

VISIONS

January, 2006

NAATP Visions is the official newsletter of the National Association of Addiction Treatment Providers (NAATP),

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ISSUE



national association of addiction treatment providers

NAATP SPEAKS WITH A LOUD BUT RATIONAL VOICE!

After several years of discussion, the National Association of Addiction Treatment Providers Board of Directors has approved a plan for NAATP to again become actively, aggressively and rationally involved in public policy at the national level on behalf of its member organizations. In 1978, NAATP was organized in order to provide "critical mass" and present its case for a uniform benefit addressing addiction treatment to be included in the Blue Cross plans offered by employers to their employees. Using that experience as a spring board, NAATP then worked with JCAHO to refine the standards which applied to freestanding addiction treatment programs during the accreditation process. NAATP was also instrumental in the discussion concerning NIAAA and NIDA, as well as, the National Health Insurance debate.

The board of directors of NAATP believes that the last ten years have been re-building years for NAATP and that the time is right for NAATP to again be a very clear voice representing the interests of the core values of the National Association of Addiction Treatment Providers. This public policy initiative will include the very traditional work done in and around the political process in Washington, DC. It will also include working with other health care provider organizations, employer organizations, and regulatory and accreditation agencies. Building a consensus on issues important to the members of NAATP will also mean working with other associations and on issues important to them.

This represents a major commitment in terms of financial and personnel resources on the part of the National Association of Addiction Treatment Providers. In order to carry out this, a plan and a strategy have been developed. In order for NAATP to provide the leadership in the area of public policy some very specific steps will need to be taken to ensure that this effort has longevity and that it is responsive to the central mission of the association. Some of those steps will include:

1. Appointment of a standing committee on Public Policy or Government Relations. (The current by-laws calls for a standing Government Relations Committee)

2. Development of a plan of action (developed annually) which identifies the specific areas of focus
3. Allocation of NAATP resources to carry out the work of the standing committee and the implementation of the plan.
4. Secure the resources (individual or organization) necessary to carry out the objectives of NAATP.

The assumption behind this is that this plan can be and should be implemented for the year 2006. At the November 2005 Board meeting there was considerable latitude given to the NAATP executive and the Board Executive Committee to have NAATP take and provide leadership in the area of public policy. The only significant point of disagreement was over the amount of money it would take to launch an effective program. Using the four steps outlined above, it is possible to begin, the leadership journey and to begin it in more than a token manner.

- * Creation of an environment in which addiction treatment is valued as a health care response to a disease.
- * Creation of an environment in which reimbursement for addiction treatment is both reliable and consistent with the service provided.
- * Supporting research through both private and government agencies which encourages long term sustainable recovery as the outcome of addiction treatment.

Another issue around the action plan is the expectations. Public Policy is the development of relationships and connections so that NAATP can access decision makers (political, business/economic and bureaucratic) in order to ask for items on our agenda to receive attention and to also make statements to the decision makers when we feel that our position has either been not represented or misunderstood. In other words, public policy is about accessing decision makers so that there is the ability to both ask and explain. In a real sense, public policy is about making sure that the doors are open to NAATP. We need to implement a plan that begins to establish a "reservoir of good will".

For 2006, the core areas of focus would be:

- * Utilizing the recent Institute of Medicine report as a catalyst to work toward removing barriers which prevent persons with private health insurance from accessing addiction treatment,
- * Supporting efforts to increase the research related to addiction as a brain disease and ensuring that the private sector plays an increasing role in research and the research to practice side,

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ust when we thought that lexicon was complete, and we had learned all of the alphabet designations and the acronyms that have pervaded the addiction treatment business, another comes along. NAATP, meet EBT. EBT, meet the National Association of Addiction Treatment Providers!

On a more serious note, if you have not yet become familiar with “ebt” (Evidence Based Treatment), you are going to need to do so as this term has crept into the vocabulary, the literature and the expectation of a lot of persons making decisions in the addiction treatment arena. In fact, the EBT focus has managed to drag along with it the terms “outcomes” and “pay for performance”. While most of this discussion has taken place within the public and therefore the “funded” arena, it is not a stretch to suspect that this same language will very shortly leak into the private or fee for service arena. If you want to know where the train is going, look at where it came from! If the National Association of Addiction Treatment Providers wants to learn about the potential impact of EBT on member organizations and on the way in which treatment is delivered and evaluated, we need to look at how EBT is being viewed, used and required in those programs what are state and federally funded.

In the simplest form, EBT grows out of the health care expectation that there should be certain Standards of Care established for the treatment of particular diseases. These standards of care are developed through research and the evaluation of the evidence gathered from that research. Thus treatment for ovarian cancer follows commonly accepted standards of care depending on the stage of the cancer, if it is the primary site, etc. These standards of care are followed whether or not the treatment is provided in Pennsylvania or Arizona. Of course there are exceptions to this as there are always clinical trials or experimental procedures which take place in an attempt to enlarge the evidence gathered and then based on the results modify the standards of care. (Still with me?)

In the area of addiction treatment that same concept is being applied. There should be specific standards of care applied to persons diagnosed with addictive disorders, relevant to the level of the disease activity and these standards should apply whether the treatment occurs in Pennsylvania or in Arizona. Only treatment provided which is “evidence based treatment” should therefore be paid for and in some states, the mandate has already been issued that only those programs offering evidence based treatment will receive funding. Those same states are not talking about linking payment to outcomes and there for the pay for performance concept.

I would be hard pressed to identify anyone who would argue with the statement that persons diagnosed with the disease of addictive disorder should not receive the best treatment possible. The problem is that we have not yet begun to really

identify what “best” is and to ensure that this best treatment is available across the spectrum of addiction treatment. There have been some modest attempts to define treatment modalities which either produce evidence that they are effective or for which there is no evidence. There have been attempts to define treatment intensity which either produce evidence that they are effective or for which there is no evidence. And, there has been a rush by federal agencies to codify these evidence based treatments. That rush is a mistake! The concept, however, has strong merit.

Some twenty years ago, C. Krauthammer wrote in *The Washington Post* (1985, Dec. 29). Psychotherapy is dying from dilution.

As long as psychotherapies resist pressure to produce scientific evidence that they work, the economic squeeze will tighten. After all, if psychotherapy is really an art, it should be supported by the National Endowment, not by Medicare. The first to face extinction will be the longer term therapies... Where it ends, though is not clear.

There is no question that at times those of us working in the area of addiction treatment consciously or unconsciously, intentionally or inadvertently fall back on the art form argument as a way to either seek to make ourselves different or to protect our own approach to treatment as a marketing differentiation tool. Whatever the reason, in the long run it has limited value. The prophetic words of Krauthammer in 1985 toward psychotherapy certainly rings true for addiction treatment as well.

So what is a treatment program to do? The first action is to not panic. It is sort of like learning to not take yourself too seriously. EBT is certainly a great concept, and we should treat this concept with respect, but not reverence. There is a danger that the federal government and state governments and then later private insurance companies will prematurely embrace this concept, so we need to be vigilant. And then secondly, we need to commit ourselves to making sure that we do not relegate addiction treatment to an art form. The last time I checked, the National Endowment was struggling to fund some very limited programs, let alone addiction treatment. The National Association of Addiction Treatment Providers needs to take some leadership in identifying and creating a consensus among its members on evidence based treatment. The general public and other health care providers should expect nothing less. Addiction treatment which is based on accepted standards of practice, based on the best evidence gleaned from honest research should be the goal of everyone.

THAT'S THE PERSPECTIVE OF RJH

THOMAS J. THELIN NAMED COUNSELOR OF THE YEAR BY MASSACHUSETTS ASSOCIATION FOR ALCOHOL AND DRUG ABUSE COUNSELORS

Westborough, MA, December 8, 2005—Thomas J. Thelin was honored with the Counselor of the Year Award from the Massachusetts Association for Alcohol and Drug Abuse Counselors (MAADAC) December 8th at the organization's holiday meeting in Westborough, MA.

MAADAC, the Massachusetts affiliate of NAADAC - the National Association for Addiction Professionals, is a professional membership organization dedicated to the needs and advancement of addiction-focused professionals (MAADAC mailing address: PO Box 61071, Longmeadow, MA 01116; web address: www.maadac-ma.org)



Mr. Thelin has over 26 years of experience in alcohol and drug counseling with community, religious, and private organizations. For the past 16 years, he has worked with AdCare Hospital in various capacities including Probation Officer and Director of the Substance Abuse Treatment Program at the Worcester District Court and Outpatient Clinician at AdCare Outpatient Services - Worcester. Mr. Thelin is presently Day Treatment Program Co-Coordinator for AdCare Outpatient Services - Worcester. "Tom is a true professional who combines exceptional clinical skills with respect for each client he treats," shares Alan Webber, Director of Outpatient Services - Worcester.

A Certified Alcohol and Drug Abuse Counselor, a Licensed Alcohol and Drug Counselor and Certified Clinical Supervisor, Mr. Thelin holds a bachelor's degree in Philosophy, two master's degrees in Divinity and Criminal Justice, and has completed post graduate courses in Counseling Psychology.

Mr. Thelin, who is a past member of the MAADAC Board of Directors, serves on numerous boards at the local and state levels including the Massachusetts Board of Substance Abuse Counselor Certification as an Evaluator; the Montachusett Addictions Council; and the Bridges Conference Planning Board.

He resides in Leominster, MA, with his wife, Terry. Camping, reading and enjoying the great outdoors are among his favorite pastimes.

AdCare Hospital offers alcohol and substance abuse treatment at outpatient sites in Boston, North Dartmouth, Quincy, West Springfield, Worcester, MA, and Warwick, RI. AdCare Hospital and its network of outpatient clinics are accredited by the Joint Commission on Accreditation of Healthcare Organizations. AdCare Hospital also sponsors 1-800-ALCOHOL, the 24-hour National Information and Referral Line.

SUSAN HILLIS, LICSW, APPOINTED TREATMENT DIRECTOR AT ADCARE HOSPITAL

Worcester, MA, January 12, 2006 – AdCare Hospital of Worcester, Inc., New England's most comprehensive provider of alcohol and drug treatment, has named Susan Hillis, LICSW, Treatment Director.

Ms. Hillis, who joined AdCare Hospital in 1990 as a therapist, has worked as Day Treatment Director, Director of Outpatient Services - Worcester, and most recently, as Assistant Vice President of Clinical Services. Experience outside of AdCare Hospital includes working with autistic children and adolescents in residential settings.

Ms. Hillis holds a master's degree in social work from Boston College and a bachelor's degree in music therapy from Anna Maria College. A Licensed Alcohol and Drug Counselor, she has taught courses in Westfield State College's Addiction Counselor Education Program at AdCare Hospital.

As Treatment Director, Ms. Hillis will be responsible for the supervision, direction and development of all inpatient treatment activities. "Susan's extensive experience supervising and training clinical staff will benefit our patients and the Hospital," commented Dr. Patrice Muchowski, vice president of clinical services at AdCare Hospital.

Ms. Hillis resides in Charlton, MA. She is a member of the National Association of Social Workers and has given numerous professional presentations at area schools and colleges on "Adolescent Substance Abuse," "Club Drugs," and "Enhancing Motivation for Change" among other topics.

Celebrating 30 years of addiction care, AdCare Hospital has grown to include outpatient clinics in Worcester, Boston, North Dartmouth, Quincy, West Springfield, MA, and Warwick, RI. AdCare Hospital is licensed by the Department of Public Health Bureau of Substance Abuse Services and accredited by the Joint Commission on Accreditation of Healthcare Organizations. The Hospital received the 2005 national award for quality improvement from the National Association of Addiction Treatment Providers.



DON'T MISS THIS OPPORTUNITY!

naatp

national association of addiction treatment providers

THE 2006 NAATP BENCHMARK SURVEY

INSTRUMENT IS NOW READY FOR COMPLETION.

LOG ONTO www.naatp.org/2006survey.html

COMPLETE THE SURVEY BY MARCH 15, 2006!

YOU MUST COMPLETE THE SURVEY TO
RECEIVE A COPY OF THE RESULTS!

2006 BENCHMARK

Save the Date! Creating Sanctuary: a Woman-Centered Approach

Stephanie
Covington



A three-day retreat for those dedicated to the healing of women. Through the creation of sanctuary, we learn to build the emotional climate necessary for women to grow larger than what wounded them.

Stephanie S. Covington, Ph.D., LCSW, is recognized nationally for her pioneering work in developing services for women and girls. Her consulting work ranges from the Betty Ford Center to the criminal justice system. Dr. Covington has published extensively, including "Helping Women Recover," "A Woman's Way Through the Twelve Steps," "Beyond Trauma" and the new curriculum "Voices: A Program of Self Discovery and Empowerment for Girls." She is Co-director of the Institute for Relational Development and The Center for Gender and Justice, based in La Jolla, California.

"We must have the courage to reinvent ourselves daily." - Maya Angelou

Naya
Arbiter



Dates: Thursday, March 23rd through
Saturday, March 25th 2006

Location: Amity Foundation's Circle Tree Ranch
Tucson, Arizona

Cost: \$295

Students \$175 Early registration (by 1/1/06) \$250

CEUs: 18.5

For more information and to register:
<http://www.circletreeranch.org>
or contact **Jodie Ramirez** at:
1-866-425-6076
or email events@outreachservices.info

Naya Arbiter's career spans thirty-five years of constant innovation. She was one of the first to modify the standard male-oriented therapeutic community to make it gender responsive - a safe and healthy place for women and their children. Her work has encompassed those who have often failed in other treatment settings including sex workers, victims and perpetrators of violence, and addicts who are 'chronic relapsers.' One of the Founders of Amity, for the past decade she has been the principal of Extensions LLC, from which she has consulted, lectured and trained throughout the U.S. and abroad. Ms. Arbiter has also developed an extensive and comprehensive series of curriculum materials to support her work and to facilitate others using her approach to addiction and related problems. Ms. Arbiter has served on the Executive Council of the World Federation of Therapeutic Communities, as Vice-President of the Therapeutic Communities of America and the Inter-American Commission for Drug Policy, amongst others. She has offices in both California and Arizona.

Amity Foundation  Fundación de Amistad
Circle Tree Ranch
A Healing and Therapeutic Community

10 REASONS TO PARTICIPATE IN THE BENCHMARK SURVEY!

Nine years ago, the National Association of Addiction Treatment Providers released its first benchmark survey. That first year, thirty five different organizations participated and received the first NAATP benchmark report displaying how their program “benchmarked” against other NAATP members in some 40 different indicator categories. The first benchmark survey was specifically designed to assist administrators in looking at operational aspects of addiction treatment. Nine years later the participating number has nearly tripled and the measured indicators have expanded to include operational, clinical and financial measures.

This remains the only benchmark tool designed specifically for addiction treatment providers. Nevertheless, only 40% of all NAATP members participate in the survey and its depth and validity could be greatly enhanced if we can move closer to 100% participation. The survey is available to complete on-line at www.naatp.org/2006survey.html and from that same site you can download a “paper” copy of the survey to complete and submit to the NAATP office. It is highly suggested that every program first obtain a paper copy and collect the information before you enter it on-line. You can also obtain a paper copy by contacting the NAATP office.

Because the survey has expanded and because it collects both operational and clinical information, a steering group will be appointed at the February 2006 NAATP Board meeting to review the survey for 2007 and potentially split the survey into two very distinct sections. One section for operational indicators and one section for clinical and treatment results indicators.

But for 2006, the Benchmark survey is ready for you to complete and here are ten (10) reasons that you should participate and complete the survey.

1. All participating members will be placed into a pool and one participating member will be selected to receive a HP iPAQ.
2. All participating members will be placed into a pool and one participating member will be selected to receive two complementary registrations to the 2006 NAATP annual conference in Palm Beach, FL.
3. If you do not participate you will not receive a copy of the results. “No information, no results!”
4. This information becomes very important aggregate information which can be used in public education and public policy work. Trends that measure all members are very important.
5. You will feel better when you read all the articles about the NAATP Benchmark survey and know that you participated.
6. This is a membership benefit. There is no charge for the very professional report. If you do not participate you “give away” value for your membership.
7. The benchmark report is an exceptional planning tool for your operations. Without the report you are missing an opportunity to look at how your program benchmarks against other NAATP members.

8. Most accreditation organizations require some demonstration of your involvement in benchmarking. This more than meets those requirements.
9. Once you complete the survey, it becomes easier to do in successive years. Make 2006 your year to begin if you have not done so before.
10. The board of directors of the National Association of Addiction Treatment Providers is asking you to participate in the 2006 NAATP Benchmark survey.

There you have it, can we count on you going to www.naatp.org/2006survey.html and completing your survey before the deadline of March 15, 2006?

Results!

“Brown Consulting, Ltd. helped Pavillion and its staff prepare for our accreditation - working thoroughly in each area. I recommend them highly to other organizations working towards their accreditation.”

*Anne Vance
CEO, Pavillion International
NAATP Member*

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CONTINUED FROM PAGE 1

- * Providing support for the re-authorization of SAMHSA in 2006,
- * Working for the passage of Addiction Treatment Parity legislation at the federal level.

These will become the basic tenants of a public policy plan for the National Association of Addiction Treatment Providers. Each of these areas will then have a specific action plan or list of activities which connect directly to the core component of the plan with a way to report on activity and to evaluate results/effectiveness.

It is understood that in any period of time, issues may emerge which were not anticipated and the environment changes so that involvement in an unnamed area is deemed critical to the association. There will be flexibility in the plan to do this as long as that activity gets reported and tracked so that it becomes part of the information used to build the plan for each successive year.

Likewise, the National Association of Addiction Treatment Providers is not the only organization engaged in activity to support addiction treatment at the federal level. Thus, NAATP will partner with other organizations from time to time but always keeping in mind the core values of NAATP and the core items in its public policy plan and not allocating a disproportionate amount of energy and resources to areas outside of the core. It will be important that NAATP protect its resources so that the majority of its efforts are in the direction of the core values of NAATP.

The anticipation is that this initiative will be done professionally and done well. This is not an activity which can be added to the current responsibility of the NAATP Executive. Since we are going to make this commitment and since we are going to allocate these significant resources, we need to ensure that the resources purchase the best possible results.

There are at least two different directions which could be taken in this regard:

1. We could hire a person and lease office space in Washington as our staff person and Washington presence. This is a familiar route in that a number of associations have their own in house public policy person who represents them and their interests. The down side of this is the risk in hiring a person and the added expense of leasing space in DC. (Of course, the board could decide that it wanted the entire NAATP office in the DC area which was the interest in the early 90's when the office was moved from the west coast to the east coast.
2. The second option is to hire the services of an individual or an organization whose primary purpose it is to represent the interests of and lobby on behalf of their clients in Washington. Thus, NAATP would hire a lobbyist or a lobbying firm to represent us and to carry out our objectives for 2006.

While there is merit to both options, the second option seems a better alternative as it would allow us to get in the game much quicker, and perhaps for less overall dollars. To move in this direction, the NAATP executive in consultation with the Public Policy committee will secure the services of an individual or organization to represent NAATP and to lead the effort on behalf of NAATP to achieve its goals and to work within the area of the core values outlined above. The responsibility of managing the contract and the work of the lobbyist on behalf of the National Association of Addiction Treatment Providers would fall on the NAATP executive.

The National Association of Addiction Treatment Providers is poised to take the next step forward as it articulates on behalf of its members its concerns about creating and sustaining an environment in which addiction treatment is valued as a health response to a diagnosed disease and reimbursement for this treatment is on par with other health care interventions and as reliable as payment is for the treatment of other diseases.

2006 NAATP MEMBERSHIP DUES

WITH 2006, NAATP HAS A NEW MEMBERSHIP DUES STRUCTURE. YOUR QUICK RESPONSE TO YOUR DUES INVOICE IS APPRECIATED. IF YOU HAVE ANY QUESTIONS REGARDING YOUR 2006 DUES PLEASE CONTACT THE NAATP OFFICE AT 717-392-8480.

This formula is based on Gross Charges for chemical dependency activity and caps NAATP dues at \$12,000. This model treats multi-site/locations as one and the dues should be

Gross Charges	Annual Dues
Individual Member	\$200.00
Associate Member	\$650.00
Gross Charges less than 1.5M	\$800.00
Gross Charges 1.5M but less than 3M	\$900.00
Gross Charges 3M but less than 5M	\$1,300.00
Gross Charges 5M but less than 8M	\$2,500.00
Gross Charges 8M but less than 12M	\$4,000.00
Gross Charges 12M but less than 18M	\$5,000.00
Gross Charges 18M but less than 25M	\$7,000.00
Gross Charges 25M but less than 35M	\$9,500.00
Gross Charges greater than 35M	\$12,000.00

THE NAATP ANNUAL LEADERSHIP CONFERENCE IN PALM BEACH, FLORIDA... MAY 20-23, 2006.



PLAN NOW TO ATTEND!

FOR INFORMATION VISIT WWW.NAATP.ORG

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REATMENT: WHY BOTHER?

For those of us who work in the treatment field, the very question is offensive. For others, though, it's a question they often struggle with.

For example, we've long known that fewer than 30 percent of primary care physicians screen their patients for health problems related to their use of alcohol and/or other drugs. And this lack of widespread screening has meant that alcoholism (in particular) is treated more often as an acute illness than a chronic disease.

Now the National Center on Addiction and Substance Abuse at Columbia University has released a study that answers a critical question: Why don't most physicians ask patients about their alcohol/drug use? After all, a blood pressure test to diagnose hypertension is s.o.p. in a doctor's office. Why not test/survey a patient's alcohol/drug use? A number of effective screening instruments for alcohol/drug use/abuse are available, including written questionnaires that can be administered and evaluated in less than five minutes during a regular office visit.

Why this conspiracy of silence in doctor's offices, when it comes to alcohol/drug use/abuse?

Well, according to the Columbia University study, it turns out that more than 50 percent of physicians surveyed said they don't diagnose or treat alcohol/drug addiction - or recommend treatment - because they just don't think treatment works.

Is that an excuse, a cop-out, or a reflection of the fact that doctors have a tough time comprehending the nature of this complex, chronic disease?

I'm sure many of those doctors - and many other health professionals besides - steer clear of the disease of addiction because in their heart of hearts they think it's a "social problem" - like poverty or crime - rather than a medical issue. But once one meets the criteria for dependence (addiction), all criteria for a medical disease are met. We know the etiology and have highly-defined diagnostic signs for alcohol/drug dependence.

The fact is, addiction is a chronic disease that does respond to professional interventions by physicians and other professional caregivers. No, we don't have a cure - a silver bullet, as it were - for alcoholism and addiction to other drugs. But neither do we have a cure for asthma, hypertension, diabetes or arthritis. Yet I don't hear us giving up on the millions of men and women afflicted with those chronic diseases.

Certainly, no one can deny that the disease of addiction to alcohol and/or other drugs has tremendous public health consequences. Fourteen million Americans have serious health problems because of their drinking; eight million men and women suffer from alcoholism. The total economic toll of addiction to alcohol and/or other drugs is a staggering \$300 billion a year - lost productivity and costs associated with law enforcement, health care, justice, welfare, and other programs and services.

In all candor, it must be admitted that "treatment" is sometimes its own worst enemy. So-called "treatment programs" in prisons are often marginal at best. "Treatment programs" with short lengths of stay (often just four to seven days) can barely detoxify the patient, much less start real treatment. "Treatment centers" staffed by caregivers with little or zero appropriate training in or knowledge of addictive disease tarnish the whole field.

The latest "hit" treatment has taken is the spate of "reality TV" shows purporting to profile alcoholics/addicts, witness the "intervention," document the "treatment process" and then report on the patient's "recovery." These shows are by their very nature both exploitive and sensational. They violate a core tenet of treatment and recovery: the right of the patient to confront his/her disease in a safe, private place.

JOHN SCHWARZLOSE, PRESIDENT
BETTY FORD CENTER AT EISENHOWER

UPCOMING EVENTS FOR YOUR CALENDER

The *National Association of Addiction Treatment Providers* Board of Directors will hold its winter/spring meeting on *February 7-8, 2006* in Phoenix, AZ.

The Society for Research on Nicotine and Tobacco (SRNT) will hold its 12th Annual Meeting on *February 15-18 in Orlando, FL*. For more information, visit www.srnt.org.

The American Association for the Advancement of Science will hold its annual meeting on *February 16-20 in St. Louis, MO*. For more information, visit www.aaas.org/meetings/annual_meeting/.

The National Center on Addiction and Substance Abuse at Columbia University (CASA) will hold a conference titled "Women under the Influence. Substance Abuse and the American Woman" on *March 2, 2006 in New York City*. The keynote address will be delivered by Nora D. Volkow, M.D. Director of the National Institutes on Drug Abuse. For more information or to register, visit www.casacolumbia.org.

US Journal Training will host the NEUROSCIENCE MEETS RECOVERY CONFERENCE, *MARCH 9-11, 2006 at the LAS VEGAS HILTON* and the 10TH RENEWAL CONVENTION ON ADULT CHILDREN, RECOVERY &

TRAUMA, *MARCH 29-APRIL 1, 2006 at the LAS VEGAS HILTON* -For Brochure Contact 800 441 5569

The Association for Addiction Professionals, NAADAC, will hold its 2006 Advocacy Action Day (March 23) and Workforce Development Summit (*March 24-25*) in Washington, DC. For more information, visit www.naadac.org.

The 5th Annual Alberta Conference on Gambling Research "Social and economic costs and benefits of gambling" will take place on Friday, April 21 & Saturday, April 22, 2006 at the Banff Centre, Banff, Alberta. http://www.abgaminginstitute.ualberta.ca/2006_conference.cfm

The American Society of Addiction Medicine (ASAM) will hold its 2006 37th Annual Meeting and Medical -Scientific Conference, *May 4-7 in San Diego*. Call ASAM office at 301-656-3920 for more information, or visit www.asam.org/conf/cong_gf.htm.

The National Association of Addiction Treatment Providers will present their annual *Leadership Conference, May 19-23, 2006 in West Palm Beach, FL*. For more information, visit www.naatp.org.

NAATP VISIONS

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V I S I O N S

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