

VISIONS

September, 2002

NAATP Visions is the official newsletter of the National Association of Addiction Treatment Providers (NAATP), the American College of Addiction Treatment Administrators (ACATA), the National Adolescent Treatment Consortium (NATC) and the National Treatment Consortium (NTC).

The SECAD Experience!

For the third consecutive year, the National Association of Addiction Treatment Providers is very pleased to provide one of the premier clinical training events in the addiction treatment field. Begun 27 years ago, SECAD has become more than an event in Atlanta, it has become an *experience!* Beginning December 4, 2002 and continuing through December 7, 2002 the Sheraton Atlanta Hotel, in Atlanta, Georgia will be the site of this extraordinary annual *experience*.

The "action" begins on the 4th with registration opening up at 7:30am and exhibitor set up also beginning at that time. Between 7:30am and 1:00pm the exhibitor hall is transformed into a virtual showcase of providers, vendors and supporters of addiction treatment with nearly 100 exhibitors represented.

The sessions begin on the 4th with Tom Claunch from New Zealand providing the early Bird Meeting followed by concurrent sessions. The plenary sessions begin at 9:45am on the first day. Throughout the SECAD event, the exhibit area becomes the focus of conversations, numerous coffee and food breaks and hub of conversations, renewing of friendships and the establishment of new connections.

A sampling of the presentations at this year's SECAD 2002 will include:

- Patrick L. Dechella, Ph.D. – "Making Effective Mental Status Exams and Suicide Assessments"
- R. Scott Boots – "Beating Burnout"
- Bitten Johnson, R.N. – "Food Addiction and Relapse"
- James L. Fenley, M.D. – "Basic Truths in Addiction: (What Goes Around Comes Around)"
- Carlton Erickson, Ph.D. – "The Problem is not in the Bottle, It's in the Brain"
- Arthur Trotzky, Ph.D. – "The efficacy of Using Paradox, Exaggeration and Humor as Therapeutic Intervention"
- Carol Falkowski – "Current Trends in Drug Abuse"
- Garrett O'Connor, M.D. – "Spirituality and Recovery"
- Judy Saalinger, Ph.D. – "Fearless Change: Embrace the Choice to Reinvent Your Life"



Reverend Dr. Barbara King



Max Schneider, M.D.

- Norman Hoffmann, Ph.D. – "Dependence and Abuse: Just Cousins Not Clones"
- Max Schneider, M.D. – "Nicotine Dependence: Could We! Should We! Will We!"
- G. Douglas Talbott, M.D. – "The Importance of Staff selection to Maximize Patient Response"
- David Mee-Lee, M.D. – "Patient Placement Criteria: Where Have we Been? What's New? What's Next?"
- John Sealy, M.D. – "Out of Control Sexual Behavior: Is it truly an Addiction or What Shall We call it?"
- Claudia Black, Ph.D. – "Depression and Addiction"
- Jerry Boriskin, Ph.D. – "Chaos and Addiction: Treating Patients of Increasing Complexity"
- The Honorable Louis W. Sullivan, M.D. – "Racial Impacts of Addiction"
- The Reverend Dr. Barbara King – "Spirituality in the Market Place"

This is only a sampling of the sensational lineup that awaits you in Atlanta, December 4 -7, 2002. The National Association of Addiction Treatment Providers is once again committed to providing you with some of the most up-to-date research and findings related to addiction treatment and helping you through the presentations to make the translations to treatment and clinical practice.

In addition to the rich collection of presentations, SECAD promises to again offer that unique experience of offering hope and excitement to those persons who are the "front line" providers of clinical services to persons with the disease of addiction. This is one of those gatherings where you will be missed and you will have missed if you are not there.

The registration forms have been mailed, but if you have not received yours you can call the SECAD office at **888-506-7394** or log onto the web site at www.naatp-secad.com and register online.

Register before October 31 and avoid the late registration fee and all NAATP members receive a 10% discount on registration. There are a few exhibit spaces remaining and there are also sponsorship opportunities available. **Call the SECAD office today and plan to be in Atlanta, December 4-7, 2002 and experience SECAD!**

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Beginning with this column *As RJH Sees it* and this issue of *Vision* you will begin to find articles about and references to the 25th Anniversary celebration of the National Association of Addiction Treatment Providers, and highlighted events from these first twenty-five years. As you are undoubtedly aware by this time, **the year 2003 marks the 25th anniversary of NAATP** and the May 2003 annual conference will be the high light celebration of this year long observance. From the early gatherings along the Pacific coast where addiction treatment providers hammered out the basis for an association that would provide a home and a platform for addiction treatment providers, this association has grown and stretched itself to the place where NAATP membership has expanded beyond the borders of this country and NAATP has truly become the association that represents the premier providers of addiction treatment who are committed to increasing the quality of the services they offer and expanding the dialogue among themselves.

Plans are well underway to mark this “*quarter century*” celebration in Indian Wells, CA under the very capable leadership of Mr. Ed Diehl as the 2003 annual conference chair. During the course of the next several months, the program will be finalized, the entertainment planned, the celebration of our past and the commitment to the future solidified and opportunities for long time members and new members to meet, mingle and to learn from each other. As much as any annual conference, this will be a time to celebrate all that we have accomplished and to commit ourselves to those goals not yet achieved.

Mr. Diehl would welcome your suggestions in terms of program ideas, celebration ideas and specific recommendations for speakers at the conference. You may communicate directly with Mr. Diehl or you can discuss your ideas with the NAATP office. No matter how you communicate, your ideas and suggestions matter and we want to hear them as soon as possible.

Along side of the celebration connected to the 25th anniversary, your Board of Directors has been working on a strategic plan that will guide and shape the organization for the next several years. In August the Executive Committee of the Board met in Atlanta to review some information that had been gathered and during the first week of October the entire Board will be meeting in Philadelphia to work at finalizing a strategic plan that will enable the Board and the NAATP staff to prioritize their efforts and recourses in the coming years as NAATP is both responsive to the needs of its growing membership and also continues to provide leadership to the larger addiction treatment field in the areas of treatment, reimbursement, accreditation, patient placement, parity, quality indicators, benchmarking and a

host of other key issues. NAATP continues to be committed to bringing together the various and at times competing voices so that there is a unified voice representing the providers of addiction treatment.

The first step in this strategic planning process will be a thorough review of the mission and vision statement for the National Association of Addiction Treatment Providers. Our commitment is to getting together a concise and clear statement that represents the very best of this association.

During the last quarter of 2002, however, there remain a number of key issues and projects that need to be completed and need your attention. A few of these are:

- The SECAD Conference which will be held December 4 – 7, 2002 in Atlanta. Be sure to check out the opportunities to register to attend, to exhibit and to sponsor special events as a part of this conference. NAATP members receive a 10% on registration and exhibit fees.
- The 2002 National Salary Survey is rapidly reaching the end point of the data collection process. If you have not provided information, contact the NAATP office today or fill out the survey on line.
- Beginning with the 2003 dues, the formula will be changed and based on the revenue of an organization. If you have not completed the form indicating your new dues, contact the NAATP office today!
- The 2003 James W. West, M.D. Quality Improvement Award applications are very shortly due. The application form can be obtained at the NAATP web site or by calling the NAATP office.

So, while plans are being made for the twenty-fifth celebration, the National Association of Addiction Treatment Providers office continues to provide the services and information that you have grown to count on and to depend on in this very complex health care environment. Check out the NAATP web site, complete the forms you receive and support SECAD by sending as many of your staff as possible. All of this activity and so much more, continues to make NAATP the premier association that attracted you and will continue to attract your colleagues.

See you in Atlanta and make plans now for May of 2003 to be in Indian Wells, California!

That's the Perspective of RJH

Final HIPAA Privacy Rule Modifications

On August 14, 2002, the Department of Health and Human Services (“DHHS”) released final modifications to its Privacy Rule, which was issued in December 2000 pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”). The date for providers to be in compliance with the Privacy Rule remains April 14, 2003. However, covered entities have an additional year to comply with the business associate requirements. This memorandum provides a general summary of the final modifications to the Privacy Rule and the implications for substance abuse treatment providers who must also comply with the requirements of 42 CFR Part 2.

Consent

One of the most significant changes in the final modifications is that a covered entity is no longer required to obtain “consent” for uses and disclosures of protected health information (“PHI”) for treatment, payment, and healthcare operations (“TPO”). This change allows a covered entity to use and disclose a patient’s PHI, without prior written patient consent, for its own TPO as well as for treatment, payment and certain health care operations of other parties. A covered entity may disclose PHI without consent to any health care provider, whether or not it is a covered entity, for purposes of the recipient’s treatment activities. It may also disclose PHI to another covered entity or to any provider for the recipient’s payment activities. The changes also allow disclosure to another covered entity that has a relationship with the patient, if the disclosure is for specified health care operations of the recipient, such as quality assessment or credentialing. Note that this change does not eliminate the need to obtain patient authorizations for other uses and disclosures. Covered entities may also choose to voluntarily obtain patient consent. Now that TPO consents are eliminated, treatment providers can continue to allow communications between or among personnel having a need for the information in connection with their duties, as allowed by 42 CFR Part 2, without patient authorization or consent. However, substance abuse treatment providers must continue to follow their current practice of obtaining consent for payment as required under 42 CFR Part 2. Similarly, sharing of information for healthcare operations will need to be evaluated to determine whether such information can be disclosed under an exception in 42 CFR Part 2.

Notice of Privacy Practices

Direct treatment providers must provide patients with a notice of the patient’s privacy rights and the privacy practices of the provider. This privacy notice must be given to each patient when services are first rendered. Providers are now required to make a good faith effort to obtain the patient’s written acknowledgment of the notice of privacy rights and practices. If the provider is unable to obtain a written acknowledgment, it must document its good faith efforts to do so and a reason as to why the acknowledgment was not obtained. Substance abuse treatment providers will need to revise the written notices they are currently using pursuant to 42 CFR Part 2 to incorporate the provisions required under HIPAA. The HIPAA notice requirements are very detailed. DHHS will allow layered notices that contain a short summary as long as the longer notice containing all of the elements required by the rule is attached. Neither 42 CFR Part 2 nor HIPAA prohibit a provider from using a single notice form that incorporates the requirements of both rules. However, the notice may not be in a single document with an authorization. Programs

must also implement procedures for obtaining a patient’s written acknowledgment pursuant to the final modifications, as outlined above.

Authorizations

The final modifications simplify the authorization content requirements and eliminate the need for separate authorization forms. A covered entity may use a single authorization form containing all of the core elements outlined in the rule for most types of uses and disclosures. A covered entity may not use or disclose psychotherapy notes for purposes of another covered entity’s TPO without the patient’s authorization. Under certain circumstances, however, the covered entity may use or disclose psychotherapy notes for its own TPO without the individual’s authorization.

A consent must be obtained under 42 CFR Part 2 before confidential information may be disclosed. This consent must include nine elements outlined in the regulations and include a prohibition on redisclosure. The authorization under the Privacy Rule is similar to the consent required under 42 CFR Part 2, however, the HIPAA authorization requires that more elements be included in the authorization. Therefore, providers will need to revise their current consents to include these additional elements.

Minimum Necessary

The Privacy Rule keeps intact the “minimum necessary” requirement, which requires covered entities to make reasonable efforts to disclose only the amount of PHI that is necessary to fulfill the purpose of the disclosure. However, any use or disclosure made pursuant to a valid patient authorization is now exempt from the minimum necessary requirement. Pursuant to 42 CFR Part 2, patient identifying information may only be used or disclosed as permitted by the regulations and must be limited to that information which is necessary to carry

[Continued on page 4](#)

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Continued From page 3

out the purpose of the disclosure. In addition, disclosures made pursuant to a court order must be limited to the criminal or non-criminal purposes stated in the court order and the regulations. Under the Privacy Rule providers must develop policies and procedures for handling routine and non-routine requests and disclosures so that only the minimum amount necessary is disclosed. Providers will need to identify staff who will need access, the categories of PHI they need access to and any conditions of access.

Incidental Uses and Disclosures

In response to comments received expressing concern that the Privacy Rule would impede customary and necessary health care communications, the Privacy Rule has been modified to make it clear that incidental uses and disclosures will not be considered a violation of the Privacy Rule as long as the covered entity implements reasonable safeguards to limit unintended uses or disclosures and the minimum necessary requirements are met. Although “incidental uses and disclosures” is not a defined term in the Privacy Rule, some of the examples provided by the DHHS include being overheard while engaged in a confidential conversation, using sign-in sheets in waiting rooms, maintaining patient charts at bedside and discarding empty prescription vials.

Business Associates

The Privacy Rule requires a covered entity to impose, through written agreements, the privacy standards on “business associates” who access and use PHI to perform functions on behalf of the covered entity. The requirements for business associate agreements and the content of these agreements remains essentially unchanged. However, covered entities have until April 14, 2004 (an additional year beyond the compliance date) to modify written contracts to comply with the Privacy Rule. DHHS also states that a covered entity does not need to actively monitor its business associates but must take the steps necessary to require the business associate to cure a breach, if the entity learns of the breach. Business associates are similar to qualified service organizations (“QSO”) under 42 CFR Part 2. However, not all business associates will be a QSO and vice versa. Both rules set forth detailed requirements. Providers will need to ensure compliance with both rules.

Accounting of Disclosures of PHI

The Privacy Rule provides an individual the right to obtain an accounting of any disclosures of their PHI made by a covered entity. 42 CFR Part 2 has no provision regarding accounting of disclosures. Therefore, this is a new requirement that treatment providers must meet. An accounting is not necessary for those disclosures for TPO or those disclosures pursuant to a patient authorization.

Marketing

A covered entity must obtain written authorization for any use or disclosure of PHI for marketing purposes, and the new rule clarifies the types of communications that are considered marketing and those that are not considered marketing. However, 42 CFR Part 2 does not have a provision exempting marketing activities from the confidentiality requirements. Therefore, a provider must obtain patient consent to disclose information for any type of marketing activities.

Unemancipated Minors

The final modifications clarify that state law, or other applicable law (including case law), governs disclosures of, and access to an unemancipated minor’s PHI by a parent, guardian or other person acting in loco parentis. If a specific provision of state law requires or permits such a disclosure, the covered entity may

disclose the minor’s PHI to the parent. Conversely, if state or other applicable law prohibits such a disclosure, the covered entity would not be permitted to make the disclosure. Additionally, the modifications clarify that state or other applicable law governs parental access to an unemancipated minor’s health information. If there is no explicit law governing access to a minor’s health records, the covered entity may provide or deny access based on the discretion of a licensed health care professional if such discretion is permitted by state or other law. This change is consistent with 42 CFR Part 2, which defers to state law regarding a minor’s rights.

Research

Another significant change in the Privacy Rule is the modification of several provisions governing research. These changes make the research provisions more consistent with the “Common Rule” governing federally funded research, including the requirements related to an IRB or Privacy Board waiver of authorization. A researcher is now permitted to use a single combined form to obtain informed consent for the research and authorization for uses and disclosures of PHI in connection with the research. Pursuant to 42 CFR Part 2, patient identifying research may be disclosed for the purpose of conducting research if the recipient is qualified to conduct the research, has a protocol with specific protections identified in the regulations and has had the protocol reviewed by three or more individuals who are independent of the research project.

Limited Data Set

The creation and dissemination of a limited data set (one that does not include directly identifiable information) for research, public health, and health care operations is permitted. The recipient of the limited data set must agree, in a written data use agreement, that it will use the data set only for the purposes for which it was given, that it will ensure the security of the data and it will not identify the information or use it to contact any individual. This would also be consistent with 42 CFR Part 2.

Hybrid Entities

Any covered entity that performs both covered and non-covered functions can elect to be a hybrid entity regardless of whether the covered functions represent the entity’s primary function, a substantial function or even a small portion of the entity’s activities. To be considered a hybrid entity, the covered entity must designate its health care components. If a covered entity does not designate any health care components, the entire entity would be considered a covered entity and subject to the Privacy Rule. The final modifications provide the entity additional discretion in designating its health care components.

Employers

The final modifications make clear that employment records maintained by a covered entity in its capacity as an employer are not PHI. Employers that have a self-insured employee welfare benefit plan should also determine whether or not they are subject to the requirements of the Privacy Rule as a health plan. Small health plans (annual receipts of \$5 million or less) have until April 14, 2004 to comply.

Conclusion

This is a general overview of the final changes to the HIPAA Privacy Rule and its effect on substance abuse treatment providers. This Rule is quite complex in itself and the additional requirements of 42 CFR, Part 2 increase the burden imposed on substance abuse treatment providers. For more detailed information regarding the impact or implementation of the Privacy Rule on your current practices, please contact the firm.



New Magazine to Serve Addiction Treatment & Prevention Profession

A new Magazine, *Addiction Professional*, will begin publication with a January 2003 issue. The new bimonthly, full-color magazine will be distributed to specialists in the treatment and prevention of addiction, and will cover a wide variety of clinical and programmatic issues affecting the future of addiction treatment. All members of NAADAC, The Association for Addiction Professionals, will receive *Addiction Professional* as their official publication, replacing *Counselor*. NAADAC is the largest association of addiction professionals and is headquartered in Alexandria, Virginia.

The circulation of *Addiction Professional* will also include the members of the National Association of Addiction Treatment Providers (NAATP) and other qualified professionals drawn from Manisses Communications Group's lists of subscribers to its other professional publications, including *Alcoholism & Drug Abuse Weekly* and *The Brown University Digest of Addiction Theory and Application*.

Gary Enos, a Manisses veteran editor and reporter, will serve as editor of *Addiction Professional*, and will continue to serve as editor of *Behavioral Healthcare Tomorrow*. *Addiction Professional* will focus on clinical issues in treatment and prevention, and will seek to create a forum for the exchange of ideas among disparate professional groups that serve patients with addiction diseases.

Addiction Professional will include contributed articles by frontline professionals introducing models of treatment and strategies for prevention.

Don't Forget!



Deadline for Completing the Salary Survey is October 15!

National Association of Addiction Treatment Providers

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Brings you a 3-binder set of HIPAA Compliance documents, designed to provide you with a complete set of the tools necessary to comply with the complex HIPAA requirements.

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- Are written specifically for substance abuse treatment providers
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Compliance Manual (Delivery by December 15)

- Copies of applicable state and federal regulations
- Sample Agreements, including:
 - Audit/evaluation
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 - Trading partner
 - Chain of trust
 - Fee payment
 - Business associate
- Sample HIPAA compliant authorizations for substance abuse treatment providers
- Notice of privacy practices
- HIPAA privacy guidance for criminal justice clients
- Guides on specific areas such as psychotherapy notes, hybrid entities, and healthcare components
- PowerPoint trainings for Board members and staff, including pre- and post-tests
- Summary of disclosures under 42 CFR Part 2 and HIPAA
- Privacy Reference Guides (set of 10), summarizing the privacy requirements applicable to substance abuse treatment facilities
- Patient Rights Reference Guides (set of 10), summarizing the six patient rights under HIPAA

Privacy Policies and Procedures (Delivery by November 1)

- Comprehensive set of policies and procedures to implement HIPAA privacy regulations
- Sample forms and compliance checklists

Security Policies and Procedures (Delivery Summer 2003)

- Comprehensive set of policies and procedures to implement HIPAA security requirements
- Sample forms and compliance checklists
- Security Reference Guides (set of 10)
- Developed in conjunction with MSJ Corp., affiliated with the Betty Ford Center

**The Final Privacy Regulations were issued 8/14 2002
There are only 7 months left to comply!**

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Of Particular Interest; Take Note!

Two recent articles provide some insight to the continual discussion regarding the impact of Managed Care and appropriate matching of patients to levels of care for addiction treatment. The overall concern is to determine to what extent undertreatment occurs and at the same time to look at the phenomenon of overtreatment. While neither article offers definitive results they do help with the ongoing discussion regarding the appropriate or inappropriate use of the ASAM Patient Placement criteria.

The two recent articles are:

- *Effects of Managed Care on Alcohol and Other Drug (AOD) Treatment*, Alcoholism: Clinical and Experimental Research, Vol 26, No 3, March 2002,
- *Feasibility of Matching Alcohol Patients to ASAM Levels of Care*, The American Journal on Addictions 11;124-134, 2002, Volume 11, Number 2, Spring 2002.

These are not the final answers, but they are more than worth your reading.



2001 National Household Survey on Drug Abuse Finds Increase in Illicit Drug Use and Driving While Intoxicated

On September 5th the annual National Household Survey on Drug Abuse (NHSDA) was released by the Substance Abuse and Mental Health Services Administration (SAMHSA). Overall, the survey revealed in 2001 an estimated 15.9 million Americans age 12 years or older used an illicit drug during the month immediately prior to the survey interview and indicated increases in the use of marijuana, cocaine, pain relievers and tranquilizers. According to the survey 7.3% of the population, or an estimated 16.6 million persons age 12 or older, were classified with dependence on or abuse of either alcohol or illicit drugs in 2001. The NHSDA survey interviews approximately 70,000 people age 12 years or older, in every State, over a 12-month period and is the primary source of information on the use of illicit drugs, alcohol, and tobacco by the civilian, non-institutionalized population in the United States. This survey provides a one-year snapshot of the problem of drug abuse in America.

Illicit Drug Use

- The percent of the population that were current users of illicit drugs increased from 6.3 percent in 2000 to 7.1 percent in 2001. There were significant increases in the use of particular drugs or groups of illicit drugs with the most significant increase being marijuana (from 4.8 to 5.4 percent). Other increases included cocaine (0.5 to 0.7) and the non-medical use of pain relievers (1.2 to 1.6 percent) and tranquilizers (0.4 to 0.6 percent).
- There was an increase in the number of youth aged 12 to 17 that were current drug users (10.8 percent in 2001 as opposed to 9.7 percent in 2000) and in adults age 18 to 25 years (15.9 percent in 2000 to 18.8 percent in 2001).

Alcohol Use

- While there were no significant changes found in heavy or binge drinking between 2000 and 2001, the number of persons reported driving under the influence increased from 10.0 to 11.1 percent between 2000 and 2001. In 2001, more than 1 in 10 Americans or 25.1 million persons reported driving under the influence of alcohol at least once in the 12 months prior to the interview.
- The rate of alcohol use and number of drinkers between 2000 and 2001 increased with almost half of all Americans age 12 or older, 48.3 percent or 109 million persons, estimated as current drinkers.

Substance Dependence or Abuse

- The number of persons with substance dependence or abuse increased from 14.5 million (6.5 percent of the population) in 2000 to 16.6 million (7.3 percent) in 2001.
- The estimated number of persons age 12 or older needing treatment for an illicit drug problem increased significantly between 2000 and 2001 from 4.7 million to 6.1 million.
- The number of persons needing but not receiving treatment increased from 3.9 million to 5.0 million. Of the 5.0 million people who needed but did not receive treatment in 2001, an estimated 377,000 reported that they felt they needed treatment for their drug problem, including an estimated 101,000 who said they made an effort to get treatment but were unable to and 276,000 who reported making no effort to get treatment.

Mental Illness and Substance Abuse Problems

- Of the adults with serious mental illness in 2001, 20.3 percent were dependent on or abused alcohol or illicit drugs. In addition, there were an estimated 3.0 million adults with both serious mental illness and substance abuse or dependence problems during the year.
- In 2001, an estimated 4.3 million youths age 12 to 17 received treatment or counseling for emotional or behavioral problems in the 12 months prior to the survey interview. This number represents 18.4 percent of the population, and is significantly higher than the 14.6 percent estimate for 2000.
- The rate of mental health treatment was higher among youths who used illicit drugs in the past year than among youths who did not use illicit drugs (26.2 percent versus 16.3 percent).

Throwing Good Money After Bad: Incarceration – A Case Study

The U.S. Bureau of Justice recently released new data on the country's correctional systems – in their words a “crisis and an opportunity”. The year 2001 showed a continuing increase throughout the nation's incarcerated population. A crisis exists in the increasing numbers of inmates, the exorbitant costs and the racial overtones that exist as well as the impact to communities, the citizens and to the country's priorities. It is indeed time for a policy change and revision. It is critical to identify and determine effective alternatives to “putting people away” and then releasing them back into disadvantaged environments; without meaningful intervention or rehabilitation efforts focused on the problems promoting incarceration. By failing to do so, we willingly foster high levels of recidivism. The opportunity for policy revision presents itself in many different forms and for the scope of this report the focus will center on the incarceration of the non-violent drug offender. It is this segment of the population that: 1. reflects the largest and fastest growing group – 57% of the federal prison system constitutes drug offenders, 2. has the highest recidivism rate – 40% of the drug offenders repeatedly return to incarceration for the same charge within a 3-year period, and 3. profiles the potential for the greatest cost reductions alternatives – substance abuse treatment vs. incarceration, reductions in law enforcement and jail costs, etc.

The current system reflects an imbalance that dictates the need for change based on the outcomes noted below:

- Although, the minority population is approximately 13%, about 66% of the nation's prison system are people of color; on Chicago's West Side 70% of the male population (between the ages of 18 - 45) are ex-offenders, yet SAMHSA (Substance Abuse & Mental Health Services Administration) reveals the typical addicted male is White between the ages of 18 to 44.
- Cost comparisons:

Incarceration Treatment	\$37,000 per inmate per year \$18,000 for residential \$3,000 for outpatient
Illinois College Education	State University cost \$9- \$12,000
State of Illinois '03 budget Treatment	\$1,303,219,800* \$350,000,000
Illinois College Education	Est. \$2,228,000,000

*Almost 4 dollars spent on incarceration compared to every \$1 dollar spent for alcohol/substance abuse treatment

- In Illinois the cost of a year of college in a state university is between \$9,000 - \$12,000, and at the top ranked University of Chicago the annual fee of \$33,309 is still cheaper than the cost of one year of incarceration, where no quality education/rehabilitation is being provided.
- At the end of 2000 nearly 4.6 million adult men and women were on probation or parole – an increase of 70,000 over the previous year. According to the Soros Institute 72% of those entering state prison for the first time were non-

violent offenders. In Illinois the correctional system cut GED and the Illinois Sentencing Project research noted that more than 100,000 prisoners are being released each year without any form of community correctional supervision. Meanwhile, less than 10% of the nation's incarcerated population receives substance abuse treatment. This is an enormous mismatch of resources when we consider that almost 60% of the federal prison system constitutes drug offenders. In Cook County alone, according to TASC (Treatment Alternative for Safer Communities) 80% of arrestees test positive for drugs/alcohol.

Substance Abuse treatment does work: (as noted below)

- Drug and alcohol use decreased markedly from baseline to follow-up
- Recidivism is readily reducible by 16-62% by broader use of existing types of programs, particularly substance abuse treatment, education, intermediate sanctions and alternatives to incarceration The Oregon Cornerstone treatment program results reduce recidivism by 45-60%; NY King's County DTAP program by 27-58% .
- The RAND study reports that treatment of heavy drug users is 15-17 times more effective in reducing crime than spending the same money on mandatory minimum sentences.
- Other effects of treatment:
 - decreased use in the public aid systems – reduction in costs
 - reduction in illegal activities – reduction in law enforcement costs
 - improved family/social relationships
 - increased employment
 - reduction in medical/mental health services – reduction in costs (projected savings in public assistance costs \$33, 186, 342 annually.)

That familiar quote, “if it works, don't fix it” can hardly apply to the current policies and procedures of the criminal justice system in this country. That treatment works as an alternative to incarceration and has significant benefits for the individual, the community and the economy should be presented to the public often enough until they in turn demand the changes necessary to institute equal application of the law and insist upon treatment on demand for non-violent drug offender with commensurate public funding. This mandating would close the revolving door to our nation's prisons and reach out the hand of recovery to those suffering from addiction. The cause of prison overcrowding is addiction...let's put the money on the front end of the problem, where it can do

Some good. Clearly treatment is better than punishment and warehousing of addicts in prisons. Public policy makers must recognize that we cannot imprison our way out of the problem of drug addiction, because incarceration has unacceptable levels of recidivism and inordinate costs compared to treatment. In a phrase – it simply doesn't work....talk about throwing good money after bad.

Anthony Cole
Vice President, Haymarket Center
NAATP Board Member

Upcoming Events for Your Calendar

The National Association of Addiction Treatment Providers will present **SECAD 2002 Dec. 4 to 7 in Atlanta**. For more information, call 888-506-7394, or outside the US 770-579-2502; fax 770-579-1218; write SECAD c/o NAATP – P.O. Box 670656, Marietta, GA 30066-0128; or visit www.naatp-secad.com.

The **State University of New York at Binghamton and Broome Community College** will present a research conference, "Treating Addictions in Special Populations: Research Confronts Reality," **Oct. 7 and 8 in Binghamton, N. Y.** For more information, contact Jane Angelone, Conference Coordinator, Professional Development and Research, Binghamton University, P.O. Box 6000, Binghamton, NY 13902-6000; phone (607) 777-4447; fax (607) 777-6041; e-mail angelone@binghamton.edu; or visit sehd.binghamton.edu/pdr/index.htm.

The **GAINS Center for People with Co-Occurring Disorders in the Justice System** will hold its second national conference, "Policy and Practice: Expanding Access to Community Based Services," **Oct. 28 to 30 in San Francisco**. For more information, visit www.gainsctr.com.

The **Fifth National HIPAA Summit** will be held **Oct. 30 to Nov. 1 in Baltimore**. For more information, call 800-684-4549; fax 760-771-3183; email conferencehq@aol.com; or visit www.hipaasummit.com.

The **Association for Medical Education and Research in Substance Abuse (AMERSA)** will hold its 26th annual national conference, "New Challenges, New Directions," **Nov. 7 to 9 in Washington D.C.** For more information, visit www.amersa.org or email Isabel@amersa.org.

The **International Council on Alcohol and Addictions (ICAA)** will hold its 45th annual international conference, "Politics, Legislation and Drug Policy: Congruence or Divergence," **Dec. 8 to 10 in Sao Paulo, Brazil and Dec. 11 to 13 in Rio de Janeiro**. For more information, contact ICAA-Brasil, Rua Joao Moura 647/184, 15412-911, Sao Paulo, SP Brasil; telephone 55 11 3083 7415; email icaa.brasil@uol.com.br

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