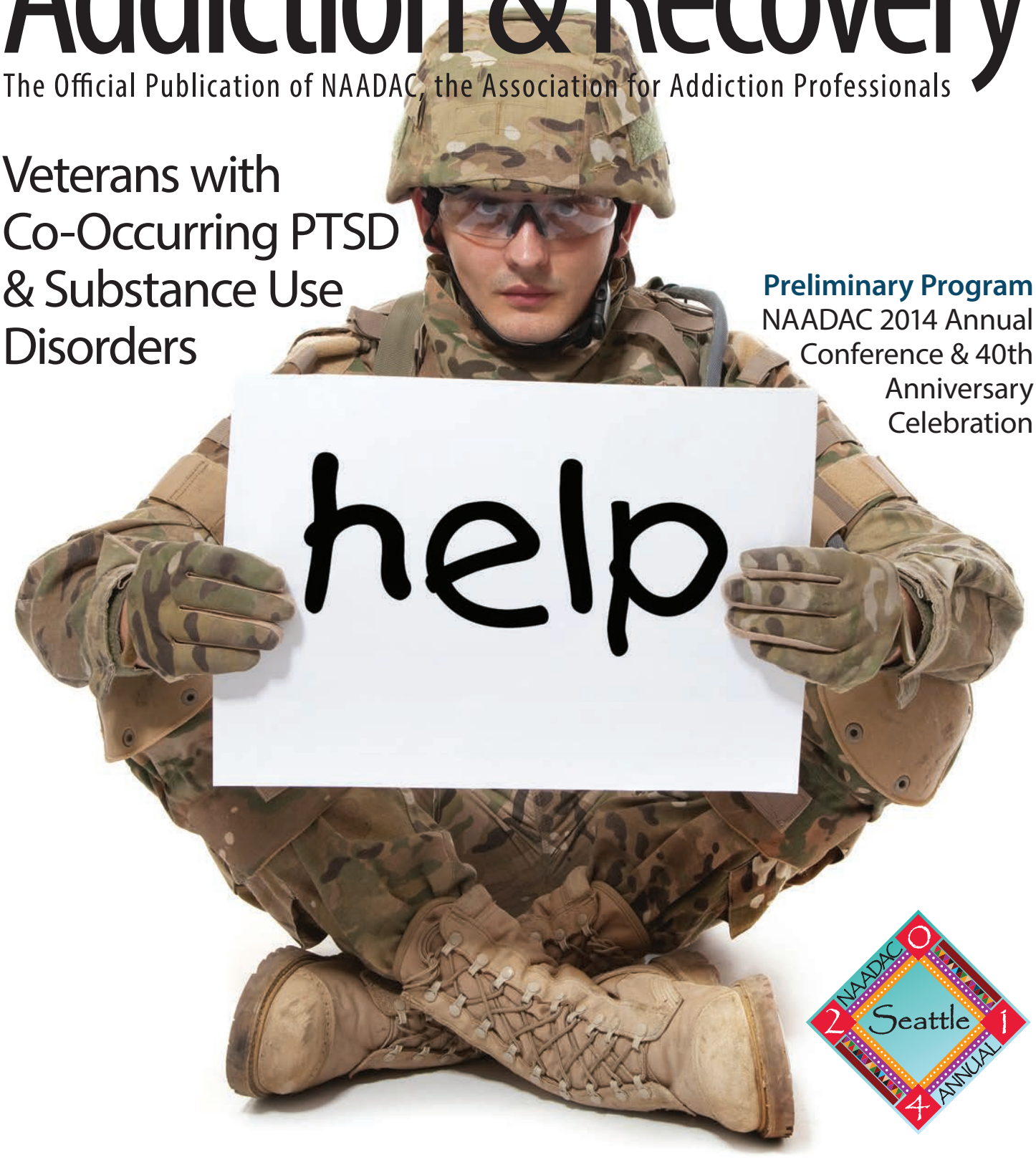
Advances in Addiction & Recovery

SUMMER 2014
Vol. 2, No. 2

The Official Publication of NAADAC, the Association for Addiction Professionals

Veterans with Co-Occurring PTSD & Substance Use Disorders

Preliminary Program
NAADAC 2014 Annual Conference & 40th Anniversary Celebration



NAADAC 2014 Seattle 40th ANNUAL

RECOVERY TO PRACTICE INITIATIVE

Hastening awareness, acceptance and adoption of recovery-based practices in the delivery of addiction-related services

RTP

PROMOTING RECOVERY TO ALL AMERICANS AFFECTIVED BY ADDICTION

FREE
WEBINARS
MAGAZINE
ARTICLES
FREE
CEs
FREE
ELECTRONIC
RESOURCES
INFORMATION
AND SKILLS

RECOVERY TO PRACTICE
Resources for Behavioral Health Professionals

As a part of the federal government's efforts to promote recovery for all Americans affected by mental illness and/or addiction, in May 2009, the United States government announced its "Recovery to Practice (RTP) Initiative." The RTP Initiative is designed to hasten awareness, acceptance, and adoption of recovery-based practices in the delivery of addiction-related services and builds on SAMHSA's definition and fundamental components of recovery. NAADAC joins a coalition of five professions to implement the Recovery To Practice Initiative (RTP): addiction professionals, psychiatrists, psychiatric nurses, psychologists, social workers and peer specialists.

RTP Initiative Tasks

To answer the call to infuse recovery-oriented practices in addiction services, NAADAC will present nine groundbreaking webinars, publish three articles in the NAADAC magazine, library a large collection of electronic resources and institute a national recovery-oriented training curriculum for addiction counselors.

RTP

To learn more about recovery, visit www.naadac.org/education/recovery

NAADAC
THE ASSOCIATION FOR ADDICTION PROFESSIONALS
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Advances in Addiction & Recovery

The Official Publication of NAADAC, the Association for Addiction Professionals

SUMMER 2014 Vol. 2 No. 2

Advances in Addiction & Recovery, the official publication of NAADAC, is focused on providing useful, innovative, and timely information on trends and best practices in the addiction profession that are beneficial for practitioners.

NAADAC, the Association for Addiction Professionals, represents the professional interests of more than 85,000 addiction counselors, educators, and other addiction-focused health care professionals in the United States, Canada, and abroad. NAADAC's members are addiction counselors, educators, and other addiction-focused health care professionals, who specialize in addiction prevention, treatment, recovery support, and education.

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Email naadac@naadac.org
Fax 703.741.7698

We are interested in accepting any interesting and topical articles that address issues of interest to addiction-focused professionals. Please submit story ideas and/or articles to Jessica Gleason at jgleason@naadac.org.

Publication Guidelines
For more information on submitting articles for inclusion in *Advances in Addiction & Recovery*, please visit www.naadac.org/advancesinaddictionrecovery#Publication_Guidelines

Disclaimer
It is expressly understood that articles published in *Advances in Addiction & Recovery* do not necessarily represent the view of NAADAC. The views expressed and the accuracy of the information on which they are based are the responsibility of the author(s) and represent the wide diversity of thought and opinion within the addiction profession.

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STAY CONNECTED

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Are Addiction Knowledge, Competencies, Skills, and Attitudes No Longer Necessary in the Behavioral Health Integration World?

By Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, NAADAC Executive Director

With the onset of the Affordable Care Act (ACA) and the push for "behavioral health" integration, many states are now turning their attention to the details of forming integrated systems that merge mental health with addiction practice. However, some states are now pushing out the foundation of addiction practice by removing the requirement of specific substance use disorder (SUD) education and experience to allow for the practice of addiction counseling without specialized education, training, or experience needed for effective and proper practice. Some states are using the need for an increase in the addiction workforce as a reason to "open the door" to this specialized profession to any counseling professional, including persons only trained in Social Work, Marriage and Family, and Licensed Counseling Professionals with no specific education in SUD nor any applied practice in SUD.

NAADAC asserts that addiction counseling and treatment is a health specialty and that the provision of culturally relevant evidence-based practices and the demonstration of significant treatment outcomes depend on an effectively trained and supported workforce specific to SUD. Along that vein, NAADAC strongly believes that only SUD professionals are qualified to provide clinical supervision for those working to become SUD professionals and not other counseling professionals that do not have this specific training.

NAADAC supports the importance of having SUD education and specific training as part of the requirement for licensure, certification, or other practice regulations. This requirement lines up with the Substance Abuse Mental Health Administration (SAMHSA) *Scopes of Practice & Career Ladder for Substance Use Disorder Counseling,* which has been accepted as a credible and reasonable requirement for those serving SUD patients (SAMHSA, 2011). Currently, there are 17 states that have a licensure law supporting substance use disorder specific licensure and supporting specific education and training requirements specific to SUD, and with the Affordable Care Act now in effect, many more states have similar licensure laws in the works. These laws and rules support the protection of the patient to receive care that is specialized to the needs of their disorder. Just as one would not send a heart disease patient to a general practitioner, one would not send a SUD patient to a general counselor who has not been educated and trained in the specific disorder or substance use.

Both the SAMHSA-funded and recommended *TAP 21: Addiction Counseling Competencies – the Knowledge, Skills, and Attitudes of Professional Practice* (SAMHSA, 2007), which outlines the 123 competencies, skills, and attitudes necessary in order to treat SUDs, and *TAP 21-A: Competencies for Substance Abuse Treatment Clinical Supervisors* (SAMHSA, 2008), which outlines the competencies, skills and attitudes to serve as a Clinical Supervisor, clearly state that without specific education, training, clinical supervision, and experience in SUD, these competencies, skills, and attitudes cannot be obtained.

NAADAC has understood the importance to set standards in SUD education, training, and services and therefore created an approval system for trainers. As the profession developed from training as the basis of training in order to learn these skills, to a more formalized education process with higher education courses, NAADAC worked with the International Coalition for Addiction Studies Education (INCASE) to create the National Addictions Studies Accreditation Commission (NASAC), the only accrediting body that represents addiction-focused educators and practitioners specifically. This further laid the infrastructure and framework in which to train and educate in SUD. NASAC has gone on to develop national standards for addiction education from the two year Associate's degree to the PhD level with the ground work developed by the Official Task Force for SAMHSA on addiction education funded by SAMHSA. This national standardized higher education framework gives solid levels of education and competency to treat SUD and build effective treatment programming. NAADAC's National Certification Commission for Addiction Professionals (NCC AP) is able to work with colleges and universities that adhere to these higher education standards to allow for testing of the certification test before the student completes their degree requirements. This allows the student to demonstrate competency before they leave the education institution with a test score, to then gather the "practice and experiential" hours necessary on the ground to then test for the credentials once those hours of experience are achieved. Since these credentials are the same from state to state, it truly becomes a reciprocal system for those states that adhere to the standards, thereby creating a strong infrastructure of trained professionals with demonstrated competency. Credentialing can be made even more transferable between states and commensurate with national credentials if all states used the NCC AP test as their state certification/licensing exam. The SUD practitioner is happy as they only have to test once and carry those scores, and they have demonstrated that skill for everyone to validate in their state credentialing system. In addition, employers, health care providers, government entities, other practitioners, and the public are happy because such standardized credentials aid in the identification of quality individuals who have met national competency standards.

It is vital in this changing environment that each state system is able to validate and ensure that that counselors performing SUD treatment services within the state carry the education, tools, and competencies necessary for effective services. Clients and their family members, and the public, deserve counselors specifically educated in SUDs to perform the tasks of assessment, adherence to treatment, and long-term recovery.

Legislative/Advocacy, continued on page 6 ☛

NCC AP New Endorsement and Credential

By Kathryn Benson, LADC, NCAC II, SAP, QCS

NCC AP
National Certification Commission for Addiction Professionals
Certified for Success

For the past two years, the National Certification Commission for Addiction Professionals (NCC AP) and its volunteer force of Substance Use Disorder (SUD) professionals have been diligently working to develop national competency standards for peer recovery and clinical supervision and recognize the talented professionals working in these important areas. We are now proud to announce the release of a new Peer Recovery Support Specialist Credential in July 2014 and National Endorsement for Clinical Supervision for Substance Use Disorders Professional in August 2014.

Peer Recovery Support Specialist (NCPRSS)

Peer Recovery Support Specialists are individuals who are in recovery from a life altering event or disruption who are able to use their life experience to provide recovery support in such a way that others can benefit from their experience. The Peer Recovery Support Specialist Credential was developed by a cadre of Peer Recovery trainers, supervisors, and nationally recognized experts to standardize, at a national level, the quality of peer support to individuals with Substance Use Disorders and Co-occurring Mental Health and Substance Use Disorders. Through standardized testing, the NCC AP is able to set a benchmark for recognition of Peer Recovery Support Specialists and monitor the abilities of those providing the identified services.

This experience-based credential focuses on the individual and provides a formal indicator of the current knowledge and competence at the national level. This national standard encourages Peer Recovery Specialists to continue to learn for the sake of their clients, and provides assistance to employers, health care providers, government entities, other practitioners, and the public in the identification of quality individuals who have met national competency standards.

To be eligible for the NCPRSS, a candidate must have:

- A High school diploma, GED, or higher;
- A minimum of one year of direct practice (paid or volunteer);
- 125 Continuing Education (CE) hours of education/training in addiction, including a minimum of six hours in addiction-specific ethics and three hours in HIV/AIDS/communicable diseases, obtained within the past six years;
- A minimum one year of recovery from Substance Use/Co-Occurring Mental Health and Substance Use Disorders; and
- A passing score on the National Peer Recovery Support Specialists exam.

For more information, please visit www.naadac.org/peer-recovery-support-specialist.

National Endorsement for Clinical Supervision for Substance Use Disorders Professional

While clinical supervision has long been regarded as a significant part of the SUD profession, the importance of effective clinical supervision in the addiction treatment process has gained increased attention over the past years. There has long been a great deal of interest among SUD professionals regarding the prevention of counselor burnout, the maintenance of SUD credentials, and the efficacy of treatment for clients. As the profession of SUD counseling grows and matures, it becomes even more critical that counselors acquire more advanced clinical skills.

The National Endorsement for Clinical Supervision for Substance Use Disorders Professional was developed to promote competency in clinical supervisors of SUD professionals by:

1. Promoting the formal recognition of the professionalism of SUD counselors.
2. Providing a national standard of requisite knowledge of clinical supervision in addiction counseling.
3. Encouraging continued professional growth of clinical supervisors for the purpose of improving the quality of treatment of addicted persons.
4. Recognizing formally those individuals who meet the standards for clinical supervision established by the NCC AP for Clinical Supervision.
5. Establishing, measuring, and monitoring the level of knowledge required for clinical supervision of SUD professionals.
6. Assisting employers, labor unions, government entities, health care providers, educators, and other practitioners, as well as the public, in identifying qualified clinical supervisors in the profession of SUD counseling.

This credential was developed by a volunteer team of highly esteemed clinical supervisors and was supported by the Georgia Addictions Counselor Association, which generously allowed access to its Clinical Supervision Credential as a foundation for this project.

To obtain the National Endorsement for Clinical Supervision for Substance Use Disorders Professional, a candidate must have:

- A Bachelor's degree or higher;
- A current state-issued certification/licensure as a SUD counselor that is commensurate with at least the NCAC II credential or higher (MAC credential);
- Five years full-time or 10,000 hours of employment as a SUD counselor with two years or 4,000 hours of experience in addiction treatment;
- 200 hours of face-to-face clinical supervision provided during the above five years of employment;

Certification, continued on page 6 ☛

Legislative/Advocacy, continued from page 4

The specialty of addiction practice is further supported by the federal government's recent support for expanding the addiction workforce. NAADAC, along with other addiction-focused organizations, has long advocated for federal funding for minority fellowships scholarships specific to the addiction workforce, commensurate with those available for other professions. After eight years of advocacy and meeting with federal agencies, this funding was finally supported in President Obama's newly released budget in the "Now Is The Time – Healthy Transitions" section (SAMHSA, 2014). The recognition of the importance of addiction-specific training and education is finally appreciated through the creation of this specific workforce-building effort. It is likely that counselors across the country will learn more about these future opportunities to apply for these Master level scholarships this fall.

Addiction professionals are an integral part of the health team and are capable of being taught the skills and knowledge areas specific to working in an integrated care environment. NAADAC is continuing to build relationships with other helping professional groups such as the American Psychological Association, American Psychiatric Association, International Association of Peer Specialists, Council on Social Work Education and the American Psychiatric Nurses Association through work on the *Recovery to Practice (RTP) Initiative* to create an exchange of information and education and build respect and understanding between our professionals that ultimately affects the services of the client/patient.

NAADAC will continue to emphasize and build relationships through intraprofessional collaboration to meet the various needs and complexities of the clients/patients we serve, especially those with mental health and SUDs. NAADAC will continue to support the specific education of addiction studies and the maintenance of the specialty of addiction treatment and care. NAADAC will also continue to build the leadership to assist in the maintenance of these goals in order to sustain the workforce needs in the future.

Now is the time to work toward licensure in the states that do not have licensure laws for addiction specific knowledge, skills and competencies. Together, we can continue to build the health care treatment needs of the future allowing for the specialty of substance use disorders through addiction professionals.

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Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, is the Executive Director of NAADAC, the Association for Addiction Professionals. She previously served as the Executive Director of Danya Institute and the Central East Addiction Technology Transfer Center and as Program Director for Volunteers of America Western Washington. In addition, she has over 20 years of experience serving as the administrator of multi-county, publicly funded alcohol/drug prevention/intervention/treatment centers with services ranging from prenatal care to the serving the elderly.

Certification, continued from page 5

- At least 30 hours of education specific to SUD clinical supervision; and
- A passing score on the National Clinical Supervision exam.

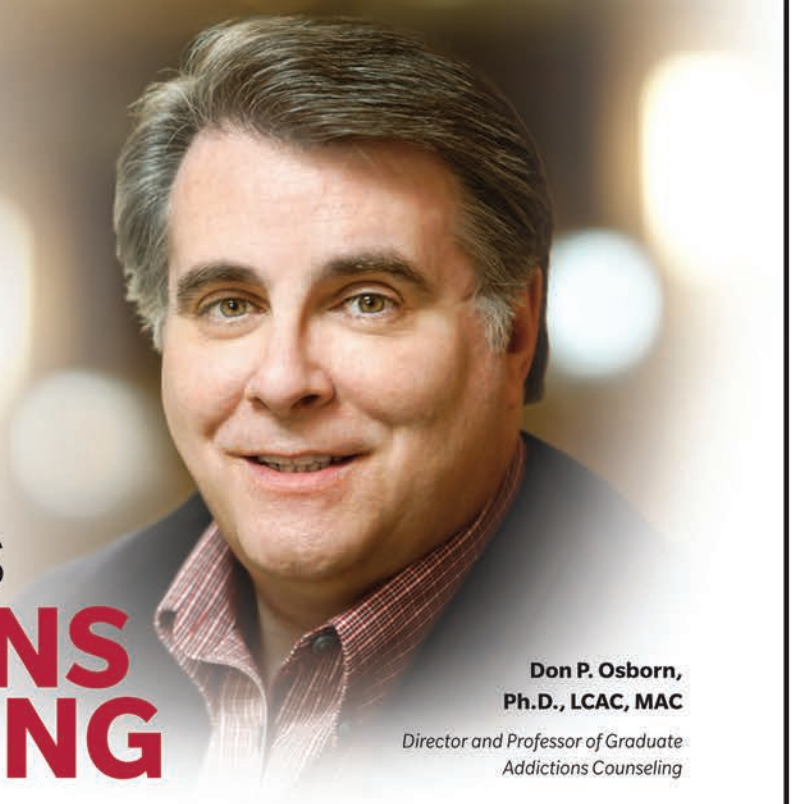
For more information, visit www.naadac.org/clinical-supervision-endorsement

The NCC AP has been successful in the oversight and development of its credentials and endorsements because of the generous support and dedication of our volunteer committees. Many who contribute to product development are not sitting members of the NCC AP yet when called upon to share knowledge and their expertise in a particular specialty, they are most willing to aid. As a profession, we should all be proud of the volunteer workforce that supports and sustains our national credentials and its testing products.

Many thanks and highest regards to our Credential Development Committees.

Kathryn Benson, NCAC II, LADC, QSAP, QSC, serves as Chair of the National Certification Commission for Addiction Professionals (NCC AP). Contact her at lightbeing@aol.com with your thoughts or questions. Every effort will be made to respond to your inquires in either this publication or a personal reply.

Announcing the Master of Addictions Counseling program is now accredited by the National Addictions Studies Accreditation Commission (NASAC) to address a national crisis in substance abuse, eating disorder, gambling addictions, and sexual addictions.



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25 Years of Reaching to the World of Treatment and Recovery

By Autumn Kramer, NAADAC Director of Operations

September 2014 will inaugurate the 25th Anniversary of *National Recovery Month,* officially sponsored by Substance Abuse and Mental Health Services Administration (SAMHSA). Over the past 25 years, *National Recovery Month* has promoted the benefits of prevention, treatment, and recovery. *National Recovery Month* marks a time to spread the message that prevention works, treatment is effective, and people can and do recover! NAADAC, the Association for Addiction Professionals, is proud to host the official launch of the 25th Anniversary of SAMHSA's *National Recovery Month.*

The theme for *2014 National Recovery Month* is "Join the Voices for Recovery: Speak Up, Reach Out," and is intended to help spread the message that recovery is a reality, substance use, and mental health disorders need to be openly discussed, those in recovery need to speak out, and others should be encouraged to reach out for help. Each year, SAMHSA asks a recovery month partner to host the official *National Recovery Kickoff Luncheon*. NAADAC, the Association for Addiction Professionals, was asked to host the *2014 National Recovery Month Kickoff Luncheon,* due, in part, to the long and close history NAADAC holds with *National Recovery Month* as the founding and original sponsor of *National Recovery Month's* precursor, *Treatment Works!* in 1989. This year holds extra significance to NAADAC, as it also celebrates its 40th Anniversary of proudly serving the needs and interests of the addiction profession. Originally founded in 1974 as the National Association of Alcoholism Counselors and Trainers, NAADAC has since played a central role in elevating the quality of addiction treatment and recovery in the United States through its advocacy, credentialing, and education and training activities.

NAADAC has partnered with Entertainment Industries Council (EIC), Young People in Recovery (YPR), the Association of Recovery Schools (ARS), and SAMHSA, to host the special 25th Anniversary *National Recovery Month Kickoff Luncheon* on September 4th, 2014, in Washington, D.C. from 12:00 pm – 2:00 pm.

Brief History: From Treatment Works! to National Recovery Month

NAADAC has a long intimate history with *National Recovery Month*. In 1988, NAADAC began to conceptualize a campaign that would recognize the hard work of individuals in the treatment field. By 1989, NAADAC along with partners on the Ad Hoc Coalition on National Alcohol and Drug Issues, led the effort to bring together an alliance of government and private treatment organizations to declare September as National Alcohol and Drug Treatment Open House Celebration, and referred to as Treatment Month, with the theme *Treatment Works!*

The purpose of Treatment Month was to educate the public and national leaders that "…treatment is an effective means to decrease the demand for alcohol and drug abuse…" The first kickoff celebration occurred on August 28, 1989 at the Alcohol and Drug Problems Association's 40th anniversary and National Conference in Washington, DC. Groups were encouraged to participate in Treatment Month by highlighting their treatment services and programs by holding open houses and rallies, scheduling press conferences, circulating literature, and obtaining proclamations to disseminate information with special events (September Declared as National Treatment Month, 1989)

Through its success, Treatment Month evolved and became ***Treatment Works!*** Through the 1990s, the *Treatment Works!* campaign continued to grow and became widely recognized through NAADAC and NAADAC's affiliates. In 1991, Suzanne Somers was invited to speak, shared her family's story of addiction and recovery, and delivered the message that treatment works. *Treatment Works!* continued to flourish, and, in 1996, NAADAC passed the leadership role on to SAMHSA/CSAT to help continue the national growth of the campaign.

In 1997, SAMHSA held the first expanded planning partner meeting where a name change was proposed to rename *Treatment Works!,* National Alcohol and Drug Addiction Month (Recovery Month). The focus of ***National Alcohol and Drug Addiction Month*** was expanded to include the accomplishments of individuals in recovery, their friends, and families.

By 2002, all 50 states planned and held events, and the first Recovery Month Presidential Proclamation was signed declaring September as *National Recovery Month.* Since the signing of the 2002 Presidential Proclamation, all following United States Presidents have declared September as *National Recovery Month.* In 2003, Recovery Month received its own website www.recoverymonth.gov.

Keeping with the times, SAMHSA launched a Recovery Month YouTube channel and Facebook page in 2009. The name of National Alcohol and Drug Addiction Month officially changed to ***National Recovery Month*** in 2011 to include all aspects of behavioral health.

Since 1988, Recovery Month has continued to grow into a large, national and multi-national observance. In 2013, *National Recovery Month* grew to more than 100 planning partners, 114 proclamations issued, 282,407,947 media impressions, 214,802 mobile website visits, and thousands of new social media loyalists (SAMHSA, 2014). Come join the movement!

National Recovery Month
Prevention Works · Treatment is Effective · People Recover
SEPTEMBER 2014
25 YEARS

NAADAC and these outstanding partners will look through the history of the recovery movement and SAMHSA's *National Recovery Month,* celebrate NAADAC's 40th Anniversary, and honor the achievements of those who through their personal and professional lives have carried the message of hope for long-term recovery from addiction. Each of these organization has put in many hours of work to spread the message of *National Recovery Month* that prevention works, treatment is effective, and people do recover!

SAMHSA will launch the September 4th kickoff with a press conference, during which it will release the latest findings published in the *SAMHSA National Survey on Drug Use and Health.* The *National Recovery Month Kickoff Luncheon* will immediately follow, featuring the SAMHSA annual community event awards, approximately 160 high-profile guests and political leaders, keynote speakers, and a speaker panel, and will be streamed live through multiple outlets. In addition to celebrating the larger history of addiction treatment and recovery in the United States, we will celebrate many of the milestones within NAADAC's 40 years of rich history as a leader in the profession.

The event will also serve as the initial launch of the video trilogy, *Looking Back at Addiction, Looking Forward to Recovery,* with a debut of the first video: "The History of NAADAC and the Addiction Profession." The video trilogy will look back through the history of the recovery movement and honor the achievements of those who have carried the message of hope for long-term recovery from addiction through their personal and professional lives.

NAADAC and its partners are honored to host the *National Recovery Month Kickoff Luncheon* and encourage all members and constituents to get involved in hosting a recovery month event. If you are interested in hosting a recovery month event, visit www.recoverymonth.gov to download the *National Recovery Month* toolkit, featuring materials to help plan your event from start to finish. The recovery month website also features a directory of recovery month planning partners to get involved with to help spread the recovery month message. Remember: You don't have to limit your *National Recovery Month* celebrations to September; recovery month events can happen all year round!

Let's continue to build on the last 25 years of the recovery movement, where we have paved the way for recovery to enter into the mainstream of the larger national community. Working together over the last three decades has made possible what many struggle to find to be a truth every day; that treatment works, and recovery is possible. Be a part of sustaining the legacy!

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Substance Abuse and Mental Health Services Administration (2014). *Recovery Month 2013 Final Report Overview.*

Autumn Kramer is the Director of Operation for NAADAC, the Association for Addiction Professionals. She directs NAADAC operational systems, processes and policies to ensure smooth support and adaptation by the organization. Kramer also works to ensure effectiveness and efficiency of all NAADAC Support Services. Her current projects include the implementation, adaptation and transition of NAADAC's database, website, customer care systems and e-correspondence systems.

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Earn up to 40 Continuing Education Hours

This year's special conference will offer daily keynote speakers in plenary sessions, breakout sessions, four full-day pre-conference seminars, four full-day post-conference seminars, and a new two-day gambling track. The conference will also feature NAADAC's 40th Anniversary Celebration and Welcome Reception, an Awards Lunch to honor outstanding addiction-focused professionals from around the nation, a jam session and auction for the NAADAC Education & Research Foundation (NERF), and optional evening events to allow you to earn more education hours or enjoy your time in Seattle.

Explore Seattle

Situated on the shore of Puget Sound between two incredible mountain ranges, Seattle is surrounded by stunning natural beauty. Built on hills lined with tall evergreen trees, the Emerald City's boats and bridges crisscross canals, scenic vistas of Puget Sound on the west and of Lake Washington on the east. On a clear day, the Cascade Mountains are silhouetted by golden light at dawn, snowy slopes of Mt. Rainier rise magnificently to the south, and the Olympic Mountain range turns purple at sunset.

Known for its diverse culture, progressive traditions, and laid-back, adventurous lifestyle, from software to jet engines to coffee to grunge rock, Seattle has always inspired world-changing ideas. As one of the most welcoming places in the country, it is a perfect place for attendees to earn education hours and learn from the profession's thought leaders.

Ready to be Seen?

Help NAADAC celebrate its 40th anniversary and highlight your business by exhibiting, sponsoring, or advertising at our 2014 Annual Conference. Showcase your institution, product, or organization at this prestigious event!

To explore the many promotional opportunities available, please visit www.naadac.org/ACpromotionalopportunities to download the 2014 conference prospectus. If you have any questions, please contact Elsie Smith at esmith@naadac.org or by calling 717.650.1209.

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Preliminary Schedule*

FRIDAY – SEPTEMBER 26TH

(Up to 7 continuing education credits)

8:30 am – 5:00 pm

PRE-CONFERENCE WORKSHOPS

The KSAs (Knowledge, Skills and Attitudes) for the Business of Behavioral Health
Jim Clarkson, MA, LADAC

Marijuana: The Forgotten Drug
Darryl S. Inaba, PharmD, CADAC III

What's New in the DSM-5 and the New ASAM Criteria? New Directions, New Criteria
David Mee-Lee, MD

Professional Ethics: 50 Shades of Gray
Michael Wagner, LICSW, MAC

6:30 pm – 8:30 pm

Welcome Reception & 40th Anniversary Celebration

9:00 pm – 10:00 pm

12 Step Meeting

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SATURDAY – SEPTEMBER27TH

(Up to 5.75 continuing education credits)

6:30 am – 7:00 am

Fun Run/Walk/Zumba

7:30 am – 8:30 am

Continental Breakfast

8:30 am – 9:45 am

Keynote: NAADAC Kick-off and Anniversary Celebration

10:30 am – 12:00 pm

MORNING BREAKOUT SESSIONS

I'm a Supervisor but Who Am I Really: a Psycho-Spiritual Approach to Supervision as a Tool to Assist the Supervisor
Christopher Shea, MA, CRAT, CAC-AD

Heroin is my Mother and Booze is my Father - Addiction as an Attachment Disorder
Michael G Bricker, MS, CADC II, LPC

The Ethics of Multiple Roles in Small Communities
Matthew Mejia, PsyD, MA, LPC, Licensed Psychologist and James Ward, MSW, LAC, LSW

Marijuana and Youth: Legal, Medical, Recreational Use and Addiction Implications
Stephen P. Bogan, MA, LMHC, CDP

Leadership Orientation (Part 1 of 2): Strategic Planning and NAADAC Initiatives
Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, Robert Richards, MA, NCAC II, CADC III, and Catherine M. Iacuzzi, PsyD, MLADC, LCS

Kids and Khemicals, an Integrated Family Program
Laura Dickerson, MC, LAC, NCAC I, SAP and Leigh Schickendantz, MA, LCPC

Tech Support: Using Technology to Support Ongoing Recovery
Susie Mullens, MS, LPC, ALPS, AADC-S, SAP

INCASE - Appreciative Inquiry Research Dealing with College Student Prescription Drug Abuse
Margaret A. Smith, EdD, LADC, John Finneran, PhD, LADC 1, Jeanelle Boyer, PhD, and Marj Droppa, PhD

12:00 pm – 1:30 pm

NAADAC Membership Lunch: The State of NAADAC
Robert Richards, MA, NCAC II, CADC III and Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP

1:40 pm – 3:10 pm

AFTERNOON BREAKOUT SESSIONS

Neurobiology-Informed Addiction Intervention and Treatment: Beyond PAWS
Joe Terhaar, PhD

Powerful Solutions for Addictions: Energy Psychology and Energy Medicine
Mary Hammond, MA, LPC, DCEP RPT-S

The Counselor's Role in Medication Assisted Recovery
Gary Blanchard, MA, LADC1

DSM-5 and Its Use by Substance Use Professionals
Greg Bauer, CDP, NCAC I

Leadership Orientation (Part 2 of 2): Strategic Planning and Initiatives: State Level
Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, Robert Richards, MA, NCAC II, CADC III, and Catherine M. Iacuzzi, PsyD, MLADC, LCS

Trauma and Addiction: Making the Connection
Denise Tordella, MA, LPC

Schedule subject to change without notice. For the most up-to-date schedule, please visit: www.naadac.org/annualconference

THE PARTNERS

Endorsing and Collaborating Partners

Part of what makes this Annual Conference unique is the depth and breadth of NAADAC's partnerships. NAADAC is proud to have 12 national and local partners joining us, including:

- American Society of Addiction Medicine (ASAM)
- International Coalition or Addiction Studies Education (INCASE)
- NALGAP: the Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies
- National Addiction Technology Transfer Network
- National Association for Children of Alcoholics (NACoA)
- National Addiction Studies Accreditation Commission (NASAC)
- NIATx Learning Collaborative
- Chemical Dependency Professionals of Washington State (CDPWS)
- Young People for Recovery (YPR)
- National Association of Recovery Residences (NARR)
- National Asian Pacific Americans Families Against Substance Abuse (NAPAFASA)
- Evergreen Council on Problem Gambling

NAADAC expects more collaborative organizations to join this already impressive list in upcoming weeks. Please see our website at www.naadac.org/annualconference for updates.

LGBTQ Affirmative and Integrative Care Models
Todd Connaughty, MA, LADC and Buster Ross, MA, CADC II, LPC-RI

4:15 pm – 5:30 pm

KEYNOTE: Beyond Opiates: Evolving Sciences of Pain and Addiction
Darryl S. Inaba, PharmD, CADAC III

EVENING EVENTS

Tillicum Village Excursion
Seattle Mariners Baseball game
Evening Out in Seattle

9:00 pm – 10:00 pm

12 Step Meeting

PHOTO COURTESY: ARGOSY CRUISES | TILLICUM VILLAGE

EVENTS

Tillicum Village Sightseeing Tour Cruise and Native American Salmon Bake
Join NAADAC conference attendees for a true Northwest experience. Tillicum Village is a cultural Native American experience you won't forget! The fee for this experience includes transportation to and from the Doubletree Hotel, and tickets to this special 4-hour escape! *Participant Fee $75*

Take Me Out to the Ball Game
Join NAADAC in rooting for the Seattle Mariners or Los Angeles Angles at Safeco Field. The fee for this experience includes shuttle to and from the Doubletree Hotel and the light-rail, and tickets to the game. *Participant Fee $15*

Night Out in the Emerald City
Join NAADAC for a tour of the Emerald City! Guides will split up participants into groups to see local attractions. *Free tour*

For full details on these evening events, visit www.naadac.org/annualconference.

SUNDAY – SEPTEMBER 28TH

(Up to 7.5 continuing education credits)

6:30 am – 7:00 am

Sunday Religious Services

7:00 am – 7:30 am

Fun Run/Walk

7:30 am – 8:30 am

Continental Breakfast

8:00 am – 5:00 pm

NAADAC Board of Directors Meeting

8:30 am – 10:00 am

KEYNOTE: The Opioid Epidemic - the Way In and the Way Out
Mel Pohl, MD, FASAM

11:00 am – 12:30 pm

MORNING BREAKOUT SESSIONS

The Future is Now: How to Succeed in a Competitive Business Environment
Kim Johnson

Grace Unfolding: Using Body-Centered Psychotherapy in the Treatment of Substance Abuse & Co-Occurring Developmental Needs, Deficits, or Trauma
Kedar Brown, MEd, NCC, LPC, CHT

Codependency, Relationship Addiction and Eating Disorders
Gregory L. Jantz, PhD, LMHC, CDP, CEDS

Cultural Elements in Treating Hispanic and Latino Populations
Cielo Mohapatra

Providing Gender Specific Treatment: Strategies for Implementing Effective Approaches
Raven James, PhD

Addressing Tobacco: A Recovery-Oriented Integrated Systems Approach
Tony Klein, MPA, CASAC, NCAC II

Equine Assisted Psychotherapy and Addictions Recovery
Lynn Moore, LADC, EAP ADV and Heather Jeffrey, EAP ADV, CTC

INCASE - Challenges in Teaching Ethics to Addictions Counselors
Alan Cavaiola, PhD, LPC, LCADC and Edward Reading, PhD, LCADC

12:30 pm – 1:30 pm

Lunch (Available for sponsorship)

1:30 pm – 3:00 pm

AFTERNOON BREAKOUT SESSIONS

Becoming More Aware of the ACA/Medicaid Impact on Insurance Billing
Beverly Remm

Feed Up, Feed Forward, and Feedback: Effective Leadership Skills for Clinical Supervisors
Thomas Durham, PhD, LADC

Breaking the Intergenerational Patten of Substance Abuse
Robert L. Neri, LMHC, CAP

Let's Look at the Competencies for Addressing Spiritual Issues in Counseling
Margaret (Peggy) Tana, LPC, LCADC

THE VENUE

Where You'll be Staying

Located at 18740 International Boulevard, Seattle, WA 98188, less than one mile from the Seattle-Tacoma International Airport, the DoubleTree by Hilton Hotel Seattle Airport is offering a limited number of rooms for the discounted price of $139 a night (plus applicable taxes) for reservations made by August 25, 2014. Every guest room includes free WiFi access, a 37-inch flat screen HDtV, and a spacious workstation. In addition, stay connected with the business center and complimentary WiFi in public areas. After your sessions, exercise in the fully equipped fitness center, swim laps in the pool or tee off on a virtual golf course with The Golf Club at DoubleTree. Please book your room early as space is limited and will sell out.

Rooms may be booked by calling 800.222.8733 or online at this dedicated website, https://resweb.passkey.com/go/NAADAC2014. Please make sure to mention the Reservation Code "NAD" to receive your special conference rate.

Room Reservation Deadline: August 25, 2014

Reservations are available on a first-come, first-serve basis. Please book your room early as space is limited and will sell out. The room reservation deadline does not ensure availability of rooms. Room reservations received after the deadline will be confirmed subject to rate and room availability.

Radical Acceptance – Getting to the Root of the Problem
Debra Meehl, DD, MSW

Process Addictions and the LGBT Community: Diverse Population, Diverse Treatment
Jeff Zacharias, LCSW, CAADC, BRI-I, CSAT Candidate

Beyond the Myths: The Science of Marijuana
Ronald A. Chupp, MSW, LCSW, LCAC, NCAC II

Resentment is the Number One Offender - and Why You Must Address It Now!
Robb Hicks, MD

INCASE - Educating Adult Students: A Comprehensive Model for Training Addictions Professionals
Beth Donnellan, MEd, ABD, FT

4:00 pm – 5:00 pm

KEYNOTE: The Seven Teachings to Live Life in a Good Way
Michael Two Feathers

6:00 pm – 8:30 pm

Anonymous People Film Screening & Panel
Facilitator: Robert Ashford
Panelists: Ivette Torres, Wilma Townsend

9:00 pm – 10:00 pm

12 Step Meeting

MONDAY – SEPTEMBER 29TH

(Up to 7 continuing education credits)

7:00 am – 7:30 am

Fun Run/Walk

7:30 am – 8:30 am

Continental Breakfast
Q&A with the President

8:30 am – 10:00 am

KEYNOTE: NALGAP's 35th Anniversary Plenary Panel Session: LGBT Addiction Treatment and Recovery - Where We Were Then; Where We Are Now
Moderator: Laura Fenster Rothschild, PsyD, CPS
Panelists: Phil McCabe, CSW, CAS, DRCC, Craig Sloane, LCSW, CASAC, Jeff Zacharias, LCSW, CAADC, and Raven James, PhD

10:30 am – 12:00 pm

MORNING BREAKOUT SESSIONS

Working with Family Members of People with Addiction: Evidence-Based Methods for Helping Family Members Get Their Loved One into Treatment
Christeine Terry, PhD and Jason Luoma, PhD

Trying Differently Not Harder: Improving Treatment Outcomes by Accommodating Brain Based Conditions like FASD
David Gerry

Family Transformation for Adolescent Males
James Campbell, MA, CAC II and Adam Brickner, MPA

The Affordable Care Act: Responding with Co-Occurring Substance Use and Mental Health Competency
Angele Moss-Baker, LPC, LMFT and Omorinike Hamilton, LPC, CRC, NCC, NCACII

When We Get Behind Closed Doors: Clinical Supervision for Client Safety and Clinician Growth
Alan Lyme, LCSW, ICCS, ICADC

Potentially Beneficial Interactions: Implications for Counselors Working in Substance Use Disorder Counseling
Kevin Doyle, EdD, LPC, LSATP

Couple Recovery Development Approach (CRDA): A Research-based Systemic Approach to Recovery
Bob Navarra, PsyD, MFT, MAC and Eve Ruff, MS, CDP

Trauma Informed Care: Using EBPs to Advanced Addiction Treatment
Samson Teklemariam, MA, LPC

INCASE: Bridging the Gap Between Disciplines: Anthropological Insights into Substance Use and Grassroots Recovery Movements
Peter L. Myers, PhD

12:00 pm – 1:45 pm

President's Award Luncheon

2:00 pm – 3:30 pm

AFTERNOON BREAKOUT SESSIONS

The Family Transformation Model for Women & Children
Adam Brickner, MPA

Mindfulness-Based Relapse Prevention: An Overview
Therissa A. Libby, PhD

Chemical Dependency Care as a Curriculum Culture: Envisioning Ourselves as Educators
Jerry Blackburn, BA, CDP

The Addict...and What the Police Officer Sees
Carlos D. Cruz

Why are National Credentials Important?
Kathy Benson, NCAC II, SAP

Promoting Collaborative Integration
Mita M Johnson, LPC, LMFT, ACS, LAC, MAC, SAP, EdD (c)

Doing Recovery Perfectly and Other Absurd Ideas
Frances Patterson, PhD, LADAC, MAC, BCPC, CCJAS, SAP, QCS

Motivation For Maintenance: Developing Discrepancy from Moments of Addictive Relapse
George DuWors, MSW, LICSW, BCD

4:00 pm – 5:30 pm

KEYNOTE: Federal and State Panel and Update on Implications for the Addiction Workforce
Representatives from ONDCP, SAMHSA, and NIDA

TRAVEL INFO

Getting to Seattle

Save Money on Your Flight to Seattle!
To help reduce costs, NAADAC has negotiated discounts with United Airlines for the 2014 conference. Receive a 2–10% United Airline ticket discount (depending on the type of ticket) when coming to Seattle between September 23, 2014 and October 4, 2014 for the Annual Conference. Book online at www.united.com and enter **ZRRY415839** in the Offer Code box when searching for your flights. If booking through a travel professional or United Meetings at 800.426.1122, please give them the following information: Agreement Code: **415839;** Z Code: **ZRRY.** Outside of the United States, please call your local United Airlines Reservation Office.

Ground Transportation
The Seattle-Tacoma "Sea-Tac" International Airport serves the Seattle area and is a ten-minute, three block walk from the conference hotel. In addition, the hotel provides a complimentary 24-hour shuttle to and from the airport. Cabs and courtesy buses for area hotels, motels, and off-site parking lots pick up and drop off passengers on the third floor of the parking garage. Dedicated 24-hour shuttle busses to and from the airport rental car facility are available outside the main terminal.

6:00 pm – 8:00 pm

NAADAC Education & Research Foundation (NERF) Jam Session & Auction

7:00 pm – 10:00 pm

INCASE Membership Meeting

9:00 pm – 10:00 pm

12 Step Meeting

TUESDAY – SEPTEMBER 30th

(Up to 6 continuing education credits)

7:00 am – 7:30 am

Fun Run/Walk

7:30 am – 8:30 am

Continental Breakfast

8:30 am – 10:00 am

KEYNOTE: Process Addictions

Moderator: Maureen Greeley

Panelists: Chuck Maurer, PhD, ABPP, NCGC-II, Jon Grant, JD, MD, MPH, Denise Quirk, MA, MFT, LADC, NCGC-II, CPGC-S, and Colin Hodgen, LADC-S, CPGC-S, NCGC-II

10:00 am – 3:30 pm

Poster Sessions

GAMBLING TRACK

10:30 am – 12:00 pm

Co-Occurring Disorders

Chuck Maurer, PhD, ABPP, NCGC-II, WSCGC-II, BACC

10:30 am – 12:00 pm

MORNING BREAKOUT SESSIONS

A New Environment for Addiction Treatment: Navigating ACA, EBTs and DSM-5

Steve Allen, PhD

Dependence and Its Dear Friend Codependence

Jeanne Hayes, LMHC, LCAC, ICAC II

Nutrition, Mental Health, and Behavior Change: Rethinking the Current Model of Health

Luke Meier, PLMHP, Certified Sports Nutritionist

Policy Considerations and Collaborative Partnerships: Working with Opioid Dependent Pregnant Women

Nancy K. Young, PhD, MSW

Suboxone on Tribal Lands

Matthew Magrath

INCASE - Addiction Faculty Round Table

Margaret A. Smith, EdD, LADC and Vicki Michels, PhD

12:00 pm – 1:00 pm

Lunch (Available for sponsorship)

GAMBLING TRACK

1:00 pm – 5:00 pm

Gambling 101

Denise Quirk, MA, MFT, LADC, NCGC-II, CPGC-S and Colin Hodgen, LADC-S, CPGC-S, NCGC-II

1:00 pm – 2:30 pm

AFTERNOON BREAKOUT SESSIONS

Spirituality and Healthcare

William G. Starr, DMin, MAC, CDP

Addiction Counselor Licensure: A National Model in Development and Rationale for Legislation

Don Osborn, PhD, LCAC, MAC

Youth Recovery and Treatment Dynamics

Robert Ashford

Mary Jane: Weeding out Fact from Fiction (a 2014 Health Perspective)

Pete Katz, LCDC, ICADC

The Perfect Storm: Gay Men, Crystal Meth, and Sex Cultural Considerations for Gay Affirming Treatment

Craig Sloane, LCSW, CASAC

New Two-Day Gambling Track: Sept. 30th – Oct. 1st

GAMBLING TRACK

Is Problem Gambling a Part of Your Practice? – You Might Be Surprised

You may already be seeing problem gamblers in your counseling practice. Gambling addiction affects 6 million to 8 million Americans (2%-3% of the population). The rate of co-occurrence of pathological gambling among people with substance use disorders ranges from 9% to 30%.

> "It is important to recognize that even though pathological gambling is an addictive disorder, clinicians cannot assume that their knowledge of substance abuse treatment qualifies them automatically to treat people with a pathological gambling problem." (U.S. Dept. of Health & Human Services)

The DSM-5 classifies gambling disorder as an addiction based upon scientific research that shows similarities to the causes and consequences of alcohol and drug problems. It's time to consider asking the right questions to determine if your clients might be struggling with a gambling problem.

NAADAC and the Evergreen Council on Problem Gambling are pleased to offer conference attendees a special opportunity to gain a better understanding of problem gambling as a process addiction and co-occurring disorder you should consider in your practice. Learn from some of the top clinicians, educators, and researchers in the country as they share keen insights and experience. We'll offer a broad look across the field from the basics of problem gambling awareness and treatment to prevention and from a fascinating look at the work in neurobiology and gambling to a fun and enlightening picture of the bio/psycho/social aspects.

Presenters include:

- Jon Grant, JD, MD, MPH, Department of Psychiatry and Behavioral Neuroscience, University of Chicago
- Maureen Greeley, Executive Director, Evergreen Council on Problem Gambling
- Colin Hodgen, LADC-S, CPGC-S, NCGC-II, Clinical Director at Renegade Counseling and Denise Quirk, MA, MFT, LADC, NCGC-II, CPGC-S, CEO and Clinical Director of Reno Problem Gambling Center
- Chuck Maurer, PhD, ABPP, NCGC-II, WSCGC-II, BACC

EXHIBITS

Please be sure to visit and support the companies that are exhibiting this year.

Exclusive time to interact with the exhibitors in both ballrooms has been set aside during Saturday and Sunday morning Continental Breakfasts and the morning and afternoon breaks on those same days.

Interested in exhibiting? Please download the Exhibit, Sponsor, and Advertise prospectus at www.naadac.org/ACpromotional opportunities or contact Elsie Smith, Account Executive, at esmith@naadac.org or 717.650.1209.

Addictions and Family Violence - A Collaborative Approach
Benton W. Granville, MA

3:30 pm – 4:30 pm

PLENARY: Art and Science of Healing: Finding the Healing Self Inside
C.C. Nuckols, PhD

4:30 pm – 5:00 pm

Conference Closing Ceremony

9:00 pm – 10:00 pm

12 Step Meeting

WEDNESDAY – OCTOBER 1st

(Up to 7 continuing education credits)

7:00 am – 8:00 am

Continental Breakfast

8:00 am – 5:00 pm

POST-CONFERENCE SESSIONS

The Training Point: How to Provide Exceptional Learning Experiences
Laurie Krom, MS

Romancing the Brain
Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP

The Science of Recovery: Advanced Seminar
C.C. Nuckols, PhD

Co-Occurring Disorders
Gerry Schmidt, MA, MAC, LPC

GAMBLING TRACK

8:00 am – 12:00 pm

Neurobiology and Gambling Addiction
Jon Grant, JD, MD, MPH

1:00 pm – 5:00 pm

Psychosocial Treatments for Gambling Disorder
Jon Grant, JD, MD, MPH

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HOW TO REGISTER

1. Register online at www.naadac.org/annualconference
2. Fax completed form to NAADAC at 800.377.1136 or mail to "NAADAC Registration" at the address above.
3. Please keep a copy of form for your records.

Pre-register now for the best rates!

NAADAC 2014 Annual Conference • Seattle, WA

Registration Fees

Full Conference: September 27–30, 2014*	Early Bird (ends July 31)	Regular (ends Sept. 14)	Late/On-site (after Sept. 14)
Member	❑ **$375**	❑ **$450**	❑ **$500**
Non-Member	❑ $500	❑ $575	❑ $625
Student/Active Military Members	❑ **$300**	❑ **$350**	❑ **$400**
Student/Active Military Non-Members	❑ $425	❑ $475	❑ $525

*Full conference attendees can participate in any session of the Gambling Track on September 30. If you wish to participate in Day Two of the Gambling Track on October 1, please add an additional Post-conference Fee.

Two-Day Gambling Track Only: September 30–October 1, 2014			
Member	❑ **$250**	❑ **$300**	❑ **$400**
Non-Member	❑ $400	❑ $450	❑ $500
Student/Active Military Members	❑ **$200**	❑ **$250**	❑ **$300**
Student/Active Military Non-Members	❑ $325	❑ $375	❑ $425

Pre-conference: September 26, 2014			
Members	❑ **$125**	❑ **$150**	❑ **$200**
Non-Members	❑ $200	❑ $225	❑ $250

Post-conference: October 1, 2014 (or Day Two of Gambling Track)			
Members	❑ **$125**	❑ **$150**	❑ **$200**
Non-Members	❑ $200	❑ $225	❑ $250

Daily Please check which day(s) you will attend: ❑ Sept. 27 ❑ Sept. 28 ❑ Sept. 29 ❑ Sept. 30

Members (rate per day)	❑ **$125**	❑ **$150**	❑ **$200**
Non-Members (rate per day)	❑ $200	❑ $225	❑ $250

Special Events: September 27, 2014 Space is limited; sign up early. Minimum registrations required.

Tillicum Village Sightseeing Tour Cruise and Dinner, departs hotel at 3:30 p.m.	❑ $75	❑ $75	❑ $75
Take Me Out to the Ball Game, departs hotel at 5 p.m.	❑ $15	❑ $15	❑ $15

FEE TOTAL SUMMARY			
Full Conference: September 27–30			
Pre-conference: September 26			
Post-conference (or Day Two of Gambling Track): Oct. 1			
Daily (_____ days at $ _____ per day)			
Two-day Gambling Track Only: Sept. 30–Oct. 1			
❑ Tillicum Village Cruise/Dinner ❑ Ball Game			
TOTAL AMOUNT ENCLOSED			

Attendee Information *(please print clearly)*

❑ **YES, I want to join NAADAC!** Please consult www.naadac.org for membership fees or call 800.548.0497 to enroll.
❑ Please send me additional information about membership.
❑ **This is my first NAADAC Training/Conference**

NAADAC, INCASE or NALGAP Member # _____ Evergreen Council on Problem Gambling Member # _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Mobile: (_____) _____ Email: _____

Payment Options *(please print clearly)*

❑ Check payable to NAADAC Please charge my credit card: ❑ Visa ❑ MasterCard ❑ American Express

Name as appears on card _____

Credit card number _____ Exp. date _____

Signature _____

Conference refund policy: A partial refund of 75% of registration cost is refundable 30 days before the conference. Thereafter, 50% of conference fees are refundable.

06052014

Promising Integrated Treatment Model to Help Veterans with Co-Occurring PTSD and Substance Use Disorders

By Robb Hicks, MD

Since the terrorist attacks of September 11, 2001, an estimated 2.5 million United States servicemembers have been deployed to support operations in Afghanistan and Iraq. Many of these brave men and women have endured multiple tours of duty with extended periods of exposure to combat-related stress and other traumatic events. While the majority of servicemembers are able to successfully readjust to civilian life, one in five (18.5%) troops returning from Operations Enduring Freedom and Iraqi Freedom are diagnosed with post-traumatic stress disorder (PTSD), also known as Post-Traumatic Stress (PTS), Combat Stress or Combat Operational Stress (Tanielian & Jaycox, 2008).

The National Institute of Mental Health (NIMH) defines PTSD as "the body's normal reaction to direct or indirect exposure to a terrifying event or ordeal, in which grave physical harm occurred, or was threatened, to oneself or a loved one." Different from physical wounds, PTSD remains invisible to other servicemembers, their relatives and society at large; yet, it has debilitating effects. Some of the symptoms, which may not appear until months after the exposure to stress, include difficulty concentrating, trouble sleeping, constantly feeling on alert, feeling numb, feeling irritable and avoiding people and places that are stressful (NIMH, n.d.).

Along with traumatic brain injuries, PTSD is oftentimes considered a "signature wound" of war that will last a lifetime. The Department of Veteran Affairs estimates one in three veterans seeking treatment for substance use disorder (SUD) also has PTSD (National Center for PTSD, n.d.). Therefore, successful treatment of PTSD/SUD is likely to have a significant public health effect on society (Ouimete, Read, Wade, & Tirone, 2010).

Experts Theorize About the Origins of PTSD/SUD

Although researchers and medical professionals are unable to identify a single explanation as to why a patient will develop comorbid PTSD/SUD, four hypotheses have been proposed. The first theory is PTSD leads to SUD. From a developmental standpoint, traumatic stress occurring in childhood would challenge maturing self-regulatory skills on both the neurobiological and behavioral levels. Patients would then be predisposed for later SUD due either to a lack of coping skills, or to the inability to manage emotions and feelings.

The second theory, the high-risk hypothesis, is based upon the reality that people with SUD tend to engage in more risky behaviors. This increases the likelihood of experiencing traumatic events, and thereby increases the probability of developing PTSD. The third theory, the susceptibility hypothesis, proposes individuals with SUD have some as-yet-undefined higher psychological and biological vulnerability to the effects of trauma exposure. This proposed susceptibility increases the probability of developing PTSD. The fourth theory proposes PTSD and SUD are related by a third variable, such as disconstraint, when it occurs in the presence of deficits in coping skills.

The addition of a SUD to PTSD also has been found to severely worsen the symptoms of this anxiety disorder. For instance, PTSD may create insomnia and/or sleep disturbances. A patient may then "self-medicate" him/herself with alcohol and/or drugs, hoping to improve their quality of sleep. PTSD makes patients feel "on edge," and SUD can amplify these feelings. Patients also may use drugs and/or drink alcohol to temporarily distract themselves from their problems, when in actuality drugs and alcohol make it more difficult to concentrate on tasks (Schäfer & Najavits, 2007).

While the symptoms of these conditions appear differently in every patient, it is believed the most effective treatments must be collaborative, multifold and developed soon if we are to successfully treat the growing prevalence of patients struggling with these unrelenting disorders.

Progressions in Treatment Methods Improve Patient Care

Practitioners, mental health and substance abuse professionals, and military leaders utilize a host of treatment programs to assist veterans with PTSD/SUD, including but not limited to: Individual or group cognitive behavioral therapy (CBT); Cognitive Processing Therapy (CPT); Prolonged Exposure (PE); behavioral couples therapy with a spouse or family member; and medications to help a patient manage their PTSD/SUD symptoms. Evidence indicates most patients will show signs of improvement when concurrently provided treatment to address both disorders (National Center for PTSD, n.d.).

As recently as 10 years ago the majority of PTST/SUD patients received sequential treatment, which required an individual to first complete a substance abuse program, and maintain a certain period of abstinence, before beginning treatment for another disorder like PTSD. A critical drawback to this method was one condition was left unaddressed while the other was being treated. In fact, sequential treatment has been shown to lead to higher relapse rates among patients with PTSD/SUD than those found in the general SUD population (Coffey, Schumacher, Brimo, & Brady, 2005). Concurrent treatments, on the other hand, involve two individual programs simultaneously treating a patient with both conditions, but in separate settings and by different clinicians (Minnesota Center for Mental Health, 2013). Although more successful, this method does raise valid concerns regarding reliability and consistency of treatment administration.

Seeking Safety Adopted by the National Center for PTSD and Spreads to Thousands of Hospitals and Clinics Worldwide

Within the past few years, integrated treatment options have yielded promising outcomes for patients with co-occurring conditions when they are provided by an individual clinician through a single intervention. As of 2010, the National Center for PTSD categorized *Seeking Safety,* a manual-based cognitive behavioral therapy program developed by Lisa Najavits in 1992, as the only truly-integrated treatment for PTSD/SUDs

(National Center for PTSD, 2010). Women who participated in clinical trials reported significantly improved substance use and trauma-related symptoms (Najavits, Weiss, Shaw, & Muenz, 1998). Generally speaking, integrated treatments have demonstrated higher levels of patient retention and overall greater symptom improvements for both conditions (Dass-Brailsford & Myrick, 2010).

Seeking Safety is considered by some to be the most promising and widely-adopted integrated treatment model. It is now being used in over 3,000 hospitals, treatment facilities and clinics in the United States and 11 other countries (Substance Abuse and Mental Health Administration, 2012). The drawback to this treatment model is its lack of a trauma-focused component; therefore, it is recommended that it be combined with additional treatment programs to ensure all problematic behaviors decrease (SAMHSA, 2012).

Veterans with PTSD/SUDs are specialized patients who may require a treatment program tailored to their individual circumstances and unique nature of combat and military culture. Clinical trials offer guidance to treatment, but clinicians ultimately must decide on the most effective approach for their specific patient's given needs and variables.

Call to Action: Overcoming Access Gaps in Mental Health Care is a Key Component in Veterans' Reintegration

The current state of national mental health is one of optimism, with undertones of urgency. Leaders of the Department of Defense, Veteran Affairs, and both the medical and research communities hope to develop advanced tools and treatment methods to effectively and efficiently care for veterans with cognitive conditions such as PTSD/SUDs. The findings of a RAND survey in 2008 indicated only half (53%) of returning troops with PTSD symptoms actually sought treatment from a professional (SAMHSA, 2012). The lack of willingness to seek help is presumed to be due to concerns about confidentiality and/or fear of losing the trust of family members, potential employers and colleagues. Furthermore, returning servicemembers may not seek treatment due to longer wait times for appointments, particularly in facilities resourced primarily to meet the needs of older veterans (SAMHSA, 2012).

Better projections of the amount and types of demands among newer returnees are needed to ensure Veteran Affairs' offices are appropriately staffed and equipped with the resources needed to care for its patients. More specialized inpatient, residential, and outpatient programs specifically for veterans with new onset, severe or complex diagnosis of PTSD/SUD also are needed. Nonetheless, we all can support veterans and their families in the reintegration process by increasing public awareness and communal support of these unseen wounds. All of these changes are a part of the National Research Action Plan (NRAP) proposed by the White House in August 2013 intending to honor the brave men and women who have selflessly sacrificed their lives to protect and defend our freedoms (U.S. Department of Defense, 2013).

Earn 2 CEs by Taking an Online Multiple-Choice Quiz

1. One in _____ troops returning from Operations Enduring Freedom and Iraqi Freedom are diagnosed with PTSD, Combat Stress, or Combat Operational Stress.
2. Which of the following is a symptom of PTSD?
3. The Department of Veteran Affairs estimates one in _____ veterans seeking treatment for substance use disorder also has PTSD.
4. Which of the following describes the "high-risk hypothesis"?
5. Which of the following describes the "susceptibility hypothesis"?
6. The addition of a substance use disorder to PTSD has been found to _____ the symptoms of this anxiety disorder.
7. Which of the following treatment options are utilized with PTSD?
8. _____ has been shown to lead to higher relapse rates among patients with PTSD and SUD than those found in the general SUD population.
9. Which of the following methods of treatment involves two individual programs simultaneously treating a patient with both conditions, but in separate settings and by different clinicians?
10. Veterans' lack of willingness to seek help is presumed to be due to concerns about confidentiality and/or fear of losing the trust of family members, potential employers, and colleagues.

Earn two continuing education credit by taking a multiple choice quiz on this article now: www.naadac.org/magazineces. $25 for NAADAC members and non-members.

REFERENCES

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Robb Hicks, MD, is a Missouri physician and surgeon who has devoted 25 years to healing the physical, emotional and spiritual maladies of his patients. He has treated hundreds of veterans who sought his help because of their perceived lack of VA medical services. Dr. Hicks graduated magna cum laude with a B.A. in Psychology from Wheaton College, then matriculated to the University of Southern California School of Medicine. He completed a general surgery internship at St. Louis University Hospitals, and began his ENT Surgery residency in 1988. Now recognized for his entrepreneurial passion, business acumen and medial wisdom, Dr. Hicks created Intentional Sobriety, which helps recovering professionals stop relapsing, so they stay sober forever, face life successfully, and become happy, joyous and free.

NAADAC and the History of Addiction Counseling:

An Interview with William White, MA

For some years, NAADAC has been laying the foundation for the development of a book on the history of addiction counseling. That project is now underway with the assistance of William "Bill" White, author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. We recently caught up with Bill to give us a progress report on the new book.

NAADAC: Bill, what or who is the inspiration behind the new book on the history of addiction counseling?

Bill White: This book was Mel Schulstad's vision. Mel was a co-founder and first president of NAADAC, and believed that no profession has come of age that lacks a history of its own development. Mel began promoting development of a history of addiction counseling by NAADAC as early as the late 1980s and began laying the foundation for our current project. Mel and I had conversations with Cynthia Moreno Tuohy, NAADAC's Executive Director, about this project for years, and as NAADAC celebrates its 40th anniversary, it just seemed like the time to do it. Cynthia pushed this book to the top of the NAADAC agenda in hopes we could finish and launch the book at NAADAC's Annual Conference and 40th Anniversary Celebration in Seattle this fall.

NAADAC: What preliminary work was done over the years to prepare for this project?

Bill White: This work began with the NAADAC Foundation National Archive Advisory Council, under the leadership of Mel, co-founder Marcia Lawton, Bill Butynski, Walter Kloetzli, and others. Creation of the NAADAC Archives was an essential step in providing the archival documents that could be drawn upon to research and write the history. I had also created a section on addiction counseling within the Illinois Addiction Studies Archives in anticipation of this project and began collecting the papers of some of the addiction counseling pioneers, including all of the early NAADAC newsletters and all of the issues of *The Counselor* and *Addiction Professional* during the years these magazines served as the communication arms of NAADAC. More recently, Jay Lewis reviewed all of the issues of *The Alcoholism Report* and created a chronology of the early professionalization of addiction counseling.

NAADAC: How are you approaching your work on this project?

Bill White: My first step was to pull together all of the key archival documents and create a chronology that will serve as the skeleton of the book. That work is all but completed, with a few rare documents remaining that we are trying to locate. The second step was to obtain the interviews completed over the years in anticipation of this project and get them transcribed. Most of that work is completed. The third step involved surveying some of the key leaders within NAADAC over these past decades about the evolution of addiction counseling and NAADAC. The final research step will be locating photographs that will help us tell this story visually. Then comes the really fun part—locking myself up, making sense of all we've collected and writing like a mad man for a few months.

NAADAC: How will this book be different than *Slaying the Dragon?*

Bill White: *Slaying the Dragon* tells the larger story of the evolution of addiction treatment in the United States. While there are sections that detail some aspects of addiction counseling, it is not a definitive history of the evolution of the addiction counselor role. I have always wanted to do a more detailed history focusing on addiction counseling and I'm delighted to now be working on this.

NAADAC: What are you most excited about with this project?

Bill White: Working on this book has given me an opportunity to hear the experiences and insights from some of the leading addiction professionals in the country. Their words are so powerful. To the greatest extent possible, we want the voices from the field to resonate within this book. I'm also excited to be able to give to the field a book that I wish someone could have placed in my hands some 45 years ago as I entered full-time work in the field. I see this book as one of my final contributions to the field and it is such an honor for me to have been selected to lead this project.

NAADAC: Will there be an opportunity for people in the field to review drafts of the book?

Bill White: Only to a limited extent because of the timeline of finishing the book before the NAADAC 2014 Annual Conference, but we will be sending out chapters as they are completed to key informants. We do anticipate future editions of the book so we are viewing the first printing as a starting point in formalizing a history of addiction counseling. My hope is that feedback on this first edition will enrich subsequent additions. No one will be happier than me if we discover missing chapters within this history through feedback we receive from our readers.

NAADAC: Why should addiction counselors be interested in this history?

Bill White: I can promise that this is going to be a very inspirational history from the quality of the interviews to date, but there is a much deeper reason addiction counselors will want to read this book. Put simply, history can serve as the ultimate experience of supervision. Where else can you get the accumulating wisdom and advice of people who have pursued this calling across multiple eras and across diverse cultural and clinical contexts? I'm not interested in history for the sake of history. I want to mine history for the lessons she can offer us to guide professional and institutional decision-making. I think the new book will provide a helpful guide to do just that.

NAADAC: You speak with a sense of urgency about this project.

Bill White: I do feel that sense of urgency. We are losing the pioneers who laid the foundation for our field. We need to capture their wisdom and their voices for future generations. If we do not do that now, their legacies and what they can continue to offer to us through their vision and their experience will be forever lost.

William L. White is a Senior Research Consultant at Chestnut Health Systems/Lighthouse Institute and past-chair of the board of Recovery Communities United. Bill has a Master's degree in Addiction Studies and has worked full time in the addictions field since 1969 as a street-worker, counselor, clinical director, researcher and well-traveled trainer and consultant. He has authored or co-authored more than 400 articles, monographs, research reports and book chapters and 16 books. His book, Slaying the Dragon – The History of Addiction Treatment and Recovery in America, *received the McGovern Family Foundation Award for the best book on addiction recovery. His collected papers are posted at www.williamwhitepapers.com.*

Culturally Appropriate Substance Use Disorder Treatment: CETPA's Practical Applications for Hispanic/Latino Populations

By Pierluigi Mancini, PhD, NCAC II

There are many destabilizing aspects of social adaptation in the United States for Latinos; a rapidly increasing population; residential segregation; shortfalls in educational attainment; language barriers; and a new political, social, legal, financial, and educational system. Any of these issues alone may cause substance use disorders or mental health problems, let alone experienced all together.

The current system of substance use disorder treatment is not set up to serve the vast majority of Latinos in need of care. In particular, it does not address the needs of immigrant Latinos, who make the least use of behavioral health services (U.S. Health and Human Services, 2001). In addition to the many barriers faced by the general Latino population, the current system provides even a greater disservice to Latinos in jail, those who abuse alcohol and drugs, those who are entering the country because of political persecution or kidnapping in their country of origin and the involuntary immigrants who include spouses and children who did not participate in the decision to immigrate but simply followed the decision made by the head of the family.

Latino youth, who are the fastest growing subgroup of this community, are at a significantly high risk for poor behavioral health outcomes. They are usually more likely to drop out of school, to report depression and anxiety, and to consider suicide than white youth (Center for Disease Control and Prevention, 2004).

Acculturated Latinos may not seek treatment for substance use disorders primarily because of the different relationship Latinos have with alcohol, making them less likely to ask for any type of help or talk about it with clergy, relatives or friends.

CETPA

The Clinic for Education, Treatment and Prevention of Addiction, Inc. (CETPA) was established in 1999 to address a growing need for culturally and linguistically appropriate substance abuse services among the Latino population in Georgia. Since then CETPA has grown from one program to multiple programs, from one employee to 53 employees, from serving one region in the State to serving five regions, and from providing solely substance abuse counseling to 65 adult clients annually to serving over 1,000 clients in need of substance use disorders and mental health counseling, and thousands of children and youth in prevention programs each year. CETPA is the only state licensed and nationally accredited agency in Georgia to provide behavioral health treatment and prevention services in English and/or Spanish. Our approach to serving the Latino community is a product of leaning about the history, demographics, utilization rates, cultural difference, and barriers to access over the last fifteen years. Here is what we have learned.

History

Latinos have been present in the United States for over 500 years. They are made up of European, African, Asian, and Indigenous backgrounds, each bringing their own culture, values, attitudes, race, color and spirituality. The United States, with almost 40 million Spanish speakers, is currently fifth largest Spanish-speaking country in the world after Mexico (117 million), Spain (47.2 million), Colombia (47 million) and Argentina (41 million) (U.S. Census Bureau, 2013).

Latino immigrants in the United States come predominantly from Mexico, Puerto Rico and Cuba. It is important to know the history of each one of these countries with the United States in order to understand the frame of mind of the potential clients. Puerto Ricans enjoy the privilege of American citizenship, given by birth due to the island's status as a U.S. Commonwealth. Many Cubans in the United States have refugee status, which provides work authorization and access to social services.

Almost all other Latino immigrants must be granted legal status by U.S. Citizenship and Immigration Services (USCIS) to enter the country, work, and/or receive social services. Unfortunately, many Latino immigrants do not have legal status to live, work, or receive social services or benefits.

Demographics

According to the 2013 U.S. Census estimate, there are over 53 million people in the United States who identified themselves as Latinos; 900,000 in the State of Georgia alone. One of the major stereotypes Latinos face is that of being recently arrived immigrants, when in fact, according to the U.S Census, more than 60% of Latinos in the United States were born in the United States (U.S. Census Bureau, 2013).

Latinos make up 17% of the U.S. population, yet, they represent nearly one out of every four uninsured Americans (Brown, Ojeda, Wyn & Levan, 2000). By the year 2012, close to 42% of Latinos in the United States were uninsured and 21.4% live below the poverty level. These high numbers are driven mostly by Latinos' lack of employer-based coverage: only 43% of Latinos are covered through the workplace, compared to 73% of whites. Medicaid and other public coverage reach 18% of Latinos. Citizenship and immigration status are other important factors that affect health insurance (Brown et al., 1999; Hanson, 2001); when you look at the insurance coverage figures closer you find that 62% of Latinos who are not yet citizens of the United States are uninsured.

The President's New Freedom Commission on Mental Health in their final report *Achieving the Promise: Transforming Mental Health Care in America,* addresses disparities in mental health by reporting:

> "Unfortunately, the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often under serving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing minorities in the criminal and juvenile justice systems."

Additionally, striking disparities in mental health services for racial and ethnic minority populations are highlighted in the report, *Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General.* It states that racial and ethnic minorities:

- Are less likely to have access to available mental health services,
- Are less likely to receive needed mental health care,
- Often receive poorer quality care, and
- Are significantly under-represented in mental health research.

Although some progress has been made in the (0.1% in the last 10 years) utilization rates of mental health, addictive disease and developmental disabilities community services in the state of Georgia continue to show a great disparity when measured by race and ethnicity (Georgia Department of Behavioral Health and Developmental Disabilities, Table 1). They are:

FY 2012 - Utilization of Community Services per 1000 population By Disability Program & Ethnicity

	Not Hispanic/Latino	Hispanic/Latino
C&A MH	14.8	8.0
C&A AD	0 .5	0.4
Adult MH	17.1	6.3
Adult AD	4 .5	1.0

Cultural Differences

In addition to language, it is important to note several differences among the members of this community, which may play a role in the seeking and utilizing addictive disease and mental health services. The different patterns of immigration include those who enter as permanent residents, holding work and student visas, visitor visas and those with undocumented status.

The personal conditions affecting quality of life also differ since the socio-economic position of the members of this community greatly varies. There are wealthy Latinos who identify more with the host culture and those who identify more with their Latino roots. Conversely, there are recently arrived immigrants who forego their Latino roots in order to try to 'fit in' faster or become 'Americanized'.

The Diagnostic Statistical Manual 5 (DSM 5) is divided into three sections – Section 1: Introduction ("DSM-5 Basics"); Section II: "Diagnostic Criteria and Codes"; Section III: "Emerging Measures and Models" – and an Appendix, which includes a "Glossary of Cultural Concepts of Distress." Section III includes a chapter on cultural formulation, featuring an updated version of the outline introduced in DSM-IV as well as an approach to assessment, using the Cultural Formulation Interview (CFI). The chapter also includes a section discussing "Cultural Concepts of Distress" (pp. 758–759). It is imperative that clinicians learn these concepts when working with consumers who come from different cultures and different parts of the world.

Barriers

The primary barrier for Latinos in accessing current available services for substance use disorders is language. The lack of Spanish-speaking mental health treatment providers is a major problem since close to 40% of Latinos living in this country have limited English proficiency. Second language conversational skills are acquired in one or two years and academic language proficiency is acquired over a longer period of time of five to seven years (Ortiz, 1997). Diagnosis and treatment of mental disorders depends greatly on the ability of the patient to explain the symptoms to a clinician and understand steps for treatment. The triangulation of this critical phase through a chance interpreter, a family member and an unqualified or untrained interpreter can be devastating. However, studies reveal that there are few Spanish-speaking and Latino providers. One survey found that there were 29 Latino mental health professionals for every 100,000 Latinos in the U.S. population. For non-Latino Caucasians, the rate was 173 providers per 100,000 (Center for Mental Health Service, 1999).

Additional organizational, systemic, and clinical barriers must also be addressed in order to provide culturally appropriate services.

Organizational barriers address the current systems of care, which include the health policies, and the people entrusted to carry them out. It is imperative that the people charged with the delivery of services include the members of this community within the ranks of its leadership, boards, staff and providers.

Systemic barriers in the structures of the health care system create major challenges for Latinos seeking addictive disease and mental health services. The operating circumstances include location, transportation, long wait times, bureaucratic intake procedures and the lack of qualified interpreters (or any interpreter services) and bilingual services.

Clinical barriers include the chronic shortage of qualified Spanish-speaking support personnel and staff. The number of bilingual/bi-cultural psychiatrists, psychologists and licensed counselors in many states is totally disproportionate to the fast growth of the Latino community including Georgia.

The absence of qualified personnel give way to ineffective and inappropriate therapies including offering services to clients who may only speak functional or conversational English. In some levels of care, it has become common practice to ask a client to bring an interpreter to the evaluation or the actual therapy session.

Even clinicians who identify themselves as Latino, speak Spanish or originate from Latin America are not necessarily culturally competent to serve this community. Socio-cultural barriers include the need for language appropriate services, acknowledges underutilization rates for addictive disease and mental health services, takes into account the patient's level of acculturation, addresses the stigma associated with these illnesses in the Latino culture, has intimate knowledge of available resources, understands the client's uncertainty about established educational, social, financial and medical system and respects Latino beliefs in spirits or sins as reason for illness or hardship.

Limited English Proficiency

The issue of providing services to persons with limited English proficiency (LEP) is actually addressed by the federal government under Title IV of the Civil Rights Act of 1964 which states "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance". The courts have interpreted national origin to include individuals with limited English proficiency. In August 2000, President Clinton, reiterated this policy by issuing Executive Order (EO) 13166, *Improving Access to Services for Persons with Limited English Proficiency,* which applied to all federal agencies.

The system of care may address this issue in several different ways. It may choose to provide the very minimum level of service in order to meet the aforementioned requirements or it may choose to truly apply the research-based data and provide the highest level of service, linguistic and culturally appropriate direct services, to serve the Latino community. Not addressing this issue is unacceptable.

The ramifications of poor linguistic access include decreased access to health services, poor patient comprehension, low patient satisfaction, reduced quality of care and an increase in health care costs.

Many Latinos today are suffering in silence from addictive diseases and mental illness in part because of these barriers.

Many Latinos who receive services for these illnesses are living healthy and productive lives today thanks, in part, to the advances achieved in pharmacology and psychotherapy. Still, many who have received successful treatment choose not to share the fact that they were helped for fear of being judged or labeled negatively. Continued efforts from advocates, providers and community members is needed to deliver to the Latino community the very important message that mental illness and addiction are treatable and that there is no shame in acknowledging the fact that we have been helped.

Solutions

In order to meet the addictive disease and mental health services of the growing number of Latinos, regardless of their socio-economic, educational, linguistic and acculturation levels, major changes need to take place at all service levels.

Policy recommendations include setting as a priority the establishment of a specific programmatic focus and supporting policy framework including access and workforce development. This will reduce systemic barriers and increase the number of substance use disorders and mental health professionals who are linguistically and culturally skilled. CETPA begins recruiting at the high schools during career days. We motivate young minds to think about the counseling field. We identify those who are bilingual and sometimes are able to offer them non-clinical recovery support jobs while they attend college. Training recommendations include developing and expanding the knowledge base for educating and training current and future mental health and addiction professionals.

The most critical and enduring service delivery issue is accessibility. Efforts should be focused on creating financial and other incentives for developing systems of services/care and utilizing innovative services alternatives that meet the identified needs of the Latino community. CETPA's hours of operation are from 9 am until 9 pm and some of our services operate on Saturday. We learned that those are the times our community can access our services. We sometimes help with bus tokens and child care. And lately we have been providing tele-counseling through a SAMHSA Health IT grant where consumers can access their counselor through a secure server for an internet-based, face-to-face session from the comfort of their own home at the most appropriate time in the language they best communicate in.Research typically drives policy, funding and system development decisions. Little information exists, and so much is needed to better understand the mental health, and addictive disease service needs of all Latinos and especially those who live in rural communities. Research must be supported and funded to make this happen.

Affordability of services is key. CETPA serves a community who is highly uninsured, underinsured and due to different types of visas or lack of legal status, are unable to be insured. CETPA has a sliding scale fee and we provide free services to those that do not have the ability to pay. We rely on foundations and donations to cover these costs. And we receive state and federal grants, and accept Medicaid and third party payers. Lately we have also begun to see adults formerly uninsured showing up with policies purchased through the Marketplace from the Affordable Care Act.

Leadership must be developed and committed to at individual and institutional levels – cultural competence must be part of the agenda and a priority for Latino leaders. CETPA would not have been able to accomplish all of this without the support of the Georgia Department of Behavioral Health and Developmental Disabilities, SAMHSA's Center for Substance Abuse Treatment and all of the supporters we have in Georgia and throughout the nation.

The message is clear, affordable, cultural and linguistically appropriate substance use disorder and mental health counseling is achievable.

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'Tech Support' Using Technology to Support Ongoing Recovery

By Susie Mullens MS, LPC, SAP and Teresa Warner

Most clinicians have experienced the vibration or ring of a cell phone during session. Depending upon whether we are "digital immigrants," "digital natives" or those who would like to seek "digital asylum" our responses might be very different (Prensky, 2001). Many clients are technologically connected in ways that counselors may not have traditionally experienced in the clinical setting. Most addiction counselors pride themselves on "meeting clients where they are," yet many find it difficult to embrace our client's connectedness or attachment to their devices. Untangling the mystery and fear of technology for "digital immigrants" doesn't have to be scary; the clinician need only be willing and open to working within the digital culture using websites and smartphone applications to enhance recovery.

First Choice Services Inc. and its sister corporation First Choice Health Systems Inc. have embraced technology for many years using the original modality of providing telehealth—the telephone. Its two phone-based programs, the West Virginia Prescription Drug Abuse Solutions program and Problem Gamblers Help Network of West Virginia (PGHNWV) program, provide information and refer-ral services across West Virginia, with PGHNWV having provided therapeutic interventions for more than 11,000 problem gamblers and their loved ones since 2000. Additionally, both programs provide a "Chat" option on their websites to engage those who are seeking help and who are more comfortable utilizing computers or mobile devices.

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In 2012, First Choice Services, Inc. was awarded a Technology Assisted Care (TAC) grant from SAMHSA to further incorporate technology into treatment services in West Virginia, and as a result developed the Appalachian Technology Assisted Recovery Innovations (ATARI) program. The ATARI program's objectives include: introducing technology into treatment and recovery support programs in West Virginia; maintaining and increasing client engagement; preventing relapse and developing community partnerships. To help achieve its objectives, ATARI contracted with the University of Wisconsin to utilize the A-CHESS (Addiction-Center for Health Enhancement System Studies) smartphone application, which has been nationally recognized and showcased in the Journal of American Medical Association Psychiatry, TIME magazine, WebMD and Yahoo News.

A-CHESS is comprised of many features to help those in recovery and is currently being vetted as an evidence-based practice. A-CHESS is theoretically based in Self Determination Theory (SDT), which focuses on how social and cultural factors facilitate or undermine people's sense of volition and initiative, in addition to their well-being and the quality of their performance (Deci & Ryan, 1985). Conditions supporting the individual's experience of autonomy, competence and relatedness are argued to be the most volitional and therefore, high quality forms of motivation and engagement (Deci & Ryan, 1985).

When clients receive the A-CHESS app, they are encouraged to create a "profile" similar to the profile feature of Facebook. The profile allows clients to share common interests that they might not know about one another. The additional features of the app allow the client to connect to recovering peers and their clinicians through the team feed, support team, messaging, and discussion boards. The messaging function is used as a private email which allows clients to contact each other, their recovery coach, and/or their counselor. The discussion board is used to engage clients in ongoing discussions about recovery topics which can be started by clients or the coach/therapist. Clients have access to recovery podcasts, recovery news, events, and recovery information which help keep them in touch with more self-directed resources.

One of the most innovative features of the app is the "panic button" which allows the client to make contact with one person or many people if they are in a risky situation or at risk of relapsing. At the touch of a button the client can choose to call or text their support team, email their therapist, or engage in various recovery based interventions through the app. They can choose to listen to podcasts that focus on assertiveness cues, relaxation techniques, dealing with urges, and refusal skills. This provides a 2–3 minute "time out" to the distressed client who may need to ride out the temporary emotional state.

The A-CHESS has an administrative function where the clinician can mass message clients, add sober events to the clients' calendar, monitor participation, and evaluate client progress and concerns on the app. Data available to the clinician include individual and group Brief Alcohol

Monitoring (BAM) survey responses. The client is prompted weekly to complete the BAM survey which assesses not only relapse triggers, but evaluates protective factors as well. If the client's BAM responses are indicative of clinical decline the treating therapist is alerted by the ACHESS system which allows for prompt intervention to occur.

The treating clinician is also provided with information regarding client's use of specific features on the app, as well as, the amount of time the client is engaged with the technology. This data can be utilized in treatment planning and developing client specific interventions. This easy to read clinical data compliments quality practice and assists in providing measurable outcomes required by the Affordable Care Act. Clinicians are given the tools needed to provide a continuum of care for each client participating in the A-CHESS program.

As a next step, First Choice Services Inc. through the ATARI program partnered with sixteen organizations around West Virginia to provide access to smartphones with unlimited talk, text and data for six months, including comprehensive behavioral health centers, smaller behavioral health centers, and private practices. The phones are pre-programed with the A-CHESS app along with several recovery-based apps that were vetted and chosen by staff, including Sober Day, 12 Steps, NA Speakers, and Room to Breathe. The additional apps were chosen to help compliment and add to the tools available with A-CHESS. While A-CHESS is more focused on recovery from alcoholism, clients may use these other apps to access to resources related to recovery from narcotic use, etc.

Client engagement is a very strong indicator of success in treatment and relapse prevention. A-CHESS allows for engagement with staff, both clinical and non-clinical, as well as peers who are in the same treatment groups. The Affordable Care Act is going to change how many treatment providers deliver service to clients and A-CHESS is a great example of a safe, secure, closed recovery environment which is very affordable at less than $2 per week per client. If clients are engaged with their clinician and peers, it seems a very good investment and would likely lead to better outcomes.

The ATARI program administers a "first day survey" through a custom A-CHESS survey option to collect information about access and impact of technology prior to joining the program. In looking at data from ATARI's first six months and comparing to data obtained in these "first day surveys," clients are reporting a 21.6% increase in abstinence, a 9% decrease in depression, a 24% decrease in anxiety, and a decline of intravenous drug use from 7% to zero. "A little over half of ATARI participants had no online recovery help before this program," says Carmen Combs, evaluator at First Choice Services Inc. and First Choice Health System Inc., "Now 87% of the clients who responded to the survey stated they feel connected with their recovery support using A-CHESS." This means recovery help is making an impact.

In the spirit of Motivational Interviewing, adopting new technology during these times of extreme changes in the field has presented challenges. Clinicians and staff enter partnership with ATARI at varying stages of fears, concerns, and excitement. The setting and role of the clinician made a difference in the willingness to embark on integration of the smart phone and apps. Many of the more traditional clinicians were extremely concerned about HIPAA and boundaries. However, recovery coaches, peer specialists, and staff at day report centers were eager to embrace technology and were excited to have the additional resources made available by A-CHESS, and saw the ability to provide a reliable form of communication with clients via the smartphone as a tremendous resource. In order to allay fears of HIPAA breaches, clients were provided an extensive informed consent, required to set a unique password on the phone, and given the option to select a user name which could be fictional.

For additional accountability, the ATARI staff participated in bi-weekly calls with 50 other TAC grantees across the nation to share program successes and problem solve obstacles

as they arose. Additionally, we worked closely with JBS International and participated in onsite reviews of the ATARI program.

In March 2014, the ATARI staff participated in a technology showcase at the SAMHSA headquarters where we were able to meet with Dr. H. Westley Clark and the TAC grantees for a two-day healthcare and technology conference. This provided a platform to not only evaluate the current Healthcare Technology Programs, but to begin to develop sustainability objectives and look toward future projects.

As a result of these successes. ATARI has begun to develop a secure online platform for the delivery of one-on-one counseling services in order to further facilitate the integration of technology in West Virginia. There are many platforms available and a very comprehensive list can be found at www.behavioralhealthinnovation.com. In addition, ATARI selected approximately 25 Master's level licensed social workers, licensed professional counselors, psychologists, and Advanced Alcohol and Drug Counselors from West Virginia and provided the face-to-face two-day training for the National Board of Certified Counselors' Distance Credentialed Counselor (DCC), a national credential recognizing a professional with training in the best practices in distance counseling.

Some states are beginning to require additional coursework, continuing education or credentialing before clinicians provide "distance counseling." West Virginia licensing boards do not require additional formal education, however, the newly released American Counseling Association Code of Ethics indicate under section "H.1.a Knowledge and Competency – Counselors who engage in the use of distance counseling, technology, and/or social media develop knowledge and skills regarding related technical, ethical and legal considerations (e.g. special certifications, additional course work)" (American Counseling Association, 2014). Additionally, counselors and agencies need to seek clarification from malpractice insurance carriers about whether distance counseling is covered under their policy, and usually provide information about the platform security and assurance that the service delivery method falls within the counselors' competencies and scope of practice. Additional resource organizations which provide training and certifications include the Online Therapy Institute and the Telemental Health Institute and the National Frontier and Rural Addiction Technology Transfer Center (NFARATTC), which solely focuses on addiction treatment and technology, instead of "telemedicine" and "telepsychiatry." These allied professions have certainly forged the path for all behavioral health professionals; however, many of the resources fall short in addressing the needs of licensed counselors. NFARATTC, International Institute for Mental Health Online, Online Therapy Institute and the TeleMental Health Institute provide more specific resources for what is considered substance abuse and mental health. The Regional Technology Resource Centers are also a tremendous resource and similar to the ATTC Network, most states have a regional center and they are happy to assist.

As "digital immigrants" being able to conceptualize technology based counseling was initially difficult. However, this project has allowed us to see how this additional layer of support has enhanced the client's treatment experience and improved client engagement. Health care reform, governmental policy, and reimbursement sources are all trending toward technology enhanced treatment. However, we have been most powerful impacted by receiving thankful messages like "I'm not sure where I would be without this program" and "this program has helped save my life quite a few times just by having instant access to my fellow addicts and counselor." This is an exciting new time.

Additional Resources

The International Society
http://ismho.org

Online Therapy Institute
http://onlinetherapyinstitute.com

National Frontier & Rural ATTC
www.attcnetwork.org/regcenters/index_nfa_frontierrural.asp

Telemental Health Institute
http://telehealth.org

Telehealth Resource Center
www.telehealthresourcecenter.org

American Counseling Association Code of Ethics 2014
www.counseling.org/resources/aca-code-of-ethics.pdf

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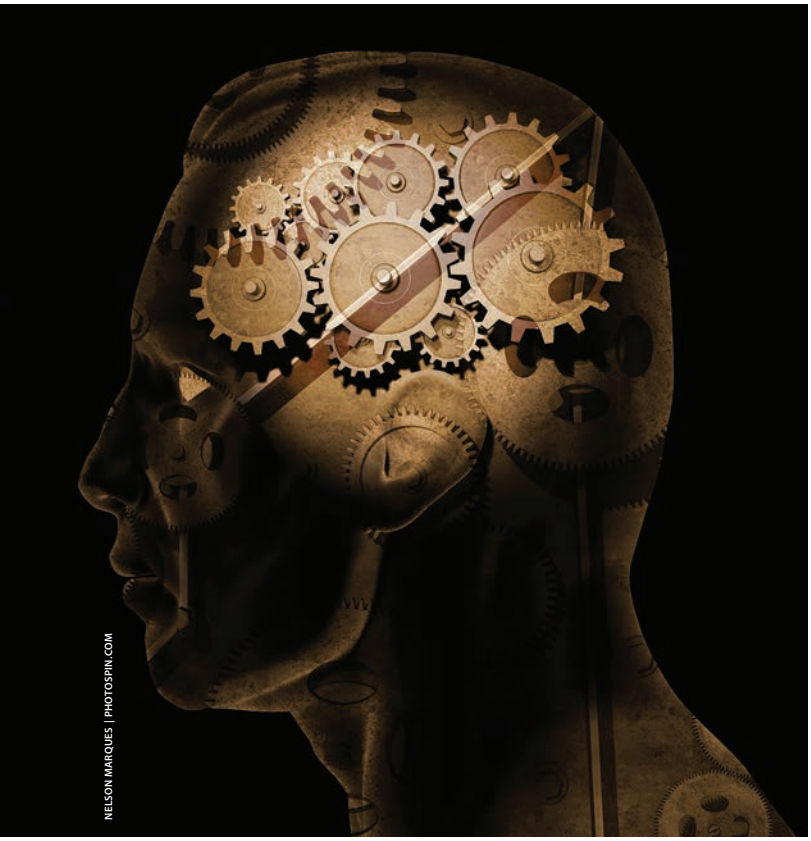
Teresa Warner is the ATARI Program Coordinator for First Choice Services, Inc. She has over 20 years working with substance dependent and the dual diagnosed clients, providing direct service in the community behavioral health centers, serving as a case manager in outpatient and residential settings, and as a probation officer for the West Virginia Supreme Court. In 2011, Ms. Warner began working for the West Virginia Physicians Health Program which provides intervention and supervision of medical professionals struggling with addiction. Under the supervision of Dr. P. Bradley Hall she obtained her Medical Review Officer Assistant Certification. Teresa was the 2012 recipient of the WVAADAC Bill Perkin's President's Award honoring her work with the recovery community. In 2013, she completed the West Virginia Recovery Coach Academy.

Neurobiology-Informed Responsive Addiction Treatment: One Therapist's Experience

By Joe Terhaar, PhD



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Since the inception of the first systematic, successful efforts to survive alcohol addiction through 12-step fellowship, there have been adaptations for other addictions (e.g., Narcotics Anonymous, Cocaine Anonymous, Overeaters Anonymous). From the application of 12-step principles in the Minnesota Model of treatment, to a variety of subsequent philosophical approaches (e.g., Cognitive Behavioral Therapy, Dialectic Behavioral Therapy, Choice Theory), our profession has diversified. We have a more holistic view of the person with a substance use disorder within the family (codependency, family behavioral therapy, etc.) and the community (sober housing, drug court, recovery-oriented systems of care, etc.) and appreciate the complexity of addressing co-occurring disorders and the complicated influence of past trauma. The profession continues to improve efforts to support life-preserving recovery.

Increasingly, treatment professionals help those with substance use disorders and families recognize that all drugs of abuse rewire the brain reward system away from survival and comfort to a drug-induced compulsion for exaggerated euphoric pleasure. These distortions of basic neurobiological mechanisms create the generic trap and craving cycle for reuse of drugs. Many chemical dependency professionals are familiar with the cycle: environmental cues and internal sensations are recognized by the amygdala brain processing center and trigger a small tempting dose of dopamine in the nucleus accumbens; then, with ingestion of the drug, there is a dopamine spike that temporarily quenches the ever-increasing appetite with ever-diminishing pleasure. With every use, the desire grows progressively and the euphoric effect lessens. All chemical dependency counselors should be well versed in conveying to clients and families this basic craving mechanism for drugs of abuse.

However, beyond the generic craving cycle and despite some shared neurotransmitters and pathways, each category of drug (e.g. cannabis, alcohol, opioids, methamphetamine, Spice, benzodiazepines) has neuromechanics that leave the drug user with characteristically different patterns of devastation and recovery needs. Most treatment centers have compelling films or presentations of the generic craving cycle, though almost none address drug-specific impacts on the brain. Tailoring the recovery plan and raising motivation with guidance that reflects the drug-specific impact on the brain is almost entirely overlooked. As a treatment community, we have not yet fully adapted and articulated our psycho-education and therapeutic responses to the actual drug-specific signature on the brain as reflected in an individualized service/treatment plan.

The Matrix Model for stimulant dependence (Rawson et al., 1995; Rawson, Obert, McCann, & Ling 1991) was a hallmark in recognizing the benefits of tailoring care to the primary drug of choice. It provided addiction professionals with an understanding of the need for and support to structure the recovering person's routine to reduced exposure to triggers. Structuring activities incompatible with drug use counteracts the frequent discharge of compulsive dopamine urges triggered a dozen times a day by environmental cues and internal sensations. However, looking at each drug's signature on the brain's wiring offers more specific guidance beyond introducing structure into the drug-user's hourly life. With treatment, we often facilitate clients and patients proceeding through generic, primarily time-driven denominations of care (by days for inpatient and hours of contact over days or months for outpatient). As professionals, we can be more responsive to the neurobiological needs of the individual suffering the drug-specific brain trap and impairments.

This article offers a sample of guiding points for providing care responsive to drug-specific brain traps for the individual, consistent with the Finlay's (1966) research on what motivated individuals to accept treatment. The crystalline element of motivation for treatment and change is in facilitating for the drug user a raised level of "concern about [him]self" (p. 76). Showing the drug user and family the mechanics of the drug-specific trap—with visual and kinesthetic examples relatable to their immediate lives—deepens comprehension of the debilitating downward spiral and the imperative for change and abstinence. This motivates far beyond the impact of the generic 'reward system being hijacked or rewired.' Presentation of the drug-specific impact unites the recovering person and family in their experiences. They can mutually understand the mechanical trap of addiction and collaborate to develop a recovery

plan that responds first to the recent adverse impact of the drug.

The most easily understood trap of drug impact is from the opioids. Often with the family and drug user together, I illustrate opioid action with the following story:

> An in-law of mine was distracted from his farm equipment, his right hand got caught in the machinery, and he lost three fingers and part of a fourth. Two days after the accident, I spoke to Phil in the hospital after his first of many surgeries. He spoke of the incredible pain, but I found it notable that despite such intense discomfort he was able to hold a conversation. Phil was being given powerful opioid 'painkillers.'

I then go on to explain that only about 20% of opioid action blocks the transmission of pain signals from the injury to the conscious receptors in the brain. With only 20% of the pain blocked, how could Phil have a cogent conversation? The other 80% of the opioid drug action is on the pain centers of the brain. The opioids were primarily reducing Phil's experience of the discomfort of the pain by triggering massive dopamine release in the nucleus accumbens pleasure center (the same area that produces the euphoria of sexual orgasm). Thus, the pain has not been killed, but overshadowed with drug-induced contentment and euphoria. Drawing the neuron-to-neuron transmission pattern and the mu receptor site on the nucleus accumbens facilitates comprehension and acceptance for the family and drug user of the physical nature of drug behavior. For the opioid user with no physical injury, there is a beyond-normal experience of euphoria and contentment.

I further explain that after weeks, months, or years of drug-induced addictive euphoria, if the appetite for the opioid drug is not satisfied, the pain receptors in the body and pain perception center in the brain scream pain. The pain is in the absence of an injury, but the pain sensing system reacts the same as if to an injury. This is happening in a person who has not developed skills and emotional capacities to cope with the physical and emotional pains of life.

When the impact of opioid drug use is explained in this way to opioid users, and in my practice family members (especially parents), motivation and relational participation palpably coalesce to provide healthy recovery supports. The necessity for abstinence is easy to accept. For the family, compassion and resolve of healthier non-enabling relational boundaries are strengthened. In family intervention preparation, the resolve to intervene is solidified and the process is tailored to target the perspective of the drug user. The family speaks with compassion to the pain, increasing the opioid user's acceptance of treatment. In treatment planning, neuro-informed compassion facilitates shifting from personalities and unresolved issues to collaboration on a plan that supports abstinence and recovery. It neither eliminates nor reduces the anger and pain of the harm from the addiction, but it motivates change to escape the neuro-trap for the individual and unites the family in meaningful relational change toward sobriety. This process nullifies denial.

The family and drug user comprehend that the imperative for abstinence goes beyond supporting engagement in activities incompatible with drug use to avoid re-experiencing the euphoria. The drug user, family, and recovery team are motivated to address the anxiety and fear of horrible pain while receptors gradually rebalance in a person ill-equipped to intrapersonally and interpersonally deal with the day-to-day discomforts of physical and emotional pain. Relapse is reduced by informing of the necessity for the drug user to engage in activities, marked by the half-hour, that are incompatible with access to any drugs of abuse in the balance with compassion for the challenges of abstinence. The family and drug user can now benefit from counseling support together, increasing their capacity to mutually support when dealing with pain. The family and the drug user are now better disposed to consider partial agonist (buprenorphine) and full antagonist (naltrexone) medication and many supports of addiction recovery.

For families with a loved-one suffering established chronic pain conditions, the mechanism for neuropathic pain can be sketched in 15 minutes. It is simple and accurate to encircle the neuron-to-neuron graphic with a red marker showing inflammation of the surrounding and supportive glia (Bland, Hutchinson, Maier, Watkins, & Johnson, 2009) that is, at least for many, caused by the short-acting opioid medications like morphine. When withdrawn from the short-acting pain medications (e.g. oxycontin, hydrocodone) and especially with the support of non-opioid pain management strategies, the pain either subsides or is manageable.

Visualizing the drug mechanism on the brain can powerfully motivate the drug user and family into action for each category of drug,

even cannabis (often viewed as only a recreational drug). When I draw the brain with arrows locating the pons and amygdala, it is easy to show the reduction of inhibitory action of GABA and the associated CB-1of cannabis use. The resulting drug-induced heightened experience of 'interest and vividness' can be illustrated in 15 minutes. Life feels more vibrant, even though one is less engaged. There is also a drug-induced sense of camaraderie and fellowship. To the observer, this is more noticeable when there is no one present or the cannabis user is not meaningfully engaged in relationship-building conversation. Families and drug users can now see the mechanism and understand why he or she has been experiencing a drug-induced contentment in the mundane, a lack of initiative or interest in novelty (with little motivation to accomplish), and deteriorating memory. This information engages the drug user and family to work together to increase structure for abstinence and informs them of the need to break down tasks into manageable and systematically rewarded steps. This is critical for the drug user with reduced neuro-biological capacity for intrinsic motivation. It also guides the team to responsively offer meaningful supports for problem-solving the alienation, lack of sober social connections, and feelings of abandonment experienced by early recovering cannabis users.

For alcohol, many counselors highlight its impact on GABA as it lowers inhibitions and impairs judgment, with the eventual impairments to gross intoxication. I find it far more motivating and transformational, in 15 to 20 minutes of an individual or family session, to highlight the impact on serotonin. Serotonin provides the sense of contentment after a good meal, a restful night's sleep, or the incredible sense of satisfaction after the euphoria of sexual orgasm. However, for the alcoholic, especially in those genetically vulnerable, as with the SLC 6A4 pattern (Seneviratne, Huang, Ait-Daoud, Li, & Johnson, 2009), serotonin levels are exaggerated with alcohol consumption and then drop well-below normal. This pattern manifests in an initial enhanced sense of contentment, as many an alcoholic has reported, 'finally feeling normal.' I draw a blue line showing the slight rise from and return to baseline of the serotonin level for the social drinker and a red line showing the alcoholic cycle that spikes up with contentment and euphoria and then drops far below normal with malaise and irritability manifesting themselves. The family and the drinker see the rollercoaster of behavior patterns they have long experienced reflected in the red line. The compulsion to feel contentment from the artificial serotonin rise and the compensatory drop afterwards into dissatisfaction and hangover are explained. The family and drinker can see the necessity for complete abstinence and transform it into resolve not to tolerate the rollercoaster ride of desperation, bargaining, and promises that have already failed. The visual, kinesthetic, and emotional interactions motivate recovery.

These interactions are also especially critical for benzodiazepine addiction recovery. Benzodiazepines very specifically enhance the inhibitory influence of GABA, particularly in the locus coeruleus, part of the brain's alarm system. Drawing this takes only about 10 minutes and makes it apparent how benzodiazepine action dampens the brain's ability to respond with alarm. Showing benzodiazepine action in the nucleus accumbens explains the creation of the highly rewarding fake euphoria. Presenting these basic mechanisms empowers and guides the drug user when responding to the chemically-induced anxiety and depression of benzodiazepine withdrawal. Recovery is motivated toward building coping capacity for stress, and in increasing relational capacity in family relationships.

With these few examples, it is clear how the neuro-biological impact of each drug category on the brain can be presented efficiently in a visually and kinesthetically representative manner to support comprehension of the addiction trap, guiding informed behavior change for the drug user, family, and interdisciplinary team. Presenting and collaboratively responding to the individual signature imprint of each drug category on the brain is the next iteration in the long evolution of saving lives.

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CEPTA, continued from page 21

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Is Human Sexuality Training Important for a Drug and Alcohol Therapist?

By Thimi W. Pappas, PhD, LSW and Richard Thurlow, PhD

How does a therapist react if a client discloses a highly personal sexuality issue associated with their substance use disorder? An experienced therapist may view such a revelation as a breakthrough that will assist in efforts to help the client move away from reliance on drugs or alcohol. A therapist who is uncomfortable with, or lacks confidence in dealing with such topics, may refer such a client to a colleague that is experienced with sexuality issues. Unfortunately, such clients might otherwise hear a response that is not so helpful: "We aren't here to talk about that. We're only here to get you sober."

A body of research, growing for at least 15 years, has identified a strong connection between use and personal issues related to sex and sexuality (Califano, 1999). However, addiction professionals, including licensed and certified drug and alcohol clinicians, usually receive little or no formal sexuality training focused on dealing with sexuality issues (Braun-Harvey, 2011). Sexuality issues connected to substance use disorders include: anxiety that is based on sex or sexuality, problems with sexual function, recovery from sexual trauma, sexual orientation, gender identity, reducing sexual inhibitions, or overcoming feelings of guilt. Despite the increased awareness of links between sexuality issues and substance use disorders, no broad consensus yet exists as to which issues, if any, are important enough that training in dealing with them should be required for certification or licensing.

There is, however, one issue related to sexuality education that is agreed to be essential for addiction certification: training in HIV/AIDS awareness. Addiction professionals receive regular training on educating clients to avoid behaviors that put them at high risk of exposure to HIV

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infection: specifically, unprotected sex or sharing of needles. But this training does not inform therapists about the sexual issues that often lead to high-risk behaviors. Therefore, a major gap exists in the sexuality training offered to addiction professionals. So … which sexuality issues should be offered in the training of addiction professionals?

In January of 2014, NAADAC, the Association for Addiction Professionals, sent emails to some of its members inviting them to participate in a survey regarding sexuality issues and addiction treatment being conducted as part of a doctoral dissertation in the Center for Sexuality Education at Widener University. The survey presented a number of sexuality issues known to be connected to substance use disorders and asked the respondents to rate the level of importance they ascribed to each issue relative to treatment of substance use disorders. The thirty-five questions on the survey were intended to investigate first; whether clinicians believe that training in sexuality issues related to substance use is important for effective therapy, and second; whether clinicians believe that some sexuality issues related to treatment of substance use disorders are more important than others. (Pappas, 2014).

Survey participants were asked to respond with one of five choices to each of the survey questions indicating the level of importance they give to the issue stated. The choices given were: Not Needed, Possibly Useful, Definitely Useful, Important, or Essential. These choices were coded numerically as 1 through 5, respectively. This means that the larger the mean score for any item, the higher the importance the respondents gave to that item, on average.

Additional addiction professionals were included in the survey, but the majority of those that responded were NAADAC members. On average, the survey respondents had 25 years of clinical experience. This indicates that the data reflects an experienced cohort of addiction professionals. While a few of the respondents felt there was little need for an increase in sexuality education, many more respondents felt that every issue mentioned in the survey reached a level of importance of saying, at least, that it was "definitely useful." Therefore, we feel confident in saying that, on average, the respondents felt that adding sexuality training on issues related to substance use disorder is important.

Sexuality Issues With the Highest Importance Ratings

The highest mean, indicating that it is considered essential by most of the respondents, was received for an item that asked about the need for addiction professionals to suspend judgment about sexuality issues that they find distasteful. Another related item, asking whether clinicians should examine their own sexuality values, also received a high rating. It seems that the respondents feel that one major objective in human sexuality education for substance professionals would be to have clinicians develop a broader understanding of, and tolerance for, sexuality values and issues that differ from their own.

Two items related to HIV and sexually transmitted diseases were also ranked among the most important issues. These rankings may be related to the prevalence of training about HIV and STDs in the current training of addiction professionals. This was mentioned in a comment from one respondent that "HIV/AIDS training of clinicians is 6 hours every 2 years ad nauseum." Two additional questions related to sexual trauma involved behaviors that result from sexual trauma and how drug and alcohol usage may put clients at risk for sexual trauma. These additional items enhance the view that other high-risk sexual behaviors are seen to be important in the training of addiction professionals. The other items rated as the most important related to setting sexual boundaries in future relationships and the role of sexuality-based anxiety in relapse. Both of these items can be seen as related to relapse prevention.

It would seem, therefore, that the highest rankings in the survey went to items related to (1) addiction professionals suspending judgment about their clients' sexuality issues, (2) helping clients avoid engaging in, or being victim to, high-risk sexual behaviors, and (3) helping clients prevent relapse due to sexuality issues.

Lowest Importance Ratings

Among the lowest ranked items in the survey are items related to specific treatment techniques, such as the use of a sexual genogram, and knowledge about the human sexual response cycle. These items might have received lower rankings due to a lack of sexuality knowledge among the respondents. For instance, a survey of members of the American Association of Marriage and Family Therapists (AAMFT) found that a therapist's comfort level in discussing sexuality issues was related to their level of training in human sexuality (Hays, 2002).

Surprisingly, in that there was a general support for adding more sexuality training, some of the lowest ranked items are items related to an increase in formal sexuality training requirements for substance addiction professionals and the use of individual treatment sessions rather than group sessions when dealing with sexuality issues. Unfortunately, both of these areas can be seen as protecting the bottom line. Increased training equates to increased costs for the therapist, while individual sessions equate to lower revenue compared to group therapy sessions. However, these items were still seen as important to most of the respondents.

What's Next?

Further research needs to be conducted to expand on these findings, however, the results from this study (Pappas, 2014) should begin a dialogue at all levels as to the importance of sexuality training for individuals and agencies involved in treatment of drug and alcohol dependency. Hopefully, such a dialogue will lead to a consensus on the need for, and the specific goals of, the specific training to be given.

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OPINION

Counselors in Glass Houses

By Janis Dauer, MS, CSAC

An item in the January 21, 2014 edition of NAADAC's *Addiction & Recovery eNews* titled "Most U.S. Doctors Fail to Discuss Alcohol with Patients" linked to a news story about a study showing that doctors aren't asking patients about their alcohol use like they should be (NAADAC, 2014). Numerous valid points were made and no doubt many addiction counselors agreed with them, but this old adage came to mind as I read it: "People in glass houses shouldn't throw stones." Before addiction treatment professionals point their fingers at a perceived gap in primary care providers' services, perhaps we should look at ourselves and assess the situation with regards to the Axis I substance use disorder most often left untreated in our programs: nicotine dependence.

"[S]urely clinicians and programs that specialize in addiction treatment should be addressing tobacco use disorder just like alcohol and other drug use disorders…No other substance use disorder is identified (diagnosed) and then ignored by our field"

If we feel physicians should screen patients for alcohol use because 38 million American adults drink excessively, about 88,000 people in the United States die each year because of drinking too much, and yet only one in six adults discuss drinking with their doctor (Beasley, 2014)—surely addiction counselors ought to be screening every client for tobacco use and dependence. In the United States, over 440,000 tobacco-caused deaths occur annually and a hugely disproportionate percent of those are people with substance abuse and mental health disorders (Schroeder & Morris, 2010). National data on how many SA/MH treatment providers assess tobacco use disorder and address it as an Axis I primary substance use disorder, which is the appropriate service for these behavioral healthcare settings, is not even available. There simply is no data collection tool that asks about this service.

If we feel primary care practices need to change and make alcohol use screening part of routine care in the same way they screen for high blood pressure and high cholesterol, surely clinicians and programs that specialize in addiction treatment should be addressing tobacco use disorder just like alcohol and other drug use disorders. Not as a risk factor for health problems, not just in our prevention programs but throughout the treatment continuum. No other substance use disorder is identified (diagnosed) and then ignored by our field.

Doctors often say they are too busy to screen patients for alcohol abuse and may view treatment options as ineffective. They frequently do not feel they have the training needed to effectively discuss alcohol or drug abuse and believe most patients are not interested in counseling (Beasley, 2014). Sadly, addiction counselors often make the same statements about tobacco use among their client population, in spite of the fact that treatment of substance use disorders is actually their specialty. Who is better trained and qualified to assess dependence to a drug, to effectively work with people not ready to totally abstain from use yet, to approach addiction as a chronic disease in which relapse is common and recovery takes time, and to provide individualized assistance?

If addiction treatment providers screen, assess motivation, and provide an appropriate counseling intervention (e.g., Motivational Interviewing or Cognitive-Behavioral Therapy) or at a minimum do an Screening, Brief Intervention, and Referral to Treatment (SBIRT) intervention and refer to a local Tobacco Treatment Specialist or trained Quitline Coach, this could result in a substantial reduction in tobacco use and increase in tobacco recovery among their client population. Instead, skills addiction providers possess are not applied and while clients are helped to recover from their other addictions, they are left to get sick and die prematurely from the drug use that kills more of them than all the others combined.

I hope this opinion piece will generate interest in discussion about the professional responsibilities of addiction counselors to provide comprehensive treatment services that address all drug use disorders with clients admitted to their programs for any substance use disorder or co-occurring disorder, including tobacco. The concept of parity should apply here, too. While it may not be possible to admit people into treatment who only have a tobacco use disorder, there is no valid reason for the addiction treatment field to be ignoring the DSM diagnostic code 305.1 when fully aware of which clients have this substance use disorder.

Is the program staff at your facility screening for nicotine dependence? Ask staff or check some charts—what percentage of clients are being counseled about tobacco use and nicotine dependence? I hope NAADAC will provide continuing leadership in advocating for full integration of treatment for tobacco use disorder into SUD/MH services provided by its members and the field in general. But change can begin with you.

For an excellent source of training tailored to addiction counselors, go to the Tobacco Recovery Resource Exchange at www.tobaccorecovery.org. You may be surprised to find out how capable you already are and realize you only need to begin using your skills.

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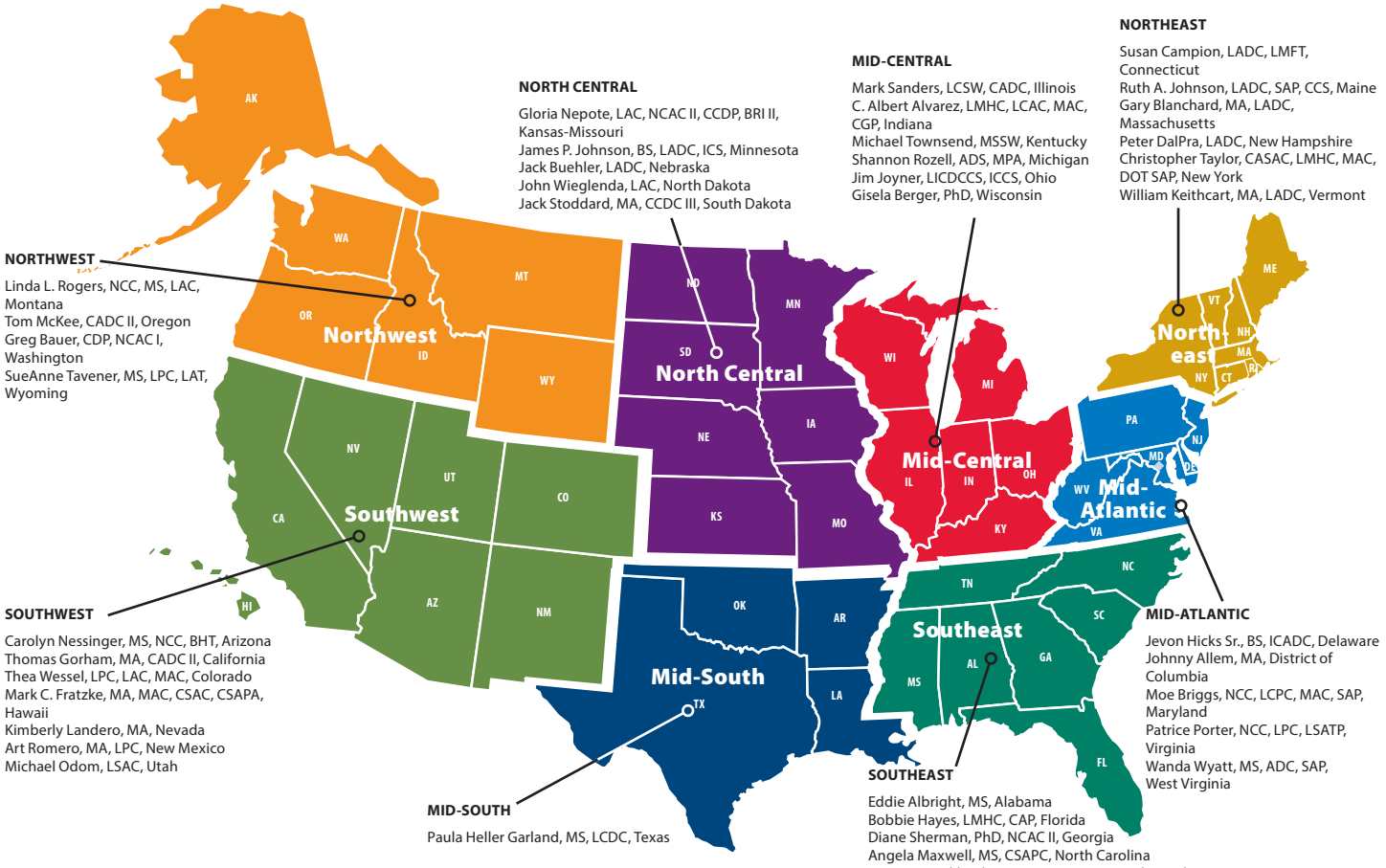

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