NAADAC’s Critical Role in the Development of a Profession: 40 Years of Achievement
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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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Reflections Over 10 Years in the NAADAC Pond

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

It is not possible to write about the past 10 years as Executive Director at NAADAC without first describing how I came to be at this wonderful association. Many of you would call it a “God Thing.” I left my children, my husband, and a beautiful home of five acres of old wooded timber to come to Washington, D.C. to work at the Central East Addiction Technology Transfer Center (CEATTC) and Danya Institute because I felt a higher calling. With my family’s words “you have to go to make a difference” echoing in my ears, I took the leap to get involved with the addiction profession on a national level. Within my first week in my new and geographically confusing city, I learned that NAADAC was facing difficulties. Within a year, I was recruited by NAADAC’s incoming President, Mary Woods, to help guide NAADAC through a potential merger and the effects of a larger financial crisis. Being a past President of NAADAC, I wanted to do everything I could to support the association that I loved and came on board to assist while continuing my work at CEATTC.

My first item of business was to stabilize NAADAC’s financial situation and build a healthier association. With a small, but dedicated, staff of nine, I went to work to create a strategy and set goals with benchmarks. A major priority was to expand revenue streams. At the time, over 90 percent of the association’s funds came from membership and certification fees. New relationships and partnerships were formed or strengthened, new cutting-edge training programs were developed and implemented across the country to increase capability and competency for addiction and other helping professionals, and annual, regional, and state conferences were created with affiliates as key stakeholders and decision makers.

Next, NAADAC needed to step up its advocacy efforts on behalf of the addiction profession. To start, we focused on the Substance Abuse Block Grant, workforce development, and advancement and medical coverage for substance use disorders. Over the past 10 years, I am proud of what NAADAC has helped achieve for both addiction professionals and the clients we serve. Some highlights include: Block Grant sustainability and/or growth; the Second Chance Act; the Patient Protection and Affordable Care Act; and the new SAMHSA Minority Fellowship Program for Addiction Counselors.

NAADAC has changed and accomplished so much just 10 years, it is hard to choose a few accomplishments to highlight. NAADAC’s Certification Commission became the National Certification Commission for Addiction Professionals (NCC AP) and expanded credentials offered to include certifications for adolescent specialists, nicotine dependence specialists, co-occurring disorders, peer recovery professionals, clinical supervisors, and student assistance professionals. NAADAC has also significantly expanded its professional development education program, with the addition of webinars to the cadre of face-to-face and home study trainings offered. Starting with 12 webinars a year, NAADAC now offers over 24 webinars a year and contracts with other groups and organizations to create even more trainings for addiction and other helping professionals. NAADAC’s dedication to the education and professional development of addiction professionals is further demonstrated by our re-launched quarterly magazine for members, Advances in Addiction & Recovery, and our two epublications, the weekly Professional eUpdate and the bi-weekly Addiction & Recovery eNews.

At the encouragement of SAMHSA’s Center for Substance Abuse Treatment (CSAT), NAADAC worked in concert with the International Coalition for Addiction Studies Education (INCASE) to create national addiction education curriculum standards for one-year certificates to doctoral-level education programs and was significant in setting the profession of addiction as a credible and legitimate profession against the backdrop of other professionals such as social work, marriage and family, and general counseling. With that accomplished, INCASE and NAADAC formed the National Addiction Studies Accreditation Commission (NASAC), the only accrediting body that represents addiction-focused educators and practitioners and accredits all levels of academic education that have Addiction Studies majors, minors, or concentrations. NASAC now sets the standards for what is acceptable education for an addiction professional. At the same time, NAADAC gave technical assistance to a national scope of practice based on a tiered system of progressive professional development that was adopted by a national stakeholders group and then promoted by SAMHSA as a national model.

I’m also proud of NAADAC’s international expansion, and the numerous opportunities for international service, trainings, and education that NAADAC and NAADAC members have been given to help other countries develop their addiction counseling workforce. NAADAC has worked in over 50 countries to train, create certification and training systems “in country,” and to build corresponding affiliates where appropriate. Since 1993, NAADAC has worked in American Samoa, Antigua, Australia, Bermuda, Cambodia, Canada, China, Czechoslovakia, Cuba, Cyprus, Egypt, El Salvador, Greece, Guam, Hong Kong, Iceland, Indonesia, Kenya, Maldives, New Zealand, Poland, Palo, Puerto Rico, South Africa, South Korea, and Vietnam. While these activities have provided crucially needed development of addiction treatment in other countries, they have also provided many life-changing personal and professional development opportunities for NAADAC staff and members.

It is hard to believe I have been at NAADAC for 10 years and exciting to think about everything the association has accomplished during that time, and during the past 40 years! What a reflection on the many professionals who have chosen to help people recover their lives. I am proud to be your Executive Director and proud to be a NAADAC member and supporter. I cannot wait to see what the future holds for NAADAC and for the addiction profession.

Blessings!

Cynthia Moreno Tuohy

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.
NAADAC Announces New Recovery to Practice Certificate Program

By Misti Storie, MS, NCC, Director of Training and Professional Development

As you know, recovery has always had a stronghold in the addiction profession and its workforce. In fact, the addiction profession, founded by individuals in recovery, laid the groundwork to provide addiction services within a recovery orientation. As such, the addiction profession has been using recovery-oriented skills and practices since its foundation, but there has not been a formalized way to demonstrate an addiction professional’s recovery-orientation and advanced education—until now.

NAADAC is excited to announce its new Recovery to Practice (RTP) Certificate Program that is now available to all professionals. The Recovery to Practice (RTP) Certificate Program is designed to further hasten awareness, acceptance, and adoption of recovery-based practices in the delivery of addiction-related services and now affords addiction professionals the opportunity to demonstrate to employers, third-party payors, and clients their advanced education in recovery-oriented concepts, skills, and practices.

The Recovery to Practice (RTP) Certificate Program builds on SAMHSA’s definition, 10 guiding principles, and fundamental components of recovery, as well as NAADAC’s work over the past three years to develop a multi-level, national Recovery to Practice training curriculum. You probably have already satisfied many of the requirements of this certificate through your participation in NAADAC’s Webinar Series, Online Courses, and Independent Study Courses over the past few years!

To qualify for the Certificate, addiction practitioners must:

• Provide documentation of 30 contact hours of continuing education from the “Approved Education List” of recovery-oriented education and training (see page 6 for list);
• Complete the application (available at www.naadac.org/rtp-certificate-program); and
• Submit payment ($50 for NAADAC members; $100 for non-members).

By completing the required education, you will receive a Professional Certificate to hang on your wall and include in your portfolio.

PLEASE NOTE: This certificate is meant purely as an educational tool and does not qualify certificate holders to counsel those with addictions.

For more information, please visit www.naadac.org/rtp-certificate-program or contact NAADAC by email at naadac@naadac.org or phone at 800.548.0497.

Misti Storie is the Director of Training and Professional Development for NAADAC, the Association for Addiction Professionals. She is the Technical Writer and advisor for many of NAADAC’s educational face-to-face, homestudy and online trainings on such topics as co-occurring disorders, medication-assisted treatment, Motivational Interviewing, DOT/SAP and SBIRT. She has also authored and edited the Basics of Addiction Counseling: Desk Reference and Study Guide, tenth edition and numerous articles and book chapters concerning addiction-related issues. Storie holds a Master of Science degree in Professional Counseling from Georgia State University and a Master of Science degree in Justice, Law and Society from American University.

Education, continued on page 6 ☛
Recovery to Practice Certificate Program Approved Education List

**REQUIRED COURSEWORK:** Each applicant must complete ALL NINE webinars from the Recovery to Practice (RTP) Training Curriculum (15.5 CEUs):
- Defining Addiction Recovery webinar (1.5 CEUs)
- What Does Science Say? Reviewing Recovery Research webinar (2 CEUs)
- The History of Recovery in the United States and the Addiction Profession webinar (1.5 CEUs)
- Defining Recovery-Oriented Systems of Care (ROSC) webinar (1.5 CEUs)
- Understanding the Role of Peer Recovery Coaches in the Addiction Profession webinar (1.5 CEUs)
- Including Family and Community in the Recovery Process webinar (2 CEUs)
- Collaborating with Other Professions, Professionals, and Communities webinar (1.5 CEUs)
- Using Recovery-Oriented Principles in Addiction Counseling Practice webinar (2 CEUs)
- Exploring Techniques to Support Long-Term Addiction Recovery webinar (2 CEUs)

All webinars are available on-demand and can be completed from your home or office. After you participate in these webinars, you are more than halfway done! Obtain the rest of the required education by selecting from over 20 different topics from the “Flexible Coursework” list below.

**FLEXIBLE COURSEWORK:** Each applicant must select from the following list to gain the remaining required continuing education hours (14.5 CEUs):
- The Addiction Professional’s Mini-Guide to Screening, Brief Intervention and Referral to Treatment (SBIRT) webinar (3 CEUs)
- Blending Solutions: Integrating Motivational Interviewing with Pharmacotherapy Online Course (2 CEUs)
- Conflict Trauma and Addiction webinar (2 CEUs)
- Conflict Resolution for Professionals and Clients in Recovery Independent Study Course (11 CEUs)
- Cultural Considerations for the Ethically Aware Clinician webinar (1 CE)
- Impacts of Addiction on the Family System and Children webinar (1 CE)
- The Ins & Outs of Medication-Assisted Treatment & Recovery for Alcohol Dependence webinar (1.5 CEUs)
- The Ins & Outs of Medication-Assisted Treatment & Recovery for Opioid Dependence webinar (1.5 CEUs)
- Integrated Cognitive Behavioral Therapy for PTSD webinar (1 CE)
- Integrating Treatment for Co-occurring Disorders: An Introduction to What Every Addiction Counselor Needs to Know Independent Study Course (18 CEUs)
- Integrating Treatment for Co-Occurring Disorders: An Introduction to What Every Addiction Counselor Needs to Know webinar (2 CEUs)
- Medication Management for Addiction Professionals: Campral Series Independent Study Course (7 CEUs)
- Motivational Interviewing: Clinical Practice with Pharmacotherapy Online Course (1.5 CEUs)
- New Innovations with Opioid Treatment: Buprenorphine Independent Study Course (12 CEUs)
- New Innovations with Opioid Treatment: Buprenorphine Online Course (1.5 CEUs)
- New Horizons: Integrating Motivational Styles, Strategies and Skills with Pharmacotherapy Independent Study Course (15 CEUs)
- Peer Recovery Support Services – Initiating, Stabilizing and Sustaining Long-term Recovery webinar (1 CE)
- Pharmacotherapy: Integrating New Tools into Practice Independent Study Course (15 CEUs)
- Providing Effective Opioid Dependence Treatment - Connecting Science with Treatment webinar (1 CE)
- Referring to Mutual Support Groups - Distinguishing between the Choices webinar (1 CE)
- Rein in Your Brain webinar (2 CEUs)
- Spirituality & Recovery: The Art and Science of Healing webinar (1 CE)
NAADAC Honors Three Professionals

By Cynthia Moreno Tuohy, NAADAC Executive Director

NAADAC will honor three of our addiction professionals who have served the profession for many years and lost their lives too early. Each will receive the President’s Award at the NAADAC Annual Conference in Seattle, with family members accepting. NAADAC leadership thanks each family for giving their loved one to the profession over their many years of service. We have been blessed by their many contributions, and they will remain in our memories for their great works to the addiction profession.

Alice Marie Kibby, LISAC, CSAC I

Alice Kibby guided hundreds of women through her state-licensed residential substance use disorder treatment program for women in Mesa, AZ, one of only a few programs in the state that took children. Kibby spent 14 years running Alice’s Wonderland helping up to 40 families at a time through a combination of tough but unconditional love, no-nonsense mentoring, professional counseling, parenting and nutrition classes, chores, and a long list of restrictions, forever changing the lives of the women and mothers she guided. After moving to Missouri to be closer to her children and grandchildren, Kibby started AM Recov, LLC, a program that continues on in her memory serving clients with addictive disorders. Kibby was a strong advocate for her clients and for NAADAC, serving on the Board of Directors and as President of the Arizona Affiliate, attending the state and national advocacy conferences, writing and meeting with legislators, and making her mark in promoting treatment and services for individuals and families. Kibby lost her battle with cancer on January 20, 2014. We will miss her smile, warm heart, ever present positivity, and remarkable dedication. Her many acts of kindness, generosity, selfless acts and unconditional love were experienced by so many and will never be forgotten.

David Powell, PhD

David Powell was a giant in the addiction profession who cast a long shadow in the lives of those he mentored and touched. His professional accolades were many. Powell was an Assistant Clinical Professor of Psychiatry at the Yale University School of Medicine, as well as President of the International Center for Health Concerns, Inc., through which he trained on a variety of topics in 50 states and 87 countries worldwide. He was the founder and Chief Executive Officer of ETP, Inc. from 1974–1999, providing employee assistance program services to companies such as IBM, US Tobacco, Berlin Steel, Trump, Aetna Insurance Company, Travelers Insurance Companies, Rolls Royce, James River, among 200 corporations. ETP also established and managed the Clinical Preceptorship Program, a comprehensive clinical supervision system for the U.S. Navy and Marine Corps, at 100 military bases worldwide, from 1976–1999. Powell served on the editorial boards of four professional journals, on advisory boards for the Harvard Medical School and Johns Hopkins University, and was the author of 10 professional books, including Clinical Supervision in Alcohol and Drug Abuse Counseling. In addition, he assisted in establishing clinical supervision systems for most of the major substance abuse treatment centers in the United States including the Betty Ford Center, Caron Foundation, Sierra Tucson, Hanley Center, Hazelden, Gateway Rehabilitation, and Phoenix House, among others. For many of us, David Powell was the person who took the textbook of clinical supervision and made into the real practice of clinical supervision. He was often a prominent speaker and trainer at NAADAC state affiliate and national conferences, and was a role model for many emerging leaders in the addiction profession. Powell died on November 1, 2013. He mentored many, taught many, and will be extremely missed.

Greg Lovelidge, LCDC, ADC III

Greg Lovelidge was a leader and influential member of the substance use disorder treatment, prevention, and education community for 40 years. From his earliest beginnings, Lovelidge, a licensed chemical dependency counselor, supported and served those who advocated for professionalism in our field. Lovelidge championed the need for furthering addiction counselor education and training, founding the Institute of Chemical Dependency Studies in Austin, TX in 1992, and starting the Recovery Today Newspaper in 1993. He served as Chairman of the Board of Trustees for the Palmer Drug Abuse Program in Texas, on the Board of the Texas Association of Addiction Professionals (TAAP), and was a Regional Vice President for NAADAC. He advocated for licensing standards and served on innumerable task forces and committees throughout Texas and the United States. Lovelidge passed away on November 18, 2013. He was a devoted father, caring and giving friend, and a mentor to many. His love for the profession and for the professionals working alongside him will always be remembered.
Advances in Addiction & Recovery | FALL 2014

NAADAC’s Critical Role in the Development of a Profession: 40 Years of Achievement


By Jessica Gleason, NAADAC Director of Communications

In 1915, Abraham Flexner, the famed medical education reformer, gave an address on the subject, “Is Social Work a Profession?” In that address, he noted the core characteristics that distinguish the professions: large individual responsibility (and resulting ethical duties), reliance on science as a foundation for practice, practical assistance, an “educationally communicable technique,” self-organization, and altruistic motivations. Nearly 60 years later, a group of pioneers envisioned addiction counseling as a “new profession” and laid the foundation for NAADAC: The Association of Addiction Professionals. After 40 years of championing this new profession and helping forge the elements that Flexner noted in his 1915 address, NAADAC is one of the oldest addiction-focused professional associations in the United States. With 9,500 members, 47 state affiliates, five Pacific Jurisdiction affiliates, and a current constituency of over 33,000 through a variety of programs, NAADAC is firmly entrenched as the premier organization for addiction services professionals, and is poised to continue that growth.

To commemorate its 40th anniversary, NAADAC recruited William (“Bill”) White, the addiction field’s premier historian and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* and related historical texts, to write a book capturing the definitive history of addiction counseling and NAADAC’s role in that history. Constructed from archival research and solicited diverse voices from the field, *The History of Addiction Counseling in the United States* traces the rise of this “new profession” from its roots in Native American “recovery circles” and nineteenth century temperance missionaries through the rise of lay alcoholism therapists in the early twentieth century, paraprofessional “AA counselors” and “ex-addict counselors” in the mid-twentieth century and the subsequent integration of multiple disciplines within the professionalization of addiction counseling. It also traces the influences of addiction medicine, addiction psychiatry, psychology, social work, and mental health counseling on the modern practice of addiction counseling. The following is a compilation of summaries and excerpts from Bill’s chapters on the history of NAADAC.

### NAADAC’s Founding and Developmental Years

Efforts to organize the nation’s alcoholism counselors at the national level began in the early 1970s under impetus of the landmark Comprehensive Alcohol Abuse and Alcoholism Treatment, Rehabilitation and Prevention Act of 1970. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) was established and began awarding over $100 million annually in grants for treatment, prevention, and research—resulting in a rapid expansion of the alcoholism field. Proliferation of treatment programs created a demand for more counselors, and a need for an organized constituency to represent their interests in a rapidly changing field.

Recognizing this need, a group of addiction counselors organized the National Association of Alcoholism Counselors and Trainers (NAACT) in 1972. Robert Dorris was elected the Association’s first president and Matt Rose was chosen to serve as its first executive director. Rose was unpaid and worked without any support staff from his Arlington, VA home. Two years later, as the emerging field faced a growing number of development issues and increased opportunities for alcoholism counselors, it became clear that counselors needed representation that had a broader, national focus.

As a result, at the 1974 NAACT annual conference in Topeka, KS, the group voted to de-emphasize “trainers,” drop the “T” from NAACT, and become the National Association of Alcoholism Counselors (NAAC).

NAAC held its first full-dress meeting in Denver on July 5, 1975, but it wasn’t until the annual conference in Kansas City, MO, in 1977 that the organization solidified its place in the association world with established bylaws and a constitution. It was decided that NAAC’s primary objective would be to establish a mechanism for the national certification of qualified alcoholism counselor professionals so as to provide for reciprocity, with a secondary objective to establish minimum national standards for the certification of qualified alcoholism counselors. At that time, NAAC had 20 state associations as affiliates, representing some 4,000 counselors, a new president, Mel Schulstad, and a new executive director, Douglas Harton. Harton became the first paid NAAC staff, and moved the Association’s headquarters to Flint, MI.

In 1975, NAAC had already begun working toward its primary objective by participating on a NIAAA...
planning panel on counselor credentialing, and in 1978, established the National Commission for the Credentialing of Alcoholism Counselors (NCCAC) with five other organizations. Critical decisions were being made at the national level in the mid-1970s on the question of nationally recognized standards and procedures for certification of alcoholism counselors, and NAAC had gained the necessary credibility to be recognized as the voice of the nation’s counselors in the deliberations on the issue. Unfortunately, the work of the NCCAC was cancelled in 1979 by a new NIAAA director, causing repercussions, such as that differing state standards and sets of national certifications for addiction professionals, all with distinct regulations and requirement, still frustrate professionals today.

In 1979, Edward Riordan, a working counselor in Virginia, became executive director and NAAC headquarters shifted back to Arlington, where it had an office suite for the first time. During this time, NAAC worked on educating members on what was going on in the field and in the Association, and also started working towards furthering the educational opportunities for members by creating the National Alcoholism and Drug Abuse Counselors Education Program (NADACEP) (now the NAADAC Education and Research Foundation (NERF)). Among other tasks, NADACEP worked with state certification boards to ensure that credits recognized in certification and re-certification.

**From NAAC TO NAADAC in the 1980s**

Having worked to bolster the administrative and financial structure of the Association and increase the public policy activities at the national level, Ed Riordan resigned from NAAC in 1981 and passed the executive director baton to David Oughton. That same year, NAAC hosted a meeting with the Certification Reciprocity Consortium/Alcoholism and Other Drug Abuse (CRC/AODA) and the National Commission for the Credentialing of Alcoholism Counselors (NCCAC) known as The South Bend Connection to discuss various levels of cooperation and a potential merger. The controversy surrounding proposals to bring two groups with distinct identities—alcoholism counselors and drug abuse counselors—within a single organization dominated NAAC leaders and the larger field in the late 1970s and early 1980s. Finally, in 1982, the NAAC Board voted to change its name to the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). Tom Claunch, then-President of NAADAC, wrote “We will in no way abandon our heritage or lessen our focus on alcoholism if we seek to better serve those whom we exist to serve. A profession must be prepared to change as its body of knowledge evolves.”

The 1982 NAAC annual meeting held aboard the Queen Mary in California was a landmark meeting: a new name, a new Board of Directors, and a new set of bylaws that enabled individual members to join the organization. This was the beginning of NAADAC as it exists today.

All of these activities were changing the face of the association, and credentialing issues were making news again. In May of 1982, NIAAA awarded a 12-month contract to Birch & Davis Associates, Inc., and its subcontractor, the National Commission for Health Certifying Agencies, to develop model professional standards and procedures for credentialing alcoholism counselors. Four years later, Birch & Davis published a report, with NAADAC’s input, that was considered a milestone in the profession’s growth and maturation. The report defined for the first time the work of alcoholism and drug abuse counselors. It also provided guidance, support, and credibility to certification efforts throughout the country.

During this time, NAADAC enhanced and marketed its Liability Insurance Program for Counselors, adopted the NAADAC Code of Ethics, and established the Peer Assistance Generic Model Program. In 1983, NAADAC’s official publication, The Counselor went from being a monthly newsletter to a bimonthly magazine that would go on to win awards and attract articles from the best and the brightest in the field. By 1984, NAADAC membership nearly doubled to 10,000. In 1985, Stephen Kreimer became executive director.

In the mid-1980s, NAADAC also focused on shaping lawmakers and the nation’s opinions on addiction through its advocacy efforts, particularly to secure adequate funding for treatment programs in all areas of the country and for clients of all need and income levels. In 1986, the Association held its first legislative conference, which included a White House briefing, a Congressional briefing, a reception on Capitol Hill, and was attended by First Lady Nancy Reagan. It also established the NAADAC Legislative Network and developed its first position paper, which declared that NAADAC believes “citizens have the right to clinically sound, cost effective prevention, intervention and treatment.” By 1988, NAADAC had increased its advocacy efforts by hiring a part-time lobbyist to address the 200 bills before Congress involving substance abuse.

In 1989, the Association published another position statement stating its belief that “the use of credentialed alcoholism and drug abuse counselors should be supported, if not mandated, by state and federal agencies.” The next year, NAADAC adopted the term National Certified Addiction Counselor (NCAC) and directed this term to be used in the development of a national credential.

Counselors were gaining respect. Addiction was finally recognized as a disease. More than ever, the work of addiction counselors was challenging, exciting, and rewarding, with employment opportunities growing. NAADAC was blossoming.
What Distinguishes Addiction Counseling From Other Helping Professions?  

Voices from the Field

Compiled by William White for his new book, The History of Addiction Counseling in the United States

Adoption counselors are distinguished in their appreciation for the primacy of severe alcohol and other drug (AOD) problems in the problems and pathologies customarily addressed by other health and human service professionals. Other professionals may tend to see the AOD problems as symptomatic of or secondary to the domains they are trained to address.

– Alex Brumbaugh

Addiction counseling is the only profession that focused exclusively on the biopsychosocial complexities of substance use disorders while seeking to resolve the full range of associated conditions and consequences.

– Thurston Smith

There are four defining premises of addiction counseling that historically separate the addiction counselor from other helping roles. These premises are that: 1) severe and persistent alcohol and other drug problems constitute a primary disorder rather than a superficial symptom of underlying problems, 2) the multiple life problems experienced by AOD-impacted individuals can be resolved only within the framework of recovery initiation and maintenance, 3) many individuals with high problem complexity (biological vulnerability, high severity, co-morbidity) and low “recovery capital” (internal assets, family and social support) are unable to achieve stable recovery without professional assistance, and 4) professional assistance is best provided by individuals with special knowledge and expertise in facilitating the physical, psychological, socio-cultural and often spiritual journey from addiction to recovery.

– William White

Addiction differs from other illnesses in three ways, and each poses unique challenges and requires special skills and knowledge. First, persons with other illnesses generally seek medical care when their condition becomes symptomatic. This is not true of persons with AOD disorders due to the stigma, hopelessness, denial, impaired

NAADAC in the 1990s

NAADAC rang in the new decade with a new executive director, Linda Kaplan, and the election of NAADAC’s first female President, Kay Mattingly-Langlois, MA, NCAC II, MAC. In the early nineties, NAADAC focused on fortifying itself as a professional organization, increasing its membership, expanding its training, credentialing, and education programs, increasing its public policy and advocacy activities, and growing its staff.

In June 1990, NAADAC formed the NAADAC Certification Commission (NCC) to “oversee and administer the NCAC National Certified Addiction Counselor” credential. The commission was founded to act independently on behalf of NAADAC in all matters related to the national credentialing of individual counselors. Specifically, the commission was to focus on establishing and maintaining current national standards of requisite knowledge in addiction counseling; providing evaluation mechanisms for measuring and monitoring the level of knowledge required for national credentialing; providing formal recognition to those individuals who meet the national standards; and establishing appropriate policies for acquiring and maintaining the national credentials. In a matter of months, the Commission announced the availability of the NCAC through an initial six-month test exemption period. More than 8,000 counselors nationwide qualified; and five months later, NCAC applicants took the first written exam. Around this same time, the National Accreditation Commission of Alcoholism and Drug Abuse Credentialing Bodies, Inc., was approved as the supporting organization of NAADAC for accrediting alcoholism and drug abuse counselor certification boards.

With the election of Bill Clinton in 1992, health care—including alcoholism and drug abuse treatment—took the spotlight and NAADAC’s lobbying efforts were beefed up in anticipation of the new President’s promise to study, propose, and implement health care reform. Even before Clinton’s inauguration, NAADAC wrote to the transition team, offering the association as a resource on alcoholism and drug abuse treatment and related issues. NAADAC also worked on a national steering committee for the Center for Substance Abuse Treatment’s project on Linking Primary Care, HIV, Alcohol, and Drug Abuse Treatment, which drafted primary health care and substance use treatment initiatives for the transition team’s use. NAADAC developed a full complement of advocacy and position papers, face-to-face trainings and conferences, appropriations and other policy recommendations, addressing issues such as the inclusion of the drug alcohol and alcoholism in our national drug control strategy, quality treatment from qualified professionals, increased insurance coverage for treatment of alcoholism and drug addiction, managed care and alcoholism and drug abuse reform, national health insurance reform, alcohol and drug treatment in the criminal justice system, and youth-at-risk for addiction.

During this time, NAADAC staff and the Board of Directors regularly served on expert panels, government training and advisory groups, and provided Congressional testimony. NAADAC played a key role in a number of visible and important coalitions, such as the National Coalition of Alcoholism and Other Drug Issues, the Coalition on Alcohol Advertising and Family Education, and the Coalition on Alcohol and Drug Dependent Women and their Children. NAADAC also worked to expand Medicaid reimbursement policies, obtain third party reimbursement, expand treatment services within the criminal justice system, and...
and increase awareness of alcohol-related problems among the elderly. The association’s legislative agenda clearly was growing.

In 1994, NAADAC earned another feather for its cap as the Department of Transportation expanded the definition of Substance Abuse Professionals (SAPs) to include addiction counselors certified by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission after a hearing that included testimony from Jerry Bunn and Cynthia Moreno Tuohy.

State chapters and nation-wide efforts continued to grow and prosper at breakneck pace. On June 11, 1992, NAADAC held its first Addiction Professionals’ Day, originally called the National Alcoholism and Drug Abuse Counselors Day, to commemorate the hard work that addiction services professionals do on a daily basis. In 2005, NAADAC’s Executive Committee made September 20th the permanent date for the annual celebration of Addiction Professionals’ Day.

Elected officials from NAADAC also had their first meeting with leaders of IC&RC to “clarify to the Alcoholism and Other Drug Abuse Treatment Professionals our respective missions, which are complementary, yet different,” said the two organizations in a joint open letter. At the meeting, the two groups came to agreement on “issues that have troubled the field in the past by clarifying the respective missions of each organization.” NAADAC and IC&RC agreed to work on health care reform issues that affected the treatment field, including scope of service, qualified providers, specialized service, and placement/discharge criteria. A year later, the two organizations met again and developed a joint plan for advancing the profession.

As 1993 drew to a close, NAADAC unveiled a strategic plan for 1994–1996 with a defined vision “to inspire alcoholism and drug abuse counselors to create healthier families and communities through prevention, intervention and quality treatment.” Several goals were outlined to enhance the counseling profession, improve training and education for treatment professionals, impact public policy at all levels and result in the best possible treatment for clients. NAADAC also reworked its mission statement to state that “NAADAC’s mission is to provide leadership in the alcoholism and drug abuse counseling profession by building new visions, effecting change in public policy, promoting criteria for effective treatment, encouraging adherence to ethical standards and ensuring professional growth for alcoholism and drug abuse counselors.”

In June 1994, NAADAC contracted with The Gallup Organization to conduct an Educational Survey of its membership. This survey, which fulfilled a goal of the strategic plan, provided the basis for planning educational programs for NAADAC members and addiction counselors. NAADAC responded promptly to the survey results, introducing a 1995 educational program that was broader and more far-reaching than ever before and included workshops on clinical supervision, DOT regulations, review of the new DSM-IV, implementation of the ASAM Patient Placement Criteria and HIV/AIDS, TB and STDs. NAADAC also published the Peer Assistance for judgment, and other issues associated with AOD problems. Therefore, treatment and recovery services for alcoholics, addicts, and their families must seek above all to reduce stigma and engender hope. Second, persons with substance disorders typically have concomitant public health, mental health, and social issues whose resolution is tantamount to substance recovery. People providing treatment and recovery services therefore need to have well developed skills and resource knowledge in the proper and timely integration and coordination of concomitant services. Third, while certain other medical interventions require a period of rehabilitation that involves behaviors or actions on the part of the patient in order for the disease to remain in remission, long term recovery from substance disorders uniquely depends in most cases upon ongoing, patient-initiated activities and involvement with non-medical, non-professional, indigenous community resources (e.g., peer-support groups). Professionals therefore need to view their role primarily as one of facilitating the client’s engagement with these resources.

– Alex Brumbaugh

One of the first of those things was the fact that the population I was now working with was largely the people that everyone else had given up on. I also firmly believe that it takes a very special person to work as and remain an addiction professional. I do not believe that the person must necessarily be recovering themselves however I do believe that wherever they come from, they do have to have the “heart” and “passion” for the profession and the work that we do.

– Robert Richards

A significant distinction is that more Addiction Counseling Professionals (ACP) have been personally and deeply impacted by addiction….I think this translates to a deep sense of mission and commitment at a personal perhaps spiritual level to help the suffering addict avoid the destruction of addiction and find the beauty of recovery. Counselors with this personal background may also need to sort out more complex issues related to personal/professional conflicts.

– Bruce Larson

The composition of the addiction field—having recovering professionals in addiction counseling—makes what we do seem more real, more intense, more important, and more rewarding.

– Gail Milgram

What the addiction counselor knows that other service professionals do not is the very soul of the addicted— their terrifying fear of insanity, the shame of their wretchedness, their guilt over drug-induced sins of omission and commission, their desperate struggle to sustain their personhood, their need to avoid the psychological and social taint of addiction, and their hypervigilant search for the slightest trace of condescension, contempt or
hostility in the posture, eyes or voice of the professed helper. . . . If there is a therapeutic stance most unique to addiction counseling, it is perhaps the virtue of humility. While seasoned addiction counselors muster the best science-based interventions, they do so with an awareness that recovery often comes from forces and relationships outside the client and outside the therapeutic relationship. It is in this perspective that the addiction counselor sees himself or herself as much a witness of this recovery process as its facilitator. In the end, the job of the addictions counselor is to find resources within and beyond the client (and the counselor) that can tip the scales from addiction to recovery. To witness (and be present within) that process of transformation is the most sacred thing in the field, and what would most need to be rediscovered if the field collapsed today.

– William White

Though we may learn and use the same skills and techniques as other helping professions, the addiction counselor has more heart and commitment to those facing the effects of addiction.

– Shirley Bekett Mikell

The persons with addictive disorders began this profession and it is through that knowledge and experience base that we have worked so diligently to create the professional care of addiction. We are in it to change it! Those roots keep us connected to the passion, resolve, desire and determination to keep pushing forward. With those roots, we never give up hope!

– Cynthia Moreno Tuohy

We are people who believe in the capacity for extraordinary resiliency and bring unwavering hope and belief in the transformative power of recovery.

– Dr. Stephen Valle

I think addiction counseling is more humanitarian. It focuses on the strengths and what’s right with somebody and conveys the message, “You can recover and you can reclaim your life.” It’s focused on your strengths and what you can do as opposed to what’s wrong with you. It is very individual-focused and about how people can reclaim their lives, not just how they can manage their illness.

– Mary Woods

One distinctive thing that we have is respect for the spiritual aspects of healing. That we are steeped in a spiritual tradition and have a lot of people who are in recovery who are working spiritual programs have influenced and distinguished addictions counseling from such allied roles as mental health counseling. We’ve got the psychotherapy and the pharmacotherapy, but we have this spiritual tradition that respects the power of spiritual change—acceptance, surrender, forgiveness, serenity and other experience of a spiritual nature.

– Dr. Cardwell Nuckols

Alcoholism and Drug Abuse Counselors Manual authored by Linda Crosby in 1995. Later that year, the Ethics Committee proposed revisions to the NAADAC Code of Ethics to respond to developments in the field and the changing needs of association members. The proposed revisions were later approved by the NAADAC Board of Directors.

The 1996 Public Policy conference on Alcohol and Other Drug Issues attracted 200 attendees, a tribute to the growing activism and legislative sophistication of NAADAC members. Charlie Cook, political analyst for Roll Call and CNN, spoke about the upcoming 1996 elections, predicting the Clinton presidential win and the continuing Republican Congress. Senator Mike DeWine (R-Ohio) highlighted the Republican alcohol and drug policy issues and pledged his continuing support for treatment and prevention efforts. The NAADAC PAC reception featured former Governor George McGovern (D-South Dakota).

Increasingly, members demanded up-to-date legislative information, and NAADAC responded enthusiastically. In 1996, NAADAC implemented a fax-on-demand system, which provided legislative updates, among other information. At the same time, the NAADAC Advocacy Update newsletter made its debut, offering the latest details about appropriations, welfare reform, elections, and other issues affecting the treatment field.

That same year, NAADAC joined the internet-age by launching the NAADAC website, which was later redesigned in 2013. Naadac.org, which was intended to provide information to current and prospective members, has since become an important conduit of information as the public face of the association. In 2006, the NAADAC site averaged over 26,000 visits per month—a figure that has now moved to more than 71,000 visits per month.

However, these achievements all unfolded in what was a challenging decade for NAADAC. Membership was decreasing. The buzz for certification was being replaced by a buzz for licensure. State associations didn’t see the importance of their connection to a national association. The addiction workforce began to dwindle, shift, retire, die or go onto higher paying professions. A renegade, mail-order certification threatened NAADAC credentials. But most importantly, challenges arose within the Association about credentialing. Some within NAADAC pushed for academic credentials, while some balked. Teams of leaders worked things out so NAADAC and IC&RC would mend fences for the second time, but not all forces were aligned. Confusion reigned amongst many, including counselors, policymakers, allied professionals, and consumers about the basic fundamentals of the profession: who and what were addiction professionals, what qualified one to be an addiction professional, what could addiction professionals do and not do, and where did addiction professionals fit into the larger field of behavioral health. While NAADAC leaders and members continued to discuss and disagree on the answers to these questions, they did agree on important thing: addiction professionals and NAADAC members were no longer just alcohol and drug counselors.

To reflect this understanding and reflect the increasing number of tobacco, gambling, and other addiction professionals active in prevention, intervention, treatment, and education, NAADAC underwent its final name change in 2001, adopting the name: NAADAC, the Association for Addiction Professionals.
NAADAC in the New Millennium

As NAADAC moved into the new millennium under the leadership of Pat Ford Rogener, NAADAC began to focus on its internal leadership to cultivate the addiction workforce and the next generation of leaders for the organization and the profession through its work on the Ohio Workforce Development Center. In partnership with the Ohio Association of Alcohol and Drug Abuse Counselors (OAAADC) and the Ohio Council for Behavioral Healthcare Providers, NAADAC hoped the Center would help maintain a competent and motivated addictions workforce with a focus on both prevention and treatment. Led by John Lisby of Ohio, the project, developed in cooperation with state and national leaders Hope Taft, Ohio’s First Lady, Senators George Voinovich and Mike DeWine and Representatives Ralph Regula, David Hobson, and Deborah Pryce, received congressional funding to focus on the workforce development goals of developing pathways for the education, recruitment, retention, training and advancement of Ohio Alcohol and Other Drug (AOD) professionals, and paved the way for similar projects in other states. NAADAC’s focus on leadership capacity building continued under the direction of Cynthia Moreno Tuohy, who assumed the Acting Executive Director role in late 2004 and became the Executive Director the following year. In March 2005, NAADAC hosted its first national Leadership Conference in Washington, D.C.

Advocacy

NAADAC advocacy activities increased in 2005–2008, including policy briefings with numerous congressional delegates and advocacy for passage of the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act, the Second Chance Act (support for prison re-entry), and the Veterans’ Mental Health and Other Care Improvements Act. Also of note were NAADAC’s support for repeal of the lifetime ban on welfare and food stamp benefits for persons with a drug felony conviction and the ban on student financial aid for students with a past drug conviction.

Recognizing the importance of the shift in demographics for the addiction services workforce, NAADAC convened its Workforce Development Summit in March 2006 in Washington, D.C. The Summit brought together many different partner organizations, including SAMHSA’s Center for Substance Abuse Treatment, Partners for Recovery, the Addiction Technology Transfer Centers (ATTCs), the Institute for Research, Education and Training in Addictions (IRETA), the National Institute on Drug Abuse (NIDA), the Institutes of Medicine and the National Association for Addiction Treatment Providers (NAATP), for the purpose of assessing the challenges facing the addiction profession and creating a Workforce Development agenda for the future. Speakers discussed various workforce development issues, including the ability to find, keep, and properly compensate addiction professionals, mentoring, the implementation of evidence-based practices, career development strategies for entry level professionals, and career advancement opportunities.

The Summit also presented the world premiere of the Workforce Development Video, produced in partnership by NAADAC, the Northeast Addiction Technology Transfer Center (NEATTC), IRETA, and the Central East Addiction Technology Transfer Center (CEATTC). The purpose of the video, Imagine Who You Could Save, was to promote career opportunities in the addiction profession while dispelling preconceived notions and/or stereotypes typically associated with the addiction/substance use disorder field. The premise of the video concentrated on the workforce development goals of developing pathways for the education, recruitment, retention, training and advancement of Ohio Alcohol and Other Drug (AOD) professionals, and paved the way for similar projects in other states. NAADAC’s focus on leadership capacity building continued under the direction of Cynthia Moreno Tuohy, who assumed the Acting Executive Director role in late 2004 and became the Executive Director the following year. In March 2005, NAADAC hosted its first national Leadership Conference in Washington, D.C.

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– Bruce Lorenz

Addiction counseling requires the willingness to engage in long-term therapeutic support with individuals managing a life-threatening chronic disease. As an addiction professional, I identify with other healthcare colleagues who treat chronic diseases such as diabetes. There is a commonly shared perspective of non-critical judgment, compassion and patience that we recognize as key components of our work. Understanding the impact of chronic disease on individuals and significant others is crucial to the provision of a safe environment for treatment and recovery.

– Kathryn Benson

The distinctive features of addiction counseling are being lost. The true distinction is that chemical addictions are a special class of health problems requiring special techniques to help support early recovery, relapse prevention and relapse management. Specialized support is needed for sober and responsible people to live in an addiction-centered culture while disavowing that culture.

– Terence Gorski

The defining essence of a profession is a distinctive body of knowledge and techniques developed through education, training and supervised experience and not available within other service settings. Such knowledge and service technologies have evolved over the past five decades and now constitute the core functions of addiction counseling as practiced in the United States and around the world. What the addiction counselor, at his or her best, contributes that is lacking in other human service disciplines is a detailed knowledge of local cultures of addiction and cultures of recovery. That knowledge is crucial in facilitating clients’ journeys between two psychological and social worlds.

– William White

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Education

Under Moreno Tuohy’s leadership, NAADAC also began focusing on delivering clinical and professional development education to addiction professionals. In February 2004, NAADAC launched a Trainers Academy that enables expert trainers to provide cost-effective on-site education to addiction professionals across the United States. The Academy includes experts in HIV/AIDS prevention, addiction specific issues, counseling therapies, practice guidelines, organizational and leadership development, and co-occurrence. Clinics, government agencies, private business, other health-related organizations, and others may contract with NAADAC to access Academy members to provide continuing education to counselors in HIV/AIDS and other areas of specialization.

In 2005, NAADAC collaborated with the American Mental Health Counselors Association (AMHCA) on a SAMHSA-funded initiative focused on co-occurring disorders and collaboration of addiction services and mental health professionals. That same year also witnessed a change in NAADAC’s official publication—from The Counselor to Addiction Professional. (In 2013, NAADAC took responsibility for publishing its own magazine, Advances in Addiction & Recovery.)

In 2007, NAADAC collaborated with Forest Laboratories on a national education series called Strengthening the Will to Say No: Medication Management for Addiction Professionals. The series, which went to 15 cities throughout the U.S., evolved from NAADAC’s long history of providing quality education courses led by counselors and other addiction-related health professionals who are trained and experienced in both pharmacology and clinical application of therapies. NAADAC also cosponsored other training events and conferences with partners such as the American Society of Addiction Medicine.

Building on this effort, NAADAC conducted its 2007 Life-Long Learning Series Pharmacotherapy: Integrating New Tools into Practice, delivering seminars in 17 cities and online working to promote the awareness of medication-assisted treatment and its use as a tool in the methods available to serve persons with addictive disorders.

In 2009, NAADAC became involved with SAMHSA’s Recovery to Practice (RTP) Initiative, designed to hasten awareness, acceptance, and adoption of recovery-based practices in the delivery of addiction-related services and built upon SAMHSA’s definition and fundamental components of recovery. NAADAC was first tasked with conducting a national situational analysis using a literature review and interviews with key informants, including academic leaders, SUD counselors, and other stakeholders, to describe a snapshot of how the addiction profession currently views and uses the concepts, services, and practices of recovery, as well as the barriers, strengths, and contextual conditions related to full integration. As a result of its Situational Analysis, NAADAC developed an outline for a recovery-based curriculum for addiction professionals, which includes nine...
webinars, three articles in NAADAC’s *Advances in Addiction & Recovery*, a large collection of electronic print resources, inclusion of recovery-oriented test questions into NCC AP certification test banks, multiple information sessions at NAADAC’s Annual Conferences and other regional and state affiliate events, and now a new Recover to Practice Certificate.

**A National Addiction Studies Curriculum**

During 2008–2009, NAADAC continued its focus on education by developing the National Addiction Studies and Standards Collaborative Committee (NASSCC), through a SAMHSA grant, to develop a national addiction studies curriculum for higher education. Composed of addiction studies educators in higher education and allied stakeholders in the field of addictions, the NASSCC divided itself into undergraduate and graduate working groups and through months of work, developed a consensus on the centrality of higher education now setting the standards for certification and licensure standards. Incorporated with this was a shift toward the emphasis of degree/educator model for addictions education and keeping this distinct from the training/trainer model.

In August 2011, the International Coalition for Addiction Studies Education (INCASE) and NAADAC created the National Addiction Studies Accreditation Commission (NASAC), one of only two organizations that accredit addiction programs, and the only organization that represents addiction-focused educators and practitioners. NASAC released new standards and an accreditation process for higher education to meet the requirements for addiction studies best practices and to provide a single standard for higher education addiction studies programs. The new process is specific to the addiction education programs and focuses on competent, knowledgeable, and evidence-based practices. With the implementation of this new standard, practitioners, educators, and people looking to join the profession will now have a professional standard they can use to judge the efficacy and quality of their educational programs.

**Current Day NAADAC**

The last two years have been among NAADAC’s busiest ever. In January 2013, NAADAC Executive Director Cynthia Moreno Tuohy issued a press release outlining the NAADAC perspective on initiatives that would improve the long-term health of the addiction profession and ultimately improve patient outcomes. The press release called for unique approaches to addressing workforce recruitment, training, and retention issues within the growing integration of the addiction treatment, mental health, and primary health care service arenas.

**Training, Education, and Professional Development**

Both in-person trainings and online education activities have been expanded, and include such cutting edge issues as new evidence-based practice and changes in addiction counseling emanating from the growth of recovery-oriented systems of care initiatives and the Affordable Care Act, and four important aspects of development and implementation: curriculum development, product development, training, and logistics management. In 2013, NAADAC offered 75 continuing education hours through its education and training resources. Recent activities included co-development with Hazelden of Integrating Treatment for Co-occurring Disorders: An Introduction to What Every Addiction Counselor Needs to Know, that later led to the training of the product: Co-Occurring Disorders Training for the Substance Abuse and Mental Health Services Administration. Recently, NAADAC developed a curriculum to assist professionals who were seeking help in establishing clinical addiction treatment methods founded upon evidence-based practices. The curriculum, which covered all eight domains and was published as “Foundations in Addiction Practice” was developed as a Train-the-Trainer manualized program. This project, implemented in partnership with professionals in the developing world, had its inaugural program in Nairobi, Kenya. The curriculum focused on capacity building and service delivery in Kenya and was later implemented with representatives of a consortium of Colombo Plan nations and now in the United States as a Train-the-Trainer program to ensure addiction practice.

**Credentialing**

The NAADAC National Certification Commission (NCC) presented a name change to the NAADAC Board of Directors on September 17, 2011 to change to the National Certification for Addiction Professionals (NCC AP) to clarify that the NCC system of certification was specific to addictive disorders. Since 2011, the NCC AP has grown and developed new standards through certifications and endorsements. As the work of the Affordable Care Act becomes more integrated, NCC AP has developed a Co-occurring Competency Test that is available at the state level to ensure knowledge and skill levels in treating co-occurring disorders. NCC AP Commissioners felt it was essential to evidence these competencies in the new integrated environment that the profession was quickly moving to embrace. NCC AP created other new credentials, including Student Assistance Professionals and Adolescent Certification. In Summer/Fall 2014, the NCC AP added a Peer Recovery Specialist credential and a Clinical Supervision endorsement to its cadre of credentials.

Conversations between NAADAC and IC&RC continue with the most current press release on February 27, 2013 announcing the collaborative activities between
NAADAC, IC&RC and NCC AP, with a focus on the following areas of collaboration:

- joint internal and external communications concerning credentialing and licensing, including conducting surveys and publicizing the results;
- developing a common advocacy agenda and combining advocacy efforts, including co-hosting the Advocacy Leadership Summit on April 16 and 17, 2013 in Washington, D.C.; and
- a crosswalk of credentials, leading toward standardized credentials and a national system of credentialing.

Membership Services

In 2013, NAADAC underwent a digital overhaul and modernization of its website, membership database, and communication channels to better serve and communicate with its members and the public. Its redesigned website makes membership information, education, and resources easily accessible and streamlines the membership and renewal processes. In addition, the website allows the public to easily search for Certified NCC AP Individuals, NAADAC Approved Education Providers, members, and the Department of Transportation’s Substance Abuse Professionals (SAPs).

Also in 2013, NAADAC’s launched its new quarterly magazine, *Advances in Addiction in Recovery*, which has become well-known as a treatment and recovery resource for both those who serve in the addiction and other helping professions and to their clients. It also launched two ePublications, the weekly *Professional eUpdate*, and bi-weekly *Addiction & Recovery eNews*, which go out to over 31,000 constituents in the addiction profession and can be easily read on any digital device. NAADAC’s involvement in print and TV media as well as social media (e.g., Twitter, Facebook and LinkedIn) has also grown exponentially and allows the Association to speak directly to its constituents through new mediums.

Advocacy Highlights

NAADAC’s advocacy work at the federal level with SAMHSA and other agencies continued to ensure that the concerns of the nation’s addiction professionals were represented at the highest policy levels, especially in the workforce arenas. NAADAC worked in partnership with the State Associations of Addiction Services (SAAS) and Treatment Communities of America (TCA) for the 2013 Advocacy Leadership Summit—NAADAC’s advocacy conference—to bring a larger voice and stronger presence to the issues of SAPT Block Grant, the Affordable Care Act implementation, and workforce. The 2014 Advocacy in Action Conference focused on workforce development and the implications of the Affordable Care Act on the addiction profession.

In Spring 2014, Congress finally passed legislation to include funding to expand the Substance Abuse Mental Health Services Administration (SAMHSA) Minority Fellowship Program (MFP) to addiction counselors, an action NAADAC has spent over eight years advocating for. This program was first established in 1973 to enhance services to minority communities through specialized doctoral-level training of mental health professionals in nursing, psychiatry, psychology, and social work, and was gradually expanded over the years to include training of professional counselors. In September 2014, NAADAC was awarded the SAMHSA grant to develop and implement the NAADAC Minority Fellowship Program for Addiction Counselors (NMFP-AC) in 2015, with the purpose of increasing the number of culturally-competent Master’s level addiction counselors available to underserved minority populations, improve training in evidence-based cultural diversity practices, and increase effectiveness and numbers of addiction counselors working with transition age youth (ages 16–25).

In September 2014, NAADAC hosted the National Recovery Month Kickoff Luncheon for a third time, partnering with Young People in Recovery (YPR), the Association of Recovery Schools (ARS), and the Substance Abuse and Mental Health Services Administration (SAMHSA), to celebrate the 25th Anniversary of National Recovery Month and NAADAC’s 40th Anniversary. In partnership with these organizations and the Entertainment Industries Council, Inc., NAADAC is working to develop a video trilogy named *Looking Back at Addiction, Looking Forward to Recovery*. The first of these three videos, *The History of NAADAC and the Addiction Profession*, was debuted at the Luncheon and will be shown at NAADAC’s 2014 Annual Conference & 40th Anniversary Celebration in Seattle, WA. The video and an archived webcast of the event can be found on NAADAC’s website.
Fetal Alcohol Spectrum Disorder (FASD) affects 5% of people born in North America. Research indicates that 46% of those with FASD will face a substance use disorder in their lifetime.

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NALGAP, the Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and their Allies, began in 1979, when co-founders Dana Finnegan and Emily McNally “came out” to faculty and fellow students at the Rutgers’ Summer School of Alcohol Studies and, along with 13 other gay men and lesbians, began the first national organization to address alcohol and addiction issues in the lesbian and gay community. It was their vision of improving treatment for gay and lesbian individuals that was the cornerstone of our association, as was a need to link the brave members of our profession who similarly advocated on behalf of their clients.

During the past 35 years, we have experienced a lot of growth as an association and have seen our field evolve significantly. Counselors gained recognition as addiction professionals. Treatment providers expanded services in the area of prevention. Research has helped to move us from the early debate of the “disease model” to recognition of the neurobiology of addiction. A single approach of treating alcoholics moved to evidence-based practices and inclusion of co-occurring disorders and trauma informed care. A more comprehensive understanding of addiction emerged. Training on Co-dependency, Eating Disorders, Compulsive Gambling, Sexual Compulsive Behavior and an expansion of 12 step fellowships, different models of recovery, self-help, Harm Reduction, Recovery Readiness, Motivational Interviewing, Stages of Change, Client Centered Approaches, Nutrition, Medication Assistance, Spirituality and Mindfulness have become essential in helping others affected by addiction. For 35 years, NALGAP has been there working with others to improve the lives of LGBTQ individuals.

I personally came out in 1978, having struggled for several years to accept myself as a gay man. I recall witnessing the struggle of our community in seeking, first, acknowledgement that lesbian and gay people existed in all walks of life, and progressing to demands for LGBT Rights, Protection, Inclusion and Equality have proliferated. What an exciting time we currently find ourselves in with the changes we have witnessed in our continued fight for equality. Let us always remember the legacy of Lesbian, Gay, Bisexual and Transgender Individuals who have led the way, sometimes at great personal lost. Two such individuals are Marty Mann whose story is in the Big Book Women Suffer Too and who later found the National Council on Alcoholism and Barry L., the author of Living Sober, which has helped so many individuals in early recovery. Both were early members of AA who made very significant contributions to our field, yet, at the time their sexual orientation was only shared with a close circle of friends.

Today we are proud of the accomplishments and struggles of our past 35 years and honor the work of so many who have carried our mission. We owe an incredible debt of gratitude to two remarkable women, our co-founders Dana Finnegan and Emily McNally. They opened a closet door, and left it open for so many others. We will continue NALGAP’s mission to confront all forms of oppression and discriminatory practices in the delivery of services to all people and to advocate for programs and services that affirm all genders and sexual orientations.

We are happy to join NAADAC for the 2014 Annual Conference & 40th Anniversary Celebration in Seattle, and invite all attendees to our workshops and the NALGAP Plenary Panel Presentation: “LGBT Addiction Treatment and Recovery – Where We Were Then; Where We Are Now?” moderated by Laura Fenster Rothschild, PhD, with panelists including myself, Craig Sloane, Jeff Zacharias, and Raven James, PhD.
Among women seeking treatment for addiction, as many as half have experienced intimate partner violence (IPV) in their lifetime—anywhere from two to five times more than the general population (Swan, Farber & Campbell, 2001; Schneider et al, 2009). Hazardous drinking and drug use—whether by the perpetrator, the victim or both—is not just associated with incidents of IPV, but also the severity level of the violence and injury (Mitchell & Anglin, 2009).

Emotionally, the combination of substance use disorder (SUD) and IPV is equally alarming. Rates of post-traumatic stress disorder (PTSD), depression, anxiety and phobias are all substantially greater for abused women in SUD treatment (Brady et al, 1994; Miller, Downs & Testa, 1993; Windle et al, 1995).

Unfortunately, coordination between SUD treatment programs and IPV services is the exception. Barriers to effective collaboration persist spurred by a lack of training on the complex presentations and impact of IPV, budget and time constraints, and the belief that addressing PTSD or IPV will do further emotional harm to a client or distract from the goal of sobriety (Swan et al, 2001). As a result, the IPV experiences of women in substance abuse treatment are often not identified, monitored or addressed (Swan et al, 2001; Chermack et al, 2009; Shumacher, Fals-Stewart & Leonard, 2003).

This gap in care is a costly one, which only grows more expensive over time. The ripple effects of IPV extend well beyond physical and emotional health, affecting interpersonal and occupational functioning, and straining the resources of our health care system (Chermack et al, 2009). Annual health care costs for women experiencing ongoing abuse are 42 percent higher than non-abused women (Bonomi et al, 2009; Rivara et al, 2007).

Research conducted by the Southern California Permanente Medical Group and Polaris Health Directions, Inc., based in Wayne, PA, suggests that automated IPV screening of female and male patients entering treatment for SUD can substantially improve detection.

Beyond screening, the project ultimately seeks to demonstrate the plausibility of addressing IPV and addiction concurrently. Doing so may improve the rate of completing substance abuse treatment, lower the likelihood of relapse, and ultimately lead to lower health care costs (Pirard et al, 2005; Easton, Swan & Sinha, 2000; Swan et al, 2001).
Establishing Best Practices

Better Screening, Better Follow Up

In 2007, Kaiser’s Southern California addiction medicine clinics implemented a best practices model for identifying and addressing IPV. Initially developed in Kaiser’s Northern California region, the “Systems Model for IPV Prevention” is centered on five components:

1. An open and supportive environment for addressing IPV
2. Protocols for inquiry and referral across all medical departments
3. On-site IPV services
4. Relationships with community IPV resources
5. Receptive leadership and oversight.

Initially, there was no standard protocol to assess for and follow up on IPV. Clinicians were expected to remember to ask, but the method and effectiveness of the inquiry varied. Detection rates ranged widely across Kaiser’s clinics, and those cases that were detected were not always documented in Kaiser’s electronic health record (EHR) system. When intimate partner violence is not diagnosed and documented, there is little basis for evaluating health risks in the future.

To strengthen and standardize their efforts, the Southern California division partnered with Polaris Health Directions to develop a systematic and reliable method to achieve the goals outlined in Kaiser’s best practices model. Comprehensive training and securing the support of clinicians, caseworkers, and administrators for addressing IPV in routine SUD treatment were key to these efforts.

Having the Right Tools, Asking the Right Questions

Since 2001, Kaiser’s Southern California addiction medicine clinics have been using a substance abuse treatment support system (SATSS) to assess the impact of services, and improve the quality of care and patient outcomes (Grissom et al, 2004). Developed with funding from the National Institutes of Health, the cloud-based system enables providers to securely collect, store, process, and report information relating to a patient’s clinical status and progress in real time. It also provides a structure for the evaluation of outcomes and the monitoring of treatment response.

The patient assessment includes demographic items and questions relating to treatment history, motivation, strengths, and risk factors for dropout and relapse. Quantitative measures include the severity of symptoms of depression and anxiety, and severity of alcohol, drug, psychiatric, family/social, employment and medical problems, based upon the Addiction Severity Index. Prior to 2007 it also incorporated four items that asked about a history of child or adult abuse, but, again, no standard protocol for those who responded affirmatively (McE1lan et al, 1992).

Between 2007 and 2009, Kaiser and Polaris worked together to incorporate new IPV screening questions into the assessment of past and current abuse. These added questions were designed as risk adjusters for the prediction of substance abuse disorder outcomes, including dropout and relapse. They were:

- Have you been the victim of spousal abuse?
- Were you physically or sexually abused as a child?
- Have you been the victim of physical abuse as an adult?
- Have you been the victim of sexual abuse as an adult?
- Within the past 12 months, has your partner hit, slapped, kicked, choked or otherwise physically hurt you?
- Are you afraid of your partner?

- Within the past 12 months, has your partner forced you to participate in any unwanted sexual activities?

In 2013, two additional items were included, asking about family violence within the past 30 days, and three of the original family violence questions were omitted.

As IPV items were added to the assessment, corresponding changes were made to the SATSS clinical reports. These included linking affirmative statements, such as the “patient was a victim of physical abuse in the past 12 months,” to diagnostic codes that could be entered into Kaiser’s EHR system. This improved the chances that the clinician would act on the information provided by the report, while also providing a foundation for future follow-up by other providers within the Kaiser system.

In 2009, the IPV information was moved to the first page of the assessment report, and counselors were instructed to initiate a conversation with patients if current abuse was indicated. Additionally, several treatment goals related to IPV were established and shared with the Kaiser treatment staff for the day-to-day care of patients with SUD experiencing IPV. These included working to ensure the patient’s safety and helping the patient think clearly, trust his or her own decisions, feel less anxious and avoidant, and establish support connections and boundaries.

Supporting the New Culture

Understanding that many providers find it difficult to discuss abuse, comprehensive training was required for treatment staff. Clinicians were instructed to validate and affirm the abuse with phrases such as: (1) “You are not alone. Help is available;” (2) “You do not deserve to be treated this way. It’s not your fault;” and (3) “I am concerned about your safety, and how this may be affecting your health.” They were given in-person training on how to obtain additional information, document it, and to make the appropriate referrals to community IPV agencies.

Other tools developed to assist clinicians in identifying and responding to IPV included a regional website that provides area-specific mandatory reporting instructions; forms and important phone numbers; bilingual patient brochures and wallet cards that contain area-specific contact numbers and safety information; and the provision of resource information and safety planning for patients exposed to IPV.

The strategic approach employed by Kaiser and Polaris had an immediate effect in identifying IPV. As shown in the chart below, in 2008, six patients seeking treatment for SUD were coded into the EHR for abuse. By the next year, the number had increased dramatically (McCaw, 2011).

An Encouraging Start to Integrating Care

There are several factors that have contributed to the initial success of this project.

First, the idea of incorporating assessment items relating to IPV was never presented as a “DV screener,” but rather as a vital part of improving overall health care for patients with SUD. The new content was...
embedded in a system with which clinical staff were familiar, giving them confidence that this change to their clinical workflow was likely to be effective. Also working in the project’s favor was awareness among Kaiser’s management and clinical leadership that IPV is strongly associated with chronic diseases and rising health care costs.

Clinicians were given the support they needed to detect and document IPV and then discuss it with their patients, using information on the reports to guide the dialogue. Adding diagnostic codes to the reports provided a reliable link to Kaiser’s EHR, and reinforced the value of addressing IPV on a regular basis. In support of consistent IPV coding, Kaiser management established performance goals related to continual monitoring of IPV coding and matching it to detection data from the system.

The SATSS platform has also been critical to facilitating the project. What might have seemed unrealistic 20 years ago is now greatly simplified with outcomes management technology. Kaiser staff have reported that the automated assessment allows patients to convey potentially shameful information without having to worry about how it is perceived by a “real” person. Research supports this premise—with many patients preferring a computer-based screener to face-to-face interviews with a health care provider (MacMillan et al, 2006; Rhodes et al, 2002; Klevens et al, 2012).

The platform used has also helped to standardize the screening process, lessening the likelihood that a person experiencing IPV remains unnoticed. Other benefits have included improved data quality, reduced response bias, and the ability for patients to respond only to questions relevant to their situation (response-adaptive logic) (Renker, 2008).

Perhaps most importantly, with an automating screening process, staff have had more time to spend on counseling, assessing the severity of the abuse, and finding additional appropriate referrals.

Second, the decline can be linked to a training deficit, including not reinforcing the importance of IPV screening and coding among staff on a continuing basis. These results offered two lessons: the need for periodic reporting of aggregate data to alert staff as soon as possible to negative trends and for training to compensate for attrition.

Within this quarter, Kaiser plans to initiate a system to ensure regular reporting and refresher training courses. It is expected that these program modifications will lead to an uptick again in coding for IPV.

The next phases of this project will explore the effect on medical outcomes of improved detection and management of IPV and its physical and emotional manifestations. New family violence measures, including scales for PTSD and Abuse Adjustment, are being added to SATSS, and a pilot study will be launched to assess the impact of IPV on substance abuse treatment engagement and long-term outcomes. The project may also offer the opportunity to better understand the prevalence and impact of victimization among men seeking treatment for substance abuse disorder, as well as the value the IPV data offer to improve overall clinical care for all patients.

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Jesse Nankin, MA, Communications & Marketing, Polaris Health Directions, has more than a decade of experience as a researcher, editor and writer for a range of audiences. Her work has appeared in a number of different publications, including The Boston Globe, ProPublica, the Journal of Behavioral Health Services & Research and the Harvard Public Health Review. Jesse holds a Bachelor of Science degree in Industrial and Labor Relations from Cornell University and a Master of Arts degree in journalism from Northeastern University.

Laura Dietzen, MS, Director of Analytics, Polaris Health Directions, has extensive experience in predictive modeling. She has developed algorithms that have been used clinically to manage and evaluate outcomes for more than 100,000 patients, including for predicting dropout and relapse in mental health and substance use disorder treatment; and changes in the likelihood of re-victimization for women who have experienced IPV. Her predictive model for dropout from addictions treatment was featured as a preeminent example of translating research into practice at the Addictions 2010 national conference in Washington, D.C. Laura received a Master of Science degree in Rehabilitation Psychology from Purdue University.

Liza Eshilian-Oates, MD, Physician Leader, Family Violence Prevention Program, Southern California Permanente Medical Group, practices Family Medicine at Kaiser Permanente in Orange County. She received her medical degree from the University of California, Irvine and completed her residency training in Family Medicine with Kaiser Permanente in Orange County. She is a current faculty member of the Kaiser Permanente Orange County Family Medicine Residency Program and is board certified in Family Medicine. As the Regional Director of the Southern California Family Violence Prevention Program, she believes that everyone deserves a healthy and safe relationship. The program provides a comprehensive and integrated approach to building awareness, provide care, and prevent family violence.

Scott P. Sangsland, MA, is the regional director of Behavioral Health Business Operations for Southern California Permanente Medical Group, where he has worked since October 1989. From 1995 until the present, he has provided clinical operations support to the Psychiatry and Addiction Medicine Departments, including collaborative care initiatives related to Autism Spectrum Disorders and Intimate Partner Violence programs. He has participated in NIDA/NIH research-funded projects related to development and implementation of clinical outcomes management systems and co-authored articles related to addiction medicine outcomes involving implementation of standardized clinical questionnaires. Scott has a Master of Arts degree in strategic management from Claremont Graduate University.

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Does Your Program or Practice Help or Hinder Those With Fetal Alcohol Spectrum Disorder?

By David Gerry

On the basis of a very common and invisible lifelong condition, this article summarizes four important ways a very large group of people currently attending addiction treatment services (having mixed results) might be better identified and served.

Five percent (May et al. 2009) of 3,952,841 (Centers for Disease Control and Prevention) people born in the United States in 2012 have an invisible, permanent lifelong and little-understood birth condition. Studies of 415 people with this condition (Streissguth et al, 1996 and 2004), found that as adults, 46 percent of those with this medical diagnosis have now, or have had, problems with drugs and alcohol.

Yet, despite the fact that this birth condition is documented to be one of the most prevalent birth conditions in the western world AND such a high percentage of people with it are known (at least in some circles) to be vulnerable to addictions, when I sought an addiction treatment program that was demonstrably Fetal Alcohol Spectrum Disorder (FASD) informed, none were readily identifiable in a brief, one month search in North America. This search was prompted by a plea from a family in British Columbia (Canada) looking for an appropriate addiction treatment program for their adult child who has both a diagnosis of FASD and a serious addiction to crystal meth.

While there were prior articles in French, Fetal Alcohol Syndrome was first defined in an English language journal by two Seattle researchers (Jones and Smith) in 1973. Since then, the field of research into FASD has mushroomed to the point that the June 2013 edition of the Fetal Alcohol Forum (NOFASD UK) reported that in the six months prior to publication, there had been 146 research papers on FASD published in 29 countries around the world. In contrast, at the annual FASD conference in Vancouver in 2013, Dr. Claire Coles reported that there were only 25 published studies evaluating the true effectiveness of programs designed to support/change behaviors of people with FASD, and only a handful of studies about treatment outcomes for people with FASD. This means that studies on the effectiveness of programs and intervention outcomes across all types of conditions for people with FASD are so scarce as to offer few details for modifying existing programs or designing future addiction treatment programs.

Suggested Addiction Treatment Modifications

#1: Understand the Importance of Adaptive Functioning

One very important and distinguishing feature of FASD (and Autism), when thinking about designing and evaluating addiction treatment services, is adaptive functioning.

Money could be used as a metaphor for the role of adaptive functioning in life. If money is a resource like intelligence, when well applied, it can improve the quality of lives. Yet, even if someone has a million dollars in their bank account (from winning the lottery), if they do not understand how banks operate and fail to make consistent mortgage or rent payments, they could face eviction despite having a seven figure bank account.

Consider a 10-year-old child with FASD (and normal intelligence) who falls from the same tree branch three times in two years. For a neurotypical child, one-trial learning would have kicked in after the first time they hit the ground and were completely winded on impact. For the child with FASD, the attractiveness of the frisbee on the tip of the branch prior to falls two and three overrode their memory of how painful the consequence of falling was.

Graph 1 is of IQ and adaptive functioning data from 45 clients of a neuropsychologist in private practice in Nanaimo, Canada. Since the cri-
Criteria for services in many programs is IQ-based, not adaptive-functioning-based; many with FASD do not qualify for services they require. Note that based on adaptive functioning, 39 of these 45 subjects were at or below the 70th percentile, which means they fall within the developmental disability range.

Like the quintessential Buddhist concept of “living in the eternal present,” someone with FASD may repeatedly forget the consequences of a previous action. Which means (in the context of a treatment program), having a schedule that is consistent from day-to-day and posted in a prominent place can help people with FASD remember the order of daily/weekly programs. When thinking in detail about everything that is required for daily living to be successful in an addiction treatment program, imagine how navigating that daily schedule would be for you if it took you three trials before you learned not to go out on a tree branch tip 12 feet off the ground? For example, when providing a structured schedule to the person in treatment, you, as the counselor, are going to need to ensure that some kind of “reminder” process in place. For some, this could be as simple as a “reminder” application on their cell phone (that is properly programmed with appointments and tasks). For others, it may mean regular or periodic check-ins with a staff member.

#2: Understand that FASD may have a paradoxical (opposite) affect on the nervous system

A second noteworthy aspect of FASD to be considered when adapting addiction recovery programs so they are more “FASD informed/friendly” is an appreciation of how prenatal alcohol exposure can greatly sensitize the nervous system to subsequent drug consumption.

In a 2014 study using an animal model of prenatal alcohol exposure (PAE) (Uban et al., 2014), animals prenatally exposed to alcohol showed increased sensitivity to amphetamine compared to their control, non-alcohol-exposed counterparts.

The fact that with repeated exposure to amphetamine the PAE group became more responsive to the drug (i.e., showed sensitization to the drug) has important implications for our understanding of the addiction process and for delivery of addiction treatment services for those with FASD. What this means, for example, is that an FASD-informed addiction treatment program would have an FASD-aware healthcare professional who can provide appropriate advice regarding prescribing and managing medication that addresses the underlying, and sometimes contradictory, reactions and responses that may be seen in this population.

#3: Consider all aspects of the treatment center environment

Environment is a third aspect of FASD to consider, when thinking about modifying an existing treatment program or starting anew. Since cells that are growing and changing in the fetus are the most susceptible to damage by alcohol in the womb and the brain and central nervous system are almost continuously growing and connecting all other systems, the developing brain is continuously vulnerable to the effects of alcohol. For example, some people may be very sensitive to the flicker of an overhead fluorescent light (subliminal to most of us) or the hum of an air conditioner. Filtering out those types of environmental distractions may heavily consume the energy of someone with FASD. This effect becomes very noticeable as the day wears on and they cannot effectively focus on group processes or concentrate on an individual conversation.

To find out how someone with sensory issues common in FASD might react in your treatment center, ask an occupational Therapist for an assessment of your setting. You could also follow the lead of an FASD charity on Vancouver Island (Canada) who developed a process whereby a team of young adults with FASD went to many different types of service agencies (i.e., police, hospital, social services, etc.) and did a formal ‘FASD friendly’ assessment of each service. For example, they would go through the process of being in a waiting area to receive services, filling out the required forms, and would evaluate what worked and what did not work. In their subsequent reports, they would detail their findings along with recommendations for appropriate changes to help make the services more inclusive of those with invisible disabilities, like FASD.

#4: Incorporate the Use of the New Life History Screening (LHS) Tool (Grant et al.,2014)

Therese Grant et al have developed a structured screening instrument that can be incorporated into your intake protocol. The Life History Screening (LHS) tool is meant to help clinicians observe the pattern of responses within the context of screening for FASD.

Next Steps Needed

My search for an FASD-informed addiction treatment program in North America to help a late 20’s adult with crystal meth addiction and FASD revealed a huge gap in addiction treatment services. When asked how current addiction treatment programs work with those with invisible brain-based differences, all responses I received indicated a poor fit between underlying characteristics of FASD and program attributes and protocols. While there may be some appropriately FASD-informed addiction treatment programs in North America, they are not easily found. This means that of the nearly 200,000 people born prenatally alcohol exposed annually, the FASD research shows that 46 percent of these people (nearly 91,000) may have problems with drugs and alcohol at some point during their life (Streissguth et. al., 1996, 2004). Without an appropriately structured, FASD-informed addiction program, treatment results will continue to be mixed for this large, under-recognized population.

Four suggested starting points to design or modify an FASD-informed addiction treatment program are to understand:
1. The importance of adaptive functioning and how independent it is of IQ;
2. FASD may have a paradoxical or opposite affect on the nervous system;
3. How all aspects of the treatment center’s environment can either help or hinder;
4. Use the new free Life History Screening (LHS) tool to use as part of your intake protocol.

A useful place to begin to address invisible, neurocognitive-based issues would be to ask a simple question like, “What if this client’s brain is wired differently?”

For a practical way to assess how FASD-friendly your treatment facility is, download the 56-page manual called Action For Inclusion: Making Community Environments More FASD Friendly. Download a copy of the Life History Screening (LHS) tool. Get both these resources free from http://LivingWithFASD.com/addiction.

To learn more about FASD and addiction, check out this year’s Living With FASD 2014 Summit, which features 24 interviews including six experts on FASD and addiction. Go to: http://LivingWithFASD.com

REFERENCES


David Gerry, BSc Biology and Psychology, began his intensive “home study” applied learning in the field of Fetal Alcohol Spectrum Disorder (FASD) as a direct result of becoming a foster parent to two children with FASD. In 2000, he co-founded a charity (The FASD Community Circle – Victoria) to develop programs and services for those with FASD. The Circle set up the first children’s multidisciplinary FASD clinic on Vancouver Island, Canada, and also set up a multidisciplinary FASD clinic for at-risk women. Gerry is co-chair of the advisory committee of Herway Home, a comprehensive support program for pregnant and early parenting women who struggle with substance use. He also co-founded the international Living With FASD Summit.

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Effective Clinical Supervision in Substance Use Disorder Treatment: What is It and Who Benefits?

By Lillian T. Eby, PhD, and Tanja C. Laschober, PhD

What is Effective Clinical Supervision?
Clinical supervision is an important part of counselors’ professional advancement and development of counseling proficiencies, and as a consequence helps ensure high quality patient care (SAMHSA, 2008). It is distinctly different from administrative supervision in that the main goals of clinical supervision are to train, educate, support, and guide counselors, as well as create a positive work environment for all clinical staff (Powell & Brodsky, 2004). Clinical supervisor responsibilities also frequently consist of interpersonal interactions with counselors, including the provision of both task-related and emotional support (Powell & Brodsky, 2004). As such, junior counselors look to their clinical supervisors for leadership, clinical direction, professional training opportunities, and encouragement.

Effective clinical supervisors are experienced and skilled senior counselors who possess a wealth of formal knowledge and professional experience regarding substance use disorder treatment and evidence-based practices that they pass on to their counselors (Powell & Brodsky, 2004; SAMHSA, 2008). They are the gatekeepers to ensuring that patients receive the highest quality of care based on accepted standards of practice. As such, effective clinical supervisors have to have the necessary and required credentials, education, and enthusiasm for counseling to motivate and support their counselors to achieve greater professional maturity, improved interpersonal skills, and increased competence for better patient care and ultimately improved patient outcomes (Powell & Brodsky, 2004; SAMHSA, 2008).

Effective clinical supervision takes many forms and includes individual and group supervision, direct observation of counselor-patient interactions, review of video and/or audio tapes, transcript reviews, and teleconferencing (Eby, McCleese, Baranik, & Owen, 2007; SAMHSA, 2008). Regardless of how clinical supervision is delivered to counselors, it is important for the supervisor to be available (e.g., open to comments, non-threatening), accessible...
(e.g., easy to talk to), able (e.g., knowledgeable, skilled), and affable (e.g., pleasant, reassuring). These are referred to as the four As of effective clinical supervision (Powell & Brodsky, 1998).

Furthermore, effective clinical supervision includes a mentoring component, which is commonly described as a working alliance between counselors and their clinical supervisors (Eflation, Patton, & Kardash, 1990). The working alliance is characterized by career-related support (e.g., helping counselors reach their career goals, providing them with opportunities to learn new skills) and psychosocial support (e.g., providing encouragement and support, modeling clinical competencies) (Ragins & McFarlin, 1990). During effective clinical supervision, the working alliance serves as a catalyst for boosting counselors’ job performance and professional competence.

Unlike other healthcare fields, effective clinical supervision in substance use disorder treatment is a relatively new practice (SAMHSA, 2008). Traditionally, many counselors who entered the field had a personal history of substance use disorders and were in recovery before entering the field (White, 1998). Due to their personal experience, they brought a wealth of information with them and provided an insider view into substance use disorder treatment. However, they often lacked formal education and training in substance use disorder counseling (White, 1998). In addition, unlike clinicians in many other behavioral health fields, substance use disorder counselors may not have received training in the form of supervised internship experiences as part of their professional preparation (Eby et al., 2007; SAMHSA, 2008).

Today, the landscape is changing in substance use disorder treatment with the majority of counselors entering the field with at least a bachelor’s degree and approximately half of them entering with a master’s degree (Eby et al., 2007; Laschober, Eby, & Sauer, 2012, 2013). Additionally, the need for and benefits of effective clinical supervision are increasingly recognized in the substance use disorder treatment field (SAMHSA, 2008).

Who Benefits from Effective Clinical Supervision?

Both counselors and patients in substance abuse treatment stand to benefit from effective clinical supervision for a number of reasons. In contrast to most other healthcare settings, there are no standard and required educational, credentialing, or licensure requirements for counselors providing direct care to patients in substance use disorder treatment programs (Eby et al., 2007; SAMHSA, 2008). Additionally, in many states counselors are not required to complete a supervised internship prior to interacting alone with patients (McCarty, 2002).

This raises a concern regarding whether or not substance abuse counselors are sufficiently prepared to provide treatment services to patients seeking substance use disorder treatment as well as other, often complex, healthcare problems (e.g., co-occurring psychological disorders, chronic medical conditions such as HIV/AIDS). In the absence of adequate training, there is evidence that effective clinical supervision is beneficial for counselors’ professional development, skill enhancement, knowledge, confidence, and competence (Laschober et al., 2013; SAMHSA, 2008), which in turn, is likely to be associated with better patient outcomes. For example, effective clinical supervisors can teach counselors how to work with different types of patients, select and apply evidence-based practices, and tailor interventions to patients’ unique needs.

Furthermore, effective clinical supervision is related to counselors’ greater commitment to the organization and occupation, job autonomy, perceived procedural justice (e.g., feeling of being included in important decisions) and distributive justice (e.g., feeling of being fairly rewarded for effort put forth), and well-being (Knudsen, Ducharme, & Roman, 2008; Knudsen, Roman, & Abraham, 2013). Additionally, effective clinical supervision is related to higher task performance (e.g., counselor skills developing treatment plans based on evidence-based practices) and relational performance (e.g., counselor modifies his/her behavior in response to supervisory feedback) (Laschober et al., 2013).

Effective clinical supervision is also related to less burnout among counselors and reduced intentions to leave the organization (Knudsen et al., 2008). This is crucial because counselor turnover is high in substance abuse treatment (Eby, Burk, & Maher, 2010; Eby & Rothrauff-Laschober, 2012) and known to have a negative impact on provision of care and patient outcomes (SAMHSA, 2008). Moreover, effective clinical supervision plays an important role in the adoption and implementation of evidence-based practices among counselors (Martino, Ball, Nich, Frankforter, & Carroll, 2008), which is another aspect of best healthcare practices.

On the patient level, effective clinical supervision may indirectly improve patient care and patient outcomes because the positive alliance between clinical supervisor and counselor is related to better counselor performance (Laschober et al., 2013). Counselors are the frontline professionals who provide more patient care and have more interactions with patients than other professionals working in substance abuse treatment such as nurses and physicians. Thus, continuous effective clinical supervision in the form of feedback, reinforcement, and support is important for counselors’ own professional development as well as the delivery of high quality healthcare services.

To be optimally effective, clinical supervisors and counselors should have similar expectations regarding the purpose and goals of clinical supervision, which should be discussed and agreed upon early in the supervisory relationship. There is some evidence that supervisors’ perceptions of what they provide to counselors in clinical supervision diverge from what is reported by counselors (Laschober et al., 2012). Aligning clinical supervisor and counselor expectations should foster more positive interactions between clinical supervisors and counselors as well as between counselors and patients, resulting in higher quality healthcare delivery.

Taken together, effective clinical supervision is an important part of counselors’ personal and professional development, particularly for those who have less formal education and training in substance use disorder treatment counseling. Effective clinical supervisors help counselors identify issues and solutions to a variety of often complex patient needs according to accepted standard practices in the substance use disorder treatment field. Accordingly, it is important to promote and encourage effective clinical supervisor-counselor relationships to meet the needs of both counselors and patients alike.

REFERENCES


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1. Clinical supervision is distinctly different from administrative supervision in that the main goal of clinical supervision is to ________ counselors.
   a. Train
   b. Educate
   c. Support
   d. Guide
   e. All of the above

2. Junior counselors look to their clinical supervisors for ________.
   a. Leadership
   b. Clinical direction
   c. Professional training opportunities
   d. Encouragement
   e. All of the above

3. ________ are the gatekeepers to ensuring that patients receive the highest quality of care based on accepted standards of practice.
   a. Counselors
   b. Clinical supervisors
   c. Administrative supervisors
   d. Medical directors

4. Which of the following is NOT an effective form of clinical supervision?
   a. Individual supervision
   b. Group supervision
   c. Direct observation of counselor-patient interactions
   d. Patient survey
   e. Review of video and/or audio tapes
   f. Transcript reviews
   g. Teleconferencing

5. Which of the following is NOT one of the four As of effective clinical supervision?
   a. Available
   b. Accessible
   c. Able
   d. Accountable
   e. Affable

6. Unlike other healthcare fields, effective clinical supervision in substance use disorder treatment is a relatively new practice.
   a. True
   b. False

7. The majority of counselors entering the field with at least a Bachelor’s degree and approximately ________ of them entering with a Master’s degree.
   a. One-fourth
   b. Half
   c. Two-thirds
   d. Three-fourths

8. Every state has the same standard and required educational, credentialing, and licensure requirements for counselors providing direct care to patients in substance use disorder treatment programs.
   a. True
   b. False

9. When a counselor modified his/her behavior in response to a supervisory feedback is referred to as ________.
   a. Distributive justice
   b. Job autonomy
   c. Relational performance
   d. Task performance

10. ________ are the frontline professionals who provide more patient care and have more interactions with patients than other professionals working in substance abuse treatment.
    a. Counselors
    b. Nurses
    c. Physicians
    d. Interns

Tanya C. Laschober, PhD, is an Assistant Research Scientist at the Institute for Behavioral Research at the University of Georgia since 2009. Dr. Laschober’s research focuses on two main areas. First, she studies workforce development including employee turnover, retention, employee work performance, employee well-being, work-nonwork balance, and mentor-mentee relationships. Second, she examines organizational behaviors, particularly the adoption, implementation, and sustainability of innovations. She also has a keen interest in quantitative research designs and methodology, working with large cross-sectional and longitudinal data, and using advanced statistical methods to analyze complex data. She has published more than 30 peer-reviewed articles in academic journals, six invited book chapters, and presented her work at over 45 national and international conferences.
### NAADAC Leadership

#### NAADAC Officers
- **President:** Robert C. Richards, MA, NCAC II, CADC III
- **President Elect:** Kirk Bowder, PhD, MAC, LISAC, NCC, LPC
- **Secretary:** Thurston S. Smith, CCS, NCAC I, ICADC
- **Treasurer:** John Lisy, LCDC, OCPS II, LISW-S, LPPC IV
- **Past President:** Donald P. Osborn, PhD, LCAC

#### National Certification Commission for Addiction Professionals (NCC AP)
- **Chair:** Kathryn B. Benson, LADC, NCAC II, QSAP, QSC
- **Executive Director:** Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP

#### NAADAC Board of Directors

<table>
<thead>
<tr>
<th>Region</th>
<th>Vice-Presidents</th>
<th>Past Presidents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North Central</strong></td>
<td>Representing Arkansas, Louisiana, Oklahoma, and Texas</td>
<td>2000–2002 Bill B. Burnett, LPC, MAC, NCAC II, MAC</td>
</tr>
<tr>
<td><strong>Southwest</strong></td>
<td>Representing Arizona, California, Colorado, Hawaii, Nevada, New Mexico, and Utah</td>
<td>2002–2004 Mary Ryan Woods, RNC, MAC, NCAC II, MAC</td>
</tr>
</tbody>
</table>

#### Standing Committee Chairs

<table>
<thead>
<tr>
<th>Committee</th>
<th>Chair</th>
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<tbody>
<tr>
<td>Bylaws Committee</td>
<td>Ronald A. Chupp, LCSW, LCAC, NCAC II, ICADC</td>
</tr>
<tr>
<td>Clinical Issues Committee</td>
<td>Frances Patterson, PhD, MAC</td>
</tr>
<tr>
<td>Ethics Committee</td>
<td>Anne Hatcher, EdD, CAC III, NCAC II</td>
</tr>
<tr>
<td>Finance Committee</td>
<td>John Lisy, LCDC, OCPS II, LISW-S, LPPC IV</td>
</tr>
<tr>
<td>Nominations and Elections Committee</td>
<td>Donald P. Osborn, PhD, LCAC</td>
</tr>
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</table>

#### NAADAC Public Policy Committee
- **Co-Chairs:**
  - Gerry Schmidt, MA, LPC, MAC
  - Nancy Deming, MSW, LCAC, CCAC-S

#### NAADAC Public Policy Committee Members
- **TBA**

#### AD HOC Committee Chairs

<table>
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<tbody>
<tr>
<td>Awards Committee</td>
<td>Tricia Sapp, BSW, CCJ, CPS</td>
</tr>
<tr>
<td>Adolescent Specialty Committee</td>
<td>Christopher Bowers, MD, CSAC, ASE</td>
</tr>
<tr>
<td>Editorial Committee</td>
<td>TBA</td>
</tr>
<tr>
<td>International Committee</td>
<td>Paul Le, BA</td>
</tr>
</tbody>
</table>

#### Leadership Retention & Membership Committee Chair
- **Chair:** Roger A. Curtiss, LAC, NCAC II

#### Product Review Committee Chair
- **Chair:** Philip L. Herschman, PhD

#### NAADAC Regional Board Representatives

#### Northeast

- **Representatives:** Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont
- **Chair:** Catherine Iacuzzi, PsyD, MLADC, LCSW
- **Vice-Chair:** James P. Johnson, BS, LADC, ICS, Minnesota-Kansas-Missouri

#### Mid-Atlantic

- **Representatives:** Delaware, the District of Columbia, Maryland, New Jersey, Pennsylvania, Virginia, and West Virginia
- **Chair:** Ron Pritchard, CSAC, CAS
- **Vice-Chair:** Peter DalPra, LADC, New Hampshire-Massachusetts

#### Southwestern

- **Representatives:** Arizona, California, Colorado, Hawaii, Nevada, New Mexico, and Utah
- **Chair:** Frances Patterson, PhD, MAC

#### National Certification Commission for Addiction Professionals (NCC AP)

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#### Regional Vice-Presidents

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#### Past Presidents

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<thead>
<tr>
<th>Year</th>
<th>Representative</th>
</tr>
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<tbody>
<tr>
<td>1994–1996</td>
<td>Cynthia Moreno, NCAC I, NCAC II</td>
</tr>
<tr>
<td>1988–1990</td>
<td>Paul Lubben, NCAC II</td>
</tr>
<tr>
<td>1986–1988</td>
<td>Franklin D. Lisnow, MEd, CAC, AAC</td>
</tr>
<tr>
<td>2007–2010</td>
<td>Patricia M. Greer, BA, LCDC, PhD, APRN-CS, MAC</td>
</tr>
<tr>
<td>2006–2007</td>
<td>Sharon Morgill Fredon, PhD, APIN-1, MAC</td>
</tr>
<tr>
<td>2000–2002</td>
<td>Bill B. Burnett, LPC, MAC, NCAC II, MAC</td>
</tr>
<tr>
<td>1998–2000</td>
<td>Mark Gallagher, NCAC II</td>
</tr>
<tr>
<td>2002–2004</td>
<td>Roger A. Curtiss, LAC, NCAC II</td>
</tr>
<tr>
<td>2004–2006</td>
<td>Mary Ryan Woods, RNC, LADC, MSHS</td>
</tr>
<tr>
<td>2006–2008</td>
<td>Sharon Morgill Fredon, PhD, APIN-1, MAC</td>
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#### Executive Directors

- **Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP**
- **Kathryn B. Benson, LADC, NCAC II, QSAP, QSC**

#### Executive Director
- **President Elect:** Kirk Bowder, PhD, MAC, LISAC, NCC, LPC
Why Join NAADAC, the Association for Addiction Professionals

NAADAC, the Association for Addiction Professionals, represents the professional interests of more than 75,000 addiction counselors, educators, and other addiction-focused health care professionals, who specialize in addiction prevention, treatment, recovery support, and education in the United States, Canada, and abroad.

NAADAC Membership Tailored To You:
- Professional, Associate, Retired, Student, Military, and International membership levels available.
- Semi-annual payment plans available to help with your budget.
- NAADAC membership dues include membership in both NAADAC and your state affiliate.

Earn Free Online Education and CEs:
- Over 75 online continuing education hours (CEs), including three online courses and over 40 webinars available to members for free.
- Simply watch the webinar/online course of your choice, complete the online CE quiz, and receive a free CE certificate to use towards your license/credential – all online, at your convenience.

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- Save $100 on national certification and re-certification of the National Certified Addiction Counselor (Levels I and II), Master Addiction Counselor (MAC), and other credentials.
- Receive members-only pricing on all NAADAC produced publications, independent study courses, and continuing education hours (CEs).
- Receive reduced pricing on all NAADAC-sponsored conferences and public policy events.
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Join NAADAC online at www.naadac.org/join or by calling 1.800.548.0497!

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Gain Free Access To:

- The comprehensive members-only information portal and directory.
- NAADAC’s official magazine, *Advances in Addiction and Recovery*, that is focused on providing useful, innovative, and timely information on trends and best practices in the profession.
- The NAADAC Calendar of Events to view events throughout the United States and online.
- Notifications about hot topics, events, opportunities, and important announcements about the addiction profession through mail, email, and social media.
- The NAADAC Career Center, where you can look through NAADAC’s national and international job listings and post openings with your organization.
- NAADAC’s eNewsletters, including the weekly *Professional eUpdate*, delivering the latest news from NAADAC and partner organizations, educational events, trainings, resources, and career opportunities, and the bi-weekly *Addiction & Recovery eNews*, providing up-to-date information to subscribers about innovations, research, and trends affecting the addiction-focused profession.

Support Your Profession:

- NAADAC members are bound by a nationally-recognized Code of Ethics.
- NAADAC member contributions help maintain the profession’s identity and a professional association that helps preserve and honor the unique and specialized talents of addiction professionals.
- NAADAC is an influential and effective voice for addiction professionals before Congress and the federal administration, the key governmental bodies that determine how addiction treatment is funded and administered in America.
- Networking opportunities through national and state conferences and workshops.

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