VISIONS

Vol. 15 No. 6
August, 2009

A lot of lessons still to be learned

As the August recess moves closer, pressure increases to produce on Health Care Reform

re-form (ree-fawrm) - Over the course of the past year, we have heard and seen this word "*reform*" used in a variety of contexts, but most notably associated with health care. It has become a benchmark argument that the most developed country in the world has the most individuals who are not covered by some health care plan. Depending on the source, that number may be as high as **48 million** individuals! These are the people you see in emergency rooms seeking routine care for issues which others receive from their primary care physician. These 48 million receive their health care, if at all, at the most expensive point within the delivery system.

> *I suffer no illusions that this will be an easy process. It will be hard. But I also know that nearly a century after Teddy Roosevelt first called for reform, the cost of our health care has weighed down our economy and the conscience of our nation long enough. So let there be no doubt: health care reform cannot wait, it must not wait, and it will not wait another year."*
> – President Barack Obama, February 24, 2009

The second argument for "reform" is that health care inflation is driving the cost of health care beyond the reach of individuals and forcing US business to move their operations out of the country in order to remain competitive. We have reached or are about to reach the point where what we want to do in the area of health care exceeds our ability to pay for doing it! A very sobering conclusion! Because of this, the language has been carefully chosen to talk about reform, not tweaking, not adjustments, not realignment, but reform. This has been great campaign language, but now with the hard work ahead, the going is getting tougher.

As the debate has progressed, it has become clear that for most players with a stake in the outcome, AMA, pharmaceutical companies, AHA, insurance companies, and a whole host of other professional societies and professional associations, including NAATP, it has become difficult to focus on reform and not on protecting the way it is and working to get more of what we currently have. Health Care Reform has turned out to be a discussion about fundamental change, and it is considerably more difficult than just *adjusting what is.*

So where are we as we begin August 2009? On June 9, the Senate Health Education, Labor and Pensions Committee released its 615 page version of a health care reform bill. You will often see this referred to as the **HELP** bill. This bill called the "Affordable Health Choices Act", lays out the frame work for addressing the lowering of the cost to deliver health care in this country and improving the quality of health in this country. A part of this fundamental discussion shift is to begin to think and therefore design systems that promote health as opposed to treating episodic illness incidents. **Within this bill there are nine (9) core benefits which must be part of any and every health insurance (public and private) plan. Mental Health and Substance Abuse Services are listed as one of the nine core benefits!**

On the House side, June 19 saw the release of a discussion draft by the House Committees on Ways and Means, Energy and Commerce and Education and Labor. This 850 page document has become known as the "House Tri- Committee bill". This bill also contains a core benefit section and in this bill there are 10 core benefits and mental health and substance use disorder services is listed as one of the 10!

From a historical perspective, we (addiction treatment field) are much further along than we were during the Clinton Health Care Reform process. Nevertheless, there will remain a lot of work to be done and not a lot of time. The administration is pushing to have one of these bills passed before the August recess. However, there is a lot of positioning as both the House and the Senate are waiting for the other chamber to open full hearings so that they can really judge the public and the "vested interest" response and push back.

For those of us in the addiction field, we also need to strengthen the language in both versions. While we are

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NAATP
National Association of Addiction Treatment Providers

Open Letter from One Who has Attempted to Promote "Principles before Personalities"

Depending on where you start the clock or the calendar, the modern addiction treatment endeavor has always had its fair share of characters, personalities, ego's and conflicts. When the National Association of Addiction Treatment Providers published its 30 year history in 2008, the material was presented through the words of individuals who had been influential in shaping the direction of that association. Not all of those voices spoke or sang in harmony. There have always been those whose words were either sharp or flat in comparison to others. Nevertheless, there has never been, nor should there ever be, any place for personality attacks! Personality attacks are inevitably vindictive and serve no purpose beyond gratifying the spleen of the perpetrator. Worse still they divert energy and focus away from the crucial issues which deserve our fullest and most uncontaminated attention!

During the course of the 12 years that I have been privileged to serve the membership of the National Association of Addiction Treatment Providers and to represent NAATP and its interests in larger circles of addiction treatment, I have worked to ensure that our focus is on ideas and not personality. This stance, which welcomes divergent ideas, has allowed us to enlarge the table for discussion and to avoid getting tripped up by the personality voicing the issue. All of us in the field who are in recovery from addiction and/or co-dependency know that we are made vulnerable by our egos, our idiosyncrasies, and our strong or fragile personalities (depending on the day!); there are no exceptions! However, we also know that it is precisely because of this generalized awareness that our imperfections are accepted, and our ideas are given a fair hearing. At least, that is the value system I have attempted to promote, and have worked hard to ensure that NAATP is an association where it is both cherished and preserved.

Recently the boundary of acceptability was crossed. In two consecutive issues of Treatment Magazine two individuals and two organizations were singled out for ridicule, and personal attacks. There is no place for this in journalism and there is no place for this in professional relationships. There is too much at stake. Our focus must be on making sure that:

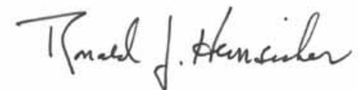
(a) addiction is recognized as a chronic disease; (b) that alcoholics and other addicts can lead extremely productive and fulfilling lives when their disease is managed properly; and (c) that appropriate health care reimbursement is legislated into existence for the treatment and management of this disease. Focusing on the behaviors and personalities of individuals, both past and present, only diverts energy away from the real issues in the field and provides those who are still suffering from the disease with yet another excuse to avoid recovery.

I call on all of you to do two things:

1. Communicate in whatever way you choose to the publisher of Treatment Magazine that potentially libelous personality attacks of the type cited above are not acceptable; and

2. Commit yourself to participating only in discussion about issues and not personality exploitation.

We need help in articulating and exploring the issues in our field that are important to our effort today and which will shape our future tomorrow. Those persons, organizations and publications that can help us with this should be valued and supported; those that resort to tabloid personality attacks need to be called to accountability or boycotted. Yes, we all have our characters, our egos, our idiosyncrasies and our personalities, but it is our focus on issues that will shape our future.



Ronald J. Hunsicker
President/CEO, NAATP

Yes, Your Son Can Have an Eating Disorder

Samuel S. Lample, MA, LPC

Remuda Ranch Programs for Eating and Anxiety Disorders

Although documented cases of boys with eating disorders date back to the 1600s, many Americans, health professionals included, act as if a boy could never be diagnosed with anorexia or bulimia. Despite the presence of textbook eating disorder symptoms, including extreme weight loss, pervasive body focus, constant food talk, binge eating, or self induced vomiting, parents and professionals typically make efforts to identify a physical cause for the symptoms rather than recognize the obvious--an eating disorder. The increasing prevalence of eating disorders among women and girls during the past 40 years and an apparent scarcity of men coming forward to talk about their disordered eating, have created a myth that eating disorders are gender specific, for females only. This notion is being challenged as more and more males, boys to adults, are seeking help for anorexia, bulimia, and binge eating disorders.

Professionals have long accepted that males constitute 10% of the eating disorder population, one male with an eating disorder for every 10 females with an eating disorder. Estimates suggest 1 million males and 10 million females in the United States with anorexia or bulimia, a staggering number in its own right. Yet Dr. Arnold Andersen, a leading expert on males with eating disorders, reflects on more recent research and posits that males are more likely to represent 25-30% of the eating disorder population. This percentage would suggest 2.5 to 3 million males now struggling with anorexia or bulimia. Coupled with clinical experience, more than enough evidence exists that a 10 year old boy, the star quarterback of the high school football team, and the anxious, driven father of three may have an eating disorder. Therefore, the need for heightened awareness and understanding of eating disorders in males has never been greater.

The behavioral symptoms of eating disorders are similar across genders: Significant weight loss, food restrictions, bingeing, self-induced vomiting, compulsive exercise, low self-esteem, and body preoccupations. The medical symptoms are also largely the same: Changes in heart rate, either too slow or too fast, the grey or yellow appearance of the skin, hair loss, eroding tooth enamel, scars on the knuckles or cracking around the lips from self-induced vomiting . One symptom specific to males is low testosterone. Inadequate nutrition can interfere with the production of testosterone, arresting puberty and resulting in the absence of pubic hair, delayed voice change, and mood fluctuation, or, in mature men, leading to decreased interest in sex, irritability, fatigue, and loss of muscle. It is not uncommon for teenage males with eating disorders to need testosterone replacement early in treatment to help restore pubertal progression. Mature men may also need testosterone replacement.

Emotion regulation, or the ability to exert appropriate control over one's feelings and associated behaviors, is paramount to eating disorder treatment, particularly with males. Due to male stereotypes and unhealthy role modeling, boys often learn to hide or ignore their feelings to avoid appearing weak or feminine. Males with eating disorders are likely have a higher emotional baseline than their peers. This increased emotionality, the perception of being different, and the lack of coping skills joined with the culture's increasing emphasis on the male body, is pushing males toward eating disorders. It is difficult for people with eating disorders to identify the true stressors in their lives; as such, the concrete nature of body focus and body change provides them significant relief from their much less tangible emotional distress. In addition, eating disorder males struggle with very low self-esteem, problems with aggression, substance use, and identity confusion--all impacting their ability to develop and maintain healthy relationships.

Boys with eating disorders appear to struggle with social skills and even seem suspicious of new people entering their lives. This may be linked to problems with trust and safety stemming from the nuclear family. A sample of patients from ReddStone, the nation's only eating disorder treatment center exclusively for boys, suggests high rates of substance use in one or both parents as well as broken family systems. Both dynamics negatively impact the father's role in teaching the boy how to deal with emotion, relate in a healthy way to men and women, and develop a male identity. Deficits in these areas result in a vulnerability to uncomfortable emotions like rejection and loneliness, triggering eating disorder or other self-destructive behaviors to contain these emotions.

In larger social context, Western culture is rapidly increasing its emphasis on the male body. Images of the unclothed male body inundate various print and visual media sources, strongly suggesting what the ideal male body should look like. The result is an increased body focus in males, often leading to early dieting, extreme health obsessions, and even steroid use, as males try to force their bodies into the ultra thin, yet highly muscular physique they constantly see in the media. For most boys and men, due to their varying genetics, this physique is almost impossible to attain without extreme measures and intense body obsession.

With many factors coming together to create and perpetuate eating disorders, treatment needs to be multi-faceted. Due to the physical consequences and unhealthy eating patterns associated with eating disorders, treatment teams need to include at minimum a therapist, primary care physician,

Continued on Page 4

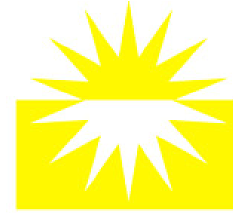
Fallon Community Health Plan appoints David W. Hillis to Chair of Board of Directors

Fallon Community Health Plan (FCHP) announces the appointment of David W. Hillis, President and CEO of AdCare Hospital of Worcester, to Chair of the Fallon Community Health Plan Board of Directors.

Hillis has serviced as a member on the FCHP Board of Directors since 2003, and in addition to serving on the boards of several community organizations, he is also a member of the Board of Directors for the National Association of Addiction Treatment Providers, a Fellow in the American College of Healthcare Executives, and a Fellow in the American College of Addiction Treatment Administrators. He also maintains several professional affiliations in the fields of hospital administration and alcohol and drug abuse.

Hillis, who has more than 40 years of hospital administration experience, has been President and CEO of AdCare Hospital of Worcester since 1974. Under his leadership, the hospital has become the most comprehensive provider of substance abuse services in Massachusetts.

A resident of Worcester, Hillis has received numerous honors for his work, including the Administrator of the Year Award from the American College of Addiction Treatment Administrators, an Honorary Doctor of Humane Letters from Endicott College, and a 30-year Achievement Award from the Hospital Financial Management Organization.



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Continued from Page 3

and dietician who specialize in eating disorders. Often, a psychiatrist is needed as well. Evidence suggests greatest efficacy for a cognitive-behavioral therapeutic approach. Family therapy becomes imperative when the identified patient is a child. Coping skills training enables patients to tolerate the emotional pain experienced during treatment. Dialectical Behavior Therapy, which focuses on emotion regulation and skills acquisition, is also effective and essential in treating eating disorders in males. Finally, males need activity based, side-by-side therapies. These allow for mentoring and coaching, which assist in identity and character development and teach males how to interact in healthy ways with other males.

Yes, it's true: your son, brother, or husband could have an eating disorder. Denying this truth gives the illness time to become entrenched but early intervention leads to better outcomes. An essential starting point is educating parents, school systems, students, health professionals, and government agencies about the growing problem of eating disorders in boys and men throughout the Western world.

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June 2009

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Key Principles:

- Ensure Universal Coverage of Health Insurance for All
- Ensure the integration of physical and behavioral health care
- Ensure that all Health Insurance provide a benefit for the diagnosis, treatment and management for addictive disease disorders
- Remove all impediments to accessing specialized treatment for addiction services including the IMD Exclusion under Medicaid

Policy Brief: Health Reform

Background

The National Association of Addiction Treatment Providers believes that successful national health care reform must balance limited resources, limitless research and innovation and the interplay of one diagnosis on another. This complicated landscape has resulted in several independent funding streams and several independent health care delivery systems. Successful national health care reform must attempt to integrate funding streams and delivery systems into a functional system that funds and provides affordable health care to all.

Such an integrated system must include both payment for and access to equitable and adequate alcohol and other drug addiction treatment and recovery support systems in all public and private health care plans and must promote prevention, early intervention, recovery and research.

This major epidemic which is ravishing our country already has the research to demonstrate:

- Alcohol and drug addiction is a treatable chronic disease – just like cancer, diabetes, and heart disease. Adequate funding for addiction treatment yields results and returns similar to the treatment of other chronic diseases. **For every $1 spent on addiction treatment, we realize $7 in reduced heath care costs over the life of that treated individual!** *"Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA)". Gerstein et al., for California Department of Alcohol and Drug Programs, 1994)*

- Research shows that a health care approach is the most effective means to treat and manage drug and alcohol addiction and the damaging consequences of untreated addiction. **For every $1 spent on addiction treatment, we realize $12 dollars in savings to society by reducing work accidents, cost to incarcerate, and other cost to not treat this disease.** *National Institute on Drug Abuse. (1999).*

- By expanding and improving the health response to addiction, health care reform can save tens of thousands of lives and billions of dollars, while strengthening families and communities across the country.

Any healthcare reform proposals considered by Congress must increase the capacity of alcohol and drug treatment and recovery services by ensuring that all public and private plans provide adequate and non-discriminatory insurance coverage of addiction treatment and the management of this disease over the life of the individual. In addition to increasing the "coverage" for addiction treatment access for all those who want treatment, no matter the funding stream, must be guaranteed.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Congress should build on the success of the recently enacted Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act by passing meaningful health care reform that ensure both coverage and access to comprehensive and universal coverage of addiction treatment and mental health services to all. *It cannot be overstated that coverage or having a benefit does not guarantee access.* Therefore we must ensure that the intent of this law is carried forward into the regulations pertaining to this law and also in any heath care reform. **We cannot realize any long term cost benefits unless barriers to accessing the needed care for this disease are removed!**

The National Association of Addiction Treatment Providers believes that Health Care Reform should be built on the following principles:

1. **Ensure Universal Coverage of Health Insurance for all**
   a. All persons covered by health insurance receive a basic benefit for the treatment of alcohol and other drug addictions
   b. Health care reform should ensure that the full range of alcohol and drug intervention, screening, diagnosis, treatment and recovery support services are *available and accessible to all who need them*
2. **Health care reform should ensure that alcohol and drug addiction is viewed, treated, and researched as a primary, progressive and chronic disease.**
   a. Increase the focus on providing disease management services over the life of the individual
3. **Ensure the integration of physical and behavioral health care**
   a. Eliminate the "behavioral health carve out" practice
   b. Integrate the use of HIT with behavioral health services
4. **Determinations about who needs what services, levels of care, and lengths of stay must be made by treatment professionals guided by the establishment of best practice principles**
   a. Establish a consensus of specific and measurable criteria as to what constitutes positive outcomes is an essential element of a reformed U.S. health system.
5. **Remove all impediments to accessing specialized treatment for addiction services including the IMD Exclusion under Medicaid**
   a. By integrating all revenue streams into one integrated delivery system, the potential exists to greatly reduce or perhaps eliminate a number of federal and state funding sources outside of the health care system

NAATP represents exceptional organizations providing exceptional addiction treatment healthcare

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Continued From Page 1

included and listed in the core benefit section, in the other "pages" there is considerable silence and noticeable lack of specific reference to the term substance use disorder. A coalition of organizations that includes NAATP has sent its recommendations to the staffers to clarify the language issue and suggestions have been made regarding inserted language.

As the days of August continue to track on the calendar, you can expect to hear from NAATP as it monitors the following issues:

- Will there be a public insurance plan offered to everyone?
- Will the "intent" of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act be recognized and incorporated into any final health care reform bill?
- What role will electronic health records play in health care reform and how will the addiction field address 42CFR in order to be incorporated into this process?
- Will there be an increased recognition of addiction as a chronic disease and if so, how will this affect both the way in which treatment is delivered and the way in which treatment is purchased and paid for?
- Will there be greater integration of the private and public addiction treatment delivery system?
- Will there be a greater integration of addiction treatment into primary care medicine?

President Obama has said that he will not sign a bill that does not achieve the reforms that he has outlined as essential. All of this brings us back to the issue of reform. What we are learning is that this process may not be so much about protecting what has been, but about rethinking the way we understand this disease and the way in which we deliver treatment for this disease. Recently the *Institute for Research, Education and Training in Addictions (IRETA)*, based in Pittsburgh, PA published a booklet entitled *When Knowing the FACTS can Help in Pennsylvania* and in it they document that for every dollar spent on addiction treatment within the acute model (single treatment episode) there is a life time savings of $4.86. However, for every dollar spent on addiction treatment within a chronic model (lifetime management of the disease) there is a life time savings of $37.72! Those numbers speak for themselves. Our description of addiction as a chronic disease will need to result in designing systems of care (systems of recovery) that emphasize the life long management of this disease! That will be health care reform!

NAATP Launches PAC Campaign

45 Days designated as official NAATP PAC 2009 Campaign

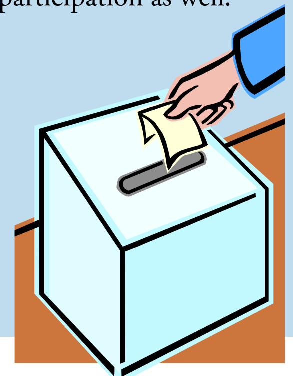
During the 2009 NAATP Annual Conference, Mr. Ed Diehl the Chair of the NAATP **Political Action Committee (PAC)** announced the official launch of the NAATP **PAC.** This is consistent with our efforts over the past two years to increase our public policy activity and represents only the second *Political Action Committee* created by an addiction association. We believe that it will serve us well as we move forward. Mr. Ed Diehl was asked and accepted the invitation to chair the committee which will guide and direct the NAATP PAC. At the annual awards luncheon we launched this effort and had nearly $5,000 pledged by those in attendance!

Recently Mr. Diehl sent out a letter to the Chief Executive of all members of NAATP encouraging them to participate in this initiative event. In that letter, Mr. Diehl explained:

"Now is the time to roll this out to the entire membership! Between now and September 1, we are asking you to give serious consideration to making a contribution to the NAATP PAC and to encourage all of your "salaried staff" to also make a contribution. Remember Political Action Committee's can only receive contributions from individuals. I am enclosing the NAATP PAC brochure which gives you all the particulars on this effort as well as some common questions and answers as well as a guideline regarding contributions. We will accept contributions to the NAATP PAC at any time, but each year we will designate a specific time frame as our "campaign". Between now and September 1 is the campaign for 2009."

If you have any questions, or if you would like additional brochures, contact the NAATP office at 717-392-8480. In the letter to all NAATP member organizations, Mr. Diehl also shared; "I am pleased to announce that I made the very first contribution to the NAATP PAC and now invite you to join myself and your colleagues in ensuring that we continue to be recognized and have a voice in the political process as it impacts addiction treatment which is so very vital to all of us."

This is a bold step forward taken by NAATP and it is a journey which needs your participation as well!



The NAATP executive was recently asked to suggest 10 questions that individuals should ask when seeking a treatment organization for themselves or a loved one. The following are the ten that were suggested by the NAATP executive.

10 Questions to Ask When Searching for an Addiction Treatment Program

Perhaps the most important process to undertake once the decision has been made to seek treatment for your addiction or the addiction of a family member is "how do I go about making the best decision on matching our needs with the strengths of a particular treatment organization. Just as there are appropriate questions to ask when seeking the *best* place to receive treatment for cancer, heart disease or surgery, so that same discipline needs to be applied to seeking treatment for addiction.

It is just as important to ask the right questions for treatment of addiction so these questions have been developed to assist you in determining which treatment organization best meets your needs.

1. Is your organization licensed by the state in which it operates and accredited by a nationally recognized health care accreditation organization?

It is extremely important that the delivery of health care be both regulated and periodically reviewed. By being licensed and by being accredited, an addiction treatment organization commits itself to maintaining the highest standards possible and to participating in continuous quality improvement processes.

2. Will you provide a listing of your clinical staff and their credentials?

Treatment of addiction is so linked to the clinical staff that delivers the treatment that it is important for you to review the clinical staff and their credentials. You need to be comfortable both with the staff and their training and experience.

3. Have you had any lawsuits filed against your organization in the last three years?

While lawsuits are not necessarily an indicator of negligence, they may give you information about the culture of the organization and the way others have experienced the organization.

4. How will communication occur with my family and designated others concerning my treatment?

It is absolutely essential that you and your family understand the communication process in terms of frequency, and quality of communication. What input will you have in terms of decisions about your treatment, etc are best addressed prior to commencing treatment. Clear expectations and clear accountability eliminates a lot of anxiety as the treatment process progresses.

5. What is the cost of treatment within your organization and what are the payment options?

We all know that the good health and recovery from addiction is priceless, but at the same time all of us are limited by our resources. It is important to have the treatment organization completely explain **all** the costs associated with treatment in their organization and review the various payment options. Their experience with insurance is very important to understand and to recognize that you may be responsible for any unpaid balance not covered by your insurance company.

6. What limitations will be placed on my personal activities?

Addiction treatment may contain a different component than some other forms of health care. You may have your phone and contacts with family and friends limited. You may be required to participate in activities provided by the treatment organization. It is critical that you have these options explained to you prior to engaging in treatment.

7. What do you expect to be the result of treatment provided to me through your organization?

When you have a hip replacement, it is standard to ask the physician what to expect in terms of mobility, range of motion, etc after surgery. Likewise, it is important to ask the treatment organization what to expect in terms of change, behavior, etc as a result of treatment. Since addiction is a chronic disease, treatment is about getting you started on the path of managing the disease for the rest of your life.

8. What resources do you provide in assisting me to manage my disease for the rest of my life after I leave your treatment program?

For most persons, the treatment experience is the beginning of a journey that lasts the rest of their life. This disease needs management as does hypertension, diabetes, etc. You should know what support services this organization has available for you and what is and is not included in your total costs.

9. How will my other medical professionals be informed about my treatment for addictive disease disorder?

As health care becomes more and more integrated, communication between all health care providers will grow in importance. Knowing the position this organization takes in terms of keeping or not keeping your health care providers informed will be critical.

10. What is your position on the use of medication to assist me in maintaining abstinence both initially and long term?

There is a growing reliance on the use of medication to assist person with their abstinence. For some persons the decision to use medication frees them up to take the step toward recovery. For some organizations, the use of medication is not part of what they offer. It is essential that you get all the information possible on the different ways to approach treatment for your disease and that you select an organization that offers an approach that best meets your needs.

Welcome New Members

GARR - GA Assoc of Recovery
Doraville, GA

Breakthrough Recovery Outreach
Tucker, GA

Miracle by the Bay
Carlsbad, CA

Above it All Treatment Center
Lake Arrowhead, CA

Preparing for Major Healthcare reform

In the June 2009 issue of *Behavioral Healthcare* (Vol. 29, No 6), the NAATP Executive offered some possible consequences for addiction treatment. This piece has sparked some lively discussion in terms of looking at our tendency to "protect our own interests" vs. fully participating in a major overhaul of the health care delivery system and the health care finance system.

A customized link has been developed for persons to read this article. For the full text of the article, you can go to http://behavioral.net/hunsicker0609.

In future issues of *Behavioral Healthcare* NAATP members and Staff will be sharing their insights.

To submit an article for consideration in Visions or for our advertising rates please email aabshire@naatp.org aor contact the NAATP office at 717-392-8480For advertsiing pricing or

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The Changing Face of Older Adult Addiction

The Baby Boomer Generation is comprised of 77 million individuals born between the years of 1946 and 1964. Both leading and trailing edge baby boomers came of age under entirely different circumstances than their parents and their children. Idealistic in their youth, they set out to change every American institution and they continue to be a driving force of change in our social framework. Their influences include the Vietnam War, man's first walk on the moon and many other political and social milestones. Today, another "Boomer" turns 50 approximately every 7 seconds.

The baby boomer profile is almost a paradox; they have spent lavishly on goods and services but want to recapture idealism. Youth oriented, they have kept many a plastic surgeon in business. They reject labels like "senior"or "older adult"and they oppose ageism. Some are helping aging parents while others still support kids in college or returning adult children. Many feel the pressure to keep working beyond retirement, may feel trapped, and yearn for a sense of fulfillment and freedom.

At Hanley Center, we are already seeing a new pattern in age 50+ or "Young Older Adult" addiction that differs from those aged 65+. Traditionally older adults tend to suffer from alcoholism or prescription medication addiction. What we are finding with older Baby Boomers reflects national statistics. According to the Substance Abuse and Mental Health Administration (SAMHSA), illicit drug use increased by people in their 50's over 60 percent. The study was conducted between 2003 and 2005, but we are also seeing patients in their mid-60's with heroin or cocaine addictions.

Recently, a 66-year old CEO was admitted to a local trauma center emergency room for severe symptoms of abdominal pain, vomiting, nausea and diaphoresis. When his medical workup showed only slight dehydration, he received a diagnosis of viral syndrome. His next visit was to the Hanley Center admissions department. He was admitted with a diagnosis of heroin dependency, intranasal route. The hospital E.R. did not test him for this, because they couldn't conceive of a 66-year old executive doing illicit drugs.

His story isn't unique. As Baby Boomers age, we'll see more of them turning to illicit drugs, just as they did in their 20's. We are diagnosing more comorbidities like hepatitis C, as symptoms surface after decades of dormancy.

In pursuit of health, youth and happiness over a lifetime, Baby Boomers are also widely dubbed as the "Me Generation."They embrace a complex set of values, including a great belief in the quick fix, for anything from rocky marriages (the divorce rate is three times higher for Baby Boomers than their parents) to physical discomfort. "Better Living Through Better Chemistry"sounds like a jest but it became a reality for many who grew up in the 60's and 70's. Many were introduced to the psychedelic age by 60's LSD guru, Timothy Leary, who entreated his followers to "turn on, tune in, and drop out."Young people at the time were also influenced by rebellion against their parent's generational values, as well as theVietnam War and the nation's civil rights crisis. Their idealism and energy was rewarded in social change and the creation of the country's wealthiest generation.

The Poly-Pharmaceutical Profile

Baby Boomers demand services of all kinds and with this, choice and answers to their questions and problems. They can be "health nuts,"who link eating organic foods and running ten miles a day to optimum health, while at the same time, millions of those over age 50 take poly-meds. The pharmaceutical industry reinforces this age group's very low tolerance for discomfort with consumer advertising for pills that promise to solve everything. These patients are coming to Hanley Center with an average of 4.5-prescription drugs and 3.5 over-the-counter medications being taken concurrently. When Baby Boomers visit their physicians, 60 percent of them leave the doctor's office with a prescription. The most commonly prescribed class of drugs is the Benzodiazepines. We don't see the patient present to treatment with just one medication. Virtually every Young Older Adult is admitted to Hanley with a poly-pharmacy.

The addiction profile for Baby Boomers is usually a complex issue as well, with dependency on both alcohol and prescription pain medications, and prescription meds with illicit drugs. Increasingly, a significant number of Baby Boomers are revisiting their old habits of illicit drug use. This is no doubt linked to a number of factors, including more available leisure time. They may find themselves face to face with such issues as loss of youth. This can be staggering for both sexes as it encompasses a loss of a sense of purpose, feeling unattractive, facing end of career, and diminished physical abilities and stamina. Increasingly, health becomes an issue. Many have suffered a loss of spouse or family member, or are caring for an older family member.

The effects of addiction in an aging population

There are jarring juxtapositions in Baby Boomer attitudes: health and vitality, self help versus demand for service and instant relief. We need to remember that in aging, there is angst for them in losing control, losing a sense of purpose and power. Baby Boomers have been confident that they would be "younger"at advancing age and live longer than their parents, and now they are experiencing, in growing numbers, tangible arthralgia, Diabetes Mellitus Type II, and other chronic conditions. These Young Older Adults profoundly feel the impact of social, physical and mental changes in their lives.

The significant increase we have found in dual diagnoses among those from age 50-65 includes anxiety, depression, and bi-polar conditions. Are bi-polar disorders on the rise in this age group as a result of better diagnosis or because of poly-drug and illicit drug use? We can't be sure, but with better diagnosis, we can

more effectively treat the individual holistically.

Physical changes occur in the aging process, and they are exacerbated significantly with addiction. Other conditions that are not generally associated with addiction are also related to substance and alcohol abuse. At Hanley Center, Axis 3 diagnoses are seen repeatedly, including hypertension, diabetes, cardiac disease, cancer, lung disease, chronic pain and liver disease.

Treatment: meeting challenges with effective therapies

When Baby Boomer patients enter Hanley Center, they face a powerful obstacle. Educated and often professional, these patients are cognitively oriented, and they're fighting the loss of personal control over their lives. They want and expect instant cures. To be back in control seems to be an overwhelming priority as they begin primary treatment. In this respect, it is paramount that we help these patients understand the neurobiological and biochemical consequences that have resulted from addiction that they must now face, accept and integrate into a long-term recovery process.

Treatment of older adults at Hanley Center has had a strong medical component from its conception, and entails a longer detox and slower primary treatment program than other age groups. Generational values are consistently addressed, including the recognition that traditional older adults judge illicit drug dependency as immoral, and in fact, suffer a strong stigma regarding even the concept of addiction.

As we address the new generation of older adults, we've developed an innovative holistic treatment model that is medically and psychologically intensive while it fully engages the individual in his or her own recovery. Detox can be a challenge due to a complex drug profile that creates difficulty in detox and recovery, as well as a "quick fix"mindset. Treatment requires an educated approach. We know that while choice is a priority with Baby Boomers, it is key that the patient does not self-direct treatment. For example, we have seen formerly fit patients engage in obsessive and risky physical exercise.

Because of the prevalence of poly-drug use, and high incidence of dual diagnosis, a ninetyday primary treatment program is recommended, with aftercare. Baby Boomers are generally not adverse to therapy; in fact self-help is familiar to most of them. After a thorough medical and psychiatric evaluation, patients respond to developing a personalized care plan with their professional team that includes wellness, spiritual, medical and psychological components.

Group therapy has shown to be more effective with Young Older Adults than with those 65+, who do better with more one-on-one counseling sessions. We have found that interactive therapies such as Dialectical Cognitive Therapy are especially effective in dual diagnoses such as bi-polar and borderline personality disorder, which emphasizes mindfulness and coping with disruptive and functionally impairing mood swings. Meditation and yoga are skills that are helpful for life-long recovery and balance. Menopausal and postmenopausal women find Hormonal Shift Assessment and self-care plans insightful, supportive and therapeutic as well. The loss of a spouse often requires grief therapy.

Treatment of patients with psychiatric conditions require appropriate treatment with psychotropic medications in primary care, balanced with holistic therapies rooted in the Twelve-Step Philosophy that will make a difference in coping, in interpersonal relationship development and perhaps most importantly, in spirituality, including finding their purpose of life.

In treatment, gaining tools to explore one's purpose is as vital to life as getting out of bed in the morning. What were the ideals of this person when he/she was young? How has this changed over the years? Accomplishments of life may not seem as fulfilling when one's career is waning, or the children live far away.

We also know that wellness therapies such as therapeutic massage are more appealing when offered in an aesthetic setting that helps build self-esteem and recognizes the person as an individual first, not just a patient. What is attractiveness as we age? Learning to value life on a daily basis, savor the moment as well as nurture and express individual talents, build relationships and explore how to meaningfully contribute are powerful components of real recovery for this age group.

Baby Boomers have profoundly impacted American society and institutions since the 1960s, from the sexual revolution to conscious raising to the Internet age. Today marketers are scrambling to reach this generation effectively and health care providers are forecasting ballooning future needs. Addiction treatment for aging Boomers must be holistic in its approach, addressing not only complex substance abuse histories but also generational attitudes and values. Lives and dynamic human resources are at stake.

For More Information

If you would like more information about the Changing Face of Older Adults Addiction or other programs and services at Hanley Center, please call 561-841-1000 or 866-4HANLEY.

Dr. Barbara Krantz
CEO & Medical Director of Research
Hanley Center
NAATP Board Member

Upcoming Events

The 19th annual Addiction Studies Institute will be held August 19-21, 2009, at the Greater Columbus Convention Center, Columbus, Ohio. This year's event will again be sponsored by Talbot Hall, Addiction Medicine at The Ohio State University Medical Center. Keynote/featured speakers include Carlton Erickson, PhD., Brené Brown PhD, LMSW, and Steven Grinstead, LMFT, ACRPS, CADC-II. Mark your calendars and make plans to attend this outstanding Institute. Twenty-one credit hours will be available for this three-day event. For further information regarding cost, lodging and registration go to www.addictionstudiesinstitute or contact Garrison and Associates at 614-273-1400.

NAADAC, The Association for Addiction Professionals, in conjunction with co-hosts including the Association of Utah Substance Abuse Professionals, (AUSAP) and NALGAP, the Association for Lesbian, Bay Bisexual, Transgender Addiction Professionals and their Allies, will hold its 2009 "Sowing the Seeds for Recovery" Annual Conference on August 19-22 in Salt Lake City, Utah. For more information, visit www.naadac.org.

The Substance Abuse Program Administrators (SAPAA) will hold its 2009 annual conference on September 14-17 in Austin, Texas. For more information, visit www.sapaa.com.

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

The SECAD 2010 will be held February 21-24, 2010 at the Gaylord Opryland in Nashville, TN. For more information see www.secad10.com.

The National Association of Addiction Treatment Providers (NAATP) will hold its 2010 Annual Addiction Treatment Leadership Conference on May 22-25, 2010 in San Antonio, TX.

NAATP VISIONS

NAATP VISIONS is published ten times a year by NAATP. Information printed in NAATP Visions does not represent official NAATP policy or positions.

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