2007, Volume 2

National Council
MAGAZINE
A quarterly publication from the National Council for Community Behavioral Healthcare

Treating Addiction Disorders

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Watch for the National Council's new bimonthly e-newsletter on Addictions Treatment in late fall 2007.

Treating Addiction Disorders

Science has improved our understanding of addictions as an illness and has helped us make tremendous progress in treatment and care. Behavioral health providers all over the country are working hard every day to help those with addiction disorders lead productive lives and contain the harmful consequences and costs to society of untreated addictions. What challenges do providers face in clinical and funding terms? What have they been able to accomplish with existing resources?

This issue of the *National Council Magazine* brings you a range of provider successes and challenges as well perspectives from experts in addictions treatment and policy. It is intended to serve as a source of information and ideas you can use for addictions treatment and prevention programs in your communities.

The National Council Magazine is a publication of the National Council for Community Behavioral Healthcare, 12300 Twinbrook Parkway, Suite 320, Rockville, MD 20852.

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We welcome your feedback and submissions for future issues of the National Council Magazine on Access and Retention, Children's Services, and Board Development.

editorial

Addictions Treatment: Still Limited After All These Years

Linda Rosenberg, MSW, President and CEO, National Council for Community Behavioral Healthcare

It's my great pleasure to introduce this issue of the *National Council Magazine* devoted to addictions services. This issue reflects the National Council's increasing attention to addictions services and to our member organizations that provide those services; our view that freedom from addictions and mental illnesses is integral to overall health; and our belief that we can win the fight for parity only if the addictions and mental health advocacy communities fight together.

Addictions has come a long way from the days when it was perceived as a moral failure and lack of willpower. Today, there is growing public awareness and acceptance of addiction as a treatable disease. But there is a long way to go.

According to a June 7 analysis published by *Health Affairs*, employer-sponsored coverage for substance abuse treatment continues to have annual limits and lifetime caps on treatment visits and inpatient days and also requires higher cost sharing than coverage for general medical care. Jon Gabel of the National Opinion Research Center and colleagues found that in 2006, 19% of workers with employer-provided health insurance had some coverage for addiction problems, but only 19 % had plans that offered unlimited office visits and hospital stays, as is typical in other areas of healthcare.

Gabel and colleagues estimated that deductibles for addiction services averaged 46% higher than those for medical and surgical conditions. Moreover, 40% of employees were required to pay coinsurance for addictive disorders, compared to 12% for other medical conditions.

In a second article published the same day, *Health Affairs* reported that many workers are exempt from state mental health "parity" laws aimed at bringing private-sector mental health benefits more in line with coverage for other types of disorders. As a result, as of 2003, only one-fifth of U.S. workers with employer-sponsored health insurance were covered by "strong" parity laws that mandate mental health benefits, prohibit limits on outpatient visits and inpatient days, and limit the extent to which enrollees can face higher cost sharing for mental health services.

"People who try to get care for substance abuse but aren't successful most often say that cost is the reason," said Gabel. "Substance abuse is a treatable chronic medical condition, similar to diabetes or heart disease, and the economic costs of not treating substance abuse can be many times the costs of treatment. Yet the higher cost sharing for substance abuse problems that many workers face can discourage them from seeking treatment. In addition, limitations on inpatient days and outpatient visits, as well the failure to limit out-of-pocket costs, can discourage the long-term treatment and follow-up that substance abuse, like any chronic disease, often demands."

> *It is as chronic medical conditions that mental illnesses and addictions can come together — and fight for equality.*

There are both shared and distinctly different policy and practice issues among mental health and addictions services, but as the Institute of Medicine urges, "Healthcare for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body." It is as chronic medical conditions that mental illnesses and addictions can come together — and fight for equality.

This is a challenging but exciting time. The mental health and addictions fields have the potential to make enormous strides in generating public support to end discrimination and to adequately fund services. Importantly, no matter whether sweeping healthcare reforms or incremental progress lie ahead, through our continued efforts we can help assure that mental health and addiction services are treated as an integral part of healthcare by national, state, and local policy-makers and private-sector decision-makers. Working together, addictions and mental health groups can be at the healthcare table and on the agenda of the 2008 presidential candidates.

Others will be in the fray, we must be as well.

Linda Rosenberg, MSW, leads the National Council and its 1,300 members in serving 6 million children, adults and families with mental illnesses and addiction disorders in communities across the country. Prior to joining the National Council in August 2004, she served for seven years as Senior Deputy Commissioner for the New York State Office of Mental Health. She led the implementation of evidence-based practices for adults and children, tripling New York's assertive community treatment capacity, initiating a major expansion of children's systems of care services and developing an extensive array of housing options for people with serious mental illness. She also implemented a network of jail diversion treatment programs and was instrumental in the opening of New York's first mental health court. A certified social worker, as well as a trained family therapist and psychiatric rehabilitation practitioner, she has extensive experience in hospital and community psychiatric treatment and rehabilitation programs. Rosenberg has held faculty appointments at several schools of social work and serves on numerous agency and editorial boards.

Measuring Outcomes Enhances Addictions Treatment Access and Retention

Maureen Fitzgerald, Editor, Network for the Improvement of Addiction Treatment

In response to increased demands for accountability and performance measures in addictions treatment, states and providers are turning to process improvement strategies to improve both treatment services and the bottom line. Since 2003, members of the Network for the Improvement of Addiction Treatment (NIATx) have demonstrated how process improvement can make a significant difference in the way agencies provide care, and the way states and providers can forge partnerships to improve service delivery.

A new NIATx initiative, Strengthening Treatment Access and Retention–State Implementation (STAR-SI), funded by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment and the Robert Wood Johnson Foundation, promotes state-level implementation of process improvement methods to improve access to and retention in outpatient addictions treatment.

Since October 2006, STAR-SI grantees have received funding to implement process improvement strategies targeting fiscal, regulatory, and policy changes. In each pilot state, the Single State Substance Abuse Authority Director and a designated state team change leader work in partnership with managed behavioral health organizations, state provider associations, NIATx treatment providers, and other stakeholders to develop provider learning networks and pilot improvements to get more people into treatment and keep them there longer.

The NIATx model of process improvement relies on collecting and measuring data to quantify the impact of change. Measuring the impact of change enhances process improvement efforts by

a. *Identifying which changes worked.*

b. *Understanding which changes resulted in the most significant improvement.*

c. *Providing feedback/reinforcement to the team.*

Collecting and measuring performance outcomes are key components of the STAR-SI initiative. Dr. Jay Ford, Chief Research Officer for NIATx, suggests that a performance management system can also serve as a mechanism to provide feedback to providers and use newly established learning communities to support the ongoing dissemination of knowledge. "Such systems help agencies learn from each other and then leverage the knowledge to move more toward a culture of improvement within the organization," Dr. Ford says.

The State of Maine was inspired to apply for the STAR-SI project by the success a Maine provider — The Acadia Hospital in Bangor — experienced as a participant in an earlier

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Acadia Measures How Process Improvement Affects Patient Outcomes

One process improvement project at The Acadia Hospital in Bangor, Maine, measured how NIATx process improvements affected patient outcomes. Acadia Hospital was using the BASIS-24 questionnaire in all of its mental health and substance abuse inpatient and outpatient programs to measure client functioning at time of admission and again at either mid-treatment or discharge to assess treatment outcomes.

"We realized that we had the opportunity to use BASIS-24 to find out if patients still got better after we implemented the NIATx changes that reduced waiting times and increased admissions," says Dr. David Prescott, Director of Psychology Services and Clinical Research for The Acadia Hospital. One of those changes was to increase the use of group therapy, rather than individual therapy, as the primary emphasis of treatment for the majority of clients.

"Moving to more group therapy freed up counselor time to complete intakes," explains Prescott. "Yet staff were concerned that the outpatient group therapy would not be as effective as the individual therapy. They couldn't argue that we were seeing more patients, but they could question whether those patients were getting the treatment they needed."

The BASIS questionnaire results showed that by their own reporting, patients got a lot better — even with the change from individual to group therapy. "Sharing the BASIS results with staff proved the effectiveness of the NIATx process changes," Prescott says.

In general, the research is consistent in finding that addictions treatment yields net economic benefits to society, mainly due to reduced crime and victimization, improved health, and greater employment

Addictions Treatment Pays — Saves Costs, Saves Lives

Steven Belenko, PhD, Temple University and Treatment Research Institute at the University of Pennsylvania

Addictions and substance abuse remain among our most serious and costly health and social problems.[1] Government agencies have invested significantly in treatment services aimed at reducing the impact of alcohol and illegal drug use. However, the behavioral health system faces growing challenges to sustain treatment funding, improve resource targeting, choose among alternative treatment models, and maximize treatment effectiveness. With soaring healthcare costs, states are likely to increasingly require that programs demonstrate cost efficiency, as well as positive client outcomes.[2] Economic analyses can help policy makers and behavioral health providers make informed decisions about treatment and cost containment.

This article briefly summarizes findings and policy implications from a comprehensive systematic review of the economic effects of drug treatment, including treatment costs, cost-effectiveness analysis, and cost benefit analysis.[3] That review was based on 51 published and 17 unpublished economic evaluations of substance abuse treatment between 1990 and November 2004 that had not appeared in previous reviews.[4] Standard search criteria and methods for conducting systematic literature reviews were utilized — details of the procedures used can be found in a previous report.[5] This article focuses on findings for adult community-based treatment.

Treatment Costs

To make informed decisions about allocating scarce treatment dollars, policy makers need a better understanding of the relative costs of providing treatment in different settings and for different clients. Lower treatment costs may yield greater cost-effectiveness or higher net economic benefits. Variations in treatment costs reflect the size of the programs, the costing methods used, staff and administrative costs, geographic differences in cost of living, and the frequency and types of services.

Costs (standardized to reflect the cost per week of treatment in 2004 dollars) vary widely depending on modality and client population. For example,

- Methadone maintenance program costs ranged from $80 to $100/week per client, but given the longer treatment stays in methadone programs, the costs per treatment episode tend to be much higher than for outpatient treatment.
- Outpatient program costs ranged from $72 to $166/week for standard services, with higher costs for intensive outpatient programs (e.g., $272/week in one study of nine programs,[6] $493/week across six programs[7]).
- Short-term residential treatment has a higher weekly cost than long-term residential treatment ($642 per week per client versus $491[8]).
- Treatment in therapeutic communities (TCs) had an average weekly cost of $626 across five programs.[9] Modified treatment costs in these communities for clients with co-occurring mental health and substance use disorders were relatively high ($707/week), perhaps reflecting more intensive services for co-occurring clients.[10]
- Studies of court-supervised treatment for offenders in the community have found a wide range of costs. Across nine programs, weekly drug court costs were somewhat lower than other outpatient programs ($87/week).[11] Other studies have estimated a wide range of total drug court treatment costs ($3,603 to $11,978 per treatment episode).

RETURN ON INVESTMENT IN ADDICTIONS TREATMENT PROGRAMS

PROGRAM	NET BENEFIT PER CLIENT	BENEFIT COST RATIO
Residential Program *(Washington State)*	$21,329	4.34
Modified Therapeutic Communities program targeting co-occurring mental health and addiction disorders	$21,329	5.19
Drug court program *(across three courts in Kentucky)*	$21,329	2.71

Only a few studies have examined the unit costs of specific treatment services or cost components. Intake assessment costs are a relatively large “up-front” treatment cost. A relatively low percentage of costs are for counseling services (54% in intensive outpatient programs, but only 28% in standard outpatient and 20% in residential programs). The remaining costs are for administrative expenses and overhead, housing, record keeping, and other costs.

Cost Effectiveness Analyses

CEA compares the relative costs of achieving specific health outcomes, and is particularly useful for comparing these costs for two or more interventions. CEA provides an estimate of the additional treatment cost that is needed to achieve a specific outcome for a client. The intervention with lower cost per unit outcome would be preferred, other things being equal.

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Brief Interventions Help Older Adults with Addictions

Lawrence Schonfeld, Ph.D., Professor and Chair, Department of Aging and Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida

With the aging of America, there is increasing concern about older adults who misuse alcohol, medications, or illicit substances. Identification is difficult as many do not exhibit the behaviors of younger substance abusers such as DUI arrests, work absences, or marital problems. Schonfeld and colleagues at the Florida Mental Health Institute of the University of South Florida have shown that elders often misuse alcohol or drugs in response to depression, loneliness, or boredom. Because many misuse at home and alone, they are considered "hidden" abusers.

Reports from the Substance Abuse and Mental Health Services Administration's Office of Applied Studies focusing on people ages 55 and older suggest that there are increasing and unmet needs. The 1999 National Household Survey on Drug Abuse (OAS, 2004) found that 9.4% were heavy drinkers and 2.3% were binge drinkers. Illicit drug use was rare, but on the rise with aging of the baby boomers. However, the Drug and Alcohol Services Information System report (OAS, 2005) noted that this age group represented only 0.1% of all people in treatment.

Prescription medication misuse is very different since it is much less likely to involve recreational use. Elders receive more prescriptions and use more over-the-counter medications. About one-quarter use psychotherapeutic drugs, with benzodiazepines and sedative hypnotics problematic due to the dependence and withdrawal they cause. Errors in use of medications often occur due to complicated regimens, memory problems, and cost. Adverse reactions result in increased medical care and even death.

The Treatment Improvement Protocol #26, "Substance Abuse Among Older Adults," published by SAMHSA's Center for Substance Abuse Treatment in 1998, provided recommendations for improving services including using age-appropriate screening instruments, employing staff trained to work with elders, providing elder-specific rather than age-mixed treatment, and teaching skills to deal with overcoming losses. Brief interventions were also recommended, since few elders enter traditional treatment. BI consists of one to five sessions of education about health and use of substances, identifying triggers for use, and motivation to change behavior. A health promotion workbook included in TIP #26 is used to guide the sessions.

Recognizing Florida's unmet needs for its sizable elder population, the Florida Department of Children and Families' Substance Abuse Program Office funded the development and implementation of a CSAT model known as SBIRT (Screening, Brief Intervention, Referral and Treatment) as a pilot program.

Florida, viewed as window to the nation's future, is the fourth most populous state. Nearly a quarter of its residents are ages 60 or older. DCF funded the Florida BRITE (BRief Intervention and Treatment for Elders) Project in 2004 to identify and serve elders aged 60 and older with problems related to use of alcohol, prescription and OTC medications, and illicit drugs. Elders are also screened for depression and suicide risk. Referrals are identified through outreach efforts as well as through aging services, healthcare providers, and senior housing sites. BRITE counselors use an age appropriate screening tool developed by Schonfeld. They usually screen and then deliver brief intervention in the individual's home. If more intensive services are required, counselors follow the cognitive-behavioral and self-management model in the curriculum "Substance Abuse Relapse Prevention for Older Adults" authored by Dupree and Schonfeld (CSAT, 2005).

From March 2004 through mid-December 2006, 3,102 older adults were referred and screened by the treatment providers in the four counties. About one-quarter of referrals were for medication misuse. About half of all screenings indicated current drinking. Of these, 17% were consuming three or more drinks on a typical day, far more than recommended limits for this age group. Problems with illicit drugs and over-the-counter medications were minimal. However, most notable was that two-thirds of the referrals demonstrated moderate to serious levels of depression. Thoughts about suicide within the past year were reported by 7% of referrals. Outcome data are still being entered and analyzed; however, preliminary results show 526 BRITE participants who received one or more sessions of BI — and with discharge and follow-up data — significantly decreased depression and/or alcohol scores.

BRITE currently operates in five sites. Recently, based on these pilot efforts, Florida was awarded a $14 million, 5-year grant from CSAT to expand BRITE. Current targets are to have 19 sites in 11 counties. Funding will pay for BRITE services as well as prescreening services by aging services, primary care practices, and hospitals.

The Florida BRITE Project illustrates how evidence-based practices can be implemented on a large scale to meet a high priority for the state service systems.

Lawrence Schonfeld, PhD, is Professor and Chair of the Department of Aging and Mental Health at the Louis de la Parte Florida Mental Health Institute, University of South Florida. His research focuses on substance abuse treatment for older adults, elder abuse, and behavior problems in long-term care. He is the evaluator for the Florida BRITE Project and co-author of "Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach," a publication of the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment.

New Reimbursement Codes Pave the Way for Integrated Care

Eric Goplerud, PhD, Director, Ensuring Solutions to Alcohol Problems,George Washington University

The 37th Annual National Council Conference (March 26–28, 2007, Las Vegas, Nevada) laid out an inspiring vision of "Holistic, high-quality, patient-centered healthcare that promotes recovery and a full, productive life in the community for all those with mental illnesses and addiction disorders." Recent developments in medical reimbursement coding may help to make that vision a reality.

In January 2007, the Centers for Medicare and Medicaid Services implemented a new policy to reimburse physicians for services to identify and treat Medicaid patients' problems with alcohol and other drugs.

CMS added two new codes to the HCPCS Level II coding system that Medicaid, Medicare, and other insurers use to process medical insurance claims. Practitioners will use one of the new codes for screening and another when they provide brief intervention so that they may be reimbursed for their services. Screening and Brief Intervention is an effective technique for addressing alcohol and other drug problems, and has been widely recommended as standard protocol by leading professional medical associations.

The American Medical Association is now considering two Category I Current Procedural Terminology codes for physicians and other healthcare providers to report alcohol and/or drug Screening and Brief Intervention. (CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures. CPT is also used for administrative management purposes such as claims processing and developing guidelines for medical care review.) If approved, the new CPT codes will become effective in January 2008.

Less than 10% of adults with alcohol or drug disorders are identified and treated. In comparison, more than 40% of people with depression are diagnosed and treated — most by primary care doctors. By adding new codes, the AMA and CMS are helping to make Screening and Brief Intervention a routine part of primary and emergency medical care. The new CPT codes will encourage doctors to address alcohol and drug problems, leading to a reduction in the tremendous social and medical costs associated with addiction.

In fact, I believe that Screening and Brief Intervention codes will help expand the treatment of addiction disorders to primary medical providers. Making the identification and treatment of addiction disorders the business of family doctors will help to increase the number of people getting treatment.

How can the new codes benefit community behavioral health? Here are some ideas:

- New reimbursement codes give you a chance to get reimbursed for services you may already be providing.
- Finding and addressing addiction disorders is critical to the successful treatment of mental health disorders.
- More screening activity on the part of primary care physicians will increase the number of patients seeking help from community behavioral health providers.

What should you do?

- Find out if your state office in charge of Medicaid has approved the use of the HCPCS codes. If it hasn't, push it to do so.
- If you don't already practice Screening and Brief Intervention, get started. Find out more at **www.ensuringsolutions.org**.
- Build stronger relationships with primary care providers in your community — ask them to make identification of alcohol and drug problems an important part of their practice and encourage referrals for treatment.

Go to **www.EnsuringSolutions.org** for a guide to using existing codes for the reimbursement of screening and intervention services.

Eric Goplerud, PhD, is a Research Professor, Department of Health Policy at The George Washington University School of Public Health and Health Services. His policy and research interests focus, among other issues, on improving access to alcohol screening and treatment. He is principal investigator for contracts and grants with the Pew Charitable Trusts, RWJ Foundation, SAMHSA, US Postal Service, NHTSA, CDC, NIAAA, and NIDA. Dr. Goplerud was Associate Administrator for Policy and Planning at the Substance Abuse and Mental Health Administration. While director of the Division of Planning and Policy Implementation at SAMHSA, he served on the Mental Health Workgroup of the White House National Health Care Reform Task Force, where he had lead responsibility for substance abuse prevention.

What is SBIRT? Screening, Brief Intervention, Referral, and Treatment

Screening, Brief Intervention, Referral, and Treatment

- Five-year national program.
- Funded by the Substance Abuse and Mental Health Administration's Center for Substance Abuse Treatment.
- Expands treatment capacity for substance use and abuse.

New target population

- Addresses persons with nondependent substance use.
- Offers effective intervention prior to more extensive or specialized treatment.

System for assessment, intervention, and treatment

- Community and/or medical setting based.
- Screens and identifies individuals with or at risk for substance use related problems.
- Determines the severity of substance use and appropriate level of intervention.
- Provides brief intervention/treatment within the community setting as appropriate.
- Motivates and refers to more extensive, specialized services as needed.

Is SBIRT effective?

Interventions such as SBIRT have been found to

- Decrease the frequency and severity of drug and alcohol use.
- Reduce the risk of trauma.
- Increase the percentage of patients who enter specialized substance abuse treatment.
- Reduce hospital stays and emergency department visits.
- Yield net cost savings — savings for each brief intervention exceed treatment costs by 3 to 1.

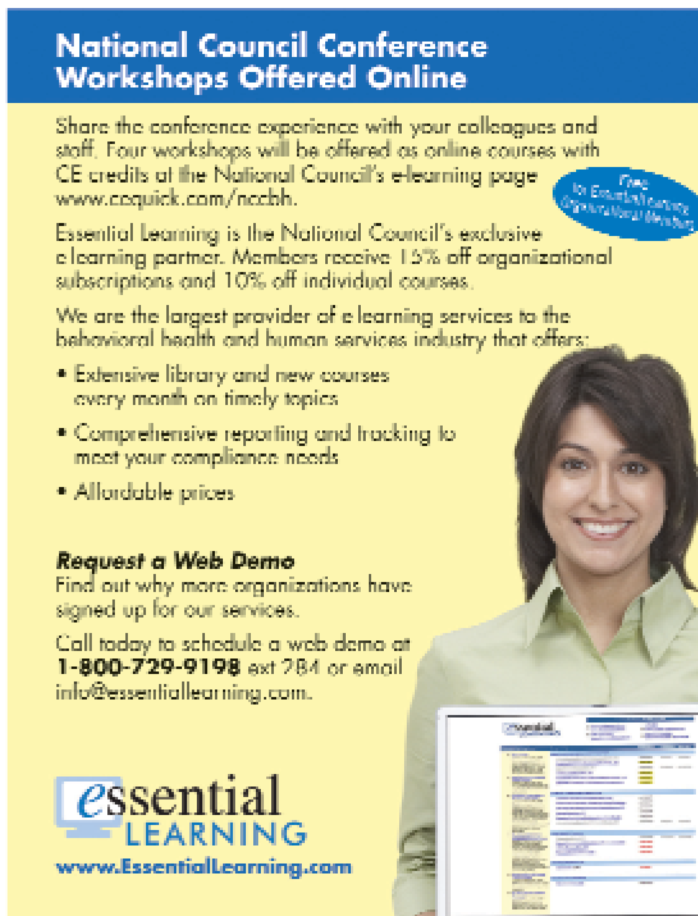
> *Such systems help agencies learn from each other and then leverage the knowledge to move more towards a culture of improvement within the organization.*

Measuring Outcomes, continued from page 2

NIATx program, the Robert Wood Johnson Foundation's Paths to Recovery. Acadia's process improvement efforts improved on each of the four NIATx aims: reduce waiting times, reduce no-shows, increase admissions, and increase continuation. With increased admissions, Acadia increased billable hours, which in turn increased revenue and enhanced its profit margin. Maine's STAR-SI project is unique in focusing on a common goal and outcome across the 10 participating providers. The project is also pilot testing the use of the Maine Association of Substance Abuse Providers website (www.masap.org) to disseminate knowledge to participating treatment providers.

Working together to remove barriers and create incentives to improve treatment access, Maine's Office of Substance Abuse and participating providers will promote continuous process improvement across delivery systems, says Kimberly Johnson, Director of the Office of Substance Abuse for Maine's Department of Health and Human Services. "We've seen how the NIATx model has changed the way providers work, and the STAR-SI project will help Maine transform the way treatment services are delivered across our state."

Maureen Fitzgerald is an editor for the NIATx National Program Office in Madison, Wisconsin. NIATx — Network for the Improvement of Addiction Treatment — is a national program of the Robert Wood Johnson Foundation, the Center for Substance Abuse Treatment's Strengthening Treatment Access and Retention program, and a number of independent addiction treatment organizations. NIATx serves as a unique "learning collaborative" to improve access to and retention in addiction treatment. Treatment organizations joining the initiative learn how to make improvements in their day-to-day practices to serve their clients more efficiently and appropriately based on their individual needs.



In a study of 99 programs, the costs per abstinent case ($6,300) and per reduced drug use case ($2,400) were lowest for outpatient clients, and highest for residential ($14,900 and $6,700) and inpatient ($15,600 and $6,100) clients.[12]

Enhanced outpatient services tend to be more cost-effective than standard services, meaning that the extra cost of enhanced services yielded a lower cost per unit improvement in outcomes.[13] For alcohol-involved clients, less intensive brief interventions have been found to be more cost-effective in certain settings.

Cost Benefit Analyses

In CBA, considered the "gold standard" of economic analysis, the positive effects of the program on post-treatment client outcomes (e.g., reduced rearrests, improved health, or increased employment) are converted to dollar equivalents.

The program costs are subtracted from these economic benefits to determine the net economic benefits. Alternatively, the total benefits are divided by costs to determine the benefit cost ratio. Treatment programs that achieve a positive net benefit, or have a BCR of greater than 1.00, are considered economically beneficial. The higher the BCR, the greater the return on investment in treatment services.

A number of CBAs have been conducted, and the results consistently find that addictions treatment yields positive net economic benefits, with BCRs well over 1.00. The largest proportion of the economic benefit accrues from reduced crime, including incarceration and victimization costs. Other economic benefits reflect improved health and increased employment.

For example, a study of five residential programs in Washington State had an average net economic benefit of $21,329 per client, and a BCR of 4.34. A modified Therapeutic Communities program targeting co-occurring mental health and substance use disorders yielded substantial net benefits of $85,527 per client, and a BCR of 5.19. Three CBAs of drug courts found net economic benefits: the BCR across six drug courts in Washington was 1.74, 2.71 across three drug courts in Kentucky, and 2.8 in the St. Louis drug court.

Conclusions and Policy Implications

In general, the research is consistent in finding that addictions treatment yields net economic benefits to society, mainly due to reduced crime and victimization. Studies of brief interventions, and CEAs of outpatient versus inpatient treatment, suggest that less intensive interventions may be more cost-effective for certain clients (although enhanced outpatient treatment may be more cost-effective than standard outpatient). However, high-need populations such as those with co-occurring mental illness, pregnant or parenting women, or criminal offenders may need long-term, intensive treatment to achieve positive outcomes. More research is needed as to which populations can do well in lower-intensity treatment.

Analyses of the costs of specific treatment components indicate that a substantial portion of treatment costs reflects nonclinical activities. Further research is needed to determine the implications of this finding for treatment effectiveness, but strategies for minimizing the non-clinical costs of treatment may be needed, as well as research on the implications of cost allocation on treatment outcomes.

Noneconomic perspectives (e.g., clinical appropriateness and clinical outcomes) can and should be considered in making treatment funding decisions and drawing conclusions about treatment effectiveness. However, given the current climate of pressure to implement evidence-based treatment practices, performance standards, and performance-based contracting, the behavioral healthcare system faces the considerable challenges of maintaining cost efficiency, serving at-need populations, and generating positive outcomes for clients.

Economic evaluations can help to convince funders to increase investments in treatment, improve allocation of scarce treatment resources, and identify the factors that can increase the cost effectiveness and net economic benefits of treatment. Given the large percentage of substance-involved persons not in treatment, the findings discussed in this article suggest the importance of increasing current investments in addictions treatment. The ultimate cost to society of not treating persons with addictions disorders is likely to be quite substantial.

Steven Belenko, PhD, is a Professor in the Department of Criminal Justice at Temple University. He is also affiliated with the University of Pennsylvania School of Medicine as adjunct Professor of Psychology in the Department of Psychiatry and is Senior Scientist at the Treatment Research Institute. Dr. Belenko has published extensively on substance abuse and crime, the impact of drugs on the adult and juvenile justice systems, and the integration of treatment and other services in criminal justice settings. He earned his BS in applied mathematics and PhD in experimental psychology from Columbia University.

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Addictions Policy Update

Allison Englen Fort, MA, Policy Associate, National Council for Community Behavioral Healthcare

The National Council continues to support increased funding for and access to addictions treatment services as part of our public policy initiatives. In 2007, the National Council is advocating for the first bills to expand parity to both mental health and addictions; increased appropriations for addictions treatment and research programs; and legislation to better meet the addictions treatment and mental health needs of people leaving prison.

Parity Legislation Includes Addictions Treatment for the First Time

There are currently 41 states with parity laws covering 26 million Americans. These laws vary substantially in terms of their scope and requirements. This year, legislation has been introduced in the House and Senate to extend parity to both mental health and addictions treatment services for the first time. In the Senate, Senators Edward Kennedy (D-MA), Michael Enzi (D-WY), and Pete Domenici (R-NM) introduced the Mental Health Parity Act of 2007 (S 558) on February 12. In the House, Representatives Patrick Kennedy (D-RI) and Jim Ramstad (R-MN) introduced the Senator Paul Wellstone Mental Health and Addiction Equity Act of 2007 (HR 1424) on March 7.

While there are differences between the Senate and House bills, both provide parity for mental health and addictions treatment services and provide for equalization of financial requirements like co-payments and deductibles while also providing for comparability regarding day and visit limits.

The National Council supports the passage of parity legislation in both chambers, and hopes that the subsequent conference process will produce a bill that will expand parity for mental health and addictions treatment.

FY 2008 Appropriations: Advocating for Increased Spending for Addictions Treatment, Research Programs

On February 5, President Bush announced his $2.9 trillion budget plan for FY 2008. The President's plan makes sharp cuts to a number of programs key to providing services to people with mental illnesses and substance abuse disorders. The proposal includes a net decrease of $76.93 million for mental health, a net decrease of $36.441 million for substance abuse prevention, and a net decrease of $46.859 million for substance abuse treatment.

This year, the President's budget proposal reversed its trend of seeking to eliminate the Safe and Drug-Free Schools and Communities State Grants Program, which supports community-based prevention programs. The Administration has proposed $100 million for the program in FY 2008. Last year, Congress restored $346.5 million in funding to the program, and the National Council hopes it will again support additional funding for this program. Level funding has been proposed for a number of important addictions research and treatment programs, including the Substance Abuse Prevention and Treatment Block Grant, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention. The National Council is advocating for increased funding for each of these important programs.

On May 17, both the House and Senate adopted a $2.9 trillion budget resolution for FY 2008 after reaching agreement on the package the previous day. The budget resolution includes approximately $18 billion more in discretionary spending than requested by President Bush in his FY 2008 budget request.

House and Senate Democrats have said their goal is to have their work on the FY 2008 appropriations bills completed by the start of the new fiscal year on October 1, with work to begin on the individual appropriations bills in May.

A Fourth Chance for the Second Chance Act

The Second Chance Act, which would help states and communities better address and meet the addictions treatment and mental health needs of people leaving prison, has been up for consideration in each of Congress' last four sessions and nearly made it to a vote on the Senate floor in the final days of the 109th Congress, only to be blocked by a single opponent who argued that there is no federal role in prisoner reentry. In the 110th Congress, it has been reintroduced in both the House (HR 1593) and Senate (S 1060) and nearly made it to the House floor for a vote in mid-May. The National Council and other mental health and addictions treatment advocates continue to advocate for the Second Chance Act and are hopeful that the measure will pass in the 110th Congress.

The Second Chance Act would reauthorize the Adult and Juvenile Offender State and Local Reentry Demonstration Program, under which states, local areas, and nonprofit organizations craft programs focusing on housing, jobs, substance abuse treatment, mental health treatment, and services for families and children of incarcerated parents in order to help prisoners transition to life in their communities upon release. Treatment for mental health and addiction disorders has high priority in the bill, given the high rate of relapse when treatment is not made available to those leaving prison.

On March 28, the House Judiciary Committee passed the Second Chance Act out of committee following the rejection of a series of amendments proposed by Representative Louis Gohmert (R-TX), which supporters argued would damage the bill. On May 14, the Second Chance Act was removed from the House's suspension calendar, taking it out of consideration by the full House for now. Sponsors of the bill removed it from this calendar, which limits debate on motions to 40 minutes and prohibits the addition of floor amendments, after learning that the Republican Study Committee planned to approach House Republican leadership to urge them to oppose the Second Chance Act. The bill's supporters are hopeful that it can be put back on the suspension calendar soon and plan to bring the Second Chance Act up for a floor vote under regular order if that does not happen.

The National Council is part of a coalition of groups lobbying for support of this important issue. The broad, bipartisan coalition includes groups such as the Legal Action Center, National Alliance to End Homelessness, National Association of Counties, and Volunteers for America.

Allison Fort supports the National Council for Community Behavioral Healthcare's federal and state policy and advocacy efforts with high-level research and analysis. She is managing editor of the National Council's weekly Public Policy Update e-newsletter and plays a key role in organizing the Annual Hill Day for National Council members from across the country.

Integrating Addictions and Mental Health Policy and Services

Pat Bridgman, MA, LICDC, Associate Director, The Ohio Council of Behavioral Healthcare Providers

> *If you mean integration then integrate — don't just jam addictions treatment policy or services into existing mental health policy or services.*

In 1993, the Ohio Council of Community Mental Health Agencies voted to invite freestanding addictions treatment provider organizations to join as members and changed its name to the Ohio Council of Behavioral Healthcare Providers. This decision ultimately expanded the policy scope of the association to include alcohol and other drug addiction treatment and prevention program policy, funding, and delivery system issues.

I was hired in 1994 as Associate Director and have had the opportunity of assisting the Ohio Council with the integration of addiction treatment and mental health providers to develop a thriving trade association that represents the interests of both types of providers. Reflecting back on the past 12 years, a few key lessons come to mind to consider when integrating at an association or provider level.

If you mean integration then integrate — don't just jam addictions treatment policy or services into existing mental health policy or services. I credit our CEO, Hubert Wirtz, for making the decision to hire me as I had plenty of experience in addictions treatment and enjoyed credibility with addiction treatment providers. I believe that having a true balance of addiction treatment and mental health trained staff has enabled our association to choose policy positions that are as beneficial for the addictions treatment providers as they are for mental health providers. Our association, for instance, recently took a difficult position by not supporting a state parity bill that was focused only on the severely mentally ill. It was the right policy stance for all of our members, not just a segment of our members.

While semantics drive us crazy, semantics are important. We overuse the term substance abuse. There is a difference between drug abuse and drug addiction, and it is important to understand the difference if you are representing the interests of both addictions treatment and mental health providers. While persons with mental illness might be using alcohol or drugs inappropriately because they are "treating their symptoms," if they are addicted, they are addicted and need addictions treatment, not a lecture on the harmful nature of drugs or alcohol. I once heard addictions expert Abraham Twerski say about addicted individuals that it didn't matter how they "got to Chicago…once they are in Chicago they are in Chicago!"!

Mental health policy makers and practitioners need to learn about differential diagnosis related to substance use disorders just as my addictions treatment colleagues need to learn about basic mental health diagnoses.

Another example is the term "co-occurring disorder," which too often refers to the severely mentally disabled population without considering other populations that should be included in clinical and policy discussions. I applaud the efforts of the Substance Abuse and Mental Health Services Administration's Co-Occurring Center for Excellence, which is now beginning to address training needs for the field for the often overlooked Quadrant III population that includes persons with high addictions and low mental illness.

There are many shared and some distinctly different policy funding and training issues among behavioral health providers. Many times, in my earnest attempt to represent the distinct interests of what was initially a minority of addiction treatment providers who had joined the Ohio Council, I missed the obvious fact that addiction treatment programs could benefit from most of the "mental health" training, especially related to leadership development, primary care integration, and fiscal and compliance capacities. We usually did not need separate trainings. What became important, however, was ensuring that presenters knew that our audience was more than just community mental health providers and that they would have better standing with our addiction provider members by including addiction treatment examples.

While there is a large overlap in serving our members, we need to recognize that there are times when policy matters play differently for those in the addictions field, such as the use of pharmaceuticals as the "answer" to the addiction problem. Many friends in the field recognize the value of medication for assisting clients with craving reduction and treatment retention. They also understandably cringe at the over-reliance on medications and remember too well products like Xanax and Librium that were marketed to "help" people in addiction recovery.

I have seen tremendous strides toward a shared vision of care by both mental health and addictions treatment providers, a vision that becomes more important as we all seek to integrate our services with primary healthcare. Many Ohio providers have sought dual certification to be able to better serve the clients. I feel privileged to work for an organization whose leadership and board seemed to "get it" from the very beginning. Integration is not forcing everyone to be the same. It is gathering diverse and capable providers together to ensure an effective capacity that is as diverse and comprehensive as the clients (and consumers) that we serve.

Ms. Bridgman has more than 25 years of experience in addictions treatment. Presently she is the associate director of the Ohio Council, a trade association that represents 160 addiction treatment and mental health provider organizations. She is also secretary of the Ohio Alcohol and Drug Policy Alliance, vice-president of the State Associations of Addiction Services, and serves on SAMSHA's Co-Occurring Center of Excellence National Steering Committee. She served as president and board member of the Ohio Credentialing Board for Certified Chemical Dependency Professionals. She has worked in a number of treatment settings and has presented to a variety of groups on substance abuse, managed care, welfare reform, behavioral healthcare integration, and addiction treatment program development.

>> *Each year, more than 23 million Americans are in need of addiction treatment, but less than 10% of those individuals receive treatment.*

Substance Abuse and Mental Health Services Administration

Medication Assisted Treatment Resources Enable Effective Care for Addiction Disorders

Robert Lubran, MPA, MS, Director, Division of Pharmacologic Therapies, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration

Medication Assisted Treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of addiction disorders. Research shows that when treating these disorders, a combination of medication and behavioral therapies is most successful. MAT is clinically focused and emphasizes individualized patient care. MAT requires physician involvement to order or prescribe appropriate medications and to participate in developing a plan of care for the patient.

The Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration regulates the use of methadone and buprenorphine by Opioid Treatment Programs and develops clinical best practices on the use of naltrexone for opioid dependence and alcohol addiction treatment medications — naltrexone, disulfiram, and acamprosate. At this time, there are no medications approved for the treatment of addictions to drugs such as cocaine or methamphetamine.

Traditionally, the effective medical treatment of opioid dependence has been conducted in opioid treatment programs, which must conform to regulations in Title 42 of the Code of Federal Regulations, Part 8. These regulations provide for a comprehensive regulatory-accreditation system, including standards on personnel qualifications for OTP physicians and other employees. Although the regulations do not set specific staffing or patient capacity standards, they do require that OTPs maintain adequate staffing and services to provide quality patient care and basic, core services such as medical, counseling, vocational, educational, and treatment services.

Because opioid addiction treatment has long been misunderstood and maligned, CSAT also supports efforts to educate the public about the positive benefits of opioid treatment, to dispel myths with facts, to reduce stigma, and to reduce community resistance. Numerous research studies over the past 30 years indicate that methadone is an effective treatment for opiate addiction and has few serious, long-term side effects when properly used for treatment. CSAT's Division of Pharmacologic Therapies works to spread the word that research shows that when patients are in treatment

- Their consumption of all illicit drugs declines
- Crime is reduced substantially
- Fewer individuals become infected with HIV or hepatitis viruses
- Individual functioning, family and social relationships, and rates of employment improve.

In addition, OTPs are now required to maintain community relations plans and diversion control plans to maintain positive relations and to prevent the illegal diversion of drugs. Although these efforts have proved fruitful, much work continues to be needed to educate and collaborate with the public.

Since 2002, DPT has also administered a physician waiver program based on the Drug Addiction Treatment Act of 2000, which expands the clinical context of medication-assisted opioid addiction treatment by allowing qualified physicians — including physicians in community-based behavioral health organizations — to dispense or prescribe buprenorphine products (Subutex and Suboxone) for the treatment of opioid dependence. This program significantly reduces the regulatory burden on physicians who choose to practice opioid addiction therapy in community-based settings by permitting qualified physicians to receive a waiver of the special registration requirements defined in the Controlled Substances Act. Most physicians who quality for the waiver are trained on the use of these medications

Continued on page 21

A SAMHSA physician waiver program allows physicians in community-based behavioral health organizations to dispense or prescribe buprenorphine products for the treatment of opioid dependence.

Prevention: A Critical Element in the Continuum of Care

Jeff L. Smart, MPA, Prevention Services Manager and Boyd Bastian, Public Relations Coordinator, Salt Lake County Substance Abuse Services

Prevention works. Whether you're talking about gang prevention, substance abuse prevention, or preventing teen pregnancy — it is an effective strategy that has been proven to work in countless areas.

However, prevention hasn't worked as well in mental health and has presented many challenges to clinicians and administrators. Traditionally, mental health providers have focused mainly on treatment interventions with relatively few resources devoted to prevention. However, prevention is a fundamental component in the continuum of care, as identified in Patrick Mrazek and Robert Haggerty's Continuum of Care Model, which was originally designed for Mental Health Prevention in 1994.

Mental health providers can draw useful lessons from prevention strategies employed by substance abuse experts.

Substance abuse prevention has followed the same basic public health theory that was used to educate our country about the risk and protective factors of heart disease. By identifying associated risk factors, substance abuse prevention has been able to develop strategies to reduce these risk factors and promote more healthy protective factors. Some of these risk and protective factors predict and mitigate mental health problems as well as substance abuse. Factors such as having opportunities, skills, and recognition within a family unit, school, or peer group can have a dramatic preventive effect.

Factors that either predict and/or mitigate behavior are often identified in assessments and used for treatment planning, but again, they are applicable to prevention and mental health maintenance as well. Addressing risk and protective factors across the service continuum is vital. It is critical that behavioral healthcare be approached holistically to ensure that symptoms and illnesses are averted or treated at the earliest possible stages.

In 2000, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention adopted Mrazek and Haggerty's Continuum of Care Model and added the following categories to its own Comprehensive Continuum of Care for substance abuse.

It is critical that behavioral healthcare be approached holistically to ensure that symptoms and illnesses are averted or treated at the earliest possible stages.

Universal Prevention: Activities targeted to the general public or a whole population group that has not yet been identified on the basis of individual risk.

Selective Prevention: Activities targeted to individuals or a subgroup of the population whose risk for substance abuse is significantly higher than average.

Indicated Prevention: Activities targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms of substance abuse, but who do not meet diagnostic levels for treatment at the present time.

All of behavioral healthcare can use the same science and techniques being used in the field of substance abuse prevention. By helping prevent problem behaviors, we can find out what factors increase or decrease the likelihood of such behaviors, and implement strategies that increase protective factors and decrease risk factors throughout the continuum of care.

The Salt Lake County Division of Substance Abuse administers services under the direction of the County Council in Salt Lake County and is the largest program in the Inter-Mountain West for alcohol and drug abuse prevention and treatment. Jeff Smart, who has served as the Prevention Services Manager since 2002 holds a masters in public administration and presides over the largest network of substance abuse prevention services in the state of Utah. Boyd Bastian is an award-winning public relations professional with several years of experience in the corporate and public sectors. He is currently involved in a number of initiatives promoting treatment and prevention programs in Salt Lake County, Utah.

>> *The cost of addictions treatment is 15 times less than the cost of incarcerating a person for a drug-related crime.*

PLNDP and Join Together (January 2000). A Physician's Guide on How to Advocate for More Effective National and State Drug Policies.

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Connecting the Dots for Effective Substance Abuse Prevention

Beverly Watts Davis, Director, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration

Community coalition leaders, substance abuse and mental health professionals, and community volunteers are always asking me "In preventing substance abuse by youth, should we focus on community-wide and systems change, or changing individual risk behaviors, or building infrastructure to sustain prevention efforts in communities?" My answer is always the same. "We must connect the dots. It's not one strategy or another, but about implementing ALL of these strategies simultaneously because when these three approaches are connected, the 'power of prevention' is realized!"

Changing community-wide norms and systems through policy change, public awareness, and media strategies has over time become the focus of community coalitions throughout the country. While this approach may appear too nonspecific to effect "real" change, consider the effect that policy change, public awareness, and media strategies have had on attitudes and behavior around smoking cigarettes, autism, and global warming. To support this type of change, the Drug-free Communities Act funds more than 700 drug-free community coalitions and has established the National Coalition Institute to provide support to another 4,300 coalitions. These coalitions harness the combined power of multiple sectors of the community to create consistency among systems, policies, and public messages to prevent and reduce the illegal use of substances by youth and, over time, illegal or irresponsible use of substances by adults.

Changing individual and family risk behaviors has become the focus of certified prevention specialists and health educators who implement prevention programs in school settings and community-based organizations using risk factor and/or developmental approaches. Supported by funding from the Safe and Drug-Free Schools program, the Office of Juvenile Justice and Delinquency Prevention, and the Substance Abuse and Mental Health Services Administration's Center for Substance Prevention, schools and community-based organizations implement effective programs focused on

- Subgroups considered at risk for substance abuse (children of substance abusers)
- Individuals displaying acute pre-use problems (academic failure, behavior problems, juvenile delinquency) or early-use signs and symptoms.

Prevention research has demonstrated that individual and family focused strategies can be extremely effective at deterring further risk behavior by increasing individual and family resiliency through the development of positive coping strategies, effective communication, pro-social behaviors, and creating positive bonding opportunities at school and in the community. Many of these strategies are reflected in the effective programs selected by SAMHSA, the Department of Justice, and the Department of Education.

Building an infrastructure to sustain prevention efforts in states and communities was a long neglected need. To the credit of current and former SAMHSA Administrators, Dr. Terry Cline and Charles Curie, there has been unwavering support to build and support state and community infrastructures that logically and systematically unify existing prevention resources and build capacity to sustain positive prevention outcomes through the following initiatives:

- Strategic Prevention Framework State Incentive Grants (SPF SIG) assist states in developing a prevention strategy based on the Strategic Prevention Framework and local needs based on relevant data provided by an Epidemiology Work Group. This grant helps states unite multiple funding streams that cut across existing programs and systems to leverage resources to maximize local impact. This grant also reinforces the importance of community-based approaches for substance abuse prevention and mental health promotion by requiring that 85% of funding go to communities to strengthen local prevention capacity and infrastructure.
- The Prevention Leadership Academy is a workforce development initiative that provides leadership development training for the State and Territorial Prevention Directors who make up the National Prevention Network.
- The Prevention Fellows Program is a workforce development initiative that helps states to cultivate and develop the next generation of prevention leaders by providing professional development opportunities and enhancing the knowledge, skills, and competencies of the Prevention Fellows in all components of the Strategic Prevention Framework.
- The National Community Anti-Drug Coalition Institute assists community anti-drug coalitions with coalition-specific substance abuse prevention policy development and provides coalition training and technical assistance on evidence-based programming and implementation, evaluation, and capacity building.
- Centers for the Application of Prevention Technologies (CAPTs) assist states and territories and community-based organizations in the application of the latest evidence-based knowledge to their substance abuse prevention programs, practices, and policies by providing state-of-the-science technical assistance and training to states and communities in the planning, implementation, and evaluation of comprehensive prevention systems.

Although prevention is the most cost-effective and humane approach we can take, connecting and interweaving all three strategies has been the challenge. By addressing the full spectrum of prevention problems simultaneously, we have a multitude of opportunities to improve and solve problems and leverage change throughout the system because many of the key health and social problems we face are interconnected. By working on population as well as individual and family level outcomes, our efforts energize one another and bring us closer to preventing substance abuse and its related community harm.

When all is said and done, it is not important that we had a strategy here or that we were effective there, but whether or not we were able to weave our strategies together in such a way as to achieve the greatest impact over the longest term for the most citizens. In order to do this, we must find a way to connect the dots.

Beverly Watts Davis' respected leadership and extensive experience in community mobilization have been described as pivotal in SAMHSA's work to reinvigorate its Center for Substance Abuse Prevention and to design and implement a strategic framework for prevention in communities nationwide. Prior to joining SAMHSA, Ms. Watts Davis was the senior vice president of United Way of San Antonio and Bexar County, Texas, as well as executive director of its San Antonio Fighting Back Anti-Drug Community Coalition. She has served as the principal investigator for Centers for Disease Control and Prevention Health Promotion Grants and as a co-principal investigator for the University of Texas Health Science Center's Community Outreach Partnership Center Grant.

Arapahoe combines treatment with life skills to give families a future

Nancy VanDeMark, PhD, CACIII, Executive Director, and Ellen Brown, PhD, Grant and Publications Specialist, Arapahoe House, Thornton, Colorado
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Serving the metropolitan Denver area since 1976, Arapahoe House, Inc.. offers a continuum of behavioral healthcare services at more than 30 sites to 17,000 unduplicated clients a year. Colorado's largest provider, the agency offers detoxification, outpatient, residential, school-based, and case management services as well as specialized services for women, individuals with co-occurring mental health disorders, homeless persons, adolescents, and offenders.

The New Directions for Families program at Arapahoe House started in 1995 with funding from the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration. Serving women and their dependent children aged 0-12 years, NDF is a family-focused, comprehensive treatment center providing addictions, mental health, and trauma treatment along with parenting and life skills. Women are assisted in locating housing and employment as they transition from the residential stay (90-120 days) to the four-month outpatient continuing care program.

The treatment philosophy at NDF is founded on gender-specific, culturally sensitive, trauma-informed, and strengths-oriented services integrating parenting and family issues, substance abuse, mental illness, and trauma simultaneously, with the following emphases:

Addictions. Individual and group therapy use an integrated "stages of change" approach, addressing drug and alcohol effects, withdrawal and consequences, maternal substance abuse, HIV and infectious illnesses, relapse prevention, the impact of addictions on families, developing substance-free support systems, and leisure skills.

Mental health services. Psychiatric evaluation, treatment, medications, individual counseling, and education on mental illness and psychotropic medication address mental health disorders.

Trauma-specific services. Education about physical, sexual, and emotional abuse and witnessed violence addresses how current behaviors including substance abuse are linked to past abuses. Skills are developed in self-regulation, boundary maintenance, communication, developing healthy relationships, and female sexuality.

Family-focused services. The needs of both parent and child are considered in the development of service plans with mothers learning positive reinforcement; limit setting; and reasonable, reinforceable consequences to promote healthy, loving family time. Children through preschool attend the licensed Child Learning Center, a therapeutic educational environment enhancing science, art, math, literature, and gross motor skills. Groups for extended families address healthy family dynamics and communications.

Self-sufficiency skills development. Basic life skills in wellness, health, nutrition, stress management, financial planning, and employment and vocational services are integrated.

Community partnership. Partnerships address the families' needs and facilitate the transition back to the community once the residential stay has ended.

Evaluations of NDF have demonstrated the following post-treatment outcomes

- Significantly fewer days of problem drug use.
- Improved overall physical health.
- Greater likelihood of children living with families.
- Greater likelihood of living in own housing.
- Significantly more days of employment.

LESSONS LEARNED

Leadership and vision. Administrators, managers, and supervisors who share a common vision for the service goals and communicate effectively are essential to make difficult decisions about clinical care, program structure, and organizational policies.

Staff support. Working with clients who have significant trauma histories can be difficult for staff and, therefore, they benefit from workplace support such as strong supervision, co-facilitation of groups, designated debriefing time after trauma groups, and mental health days.

Integration of consumers. Promoting fair and equitable treatment of individuals in consumer-identified positions while recognizing the value of lived experience in delivering services is very delicate. Professional and consumer-identified staff need regular opportunities to discuss concerns related to boundaries, the value of expert knowledge versus knowledge from lived experience, and roles.

Safety. Accepting clients with severe trauma histories requires clear safety procedures for clients and their children that address self-harm, threats from violent partners, promoting emotional safety, and emergency hospitalization procedures.

Collaboration. Regular staff meetings regarding client cases are most helpful when all agencies involved participate to address client goals, support, and barriers.

NDF has successfully used these lessons in integrated treatment to help families struggling with addictions overcome obstacles and envision a healthy and productive future.

Our primary objective is to promote healthy behavior by creating self-reliance based on an understanding of Diné origins.

Network180 sees collaborative system change as the key to integrated care

Jane Konyndyk, LMSW, MSW; Deputy Director of Program Services, and Nancy Murphy, LMSW, ACSW, Contract Manager/Planner, Network180, Grand Rapids, Michigan
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Network180 serves as the Community Mental Health and Substance Abuse Coordinating Agency for Kent County, Michigan. We have been deeply involved in the development of an integrated mental health and addictions service system for seven years now, with integration occurring at the system, program, and clinical levels. We've successfully utilized a system change process to develop an integrated system of care that is built on Dr. Ken Minkoff's Comprehensive, Continuous, Integrated System of Care model.

CCISC is a model for organizing services for individuals and families with a co-occurring mental health and addiction disorders, based on the fact every program and clinician must have dual diagnosis capability to address co-occurring disorders expected in every setting. The goal is for the whole system to become more welcoming, accessible, integrated, and continuous.

Network180 started to develop an integrated system of care based on the CCISC model in 2001. The first years focused on building consensus on the model and developing universal dual diagnosis capability at the individual provider level. Collaborative service models integrating mental health and addictions disorder treatment emerged in 2004 and enhanced programs, such as the Integrated Dual Disorder Treatment program, started in 2006.

A key element of Network180's integrated approach was the development of a systemwide, vision driven performance improvement project. First, a charter agreement was signed by Network180 and contract treatment agencies that articulated the changing relationships necessary to support an integrated system. The system change process also relied on organizational self-assessments, using COFIT at the system level and COMPASS at the program level to generate action plans to address the agency's co-occurring capability. The Integration Leadership Group (Network180 and selected provider leadership staff) is responsible for promoting the larger system change effort. The CCISC Team (Network180 and agency program managers/supervisors) promotes training and necessary change at the provider level.

There have been a number of changes in the service system that demonstrate progress toward capability to treat co-occurring disorders:

- System structures promote integrated services — including system trainers, data collection processes, and use of existing funding streams — to support integrated services in each type of program.
- Providers have access to funding for psychiatric services and medication for clients with co-occurring disorders served in a substance use disorder funded setting.
- Co-occurring disorder-capable clinical case management services have been developed for SUD clients who need continuous, community-based, long-term service.
- Integrated Dual Disorder Treatment is in development in the case management provider system.
- In 2005, Network180 received SAMHSA funding to provide IDDT and Assertive Community Treatment services to individuals who are homeless with co-occurring mental health and addiction disorders.
- In 2006, Network180 began to contract outpatient services only to providers able to treat individuals with mental health, substance use, or co-occurring disorders.

LESSONS LEARNED

- Position the initiative to include deputy director-level staff and staff from other departments, including other population units, quality and data staff, and the Access Center to facilitate broader system change, more targeted work with providers, and the integration of care into ongoing administrative processes.
- Involve psychiatrists to support changes in medical care, and involve consumers to keep the change focused on what works for the consumer.
- Approach this as a quality improvement initiative, not a contract compliance initiative, and include the right incentives for providers for quality improvement efforts. Network180's current charter agreement includes financial incentives for documentation of completion of the COMPASS and a responsive Action Plan.
- Implement the initiative through collaborative leadership with providers, rather than a top-down administrative leadership. For Network180, this required a shift in our relationships with contract agencies, and providers established system improvement performance indicators that Network180 supported and provided incentives for.
- Recognize that shifting from a silo model of care to integrated care takes time, and is incremental. If the system changes necessary to support integrated treatment are not in place, the program changes and development will not be well positioned.

Network180 also recognized that the complex needs of individuals with co-occurring disorders require closer and more reciprocal partnerships outside of our service system. This has led to collaborative projects with the criminal justice system, child welfare, housing/homeless service providers, and the primary healthcare system.

Network180's integration system change process and experience has also enriched our staff, organization, and our community partners far beyond initial expectations.

ACCESS supports harm reduction for productive lives

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Treatment methodologies between mental health and addictions disciplines are more compatible today than just a few years ago. Until recently, these disciplines were at opposite ends of the treatment spectrum. It was common for each to defer treatment until the other "unrelated" ailment was addressed.

Where treatment is provided for clearly identified co-occurring mental health and addiction disorders, any clinical practice is challenged to consider creative, flexible, and tolerant methodologies, including well-established treatment programs adopting evidence-based practices. The inherent complexity of treating addictions in a co-occurring framework invites consideration of "harm reduction" as acceptable in some instances.

The ACCESS Team at Spring Harbor has utilized evidenced based practices in treating co-occurring disorders. As the first Assertive Community Treatment team in Maine (1993), ACCESS was designed specifically to treat persons with co-occurring disorders. ACCESS recognized that when treating addiction disorders in the ACT model, multiple treatment modalities are needed, including both abstinence and harm-reduction models. While "abstinence" and "harm-reduction" appear contradictory, they can effectively co-exist within a single treatment program. Creativity and flexibility are the rule.

ACCESS accepts that abstinence, for persons with abusive and addictive patterns of substance use, is ideal, and always the goal. However, reducing the harm caused by addictions in a person's life, is an accepted practice – this is where tolerance is the operative term. Each person has unique challenges and requires an individualized approach.

An early challenge that put this practice to the test came when a 34-year-old male, with paranoid schizophrenia, was only minimally helped by medication. Despite trying a variety of medications, "Bob" continued experiencing distressing levels of symptoms, including command hallucinations, voices, and an overall sense of doom. Combinations of antipsychotic medications and a low-dose benzodiazepine provided some relief. Despite ACCESS' attempts to encourage abstinence from illegal drugs, Bob claimed that use of marijuana actually worked better at helping him tolerate symptoms than medications alone. He stated the voices or "vapors" were more manageable, and "quieter." In fact, he often appeared distressed, psychiatrically, when abstaining from marijuana (unrelated to withdrawal phenomenon).

ACCESS staff were always concerned Bob's continued use of marijuana would prolong exposure to a drug culture in which other substances are readily available, and influence him negatively. While some of these concerns actually played out, overall, Bob has been relatively successful. He has held a part-time job for seven years, has maintained stable housing for eight years, and has not been hospitalized for five years. All this is remarkable for this previously homeless, psychiatrically unstable man.

Program staff never advocated for Bob's use of marijuana. Bob's success is not owing to continued use of marijuana. Instead, his desire to improve his life, along with a program whose clinical perspective welcomes people in the midst of their struggle for recovery has allowed for his progress. There is recognition that the struggle is complex, sometimes long, and yet, not insurmountable. If Bob had been discharged from care for continued use of drugs eight years ago, he most likely would have been incarcerated or died.

Totah integrates culturally relevant practices to treat homeless clients

Paul Ehrlich, MA, Executive Director, Totah Behavioral Health Authority, Farmington, New Mexico
Contact: **Paul_Ehrlich@pmsnet.org**

In 2000, officials in Farmington, New Mexico, estimated that there were a minimum of 700 uninsured and untreated chronic public inebriates who were homeless and estranged from their families. Caring for this population through emergency room and protective custody services proved costly, and left the root syndromes of addiction and co-occurring mental health disorders untreated, creating a revolving door effect that tended to amplify and prolong these problems.

The Totah Behavioral Health Authority is charged with serving the homeless alcoholic who is often diagnosed with co-occurring psychiatric disorders. TBHA provides intensive outpatient services including individual, group, and family counseling; case management; referrals to residential chemical dependency treatment; psychiatric assessment; and other behavioral health services. We also provide referrals to primary medical, dental, and vision care.

TBHA's principal aim is to establish access to culturally relevant and clinically proficient behavioral healthcare and related support services. We promote the health and well-being of the uninsured, indigent multicultural population in the area; intervene in the progression of alcoholism, drug addiction, and co-occurring disorders; assist in appropriate treatment referrals; and support healthy, productive reintegration into family and community life.

During the past year, TBHA participants have demonstrated

- 33.3% reduction in harm associated with the use and abuse of alcohol or other drugs
- 76.5% positive rate of change in employment or school enrollment
- 133.3% positive rate of change regarding housing for those who were formerly homeless
- 46% decline in overall referrals to protective custody and detoxification services
- 54% decline in disorderly conduct arrests

Continued on page 17

Totah, continued from page 16

LESSONS LEARNED

Culturally oriented program philosophy. The essence of TBHA's traditional counseling program is rooted in Diné (Navajo) philosophy and ideals. Our primary objective is to promote healthy behavior by creating self-reliance based on an understanding of Diné origins. Our intent is to provide the opportunity for participants to regain knowledge of and integrate traditional values. By building a positive sense of identity and an understanding of the foundation of the Diné way of life, we endeavor to enhance self-esteem and self-respect through K'é – meaningful relationship and a reorientation to the Diné clanship system.

When appropriate, the program employs traditional Native American healing practices comprising traditional rituals such as talking circles, tobacco, cedar burning, and sweat lodge ceremonies. Additionally, we employ contemporary treatments such as Motivational Interviewing and the Community Reinforcement Approach. Experience has demonstrated that the combination of clinical best practices and traditional Native American healing approaches makes each stronger than either alone.

Community Partnerships. TBHA is a collaboration between the Navajo Nation, San Juan County, and the City of Farmington as well as six agencies that are the predominant providers of primary medical and behavioral health services in the area. Two-thirds of our staff and our board of directors are Native American. A number of formerly homeless, recovering individuals are on staff as well as the TBHA board and its advisory committees.

We are funded in part through a federal award from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment and the Homeless Programs Branch. We also receive local funding from the Navajo Nation, the City of Farmington, San Juan County, and the State Department of Health via its MCO ValueOptions of New Mexico.

TBHA's principal aim is to establish access to culturally relevant and clinically proficient behavioral healthcare and related support services.

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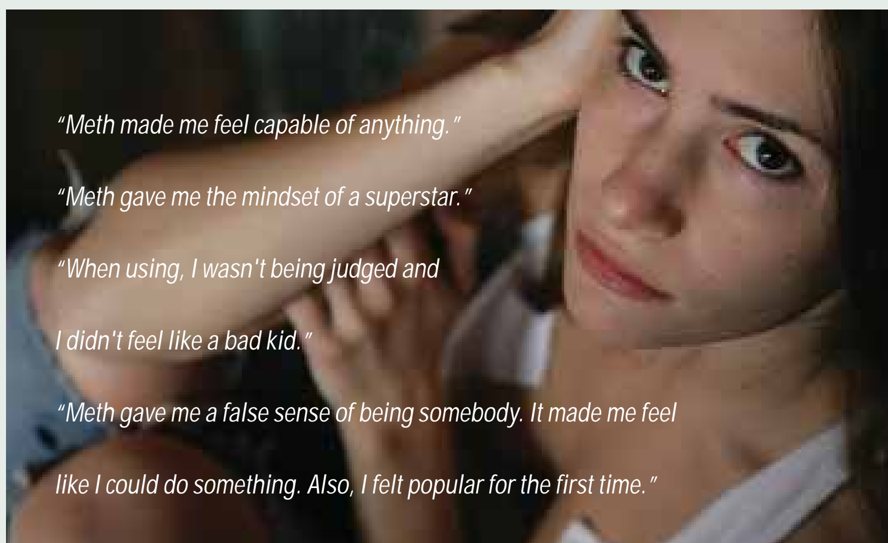
BHR's integrated model addresses treatment and socio-economic issues

Carl Flowers, Program Director, Behavioral Health Resources Recovery Services
Tumwater, Washington
Contact: **cflowers@bhr.org**



These are direct quotes from women in chemical dependency treatment at Behavioral Health Resources Recovery Services in Olympia, Washington. The women are participants in BHR Recovery Services' Family Treatment Court Program, which serves parents with methamphetamine abuse/addiction who are involved in State of Washington Dependency Court hearings.

Clients in this program have struggled with significant personal and economic challenges including

- Low socioeconomic status.
- Poor educational achievement and cognitive functioning.
- Family history of emotional, physical, and/or sexual abuse.
- Adolescent entry into nicotine, alcohol, and other drug abuse.
- Early sexualization with high level of unprotected adolescent intercourse.
- Co-occurring mental health and substance abuse/dependence diagnoses.

To establish the client in successful recovery, BHR's treatment program developed an integrated treatment model that addressed these social and economic issues while dealing with post-acute withdrawal from methamphetamine, a drug that clients describe as providing the greatest sense of euphoria they have ever experienced. BHR addresses the specialized needs of these clients through a range of services not typically provided through publicly funded chemical dependency treatment, yet critical for success with clients exhibiting this profile.

Services provided by BHR include

- Psychiatric evaluation and medication support.
- Financial support for housing/home-making.
- Ongoing integrated mental health/substance abuse counseling by co-licensed professionals.
- Individual therapy focused on PTSD, depression, and personality disorders.
- Parenting education and nurturing parent therapy.
- GED and job placement assistance.

Continued on page 24

Tarrant County sees results with adequately funded evidence-based treatment program

Daniel McDonald, Director of Addiction Services, Mental Health Mental Retardation of Tarrant County, Fort Worth, Texas
Contact: **Daniel.McDonald@mhmrtc.org**

The addictions services and research divisions of Mental Health Mental Retardation of Tarrant County, along with the Recovery Resource Council, operate one of only six evidence-based methamphetamine treatment programs in the country. The program is funded through a three-year grant from the Substance Abuse and Mental Health Services Administration, awarded to the Tarrant County Community Development Division in Fort Worth, Texas, in October 2004.

Counselors at MHMRTC use an empirical evidence-based cognitive behavioral curriculum called the Matrix to implement group, individual, and family therapies. This approach was developed at the Matrix Institute in California. MHMRTC methamphetamine clients also receive auricular acupuncture and exercise as adjunct services. The Recovery Resource Council provides peer support groups and case management.

The Matrix approach with adjunct services, supported by SAMHSA funding, has resulted in clients improving and has strengthened external collaborative efforts such as with the Adult Drug Court. It is certainly not easy to obtain funding for effective treatment approaches in addictions. We are focused on evidence-based programming, not evidence-based funding. But either of these aspects, taken individually, is not as impactful as the combination of both.

A literature review shows few, if any, articles advocating how to fund effective approaches. But if federal funding has produced results, then policy scientists developing state regulations and state budgets need to understand the confluence of effective treatment and effective funding in order to predict the best way to expend public dollars.

How can providers advance this process? Send a "white paper" or a briefing paper outlining the benefits of a specific approach to your state funding organization or trade association and include ways to fund effective treatment models/approaches or specific components of an approach through the unbundling of funds. Submit a brief proposal for special funding for a specific approach that helps your state agency respond when the need arises. Finally, develop relationships with the media, grant project officers, and political staff and educate them on the need for evidenced-based funding.

CBH shares lessons from implementing Matrix Intensive Outpatient Model

Cathi Norton, Community Relations Specialist, and Linda Grove-Paul, MSW, Addictions Manager, Center for Behavioral Health, Bloomington, Indiana
Contact: **cnorton@the-center.org**

Center for Behavioral Health uses the "Matrix" Intensive Outpatient Program to treat more seriously addicted clients. Currently 10 – 15% of our Matrix clients are addicted to methamphetamine, though most are cross-addicted to other substances as well. The rest of the clients have frequently relapsed or have proven resistant to other treatment.

The Matrix model was developed in the 1980s to provide intensive, structured treatment for clients with stimulant use disorders (most notably methamphetamine and cocaine), many of whom have proven resistant prior to treatment. It draws from numerous, empirically tested treatment approaches to form an approach encompassing individual/conjoint family sessions, early recovery skills, relapse prevention, family education, and social support.

Critical components for success

Financial resources. Treatment is extensive, prolonged, and expensive — 16 weeks of intensive outpatient sessions and 36 weeks of follow-up and support programming, as compared to four-and-a-half months for first-time substance abusers. If CBH didn't have Matrix as part of our continuum of care, we could not afford it as a stand-alone program. Matrix programming is costly, commanding nearly three-quarters of our available resources. Other services are not as intensive, affording us more clients/income, which helps subsidize the Matrix portion of our system of care.

Cooperation with other agencies. These include the justice system (which often provides enforcement) or the Department of Children and Families, which supports attendance and payment for services.

Training and adherence to proven protocol. Initial training for staff in the Matrix-model provider organization is an investment. Materials alone are $900. However the best results occur when staff attend official trainings, which add to the overall costs. Adherence to established treatment protocol is key to success.

Continued on page 24

Children's Center trains caregivers and teachers to help children exposed to methamphetamine

Antonia Rathbun, MA, ATR, LMHC, Children's Center, Vancouver, Washington
Contact: Pat Beckett, Executive Director, at **patb@thechildrenscenter.org**

In 2005, county commissioners in Vancouver, Washington, held a work session to share sobering figures about the methamphetamine problem in our community. According to their fact sheet for Clark County, which has a population of 412,938, 70% of incarcerations during 2004 were estimated to be methamphetamine related. The drug task force reported that nearly 80% of identity theft and related crimes were committed by methamphetamine addicts. At the Department of Human Services, around 60% of incoming calls concerned children exposed to methamphetamine. Treatment for methamphetamine addicts, drug court, and other vital programs were discussed, but the children did not have a voice at the table.

Children's Center, an outpatient mental health agency specializing in services to children and families, served 1,310 children in 2006. Of those, 15% were exposed to methamphetamine. With a grant from the Legacy Health Foundation, Children's Center developed a unique program, COACHES, to address the recovery of young children from the effects of methamphetamine, neglect, and maltreatment.

Presenting symptoms and prognosis for children seen at COACHES vary widely, consistent with early findings from research on children with methamphetamine exposure. Symptoms may include

- Neuropsychiatric symptoms and damage to the central nervous system

Continued on page 24

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Smoking in the Mental Health Industry Contributes to Premature Death

Lea Ann Browning McNee, MS, Outreach and Development Officer, National Council for Community Behavioral Healthcare

“People with psychiatric disorders and substance abuse disorders are two to four times more likely to smoke.”

There is a smoking epidemic in the mental health industry: 75% of people with mental illnesses and/or addictions smoke as do 30% to 40% of mental health professionals. Smoking reduces a person’s quality of life and contributes to high mortality rates.

“We believe that this high occurrence of smoking is one of many contributing factors to the premature death of individuals with serious mental illnesses,” says Linda Rosenberg, MSW, President and CEO of the National Council. Earlier this year, both the National Association of State Mental Health Program Directors and the Centers for Disease Control and Prevention documented the increased morbidity and mortality rates, with NASMHPD finding that people with serious mental illnesses die 25 years younger than the general population.

The American Psychiatric Association’s Practice Guideline for the Treatment of Patients with Substance Use Disorders recommends that all individuals with mental health disorders should be asked if they are smokers, and identified smokers should have smoking cessation integrated into their overall treatment plan.

In the coming months, you will be hearing a lot more about smoking cessation from the National Council. “We are fully invested in taking on the challenge of saving lives and know that our members are conducting innovative programs on health and wellness,” says Rosenberg.

For more information on smoking cessation, go to the Smoking Cessation Leadership Center’s website at http://smoking cessationleadership.ucsf.edu/resources.html. You’ll find a wealth of information, ranging from new research to tips for clinicians.

Lea Ann Browning-McNee has nearly 20 years of health communications and marketing experience. As the Outreach and Development Officer for the National Council, she creates new programs that connect education to policy and practice priorities and develops training and technical assistance programs. Before joining the National Council, she oversaw the external relations programs of the National Mental Health Association, including public education/social marketing, media relations, development, and affiliate relations. She currently serves as adjunct faculty at the George Washington University Graduate School of Political Management.

Below are some statistics that we should all be aware of:

- People with psychiatric disorders and substance abuse disorders are two to four times more likely to smoke.
- Nearly 41% of current smokers report having a mental health diagnosis in the last month.
- 60% of current smokers report a past or current history of a mental health diagnosis sometime in their lifetime.
- Among current smokers, the most common current (within the last 30 days) mental illness diagnoses are major depressive disorder, anxiety disorders, alcohol abuse, and other substance abuse disorders.

Source: Oregon Health & Science University Smoking Cessation Center

>> The National Council is pleased to announce a new partnership with the Smoking Cessation Leadership Center, a national program office of the Robert Wood Johnson Foundation. Funding from the Center allowed the National Council to incorporate smoking cessation education into our 2007 Annual Conference and to disseminate QUIT NOW cards, featuring a national toll-free support line, to many of our members. We are now launching a survey to gauge member engagement in smoking cessation programs and plan to work with the Center to create additional educational and technical assistance tools for National Council members.

Medication Assisted Treatment, continued from page 10

through one of the specialty medical and psychiatric organizations identified in the DATA 2000 legislation, e.g., American Psychiatric Association and the American Society for Addiction Medicine, and are treating thousands of individuals, many of whom had never previously accessed addiction treatment services. The Physician Clinical Support network, funded by a grant from SAMHSA, provides technical assistance and mentoring services to physicians who are not addiction specialists and want to use this treatment approach.

Technical assistance is available to help OTPs meet accreditation standards by identifying potential deficiencies and providing resources to assist in making the necessary changes. To learn more, please contact Sharon Dow at 800-839-6120. If you need additional information or have additional questions please visit our website or contact Ken Hoffman, M.D., at Kenneth.Hoffman@samhsa.hhs.gov or at 240-276-2701.

DPT offers further resources on medication-assisted treatment at www.dpt.samhsa.gov. SAMHSA has published a number of guides called Treatment Improvement Protocols and Technical Assistance Publications that provide comprehensive information on addictions treatment issues and medication assisted treatment. Two particularly useful publications on this site are TIP 40: *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction* and TIP 43: *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. TIPs and TAPs are available at http://www.kap.samhsa.gov/products/manuals/.

The Addiction Technology Transfer Center Network is funded by CSAT to upgrade the skills of existing practitioners and other health professionals and to disseminate the latest science to the treatment community. The ATTC Network creates a multitude of products and services that are timely and relevant to the many disciplines represented by the addictions treatment workforce. Serving the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Islands, the ATTC Network operates as 14 individual Regional Centers and a National Office. The ATTC website is located at www.nattc.org.

Robert Lubran oversees SAMHSA regulations affecting more than 1,100 Opioid Treatment Programs, monitors OTP compliance with SAMHSA certification requirements, and develops best practice guidelines on opioid addiction treatment. The Division of Pharmacologic Therapies that he heads is responsible for implementing the physician waiver requirements of the Drug Addiction Treatment Act of 2000, which permits qualified physicians to prescribe and dispense buprenorphine for the treatment of opioid addiction. Prior to coming to SAMHSA in 1989, Lubran was involved with medical quality assurance, utilization management, and peer review activities in the Department of Veterans Affairs' Office of Quality Management.

>> For every additional dollar invested in addictions treatment, the taxpayer saves at least $7.46 in costs to society (including the cost of incarceration).

Rydell, C.P. & Everingham, S.S. (1994) Controlling Cocaine Supply Versus Demand Programs. RAND Drug Policy Research Center. Santa Monica, CA.

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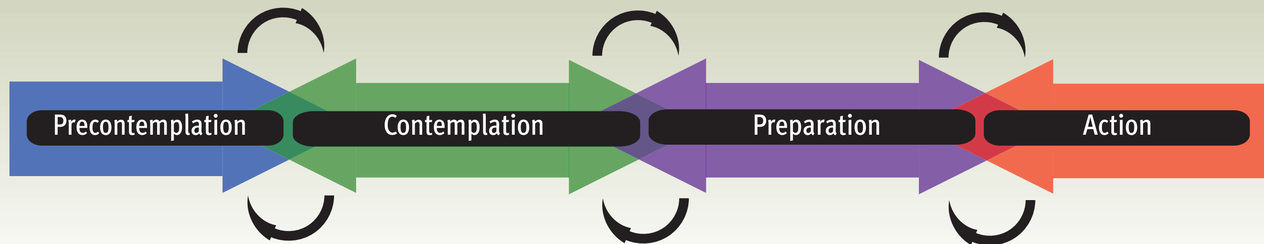
Dual Diagnosis Treatment and Motivational Interviewing for Co-occurring Disorders

Kathleen Sciacca, MA, Consultant, Executive Director, Sciacca Comprehensive Service Development for Mental Illness, Drug Addiction and Alcoholism



Dual diagnosis and motivational interviewing interventions match stages in the client's readiness

A "simultaneous approach" that addresses the "how to do it" elements concurrently with the systemic guidelines, is most effective in implementing integrated services for co-occurring mental illness and addiction disorders. This approach helps participation branch out beyond small pilot groups into broader communities and statewide arenas.

The simultaneous approach is quite different from the traditional sequential approach, which focuses on systems or infrastructure elements while program implementation, staff development, and service provision elements are hardly addressed. Service implementation frequently gets couched in discussions of charters and guidelines and is often experienced as complex, laborious, and abstract. This approach can be time-consuming, wasteful, and delay treatment and services. It is usually limited to a small number of participants.

Implementing a Simultaneous Approach

To successfully implement a co-occurring program track, the following elements are necessary

- A screening tool.
- An empathic engagement strategy that recognizes client's readiness.
- Interventions that are stage and phase specific.
- A co-occurring clinical assessment.
- Outcome measure.
- Program implementation tracking.[1]
- Staff development and training that results in participant's learning "how to" provide services and intervention.[2]

The materials and protocols for implementing integrated, co-occurring services are readily available and include effective approaches such as best practices dual diagnosis treatment and evidence-based motivational interviewing interventions that are clear, learnable, and have been practiced for more than 20 years.

An outstanding example is the State of Georgia, which, for the past five years, has implemented dual diagnosis programs across systems in a clear, concise way while continuing to refine its infrastructure.[3] The state's goal is to make every state-affiliated program capable of addressing co-occurring disorders. Every year, a series of training seminars and intensive program implementation groups are offered at numerous times for managers and direct care providers. Each intensive training and technical support group focuses on program implementation across systems and programs, includes dual diagnosis treatment and motivational interviewing, and yields at least 16 new dual diagnosis programs.[4]

Dual Diagnosis and Motivational Interviewing Interventions

The dual diagnosis model described here originated in 1984 in the mental health field[5] and set precedents for interventions that followed. Motivational interviewing also evolved in the 1980s, but from the addictions field.[6] Both models employ similar approaches yet offer separate sets of skills.

Dual diagnosis and motivational interviewing[7] employ acceptance, nonconfrontation, and recognition of client's readiness levels, and assess change incrementally. Building rapport, respect, trust, and safety in groups and individual interactions is paramount. In contrast to the symptom-focused medical model, these models employ interventions that connect to individuals and strive to understand their thoughts, feelings, struggles, aspirations, and disappointments. Providers serve as empathic allies while working toward facilitating thorough exploration of an issue.

These models depart from traditional mental health and addictions programs that view clients who enter services as "action" ready and quickly forge an action plan. Dual diagnosis and motivational interviewing engage clients at their various levels of readiness to change. Each model initially employed a way to determine clients' level of readiness to change. Motivational interviewing cited the Stages of Change[8] as an incremental process of change. Dual diagnosis developed a Readiness Scale,[9] which is descriptive, numerical, and a phase-by-phase treatment model that defines a client's movement along the continuum of change. The stages, phases, and numerical descriptors correlate and provide a cross check when they are used in combination. These stage and phase models are recommended as best practices for co-occurring disorders by the Substance Abuse and Mental Health Services Administration.[10]

Combined Interventions Along the Continuum of Change

Clients' readiness level provides the explanation for their attitude toward change and rids providers of negative interpretations such as the "uncooperative" or "resistant" client. Interventions concur with the client's readiness level. Dual diagnosis and motivational interviewing models are empathic, collaborative, and strategic. Providers remain connected and follow along with the client (client-centered) while simultaneously employing directive strategies to facilitate clients' movement along the continuum of change. The process of movement through stages and phases is nonlinear; clients may move back to earlier stages and stages may overlap.

Continued on page 23

Precontemplation

Each model begins (if necessary) with the client who is in the "precontemplation" stage. In dual diagnosis treatment, clients are engaged in group discussion and exposed to information and education that they critique from their own experiences or beliefs. Clients become more accepting of their symptoms when they understand the true properties of addictive disorders and mental illness and forego judgments, moral interpretations, and stigma. In motivational interviewing, "change talk" — exploring the client's positive experiences while identifying the negative consequences and the benefits of making a change — can result in this "cognitive shift." This shift in thinking and feeling may move the client to recognize both positive and negative consequences and her/his ambivalence.

Contemplation

Further exploration and resolution of ambivalence is a central focus in both models. The client is now in the "contemplation" stage. In this stage, the dual diagnosis model administers a clinical assessment. Details about discreet disorders, interaction effects, etiology, functioning, etc., inform the refined plan.

Preparation

If ambivalence is resolved and the client moves towards making a change, the client enters the "preparation" stage. The provider is always prepared to accept that the client may decide not to change.

Motivational interviewing employs strategies to facilitate this shift in thinking or "change talk," as well as active listening and reflecting. The goal is for the client to make the argument for change. In dual diagnosis treatment, group strategy and dynamics are employed to identify adverse effects, facilitating a cognitive shift. In the preparation stage, a collaborative approach is used to determine "how to change." In dual diagnosis treatment, other group members may participate in this process. This stage also focuses on confidence building. "How to" elements are prioritized according to potential for success.

Action

When the client implements an element of the change plan, he or she enters the "action" stage. The client may engage in additional services both within and outside of the program, such as a medication regime and/or a self-help program. Success is measured incrementally with the focus shifting from the failing client who is not engaged in action, to a successful client who is making progress incrementally. Our outcome now includes program success, provider success, and client success.

Both dual diagnosis and motivational interviewing models are interchangeable for use in individual work and in groups. A provider who is trained in both sets of skills and strategies is well equipped to work with people who have co-occurring disorders and is far less likely to experience frustration or burnout. As clients improve, provider enthusiasm is notable and results in further utilization of these approaches.

Kathleen Sciacca is a pioneer in the development of integrated treatment for co-occurring mental illness and substance disorders. As the Executive Director and Consultant for Sciacca Comprehensive Service Development for Mental Illness, Drug Addiction and Alcoholism, she provides national and international consulting for program development, training, and program materials specific to integrated/co-occurring treatment. She is former Director of the Mental Illness Chemical Abuse and Addiction Training Site for Program and Staff Development, New York. She is also a trainer and program developer for motivational interviewing, is trained as a trainer by Miller and Rollnick, and is a member of the Motivational Interviewing Network of Trainers. Ms. Sciacca's integrated treatment programs have been implemented across numerous states, communities, and programs.

[1] Sciacca, K., 1990-2007. "MIDAA SERVICE MANUAL: A Step by Step Guide to Program Implementation and Comprehensive Services for Dual/Multiple Disorders. Pub. Sciacca Comprehensive Service Development for MIDAA, NYC, revised 1995, 2000, 2001, 2002, 2007.

[2] Sciacca, K., and Thompson, C. M.,1996. "Program Development and Integrated Treatment Across Systems for Dual Diagnosis: Mental Illness, Drug Addiction and Alcoholism, MIDAA," The Journal of Mental Health Admin. Vol.23, No.3. Summer 1996, pp.288-297.

[3] Alcoholism and Drug Abuse Weekly, 2003, "GA seeks statewide implementation of dual-diagnosis strategy" Vol. 15, No. 17, Pgs. 1/6/7. April 28, 2003, Manisses, Inc. Providence, RI.

[4] Mental Health Weekly, 2006, "States Build Competence to Serve Clients with Co-occurring Illness" Vol.16, No.41, Pgs.1/2/3. October 23, 2006, Wiley Periodicals, Inc.

[5] Sciacca, K., July-1996. "On Co-occurring Addictive and Mental Disorders: A Brief History of the Origins of Dual Diagnosis Treatment and Program Development." Invited Response, American Journal of Orthopsychiatry (66) 3, July 1996.

[6] Miller, W.R. and Rollnick, S. 1991 "Motivational Interviewing: Preparing People to Change Addictive Behavior" The Guilford Press, New York, 1991.

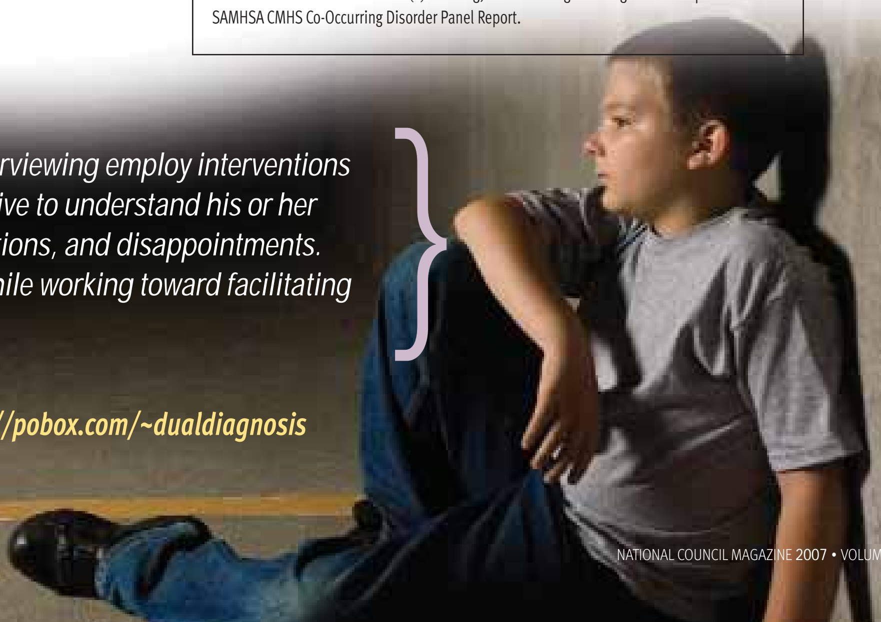
[7] Sciacca, K. 1997. "Removing Barriers: Dual Diagnosis Treatment and Motivational Interviewing" Professional Counselor, Volume 12, No.1, February 1997, pp. 41-46.

[8] Prochaska, J.O., and D'Clemente, C.C., 1984 "Transtheoretical Approach: Crossing traditional boundaries of therapy" Homewood, IL: Dow Jones/Irwin.

[9] Sciacca, K., 1990-2007. "MIDAA SERVICE MANUAL: A Step by Step Guide to Program Implementation and Comprehensive Services for Dual/Multiple Disorders. Pub. Sciacca Comprehensive Service Development for MIDAA, NYC, revised 1995, 2000, 2001, 2002, 2007.

[10] SAMHSA-CMHS Managed Care Initiative Co-Occurring Disorder Panel Report 1998: Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies and Training Curricula.

*Sciacca, K. 1998, "Curriculum for MICAA and CAMI Direct Care Providers: Mental Illness, Drug Addiction and Alcoholism MIDAA(R): Training, Cross-Training and Program Development" SAMHSA CMHS Co-Occurring Disorder Panel Report.



{ Dual diagnosis and motivational interviewing employ interventions that connect to the individual and strive to understand his or her thoughts, feelings, struggles, aspirations, and disappointments. Providers serve as empathic allies while working toward facilitating thorough exploration of an issue. }

Visit the Dual Diagnosis website at ***http://pobox.com/~dualdiagnosis***

BHR *Continued from page 18*

These services are integrated into the chemical dependency treatment structure and are funded by weaving various resources together. One principal source of funding has been a grant from the U.S. Department of Justice to the Washington State Governor's Methamphetamine Commission. While most of the grant funding has gone into law enforcement and meth lab interdiction, a small amount has been directed towards support of three Family Treatment Courts, including BHR's Family Treatment Court Program. BHR has been able to design the services and create effective integrated treatment because the funds are not restricted like federal and state chemical dependency funding. With these enhanced, intensive services, the Family Treatment Court in Thurston County, Washington, has had significant success in reunification of parent and child and in establishing most of these families in stable recovery with no re-entry into the CPS system.

Treatment of women with the profile described requires significant skill and training of the treatment professionals and comprehensive funding to address the range of issues that affect the client's recovery. The clinicians working at BHR Recovery Services are chemical dependency professionals who have significant training and experience working with clients with co-occurring disorders and co-licensed mental health professionals with a CDP. Due to the difficulty in recruiting co-licensed professionals, BHR Recovery Services has found it crucial to provide training toward co-licensing for staff members.

The Olympia, Washington, community has benefited greatly from BHR's program. Several of our early graduates now provide peer support and community advocacy for the program. As we look to the future, we face funding challenges, which we hope to resolve in order to sustain this successful program.

CBH *Continued from page 19*

Biggest challenges to success

Compliance. Most clients abusing methamphetamine are referred through DCF, not the justice system. Therefore, they don't face legal consequences if they do not comply with treatment.

Medical impact. Complications for methamphetamine addicts are both behavioral (shame, domestic violence, child neglect and abuse) and medical (sex addiction, HIV, hepatitis, brain changes, etc.).

Lack of foster care. With a high percentage of clients with dependent children, the need for foster care is rising swiftly, already overpowering resources for childcare. Will group homes for appropriate childcare be necessary?

Declining financial support. As the science of treatment improves, the finances to support it — on local, state, and governmental levels — decline.

Issues to consider in order to develop effective programming

Outcomes measurement. Our treatment model seems to be successful with our toughest clients. It provides a level of structure and support they otherwise might not obtain. Yet to our knowledge, outcome measurements have not yet been effectively implemented. CBH is now working to develop measurable outcomes to establish efficacy of the Matrix treatment model. We need these, because our observations so strongly suggest it works. Matrix is better because we put more resources into it. Yet we don't have enough resources to do it for everyone.

Repetition, accountability, and positive reinforcement. These are the underlying foundations of successful behavioral modification. Education and repetition are critical. Clinicians must recognize that clients have a cognitive impairment. The Matrix model also allows for coordination of client care with family, and the education of family members about addiction. Ultimately, support (or lack of it) from the client's social network will determine her/his success or failure. Integrating family into the treatment is critical.

A combination approach. Matrix IOP combines group, individual, and family therapy, as well as relapse prevention, into one program, with a structure and several different approaches that other IOPs do not provide. This can increase the difficulty in providing treatment as each case requires a great deal of individual attention.

Children's Center *Continued from page 19*

- Communication delays or impairments
- Behavioral problems such as unprovoked aggression
- Serious sleep abnormalities
- Rage-panic episodes and mood extremes
- Psychotic symptoms otherwise very rare in young children.

Beyond ADHD, the excessive energy and physical strength of these children exhaust and frustrate parents and teachers, who are mystified about how to help them calm down and organize their behavior.

Early research found abnormalities of energy metabolism in the brain. Creatine levels were 10% higher in the striatum, an area involved with regulation of attention and impulse, for children exposed to meth compared to "normals," according to a study done at UCLA Medical Center's Department of Pediatrics (Smith et al, July 2001; Neurology).

Tantrums may be prolonged and unresponsive to interventions such as time out or consequences. A three-year-old, with a blank stare rakes his arms to bleeding when upset, unable to find words for his distress. A five-year-old's sudden agitation swells into glassy-eyed rages lasting 45 minutes to three hours at least three times a day. Children affected by methamphetamine often think better than they communicate. When over-aroused by routine stressors, language goes "offline" and frustration and agitation soar. The COACHES program trains caregivers and school personnel in neurobehavioral strategies to coach calming techniques at home and other environments. These strategies allow a child to learn to function in a family in a safe and developmentally appropriate way. As parents and children learn these new strategies, remarkable progress is made in their ability to "practice safety" when their distress spikes and to use their newly found tools and techniques to "stay safe and calm."

Teamwork is expanded to include preschool through elementary school staff to prevent expulsion from academic programs. With training in these strategies, teachers, bus drivers, and other school staff better understand the anxious and defensive behaviors typical of these children.

Given the numerous horror stories in the media about children exposed to methamphetamine, Children's Center is fortunate to witness the progress that children make with responsive individualized treatment and community coordination.

Building a quality mental health and addictions treatment workforce

The National Council **JOBank**

www.nccbh.org/jobank

The popular web-based **National Council JOBank** is your premier resource for an adequate and competent workforce. The only national recruitment bank dedicated to behavioral health, the **National Council JOBank** matches qualified candidates with executive, administrative, policy, clinical, and direct care job openings.

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Healthy Minds. Strong Communities.

The National Council for Community Behavioral Healthcare is the leading national association representing community-based mental health and addictions treatment organizations. Workforce development, recovery, and the employment of peer specialists are priorities in our advocacy and technical assistance initiatives.

Resources for Addictions Treatment

>> The Substance Abuse and Mental Health Services Administration recently launched the National Registry of Evidence-based Programs and Practices, a searchable database of current information on the scientific basis and practicality of interventions. Users can perform custom searches based upon desired outcomes, target populations, and service settings. Learn more at **www.nrepp.samhsa.gov**.

>> Eye on the Field — a monthly email magazine published by the Addiction Technology Transfer Center National Office — highlights funding opportunities, research, diversity, current events, resources, and news related to substance misuse. Sign up at **www.nattc.org**.

>> The National Institute on Drug Abuse has developed a Community Drug Alert Bulletin that addresses the latest scientific research on the nonmedical use of prescription drugs of abuse and addiction. NIDA has also produced the Research Report Series: Prescription Drugs Abuse and Addiction and a companion Commonly Abused Drugs chart. The research report describes the consequences of prescription drug abuse and reviews recent research in this area. To order these free resources, visit **www.drugabuse.gov**, go to the publications page, then type in the name of the publication(s) you would like to receive. Or order by phone at **800.729.6686**.

>> Drugs, Brains, and Behavior: The Science of Addiction, a 30-page full-color booklet developed by the National Institute on Drug Abuse explains in layperson terms how science has revolutionized the understanding of drug addiction as a brain disease that affects behavior. NIDA hopes this new publication will help reduce stigma against addictive disorders. A PDF copy can be downloaded at **www.drugabuse.gov**.

>> NIATx works with addiction treatment providers to make more efficient use of their capacity and shares strategies for improving treatment access and retention. Using existing resources, NIATx collaborative members have transformed their business processes and the quality of care their clients receive. NIATx cutting-edge process improvement tools have proven successful for treatment organizations across the nation. Learn more at **www.NIATx.net**.

>> Getting To Outcomes 2004: Promoting Accountability Through Methods and Tools for Planning, Implementation, and Evaluation. This manual's 10-step process enhances practitioners' substance abuse prevention skills while empowering them to plan, implement, and evaluate their own programs. The manual's text and worksheets address needs and resources assessment; goals and objectives; choosing programs; ensuring program fit; capacity, planning, process, and outcome evaluation; continuous quality improvement; and sustainability. Order at **www.rand.org/publications/TR/TR101/**

>> The Addiction Technology Transfer Center Network is funded by SAMHSA's Center for Substance Abuse Treatment to upgrade the skills of existing practitioners and other health professionals and to disseminate the latest science to the treatment community. The ATTC Network creates a multitude of products and services that are timely and relevant to the many disciplines represented by the addiction treatment workforce. Serving the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and the Pacific Islands, the ATTC Network operates as 14 individual Regional Centers and a National Office. Visit the ATTC website at **www.nattc.org/aboutus.html**.

>> The Physician Clinical Support System is a national network of 70 physician mentors with expertise in buprenorphine treatment who provide free telephone, email, and onsite mentorship to more than 1,400 participants located in all 50 states and Puerto Rico. The American Society of Addiction Medicine, in consortium with other specialty addiction medicine, psychiatric, pain and general medicine societies, created the PCSS to assist physicians in the appropriate use of office-based treatment of opioid dependence using buprenorphine. The PCSS Warmline (**877.630.8812**) provides a national system of telephone triage, registers participants, and matches them with an appropriate mentor within 48 hours. A number of online resources have been created including the **www.PCSSmentor.org** website, which includes self-study materials such as Clinical Guidances, and active daily exchanges among mentors on the PCSS listserve.

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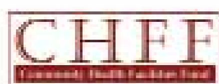
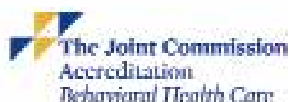
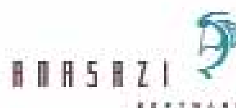
Thank You

The National Council appreciates the support of sponsors for its 2007 Annual Conference, March 26–28, in Las Vegas.







The 2008 National Council Conference takes place in Boston, MA, April 30–May 3.

About the National Council

An 85-year-old — anxious and depressed; a 9-year old, lonely and frightened, living in a foster home — acting out at school; a college student — hearing voices, afraid to leave his room and suicidal; a 42-year-old man who served his country — homeless and addicted; the young mother with schizophrenia — abused, incarcerated, and about to be released back into the community...are among the millions being helped by the members of the National Council for Community Behavioral Healthcare.

Healthy Minds. Strong Communities.

The National Council is an association of 1,300 organizations that help people in trouble — adults and children with mental illnesses or addiction disorders. The people our members treat live with their families or alone; some are in hospitals, jails, or juvenile detention facilities and others are in residential programs, foster care, or group homes. Each year, our member organizations give nearly 6 million children, adults, and families in communities across the country the chance to recover and lead productive lives.

We're proud of our member organizations. Our job is to help members do their jobs. As a not-for-profit 501(c)(3), the National Council advocates for policies that ensure that people who are ill can access services. And we offer state-of-the-science education and technical assistance so that services are efficient and effective.

We believe...

- *the best healthcare includes behavioral healthcare.*
- *in a holistic approach, personalized to meet the needs of the individual.*
- *people must be treated with respect, dignity, and cultural sensitivity.*
- *consumers and their families must be central to accessible, high-quality care.*
- *prevention and early intervention are our most efficient services.*
- *sharing education and information is critical to our effectiveness as providers.*

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