

## TWELVE STEP PROGRAMS ARE CONSISTENT WITH THE SCIENCE OF ALCOHOLISM AND ADDICTION

**N**ext month, at the 2007 NAATP Annual Leadership Conference, Dr. Carlton Erickson will be presented with the prestigious 2007 Nelson J. Bradley Life Time Achievement Award. Below we highlight his recent article, ***Twelve Step Programs are Consistent with the Science of Alcoholism and Addiction***.

With the new science of addiction that has recently been covered by television and the print media, it is easy to understand why established programs like Alcoholics Anonymous (AA) can get lost in the shuffle. After all, what do brain anatomy, brain chemistry, new medications, and genetics have to do with recovery?

The public, policymakers and our field of alcoholism and drug dependence have long suffered from insufficient knowledge about the nature of these diseases. Even worse is the inaccurate knowledge among those outside the field about what causes these diseases, how treatment can be effective, and how spiritually-based programs work. Insufficient knowledge has led to myths, stigma and policy discrimination against those who are afflicted by the disease of alcoholism and addiction.

In actuality, the newest science of addiction expands upon and confirms what people in recovery know about their disease and about how treatment works. Further, the science is leading to better treatments to help more people who previously were lost to this disease.

### CLARIFICATION OF TERMINOLOGY

Alcoholism and addiction (scientifically known as alcohol and other drug dependence) are not the same as alcohol and other drug abuse. Those who abuse alcohol and other drugs include binge-drinking college students and recreational pot smokers, most of whom will never become dependent.

Clinicians are now able to discern the difference between people who abuse alcohol and drugs, and people who are dependent. Diagnostic criteria found in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA) and the International Classification of Diseases (ICD), published by the World Health Organization (WHO), can now be used to determine the severity of the condition and who needs more intense, long-term treatment (i.e. abusers often mature out of their drug using behavior; dependent individuals need more intense treatment; twelve step programs apparently help both).

### ADDICTION IS A BRAIN DISEASE

Alcoholism and drug addiction (not alcohol and drug abuse) is a chronic medical brain disease (recently affirmed by NCADD). The latest research confirms the facts and provides a means of understanding how the brain disease occurs. Increasingly, treatment programs are designing programs to take advantage of such research findings.

Based upon the latest neurobiological and genetics research, we no longer talk about the "disease concept" or "medical model". Research by leading neurobiologists and geneticists has now clearly shown that the brain area where chemical dependence occurs is the mesolimbic dopamine system - the brain's reward pathway. Alcohol and other drugs that produce pleasure, hijack the neurochemistry of this system. This leads to long-term changes that make it extremely difficult for people to stop their alcohol and drug-seeking behavior without intervention and treatment. In order for treatment programs to be effective, they must do something powerful and effective to reverse this dysregulated brain chemistry.

### ADDICTION TREATMENT

Erroneously, many people believe that since the behavioral signs of "alcoholism and addiction" are so predominant that this must be a behavioral problem. We need to remember that the behavior (alcohol and drug-seeking, criminal behavior, aggressive behavior) is the result of uncontrolled alcohol and drug use and the accompanying emotional and cognitive disruptions caused by long-term alcohol and drug use. Thus, the target for treatment is not the behavior; it is the underlying cause of the behavior - addiction - the hijacked neurochemistry of the mesolimbic dopamine system. But how can twelve-steps, counseling, group and individual therapy, detoxification, inpatient treatment and other interventions change this brain chemistry? Aren't medications the only agents that can do this?

In actuality, brain imaging studies over the past 7 years clearly show that brain function changes with structured cognitive therapy. It is highly possible, then, that when people begin to recover from chemical dependence that the combination of abstinence and psychosocial interventions, treatment and self-help (including A.A., N.A. etc.), change brain function in the direction of "normal". Like most diseases, we believe treatment does not remove the basic cause of the disease. But moving brain function in the desired direction of "normal" gives a person a heightened chance of learning to live a life "happy, joyous, and free" from alcohol and drugs.

The above statements are based upon a few good studies in a growing body of research. As yet, there is not yet a solid "weight-of-the-evidence" amount of research to confirm the brain mechanisms of recovery. Since we know the brain area that is involved, we are pretty sure of the neurochemical disruptions which occur (much has been learned from research on the genes involved in neurochemical function), and since we can see the

brain changes that occur, there is optimism that recovery involves measurable brain changes. Wouldn't it be exciting if we could track mesolimbic dopamine system changes as a person gets better, and be able to quantitate the degree of recovery?

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**D**uring the past two months, William White has been contacting a number of individuals who were involved with helping to bring into being the National Association of Addiction Treatment Providers in 1978. These interviews are being done in order to gather information which will become part of the 30 year history of the National Association of Addiction Treatment Providers, which will be available at the NAATP annual conference in May of 2008. These interviews will also become part of the archival material as we continue to collect important documents, publications and memories which we want to keep as part of the historical legacy of NAATP. We still have organizations and individuals who were part of that movement in the 70's which quickly emerged into a national association in the 80's and beyond. Our history is a precious resource which we need to preserve and also provide to those organizations and individuals who themselves do not have first hand experience with NAATP in the early 1980's and beyond.

In taking a look at these first interviews, it is very interesting to note what some of the motivations were to become part of what is now the National Association of Addiction Treatment Providers and to examine the recollections of what the early issues were, what, from their perspective, some of the key accomplishments have been and the key areas of "engagement" for NAATP. The history itself will chronicle those accomplishments, but it is not too early to identify some of the emerging themes which seem to have given shape to NAATP and which have been critical to our heritage and which may well influence us for the next period of time before we spend some more retrospective examination of our history. (Perhaps in 20 years when NAATP celebrates its 50<sup>th</sup> anniversary!)

A few of the benchmark activities which seem to be remembered and valued by those individuals who have contributed so much to the early history of NAATP include:

- Providing an opportunity and forum for providers of addiction treatment to get together and learn from each other and to raise a more unified voice on critical issues related to addiction treatment.
- Developing a persuasive and rational argument for a standardized benefit to be included in employer sponsored insurance plans. (Today much of the discussion has been about parity if an employer offers this benefit, but 30 years ago, it was about getting a standardized benefit into plans offered by employers to their employees.)
- Working with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to build into its standards specific standards for addiction treatment and to make sure that the developing standards for Behavioral Healthcare organizations were not, mental health only!
- Assuming leadership in taking a look at the more than 50 different patient placement criteria floating around and driving us toward what is now know as the ASAM Patient Placement Criteria.

- Filling an amicus curiae with the United States Supreme Court as part of the case against the administrators of the Veteran's Administration in what has now become know as the Willful Misconduct case.
- The plethora of workshops and seminars offered at national and regional gatherings on leadership, charting, treatment plan development, marketing, and issues related to managed care.

In reviewing the material from these interviews, it is clear that these early leaders continue to value the association as a way for information to be exchanged whether or not it was through workshops or at coffee breaks during conferences. The opportunity to learn from the best was and continues to be a very critical component of membership and of the mission of NAATP.

These interviews also point out how important it is for NAATP to be the leader and to challenge organizations to examine their assumptions when it comes to the direction they are taking. NAATP took this position with employers in persuading them to include a benefit for addiction treatment, it took this position with the supreme court in challenging their interpretation of this disease, it took this position when it undertook to work with MedStat in examining the health records of a large number of health care beneficiaries and demonstrating that the cost of treating addiction was far less than the cost of treating numerous other diseases which often manifest themselves when the disease of addiction is not responded to and treatment provided.

Finally, these interviews demonstrate the commitment which these leaders had to the effort to gain recognition for this disease and to provide quality, long term treatment for which recovery is the ultimate goal. It is great to know that this leadership was there when we needed it 30 years ago and it is just as satisfying that the membership in NAATP continues to grow and that persons are stepping up to the plate to be the leaders for the next crucial chapter in the history of NAATP and for addiction treatment.



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# LEADERSHIP LUNCH & LEARN

Sequest and the National Association of Addiction Treatment Providers (NAATP) have designed a series of regional seminars that discuss leadership issues related to technology. Ron Hunsicker, NAATP Executive Director and Bill Connors, Sequest President/CEO, have developed a ¾ day “lunch and learn” format that provides executive management with topics identified in the NAATP IT Survey found at [www.naatp.org/ITSurvey.html](http://www.naatp.org/ITSurvey.html).

The NAATP IT Survey found several key areas of interest among leadership:

- ❖ Aspects of a successful EHR implementation
- ❖ Lessons learned from fellow NAATP members
- ❖ Federal and other impacts on the future of automated records

The first of these seminars was held on March 15, 2007 at Hanley Center in West Palm Beach Florida. The content focused heavily on providing materials and discussion on the above identified topics. Ron Hunsicker and Bill Connors opened with a brief overview of the seminars’ purpose, “To provide insight into the many technology influences on the day to day business of NAATP members,” as emphasized by Connors.

The initial session was presented as a snapshot of Federal standard setting movements and the push toward interoperability. A concise and broad overview was provided by Bill Connors, describing the Federal mandates for standards and the concepts

of derived profiles for substance abuse. “The vision was laid by current administration but the practical aspects on how to get there will be very difficult especially when dealing with the right to know and confidentiality as related to addiction records,” stated Ron Hunsicker.

Hanley Center was highlighted during the seminar as a case study of how a successful EHR can happen and what it takes to deliver one. Barry Goldman, Hanley’s IT director, presented a PowerPoint presentation that led attendees through the Hanley software needs, software selection and the implementation of the TIER® Software System. Hanley’s need for software included; intuitive/friendly user interface that they themselves could customize; software that easily adapted to Hanley’s processes which supported JCAHO and HIAA compliance and integrated with billing. Not least of which was to find a software company that clearly focused on its client’s needs. Goldman continued to outline the training process for the Sequest TIER®

## NEW to NAATP

The National Association of Addiction Treatment Providers is pleased to announce a members only section now available on the NAATP web site ([www.naatp.org](http://www.naatp.org)). This area will allow members of NAATP to share information and to interact with each other.

We have launched a bulletin board section which currently contains four topics:

**Benchmarking  
Accreditation**

**Electronic Health Records  
Managed Care**

This feature will allow you to post responses to these topics and to follow the debate, flow of information and ideas being exchanged. In order to access this section, you need to be an employee of a member organization of NAATP and then you can:

1. Go to [www.naatp.org](http://www.naatp.org)
2. Click on **Members** button on the right side of the page
3. Under the **Members** section click on the “**Bulletin Board**” tab
4. Click the **Register** option and follow the directions.

Your request will be then be processed. You will receive an email when you have been approved and you can begin participating and posting on the bulletin board.

We hope to continue to expand this members only section of the NAATP web site and will be looking to you, the members, for suggestions in the future.

THE INDIANAPOLIS STAR, A PROMINENT NEWSPAPER IN THE INDIANAPOLIS, INDIANA AREA, RECENTLY RAN AN ARTICLE RECOGNIZING THE EFFORTS WHICH HAVE BEEN UNDERTAKEN BY THE LILLY CORPORATION (A MAJOR FORCE IN THE AREA), TO ADDRESS THE BRAIN CHEMISTRY ISSUES ASSOCIATED WITH ALCOHOLISM. THE ARTICLE SUGGESTED THAT ELI LILLY AND OTHERS ARE SCOURING THE BRAIN FOR ELUSIVE, LUCRATIVE ANSWERS TO THIS DISEASE. WHILE THE ARTICLE LISTED THE MANY HOPEFUL SIGNS FOR SOLVING SOME OF THESE ISSUES, IT DID NOT REFERENCE WHAT IS NOT BEING DONE TODAY TO PROVIDE TREATMENT FOR THOSE SEEKING TREATMENT. HELEN CROSS, PRESIDENT/CEO OF FAIRBANKS AND A MEMBER OF THE NAATP BOARD OF DIRECTORS RESPONDED WITH THIS LETTER TO THE EDITOR. THE REST OF THE ARTICLE CAN BE FOUND AT: [HTTP://WWW.INDYSTAR.COM/APPS/PBCS.DLL/ARTICLE?AID=2007703260391](http://www.indystar.com/apps/pbcs.dll/article?aid=2007703260391)

The "Science of Sober" Indianapolis Star headline article featured the possibility of great economic news once a pharmacological breakthrough for alcoholism is found. We applaud Eli Lilly and other drug companies for their investment in this research and to the Star for this important feature on alcoholism. Yes, the market is big; there are many alcoholics. Lilly is a welcome partner in treatment. The other news meriting front page coverage is the scientific basis for this important research investment: Alcoholism is a chronic disease! Let's also celebrate and communicate that news! Alcoholics are not cast-away individuals who can't control their drinking. They are people with "a complex biological disorder;" a brain and genetic disease that can be treated. Each year Fairbanks and other treatment facilities provide treatment to thousands of individuals who go forward to lead successful, sober lives, one day at a time.

The Star article reported the disproportionate relationship between persons with the disease of alcoholism and those who receive treatment. What is the story behind those numbers? Part of the answer centers around issues of insurance parity, limited State, Federal and donated dollars to provide treatment and the stigma associated with alcoholism. According to RAND Drug Policy Center, "for every additional dollar invested in addictions treatment, the taxpayer saves at least \$7.46 in costs to society (including incarceration costs)." While we wait for science to advance, why are we holding back on treatment?

The Star accurately reported that, following treatment, many people relapse. Please, however, reconsider describing that reality as "a checkered track record". In a comparison with three other chronic medical illnesses, hypertension, diabetes and asthma, Thomas McLellan reported in his research (2002) that alcoholism had the lowest relapse rate. For the study, McLellan defined "relapse" as requiring emergency room or hospital care. Yet, relapsing alcoholics are often unwelcome guests in hospital ERs.

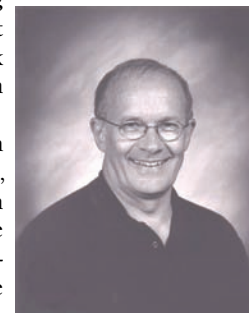
Embracing alcoholism as a disease, we must move forward together with pharma research and, at the same time, encourage more investment in treatment and finally remove the stigma. Thank you.

Helene M. Cross  
President and CEO  
Fairbanks

#### TWELVE-STEP PROGRAMS

The brain recovery story is even better when we talk about twelve-step programs. First, the Big Book of Alcoholics Anonymous (AA) is so far consistent with the latest science. On page xxviii, the Big Book says, "people drink to overcome a craving beyond their mental control". On page 18, it says, "addiction is an illness". Thus, the Big Book seems to acknowledge the difference between abusers and dependent drinkers.

Although A.A. takes in all people with a drinking problem who want to stop drinking, presumably some A.A. members have the brain disease of dependence whereas others are abusers whose lives have become unmanageable as a result of alcohol. This leads to the explanation why some people get better more quickly. Sadly, some people who really want to get better cannot do so, no matter how hard they work the steps. They struggle and sometimes die because of a severe form of dependence disease. However, future brain imaging should be able to a) aid in the diagnosis of those for whom more intensive treatment is needed, b) track the recovery process, and c) help find more effective treatments to help those with a more severe form of the disease.



#### MEDICATION AND ALCOHOLISM AND ADDICTION TREATMENT

Addiction science has provided a solid foundation for understanding the neurochemical problems that take place at the cell level in the mesolimbic dopamine system. Based upon this understanding, new medications have been developed that alter the basic neurochemical process. The medications are not "magic bullets", they require concurrent counseling and/or abstinence-based programs to work best.

The medications work to reduce relapse, enhance abstinence, and reduce craving for the primary drug of choice. All are "non-addicting", do not seem to be abused by people for whom they're prescribed, and have minimal side effects compared to other powerful prescription drugs. The exceptions to the above statement are methadone and buprenorphine, "addictive" medications that work at the same receptors as morphine and heroin but reduce craving and allow opioid dependent individuals to recover at their own pace and hopefully become alcohol and drug-free.

Medications for treating alcohol dependent individuals include naltrexone and acamprosate; for nicotine dependent individuals, bupropion and varenicline. All have been approved by the Food and Drug Administration (FDA) for use in alcohol and dependence treatment, along with counseling.

#### CONCLUSIONS

Science is beginning to support the Big Book of AA, which is fair play since Bill W. (AA Co-Founder), supported the efforts of physicians and researchers in finding help for those affected by alcohol and other drugs. The more science we have, the more varied types of treatment we will have, and the more people will have the opportunity to recover from these diseases. Twelve-step programs will continue be in the forefront of recovery, since people will need mutual support and help to overcome the "wreckage of the past" that dominates the lives of those in early recovery. There is indeed room for all types of help in treating these widespread medical problems.

About the Author: Carlton K. Erickson, Ph.D. is Co-Chair of the NCADD Medical-Scientific Committee and author of a new book on this topic: "The Science of Addiction: From Neurobiology to Treatment", W.W. Norton, New York (2007).

*This article first appeared in the most recent edition of the NCADD's publication, Amethyst. Dr. Erickson is a member of the NCADD Board and Co-Chair of the NCADD Medical-Scientific Committee. This article is used with permission of NCADD.*

## TREATMENT WITHOUT WALLS

**I**n the mid-twentieth century, visionary educators conceptualized new strategies of moving education from college campuses into the very heart of local communities across the country. That movement called for “universities without walls” and spawned satellite campuses, the proliferation of community colleges, and non-traditional degree programs, as well as the vision and development of Internet-based college communities. A similar revolution is quietly unfolding in the behavioral health care field.

Through most of the era of modern addiction treatment, the health of a treatment organization was measured first by the size and attractiveness of its treatment facility or treatment campus and then by the number and geographical dispersion of such facilities/campuses. In my early career as a young CEO, I oversaw the growth of the size and number of my organization’s service facilities in tandem with the growth of annual budgets, numbers of employees and service capacities. Much of my energies were absorbed in capital fundraising and the details of building these structures. When one thought of addiction treatment in these years, one thought of a physical campus that enveloped employees and volunteers and the individuals and families they served. The active ingredients of addiction treatment were delivered inside the boundaries of these campuses. Our goal was to get people in need of services from their natural living environment to our service environment. That model of service delivery is changing, and doing so with little fanfare.

When I look at the evolution of behavioral health care, I am struck by the trend of reaching beyond the boundaries of our physical plants to take services to people where they live and work. The histories and current activities of NAATP organizational members and the larger treatment field illustrate this shift. That reaching out process has spawned parallel industries: employee assistance, student assistance, professional assistance (e.g., physician health programs), and intervention services. It has sparked specialized services within the criminal justice, child welfare and public health arenas, and an ever-widening range of services provided by traditional addiction treatment organizations. As a field, we are moving beyond the boundaries of our campuses and delivering both traditional and innovative services in new locations and through new delivery media.

This trend far transcends the early development of satellite facilities and co-location experiments with other providers. This is not simply doing more of what we’ve always done in new locations. This is more than crossing local, regional, national and international boundaries. When Betty Ford Center staff members travel to British Columbia to provide services to the Alkali Lake Band, it marks our movement beyond the model of inpatient care that has dominated modern addiction treatment. When Hazelden offers telephone- and Internet-based continuing care, it marks our escape from the confines of our physical campuses.

The history of Chestnut Health Systems mirrors many modern addiction treatment organizations and the shift in identity from that of a provider of institutional care to a provider of a wide array of community-based services. Our early history was marked by the expansion of residential services for adults and

adolescents, the replication of those services in other locations, and then a marked diversification of services and delivery formats. The latter included the acquisition of other organizations providing family and mental health services and increased outpatient and home-based services, but it also included prevention and early intervention services in educational settings, development of an employee assistance service division, and development of a research and training division. In our employee assistance subsidiary company (Chestnut Global Partners), we have established equity joint ventures in other countries and built an international network of service providers, with current development focusing on South America and China. Through this global expansion we provide a variety of behavioral healthcare services to both local nationals and expatriates and families working abroad literally thousands of miles from our historic base of operation. Today, we serve clients who will never see Chestnut’s major facilities and do so through staff and consultants who are increasingly work from remote offices or their homes. This shift has required new ways of thinking about how to deliver services and new approaches to managing employees and service contractors and consultants.

Addiction treatment organizations in the private and public sector were criticized in the 1990s for having become isolated from the grassroots communities out of which they were born. There was concern that addiction treatment had become disconnected from the larger and more enduring process of addiction recovery. I believe those criticisms were justified. Today, addiction treatment providers are moving back into the life of our communities, and we are re-involving ourselves in recovery-related policy issues that go far beyond those touching our institutional interests. We are exploring ways to reach the large numbers of individuals and families impacted by addiction who do not currently seek treatment. Rather than waiting on the cumulative consequences of addiction to bring them to us, we are reaching out to identify and engage them before such devastation is reached. We are rebuilding our relationships with local communities of recovery and rebuilding our volunteer programs and alumni associations. We are getting involved in recovery housing initiatives. We are, quite simply, moving back into the center of life in our communities.

In our early development as a field, we asked “How can we get the person suffering from severe alcohol and other drug problem from their world to ours?” Our answers to that question generated highly successful models of intervention and biopsychosocial stabilization, but long-term recovery outcomes lagged as this model became ever-briefer under the influence of an aggressive system of managed behavioral health care. Today, we are asking, “How do we nest and anchor the enduring process of recovery within the natural environment of each client, or failing that, help each individual construct an alternative, recovery-conducive environment?” Answers to that question are pushing us to shift from an acute model of intervention to a model of sustained recovery management. In that process, greater resources are being directed

toward reaching people in those natural environments and finding ways of delivering sustained recovery support services within those environments.

The shift from institutional to community models of care will require significant changes on our part and significant changes in funding and regulatory policies governing addiction treatment. Ironically, our physical infrastructures may actually shrink as we increase our service presence in local communities. Concerns about transferring institutional learning to natural environment and the growing emphasis on delivering long-term recovery support services will alter the very identity of addiction treatment organizations and blur the boundary between institutional care and natural recovery support systems in local communities. The focus will be on continuity of contact in a sustained recovery support relationship. In that shift, we will have transitioned from a singular focus on recovery initiation to a broader and more sustained focus on recovery maintenance. We will have achieved the status of treatment without walls.

**RUSSELL HAGEN/ CEO**  
**CHESTNUT HEALTH SYSTEMS, INC.**  
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## UPCOMING EVENTS FOR YOUR CALENDER

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

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

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

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

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

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

The **Network for the Improvement of Addiction Treatment (NIATx)** will hold its first annual summit, "Improving Access and Engagement in Addiction and Behavioral Health Treatment" on **April 23-24** in **San Antonio, Texas** in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment and the Robert Wood Johnson Foundation. For more information and to register, visit [www.NIATx.net](http://www.NIATx.net).

## NAATP VISIONS

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