NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS

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addiction LEADER

THE NEWSLETTER of the NATIONAL ASSOCIATION of ADDICTION TREATMENT PROVIDERS

SUMMER 2016 Volume 1 | Issue 1

IN THIS ISSUE

naatp.org

Addiction Leader is the quarterly newsletter of the National Association of Addiction Treatment Providers (NAATP).

The NAATP is a professional membership society of addiction service providers.

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MISSION
To provide leadership, advocacy, training, and member support services to assure the availability and highest quality of addiction treatment.

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EXECUTIVE DIRECTOR'S COLUMN

EVOLUTION OF PROVIDER PERSPECTIVE: Moving Beyond False Dichotomy

By Marvin Ventrell, JD, NAATP Executive Director

Marvin Ventrell became the fifth chief executive of the National Association of Addiction Treatment Providers on May 1, 2015, continuing his 30-year career as an attorney, teacher, writer, association director, and policy advocate.

His career has been devoted to building and implementing legal and health care system responses to the needs of people in crisis.

dichotomy | dīkätmē |
noun
a division or contrast between two things that are or are represented as being opposed or entirely different: a rigid dichotomy between science and mysticism.

Science is How God Thinks.

If the above-referenced epigraph causes discomfort, we have a problem. It shouldn't. Scientists should not be offended by the G word and spiritualists should not be offended by the S word. It is a tired and tiring discussion, this god-versus-science business, one that the addiction profession has wrestled with for decades.

One might argue that it was resolved in the 1950s with the Minnesota Model of treatment that embraced a multifaceted and integrated approach to care. One might even argue that it was resolved in 1939 when the writers of Alcoholics Anonymous included *The Doctor's Opinion* in a spiritual text, identified alcoholism as a disease, and encouraged alcoholics to seek professional care where needed. Yet the apparent dichotomy of science and spirit continues to exist in our work and emerges as a roadblock to good care when we attempt to improve upon what we have. Until we put it to rest, our effectiveness as care providers will be limited.

IS IT SCIENCE OR SPIRIT?

The answer is, of course, that the question is not susceptible to an either/or answer because the question is framed unfairly. It poses a false dichotomy, also called false dilemma or the fallacy of a false choice. A false dichotomy presents limited alternatives when, in reality, there is at least one additional option. In debate, false dichotomies can be presented out of ignorance (the questioner does not know any better) or intentionally, when a fallacy is used in an attempt to force a choice or outcome that traps the responder into the questioner's predicate.

False dichotomies are also presented to force one to choose sides to an argument rather than acknowledge the mutual compatibility of alternatives. This has the effect of polarizing the argument and even demonizing the answerer. In other words, "If you are not with us, you are against us."

False dichotomies are easy to frame. They are convenient. They may even make us feel better; that we are on the right side of the "fight." Humans are drawn to the easy, the convenient, the simple, and the safe. We are also influenced by our personal circumstances and belief systems. When our systems are challenged, rather than exploring complexities and compatibilities, we may take refuge in what we know to the exclusion of what we do not.

For many in the recovery community, this is understandable. It is not everyone's role to parse arguments and synthesize practices. We should not be surprised if a 12-step member in a meeting discounts treatment or medication as a component of sobriety. That person's life may have been salvaged by strict Big Book application without addiction center treatment, medication, or mental health counseling. They know that the approach they took worked for them, and they don't know what they don't know.

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YOUR PASSION AND COMMITMENT ARE AN INSPIRATION AND WILL BE THE FUEL THAT HELPS US RISE TO CREATE OPPORTUNITIES WHERE OTHERS SEE CHALLENGES.

FROM THE NAATP BOARD CHAIR

The NAATP'S Next Era of Influence is Now

By Carl Kester, Chair, NAATP Board of Directors

In 2015, the NAATP board elected a new executive committee to serve a two-year term. I am excited to have the opportunity to serve as board Chair. The quality and importance of our collective work is inspiring, and it is an honor to be part of the NAATP, a member of the board, and part of an executive team up to today's challenges. I'm pleased to work alongside Past Chair Kermit Dahlen, Vice Chair Art VanDivier, Treasurer John Driscoll, and Secretary Bob Ferguson. The skill, experience, and variety of programs these members represent will be invaluable as we work in support of our new Executive Director Marvin Ventrell in leading our great organization.

Since its founding in 1978, the NAATP has stood at the forefront of the addiction treatment field, speaking with a clear and unified voice on behalf of its 350 member organizations. Those organizations consist of more than 600 treatment facilities that set the standard for quality, caring therapeutic services for men and women, young and old, suffering from addictive diseases. The NAATP has a long history of advocating for fair and equal legal recognition of the services its member organizations provide, with the same fair and equal reimbursement benefits for the patients served by its members. The membership of NAATP covers a wide range of providers, nonprofit and for profit, hospital-based, residential, outpatient, and extended-care facilities, some that follow the time-tested 12-step model and others that have modified that model.

But one clear, unifying objective ties all the membership together—a strong commitment to giving addicted persons and those important to them a new chance at a sober, clean, productive life. The NAATP is their voice, but our membership puts that voice into action.

Over my 12 years on the board, I have had some incredible opportunities to learn what is working for other providers and what their challenges are. We have been able to use the formal and informal sharing of information from our collective experience to gauge the effectiveness of what we do and learn where there are opportunities that fit within our own organization's philosophy and principles. The collaboration with other providers improves our collective work and increases the chance for those we serve to access care and begin to heal.

The board's goal is that all NAATP members have an invaluable experience with the organization and that membership greatly enhances quality of care and the professional experience of those delivering it. Over the next two years, our administrative team's work and board decisions will be directed by committee work. Currently there are committees for Ethics, Finance, Membership, Outcomes, Government Affairs, and our conference. These committees comprise both board members and association members from outside of the board. We are committed to improving the effectiveness of our communication of these activities and the results they achieve.

TODAY IS AN IMPORTANT TIME FOR OUR FIELD'S FUTURE.

The Affordable Care Act, parity laws, and the opiate epidemic are topics that have put our work under a greater spotlight than in years past. This has created new challenges, but also an era that is rich with opportunities to reach those in need of help. Our collective efforts have put us in a position to lead the field and impact care for generations. The times call for us to be at our best. Your passion and commitment are an inspiration and will be the fuel that help us rise to create opportunities where others see challenges. It is an honor to be serving in this position and to work with you.

Thank you for your commitment to the NAATP, and I thank you for all you do.

ETHICS AND PROFESSIONALISM

Creating a Culture of Professionalism and Service

By Art VanDivier
Chair, NAATP Ethics Committee

As the new CEO for a child and adolescent developmental institute, I was invited to attend a corporate retreat for CEOs and business development directors. At the first meeting, a corporate-level financial officer laid a transparency on the overhead projector and said as he wrote, "Our corporation has two goals, first to make money and second [he said smiling] to make even more money."

Years later, I was interviewing the owners of a successful addiction treatment center. I have always been interested in what are referred to as "mom and pop"owners, as there is almost always a great story behind the title. At the conclusion of the interview, I asked what their operational strategies for the business were. They replied, "We have only two goals: patient care comes first, employee benefits next, and we believe if you take care of the first two you won't have to worry about the bottom line."

Clearly, you have to make money to stay in business, but it isn't hard to guess which of these organizations had the best potential for successfully creating a culture of professionalism and genuine service. It might be of interest to note that 20 years later, the above corporation no longer exists, but the treatment center is still operating successfully.

Treatment organizations need to have clearly defined core values. Professionalism is made up of a combination of qualities. Words like honesty, integrity, accountability, responsibility, and clear communication are synonymous with professionalism.

Handbooks filled with policies and procedures, rules, and regulations that give specific direction on legal, ethical, and moral issues will not create a culture of professionalism alone. Core values must be embraced by leadership and reflected in their attitudes and behaviors.

Currently much is being written about unethical behavior in our industry. One wonders if society has reached the point where it is acceptable to abandon core values in the workplace. To let you know this isn't new to the addiction treatment industry, an executive director I worked for in the late '80s drolly said, "It seems in our business, once you set ethics aside, success is a piece of cake." The disturbing thing to me is that in 2016 we appear to be reenacting many of the unethical behaviors that appeared in the late '80s. If you are interested, research that period in our history; it is dark indeed.

The 1980s cycle began with the appearance of a dozen large corporations buying up small treatment centers and building dozens of new centers nationwide. There were widespread media campaigns and lots of television talk show exposure, and for the first time, famous individuals openly shared their struggles with addiction. The treatment business was off and running on a scale never seen before.

In those days, many insurance plans paid generously, and it didn't take long for some treatment providers to over utilize and over charge for medical and clinical services. As the insurance industry caught on, its response was to implement managed care through case management in an attempt to control runaway costs. As competition for the treatment dollar became more intense, patient brokering and referral fees (to name a couple of indiscretions) appeared, and next came investigations at both the federal and state levels, followed by indictments, convictions, and prison terms for some. Many states passed laws restricting how treatment centers could conduct business. The end result was the collapse of a number of large corporations, closing hundreds of treatment centers nationwide. Sound familiar? Today, some appear to be heading toward that same precipice.

Looking back over 35 years of working in the addiction treatment industry, I am still amazed at the thousands of lives I've seen restored. I won't let past or present unethical behavior by some cause me to lose sight of the importance of this work.

As the NAATP moves forward, I assure you we are committed to encouraging the development of a culture of professionaism and genuine service within our industry. Let us know what you are doing to develop organizational core values and how it is impacting the attitudes and behaviors of your employees, patient care, and your other business practices. We don't need a workshop to recognize ethics; professionalism stands out! Let's celebrate it when we find it by supporting those organizations that choose the ethical path.

Editor's Note: The NAATP Code of Ethics provides guidance to treatment providers in their efforts to produce values-based care. Recently, the NAATP adopted a process to field ethics complaints against NAATP members. Read the full text of the NAATP Code of Ethics, Ethics Complaint Procedure, and NAATP Statement of Values at **naatp.org**.

THE NAATP OUTCOMES PILOT PROGRAM

Groundbreaking National Research

By Jessica Swan, NCAC II, CAC III
NAATP Outcomes and Surveys Manager

Transforming from consumer surveys and anecdotal evidence to academic rigor and publishable research in the addiction treatment industry is a necessity as our industry evolves. While there has been much research completed in the public sector, little research has been done in the form of academic national outcomes studies of private addiction programs. At the NAATP, we are conducting a pilot study in order to fill this gap in research.

The Outcomes Pilot Program (OPP) will track patient outcomes from multiple residential and outpatient addiction treatment programs. It will be conducted by the NAATP, together with the research firm OMNI Institute, and it will provide unique cross-program comparison, compilation, and analysis. The research team will collect a large data sample of over 1,000 patients, following outcomes from baseline to discharge, and at five time points for one year after discharge from treatment. Outcome influences will be measured, including the detoxification process, patient engagement, medication, psychological and psychiatric care, education and addiction counseling received, peer and family support, economics, and 12-step activity. An initial draft of the study is expected in the second quarter of 2017.

The data, derived from the instrument created by Norman Hoffman, PhD, will provide benchmarks for not only abstinence but also mental health and after care. Study objectives include compilation of the outcome data for peer-reviewed journal publication and creation of a replication protocol that will be made available for NAATP member providers to use in their treatment centers.

This study is imperative in order to inform our work as treatment providers and to validate the successes we have. The industry lacks this information, and this study is seminal in terms of its outcomes measures, cross-program data, and scientific rigor.

We, as an addiction treatment industry, know that treatment works and saves lives, but we must demonstrate this and gain new information. We must also do it in a fashion that has scrutiny and fidelity and is not connected to a payer or business development motive.

The study, which includes strong fidelity protocols, reviewed by an institutional review board, will be driven by OMNI Institute Senior Researcher Holen Hirsh, PhD. Data will be collected under the supervision of OMNI staff through the following treatment center pilot site participants. The pilot participants are all successful, highly regarded treatment programs that represent a broad sampling of addiction treatment patients.

THE TREATMENT CENTER PILOT SITE PROGRAMS ARE:

- Addiction Recovery Resources of New Orleans
- Ashley Treatment Centers (formerly Father Martin's Ashley)
- Caron Treatment Centers
- Hazelden Betty Ford Foundation
- Jaywalker Lodge
- New Directions for Women
- Seabrook House
- Sundown M Ranch
- Tully Hill

Measurements used in the OPP include standardized self-report instruments measuring substance use, substance use consequences, history, and general functioning. A clinician review is an additional component in the study, providing treatment data and chart review insights from a clinical perspective. The OPP is a randomized study design, falling under the umbrellas of the observational study and the interview.

Outcomes research has been notoriously difficult in the addiction treatment industry due to the nature of the brain disease and the behaviors associated with the disease. With the impact of confounding factors, such as selection bias, access to care, therapeutic expectations, financial means, family, mental capacity/learning, mental illness, and other co-occurring illness, progression of disease, and other follow-up data collection problems, it can seem impossible to do the work required. However, these difficulties in data collection should not discourage industry leaders from completing research.

With one in three Americans dying each year from alcohol- or drug-related problems, it is crucial for our field to persevere in outcomes research.

In the past, data collection was dependent upon an interview process between a clinical worker and the patient who self-reports. While the OPP relies on this process, data collection also can take place via text, email, phone, and web. Technology provides us more opportunity for data collection and precise measurement, if the data is initially collected properly. Our research staff will train pilot site staff on the how-to's of data collection in order to ensure this is done accurately. Data will be collected at several time points from over 1,000 subjects at nine residential addiction treatment programs in the United States. All data will be input into a dashboard designed specifically for this study, and it will provide sites with a timely, current picture of their data collection progress. Each site provides the same number of subjects in order to have same size sample across sites.

Input data that is de-identified at the site level will be automatically uploaded to a confidential dashboard that our staff will analyze. We will be producing periodic reports on the progress and data as we see it throughout the study. The final products include a research publication. Ultimately, the research has the potential to provide standardization in the addiction treatment field and the ability to create benchmarks for providers.

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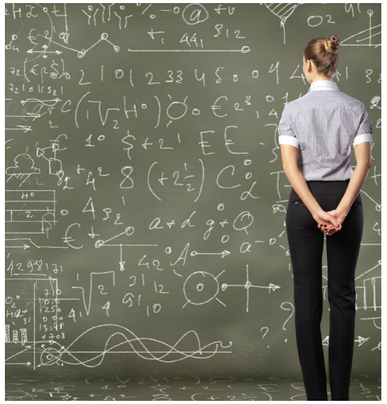

There are common goals across the health care community with regard to outcomes research. Typically, the main goal of health outcomes research studies is to attempt to achieve the best approximation of the truth of the treatment-outcomes relationship. The goal, therefore, is to establish if a given treatment causes a particular outcome. In the OPP, we are collecting data at many residential programs from substance use disorder patients to see which X treatments might bring about which Y outcomes.

AS A RESULT OF THE PILOT STUDY, THE NAATP HAS SEVERAL SPECIFIC GOALS:

1. Refine methodology based on study
2. Complete Outpatient Outcomes Research Pilot
3. Complete a toolkit and provide to membership
4. Publish journal article
5. Provide industry benchmarks

With the growth in our industry and the potential to provide more treatment to more people, the addiction treatment field must seek to perform the highest quality research. The OPP hopes to fill some current gaps in research studies within the not-for-profit/profit sector of addiction treatment outcomes.

Please look for our periodic reports providing you with updates on data collection and insights as we move through this seminal project.

NAATP LAW AND PUBLIC POLICY ADVOCACY

Your Voice on the Hill

By Mark Dunn

We are nearing the end of the Obama Administration. During the past seven and a half years, I think everyone would agree that incredible changes have occurred in the health care field, whether or not they supported them.

Certainly the Affordable Care Act (ACA) is at the top of that list. The inclusion in the ACA of the Mental Health Equity and Addiction Parity Act (MHEAPA), passed during the Bush years, has changed the outlook for treatment of the disease of addiction for many years to come. Getting residential addiction treatment included as one of the 10 essential health benefits was also a gigantic step.

As with any change in administrations, there will be a lapse in activity as a new cabinet is chosen, vetted, and put in place. That will occur regardless of who wins the White House this fall. Given that incredible successes have already been achieved, there is a natural instinct by some to enjoy the fruits of their labor and wait for new opportunities under the next president.

The NAATP will not to fall into that mode. There is still a great deal that can and should be accomplished in the next eight months. If our field continues to push, some very positive outcomes are still possible that could greatly benefit those who are still suffering. There is still "unfinished business" that can be achieved if we continue the momentum. In my opinion, this is no time to coast.

The obvious example is our continued focus on enforcement of the requirements under Parity. Violations continue to occur on a daily basis all across the country. Enforcement is made more cumbersome due to the initial responsibility at the state level. Federal guidelines to the states would at least provide a roadmap for enforcement and should be a priority. The NAATP will continue to advocate for federal guidance through any possible avenue. Those avenues are directly from the federal government agencies as well as through congressional legislative action. We have recently learned that the federal agencies have been working on this, and progress is forthcoming.

A recent success story is the Senate passage of CARA, the Comprehensive Addiction and Recovery Act. This has been another example of what can happen when there's bipartisan support to deal with a critical issue facing our country. While it certainly does not solve all the problems in the world of addiction treatment, it does take some significant steps forward.

The next step will be working CARA through the House of Representatives. We hope to use the momentum from Senate passage to keep it moving in the House. So far we have achieved continued bipartisan support from many members of Congress.

Another area of focus is the IMD exclusion. The NAATP, along with many of our treatment community allies, offered strong comments to the proposed Medicaid rules, urging elimination of the exclusion. To their credit, our federal agency partners have proposed some changes, even if they are limited and somewhat cumbersome. Nevertheless, we will continue to push for the elimination of this exclusion.

Passage of CARA, Parity enforcement, and IMD exclusion are just a few examples of major items that should be priorities in the next few months. Should these examples be dealt with in a positive way, hundreds of thousands of individuals needing treatment for addiction will benefit.

THE NAATP WILL DO ALL WE CAN TO ADVANCE THESE AND OTHER ISSUES IMPORTANT TO OUR MEMBERS.

A NEW DAY AT THE NAATP

The Revitalization of the NAATP: Office, Brand, Staff, Website, and Action Plan

In 2015, the NAATP Board of Directors committed to empowering the Association for greater success with new and enhanced staffing, financial resoures, and strong accountability and transparency measures. The board recognized that a highly effective organization requires a highly effective (educated, trained, experienced, and knowledgeable) staff directed by a professional chief executive. Following a comprehensive national search process, the board retained Marvin Ventrell as Executive Director, the NAATP's fifth chief executive. Marvin's experience includes a career as an attorney, law school instructor, addiction program director, and founder and CEO of two successful social service agencies. Marvin also identifies himself publicly as a person in long-term recovery from addiction.

The tasks of the new staff included a review of all the NAATP administrative and program activity, completion of an environmental scan of the current addiction industry, and preparation of a new strategic plan. Within 10 months of the installation of the new staff, the NAATP had completed its move to Denver, Colorado, approved a new strategic plan, completed a branding process, begun work on the new website and member management system, and developed a member and stakeholder communications plan. Each of these initiatives is scheduled to launch one year after installation of the new staff at the 2016 NAATP National Leadership Conference in May.

While building new systems and securing a strong foundation, the NAATP also began delivering program service more aggressively in areas including member communications, news releases, visibility, social media, and our conference program. In February 2016, the NAATP launched its Outcomes Program Pilot as well.

The NAATP's revitalization comes at a time when the addiction field faces serious challenges, including access to care, new competition from the for-profit sector, ethics and professionalism concerns, treatment modality integration, institutional integration, and unfavorable industry news coverage.

We are pleased to represent our members as we work together to build best practices.

NAATP staff at the new Denver headquarters, The Chancery Building: Jessica Swan, Marvin Ventrell, Katie Strand, and Tiffany Rode

Read the new NAATP Strategic Plan at **naatp.org**

THE NEW NAATP LOGO!

NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS

Voice. Vision. Leadership.

NAATP members will receive the new logo artwork for your websites and other materials in June.

CONGRATULATIONS

TO OUR 2016 AWARD RECIPIENTS!

NAATP 2016 AWARDS

The NAATP is dedicated to recognizing the outstanding work and achievements of addiction treatment providers.

We celebrate the way these individuals have advanced the ethics, policy, and practice of addiction treatment.

John Hiatt
Singer Songwriter

Jasper G. Chen See, MD
Volunteer Service Award

Peg Wilkerson
Rosecrance Board Member

Jasper G. Chen See, MD
Volunteer Service Award

Nora Volkow, MD
Director of the National Institute on Drug Abuse (NIDA) at the National Institutes of Health (NIH)

Nelson J. Bradley, MD
Career Achievement Award

Alison Knopf
Editor of Alcoholism and Drug Abuse Weekly (ADAW)

Michael Q. Ford
Journalism Award

Nominate Candidates for NAATP's 2017 Awards

- Nelson J. Bradley, MD Career Achievement Award
- Michael Q. Ford Journalism Award
- Administrator of the Year Award

Nominations open online July 1, 2016 at naatp.org

EVOLUTION OF PROVIDER PERSPECTIVE:
Moving Beyond False Dichotomy
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This type of simplistic either/or thinking is not, however, acceptable for those of us leading the addiction recovery profession.

As leaders of a nascent professional field at a critical juncture in our development, it is imperative that we have the training, education, courage, and perspective to dig deeper into the complex issues we face and find the nuances that lie beneath.

To take refuge in the easy false dichotomy will not lead to meaningful solution. It is likely, in fact, to lead to harmful practices and the regression, rather than the growth, of our profession.

A colleague of mine said he disagrees with the move toward evidence-based practices in addiction treatment. I paraphrased his statement back to him: "You disagree with using techniques which we can demonstrate are highly successful in saving lives?" Another colleague of mine told me that he was glad to see that the treatment center at which I then worked was "finally moving to a medical model." When asked what he meant, he explained that it was good to see the center applying medical, pharmacological, and psychiatric care. I responded that really nothing had changed; that the center, using the Minnesota Model that has been in place for decades, had always applied such techniques as they had become known and reliable, in addition to a social and spiritual program.

It seems we do not always know what evidence-based practice or medical model means on the one hand and what a psycho-social-spiritual model looks like on the other. Without that understanding, we are hard pressed to develop policy and implement services that synthesize the best of both worlds. But that is our charge as addiction professionals, and now is the time to use our best thinking.

"ONE-THIRD OF THE U.S. POPULATION DEATHS EVERY YEAR ARE FROM DRUGS AND ALCOHOL."

Environment of Addiction

The need for our best thinking is great. We face an addiction health care crisis in our country with massive health, social, and economic implications. According to one of our most authoritative scientific resources, the Journal of the American Medical Association (JAMA), alcohol use disorders (AUD) affect more people than any other substance or mental health disorder (JAMA, Psychiatry, 2015). According to the same study, of the 32.6 million people with AUD, only 7.7% even sought treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) similarly reports that only 6.3% of individuals 12 and older with alcohol dependence or abuse received treatment the year prior to being surveyed; 9 out of 10 do not get treatment (SAMHSA, Center for Behavioral Health Statistics and Quality, 2013).

Before we even discuss the prescription or illegal-drug market problem, it is plain to see there is a health care crisis that dwarfs many other health care concerns, and it is the same crisis we have faced for decades.

We can assume, conservatively, that 40 million Americans suffer from substance use disorder (SUD), and only 10% receive care. Compare that to the 29.1 million Americans who suffer from diabetes, of which 85.6% receive dedicated medical care (Centers for Disease Control and Prevention, [CDC], 2014).

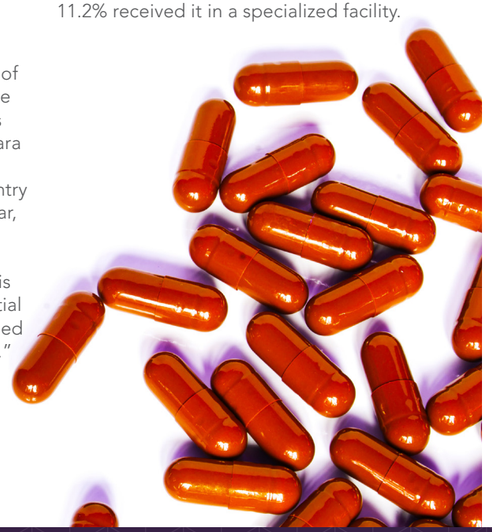
Add prescription drugs to the picture and our crisis worsens. Non-medical use of prescription drugs is growing, with an estimated 48 million people age 12 and older using prescription drugs for non-medical purposes; that is a shocking 20% of the U.S. population (NCAD, 2015). And the addictive qualities of many of these drugs are frightening, particularly opiates. Barbara Krantz, MD, FASAM, ABAM, writes, "One hundred people die every day in this country from accidental drug overdoses. Every year, more than 16,500 people in the U.S. die, specifically, from prescription opiates. In fact, every 19 minutes, a death occurs. This is equivalent to 1.2 million years of potential life lost before age 75. These deaths exceed those from heroin and cocaine combined." The National Institute on Drug Addiction (NIDA) estimates 2.6 million Americans had an opioid addiction in 2012.

ADDICTION RATES AND DEATHS FROM ILLICIT DRUGS HAVE ALSO BEEN RISING STEADILY AND ARE AT ALARMING RATES.

According to the CDC, over 14,000 people died from illicit drug overdoses in 2013, and over 8,000 of those were from heroin alone. In 2013, 42,982 people died from some type of drug overdose (Caron reporting from the CDC). Added to that, the CDC estimates that approximately 80,000 people die from alcohol-related deaths each year. In other words, excluding tobacco, (are you sitting down?) one-third of the U.S. population deaths every year are from drugs and alcohol.

Of course the economic numbers are staggering, as well. Drug- and alcohol-related costs in this country exceed $400 billion annually (USHHS, CDC, and NDIC, 2016).

Despite the numbers, addiction does not receive the attention and response it warrants. The result for those of us in addiction services is the alarming reality that the vast majority of people who need our services do not receive them. Of the fortunate few who receive some type of treatment, only 9% received non-hospital residential addiction care, according to SAMHSA's National Survey of Substance Abuse Treatment Services (N-SSATS, 2013 Data on Substance Abuse Treatment Facilities). Similarly, according to the National Institutes of Health's (NIH) 2011 study, 23.5 million people age 12 or older needed addiction treatment, and only 11.2% received it in a specialized facility.



The Response

The response to the addiction reality in the U.S. should be multidimensional and concurrent. For our purposes, let's look at how that is not often the case in our treatment communities.

The 12-Step Community

It seems axiomatic that 12-step recovery works. Our personal experiences, observations of others, and anecdotal reports indicate the success of the method for millions. The 12-step method is well grounded in behavioral health wisdom that calls for acknowledgment of one's condition, relinquishment of overreliance on self, self-examination and awareness, and implementation of a peer-supported lifestyle.

Some critics outside the 12-step world wrongly criticize AA and its related communities as religious programs that require belief in a deity, self-blame, and human powerlessness. These are misinterpretations of 12-step methodology to be sure, but they also are fostered by members within 12-step rooms themselves. AA, which has its roots in the Christian Oxford Group of the early 20th century, regularly includes Christian prayer, the promotion of the idea of human powerlessness, and the teaching that one's God concept should be an interventionist deity that directs outcomes. Problematically, it is not uncommon to blame those who "fail" at sobriety as not being willing to achieve it. Additionally, it is not at all uncommon to suggest that members who use pharmaceutical therapies are not working a program correctly or are not even sober. Finally, the application and potential misapplication of the principle of anonymity can make 12-step help difficult to access and can inhibit program development and improvement.

Federal Policy

Federal law and policy regarding substance use disorders historically have been focused on blame and criminalization. We have, as William White has said, tried to incarcerate our way out of the problem. That has improved considerably with sound policy statements from the SAMHSA, NIH National Institute on Drug Addiction (NIDA), and the Office of National Drug Control Policy (ONDCP), all making it clear that addiction is a primary and chronic disease of the brain. Additionally, the move toward a national law that addresses addiction as a health care problem and not a criminal one in the form of the Comprehensive Addiction and Recovery Act (CARA) is very promising.

Problematically, however, messaging from the federal government can be rather one dimensional, focusing on "Medically Assisted Treatment," interpreted as a singularly pharmacological response to a multifaceted disease, and it may not incorporate the critical behavioral health therapies that allow people to make necessary life changes. The notion of recovery as a transformation of a person is often neglected.

The Medical and Mental Health Community

Discrete sections of medicine and mental health have been instrumental in addressing addiction from the founding of AA. William Silkworth, MD, treated alcoholics in the hospital setting in the 1920s and wrote The Doctor's Opinion for AA. Pioneering psychiatrist Carl Jung recognized addiction recovery required a psychic change in the way one views oneself. The American Society of Addiction Medicine (ASAM) has worked to address addiction as a disease and empower the medical community to treat it for decades.

Yet it is fair to say that addiction has not been prioritized on par with other diseases in medical schools or care delivery.

Many physicians know little about the need for a comprehensive health care response for the patient suffering from addiction. To the extent that solutions are proposed, they too can be singularly "MAT" focused. ASAM's Guideline for Treating Opiate Addiction does include a psycho-social component as the final guideline, but it does not hold a prominent place. The media effort that launched the guideline in 2015 included anecdotal information from a grieving parent about how the 12-step program had failed his son who tragically died, but no one spoke about how 12-step programs worked well or how pharmacotherapy alone had, in fact, failed some.

The Resolution

Through the foregoing responses, undoubtedly well-intended and even effective when part of a comprehensive whole, we see the positioning of false choices in order to ensure the success of one's favored option.

We are quick to point out the limitations of an approach other than our own, and to minimize or ignore our program's deficiencies.

This needs to stop.

Instead, we need to commit to a higher level of critical analysis of treatment modalities, be willing to credit all options that have merit, and, perhaps hardest of all, criticize and repair our own favored method where limited or flawed. Fundamentalist adherence to our own practices, whether spiritual or scientific, is antithetical to progress.

As an addiction policy executive, I am regularly frustrated by the imbalanced thinking of the particular setting in which I find myself. Among scientists and federal officials, I sometimes find myself imploring the group to learn more about and recognize the value of 12-step and psycho-social-spiritual care. In my 12-step environment, I struggle to advise people that there are multiple pathways to recovery and that for some people, medication is an appropriate component of recovery.

Success in integrating our approaches must include give and take. The medical and scientific communities should take care to learn what really happens in a 12-step psycho-social-spiritual environment and explore the neurobiology of spiritual methods. In-turn, 12-step communities should advance their understanding of brain science, recognize that certain populations require extended MAT, and consider that their program's concepts of spirituality need to evolve.

The addiction treatment provider community is ideally situated to lead an effort to move from fundamentalist false choices toward a learned perception of care. This comes at a critical time when we have both significant interest in addressing addiction as a health care crisis and criticism from the public and policy makers about how we do our work. With a willingness to conduct honest and rigorous inventory of methods, an openness to the unfamiliar, combined with a desire to convene and problem solve together across "party lines," we are poised to produce the best treatment available for the most people in need.

The NAATP displays coffee mugs from its member treatment centers around the country at its new headquarters in downtown Denver.

Join us and bring your mug to the table.

NAATP Member Services

The NAATP is a nonprofit professional membership society that supports addiction treatment providers through leadership, clinical and operational resources, and systemic law and policy advocacy. Member services include training and education, industry surveys, networking and convening, law and policy advocacy, visibility, awards, and recognition, resources, ethics and professionalism, a job center, and publications.

Member Benefits

- **Education and Training Opportunities:** Attend the premier national annual conference for addiction treatment providers
- **Networking and Dialoguing:** Meet other leaders in the industry to share resources and solve problems together
- **Capacity-Building Resources:** Access clinical and operational resources
- A**wards and Recognition:** Nominate and honor the industry leaders you most admire and participate in an activity that features your center
- **Careers:** Find and post job opportunities
- **Salary Survey:** Get salary and benchmark data
- O**utcomes Data**: See how our industry is showing results and learn to measure your own outcomes
- **Policy Advocacy:** Have your voice heard in Congress and at the policy-making level, and learn about our advocacy priorities

Check your member listing or become a member at **naatp.org**

NEW NAATP MEMBERS

Addiction Hope & Help Line
Boca Raton, FL

Akua Mind and Body
Newport Beach, CA

Alpha Healing Center
Jersey City, NJ

AspenRidge Recovery
Lakewood, CO

Azzly
Vero Beach, FL

Bayshore Retreat
Destin, FL

Beachside Rehab
Ft. Pierce, FL

Behavioral Rehabilitation Services
Harrison, MI

Bella Monte Recovery
Desert Hot Springs, CA

Blend Integrated Marketing
Madison, WI

Brass Tacks Recovery
Woodland, CA

California Recovery Centers
Newhall, CA

Canadian Centre for Addictions
Toronto, ON, Canada

CARES Treatment
Celebration, FL

Cold Creek Behavioral Health
Kaysville, UT

College Recovery
New Brunswick, NJ

Constellations Recovery
Yorktown, NY

Cornerstone Recovery Center
Fort Lauderdale, FL

Darryl Strawberry Recovery Center
DeLand, FL

EHD Insurance
Exton, PA

Elevate Rehab
Watsonville, CA

Embark Recovery
Prescott, AZ

Epiphany Resources
Delray Beach, FL

Five Sisters Ranch
Petaluma, CA

Gardens Wellness Center
Miami, FL

Gemma House
Shandaken, NY

Grace's Way Recovery
West Palm Beach, FL

Harmony Place
Woodland Hills, CA

Kemah Palms Recovery
Kemah, Texas

Key Mentoring
Los Angeles, CA

Lifeline Connections
Vancouver, WA

Luminance Recovery
San Clemente, CA

Maneuver Up Marketing
Traverse City, MI

Meridian Behavioral Health
New Brighton, MN

Mountainside Estate for Women
Moscow, PA

New Beginnings Recovery Center Denver
Littleton, CO

New Life Addiction Treatment Center
Palm City, FL

Next Chapter Addiction Treatment
Delray Beach, FL

Northpoint Recovery
Boise, ID

Oceanica
Mazatlan, Sinaloa, Mexico

Oceanview Treatment Solutions
Boynton Beach, FL

Palm House Recovery Center
Athens, GA

Peaks Recovery Centers
Colorado Springs, CO

QUALHEALTH
Huntingdon Valley, PA

Recovery Centers of America
King of Prussia, PA

Recovery Worldwide
Orlando, FL

Sabino Recovery
Tucson, AZ

Sagewood Recovery
Maple Ridge, BC, Canada

San Diego Student Recovery
San Diego, CA

Sandstone Care
Denver, CO

Serenity House of Broward
Wilton Manors, FL

Skip Murphy's Structured Sober Living
Portland, ME

Steps to Recovery
Levittown, PA

Summer House Detox
Miami, FL

The Hills Treatment Center
Los Angeles, CA

The Hope Center for Rehabilitation
Boynton Beach, FL

The Lighthouse
Westport, CT

The Raleigh House of Hope
Denver, CO

TIME Recovery Center
West Palm Beach, FL

Vertisense
New York, NY

Waters Edge Recovery
Stuart, FL

West Coast Wellness Centre for Women
Maple Ridge, BC, Canada

Windward Way Recovery
Fort Lauderdale, FL

ZenCharts
Boca Raton, FL

2016 NAATP National Leadership Conference

THE 38TH ANNUAL NATIONAL ADDICTION LEADERSHIP CONFERENCE

The Addiction Industry at a Crossroads: Treatment System Evolution and Synthesis

Over 100 exhibitors, 60 faculty presenters, and 500 addiction professionals are registered for the conference. Session topics include Parity implementation and enforcement, the NAATP Code of Ethics and complaint policy, the neurobiology of spirituality, and treatment program integration. Special leadership roundtable discussions will be held to allow thought leaders to create action steps to improve responses to insurance matters, ethical marketing issues, and the mergers and acquisitions climate.

Harbor Beach Resort
Fort Lauderdale, Florida
May 15 - 17, 2016

ADVOCACY

The NAATP PAC

The National Association of Addiction Treatment Providers Political Action Committee (NAATP PAC) was formed in 2008 to help support and elect political candidates who understand and support the legislative and regulatory concerns that affect your organization and our association, which represents addiction treatment providers.

The Power of a Collective Voice

As the business of addiction treatment has become increasingly scrutinized, it is important that the concerns of the NAATP and its member organizations are heard and heard clearly.

NAATP PAC contributions do more than support candidates who understand our issues; they leverage our individual contributions into a powerful collective voice that demonstrates the strength of the NAATP.

Who Is Allowed to Participate?

Salaried employees of NAATP member organizations may contribute to the NAATP PAC, but are precluded from participating via payroll deduction. No contribution is too small, and members may contribute up to $5,000 annually. Only personal contributions are allowed under federal law.

Participation and support is strictly voluntary. Neither the choice to participate nor the amount of your contributions will have any effect on your position or advancement as a NAATP member organization.

For more information and to contribute to the NAATP, please visit **naatp.org.**

JOIN US FOR THE 39TH ANNUAL
NATIONAL ADDICTION LEADERSHIP CONFERENCE

NAATP 39th National Addiction Leadership Conference

2017

May 21 – 23, 2017
Omni Barton Creek Resort and Spa
Austin, Texas

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