

March, 2007

THE NAATP ANNUAL LEADERSHIP CONFERENCE IS JUST AROUND THE CORNER!

“San Diego is a coastal Southern California city located in the southwestern part of the continental United States. As of 2005, the city has a population of 1,255,540 people. It is the second largest city in California and the seventh largest in the United States. It is the county seat of San Diego County. The San Diego metropolitan area has over 2.9 million people while the larger metropolitan area which includes Tijuana, Mexico, is the 21st largest in the Americas, with a population over 4.8 million.”

The picturesque setting provided by San Diego and the surrounding area will be the location for the 2007 NAATP Annual Leadership Conference. With beaches, waves, sail boats and so much more, this beautiful location will again host the NAATP annual gathering. The Loews Coronado Resort, located on Coronado Island, will be the location for exhibits, receptions, golf, presentations, and the innumerable conversations which have come to shape and describe this annual conference.

The bookend presentations for this Sunday through Tuesday noon conference will feature Mr. Stephen Ummel who will open the conference with a presentation on leadership. Mr. Ummel will share his ideas about leadership development as well as succession planning. This is an extremely important presentation as leadership development has been a consistent theme of the association for the past several years. One glance at the organizations represented by NAATP will verify how critical it is for us to be intentional about grooming and selecting leaders for the future. Mr. Ummel brings a very impressive background to this presentation in the area of healthcare leadership.

Mr. Ummel was appointed Director, Healthcare Advisory Practice at PricewaterhouseCoopers in September 2003. He has leadership responsibility for multiple, major clients as relates to relationship management, business development and sales, engagement delivery, client satisfaction/quality, educational offerings, and providing other value-added services. PWC is one of the leading health consulting practices with a full range of offerings.



Stephen Ummel

From 1996 to 2003 Mr. Ummel was Principal and National Advisor on Integrated Delivery Systems at Cap Gemini Ernst & Young LLC (Health Care Consulting), Chicago. In this strategic advisory capacity he consulted healthcare providers in consolidation, operations improvement and repositioning.

At the other end of the conference, the closing presentation will feature William Cope Moyers who is no stranger to NAATP or to the addiction treatment field. William has been crisscrossing the country speaking about his own recovery as well as encouraging others



William Cope Moyers

to join him in erasing the stigma associated with this disease and forcing audiences to put a face with the diagnosis of alcoholism and other drug addictions. William has recently published his story of addiction and treatment; *Broken: My Story of Addiction and Redemption*. For this publication the National Association of Addiction Treatment

Providers will present William with the 2007 Michael Q. Ford Journalism Award.

Between these two bookend presentations, there will be receptions, a Sunday evening where Judy Collins will speak and sing, a presentation on how to develop research programs at the organizational level, presentations on how to manage multi-site locations, the awarding of the Dan Anderson Researcher of the Year award presented by Hazelden Foundation at the NAATP annual conference and so much more.

If you have not received a registration form, you are invited to go to www.naatp.org and you will find a registration form waiting for you. This event is as



Judy Collins

much of a celebration as it is a conference, so plan now to be present for the 2007 celebration and begin at the same time to make plans for the 2008 celebration which will be the 30th anniversary of NAATP.

IN THIS ISSUE...

- | | |
|-----------------------------|------|
| • NAATP Annual Conference | P. 1 |
| • Washington Update | P. 4 |
| • Career Opportunities | P. 5 |
| • Welcome New NAATP Members | P. 6 |



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RJH SEES IT

One blustery, but clear day in early March, I spent the entire day along with a number of my colleagues representing other organizations in the area of addiction and addiction treatment, following hallways, maps on the wall and other forms of instructions so that we could navigate our way to a variety of members of congress as we presented them with a unified message about the state of addiction treatment. In preparation for this rather historic event, we had agreed that our message would have a three fold focus. While all of us would have liked to have added our particular twist to each topic, and even perhaps enlarge the number of issues, we did stick to our game plan. Our day was to focus on 1.) Federal Budget issues, especially the addiction treatment and prevention block grant issues; 2.) Discrimination in its many facets; and 3.) Workforce development related issues.

Appointments made and armed with a crisp packet to leave at each office, we set out early on this particular Tuesday morning. It did not take me long to make a number of observations and in some cases draw some conclusions. I would like to share them with you in that they may be helpful as we continue to plot our course in the entire area of public policy.

1. On this particular Tuesday, it seemed that every other group in the country had the same idea as we did. The hallways were crowded, the offices overflowing, and in many cases there were two or three different groups in the same congressional office at the same time meeting with different staff members. **Almost everyone and every group has some thought about everything that is going on, whether or not it is an official bill.**
2. As we went from office to office, it became apparent that some offices had more interior rooms, some had larger reception areas, and some had views which were actually appealing. Not all offices are the same. **The government (whatever that is) works on a rewards system which says that if you get re-elected often enough you get rewarded with the location of your office. Your floor number, whether or not your office is in the corner of a floor or the middle, etc is based on getting re-elected and having "seniority". Rewards are not necessarily connected to accomplishments to the greater good of society!**
3. Our elected officials in Washington have staff persons, most of which are assigned a particular area of interest. On this Tuesday, I saw these staff persons fill pages of notes from presentation after presentation as one group after another kept their appointments. **How do those notes get translated to information presented to the congressional official? Who determines what information gets passed along and what information gets filed as interesting but not essential?**
4. The House and the Senate office buildings are not new buildings. It is not easy to get from one office building to another and one wrong turn and 10 minutes later you realize you are not close to where you want to be. The Speaker of the House has her office in the Capitol building which are accessed via long narrow winding hallways, all staffed by security. **It is not hard to believe that the stories and rumors about hidden "hideaways" and secret meeting rooms are not only true, but bigger than life.**

As the sun began to sink low in the western sky on that Tuesday, we completed our visits to seven different congressional representatives. We met with congressional aids and they took notes, collected our business cards and received our prepared information. We spoke to them about budget issues including the cost shifting away from insurance payments to funded programs which puts increased pressure on the federal budget. We spoke about discrimination and the need for federal parity legislation, pointing out to them that we hoped if they were not co-sponsors of the House bill, they could consider doing so. We also spoke about how other health care fields have received some help from the federal government around work force issues and hoped that they would consider this as well.

In two instances, we actually spent some time with the elected officials themselves, though they were always watching the clock and listening for the bells ringing indicating a vote on the floor of the House was imminent. When meeting with the elected officials, they were courteous, had some understanding of our issues and were especially clear about accountability issues. "Any money allocated needs to be tied to accountability measures", was more than a prepared statement; it seemed like a genuine commitment.

As the sun rose the next day in Lancaster, letters of appreciation were sent and more offers to assist them with any questions, or concerns they might have in the area of addiction treatment. And, I suspect, while I was writing the letters thanking them for taking the time to meet with me, another bus load of persons and another plethora of organizations were keeping their appointments. To keep this on the radar screen of these individuals we need to make sure that we build the case for them as to how this impacts their constituents (they want to get elected again and get the bigger office), we need to be ready to answer the questions of accountability and outcomes and we need to offer them a way to take credit for what we do. That is what I learned this day in March, but I will be back to learn more as I am sure many of you will also make the journey to our nation's Capitol.



THAT'S THE PERSPECTIVE OF RJH

H.R. 1424, THE “PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT”
INTRODUCED IN HOUSE OF REPRESENTATIVES

In the House of Representatives, Rep. Patrick Kennedy (D-RI) and Rep. Jim Ramstad (R-MN) introduced H.R. 1424, the “Paul Wellstone Mental Health and Addiction Equity Act” with 254 original House cosponsors. H.R. 1424 would expand the Mental Health Parity Act of 1996 by requiring group health plans that offer benefits for mental health and addiction to do so on the same terms as benefits for substantially all medical and surgical benefits. The Kennedy-Ramstad legislation is modeled after the Federal Employees Health Benefit Program, which covers Members of Congress and other federal workers and dependents and which implemented equality in mental health and addiction coverage in 2001. The legislation includes a provision that no State laws that provide greater consumer protections, benefits, methods of access to benefits, rights or remedies would be preempted. In regards to scope of coverage, H.R. 1424 applies to group health plans with 50 or more employees.

Key provisions of the legislation include:

Treatment Limits:

- If the plan or coverage does not include a treatment limit (defined as a limitation on the frequency of treatment, number of visits or days of coverage, or other similar limit on the duration or scope of treatment under the plan or coverage) on substantially all medical and surgical benefits, the plan or coverage may not impose any treatment limit on mental health and substance-related disorder benefits that are classified in the same category. If the plan or coverage does include a treatment limit on substantially all medical and surgical benefits, the plan or coverage may not impose such a treatment limit on mental health and substance-related disorder benefits that is more restrictive than the limit that is applicable to the medical and surgical benefits.

Financial Requirements:

- If the plan or coverage does not include a financial requirement, such as a deductible, a limitation on out-of-pocket expenses, or similar financial requirement on medical and surgical benefits, the plan or coverage may not impose such a requirement on mental health and substance-related disorder benefits.
- If the plan or coverage includes a deductible, a limitation on out-of-pocket expenses, or similar financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits, it should be applied to both medical and surgical benefits and to mental health and substance-related disorder benefits in the same manner. Financial requirements cannot be imposed on mental health and substance-related disorder benefits in a way that is more costly than the requirement applicable to other comparable medical and surgical benefits.

Availability of Plan Information:

- The criteria for medical necessity determinations made under the plan with respect to mental health and substance-related disorder benefits shall be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

- The reason for any denial of reimbursement or payment for services with respect to mental health and substance-related disorder benefits shall, upon request, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary.

Additional Key Provisions:

- If the plan or coverage offers out-of-network benefits for medical and surgical benefits under the plan, then it must also offer out-of-network coverage for mental health and addiction benefits.
 - The Government Accountability Office (GAO) shall conduct a study that evaluates the effect of the implementation of the amendments made by this Act on—
 - the cost of health insurance coverage
 - access to health insurance coverage (including the availability of in-network providers);
 - the quality of health care;
 - Medicare, Medicaid, and State and local mental health and substance abuse treatment spending;
 - the number of individuals with private insurance who received publicly funded health care for mental health and substance-related disorders;
 - spending on public services, such as the criminal justice system, special education, and income assistance programs;
 - the use of medical management of mental health and substance-related disorder benefits and medical necessity determinations by group health plans (and health insurance issuers offering health insurance coverage in connection with such plans) and timely access by participants and beneficiaries to clinically-indicated care for mental health and substance-use disorders; and
 - other matters as determined appropriate by the Comptroller General.
 - Every two years, the Comptroller General shall submit to each House of the Congress a report on obstacles that individuals face in obtaining mental health and substance-related disorder care under their health plans.
 - Within 18 months of the date of the enactment of this Act, the Comptroller General shall submit to each House of the Congress a report on availability of uniform patient placement criteria for mental health and substance-related disorders that could be used by group health plans and health insurance issuers to guide determinations of medical necessity and the extent to which health plans utilize such criteria. If such criteria do not exist, the report shall include recommendations on a process for developing such criteria.
- H.R. 1424 was referred to the House Committee on Energy and Commerce, and in addition to the House Committees on Education and Labor, and Ways and Means. More information regarding H.R. 1424, including the complete text of the bill, can be found at <http://thomas.loc.gov>.

CAREER OPPORTUNITIES

La Hacienda, located in Hunt, Texas, is a privately owned inpatient drug and alcohol dependency treatment center located 75 miles northwest of San Antonio in the heart of the beautiful Texas Hill Country. Our treatment program is based on 12-Step recovery principles and our goal is to provide our patients with quality care. Do we meet that goal? Dr. Phil thinks so! He has repeatedly told his audience of his confidence in La Hacienda. How do we accomplish that goal? With the backing of committed owners, long tenured dedicated staff members and over 30 years in the business.

We are currently seeking the following professional to join our dedicated family:

Case Manager – Adult Program

We are seeking a dedicated energetic professional to assume primary responsibility for case management of an assigned case load. Duties include assessment, treatment planning, individual and group counseling, dictation, charting and communication with family members and referring agents. Our ideal candidate must hold a current Texas license (LCDC, LPC, LMSW), and will have one or more of the following: five years experience working with chemically dependent patients, a Bachelor's degree in a Human Services field or a graduate degree in a Human Services field.

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Email: greg@thebridgetorecovery.com

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To provide leadership to clinical staff including team building and development, participate in programmatic improvements, and ensure facility performance objectives are aligned with strategic plan in our Adult Relapse Unit. Must have effective leadership skills that foster teamwork, proven public speaking and facilitation skills, and above average organizational skills. Requires a minimum of 3 yrs. clinical exp., preferably in a CARF accredited CD facility, a Bachelor's degree in related field (Master's preferred), and 1 yr supervisory experience preferred.

Please submit resume and salary requirements to: Caron Treatment Centers, Galen Hall Road, PO Box 150, Wernersville, PA 19565 Attn: Recruiter. Fax: 610-678-8583

Email: recruiter@caron.org

www.caron.org

PRIMARY THERAPIST

Asheville, N.C. wilderness treatment center for young adults with substance abuse issues is seeking a primary therapist. Qualified candidate must have a certification or license in addiction (CSAC or LCAS) or a license in another mental health field (LCSW or LPC). Please send resume to 828-891-2224 or email thopkins@fourcirclesrecovery.com.

COUNSELORS

Sunrise House is seeking Full Time Counselors for Inpatient and Outpatient programs.

Education requirements: Degree or LCADC/ CADC Certified.
Experience in the chemical dependency field.

Please send resume to Sunrise House, P.O. Box 600, Lafayette, NJ 07848 Attention: Human Resources or Fax (973)383-3940 or Email: hr@sunrisehouse.com

Women and minorities encouraged to apply. EOE

2007 NAATP

NEW MEMBERS

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THE HASKELL HOUSE
CLIMAX, NY

CARRIER CLINIC - BLAKE RECOVERY CENTER
BELLE MEAD, NJ

CANTERBURY INSTITUTE
ISELIN, NJ

CONTINUED FROM PAGE 7

programs within our own field which, while maintaining their belief in the 12 steps and the disease model, advocate treatment programs and modalities which treat a variety of mental health problems including trauma, "co-dependency," low self-esteem, family-of-origin issues, adult child issues, etc, etc, etc as if they are the cause of the disease. Certainly, for many of our patients, these are real issues that need to be addressed, but when they become the focus of primary chemical dependency treatment, it is no wonder that the former director of SAMSHA saw no need for specialized addiction treatment specialists. Most mental health providers can address these issues equally as well as, if not better than addiction specialists.

For those of us who have been in this field long enough to appreciate the progress we have made toward recognition, professionalism, and accountability, it is frustrating to watch new people entering the field embrace a "mental health model" as if it is a new and innovative form of addiction treatment instead of a return to a failed model that has been dressed up in new "jargon".

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By offering education and training opportunities which emphasize the history of our field and its importance to our future survival, NAATP can provide an invaluable service to traditional 12 step based programs. While I continue to talk to our staff about the 41 year history of Cumberland Heights and the addiction field in general, I can sometimes sense the eyes of the newer employees starting to roll and almost hear the "Oh no, here goes the old man with the history stuff again". NAATP is in a unique position to validate our local efforts and emphasize to our future leaders, the truth in the old maxim, "Those who don't learn from the past are doomed to repeat it."

JAMES B. MOORE, EXECUTIVE DIRECTOR
CUMBERLAND HEIGHTS TREATMENT CENTER

The board of NAATP has devoted significant time to the topic of succession planning and its importance to the future of our field. Planning for future leadership is important in all institutions but with the many issues and threats facing the field of addiction treatment, planning for future leadership might seem, to many, to be a topic better left to individual programs and centers. As I have attempted to address this issue at Cumberland Heights, the need for NAATP to play a major role in the training and education of the field's future leadership has become more and more apparent.

In the 30+ years I have been in the field of addiction treatment, I recently received the greatest compliment anyone could offer. It occurred last year when one of the respected "old timers" in the field, after visiting Cumberland Heights, said "you are one of those rare centers that has managed to stay current with the field while holding on to all the things that made you great." As much as I might like to take the credit for holding on to all the parts of Cumberland Heights that have made it one of the nation's great treatment facilities, the truth is that it has been a joint effort. It starts with a dedicated (but aging) board of directors who have a passion for Cumberland Heights and for helping the alcoholic who still suffers; men and women who are more interested in what is best for our patients than what is best for our business. It is also a testament to a wonderful (but aging) staff that, despite pressures from managed care, JCAHO, and others, and despite lack of dependence on "evidence based practices" and "outcome studies," tenaciously hold on to treatment modalities that many years of personal and professional experience have proven to be most effective in treating chemical dependency. From the board members to the CEO to the professional staff, we all share one thing in common. We are anchored by a connection to the past and an intimate knowledge of, and respect for, the history of the institution and the field of addiction treatment.

At Cumberland Heights and many of the older centers throughout the country, this "anchor" begins with a commitment to the program of Alcoholics Anonymous as the basis most effective treatment for the disease of addiction. Along with this commitment comes the recognition that addiction is a primary disease that is both physical and spiritual in nature and origin and that successful treatment must address both the spiritual and physical malady. We believe that for most, this process is most effectively begun by working on the first five steps of the AA program in an inpatient setting. The goal of everyone at the center, from the board of directors to the housekeeping staff, is to create a therapeutic, safe and loving environment in which patients may begin the process of achieving a "spiritual awakening," which we believe to be the key to recovery from this disease. Most of us "old timers" in the field believe in this process because we have seen it work for thousands and thousands of addicts, many of whom have exhausted the resources of both the mental health and medical professionals who they have previously turned to for help. In fact, in today's health care

environment, it is easy to forget that the whole field of addiction treatment began as a result of the failure of traditional medical and/or mental health treatment in treating addiction.

Unfortunately, as those of us who were in the field through the 1980's are painfully aware, our years of experience and observation remained mostly anecdotal. As a result, when insurance companies, managed care companies or others began to demand "evidence" that 28 days was more effective than 14 days or that inpatient was better than outpatient, we had little in the way of empirical data to offer. And to a large extent, that remains the case today. As I look at the funding for research aimed at improving outcomes, I have yet to see money for a project that seeks to show the efficacy of traditional 12-step based treatment which emphasizes the importance of a spiritual awakening as an essential ingredient of successful treatment.

But what about the new people entering our field; what about those who have no connection to the past history of their facility or the history of the field in general? As I have sought to support those who "hold on to those ideals which made us great," I have become more and more aware of the forces which are subtly but persistently undermining our efforts.

My earliest recollection of this process began in the early 80s when a surveyor from JCAHO noted that our treatment plans were not "individualized." It was not that the plans did not employ differing techniques to help the patients personalize or apply the steps in their own lives; this surveyor maintained that the program itself did not allow for individualized treatment since all patients participated in essentially the same groups and lectures. As therapist began to attempt to "individualize" treatment plans, the plans themselves began to reflect less and less of what was actually going on in treatment.

This process was made much worse with the advent of managed care and placement criteria. As therapists became more familiar with factors which could be used to gain the patient a few more days in inpatient treatment, the treatment plans began to look more and more like plans to address the symptoms of the disease instead of plans to address the disease itself. Treating "trauma", depression, homelessness, or a toxic home environment would gain additional days in treatment whereas treating "denial" was a sure ticket to discharge or at best, outpatient treatment.

None of this should be construed to discount or minimize the importance of treating the individual or to deny that many patients presenting for treatment today have more complex issues or co-occurring disorders than did the patients of 25 years ago. The danger lies in the message being sent to new people entering the field. Regardless of how much we may say that addiction is a primary disease, if insurance companies and regulatory bodies continue to confuse treating the symptoms of the disease with treating the disease itself, we will continue to fight an uphill battle. Perhaps even more threatening are

CONTINUED ON PAGE 6

UPCOMING EVENTS FOR YOUR CALENDER

Haymarket Center will present the 2007 Spring Workshop Series starting on **February 17, 2007, thru April 14, 2007** (selected Saturdays) at Haymarket Center, 932 W. Washington, **Chicago, Illinois**. For more information, contact Carol Blyskal at (312) 226-7984 x314 or view our website at www.hcenter.org.

The National Association of Addiction Treatment Providers presents its Annual Leadership Conference in **San Diego, CA, May 19-22, 2007** at the Loews Coronado Bay Resort. For more information, visit www.naatp.org.

The Refuge will hold a Somatic Experiencing® training in Florida! Developed by Peter A. Levine, Ph.D., author of *Waking the Tiger*, it is a naturalistic approach to healing trauma. This Beginning level training is co-sponsored by The Refuge and will be held at their facility **June 1-4, 2007**. Visit www.traumahealing.com or call 303-652-4035 for additional information.

The National Council on Problem Gambling will hold its national conference "Gambling and Co-Occurrence: Improving Practice and Managing Consequences," **June 9-11, 2007 in Kansas City, MO**. For more information, visit www.ncpgambling.org

Treatment Solutions 411 will present a Back to Basics Labor EAP conference **APRIL 26TH 27TH at the Trump Plaza Hotel and Casino in Atlantic City**. Register

online at www.treatmentsolutions411.com/register.html

SAVE THESE DATES for the **Haymarket Center** upcoming 13th Annual Summer Institute on Addictions on **June 27, 28, & 29, 2007, at The Drury Lane in Oakbrook Terrace, Illinois**, with nationally-known speakers: Stephanie Covington, Ph.D., Earnie Larsen, Peter Bell, Stanton Peele, J.D., Ph.D., Cardwell C. Nuckols, Ph.D., and Delbert Boone. For more information, contact Carol Blyskal at (312) 226-7984 x314 or view our website at www.hcenter.org.

Ben Franklin Institute will present the 2007 Summits for Clinical Excellence Conferences **April 13 PHILADELPHIA, PA; June 21-24 LAS VEGAS, NV; July 19-22, BOULDER, CO; October 18-21, TEMPE, AZ**. For more information, visit www.BFIsummit.com or call 1-800-643-0797.

The Ohio State University and the Ohio Department of Alcohol and Drug Addiction Services presents the Annual Addiction Studies Institute **August 14-17, 2007** at the Greater Columbus Convention Center in **Columbus, Ohio**. Contact Garrison and Associates, Inc. at 614.273.1400 or email asi@garrisonevents.com

NAATP VISIONS

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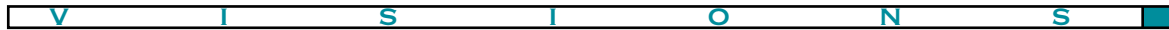
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