Editor’s Note

There’s no denying it. Schools are shutting down for the summer. The heat index rises and the sun makes its undeniable presence felt. Before you think about time off for the summer, please take some time to peruse this issue, including the article written by Dale P. Svendsen, MD. Many of the clients who receive the treatment from addiction professionals have modest means, and don’t always have access to air conditioning or other means to cool down in the summer heat. Dr. Svendsen’s tips can really help if you have a client suffering from a heat related illness.

Save a little time to think about the end of summer, too. September will be a busy month with people around the nation celebrating Recovery Month, Addiction Professionals’ Day and traveling to Burbank, CA for the CAADAC/NAADAC/NALGAP Annual Conference.

I’d also like to offer congratulations to the winners of the NAADAC elections and thanks to the many people who contested the 2006 elections. All the candidates showed their belief and commitment to NAADAC by putting their names forward and the members of NAADAC were the real winners. As former British Prime Minister Sir Winston Churchill put it, “It has been said that democracy is the worst form of government, except for all the others.” I hope your summer is safe, sunny and satisfying. Enjoy the issue!

Donovan Kuehn
NAADAC News Editor
dkuehn@naadac.org

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Shirley Beckwitt Mihal, MAADAC

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NAADAC NEWS is a publication of NAADAC, the Association for Addiction Professionals.

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Layout: Design Solutions Plus/Elise Smith

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Photo contributions: Donovan Kuehn and Monika Gerhart.

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2006 NAADAC: The Association for Addiction Professionals, June 2006

Volume 8

Issue 2

CHANGE OF ADDRESS: Notify NAADAC three weeks in advance of any address change. Changes of address may take up to six weeks, so please notify us as soon as possible.

Send your old and new addresses to NAADAC, 901 N. Washington Street, Suite 600, Alexandria, VA 22314; phone 800/548-0497; fax 800/337-1136 or send an email to dkuehn@naadac.org.
Healing the Divisions

Is the Fracturing of our Profession Inevitable?

By Mary R. Woods, RNC, LADC, MSHS, NAADAC President

“I am confirmed in my division of human energies. Ambitious people climb, but faithful people build.”

-Julia Ward Howe

Slavery abolitionist, suffragette and writer of the “Battle Hymn of the Republic”

I began my career in the addictions profession as a nurse practitioner at the Kenmore Square Detox Facility in Boston, Massachusetts in 1978. Since that time, I have seen many trends develop in the addiction profession, met many skilled and charismatic leaders and advocates for the addiction profession, and had the opportunity to grow as a professional. But one thing that has remained constant has been a conflict within the profession regarding standards, approaches and treatment philosophy.

Sadly, the addiction profession has in some ways mirrored the shift towards the polarization that characterizes the political discourse in Washington, DC. People stick to their views and are reluctant to engage in conversation. The difficulty is, when people are too convinced that they are correct, it leaves out the critical ability to re-assess issues, to incorporate new thinking into their reasoning and to shape treatment and clinical philosophies.

These tensions can be seen in the addiction profession.

As the addiction profession developed, it struggled for recognition and acceptance. Like any profession moving from an informal to a formalized structure, there will be fits and starts, debates about where the profession needs to go and strategizing on how to move the profession in the right direction.

More and more a conflict is developing between people who have a less formalized training and those who have academic credentials. What often happens is one group or the other often turns to the state or local government to legislate (through licensure) minimum standards, which often can turn into a battle to either protect people’s turf, or to set standards that can often be out of reach of ordinary clinicians. This is the wrong way to go.

Anyone engaging in this process needs to re-focus and take a holistic approach. Just as there should be no wrong door to treatment, there should be no wrong door to entering the addiction profession. Any formalized licensing process needs to provide multiple ways to enter the profession, and allow for people to move up through the process. What person doesn’t like to hear about a CEO who worked her way up from the mailroom?

In addition to progressive opportunities, there also needs to be support for people to go back to school and the development of a career ladder. Some people are intimidated by the thought of going or returning to school, but if the process were more supportive, and really helped people strengthen their skills as clinicians, it needn’t be such a challenge. A national addiction curricula that is the same from campus to campus and coast to coast, would also benefit the addiction profession by creating a truly portable and professional base of knowledge. Giving people from around the nation (and ideally around the world) a similar education would have a powerful impact on the addiction profession.

The addiction profession was once dominated solely by people in recovery. The shared perspective and tribulations carried weight with clients because they had a role model in their counselor as someone who “had been there.” Part of the success of the recovery movement is people in recovery are no longer stigmatized out of other professions. People in recovery can, and do, pursue any career path they desire.

Now, more and more people entering the addiction profession are not in recovery. Many of the “old timers” are frustrated as they are passed over by new professionals who may hold high level degrees, but often lack the background knowledge of how things work in the addiction profession. New professionals can be frustrated by an “old boys network” that can be challenging to break through.

Those of us in the addiction profession need to honor the work done by the “old timers” and tap into their knowledge and experience. We also need to respect the perspectives of those who enter the profession. They are the new generation of addiction professionals, and will ensure that this profession will be around for a long time to come.

Without committing to listen to one another and build the addiction profession, the elements of polarization and fragmentation can pull us apart. NAADAC is committed to strengthening our profession and building for the future.
NAADAC’s elections are over and the results are in. Over 2,200 NAADAC members voted in this election, the highest turnout in years. Interest was so high that 12 people put their names forward to serve.

Joining the Executive Committee will be three new faces and several others who were re-elected to the board. Voted in as President-Elect is Patricia Greer, the new Secretary is Sharon DeEsch and the new Treasurer will be Alvin Feliciano. Edward Olsen and Robert Richards were re-elected to their positions as Northeast and Northwest Regional Vice-Presidents while Nancy Deming was elected to the position of Mid-Atlantic Regional Vice-President. Winners’ full biographies are included below.

PRESIDENT-ELECT
Patricia M. Greer, BA, LCDC, AAC
City: Rockwall, Texas
E-mail: pmsgreer@sbcglobal.net

Pat Greer has served as Mid-South Regional Vice president for three years, having filled the previous RVP’s unexpired term for one-and-a-half years. She has served on the NAADAC Continuing Education/Professional Development Committee, as well as the Texas Chapter’s conference committee on the development and delivery of the 2005 annual conference in Corpus Christi. She is continuing in this work, on the 2006 annual conference in Burbank, which will be held in conjunction with CAADAC/NALGAP.

Greer has mentored officers in the Texas chapter, and has assisted in the development of a membership campaign there. She has reached out to the non-affiliate states in her region, to identify interested professionals and to connect them to NAADAC. She is a member of the Public Policy Committee and the Political Action Committee, and is passionate about the need for the profession of chemical dependency counselors to identify themselves to their elected officials and their communities. On behalf of NAADAC, she attends state and local meetings and events, and forwards information from NAADAC to the local membership.

Greer has also been a part of the workgroup tasked with the investigation of a potential merger of the National Certification Committee (NCC) of NAADAC with the International Certification and Reciprocity Consortium (IC&RC).

SECRETARY
Sharon DeEsch, LPC, LCDC, MAC, CCJP, SAP
City: Dallas, Texas
E-mail: sdrecovery@hotmail.com

Sharon DeEsch has been involved with state and national Ethics Committees and has served as Chairperson of both. She has been published on the subject of ethics both in the Counselor Magazine and Professional Counselor magazine.

For the past 19 years, she has been very active in her state and national professional association, serving at the national level as the Regional Vice President on the NAADAC Executive Committee as well as the NAADAC’s Board of Directors. She presently sits as a commissioner of the National Certification Commission (NCC), which provides national counselor credentialing. She also represents the Commission by serving on the NAADAC Ethics Committee.

DeEsch has worked in the field of addictions for the past 23 years. She has worked in both inpatient and outpatient modalities providing direct care to chemically dependent persons and their families. She is presently Clinical Director of Genesis Counseling Assoc. in Dallas, Texas.

TREASURER
Alvin Feliciano, CADC II, ILSAC, MA
City: San Diego, California
E-mail: aafeliciano@yahoo.com

Alvin Feliciano has been actively engaged in addiction counseling as a treatment professional for over 10 years. He holds a Bachelor of Science in Law from the University of West Los Angeles, a Master of Arts in Counseling Psychology, and trained at the University of New Mexico in Motivational Interviewing. He is an Arizona Licensed Independent Substance Abuse Counselor and a Certified Alcohol and Drug Counselor-II in California. Feliciano serves as the Treasurer for the California Association of Alcoholism and Drug Abuse Counselors, is the Program Manager of a 14-bed treatment facility, trains student counselors in Case Management at the University of San Diego, and serves as Executive Director for Comp Care, Inc.

Feliciano believes that treatment for alcoholism and substance abuse works and that there is a need for more treatment professionals. To this end, he promotes the education and professionalism of treatment professionals by advocating certification and unification through participation in professional organizations. He also promotes participation in NAADAC by presenting at various
educational institutions that are training tomorrow’s treatment professionals and at various forums attended by treatment professionals.

MID-ATLANTIC REGIONAL VICE-PRESIDENT
Nancy Deming, MSW, LCSW, CCAC-S
City: Fairmont, West Virginia
E-mail: ndeming@valleyhealthcare.org

Deming currently serves on NAADAC’s Public Policy Committee and has attended and participated in annual NAADAC Board meetings (2000–2003) as the West Virginia representative. She served as President of WVAADC, the West Virginia affiliate and attended numerous NAADAC educational conferences and participated in the regional caucuses.

She has over 20 years of experience in the addictions field in the area of both direct practice and management of residential CD treatment programs and active involvement on the WVAADC Board, NAADAC’s WV affiliate. She has also coordinated trainings for WVAADC membership with the Mid-Atlantic Addiction Technology Transfer Center (ATTC), and received various trainings including Trainer of Trainers from the ATTC.

NORTHEAST REGIONAL VICE-PRESIDENT
Edward Olsen, LCSW, CASAC, SAP
City: Lake Grove, New York
E-mail: elo50@msn.com

Edward L. Olsen is the Director of the EAC Outpatient Program in Hempstead, New York. Olsen has been in the chemical dependency treatment profession for the past 25 years as a member of NAADAC and the Association for Addiction Professionals of New York (AAPNY). Olsen served as the chairperson of the AAPNY Public Policy committee and began work on state licensure for addiction professionals. Also, through that committee, AAPNY became a strong and vocal advocate in New York State Parity Legislation called “Timothy’s Law.”

On the state level, Olsen is a member of the Workforce Committee for the New York State Office of Alcoholism and Substance Abuse Services and member of the Credentialing sub-committee. On the local level, he is a member of the advisory board for Suffolk Community College Chemical Dependency Counseling Program. Olsen also serves as a member of the Education Advisory Committee for the Suffolk Coalition Against Chemical Dependencies as well as a member of the Substance Abuse committee for the Ryan White Foundation for HIV/AIDS.

Northwest Regional Vice-President
Robert C. Richards, MA, CADC III, NCAC II
City: Eugene, Oregon
E-mail: robrich88@yahoo.com

Robert Richards was re-elected as the NAADAC Northwest Regional Vice-President. He has been a NAADAC member for nearly 17 years and is the past president and currently a board member for AADACO, The Oregon Association of Addiction Professionals and Oregon affiliate of NAADAC. He served as President and NAADAC delegate for four years and has been a board member for nearly nine years. He is the Director of Buckley Center in Eugene, Oregon and is a former president and current member of the Oregon Detox Providers Association. He is also a member of the Eugene Community Response Team, Lane County Human Services Network and United Way Agency Directors Organization.

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<tr>
<td>President-Elect</td>
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<tr>
<td>Patricia Greer</td>
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<td>Votes: 560</td>
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<td>Percent: 26.0%</td>
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<td>Donald P. Osborn</td>
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<td>Warren A. Daniels III</td>
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<td>Thurston C. Smith</td>
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NAADAC Joins with CAADAC and NALGAP to Host Annual Conference
Join us in Burbank from September 28 to October 1, 2006

By Donovan Kuehn, NAADAC Director of Outreach and Marketing

NAADAC is pleased to be working with the California Association of Alcoholism & Drug Abuse Counselors (CAADAC) and the National Association of Lesbian and Gay Addiction Professionals (NALGAP) in co-hosting its Annual Conference in Burbank, California from September 28 to October 1, 2006. The conference’s theme: Strengthening the Addiction Workforce: Building for the Future, emphasizes the importance of Workforce Development to the future of the addiction profession.

By working together, CAADAC/NAADAC/NALGAP are able to bring nationally recognized keynote presenters, as well as great local presenters, to the conference. The innovative workshop sessions will offer over 23 continuing education credits. You’ll be earning those credits at the four star Hilton Burbank Airport and Convention Center for an amazing room rate of only $110 per night ($159 for suites).

CAADAC/NAADAC/NALGAP will be featuring speakers who will be presenting on many topic areas. Featured topics include:

- Clinical Supervision
- Criminal Justice
- Co-Occurring Disorders
- Cybersex & Chemical Dependency
- Eating Disorders
- Ethics
- Gambling Addiction
- HIV/AIDS and STD Prevention
- Management of Grief and Loss
- Medication Management
- Patient Placement Criteria
- Pharmacologic Therapies
- Post Traumatic Stress Disorder
- Relapse and Recovery
- Special Populations

The CAADAC/NAADAC/NALGAP conference will also include 12 hours of special training for Substance Abuse Professionals who need to re-qualify under US Department of Transportation regulations (an additional fee of $350 applies) and will offer two special tracks for National Association of Lesbian and Gay Addiction Professionals and Workforce Development.

Don’t miss this exciting educational opportunity. Come earn your continuing education credits at the CAADAC/NAADAC/NALGAP conference, and bring the family for some fun in the sun in California.

For more information, please visit www.caadac.org or www.naadac.org, call (916) 368-9412 or 1-800-548-0497 or e-mail counselors@caadac.org or naadac@naadac.org (please put “Annual Conference” in the subject line).

Conference Agenda*

**September 28, 2006 (Thursday)**
- 7:30am–9:00pm  Registration Open
- 8:30am–10:00am  CAADAC/NAADAC/NALGAP Opening Plenary Session, Dr. Ron Perkinson
- 8:30am–10:00am  Substance Abuse Professional Re-Qualification Course (DOT/SAP) Separate Track/Additional fees will apply
- 10:30am–12:00pm  CAADAC/NAADAC/NALGAP Diversity Panel
- 10:30am–12:00pm  DOT/SAP Re-Qualification, cont.
- 1:00pm–5:30pm  Workshops
- 1:00pm–5:30pm  DOT/SAP Re-Qualification, cont.
- 6:30pm–8:30pm  Leadership Orientation and Certification/Licensure Presentation, Mary Woods, Cynthia Moreno Tuohy and Shirley Beckett Mikell
- 8:30pm–10:00pm  NALGAP Reception with celebrity speaker. Open to All!
- 7:00 pm–9:00pm  Workshops
- 9:00pm–10:00pm  Optional 12 Step Meeting

**September 29, 2006 (Friday)**
- 7:30am–8:00pm  Registration Open
- 7:00am–8:00am  Optional 12 Step Meeting
- 7:30am–5:30pm  Exhibit Hall Open
- 8:30am–10:00am  DOT/SAP Re-Qualification, cont. from previous day
- 8:30am–10:00am  CAADAC/NAADAC/NALGAP Opening Plenary Session: Workforce Development, Kathy Jett
- 10:30am–2:00pm  Workforce and Evidence Based Practices
- 10:30am–12:00pm  DOT/SAP Re-Qualification, cont.
- 12:00pm–2:00pm  Membership Meeting Box Lunch
- 2:00pm–4:30pm  Workshops
- 2:00pm–4:30pm  DOT/SAP Re-Qualification, cont.
- 4:30pm–6:00pm  NALGAP Membership Meeting
- 7:00pm–9:30pm  CAADAC/NAADAC Political Action Committee Reception

**September 30, 2006 (Saturday)**
- 7:30am–7:00pm  Registration Open
- 7:30am–5:00pm  Exhibit Hall Open
- 8:30am–10:00am  Plenary Session
- 10:30am–12:00pm  Workshops
- 12:00pm–1:00pm  NALGAP Membership Meeting
- 1:00pm–5:00pm  Workshops
- 6:00pm–10:00pm  CAADAC/NAADAC/NALGAP Annual Presidents’ Dinner & Dance and Entertainment (Optional black tie attire; theme is Hollywood)

**October 1, 2006 (Sunday)**
- 7:30am–1:30pm  Registration Open
- 8:30am–10:30am  Workshops
- 11:00am–1:00pm  CAADAC/NAADAC/NALGAP Closing Plenary, Willie Wolf

*Schedule subject to change
NAADAC ANNUAL CONFERENCE

Bring the Family!
The NAADAC/NAADAC/NALGAP conference will be offering special rates with local tours and unique opportunities to enjoy all that southern California has to offer. For more information, visit www.caadac.org or www.naadac.org.

Nearest Airport
Fly into the Bob Hope Airport Burbank (Airport Code: BUR). Airlines that serve the airport include Alaska, America West, American, Delta, JetBlue, Southwest and United.

www.naadac.org
In the warm summer months, think about developing a heat emergency preparedness plan. We recommend you evaluate each consumer in your care. Risk factors such as chronic medical conditions, particularly heart disease or high blood pressure, obesity, diabetes, alcohol use, psychotropic medication usage and age all put an individual into higher risk of heat related illness.

Individuals who fall into the high risk category should be further evaluated for heat exposure. Is their residence, place of employment or training setting air conditioned? Do they have appropriate clothing to wear during warmer weather? Are they taking more than one medication? Are they aware of the risk factors? Consumers and family members should be involved in education, monitoring risk factors and interventions.

The next step is to monitor the weather. Set a limit that will trigger you to take action. Two or more successive days of 85 degree heat is a suggestion. Notify staff and clients of the high heat condition and precautions. Make sure there are plenty of cool liquids available, encourage clients to dress in lighter clothing and do not encourage activities that will expose persons to prolonged periods of high heat and humidity.

We should always be alert for signs of heat exhaustion or heat stroke, especially among high risk clients. Heat stroke can lead to death if left untreated. Please advise your staff and caregivers of the symptoms to watch for and if it is suspected, seek medical care immediately.

Medications Affect Body Heat
Medications may impair the body’s ability to regulate its own temperature. During hot and humid weather, individuals taking antipsychotic medications are at risk of developing excessive body temperature, or hyperthermia, which can be fatal. Individuals with chronic medical conditions (i.e., heart and pulmonary disease, diabetes, alcoholism, etc.) are especially vulnerable.

Prevention of Heat Related Illness
During periods of high temperature (90ºF and above) and humidity, there are things everyone, particularly people at high risk, should do to lessen the chances of heat illness.

Try to stay cool.
• Stay in air conditioned areas if possible. If you do not have air conditioning at home, go to a shopping mall or public library.
• Keep windows shut and drapes, shades or blinds drawn during the heat of the day.
• Open windows in the evening or night hours when the air outside is cooler.
• Move to cooler rooms during the heat of the day.
• Avoid overexertion and outdoor activity, particularly during warmer periods of the day.
• Apply sunscreen and lotion as needed.
• Drink plenty of fluids.
• Dress in loose fitting, light colored clothing. Wear a hat, sunglasses and other protective clothing.
• Take a cool shower or bath.
• Eat regular meals to ensure that you have adequate salt and fluids.

Heat Stroke
This occurs mostly during heat waves. People with chronic illnesses are most vulnerable. Heat stroke, the most common serious heat illness, can lead to death if left untreated.

Warning Signs of Heat Stroke
• Confusion, dizziness, nausea, unconsciousness
• High body temperature (103ºF or above)
• Rapid, strong pulse
• Throbbing headache
• Red, hot and dry skin

Treatment of Heat Stroke
As soon as you recognize the signs of heat stroke, take immediate action:
• Call 911 immediately
• Loosen or remove clothing
• Move to a cooler place as soon as possible
• Cool the victim using cool water
• Do not give the victim alcohol to drink
• If emergency medical personnel are delayed, call the emergency room for further direction.

For more information, visit the Ohio Department of Mental Health’s website at www.mh.state.oh.us.
Reader’s Corner

Untangling Co-Dependence
By Misti A. Storie, MS, NAADAC Education & Training Consultant

NAADAC, The Association for Addiction Professionals recognizes the varying range of problems a patient presents to a counselor while being treated for chemical dependency, and even more so, we recognize the extensive amount of knowledge and skills an addiction counselor must possess to effectively address these issues. Co-dependence is one such theme that is often found among families and friends of chemically dependent individuals. This cycle is often difficult for loved ones to recognize and further, to break free from.

Nancy Johnston’s book, Disentangle, educates the reader of how co-dependence slowly develops and how the dysfunctional foundation of the relationship solidifies. Johnston then outlines the steps necessary to regain an independent identity and separate purpose in life by proposing over 50 specific ideas to help the co-dependent stop the self-destructive process of relationship entanglements, re-center, and act in a healthier manner. This helpful book is intended for people who want to emotionally break free from unhealthy relationships, as well as for the counselors who treat them.

Derived from counseling theory and 12-step wisdom, Disentangle does not necessarily endorse the process of ending the co-dependent relationship but rather of creating enough emotional space and establishing a stronger self so the patient can then decide what to do about the entangled relationship. Whether purchased for a loved one involved in a co-dependent relationship or for an addiction counselor looking for more tools in this arena, Disentangle is insightful and useful for treating this issue.

Disentangle is available for order through NAADAC’s online bookstore at www.naadac.org or by calling NAADAC at 703-741-7686.

Regular Price: $24.95
Member Discounted Price: $19.95

Share Your Story for 2007 Recovery Month
By Anh Nguyen, Public Relations Intern

Recovery Month is quickly approaching as September is only a few months away. However, planning for Recovery Month 2007 is already under way.

Sharing personal stories of successful recoveries is a powerful way to celebrate National Alcohol and Drug Addiction Recovery Month in September 2007. Personal stories of recovery can give hope to the millions out there who are trying to overcome this disease.

If you would like to submit a story about recovery from a substance use disorder (about yourself, a friend, a family member or colleague recovery), the story should:

1) Be very brief—no more than a short paragraph in length.
2) Include a photo of good quality—high resolution with a close-up of the person’s face. (Preferred: electronic files such as JPG, TIF or EPS; or hard-copies must be 35mm film or equivalent. We cannot accept photos embedded in a Word file.) Also, if photo includes more than one person, please indicate which person is you.

Please send your story and photo to:
Anh Nguyen
NAADAC
901 N. Washington Street, Suite 600
Alexandria, VA 22314-1535
Direct: 703-562-0212
E-mail: anguyen@naadac.org or naadac@naadac.org
The NAADAC Workforce Development Summit held in late March helped NAADAC members assess the challenges facing the addiction services profession and work towards planning for the future. The summit, the second of its kind hosted by NAADAC, brought together many different partner organizations including the Center for Substance Abuse Treatment (a part of SAMHSA), Partners for Recovery, the Addiction Technology Transfer Centers (ATTCs), the Institute for Research, Education and Training in Addictions (IRETA), the Institutes of Medicine, the National Association for Addiction Treatment Providers (NAATP) and the International Certification and Reciprocity Consortium (IC&RC).

NAADAC’s President, Mary Woods, was pleased with the concept and execution of the conference. “This is the first NAADAC conference to address the way addiction professionals can take leadership roles to benefit their careers, other professionals and the clients they serve,” she said. “The focus on Workforce Development: the ability to find, keep and compensate the people who work in the addiction profession is critical to our collective success.”

Mary Woods, RNC, LADC, MSHS
Strategic Workforce Development Planning

Mary Woods, NAADAC President, presented on behalf of Pamela Waters, MEd, describing the strategic workforce plan implemented in Florida. Woods began her presentation by describing workforce planning as a process:

- Phase I–Set Agency Strategic Directions
- Phase II–Conduct Workforce Analysis
- Phase III–Implement Workforce Plan
- Phase IV–Monitor, Evaluate and Revise

Woods emphasized that a strategic workforce development plan could help ensure better development of talent and replacements; provide realistic staffing projections for budget purposes and a clear rationale for training, career counseling, recruiting and contracting efforts; and help maintain a diversified workforce and clarify the need for restructuring, reducing or expanding a workforce.

The critical points to bear in mind while going through this process is the importance of giving step by step instructions on how to conduct workforce planning; instituting comprehensive workforce analysis, strategy, plan development and implementation. Woods used Florida’s workforce development plan as an example of how to create a workforce plan, and how to monitor, evaluate and revise that plan as necessary.

Faye Calhoun and Mark Willenbring
NIAAA Update

Calhoun and Willenbring from the National Institute on Alcoholism and Alcohol Abuse addressed the need for addiction professionals in the future by discussing drinking across age groups. Data from 2000 indicated that 3.5 percent of all deaths in the US were alcohol related, second only to tobacco and poor diet/physical inactivity for external and modifiable factors that cause death in the United States.

Children of alcoholics are four times more likely to develop alcohol problems than children of non-alcoholics. Still, half of all children of alcoholics do not become alcoholics themselves. Calhoun stressed that different populations need individual attention. For women and alcohol, she suggested research on treatment approaches for women of childbearing age. She also suggested collaboration with SAMHSA. Drinking in childhood and adolescence, Calhoun suggested, could be reduced by focusing on underage drinking in rural communities. As young adults transition to middle age, Calhoun suggested alcohol and the workplace research, as well as treatment and recovery research.

Calhoun and Willenbring emphasized that as people transition through the phases of their lives, their risk factors change. About three percent of people in mid-life to pre-seniorhood are dependent on alcohol, with another five percent who are abusers. Only 8.5 percent of these will receive any type of treatment during their lifetime. Seniors are at an increased risk of drug interaction and injury if they use alcohol.

As American baby-boomers move into retirement, more and more issues of addiction and lifestyle will become important to addiction professionals.

Michael T. Flaherty
The "Annapolis Coalition"

Michael T. Flaherty, PhD, serves as the CEO of the Institute for Research, Education and Training in the Addictions (IRETA) located in Pittsburgh, Pennsylvania. He spoke about the “Annapolis Coalition” and updated participants on the work it has done so far.

The Coalition was formed to address the national crisis in the training of the behavioral health workforce. Dr. Flaherty opened his remarks with some startling statistics:

- One million people a day are in treatment for alcohol or drug addiction
- Seven million people have co-occurring disorders
- There is a 25 percent turnover
- The addiction services profession’s aging workforce (50+)

Members of the Coalition are focused on building a national Strategic Plan for Behavioral Workforce Development. Incorporated into this process is a planning process with the
coleation serving as an intermediary between SAMHSA and panels of experts. The coalition is trying to build on what already exists and feels that building around strategic workforce goals is the best option for the addiction profession.

The initial recommendations of the Annapolis Coalition are comprehensive. It wants to make infrastructure development (professional education, clinical and organizational infrastructure) its highest priority, to develop a talent and skill pool within the existing addiction workforce, implement pre-service professional development and increase the focus on recruitment and workforce research.

Michael S. Shafer
*The Workforce Development Survey Results*

Michael S. Shafer, PhD, serves as the Executive Director of Applied Behavioral Health Policy (ABHP). He spoke about the Workforce Development Survey results from the Southwest region of the US. The survey was conducted in the fall of 2003 and was a comprehensive assessment of the addiction services profession in that region.

The key results were:
- 54 percent of directors and 63 percent of agency staff had experience in recovery
- over 25 percent of agency staff had salaries below $25,000
- over 50 percent of directors had salaries above $50,000
- 10 percent of respondents do not have health insurance
- nearly one-third do not receive employer based retirement benefits
- In the next two years, 8 percent of respondents said they plan to leave the addictions treatment profession
- 51 percent named budgetary restraints as a barrier to additional training
- 32 percent said workload pressures were a barrier to additional training
- 80–90 percent said they prefer in-person training

These results are helping to shape how employers, educators and government form their long-term workforce strategies in the southwest.

Ann Page
*Report on Improving Quality of Health Care*

Ann Page, Senior Program Officers with the Institute of Medicine (IOM) spoke on the recently released report *Improving the Quality of Health Care for Mental and Substance Use Conditions*. The report focuses on six aims the Institute desires for quality health care, which include health care that is safe, effective, patient-centered, timely, efficient and equitable.

The IOM report also proposed 10 guidelines for achieving these six aims. These principles are:
1. Care based on continuous healing relationships
2. Care customized to patient needs and values
3. Patients who are the source of control
4. Information and knowledge that is shared and flows freely
5. Evidence based decision making
6. Safety is a system responsibility
7. Transparency is necessary
8. Needs are anticipated
9. Waste is continuously decreased
10. Cooperation among clinicians is a priority

These recommendations were deemed necessary by the IOM because mental health and substance abuse conditions are pervasive. With 33 million Americans treated annually for substance abuse and 20 percent of all working adults (18–54) and 21 percent of all adolescents impacted by these conditions, these issues are frequently intertwined and often influence general health as they frequently accompany chronic illnesses.

John Lisy
*The Ohio Workforce Development Project*

John Lisy, LISW, LPCC, CCDC III-E, is coordinating the Workforce Development Project in Ohio (OWDP) for the Ohio Association of Alcoholism and Drug Abuse Counselors (OAADAC). He currently is Executive Director of the Shaker Heights Youth Center and is a past president of OAADAC. The OWDP was begun in 2004. It received congressional funding to focus on the workforce development goals of developing pathways for the education, recruitment, retention, training and advancement of Ohio Alcohol and Other Drug (AOD) professionals; helping the state maintain a competent and motivated AOD workforce and focusing on both prevention and treatment.

The project is intended to serve as a national model for stakeholder partnerships to meet AOD workforce challenges. The first year accomplishments of the OWDP are impressive. Within 12 months, the project was able to assemble a workforce development team, provide education on workforce issues, conduct Ohio-specific research and a national literature review, evaluate the workplace environments and design a website.

The goals for the second year of the project are to continue the development of the website and complete the portion devoted to e-based treatment, complete the prevention survey and strategic planning, initiate a higher education project, organize a national conference to discuss these developments and begin the development of a marketing plan.

In the long term, the OWDP hopes to develop a plan for both prevention and treatment to support the workforce, create an education structure that includes ATOD specific degrees and support a career path for addiction professionals.

Allison Sharer
*OWDP Surveys*

Allison Sharer, OCPSII, has worked in the addiction profession since 1983, and is an independent trainer and consultant for Wingspan Training, LLC. She discussed surveys conducted for the Ohio Workforce Development Project (OWDP).

Research was conducted to help stakeholders strategically address systemic issues impacting Ohio’s prevention workforce; to help employers address recruitment and retention of an effective workforce and to help practitioners to advocate for their career development needs.

(Summit, continued on page 12)
The project surveyed ATOD prevention managers and found that:
1. 65 percent of reporting organizations require a prevention worker to either have the Ohio Certified Prevention Specialist (OCPS) credential or be in-process
2. 26 percent do not require the OCPS for prevention workers
3. 59 percent require a prevention supervisor to either have the OCPS or be in-process
4. 30 percent do not require the OCPS of prevention supervisors
5. 63.7 percent of prevention practitioners report their supervisor does not have an OCPS and is not in-process.

The survey also asked managers what factors were the most problematic for recruitment. The findings revealed that:
- Lack of qualified candidates
- Hiring freeze
- Managers suggested four major strategies to overcome recruitment problems:
  - Offering a flexible work schedule (rated most effective)
  - Creative job advertising
  - Enhanced/flexible benefits
  - Raising salaries beyond normal inflationary increases

The survey also asked employees what factors they considered most important when thinking of their careers in the addiction services profession. The respondents identified:
1. Increasing salary
2. Offering more flexible benefits
3. Ensuring a predictable, reasonable workload
4. Enhancing training for supervisors
5. Improved organizational orientation
6. Offering a better career path with more opportunity for advancement.

Thomas Durham and Joseph D. (Jody) Biscoe III

Clinical Supervision

Thomas G. Durham, PhD, LADC, CCS, Executive Director, Danya International and the Central East Addiction Technology Transfer Center and Jody Biscoe, Assistant Professor of Psychology, Co-Director, Louisiana Addiction Technology Transfer Center and Coordinator of the Northwestern State University Substance Abuse and Prevention programs, addressed the critical issue of clinical supervision.

Biscoe began by discussing the Louisiana’s Addiction Counselor Career Path. This new initiative had four key elements in mind:
1. Development of a career path for the addiction profession
2. A tiered scope of practice to support the profession
3. To be progressive and inclusive within industries’ standards
4. To enable the field of addiction in Louisiana to reflect other professional organizations.

Biscoe explained that the vision of the Louisiana Department of Health and Hospitals–Office for Addictive Disorders is to build and operate a seamless system of prevention and treatment services which are: client/family focused, evidence-based, outcome driven, and cost-effective. The ultimate goal of the program is to create a state in which prevention and treatment services are widely available and delivered by highly trained professionals.

Biscoe related the results of the Status of the Addictions Treatment Workforce in Louisiana survey that was conducted in 2003. There were several important findings.

In recruitment and retention issues, it was found that 140 staff left their jobs in the past year (2003). The five main reasons why they left were finding a better work opportunity within the addiction profession; personal reasons (illness, family issues or something else); a lack of adequate salaries; finding a better work opportunity outside the addiction profession and burnout.

Of the directors contacted by the survey, 70 percent reported continuing difficulty in filling open positions. They attributed this difficulty to:
1. Insufficient number of applicants meeting qualifications (due to a lack of experience, certification, education)
2. A small applicant pool in specific geographic areas
3. A lack of interest due to salary and limited funding.

The majority of directors felt addictions counselors have a lower status compared to other helping professionals. They attributed the lower status to less formal education or training in the addiction profession, lower credentialing/license requirements, stigma in association with abusers, a history of substance abuse for some working in the profession and a lower quality formal education or training.

Dr. Durham spoke about clinical supervision and the positive impact increased supervision has on the addiction profession. He spoke of the ultimate goal for addiction professionals: quality supervision for all staff. Durham was clear that this did not indicate that staff can’t be trusted and that was it is not an insult for experienced staff to be supervised. He explained that supervisors, employees and the organization all benefit from training in direct observation and “live” supervision, training in leadership and organizational skills and from the development of team-building skills and healthy communications.

Dr. Durham felt that modeling learning created some of the most positive results in the workplace. He explained that modeling learning promotes a sense of safety openness and trust; it supports a learner-centered approach; it helps to encourage the exploration of alternatives, problem solving, critical reflection and reduce dissonance and conflict. It also creates a mutual feeling of validation and allows for the exploration of newly acquired assumptions and beliefs.

Ultimately, Dr. Durham encouraged people to look at what motivates them most. He called this the Passion to Vision Reality. If people don’t honestly ask the questions of “what is your passion?”, “what can you do more of to promote ongoing
counselor development?” and “how can you use your passion to make your vision a reality?”, they will find it much more difficult to set themselves on a successful career course.

**Warren Daniels**  
*California Workforce Development Initiative*

Warren Daniels, BA, NCAC I, CADC II, ICADC, CDIS, ICHOW, is President of the California Association of Alcoholism and Drug Abuse Counselors (CAADAC) and serves as Executive Director for the Community Recovery Resources in Nevada County. Daniels presented on the California Workforce Development Initiative supported in partnership by CAADAC and NAADAC, The Association for Addiction Professionals.

The plan that CAADAC and NAADAC developed encompasses four key steps: initiation, preparation, action and maintenance. The initiation stage will develop a targeted workforce development survey and then review survey with the California Department of Alcohol and Drug Programs, the single state agency. Finally, the survey will be distributed and tabulated to participants of the CAADAC/NAADAC/NALGAP conference in Fall of 2006.

The preparation stage will involve the development of a workforce plan and will identify resources to implement the plan. The action component will encourage advanced training and education for addiction counselors and create a brochure and identify distribution channels to get it into the hands of frontline counselors. The final stage of maintenance will focus on fund “discovery” (i.e. fundraising) for workforce development efforts and will evaluate and discover other issues that have arisen throughout the research and implementation phases.

In addition to these actions that revolve around the collection of data, CAADAC/NAADAC will also consider several other issues, including the establishment of a 1-800 easy access workforce development information line in English and Spanish, to promote and encourage regulatory loan forgiveness programs for addiction counselors and to encourage advanced training and education for addiction counselors.

**George C. Gilbert, JD**  
*Workforce Development Trends: SAMHSA’s Perspective*

Participants heard from critical voices in the addiction profession, including George Gilbert, JD, Acting Deputy Director of the Center for Substance Abuse Treatment (CSAT), SAMHSA, who spoke on workforce development issues. Gilbert outlined the trends facing the addiction workforce, including:

- Insufficient workforce/treatment capacity to meet demand
- Changing profile of patients/clients
- A shift to increased public financing of treatment
- Provision of services in generalist and specialist settings;
- Discrimination associated with addictions.

CSAT research discovered that there is a shortfall in skilled employees in the addictions profession and even greater shortages are anticipated in the near future. Gilbert asserted that even a modest 10 percent increase in treatment capacity would require 6,800 clinicians above the annual number to replace those leaving the field.

Gilbert also felt that the addictions profession lags behind other industries in its ability to access and use information technology. In a 2003 study, it was found that 20 percent of the 175 counseling centers studied had no information systems, voice-mail or e-mail access (source: McLellan et al., 2003). This has a huge impact on simple issues like managing caseloads and paperwork, not to mention keeping clinicians current on best practices and cross-professional communication.

Poor infrastructure, coupled with a $28,510 median income for substance abuse counselors was (according to the US Department of Labor, 2003) and a lack of benefits for a significant number of clinicians (30 percent had no medical coverage, 40 percent had no dental coverage and 55 percent were not covered for substance use or mental health services) may be leading to the Bureau of Labor Statistics estimates that there will be 3,000 unfilled positions for addictions counselors by 2010 (Landis et al., 2002). Individuals are reluctant to enter the field because of low salaries, minimal benefits, negative perceptions of the field, low professional status and stressful working conditions (according to the US Department of Labor, 2003).

CSAT has targeted employee retention, national accreditation and standards and the development of leadership capacity as its priorities for workforce development.

**Linda Kaplan, MA**  
*Addiction Workforce Issues*

Linda Kaplan, MA, is a seasoned administrator and manager with vast experience in the areas of addictions treatment and prevention, including workforce development issues, training, education, certification and current trends in addiction treatment. She is a Special Expert, Substance Abuse and Mental Health Services Administration (SAMHSA) and previously served as the Executive Director of the Danya Institute and the Executive Director of NAADAC, The Association for Addiction Professionals.

Kaplan presented on issues in the addiction workforce, explaining that the lack of national standards has resulted in less recognition for and lower status of the certification process. Citing an aging population and few new entering into the profession, Kaplan also discussed recruitment and retention.

Kaplan stressed the need to recruit more diverse staff; to focus on new marketing strategies and work with colleges and universities, particularly historically black colleges and universities (HBCUs) and other minority schools to recruit staff; Provide intensive orientation to new staff, to provide ongoing clinical and administrative supervision to new staff and to ensure adequate in-service training and support for ongoing continuing education.

Kaplan revealed that turnover rates in the addiction services (Summit, continued on page 16)
On May 21st, NAADAC, together with a coalition of eight organizations and the District of Columbia HIV/AIDS Administration, hosted the International AIDS Candlelight Memorial. The event was one of hundreds of memorials that took place in over 4,500 communities in more than 93 countries. The International AIDS Candlelight Memorial has become the largest grassroots AIDS event in the world. With the highest prevalence rate of new HIV infections being concentrated in the District of Columbia, NAADAC recognizes the need to take local action on this global pandemic.

Noteworthy guests included Jeanne White, mother of Ryan White (1971–1990) for whom the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is named. Ryan White legislation addresses the unmet health needs of persons living with HIV disease by funding primary health care and support services. Also present were the District of Columbia delegate to the US House of Representatives, Eleanor Holmes Norton, and DC City Council Chairperson Linda Cropp, who read a mayoral proclamation. Ride for World Health (www.rideforworldhealth.org), a group of physicians affiliated with Partners in Health, arrived at the event after a 3,700 mile bike ride from San Francisco. Numerous speakers joined addiction treatment providers, local community leaders, HIV/AIDS activists, clergy and others for the event.

This year’s memorial hosted 200 participants from a wide diversity of backgrounds who came together to advocate for increased financial, human and political resources to stem the HIV/AIDS pandemic. NAADAC demonstrated its commitment to supporting those living with HIV/AIDS, honoring the memory of those lost to AIDS, celebrating the hard and enduring work of treatment providers and mobilizing individuals to stop the spread of a preventable disease. Research demonstrates that drug abuse treatment is effective and essential HIV prevention.

**NAADAC and HIV/AIDS**

Globally, sexually transmitted HIV continues to be the most common way the virus is spread, but drug use contributes to the pandemic in at least four ways.

First, although the best researched method of transmission for those that abuse drugs is contaminated injection equipment, the risks and transmission routes for HIV/AIDS goes well beyond dirty needles. Drug abuse continues to be a major avenue for the spread of HIV/AIDS in the US, owing in large part to the correlation between drug use and other risky behaviors. Far beyond the implicit dangers of injecting drugs and becoming infected by contaminated needles, drug and alcohol use also leads to poor decision making and unsafe sexual behavior that put individuals at risk for acquiring HIV.

Sexual transmission of the virus between those who inject drugs and their sexual partners, including the dual transmission risk in the case of sex workers who also inject drugs, can lead to epidemics that expand quickly and act as a bridge to the non-injecting segment of the population.

Third, non-injecting use of drugs such as cocaine and amphetamine-type stimulants leads to high-risk sexual behavior. And finally, the effect is compounded through mother-to-child transmission. An infected mother, either an injected drug user and/or a sexual partner of a drug user, can transmit the virus to her child. Worldwide, we are witnessing a feminization of the HIV/AIDS epidemics, meaning that the share of people with HIV/AIDS who are women is steadily and disproportionately rising. Mother-to-child transmission rates rise with the feminization of the disease.

In addition to transmission, drug abuse can adversely affect health and susceptibility to diseases. Addiction may accelerate the HIV infection itself. Substance misuse is also associated with poor compliance with HIV medication regimens. Moreover, many physical symptoms of HIV infection overlap with those of substance misuse (e.g., withdrawal, including malaise, fatigue, weight loss, fever, diarrhea and night sweats.) Alcohol increases susceptibility to some infections that can occur as complications of AIDS. Infections associated with both alcohol and AIDS include tuberculosis, pneumonia, and especially Hepatitis C (HCV). HCV, which is commonly spread through injection drug use, infects about 14 percent of all people with HIV/AIDS (with much higher rates in urban areas) and is a leading cause of death among HIV positive individuals. Alcohol may also increase the severity of AIDS-related brain damage, which can cause profound dementia and a high death rate.

For more information, visit http://hiv.drugabuse.gov or www.naadac.org/hiv.
Keeping the Faith in Practice

Good, Bad and Complications with Spirituality in Addictions Treatment

By Jessica Krupke, Public Relations Intern

Almost all counselors understand that recovery from addiction often includes a higher power for many patients. Addictions counselors’ views on recovery and faith, however, are anything but similar. They generally fall into two categories, with the delineation falling between a specific religion and spirituality in general. This article is merely an exploration of faith in the profession, and is not meant to support or criticize any one way of treatment.

Spiritual Nature to Addiction

Most addiction counselors agree that some form of spirituality must be part of the recovery process. Thomas Baker, a substance abuse counselor and Presbyterian Minister explains how patients, like those of faith, are looking for something beyond the world around them. For some, he explains, this is found in faith, but others get sidetracked with the seductive nature of chemicals. Baker elaborates, “There is a spiritual nature to addiction.”

Tammie Dahlmann, a licensed drug-alcohol counselor from Texas, notes that in her practice she finds it is important to tell people they are not alone. She also says she stresses that there is free will and employs a general concept of spirituality.

In treatment, one counselor explains, patients need to grasp spirituality as a first-stop early on. Other counselors prefer to wait longer, so as not to overwhelm the patient.

Many counselors agree that while some treatments based on a specific religion can be beneficial, they can just as easily be harmful to the recovery process. A person’s history with faith or a particular religion will likely determine the role of spirituality or religion in recovery. Baker notes how addiction has been labeled sinful by many religions, and as a result, some addicts have an outright intellectual rejection of God. Really good treatment, Baker advises, needs to be sensitive to the fact that some patients are hostile to religion or already believe in a specific religion. A solid foundation in religion, coupled with a faith-based treatment can be helpful to patients, notes one South Carolina counselor. Yet, if a person does not have this solid foundation, she warns, it may be too confusing or overwhelming for them at first. Treatment also needs to insure that religion does not become a diversion to the layers of addiction as a disease.

When confronted with a patient who rejected traditional religions, one counselor encouraged him to find spirituality elsewhere. His choice? A dog. Another patient found it in a tree. Dr. Rose Tijerina-Swearingen founded and runs a treatment facility that employs a holistic approach. “Spirituality has no right or wrong,” she says, but for recovery she feels that patients “do need to look at a higher power, to have some hope that there is light at the end of the tunnel.” Alcoholics Anonymous is one example of a way toward recovery that allows its members to find their own way with faith, as it is non-denominational.

Downsides of Religions Based Treatment

Downsides of religious based treatment lies mainly with the individual counselor’s approach to how they try to put their faith on clientele, explains counselor Al Everette. Recruitment into a church or religious group could cause harm to an addict at certain points in their recovery, in the eyes of some counselors. Dahlmann agrees, noting how some fundamental religions can bring about a downside if they are too strict. Practicality and basing treatment on the individual’s needs seems to make sense to many counselors. “Meet the persons life where they are at,” suggests Everette.

Recent criticism of faith-based treatment is that some newer programs treat the recovery process with the mentality that God or a spiritual being will save the patient. Tijerina-Swearingen says she feels it is important that patients feel accountable for their actions and realize their own responsibility in recovery. “God’s not going to do it for them, but a higher power will provide clarity and guidance.”

If those leaders of faith treating addiction have limited training in being drug and alcohol counselors, then they don’t understand traditional recovery, some counselors criticize. This understanding, Everette suggests, is essential because the methods of the 12-step program have been proven over the past decades.

Specific Religions

Many counselors, however, do use religion—not just spirituality—in their practice with great results. Clinical supervisor and Pastor Don Osborne recalls how he has been present when “individuals have made a confession of faith…and they do not crave the drug from that point there.”

Dennis Greene does not see any problem with Christian treatment because the individual entering his program knows ahead of time it is a Christian facility. He works at works at a state certified outpatient Christian counseling facility. The name itself, he explains, provides a screening process for anyone who would be offended by receiving care from that perspective. In addition, he says about half of his treatment techniques come from the traditional addiction recovery, while the other half is Biblically based. He sees his practice as serving the interests of people who want their treatment to include messages of Christianity. For example, many of his patients’ parents want their children to be taught from a Christian perspective.

Many counselors find it important and complicated to forge what they feel is an essential compromise between common addiction recovery methods and faith. “I
workforce are higher than for most other fields and range from 17–33 percent. These numbers are high, but people are not necessarily leaving the field. Often they are “churning”—going to another agency—for as little as $500-$1,000 a year salary increase.

Kaplan felt that employers could adopt several management practices to improve employee retention, including providing clinical supervision; providing staff development and/or training, providing more job autonomy, recognizing and rewarding staff for strong job performance and encouraging better communication between management and staff.

Recruitment Video Premiere

The world premiere of the Workforce Development video (produced in partnership between NAADAC, the Northeast Addiction Technology Transfer Center, IRETA and the Central East Addiction Transfer Technology Center) was presented at the Summit. The purpose of the video, Imagine Who You Could Save, is to promote career opportunities in the addiction profession while dispelling preconceived notions and/or stereotypes typically associated with the addiction/substance use disorder field. The video’s premise centers around the word “addiction” and the horrific toll it takes on substance users, their jobs, their families and their lives—regardless of age, race, gender or persuasion.

The Summit was well received by those who participated and generated energy, enthusiasm and knowledge for people to share on Workforce Development issues. The challenges of recruitment, retention and rewards still face the addiction profession, but the Summit was a powerful step forward in resolving these issues.

Don’t know what licensure has to do with faith…on the other hand, I can see where proper training and education come into play,” said Osborne.

This balance between too much licensure on faith, while still ensuring successful counseling is key. One professional felt that the rate of relapse was high for strictly religion based counseling. “NA and AA have to be a part of faith-based programs” Everette explains, comparing Christian counselors to Christian doctors: they still need certification.

Certificate Program Development

NAADAC is working to help solve this issue. Together with the National Association for Children of Alcoholics (NACoA), a certificate program is being developed that would allow clergy, ministers, pastors and other heads of congregations the opportunity to obtain training that will validate that they have knowledge in the addiction field. Currently, NAADAC has only 217 members who are certified members of the clergy, who represent only 2.8 percent of the membership surveyed.

This certificate program, due out late this fall, will encourage existing congregation leaders and potential members to enhance the quality and quantity of their work. It would enhance preexisting licenses and degrees that these faith leaders already hold. It does not take as long to acquire a certificate as it does a full credential, as the certificate validates 200 preexisting hours or allows the faith leader to acquire them.

Whether recovery relies on faith or not, all counselors can agree that they important part is helping the addicted person find their new path. It seems that properly qualified counselors will help this best, for any form of treatment.

For more information on this topic, see Addiction Professional magazine, May/June (Vol.4 No. 3). Or contact Donovan Kuehn at donovan@naadac.org for contact information of those quoted in this article.

Two Organizations Join NAADAC

By Donna Croy, NAADAC Director of Membership Services

NAADAC is please to welcome two companies as new organizational members. For a full list of NAADAC organizational members, please visit www.naadac.org.

The Tennessee Association of Alcohol, Drug and other Addiction Services (TAADAS), Inc. is a statewide advocacy association founded in 1976. TAADAS is made up of alcohol and drug abuse treatment, prevention and recovery service professionals, and others who are interested in addiction issues. The TAADAS mission is to educate the public and influence state/national policy decisions in order to improve services to those who are affected by alcoholism, drug dependency and other addictions. TAADAS strives to be THE voice for recovery in Tennessee through its membership and many programs. For more information, please visit www.taadas.org. Or contact Stephanie Giddens, Information Specialist, 1800 Church St., Ste. 100, Nashville, TN 37203, phone 615-780-5901 ext 16 or stephanie@taadas.org.

The Addiction Technology Transfer Center of New England (ATTC-NE) offers a diverse menu of innovative and flexible programs that puts the research to work for you and your agency. These include the annual Science to Science Laboratory and Leadership Institute, didactic training events, distance learning courses, focus groups, technical assistance, and program development. ATTC-NE has also developed collaborative relationships with the faith, treatment, and recovering communities, as evolving partners in the behavioral healthcare system. ATTC-NE is a local resource with global expertise dedicated to serving the needs of New England. Visit their website at www.attc-ne.org or contact Susan A. Storti, PhD, RN, Director, Brown University, Box G-BH, Providence, RI, 02912, phone 401-444-1805, fax 401-444-1881 or Susan_Storti@brown.edu.
**DUES RATES**

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- *State affiliate membership not available in Arkansas, Louisiana, Minnesota, Oklahoma and Wyoming. Dues subject to change without notice. 10/05*

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**MEMBERSHIP CATEGORIES**

- **Full Membership** is open to anyone engaged in the work of counseling or related fields who is interested in the addiction-focused profession. (Certification is not a requirement of membership in NAADAC.)

- **Student Membership** (proof of status must be submitted along with this application) is open to any new or renewing member who is a full-time (9 hours) student at a college or university, or a student who is involved in a full- or part-time internship. Members who meet the above criteria can be eligible for student membership for four years.

**MEMBERSHIP CATEGORY RATE** (see rates below)

**NAADAC PAC CONTRIBUTION** (optional)

- $50
- $100
- $120
- $150
- Other $_____

**Total Amount Enclosed**

- **If you are paying NAADAC dues by company check, you must endorse a SEPARATE PERSONAL check, made payable to NAADAC PAC. Contributions to the NAADAC PAC are optional and are not tax-deductible.**

**PAYMENT INFORMATION**

- Check (payable to NAADAC)
- VISA
- MasterCard
- American Express

**FAX YOUR APPLICATION WITH CREDIT CARD INFORMATION TO:**

- 800/377-1136 or 703/741-7698

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**JOIN NAADAC TODAY—Reap Benefits Tomorrow!**

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**JOIN ONLINE AT WWW.NAADAC.ORG**

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**For more than 30 years, NAADAC has been the leading advocate for the addiction professional. With your support as a member we can continue to uphold our association’s mission to developing leaders committed to the unification, regeneration, and growth of the addiction profession.”**

—Mary Woods, RNC, LADC, MSHS, President
Recovery Foods

By Kay Cauthorn, MS, LCDC

The Dallas Chapter of the Texas Association of Addiction Professionals has been eating healthier at its noon monthly meeting. We had been eating Chinese food, sandwiches and fried chicken for years. I suggested that we use the same amount of money that we spend on high carbohydrate foods and that we try a higher protein diet. We decided to find out if the group liked these foods.

Research has shown that there is a connection between addiction and nutrition. Alcoholics are “…uniquely disordered—both behaviorally and nutritionally all evidence so far continues to point out that the major nutritional elements in behavioral disorders of all kinds are deficiencies in vitamins, major minerals and trace elements.” (Beasley, MD, J., Wrong Diagnosis, Wrong Treatment, p. 87).

The alcoholic who still suffers may no longer be drinking or drugging, but the suffering is now directly related to nutritional deficiencies and illnesses related to using alcohol and/or drugs. Joan Larson, PhD, has found that many of her clients have:

• An alcoholic parent or close relative
• An abnormal glucose metabolism (hypoglycemia or diabetes)
• Allergies to various foods (most common, gluten and dairy)
• Deficiencies in a number of essential nutrients
• Candida-related complex (fungal infection)

(Larson, PhD, J., Seven Weeks to Sobriety, p. 41)

Unfortunately, many recovering people are totally unaware of their illnesses or their allergies. The genetically influenced alcoholic may have many allergies. Often, many can be allergic to corn, rye, wheat and barley because their ancestors drank corn mash, rye whisky and beer from barley. Continuing to eat these foods can cause an allergic reaction which may show up as hives, red eyes, breathing problems, congestion and, most concerning, as brain dysfunction. In the “Doctors Opinion XXIX” (Alcoholics Anonymous Big Book), he states “I do not hold with those who believe that alcoholism is entirely a problem of mental control…these men were not drinking to escape; they were drinking to overcome a craving beyond their mental control.” It seems that “Contempt prior to investigation” might keep recovering people from investigating their allergies, fungus infections or nutritional deficiencies.

When conducting medical research, it is seen as sound science to study all possible aspects that can impact on the health of patients. However, it is interesting to note that because researchers emphasized behavior (the metabolic evidence was not available yet)…because alcoholism was accepted as a behavioral/psychiatric disorder by the AMA…and because virtually all hospitalized alcoholics shared certain psychological symptoms (passive-dependent, egocentric, sociopathic, lacking in self esteem, etc)—it was decided that those symptoms were not secondary to the disorder but the major elements of a pre-morbid personality profile for alcoholism. This belief still exists in the medical community, although enough evidence has appeared to disallow it and it is, in my opinion, no longer valid at all in the face of over-whelming evidence for a metabolic genetic etiology for alcoholism (Beasley, MD, J., Wrong Diagnosis, Wrong Treatment, p. 49).

Recovery from addiction is a difficult process often filled with relapses, which could be accounted for by some of these medical difficulties. It is known that thiamine can help prevent or heal some brain dysfunctions caused by alcoholism. It is also known that because alcohol is fermented that it is possible for drinkers to develop systemic fungal infections. The process of recovery can be greatly hampered by eating junk food, sweets, and a diet high in carbohydrates. According to Dr. Larson, and other experts in the field of addiction, it is imperative that recovering people study and change their eating habits as thoroughly as they would examine their thinking and decision-making processes while in recovery.

This research impelled me to begin cooking for the Dallas Chapter of Addiction Professionals. I began by serving meatloaf, then spaghetti with spaghetti squash, beef stew with corn bread, roast and vegetables, turkey and dressing, rice elbow macaroni casserole and Rock Cornish Game hens with Bing cherry sauce (cherry juice is reportedly helpful for people with a propensity for gout). I used 99 percent fat free beef, vegetable casseroles and had a mixed green or spinach salad with each meal. For dessert we had flan (custard), fruit and homemade apple cobbler.

Kay Cauthorn, MS, LCDC, has been in the field of addiction for over 30 years. Cauthorn is a published educator who has been in private practice since 1986. She plans formal interventions with meals to facilitate the interventions.
**Favorite Meat Loaf**  
(can be made for 4 people)

- 1 lb. Extra lean ground beef
- ½ cup grated carrot, ½ cup grated green/red peppers
- 4 tablespoons grated celery
- 1 purple onion finely chopped
- 10 cloves of garlic minced
- 3 slices Ezekiel bread crumbled (found in health food store)
- 2 tablespoon chopped fresh parsley
- 3 eggs lightly beaten (Omega 3 eggs from health food store are best)
- 12 cut chopped and cooked for 2 minutes tiny tomatoes
- ½ teaspoon sea salt
- ½ teaspoon fresh ground pepper

To make the meat loaf, preheat the oven to 450 degrees.
Combine ground beef, carrots, peppers, celery, onions, bread, parsley, eggs, tomatoes, garlic, salt and pepper.
Pack the mixture in a 9 X 5 inch loaf pan. Pour ketchup (with no sugar added) on top after baking for 45 minutes. Cook for another 10 or 15 minutes before ketchup darkens.

**Egg and Vegetable Quick Dish**

- 2 cups diced cooked sweet potatoes
- 1 cup of mixed fresh vegetables (peas, carrots, celery & green pepper)
- 5 hard-cooked eggs (Omega 3 eggs from health food store are best)
- ¾ cup low fat grated cheese
- 5 garlic cloves, diced
- 5 tablespoons chopped onion
- 3 tablespoons chopped pimento
- 2 cups of no fat half and half milk and cream

Warm half and half, add all ingredients except the cheese. Pour into a butter greased casserole dish and top with grated cheese. Bake in hot oven at 450 degrees about 15 minutes or until slightly brown. Sprinkle with salt and pepper.

**Apple Cranberry Dessert**

- Core 4 apples and slice in 1/3 inch slices
- ½ teaspoon cinnamon
- Peel and make chunks of 1 butternut squash
- Juice from 4 oranges
- 1 can cranberries

Place pieces of butternut squash in slow cooker, then place apple slices over the squash and cover with the orange juice. After 4-6 hours cook the cranberries until the syrup is thick. Test apples for doneness and serve with cranberries on top of apples and squash. Sprinkle cinnamon on top.

**Make-Ahead Casserole**

- 1 ½ cups elbow Lumburg rice pasta (found in health food store)
- 2 lbs. Extra lean ground beef
- 3 purple onions finely chopped (medium to large)
- 10 Garlic cloves, minced
- 1 green or red bell pepper, seeded and diced
- 2) tiny tomatoes, minced and cooked for 20 minutes
- 4 ears of corn, cut off corn and cook for 15 minute in pan wiped with butter
- 1 cup low fat white cheese, graded
- 2 tablespoons chili powder
- 1 teaspoon fresh ground black pepper
- ½ cup white sparkling grape juice (with no sugar added)
- ½ cup Ketchup (no sugar added) (usually found in health food store)

Cook pasta shells, rinse with cold water, and set aside.

Over medium-high heat sauté beef in a very large non-stick skillet or Dutch oven, breaking up with a wooden spoon, until all trace of pink disappears.
Drain any accumulated fat. Add onions, garlic, and green/red pepper, mix well and cook until vegetables soften about 8 minutes.
In your largest casserole combine tomatoes, corn cheese, ketchup, chili powder, pepper, and sparkling grape juice.
Stir in cooked shells and beef mixture. Can be placed in refrigerator for several hours or overnight.
When ready to cook, preheat oven to 350 degrees. Bake casserole for 1 hour or until hot and bubbly.
Note: An additional ¼ cup of grated cheese may be sprinkles over the top of the casserole before baking.

**Buffalo Meat Balls in Spaghetti Sauce**

- 1 medium onion, minced
- 1 pound ground Buffalo meat
- 7 garlic cloves, minced
- 2 slices grated Ezekiel Bread
- 1 celery stalk, minced
- 1 egg
- ½ red bell pepper, seeded and minced
- 1 jar of tomato puree (small) unbleached flour
- ½ cup sparkling white grape juice
- ½ teaspoon salt
- ¼ teaspoon freshly ground black pepper
- 1/8 teaspoon ground nutmeg
- 1 cut beef stock
- 1 small container of tiny tomatoes
- salt and pepper to taste

In non-stick pan place 1 teaspoon of olive oil and heat adding onion, garlic, celery, bell pepper and last add small tomatoes chopped up with juice added with white grape juice.
Cook until browned, add grape juice, tomato juice, and beef stock. Cook slowly and add meat balls after sauce is done. Add one egg to 1 pound of buffalo meat with bread crumbs. Form balls, roll in flour and cook in non-stick pan with ½ teaspoon butter. When very brown add to spaghetti sauce.
2006–2007 UPCOMING EVENTS

June 16, 2006  NAADAC Life-Long Learning Series: Medication Management for Addiction Professionals – Campral Series
Pioneer Campus of Penn Valley
2700 E. 18th Street
Kansas City, Missouri
More details at www.naadac.org or contact Donovan Kuehn at dkuehn@naadac.org or 1-800/548-0497, ext. 125.

June 21, 2006  NAADAC Life-Long Learning Series: Medication Management for Addiction Professionals – Campral Series
Omni Corpus Christi Hotel
900 N. Shoreline Boulevard
Corpus Christi, Texas 78401
More details at www.naadac.org or contact Donovan Kuehn at dkuehn@naadac.org or 1-800/548-0497, ext. 125.

June 30, 2006  NAADAC Life-Long Learning Series: Medication Management for Addiction Professionals – Campral Series
The Lesbian, Gay, Bisexual & Transgender Community Center
208 West 13th Street
New York City 10011
phone: 212/620-7310
Co-sponsored by the Lesbian, Gay, Bisexual & Transgender Community Center.
More details at www.naadac.org or contact Donovan Kuehn at dkuehn@naadac.org or 1-800/548-0497, ext. 125.

July 29, 2006  NCAC I/ NCAC II/ MAC Exam
The Professional Testing Corporation (PTC) provides NAADAC approved certification testing.
More details at www.ptcny.com

August 13, 2006  Last day to apply for a NAADAC Scholarship to the CAADAC/NAADAC/NALGAP Annual Conference
Scholarship applications at www.naadac.org

September 19, 2006  NCAC I/ NCAC II/ MAC Application Deadline for November 18 Exam date
The Professional Testing Corporation (PTC) provides NAADAC approved certification testing.
More details at www.ptcny.com

September 20, 2006  National Addictions Professional Day
Celebrate the invaluable work that addiction professionals do!
Activities nationwide.
Organizer’s toolkit available from the NAADAC office.
More details at www.naadac.org or contact Donovan Kuehn at dkuehn@naadac.org or 1-800/548-0497, ext. 125.

September 28–October 1, 2006  NAADAC/CAADAC Annual Conference
Burbank, California
NAADAC is joining with the California Association of Alcoholism and Drug Abuse Counselors (CAADAC) to present NAADAC’s annual conference with CAADAC’s Annual Meeting.
More details at www.naadac.org or www.caadac.org or call 1-800/548-0497.

November 18, 2006  NCAC I/ NCAC II/ MAC Exam
The Professional Testing Corporation (PTC) provides NAADAC approved certification testing.
More details at www.ptcny.com

September 5–8, 2007  NAADAC Annual Conference held in association with the Tennessee Association of Alcoholism and Drug Abuse Counselors (TAADAC)
More details at www.naadac.org or contact NAADAC at naadac@naadac.org or call 1-800/548-0497.

Have an event we should know about?
Contact 1-800/548-0497, ext. 125 or e-mail dkuehn@naadac.org.