The PREVENTION CONNECTION
NEWSLETTER

What *is* Treatment?

Defining treatment sounds easy, but it is more complex than it appears.

We know what treatment *offers*: hope.

We know what treatment is *for*: to help chemically dependent individuals overcome disease.

We know what it *does*: improves lives by helping people learn to live with addiction while changing their behavior.

We know what *happens*: personal change and growth.

We know *where to find it*: in local or community-based agencies.

And finally, *we know that it works*, resulting in healthier lives, reduced crime and increased productivity.

But what is treatment?

Chemical dependency is an illness that results in injury to the brain and the body. Chemical dependency *treatment* is the opportunity to spend time in a supportive environment where, through a chemical-free lifestyle, the mind, body and spirit can begin to heal. Sobriety—the state of being alcohol and/or drug free—is the goal.

The treatment environment allows people to begin to learn how to live without chemicals and to function in day-to-day life. This respite allows time to regain dignity and self respect, and to recognize choice, find acceptance and hope.

Treatment services

Montana's treatment programs provide individualized care based on the American Society of Addiction Medicine (ASAM) patient placement criteria. Services are provided along a continuum of care. This includes a system through which the patient receives uninterrupted and sustained treatment in the least restrictive environment, and with the appropriate level of intensity to support recovery. Services available in Montana include: recovery homes for mothers and children; crisis intervention; drug-free supportive living facilities; prevention and education programs; detoxification; continued care services; individual, family and group counseling; outcome evaluation; and case management.

Why is treatment important?

Addiction is a chronic and preventable disease, but left untreated, its consequences impact every facet of our society. Abuse and addiction involving illegal drugs, alcohol and tobacco are implicated in virtually every domestic problem our nation faces: crime; chronic diseases including cancer, heart disease, AIDS, HIV and cirrhosis; child abuse and neglect; domestic violence; teen pregnancy; Fetal Alcohol Syndrome and Fetal Alcohol Effect; learning disability and conduct disordered children; poor school performance, school drop-out, teen pregnancy and disrupted families. Effective treatment can mitigate the effects and help people restore their lives. The cost and human savings are immeasurable.

Tremendous public savings are generated by an investment in treatment. The savings most often cited by national studies is around $7 saved for every $1 spent on treatment. The cost per client treated in FY 2002 in Montana was $1,767. Using this figure, it is possible to estimate that $12,369 is saved for each client treated – or approximately $69.4 million in FY 2002 alone. Ultimately, treatment benefits Montana in ways too numerous to count.

Source: Montana Chemical Dependency Bureau Annual Report, 2002.

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The Vicki Column

With this issue, we continue to explore the continuum that includes pure prevention at one end and aftercare at the other. This topic is so complicated that before we can really begin the conversation, we must be sure that we're all speaking the same language. The Governor's Alcohol, Tobacco and Other Drug Policy Task Force recommended that the Interagency Coordinating Council (ICC) define "intervention." The ICC Workgroup recommendations for prevention, intervention and science-based definitions are included at the end of this article. They are designed to serve as universal language. Another universal principle is one that maintains something we've discussed in this newsletter many times. Parents are key to a child's success. In order for treatment to be effective with youth—particularly youth who will return to the family—parents *must* be involved in a positive way.

In Montana, as everywhere, there is growing need, but youth treatment alternatives remain limited. The best way to inspire better access is to reduce the stigma that attends the disease of addiction. And the best way to do *that* is to talk about it and continue to talk about it. This is a start. The next step is up to all of us.

Vicki

ICC Workgroup recommendations

Prevention—The proactive process of creating and sustaining conditions that reduce risk and promote the safety, personal responsibility, and well being of people.

Intervention—Activities or policies directed at those who have already begun one or more of the risk behaviors, with the goal of reducing or eliminating the behavior.

Best Practices—Those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying risk behaviors.

Promising Practices—Those programs or strategies that have some quantitative data showing positive outcomes in delaying risk behaviors, but not enough research or replication to support generalized outcomes.

Some Facts About Marijuana

Although dangers exist for marijuana users of all ages, risk is greatest for the young. The impact on learning is critical, and pot often proves pivotal in the failure to master vital interpersonal coping skills or make appropriate life-style choices. (drughelp.org)

Marijuana is an addictive drug with significant short- and long-term health consequences. Short term effects include: memory loss, distorted perception, trouble thinking and problem solving, loss of motor skills, decrease in muscle strength, increased heart rate, and anxiety. Harvard University researchers also report that the risk of a heart attack is five times higher than usual in the hour after smoking marijuana.

Marijuana contains more than 400 chemicals, including most of the harmful substances found in tobacco smoke. A Columbia University study found that a control group smoking a single marijuana cigarette every other day for a year had a white-blood-cell count that was 39 percent lower than normal, reflecting a damaged immune system and making the user far more susceptible to infection and sickness.

Users can become dependent on marijuana. More teens are in treatment for marijuana use than for any other drug or for alcohol. Adolescent admissions to substance abuse facilities for marijuana grew from 43 percent of all adolescent admissions in 1994 to 60 percent in 1999. Additionally, marijuana users are far more likely to use other drugs than non-marijuana users.

According to data from the Potency Monitoring Project at the University of Mississippi, the tetrahydrocannabinol (THC) content of commercial-grade marijuana rose from an average of 3.71 percent in 1985 to an average of 5.57 percent in 1998. The average THC content of U.S. produced sinsemilla increased from 3.2 percent in 1977 to 12.8 percent in 1997.
Resource: http://www.usdoj.gov/dea/ongoing/marijuana.html

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Notes From the Edge

Parent to Parent: The Road No One Wants to Travel

Submitted by Liz Moore

Looking back, I still wonder how I could not have known the extent of my sixteen- year-old daughter's drug use. We knew Sam occasionally drank, and that she had used marijuana a couple of times. Then on September 9th of last year, Sam jumped on the hood of a moving car and was run over. During the three weeks she was in the hospital, she talked about using this event as a fresh start. We felt blessed that she was relatively intact, and were optimistic that things would begin to get better. When Sam got out of the hospital, we asked her to have a chemical dependency evaluation done. After several visits between Sam and the counselor, her dad and I met with him. He told us that Sam's drug of choice was meth. I was stunned. In spite of what I "should" intuitively have known about my daughter, I would not ever have guessed Sam had used meth. Ever. We took her to Rimrock Foundation in Billings the next day. Following in-patient treatment, she went to an extended care facility—the *Gables* in Rochester, Minnesota—where she stayed for two months. Afterward, she returned home. Following are some reflections on my experience with treatment.

It was tremendously helpful to have the support of a CD counselor in our community. As parents, we were in shock. The counselor helped us locate resources quickly, which meant that Sam got into treatment rapidly. When we were looking for extended care facilities, he steered us in the right direction. As Sam was preparing to come home, he was part of planning after-care. At the time of her accident, Sam had been seeing a therapist who, fortunately, understood the difference between what she had to offer and what a chemical dependency expert could offer. Sam needed both.

Sam went to a treatment facility that handled co-occurring disorders. They were able to treat her chemical dependency issues and her underlying depression. Rimrock had a psychiatrist on staff, and the Gables worked with a psychiatrist in the community. It's possible that every patient may not need this. Sam did, and it was helpful to know ahead of time that the facilities were equipped to work on mental health issues alongside chemical dependency. Because of her injuries, it was also important to have ready access to medical care, and both facilities provided that.

Rimrock recommended an extended placement for Sam following in-patient treatment. Our criteria were: female only; ability to work with co-occurring disorders; access to good medical resources including a psychiatrist; some capacity to address school/academic issues; a behavioral plan that was clear and structured, but did not dominate the program's description of themselves; and longevity in the field. Sam wanted a program that specifically addressed spirituality. As we talked to each facility, we asked them about these areas.

All of this costs a lot of money, but we were able to make this work for us. Obviously not everyone is that fortunate. We made a decision to spend as much as we felt we could to find the best places within our means.

The most important thing I did for myself in this whole process was absolutely free. I began attending Al-Anon. Al-Anon has given me tools for my whole life . . . not just my life with Sam. Although the past 10 months have been overwhelming and frightening, I have been able to do more than just cope . . . I have grown because of what I have gained from being part of Al-Anon.

Well, it's time for the end of the story, but I don't have one. Sam's road has not been pretty. She has made some wrong turns, and by some grace she has found her way back for the moment. To the best of my knowledge, she is working her program. But I'm still grieving and afraid.

Do I have regrets about all we did to get her treatment? Absolutely not. Parents have to decide what they can and cannot do. At this time, I know I've done everything within my power to help my daughter. The rest truly is not in my control. Sam is a beautiful, talented, delightful young woman. She is also an addict. My hope and prayer is that she will truly and permanently find her way back.

Interagency Coordinating Council (ICC)

Mission: To create and sustain a coordinated and comprehensive system of prevention services in the State of Montana.

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Creating the Desire for Change:
The Dynamics of Adolescent Treatment

By Dirk D. Gibson, LAC

I was once asked, "What is the most difficult part about treating adolescents?" After giving it some thought I replied, "Creating the desire to *want* to change their behavior."

Since then, the importance of internal desire to change—and the process of facilitating movement along the natural path of change—have been widely researched and discussed. Studies such as *Project Match* and *MIDAS* have reinforced the key role motivation plays in successful behavioral change. During the past decade, efforts have been made to identify the components necessary to the process of change and the skills needed to facilitate it.

Motivational Interviewing (Miller and Rollnick) begins to define what helps people make positive change and what predicts positive change outcomes. Their work has become a Best Practice approach in the field of substance abuse treatment. It also forms a key body of work for clinicians who work with adolescents and their families.

Another helpful body of work comes from writings about the *Transtheoretical Model of Change* developed by Jim Prochaska and Carlos DeClimente. These authors have identified three constructs: the Stages, Levels and Process of Change.

Taken together, the *Transtheoretical Model of Change* and *Motivational Interviewing* not only explain why and how people change—along with ways clinicians can help the process along—but provide the expectation that resistance is normal. This expectation opens the door for understanding the phenomenon of *ambivalence to change*, which can help clinicians begin examining the ways they work with clients. This in turn allows the opportunity for change to occur. Those in the treatment field must become proficient at providing services that create and strengthen internal desire or motivation to change. These tools are so effective that even those clients brought to treatment through external forces can be assisted to find and strengthen internal motivation for making positive change.

Treating adolescents

Treatment is a dance—When program structures, rules, treatment plans, staffing patterns and processes are examined, we often find that systems and cultures are *not* client centered. This is despite the fact that National Institute on Drug Abuse (NIDA) principles hold individualization to be key to effective treatment. Treatment is a dance between therapist and client. It isn't a wrestling match. Ultimately, the client is the expert on what s/he is willing to do and what s/he believes can be done.

Ready, *willing* and *able* are the hallmarks of individualized care. The treatment plan must be compatible with a client's individual dynamics in terms of desire, ability, reasons, need and commitment. Human beings are dynamic beings with fluctuating and complex connections to all aspects of their daily existence. Commitment to change in various areas of life will be uneven.

There is no chicken, there is no egg—We must learn to provide one-stop shops for behavioral health services where adolescents can have all of their needs attended to by the fewest professionals, in the same setting, and at the same time. There *is* no chicken and there is no egg: it is impossible to split DNA strands and retain the same composite. Adolescents need professionals who are hybrid mental health/chemical dependency experts who can work with them on self-esteem *and* depression *and* marijuana use . . . or on their attention Deficit Hyperactivty Disorder and their meth use. At the same time, this hybrid therapist should be working with the family and any medical personnel prescribing medication.

Homework—Families need to know that the work being accomplished by the adolescent is important and that they need to make time to participate, prepare, do homework and to make some changes themselves. The information and techniques the therapist can make available to parents on developing capable, independent

Continued on Page 5

The MYTHS about Marijuana

Myth 1: *Marijuana is harmless*

Myth 2: *You can't get addicted to marijuana*

Myth 3: *Marijuana won't hurt you—it's just a plant.*

Myth 4: *Marijuana won't make you lose control. It just makes you mellow.*

Myth 5: *Marijuana isn't as popular among kids today as other drugs like ecstasy.*

Myth 6: *There's not much parents or anyone else can do to stop kids from experimenting.*

The Office of National Drug Control Policy (ONDCP) launched its marijuana initiative in September 2002..
To learn more, please visit:
www.whitehousedrugpolicy.gov

Most common addictions in Montana

— In FY 2002, 92 percent of people admitted to state-approved treatment facilities identified one of three drugs as their primary drug of abuse: alcohol, marijuana and methamphetamine. Of those taking part in state-approved treatment:

— 62 percent of clients abused two or more substances.

— 53 percent use marijuana/hashish

— 27 percent of people age 28 and older used methamphetamine.

Data source: Montana Alcohol and Drug Treatment System (ADIS); 2002.

Creating the Desire for Change

Continued from Page 4

children and on strengthening relationships can make or break outcomes.

Working With Resistance—When working with adolescents at the lowest possible level of care, it is crucial to encourage engagement in positive activities outside of treatment (e.g., school, sports, church groups, or work). In fact, helping an adolescent find a good job can have more of a positive impact on long-term outcomes then completing a treatment program. Understanding perceived resistance and mastering the skills to reduce and resolve ambivalence are key. Learning to join up with the client to improve the situation rather than contribute to the normal response to resist change can make all the difference. We must model flexibility.

The Evolution of Society—In Norway, both parents are required by law to take six months off when a child is born. The Norwegians have made the connection between being home with a child, bonding and teaching, and preventive savings in treatment and social costs. Where are we headed in America—and at what cost?

What is Effective Treatment?—If an adult doesn't consistently follow treatment prescribed for diabetes or hypertension, are the physicians considered failures? If the heart patient has a steak, is he labeled as being in denial, resistant or bad? Of course not.

Is the *only* criterion for success abstinence? If, with treatment, an adolescent begins using fewer drugs, taking medications as prescribed, engaging with their families, staying in school, changing friends, having fewer legal problems, aren't these signs that treatment is having a positive impact? It adds emotional baggage when we say that treatment isn't working if the adolescent hasn't achieved total abstinence. Maybe we've just been conditioned to define success through lenses that are too narrow.

A Brave New World—A whole new world of research is bringing hope through physiological and biological agents that block euphoria and suppress cravings. This valuable adjunct to counseling is creating the opportunity to help patients more effectively. The developing field of knowledge related to the brain is creating technologies that will continue to reshape the way we manage behavioral health issues. Thank goodness for the brave souls experimenting with harm reduction and pharmacology . . . they are saving and improving lives.

It's All Connected—Keep an eye on the big picture . . . kids are drowning. We have to try to save those who are about to go under and find time to teach those who will eventually find themselves facing white-water rapids. Treatment, intervention and prevention are all connected. We must attend to all three in an integrated way . . . all the time.

As far as adolescent treatment goes, we are getting smarter about what works and what doesn't. In my experience, we are more effective with adolescents when we model good self-care and practice what we teach. And periodically, we must lift our heads from the trenches long enough to ask ourselves, *Would this be good enough for my own children?* We'll know it's time to stop improving services when we can answer with a resounding "*Yes*!"

– Dirk D. Gibson is a Licensed Addictions Counselor and the Supervisor of Behavioral Health Services at Benefis HealthCare in Great Falls. He has been working with adolescents with substance abuse and other mental health diagnoses since 1989.

The *Transtheoretical Model of Change* describes lifestyle change as a process rather than an event. James Prochaska, Ph. D., John Norcross, Ph.D. and Carlo DiClemente, Ph. D. and others have conducted research on how people make successful and lasting positive change in their lives. Their work has resulted in a scientifically proven model documenting how people change and how their efforts can best be assisted along the way. The stages through which all successful self-changers pass are:

— Precontemplation
— Contemplation
— Preparation
— Action
— Maintenance
— Termination

Source: http://www.uri.edu/research/cprc/TTM/detailedoverview.htm

Sources Cited:

For more information on Project Match, see the National Institute on Alcoholism and Alcohol Abuse website at: http://www.niaaa.nih.gov/publications/match.htm

The MIDAS Project is being conducted at UNM-CASAA. The MIDAS Project is designed to yield new knowledge on motivation to change drug use behavior. Researchers are testing a brief motivational counseling intervention to help people change problematic drug use. For more information, see http://casaa.unm.edu/projects/MIDAS.html

In Motivational Interviewing, *William R. Miller and Stephen Rollnick explain how to work through ambivalence to facilitate change, present detailed guidelines for using their approach, and reflect on the process of learning motivational interviewing. The book is currently in its second edition. (ISBN #1-57230-563-0)*

Home on the Range

By Laurie Olson

Home on the Range, a corporation under the auspices of the Catholic Diocese of Bismarck, is a residential child care facility that provides a therapeutic environment for disadvantaged, neglected, problematic, pre-delinquent and delinquent adolescents.

Home On the Range/Big Sky Ranch is six miles north of Glendive on Highway 16. Many of our residents from the western side of Montana feel like they've moved to a new country by the time they make the long drive across the state. The staff tends to agree on the length of the drive, but are pleased with the location because it completely removes young clients from the negative environments they were in. Once here, they step into a positive, healthy and structured environment.

Big Sky Ranch is located on 65 peaceful acres. We have six miniature horses, including a new colt, that our residents care for and spend time with. Daily chores have also recently included bottle-feeding a young calf twice a day.

Big Sky Ranch is an 8-bed moderate level therapeutic group home This all-female facility is accredited by the Council on Accreditation for Children and Family Services. The young women who stay here range in age from 12–18, with an average length of stay of 12–18 months. This varies depending upon the reasons the client was referred here in the first place, as well as the resident's willingness to address her issues. On average, Big Sky Ranch serves 12 clients per year.

Our clients are generally referred by mental health case management agencies—either AWARE or Youth Dynamics, Inc. Some referrals also come through the Department of Public Health and Human Services, and others from youth probation officers. Occasionally, a parent will call and request placement information. Big Sky Ranch accepts private placements, but this is less common.

Referring issues vary with the client, but some of the information required for admission is unchanging. Residents must have a minimum IQ of 75 and a Global Assessment of Functioning (GAF) score of 40. The GAF rates an individual's psychological, social, and occupational behavior on a continuum that indicates level of functioning. Though subjective, the numerical score denotes a particular level of mental health/illness. This score is included as a part of current diagnoses and taken from a psychological or psychiatric evaluation. These parameters have been set to help ensure a level of functioning appropriate to the level of care we offer.

Mental health issues are the primary focus here, but chemical dependency (CD) issues are also addressed. The majority of young women referred to Big Sky Ranch have significant CD issues in addition to the issues for which they have been referred. A prospective resident must be substance-free for a minimum of 28 days before admission to Big Sky Ranch. Therapeutically, co-occurring disorders are addressed through a variety of groups as well as through weekly individual therapy. The most common—chemical dependency—is addressed on a weekly basis through a low intensity drug and alcohol group. The majority of residents with co-occurring CD issues work concurrently in individual therapy, addressing the issues that often preceded their substance abuse.

In addition to individual and group therapies, Big Sky Ranch conducts bimonthly family therapy with 2-day workshops held onsite. This concept is patterned after the successful system used at Boys and Girls Town, Nebraska. The groups are small and include 2-4 families. Caseworkers are also invited to participate. The Social Skills Behavior Modification Program is the primary teaching tool used at Big Sky Ranch, and all staff members are trained to use it. Our goal is to teach life skills to youth and their families and to foster family reunification whenever possible.

For more information, contact Laurie Olson at (406) 687-3839 or visit the website at www.gohotr.org.

Note: *This project is funded (in part) under a contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the Department.*

Turning Point

By Beth Done

The adolescent program at Turning Point Addiction Services in Missoula offers quality professional out-patient chemical dependency services for youth and their families. Services begin with a free and confidential assessment of a youth's chemical use and the impact it is having on his/her life. Referrals come from many sources, including youth court, parents, schools and private therapists. Typically, we provide 4-6 assessments a week.

After assessment, some youth are referred to our Primary Level I Out-patient Program. Activities include weekly group and individual sessions. Other youth may be referred to the Intensive Outpatient Program, which consists of an educational group three times a week as well as individual sessions with a counselor. Continuing care offers youth a twice-weekly process and implementation group that helps them remain focused on staying clean.

Counselors continually assess the individual needs of each client, and make every effort to meet those needs. For example, a youth suffering from social anxiety will find it difficult to enter the group process. In that case, counselors work with him/her individually until s/he is comfortable enough to participate in the group. All of the programs at Turning Point incorporate art and recreation therapy in group settings. This helps youth express themselves and to learn to cooperate with one another.

Turning Point's youth liaison helps clients attain jobs and housing, and will provide transportation, if needed. The liaison also works closely with the family to coordinate services and support. As part of its coordinated services, Turning Point offers a Shelter Care Program that provides the means to place a client in a group home setting and to fund the stay if necessary. The program is designed for youth with a chemical dependency diagnosis and a need to be in a structured setting while completing treatment.

Turning Point also has two school-based programs—*Flagship* and *Project Success*. Flagship is an activity-based after school program that provides alternatives to unsupervised time after school. Keeping youth busy during the out-of-school times before their parents get home from work is critical to keeping them alcohol and drug free. Project Success is an early intervention program in the schools, which staffs and alcohol and drug counselor in each high school in Missoula. These counselors provide education to students and early screening services to at-risk youth.

Working with youth who are at risk of alcohol or drug abuse and working with youth who are struggling with alcohol and drug abuse issues presents many challenges, yet many successes. Our counselors work hard to get to know each individual as a unique person and to provide counseling services that are fun yet productive.

Our program recognizes the need for families to be involved in the youth's treatment. Family night is scheduled once a week, to encourage families to get to know one another and to offer support, suggestions and ideas. It also provides an opportunity to discuss their struggles with one another in a safe, supportive environment. One at a time, we work hard to empower youth to live a life free from alcohol and drugs.

For more information, contact Beth Done at Turning Point: 532-9800.

This is one you won't want to miss!

Addiction, Recovery and the Family—A conference at Grouse Mountain Lodge in Whitefish, Montana—September 11, 12 and 13, 2003

This symposium will provide a forum for exploring the most up-to-date information on addiction issues facing families, as well as the treatment applications facilitating recovery. Nationally known speakers including Claudia Black, Ph.D., Robert J. Ackerman, Ph.D., Ray Baker, M.D., and Anne E. Linton, M.D.

Sponsored by Pathways Treatment Center—Kalispell Regional Medical Center in collaboration with the Montana Department of Public Health and Human Services Addictive and Mental Disorders Division.

For more information: www.mtreservations.com or call toll free: 1-866-755-4658

Children's Program Kit: For Children of Alcohol- and Drug-Addicted Parents

This Children's Program Kit incorporates years of research and hands-on experience from consumers and professionals who have helped children overcome the problems associated with living in a home where alcohol and drug abuse is prevalent.

*The Substance Abuse and Mental Health Services Administration's (*www.samhsa.gov*) Center for Substance Abuse Prevention (*www.samhsa.gov/centers/csap/csap.html*) is offering this free kit to help provide support to children of alcohol and drug addicted parents. The toolkit includes:*

- *a support program curriculum for children in grades K-12;*
- *a program manual including start-up instructions, research-based tools, and program evaluation materials; and*
- *4 videos illustrating concepts such as coping skills, problem solving, and social competence.*

To order, call 800/729-6686 and ask for the "Children's Program Kit" #CPKIT, or order online at http://ncadi.samhsa.gov/promos/coa/.

http://www.cwla.org/programs/bhd

Gateway Recovery Center: *Taking the Mountain to Muhammad*

By Judy Kolar, MHS, LAC, MAC, Executive Director

> *If the mountain will not come to Muhammad, then Muhammad will go to the mountain. —a proverb*

Although Gateway Recovery Center has been in operation since 1968, it is just in the last several years that we have developed programs designed to meet the unique needs of adolescents in an out-patient setting. Gateway's in-house programming has always consisted of a wide continuum of services, including assessment, evaluation, substance abuse groups, out-patient treatment, and intensive out-patient treatment, as well as Minors In Possession (MIP) and family programming. Even so, we gradually became aware that there were many youth in our community who were not accessing the services they needed. If they would not come to us, we needed to go out into the community, to them. This resulted in our involvement, during the past four years, with more community-based programming. Some of these efforts are detailed below.

Local efforts

— In the fall of 1999, we began a pilot project designed to work with high-risk youth at one of the middle schools in Great Falls. Using Community Incentive Program (CIP) funding, we were able to expand that program to include the other two local middle schools. The program that was put in place is based on the *Behavioral Monitoring and Reinforcement Program* (BRY) designed by Dr. Brenna Bry and the Monmouth County Narcotics Council, a best practice program.

— We are currently beginning our third year of participation in a *Youth Assessment Center*, a service provided in conjunction with the local Youth Court Services Office. The center provides a central location where the multiple needs of youth can be assessed, and case management services used to direct youth to agencies where they can access further evaluation or care. This concept is designed to coordinate efforts and to prevent the duplication that families often find when they must move between/among agencies to get the needs of their children met.

— We are actively involved with the local Boys and Girls Club in providing a prevention specialist to work at one of their rural locations, and to provide staff to serve on a committee coordinating a Weed and Seed grant in the Great Falls community.

— We recently began program implementation at the Juvenile Detention Facility for on-site evaluations, educational groups and lower level out-patient treatment groups for the youth incarcerated there.

— At this same facility we are now providing staff to coordinate *Parenting Wisely* programming—designated as a Model Program by SAMHSA/CSAP—that focuses on low-income, underserved, at-risk teens/pre-teens and their families.

For more information, call Judy Kolar, MHS, LAC, MAC, Executive Director of the Gateway Recovery Center in Great Falls.

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406-727-2512.

COOL WEBSITES

America's Children: Key National Indicators of Well-Being 2003:
http://childstats.gov/americaschildren/

Missoula Forum for Children and Youth
www.missoulaforum.org
forum@co.missoula.mt.us

An Integrated Substance Abuse Treatment Needs Assessment for Montana: Final Report

http://www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/substance_abuse_needs_assessment/substance_abuse_needs_assessment.htm

Reduce youth use of tobacco, alcohol and other drugs by promoting alternate activities and healthy lifestyles.

National Alcohol & Drug Addiction Recovery Month 2003

September is National Drug and Alcohol Addictions Recovery Month

http://www.recoverymonth.gov/2003/

Defining the Next Steps: The Great Falls Assessment

By Judy Kolar and Tracy Houck, Gateway Recovery Center

I think we need more after-school programs, and I don't think we're doing enough to discourage under-age drinking.

Have you ever heard these comments at *your* community meetings? Or have you actually been the one making the comments? So how do you know when your community is making the grade? The Prevention Needs Assessment and the Youth Risk Behavior Survey are two great instruments that can help you evaluate your community's needs and accomplishments. But what do you do when you want to start a new program? And how do you even know if you *need* a new program?

This spring, the Great Falls Healthy Youth Coalition and Gateway Recovery Center teamed up to do an old-fashioned service assessment. Staff and volunteers called local organizations and asked if they offered youth programming. From there, a myriad of questions followed. What CSAP strategies were they using? Which one of America's Promises was identified? Did the program evaluate the data they collected? If so, what kind of evaluation were they using?

The results were fantastic. Over 100 youth programs were identified in this first attempt to gather information. We have snapshots of data that detail our community programs by Community, Individual and Family Risk factors, ages served, and target populations. The best part is that all of the data has been put in Excel spreadsheets, which allows quick updates. It's also been incorporated into PowerPoint presentations for those of us who need to see it to understand it.

We found that 50 percent of programs evaluate whether predetermined outcomes have been met, and 24 percent use pre- and post-surveys. Surprisingly, the majority of funding comes from private sources and fees for services. We also learned that local agencies are employing all six Center for Substance Abuse Prevention (CSAP) strategies for focusing prevention efforts:

— Alternative activities: 35%

— Education: 27%

— Community-based Process: 9%

— Information Dissemination: 9%

— Problem Identification and Referral: 12%

— Environmental: 8%

Knowing what is already in place and where the concentration of efforts lies will assist our community in targeting the kinds of programs needed to help local youth become healthier and to lead more productive lives.

Judy Kolar, MHS, LAC, MAC, is the Executive Director of the Gateway Recover Center. Tracy Houck is Gateway's Community Services Manager.

Wilderness Treatment Center

"The disease of addiction destroys all aspects of these young men's lives. The program gives them the opportunity to live productive lives."

– John Brekke, Founder

The Wilderness Treatment Center opened its doors for treating chemically dependent young men in August 1983. It was the first program of its kind to combine traditional in-patient treatment with a separate wilderness component. The Wilderness Treatment Center is a 60-day program. The 35-bed facility is set on a working cattle ranch in Marion, Montana.

Wilderness Treatment Center provides opportunities for young men to build and regain personal character while recovering from their disease. The first 30 days are spent on the ranch in a conventional in-patient setting. The focus of this phase is education, overcoming defenses, and working through the first 3 of the 12 steps. This is done through individual therapy, group therapy, work and recreational therapies. In addition to conventional treatment, the guys participate in work therapy, which consists of doing chores on the ranch. This population responds well to this unique approach, giving them an added sense of accomplishment.

"You can't cheat the trail."

– WTC Founder John Brekke

The second part of the program is a 16—21 day wilderness expedition where patients can put the skills they've learned during the first 30 days into practice. Led by licensed counselors and experienced wilderness instructors, these expeditions provide opportunities to make progress toward a number of goals. Wilderness Treatment Center is one of the largest outfitters in the state and has a group in the woods every day of the year except Christmas.

Since its inception, there has been a boom in the field of wilderness and experiential therapy. This validates what W.T.C. has always known—that the best way for young people to learn is by doing. Sticking to the principles that led to the creation of the program has been one of its keys to success. Wilderness Treatment Center enjoys world-renowned recognition with referrals from all 50 states and many other countries.

For more information, contact Patrick Hawkins at 406-854-2832.

The Challenge of Adolescent Assessment

By Mona Sumner, Chief Operating Officer, Rimrock Foundation

The challenge of adolescent assessments is well know by most professionals working in addiction treatment. Despite the fact that there is a range of assessment instruments, most fail the "lie" test. In spite of the weakness of assessment instruments, we have been experiencing significant success with a pilot project put into operation for School District II in Billings, the largest district in Montana. The Truancy Project involves assessing students referred to the district's truancy center after being suspended from school.

The Assessment Process

The assessment process consists of three sessions. Parents are required to escort their child to his/her first day at the Truancy Center, and a brief history is taken. The first session involves orienting the student/adolescent to the process, obtaining releases, building rapport and administering a variety of testing instruments. A collateral school contact is made to obtain the child's academic history and the school's view of his/her problems and usage. If the child is on probation, the probation officer will also be contacted.

The second session consists of a standard clinical history and interview, during which the child's view of the problem is elicited, and the clinician clarifies any questionable test responses with the child. The third session includes the child, parents and assessment team. During that session, clinical findings and recommendations are presented. At the very least, the team will offer recommendations and assist the family to negotiate a no-use contract with the child. Inexpensive drug testing kits are also offered. If treatment services are indicated, these will be explained during the third session as well. A 90-day follow-up visit is scheduled in order to continue monitoring the child's progress and the progress of the family in implementing zero-tolerance for mood altering substances.

The Instruments

Because we've learned that kids are likely to be more honest in responding on a computer or with paper and pencil, we use multiple assessment instruments, which might include a combination of:

- MMPI-A-II or Millon Inventory
- Shipley Hartford Screen (intellectual/cognitive functioning)
- Adolescent Alcohol Involvement Scale
- Marijuana Self Assessment
- Drug Abuse Screening Test
- Beck Depression Inventory
- Adolescent Screening Inventory
- Adolescent Self-Report Assessment Guide
- Marijuana Involvement Test
- Crank/Cocaine Involvement (Optional, depending on history)

The *Adolescent Screening Inventory* and the *Adolescent Self-Report* were developed by Rimrock. They were designed to elicit paper/pencil responses to issues or questions that kids frequently lie about in face-to-face encounters with clinicians. The MMPI-A is used to identify co-occurring problems and substance abuse as measured by the three addiction-specific scales. The Millon is useful for identifying delinquency proneness and other behavioral patterns.

This fall, we will incorporate an instrument that was published in the *Archives of Pediatric Adolescent Medicine*, the CRAFFT test. This instrument was developed with funds from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Center for Substance Abuse Treatment (CSAT) and the Robert Wood Johnson Foundation. It takes five minutes to administer. Two or more "yes" responses are highly predictive of a substance use disorder. Dr. John R. Knight of Harvard Medical School found that one in four adolescents presenting for routine physical care were testing positive on this instrument. This would be a useful tool for brief screening in a variety of adolescent settings. Feel free to use this instrument as it is public domain.

Mona L. Sumner, ACATA, MHA is the Chief Operating Officer and Clinical Director for Rimrock Foundation. For more information, visit www. Rimrock.org or call 406) 248-3175 or 1-800-227-3953.

THE CRAFFT TEST

The acronym stands for key words in the questionnaire: car, relax, alone, forget, friends, trouble.

***1. Car**—Have you ridden in a car driven by someone (including yourself) who was high or who had been using alcohol or other drugs?*

***2. Relax**—Do you ever use alcohol or drugs to relax, feel better about yourself or fit in?*

***3. Alone**—Do you ever use alcohol/drugs while you are buy yourself, alone?*

***4. Forget**—Do you ever forget things you did while using alcohol or drugs?*

***5. Friends**—Do your family or friends ever tell you that you should cut down on your drinking or drug use?*

***6. Trouble**—Have you ever gotten into trouble while you were using alcohol or drugs?*

Editor's Note: *In the next newsletter, Mona Sumner will share the results of the initial work on the Truancy Project.*

St. Patrick's: *Serving Adolescents*

By Melody Barnes, MSW, LAC, Adolescent Clinical Supervisor

Like most communities in Montana, Missoula is witnessing some worrisome trends in adolescent drug use. In the past, Missoula's adolescents typically used alcohol, marijuana and hallucinogens. Approximately six years ago, methamphetamine hit the high school population. Then, two years ago, cases of heroin and opiate abuse and addiction began to surface. Over the last year, adolescents have been seen in emergency rooms and the mental health unit for overdoses of Coricidin, Robitussin and Dramamine. Selling prescriptions, shoplifting over-the-counter medications and stealing prescriptions from the medicine cabinets of family, friends and neighbors is also becoming more of the norm for the local adolescent drug culture. Another very worrisome trend is the growing familiarity with the use of needles in this vulnerable age group.

The mission of the Adolescent Addiction Services at St. Patrick's Hospital is to stay abreast of these factors and of changes in the field of addiction, in order to better serve this very special population. Nearly all of the adolescents referred to the program are involved in the legal system. Nearly all have psychiatric and/or neurological conditions and need assessment and on-going care. Many have a history of trauma, particularly sexual trauma. A challenging sub-group are those addicted adolescents who have lost a parent and/or experienced multiple losses.

The dually diagnosed adolescent is often involved in the corrections system. The issues they face pose specific ethical and practical challenges. They are generally hard to manage in the community, as evidenced by: difficulty in sustaining abstinence; establishing behavioral stability in the home and community; and interrupting patterns of criminal activity.

Numerous questions rise around addressing the needs of this population: should the adolescent be subject to the traditional corrections interventions regardless of chemical dependence or other mental health/neurological problems? Should the adolescent be criminalized so that they can better access treatment resources? What can be done to enhance the response to treatment interventions so that the adolescent isn't removed from the community and placed in correctional facilities?

St. Patrick Hospital's Adolescent Addiction Services Team works with the adolescent and the family using a community treatment team model. We believe that the treatment team must be sensitive to the experience of the adolescent *and* the family within the context of the community and culture. Treatment cannot be effective without sensitivity to this context and recognition of inherent strengths and challenges for the adolescent and his/her family. Effective treatment strategies reflect an emphasis on addressing the adolescent's needs as an individual, as a member of a family and as a member of the community.

For more information on St. Patrick Hospital and Health Sciences Center Adolescent Chemical Dependency services, see http://www.saintpatrick.org/acdt.html or call (406) 543-7271.

Intervening in and treating the adolescent struggling with substance use is challenging for families, communities and treatment professionals. Many factors circumvent traditional approaches to this population's recovery needs, including:

- *co-occurring psychiatric/ neurological conditions;*
- *issues related to grief and loss;*
- *trauma;*
- *stage of personality development;*
- *cognitive impairment;*
- *influence of peers;*
- *dependence on a family that may not support recovery goals;*
- *increasing involvement in a criminal lifestyle;*
- *ever-changing trends in a community's drug culture; and*
- *access to affordable treatment.*

Warning Signs of Substance Abuse

- *A drop in grades*
- *Poor achievement*
- *Moods are up and down*
- *Dishonesty about whereabouts*
- *Dishonesty about a lot of things*
- *Early cigarette smoking*
- *Parental defiance*
- *Red, watery or glassy eyes*
- *Uses eye drops to hide red eyes*
- *His delinquent friends*
- *Late or unexplained hours*
- *Rejection of parental values*
- *Have found drugs and/or paraphernalia in his/her possession*
- *Disappearance of money or possessions*
- *Defensive about drug use*
- *Antisocial behavior*
- *Seems to have drug-using friends*
- *Often draws pot leaves, drugs or drug symbols*

Source: NotMyKid.org

Billings Area Indian Health Services
Alcohol and Substance Abuse Programs

The Indian Health Service has been functioning within the American Health System since 1955. The Billings Area Indian Health Service serves all seven reservations in Montana, which include the Blackfeet, Crow, Northern Cheyenne, Fort Peck, Fort Belknap, Rocky Boy and Flathead. It also serves the Wind River Reservation in Wyoming. There is a team effort between the tribes and Billings Area IHS, with the goal of providing the best possible health care to the Native Americans in this area. All 15 of the tribal and tribally compacted Indian Health Service programs provide out-patient and aftercare services to adolescents and adults. All 15 programs include a prevention component. The Billings Area IHS also supports three (3) substance abuse program staff members at one youth detention facility, which has 16 beds for male and female adolescents.

Montana and Wyoming, with their wide-open spaces, rural atmospheres and western history, are lasting homes for the ancestral lines of Native Americans. The Indian Health Service in the Billings area continues to honor and protect the inherent sovereign rights of tribes.

For more information, visit the Billings Area Indian Health Service Website at http://www.billings.ihs.gov/v2/

Tribal Programs: In-patient		
Program	**Services**	**Capacity**
Blackfeet Chemical Dependency Program* Phone: (406) 338-6319 CARF (Commission on Accreditation of Rehabilitation Facilities) Accreditation	In-patient (Primary Residential Treatment) Out-patient, Aftercare Assessments, Screening Referrals, Counseling Education, Intervention and Prevention Serving adults and adolescents	20 beds: male & female adults
Spotted Bull Treatment Center Phone: (406) 768-3852 CARF Accreditation	Transitional living center Assessment & Evaluation Counseling, Referrals, Education and Prevention Out-patient and aftercare services for adults and adolescents In-patient services for adolescents	12 beds: 6 male 6 female
Fort Peck Juvenile Services Detention Center Phone: (406)	Adolescent, Rehabilitation, Chemical Dependency Screening, Counseling	16 beds: 8 male 8 female

Tribal Programs: Out-patient / Aftercare	
Program	**Services for Adults and Adolescents**
Crow Substance Abuse Program JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Accreditation **Phone: (406) 638-3361**	Assessment & Evaluation Referrals, Counseling Education, Prevention Motivational Enhancement Therapy
Fort Belknap Chemical Dependency Center **Phone: (406) 353-2205 ext. 480**	Assessments, Referrals Cultural/Spiritual Guidance Counseling and Prevention, CARF Accreditation
Northern Cheyenne Recovery Program **Phone: (406) 477-6381**	Assessment & Evaluation Counseling Referrals, Education, Prevention
White Buffalo Healing Center **Phone: (406)**	Assessments/Referrals Education, Counseling, Prevention
Eastern Shoshone Recovery Center **Phone: (307) 332-7604**	Assessments/Referrals Education ,Counseling, Prevention Groups, JCAHO Accreditation
Rocky Boy Chemical Dependency Prog. **Phone: (406) 395-4837**	Counseling, Education Assessment & Evaluation Prevention Referrals
Flathead Alcohol Program **Phone: (406) 676-2500**	Assessment & Evaluation Counseling, Education, Prevention
Indian Health Board of Billings* **Phone:(406) 245-7318**	Assessments Referrals, Counseling Anger Management Prevention Mental Health
Indian Family Health Center, Great Falls **Phone: (406) 329-3373**	Assessment & Evaluation Referrals, Counseling, Prevention
Missoula Indian Center* **Phone: (406) 721-2700**	Assessment & Evaluation Referrals, Counseling Prevention
Helena Indian Alliance **Phone: (406) 442-9244**	Referral Assessment & Evaluation Prevention
North American Indian Alliance, Butte* **Phone: (406) 782-0461**	Assessment & Evaluation Referrals, Therapy, Education, Prevention

* State Approved

Typical challenges facing alcohol and substance abuse programs in the Billings Area Indian Health Services:

1. *Insufficient funding for in-patient treatment for adolescents and adults;*
2. *Inability to motivate aftercare participation with most of the clients after in-patient treatment;*
3. *The lack of a safe location for stabilization ("detox") of methamphetamine addicts long enough to recover cognitive ability to participate in treatment;*
4. *Lack of residential aftercare for adults (e.g., halfway houses);*
5. *The increase in the number of injection drug users and a counseling staff needing more familiarity with treatment of injection drug dependency;*
6. *The shortage of licensed/certified addiction counselors and the lack of younger people choosing to enter the field;*
7. *Mental health disorders complicating addiction treatment, with scarcity of funding for Indian health for mental health treatment; and*
8. *Lack of funding for full time prevention specialists to provide first hand information to community members and their families.*

For more information, please contact Kathy Masis, MD, Indian Health Service Alcohol & Substance Abuse Program, 2900 4th Avenue N.,Billings, MT 59101;(406) 247-7124 or kathleen.masis@mail.ihs.gov

Historical Trauma & Stressors

By Donald P. Fish, B.S., LAC

The emotional, mental, physical and spiritual pain of Native Americans that has been passed down through successive generations throughout history is not widely known, nor well understood by substance abuse and mental health professionals within the dominant culture. Awareness and knowledge of historical trauma and stressors comes from recent research by Dr. Joseph B. Stone and by the National Association of Native American Adult Children Of Alcoholics (NANACOA).

The historical trends of genocide, oppression, assimilation, violence, acculturation and repression of a spiritual way of life have long affected tribal communities, and are still having devastating affects. Dr. Stone has developed a breakdown of these historical developments as follows:

1. The introduction of disease into the system, for which there was no immunity;
2. Dispossession of property and enforced moving to reserved lands (e.g., typically lands of marginal value);
3. Persecution and murder during the various *Indian Wars*;
4. Enforced assimilation and acculturation through the General Allotment Act and the federal boarding school system;
5. Oppression of and outlawing of religion, cultural traditions, and language, which together represent the traditional carriers of culture;
6. Introduction to vices such as alcohol and drugs;
7. Inappropriate and inefficient management of governmental and health care systems by dominant culture bureaucrats; and
8. The acting out of internalized oppression through domestic violence and child sexual abuse on other tribal peoples, both within and outside the nuclear family.

According to Dr. Stone, these atrocities have had an intergenerational effect that often leads to the manifestation of substance abuse problems and mental or behavioral health diagnoses and disorders. Understanding this will give the professional helper the depth and breadth of the underlying dynamics associated with these influences across history.

Much more can be written about what Dr. Stone calls "detrimental systemic influences." Ultimately, what needs to be emphasized is that substance abuse and mental health professionals need to develop cultural understanding in order to be sensitive to the Native American client. If this does not happen, then it would seem the professional helper would continue the oppressive cycle.

– Donald P. Fish, of the Southern Pikuni (Blackfoot) Tribe, has spent most of his life on the Blackfeet Reservation. He acquired a Bachelors Degree from the University of Great Falls and has been a State Licensed Substance Abuse Counselor since 1987. Mr. Fish currently works at the Indian Family Health Clinic in Great Falls as a Substance Abuse/Behavioral Health Coordinator.

Measuring Success

After 6 months of in-patient treatment, participants experienced consistently fewer arrests.

Change in 1997-2000 Arrest Rates (*Following six months of in-patient treatment*)

- **47% of 251 adults and 50.3% of 119 adolescents experienced fewer arrests after treatment (1997)**
- **52.4% of 328 adolescents and adults experienced fewer arrests after treatment (1998).**
- **51% of 207 adults experienced fewer arrests after treatment (1999)**
- **55.2% of 96 adolescents experienced fewer arrests after treatment (1999)**
- **83.5% of 248 adults and adolescents experienced fewer arrests after treatment (2000)**

*** Source: I/T/U Alcohol Substance Abuse Programs Montana & Wyoming Chemical Dependency Management Information Systems (CDMIS) Statistical Outcome Data**

Trends in the Well-Being of America's Children 2002*—The seventh annual report from the Federal Interagency Forum on Child and Family Statistics finds increasing diversity among the child population. The median income for families with children rose to $50,990 in 2001, but two-parent families earn more than three times the average earnings of single-mother families.*

http://www.aspe.hhs.gov/hsp/02trends

How Children Are Doing: The Mismatch Between Public Perception and Statistical Reality*—Teen pregnancies are down and youth violent crime rates are at their lowest level in 25 years, yet most of the American public is unaware of these positive trends, according to this Child Trends report. While many American children and youth still face daunting challenges, public ignorance of progress in the 1990s means voters may be less willing to support the policies and programs that helped bring about these successes.*

http://www.childtrends.orgn_
PublicPerc63003.asp

State Approved Programs

The following programs provide substance abuse and dependency services. They accept patients from all economic levels, with services provided on a sliding fee scale based on financial ability. When a family is on Medicaid or living on an income of 200 percent or less of federal poverty, services may be billed by state approved programs under contract with the Chemical Dependency Bureau. Regardless of family gross income, the patient is strongly encouraged to contribute toward the cost of treatment because taking responsibility for recovery is an important part of treatment.

If you have questions, contact the state-approved program for the county where you reside or contact the Chemical Dependency Bureau at 444-6981.

Programs under contract with the Chemical Dependency Bureau Substance dependency/abuse treatment services

Alcohol & Drug Services of Gallatin County—Bozeman: 586-5493. Serving Gallatin County

Indian Health Board of Billings—Billings: 245-7318. Serving adults only

District II Alcohol & Drug Program—Glendive: 377-5942. Serving Dawson, McCone, Prairie, Richland and Wibaux counties

Alcoholism Services of Anaconda-Deer Lodge—Anaconda: 563-6601. Serving Deer Lodge and Granite counties

Boyd Andrew Community Services—Helena: 443-2343. Serving Lewis & Clark, Jefferson and Broadwater counties

Gateway Recovery Center—Great Falls: 727-2512. Serving Cascade County

Butte Silver Bow Chemical Dependency Services—Butte: 497-5070. Serving Silver Bow County

Western Montana Addiction Services—Missoula: 532-9800. Serving Granite, Powell, Missoula, Mineral and Ravalli counties

Substance Abuse/Dependency Services—Miles City: 232-1687. Serving Carter, Custer, Daniels, Fallon, Garfield, Powder River, Phillips, Roosevelt, Rosebud, Sheridan, Treasure and Valley counties

Journey Recovery Center—Billings: 354-1314. Serving Big Horn, Carbon, Musselshell, Stillwater, Sweet Grass, Golden Valley and Yellowstone counties

Flathead Valley Chemical Dependency Clinic, Inc.—Kalispell: 756-6453. Serving Flathead County

Lake County Chemical Dependency Services—Polson: 883-7310. Serving Lake County

Missoula Indian Center—Missoula: 721-2700. Serving Lake, Mineral and Ravalli Native American populations

Alcohol & Drug Services of Central Montana, Inc.—Lewistown: 538-8421. Serving Fergus, Judith Basin, Petroleum and Wheatland counties

Southwest Chemical Dependency Services—Livingston: 222-2812. Serving Beaverhead, Park, Meagher and Madison counties

TLC Recovery, Inc.—Fort Benton: 622-3211. Serving Blaine, Choteau, Glacier, Hill, Liberty, Pondera, Teton and Toole counties

In-Patient Services

Rimrock Foundation—Billings: 248-3175. Serving adult out-patient and youth in-patient

Pathways Treatment Center—Kalispell: 756-3950. Serving in-patient youth

Montana Chemical Dependency Center—Butte: 496-5400. Adult in-patient

Blackfeet Chemical Dependency Program—Browning: 338-6330. Serving adult women in-patients

The Governor's Drug Policy Task Force: *Treatment*

Submitted by Mary E. Fay

To understand the complexities and importance of the treatment system, it is important to understand the science and nature of addiction. Drug addiction is a "brain disease." Use of addictive drugs changes the structure and the function of the brain. Effective treatment recognizes the individual and his/her varied needs.

Montana's youth have the 2nd highest rate of illicit drug use of all 50 states (6th highest rate of tobacco use and 4th highest for alcohol use). Montanans spent approximately $256 *million* in 1998 on programs related to the negative effects of substance abuse. Less than one percent was invested in prevention and treatment, even though a study of California alcohol and drug treatment services found that every dollar invested in treatment yields savings of $7.14 in future costs for taxpayers.

Several studies have demonstrated that the success and cost effectiveness of treatment can be predicted based on how well the treatment matched the specific needs of the patient. The American Society of Addictive Medicine (ASAM) has developed patient placement criteria (PPC-2R) that identify the "level of care" needed to most effectively treat a drug abuser or drug dependant patient based on the patient's specific needs. Historically, Montana has only had two levels of treatment care, in-patient and out-patient, without much in between.

The vast rural areas of this huge state further complicate the treatment picture, making lack of access to treatment a significant problem in Montana. Treatment needs to be readily available, but our present system simply does not have the capacity to respond to the growing need for treatment. There is a huge gap between those who need treatment and those who receive it. According to the 1999 Household Needs Assessment, in Montana—among those who needed treatment—88 percent of adults, 95 percent of youth, 87 percent of Native Americans and 88 percent of pregnant women did not receive it.

The "just say no" campaign did not consider those who had already made the mistake of using drugs.

Montanans' perpetuation of the myths surrounding addictions continue to be barriers to treatment. One myth, according to Alan I. Leshner, Ph.D., Director of the National Institute on Drug Abuse, is that in order for treatment to be effective, an individual must *want* it. Dr. Leshner points out that virtually *no one* actually wants drug treatment. The good news is that scientific studies have shown that even those who are coerced into treatment can be successful.

Another commonly held myth is that "treatment is a one-shot deal." Dr. Leshner explains that—like many other illnesses—drug addiction is chronic. Most of those who abuse drugs require long-term treatment and, in many cases, repeated treatments and a lifetime of day-to-day aftercare and support. Another commonly held myth is that drug addiction is a character flaw rather than a disease.

Cost can be a barrier to effective addiction treatment. With Montana's poor economy and a deficit state budget, drug treatment has not been treated as a priority. Generally, those with drug dependencies do not have the means to pay for treatment. Many end up in jails and prisons. A 1997 study showed that of those entering our prison system, 89 percent had a lifetime substance abuse disorder. Our corrections population is exploding, but does not have the resources to effectively manage drug treatment among the population it serves. Consequently, 50 percent of the offenders released from prison will return to prison via probation and parole violations, most due to alcohol and drug abuse.

Putting our heads in the sand and wishing this issue would all go away on its own is pie in the sky thinking. Without a social system that can deal effectively with drug offenders, our communities will be sucked dry—financially, mentally, emotionally, and morally. Developing and promoting a healthy social system will be difficult, but ultimately, doing nothing will destroy the quality of life we enjoy in Montana.

Mary E. Fay was a member of the Governor's Tobacco, Alcohol and Other Drug Policy Task Force, where she served on the Treatment Subcommittee.

The Task Force identified and explored six areas that function as barriers or challenges to providing effective drug treatment in Montana:

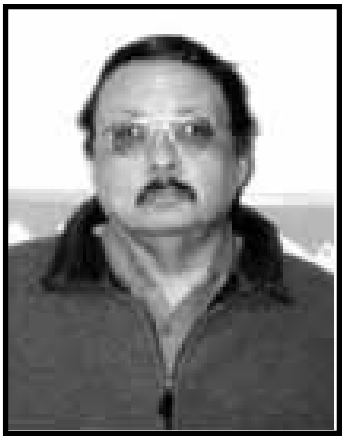
- *Lack of access to treatment;*
- *Attitudes and stigma;*
- *Funding and treatment costs;*
- *Lack of education and engagement;*
- *Lack of specific care levels; and*
- *Workforce challenges.*

See the Alcohol Cost Calculator at www.ensuringsolutions.org.

It takes two minutes to answer the questions and receive an estimate of the costs to your business generated by the risks and realities related to workforce alcohol use. Ensuring Solutions to Alcohol Problems is located at George Washington University Medical Center and funded by the Pew Charitable Trusts.

Source for facts cited in the Task Force article: *The Comprehensive Blueprint for the Future, A Living Document*, was submitted to Govenor Judy Martz and Attorney General Mike McGrath in September 2002. The full report can be found at http://www.discoveringmontana.com/gov2/css/drugcontrol/default.asp.

Honoring a Montana Hero: *Gordon Belcourt, MPH*



"Gordon Belcourt has done some magnificent work in consulting and in the areas of public health."

– Leonard J. Duhl, MD, Professor of Public Health and Urban Planning, University of California Berkeley

In March of this year, Mr. Gordon Belcourt was honored at the 7th Annual Public Heroes Event. There he received a national award for assisting in establishing 235 alcohol prevention programs in 36 states and for advocating for American Indian health throughout the country. The award was specially crafted for the event by Tiffany. In addition, he received a Tradition Blanket from American Indian faculty and staff, and was accorded the honor of a traditional Honor Song as part of the award ceremony.

These were richly deserved honors. Throughout his career, Gordon Belcourt has focused on improving service to American Indian people, access to health-care resources and restructuring Indian Health Services. He continues to advocate on behalf of 556 federally recognized tribes as a board member on the National Indian Health Board.

There is no question that Gordon Belcourt is a leader—he's the Executive Director of the Montana-Wyoming Tribal Leaders Council. In this capacity, he helps coordinate the flow of information through tribal health departments, tribal councils and federal and state agencies. He is knowledgeable in issues pertaining to public health for the 100,000 tribal members, 10 tribal governments and eight large land-based reservations in Montana and Wyoming.

Gordon Belcourt also has a lifetime appointment as an Appellate Justice of the Blackfeet Nation, serves as staff for the Subcommittee on Health, and as a member of the Steering Committee of the Montana Faith-Health Cooperative. He works closely with Indian Health Services through an Annual Cooperative Agreement and as a member of the Institution Review Board (IRB) for Research Programs on the Reservations. He is a board member of the *InPsyche* Program of the University of Montana Psychology Department.

Gordon Belcourt has been nationally recognized in the field of American Indian alcoholism since the 1970s, when he served as the National Field Director for the American Indian Commission on Alcoholism and Drug Abuse. During that time, he had the opportunity to visit at least half of the federal American Indian reservations in the country, as well as many American Indian communities where he assisted in developing alcohol and substance abuse prevention programs.

One thing that has made Gordon Belcourt so effective in his work is his perspective. He understands that when communities are facing 70 percent unemployment, people become discouraged. Colleges and universities offer a breath of hope, but it can be difficult for Native American students to go from small, insular environments—where there is an abundance of family and a rich sense of community—to huge, impersonal campuses. This adds tremendous stress to the already tenuous connections to the outside world.

One of the best prevention measures Mr. Belcourt has found is adherence to tradition and traditional spirituality. Although there are hundreds of distinct Native American tribes, most share some cultural focal points that are familiar—in one variation or another—to most tribes. Native American religions are primarily monotheistic. Other commonalities include sweat lodges, morning and evening smudging, pipe ceremonies and the Sun Dance. Similarities in the way ceremonies are conducted—and in the belief system they represent—can offer a sense of cultural familiarity as well as the opportunity to commune with a higher power. Ceremony—and spirituality—can help people feel part of something bigger than themselves. This can help people maintain the strength they need to achieve and maintain sobriety.

Mr. Belcourt believes strongly in the need for a connection to a spiritual tradition. In his volunteer work with Native American prisoners and others, he has found that once people have been introduced to traditional spiritual ways, they often say they wish they would have known . . . or listened . . . sooner. Unfortunately, he says, no one is really using traditional medicine and spirituality as a treatment/prevention model for Native American people.

A belief system that perceives all things as interrelated has helped this man dedicate his life to achieving a positive difference . . . for communities and families. But if all things truly are interrelated, we need to invest—in prisoners, and in the children of prisoners. We need to invest in opportunities for children, good jobs, safe environments for families, and in healthy communities. "The key is to take what you can control," says Gordon Belcourt, "All we can influence is our own environment."

It is lucky that Mr. Gordon Belcourt takes a wide view of his environment, because in doing so, he is making a difference for all of us.

Editor's Note: *It was my great privilege to interview Mr. Gordon Belcourt for this article.*

See the Montana-Wyoming Tribal Leaders Council at http://tlc.wtp.net/

Age of First Use:
The Impact in Defining Treatment

By Dave Peshek, Administrator, Montana Chemical Dependency Center

At Montana Chemical Dependency Center (MCDC), we do not treat adolescents, but adults 18 years of age or older. Rest assured, this age division does not an adult make! We consistently see very adolescent behavior exhibited by many, if not most, of the individuals aged 18–25 who suffer addictions and are in treatment,. The fact that addiction is a brain disease is readily evidenced in these individuals, and is clearly demonstrated by their developmental and behavioral deficits. We find it necessary to conduct special groups to work with these individuals due to their lack of appropriate social skills, cognitive skills, thinking errors and response mechanisms. If the addiction is further compounded by a psychiatric disorder, the problems associated with effective treatment increase exponentially.

The data reflected in the table below was gathered at MCDC for the years 1998-2003. It provides some interesting insights. The data would suggest that males typically begin use earlier than females and that the earlier age in treatment corresponds to an earlier age of first use. This would appear to support what prevention specialists already know—we must reach our children at a very early age to help them detour from the addiction path.

MCDC	Age of Client		
	Age 18–25	Age 26+	All Ages
Average Age Males	21	38	32
Age of First Use Males	14	15	15
Average Age Females	21	36	33
Age of First Use, Females	15	18	17

A recent study published in the June 2003 issue of the *American Journal of Psychiatry* examines how brain development makes teens vulnerable to addiction. The study led by R. Andrew Chambers, an assistant professor of psychiatry at Yale University, found that the ability of the adolescent brain to change in response to various experiences could also make teens more vulnerable than adults to addiction. Chambers reports that during adolescence, motivational systems in the brain go through changes. These serve as "motivational repertoires," or skills and interest that help teens in their transition to adulthood. These motivational repertoires remain throughout life. However, since the teen brain seeks rewarding activities, addictive substances could obstruct other—positive—activities. "When you're addicted," Chambers said, "all your motivation gets funneled into seeking or taking the drug." Another article in this same issue (by Ralph E. Tarter, Ph.D. and associates), found that *neurobehavioral disinhibition* is a stronger predictor of a substance use disorder than frequency of consumption.

Immediate gratification and high stimulation are often the standards upon which adolescents and young adults base their satisfaction with life. If productive skills and interests are not developed that provide an appropriate level of satisfaction, addictive substances might. Obviously, once substances are chosen over productive choices, the brain damage begins and motivational repertoires become compromised while evidence of neurobehavioral disinhibition increases. Therein lies much of the challenge of treating adolescents and young adults; when the developing motivational systems are compromised by chemical use, patients often act and respond at the level when the development was first compromised. This correlates back to the beginning of this article when I noted that individuals between the ages of 18–25 who are in treatment often behave and respond as if they were adolescents, which often corresponds to age of first use. This is not to mean that treatment is hopeless. It does mean that treatment may need to be modified to adequately address cognitive and behavioral deficits. This also means that treatment is likely to take more time—time to build adequate skills, time to focus on addictions and behaviors, time to create future reference, time to work on psychiatric issues, time to do a multitude of work with the individual. For treatment to have optimum success, time is critical and must be coupled with copious amounts of patience. Unfortunately, the people being asked for time and patience have not developed these virtues. These are people who like immediate gratification and high stimulation.

Given these considerations, the adage of an ounce of prevention being worth a pound of cure is worthy of some specific application. Although the value of teaching children and adolescents the pitfalls of chemical use is important, it is probably as important to focus on building age appropriate developmental skills. Higher cognitive functioning, effective life skills, productive interests and activities, strong family and peer relationships, motivation and rewarding outcomes will offer children and adolescents an opportunity to make effective choices. Prevention activities are not an absolute deterrent any more than treatment is a cure; it still requires that the individual make effective choices and that requires—at minimum—an effectively functioning brain, uncompromised by addictive substances.

Who is served by MCDC?

The Demographics

- *65% male*
- *73% unmarried*
- *49% have some level of legal involvement*
- *77% unemployed*
- *51% have a co-occurring mental illness*
- *12% were homeless prior to admission*

Based on average daily census for Fiscal Year 2002

Treating Co-Occurring Disorders at Montana State Hospital

By Polly Peterson, Ph.D., Chief of Psychology

An increasing awareness of the prevalence of co-occurring disorders prompted the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) to issue a report to Congress in November 2002 outlining the scope of the problem, current treatment approaches, best-practice models, and prevention efforts. The report outlines a five-year "blueprint for action" that focuses on developing a "seamless" system of comprehensive and integrated care where "any door is the right door" to receive treatment for co-occurring disorders.

Resource: U.S. Department of Health and Human Services. (2002). Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders. http://www.samhsa.gov/reports/congress2002/index.html

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Co-occurring substance abuse and mental disorders are complex problems that are estimated to affect 7 to 10 million adults in this country in any given year. In a 1999 report, the U.S. Surgeon General estimated that 41–65 percent of individuals with a lifetime substance abuse disorder also have a history of at least one mental disorder, and about 51 percent of those with a lifetime history of a mental disorder also have a history of at least one substance abuse disorder. The population served at Montana State Hospital (MSH) falls in line with national trends: over the past year, 58 percent of those admitted to MSH for treatment of a severe mental illness also received a diagnosis of some form of substance abuse or dependence.

As a member of the clinical management team in a state agency with a limited budget, I tend to focus on what we don't have or what's missing. When asked to assess our program at a conference on co-occurring disorders in May, I was sure we would fall short. To my delight, Montana State Hospital qualifies as a "dual diagnosis enhanced" (DDE) program. This means we can accommodate individuals with co-occurring disorders so severe that they require psychiatric *and* mental health support, continuous monitoring and accommodation in order to participate in addiction treatment.

DDE programs are staffed by psychiatric and mental health clinicians, as well as addiction treatment professionals. At MSH, we provide individualized assessment, treatment and discharge planning to accommodate the needs of people with co-occurring disorders.

Approximately two years ago, we identified and dedicated a specific clinical pathway to the treatment of co-occurring disorders. We currently employ two full-time, licensed addictions counselors who assess individuals admitted to MSH for the presence of substance abuse disorders. The psychiatrists, nurse manager and team leader on our admissions unit have extensive training and experience in the treatment of substance abuse and chemical dependency issues. They identify and refer patients exhibiting symptoms consistent with co-occurring disorders. The psychology department is also fortunate to have interns and trainees from the University of Montana and Montana State University who contribute knowledge of the latest research and contemporary treatments.

The Co-Occurring Clinical Pathway at MSH includes use of evidence-based practices for increasing motivation and expanding capacities for change. We have had a Co-Occurring Process Group in place for nearly three years where stage-of-change issues are explored and motivation for change enhanced. Other evidence-based practices include dialectical behavior therapy (DBT), cognitive behavior therapies (CBT), and treatment activities that teach patients skills and strategies for effective problem solving and relapse prevention. DBT is a major focus of our treatment program and has been proven very effective in the treatment of co-occurring mental and substance abuse disorders, especially with individuals who have co-occurring personality disorders and dysregulated affect and behavioral problems.

As with many things in life, there is room for growth and improvement. Enhanced cross-training of clinical staff, especially those with the most patient contact, is needed. Since only two CD counselors serve a population that often exceeds 180 patients, the majority of their time is spent performing assessments and providing treatment. Time for program development is limited. Yet, with the level of commitment to the process of growth demonstrated by the management and clinical staff at MSH and embedded within a proactive state system, Montana State Hospital is steadily moving toward a comprehensive, continuous, integrated system of care.

– Dr. Polly Peterson is a native Montanan who received her Ph.D. from the University of Montana. She recently returned to Montana after spending twelve years in private practice in Tampa, Florida. She is Chief of the Psychology Department at Montana State Hospital.

Recovery Homes:
Safe, drug-free housing

By Chuck Michaud, Chemical Dependency Bureau Planner

The Montana Continuum of Care Coalition conducted a survey in April 2002. At that time, they located 2,229 homeless persons in Montana. They estimated that 30–40 percent were mentally ill, 23 percent had substance abuse or dependency issues, and 25 percent were unemployed or lacking job skills. When basic needs are not being met, recovery seems impossible. Without recovery, making significant improvement in lifestyle is impossible.

Recovery Homes provide appropriate intervention to interrupt a downward spiral and restore hope. The individuals served are stable enough to be treated at the community level despite significant deficits in mental state. They gain a livable environment, become ready to change and gain ability to cope with basic human needs. Through community-based residential treatment, these individuals participate in direct interventions facilitated by addictions treatment professionals and case management services. The ultimate goal is successful community reintegration.

Bozeman and Livingston opened the doors to their Recovery Homes in September 2002. As of June 30, they have served 32 clients.

While living in the Recovery Homes, clients receive outpatient substance abuse treatment from the local, state-approved programs. In addition to substance abuse counseling, clients are assisted as they address other issues including employment, housing, and responsibilities to family and the community. The residents also receive help in accessing auxiliary medical, mental health and social services. All are geared toward improved quality of life and chances of recovery, with a philosophy of promoting independence and self-reliance and of instilling confidence, self esteem and hope.

Jean McCauley, Director of Southwest Chemical Dependency Program, Livingston, has spent 20 years in the field of addiction treatment. "Since starting the Recovery Home," she says, "I have had a level of intimacy with clients that I haven't experienced before. When I hear people talking about life issues, I find that I'm listening at a whole new level of involvement since they've begun to reside with us."

The Livingston Recovery Home has admitted clients with serious recovery issues that expand the notion of traditional out-patient service. These clients have experienced such debilitating conditions as mental illness, diminished cognitive functioning, homelessness, physical disability and neglected health issues. Jean McCauley states that if the Livingston Recovery Home were not available, half of those served need a higher level of services or extended in-patient care. In itself, this represents great savings to publicly funded systems.

Shelly Johnson, Director of Alcohol and Drug Services of Gallatin County, Bozeman, tells of a 39-year-old client with Hepatitis C and chronic alcoholism. When admitted upon referral from the local hospital, he was homeless and living under a bridge. At the Bozeman Recovery Home, he has begun interferon treatments for hepatitis, and has been reunited with his children. He's gotten a job, is contributing to his room and board, and is voluntarily addressing an outstanding warrant.

Outcomes

The positive outcomes of the services provided by the Recovery Homes are obvious. The savings are substantial, particularly in terms of the human condition. Instead of *costing* society money through lost productivity and the need for higher-cost, in-patient services, residents have contributed $7,534 in child support, $1,190 in offender restitution and $11,225 in room and board during the short time they've been living in the Recovery Homes. This is as close to a perfect win-win solution as we're likely to see.

—For more information, contact Chuck Michaud, Chemical Dependency Planner, Addictive and Mental Disorders Division: 444-7924 or cmichaud@state.mt.us.

". . . dealing with these diverse and demanding human issues is challenging and rewarding. I think there should be one of these programs in every community."

– Jean McCauley, Director, Southwest Chemical Dependency Program

Recovery Home Client Demographics

- *34% women;*
- *20% were homeless or had been living in substandard housing;*
- *69% were unemployed at admission.*
- *50% used drugs as their primary substance;*
- *50% had a history of IV drug use;*
- *43% had co-occurring substance abuse and serious mental illness diagnoses.*
- *100% required 24-hour support and supervision.*
- *Average age: 31;*
  - *25% 18 – 23;*
  - *22% 23 – 35; and*
  - *44% 35+ years of age.*

Pathways Adolescent Treatment Program: *The Nuts and Bolts*

Submitted by Martina Boothman

Referral

Referral for in-patient services generally occurs when an adolescent has not been successful in out-patient services. Before an adolescent can be accepted for referral to a state-approved program, the family must meet financial guidelines. Initial paperwork is completed by a local state-approved agency, after which the application is sent to the state for approval. The program is based on a 28-day stay, although that doesn't mean that the patient must stay the full time, nor that they are limited to 28 days. The actual length of stay is based on a patient's individual needs.

Starting Treatment

As soon as an adolescent arrives at Pathways Treatment Center, s/he is assessed by the multidisciplinary treatment team comprised of chemical dependency and recreation therapists, psychiatrists, medical and mental health professionals. At Pathways, either Dr. Richard Wise or Dr. Robert Sherrick performs the preliminary assessment, during which they decide whether the patient meets criteria and whether or not s/he will be accepted for admission.

When the patient is brought onto the treatment unit, s/he is assessed by the charge nurse. This assessment includes eliciting preliminary background information from the parent(s). Afterward, the patient is escorted to his/her room by a Mental Health Specialist. The patient and the patient's belongings are searched for contraband, after which the patient is oriented to the program. Each patient receives a workbook and the *Alcoholics Anonymous Big Book*. Within 24 hours, the patient will be seen by a medical doctor who specializes in addiction. This physician will take a medical history and perform a physical examination.

A recreation therapist also performs an assessment to determine the kinds of activities the patient has been engaging in and whether s/he knows how to have fun without drugs and/or alcohol.

The first full school day that the patient is in treatment, s/he will undergo testing by the educational specialist, to determine academic needs. Within the first four days, the primary therapist will complete a bio-psychosocial evaluation. If the evaluation process reveals that a psychiatric consultation would be beneficial, or if a parent or referrals source has requested it, this is discussed by the entire team. Psychiatric consultations are not performed without parental consent.

During their stay at Pathways, adolescents see their primary therapists a minimum of twice a week. They see their primary doctor once a week, but may request additional appointments whenever they feel it is necessary.

The evening schedule varies depending upon the day of the week, but always includes a Life Skills group. Patients also attend AA or NA meetings five days a week. Spiritual care and art therapy are each provided once a week.

Daily Activities

Goals and Medication Group: Each adolescent sets a number of goals each day. These include an overall goal, a behavioral goal and an assignment goal. Goals must be measurable, attainable, specific, challenging and positive. After setting their goals, the adolescents read from one of several daily meditation books and discuss how they can use the information in their own lives.

School: Academic assessments reveal the adolescent's level of skill, which are then used for treatment and educational purposes. During the school year, adolescents perform work assigned by their schools. Students not currently enrolled are assisted in studying for the GED.

The *Step Study* group involves an interactive process during which staff and adolescents spend time on their workbooks. These groups assist patients in their 12 Step process.

The workbook includes information on rules and expectations, group therapy, relapse planning and Steps One—Three of the 12 Steps delineated by Alcoholics Anonymous. Assignments include writing a life story, an ingestion history, 20 consequences of using/drinking, and Steps One, Two and Three. This work is then presented in the daily Process Group. The therapist and floor staff are available to assist the patient with these assignments.

Pathways incorporates the belief that *If you fail to plan, you plan to fail.* Relapse planning can be compared to a fire drill. If you know what to do before the event occurs, you have a better chance of survival. Relapse planning simply acknowledges the fact that addiction is a chronic disease with a high potential for relapse.

The *Process Group* provides time for presenting assignments to the group and for discussing community and/or personal issues.

Recreational Therapy varies daily, but the primary purpose is having fun in recovery. This provides the adolescent with the opportunity to try a variety of activities while clean and sober.

Life skills are daily presentations and discussions about issues that arise in daily life, including depression, communication, dating, and being assertive. *Spiritual care* is provided by hospital chaplains and is based on spirituality as versus any particular religion. Patients may request that a minister or priest of their faith provide assistance with their religious needs.

The Level System

Pathways uses a "level system" to promote emotional growth.

Level A: All patients start at this level. While patients are on level A they are not allowed to leave Pathways.

Level B: Patients have been at Pathways a minimum of 72 hours, have completed their orientation assignments, presented their life stories in group and met basic behavioral expectations.

Level C: Patients have been at Pathways for 14 days, be behaviorally compliant and must have completed their 1st Step.

Level D: Patients have been at Pathways for 21 days, and have completed Steps 2 and 3 of the 12 Steps. They must also be actively *walking the talk* – in other words, their actions must reflect what they are saying during group and individual therapy.

Pathways uses the *Love and Logic* concept of discipline. This curriculum was developed by Foster Cline and is an excellent method of assisting adolescents in developing an internal sense of responsibility.

For more information, contact Martina Boothman at Pathways Treatment Center in Kalispell at 1-800-752-3950 or 406-756-3950 – or visit Pathways on the web at http://www.krmc.org/services/pathways.html.

Firefighting at the Blackfeet Chemical Dependency Center

By Fred Cobell, Administrator

Chemical dependency treatment is a lot like firefighting. The bigger the fire and the longer it has burned, the more difficult it is to put out.

At the Blackfeet Chemical Dependency Center, we have had many years to become skilled at putting out fires. This is a tough job. Many of our clients don't want to be here and have come only because the court ordered them to, as a condition of probation, by referral from the police or the Bureau of Indian Affairs. Recovery is difficult and can be very stressful for patients and counselors alike. Terrible things happen as a result of chemical dependency, and people with chemical dependency issues are usually experiencing problems in every aspect of their lives. Many of our clients have medical problems, many have co-occurring mental health disorders. Despite these difficult realities, the Blackfeet Chemical Dependency Center is proud of the very positive patient evaluations it receives. All of them mention how caring the staff is, and people consistently tell us how thankful they are.

The facility is state and federally licensed and has Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. In addition to treatment, the Center provides aftercare and assessment services. Clients come to the Center during the week to attend out-patient meetings. The staff:patient ratio for in-patient treatment is 5:1; for out-patient, it's 8 or 10:1. The staff here is highly professional and very well educated. Most also have a history with the facility and the local people. This can be very positive because people often respond to treatment better if they share cultural ties with their counselors.

There is almost always a long waiting list for services. In the past, we've treated a lot of people for alcoholism. We still do, but methamphetamine addiction is on the rise. This is compounded by the fact that meth is relatively cheap and easy to manufacture. For some time, we have also been seeing a number of people who are addicted to prescription drugs such as Oxycontin and Percocet.

Because people in recovery can't see clearly at first, it's important that they stay with treatment, then carefully follow aftercare plans. It takes some time before the fog lifts and people can begin to deal with reality. There are times when people don't make it long enough to achieve clarity. We try to convince people to stay, to stick with treatment, but we don't lock people up or hold them against their will. Relapse is part of the disease, and even when people have done well during treatment, it can be hard to go back out into the community. Many—if not most—of our clients have always lived in poverty. They started with very little, and in most cases have little or nothing to return to or to hope for after treatment. Often a client's only option is to return to ground zero and the environment s/he came from, an environment where using or drinking is the norm.

There are still some needs in the community that aren't being met. We need to find an effective way to reach children at younger ages. Even Kindergarten isn't too early to begin giving children an anti-drug message. Aftercare remains a problem: people need additional help after they get out, but there are no recovery homes, so transition can be difficult. No matter how skilled the counselors are, or how hard people try, treatment is often just not long enough.

We believe that it is important for our clients to have the opportunity to participate in sober cultural and social activities. We employ a number of traditional activities in our treatment process. One event we've begun holding is the Sobriety Campout. Last year, this 3-day retreat was held on Chewing Black Bone on St. Mary's Lake. We set up teepees and camped. Families attended parts of it, and there were lots of activities, including a sobriety run, sweats and lectures. Families joined in for some of the activities.

Cultural activities, including talking circles, sweats and traditional ceremonies, have proved helpful for a lot of people. We also introduce patients to the 12-step program. Finally, every 3 weeks, a family counselor conducts a family session during which the family has the opportunity to learn about addiction and to meet with the counselor. Ultimately, though, the key is finding *what works* for each individual.

The Blackfeet Chemical Dependency Center has 18 in-patient beds, and provides in-patient services to adults aged 18+. The Center also provides in- and out-patient services, as well as assessment, referral and aftercare services for adolescents. Length of stay in the in-patient facility varies from 2 weeks to as much as 9 months for pregnant women. The length is based on need, as well as the individual counselor's recommendation. Though the Center serves a range of ages, in recent years, there has been an increase in the number of people between the ages of 18 – 21.

The opinions expressed herein are not necessarily those of The Prevention Recource Center and the Addictive and Mental Disorders Division of the Montana Department of Public Health and Human Services.

The Prevention Resource Center and the Addictive and Mental Disorders Division of the Montana Department of Public Health and Human Services attempt to provide reasonalbe accommodations for any known disability that may interefere with a person participating in this service. Alternative accessible formats of this document will be provided upon request. For more information, call AMDD at (406) 444-1202, 1-800-457-2327 or the Prevention Resource Center at (406) 444-5986.

Get a *GRIP*

As an employer concerned with your company's bottom line, how can you get a handle on employee turnover, persistent absenteeism and rising health care costs?

Submitted by Jenne Caplette

GRIP, Gallatin Responsive Interventions Partnership, has set an ambitious goal: to increase the number of community, health, and self- referrals for substance abuse programs and services in Gallatin County. Outreach targets include the business, faith, health and educational communities.

Alcohol and Drug Services of Gallatin County was chosen from among 50 applicants by *Join Together*, a national resource for communities taking action against substance abuse. *Demand Treatment*! is Join Together's national initiative to increase the number of people getting quality treatment for substance use disorders by building local leadership, providing information for action, improving treatment quality, and ending the stigma alcohol uses and abusers can face. *Join Together* is supported by the Robert Wood Johnson Foundation.

GRIP's first focus has been to establish screenings and brief interventions as normal procedures in healthcare settings and the workplace. In June, they released the first issue of their monthly e-zine, initially focusing on alcohol prevention and intervention in the workplace. Dave Douglass, GRIP Project Director says, "Managers and supervisors should be given the knowledge and tools necessary to identify early signs of substance use and to make proper referrals for them. It can—or should be—more cost effective to retain an employee with a problem than to let that employee go and have to retrain a new employee."

Alcohol in the workplace

Alcohol use can reduce employee productivity, lower job performance, drive up health care costs and threaten public safety. Not in your workplace? Doubtful. Eighty-five percent of problem drinkers work; 7.4 percent of full time workers, aged 18 to 49, have drinking problems. That's a national figure. In Montana, where information on alcohol use and abuse is often lacking, percentages could well be much higher.

According to *Ensuring Solutions to Alcohol Problems*, on a national basis, alcohol costs American business about $134 billion in productivity losses. Most of these result from missed work. People with alcohol use issues use twice as much sick time and are five times more likely to file a worker's compensation claim. They tend to run through multiple jobs annually: high turnover exacts a heavy cost on any business.

Surprisingly, these numbers are not just for heavy users. Sixty-percent of the cost of alcohol's effect on business rests with moderate drinkers, people who drink too much at lunch or the night before work. All of these impacts increase in proportion to the age of your workforce: young adults tend to have much greater rates of problem drinking.

Nationally, one out of five employees reports that alcohol problems of people they work with resulted in increases in their workload to compensate for poor or incomplete work. Hung-over workers can be particularly defensive and argumentative, quick to ignite to anger. Imagine the impact of that on staff morale.

According to Hazelden Foundation's *Workplace Recovery Benefits Survey*, more than one in five insured employees fear they will face negative consequences for self-reporting. Those consequences range from being fired to losing a license to failing to get a promotion.

In Montana, state-mandated benefits for treatment are low: $2,000 over a lifetime. That's not going to be of much help with long-term treatment, and support of drinkers and their families, particularly on the kinds of wages most Montanans earn. Self-insured entities don't even need to provide *that* much coverage. Add to that the fact that the deductible for treatment-related services can be much higher than other health costs, and you further discourage workers from treatment.

– Jenna Caplette is the Marketing Coordinator for Gallatin County Demand Treatment. The information in Alcohol in Your Workplace was excerpted from an article of the same name published on the Join Together Online website. http://www.jointogether.org/sa/action/dt/news/reader/0,2812,563216,00.html

For more information, contact Jenna Caplette at 406-920-2691 or jennac@intch.com.

Too many people fail to get the treatment they need because they don't think it will work, or fear they will be fired or forced out of their homes. We are very pleased that fourteen communities will join us as we demand that the health, criminal justice and specialized treatment systems be expanded and improved. – David Rosenbloom, Director, Join Together

For more information about GRIP: call Dave Douglass, Project Director, at 586-5908. To subscribe to GRIP's monthly ezine, email: mailto:dkdouglass@juno.comgripmt@juno.com

For a free, quick, and private alcohol screening tool visit: www.alcoholscreening.org.

To read GRIP's article, "Alcohol in Your Workplace," published by Demand Treatment! News: http://www.jointogether.org/sa/action/dt/news/reader/0,2812,563216,00.html

To subscribe to Ensuring Solutions e-newsletter, email info@ensuringsolutions.org.

Treatment Parity
If it is to be, it is up to us

By Roger Curtiss, NCAC II, LAC

True parity would require that insurers provide benefits for the treatment of mental illness and substance abuse disorders *equal to* benefits provided for physical disorders and diseases.

The *Help Expand Access to Recovery and Treatment* (HEART) Act of 2003 is specifically aimed at employer-sponsored health insurance coverage. Under this measure, introduced by Senator Norman Coleman (R-MN) and Rep. Jim Ramstad (R-MN), health insurers would be required to offer addiction treatment coverage in line with medical and surgical benefits. The bill extends to such areas as co-payments, deductibles and treatment. If a group health plan currently provides addiction treatment benefits, the bill would prohibit treatment limitation or financial requirements unless similar limitations or requirements are imposed for medical and surgical benefits.

Fact: Thirty-three states have a comprehensive, full or limited mental health parity law, but only fourteen include substance abuse treatment.

In a recent article in the *Star Tribune*, Minnesota's largest newspaper, William Cope Moyers, Vice President of External Affairs for the Hazelden Foundation, said, "Ramstad and Coleman's substance abuse/dependency bill has a straightforward aim. It will bar health plans that offer addiction treatment from imposing different rules for such care than for other medical benefits."

"The first major step . . . is to insist that health plans that do offer benefits recognize it as just another form of medical care. And once that hurdle is cleared, insurers and employers are likely to notice what researchers have long known: providing fair addiction coverage doesn't appreciably increase insurance premiums. Over the long haul, it saves money."

Fact: While health care costs are a concern for insurers, we all pay the price.

John Avery, Government Relations Director for the National Association for Addiction Professionals (NAADAC), stated in their newsletter, "NAADAC supports the mental health parity bill because it is an incremental first step in achieving our goal of full parity. It requires that health benefits for brain disorders be on par with medical benefits by setting a framework in law based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Coverage is based on reaching a threshold of symptomatic criteria for clinically recognized disorders."

Avery also states, "Addiction is a chronic relapsing condition with high rates of co-morbidity and mortality. Congress and the administration are perpetuating the prejudice that addiction is a moral issue rather than a brain disease by condoning its exclusion."

Fact: In 2000, medical costs for mental health disorders totaled over $300 billion, nearly equal to costs for cancer, AIDS, respiratory and coronary diseases combined (National Institute of Health).

President Bush has said he supports the concept of health parity. Last summer he called for parity in a campaign visit to Senator Pete Domenici's (R-NM) home state. The senator has pledged to push for passage of the parity legislation early in 2003. House Speaker Dennis Hastert/(R-Ill), is in strong opposition, as are insurance and business lobbies.

Fact: Arguments for parity point to several studies indicating the cost benefits of providing parity. A 1999 report from the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that the average yearly insurance cost increase for full parity for substance abuse treatment would be $5/person. California Drug and Alcohol Treatment Assessment findings that every $1 spent on treatment saved the state taxpayers $7 in future cost (e.g., emergency health care, imprisonment, court costs).

Bill Burnett, past President of NAADAC, stated that defeating the 2001 Mental Health Parity Law by the United States Congress hurt patients and counselors in three major ways:

— It discriminates against a group of people with biological brain disorders;

— It will usher in an increase of pain and suffering for families of patients because healthcare will be unaffordable; and

— Many people with very serious mental health disorders will go undiagnosed and consequently untreated.

Fact: Over 50 million adults—22 percent of the U.S. adult population—suffer from mental illness or substance abuse disorders every year. (National Institute of Mental Health)

Parity in Montana

Fact: A significant barrier to appropriate chemical dependency treatment is the fact that health plans and third party payers typically provide far less coverage for substance abuse treatment than they do for other medical services. Montana's *Mandated Benefit Law* (MCA-33-22-703) provides minimum coverage for chemical dependency treatment. It is *not* on parity with other disease coverage and is *not* sufficient to cover all treatment costs.

Fact: In 1999, Montana passed legislation providing minimum mandated benefits for comprehensive substance abuse treatment. This means that Montana mandates coverage less than equal to that for physical illnesses, including different visit limits, co-payment, deductibles, annual and lifetime limits.

As Director of Alcohol & Drug Services of Anaconda/Deer Lodge County and the President of the National Association for Addiction Professionals, I ask all of you to make phone calls, write letters or fax your representatives in Montana and the U.S. Congress. Encourage them to support mental health and substance abuse parity legislation on state and national levels.

Fact: It's the right thing to do. Parity legislation is needed to ban insurance discrimination against people with mental illness and substance abuse disorders, but if it is to be, it is up to us.

– Roger A. Curtiss, NCAC II, LAC is the Director of Alcohol and Drug Services of Anaconda/Deer Lodge County and the President of the National Association for Addiction Professionals (NAADAC).

The Last Word:
Using our Building Blocks

By Roland M. Mena, Bureau Chief, Chemical Dependency Bureau

Since September is National Recovery Month, this issue has focused on treatment. But before we can truly impact the problem of addiction in Montana, we must be very clear on what that really means. Addiction is a chronic, preventable disesase characterized by fundamental, long-lasting changes in the biochemical make-up of the brain. Although the disease manifests behaviorially, many of these changes can be observed through use of advanced medical techniques. Hallmarks include changes in mood or temperment, impaired memory processes or motor skills, and/or reduced cognitive and social functioning. Changes can occur at any stage of life, from childhood through the senior years.

Left untreated, the consequences of addiction touch every one of us. Abuse and addiction involving alcohol, cigarettes and illegal drugs are implicated in virtually every domestic problem we face: crime; cancer, heart disease, AIDS, hepatitis and cirrhosis; child abuse and neglect; domestic violence; teen pregnancy; chronic welfare; school drop-out; overcrowded prisons; learning disability and conduct disordered children. The costs simply cannot be over-estimated.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has defined cross-cutting principles to guide program, policy and resource allocation for the agency around recovery issues. The overarching themes are that everyone deserves a chance to live a productive, fulfilling life and that we must concentrate our efforts on building resilience and facilitating recovery. This is consistent with Montana's goals.

The ***Robert Wood Johnson Foundation*** is actively supporting our efforts. The RWS Foundation recently selected Montana to participate in their 2-year Policy Forum on Alcohol and Other Drug Treatment and Financing. Because of the *Resources for Recovery State Practices that Expand Treatment Opportunities* competitive grant, Montana will have access to technical assistance and support. The program will assist Montana in identifying and implementing financing strategies that expand treatment capacity. By increasing our capacity to facilitate recovery, we will be ensuring that we incorporate our most important building blocks:

1. Investing for results;
2. "No wrong door" treatment for substance abuse and mental health issues;
3. Commitment to quality:
4. Changing attitudes; and
5. Building partnerships.

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Substance Abuse and Mental Health Services Administration

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