

In this issue...

Methamphetamine Abuse—A Rising Epidemic

By Aaron M. Williams, MA

The abuse of methamphetamine (meth)—a powerful stimulant—has become a problem of epidemic proportions in some parts of the country. According to Federal data, more than 12 million Americans have tried methamphetamine and at least 1.5 million are regular users. In a recent survey of local law enforcement agencies done by the National Association of Counties, methamphetamine was cited as the number one problem affecting local law enforcement agencies. Roughly 90 percent of those surveyed reported that in their counties meth-related arrests have increased substantially over the last three years. Meth-making labs have been uncovered in all 50 states.

The use of meth became widespread in the rural southwest about a decade ago and has now begun to spread to the north and eastern parts of the United States. Due in large part to its relatively cheap price, the use of meth has become much more mainstream and now counts abusers from all socioeconomic classes among its victims. The growing problem has also begun to place considerable strain on other non-law enforcement agencies dealing with the aftermath of meth production and abuse[2].

The production of meth can cause considerable environmental problems. Meth production leaves behind a significant amount of toxic waste material, which is environmentally hazardous and highly combustible. Production of the drug has led to numerous lab explosions, which can kill or maim scores of people, and the use of considerable time and government resources cleaning up meth production sites [2].

Social service agencies have also been severely impacted by the meth crisis. In a survey taken this year of child welfare officials, 40 percent reported an increase in out-of-home

placements last year due to methamphetamine use. Most alarming to some in the social services community is the link between crystal methamphetamine (smoked form of the drug) use and unsafe sex. Use of meth can cause many users to feel euphoric and hypersexual, resulting in binges with multiple partners that can last until the user comes crashing off the drug a few days later. These practices could lead to an increase in the transmission of sexually transmitted diseases including HIV. This problem is of particular importance in the gay community where reports have already indicated a significant increase in the number of homosexuals who have tested HIV positive and also report using crystal methamphetamine[2].

How does Meth work?

Methamphetamine is a powerful stimulant commonly known as “speed,” “meth” and “chalk.” In its smoked form, which has increased in popularity in certain areas of the country, it is commonly referred to as “ice,” “crystal,” “crank,” and “glass.” It is a white, odorless, bitter-tasting crystalline powder that quickly dissolves in water or alcohol. Meth was created in the early half of this century from amphetamine and was used in decongestants and bronchial inhalers. Meth works similarly to cocaine in that use of the drug results in the accumulation of the neurotransmitter dopamine in the brain. This excessive dopamine in the brain seems to cause the stimulation and feelings of euphoria that are experienced by users. Unlike cocaine, meth has a much longer duration of action and a much larger percentage of the drug that remains unchanged in the body, whereas cocaine is quickly removed from the body. The extended presence of meth in the brain

(Meth, cont. on page 2)

see page...

4  
NIDA Science to Service

6  
Washington, D.C. News

7  
Kentucky News

7  
Tennessee News

8  
Delaware News

9  
Maryland News

10  
Counselor Tips

11  
Products



Unifying science, education, and services to transform lives.

www.ceattc.org

ultimately leads to the prolonged stimulant effects caused by the drug. The effects of the drug can last anywhere from 6–12 hours or more[4]. The short-term effects of methamphetamine use can include:

- Increased attention and decreased fatigue
- Increased activity
- Decreased appetite
- Euphoria and rush
- Increased respiration
- Hyperthermia

Long-term use of meth can cause numerous negative physical effects such as:

- Addiction
- Paranoia
- Hallucinations
- Mood disturbances
- Repetitive motor activity
- Decreased lung functioning
- Memory loss
- Poor cognitive functioning
- Stroke
- Weight loss

In addition to these side effects, recent research has indicated that meth users report higher levels of depression and suicide attempts, as well as significant problems controlling anger and violent behavior[1] [4] [7].

## The Federal Response

In August of 2005, top Bush Administration officials met in Nashville, Tennessee, one of the cities and states hardest hit by the meth crisis, to detail the government's comprehensive approach to addressing the methamphetamine crisis. The Bush administrations plan deals with the meth problem in the U.S. on a number of different levels

### *Production/Trafficking and Enforcement*

The Bush Administration strongly supports the passage of Federal legislation that would limit the amount of pseudoephedrine (PSE) an

individual can purchase per retail transaction and eliminate the blister pack exemption for PSE products, which allows certain products to not be subject to federal law. Measures to prevent the diversion of PSE shipments for illegal use and a requirement that would force the importers to seek approval from the Drug Enforcement Administration (DEA) if there is a change in the shipment's original purchase are also included in the proposed legislation. Additionally, the DEA successfully negotiated agreements with private sector companies like eBay, as well as governments from China, Mexico, and Panama to restrict the diversion of precursor chemicals like PSE to meth labs in the U.S. and elsewhere.

The DEA has begun to aggressively target meth producers and traffickers, resulting in the initiation of 2,830 criminal cases related to meth production, distribution, or diversion of precursor chemicals in the past year alone. Over the last year, the number of meth "superlabs" (labs capable of producing 10 pounds of meth or more in a 24-hour period) has been dramatically reduced based on increased enforcement efforts of the DEA.

The DEA also expects to initiate a Federal Clandestine Lab Container Program in fiscal year 2006. Under this program, toxic waste from meth labs will be transported by trained law enforcement personnel to centralized containers that meet all hazardous waste storage requirements and will then be picked up and removed by DEA contractors. This program will significantly reduce the cost of lab cleanups and law enforcement overtime, while safely removing dangerous toxins from communities across the country[5].

### *Treatment/Social Service Initiatives*

The U.S. Department of Health and Human Services (HHS) has begun to increase its efforts in dealing with the problem of meth addiction and the other related social problems that stem from this addiction. In fiscal year 2004, HHS, through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT), awarded \$10.8 million in competitive grants for projects related to treatment of individuals using methamphetamine. This year HHS is awarding 11 new grants worth \$16.2 million over three years to

address meth abuse in seven of the most severely impacted states. The President has also proposed expanding the Access to Recovery program by \$50 million in 2006 to further address the meth abuse issue. The state of Tennessee is currently using its Access to Recovery grant to improve the availability of treatment and recovery programs to meth abusers. State substance abuse agencies are partnering with regional Addiction Technology Transfer Centers (ATTCs) to conduct trainings and provide technical assistance on effective treatment methods for meth addiction. Since 2000, HHS funding for meth related research has increased 150 percent from \$15 million in fiscal year 2000, to \$37 million in fiscal year 2004.

Meth addiction has placed a considerable strain on addiction treatment and prevention services at the state and federal levels. In addition to this, meth abuse has placed a significant burden on other social service agencies particularly, child welfare and child protective services agencies. To address this problem, HHS has set up a number of resources to provide training and technical assistance to state and local agencies to help them more effectively deal with child welfare and safety issues[5].

For more information about federal initiatives related to methamphetamine abuse you can access SAMSHA's website at [www.samhsa.gov](http://www.samhsa.gov).

## Treatment Approaches

Psychosocial and behavioral approaches remain the standard of care for the treatment of methamphetamine addicted individuals, however, research is continuing on replacement pharmacotherapies. SAMHSA's Center for Substance Abuse Treatment's TIP# 33, *Treatment of Stimulant Abuse* is still a basic guide for clinicians on this topic. *The Matrix Model*, a manualized 16-week outpatient treatment approach for treating stimulant disorders, combines techniques and materials from the cognitive behavioral therapy literature to include accurate information on the effects of stimulants, family education, Twelve-Step program participation, and positive reinforcement for behavior change and compliance. Research indicates that this treatment approach has had a positive effect on outcomes for methamphetamine abusers[3] [6].

The Pacific Southwest Addiction Technology Transfer Center (PSATTC) has developed a number of products and services related to the treatment of methamphetamine abuse.

For more information about these services, you can go to their website at [www.psattc.org](http://www.psattc.org).

### References

1. Greenwell, L., Brecht M. (2003). Self-reported health status among treated methamphetamine users. *The American Journal of Drug and Alcohol Abuse*, (1); 75-104
2. Jefferson D., (2005). America's Most Dangerous Drug. *Newsweek Magazine* (August 6th edition), 40-48.
3. Maxwell, J. (2005). *Implications of Research for Treatment: Methamphetamine*. The Center for Excellence in Drug Epidemiology.
4. National Institute On Drug Abuse. (2002). Methamphetamine Abuse and Addiction; *Research Report Series*. National Institutes of Health (NIH). Publication No. 02-4210.
5. Office of National Drug Control Policy website. (2005). Bush Cabinet Officials Highlight Administration Anti-Meth Programs. Retrieved August 19, 2005 from <http://www.whitehousedrugpolicy.gov/news/press05/081805.html>.
6. Rawson, R., Marinelli-Casy, P., Anglin, M. et al. (2004). A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. *Addiction*, 99; 708-717.
7. Zweben, J., Cristian D. et al. (2004). Psychiatric symptoms in methamphetamine users. *American Journal of Addiction*. 13(2) 181-190.

# NIDA Science to Service

## Promoting Parenting Skills: Supporting Substance Abusers Key to Participation

By Paula Jones

Approximately 20 percent of adults receiving substance abuse treatment live with children ages 2 to 18, and research indicates that children living with parents who are receiving treatment for substance abuse are likely to face more problems than children in the general population. They are also more prone to socioeconomic disadvantages, higher stress levels, and social isolation. Research indicates that parenting problems, such as parent-child interaction problems, are common among substance abusing parents and this absence of

parenting skills can result in behavioral problems and possible future substance abuse in children. Enhancing parenting skills through parent management training has proven to be an effective approach to the prevention and treatment of childhood conduct problems.

The benefits of providing substance abusing parents with effective parenting techniques are two-fold. Research indicates that the parents themselves derive personal benefits from improved relationships with their children, such as reduced stress and improved mood. In turn, less stress and improved mood can help support abstinence and the recovery process. For children, better parenting can prevent future social/emotional problems and the likelihood of future substance abuse on the part of the child.

In 2004, Catherine Stanger, PhD, of the University of Vermont, College of Medicine, Department of Psychiatry, received a grant from the National Institute on Drug Abuse (NIDA) to explore interventions designed to increase the parenting skills of parents with a history of substance abuse. The study is exploring the use of incentives to improve participation in a 12-week group intervention. Study participants are divided into two groups—one receiving the standard intervention and one receiving incentives for attending group sessions and completing group-related assignments. The researchers are seeking to determine if the use of incentives improves participation in the program. The study uses the *Incredible Years* parenting curriculum, a social-learning-based curriculum that focuses on teaching parenting skills to promote positive child behaviors and to reduce inappropriate child behaviors in children, 3 to 10 years old.

In the study, each group is made up of five to 10 families. Participants include the substance-abusing parent as well as a second parent or adult, such as a grandparent, that also lives in the home. Active substance abusers are allowed to participate in the program. However, participants established the rule that attending the group under the influence of drugs or alcohol is not acceptable.

Each group is facilitated by two leaders. The curriculum presents a systematic set of skills that build upon each other, making attendance at each of the sessions critical. Each week, videotape

### The Incredible Years Program

The *Incredible Years* Parents, Teachers, and Children Training Series is a comprehensive set of curricula designed to promote social competence and prevent, reduce, and treat aggression and related conduct problems in young children (ages 4 to 8 years). The programs were developed by Carolyn Webster-Stratton, MSN, MPH, PhD, Professor and Director of the Parenting Clinic at the University of Washington. The interventions that make up the series are guided by developmental theory concerning the role of multiple interacting risk and protective factors (child, family, and school) in the development of conduct problems.

The curricula have been selected by the U.S. Office of Juvenile Justice and Delinquency Prevention as an exemplary best practice program and as a “Blueprints” program. It was selected as a model program by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). As such, it has been subject to three quality evaluations by independent groups. The program has been recommended by the American Psychological Division 12 Task force as a well-established treatment for children with conduct problems.

A website about the curricula offers a wealth of information for organizations considering implementing the programs including an agency readiness questionnaire, tips for making the program work in various settings, cost planning for administrators, and how to select an intervention based on the risk status of a population. Also on the website is information for parents and teachers that explains the interventions.

More information is available at <http://incredibleyears.com>.

vignettes addressing a specific topic are shown. Parents discuss each vignette and the group practices new skills through role playing, with participants portraying both children and parents. In addition, participants are given home practice assignments, to be completed with their children, and are asked to report by phone on a daily basis about their own and their children's behaviors. The daily check in is important since parents can report on events while they are fresh in their mind. If the check in was conducted at the weekly meetings, parents would probably report either their most recent behaviors or major, usually negative, events that occurred during the week. At the weekly meetings, participants are provided a graph portraying their children's behavior over the past week. Discussing the graph in a group allows the parents to learn from each other. Successful parenting techniques are used as models and parents experiencing difficulties receive advice from their peers.

## Filling a Gap

According to Dr. Stanger, there is a great need for parenting training in the target population. "They need this support and take advantage of it," she explains.

That doesn't mean that participation is without challenge. Many of the families participating in the program lead very chaotic lives. Committing to attend group sessions for 12 weeks, two hours each session, can be difficult for families with transportation, child care, and other daily living challenges.

"Extraordinary efforts may be needed to help people participate in this intervention," states Dr. Stanger. The researchers work hard to facilitate attendance for group members. This can include arranging and paying for transportation and reimbursement for child care. The researchers also follow up with participants in the event of an absence. At the start of each weekly session, if a participant is not present, one of the group leaders will call them and encourage them to attend the session. If a session is missed, the researchers try to arrange a make up prior to the next session so that the continuity of the series is not interrupted.

Facilitating participation in the sessions themselves is only part of the challenge for the researchers. "There is a lot that can derail participation," reports Dr. Stanger.

If the researchers detect active substance abuse in a participant, they will seek to connect that person with treatment. This is not just a referral but can actually mean locating available treatment, making an appointment, and following up with the participant to ensure that they went to the appointment. For those participants that are in substance abuse treatment, the researchers ask them to sign a release allowing the treatment provider to be contacted. The researchers can then make the treatment provider aware of the participant's efforts to improve their parenting skills so that these efforts can be supported.

The researchers also screen for mental health problems. Many of the participants suffer from depression and anxiety, both of which can negatively impact parenting efforts. When necessary, referrals and follow up to mental health services are provided.

## A Community-Wide Approach

The intervention targets a relatively small population of substance abusers—those with children living at home. Within the general population of substance abusers, many do not have children or do not live with their children, their children are grown, and a small minority have had their children removed from the home. Given that the majority of their clients do not require services relating to parenting skills, it is unlikely that many substance abuse treatment organizations will offer such a comprehensive program.

"You need to partner across providers to identify the people who need this service," emphasizes Dr. Stanger. "This collaboration needs to be encouraged in agencies that are providing substance abuse-related services to their clients."

In Vermont, the program was very well received by the larger social service agencies in the community. Many substance abusers are interested in receiving family services and parenting training but these services are generally not available. There were no programs to build parenting skills to which these agencies could refer their clients. "They recognize that parents who have substance abuse problems also have many other problems and are in need of various types of assistance," states Dr. Stanger.

(Parenting, cont. on page 6)

## Retention Easier than Recruitment

While some parents who participate in the group are required to do so, the vast majority of the participants do so on a voluntary basis. Participants are recruited from social service agencies and drug treatment providers. The program is also advertised throughout the community.

According to Dr. Stanger, once parents are participating in the program retention is very high, despite the challenges associated with participation. "Once families start the group, we have excellent participation," she reports.

However, there are potential participants that express interest in the group, and even complete the intake process, and then fail to attend. This is indicative of the many barriers confronting this population.

Dr. Stanger also reports that some families drop out of the program but then sign up again at a later date. "Parents seem genuinely willing to participate," she relates, "but there can still be many barriers to participation."

## A Shift in Venue

In August 2005, Dr. Stanger joined the faculty at the University of Arkansas for Medical Sciences, Department of Psychiatry, Center for Addiction Research. Despite the move, Dr. Stanger will be continuing her research. She will be identifying new community partners to collaborate with and will also be providing the intervention in a residential drug treatment agency providing services to women and their children. The study is scheduled to conclude in February 2007.

For more information on the study, contact Dr. Catherine Stanger at [cstanger@uams.edu](mailto:cstanger@uams.edu).

---

*Paula Jones is a science writer/consultant for the CEATTC.*

### Sources

- Stanger, C. (2003), Behavioral and emotional problems among children of drug abusers. *Psychiatric Times* 20(2).
- Stanger, C., Higgins, S.T., Bickel, W.K. et al. (1999), Behavioral and emotional problems among children of cocaine- and opiate-dependent parents. *J Am Acad Child Adolesc Psychiatry* 38(4):421-428.

## Key Elements for Success

- Facilitate parents' participation in the training through the provision of transportation, child care, and other support.
- Help parents access other needed services such as drug treatment and mental health services.
- Follow up with parents when they are absent from training.
- Build bridges with community agencies to assist in the recruitment of parents.

# Washington, D.C. News

In August of 2005, the Washington D.C. Addiction Prevention and Recovery Administration (APRA) was visited by surveyors from The Commission on Accreditation of Rehabilitation Facilities (CARF). CARF is a nonprofit organization which uses its expertise to provide consultative accreditation services to providers. In order to be accredited, a provider has to invite CARF surveyors to conduct a site visit to evaluate the quality of their services. The surveyors consult the staff, clients and stakeholders. Based on the outcome of the survey, the provider is then either accredited for three years, accredited for one year, or not accredited.

The APRA Behavioral Programs surveyed were: Administration, Detox, Assessment and Referral, Continuing Care/APEX, and Prevention. APRA's Opioid Treatment Programs surveyed were: Detox, Women's Services, and Model Treatment. The Medical Records, Research and Evaluation, Patient Advocacy, Human Resources, Health and Safety, Training, Risk Management and Performance Improvement departments were a part of the survey as well.

APRA was surveyed August 24–26, 2005. The results of the survey will be mailed to Mr. Robert Johnson, Senior Deputy Director of APRA, in six to 10 weeks.

---

## Kentucky News

### What's Happening in Kentucky's Division of Mental Health and Substance Abuse Services

- We are in the beginning stages of planning for our annual alcohol and other drug conference to be held July 2006 at Northern Kentucky University.
- We were fortunate again this year at our annual alcohol drug conference this past July to have great participation from the field as well as from sponsors such as the CEATTC.
- Since July, we have had other conferences across the state for the field of mental health and substance abuse—the Mental Health Institute was held at the end of September 2006 where we had 850 participants; we also held a Suicide Prevention Conference that was well attended at the beginning of September 2005 which was preceded by a press conference by the Governor of Kentucky which addressed the issue of Suicide Prevention; 20 participants from Kentucky attended the Southeastern School of Alcohol and Other Drug Studies which is an eight-state collaboration—total attendance was around 400.
- We are working with the Office of Drug Control Policy in Kentucky to help plan a Student Drug Testing Summit for the early part of 2006, as well as participating in the CAPTASA Conference in January 2006.

## Tennessee News

### The Summit 2005, “Change Is Inevitable—Growth Is Intentional”

*By Jay Jana, Statewide Training Coordinator*

The Summit, Tennessee's Advanced School On Addictions, was held May 29 through June 3, 2005 at Belmont University in Nashville, Tennessee. It was sponsored by the Bureau of Alcohol and Drug Abuse Services, Department of Health. The Summit was heralded as a tremendous success by newcomers—“This is my first year at The Summit and it was a life-changing experience for me. I plan to return next year!” as well as the veterans—“The best overall conference that I've attended since 1991.”

Sharing the success of The Summit was the Central East Addiction Technology Transfer Center (CEATTC) which sponsored four courses: Conflict Resolution & Communication Styles, Culturally Competent Service Delivery, Enhancing Alcohol & Other Drug Abuse Services, and Cruda, Hechizo and Alcohol: Latino Substance Abuse. Participants in these classes were personally challenged and educationally informed. Some of the comments were “This training is excellent! Very thought provoking! Excellent instructor! ...it was an excellent

way for Americans to know and understand better our Hispanic Community. Thank you!”

John Bradshaw, the featured speaker and trainer for Wednesday, June 1st, offered three workshops based on his most read publications, “Homecoming: Reclaiming Your Inner Child,” “Healing: The Shame That Binds You,” and “Creating Love.”

Wednesday evening's event, which was open to the public and the recovery community, drew over 700 attendees. In addition to John Bradshaw, John McAndrew shared a compilation of personally composed songs of recovery. Similar to the closing ceremonies of the 2000 International AA convention, Johnny Mac concluded his performance with, “Like We Were Made of Gold.”

With more than 450 enrolled participants and all Thursday/Friday workshops filled to capacity, many considered the week's training uplifting and gratifying—“...it makes me feel renewed for the months ahead. I got so much from being here personally and professionally. I can't wait for next year!” With like forethought, the Bureau looks forward to The Summit 2006 as well as collaborating again with the CEATTC. Mark your calendar now! The Summit 2006 is currently scheduled for May 28 through June 2, 2006.

---

# Delaware News

## Delaware NIATx

Delaware is currently one of four states participating in the Network for the Improvement of Addiction Treatment (NIATx) State Pilot Projects. NIATx is a collaborative initiative between the Robert Wood Johnson Foundation and the Center for Substance Abuse treatment. The goal of NIATx is to help substance abuse treatment providers become more efficient in providing services by making ongoing improvements in access and retention. The specific four aims of the project are:

- 1) reduce waiting times
- 2) reduce no-shows
- 3) increase admissions and
- 4) increase continuation rates.

NIATx originally began working with individual treatment providers across the country and has now expanded to work with State agencies.

According to NIATx, the purpose of the State Pilot Project is to

- 1) have States function in leadership roles to improve quality of treatment,
- 2) use process improvement methods to work collaboratively with providers to improve access and retention and
- 3) disseminate innovative practices to improve quality performance.

In Delaware, DSAMH is piloting the NIATx project with four agencies (Brandywine Counseling, Inc., Connections Community Support Programs, Inc., Kent Sussex Counseling Services, and Thresholds, Inc.) contracted to provide comprehensive outpatient services at 11 sites statewide.

The first step of the change process was for each agency to conduct a walk-through. A staff person will walk through the intake and assessment process as if they were a client entering treatment. The walk-through lends a more objective view of the client's path through treatment. The staff person conducting the walk-through is asked to write a summary of the experience including recommendations for what improvements could be made to process. A change team, made up of different levels of staff is developed to begin to address the recommendations. Changes are made in small but quick cycles. The change will be evaluated after 30 days and a decision will be made to keep the change or eliminate the change.

In Delaware, the four agencies have successfully applied the NIATx model to make improvements. The changes made often times are small, but have big results in client access and retention. An example is that the agencies have increased admissions and reduced no-show rates to appointments by making reminder phone calls to clients 24 hours prior to their appointment. Also, a follow-up phone call is made if the client misses their appointments. One provider assessed that a major reason for missing appointments was lack of transportation, so they began distributing bus passes.

Each of the four agencies continues to identify areas to address. The process improvement cycles are ongoing. The providers share changes with each other so that they may learn from the process. The NIATx model has definitely made improvements in Delaware.

# Maryland News

In July, directors and program staff of over one-half of the programs that comprise Maryland's addiction service delivery system were sent workforce surveys. The surveys were the result of intense collaboration around workforce development between the Alcohol and Drug Abuse Administration and the Central East Addiction Technology Transfer Center (CEATTC). The positive response of the field in completing and returning the surveys to the CEATTC allowed an opportunity to share some of the preliminary findings of the Workforce Development Survey at our annual Management Conference. At the conference, we were fortunate to have Aaron Williams of the CEATTC and Jeffrey Knudsen of the RMC Research Corporation who presented an initial analysis of the returned surveys. The initial findings are posted on the ADAA website at [www.maryland-adaa.org](http://www.maryland-adaa.org). We will continue to work closely with Aaron and Jeff to refine the data so we can make informed decisions on recruitment and retention in the addiction workforce.

The Management Conference, held this year October 5–7 in Easton, Maryland, featured excellent plenary presenters. Dr. Deni Carise PhD, of the Treatment Research Institute of Philadelphia, spoke on “The Power of Transforming Data into Information.” Dr. Carise focused on the importance of using standardized nationally accepted data collection instruments to quantitatively demonstrate the success of treatment. She pointed out ways in which data tracked through uniform standards can be used to track drug usage trends within population groups. In addition, she discussed how it can assist the clinician in tailoring treatment to specific problems. This increases the likelihood of improved retention in treatment and thereby fosters better outcomes.

Also, we had the opportunity to hear the results of a study on the assessment and treatment of DWI offenders in Maryland. Dr. Amelia Arria, Deputy Director of Research, Center for Substance Abuse Research (CESAR), University of Maryland, was the principal researcher on this study. The study examined the assessment process for DWI offenders. It found that problem drinker determination varies by county, income level and assessment center funding status. The study also found that over half of problem drinkers do not en-

ter treatment. The number of those who do enter treatment varies by county. Treatment completion was significantly associated with a reduced likelihood of re-assessment. Reassessment was the measure used to account for re-offenders.

The last day of the conference, we were honored to have Dr. Jerome Jaffe, MD. Dr. Jaffe, a pioneer in the addiction treatment field, created the first methadone treatment facilities, detoxification programs and therapeutic communities in the U.S. in the 1970's. He was an early proponent of the use of multiple approaches to addiction treatment. Dr. Jaffe continues to be a groundbreaker in our field. In his remarks, he spoke about the mega-trends in health care: the evolving professionalism, the demand for evidence based practices, the necessity of advanced information technology and the use of incentives to improve quality-rewarding results. He spoke about how these health care trends will affect our addiction system.

Workshops were offered around a variety of managerial and clinical practices. The workshops covered topics such as evaluation outcomes in treatment, practical approaches for the inclusion of substance abuse prevention within the continuum of care, how to facilitate our patients' (re)engagement in the labor force and approaches to take with our patients to reduce high risk behaviors that can result in liver damage and the spread of viral hepatitis.

Closing remarks for the conference were provided by the Director of the Alcohol and Drug Abuse Administration, Dr. Peter F. Luongo. His remarks placed in context the major theme of the conference, the need to continue to infuse research into our addiction practices in Maryland.

If you are interested in viewing the various Powerpoint presentations given at the conference, you can find them on the ADAA website at [www.maryland-adaa.org](http://www.maryland-adaa.org).

Four years ago, after a long interval, our administration reinstated the annual management conference. It has been a productive undertaking. This year, as in other years, we have been the recipients of CEATTC's generous support in this endeavor, as well as other vital training activities and workforce matters.



## Counselor TIPS

### Counselor Tip #4

#### Confidentiality

In the last issue of *The Dialogue*, we talked about ethics and the importance of maintaining ethical principals. In this issue, we will present the key points in maintaining confidentiality. Confidentiality and ethics go hand-in-hand. A brief overview of the basic standards will be presented.

#### Confidentiality Federal Regulation: The History

The Confidentiality Federal Regulations are regulations set forth by the Federal government that protect the confidentiality of persons in alcohol and drug abuse treatment. The regulations are set out as ***Title 42, Part 2, of the Code of Federal Regulations (C.F.R.)***. The Federal government enacted two laws in the early 1970's to generate the strict confidentiality of information about treatment services. The legal citation for these laws is ***42 United States Code (U.S.C.)***.

The regulations implementing the confidentiality of client and patient records and treatment were issued in 1975 and revised in 1987 as ***42 C.F.R., Part 2***.

#### Confidentiality: Key Factors

- The purpose of the confidentiality regulations is to provide persons seeking alcohol and drug abuse prevention and treatment services the highest possible ***privacy***.
- Confidentiality of patient records must be protected if individuals are to be encouraged to seek substance abuse treatment voluntarily.
- Familiarity with the confidentiality regulations is essential to anyone directly or indirectly involved with persons in alcohol or drug abuse prevention and treatment.
- Confidentiality is an ***ethical standard of behavior*** that obligates a professional not to share information about a client with anyone.

- Confidentiality is the ***prohibition of disclosure*** of information about a patient's diagnosis, treatment, or prognosis, whether the information is written, kept electronically, retained in the professional's memory, or stored in any other manner.
- Confidentiality means that the ***giver*** (patient) has entrusted the ***receiver*** (counselor) with information with the confidence that it would be kept secret from others, and that the receiver of such information would keep it secret.
- Information about a patient cannot be revealed unless it is medically justified, necessary to protect the patient or others from harm, authorized in writing by the patient, or required by state or federal law.

#### Confidentiality: Need to Know

- Only those persons with a ***need to know*** may have access to a patients' confidentiality information.
- Those persons who ***need to know*** are those who have a ***legal, medical, or other professional responsibility for the patients' treatment***.
- Others who may ***need to know*** patient information include persons ***providing treatment*** to the patient, the person directly responsible for ***supervising the patients' treatment, and third party insurers***.

#### Counselor Reminder!

This language is designed to protect the patient and should not be confused with a right to know, which is designed to protect the professional as an employee.

For example, if a substance abuse patient has active tuberculosis, all employees coming into close contact with the patient have a right to know the patient has active tuberculosis so they can protect themselves from exposure to the disease.

## Products

### Confidentiality: Violations

- Violators of the regulations are subject to a criminal penalty in the form of a fine of up to \$500 for the first offense and up to \$5000 for each subsequent offense.
- Violators who are licensed or State certified jeopardize their license or certification.
- Violators may also be sued by the patient for unauthorized disclosure.

### Counselors Reminder:

The general rule is that the program staff may not disclose any information about any patient at any time without a written signed consent form (to be explained in the next issue).

### When in doubt, scream and shout!

**If you are confused about whether you can or cannot disclose certain information, please ask your supervisor.**

In the upcoming issues of *The Dialogue* we will continue with Confidentiality: Youth, Disclosure, Telephone or Visitor Disclosure, Duty to Warn, Medical Emergencies, Court Order, Search and Arrest Warrants, Consents & Forms, Urinalysis Monitoring, Research, and Internet use. We will also present a series on the Health Insurance Portability and Accountability Act (HIPAA) Regulations.

We welcome your comments and feedback on this topic and welcome suggestions for further topics related to substance abuse counseling.

*Peace & Blessings*

*Valerie E. Robinson, MS, LPC  
Advising Consultant/CEATTC*

### Novel Approaches to Engagement in Care

In this two-hour video with a companion booklet, three expert researchers in substance abuse treatment discuss three evidence-based practices that have been demonstrated to promote positive patient outcomes: Contingency Management, Role Induction and Motivation Interviewing.

**Video (2 hours) and Booklet:  
\$75 (set)**



### HIV/HCV Resource Disc

This mini-CD contains many resources and links, including a clinical and prevention toolkit, resources for specific populations, and resources in Spanish.

**CD-ROM: \$3**



### To Order

The CEATTC offers many other products and resources for counselors. For a complete list and ordering information, visit [www.ceatc.org](http://www.ceatc.org) and click on the link to Resources > Products.

You may also order by calling 240/645-1145.

The **DIALOGUE**

Fall 2005

The **DIALOGUE** is published by the Central East Addiction Technology Transfer Center (CEATTC)

8737 Colesville Rd., Ste. 300  
Silver Spring, MD 20910-3921  
Phone: 240/645-1145  
Fax: 301/565-3390  
www.ceattc.org

**Director**

Cynthia Moreno Tuohy,  
NCAC II

**Editor**

Aaron Williams, MA

**Director of Operations  
and Conferences**

Kathleen Hauck, CGMP

**Director of Training  
and Special Projects**

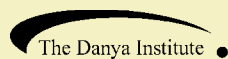
Tom Durham, PhD

**Administrative Assistant**

Tamara Henry

**Special Assistant  
to the Executive Director**

Sarah Wenchel



The Danya Institute •

www.danyainstitute.org



8737 Colesville Road, Suite 300  
Silver Spring, Maryland 20910-3921

FIRST-CLASS MAIL  
U.S. POSTAGE  
**PAID**  
PERMIT # 1228  
MERRIFIELD, VA

# KEEPING IT REAL 2006 CONFERENCE

**Street-Level Intervention Strategies for Addiction,  
HIV/AIDS, and Hepatitis**

**March 22–24, 2006**

**Clayton Hall at the University of Delaware  
Newark, DE**

Our fifth conference will provide cutting-edge information on issues related to HIV/AIDS, hepatitis, and substance abuse. All outreach workers, substance abuse counselors, and other related healthcare personnel who work with the drug-addicted and HIV/AIDS/HCV population are encouraged to attend.

The conference is based on the seven Outreach Competencies developed by the Center for HIV, Hepatitis, and Addiction Training and Technology (CHHATT); and an additional track will focus on the administration of these competencies. Attendees will find this an informative and interactive forum providing the most up-to-date information and techniques available in the field.



**Registration is now open!**

**Download registration form at [www.ceattc.org](http://www.ceattc.org).**