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Pioneers of the Chronic Care Model

Michael T. Flaherty, PhD, Principal Investigator, Northeast ATTC

HIGHLIGHTS

- In the past ten years, experts have reconceptualized addiction as a chronic disorder, leading to longer, more diverse treatment experiences
- The field is moving toward a common vision of addiction as a chronic condition from which recovery is possible, even common

THE MOST EXCITING INNOVATION in the field of addictions is happening right now—today. It is the process of replacing an acute care model with a chronic care model and we are right in the midst of it.

Research shows that people who successfully manage their addiction as a chronic disease experience very real recovery. Based on these findings, the field of addiction treatment has developed "recovery-oriented systems of care." We now recognize that seeing a client once or twice for a drug or alcohol problem and calling it treatment is inadequate. We acknowledge that treating clients as if chemical dependence is their fault is ineffective. Instead, we can offer an alternative to substance abuse: a higher quality of life for individuals and their families. We achieve this goal by offering clients a multitude of pathways to travel, and we call this journey *recovery*.

For many years, those in recovery, providers and a few bold researchers courageously advanced the notion that substance dependence is best addressed as a chronic disease in need of continuing care. These pioneers were often ignored and sometimes shunned. Progress came in the year 2000, when McLellan, Lewis, O'Brien, and Kleber published a landmark research article in the Journal of the American Medical Association entitled, "Drug Dependence, a Chronic Mental Illness: Implications for Treatment, Insurance, and Outcomes Evaluation."[1] While others—including Ernie Kurtz, Doug Angline, Rudy Moos, Bill White, George DeLeon, and George Vaillant—had been expounding on the same subject, they routinely ran up against an entrenched acute care medical model (and corresponding payment structure) applied to treatment.

In 2005, the Institute for Research, Education and Training in Addiction (IRETA) gathered experts from a range of stakeholder groups (prevention and treatment practitioners, researchers, payers, insurers, those in recovery, and others) and held a series of meetings to address one question: Do we have a common vision of addiction in this country? The resounding answer was "no." In addition, there was collective shock in response to the National Institute of Medicine's 2001 report, "Crossing the Quality Chasm: A New Health System for the 21st Century," in which addiction didn't make the list of major health concerns. The group agreed that in terms of prevalence and as a root cause of other illnesses, addiction could well be the number one health concern in the country. We recognized the need for a more uniform vision of addiction and agreed that since it bears striking similarities to other chronic diseases like diabetes and hypertension, addiction is best treated similarly, with ongoing care. We saw that treatment and payment methodologies were not aligned with a chronic care model. Those meetings five years ago ignited a fire within us; we returned to our jobs with a sense of energy and mutual support for a system-wide transformation. The world had changed.

Later in 2005, the federal Substance Abuse and Mental Health Services Administration (SAMHSA), through the Center for Substance Abuse Treatment (CSAT), held a National Summit on Recovery to refine and establish the first set of Guiding Principles of Recovery.[2] In 2008, the Great Lakes Addiction Technology Transfer Center (ATTC) sponsored its first provider-focused Recovery National Meeting, followed that same year by a national recovery symposium of 22 state leaders sponsored by IRETA and the Northeast ATTC. Meanwhile, William White wrote a series of monographs aggregating clinical best practices and practical steps toward systems change around this new, person-centered view of addiction treatment. His monographs were read around the world.

While we weren't the first to articulate a vision of addiction as a chronic condition from which recovery is possible, even common, we *were* the first to try to unify stakeholders around that vision, which created the potential for the field of addiction treatment to undergo a transformation. Today, stakeholders and policymakers are hungry for information about how science, practice, and payment methodologies can be restructured to provide better service for individuals and families along the full continuum of care: prevention, intervention, treatment, and recovery. The workforce is growing and changing to accommodate this system change. The traditional addiction counselor is now a specialist among other types of providers who aid in recovery: primary care providers perform addiction screenings and recovery support specialists (a newly accredited profession) provide ongoing support to individuals in treatment.

New federal parity legislation and healthcare reform will only fuel this system-wide change. Many previously uninsured Americans will now have access to treatment through their health plans. Group plans will be required to cover mental health and substance use services in the same way they do medical care.

As our systems change, so too must our language. One of the reasons that I believe in the longevity of this change is the earnest attempt by everyone involved to create a language that defines recovery and uses the best available science to describe the most effective methods of prevention, intervention and treatment—all in support of recovery. This shift, on all levels, is the greatest innovation within the field that I've seen in my career. This is a transformation that will stick. ■

[1] McLellan, AT, Lewis DC, O'Brien CP, Kleber HD (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-95.

[2] http://www.samhsa.gov/samhsanewsletter/Volume_17_Number_5/GuidingPrinciples.aspx

An Interview with Jay Ford, PhD, Director of Research, NIATx

HIGHLIGHTS

- NIATx designed a model for improvement specifically for behavioral health care that allows payers and providers to make small changes that substantially impact outcomes
- Strategizing to reduce barriers like long wait times and creating a warm environment are two steps that often improve outcomes

What makes an innovation successful?

That it achieves the objectives and goals established by the agency. We encourage folks to start off with a walk through of their organization from the perspective of their clients. What is it like to be someone coming into your organization? How easy is it to find the organization? Is it warm, open, inviting, and friendly or is it more institutional-feeling? We encourage them to go through the actual intake process. Based on that, the organization should identify some areas for improvement.

What models of process improvement do you draw upon?

A lot of the quality improvement is based on the early work of Edward Deming and Joseph Duran. The focus on the customer is work that Dave Gustafson, who is the director of NIATx, did about 10 or 15 years ago where he identified a whole series of factors that separate organizations that were successful at implementing change from those that were unsuccessful. That kind of led to the five NIATx principles. Rapid-cycle changes are based on work that Langley and Nolan did. So it's bringing those three things together along with the Institute for Healthcare Improvement learning collaborative model.

When you look at organizations, what are some common barriers to accessibility for their clients?

Long wait times: it takes two to four weeks to get in for an intake appointment or to see a psychiatrist. We might see too many steps in the process: I schedule one appointment to come in and they collect my financial information. When that's over, I schedule another appointment to come back in and do my intake. So it's a cumbersome process. We might see paperwork that is duplicative in nature, asking you the same questions over and over again. Or broad environmental issues in the organization, such as it's not easy to find, or it's not very warm and welcoming, or you don't have any privacy when you're completing the paperwork.

The Five NIATx Principles

1. **Understand and involve the customer**
2. **Fix the key problems**
3. **Pick a powerful change leader**
4. **Get ideas from outside the organization or field**
5. **Use rapid-cycle testing to establish effective changes**

What can organizations do to improve client retention?

There are different points of retention. When people first call the organization, and I'm trying to now retain them to the assessment appointment. We've seen agencies transition to walk-in appointments. Or maybe the organization has phone calls to remind people of their appointments, much like your dentist or doctor's office might do. Then, once people are engaged in treatment, some agencies have used incentives, such as giving coupons to local businesses if clients make it to a certain number of sessions (see article, page 4).

If a consumer is moving between levels of care, we find that giving them an opportunity to go and experience that new level of care is helpful. Maybe I have a chance to meet my outpatient counselor and talk to them before I go so I can establish that one-on-one rapport.

What's the benefit to the organization to improve retention beyond meeting their mission statement? Is there a benefit in gaining reimbursements?

In fee-for-service environments, obviously there's an incentive there. If you can get people to come into treatment, then you are going to get reimbursed for it. This is anecdotal, but other organizations talk about how they've used the NIATx process to improve and then maybe they get better rates from a private insurance company. Or maybe the fact that they've used NIATx helps them land a grant from SAMSHA or another agency. We conducted some research around the impact of the NIATx model of process improvement on the business case for change. Information about this can be found on our website (http://www.niatx.net).

If a treatment provider could make just one change, what would you recommend?

The organization needs to try something that's going to best suit their needs. We do try to provide case studies for all the different ideas of changes that people have come up with. The ones that I've mentioned because are the ones that people have tried and have had the most success with. ■

Implementing Change: A Case Study

Holly Hagle, MA, Training Officer and Eric Hulsey, DrPh, Scientific Director, IRETA

HIGHLIGHTS

- Regional Addiction Technology Transfer Centers are available in every state to assist in the implementation of evidence-based practices (EBPs)
- The Northeast ATTC assisted POWER (a women's recovery organization in Pittsburgh) with the implementation of motivational incentives and motivational interviewing
- The Northeast ATTC and POWER collaborated for 18 months with a clear plan for developing and implementing an EBP customized for the organization

THE NORTHEAST Addiction Technology Transfer Center (ATTC) is housed in Pittsburgh and covers all of Pennsylvania and New York State. It is one of 14 regional ATTCs in a national network whose role is to help accelerate the implementation of innovative EBPs, once developed and tested, into practice at organizations that provide addiction treatment services. In April 2009, the Northeast ATTC began to work collaboratively with the Pennsylvania Organization for Women in Early Recovery (POWER) to implement an EBP of its choosing and the story, which spans 18 months, exemplifies the fruitful results of an organizational partnership with an ATTC Center.

Because research has shown that innovations in care delivery that have buy-in from staff members at all levels of an organization are more likely to be sustained, the Northeast ATTC-designed kickoff workshops include both the professionals who would be using the new practice with clients as well as professionals in administrative roles who provide resource and leadership support. The workshop content in spring 2009 included:

- An overview of EBPs in general and motivational interviewing and motivational incentives in particular
- Tools for planning to use of one of the EBPs

Follow up with POWER included:

- An assessment of individual readiness to adopt an EBP in the form of an online survey to assess their organizational strengths and weaknesses, including organizational culture, administrative support, openness to training, and quality of communication
- A meeting to provide POWER with feedback from this assessment and to review their plan to use one of the EBPs

As a next step, POWER chose which practice to implement and a team to spearhead those efforts, developed an action plan and a start date, and identified a clear and measurable objective that they wanted to achieve. POWER decided to implement motivational incentives in order to increase client retention, which led to an additional set of decisions:

- What client behavior will we incentivize?
- What incentives will we offer?
- How will we track when an incentive is warranted?
- Who will purchase the incentive items?

Research finds that motivational incentives are most effective when clients have a say in what items are important to them; they work in part because they reframe the culture of treatment to reinforce positive behaviors instead of punishing negative actions.

Once the details of putting the plan into action were worked out, POWER began using motivational incentives. Because they had particularly enthusiastic staff members and supportive leadership, they moved quickly to apply motivational incentives to achieve a specific objective in their service delivery: retaining consumers after their initial assessment. As employees' experience with motivational incentives increased and the organization retained clients longer, they began to apply it with more nuance, helping some clients shift from external motivators to internal motivators.

While staff initiative and flexibility are important characteristics, the ATTC Network emphasizes the importance of continuing to execute new practices as they were designed. This ensures that those innovations remain effective and sustainable. POWER was particularly forward-looking: when they realized that motivational incentives were helping them to retain clients, they grew concerned that they wouldn't have the resources to continue using the innovation. A presentation to their board of directors illustrating the success of the technique helped them to secure even more resources—and full support from the board to move ahead!

During initial meetings with POWER, the Northeast ATTC addressed the fact that implementing EBPs can sometimes cost money up front. However, they stressed that these innovations can be good for clients as well as the bottom line: EPBs can certainly increase the quality of care provided and can increase billable hours, as well.

Even highly motivated organizations face challenges on the road to change. The staff members must do the hard work of introspection and designing new administrative systems and processes. Administrative staff must commit staff time and other resources to these initiatives. There are often fears about the dissolution of familiar roles and comfortable routines. But if providers accept the challenges and boldly adopt practices and programs that research has shown to be effective, they can look forward to improving client outcomes and helping them to maintain long-term recovery. ■

THE PHILADELPHIA EXPERIENCE

EARLY IN THIS DECADE, Philadelphia made a commitment to provide integrated behavioral health services based on the principles of recovery-oriented care. The city brought all of its associated services into a single department (DBHMRS) under the leadership of Dr. Arthur C. Evans, a veteran of the successful effort to transform services in Connecticut. The department's tagline succinctly expresses its philosophy: It fosters "Recovery, resilience, self-determination."

The department has partnered with many of the behavioral health network providers to develop recovery-oriented programs, which evidence increasingly demonstrates are more effective than traditional approaches to treatment. In some cases, DBHMRS issues requests for proposals, asking service providers to develop new recovery-oriented programs. In other cases, the department asks programs with unused capacity if they are willing to try a new approach. Dr. Evans says DBHMRS has three critical questions when considering whether to purchase services from a new, innovative program:

1. Do the services meet the needs of the individual?
2. Does the programming integrate the recovery-oriented philosophy?
3. Are the services effective?

Here are three Philadelphia-area programs that have met these criteria. For more information on fostering innovation in your agency, visit www.dbhmrs.org/transformation-tools. ■

Transforming Treatment for Chronically Homeless Men

Laura Boston Jones, MEd, Vice President of Behavioral Health Services, North Philadelphia Health System

HIGHLIGHTS

- North Philadelphia program emphasizes partnership between staff and patients and assumes that the individual in treatment inherently understands better than the professional what they need to move forward
- Almost all patients are welcomed back to the program after relapse
- In 2009, 65% of the men who left the program were no longer homeless

IN THE SUMMER OF 2007, the North Philadelphia Health System developed a recovery-focused program for chronically homeless men. Our first task was to reexamine our own beliefs about what treatment should look like. Would individuals be allowed to return to the program if they left and used drugs during the course of treatment? How long would we allow the men to rest, not participate in "treatment," and still utilize services? Could treatment be effective without a set of cardinal rules and groups running on a schedule determined by the staff? Could staff members be partners instead of leaders in the new program? Could we find staff members that understood and accepted a model of "servant-leaders" or "partnership" instead of "expert?"

PROGRAM PHILOSOPHY

We began with the ideas of engagement and respect. While these two tenets seemed like a part of all of our programs, when we honestly examined them we had to admit that too often, treatment assumed that the expert knew more and was more capable than the individual, and in making this assumption we failed to respect or listen to those we served. This new program began with the belief that treatment needs to be person-directed, not just person-centered. The program philosophy requires that staff believe that the individual inherently understands better than the professional what they need to move forward and that staff members take the role of partners rather than leaders.

This philosophy led to two great challenges: Where do you find staff willing to give up control and authority, and how do you convince individuals who have been told what to do in all previous treatment experiences that they have the right to choose? Staff members were interviewed over several months and trained in the recovery model for several weeks prior to the program's opening.

HOW IT WORKS

Miracles in Progress II-Sanctuary opened in December 2007 without a program schedule or rules. The Philadelphia Department of Behavioral Health agreed to two fundamental innovations: an open-ended length of stay and the guarantee of permanent housing for those who complete the treatment program.

Within the first two weeks, the program was full and the staff and program participants partnered to design the schedule and develop a framework for the program. During those first months several men left the unit to use drugs, but returned to the program. Each time a relapse occurred, the community gathered to discuss the impact of that event. Only once was a man not allowed to return, a decision made by the community. Although the participants were accustomed to them, we decided not to employ a level system. We talk about privileges based on a plan.

The staff and participants developed a mantra of "Show us your plan. With a good plan, anything is possible." In addition to daily plans of action, participants develop detailed recovery management and crisis plans. The recovery management plan asks

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Sobriety Through OutPatient, Inc. (STOP)

Natalie J. Charney, PhD, Project Director, STOP

HIGHLIGHTS

- Diverse treatment menu includes anger management, art and dance therapy
- Expansive ancillary services include vocational training, legal services
- Fee-for-service payment structure, with the cost of non-billable services offset by client volume
- 60% of participants complete the program successfully, with benchmarks like negative urine screens, high school/GED completion, and gainful employment

SOBRIETY THROUGH OUTPATIENT, Inc. (STOP) is a community-based, minority-owned and -operated behavioral healthcare provider in North Philadelphia. Its mission is to raise the standard of behavioral healthcare in the African American community by providing evidence-based services for prevention, recovery, and resiliency.

STOP serves more than 1,000 people each year in outpatient, intensive outpatient, and partial hospitalization programs for drug and alcohol use, co-occurring, mental health, and gambling disorders. STOP believes treatment is a process that must address the biological, psychological, and sociological damage caused by negative life experiences and disability.

Our holistic array of services has a focus on wellness. In addition to HIV/AIDS counseling, rapid testing, and a referral service, we provide comprehensive biopsychosocial evaluations, psychiatric assessments, psychotropic medication prescription and management, physical and vision exams, and dental health referrals. Our interventions include behavior modification, cognitive restructuring, psychiatric symptom management, anger and stress management, and problem solving and coping skills training. Staff members are trained in trauma-informed cognitive therapy, an evidence-based treatment that restructures thinking and behavior into more adaptive patterns.

Choices are a salient part of our programming. Individuals choose from a menu of services that includes weight management, nutrition and physical fitness; writing and literacy assistance; music, art, and massage therapy; and specialty vocational groups (such as basic computer, barber, food service, radio station and recording studio, and photography and film development). On-site legal assistance is also available.

The person-first care model is a key element of our recovery- and resiliency-oriented services. Because this model tailors health care to individuals, it improves health outcomes.

STOP's programming includes recovery supports. We support our participants' religious practices and encourage them to actively participate in their churches, mosques, and synagogues. Individuals are motivated to seek out self-help groups like Alcoholics and Narcotics Anonymous. Because families play an important part in the recovery process, STOP supports client and family involvement from intake through discharge. Family members are offered education, counseling, support, and a safe arena in which to address and resolve issues. We also link participants to peer mentors and support within and outside our service. A number of our staff are, themselves, in recovery from drug and alcohol and co-occurring disorders or mental illnesses. They serve as role models for our members and show them that recovery is possible.

We include opportunities for peer leadership within our organization and in the community. Program participants complete member satisfaction surveys each month, use our suggestion box, and meet with staff and management to collaborate on ways to expand services and growth opportunities. As a result of participant input, STOP supports a member-operated recording studio and internet-based radio station, and has contracted with Community College of Philadelphia and Springfield College to provide on- and off-site education leading to general equivalency, associates, and bachelors degrees.

STOP provides care on a fee-for-service basis. We do not receive program or other funding, and some of our service choices are non-billable. For example, we provide clients with a hot, nutritious lunch and offer free haircuts and transportation assistance. How do we overcome the financial challenge? Volume. As a result of our innovative programming, the number of clients referred to us has increased dramatically. Our fee-for-service billing has increased accordingly. The added income helps offset the cost of our non-billable services.

At least 60 percent of our participants complete their programs and move on to be productive members of society. We have data on milestones including negative urine drug screens, consistent consumer program attendance, successful program completion, high school/GED completion, continuing education, and gainful employment that shows our program is successful. ■

New Pathways Projects

Eugenia Argires, MSS, Program Director, Public Health Management Corporation

HIGHLIGHTS

- Drop-in centers function as "front porches" for anyone seeking help with recovery
- Special program for women focuses on connection between trauma and drug use
- 70% of enrolled participants respond to surveys after leaving the program; 40% of these respondents report abstinence from all substances, others report significant decreases

PUBLIC HEALTH MANAGEMENT Corporation's (PHMC) New Pathways Project and its sister program, New Pathways for Women Project, are community-based drop-in centers welcoming men and women who are using drugs and seeking help with their recovery, but who are not in treatment.

Both New Pathways projects operate in North Philadelphia neighborhoods hardened by extreme poverty and the twin epidemics of substance abuse and HIV. New Pathways Project is supported with funding from the City of Philadelphia, Department of Behavioral Health and Mental Retardation Services. New Pathways for Women Project is supported by the Center for Substance Abuse Treatment.

We serve as "front porches," welcoming individuals with long-standing struggles with drugs and alcohol to come in off the street, gather their strength in partnership with caring and skilled staff and others seeking recovery, and increase their readiness to enter substance abuse treatment to eliminate their use of drugs. Following treatment, participants are free to come back on the "porch" and again find support to return to their communities and maintain their recovery over time.

New Pathways for Women was created as a response to the repeated requests of women enrolled in New Pathways for the establishment of a women-only space and pretreatment program sensitive to gender-based violence against women. Both New Pathways projects reduce service gaps between active addiction and acute care treatment while providing community-based safety nets for individuals who have completed substance abuse treatment and wish to remain drug-free, or have relapsed and need additional support to maintain their recovery. Each have been identified as model projects, operating in alignment with the Philadelphia Department of Behavioral Health and Mental Retardation Services' continuing systems transformation and exemplifying their shift from an acute care model of addiction treatment toward recovery-oriented systems of care.

HOW IT WORKS

Outreach teams of two individuals—themselves in long-term recovery or with family histories of addiction and recovery and who reflect the racial and ethnic communities they engage—walk the streets, visit the shelters, and go places where drug and sex trafficking occur. They distribute cards with our project information, review our services with all who show interest, and invite (and even escort, if requested) individuals back to the office to meet staff and enroll in the project. The people who walk through our doors are impoverished and have longstanding chronic addictions, lifetime exposure to severe repeated traumatic stressors, and histories of incarceration and homelessness.

In individual sessions, our case managers partner with participants to identify barriers to decreasing or ending their use of drugs; explore any ambivalence associated with abstaining from substance use; and negotiate a plan for change on their terms, in their time. At any time and in any combination following intake and enrollment, individuals may enter treatment, continue to meet with case managers, or attend twice-weekly recovery groups where peers explore challenges and strategies to beginning and sustaining ongoing recovery.

PHILOSOPHY

Our services are implemented with the following intrinsic core values held firm by staff members in every role—from senior management, to outreach specialists, to case managers, to site supervisors, to senior researchers:

We provide services to all adult individuals who want help with their recoveries. There are virtually no barriers to service delivery. All participation in our projects is by choice with informed consent, with no one mandated to enroll as part of their parole requirements, or to maintain housing, retain custody of their children, defer incarceration, or by any requirement other than a desire for recovery.

We believe that anyone can recover and that recovery is often an incremental process that can be effectively managed over time. Therefore, while abstinence remains the ultimate goal, we understand someone to be in recovery if their use of drugs decreases from, for example, once a day to once a week—and we celebrate that success and provide support to continue forward with hope.

We recognize that many women's lives have unfolded within violence and victimization. In our gender-specific, trauma-informed women's project, we recognize that their use of substances was their way to manage the distress of that violence and victimization, and that their continued use of substances puts them at further risk for more violence and victimization. Our psycho-educational groups help women connect the dots between drug use and profound loss and explore the ways that trauma has affected their lives.

We practice intentional hospitality, offering all who enter our offices a warm welcome, access to restrooms, and a comfortable seat in a beautiful, clean, and colorful environment. Waiting times to meet with staff are always minimal. Positive first impressions are critical trust building experiences for deeply wounded individuals accustomed to the brutality of the streets.

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The *Your Story Matters* Campaign

Rachel Leigh Murphy, BFA, Campaign Director, *Your Story Matters*, New York State Office of Alcoholism and Substance Abuse Services

OASAS
Improving Lives.

HIGHLIGHTS

- The New York State Office of Alcoholism and Substance Abuse Services (OASAS) launched a campaign in January 2009 to share individuals' stories of addiction and recovery, in an effort to raise awareness, combat stigma, and promote hopeful, accurate messages
- An in-house creative designer is responsible for campaign outreach, photography, videography, and graphic design, which saves the agency $50-75,000 a year and has resulted in a campaign that reflects a deep understanding of recovery

INTRODUCTION

AS ONE OF THE NATION'S LARGEST addictions services systems and a nationwide leader of innovative prevention, treatment, and recovery initiatives, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) saw the need for a "real-life stories" campaign in which New Yorkers in recovery could share their experiences with others. The time had come to increase awareness of the many diverse pathways to recovery and to promote the reality of recovery from addiction. In January 2009, OASAS launched the *Your Story Matters* campaign to help raise awareness of the chronic disease of addiction, combat the stigma wrongly-associated with substance use disorders and problem gambling addiction, and promote the message that prevention is proven, treatment works, and recovery is real.

The goals of the *Your Story Matters* campaign are:

- to inspire those struggling with substance-use disorders and problem gambling addiction to seek the help they need to find a life of recovery, health, and wellness
- to celebrate with those in sustained recovery the joy, respect, responsibility, and endless possibilities of a life of recovery
- to raise awareness of the chronic disease of addiction and to promote the message that prevention is proven, treatment works, and recovery is possible

The image shown here represents some of the material developed for the 2010-2011 *Your Story Matters* campaign. Full-size color posters and wallet cards are available from OASAS or by download from www.iamrecovery.com. They are intended to be displayed and discussed and used as tools for engaging others about the power and reality of recovery.

YOUR STORY MATTERS

We invited people to share their stories of recovery at the campaign website www.iamrecovery.com. Hundreds of stories have been submitted from around the country, and more come in every week. In addition to collecting and showcasing unique and inspirational stories of recovery, *Your Story Matters* selects 12 individuals every year to be spokespeople for recovery and for the campaign. The "What's Your Story?" tagline was intended to start the dialogue, to encourage others to share their stories of recovery. "My story is about forgiveness...or family... or potential, now let me tell you why." This has proven to be a powerful component of the campaign, separating it from popular images like "Intervention" on television.

Your Story Matters aims to reach the general public by catalyzing a change in the way our society views addiction. The campaign uses the power of the success story to remove the stigma associated with seeking treatment and living a fulfilling and proud life in recovery.

It is important to note that the campaign also intends to engage the friends and family members of individuals in recovery. They, too, have stories to tell that could give others the hope and guidance they need. Recovery can have the power to bring back what addiction has taken away.

Your Story Matters was initially conceived by OASAS Commissioner Karen M. Carpenter-Palumbo and conceptualized by the OASAS Communications Bureau under the guidance of its director. An in-house creative designer is responsible for campaign outreach, photography, videography, and graphic design. This was a strategic decision that not only saved the

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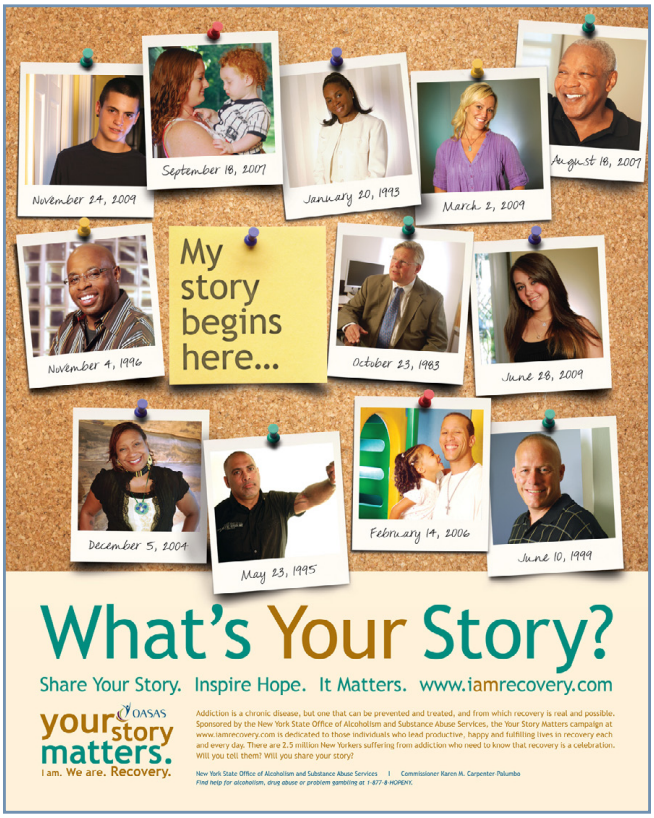

The Three R's: Reading, Writing, and Recovery

Alexandre B. Laudet, PhD, Director, Center for the Study of Addictions and Recovery, National Development and Research Institute, Inc.

HIGHLIGHTS

- Youth and adolescents have a place in the recovery community
- It may be especially difficult for young people to maintain recovery through peer pressure and adolescent stress
- Recovery schools (both high school and college) provide a protective "cocoon" for youth in recovery
- Texas Tech University houses a Collegiate Recovery Community that allows students to recover with peer support within a university setting

THE TYPICAL IMAGE of a person in recovery is someone aged 30 or older who has struggled with drug and/or alcohol use for a decade or longer, attempting treatment more than once before overcoming the disease of addiction. Substance use, however, typically starts years earlier in adolescence. Data from the National Survey on Drug Use and Health shows that in 2007, 9.5 percent of youths age 12 to 17 had used illicit drugs in the past month, and 15.9 percent had consumed alcohol.[1] The study also found that 5.4 percent of youth met the DSM-IV criteria for dependence on or abuse of alcohol in the past year; 4.3 percent met the criteria for illicit drugs.[2]

While seeking recovery in adolescence is the exception rather than the norm, doing so is likely to minimize the many negative consequences of active substance use for individuals, their families, and communities. As a growing number of adolescents enter substance abuse treatment, they show that recovery can indeed be a reality for young people, exemplified by the inspiring essays written by students in recovery collected in a booklet entitled *In My Own Words...*, recently published by the ATTC.[3]

Maintaining recovery is challenging at any age. It may be especially difficult for young people who face peer pressure and the added pressures of adolescence. These stressors make them extremely vulnerable to relapse. It is estimated that fewer than 20 percent of youth who have completed substance abuse treatment maintain sobriety after returning to their homes, schools, and old peer groups.[4] Two of the main challenges to sustaining sobriety for young people are the lack of social support and the ready availability of drugs and alcohol: according to one study, almost all adolescents returning to their old schools after completing a treatment program were offered drugs on their first day back.[5] Educators are beginning to recognize the importance of addressing the growing need for recovery support in their student population. The past decade has seen the emergence of innovative programs designed to provide academic services and assistance for students in recovery from drug and alcohol addiction.

Recovery schools, most of which are members of the Association of Recovery Schools (ARS),[6] exist at both the high school and college level. With embedded supports, recovery schools provide students in recovery the opportunity to receive credit towards a high school diploma or a college degree in a "protective cocoon." Since 2002, the number of recovery schools has grown to 25 high schools in a dozen states and 14 colleges in 10 states. In July 2010, ARS held its ninth annual conference in Boston with the theme "On the Trail to Freedom," to give participants the opportunity to share best practices, learn from experts in the field, and connect with colleagues from all over the country.

An alternative model of recovery support in the academic environment is the Collegiate Recovery Community (CRC)[7] developed by the Center for the Study of Addiction and Recovery (CSAR) at Texas Tech University.[8] A CRC provides a nurturing, affirming environment where individuals recovering from addictive disorders can find peer support while obtaining a college education. CRCs allow recovering students to extend their participation in a continuing care program without the need to postpone or eliminate their educational goals. This is critical because many young people in recovery may fear that the "partying" culture on campuses will jeopardize their progress. CRC Students have access to extensive services to support recovery and to improve general life skills; they also attend 12-step meetings held regularly on the Texas Tech campus. Through this holistic approach to continuing care for recovering students, the CRC addresses the challenges associated with transitions from high school to college and from active addiction into recovery. Rather than the protective cocoon approach of the recovery schools model where all students are in recovery, the CRC model is unique in that it provides a peer-based recovery support community in the context of a conventional college campus. In 2004, CSAR received SAMHSA funding to develop a model curriculum to assist other college campuses in replicating the CSAR model. CSAR hosted its first conference in April 2010: "Recovery and relapse prevention: Best practices for combating addiction and support recovery on college campuses."[9] ■

[1] http://oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm#2.2

[2] http://oas.samhsa.gov/2k8/youthTrends/youthTrends.pdf

[3] http://www.attcnetwork.org/learn/topics/rosc/docs/studentessaybklet.FL.pdf

[4] http://www.recoveryschools.org/products.html

[5] Toft, D. (2005) Recovery Schools Support Sobriety for Young People http://www.jointogether.org/news/features/2005/recovery-schools-support-for.html

[6] http://www.recoveryschools.org/

[7] http://www.depts.ttu.edu/hs/csa/collegiate_recovery.php

[8] http://www.depts.ttu.edu/HS/CSA/

[9] http://www.depts.ttu.edu/hs/csa/collegiate_recovery_conference/agenda.php

Recovery and Medication Assisted Treatment: The MARS Project

Joycelyn Woods, MA, Project Coordinator, MARS Project and Executive Director, National Alliance for Medication Assisted Recovery

HIGHLIGHTS

- Medication Assisted Recovery Services (MARS) is a methadone and buprenorphine clinic run by peers in recovery
- It provides training for all patients on the science of medication-assisted treatment

THE MARS PROJECT is the first and only recovery center for medication assisted treatment (MAT) run by peers (that is, patients and former patients) for peers (patients and former patients). The original MAT program founded by Drs. Vincent Dole and Marie Nyswander had a strong peer-to-peer component, but as the field of methadone treatment became more professionalized, many programs refused to hire patients until they withdrew from medication. This says something very powerful to patients: you are not complete until you finish the program.

Through our experiences at the National Alliance for Medication Assisted Recovery (NAMA Recovery), our website forum, We Speak Methadone, and the Certified Methadone Advocate training, we learned that patients want to know about methadone as a medication, how treatment should work, and the science behind it. For years, patients were told—and treated as though—their addictions were a behavior problem that could be overcome with willpower. Whether they believed it, these statements resulted in low self-esteem. Instead, we want patients to understand their condition.

The MARS Project is a partnership with the Albert Einstein College of Medicine, funded by the Recovery Community Services Program through the SAMHSA's Center for Substance Abuse Treatment. MARS provided a solution to the College's difficulties keeping patients in treatment long enough to have significant effects. Many of their patients needed services and assistance that most opiate treatment programs (OTPs) are not able to provide. Many patients were entering methadone treatment a second time or third time, having had previous negative experiences.

HOW IT WORKS

In addition to methadone maintenance, the MARS program offers training in medication-assisted recovery, a mix of culturally appropriate support groups, drug- and alcohol- free social activities celebrating recovery, and peer-leader training and mentoring.

Each of our patients participates in Core Training. Most professionals working in OTPs do not understand the science behind MAT or how methadone and buprenorphine work. Over the years, myths and fairy tales have developed to fill the void. Education gives peers the knowledge to make informed decisions about their treatment and helps them realize that they are candidates for recovery.

The Core Training is a unique feature of MARS. It has three components: 1) The science of addiction, 2) How methadone and buprenorphine work and basics of MAT treatment, and 3) Recovery with MAT. Core training helps patients understand they have a chronic medical condition or disease, that treatment is effective with medication, and that recovery is possible.

Believing all the myths about methadone treatment, many newly arrived patients intend to stay on the lowest dose for the shortest time possible so they can taper off in three to six months and leave. The Core Training gives them a new perspective. They learn that methadone is the most effective treatment, relapse rates for opiate addiction are high (70 percent for patients with good prospects) and to get the best benefits, they need to stay on a dose that is effective and to take their time when tapering. It is not unusual for new patients to increase their dose after the Core Training because they realize their dose is not effective. But more important, they decide to stay in treatment and to wait to make the decision to taper from methadone until they are ready.

Peer involvement is the other hallmark of MARS. The peers who run MARS make decisions on a daily basis. The staff works for the peers, who decide what groups to run, who will facilitate them, and where to go for monthly sober events. When issues arise, they are resolved by the community or peers. All this is done at the MARS Council, which meets weekly.

IMPACT

It is not uncommon for patients who have been in treatment before to distrust methadone programs. Because the Core Training was developed by patients and is presented by patients, it is credible and believable. Patients who have been in treatment for many years often say, "I never knew any of this. Why didn't someone tell me?"

Everyone seems to agree that drug users have low self-esteem. Yet when methadone patients reveal themselves and their status they are commonly met with misunderstanding, mistrust, or disgust. The methadone patients that the public notices are the ones struggling with many problems. Even methadone patients themselves harbor these stereotypes because they don't see the patients that are lawyers, teachers, nurses, and doctors. Successful patients are rarely seen because they have privileges and attend the clinic once a month. New patients, especially, suffer significant damage to their self-esteem as a result.

Every couple months a peer will bring a new peer into my office, or to Project Director Walter Ginter's office, and say, "Tell them you're a patient!" It is difficult for people new to treatment to think of patients as college graduates with their own businesses, dressed in business suits. The stereotypical methadone patient is sloppy with wrinkled clothes, hanging out with nothing to do. But the peers who run MARS don't fit

CONTINUED ON PAGE 12

SBIRT at Work: The BIG (Brief Intervention Group) Initiative

Eric Goplerud, PhD, Director, and Tracy McPherson, PhD, Assistant Research Professor, Ensuring Solutions to Alcohol Problems, Department of Health Policy, George Washington University

HIGHLIGHTS

- Screening, brief intervention and referral to treatment (SBIRT) can be conducted in various settings
- The BIG (Brief Intervention Group) Initiative is a campaign to make alcohol SBIRT the industry standard for Employee Assistance Programs (EAPs), which many businesses offer to their employees for help with mental health, substance use, work stress, and family issues
- In pilot studies with Aetna Behavioral Health and Optum Health, most employees who screened positive for alcohol interventions set up appointments with counselors to further address issues

SBIRT FOR ALCOHOL AND SUBSTANCE abuse is a technique used to identify and intervene with people who use alcohol or dugs in a harmful or hazardous way and are at risk for substance use-related problems or injuries. The goal is to have sites of care such as trauma centers, hospital emergency departments, ambulatory medical practices, and school clinics screen patients at risk for substance use and, if appropriate, provide them with brief intervention or referral to appropriate treatment. By screening people in these settings, it is possible to identify people who have had an alcohol-related illness or injury that could provide a motivation for behavior change. In addition, screening serves as a form of primary prevention by educating patients about the health effects of using alcohol and other drugs.

Employee assistance programs (EAPs) are another potential point of care at which the SBIRT technique might be applied. EAPs are often provided to employees along with health benefits and are intended to provide people with resources to help them through personal, family, or professional transitions and difficulties. Services offered by EAPs include assessments, short-term counseling, and referrals to additional services.

Businesses increasingly rely on EAPs to assist workers and their families who have substance use and mental health problems. In the last fifteen years, the proportion of businesses with EAPs has more than doubled, from about 33 percent in 1995 to 75 percent in 2009, according to surveys of the Society for Human Resource Management. Well over 100 million American workers are now estimated to have access to an EAP.[1] Approximately two-thirds of small firms (1-99 employees), three-fourths of mid-size firms (100-499 employees) and 88 percent of large firms have an employee assistance program.

Annually, about five percent of workers who have access to EAPs use them for brief counseling for mental health, substance use, work stress, and family issues. That translates into between five and seven million working people accessing EAP services. Unfortunately, despite the wide availability of EAPs and the high prevalence of alcohol use disorders among working people, only about 160,000 of EAP cases explicitly identify alcohol use as a primary problem.[2] EAPs engage only about one worker in 20 who has a serious alcohol problem. The lost productivity, absenteeism, excess emergency department, and hospital use by the other 19 out of 20 workers with alcohol problems who are not treated add $61 billion (or approximately $200 for every man, woman and child in the United States) to the nation's health care bill. American businesses absorb much of this cost in the higher premiums they pay for employer-based health insurance as a result of unidentified and untreated alcohol and drug problems.

We developed the BIG (Brief Intervention Group) Initiative to make alcohol SBIRT the industry-wide standard for EAPs across the US and Canada in one year. In three large pilots associated with the BIG Initiative, EAPs implementing SBIRT increased rates of detecting alcohol problems to 18 to 24 percent of cases. If substance use SBIRT were implemented across the EAP industry, between 900,000 and 1,200,000 workers with alcohol or drug problems would be identified and treated each year.

The BIG Initiative involves senior leadership, operational managers, and clinicians from almost every EAP in the country working together in a learning collaborative to implement SBIRT. The Initiative is supported by a cooperative agreement from the National Highway and Traffic Safety Administration (NHTSA) and the Center for Substance Abuse Treatment (CSAT).

Pilot studies conducted in 2007 and 2008 by George Washington University in partnership with Aetna Behavioral Health and OptumHealth demonstrated that medical SBIRT can be adapted to workplace settings. The pilot with Aetna integrated SBIRT into their telephonic EAP service for employees of a large financial services company. By the end of the five-month pilot project, 274 (93 percent) of 295 members (self-referred employees) who contacted the EAP for services completed the AUDIT-C prescreen; of those, 40 percent (110) screened positive on the AUDIT-C; 20 percent (41) screened at moderate risk on the full AUDIT, and 6 percent (11) scored at high risk. Brief intervention was offered to all who screened positive. At 3.5 and 5 months, overall estimates of identification approached those in the general population, 23.5 percent and 18.23 percent respectively. Most (78 percent) members offered SBIRT at intake agreed to clinical follow-up by telephone and 72 percent set an appointment with a face-to-face counselor to further address issues discussed during the telephone consultation.

The workplace EAP pilot with Optum/United produced similar results. We are currently conducting three replication pilot

CONTINUED ON PAGE 12

Homeless Men FROM PAGE 5

participants to outline goals, assets, and what they would like to give back to their communities when they have achieved their goals in the following areas: substance abuse, mental health, physical health and wellness, family and relationships, vocation, education, spirituality, housing, and finances.

Focusing on goals and dreams instead of problems is one of the hallmarks of the program. Many men had difficulty answering the question, "What's right with you?" because people have always asked them, "What's wrong with you?" Every day, the members participate in the program by defining what groups they need, what outside resources they need access to, and by taking on leadership roles in our program and throughout the institution. While we offer groups based on motivational interviewing and cognitive-behavioral and motivational enhancement therapies and other evidenced-based techniques, the more important point is that the consumers have the opportunity to choose the groups they want to attend.

OUTCOMES

Miracles in Progress II-Sanctuary has seen significant positive outcomes, serving men with an average of 12 years of homelessness, both on the streets and in shelters. In 2009, we saw 34 men leave our program; 65 percent (22) were successful. Of those, 13 men went to independent housing, four returned to their families, four went to nursing care, and one man went to a mental-health-supported residence. Seven individuals left and have been untraceable, while five were readmitted to detoxification and continue in their recoveries (in which, it is important to note, we continue to consider ourselves partners). ■

New Pathways Project FROM PAGE 7

We understand recovery is most consistently maintained in a community among the support of peers who draw strength, resilience, and wisdom from each other.

OUTCOMES

We are able to reach, on average, 70 percent of our enrolled participants and conduct a follow-up survey six months after intake. Approximately 40 percent of participants have ceased all use of substances, with others reporting significant decreases in their use. In addition to this positive change, participants report striking increases in their social connectedness.

Both projects stand as examples of recovery communities sustaining exceedingly vulnerable individuals whose drug and alcohol abuse is embedded in their experiences of homelessness, interpersonal violence and victimization, untreated medical and mental health conditions, and profound social isolation. It is a template for replication in other communities. ■

Your Story Matters FROM PAGE 8

agency an estimated $50,000 to $75,000 per year on creative and technical services, but culminated with a campaign that reflects a deep understanding of recovery. *Your Story Matters* also has an in-house web editor to review stories of recovery that are submitted for possible anonymity issues and profanity. The OASAS web master is responsible for any major updates to the www.iamrecovery.com infrastructure.

States from all across the country have inquired about *Your Story Matters* with the hopes of launching their own "real life stories" campaign. The testimonial, or "share your story" technique, is now being used in nearly every form of communication today, by energy supply companies and car companies, and in healthcare. For agencies that are interested in formulating their own "real-life stories" campaign, it is important that the audience be willing to offer a testimonial, to share their stories so that others may benefit. A strategic plan, budget, and timeline are instrumental to creating a timely and effective campaign. Agencies without in-house creative designers and writers will need to contract out for the bulk of the work. A concrete grasp of the campaign's intended audience, agency population, and constituency is critical. ■

For more information on *Your Story Matters* or to suggest an individual in recovery to be spotlighted by the campaign, please contact the OASAS Communications Bureau at 518-457-8299 or communications@oasas.state.ny.us.

The MARS Project FROM PAGE 10

that image, and they help new patients see an alternative.

Most important, MARS is a safe and positive place where patients can go to meet other patients. Some patients that cannot work or attend school use MARS as a place where they can go to socialize in a positive environment. Other patients find a job or attend school but they return occasionally just to drop in and say hello to the friends they have made. MARS has given NAMA Recovery the opportunity to demonstrate that education improves treatment outcomes and that patients want recovery. ■

SBIRT FROM PAGE 11

studies through the NHTSA/CSAT cooperative agreement with Aetna EAP, OptumHealth EAP, and ValueOptions EAP.

Dan Conti, the director of JP Morgan Chase's EAP said, "For us, it was a no brainer to ask a few standardized questions about drinking for every EAP call. We know alcohol is a problem. We just told our EAP to do it and we now expect them to." ■

[1] Masi, D. (2004). EAPs in the year 2002. Mental Health, United States. Rockville, MD: Substance Abuse Mental Health Services Administration. (DHHS Publication No. SMA 3938, pp. 209-223)

[2] Amaral, T. M. (2008, April). Global benchmarking and EAP best practices. Presented at the annual institute of the Employee Assistance Society of North America, Vancouver, BC, Canada.

RESOURCES

PIONEERS OF THE CHRONIC CARE MODEL
Michael T. Flaherty

SAMHSA white papers addressing approaches to recovery-oriented systems of care: pfr.samhsa.gov/rosc.html

AN INTERVIEW WITH JAY FORD, PHD - NIATX
NIATx: www.niatx.net

PI101 webinar:
www.niatx.net/Content/ContentPage.aspx?NID=545

Conducting a Walk-through:
www.niatx.net/Content/ContentPage.aspx?NID=32

Provider Toolkit:
www.niatx.net/Content/ContentPage.aspx?NID=45

Case Studies (link to multiple types):
www.niatx.net/Content/ContentPage.aspx?NID=361

Business Case for Change:
www.niatx.net/Content/ContentPage.aspx?NID=362

IMPLEMENTING CHANGE: A CASE STUDY
Holly Hagle and Eric Hulsey

Promoting awareness of motivational incentives (PAMI) curriculum and resource materials:
www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/pami/

PAMI supplemental materials:
www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/pami/other_resources.asp

The ATTC on technology transfer:
www.attcnetwork.org/explore/priorityareas/techtrans/index.asp

PAMI materials from NIDA's Clinical Trials Network and the ATTC Network:
www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/pami/product_materials.asp

THE PHILADELPHIA EXPERIENCE: TRANSFORMING TREATMENT FOR CHRONICALLY HOMELESS MEN
Laura Boston Jones

THE PHILADELPHIA EXPERIENCE: SOBRIETY THROUGH OUTPATIENT, INC.
Natalie J. Charney

THE PHILADELPHIA EXPERIENCE: NEW PATHWAYS PROJECTS
Eugenia Argires

City of Philadelphia Department of Behavioral Health/Mental Retardation: www.dbhmrs.org

North Philadelphia Health System: www.nphs.com

Sobriety Through OutPatient, Inc.: stop-phila.org

Public Health Management Corporation: www.phmc.org

White, W. (2009). *Peer-based Addiction Recovery Support: History, Theory, Practice and Scientific Evaluation. Chicago, IL: Great Lakes Addiction Technology Transfer Center.*

www.attcnetwork.org/regcenters/productdetails.asp?prodID=510&rcID=3

White, W. (2008). *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

www.attcnetwork.org/regcenters/productdetails.asp?prodID=258&rcID=3

White, W. (2008). *Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.
White, W. (2006). *Recovery Management.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

www.attcnetwork.org/regcenters/productdetails.asp?prodID=413&rcID=3

White, W. & Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches.* Pittsburgh, PA: Northeast Addiction Technology Transfer Center.

www.attcnetwork.org/regcenters/productdetails.asp?prodID=334&rcID=9

THE *YOUR STORY MATTERS* CAMPAIGN
Rachel Leigh Murphy

NY State Office of Alcoholism & Substance Abuse Services: www.oasas.state.ny.us

OASAS - Your Story Matters: www.iamrecovery.com

RECOVERY AND MEDICATION ASSISTED TREATMENT: THE MARS PROJECT
Joycelyn Woods

NAMA Recovery website: www.methadone.org

MARS Project website: www.marsproject.org

We Speak Methadone Forum:
www.methadone.org/wespeakmethadone

SBIRT AT WORK: THE BIG (BRIEF INTERVENTION GROUP) INITIATIVE
Eric Goplerud and Tracy McPherson

Employee Assistance Programs: Workplace Opportunities for Intervening in Alcohol Problems
www.ensuringsolutions.org/usr_doc/Primer5_EAPspdf

Brief Intervention: Cost-Effective Help for Problem Drinkers
www.ensuringsolutions.org/resources/resources_show.htm?doc_id=329150

Alcohol Screening: A Quick First Step to Reduce Problem Drinking
www.ensuringsolutions.org/resources/resources_show.htm?doc_id=328506

IRETA PA-SBIRT: www.ireta.org/sbirt/

Learn more...
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www.ireta.org www.neattc.org