accounts for SUDs in adults with BPD. Another confounder is ADHD, which has consistently been reported in high rates among children and adolescents with BPD. ADHD has also been found to be a risk factor for SUDs in young adults.

For the research, the authors, headed by Timothy E. Wilens, M.D., examined findings from an ongoing longitudinal family-based study of adolescents with BPD. Based on previous findings, they hypothesized that the adolescents with BPD would be at higher risk for SUDs than adolescents without mood disorders, and that the BPD-SUD link would be independent of ADHD, CD and anxiety.

Study details

The researchers conducted a case-control study of adolescents with bipolar disorder (105, mean age: 13.6 years, 70 percent male) and controls without bipolar disorder (98, mean age: 13.7, 60 percent male). They assessed other disorders, including SUDs, using structured interviews (KSADS-E for subjects younger than 18, SCID for 18-year-old subjects).

SUDs included abuse of or dependence on any alcohol or drug — excluding nicotine.

Results

After adjusting for age, bipolar disorder was associated with a significant risk for any SUD (8.68 times the risk compared to controls), for alcohol abuse (7.66), for drug abuse (18.5), for drug dependence (12.1) and for cigarette smoking (12.3). These results were independent of ADHD, multiple anxiety disorders and CD.

The primary predictor of SUDs in youth with bipolar disorder was older age.

In terms of demographics, BPD subjects had significantly lower socioeconomic status (SES) than controls. They also had more parents with an SUD. There were no differences in age.

The researchers controlled for SES differences in all of the results.

When assessing the effect of CD, ADHD and multiple anxiety disorders on SUDs and smoking, the researchers found a significant effect of BPD-CD on risk for SUDs. The effect of CD alone was also significant.

When adding ADHD to the model, however, the effect was not significant — the risk of an increased SUD was due to the BPD, not the ADHD.

There was no effect of an SUD on the probability of rapid cycling (more than four manic episodes a year).

In most of the cases, BPD and CD preceded the onset of SUDs. The duration of SUDs in BPD subjects ranged from 1 to 7 years, with the average duration no greater than 1.91 years. Out of 33 subjects with both an SUD and BPD, 22 (67 percent) had the BPD before the SUD; 8 (24 percent) had BPD and SUD within the same year, and 3 (9 percent) had the onset of BPD after the onset of SUD. In the 27 BPD subjects with SUD and CD, 15 (56 percent) had the onset of CD before SUD onset, 7 (26 percent) had the onset of CD in the same year as the onset of SUD and 5 (19 percent) had CD after the onset of SUD.

Implications

BPD is treatable, so efforts to improve the association between the disorder and SUDs in the young can help mitigate the risk in the future, the authors write. Clinicians treating adolescents with bipolar disorder should screen them for SUDs and cigarette smoking.

The study found that BPD in youth was associated with a higher risk of SUDs (31 percent) compared to controls (4 percent). "Our findings that juvenile BPD increased the risk for cigarette smoking and SUD provides compelling support for a growing literature documenting this risk in pediatric and adult samples," the researchers wrote.

There were also consistently higher rates of psychiatric comorbidity among the BPD subjects compared to controls. However, these did not account for SUD or cigarette smoking in the BPD sample — and this includes CD, which had been suggested previously to be linked to SUDs. Still, there was an elevated rate of CD among BPD subjects, which suggests that BPD is a separate and major risk factor for SUDs.

Limitations included the fact that SUD was defined as meeting full *Diagnostic and Statistical Manual of Mental Disorders* criteria for abuse or dependence by either parent or youth report. Therefore, use and misuse, as well as subthreshold psychopathology, was not captured. Future studies should aim to look more closely at possible substance abuse.

Potential conflicts of interest applied to authors who receive research support from multiple pharmaceutical companies, and are on speaker bureaus for multiple pharmaceutical companies. •

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Act, such developments are seen as fueling ill will toward all operators in communities that say they have been overrun with sober homes that have compromised their quality of life.

Moreover, supporters of the recovery residence community point out, initiatives that target sober homes fail to appreciate the symbiotic relationship between some questionably run primary treatment facilities and recovery residences.

"The recovery residence side is the yin to the yang of the treatment center side," Jeffrey Lynne, a South Florida attorney who has represent-

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FROM THE FIELD

Prescription heroin as a treatment for opioid use disorders

By Sam Snodgrass, Ph.D.

Opioid addiction is a disorder of brain structure and function. It is an illness. And the most effective treatment for this illness is medication. And as with any illness, the medication that should be used is the one that proves most effective for that patient. And yet, there are those that argue we should limit the medications we use to fight this epidemic of opioid addiction and death.

We're dying out there. Look at the number of overdoses that have occurred in the last month to heroin and to fentanyl- or carfentanyl-laced heroin. If something, anything, can be used to save lives, then please, let's put ideology aside and let's do that. When used as a medication, prescribed by a physician, diacetylmorphine — prescription heroin — stabilizes brain function and allows the person to become well, stay well and, most importantly, stay alive. And this treatment is for those that are refractory to the other medications used to treat this medical condition. Methadone and buprenorphine don't work for them. So, because those treatments failed, should we just discard the people?

According to the NAOMI study, the countries that have established heroin treatment programs — Switzerland, the Netherlands, the United Kingdom, Germany, Spain, Denmark, Belgium, Canada and Luxembourg — have all reported positive results for those individuals who are refractory to methadone and buprenorphine treatment.

It sounds radical, the provision of heroin to those addicted to heroin. But do understand, a drug is just a drug. It just does what it does. This controversy over using heroin as a treatment to control opioid addiction — it's not about the data. It's not about the research. It's about stigma, ideology and people protecting their turf.

In a previous *ADAW* issue, Robert Lubran, then with the Substance Abuse and Mental Health Services Administration, stated, "It's not difficult to find individuals who will prefer access to heroin over methadone maintenance treatment" (see *ADAW*, Aug. 31, 2009). He seems to believe this is a bad thing. I do not. If we can get more people into treatment, if heroin treatment will do that, how many lives can we save? And every life is someone's son, it is someone's daughter, and we would not only be saving them but also their mothers and fathers from the devastating loss of their child. We should be doing everything we can to keep them alive. And, yes, that includes treatment with diacetylmorphine.

The NAOMI studies show that, for those refractory to methadone or buprenorphine, heroin-assisted treatment is effective, with retention rates of about 88 percent. But there seems to be a problem. The acceptance of this form of treatment is opposed by some in the treatment field.

This is not a game. This is not a "my treatment is better than your treatment" contest. This is about saving lives. Heroin can produce addiction, or it can be used to stabilize (with medication) an addiction. It is how we use it that determines its effects. In this epidemic, we have an obligation to do everything we can to save lives. If the use of heroin-assisted treatment will do that, and the data show that it will, then please, put the ideologies aside, put the financial interests aside, push back on the stigma and let's do everything we can to reduce the harm of this epidemic to those who suffer from this disorder of brain structure and function we call opioid addiction. Because every death, every loss, is someone's son or daughter, and their lives are precious too.

Sam Snodgrass, Ph.D., works at Stockton Medical Group, a buprenorphine clinic in North Little Rock, Arkansas. He has worked and published in the field of behavioral pharmacology and he is on the board of Broken No More. He also has many years of personal experience with opioid use and addiction. Reach him at samphd87@gmail.com. (For an article profiling his experience and work, see ADAW, *Jan. 18.)*

ed treatment and recovery support organizations, told *ADAW*. "You can't bifurcate the two."

Intensified emotions

Dave Sheridan, executive director of the Sober Living Network in California and president of the National Alliance for Recovery Residences (NARR), told *ADAW* that a flurry of negative headlines about sober homes has many questioning whether the behaviors of some operators are worsening. He sees the headlines instead as reflecting the proliferation of treatment opportunities and the concomitant need for safe housing options for these patients.

"There is a lot of new supply of treatment and recovery capacity because of the [Affordable Care Act]," said Sheridan. "What a lot of people don't understand is that some are gaining access to care for the first time in decades." Housing needs logically emerge from that.

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"We're the big piece that everyone wants, but no one wants to pay for," Sheridan said of recovery housing.

While groups such as NARR don't defend the actions of the unethical providers of recovery housing, Sheridan says frank conversations need to happen with insurers who in the past have not questioned large payments for drug testing and outpatient treatment, which in turn have enabled the offers of free housing to individuals who don't need the excessive services.

Lynne, who is a member of a Palm Beach County–based task force that is expected to make recommendations for 2017 legislation pertaining to sober homes and treatment centers, said some operators are using so-called recovery residences as warehouses from which to "sell" patients to the highest bidder. He added that existing laws in Florida and Massachusetts that prohibit most treatment centers from referring patients to noncertified sober homes ignore the fact that the referral direction in many cases moves from the sober home to the treatment center — the reverse of what those laws address.

Sheridan believes in theory that there can be constructive conversation around the issue of an overconcentration of care facilities in some communities. State regulations in California that allow operators to establish treatment facilities of six beds or fewer without local government oversight have enabled companies in places such as Malibu to cluster such sites and operate them essentially as one large treatment center, he pointed out.

The problem in the discussion, however, becomes how some local communities define an overconcentration. Because of what Sheridan terms an abundance of "bad blood" toward sober homes in some cities, "It's tough to separate out the legitimate concerns." He added, "When we've broached the idea of concentration limits, we hear that local communities should be given control over what the number should be. To some of them, two homes would be an overconcentration."

A spokesman for Rep. Issa suggests that federal legislation is needed because rightful attempts to address the issue at the local level have been thwarted by sober home operators.

'If we make it easy to operate accountable, standards-based homes, the fly-by-night homes will find it harder to operate.'

Dave Sheridan

"Federal legislation needs to clarify that laws like the Fair Housing Act — which were intended to prevent discrimination in housing — are not exploited and used as a shield for poorly run facilities who do not want to be held accountable," read part of an emailed statement provided to *ADAW* by Issa's communications director, Calvin Moore.

Issa's legislation would amend the Fair Housing Act to allow any local, state or federal government agency to enact a zoning ordinance or regulation to limit the number of sober homes in a neighborhood. It also would require sober home owners and operators to register with the government and to obtain an operating license or permit, and would require them to adhere to standards that would maintain a safe and sober living environment for residents.

"Oftentimes those seeking help are falsely sold an environment for treatment and recovery but find themselves unable to make the steps they need toward recovery due to the conditions of these homes and the inability of state and local government to ensure these facilities are being run well," read the communication from Issa's office.

Recent attempts by political leaders in states such as Florida and California to seek clarifications to Fair Housing Act interpretation, generally on behalf of communities seeking to control the growth of sober homes, have been rebuffed at the federal agency level.

Will certification help?

Laws in both Massachusetts and Florida that prohibit state-funded primary treatment centers from referring patients to noncertified sober homes in the states both rely on NARR standards of operation in their certification reviews. Florida has made progress in its effort to certify homes as well as individual recovery residence operators under the law, though the agencies charged with this responsibility have been slowed by a stalled disbursement of state funding for this purpose.

Sheridan said that in Massachusetts, about 90 sober homes have received certification so far, and around another 90 are in some stage of the approval process. "If we make it easy to operate accountable, standards-based homes, the fly-by-night homes will find it harder to operate," he said.

But the eventual outcome of this process for the industry as a whole remains uncertain. Other countervailing forces continue to challenge the ability to meet the demand for high-quality housing. "Several south Orange County cities have instituted moratoria on recovery residences, or instituted regulatory requirements," Sheridan said. "None of them are being particularly clever about [claiming to be] not discriminating against a protected class." •

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Study: Opioid epidemic is worst in black urban communities

Last month, the Illinois Consortium on Drug Policy at Roosevelt University issued a report that showed that the overwhelming victims of the opioid epidemic are black and urban. The report, titled "Hidden in Plain Sight: Heroin's Impact on Chicago's West Side," focused on the West Side of Chicago, which is mentioned in news reports about the heroin epidemic, but only in passing as a place where white suburbanites go to buy the drug. In fact, the report showed that 80 percent of the heroin treatment admissions across the state occurred in the Chicago metropolitan area; Chicago West Side hospitalizations for opioids, including heroin, comprise 23 percent of the opioid hospitalizations statewide; and 83 percent of those hospitalized for opioids on Chicago's West Side were black.

"I am so sick of the 'white suburban heroin epidemic,'" Kathleen Kane-Willis, director of the consortium, told *ADAW* last week. "Black folks in Chicago have been completely left out." Her report was largely ignored, despite the almost constant media attention to opioids, because "no one cares about black folks," she said. "I have made a lot of good changes and now it is time to translate them into the most impacted communities."

Despite the fact that the news media has been suggesting that heroin overdose is primarily a white problem, the consortium report found that the mortality rate from heroin overdoses in Illinois is significantly higher for blacks: 8.94 per 100,000, compared to 5.86 for whites. The highest rate of heroin overdoses (7.42 per 100,000) was in Chicago, significantly higher than the surrounding suburban counties.

The report used the federal Treatment Episode Data Set data, the Illinois Department of Public Health data on hospitalizations and overdoses and the City of Chicago data portal on crimes.

Recommendations

Blacks comprise most of the treatment episodes for Chicago, where 61 percent of publicly funded treatment capacity was cut between 2009 and 2013. In Peoria, treatment capacity remained stable. So the report urged that Cook County, where Chicago is located, have an increase in community-based treatment capacity for medication-assisted treatment. In addition, methadone and buprenorphine should be provided in the county jail, with linkages created to treatment providers.

Harm reduction is also a significant aspect of the report, which recommends naloxone dispensing to patients in the emergency department after overdose, in treatment centers and after detoxification treatment, and in jails (naloxone is already being dispensed in the Cook County Jail in a pilot program).

But even some of the harm-reduction approaches may need to be altered to be more appropriate to black communities. Kane-Willis is concerned that the injectable naloxone being dispensed may not be appreciated by black communities, where there is more intranasal use of heroin than injecting use. "We are going to give out injectable naloxone to sniffers who have a huge stigma against needles," she said. "It's a total failure." •

For more information, and a link to the report, go to https://www.roosevelt.edu/News_and_Events/News_Articles/2016/20160831-HeroinStudy.aspx.

Two NSDUH reports: One for SUDs/MI and one for Rx drugs

The National Survey on Drug Use and Health (NSDUH) for 2015 shows a steady continued increase in substance use disorders (SUDs) and mental illness, especially depression, among some age groups. The annual report is issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) and has been conducted since 1979 by survey. This year, a second NSDUH focuses on abusable prescription drugs only.

Key findings of the report, released Sept. 8, include a leveling off of marijuana and heroin use by youth and young adults, and a reduction in use of alcohol and tobacco by youth. SAMHSA has chosen to feature mental illness in recent years' issues of the NSDUH, and this year found that mental illness has leveled off among adults 26 and older, but there has been a slight rise in major depressive episodes among adolescents and young adults.

The rate of current (past-month) cigarette smoking dropped from 26 percent for all people aged 12 and older in 2002 to 19.4 percent in 2015. Among young adults, the rate is down from 40.8 percent in 2002 to 26.7 percent in 2015. The rate of daily cigarette smoking by adolescents and young adults also decreased significantly, from 31.8 percent of adolescent smokers in 2002 to 20 percent in 2015, and from 51.8 percent of young adult smokers in 2002 to 42 percent in 2015. However, vaping and e-cigarettes are not included in NSDUH survey questions, so some of the decline may reflect nicotine delivery by e-cigarette use, according to SAMHSA.

The level of current alcohol use by adolescents dropped from 17.6 percent in 2002 to 9.6 percent in 2015. Alcohol use disorder rates also dropped among adolescents from 5.9 percent in 2002 to 2.5 percent in 2015. Rates of alcohol use and alcohol use disorder also dropped

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among young adults, from 60.5 percent in 2002 to 58.3 percent in 2015 for alcohol use, and from 17.7 percent in 2002 to 10.9 percent in 2015 for alcohol use disorder.

Marijuana is still the most commonly used illicit drug, with 8.3 percent of people aged 12 or over using it at least once a month — comparable to 2014, but higher than 2002 (6.2 percent). The percentage of adolescents who were current marijuana users remained steady over the past year — 7 percent in 2015 versus 7.4 percent in 2014 — and is similar to recent years.

SAMHSA also released a new, second NSDUH report focusing on misuse of prescription drugs. This report includes tranquilizers, stimulants, sedatives and pain relievers (including those containing opioids). This report contains information on the total number of people using these medications based on questions on any use and misuse. It also provides insight into several important issues such as why people misuse these medications and how misuse may be associated with other forms of substance use and/or mental issues.

This report shows that among people aged 12 and older, 6.4 million people currently (in the past month) misuse psychotherapeutic medications. About three-fifths (59.3 percent) of this current misuse consists of the 3.8 million people currently misusing prescription pain relievers. The report also shows that most people who used prescription drugs in the past year did not misuse them. In fact, 84.1 percent of them did not misuse prescription drugs even once in the past year. •

To view the reports, go to www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.htm; www.samhsa.gov/data/sites/default/files/NSDUH-FFR2-2015/NSDUH-FFR2-2015.htm.

Coming up...

Moments of Change will be held **September 26–29** in **Palm Beach, Florida**. For more information, go to **http://foundationsevents.com/moments-of-change**.

NAADAC, the Association for Addiction Professionals, will hold its annual conference **October 7–11** in **Minneapolis**. Go to **http://naadac.org/conferences** for more information.

In case you haven't heard...

Recently Jay Z came out with a film calling the drug war an "epic fail" and singling out injustice to blacks who are arrested and incarcerated in grossly unfair disproportion for drug crimes. According to Asha Bandele, who wrote about the film last week in an op-ed for *The New York Times*, Jay Z wanted to deal with the contention by Michelle Alexander in *The New Jim Crow* that white men were now profiting by selling marijuana commercially in an era of legalization, getting rich for the same thing that black men had been going to prison for for decades. Justice reform is long overdue — for blacks, and for drug users who need treatment and not prosecution. But the entire affair, done in collaboration with the Drug Policy Alliance, raises questions about what is really important here — is it justice reform, or is it marijuana profits? Jay Z is also one of many black rappers who has an investment in the marijuana industry — in his case, his own brand. How many young people idolize these singers? And to what extent are they getting a justice reform message, compared to a consumption message? *ADAW* has written many stories about the importance of justice reform, especially for people who need treatment for substance use disorders. Bandele and Alexander are brave visionaries who would never allow themselves to be shills for any industry. So what is really going on here? To see the film, go to www.nytimes.com/2016/09/15/opinion/jay-z-the-war-on-drugs-is-an-epic-fail.html. And we're happy to hear your answers: email adawnewsletter@gmail.com.

Briefly Noted

PAARI head steps down, placed on administrative leave as police chief

Last week, Leonard Campanello, co-founder of the Police Assisted Addiction and Recovery Initiative (PAARI), was relieved of his duties temporarily as police chief of the city of Gloucester, Massachusetts. According to a statement from John Rosenthal, co-founder and chairman of PAARI, Campanello was placed on administrative leave "pending an investigation related to a personal matter, which we understand has noting to do with P.A.A.R.I." The organization will continue its work, according to Rosenthal, a businessman and philanthropist. Gloucester and other police departments across the country try to help opioid users get treatment instead of prosecution. Gloucester Mayor Sefatia Romeo Theken would not tell reporters why the chief was placed on leave. "We don't know what's going on. I don't know what's going on. I really don't," she said. "I have no idea." She said the city's personnel department will hire an outside agency to investigate Campanello, who has received an award from the White House for his work. Campanello was on vacation when he was placed on leave, Rosenthal told reporters. He had taken time off to speak on behalf of PAARI across the country. Terrence Kennedy, an Everett-based attorney representing Campanello, told reporters that the administrative leave is not tied to his performance as police chief. Rosenthal said that as a result of the investigation, Campanello has also stepped down from his position at PAARI.