Can the Science of Addiction Help Reduce Stigma?

By Nora D. Volkow, MD
Director
National Institute on Drug Abuse

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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.

Mailing Address
1001 N Fairfax Street, Suite 201
Alexandria, VA 22314

Telephone
800.548.0497

Email
naadac@naadac.org

Fax
703.741.7698

Managing Editor
Jessica Gleason, JD

Graphic Designer
Elsie Smith, Design Solutions Plus

Editorial Advisory Committee
Kirk Bowden, PhD, MAC, LISAC, NCC

Río Salado College
Alan K. Davis, MA, LCDC III
Bowling Green State University
Carlo DiClemente, PhD, ABPP
University of Maryland, Baltimore County
Rokelle Lerner, MA
Cottonwood de Tucson
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Robert Parkinson, MD
Keystone Treatment Center
Robert C. Richards, MA, NCAC II, CADC III
Willamette Family Inc.
William L. White, MA
Chestnut Health Systems

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STAY CONNECTED

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Addiction counselor licensing is vitally important to the future and health of our profession. As such, NAADAC has been working vigorously to keep the topic in the national eye. However, addiction counseling licensing cannot be accomplished at the national level. Licensing is a state-specific issue that NAADAC and its affiliates must address on a state-by-state basis. State statutes require the state’s legislature to pass legislation to enact the licensing, or to change the name of an existing license title, or to add addiction counseling-specific education and training requirements.

NAADAC plans to continue this effort until all 50 states have addiction counselor licensing. NAADAC also seeks to increase the standardization of licensing among states. Currently, approximately half of the states have an addiction counseling license. The remaining states have various forms of counselor certification. Mandatory addiction counseling education requirements vary greatly from state to state, with some states requiring as little as a GED and 300 clock hours of training, while other states require as much as a 60 credit hour Master’s Degree. Work experience requirements also vary, ranging from no experience requirements to requirements of several thousands of hours. Other behavioral health professions have far more licensing standardization from state to state. For example, Licensed Clinical Social Workers, Licensed Psychologists and Licensed Professional Counselors have a much higher level of standardization in their professional titles and licensing requirements from state to state. For the sake of the addiction counseling profession, it is essential that as a profession, we too obtain much greater standardization of licensing requirements and titles from state to state.

In order to move forward with these vital efforts, it is important for all addiction counselors and their advocates to understand the following key terms:

**Licensure** is the state-specific granting and regulating of licenses to engage in the practice of a specific activity. Simplistically, it is the granting of permission to participate in an activity that is otherwise forbidden. Two good examples of state-granted licenses are drivers’ licenses and medical licenses. Obtaining a driver’s license is mandatory to drive legally in a person’s state of residence. The requirements to obtain a driver’s license are state-specific and vary from state to state. Normally drivers’ licenses are transferrable from state to state, and states are willing to grant temporary permission to drivers from other states to drive in their state for a specific period of time. In contrast, medical licenses are not automatically transferrable from state-to-state. For example, when a doctor obtains a medical license in my home state of Arizona, that doctor is not automatically licensed to practice in any other state. If an Arizona doctor decides to practice in California, the doctor must first obtain a California medical license. Licenses are state-specific, not national. Each state grants and regulates licenses in their state as a state government privilege. Licenses are not a national privilege. If a person violates licensure laws, that person can be prosecuted under civil or criminal law.

A **professional license** grants a licensee the authority to use a specific professional title. Examples include the professional titles Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC) and Licensed Independent Substance Abuse Counselor (LISAC). Normally professional licenses also grant the legal authority to practice in a specific profession and under a regulated scope of practice as defined in the statutes and/or rules of the state. As mentioned above, license requirements and scopes can vary greatly from state to state.

**Credentials** are normally a certificate or other form of documentation attesting to a person’s qualifications. The terms credentials and licenses are frequently used interchangeably, but they are not synonymous terms.

A **national credential** is simply a credential issued by a national certification organization, like NAADAC and its National Certification Commission for Addiction Counselors (NCCAP); it is NOT a national license. A license must be issued by a state. I frequently hear people in our profession discuss the need for a national credential. Holding a national credential does not automatically translate into a state license. For example, NAADAC’s Master of Addiction Counseling (MAC) certification is an outstanding national credential. The MAC is extremely valuable in attesting to an addiction professional’s high level of qualifications, but it is not a license. National credentials are not a substitute nor can they replace the need for state-issued licenses. I have a MAC, which I am proud of, but the MAC does not give me the authority to practice addiction counseling in my state of Arizona. To practice, I must be licensed by the Arizona Board of Behavioral Health Examiners. The benefits of national credentials are described in Executive Director, Cynthia Moreno Tuohy’s article in this issue of *Advances in Addiction & Recovery*.

**Certification** is normally a voluntary credential, offered by private organizations. A certification is a form of documentation attesting that...
a person has met specific criteria established by a certification organization. This criteria normally include education requirements and the passing of an exam. A certification is not a state license and neither replaces a license, nor offers the same level of power, authority, and/or protection as a license within a state. A certification is not a granting of permission by a state but rather a documentation of specific qualifications.

**Statutes** are laws that are written and passed by legislative bodies of government.

**Tiered licensing levels** are the different levels of licensing required by states. Some states have a single level of licensing, while others have two or three tiers of licensing. A few states have a single level of mandatory licensing for counselors practicing independently and certification for counselors working under supervision.

**Titles of licenses** for addiction counselors vary from state to state. The currently preferred titles of licenses include “addiction counselor” in the title. However, many states have had counseling licensing for many years and use outdated titles. In my state of Arizona, we have tiered licensing, of which the highest level of counselor license is “Licensed Independent Substance Abuse Counselor (LISAC).” I have been actively advocating in my state to change the title to “Licensed Independent Addiction Counselor” or “Licensed Addiction and Substance Use Disorder Counselor.” Texas has a single level of counselor licensure, and titles its license “Licensed Chemical Dependency Counselor (LCDC).” NAADAC encourages use of “Addiction Counselor” in the title of future state licenses. Note: the change of the title of a license is not a simple issue. The title is normally written in state statute and requires the passage of a bill by the state legislature.

In addition to serving as NAADAC’s President, Kirk Bowden, PhD, MAC, NCC, LPC, serves on the Editorial Advisory Committee for Advances in Addiction & Recovery. While serving in many capacities for NAADAC through the years, Bowden also serves as Chair of the Addiction and Substance Use Disorder Program at Rio Salado College, consultant and subject matter expert for Ottawa University, a past-president of the International Coalition for Addiction Studies Education (INCASE), and as a steering committee member for SAMHSA’s Center for Substance Abuse Treatment (CSAT), Partners for Recovery, and the Higher Education Accreditation and Competencies expert panel for SAMHSA/CSAT. Bowden was recognized by the Arizona Association for Alcoholism and Drug Abuse Counselors as Advocate of the Year for 2010, and by the American Counseling Association for the Counselor Educator Advocacy Award in 2013, the Fellow Award in 2014, Outstanding Addiction/Offender Professional Award in 2015, and most recently the California Association for Alcohol/Drug Educators’ Lifetime Achievement Award in 2015.

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President Bowden’s article in this issue of Advances in Addiction & Recovery discusses the importance of licensure and addresses the key terms in the licensure discourse to help better explain the differences between licensure, credentials, and certification. In addition to NAADAC’s efforts to promote state-specific licensing and the standardization of licensing requirements across all 50 states, NAADAC will continue to voice the importance of national credentialing and its benefits to all addiction professionals, third-party payors, community and government stakeholders, and the public at large.

As Dr. Bowden points out, a national credential is not a license and does not automatically translate to a state license. However, national credentials set national standards for education, experience, and competency, and can be used at both the state and national level. NAADAC’s National Certification Commission for Addiction Counselors (NCC AP) issues nine different kinds of national credentials, including three credentials that align with the three main levels of practice in SAMHSA’s scopes of practice for substance use disorder professionals:

- the Master Addiction Counselor (MAC) for Category 3 — the Master’s level;
- the National Certified Addiction Counselor Level II (NCAC II) for Category 2 — the Bachelor’s level; and
- the National Certified Addiction Counselor Level I (NCAC I) for Category 1 — or the Associate’s level.

In addition, NCC AP offers a National Certified Peer Recovery Support Specialist (NCPRSS) national credential for those in Peer Recovery. (For a guide to all NCC AP credentials, please visit www.naadar.org/typeseligibility). Each of these national credentials identifies its holder as having a certain level of education, experience, and competency that is standardized and uniform, regardless of which state or country the credential holder resides in. National credentials and standards remove the following questions from the public and payor discourse: What acronym do we use for addiction counselors that identifies them to the medical professionals, school and community stakeholders and the public? How do we know if they are educated or not and at what levels of education? What standards of experience do they meet? What levels of care are they able/allowed to treat? Are they, in fact, a discipline onto themselves? Can I expect to find the same level of education, experience and standards in the state I live now and where I may live in the future? Managed Care Organizations (MCOs) and other payors do not need to wonder what this credential means in terms of education, experience, and competency from state to state. With over 56 acronyms (last time I counted), our profession is nothing short of confusing to the payors we hope to attract. And our competitors use this lack of clarity as a detractor when they speak about unprofessionalism in the substance use disorder field. National credentials allow for the identification of clear, standardized education, experience, and competency requirements necessary for substance use disorder counselors to receive the recognition and reimbursements they deserve.

As the addiction profession works to build our place in the healthcare mainstream, it is vital that MCOs, Medicaid, and other payors understand that proper and competent treatment of persons with substance use disorders requires specific education and training in substance use disorders. Thus, it is necessary to adopt national credentials in order for these national payors to see addiction counselors as legitimate providers of care that qualify as healthcare providers.

NAADAC believes that tiered licensing and credentialing grants a full continuum of care for service providers that wish to capture whatever segments of the treatment and recovery support services continuum in their provider services. We also believe these same levels translate to tiered licensing levels so that reimbursement is open to anyone holding these credentials.

NAADAC and the NCC AP continue to work towards greater credibility and standardized payor status for addiction professionals through use of its national credentials to allow for consistent reimbursement by payors. NAADAC is working with payors who want to feel informed and secure in the standardized of credentials for addiction professionals. This is why Optum recently accepted the NCC AP’s MAC and Peer Recovery Support Specialist credentials nationally. And, NAADAC is working to carry that same message and gain that same recognition and payment reimbursement status with other MCOs and government payors. Now is the time for national recognition by payors for those serving in the addiction profession. With NCC AP opening up its credentials to any person who has a state credential that matches any of the NCC AP’s levels of national credentials, it is easier now, more than ever, to obtain a national credential and use it for your benefit.

National credentials and standards also help addiction professionals address a variety of other issues inherent in the addiction profession. Addiction professionals have suffered low salaries and benefits for decades and will continue to struggle if we cannot achieve a standardized scope of practice and level of recognition for the services that we provide. In building the vision of the addiction profession within the medical health-care system and working towards the integration and recognition of substance use disorders as a specialty, national credentials and their standardized education, experience, and competency requirements provide a clear, uniform guide for payors, stakeholders, and the public to understand our worth and the value of our work. Very few wonder what a “MSW” performs in terms of services, or scope of practice or the level of education they have achieved. Not everyone knows the exact nature of a MSW’s experience; however, there is general trust as to what those
credentials mean. Now is the time to create that same level of trust when stakeholders and the public refer to substance use disorder professionals.

Substance use disorder professionals have also struggled with the lack of transportability of their credentials from state to state, which ultimately affects and attributes to the national workforce shortage. National credentials (able to use for licensure or certification or both in any state) would allow for easy transportability across state lines because all levels of education, experience, and competency would be uniform across all states. No longer would a substance use disorder professional be told when they move from one state after achieving credentialing or licensing in that state (and 20 plus years of experience) that they have to start over with earning credentials in the their new state. Now is the time to honor the education and experience that substance use disorder professionals achieve no matter what state they have practiced in or level of credential they have achieved.

We have com a long way on our journey through the past 50 years to gain credibility, raise awareness of the addiction profession, and create public policy that pays for substance use disorders treatment and research and creates opportunities for more students to specialize in a substance use disorders career; however, we are not quite there yet! We have not created “household credentials” for our profession that are easily recognized by payors and the public, alike. Now is the time to move our discipline forward to create the visibility and credibility that will move our profession past the questions of “who are they, what do they do, what standards do they meet, and why should we pay them for services?”

With over 11 million new persons over the age of 12 with substance use and mental health disorders now eligible for healthcare, now is the time to build a stronger, more viable, and recognized workforce and NAADAC is here to help achieve that as a reality!

Many blessings on Your journey!

Cynthia Moreno Tuohy, NCAC II, CDC III, SAP, is the Executive Director of NAADAC, the Association for Addiction Professionals, and has worked as an addiction professional for over 35 years. She has been a trainer in Domestic Violence/Anger Management and Conflict Resolution for over 25 years, as well as an international, national and state trainer in a variety of topics. Moreno Tuohy is also a curriculum writer in addiction screening and evaluation, counseling methods, conflict resolution, co-occurring disorders and medicated assisted treatment and recovery, and has written articles published in national and other trade magazine. She holds a Bachelor’s Degree in Social Work and is certified both nationally and in Washington State.

REFERENCES

NAADAC Honors 2015 National Award Winners

Compiled by Jessica Gleason, NAADAC Director of Communications

Each year NAADAC honors the work of dedicated addiction professionals, organizations, and public figures during its President’s Awards Luncheon at the Annual Conference. This year, NAADAC will present awards to five outstanding individuals for their extraordinary service and contributions to the addiction profession, and one outstanding organization and its CEO for their strong commitment to the addiction professional and to individual addiction professionals.

**Lifetime Honorary Membership Award: James McKenna**

This esteemed award is presented to James McKenna, LCSW, LADC I, BRI II, who has dedicated his career over the past 40 years to enhancing treatment opportunities for persons and families struggling with substance use disorders. Most notable has been McKenna’s 23-year tenure with AdCare Hospital in Worcester, MA, where he has played a key role in the Hospital’s success growth to a 114-bed inpatient facility that treats over 6,000 patients per year and delivers over 100,000 outpatient services at six offices throughout Massachusetts and Rhode Island.

As founding member and past treasurer of NAADAC’s affiliate, Massachusetts Association of Alcoholism & Drug Abuse Counselors (MAADAC), McKenna brought a fragmented organization of counselors to its present robust status. Through AdCare, he has provided space for meetings, trainings, and events, and promotes MAADAC/NAADAC membership to all he works with. McKenna is also an advanced member of the American College of Addiction Treatment Administrators and the Employee Assistance Professional Association, a founding member of Drug and Alcohol Treatment Association (DATA) in Rhode Island, serves on the Board of Directors of Caritas, Inc., and has served as a mentor to many new addiction counselors and teacher through AdCare’s Educational Addiction Counselor Education Program and Westfield State University.

Through the years, McKenna has received numerous awards, including recognition from the MA/RI Chapter of the Employee Assistance Professionals Association, Rhode Island Labor Assistance Professionals, and MAADAC in 2015, Massachusetts Organization for Addiction Recovery (MOAR) and Gateway Healthcare in 2014, and the Rhode Island Council of Alcoholism and Other Drug Dependence in 2009.

**Lora Roe Memorial Alcoholism and Drug Abuse Counselor of the Year: Martha Deering**

This award, renamed for Lora Roe in 1988, is presented to a counselor who has made an outstanding contribution to the profession of addiction counseling.

Martha Deering, MA, CAGS, LADC I, CADC II, LRC, CRC, DOT SAP, is the recipient of NAADAC’s Counselor of the Year award for her outstanding teaching and clinical skills, strong ethics, commitment to her clients’ needs, and never ending compassion for her work as a counselor, consultant, and trainer in Massachusetts since 1978. Besides providing counseling through her private practice and working AdCare, Deering provides consultation, supervision, and trainings to businesses, higher education, municipalities substance abuse agencies, human service agencies, private clinicians, and community organizations. Deering has taught or spoken at a variety of colleges and universities in New England, New York, Pennsylvania, and Florida, and is a frequent presenter at state and regional conferences, has multiple publications in the fields of Rehabilitation Counseling and Substance Use Disorders, and has over 20 years of experience working with Employee Assistance Programs.

Deering has served in leadership at the Massachusetts Rehabilitation Association, the Massachusetts Rehabilitation Counseling Association, and National Rehabilitation Counseling Association, and as an evaluator for the Massachusetts Board of Substance Abuse Counselor Certification. She is the recipient of MAADAC’s 2015 Counselor of the Year Award.

**Mel Schulstad Professional of the Year: Edward Reading**

This award recognizes an individual who has made outstanding and sustained contributions to the advancement of the addiction counseling profession.

This year’s recipient, Edward Reading, PhD, LCADC, is the Assistant Director of the Professionals Assistance Program in Princeton, President of the Matt Talbot Institute for Addiction Studies in Trenton, NJ, an Adjunct Graduate Faculty member at Stockton University in Galloway, NJ, and an ordained Catholic Priest for the Diocese of Paterson, NJ. He has spent the past 46 years supporting persons with substance use disorders and using his counselor, educator, consultant, board member, and advocate experiences, roles, and leadership positions to advance the addiction counseling profession at the local, state, and national levels.
As a counselor, Reading has raised standards while working in pastoral counseling, outpatient clinics, halfway houses, residential programs, professional assistance programs, and was the first Executive Director of New Jersey Prevention, Inc. in 1980. Since 1980, Reading has been intimately involved in the improvement of addiction studies education, teaching addiction studies courses at over 10 colleges and universities, publishing over 27 articles, training and speaking at conferences, working with INCASE to develop first curriculum standards for academic addiction studies programs, and playing a key role in INCASE and NAADAC’s creation of the National Addiction Studies Accreditation Commission (NASAC), the only academic accreditation organization for higher education addiction studies programs. In addition, Reading is a member of the New Jersey State Board of Marriage and Family Therapy Examiners, where he chairs the Alcohol and Drug Abuse Committee, chair of the New Jersey Licensing Board for Clinical Alcohol and Drug Abuse Counselors, founder of the Federation of State Physician Health Programs, and chair of the coordinating committee of the newly formed Federation of State Addiction Counseling Licensing Boards, which will have its first meeting at the 2015 NAADAC Annual Conference in Washington, D.C. Reading was one of the first non-physicians to be granted membership in the American Society of Addiction Medicine (ASAM), and one of eight non-recovering people to be invited to speak at the 75th International Meeting on Alcoholics Anonymous.

Finally, as an advocate, Reading has worked tirelessly in the subspecialty area of Healthcare Professional Impairment treatment and monitoring, and at both the State and National levels to improve access to treatment, higher standards for addiction counselors, and workforce development.

William F. “Bill” Callahan Award: Peter Crumb
This award recognizes sustained and meritorious service at the national level to the profession of addiction counseling.

Peter Crumb, MEd, CAC, was nominated for this award due to his tireless commitment to developing and promulgating quality, professional adolescent substance use disorder programs in the public sector during his 35 years as a counselor, educator, mentor, and advocate. Moving from counselor to student assistance counselor in 1987, Crumb spent over 17 years developing and improving student assistance programs at 13 schools in the Pioneer Valley. In 1991, he founded the Western Massachusetts School Substance Abuse Counselors Association (WMSSACA), which meets monthly to discuss problems and trends being seen in schools and the best way the bring the message of addiction and recovery to faculty and students. Under Crumb’s leadership, WMSSACA advocacy efforts for an adolescent treatment facility in Western Massachusetts led to the establishment of the Phoenix Academy and later to the Recovery High School in Springfield, MA. After his retirement in 2003, Crumb continued his commitment to adolescent treatment, serving on advisory boards for the MA Department of Education Health and Springfield Recovery High School.

Lifetime Achievement Award: H. Westley Clark
In Fall 2014, NAADAC and the addiction prevention, treatment, and recovery communities lost a giant in their corner in the federal government with the retirement of Dr. H. Westley Clark, MD, JD, MPH, CAS, FASAM. While Clark has moved into academia as a Dean’s Executive Professor of Public Health at Santa Clara University in Santa Clara, CA, NAADAC recognizes the tremendous impact Clark made on substance use disorder research, practice, policies, and programs during his 16 years as the Director of Center for Substance Abuse Treatment (CSAT) at the Substance Abuse and Mental Health Services Administration (SAMHSA), and more than 30 years in the federal government, not only on the addiction profession, but also on NAADAC as an organization.

At SAMHSA, Clark provided oversight over a range of programs including medication assisted treatment, drug courts, buprenorphine, federal substance use block grants, children and adolescents, and grants for people with HIV and people experiencing homelessness. Under his leadership, NAADAC formed the National Addiction Education Task Force that developed national curricula in Addiction Studies from one-year certificate to doctoral levels. Building on that work, NAADAC and the International Coalition for Addiction Studies Education (INCASE) created the National Addiction Studies Accreditation Commission (NASAC) to evaluation and accredit addiction-specific education programs.

Prior to CSAT, Clark was the former chief of the Associated Substance Abuse Programs at the U.S. Department of Veterans Affairs Medical Center (DVAMC) in San Francisco, CA, and a former associate clinical professor, Department of Psychiatry, University of California at San Francisco (UCSF). In addition to his duties at the DVAMC, Clark served as a senior program consultant to the Robert Wood Johnson Foundation Substance Abuse Policy Program, and was a co-investigator on a number of the National Institute on Drug Abuse-funded research grants in conjunction with UCSF. Clark also worked as Health Counsel for Senator Edward Kennedy (D-MA) on various health policy issues.

Clark is a true expert steeped in the science of addiction and its treatments. Clark is a graduate of Wayne State University, the University of Michigan Schools of Medicine and Public Health, and Harvard Law School. He also completed a two-year Substance Abuse Fellowship at the Department of Veteran Affairs Medical Center in San Francisco, where he served as Associate Clinical Professional, Department of Psychiatry, University of California at San Francisco. Clark received his board certification from the American Board of Psychiatry and Neurology in Psychiatry and sub-specialty certification in Addiction Psychiatry. He is licensed to practice medicine in California, Maryland, Massachusetts and Michigan, and is also a member of the Washington, DC, Bar Association.

Clark has been the recipient of the John P. Govern Award and Presidential Rank Award from the American Medical Association (ASAM), Vernelle Fox Award from the California Society of Addiction Medicine, the Solomon Carter Fuller Award from the American Psychiatric Association, and multiple Awards for Distinguished Service from the Secretary of the Department of Health and Human Services. He has also served on the Board of Directors for ASAM, the East Bay Recovery Project, the California Advocates for Pregnant Women, and the Pacific Graduate School of Psychology. Clark has always performed his duties with unrivaled integrity and commitment, and NAADAC greatly admires and appreciates his leadership and contributions to the addiction profession.
working with a youth diversion program and a juvenile drug court, and advocating that school substance abuse counselors be certified in addiction treatment and for improved adolescent access to treatment. In addition, Crumb has worked as a Driver Alcohol Education Instructor since 1986.

Crumb is a member of the Massachusetts Organization for Addiction Recovery (MOAR), served in numerous MAADAC leadership positions, including President, and served as MAADAC’s Delegate to NAADAC for seven years. In addition to his advocacy efforts on behalf of adolescents, Crumb was as instrumental in advocating for parity, licensure for addiction counselors, and insurance reimbursement.

Crumb has won numerous awards for his work, including MAADAC’s 2013 Outstanding Service Award, the Mental Health and Substance Abuse Corporations of America’s 2008 Advocacy Leadership Award, the Massachusetts Department of Education’s Interdisciplinary Health Council’s 2005 Outstanding Service Award, and MAADAC’s 1999 Counselor of the Year Award.

Organizational Achievement Award: New Beginnings Adolescent Recovery Center & CEO, Johnny Patout

This award recognizes an organization that has demonstrated a strong commitment to the addiction profession and particularly strong support for the individual addiction professional.

NAADAC recognizes New Beginnings Adolescent Recovery Center (“New Beginnings”) of Opelousas, LA, as its 2015 Organizational Achievement Award winner for its high level of care, support, and commitment to the addiction professionals on its staff and through the industry. New Beginnings offers medically monitored detox services and residential, partial hospitalization, intense outpatient, and extended care programs for patients ages 13 to 18. With the leadership of its CEO, Johnny Patout, LCSW, New Beginnings transformed from a struggling program in 2011 to one of the leading award-winning treatment centers in the country today. Through the recruitment of qualified, Master’s level therapists, nurses, and physicians who are dedicated to providing the highest quality of care possible for their patients, New Beginnings has become a center of excellence for struggling teenagers from across the country. The highly experienced leadership team, many of whom are in recovery themselves, offer their experience, training, knowledge, and skills in treating addiction to offer real hope for adolescents and their families.

In 2013, New Beginnings was honored as the recipient of the National Association of Addiction Treatment Providers (NAATP)’s James W. West Quality Improvement Award. In 2014, Behavioral Healthcare magazine named Patout a Behavioral Healthcare Champion for his contribution to the addiction profession and for his leadership over the past three decades.

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The **Now is the Time: Minority Fellowship Program for Addiction Counselors (NITT-MFP-AC)** is part of the President’s Plan to increase behavioral health services for youth in America. And for the first time since the national Minority Fellowship Program (MFP) was established in 1974, funds to support Master’s level education for addiction counseling became available through the 2014 Consolidated Appropriation Act. Originally the MFP enhanced services to minority communities through specialized training of mental health professionals in psychiatry, nursing, social work and psychology. Over the years, the MFP was transferred to the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration (SAMHSA), and the program was expanded to include marriage and family therapists and professional counselors. Clearly, including addiction counseling as an eligible discipline for the MFP was a long time in coming, and NAADAC played a significant role in advocating for its consideration for over eight years.

NAADAC responded to the Request for Applications issued by SAMHSA and was one of two organizations awarded the $3.2 million four-year grant to identify and select students going into their last year of a Master’s Degree in addiction counseling at an accredited institution of higher learning to receive a tuition stipend as part of the NAADAC Minority Fellowship Program for Addiction Counselors (NMFP-AC). NMFP-AC Fellowships are open to any Master’s Degree addiction counseling student with a commitment to working with transition age youth in underserved populations in underserved communities, including minority and LGBT populations. Closing in on the first year of the grant, much has been accomplished.

**Selected Highlights**

An Advisory Committee was established consisting of individuals representing a wide cross-section of stakeholders from recovery, consumer and treatment communities for adults and adolescents, as well as national organizations and centers operating in the field. Although its purpose is to provide leadership for the NMFP-AC, the Advisory Committee was also envisioned as an adjunct workgroup, so committee members rolled up their sleeves to create plans and policy, develop associated documents for administering the project, select and support fellows, provide education, and assist with monitoring and evaluation.

NAADAC extended the use of its sophisticated secure cloud-based database and management system (IMPal) and created a customization to collect and manage all incoming and outgoing NMFP-AC data and information. IMPal was used to develop a portal for fellows that will progress with them; first to house their applications and supplemental documentation, then to track program requirements and milestones, and eventually to evolve into an online career profile to market their skill sets to potential employers through the NAADAC website.

NAADAC’s Communication Department provided multiple layers of support for the NMFP-AC, beginning with the design of a logo for all forms of distribution (letterhead, website and other publications distribution). Within a month of the award, NMFP-AC webpages were launched (www.naadac.org/NMFP-AC) and the program was announced to NAADAC’s email list of over 37,000 addiction professionals. Once the NMFP-AC application was developed in time for the January 1, 2015 application session, it was made available on the NMFP-AC webpage as a convenience for potential applicants. Since its
launch, the NMFP-AC webpage remains a popular area of the NAADAC website.

An objective of the NMFP-AC included improved training in cultural diversity, recovery-based practices, and evidence-based practices for working with transition age youth in underserved populations and communities. Toward this objective, NAADAC pledged the development of a series of six webinar trainings, the last of which was offered as a live event on August 26, 2015. The webinars are free to Fellows, NAADAC members, and the public and are available on-demand through the NAADAC website. After viewing each required webinar, and finishing and passing the corresponding online quiz, each Fellow receives a continuing education certificate to document the completion of this education requirement of the NMFP-AC.

Finally, the selection of the first cohort of NMFP-AC Fellows was announced on July 15, 2015. Applicants were vetted through a rigorous review and selection process. Once it is determined that an applicant has met all of the eligibility criteria, the application and all required supporting documents are sent to a reviewer, who scores each component with the aid of scoring rubrics designed specifically for the NMFP-AC. Applicants receive points for academic honors, professional association memberships, work experience in addiction/substance use disorders, letters of recommendation, application essay, and grade point average. A total score is derived and a cut-off score applied to determine the final selection of Fellows. The amount of time and effort required to develop (draft, review, revise) the necessary documents and procedures for the review and selection process by the NMFP-AC staff and advisory committee members cannot be overstated, and is a measure of their commitment to this historic workforce award.

An online orientation for new NMFP-AC Fellows was conducted on August 21, 2015 by NMFP-AC staff. A general overview of NMFP-AC requirements was discussed regarding tuition stipends, NAADAC memberships, the assignment of mentors, access to webinars, completion of the Individual Fellow Development Plan, and suggestions for future communication. The effort and patience of all was rewarded when hearing the gratitude for the Fellowship opportunity expressed freely by the Fellows during the online session. Enthusiasm was evident in their introductions and in the personal stories they shared. The NMFP-AC is off to a good start, with nothing but success anticipated in the future for this cohort of fellows.

Application Period for Second NMFP-AC Cohort Opens December 15, 2015

NAADAC will be looking for qualified applications for its second NMFP-AC Cohort in late 2015. Be sure to spread the word!

Paula Horvatich, PhD, is the NAADAC Program Manager for the Now is the Time: Minority Fellowship Program for Addictions Counselors (NITT-MFP-AC) grant awarded by SAMHSA. Her career in higher education at three university medical schools focused on improving clinical curricula, evaluating competencies and teaching medical interviewing and health behavior. In addiction medicine, she directed projects funded by NIDA and SAMSHA. Her leadership contributions to SAMHSA included the Panel V Workforce report for the 2000 National Treatment Plan, and chairing the 2006 committee that revised TAP 21: Addiction Counseling Competencies: the Knowledge, Skills and Attitudes of Professional Practice. Horvatich is looking forward to recruiting students to the MFP-AC, partnering with college and universities, and continuing to contribute to the development of the addiction workforce.

Indiana Wesleyan University is recognized in setting the national academic standards and professional integrity for the treatment of addictions. • Program is an approved provider of NAADAC, the Association for Addiction Professionals and the Indiana Association for Addiction Professionals (IAAP). • Graduates of our 48-credit hour program are eligible to sit for the Master Addictions Counselor (MAC) exam. • Addictions Counseling program brings a Christian worldview to the subject of addictive behavior. • Classes offered online or in an online/onsite blended format at IWU’s main campus in Marion, IN and in Indianapolis, IN.

Don P. Osborn, Ph.D., LCAC, MAC Director and Professor of Graduate Addictions Counseling

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Moving Forward As One – You Can Become Nationally Certified

By Kathryn Benson, LADC, NCAC II, QCS, NCC AP Chairperson

Perhaps it’s the fact that presently I’m focused on the National Certification Commission for Addiction Professionals (NCC AP)’s launching of its next step toward our greater commitment for all to hold a single national credential that my energetic thoughts and excitement have clients and colleagues alike inquiring about addiction credentialing standards and process. Perhaps it’s the fact that more and more we’re seeing media coverage of the importance for medical professionals and treatment service agencies to demonstrate their competence to do the work they are entrusted to do. Whatever the catalyst, now is the time to get your national credential!

Recognized globally since 1991 as a professional vanguard, NCC AP has been issuing national credentials that are highly valued by employers, clients and other stakeholders who rely upon them to convey excellence in the addiction profession. NCC AP national credentials carry a distinct meaning in the Substance Use Disorders (SUD) profession and are a promise of determination, proficiency and skill.

We all fully understand the benefit to all parties to have and work from a national standard of professional competence, skill and practice. We all fully understand and appreciate how imperative it is that we have SUD standards of care that are essential to protect the health, safety and welfare of the general public. We all fully understand the legal benefit to measure and enforce competent care, to insure professionals have met the requirements to hold the credential as a qualified SUD professional. We all fully understand the recognized scope of practice that a national credential identifies, supports, and reinforces with continuing education requirements. We all fully understand the need to establish and promote a consistent standard of practice which is enforceable by a professional code of ethics and a disciplinary action process against non-compliant practitioners who put the public at risk. We all fully understand the precarious position in which our SUD profession finds itself, within the behavioral and health care industry — a position being undermined by the falsely promoted belief that addiction service does not have to be performed by helping professionals that are trained specifically in addiction treatment and recovery and who evidence competencies of knowledge, clinical skills and attitudes necessary to successfully treat someone with substance use disorders.

Mastering our specialty is a key differentiator of top professionals and obtaining an NCC AP national credential is the best way to get each of us where we need to be in our role as a skilled, compassionate SUD healthcare provider.

The fact is we are better equipped to care for those who seek our assistance with confidence and assurance through our determination to:

• Master our specialty with invaluable knowledge and skill;
• Learn and share innovative, leading-edge practices of best care;
• Boost our confidence and stand out in our area of expertise;
• Expand our credibility with clients, employers, and colleagues;
• Expand our professional network; and
• Advance our career opportunities.

Professionals who have the drive and tenacity to strive for new heights in our profession are becoming an essential element for personal and organizational success while also bringing recognition and strength on a much broader level to our credentialed members.
Your patients in recovery are making great strides towards a brighter future and Roxane is committed to helping you encourage them to live free from dependence. Determined to bring hope, help, and healing, we take great pride in supporting the unique needs of the Addiction Therapy community.

www.roxane.com
In this time of unprecedented healthcare change, SUD treatment providers face new challenges and opportunities. By taking on new, expanded roles, counseling professionals are helping providers achieve new levels of efficiency, patient satisfaction and quality of care. This growing importance, combined with a growing demand for competent SUD professionals, makes the need for a single national standard more critical and urgent than ever. Credentialing through a national credentialing organization is the only way to ensure all have the standardized skill sets and level of competence needed to care for those who put their lives and futures in our care.

NCC AP understands that increasingly MCOs, government-funded grants, and the Department of Transportation (DOT) all seek professionals who hold a national credential. Therefore, we encourage you to position yourselves for the greatest possible career opportunity.

For over 31 years, SIERRA TUCSON has helped to navigate the path of hope and healing. You can take comfort that your patients are at the center of a recovery program that is world renowned. Within a natural healing environment, their journey will be with others who are experiencing a similar process, yet tailored to their individual needs.

Sierra Tucson is accredited by The Joint Commission and licensed as both a special hospital and a behavioral health residential treatment center.

New Test Exemption Opportunity for NCAC I & II Credentials

NCC AP is announcing an open window of test exempt opportunity for all currently state credentialed addiction professionals to receive, based on their already demonstrated competence, skill, training and experience, either the National Certified Addiction Counselor I (NCAC I) or the National Certified Addiction Counselor II (NCAC II) credential.

This one time only test exemption offer for a NCAC I or NCAC II national credential will be available for a six (6) month period beginning November 1, 2015 and ending April 30, 2016. No test exemption applications will be accepted after the close of this offer. Applications must be postmarked by April 30, 2016.

SUD professionals may access the application on the NAADAC website at www.naadac.org/NCACTestexemptionoffer. NCC AP’s continued purpose of credentialing is to standardize quality of addiction prevention, intervention, treatment and continuing care services. Our goals remain consistent in our efforts to focus on the individual counseling professional; maintain standards that frequently exceed state requirements; encourage continued educational enhancement; bring forth most current research and therapeutic tools consistent with best practices and to provide assistance to employers, health care providers, educators, government entities, labor unions, other practitioners and the public in the identification of quality SUD counseling professionals.

NAADAC and the NCC AP wish to extend our support and encouragement to all of you who wish to enhance your professional standing and future opportunities by joining us in this time-limited invitation.

Wishing for you a gentle journey to national certification!

Kathryn Benson, NCAC II, LADC, Qsap, Qsc, serves as Chair of the National Certification Commission for Addiction Professionals (NCC AP), and has worked in the counseling profession since 1972, specializing in addiction issues since 1978. She may be contacted at lightbeing@aol.com with your thoughts or questions.
Can the Science of Addiction Help Reduce Stigma?

By Nora D. Volkow, MD, Director, National Institute on Drug Abuse

For many years, clinicians and researchers in the drug addiction field have promoted the view that addiction is a disease, not a moral failing. This has been crucial not only for supporting research in new treatments but also for reducing the stigma that surrounds disordered drug use. However, the concept of addiction as a disease of the brain has been questioned by many, both in the health care field and in the lay public. In particular, some policymakers and treatment providers have rejected the notion that brain changes underlie the lack of behavioral control in those suffering from addiction. This has hindered the adoption and utilization of effective harm-reduction measures like needle exchange programs and medications for treating drug addiction.

By focusing our past educational efforts mainly on one easy-to-understand aspect of the brain changes involved in addiction — those of the reward circuits — addiction researchers bear some of the responsibility for failing to educate the public about addiction’s complexity. If the public knows anything about the brain chemistry of addiction, it is that drugs cause surges of dopamine, which we used to call the reward chemical, to flood the reward circuits — the nucleus accumbens and dorsal striatum. This is associated with extreme euphoria, which then motivates the user to seek to repeat that pleasurable experience. But more than two decades of science using advanced neuroimaging and animal models of addiction have greatly expanded our understanding of how drugs cause lasting changes to the brains of users, and dopamine flooding the reward areas is just one small part of the bigger picture. In fact, when susceptible individuals become addicted, even those surges of dopamine are often no longer experienced as pleasurable. It is necessary to convey some sense of the larger systemic imbalances that occur within the brain that drastically compromise a person’s ability to control drug use.

It is now known that dopamine is not simply rewarding, but rather that it is the neurotransmitter central to anticipation, both of rewards and of punishments. If dopamine remains a key neurotransmitter to understanding the brain of addicted individuals, it is because we now understand that altered dopamine signaling is implicated in a whole ensemble of brain changes involving not only the reward regions but also several other brain circuits that are involved with executive function including self-control, the processing of negative emotions and memories, and the shaping of behavior through conditioning. The disrupted neural circuits in addicted persons continually subject them to depressed moods, irritability, and restlessness, while dangling the faint (and usually disappointing) relief of the drug before their eyes, wherever they turn. A group of brain structures collectively known as the extended amygdala act in concert with the reward circuit as the other half of our internal pleasure-displeasure thermostat. The research of my colleague George Koob, director of the National Institute on Alcohol Abuse and Alcoholism, has examined how this circuit, which he calls the “anti-reward” system, increases in sensitivity with repeated substance exposure. The result is significant stress and suffering during the phase of withdrawal, when the person is no longer taking the drug. This is coupled with reduced sensitivity in the reward regions to the surges of dopamine mentioned earlier; these circuits get re-set so that the addicted person requires those dopamine surges just to feel a normal amount of motivation or excitement. As a result, during the state of intoxication, drugs provide a brief respite from the stress and negative moods but can no longer trigger the intense euphoria when they were first taken, and ordinary rewards such as food, sex, and other healthy behaviors no longer are capable of motivating the person much or at all. This is one reason why it is so misleading to speak of drug addiction as being about “getting high”; motivationally, it is about escaping being very low.

At the same time that the reward regions reduce their sensitivity to the drug and other rewards, they become rewired to respond to drug-related cues, or conditioned stimuli, through learning processes that Pavlov first described well over a century ago. Anything associated with the drug and drug-taking — which for an addicted person may be everything in their normal routine, including friends and family, home and work environments, and a host of other daily stimuli — trigger anticipatory dopamine release, signaling the expectation of the drug and motivating the individual to seek it out. It then becomes very difficult for the addicted person to avoid this array of motivating signals related to the drug, the strength having become enhanced by the learned anticipation that the drug will relieve the negative moods that overcome them during withdrawal.

Can the Science of Addiction Help Reduce Stigma?
But there is still more to addiction than the unbalancing of pleasure and unpleasure and the reshaping of the individual’s motivational landscape through conditioning. Addiction also involves changes to the prefrontal cortex and associated control networks necessary for self-regulation, including the control of impulses and desires. \(^5\) It is these changes that often prevent an addicted person from being able to follow through with a sincerely made decision to endure suffering in the interest of becoming free of their dependency.

The changes in the prefrontal cortex, a key component in the control circuits, also involve a desensitization to dopamine, just as has occurred in the reward regions, but in this case the circuits using this neurotransmitter govern the individual’s capacity to exert self-inhibition, to resist impulses, and to persist with plans, choices, and resolutions. When these circuits lose their sensitivity to dopamine, self-control in the face of highly motivating stimuli like drug cues, or the drug itself, becomes extraordinarily difficult to exert. The addicted individual no longer has a completely functioning guidance system that is able to steer clear of or resist threats to sobriety.

Healthy non-addicted behavioral choices and decisions are the outcome of highly orchestrated brain processes acting in concert and keeping each other in check. Just as the anti-reward circuitry feeds back on the reward circuitry in a healthy person, the prefrontal circuits also play a key regulatory role that allows to the individual to make optimal decisions that are likely to result in the best outcomes. But dopamine desensitization in these circuits, along with other changes that include the sensitization of the main excitatory neurotransmitter in the brain, glutamate, throw this regulatory process off balance, making drug seeking and drug taking an almost automatic behavior, a drive, with little or no inhibitory brake.

This ensemble of brain changes could be likened to a broken video game. Because of the conditioning processes described above, the addicted person’s world is like a threatening virtual environment, a landscape calculated to pose maximal threats to their sobriety — in the form of drugs and drug cues — around every corner and lurking in every shadow. Yet the person playing the game must navigate this environment with a broken controller, such that no matter how hard they try to steer clear of hazards, their game-world avatar heads straight for the drug that will lead them to relapse.

The brain disease model of addiction has facilitated research leading to effective treatments. Restoring normal balance between reward, anti-reward, and executive systems in the brain may require behavioral interventions and, when they are available, medications. Crucial prongs in the current efforts to curb the epidemic of prescription opioid and heroin addiction include effective medications that can make the difference between recovery and relapse — or in all too many cases, death from overdose. Agonist or partial agonist medications like methadone or buprenorphine control withdrawal and cravings, and antagonists like extended-release naltrexone prevent intoxication from occurring when opioids are taken.

One of the terrible consequences of the slow acceptance of the brain disease model of addiction has been the low rate of adoption of methadone and buprenorphine. Since they are, themselves, opioids, they continue to be viewed as a “crutch,” and do not fit with erroneous but all-too-common perceptions that the addicted person must simply have the strength to endure sobriety, without aid, from day one. This comes from a failure to understand that the brain, which is comprised of the various self-control and reward circuits involved in addiction, is an organ like any other in the body (albeit much more complex), requiring time as well as support to heal. In fact, we do not ask a person who has suffered severe injury as a result of a car accident to walk without aid while their bones engage in self-repair; external support — often, crutches — are needed to take the burden of healing limbs. In some cases long periods of rehabilitation, lasting years, may be needed after accidents, to restore functioning that was lost. Brain diseases are no different.

Medications including naltrexone are also available to treat alcohol addiction — although fear of stigma prevents many people with this addiction from seeking treatment that could help them — and a range of medications exist to help curb current and ex-smokers’ craving for nicotine. Over the coming years, the rapidly advancing science of the brain mechanisms underlying disordered substance use and the transition to addiction are expected to produce new medications for other drug addictions like cocaine, methamphetamine, and marijuana, as well as entirely new treatment approaches like vaccines and other immunotherapies that neutralize a drug in the bloodstream, not allowing it to enter the brain, and non-drug interventions such as transcranial magnetic stimulation and direct current stimulation.

The extreme brain changes characteristic of addiction are by no means automatic, even in people who use drugs regularly. Factors contributing to an individual’s unique vulnerability or resilience — both to experimenting with drugs initially and to the progressive brain changes associated with addiction — include family history of substance abuse, exposure to drugs in early adolescence, exposure to stressful environments and life circumstances across development and adulthood, and certain mental illnesses. Of those who are exposed to drugs, we roughly estimate that about 10 percent will become addicted. The non-inevitability of addiction is a point frequently emphasized by people challenging the brain disease model, with the faulty reasoning that it cannot be a disease because the condition is initiated by a decision to take a drug, which is viewed as a voluntary behavior, and also because most individuals never escalate their drug taking. However, this is no different from many other diseases that also have complex genetic, environmental, and developmental origins, may be triggered by voluntary behaviors or their omission, and may only affect a small subset of those at risk.

I often compare drug addiction to another chronic, relapsing disease, diabetes. In diabetes, the pancreas is not able to make the insulin necessary for our cells to use glucose as fuel. No one thinks that, with sufficient willpower, a person with this condition could push through without medication. Their disease, even if it had behavioral antecedents and may have involved free choices in a person’s past — such as decisions about food or exercise — has a physical basis and requires medical management once it has developed. Fortunately, people often have a basic understanding that the diseased pancreas is the reason people with diabetes require constant medication, and thus no one questions when a person with diabetes excuses themselves before meals to take insulin or requires snacks at odd times. Drug addiction, despite decades of effort, still has not attained an equivalent level of social understanding. Just as the diseased pancreas cannot supply sufficient insulin, the brain affected by addiction cannot supply sufficient self-control, and the addicted person requires medical management — not judgment — to recover and lead a normal life.

But a medical approach to treating addiction by no means lessens the importance of prevention — in fact, understanding the scope and complexity of the brain changes occurring with addiction underscores how crucial prevention is. The more we learn, the more focused and skillful we can be in learning to prevent those changes from occurring. Increasing research into risk and protective factors not only in the highest periods
The NCC AP announces an opportunity for all currently state credentialed/licensed addiction professionals to apply for the National Certified Addiction Counselor Level I or Level II credential based on their already demonstrated competence, skill, training, and experience. 

No testing necessary!

NCAC I & II Grandfather Credential Offer

This one-time offer for a NCAC I or NCAC II national credential will only be available from November 1, 2015 to April 30, 2016!

The NCC AP announces an opportunity for all currently state credentialed/licensed addiction professionals to apply for the National Certified Addiction Counselor Level I or Level II credential based on their already demonstrated competence, skill, training, and experience.

No testing necessary!

For more information about the NCC AP and its substance use disorder counselor certification and specialty endorsement opportunities at the national and international level, visit www.naadac.org/certification.

For details, including requirements for credentialing, recredentialing and exam schedule and fees, go to www.naadac.org/certification
of vulnerability during adolescence but also in the first years of life are leading to new and effective interventions, even targeted toward pregnant women and young families. Depending on the age and population to which they are targeted, prevention interventions may enhance participants’ social skills and self-control, screen them for mental illnesses or their early signs, and create opportunities for furthering their educational and emotional development.

An upcoming major prospective study to be funded by a consortium of NIH Institutes, the Adolescent Brain Cognitive Development (ABCD) study, will use neuroimaging and advanced genetic and other technologies to study brain development in a large cohort of adolescents over ten years. This will teach us a great deal about the effects of various drug trajectories (including alcohol and nicotine), from abstinence through poly-drug use and substance use disorders, on the developing brain and related outcomes. It will also help inform new prevention approaches, as well as providing valuable insight into the ways drugs affect the brain during some of the most vulnerable years of life and, in a subset of cases, lead to addiction.

People suffering from addictions are not morally weak; they suffer a disease that has compromised something that the rest of us take for granted: the ability to exert will and follow through with it. The desire to be rid of the drug and its destructive influence on their life and health and relationships is usually quite sincere, but the ability to follow through on the choice to not use the drug has been compromised by their disease. I have seen all too often how the cycle of relapse and the shame and self-disappointment this disease produces can rob a person of hope and even, in extreme cases, the will to continue living.

Reducing the stigma that still surrounds drug addiction and its treatment requires getting across to the public, including policymakers, physicians, and addicted persons and their families, the complex nature of this condition. The complexity is not only biological but also philosophical, because it affects how we think about our own free will. It requires understanding that something as basic as our ability to make and follow through with choices in our own best interest is rooted in biological mechanisms that can become disrupted by drugs and, in some cases, compromised by a chronic disease.

Dr. Nora Volkow is Director of the National Institute on Drug Abuse at NIH. Dr. Volkow’s work has been instrumental in demonstrating that drug addiction is a disease of the human brain. As a research psychiatrist and scientist, Dr. Volkow pioneered the use of brain imaging to investigate the toxic effects and addictive properties of abusable drugs. She has published more than 600 scientific articles and edited three books. She has received multiple awards, including membership in the Institute of Medicine, and named one of Time Magazine’s “Top 100 People Who Shape our World”, “One of the 20 People to Watch” by Newsweek magazine, Washingtonian Magazine’s “100 Most Powerful Women” and “Innovator of the Year” by U.S. News & World Report.

REFERENCES
Ethics Dilemma: A client has invited his therapist to attend a graduation ceremony and reception afterwards. The therapist wants to go but is unsure how to proceed.

If we were to survey clinicians and supervisors working in the behavioral health professions regarding the definition and differences between “ethical maturity” and “ethical adherence” the answers would invariably lead back to “doing the right thing.” While ethical adherence relates to attitudes and actions in alignment with standards of practice, ethical codes, and laws specific to our profession, ethical maturity puts the spotlight on the development of the clinician through conscious, intentional learning that is fluid and ongoing.

Ethical maturity is defined as the reflective, rational, emotional, and intuitive capacity to decide which actions are right and wrong, or good and better; the resilience and courage to implement those decisions; the willingness to be accountable for ethical decisions made (publicly or privately); and the ability to learn from and live with the experience (Carroll & Shaw, 2013, p. 30). Carroll and Shaw (2013, p. 30) posit that there are six components that move ethical maturity beyond ethical decision making:

1. Ethical sensitivity and watchfulness: the creation of ethical antenna that keep us alert to when ethical issues/dilemmas are present. This results in a moral compass/moral character.
2. Alignment: the ability to make an ethical decision aligned to our ethical principles and values.
3. Implementation: implementing ethical decision(s) made.
4. Articulation: the ability to articulate and justify to stakeholders the reasons why ethical decisions were made and implemented.
5. Closure: to achieve closure on the event, even when other possible decisions or “better” decisions could have been made. The ability to live peacefully with the consequences of ethical decision making is crucial to ongoing well-being.
6. Reflective learning: to learn from what has happened and “test” the decision through reflection. The integration of what we have learned into our lives develops our moral character and extends our ethical wisdom and capacity. Part of the process of developing ethical maturity is learning from experience.
Ethical sensitivity relates to our intuitive and reflective capabilities. Hopefully, our radar is constantly surveying the landscape for signs requiring attention and reflection. Oftentimes we get so busy with the details that we miss blips on the screen notifying us of potential areas of concern. Our antennas help us to develop an active moral compass — a compass that has boundary markers and boundary crossing markers. Contemplating and negotiating boundary crossings requires ethical maturity. Boundaries define a relationship — personal and professional. Boundary violations are departures from the standards of practice; real or perceived boundary violations tend to be harmful, exploitive and risky. Ethical maturity and sensitivity is lacking or is being ignored when a clinician is contemplating and/or engaging in a boundary violation. Ethical intuitiveness and watchfulness, rational alignment, and reflective learning may not be active or are being ignored when considering or engaging in a boundary violation. Examples of boundary violations might include sexual contact with a client, release of information to third parties without a release, exploitive business relationships, and supervising friends. Most codes of ethics offer compass markers for boundary violations and assert that clinicians should avoid relationships with clients that could impair the therapist’s effectiveness or cause harm. Boundary crossings are different than boundary violations.

Boundary crossings are deviations from “traditional” therapy; boundary crossings can be an integral part of well-formulated treatment plans or evidence-based treatment plans (Zur, 2015). A boundary crossing does not automatically equate with being a sexual boundary violation; not all boundary crossings are dual relationships. Examples of typical boundary crossings include giving a supportive hug to a grieving client, accepting a small gift from a client, bartering with a cash-poor farmer, lending a CD or book to a client, making a home visit to a home-bound client, attending a wedding, or accompanying a client to a dreaded but important doctor’s appointment (Zur, 2015). In rural and frontier communities boundary crossings tend to be unavoidable. In addition, every cultural group (i.e., ethnic, military, religious, collegial, LGBTQ) has its own definitions and markers specific to boundaries, boundary violations, and boundary crossings.

To operate with ethical maturity is to be reflective, rational, emotional, and intuitive. This is an intentional journey — we never arrive at a final destination point. Ethical deliberation should be ongoing rather than after-the-fact when attention has been drawn to an issue. If we look at ethical maturity as an ever-unfolding process that involves conscious attention to ethical reflection and the accumulation of ethical wisdom — we are willingly engaging in authentic, flexible, and lifelong learning (Carroll & Shaw, 2013). If we go back to the original dilemma, the therapist needs to reflect on the following questions: (1) why do you want to engage in this activity, (2) what are the potential benefits and potential concerns if you go, (3) how does this engagement line up in relation to your personal and professional values, (4) will engagement in this activity change the therapeutic relationship developed between you and your client, (5) have you sought supervision and accountability regarding this activity, and (6) from a state of mindfulness, what are the emotional and intuitive factors that are influencing this decision?

The proactive course of action that protects both the clinician and client(s) — when we are not sure about the changing landscape — is to seek guidance and direction from a trustworthy supervisor, consultant, mentor, and/or colleague. A clinician who is developing ethical maturity is a clinician who is connected to others who have navigated the clinical landscape with the goal of excellence in practice. Decisions made from a place of wisdom and reflection, with the goal being ethical excellence in practice, protect the client while cultivating clinical and ethical maturity.

**REFERENCES**


What You – and Your Legislator – Need to Know About Marijuana Policy
Or, some commonly held misconceptions and how to counter them

By Kevin A. Sabet, PhD

From pot shops in Denver to medical marijuana for kids, pot is a hot topic these days. But there is a lot of smoke and mirrors in the discussion about the drug in the United States. In this series, Kevin Sabet uncovers some commonly-held notions about the drug — including what it does to the brain, how it has changed in composition since the hippie heyday of the 1970s, and why our young people should steer clear of it.
**MYTH: Legalization is about getting rid of the “war on drugs.”**  
**FACT:** Legalization is about one thing: making a small number of business people rich. If it were about ending the War on Drugs, recent law changes would be limited to decriminalization. Rather, a host of business interests are getting involved with the legal marijuana trade in Colorado and elsewhere. They have set up private equity firms and fund-raising organizations to attract investors and promote items such as marijuana food items, oils, and other products. We also know these industries target the poor and disenfranchised—and we can expect the same in order to increase profits.

**MYTH: Marijuana users are clogging our prisons.**  
**FACT:** We shouldn’t give marijuana users criminal records nor deprive them of a second chance, but it’s far from the truth to say they are clogging our prisons. A survey by the Bureau of Justice Statistics showed that 0.7 percent of all state inmates were behind bars for marijuana possession only (with many of them pleading down from more serious crimes). In total, one tenth of one percent (0.1 percent) of all state prisoners were marijuana-possession offenders with no prior sentences. Other independent research has shown that the risk of arrest for each “joint,” or marijuana cigarette, smoked is about 1 arrest for every 12,000 joints.

**MYTH: Marijuana is harmless, or at least less harmful than alcohol, and therefore should be legal.**  
**FACT:** Science has proven—and all major scientific and medical organizations agree—that marijuana is both addictive and harmful to the human brain, especially when used as an adolescent. One in every six 16-year-olds (and one in every eleven adults) who try marijuana will become addicted to it. To your brain, addiction is addiction. Different addictions have different symptoms, but whether its food, sex, marijuana, or heroin—your brain knows it wants more of that feeling of pleasure. Just as with alcohol and tobacco, most chronic marijuana users who attempt to stop “cold turkey” will experience an array of withdrawal symptoms such as irritability, restlessness, anxiety, depression, insomnia, and/or cravings. This signals that marijuana can be addictive. Science has shown that 1 in 6 kids who ever try marijuana, according to the National Institutes of Health, will become addicted to the drug. Today’s marijuana is not your “Woodstock weed”—it can be 5–10 times stronger than marijuana of the past. Our currently legal drugs—alcohol and tobacco—provide a good example, since both youth and adults use them far more frequently than illegal drugs. According to recent surveys, alcohol use is used by 52 percent of Americans and tobacco is used by 27 percent of Americans, but marijuana is used by only 8 percent of Americans.

**MYTH: Smoked marijuana is medicine, and therefore should be legalized to help the suffering of the very sick.**  
**FACT:** Marijuana may contain medical components, like opium does. But we don’t smoke opium to get the effects of morphine. Similarly we don’t need to smoke marijuana to get its potential medical benefit. We need more research. Research shows that very few of those seeking a recommendation for medical marijuana have cancer, HIV/AIDS, glaucoma, or multiple sclerosis; and in most states that permit the use of medical marijuana, less than 2–3 percent of users report having cancer, HIV/AIDS, glaucoma, MS, or other life-threatening diseases.

**MYTH: Marijuana should be rescheduled.**  
**FACT:** Rescheduling is a source of major confusion. Marijuana meets the technical definition of Schedule I because it is not an individual product with a defined dose. You can’t dose anything that is smoked or used in a crude form. However, components of marijuana can be scheduled for medical use, and that research is fully legitimate. That is very different than saying a joint is medicine and should be rescheduled. It is important to note, too, that rescheduling does not generally correspond with criminalization or penalization. So if your target is to reduce penalties for use, focusing on rescheduling is the wrong target.

**MYTH: Colorado has been a good experiment in legalization.**  
**FACT:** Colorado has already seen problems with this policy. For example, the under-aged college student who jumped to his death after ingesting a marijuana cookie. The significant rise in the number of parents calling the poison-control hotline to report their kids had consumed marijuana. Marijuana edibles and marijuana vaporizers have been found in middle and high schools. And Denver’s own police department reported that teen arrests for marijuana at local schools have increased since last year. A large construction company in the state recently reported that they have encountered so many job candidates who have failed pre-employment drug tests because of their marijuana use that it is actively recruiting construction workers from other states.

The State of Washington isn’t fairing much better. Marijuana poisonings are up according to the Washington State toxicologist, as are driving while intoxicated under marijuana incidents. In both states, use among those 18 and up, according to the National Survey on Drug Use and Health, have gone up.

It will take 20 years to assess the damage—from mental health, school dropouts, and other factors—but I worry about this new policy. And apparently Coloradans do too—most localities have actually banned the sales of recreational marijuana within their city limits. Denver, of course, has not, but it tells me that many Coloradoans do not want a marijuana store on Main Street.

Now this doesn’t mean we have to punish or incarcerate users. We should focus on early prevention, intervention, treatment, and we should also ensure that we do not give criminal records to young people for simply using marijuana. The alternative does not have to be legalization.

**MYTH: Legalization would help tax revenues.**  
**FACT:** With increased use, public health costs will also rise, likely outweighing any tax revenues from legal marijuana. For every dollar gained in alcohol and tobacco taxes, ten dollars are lost in legal, health, social, and regulatory costs.

**MYTH: Legalization is justified because of individual rights.**  
**FACT:** Legalization is not about just “getting high.” By legalizing marijuana, the United States would be ushering in a new, for-profit industry—not different from Big Tobacco. Already, private holding groups and financiers have raised millions of start-up dollars to promote businesses that will sell marijuana and marijuana-related merchandise. Cannabis food and candy is being marketed to children and are already responsible for a growing number of marijuana-related ER visits. Edibles
with names such as “Ring Pots” and “Pot Tarts” are inspired by favorite candies and children and dessert products such as “Ring Pops” and “Pop Tarts.” Moreover, a large vaporization industry is now emerging and targeting youth, allowing young people and minors to use marijuana more easily in public places without being detected.20

**MYTH:** Legalization would get rid of the black market for marijuana.

**FACT:** Criminal enterprises do not receive the majority of their funding from marijuana. Furthermore, with legal marijuana taxed and only available to adults, a black market will continue to thrive. The black market and illegal drug dealers will continue to function — and even flourish21 under legalization, as people seek cheaper, untaxed marijuana.

**REFERENCES**


17 As of April 2015, the Colorado Municipalities League put reported that 180 out of 271 municipalities had banned marijuana sales altogether. See Municipal Medical Marijuana Status. (2015, April), Retrieved from http://www.cml.org/Issues/Marijuana/Retail/Municipal-Retail-Marijuana-Status


19 Note: Total revenues are state and federal combined from 2012. They are compared with costs that were adjusted for inflation and are stated in 2012 values.


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Now Approved by NASW for Social Workers
How many clinicians have heard this phrase? “I don’t want to be here and I don’t understand why my doctor said I had to see you in the first place.” Obviously, this is not the best way to start a therapeutic relationship, but if you are prepared to work with a client’s resistance, and not against it, there is the potential for enormous growth.

I believe that at the root of resistance is a client’s automatic and unconscious defense mechanism — denial. This denial system is protecting them from facing some kind of painful reality in their life. In fact, this system has served a very useful purpose in a client’s past, but today causes more pain and problems than it solves.

In my clinical, training, and consultation practice, I discovered there are three crucial steps that clinicians need to implement in order to obtain positive treatment outcomes with resistant clients who are in denial. The first step, and most important in any therapeutic relationship, is developing client rapport. This can be challenging if a client’s denial system is firmly entrenched and they have underdeveloped coping strategies that border on self-destructive.

I believe it is a big mistake to confront a client’s resistance head on. This is what I call a “formula for disaster” — pre-judgment plus insensitivity plus confrontation. It is a path that usually leads to a power struggle that nobody wins. Instead, I suggest implementing the “formula for success” — understanding plus compassion before strength-based positive challenges. In my experience, this usually leads to authentic collaboration where clients are heard, understood, and affirmed.

To gain true understanding, the effective use of respectful active/reflection/empathic listening, including frequent accuracy checks, is essential. The active listening method needs to continue throughout the therapeutic process to support the creation of a therapeutic bond so that the motivational crisis that resulted in the client referral in the first place can be fully understood. Getting outside verification of the facts whenever possible is helpful, so obtaining releases for the referral source and any other important party is essential. As a result, the clinician will be able to develop a more accurate picture of why the client was referred to treatment.

The next step is to determine which defense mechanisms the client is using to protect themselves from their painful reality. These defense mechanisms are also called denial patterns. It is important to remember that these denial patterns are automatic and unconscious processes. There are twelve common denial patterns and each one has its own cognitive theme, or self-talk — see the following list which is based in part on the Denial Management Professional Guide by Terence T. Gorski and Stephen F. Grinstead (2000).

<table>
<thead>
<tr>
<th>Title</th>
<th>Cognitive Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance</td>
<td>I’ll talk about anything but the real problem</td>
</tr>
<tr>
<td>Rationalization</td>
<td>I have a problem but I have a good reason for it</td>
</tr>
<tr>
<td>Minimization</td>
<td>I guess I do have a problem, but it’s not that bad</td>
</tr>
<tr>
<td>Blame</td>
<td>It’s not my fault—he, she, they, are to blame</td>
</tr>
<tr>
<td>Total Denial</td>
<td>I do not have a problem—you’re crazy for thinking I do</td>
</tr>
<tr>
<td>Comparing</td>
<td>Others are worse than me; proving I don’t have a problem</td>
</tr>
<tr>
<td>Manipulating</td>
<td>I’ll only do this if you do what I want</td>
</tr>
<tr>
<td>Fear of Change</td>
<td>I won’t know who I am without my problem</td>
</tr>
<tr>
<td>Compliance</td>
<td>I’ll say or do anything to get you off my back</td>
</tr>
<tr>
<td>Flight Into Health</td>
<td>I’m suddenly cured and I don’t need to be here</td>
</tr>
<tr>
<td>Strategic Hopelessness</td>
<td>I can’t be helped so don’t even try</td>
</tr>
<tr>
<td>Democratic State</td>
<td>I have the right to behave any way I want so leave me alone</td>
</tr>
</tbody>
</table>

Once the cognitive theme has been noted and the denial patterns identified, the final step is to support the client in letting go of his or her self-defeating defense mechanisms. However, you never want to take away a client’s defenses without offering clients new, healthier tools. This can be accomplished using a four-step process.

**Step One – Expose** the denial pattern the client is using. As mentioned above, the clinician must be able to recognize the denial pattern by its cognitive theme. However, caution needs to be used in order to keep the client from becoming even more resistant. You first expose the denial pattern by naming it and describing the cognitive theme the client used. For example if the client was blaming their doctor for needing to be in therapy,
The Denial Management Process

1. **Identify** denial by its cognitive theme
2. **Expose** the identified denial pattern
3. **Educate** the client about what they are doing
4. **Challenge** them in a positive manner
5. **Teach** them a new way of thinking and behaving

you can say “what I’m hearing is you know you have a problem but it’s not your fault. Did I get it right?” The next step is to show the client what he or she is doing and explore with them exactly what role their behavior plays in the negative consequences they are experiencing. Once this unconscious game is out in the open its power is diffused.

Unfortunately, most clients will then automatically and unconsciously switch to another denial pattern. In the real world, denial works in clusters and most resistant clients have a preferred defensive structure using between two to six denial patterns. Before you can fully diffuse one pattern, they rapidly cycle to another. When this happens, it is important to stop the process by staying focused on the original denial pattern being used. This is done by switching from an interviewing format to a mini-education mode with the goal of teaching the client about the original denial pattern.

**Step Two – Educate** the client about denial. You want to keep the client focused on the denial pattern that was exposed. You need to teach them to be consciously aware of the pattern they are acting out, support them to recognize the related cognitive theme or self-talk, and what is the underlying mistaken belief system on which it is based. This mini-education session is a one or two minute educational overview of the denial pattern.

**Step Three – Challenge!** Once you have completed educating the client, you need to move quickly to positive, strength-based challenge. When challenging a client’s denial pattern, it is important to help the client see why using their denial pattern is problematic and what the negative consequences are of staying in denial. This needs to be followed by a therapeutic injunction against continuing to use the denial pattern and positive permission to get out of the problem and into the solution.

**Step Four – Teach** clients effective denial management strategies: getting to the solution. Clients need to learn how to recognize they are using denial patterns, and how to implement new skills that identify and solve their painful reality problems. This is where a collaboration with the client is so important. I often ask, “Are you willing to learn a new way of thinking and behaving that will better get your needs met?” Most of the time the answer is a little tentative, but often “yes, I am willing.”

The alternative to denial is recognition, acceptance, and problem solving. In order to achieve proficiency, clients need to learn how to self-monitor their thinking, emotions, urges, and behaviors. This is where cognitive restructuring techniques can be implemented. Only by learning to identify their irrational thinking and challenging it can clients effectively manage the uncomfortable feelings that lead to self-defeating impulses and self-destructive behaviors.

Once denial is uncovered and managed, the client’s resistance to ongoing treatment is significantly reduced. Working with resistance and denial takes tremendous patience and perseverance. But most of all, it requires developing understanding, empathy, and compassion before offering a strength-based challenge, thus giving people permission to stop using automatic and unconscious defense mechanisms that cause more negative consequences than benefits.

I hope my experience with this denial management approach will significantly improve treatment outcomes with resistant clients in your practice.

**REFERENCES**


The National Addiction Studies Accreditation Commission (NASAC) will be celebrating its fifth anniversary this Fall at the 2015 NAADAC Annual Conference. CAADE, the California Association of Alcohol and Drug Educators (1985), and INCASE, the International Coalition of Addiction Studies Educators (1990) were the first to “accredit” college Addiction Studies academic programs. NAADAC, also “approved” colleges for pre and post credentialing education. As this article will describe, there has been both an evolution of Addiction Professionals as well as the specific education and training they require. NASAC is the only national accreditation for Addiction Studies that accredits all four levels of academic degrees (Associates, Bachelors, Masters and Doctoral Degrees).

A Quick History of Addiction Counseling

Addiction Counseling, as a specialty, began over 60 years ago with people in recovery beginning to work as “para-professionals” in early detoxification and outreach programs. Early in the history of Alcoholics Anonymous, Bill Wilson was offered a paid position to work as a para-professional in a New York psychiatric hospital. He declined the offer, knowing that there should be a separation between the 12-step recovery programs and paid alcoholism counselors. This set the stage for the birth of the profession of Addiction Counseling. These early para-professionals were trained by their agencies with in-service training which was integrated with their 12-step experience. Experiential learning was the standard. Most of these para-professionals were persons in recovery from their own alcoholism and addiction, while a small minority were non-recovering people who believed in the “disease concept” and 12-step recovery, and who were also enthusiastic to work with those with addictive disorders.

In the 1970s, there was a movement towards identifying a basic core knowledge base, and the “certification” of alcoholism counselors, and soon after, drug abuse counselors. As these two certification processes blended together, the certification process developed around a bilateral approach of learning core content of the knowledge and supervised counseling experience. This approach was the initial standard, while the IC&RC examination process would soon follow (both written and oral exams). Later, the NAADAC Counselor Certification Commission developed similar standards.

During this time, there also emerged a group of recovering people who also had academic training. Some even had...
clinical licenses (e.g. MDs, MSWs, MFTs, Nurses and Pastoral Counselors). These early addiction professionals learned from their experience that academic training had valuable competencies and skills that would add to the self-help recovery model.

Some colleges began to add addiction coursework as electives within the curriculum of various counseling and social service disciplines. As time passed, coursework to include all of the core content required for addiction counselor certification was added, frequently in the form of certificate programs. The next level of development evolved into degree-based programs with “concentrations” or “minors” within professional disciplines.

The Current Standards

Today we have two approaches to academic credentials in Addiction Studies. The first group includes degrees in specific mental health disciplines, with an Addiction Studies Minor. Examples include a Master’s in Counseling or Social Work with a concentration in Addiction Studies, or an Associate’s Degree in Human Services with a concentration in Addiction Studies. The second type of degree, which is a newly developing model, is specific to the independent “Discipline of Addiction Studies”; for example, a Master’s in Addiction Counseling, or a Master’s in Addiction Studies. NASAC has a mandate to accredit both of these types of Addiction Studies programs.

Why Do We Need Addiction Studies Accreditation?

If we were to allow other disciplines to determine curriculum standards and content based solely on their own discipline, they would most likely not have the most evidence-based curriculum content and skill sets for effective addiction treatment. Addiction professionals have this knowledge, competence and skill set based on very specific training and education. This is why Addiction Studies must have “self-governance of addiction studies within higher education.”

NASAC supports Addiction Studies Educators in their advocacy for their existence, as specialists, within their institutional environment. At the same time, NASAC supports students in the development of a career ladder for addiction professionals. NASAC accreditation also assists in the interstate transferability of education and credentialing. This is done by aiding in the linkage of academic programs to workforce development issues and trends, and enhancing employability and interstate career mobility. NASAC was a strong advocate for NAADAC’s Minority Fellowship Program for Addiction Counselors at the Master’s level, funded by a federal SAMHSA grant awarded in 2014 and already providing tuition stipends, education, and mentoring for its first cohort of graduate students.

NASAC ensures that curricula and institutional modalities, resources, and qualifications of faculty are inclusive of the higher academic standards, including but not limited to Prevention, Treatment, Recovery Support, Administration and Research.

NASAC is part of the network that ensures that the addiction specialty is maintained as a primary discipline, and not simply a sub-specialty of a variety of mental health or counseling “generalists.” Generally, mental health curricula have minimal, if any, addiction studies content beyond an introduction to alcohol and drug abuse, or other entry-level classes. This is not enough specific education to adequately provide for the public safety with a quality of care that gives the best, and most up to date evidence-based prevention treatment and recovery support modalities. NASAC will not accredit programs that are less than adequate.
The Birthing of NASAC

In the early 2000s, SAMHSA began moving the addiction profession towards concretizing its place among the professional disciplines. At a meeting in 2007 of addiction stakeholders, which included about 20 national and state organizations, including the two major addiction counselor credentialing bodies, IC&RC and NAADAC/NCC AP, a decision was made to add a new component to solidify the professional discipline of Addiction Counseling. This new component would add two missing elements: academic standards and an academic accreditation process.

Among the stakeholders at that meeting were NAADAC, representing addiction counselors and professionals, and the International Coalition for Addiction Studies Education (INCASE), representing academic educators and the academic accreditation process. NAADAC provided the infrastructure to build upon and expand the addiction studies accreditation developed by INCASE. It was decided that a “marriage” between NAADAC and INCASE would be the most efficient way to establish the necessary structure to be a credible accrediting body. A new corporate entity was created, and NASAC was born.

The Process

The process of becoming a NASAC Accredited Program is voluntary, although some State Licensing Boards have already included the requirement of NASAC Accredited degrees to qualify for licensure. The NASAC accreditation process requires another accreditation from one of the five Regional Accrediting Agencies for colleges and universities to assure a broad span of already documented educational standards. This makes NASAC a “specialty professional accreditation” similar to other discipline specific accreditations (e.g. Counseling, Medicine, Nursing, Social Work, etc.).

The first part of the process is a “Self-Study” completed by the applicant. The Self-Study helps the college or university to refine its curriculum and make sure it is in compliance with SAMHSA’s TAP 21 Addiction Counseling Competencies, published in 2006. This self-study is the basis of the application, and is submitted electronically to the NASAC office.

After a review for completeness, the Self-Study is reviewed by a three-person team of evaluators. These evaluators have experience with the same academic level of the degree (Associate, Bachelor’s, Master’s, or Doctorate) as the applicant seeking to be granted accreditation. After the Self-Study evaluation/review by the evaluation team, there may also be a site review, or a distance/Skype-type version of a site visit.

Once this is complete, the evaluation team makes a recommendation to the Commission for a seven year Full Accreditation, a one year Probationary Accreditation with a remedial plan, or denial.

Finally, the Commission reviews all the materials and either awards Full or Probationary Accreditation, or denies the application.

Benefits of Accreditation

Several colleges and universities who have achieved accreditation have indicated that they have seen a significant increase in applicants to their program and added prestige to the degree program and the college or university. Additionally, concrete benefits are seen in helping students climb the career ladder and gain both addiction credentials and employment.

Currently Accredited Colleges and Universities

As of September 2015, 19 colleges and universities have received NASAC Accreditation (see sidebar) and several schools are in the initial application process. Since this is still a relatively new accreditation process, we anticipate more colleges applying as the need for this specific programming expands.

Edward Reading, PhD, LCADC, is a founding Commissioner of NASAC, Past-President of INCASE, Chair of the licensing body for Alcohol and Drug Counselors in New Jersey, and Lead Faculty Member of Stockton University Graduate Addiction Studies Program. He is also a Catholic Priest of the Diocese of Paterson, NJ.
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