YOUTH AT RISK

Substance misuse and mental health...
The most important questions New Jersey schools can ask.

NEW JERSEY
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Executive Summary

Youth substance use, mental illness, and suicide have reached alarming levels in many New Jersey communities, whether urban, suburban, or rural. As an example, new research finds the state's youth and young adults are suffering some of the worst fallout from the past decade's opiate epidemic. The annual fatal overdose rate for 15 to 24 year-olds was more than 9 percent between 2006 and 2015.[1]

The crises has significant near and long-term health consequences for New Jersey's future. The state has incurred substantial costs for its taxpayers in increased health care utilization, incarceration, and diminished labor force participation, to say nothing of the many thousands of young lives lost to New Jersey families and communities.

As troubling as these circumstances are, youth substance use and mental health problems can be prevented and interrupted early on, before they undermine the futures of today's adolescents. One way to do so is to incorporate assessments and other support services in schools to identify youth early on who are struggling with these issues and intervene.

New Jersey already requires schools to provide staff training to establish a prevention, intervention, and referral program for student substance abuse, as well as suicide prevention.[2] An evidenced-based, early intervention, cost-effective tool known as SBIRT - Screening, Brief Intervention and Referral to Treatment – can help schools fulfill this mandate. SBIRT has been shown to have the following benefits:

- reduce youth substance use and address mental health issues early on
- prevent the occurrence of substance use disorders later in life
- improve academic performance
- reinforce the behavior of abstinent students.[3]

Several states have expanded SBIRT's use as a means of addressing the growing opioid and mental health crisis among youth and prevent substance misuse overall. In 2016, Massachusetts passed an opioid response bill that included annual SBIRT implementation in all middle schools and high schools.[4] In 2018, the Georgia State Senate passed a resolution encouraging schools to use SBIRT to improve academic outcomes, reduce chronic absenteeism, and improve school climate.[5] More than a dozen other states have expanded access to youth SBIRT in schools and community settings.

New Jersey could be next. Legislation has been introduced that would expand SBIRT to all high schools across the state, requiring annual assessments for all students. School supervisors, administrators, and staff who have been introduced to SBIRT have expressed interest in such a program provided adequate resources can be secured. State funding for school SBIRT initiatives can be supplemented by potentially tapping Medicaid, federal education funds, or other state and federal grants.

The current crises of substance use and mental health cries out for a response. SBIRT is a proven tool for meeting this devastating challenge that is putting so many lives at risk. In order to have the greatest impact, all students need to be screened, not only those already showing signs of a substance or mental health problem. SBIRT needs to be implemented as widely as possible, as soon as possible.

Youth Substance Use And Mental Health Today

The past decade and a half has seen a significant increase in substance use as well as a surge in mental health issues among youth. In 2015, a quarter million adolescents (12 to 17 years old) used pain medication for non-medical purposes. These ills, which often overlap, have increasingly jarred families and communities with fatal overdoses and an emerging surge in youth suicides and suicidal ideation. The Centers for Disease Control noted that between 2007-2016 there was a 56 percent increase in suicides among youth ages 10 to 19.[6]

In addition, widespread opioid use has caused a devastating surge in addiction and drug overdoses. Youth who are exposed to or experiment with opioids do serious injury to their developing brains.[7] Research shows that substance use while the brain is still developing increases the risk of developing substance use disorders. According to the Substance Abuse and Mental Health Services Administration (SAMSHA), 90 percent of people who develop an addiction as an adult began using substances before age 18.

56%

INCREASE IN SUICIDES AMONG YOUTH AGED 10 TO 19 BETWEEN 2007-2016

Fallout from adolescent substance use and mental health problems includes reduced academic performance and increased drop-out rates. High school age seniors (16 to 18) who drop out of school were more likely to use any illicit drugs than seniors overall. Drug use had a negative impact on grades: just one in four A students reports lifetime marijuana use, compared to two in three D/F students.[8,9]

Many youth use substances as a form of self-medication to cope with past trauma or an untreated mental illness such as depression or anxiety. Students who experience bullying, harassment or social isolation – notably Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) teens – are more likely to develop mental health issues and begin using substances to cope. Stigma facing these youth segments make them nearly five times more likely to attempt suicide than heterosexual youth.[10]

As with substance use, mental health problems can go undetected until they advance to a serious, possibly life-threatening stage. According to the New Jersey Department of Children and Families website, suicide is the third leading cause of death in youth ages 12 to 20. When the tragedies of fatal overdose or suicide occur, families and teachers often say they were caught completely off-guard, having seen no sign of what was to come. Youth who survive an overdose or suicide attempt often voice a common lament: ***If only someone had asked***.

Given the adverse impact of substance use on academic outcomes, future employment, and health, there is a compelling need to confront the problem as early as possible in every student. SBIRT is a way trained professionals can engage and support young people to address their substance misuse and mental health issues early on. Such early intervention can reduce the number of youth who develop substance use disorders or suicidal ideation.

SBIRT: AN EVIDENCE-BASED EARLY INTERVENTION

SBIRT is an evidenced-based public health approach that can engage young people in conversations about their substance use and mental health. It involves three components:

1) Screening. The screening component of SBIRT is a series of questions about at-risk behavior that, where warranted, prompt a brief conversation about an emerging substance or mental health issue. This conversation is between a trusted, trained adult and a young person. The goal of the screening is to understand whether the young person is misusing or at-risk of misusing substances. Most SBIRT models use a validated questionnaire to identify the level of use and other at-risk behaviors. Validated screening tools are short, and this step usually takes less than 5-10 minutes. These include the CRAFFT, Global Assessment of Individual Needs - Short Screener (GAIN-SS), and the Rapid Assessment for Adolescent Preventive Services (RAAPS) (see appendix A for additional information). Depending on the young person's level of use, they may or may not be engaged in a brief intervention or referral to treatment. The SBIRT flowchart below illustrates how the process addresses different scenarios.

SBIRT CAN HELP IDENTIFY ADOLESCENTS NOT VISIBLY DEMONSTRATING BEHAVIORAL PROBLEMS AT HOME OR IN SCHOOL

2) Brief intervention. Youth whose screens show moderate to high risk substance misuse or signs of mental health issues are engaged in a brief intervention. Brief interventions are structured conversations with licensed health professionals, paraprofessionals (e.g., health educators), or peers who are trained in brief intervention techniques. The goal of the intervention is to gain additional insight regarding the risk factors in the young person's life (e.g., depression, peer pressure, trauma, etc.) and any potential motivation toward making behavioral change. The intervention is age-appropriate and tailored to the level of drug and alcohol use indicated by the young person. For example:

- **No use:** Positive reinforcement for abstaining from drug and alcohol use.
- **Minimal and infrequent use:** Brief advice to advise against future use.
- **Risky or severe use:** Brief intervention or brief treatment using motivational interviewing or other approaches that elicit a young person's desire to change using a non-judgmental, empathic approach. The brief intervention may be followed by a referral and warm hand-off to a behavioral health treatment provider.

Other models, such as Project Amp for example, include multiple sessions with mentors who can relate to the lived experience of the young person.[11] Project AMP enlists young mentors who are in recovery from a substance use issue. These near-peers are in a good position to talk with youth about making different, healthier decisions by presenting themselves as examples of what the consequences of not changing one's behavior are.

3) Referral to treatment. Youth who are actively misusing substances and demonstrating addictive behaviors are referred to treatment. Referral to treatment can include traditional treatment for substance use disorders or a referral to a broader range of services, depending on the young person's needs and risk factors.

Referrals to treatment are rare. According to SAMHSA, only 3% of patients receive a score that indicates a brief treatment is necessary.[12]

There are a number of existing resources available for schools to support the brief intervention and identify treatment providers should referral be needed. These include: School-based personnel such as Student Assistance Coordinators (SAC) or clinical staff, local and county drug and alcohol alliances, County Department of Human Services, NJ Connect, NJ Addiction Services hotline, County chapters of the National Alliance on Mental Illness, or the individual's health insurance provider. SACs are among the best suited for administering SBIRT, but only one in three New Jersey districts fund this position.

SBIRT DEMONSTRATIONS IN NEW JERSEY

Several New Jersey hospitals and primary care centers have implemented SBIRT demonstration projects for adults funded through the New Jersey Medicaid Delivery System Reform Incentive Program and a SAMSHA grant awarded to the

state in 2012. Project participants included Inspira, Trinitas and Capital Health systems, Trenton's Henry J. Austin Health Center (HJAHC), the Rowan School of Osteopathic Medicine, Department of Family Medicine, and Rutgers Robert Wood Johnson Medical Group in New Brunswick. Research and training support were provided by Rutgers University.

These projects illustrate SBIRT's effectiveness in identifying individuals who are at risk and the appropriate level of intervention to modify their behavior. For example, Henry J. Austin saw a consistent reduction in substance use. In every category of use, including alcohol, cocaine, and heroin, there was a reduction in past 30-day use. Drinking to intoxication went from eight days to four days in the past 30 days. Heroin use dropped from approximately 18 days to just under eight.

Henry J. Austin subsequently implemented SBIRT to screen adolescent patients for both substance use and mental health between August 2017 and April 2019.

The health center screened a total of 3,014 adolescents for substance use between 2017 and 2019. Over 400 young people were screened as having at least one risk factor for misusing substances. These youth were engaged in brief interventions or conversations by the primary care or behavioral health provider.

Henry J. Austin's Director of Behavioral Health, Lee Ruszczyk, described the effectiveness of youth SBIRT in this way: "The SBIRT screening we do on all adolescents ages 12 to 17 years old has helped to identify adolescents not visibly demonstrating any type of behavior problems at home or in school. It allows us to intervene early in their substance use, educate them, and allow them to make informed decisions about substances with the goal of preventing an addiction down the road. A simple five to ten-minute screening and intervention has the potential to prevent years of addiction, saving not only the individual and family extensive pain but the fiscal cost to the larger community."

SCHOOL-BASED SBIRT – A GROWING NATIONAL TREND

The impact that youth substance misuse and mental health has on adolescents' academics is significant and worsening. A study published in 2016 in the *Journal of Drug Abuse* by Allison C Paolini of Kean University found that, "...students who are utilizing drugs are more likely to suffer from chronic absenteeism, drop out of school, are exposed to negative peer influences..." Additionally, the study noted that, "adolescent drug use is related to reduction in sustained engagement in their academic pursuits ..."[13]

Schools can play a critical role in ensuring all youth have access to SBIRT. Several states have implemented school-based SBIRT. These states have recognized SRIRT's effectiveness in reducing serious substance and mental health problems.

Several states have taken steps to implement school-based SBIRT projects or pilots. These include: Colorado, Georgia, Massachusetts, New York, North Carolina, Vermont and Wisconsin.

For example, Massachusetts, in 2016, became the first state in the country to require schools to implement an SBIRT program. The state allocated $2.4 million to the Department of Health in the first two years to establish the program. These funds covered the cost of implementation planning, development of school SBIRT resources, training materials, and funds to support schools that required outside per diem nursing staff to cover other school nurse duties during screenings. Massachusetts has 405 school districts. These districts implemented SBIRT in both middle school and high school. The Department of Health and Boston Medical Center's MA SBIRT TTA website serves as a resource to Massachusetts schools and other states seeking training and technical assistance needed to establish and implement SBIRT.

MASSACHUSETTS ALLOCATED $2.4m TO THE DEPARTMENT OF HEALTH IN THE FIRST 2 YEARS TO ESTABLISH THE PROGRAM

In North Carolina, an SBIRT initiative, undertaken by the Pender Alliance for Teen Health (PATH), has been conducted over the 2018-19 school year. It was funded at $50,000 by a grant made available by the state legislature. This project used RAAPS.

Wisconsin is undertaking a school-based SBIRT initiative funded by federal and state dollars. They have taken steps to implement screenings for substance use and mental health issues in middle and high schools. Over the past five years, 175 districts have had staff take part in SBIRT training.

School-based health centers across the country are also implementing youth SBIRT. The School-Based Health Alliance has been fostering and refining SBIRT practice in school settings since 2015. Among the Alliance's undertakings are establishing a national school-based learning collaborative to share tools and resources, promoting dialogue on best practices and developing well-defined outcome measures.[14]

The cost of these programs is minimal when compared to the potential benefits and cost savings realized by early intervention and treatment. According to the National Office of Drug Control Policy, SBIRT reduces Medicaid spending. The same report shows that every dollar invested in prevention and treatment leads to $4 in savings

related to health care. The state could realize $7 in savings related to law enforcement and criminal justice costs for every $1 spent on prevention and treatment.[15]

While significant, these numbers only tell part of the story. It is difficult to quantify the cost due to an adolescent's lost productivity over the course of a lifetime if cognitive impairment is suffered from sustained drug use or simply not realizing potential due to a long-delayed mental health diagnosis.

THE CASE FOR UNIVERSAL SCHOOL-BASED SBIRT

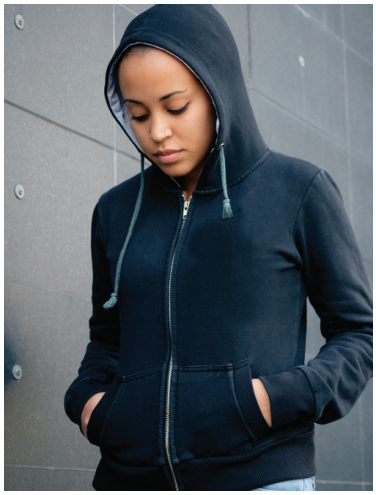
In view of the clear and significant nexus between substance use and/or mental health problems and student academic performance and attendance, there is a compelling need to confront the problem as early as possible in every student, not only the ones whose substance use or mental health issue is apparent.[16]

Too often, substance use has been met with a punitive response. Schools commonly enacted zero tolerance policies that led to students being temporarily or permanently removed from school, despite little evidence to support the effectiveness of such policies in improving student behavior. In fact, "data on suspension and expulsion raise serious concerns about both the equity and effectiveness of school exclusion as an educational intervention."[17] These harsh measures disproportionately harm students of color, who are more likely to be disciplined than their white peers, while also preventing them from accessing needed services.

Use of supportive responses to youth substance use improve academic outcomes. Replacing punitive disciplinary policies with in-school substance use prevention services such as universal SBIRT, restorative practices, and other support would result in healthier youth who are more likely to complete their education and develop into healthier adults.

Universal SBIRT describes the practice of engaging all students in the SBIRT process rather than individually targeting sub-populations of students. This practice is based on research documenting that young people of all backgrounds misuse substances and has numerous benefits.

- A universal approach maximizes the benefits of SBIRT as an early intervention model by increasing the likelihood that youth receive the support they need before their substance or mental health issues becomes a significant adversity in their lives.
- A universal approach ensures that students in need of support aren't overlooked. Experts note that many youth in need of help keep a low profile and their problems go undetected - that is, they "fly under the radar."
- Universal approaches minimize the influence that individual biases may have on who gets screened and who doesn't.
- The benefits of universal SBIRT extend to students who do not drink or use other drugs, as they receive positive reinforcement about their abstinence.



A NUMBER OF RESOURCES EXIST TO SUPPORT SCHOOLS IN LAUNCHING, IMPLEMENTING, AND MAINTAINING SBIRT PROGRAMS

- Universal screenings normalize behavioral health screenings. Screenings for physical health are increasingly routine and promote early detection of illnesses such as diabetes or high blood pressure. Screenings for substance use and mental health need to be widely adopted as part of teenagers' overall health. This will also help to reduce the stigma that prevents many from seeking help for behavioral health issues.

RESOURCES FOR IMPLEMENTING SBIRT

Training & Staffing

Schools offer the best chance of making SBIRT universally available to youth. While the process itself is standardized, schools can determine how, when, and by whom SBIRT is administered. Like Massachusetts, New Jersey will need to defer to local educational authorities on how best to implement SBIRT given staffing considerations and other factors.

New Jersey currently requires school districts to:

- Provide staff training in the identification, intervention, and prevention of substance abuse, as well as suicide prevention.[18]

- Establish programs of "prevention, intervention, referral for evaluation, referral for treatment, and continuity of care for student alcohol, tobacco, and other drug abuse…"[19]

SBIRT is an objective, evidenced-based tool that can help school districts meet these requirements. A number of resources exist to support schools in launching, implementing, and maintaining SBIRT programs.[20]

Individuals administering the screening and follow up need to be trained but not licensed. Online and in person training options are available to schools to support them with SBIRT implementation and prepare personnel (i.e. school nurse, student assistance or guidance counselor, health class teacher, or athletic coach), to administer SBIRT.[21] Rutgers University Center for Alcohol & Substance Use Studies, which provided training assistance to support New Jersey's SAMHSA project, is another resource that can be leveraged to provide comprehensive training to support SBIRT in schools.

Other alternatives to having school staff conduct screenings and/or intervention is to enlist college interns, young people in recovery, or an outside agency.

New Jersey's Bordentown School District has been using SBIRT on a limited basis, enlisting interns to assist the Student Assistance Coordinators. Using college interns can help free up school personnel for other student needs and provide students with a peer model or mentor.

Preliminary findings from a national research initiative known as Project Amp

have shown that using young adult peers as mentors to conduct the intervention has increased youth engagement and positive outcomes. In this model, students are connected with peer mentors who have first-hand experience with substance misuse. Now in recovery, these mentors help strengthen the teen's resilience and help them develop important protective factors. Project Amp will soon be introduced in New Jersey. The many benefits to such peer recovery models has also been well documented by SAMHSA.[22]

Morris County Prevention Is Key (MCPIK) has secured a five-year SAMHSA grant that will establish an SBIRT program in some schools beginning this year. The project's goal is to expand the capacity of student services to effectively and efficiently address a range of behavioral health concerns (e.g., alcohol/drug use, mental health) which, in turn, promotes school engagement and improved learning outcomes. MCPIK will train school-based health professionals in up to ten schools to administer SBIRT to 2,000 students over a five-year period.

Funding

As interest in increasing school-based screenings and intervention services grows, so to do questions about how such activities can be funded. Massachusetts launched their statewide school-based SBIRT program with $2.4 million in state funds. Similarly, New Jersey will need to dedicate state funds in order to help local school districts establish and prioritize SBIRT programs. Other potential revenue sources that could supplement state support include Medicaid, federal funds available under the Every Student Succeeds Act (ESSA), and state, federal or private foundation grant funds.

Medicaid

There is precedent for schools receiving Medicaid reimbursement for health services. Currently New Jersey schools receive Medicaid reimbursement for health-related special education services they provide through the NJ Department of Education Special Education Medicaid Initiative (SEMI) program, which all districts are required to participate in. The reimbursements received help offset the state and local costs of providing these services.

But a 2014 rule change to Medicaid's "free-care" rule has opened the door for schools to be reimbursed for an expanded array of health services delivered to Medicaid eligible students. In the past, reimbursement was restricted only to services not available free of charge to other students. A number of states have taken steps to implement this free care rule policy reversal.[23]

New Jersey Family Care, the state's Medicaid program, has reimbursed for alcohol and substance use screenings and brief interventions since 2008. However, reimbursement has been limited to services administered in a physician setting or clinic by a licensed clinician whose scope of practice allows them to provide the treatment component. This includes a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker in a non-substance abuse treatment setting. Screenings alone are not eligible for reimbursement. Only those evaluations that include the "brief intervention" portion can be billed.

These requirements present opportunities but also challenges to schools being able to seek reimbursement for SBIRT services. In New Jersey, school personnel such as guidance counselors, student assistance coordinators, and psychologists may meet the scope of practice standard set by Medicaid. However, unlike Massachusetts, school nurses do not. Schools would require guidance from NJ Department of Human Services and Department of Education before seeking reimbursement for SBIRT services. One way schools could meet the current criteria for reimbursement is to contract with an outside agency to conduct the screening and interventions.

THE POTENTIAL TO IDENTIFY PROBLEMS EARLY IN LIFE HAS INCREASED SIGNIFICANTLY

The value in expanding access to such screenings was highlighted by the New Jersey Health Care Quality Institute's *Medicaid 2.0: Blueprint For The Future*. They recommend the State support integration of health care services in schools and other settings. "With the emergence of defined screening techniques to detect behavioral health problems, particularly for children, the potential to identify problems early in life has increased significantly. Integrating screening services into primary health care systems, school settings, and community-based programs can lead to early interventions that can prevent problems from arising or escalating."[24]

Ensuring New Jersey Family Care, covers school-based SBIRT is one way New Jersey can help prevent problems of substance misuse and mental health issues from escalating.

Every Student Succeeds Act (ESSA)

The Every Student Succeeds Act (ESSA), the successor to No Child Left Behind, was adopted in 2015. ESSA gives states greater flexibility allowing them to use federal funds to address non-academic factors that can improve school performance.

Under ESSA, each state must identify the lowest performing schools who then must submit a plan for improvement. Schools can address academic performance and graduation rates as well as other non-academic factors chosen by the State that inhibit performance. New Jersey, like 36 other states and the District of Columbia, selected chronic absenteeism as the non-academic factor of school quality and student success schools could address. Research shows that substance use disorders are deeply interconnected with student absenteeism, disciplinary suspension, and school failure.[25] Since substance use can contribute to absenteeism, ESSA can provide resources to implement evidenced-based prevention and early intervention services such as SBIRT within schools.[26]

Substance Abuse Prevention and Treatment Block Grant (SAPT)
SAPT provides federal funds to states to plan, implement, and evaluate activities that prevent and treat substance misuse and promote public health. States can use SAPT funds for youth prevention and early intervention services, but that funding may not come from the 20 percent of the state's SAPT funds allocated to primary prevention strategies.

Schools that are interested in moving forward now, can explore these supplemental funding options to support SBIRT programs pending allocation of state funds.

POLICY RECOMMENDATIONS

There are a number of actions state policy makers can take to reduce implementation barriers and expand school-based SBIRT across the state.[27] Priorities for New Jersey include:

1. Pass legislation that requires all high schools to annually conduct written or verbal substance use/mental health screening on all students using SBIRT.

2. Establish a state funded SBIRT training and technical assistance program through the Department of Human Services that can provide resources to support schools implementing SBIRT.

3. New Jersey should explore ways to expand the availability and Medicaid reimbursement for school-based behavioral health screenings such as SBIRT.

4. New Jersey Department of Education can issue a formal recommendation to move away from zero-tolerance policies and towards alternatives to suspension for students who are caught under the influence or with possession of substances.

5. Pass a resolution that recognizes SBIRT as a best practice in school ESSA activities and offer districts resources and guidance on how schools can incorporate SBIRT into their improvement plans.

CONCLUSION

The current substance use and mental health crises are unprecedented in their scale and impact on the future of New Jersey. SBIRT can provide a lifeline to the adolescents imperiled by these entwined ills. It is a well-established, evidence-based tool with the virtue of easy and affordable implementation. Its value is recognized by experts in the medical, behavioral health, and scholastic fields.

New Jersey schools are the best vehicle for delivering SBIRT to the greatest number of youth. Screening all students is essential to helping the many who otherwise, as noted above, will slip under the radar. The state's many districts will choose for themselves the course best-suited to them.

In recent years, a number of states have implemented school-based SBIRT, with Massachusetts' statewide effort leading the way. New Jersey needs to be added to this growing list and contribute its own success stories. Delivering SBIRT to all New Jersey's adolescents will prove to be one of the best investments the state could make. It is incumbent on New Jersey's legislators, school officials, pediatricians, and faith-leaders to provide SBIRT to teenagers, thereby giving them the chance to respond to questions so many of them are more than ready to answer.

ABOUT THE AUTHOR

Daniel Meara, the primary author of this paper, is a writer and editor who has focused on addiction issues for much of his career. He was the long-time editor of Perspectives, NCADD-NJ's journal on addiction policy and treatment issues. His writing and editorial work was recognized by the New Jersey Association of Mental Health and Addiction Agencies with the 'Truth in News Award' in 2015. His opinion articles on addiction and behavioral health issues, including SBIRT, have regularly appeared in New Jersey's major newspapers, including the Newark Star-Ledger, the Asbury Park Press, and the Times of Trenton.

APPENDIX

A variety of free or low-cost brief behavioral health screening instruments for adolescents are available. Below is a sample list of these, some of which are strictly for substance use, some only for mental health, and others covering both.

CRAFFT (Car, Relax, Alone, Forget, Friends Trouble)
Focus: Substance use
Ages: 12-18
Contact/permission: Children's Hospital Boston, 300 Longwood Avenue, Mailstop 3189, Boston, MA 02115

Substance Abuse Subtle Screening - Adolescent
Focus: Substance use
Ages: 12-18
Contact/permission: The SASSI Institute

Global Assessment of Individual Needs – Short Screen GAIN-SS
Focus: Mental health/substance use
Ages: Adolescents
Contact/permissions: Chestnut Health Systems 448 Wylie Drive Normal, IL 61761

Rapid Assessment for Adolescent Preventive Services¬
Focus: Substance use/mental health
Ages: 13-18
Contact: Possibilitiesforchange.com

Child and Youth Resilience Measure
Focus: Mental health
Ages: 10-23
Contact/permissions: Resilience Research Center, PO Box 15000, Halifax, NS B3H 4R2

Center for Epidemiologic Studies Depression Scale
Focus: Mental health
Ages: All ages, validated for adolescents
Contact/permissions: National Institute of Mental Health, 6001 Executive Boulevard, Bethesda, MD 20892-9663

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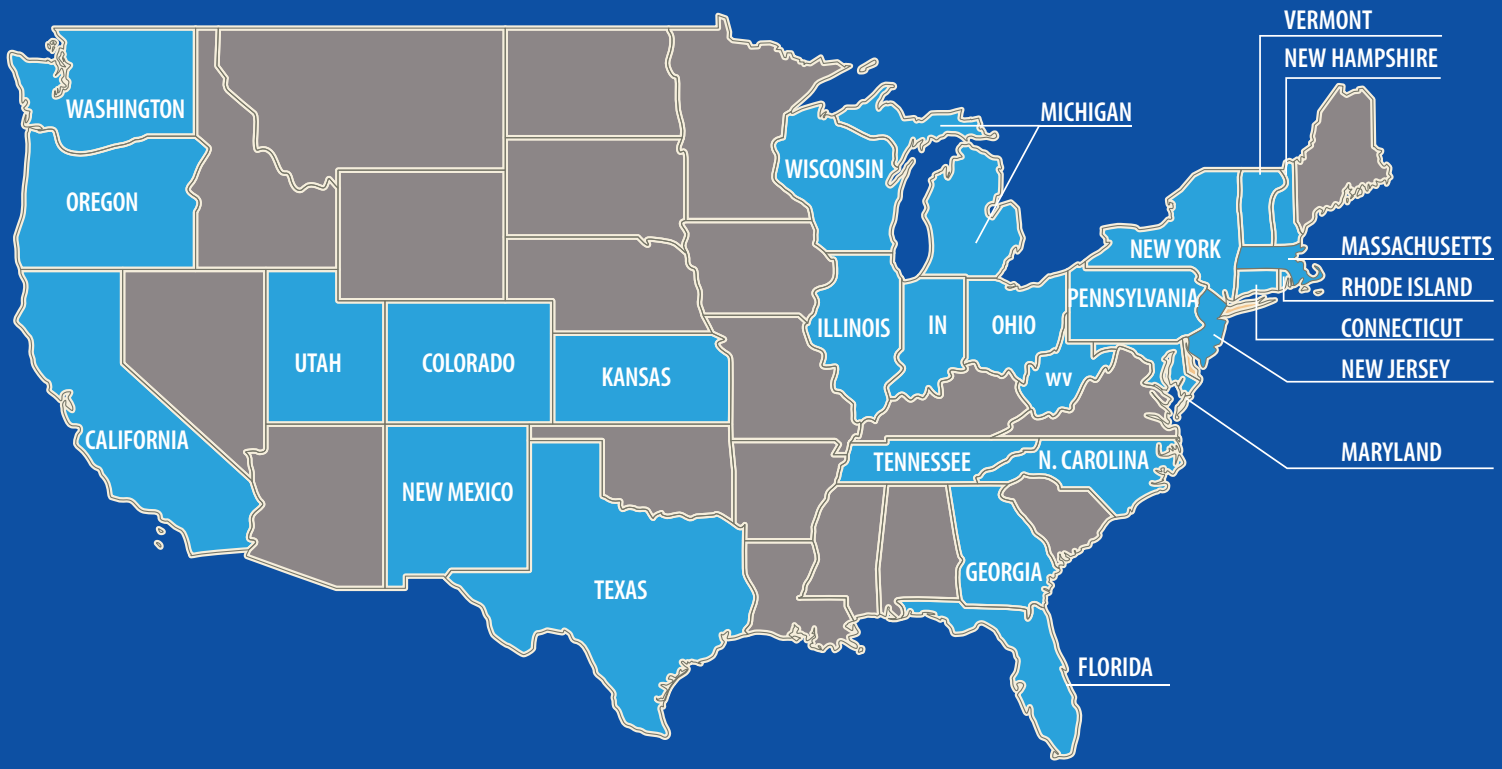
States Implementing Youth SBIRT



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