Special Issue: Addiction Workforce

ALCOHOLISM & DRUG ABUSE WEEKLY

News for policy and program decision-makers

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Volume 25 Number 16
April 22, 2013
Print ISSN 1042-1394
Online ISSN 1556-7591

In This Issue...

As the recovery industry continues to grow, the need for peers is expected to dovetail with the increased demand for treatment under the Affordable Care Act. What is clear, however, is that the addictions workforce needs to be staffed by people trained in — and, if peers, with experience in — addiction.
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DOI: 10.1002/adaw.20374

In the blossoming recovery industry, who are the addiction workers?

One clear healthcare path paved by the Affordable Care Act and the Obama administration's Department of Health and Human Services (HHS), across all of health, is the idea of recovery. Acute treatment is out; long-term recovery is in. Many believe that nowhere is this more appropriate and glaringly overdue than in the field of addiction treatment.

But who will "staff" the growing recovery industry, and how they will be paid, is a critical question, according to recovery researcher Alexandre Laudet, Ph.D., writing in "Promoting Recovery in an Evolving Policy Context: What Do We Know and What Do We Need to Know About Recovery Support Services?" in press at the *Journal of Substance Abuse Treatment*.

Bottom Line...
Healthcare reform will open up access to treatment and recovery supports. Peers — people in recovery from addictions — will be called on to help. But their exact roles and how they will be paid are still unclear.

Anticipated increased demand for recovery support services due to insurance expansion under the ACA
See **Recovery** page 2

Treatment Program Profile

Program staff that faced tragedy now encouraged toward self-care

Because the clinical staff at Twin Town Treatment Centers in Los Alamitos, Calif., takes great pride in the role it plays in helping individuals achieve sobriety, a 2012 incident in which a staff colleague in recovery allegedly caused the death of a young man shook employees to the core. In an organization where around 90 percent of the nearly 50 employees have an addiction history, attention in the months since the tragedy has focused on encouraging busy employees to remain aware of their own recovery and to take advantage of support resources when needed.

Bottom Line...
Twin Town Treatment Centers, which employed an addiction counselor now charged with murder in a drunk-driving incident, has emphasized to its recovering employees the availability of support services in times when they may be struggling.

"We're trying to increase employees' awareness of the need to practice healthy activities, whether that's through therapy, our employee assistance program or recreational activities," Twin Town President and
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will require an increased workforce, and it is "promising and desirable" to rely on the experience of the recovery community to help meet that need, writes Laudet, who is senior staff with National Development and Research Institutes in New York City.

Roles in recovery

Peer-based recovery support is nonprofessional, nonclinical assistance to help people in recovery on a long-term basis, and is provided by people who have experienced substance use disorders (SUDs) themselves, and are either volunteers or paid, according to Laudet. Peer services can be delivered in recovery community centers, faith-based institutions, jails and prisons, mental health and addiction treatment programs, health and social service centers, and other community venues.

Recovery coaching involves a peer mentoring the individual seeking recovery, helping with setting recovery goals, for example. Peer recovery coaching can also involve helping negotiate employment and other supports. Peer recovery coaching has not yet been evaluated, said Laudet. However, reports on broader recovery-oriented efforts are promising, she said.

Sober residences are homes that are also peer-based, offering financially self-sustaining, self-governed (in the Oxford House example) or sometimes run by treatment programs or others. These residences have been associated with greater abstinence rates as well as improvements in other parts of life, such as housing and employment, according to Laudet. Operators, depending on the level determined by the National Association of Recovery Residences, may be clinicians or peers (see *ADAW*, December 17, 2012).

Different from treatment

"We like to think of peers as transformative, rather than an add-on," said Tom Hill, director of programs for Faces & Voices of Recovery. "These new peer service roles do shake things up a little bit."

Peers are not just a part of treatment, he said. For example, they may be able to help people who are reentering society from the criminal justice system stabilize their recovery, he said.

But when peer services are embedded in treatment programs, it's important that they not be put into "inappropriate services roles, like junior counselors," Hill told *ADAW*. "They are there to help the clinicians."

Treatment will always be needed, said Hill. "This needs to be developed in a comprehensive way so that everybody knows their role," he said.

'Behavioral' workforce at SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA) has promoted recovery, in accordance with the HHS philosophy, but not surprisingly, there is some confusion about the distinctions between recovery from mental illness and recovery from addiction.

Paolo del Vecchio, director of SAMHSA's Center for Mental Health Services (CMHS), is the point person in charge of workforce at SAMHSA — and since his perspective is mental health, we asked him how recovery from mental illness is distinguished from recovery from addiction, in terms of workforce. Specifically, are peers in recovery from addiction appropriate to help people with mental illness, and are peers in recovery from mental illness appropriate to help with people with SUDs? "We're inclusive in how we approach the recovery workforce," he told *ADAW*. "We're inclusive of recovery coaches for addiction, and peer specialists for mental health" — meaning that the term "recovery coach" is viewed as more for addiction, while "peer specialists" is for mental health. Nevertheless, del Vecchio said that SAMHSA's approach is a broad one that

ALCOHOLISM & DRUG ABUSE WEEKLY
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Alcoholism & Drug Abuse Weekly (Print ISSN 1042-1394; Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the second Monday in July, the second Monday in September, and the first and last Mondays in December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Print only: $695 (individual, U.S./Can./Mex.), $839 (individual, rest of world), $5433 (institutional, U.S.), $5577 (institutional, Can./Mex.), $5625 (institutional, rest of world); Print & electronic: $765 (individual, U.S./Can./Mex.), $909 (individual, rest of the world), $6251 (institutional, U.S.), $6395 (institutional, Can./Mex.), $6443 (institutional, rest of the world); Electronic only: $555 (individual, worldwide), $5433 (institutional, worldwide). **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Subscription Distribution US, c/o John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774; (201) 748-6645; e-mail: subinfo@wiley.com. © 2013 Wiley Periodicals, Inc., a Wiley Company. All rights reserved. Reproduction in any form without the consent of the publisher is strictly forbidden.

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comprises behavioral healthcare.

Addiction recovery researcher Laudet offered this clarification: "Because each chronic condition requires condition-specific lifestyle changes, triggers and challenges, and self-care strategies, it's not intuitively desirable or logical that a person managing the symptoms be assigned to assist somebody managing the symptoms of another chronic illness, be it diabetes, mental illness or addiction."

Del Vecchio added that in the proposed budget announced earlier this month (see *ADAW*, April 15), a peer professional workforce development program was announced, which includes substance abuse peers.

SAMHSA's problems in delineating an addictions workforce were seen clearly in its workforce report to Congress, delivered a year late, last month (see *ADAW*, April 1). That report was requested by the Senate Appropriations Committee and was supposed to be only about the addictions workforce; however, SAMHSA, citing lack of information about the addictions workforce, focused on the behavioral workforce.

Accreditation

SAMHSA is advancing the Recovery-Oriented Systems of Care (ROSC) model, which has as goals: (1) early intervention with people with SUDs, (2) supporting sustained recovery from SUDs and (3) improving the health and wellness of people and families affected by SUDs. However, ROSCs go far beyond peer supports, including education and job training, housing, childcare, transportation, spiritual support and case management, as well as SUD-specific services such as relapse prevention, recovery support, SUD education for family members, and peer and coaching services.

'We're inclusive of recovery coaches for addiction, and peer specialists for mental health.'

Paolo del Vecchio

Faces & Voices of Recovery has long seen a need to have quality standards for the recovery field, and recently issued a set of guidelines to accredit Recovery Community Organizations (RCOs), with site visits for the pilot due to start this summer. Peers — people with experience with SUDs themselves — will be staffing many recovery organizations that will be accredited by Faces & Voices.

SAMHSA is developing core competencies for the peer workforce that include both mental health and addiction, said del Vecchio. "What's important is the training of those providers to be in recovery-oriented approaches," he said. For the last five years, SAMHSA has developed the concept of "recovery to practice," working with the American Psychological Association, American Psychiatric Association, NAADAC, the Council on Social Work Education, the American Psychiatric Nurses Association and the National Association of Peer Specialists to develop curricula on recovery-oriented practices, he said.

From the beginning, the strategy of Faces & Voices has been to build an accreditation system, said Hill. "If they meet our standards, and get accredited, then they would be authorized entities," he said. Faces & Voices would only accredit the organizations, and the peers who work there would have to be supervised.

The recovery industry has outliers, like the $1,000-per-day recovery coaches who market their services to corporate executives and celebrities, said Hill. "It's not necessarily bad," he said. "But there is this whole industry that has been growing in parallel with the peer movement." Some of them call themselves "life coaches" with a recovery focus, he added. "But what they're doing is rebuilding a life that may have been devastated," he said. •

Survey: SAMHSA employees feel untrusted, overly supervised

An internal survey of employees of the Substance Abuse and Mental Health Services Administration (SAMHSA) reveals that many employees feel they are not trusted, are overly supervised and need more "empowerment." The problem is worse in some centers — notably, the Center for Substance Abuse Treatment (CSAT) — and divisions than others.

For more addiction information, visit
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The survey report, a copy of which was obtained by *ADAW*, comes in the wake of the 2012 federal Government Employee Viewpoint Survey (EVS) conducted by the Office of Personnel Management; SAMHSA looked at the results and contracted with an independent consulting firm to administer an online survey to its own employees. The survey, called Pulse Check, was emailed to 622 SAMHSA employees on March 11, and results closed on March 18. A total of 399 people responded.

In general, SAMHSA employees associate empowerment with the ability to use their expertise and skills "without excessive supervision which conveys a lack of trust in them," according to the report. They would prefer "collaborative decision-making," especially in the branch or division in which they work.

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Better communication

In the area of "communications," the results were more positive, with an improvement compared to the EVS communications results. The results were best for the Center for Mental Health Services (CMHS) and the Center for Behavioral Health Statistics and Quality (CBHSQ). However, there was a doubling in the number of employees who said communication improvements are needed at the SAMHSA-wide level.

Employees would appreciate better sharing of information "to ensure subordinates are well informed on a regular basis," the report said, citing higher-level meetings in particular. "The frequency and quality of communication seem most important, as employees want to be informed regularly and want respectful, honest and interactive communication that is accurate, appropriate and timely."

Analysis of results of employees in the Office of the Administrator and the Office of Communications was not possible, because the number of responses was under 10. Those responses are included in the totals but not shown as separate results to safeguard the confidentiality of respondents.

For empowerment, the results showed a net satisfaction of 30.8 percent, a decrease from the 2012 EVS. Some centers, however, had greater improvement. The Center for Substance Abuse Prevention (CSAP) only had a 21.7 percent net satisfaction,

Letter to the Editor

To the Editor:

I was quite puzzled to read James Finley's comment on the addiction treatment workforce in the April 1 edition of *ADAW* (Finley is director of public policy for the Mental Health Counselors Association).

He indicated that "No mental health professional would say 'I started out as a psychiatric patient.'" I would hope that he does not mean that is anything to be ashamed of for the 30 percent of the professional addiction workforce in recovery. These counselors who bring the benefit of personal life experience of recovery help strengthen and inform our workforces and have nothing to be ashamed of in acknowledging their recovery status. Recovering persons are an asset to both of our fields, not a liability.

For many of us in recovery, living our lives as we do is quite similar to being immersed in a new culture. The culture of recovery is additive to our lives with all the richness of any form of a cultural experience.

Unfortunately, stigma remains quite strong in regard to recovery from addictions as they are from mental health disorders. Yet there is hope. We will overcome stigma and a day will arrive when there is no professional or personal risk in acknowledging who we are and our experiences as recovering members of society.

There will soon come a day when there is no more controversy or shame in a professional counselor acknowledging their recovery status than there is for a physician who acknowledges that they too have suffered from common medical ailments such as diabetes and heart disease and the lifestyle changes they made to return to healthy living.

Surely we all wish to live in that world.

William Stauffer, LSW, CADC
Executive Director
The Pennsylvania Recovery Organization Alliance

Employees have a feeling of personal empowerment with respect to work processes

		SAMHSA	CBHSQ	CMHS	CSAP	SCSAT	OFR	OMTO	OPPI
2013 SAMHSA Pulse Check results	**Strongly agree**	7.2%	6.9%	5.4%	6.7%	5.6%	5.7%	12.5%	16.1%
	Agree	23.6%	24.1%	27.0%	15.0%	21.1%	22.6%	29.2%	29.0%
	Neutral	22.2%	31.0%	16.2%	25.0%	22.5%	26.4%	20.8%	16.1%
	Disagree	28.5%	17.2%	39.2%	41.7%	23.9%	13.2%	25.0%	29.0%
	Strongly disagree	18.4%	20.7%	12.2%	11.7%	26.8%	32.1%	12.5%	9.7%
2012 EVS results	**Net agree**	27.5%	26.9%	15.7%	35.0%	22.2%	26.8%	32.1%	56.3%
	Neutral	18.6%	11.6%	17.2%	16.2%	19.1%	22.0%	17.9%	12.4%
	Net disagree	53.9%	61.5%	67.1%	48.8%	58.7%	51.2%	50.0%	31.3%
Net change from EVS	**Net agree**	3.3%	4.1%	16.7%	–13.3%	4.5%	1.5%	9.9%	–11.2%
	Neutral	3.6%	19.4%	–1.0%	8.8%	3.4%	4.4%	2.6%	3.7%
	Net disagree	–7.0%	–23.6%	–15.7%	4.6%	–8.0%	–5.9%	–12.5%	7.4%

Source: SAMHSA

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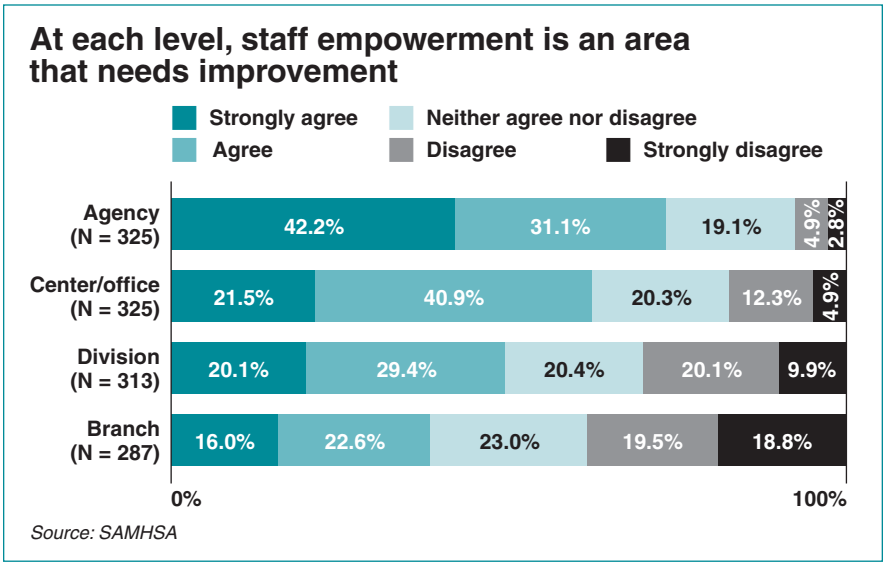

compared to 45.1 percent for the Office of Policy, Planning, and Innovation (OPPI). In general, SAMHSA employees do not feel empowered, the report said. "In fact, more feel disempowered than empowered," the report said.

The table on page 4 and the graph to the left give an indication of how employees at different centers, branches and divisions feel about their empowerment at SAMHSA. They compare the 2012 EVS survey with the March Pulse Check, showing what has improved and what has gotten worse.

The feeling of lack of empowerment decreased at each progressively higher level. One of the issues is "knowing who to talk to if one has questions," according to the report. "This suggests that employees are not certain what the 'rules of engagement' are, which makes them uncertain about how to get things done, what the policies and practices are, and what the boundaries are in which they are to operate." •

New county-CRC program focuses on co-occurring disorders

The White Deer Run division of CRC Health Group and Lehigh County, Pennsylvania, last month opened a facility devoted to treating co-occurring mental illness and substance use disorders (SUDs). The Lehigh County Center for Recovery, in Bethlehem, is licensed by the state and will be an adult co-ed, inpatient, detoxification and rehabilitation program with a focus on dual diagnosis. The program, 10 years in the making, will have 31 beds and 7 detox beds. It's one of the first in the nation, which is "remarkable given the unmet need," said Barry McCaffrey, a member of the CRC advisory board.

The center opened last month and immediately filled up, McCaffrey told *ADAW*. "What we'll see is a payoff to the county on reduced crime, reduced ER costs, reduced court costs," said McCaffrey. The county isn't paying for all of the treatment — 70 percent of the beds are reserved for county-paid patients. "We're still going to have to string along private-pay," said McCaffrey. But this gives the public sector an opportunity to look at results when co-occurring disorders are addressed.

"It's a county investment, but the county will be utilizing the state," said Jerry Rhodes, chief operating officer of CRC Health Group, adding that Pennsylvania has a "very progressive publicly funded system."

> **'It's a myth that you can't diagnose psychiatric problems until after detox.'**
>
> Jerry Rhodes

The state has a special funding category for co-occurring patients that goes through the existing payment system, said Rhodes.

In Pennsylvania, no special credential is needed to treat people with co-occurring mental illness and substance use disorders. However, CRC says clinical staffers in the program have master's degrees and are trained not only in addictions but in mental health issues as well. Staff gets extra training on serious mental illness, including schizophrenia and bipolar disorder. Some of the employees at Lehigh transferred from other CRC treatment programs in the state and some were new hires, said Rhodes.

From a policy perspective, said McCaffrey, it's hard to believe that for almost 15 years treatment for mental health and addiction has been separated. "The constant funding struggle is dysfunctional," he said. "Even in a methadone treatment program, we know people still have other issues."

Once someone has a serious drug addiction, by the age of 30 that person also has mental health problems, said McCaffrey. "It's almost impossible to separate," he says. While the figure typically cited is 40 percent, McCaffrey says that more like 100 percent of people with addiction also have a mental illness. Federal estimates are that there are 9 million people with co-occurring disorders. Many of CRC's inpatient substance abuse programs do have

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psychiatric services available.

Co-occurring services will be delivered based on the needs of each patient, said Rhodes. "There will be consulting psychiatric services available," he said. Patients entering the dual-diagnosis treatment program will already have been through detoxification, and free of illicit drugs, he said.

"It's a myth that you can't diagnose psychiatric problems until after detox," said Rhodes. "You have to rely on the expertise of your clinical team to evaluate individuals." But this evaluation can be done even before the patient has been through detoxification. •

Faces & Voices tells NIDA it's time to study recovery

In response to a Request for Information (RFI) from the National Institute on Drug Abuse (NIDA) on evidence-based treatment for substance abuse, Faces & Voices of Recovery Executive Director Pat Taylor wrote an incisive letter detailing the need to research one of the biggest mysteries of addiction: how do people get into recovery and what is the role of peers? The RFI was issued March 1 and had a due date of March 30.

Taylor noted in her letter to NIDA that there is a gap not mentioned in the RFI — that of a "systematic, empirical investigation of recovery from addiction that would include the development of an evidence base for peer and other recovery support services and the identification and transfer of information about services and supports that engage and sustain individuals in managing their recovery from addiction to alcohol and other drugs."

NIDA, in the RFI, stressed the gap between research and practice. But Taylor said that the knowledge gap of how people recover is important to address as well. The implementation of the Mental Health Parity and Addiction Equity Act gives NIDA the opportunity "to focus on how people are getting well," and how the people who support them "can be most effective," said Taylor.

An estimated 23 million people in America are in recovery, and "there is growing awareness, one-on-one and in communities, about individual recovery experiences," said Taylor. Yet, there is still no "science behind those stories," she said.

Faces & Voices recommended the following areas for research:

- Peer and other recovery supports, recovery support institutions and service roles. "There is a robust body of research on the value and effectiveness of peer supports for a number of chronic health conditions such as diabetes, cancer, obesity, HIV/AIDS and mental illness," said Taylor. "There is limited research on the effectiveness of addiction peer recovery support services, mostly focused on recovery residences (housing). While there is a good start on this research, there is very little research on the effectiveness of other recovery support institutions such as recovery schools, recovery community organizations, recovery community centers, recovery industries or recovery ministries. And there is next to no research on the emerging peer and other recovery support service roles of recovery coach and peer recovery support specialist."
- Pathways, processes, stages and styles of long-term recovery. Research is needed to understand longitudinally the multiple pathways to long-term recovery, said Taylor. "We also need to understand what the factors are that contribute to initiating alcohol and drug use after a period of sustained recovery. "What is the overall health impact of recovery from addiction? To what extent and how does health improve? How does the length of recovery time affect this process?"
- Barriers to recovery. For many people in early recovery, it's known anecdotally that the criminal justice system and discriminatory policies in the areas of insurance, employment and housing can impede continued recovery. •

For the RFI, go to http://grants.nih.gov/grants/guide/notice-files/NOT-DA-13-014.html.

Relapse from page 1
CEO David Lisonbee told *ADAW*.

In the aftermath of the incident last November in which Twin Town counselor Sherri Lynn Wilkins was charged with murder in a case of drunk driving that resulted in the death of 31-year-old pedestrian Phillip Moreno, Lisonbee decided to begin asking all employees to complete a questionnaire designed to highlight warning signs for relapse (see *ADAW*, Dec. 17, 2012). Lisonbee said this month that employees in general have eagerly participated, and the questionnaires are generally completed at the time of hire and then in conjunction with a staff member's annual performance review.

Asked whether the increased attention to self-care has resulted in an uptick in accessing EAP resources, Lisonbee said, "So far, not so much."

Respecting privacy

Lisonbee acknowledges that the effort to learn more about staff members' own wellness largely is being conducted on a voluntary basis. "In California we're generally

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protective of people's privacy," he said. "Our effort has a focus on increasing people's awareness of their own recovery."

In the days immediately following the death of Moreno, Lisonbee said the decision was quickly made to address the issue openly. "In sobriety, with my own and most people's, we don't like to run away from problems," he said. "We look at the evidence. We look soberly at the facts. We're not frozen or intimidated."

Twin Town also looked outward, asking colleagues in the field to offer their perspective on the situation and on the organization's quality improvement practices. "We have strong advocates, including our own patients, the state and the Joint Commission," said Lisonbee. "We asked all of them to take a look at the situation."

Twin Town decided to employ the AWARE (Advance Warning of Relapse) questionnaire, a public-domain instrument originally co-developed by relapse prevention expert Terence Gorski, because there are few instruments like it elsewhere and because it is validated and relatively easy to use, Lisonbee said. While the 28-item questionnaire is designed to evaluate relapse risk among individuals in recovery, Twin Town also encourages non-recovering employees to fill out the survey.

"Even those who don't need abstinence face stressors in their lives, such as financial stress," Lisonbee said.

Although Lisonbee said the use of the questionnaire in conjunction with the performance review process makes sense in terms of encouraging annual participation in the survey, he emphasized that the questionnaire is in no way used as a tool to evaluate employees' performance.

Twin Town is also trying to convey to employees the consistent availability of services and support through its EAP contractor. Lisonbee says it promotes the scope of its EAP services through paycheck stuffers, wall postings and e-mail distributions.

He added that three individual counseling sessions are made available through the EAP at no cost to the employee. If further therapy is needed, referrals are made to insurance-contracted therapists or free resources, he said.

Finally, in cases where stress is clearly impairing a worker's performance on the job, a formal referral to the EAP may be made; this allows for the tracking of progress made in treatment, Lisonbee said.

Twin Town Treatment Centers

Location: *Los Alamitos, California*
Services: *Intensive outpatient and partial hospitalization services for about 50 to 60 primary patients on a typical day*
Employees: *44*
Percentage of Staff in Recovery: *90 percent*
Payer Mix: *85 percent insurance, 15 percent self-pay*

'We all recognize how fragile sobriety can be.'

David Lisonbee

Twin Town also has brought in licensed therapists to consult with staff on subjects such as trauma debriefing and relapse prevention strategies, to beef up their understanding of areas that could help them as both employees and recovering individuals. "Bringing in others to meet with us has been helpful," Lisonbee said.

Of course, much of the stress that employees typically face plays out mostly in the realm of their private life rather than their work life, and therefore out of the reach of the organization that employs them, Lisonbee indicated. This is why no questionnaire or EAP initiative is necessarily going to capture every problem before it manifests as a crisis.

A hit to the image

There is a sense that it helped Twin Town as an organization not to hide from an event in which one of its employees became the subject of sensationalistic headlines. Wilkins' blood alcohol level at the time of the accident was reportedly twice the legal limit, and she allegedly continued to drive for two miles with the victim pinned to the windshield of her car.

Lisonbee said any news items related to drug and alcohol use affect the mind-set of the recovering employees at Twin Town. "Drug- and alcohol-related current events and media coverage affect my recovering employees as they would anyone else in recovery," he said. "We are saddened when we are unfairly stereotyped or labeled."

He added, "We are frustrated when we learn of relapse and/or observe the tragic consequences of addiction. We are excited when we hear of someone facing their demons and achieving sobriety."

He said that in many ways, an event directly affecting a colleague could resonate even more than one affecting a client. "They identify more with one another than with their clients," he said. "We all recognize how fragile sobriety can be." •

From the editor: This will be the last "Treatment Program Profile," a department which has run for more than 2½ years. Next week, *ADAW* will launch a new department called "The Business of Treatment."

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Briefly Noted

Recovery-oriented organization helps students get health IT jobs

NADAP, an organization that helps people in recovery get jobs, has been selected by the New York City Economic Development Corporation to launch the Learn As You Earn Advancement Program (LEAP) for health information technology students. This program helps students enter the workplace and is within a larger New York City strategy called the LINK (Leveraging Innovations and our Neighborhoods in the Knowledge economy) initiative. LEAP provides services to 100 "exceptional students" in colleges who are in associate degree or certificate programs in health IT. Students receive employment-readiness training and career counseling, and then are matched with employers for paid internships. For more information, go to www.nadap.org.

State News

California's CAADAC and CAARR considering a merger

Not only are the three national counselor certification organizations collaborating (see *ADAW*, March 18), but the two leading organizations in California have announced that they are discussing a potential merger. The California Association of Alcohol and Drug Addiction Counselors (CAADAC) and the California Association of Addiction Recovery Resources (CAARR), like NAADAC, NCC AP and IC&RC, are considering working more closely together because of some provisions of the Affordable Care Act and the parity law. In addition, the California Department of Alcohol and Drug Programs is going to be absorbed into the Department of Health Care Services in July (see *ADAW*, August 27, September 10, 2012). "These are challenges that affect the entire field in California including the workforce, treatment programs, prevention efforts and clients of SUD service providers," according to a press advisory from CAADAC and CAARR. While both groups have affiliated boards that certify counselors, they are also membership organizations, with CAADAC primarily for counselors and CAARR primarily for treatment programs. A new association would present "its own set of challenges and opportunities," according to the press advisory. "Ultimately, however, the goal is to have the strongest possible organization in California in order to advocate most effectively for both programs and counselors as we enter a period in which change is occurring at an ever-increasing rate." John Madsen, CAADAC board president and a member of the due diligence committee, said that in 2010, "our two organizations led an effort to write an 80 page bill to strengthen counselor certification by giving ADP the authority they needed to enforce the system," adding that during the process, the two organizations "learned to trust and rely on each other." And Paul Savo, CAARR board president and also a member of the due diligence committee, said a united organization could help improve standards affecting residential and outpatient treatment programs. "CAARR was formed in 1972 and we've been highly effective," said Savo. "In 2013, we are at a crossroads. We have multiple reasons for trying to make this unification work, and our Board Members are committed to the process." Both CAARR and CAADAC sent representatives to the IC&RC meeting held in San Diego April 8–12.

Coming up...

The annual medical-scientific conference of the **American Society of Addiction Medicine (ASAM)** will be held **April 25–28** in **Chicago**. For more information, go to **www.asam.org/education/annual-medical-scientific-conference**.

The **Global Addiction and EUROPAD Conference** will be held **May 7–10** in **Pisa, Italy**. Go to **www.globalladdiction.org** for more information.

The annual conference on **Treatment Accountability for Safer Communities (TASC)**, with a focus on reentry, will be held **May 9–10** in **Columbus, Ohio**. For more information, go to **www.nationaltasc.org/index.php**.

The **National Association of Addiction Treatment Providers (NAATP)** will hold its annual conference **May 18–21** in **San Antonio**. Go to **www.naatp.org** for more information.

In case you haven't heard...

Another omission by SAMHSA for addiction treatment? The report by SAMHSA to Congress on the addictions workforce ended up being a report on the behavioral health workforce — and the file was called "MH workforce issues." Then, the National Association of Addiction Treatment Providers (NAATP) 2011 salary survey, which was done with the National Council for Community Behavioral Healthcare, was described in the workforce report as "the NCCBH report." The NAATP was not mentioned at all in the entire SAMHSA workforce report. Rather, the SAMHSA report said the National Council conducted the salary survey, and described the National Council as "delivering both mental health and substance abuse services." NAATP's annual survey is due out later this month. The National Council does not conduct a salary survey of its own.