

IT ALL BEGINS WITH THE NAATP BENCHMARK SURVEY

As the Addiction Treatment field moves forward and participates in the health care reform discussions, we are going to be challenged by the recurring theme in this discussion known as “best practice”. There is a growing commitment on the part of the key participants in this discussion to focus on identifying best practices in addressing the treating of acute diseases and managing chronic diseases. This emphasis means that we identify the clinical interventions which provide the optimal results and which can be provided in the most cost efficient manner.

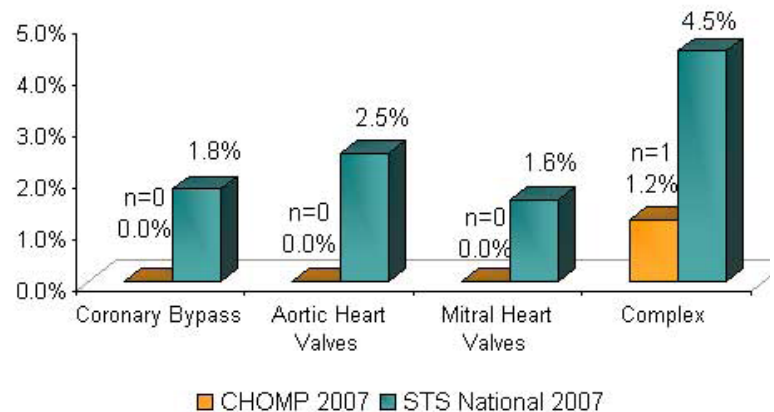
As the conversation intensifies, there is even talk about linking payment to performance so that those who provide the most optimal results with the least amount of resources will be the most favorably reimbursed. This concept will be or can be applied to heart disease, kidney stones, the management of diabetes and a plethora of other diagnoses. Yes, it can even be applied to the treatment of addictive disease disorders. And that is where the challenge will begin. How do we begin to arrive at some consensus as to what the optimal results of treatment ought to be and how do we then compare what we individually do to that standard?

As the discussion, debate and formulation of policy around health care reform takes place, we have argued that we need to be at the table as an active participant. In fact, some in our field have suggested that any health care reform that does not include a strong commitment to addressing the disease of addiction will be doomed to failure. Make no mistake about it, this health care reform process will be serious and it will shape the future. **If we want to be at the table and if we want to participate in the discussions, then we are going to have to understand the rules, play by the rules and be ready to understand that we will need to shed our ambiguity about being part of “mainstream” health care in this country.** We will be held to the same standards as other diseases will be held!

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Mortality vs. National Rate



One of our challenges then will be to determine just what it is that will constitute this optimal result. My prediction is that this is what will be covered in any reimbursement plan, be it one funded by the government, or by the private sector. For the past eleven years, the National Association of Addiction Treatment Providers has been gently nudging its members along to begin to standardize some of their processes and their outcomes so that they can be measured and consequently “benchmarked” against each other.

In the business world it is easier because we regularly ask; “Who is the best sales organization? The most responsive customer service department? The leanest manufacturing operation? And how do we quantify that standard? Once we decide what to benchmark, and how to measure it, the object is to figure out how the winner got to be the best and determine what we have to do to get there. The assumption here, of course, is that we are all producing the same widget or we are all working toward the same goal. Healthcare has moved into this later, but we now know that in many states, comparative data is provided to show the relative cost to provide the same procedure and get the same outcomes from one hospital to another. **They are benchmarked against each other!**

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as **RJH** sees it....

THE THREE LEGGED PUBLIC POLICY APPROACH

Almost everyone knows that to have any stability, you need to have at least three legs on a stool! One leg just does not get it done, two legs take an awful lot of balance, but three legs provide stability and you can use the stool and get things done. The same thing is true with public policy; you need to have a three legged approach in order to be effective. **The National Association of Addiction Treatment Providers has such an approach!**

NAATP has spent a lot of time lately testing the waters, designing approaches and evaluating just how to put the three legs of this plan together. It is now in place and it is working! At a pace which is almost impossible to process, there are new reports that have significant implications for the addiction treatment world. In addition to information about the *stimulus package, the credit issues, the unemployment impact and the need to solidify "consumer confidence"*, there are other very significant issues which also have a direct impact on us.

While we have been doing what we do every day, the discussion about *Health Information Technology* has more than heated up; it is front and center in the stimulus bill! Without a blink of an eye we are now back examining ways to engage in health care reform which should include the reimbursement portion of the equation. We still have Parity which was passed in 2008 and now we need the regulations written to ensure that there is some leverage in the bill as well as language which will help us in the health care reform discussions. And, if that were not enough, we have a bill originating in the House (H.R. 911) which seeks to impose an additional layer of reporting, oversight and potential penalties on organizations that offer services to adolescents. These and many more items will keep our plate full in the days, weeks months and years to come!

In order to address these issues and to ensure that our thoughts and ideas get into the discussion, the National Association of Addiction Treatment Providers has developed the following approach to its public policy activities

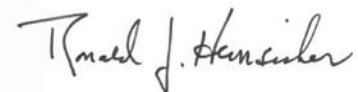
1. First we have a system in place to continuously update you the membership on issues, actions and events that are central to addiction treatment. Updates via email distribution lists is the fastest and most effective way to get to you the information you need to make decisions and to inform your staff about events happening. You have and will continue to receive information about the items referenced above and others that impact you and the work you do. You will also be provided information and directions when it is time to contact your decision makers about your positions on key issues. Between the NAATP newsletter and emails *blasts* you will be kept informed.
2. NAATP and NAADAC have been working together to develop single positions on such key issues as parity regulation language, health reform and H.R.

911. These statements are critical so that when we meet with decision makers, we have a clear message, it is consistent and we are very precise in what it is that we are asking for from them. Our public policy consultant develops a strategy as to whom we need to meet with and how best to present our message. Given the fact that on most issues there are many voices attempting to get the attention of the decision makers, a strategy which identifies the best chance of impacting the outcome is very important!

3. The last leg of this stool is a Political Action Committee (PAC). For NAATP, this is a brand new endeavor. Political Action Committees are the tools used to help support and elect those individuals who are not only sympathetic to our causes, but who are willing to listen to us and carry our message. NAATP has developed a PAC and will roll out this effort at the national conference in May. The PAC can only receive money from individuals and not from organizations. As we roll out this effort we will also provide all of the details on the PAC. But it is now the third leg of a very important strategy for both today and for the future.

This public policy effort is going to take a significant amount of resources on the part of NAATP. It will take time, energy, attention and finances. A lot of other organizations, some of which do not share our interests have been at this for a long time. They also have considerably more resources than we do to carry out their strategies. Nevertheless, we must be "at the table" as they say as decisions are made about health care reform (we cannot be excluded, but only we can make that argument); we must be at the table as the regulations are written for parity, and we must be at the table as health IT conversations take place.

NAATP is currently committed to not altering the dues structure for this effort and is funding this out of general operating costs as well as contributions from member organizations that are able to assist with this effort. If you have an interest in helping to fund this activity, contact the NAATP office for more information. Our public policy effort is not just about today, it is also about tomorrow and the tomorrows to come. Addiction treatment must be included in every possible health plan proposed, it must be accessible to everyone who wants it and reimbursement must be reliable and commensurate with the services provided. We are the only ones that can make this case!



Ronald J. Hunsicker
President/CEO, NAATP

THE 2009 NAATP BENCHMARK SURVEY IS NOW READY FOR COMPLETION



WE NEED YOU TO PARTICIPATE IN ORDER FOR THIS TO BE ANOTHER SUCCESSFUL EVENT!

We are very pleased to announce that the 2009 NAATP Benchmark survey instrument is now ready for completion. All surveys need to be completed by April 30, 2009! *This is the only benchmark information available that is addiction treatment specific. You must complete the survey to receive a copy of the results.* All respondents will receive a color copy of the results where the collected data points will be displayed on individual graphs with the average and standard deviation indicated. You will also receive a cover letter identifying your bar number on the graphs, while the other participants will remain anonymous to you. This benchmark survey provides you with information and a graphic display as to how you *benchmark* in a wide variety of areas to other addiction treatment organizations who are members of the National Association of Addiction Treatment Providers

NOTE: You may complete more than one survey if you have “discrete” programs or product lines that you would like compared to each other and to all others who complete the survey. You may only want to complete the *individual* areas of each survey and then report the “financial and administrative” information on one survey. All of the information you provide will remain strictly confidential and only accessible by the NAATP executive.

When the reports are complete, you will also receive information on how you can receive custom reports that compare you to “most like” programs and/or look at your trends over the 10 year history of this data being collected.

AS YOU COMPLETE THE SURVEY, WE ASK THAT YOU PAY PARTICULAR ATTENTION TO THE FOLLOWING GUIDELINES AND SUGGESTIONS:

Important Guidelines:

- Make sure you are using the most up-to-date version of Adobe Acrobat Reader. There will be a place for you to *click* on the website to download the most recent version of Adobe Acrobat Reader.
- To access the survey visit: http://www.naatp.org/survey/benchmark_survey/survey.php
- Print out a hard copy for your reference and note information that needs to be collected. *If you would like to print your completed form you must print one page at a time.*
- The information that is requested is for your most recently completed fiscal year!

- You do not need a password to begin the survey, simply click **start** . If you do not complete the survey in one session you may choose to save the survey. You will be prompted to provide an email address and create a password. Please write down this username and password, as you will need it to access your survey later.

EXTREMELY IMPORTANT: Because Zeros can skew the reported averages all instances where a cell contains a zero will be recorded as null or N/A. If you do not have the information or wish to skip a question you may leave the zero in the cell and it will be deleted on the backend. If there is an instance where you need to report a zero please email Angela Abshire at aabshire@naatp.org

Once you have completed the survey, you can click “Submit”. *If you receive a warning indicating there are errors please look for the cell(s) outlined in red. There are a few questions that require an answer in order to submit the survey. If you have double checked your data and still are unable to submit please save the survey and email aabshire@naatp.org and she will submit the survey for you.*

Because of the cost involved in re-configuring the collection instrument in this web based application, we needed to go with the same instrument we used last year. We will be exploring other options for 2010.

Thank you very much for your assistance in making this a very successful and valuable resource for the National Association of Addiction Treatment Providers members.



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CONTINUED FROM PAGE 1

The time is nearly upon us when we are going to need to determine just how we are going to benchmark ourselves. The time is nearly upon us when we are going to need to determine what best practices look like in addiction treatment and how to get those results in the most cost effective manner. Remember, the ultimate goal at the end of the day in this health care reform debate is to reduce the cost of providing health care in this country. What everyone agrees on is that as a country we cannot remain competitive as long as health care costs what it does today and continues to rise at the rate that it has in the past ten years!

Therefore, it all begins with benchmarking. Once again the National Association of Addiction Treatment Providers has a process in place for a beginning comparison in a wide variety of areas. Like every other effort, it is not perfect! But it is a beginning. We need to have as many of our members participate as possible and begin then to utilize the results. Questions like:

- I wonder why the average wait from first call to first appointment in my organization is 23 hours below the average.
- I wonder why the AMA rate in our organization is

some of the lowest in the country. Are the processes we use "best practice" and how can we duplicate them in other organizations.

- I wonder what happened to the 27% of scheduled admissions that never show up for actual admissions.

This list could go on and on, but the point is that the benchmark survey provides us with the opportunity to begin to determine what best practices are and perhaps to get some feel about where those numbers ought to be. We are going to have to be willing to go to the table and talk about best practices, we are going to need to talk about optimal results, we are going to have to participate in talking about resource management to get optimal results. For many of us, we know what we would like to see happen to persons in addiction treatment, we are less comfortable talking about what we can afford. The health care debate, will be an opportunity for us to talk both about what we want (wish for) and what is affordable. This may not be comfortable, but it will get us and keep us at the table. It all begins with participating in the NAATP benchmark survey and then taking the results and asking all the questions we can.

LOWERING THE DRINKING AGE MISSES THE POINT

On Feb 22, 2009 on the CBS TV program *60 Minutes*, the debate about lowering the drinking age continued as a segment on this program, hosted by Ms. Lesley Stahl presented the arguments for why it was not working to having the legal drinking age at 21. The argument for lowering the drinking age was primarily presented by Mr. John McCardell the former president of Middlebury College in Vermont and Mr. Mark Beckner, the chief of police in Boulder, CO. The argument of both of these individuals was that the current situation was not working on college campus. Because it is not possible or affective to enforce the current drinking age, the argument has been to lower the drinking age and then push the responsibility and liability to another segment of our society. *When will we stop pushing the issue to someone else instead of looking squarely at the responsibility side?*

Granted, this is a very complex issue and simple solutions will do little to effectively address the issue. To simply lower the drinking age will not solve anything! Likewise, to keep the drinking age at 21 and to ignore the carnage which is taking place in our society is also equally irresponsible! At the very least there is a ton of irresponsible drinking going on and there are alcoholics who are in the process of killing themselves with their drinking be it legal or illegal.

On the recently aired *60 Minutes* McCardell suggested that every college student needed to take a course in alcohol and the chemistry of this drug and only if they passed it would they be granted a "drinking license". On the surface this might have some merit. However, if college campuses do not want to enforce the underage drinking now, who is going to enforce the drinking license? It does not sound like the police chief of Boulder, CO has any interest in this.

But it might be a beginning. What if everyone needed to take a course in alcohol and *alcoholism*? What if everyone needed to take a course in the effect of alcohol on the brain? What if everyone was screened for their predisposition toward alcoholism? What if everyone was tested for blood alcohol levels at major public events? What if major piece of machinery (including cars and trucks) were equipped with sensors that would make it impossible to start if the operator tested higher than a normal blood alcohol level? We screen for Cancer, we screen for diabetes, we screen for heart disease. It is too much to ask that we screen for alcoholism as well?

Before we go down the path and think that there is magic in the drinking age, it really does not make any difference whether or not it is 16, 18, 21 or 25. The issue is awareness and responsibility. Let us stop thinking that age is the issue. Instead, can we learn from those that are in long term recovery...recovery is responsibility! We need to get back to promoting responsibility at every age! Until we treat this as a disease and not just a social inconvenience we will continue to look for ways to pass the issue off to someone else. Recovery is about responsibility and perhaps if we focused on recovery, for those with the disease and for those setting policy, we might make some progress.

VISIONS

ADVOCACY IN ACTION CONFERENCE HAS COME AND GONE, BUT ADVOCACY CONTINUES

For the 23rd time individuals gathered in Washington, DC to be briefed, to be trained, to be encouraged and then they headed out on March 10, 2009 for visits with their elected officials on Capitol Hill to carry the cause for addiction treatment. Like every other group that has a cause, an issue and an interest, the addiction community must make its message heard and must be clear about what its message is! With the collaborative effort of the National Association of Addiction Treatment Providers and NAADAC this conference prepared the 100 plus attending individuals to take a very consistent and precise message to the "Hill".

For two days prior to the Hill visits, the participants were able to attend panels and individual presentations as varied as:

- Current Issues in Addiction Policy
- The future of Addiction Treatment in Medicare and Medicaid
- Health Care Reform in 2009 and Beyond
- Is it time to lower the drinking age
- What's Next for Insurance Parity

In addition to these sessions, there were awards, recognition of legislators who have championed our cause and who can be counted on in the future. Senator Edward Kennedy and Senator Michael Enzi received the Legislator of the year awards.

Those that attended were encouraged to take a very modest but bold message to all their elected officials asking them to be committed to ensuring that in any health care reform proposals that there is equal and complete inclusion of Addiction Treatment Services. The NAATP/NAADAC Public Policy effort will be following up on these visits to provide information to those contacted during the Hill visits.

Watch for other articles and email communication on how we are positioning ourselves to carry the message that not only does the benefit need to include addiction treatment but that there must be reform in the way that persons access this benefit and how care for the treatment of this disease is available throughout the life of the individual.

There is a lot of work to be done, but you have a team in place working for you!

PUBLIC POLICY



ECHOING KENNEDY EFFORTS, BAUCUS SPREADS REFORM EFFORTS

Senate Finance Chairman Max Baucus will share with committee members from both sides of the aisle Thursday his intention to divide the panel's pursuit of universal health coverage into a few key areas, sources said.

The idea is to tackle cost containment, insurance coverage and payment system improvements separately. How exactly Baucus plans to divvy the workload, potentially by centralizing the heavy lifting with his staff or assigning members to work on the different issues, is unclear.

The arrangement might resemble one set up previously by Senate Health, Education, Labor and Pensions Chairman Edward Kennedy. Kennedy set up three working groups headed by different members of his committee on prevention and public health, quality improvement and insurance coverage. The working group leaders already have held a few hearings.

Kennedy plans to return to Washington this week, spokesman Anthony Coley said, though his intention is not to attend President Obama's health summit Thursday. Kennedy has been in Florida recovering from a brain tumor. He will travel between Capitol Hill and Florida until the weather is warmer, Coley said.

Baucus told reporters at a breakfast meeting Tuesday he and Kennedy have talked regularly by phone. "We're moving in tandem," Baucus said.

While the top healthcare senators will break bread together this week, behind the scenes health wonks are wondering whether the committees are collaborating as well as they put on.

"I hope it's not a fight, and I don't have to referee," Senate Majority Leader Reid said Tuesday when asked about the potential for jurisdictional clashes.

A Baucus aide said Tuesday the committees anticipate syncing their timelines for moving universal health efforts along jurisdictional lines and eventually merging those ideas into one bill. Baucus said he would like to have a bill ready for debate on the Senate floor by early summer.

Baucus focused Tuesday on payment and delivery system changes that would base healthcare provider payments more on quality. He also said improvements could include bundled payments where healthcare providers are paid one sum rather than separately for different points of care and the medical home concept that stresses care coordination.

"That, to me, is the biggest area of opportunity," Baucus said about the delivery system. "It's going to be the driver for meaningful healthcare reform."

As for the House, Baucus said he has coordinated with healthcare leaders there to some extent. "I regret that it's probably not as much as it should be," the chairman said.

He and House Energy and Commerce Chairman Henry Waxman started meeting twice a month, and he already meets with House Ways and Means Chairman Charles Rangel weekly. To a lesser extent, he has met with House Education and Labor Chairman George Miller as well.

Baucus said he hopes to expand the coordination with the House on universal health care efforts.

OBAMA STARTS BIG PUSH FOR HEALTH CARE OVERHAUL

PRESIDENT: 'THE STATUS QUO IS THE ONE OPTION THAT IS NOT ON THE TABLE'

President Barack Obama summoned allies, skeptics and health care figures of all stripes to the White House March 5, 2009 to debate ideas for overhauling the nation's costly system and declared, "*The status quo is the one option that is not on the table.*"

"In this effort, every voice must be heard. Every idea must be considered. Every option must be on the table. There will be no sacred cows in this discussion," Obama said as he opened his White House forum on what he calls the greatest threat to the foundation of the U.S. economy. The U.S. system is the world's costliest and leaves an estimated 48 million people uninsured.

Although he wants coverage for all, the president suggested a willingness to compromise even if it means not fully meeting his goal. This time, Obama said, "Each of us must accept that none of us will get everything we want, and no proposal for reform will be perfect." And, he said, "While everyone has a right to take part in this discussion, no one has the right to take it over."

Obama is setting a rigorous timeline to address the "crushing cost of health care this year, in this administration." His advisers say he's determined to pass legislation in his first year in office, and they say while he hopes for a bipartisan measure, he won't be deterred by ideological fights.

From the introduction made at the beginning of this health care summit, it is clear that this discussion and this process will be framed in the context of the current economic condition and the long term affordability of health care in this country. Therefore the tension will be to truly reform the system so that health care (including **addiction treatment and management of the disease**) are available to everyone and at the same time recognizing that the ultimate goal of reform is to reduce the cost! What is different about this discussion is that if we want our fair share of the health care dollars, then it will need to come from dollars currently used to treat other diseases, because the ultimate goal is not to add costs (new money to the system) but to actually reduce real costs. This is a challenge which will take our collective best skills to participate in the discussion, debate and decision making.

HEALTH: OBAMA LINKS ECONOMIC RECOVERY TO HEALTHCARE REFORM...

President Obama took the first step today toward what he hopes will be a major overhaul of health care in the United

States, summoning 150 lawmakers and stakeholders to the White House and assigning them a challenge that has stymied more than one president in the last 100 years. But with 47 million Americans without insurance and the system an ever-heavier burden on the economy, he said, another effort is needed. "We have talked and tinkered. We have tried and fallen short, stalled time and again by failures of will, or Washington politics, or industry lobbying," he said.

With lobbyists representing insurance, medical and corporate interests poised to protect their stakes in the system – and many of them in the East Room listening to him – Obama said he understands why so many are skeptical he can succeed 15 years after President Bill Clinton failed. "Our inability to reform health care in the past is just one example of how special interests have had their way, and the public interest has fallen by the wayside," he said. "And I know people are afraid we'll draw the same old lines in the sand, give in to the same entrenched interests, and arrive back at the same stalemate we've been stuck in for decades." Obama's goal is to enact comprehensive health reform by the end of the year. Away from the summit, leading congressional Democrats announced legislative timetables that kept that goal in mind. Senate Finance Chairman Max Baucus announced plans for a June markup and said he and Health, Education, Labor and Pensions Chairman Edward Kennedy agree that moving one overarching bill is ideal. House Majority Leader Hoyer said this morning that he wants to deal with health legislation before the August recess.

Participants in Obama's summit included 32 members of the House, 23 senators, eight "everyday Americans," and 82 stakeholders, including the U.S. Chamber of Commerce, union leaders, Blue Cross and Blue Shield and the American Medical Association. The stakes for the economy, Obama told them, are high. "Medicare costs are consuming our federal budget. Medicaid is overwhelming our state budgets," he said. He added that "skyrocketing costs" are a threat to getting the economy back on track. "Healthcare reform is no longer just a moral imperative, it is a fiscal imperative," the president said. "If we want to create jobs and rebuild our economy, then we must address the crushing cost of health care this year, in this administration." But while seeking coverage for all, he had reassuring words for those who are content with their existing care. "If you have insurance you like, you'll be able to keep that insurance," he said. "If you have a doctor you like, you can keep that doctor. You'll just pay less for the care that you receive."

HEALTH: ... AS CHAIRMAN BAUCUS LAYS OUT THREE-PART OVERHAUL PLAN

The Senate Finance Committee will tackle universal health care in three pieces as it prepares for a June markup of comprehensive legislation, Senate Finance Chairman Max Baucus said today after informing panel members of the strategy. The committee's work will be broken up into delivery system improvements, coverage and cost containment. Each topic will feature a public roundtable discussion among members and experts, beginning in late April with delivery system improvements, moving to coverage in early May and ending later that month with cost containment issues,

Baucus said. Staff will comb through specifics on each topic with members in preparation for the markup, although Baucus said he was unsure whether the sessions would be public. He is attempting to coordinate with Senate Health, Education, Labor and Pensions Chairman Edward Kennedy. The pair will meet Friday to discuss their universal healthcare strategy. Kennedy has said he wants the two committees to produce one comprehensive healthcare bill, and Baucus confirmed today the one-bill approach is his preference.

Senate Finance ranking member Charles Grassley praised Baucus' plan. "The process is worked out in a way that I think is going to encourage members to participate," Grassley said. He acknowledged members likely will encounter differences along the way. "That's why we're having so many meetings," Baucus said. "Just get these concepts out, so senators on both sides of the aisle who may want to dig their heels in a little bit are less likely to dig their heels in if there's a culture and atmosphere where we're openly discussing trying to find ways to reach a compromise and still reach an objective of getting healthcare costs down."

Baucus and the administration are likely to clash in some areas. President Obama's budget included a \$634 billion healthcare reserve fund, half of which is funded by raising taxes on the wealthy by limiting itemized deductions. Baucus questioned the viability of the plan and instead has pushed to limit the tax exclusion that prevents people from paying taxes on their health benefits. The White House is "open to listening to what Sen. Baucus has to say, this is his idea," Melody Barnes, the administration's Domestic Policy Council director, said today. "[Obama is] being very pragmatic about this. We are in listening mode and eager to engage with Congress." Baucus said he hopes to have a bill ready for the Senate floor by July.

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TREATING DRUG-ADDICTED DOCTORS IS GOOD MEDICINE

Doctors who become addicted to alcohol and other drugs can be treated successfully and returned to medical practice with the help of special programs that couple referral to treatment and monitoring with rapid responses to noncompliance, University of Florida researchers report.

The study is the first national-level analysis of such Physician Health Programs, and confirms they are effective alternatives to simply punishing drug-addicted doctors. The findings are published in the March issue of the *Journal of Substance Abuse Treatment*.

More than three-quarters of doctors enrolled in state programs stayed drug-free over a five-year monitoring period. The results were the same regardless of whether the doctor's drug of choice was alcohol, crack cocaine, prescription drugs or other substances.

"Treatment works," said Dr. Mark Gold, psychiatry chairman at the UF College of Medicine and the McKnight Brain Institute. "It has been shown now to be safe and effective and cost-effective."

But it's not just for doctors, said Gold, who with UF colleagues pioneered evaluation and treatment for drug-addicted doctors. "It should be a model for treatment of anyone with these diagnoses."

In general, rates of illicit drug use are lower among physicians than the general public, but rates of prescription misuse are five times higher among physicians, according to a 2008 review Gold co-authored in the *Harvard Review of Psychiatry*.

Gold and others conclude that drug problems in doctors are related to medical specialties that put them in regular contact with drugs of addiction, ease of access to drugs, stress and lack of early detection. Addiction also appears linked to physician-suicide.

Physician Health Programs are not addiction treatment programs, however. Instead, they provide intensive, long-term case management and monitoring. Fifty-five percent of doctors enrolled are mandated formally by a licensing board, hospital, malpractice insurance or other agency. The rest are informally "mandated" by others such as employers, families and colleagues. Doctors sign contracts agreeing to abstain from drugs or face intensified treatment, being reported to their medical licensing boards or losing their license.

The programs aim to save the lives and careers of addicted physicians, and to protect the public by addressing substance use among doctors. They are also an effective way to remove noncompliant doctors from the practice of medicine.

"This isn't to cover it up, it's quite the opposite," said Temple University psychiatry chairman Dr. David Baron, who oversees Pennsylvania's program. "It allows for quality treatment and to make sure that we're still ensuring the safety of the public." Baron was not involved in the current study.

Program measures include group and individual therapy, residential and outpatient programs, surprise workplace visits from monitors, and links to 12-step programs of Alcoholics Anonymous and Narcotics Anonymous. Doctor-patients get

care not just for drug problems, but also for accompanying medical or psychiatric disorders. They pay for their treatment, drug tests and follow-up care.

The research, funded by the Robert Wood Johnson Foundation, evaluated 904 physicians admitted to 16 state-run Physician Health Programs from 1995 to 2001. Collaborators included founding National Institute of Drug Abuse Director and former drug czar Dr. Robert Dupont, A. Thomas McLellan, of the University of Pennsylvania, and Lisa Merlo, of UF.

Previous studies have shown that in individual states, and on a small scale, the programs are effective. The current study, first reported at the Betty Ford Institute, has the largest sample of physicians ever followed, and over the longest period.

Doctors in the programs had to abstain from alcohol or other drugs, and were tested frequently at random for five or more years. If tests revealed they had returned to substance abuse, swift action was taken — doctors were reported to the medical board, which could lead to loss of their licenses.

"It's the idea of a carrot and a stick," said Dr. Scott Teitelbaum, director of the UF-run Florida Recovery Center, which treats addicted physicians referred from around the country. "There's always a level of resistance — people never feel they need the level of care that's recommended. Someone might not agree with you, but if they want to practice medicine they have to comply."

Often, with the support of peers and growing realization that treatment is working, physician-patients' motivations change from simply wanting to obey the rules to wanting to change their lives, Teitelbaum said.

One-fifth of doctors were reported to their board during treatment and monitoring — some more than once with multiple disciplinary actions taken.

But 78 percent of doctors in the programs had no positive drug tests during five years of intensive monitoring. And five to seven years after starting treatment, 72 percent were actively practicing medicine, without drug abuse or malpractice.

Eighteen percent left medical practice, while others relapsed into drug use. Three percent of those who didn't complete their programs had substance-related deaths or committed suicide.

Although the programs employed a variety of approaches, the researchers found that success was not related to specific therapists or modes of therapy, but rather to the long-term nature of the treatment.

Still, there are some "essential ingredients" that successful programs have in common, Gold said. Those include treatment extended over years — not weeks or months — and unambiguous success markers such as urine testing and return to work and normal family activities.

The above information was taken from an article published in the University of Florida News, February 24, 2009

TESTS OF CAUSAL LINKS BETWEEN ALCOHOL ABUSE OR DEPENDENCE AND MAJOR DEPRESSION

David M. Fergusson, PhD; Joseph M. Boden, PhD; L. John Horwood, MSc

Arch Gen Psychiatry. 2009;66(3):260-266.

Context There has been a great deal of research on the comorbidity between alcohol abuse or dependence (AAD) and major depression (MD). However, it is unclear whether AAD increases the risk of MD or vice versa.

Objective To examine the associations between AAD and MD using fixed-effects modeling to control for confounding and using structural equation models to ascertain the direction of causality.

Design Data were gathered during the course of the Christchurch Health and Development Study, a 25-year longitudinal study of a birth cohort of children from New Zealand (635 boys, 630 girls).

Setting General community sample.

Participants The analysis was based on a sample of 1055 participants with available data on AAD and MD at ages 17 to 18, 20 to 21, and 24 to 25 years.

Main Outcome Measures Symptom criteria for AAD and MD from the *DSM-IV* at ages 17 to 18, 20 to 21, and 24 to 25 years as well as measures of life stress, cannabis use, other illicit drug use, affiliation with deviant peers, unemployment, partner substance use, and partner criminality at ages 17 to 18, 20 to 21, and 24 to 25 years.

Results There were significant ($P < .001$) pooled associations between AAD and MD. Controlling for confounding factors using conditional fixed-effects models and time-dynamic covariate factors reduced the magnitude of these associations, but they remained statistically significant. Structural equation modeling suggested that the best-fitting causal model was one in which AAD led to increased risk of MD.

Conclusions The findings suggest that the associations between AAD and MD were best explained by a causal model in which problems with alcohol led to increased risk of MD as opposed to a self-medication model in which MD led to increased risk of AAD.

Author Affiliations: Christchurch Health and Development Study, Department of Psychological Medicine, University of Otago, Christchurch School of Medicine and Health Sciences, Christchurch, New Zealand.

INVESTOR OR PARTNERSHIP FOR REHAB FACILITY IN ECUADOR

If you are looking for an excellent investment opportunity, The Ocean Rehab, in Ecuador might be the answer. We are fully recognized by the Ecuadorian government. We are licensed for Recovery as well as Detox on the premises. We have 3 acres directly on the Pacific Ocean 4 hours by plane from Miami. The facility consists of a brand new building with 6 bedrooms, 6 ½ baths (12 client capacity). Three other buildings: 1 for the property caretakers, 1 a 2 bedroom 2 bath cottage, 1 a 4 bedroom, 4 bath house (Can house staff or clients). There is an exercise room, meeting room, large fresh water pool, tennis court (which needs refurbishing) and recreational patio with BBQ area. We have high speed internet and satellite TV. There are a great variety of activities available locally including Thermal Springs, Deep Sea Fishing, Canopy Tours, Surfing, Horseback Riding, Jet Skiing, and Museums. The property is just 15 minutes from a modern Mall and modern hospital and ER. Maintenance is low. We are fully staffed to provide food service, maid service, and custodial services. We also have an on-site American (Bilingual) manager to oversee the staff and supplies. Ultimately, we would like to offer Rehab services to both English and Spanish speaking clientele.

We would consider a joint venture with a U.S. based program to provide staffing and clients or simply an investor who wants to own a percentage in the business. Interested persons please E-Mail Joel Savitch, M.D. with what you are looking for and details will be E-Mailed back with facts and figures. 954-993-5635

Web site: THEOCEANREHAB.COM

E-Mail: SAVITCHRECOVERY@AOL.COM

LONG-TERM RECOVERY OPTIONS INCREASE LONG-TERM ABSTINENCE FROM DRUGS.

A recently released “White Paper” by CASA, the National Center on Addiction and Substance Abuse at Columbia University reported that addicted women’s abstinence from drugs and alcohol is directly proportional to the length of time they stay in a structured, long-term recovery program.

In a 2009 CASA study, long term recovery doubled rates of abstinence (47% vs. 24%) and full time employment (22% vs. 9%) for women patients by their 24th month of treatment.

A complete copy of the text of this study can be found at: <http://www.jointogether.org/resources/pdf/casasard-white-paper.pdf>.



THE 2008 SALARY SURVEY RESULTS ARE READY!

NAATP Salary Survey done in Conjunction with NAA-DAC now ready for distribution.

For those organizations which provided data, one complimentary copy will be electronically sent to you. For the rest, you can order your copy through the NAATP office by contacting Sherry Anderson at sanderson@naatp.org.

Father Joseph Martin, S.S
Friend, Mentor, Inspiration to so
many will be missed!



March 9, 2009 will be marked as the day that a very special person who meant so very much to so very many, ceased to walk among us here on earth, entertain us with his stories and encourage us with his dedication. Father, as he was so affectionately called, meant so much to so many. Father Mark Hushen, O.S.F.S. bellows shares with us the announcement of Father Joseph Martin's death.

On behalf of everyone at Father Martin's Ashley, I am very saddened to tell you that our co-founder, Father Joseph Martin, S.S. passed away this morning at the age of 84. Many of you have personally known Father for years and others of you have known him only by reputation and his legacy of leadership in the addiction treatment field. We are all indebted to him for the grace, dignity and respect that he championed in our industry as he and a precious few others paved the way for the dignified treatment of chemically addicted individuals.

You can learn the details about the services for Father, view a brief video of his life and share your own remembrances of him by visiting our website: www.fathermartinsashley.org. All of us at Ashley are committed to carrying on his legacy of love in the work we do with our community members and their families every single day. It is what Father would want us to do.

Sincerely,

Father Mark Hushen, O.S.F.S
CEO

IMPORTANT REORGANIZATION ANNOUNCED AT BETTY FORD CENTER

Today (March 9, 2009, on behalf of Susan Ford Bales, and the Board of Directors, I am announcing a historic reorganization of the Betty Ford Center, one which will serve us well as we embrace new opportunities and face new challenges. Last year the board of directors and senior leadership recognized the importance of clarifying the distinctions between our three major entities; namely the **Betty Ford Institute**, the **Betty Ford Center Foundation**, and the **Betty Ford Recovery Hospital**, and positioning each entity in order to maximize their individual potential while maintaining a spirit of collaboration. This reorganization accomplishes that task. Garret O' Connor will continue to lead the Betty Ford Institute with the title of President. John Boop will become the President of the Betty Ford Center Foundation. Mike Neatherton has been named the President of the Betty Ford Recovery Hospital. I will continue to function in the capacity of Chief Executive Officer of the Betty Ford Center and provide leadership and guidance to Garrett, John, and Mike. Please join me in recognizing the efforts and contributions of these three individuals and congratulating them on this well deserved recognition.

John Schwarzlose
March 9, 2009

Many of you who work with adolescents know the statistics from the national studies that report relapse rates ranging from 35% - 85% within the first six months post treatment. As hard as we try to provide the tools to begin making the right choices, the reality is that the “people, places and things” of a student, are usually back at school. Many recovering students return to high schools that have implemented “zero tolerance” policies in regard to alcohol and drug use. Thus, a relapse may trigger a student’s expulsion from school. Most classroom teachers and school counselors have had little or no professional training about recovery or on how to work with substance-impacted students. Some recovering students deal with the pressure of relapse issues by dropping out of school, thereby setting up increased involvement with the juvenile justice system and social service agencies. Schools struggle with addressing the needs and problems of young addicts; they find it difficult to implement solutions due to limited resources. Further, it is not within schools’ missions or capacities to provide the focused support that many young alcoholics and drug addicts require if they are to remain sober, deal effectively with their life issues and do well academically.

Studies on alcohol and drug-abusing adolescents (whether in recovery or not) indicate they bring to school a number of co-occurring emotional, behavioral and learning problems that demand time-intensive, individual attention and aid from adults. Addicted students have been found to suffer from significant levels of depression and anxiety. They tend to be more emotionally unstable and can be quite volatile. They often lack motivation for school success. Problems with being organized, knowing what is expected, when work is due, misplacing work, forgetting work and turning in sloppy and/or incomplete work are deficit-related hurdles for many recovering students. It is no wonder that they often do poorly in school.

As a response to this issue and as part of our recovery-focused strategic plan objectives, Fairbanks sponsored a public charter school for adolescents recovering from drug and/or alcohol addiction. The Recovery High School at Fairbanks, named Hope Academy, opened in August 2006. The mission of Hope Academy is to provide a safe, sober, restorative and challenging school experience for high school students recovering from alcoholism and/or drug addiction who have made a commitment to personal recovery, have a desire to learn, want to attain a high school diploma and are willing to be an active part of a school community of like-minded students and faculty.

This year’s enrollment at Hope Academy is 35 students. It is our hope to increase enrollment over the next few years to a maximum of 60 students. Currently there are 20 recovery high schools in the United States. They all share the same financial and operational challenges that we have. To develop these schools as positive, peer-supportive recovering communities that enable school success requires a relatively small, closely

knit community with strong adult presence and guidance. This requires a high teacher to student ratio; that, of course, also translates to a higher per student cost. The estimate according to a 2008 survey by the Association of Recovery Schools indicated that, of 17 schools surveyed, 15 received public funding. In the case of Hope Academy, less than one-third of the cost is reimbursed from State of Indiana public education funds. Costs per student range from \$12,000 per student per year to \$20,000. All the schools surveyed reported that shortfalls are covered by donations, foundations, grants and fundraisers.

Who are the Hope Academy students? All the students are diagnosed with a substance abuse disorder and have had some form of treatment. They have come from 15 Indiana counties. At enrollment, the students’ average GPA was 1.348 on a 4.0 scale; 55% were reading below grade level; and 31% were special education students. Most of the students enter Hope Academy behind on credits to graduate on time; 27% of the seniors are in their 5th year of high school.

What are our outcomes? In the short two and one half years of service, Hope Academy has had some very good outcomes. Sixty-seven percent (67%) of the students enrolled showed significant gains in grade point average during their first semester at Hope Academy; 89% of students that have remained at Hope for a minimum of one year showed growth in their standardized test scores for reading; 73% of students showed growth in their standardized test scores in math. Students with 200 or more days of sobriety have shown a 40%+ increase in their grade point average while at Hope Academy. So far, twelve students have graduated, each earning a Core 40 diploma and one student received an academic honors diploma. Four of the graduates completed their course work in their 5th year (nontraditional timeline). Nine were admitted into post secondary programs. We are happy with the success so far and we are committed to the continued progress of our school.

For more information visit our website at www.fairbanks.cd.org or the Association of Recovery Schools, www.recoveryschools.org The Association for Recovery Schools 8th Annual Conference will be held in Indianapolis this year, July 23-25th.

Helene M. Cross
President/CEO
Fairbanks
Board Member NAATP



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Upcoming Events

The **Alabama School of Alcohol and other Drug Studies (ASADS)** will hold its 34th annual conference on **March 24-27** in **Tuscaloosa**. For more information contact ASADS by phone at (205) 221-5644 or Kathy Seifried at (344) 242-3967, or e-mail her at Kathy.seifried@mh.alabama.gov.

The **Alabama Department of Mental Health and Mental Retardation (DMH/HR)** is co-sponsoring the 29th annual Alabama School of Alcohol and Other Drug Studies annual Conference on **March 23-26** in **Tuscaloosa, Ala.** For more information, visit <http://asadsonline.com/conference.html>.

The Ben Franklin Institute will host The Summit for Clinical Excellence, "Advanced Clinical Strategies for Tough Times: Creating Resilience on Main Street", April 2 - 4, 2009 in Philadelphia, PA. Speakers include Dr. Stephen Grinstead, Robert Weiss, John Bradshaw, Dr. Robert Johnson, and many more. Topics include Pain Management, Sexual Addiction, Trauma Therapy, Dual Diagnosis, and others. Go to www.bfisummit.com or call 1-800-643-0797 for more information.

The **California Institute for Mental Health** will host the Ninth Annual National Information Management Conference and Exposition: Addressing the Needs of Mental Health, Alcohol and Other Drug Programs on April 22-23, 2009 at the Crowne Plaza Hotel in Anaheim, California. More information about the program and how to register can be found at: <http://elearning.networkofcare.org/CiMH/EventOverview.asp?Id=171694>

The **American Association for the Treatment of Opioid Dependence (AATOD)** will hold its national conference **April 25-29, 2009** in **New York City**. Visit www.aatod.org or call 856-423-3091 for more information.

The **American Society of Addiction Medicine (ASAM)** will hold its 40th Annual Medical-Scientific Conference on **April 30-May3, 2009** in **New Orleans, LA**. For more information visit www.asam.org.

The **National Association of Addiction Treatment Providers (NAATP)** will hold its 2009 Annual Addiction Treatment Leadership Conference on **May 17 - 20, 2009** in **West Palm Garden, FL**.

The Ben Franklin Institute will host the 3rd Annual National Eating Disorder Conference June 4 - 7, 2009 in Las Vegas, NV. Go to www.bfisummit.com or call 1-800-643-0797 for more information.

The Ben Franklin Institute will host The Summit for Clinical Excellence Conference, October 1 - 4, 2009 in San Diego, CA. Go to www.bfisummit.com or call 1-800-643-0797 for more information.

The Ben Franklin Institute will host The Summit for Clinical Excellence Conference, October 22 - 25, 2009 in Scottsdale, AZ. Go to www.bfisummit.com or call 1-800-643-0797 for more information

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The editorial office is located at:
313 West Liberty Street, Suite 129
Lancaster, PA 17603-2748



Editor

Ronald J. Hunsicker
President/CEO
Phone: 717-392-8480
Fax: 717-392-8481
E-Mail: RHunsicker@naatp.org
Web Site: www.naatp.org

NAATP Board Chair

Ed Diehl, President
Seabrook House
Phone: 856-455-7575
Fax: 856-455-7015
ediehl@seabrookhouse.org

Newsletter Submissions may be sent to
Angela Abshire at
aabshire@naatp.org