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# NAADAC NEWS

The Association for Addiction Professionals • We help people recover their lives.

Vol. 16, No. 4, October 2006

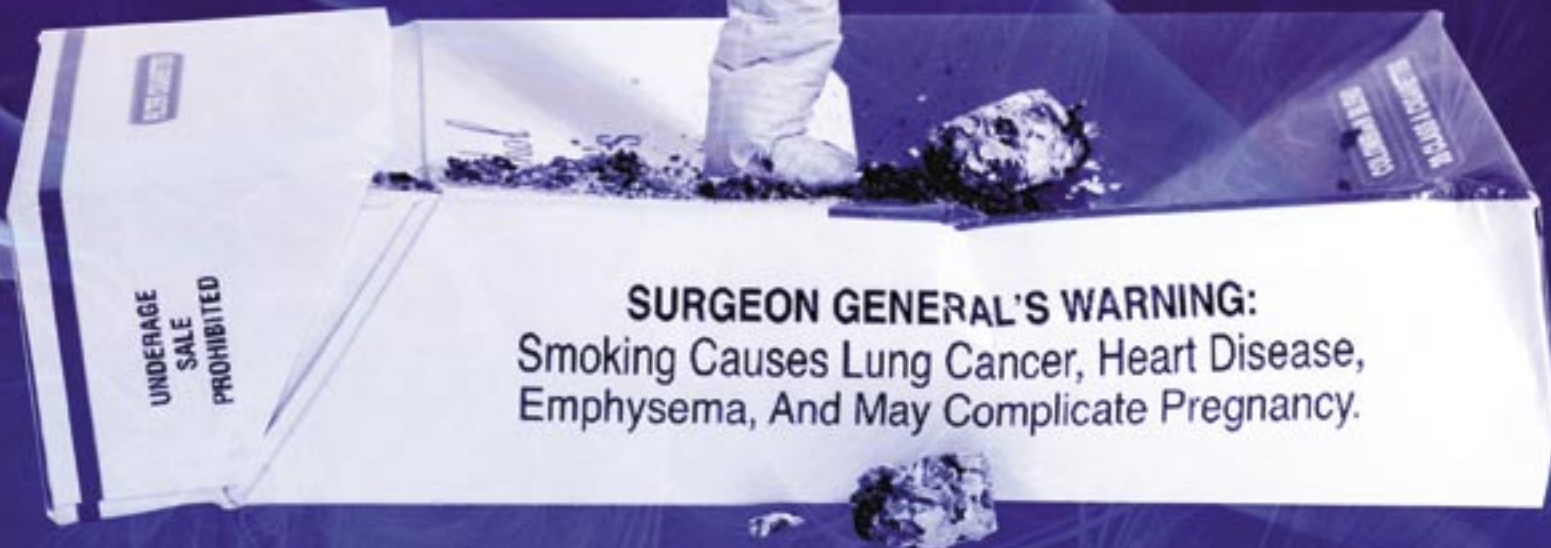
## Tobacco Addiction

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**SURGEON GENERAL'S WARNING:**  
Smoking Causes Lung Cancer, Heart Disease,  
Emphysema, And May Complicate Pregnancy.

UNDERAGE  
SALE  
PROHIBITED



## Editor's Note

Thanks for joining us for the October issue.

October has the changing of the seasons, and every two years it also has the changing of NAADAC's leadership. With new leaders come a new perspective and new opportunities for NAADAC members.

The *NAADAC News* is also going through its own evolution. The *NAADAC News* has several themes planned for 2006 and 2007, including:

### 2006

HIV/AIDS – World AIDS Day December 1st/  
HCV (December 2006)

### 2007

Cultural Diversity (February 2007)  
Elections (April 2007)  
Professional Development/Education  
(Returning to School) (June 2007)  
35th Anniversary (August 2007)  
Adolescents (October 2007)  
Older Adults (December 2007)

If you are interested in writing on any of these topics, please let me know!

Enjoy the issue.

Donovan Kuehn  
NAADAC News Editor

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(updated 10/1/06)

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## NAADAC Members Matter

### The Views and Opinions of Our Members Shape the Future of NAADAC

By Sharon Morgillo Freeman, PhD, APRN-CS

It is my honor to step into the position of President of NAADAC. I want to first thank our members who joined us in Burbank, Calif., for the annual conference. Thanks and congratulations to the California Association of Alcoholism & Drug Abuse Counselors and the National Association of Lesbian and Gay Addiction Professionals for their professionalism and commitment in this cooperative venture with NAADAC.

That commitment is reflected in the work of NAADAC's past leaders including Roger Curtiss, Kathryn Benson and Paul Potter who spent so much of the last four years building our association and I owe them a debt of gratitude. Thank you to Mary Woods who is staying on as Immediate Past President providing continuity and support for the work ahead.

A strong organization facilitates, reflects and utilizes input creating a living "team" and strong leadership. I know that NAADAC has worked hard on strengthening the relationship it has with its members, and I want to help to continue to facilitate that process.

I believe three principles will help us move forward.

#### Member Input

Dynamic teams encourage discussion and feedback. This produces quality results. NAADAC is a dynamic quality team. My desire is to help strengthen a process where NAADAC hears from its members on the significant issues that impact on how our organization grows and develops.

Over the next few months, NAADAC will develop systems to improve facilitation of two-way communication between NAADAC and its members. You will see surveys, questionnaires and other mechanisms for members to fill out to provide information to shape NAADAC's policies, programs and progress.

My commitment to our members is that what we hear from our members




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*NAADAC has  
worked hard  
on strengthening the  
relationship it has  
with its members,  
and I want to  
help to continue to  
facilitate that process*

---

will be reflected in the initiatives that NAADAC undertakes as an organization.

#### Member Involvement

The dynamism of an organization is limited only by the contributions of its members. With a membership of over 11,000 professionals from around the world, NAADAC has an amazing resource base to tap into. Having such diverse and talented membership means that NAADAC truly has the talent to

contribute at all levels.

I often hear that NAADAC needs more input from members. Input often comes through NAADAC committee recommendations, so if you have advice, special training or want to contribute, please *get involved*. Committees are forming under new leadership right now and this is a perfect opportunity to have your opinions put into action. Applications for committee membership are available from the NAADAC office by calling 1-800.548.0497 or by sending an e-mail to [naadac@naadac.org](mailto:naadac@naadac.org) (please put "committees" in the subject line).

In addition to the committee process, NAADAC will be issuing a call for papers for its 2007 conference, will be hosting workshops across the country where you can participate and/or volunteer, has state affiliates that are always looking for people to get involved and needs legislative liaisons at the local level.

#### Member Services

NAADAC is committed to emphasizing the most customer service-oriented focus for its members. We will continue to strive to ensure that every request is responded to in a timely manner and that every interaction between NAADAC and its members is positive, polite and pleasant.

The addiction profession is at a crossroads and faces many challenges: workforce development issues, professional development and the development of a culture that focuses on evidence-based practices instead of anecdotal precedents.

The future of NAADAC, and the addiction profession as a whole, will rely on the contributions and ideas of NAADAC members. The attitude and commitment of our leaders helps determine the attitude and commitment of the team and therefore our future.

If you have any ideas, please feel free to share them with me. I can be reached at [morgillofreeman@aol.com](mailto:morgillofreeman@aol.com).

# Youth Drug Use Declines, More Adults Abuse Prescription Drugs

## SAMHSA Survey Reveals Drug Trends

By Donovan Kuehn, NAADAC News Editor

The 2005 National Survey on Drug Use and Health (NSDUH) Substance Abuse and Mental Health Services Administration (SAMHSA) announced that current illicit drug use among youth (ages 12–17) continues to decline. The rate has been decreasing since 2002. The study, which examines general drug use amongst youth in the previous 30 days, has shown a decline with 11.6 percent of youth using drugs in 2002 to 11.2 percent in 2003, 10.6 percent in 2004 and 9.9 percent in 2005.

This initial report from SAMHSA, the lead federal agency for improving the quality and availability of substance abuse prevention, addiction treatment and mental

health services in the United States and a public health agency within the U.S. Department of Health and Human Services, was released at the annual observance of National Alcohol and Drug Abuse Recovery Month.

The survey also found that under-age drinking among teens declined, with 16.5 percent of youth ages 12–17 reporting current alcohol use and 9.9 percent reporting binge drinking. This compares with 17.6 percent of this age group reporting drinking in 2004 and 11.1 percent reporting binge drinking in the past month in 2004. These declines in alcohol use by youth, ages 12–17, follow years of relatively unchanged rates.

Hidden in this survey were some disturbing increases in consumption of drugs by youths. Cocaine use increased from 2.0 in 2002 to 2.6 percent in 2005. Non-medical use of prescription drugs among young adults increased from 5.4 percent in 2002 to 6.3 percent in 2005, due largely to an increase in the non-medical use of narcotic pain relievers.

While general trends indicate youth are using less drugs, the baby boomer generation presents a different story. Among adults aged 50 to 59, the rate of current illicit drug use increased from 2.7 percent to 4.4 percent between 2002 and 2005.

“The decline indicated in the 2005 survey among youth is a positive step and reflects the hard work of addiction professionals and educators in their prevention and intervention work,” said Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, Executive Director of NAADAC. “One aspect that needs to be assessed in this survey is the increasing prevalence of drug abuse among older adults. This shows that treatment providers need to know to target the 50–59 age group and illicit drug use and to adjust their therapy to treat older addicts,” she added.

“The news today is there is a fundamental shift in drug use among young people in America,” said Assistant Surgeon General Eric B. Broderick, DDS, MPH, and SAMHSA Acting Deputy Administrator. “We first saw this shift towards healthier decisions when rates of tobacco use among young people began to go down. Now, we see a sustained drop in rates of drug use. We will see if the decline in drinking among 12 to 17 years olds becomes a continued pattern as well.”

The National Survey on Drug Use and Health is an annual survey of approximately 67,500 people. The survey collects information from residents of households, residents of non-institutionalized group quarters and civilians living on military bases.

For a brief summary of the survey results, see pages 5 and 7. The full National Survey on Drug Use and Health is available on the web at [www.oas.samhsa.gov](http://www.oas.samhsa.gov).

*The decline indicated in the 2005 survey among youth is a positive step and reflects the hard work of addiction professionals and educators in their prevention and intervention work.*

Cynthia Moreno Tuohy, NAADAC Executive Director



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## Results of the 2005 National Survey on Drug Use and Health

### Marijuana

The survey shows there were 14.6 million past month users of marijuana in 2005. Among those ages 12 and older, the rate of past-month marijuana use was about the same in 2005 (6.0%) as in 2004 (6.1%), 2003 (6.2%) and 2002 (6.2%).



### Prescription Drugs

6.4 million people aged 12 and older used prescription drugs non-medically in the past month. Of these, 4.7 million used narcotic pain relievers, 1.8 million used tranquilizers, 1.1 million used stimulants (including 512,000 who used methamphetamine) and 272,000 used sedatives. Each of these estimates is similar to the estimates for 2004.

Those who used prescription drugs non-medically were asked how they obtained the drugs. In 2005, the prevalent source for drugs used non-medically was "from a friend or relative for free" (59.8%). Another 16.8 percent reported getting the drug from one doctor, while 4.3 percent reported getting narcotic pain relievers from a drug dealer or other stranger, and 0.8 percent reported buying the drug on the internet.

### Methamphetamine

Although the number of past month users has remained steady since 2002, the number of methamphetamine users who were dependent on or abused some illicit drug rose significantly during this period, from 164,000 in 2002 to 257,000 in 2005.

The number of recent new users of methamphetamine, aged 12 and older, was 192,000 in 2005. Between 2002 and 2004, the number of new methamphetamine users remained steady at around 300,000 per year, but there was a decline from 2004 (318,000 users) to 2005.

### Heroin

There was no significant change in the number of current heroin users in 2005 (136,000), nor in the rate of heroin use (0.1%), compared with estimates from 2004, 2003, and 2002.

### Alcohol

Almost a quarter of people aged 12 and older participated in binge drinking in 2005. Binge drinking is defined as having five or more drinks on the same occasion on at least one day in the 30 days prior to being surveyed. This translates as about 55 million people, comparable to the 2004 estimate. The binge drinking rate among young adults ages 18–25 was 41.9 percent, and the heavy drinking rate was 15.3 percent.

In 2005, 6.6 percent of the population ages 12 and older (16 million people) engaged in heavy drinking. This rate is similar to the reported rate of 6.9 percent in 2004. Heavy drinking is defined as binge drinking on at least five days in the past 30 days.

About 10.8 million youth reported past month alcohol use in 2005. Nearly 7.2 million of these underage drinkers (18.8%)

were binge drinkers and 2.3 million (6%) were heavy drinkers. These figures have remained essentially the same since 2002.

Most of the new initiates to alcohol use (88.9%) were younger than 21 at the time of initiation.

### Tobacco

In 2005 there were an estimated 71.5 million Americans ages 12 and older who were current users of a tobacco product. Of these 60.5 million were current cigarette smokers; 13.6 million smoked cigars; 7.7 million used smokeless tobacco and 2.2 million smoked tobacco in pipes.

### Substance Dependence or Abuse and Treatment

In 2005, an estimated 22.2 million people (9.1% of the population ages 12 and older) were classified with substance dependence or abuse in the past year, based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV). Of these, 3.3 million were dependent on or abused both alcohol and illicit drugs; 3.6 million were dependent on or abused illicit drugs but not alcohol; and 15.4 million were dependent on or abused alcohol, but not illicit drugs. These numbers are basically unchanged since 2002.

There were 2.3 million people who received treatment at a specialty facility in 2005. There were 1.2 million persons who reported that they felt they needed treatment for an illicit drug or alcohol use problem, but of these 865,000 reported making no effort to get treatment. There were 296,000 who reported they had made an effort to get treatment. These numbers were not statistically different from the numbers in the 2004 survey.

Adults ages 21 or older who had first used alcohol before age 21 were almost five times more likely than adults who had their first drink at age 21 or older to be classified with alcohol dependence or abuse (9.6% compared to 2.1%).

### Driving Under the Influence

In 2005, an estimated 31.7 million people aged 12 and older drove under the influence of alcohol at least once in the past year.

### Co-occurring Substance Use and Serious Psychological Distress

Serious psychological distress, as measured by the survey administered to adults ages 18 and older, was associated with past year substance dependence or abuse in 2005. Among the 24.6 million adults with serious psychological distress in 2005, 21.3 percent (5.2 million) were dependent on or abused illicit drugs or alcohol. The rate of substance dependence or abuse among adults without serious psychological distress was 7.7 percent (14.9 million people).

Among the 5.2 million adults with both serious psychological distress and substance dependence or abuse in 2005, 47 percent received mental health treatment or substance use

(Survey, continued on page 7)

## The Toll of Tobacco

### Tobacco use is the number one cause of preventable death and disease in America

By Sharon Czabafy, MSS, LSW, CAC, NCTAS

Bill Wilson, one of the founders of Alcoholics Anonymous, died from emphysema. Even though he greatly contributed to the alcoholism recovery movement, he was not able to overcome his addiction to tobacco. His desk, which can be seen at his home, Stepping Stones, has many burn marks on it from cigarettes. It is said he had a great affinity for his cigarettes.

And Bill W. is not alone. More alcoholics and other drug addicts in recovery will die from their tobacco use rather than their other drug use. As a matter of fact, more people will die from tobacco use than die from all the other drugs, combined with fatalities from AIDS, suicide, murder and drunk driving. In the next 24 hours, 1,200 Americans will die from tobacco use according to the American Lung Association. These are startlingly statistics.

Tobacco use is the number one cause of preventable death and disease in America. One would think the addiction community would be tackling this issue and promoting tobacco addiction recovery among themselves and with their patients. However, addiction professionals often work to help people attain sobriety, only to have them die from tobacco use because it was not included in treatment. This is even more tragic when research conducted by the University of Medicine and Dentistry of the New Jersey-School of Public Health shows that when smoking cessation is included with the treatment of other drugs, the abstinence rate after one year is almost doubled. Recovery rates from tobacco addiction could just about double if tobacco addiction treatment were incorporated into all treatment programs.

There is much talk about treating particular populations in the world of tobacco control, like certain ethnic groups, adolescents and pregnant women. However, there is little talk about treating addicts as a unique population, despite the fact that tobacco use is a co-occurring factor in about 50–80 percent (depending on what research you look at) of those with chemical dependencies. The evidence clearly indicates more addicts use tobacco than the average population.

Nicotine, the addictive substance in tobacco is a vasoconstrictor, has a short half life and is very addictive. Tobacco is a most efficient delivery system for the drug, giving the user a mood altered effect in about seven seconds. While it is a stimulant, many of its users say it calms them down and helps them deal with stress.

The addiction to tobacco is cunning, powerful and baffling. Why else would someone with a tracheotomy continue to smoke? Why else would someone continue to use a drug that will make them ill, take years off their life and/or kill them? The destruction from tobacco use usually takes years to show up, so often the users think they are “safe.”

This is a socially accepted drug that has been part of our culture for decades. It is big business. And many of its users

are in denial that it is a problem. However, let’s look at the pattern of use:

- **Obsession with the drug.** Constant thoughts of “when can I smoke,” “where can I smoke,” “I can’t have cigarettes so I’ll take chew,” or “I can’t smoke there, so I’m not going.”
- **Protection of using the drug.** Simply take a look at any newspaper and see the fight against smoke-free air, restaurant and bars going smoke-free, and the increasing federal, state and local laws regulating smoke-free public spaces. “It’s my right.” Enough said.
- **Tolerance.** Most users did not start smoking a pack or two a day. They worked up to it over the years.
- **Craving.** Craving is an indication the person is in withdrawal and the withdrawal symptoms may be unpleasant; enough to cause anxiety about not having the drug. The person loses focus, gets agitated, and wants that cigarette or another tobacco product.
- **Rationalization.** “I have to die of something,” “Who are they to tell me I can’t smoke or use tobacco products?” “At least it better than drinking alcohol.” And on and on.
- **Behavior.** How many times has a user gone through the couch, chair, or pants pockets to find the last quarter needed to buy more tobacco? Or robbed the child’s piggy bank or borrowed money to purchase the drug?
- **Rituals associated with use.** The rush the user gets thinking about smoking, how they open the pack, brand loyalty, the first use of the day and the last puff at night.
- **Social life.** Many users only associate with other users. They only attend functions where they can smoke or spend some time thinking about how they will get their drug if in a smoke-free environment.
- **Physical.** Deterioration begins and the user is in denial and/or rationalizes the symptoms. “I get winded going up steps—must be old age setting in,” “I am just a little out of shape” or “I always seem to have this cough; must be allergies.”
- **Spiritual.** The user’s higher power is the chemical.
- **Relapse.** Nicotine Anonymous describes the challenges of relapse of tobacco users: “relapse happens in the head before it is held in the hand” and “you are always a puff away from a pack a day.”

Tobacco addiction is a chronic illness that requires treatment. Recovery is possible. Let’s all take on this addiction and help people fight for their lives.

*Sharon Czabafy, a licensed social worker, certified addictions counselor and nationally certified tobacco addiction specialist, has been working in the addiction profession since 1983. Her duties include program development, supervision, training, consulting, education and therapy. The past five years have been solely devoted to working with tobacco dependence.*

## NAADAC's New Leadership Team

### Diverse Backgrounds, Talents Possessed by NAADAC Leaders

Four NAADAC leaders assumed office on September 30, 2006. Their biographies are listed below. For a full list of the NAADAC leadership, their biographies and contact information, please visit [www.naadac.org](http://www.naadac.org) and click on "Executive Board."



#### NAADAC President

**Dr. Sharon Morgillo Freeman** serves as Director of The Center for Brief Therapy, PC, in Fort Wayne, Indiana. She is board certified as a Cognitive Therapist by the Academy of Cognitive Therapy in addition to achieving national certification as an Advanced Practice Psychiatric

Clinical Nurse Specialist and senior level international certification as a Master Addiction Counselor (MAC) through NAADAC. She has a PhD in Sociology and her two master's degrees were awarded in Psychology through the Adler School of Professional Psychology and Advanced Practice Psychiatric nursing at the University of Pennsylvania. She is the previous Clinical Director of Inpatient Addiction Services, Inpatient Acute Psychiatric and Dual Diagnosis Units for the University of Pennsylvania Medical Center at Presbyterian which won the national treatment program award in 2002.

E-mail: [morgillofreeman@aol.com](mailto:morgillofreeman@aol.com)



#### NAADAC President Elect

**Patricia Greer, BA, LCDC, AAC**, is a member of the Dallas Chapter of the Texas Association of Addiction Professionals (TAAP). She is the recipient of the 2005 TAAP Elvies Smith Counselor of the Year Award, and first practiced substance abuse counseling 28 years ago in

the state of Pennsylvania. She has chosen to work in just

about every alcohol and drug related service environment, including administration, counseling, prevention, education, family therapy and clinical supervision. She moved to Texas with her family in 1982 and has lived there since.

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#### NAADAC Secretary

**Sharon DeEsch, LPC, LCDC, MAC, CCJP, SAP**, 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 and the Addiction Professional magazines. 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 on the NAADAC's Board of Directors.

E-mail: [sdrecovery@hotmail.com](mailto:sdrecovery@hotmail.com)



#### NAADAC Treasurer

**Alvin Feliciano, CADC II, ILSAC, MA**, 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 profes-

sional organizations. He serves as the Program Manager at Veteran's Village residential treatment program in San Diego and has been there since 1995. He is also an Independent Licensed Substance Abuse Counselor in the state of Arizona.

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#### (Survey, continued from page 5)

treatment at a specialty facility: 8.5 percent received both treatment for mental health and substance use disorder, 34.3 percent received only treatment for mental health problems and 4.1 percent received only specialty substance use treatment.

#### Depression

There were 30.8 million adults who had at least one major depressive episode in their lifetime, and 15.8 million adults who reported a major depressive episode

in the past year. This is a statistically significant decline from 17.1 million adults reporting past year major depressive episodes in 2004.

Having a major depressive episode in the past year was associated with past year substance dependence or abuse. Among adults in 2005, 20 percent were dependent on or abused alcohol or illicit drugs, while among those without a major depressive episode only 8.4 percent were dependent on or abused alcohol or illicit drugs.

In 2005 there were 3.4 million youths ages 12 to 17 who had at least one major depressive episode in their lifetimes and 2.2 million youths who had a major depressive episode during the past year. The occurrence of a major depressive episode in the past year among youths ages 12 to 17 was associated with a higher prevalence of illicit drug or alcohol dependence or abuse. This compares to 6.9 percent for youths who did not report past-year major depressive episodes.

## Nicotine Addiction

### The Science Behind the Addiction

By Carol Southard, RN, MSN, Smoking Cessation Specialist, Northwestern Memorial Hospital

Although the now famous advertising slogan, “Just Do It” may be applicable to many behavioral changes people attempt, it is naïve to think this notion will work when it comes to smoking cessation. Nicotine addiction is a powerful and complex physiologic and behavioral addiction. We cannot begin to help our patients overcome this addiction unless we understand its physiologic and psychological characteristics.

Nicotine meets all critical standards for an addictive drug. Cigarette smoking and tobacco use meet the primary and additional criteria for drug dependence described by the Surgeon General, the World Health Organization and the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders, Revised Fourth Edition (DSM-IV)*. Nicotine withdrawal, as identified in DSM-IV, includes dysphoric or depressed mood, insomnia, fatigue, irritability, frustration or anger, difficulty concentrating, restlessness, decreased heart rate, increased appetite or weight gain and gastrointestinal disturbances. Physiologically, there is a decreased heart rate, slowing on electroencephalographic studies and impaired reaction times. These signs and symptoms begin within an hour of the last cigarette, peak in 48 to 72 hours, and may persist up to three months after quitting.

Considerable behavioral and pharmacologic evidence shows that nicotine is the dependence-producing constituent of tobacco and is capable of creating tolerance, physical dependence and withdrawal syndromes. The most convincing studies used intravenous nicotine which objectively and subjectively produced a euphoriant effect and, when self-administered, reinforced its repeated use. This is also true with cigarettes of varying nicotine concentration, smokeless tobacco and



nicotine polacrilex, even though the abuse potential with the gum is substantially less.

The average cigarette contains 10mg of nicotine, of which between 1 and 2mg is delivered to the lungs when smoked. A small amount of nicotine is absorbed through the buccal mucosa, but an alkaline pH is required for a considerable amount to be absorbed. Once the smoke reaches the small airways and alveoli of the lung, the nicotine is absorbed rapidly, regardless of pH factors.

Once absorbed, nicotine readily crosses the blood-brain barrier and is distributed throughout the brain within seven seconds, which is faster than by intravenous injection. Nicotine in low doses causes ganglionic stimulation and therefore produces a centrally mediated cardiovascular stimulation, while high doses cause ganglionic blockage with subsequent hypotension, bradycardia, nausea, vomiting and pallor. However, tolerance to these effects develops within a day.

Consistent with a half-life of two hours, nicotine accumulates over six to eight hours of regular smoking. Nicotine is then metabolized rapidly and extensively by the liver and to a small extent by the lung. The level of renal excretion depends on urinary pH and urine flow and accounts for 2–35 percent of total elimination. Cotinine, a primary metabolite of nicotine with a half-life of 24 hours, has been used as a marker to confirm cessation in treatment studies.

Nicotine influences the release and effects of acetylcholine, cortisol, catecholamines, dopamine and endorphins; endorphins increase in proportion to the plasma nicotine levels. Nicotine also has peripheral effects, exerted via the autonomic nervous system. After receiving a dose of nicotine, a person’s heart rate, blood pressure and serum adrenaline increase and cutaneous vasoconstriction (constriction of the skin’s blood vessels) occurs.

Nicotine’s psychoactive effects are facilitated when nicotine binds to the acetylcholine receptors (neurotransmitters that function primarily to mediate activity of the nervous system and skeletal muscles), producing an enhanced alertness and a mild euphoria. However, exogenous nicotine binds to the acetylcholine receptors for longer than endogenous neurotransmitters, thereby producing a secondary blockade of these receptors. Over time, the body adapts to this chronic secondary antagonism and up-regulates its central nervous system acetylcholine receptors. The increased number of nicotine receptors makes the normal amount of acetylcholine released into the synapse insufficient to maintain the previous mood and the biological basis for the physical dependence is established.

The chief physiological obstacle to quitting is the additive nature of nico-



tine. Smokers regulate their nicotine dose to obtain desired effects, whether to avoid physical withdrawal, or respond to a negative mood, or to gain any other perceived reward. Clinicians and smokers need to recognize that smoking is both physically and psychologically addictive and that it is in fact the most powerful of all addictions to overcome.

Over 90 percent of tobacco users who try to quit without treatment assistance will fail. The observation that alternate nicotine delivery formulations can substitute for nicotine from tobacco has opened the door to the use of nicotine replacement therapies (NRT). A systematic review of 47 trials including over 23,000 patients showed that NRT doubled smoking cessation rates when compared to placebo, with follow up periods of 6–12 months. The effect was consistent across a range of settings, from specialized clinics to brief interventions.

There are now seven FDA approved, first-line medications for nicotine dependence. Medications constitute an important cessation intervention and all tobacco users should consider trying at least one of the pharmacological options. Despite what one reads on labels, there are no longer any true contraindications for nicotine replacement therapy. Almost all researchers agree that nicotine is not a carcinogen. Although nicotine's hemodynamic effects increase the myocardial workload, several well-controlled studies in people with active heart disease have shown that NRT is safe to be used by people with cardiovascular disease. NRT use is now considered safe in pregnant women, as the fetus is exposed to much less nicotine with NRT than with tobacco use.

Some 70 percent of smokers will have at least one office visit with a clinician this year. Health care providers can help their clients even with only brief interactions. Appropriate pharmacotherapy to reduce withdrawal symptoms gives the patient the opportunity to initiate psychological and behavioral changes that are of utmost importance for long term success. Communication regarding tobacco

cessation is critical. With effective education, counseling and support (rather than condemnations and warnings about dangers of smoking), health care providers can provide effective interventions and thereby decrease the incidence of illness and death in tobacco users.

The efficacy of even brief tobacco dependence treatments has been well established and is also extremely cost-effective relative to other medical and disease-prevention interventions. Helping someone overcome a nicotine addiction may be the most broad-reaching health care intervention a health care provider can achieve. It is crucial that we give this complex and difficult medical problem the attention, diligence, and compassion it warrants. Our patients deserve nothing less.

*To contact Carol Southard about this article or the Smoking Cessation Initiative Project, call 1.800.243-ADHA, ext. 220 or 312.440.8920 or send an e-mail to smoking-cessation@adha.net or carols@adha.net.*

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## New Organizational Member Joins NAADAC

*By Donna Croy, Director of Membership Services*

NAADAC is pleased to welcome **Choices Recovery Center** as a new organizational member. Choices Recovery Center is a substance abuse treatment facility fully licensed by the state of Florida. Those suffering from addictive disorders are treated at a partially hospitalization and intensive outpatient level of care by a psychiatrist and licensed and certified clinicians (Licensed Clinical Social Workers, Licensed Mental Health Therapists and Certified Addictions Professionals).

Choices Recovery Center has made the conscious decision to treat only 30 clients at one time for a reason. Quite simply, the quality of care that a suffering addict or alco-

holic needs to successfully recover can only be achieved in an environment that is supportive and loving, and meets the individual needs of that person. This is easily achieved at Choices Recovery Center because of the individual attention provided by the highly qualified staff for each and every one of Choice's clients.

For more information about Choices Recovery Center, send an e-mail to richardgjensen@aol.com, visit [www.choicesrecoverycenter.org](http://www.choicesrecoverycenter.org), phone 1-800.981.9228, or via sending a fax request to 772.460.5054. You can contact Lynne Tiedemann, Clinical Director by writing to 606 N. U.S. Highway 1, Fort Pierce, FL 34950.

# Helping the Tobacco Dependent Client Learn From Relapse

## Tobacco Recovery is Possible for Everyone

By Corinne Kalat, MS, LCPC, CADC, TAS, PCGC

As a clinician, one of the most important things that can be offered to the tobacco dependent client is help with learning from lapses and relapses and returns to smoking. As a counselor specializing in working with tobacco-dependent clients, my best credential is personal experience with tobacco recovery since 1995 after having smoked two packs per day for over 25 years. With multiple quit attempts before experiencing tobacco recovery, the most important thing I learned is relapses are learning experiences.

Most tobacco dependent people experience patterns in their use, dependence and recovery. They enter a quit-relapse cycle that they constantly repeat, and from which it is difficult to escape. With each relapse, clients seem to



mentally rack up another “failure.” We hear the negative label they place on the quit attempt when they return to smoking. They arrive for their counseling appointment with comments such as “I screwed up again,” “I messed up again,” “I guess I just can’t do it,” or “It’s just so hard; I don’t know if I can ever quit and stay stopped,” or other

similar comments expressing their frustration.

Tobacco recovery is a process and most people return to smoking several times before they become tobacco-free on a permanent, long-term basis. The best predictor of eventual success is continued attempts at cessation. That’s why it is so important to examine each quit attempt *regardless of the outcome* of the attempt. Each quit attempt is a valuable learning experience because the more times one abstains from smoking, the more practice one has at being a non-smoker. The longer the most recent quit attempt, the better the individual can remember the skills involved in being tobacco-free.

One of the tools I developed is called a “From Relapse to Recovery” worksheet (these worksheets are available to fellow professionals; see contact information below). The purpose of the worksheet is to help the client examine previous quit attempts and to learn from those experiences. The worksheet provides a way to help the client to view the quit attempt as a positive, information-gathering learning experience rather than as a failure.

The six-question worksheet includes the following areas:

1. (When) Identify the month and year of the quit attempt.
2. (How) Identify the method used to become tobacco-free, e.g., cutting down on the number of cigarettes smoked, changing brands, using nicotine replacement, obtaining prescription medication, counseling and/or alternative therapies.

3. (How Long) Identify the number of hours, days, weeks, months or years of tobacco-free time during the quit attempt.
4. (Recovery Maintenance) Identify the tools, skills and methods used to remain tobacco-free during this time.
5. (Relapse Occurrence) Identify the way the return to tobacco use occurred.
6. (The Most Important Issue) Identify what was learned from the quit attempt.

Clients are asked to fill out one of these worksheets for each previous quit attempt, as best as they can remember. Sometimes the act of completing a worksheet and writing (versus talking) about the quit attempt helps to trigger thoughts and memories of what worked and what didn’t work with a previous attempt. The purpose of completing a worksheet for each quit attempt is to identify any positive or challenging patterns which may emerge.

Positive patterns include remaining tobacco-free by use of certain tools, skills or strategies. Noting these positive patterns is consistent with the motivational speaker Tony Robbins’ message that “Success is not an accident. Success leaves clues. It is the result of consistent and logical patterns of action.”

Challenges include noting that relapse occurs every year around the anniversary of a loss or death; that the use of alcohol triggers smoking; that certain stressors serve as cues to return to smoking; or identifying any other patterns that the patient develops. These patterns provide important information for future relapse-prevention strategies.

Helping clients to learn from lapses and relapses reinforces the fact that tobacco recovery is a process instead of an event. Review of previous attempts can help the client recognize the progress made, lessons learned, skills acquired and tools gained with each attempt to quit.

By engaging clients in the process of this review, we actively remind them of the belief in their ability to become nicotine-free and our willingness to take this journey with them. Support is an important component of recovery. Swami Satchidananda, one of the most revered Yoga masters of our time, says that the difference between illness and wellness is that illness begins with “I,” and wellness begins with “We.”

Helping clients to learn from relapse encourages clients to keep trying, to not give up, and underscores the message that tobacco recovery is possible for everyone, regardless of the challenges they face.

*Corinne (Cory) Kalat, MS, LCPC, CADC, TAS, PCGC, is a Chicago-area counselor in private practice specializing in tobacco dependence and recovery. To obtain a copy of the “From Relapse to Recovery” Worksheet, please contact Cory crkalat@aol.com or www.crkalat.com.*

## Clinicians and Government Develop Tobacco Consensus

### Effective Strategies for Tobacco Cessation Exist but are Underused

By Mildred S. Morse, JD, CTAS, Founding Director, National Tobacco Independence Campaign

This summer, an independent panel of health professionals and public representatives was convened at the National Institutes of Health (NIH) during a three-day State-of-the-Science Conference on Tobacco Use, Prevention, Cessation and Control.

During the two-day public session, the panel considered several key areas including the results of a rigorous, systematic review of available literature on tobacco use, responded to questions raised and statements made by conference attendees, and participated in panel presentations about tobacco use, prevention and interventions.

Six main questions were considered by the panel:

1. What are effective community-based interventions to prevent tobacco use in diverse populations of adolescents and young adults?
2. What are effective strategies for increasing the use and demand of proven individual oriented cessation treatments, including among diverse populations?
3. What are effective strategies for increasing the implementation of proven tobacco use cessation strategies, particularly by healthcare systems and communities?
4. What is the effect of smokeless tobacco product marketing and use?
5. What is the effectiveness of prevention and cessation interventions in populations with co-occurring morbidities and risk behaviors?
6. What research is needed to make the most progress and greatest public health gains nationally and internationally?

After deliberating on these questions, a consensus was reached in each of the six areas which included these key points:

- Recognition that smokers must be motivated to want, to expect and to use tobacco use treatments.
- The need for a national, coordinated strategy for tobacco control that casts a wide net is needed to address the critical gap between available cessation interventions and the utilization of those interventions.
- Recognition that smoking cessation interventions/treatments such as nicotine replacement therapy, telephone quit lines and counseling are individually effective and even more effective in combination.
- Recognition that there is strong evidence to support the effectiveness of economic strategies such as increasing the costs of tobacco products through taxes and reducing out-of-pocket costs for effective cessation therapies.
- Mechanisms must be developed to ensure that effective interventions reach the people who need them most.



- The use of multiple approaches that include the use of mass media campaigns and price increases through taxes on tobacco products to prevent tobacco use in youth.
- While there currently is limited data about the impact of smokeless tobacco products on public health, they are nevertheless associated with numerous health risks, and their use may increase due to aggressive marketing.

One of the particularly encouraging results of the conference was the repeated references to nicotine as the highly addictive compound that should cause public demand for intervention services. Also encouraging was the relevance of the NAADAC National Certification Commission (NCC) Tobacco Addiction Specialist (TAS) credential that is consistent with the state-of-the-science as known today. One troubling aspect of the discussion at the State-of-the-Science Conference on Tobacco Use, Prevention, Cessation and Control was the apparent belief that only “clinicians” or “physicians” can or should provide tobacco use intervention services, including counseling. Several participants spoke on the floor of the conference, opposing such limits because they serve as a barrier to the full utilization of effective interventions by individuals who need service but lack access to a physician or clinician who has been trained to counsel on nicotine addiction.

Of the 44.5 million adult smokers in the United States, 70 percent want to quit and 40 percent make a serious quit attempt each year, but fewer than five percent succeed. Effective tobacco cessation interventions are available and could double or triple quit rates, but not enough smokers’ request, or are being offered, these interventions. Conferences like the one hosted this summer are a first step in a long process to deal with tobacco addiction.

Photo by Bruce Beh, April 6, 2006, and distributed by through the flickr.com creative commons agreement, 2006.

## Arizona Health Groups Go Directly to the Voters

By Joseph W. Cherner and Donovan Kuehn, NAADAC News Editor

After tiring of the Arizona legislature's refusal to pass smoke-free workplace legislation, Arizona health groups are taking their case directly to the voters. On Friday, the Arizona Secretary of State's Office approved petitions clearing the way for a ballot initiative in November 2006. The initiative would provide virtually all Arizona workers with a safe, healthy, smoke-free workplace.

The American Cancer Society, American Heart Association, American Lung Association and Arizona Hospital and Healthcare Association formally created the Smoke-Free Arizona campaign committee by filing official petition language to eliminate secondhand smoke in all enclosed public places and places of employment. The committee will be led by campaign chairman Bill J. Pfeifer, President and CEO of the American Lung Association of Arizona, as well as campaign treasurer John Rivers, President and CEO of the Arizona Hospital and Healthcare Association.

The initiative ensures that all offices, healthcare facilities, retail stores, licensed childcare facilities, sport arenas, hotel and motels, restaurants, bars and bowling alleys are smoke-free. It will not preempt local jurisdictions the ability to enact stronger tobacco control policies.

"We are launching a historic endeavor that will ensure that Arizonans have the opportunity to create a state free from the dangers of secondhand smoke," said campaign chair Pfeifer. "There should be no compromise when dealing with the dangerous effects of secondhand smoke. Whether an Arizonan works in an office building, a restaurant, or a bar, they deserve the right to breathe clean air."

"The Smoke-Free Arizona initiative will protect the health of all Arizonans, including children, seniors and those with existing health problems," said Pfeifer. "Each year approximately 52,000 Americans die from secondhand smoke and it remains a leading cause of preventable death in the United States. There is no safe level of exposure to secondhand smoke."



More than 4,000 chemical compounds have been identified in tobacco smoke, including arsenic, formaldehyde, cyanide, carbon monoxide, ammonia and nicotine. Exposure to these toxins causes heart disease, respiratory illness, cancer and chronic lung disease in adults. Secondhand smoke is especially harmful to children, causing respiratory illness, asthma attacks, pneumonia, ear infections, bronchitis, coughing and wheezing.

Smoke-Free Arizona will be fighting a competing proposal backed by R.J. Reynolds tobacco company. That proposal, misleadingly called the Arizona Non-Smoker Protection Act, would actually allow smoking in many locations and strike down all local smoke-free ordinances that are more restrictive than the state standard.

If your state legislature still hasn't passed smoke-free workplace legislation, maybe

it's time for your state's health groups to do like Arizona and take the issue to the voters.

To send a letter to your legislature, go to [www.smokefree.net/alerts.php](http://www.smokefree.net/alerts.php). For more information on the Smoke-free Arizona initiative, please visit [www.smokefreearizona.org/grassroots](http://www.smokefreearizona.org/grassroots). A partial list of supporters of the Smoke-free Arizona Initiative appear on the following page.

*Joseph Cherner is the President of SmokeFree Educational Services, Inc. and Founder of BREATHE (Bar and Restaurant Employees Advocating Together for a Healthy Environment). Formerly a bond trader at Kidder Peabody, Cherner gave up a lucrative career 15 years ago to fight the tobacco cartel for free. He was the expert financial witness in the Engle Class Action suit which resulted in the largest jury verdict in history (\$147 billion, currently on appeal). He has won many awards for his anti-smoking advocacy, including most recently, the New York City Department of Health and Mental Hygiene's Annual Award for Excellence.*

## Smoke-free Arizona Initiative Supporters

*Organizations and individuals who have endorsed the Smoke-free Arizona Initiative (as of 10/1/2006). See article on preceeding page.*

### Health Community

Allergy & Asthma Network Mothers of Asthmatics  
 American Academy of Pediatrics - Arizona Chapter  
 American Cancer Society  
 American College of Cardiology  
 American College of Chest Physicians - Arizona Chapter  
 American College of Emergency Physicians - Arizona Chapter  
 American College of Physicians - Arizona Chapter  
 American Diabetes Association  
 American Heart Association  
 American Lung Association of Arizona  
 Annual Arizona Red Ribbon Campaign  
 Arizona Academy of Family Physicians  
 Arizona Addiction Treatment Programs  
 Arizona Allergy and Asthma Society  
 Arizona Association of Community Health Centers  
 Arizona Asthma Coalition  
 Arizona Dental Association  
 Arizona Heart Institute  
 Arizona Hospital and Healthcare Association  
 Arizona Latin American Medical Association  
 Arizona Medical Association (ArMA)  
 Arizona Nurses Association  
 Arizona Osteopathic Medical Association  
 Arizona Pharmacy Alliance  
 Arizona Public Health Association  
 Arizona Rural Health Association  
 Arizona School of Dentistry & Oral Health  
 Arizona Society for Respiratory Care  
 Arizona Surgical Specialists Center  
 Arizona Thoracic Society  
 Arizona Urological Society  
 Arizonans Concerned About Smoking  
 Arizonans for Drug Free Youth & Communities  
 Art Mollen, D.O.  
 C. Everett Koop, M.D., Sc.D.  
 Catholic Healthcare West

Dale Webb, M.D.  
 Dental Team Council of the Arizona Dental Association  
 Dr. Bruce Miller, MD  
 Dynamic Chiropractic Acupuncture Clinic, P.C.  
 Family Assistance Program Y Su Clinica  
 Gary Rostan, D.O.  
 Gretchen K. Henson, DDS  
 HealthCare Connect  
 Healthy Arizona  
 Hopi Health Advisory Council  
 Hospice of the Valley  
 John C. Lincoln Health Network  
 La Loma Village  
 Las Fuentes Health Clinic  
 March of Dimes - Arizona Chapter  
 Maricopa County Asthma Coalition  
 Maricopa County Medical Society  
 Mayo Clinic Arizona  
 Medical Staff, Banner Desert Medical Center  
 Merlin K. DuVal, M.D.  
 Northern Arizona Nurse Practitioner Group  
 Paul Steingard, D.O.  
 Phoenix Children's Hospital  
 Pima County Medical Society  
 Praxair Healthcare Services  
 Schaller Anderson, Inc.  
 Scottsdale Healthcare  
 Southwest Autism Research & Resource Center  
 Sun Health  
 Sun Health La Loma Senior Living Services, Inc.  
 Translational Genomics Research Institute (TGen)  
 West Valley Hospital  
 Yuma County Medical Association  
 Yuma Regional Medical Center

### Business Community

Accurate Oxygen and Medical Supplies  
 Asian American Times  
 Axis Sports & Apparel  
 Chinese Chamber of Commerce  
 Colby and Company CPA's PLC  
 Colby Management, Inc.  
 CPC Construction, Inc.  
 Dana Tire Company  
 Doug Holloway, State Farm Insurance

Dukes Sports Bar and Grill  
 Elephant Bar Restaurant  
 Half Moon Sports Grill  
 Messinger Mortuary & Chapel, Inc.  
 Mrs. Whites Golden Rule Café  
 MyBizNow.com  
 Q Design  
 Randy's Restaurant and Ice Cream  
 Riester~Robb  
 Robson Communities Inc.  
 Southwest Ambulance  
 Southwest Gas  
 Southwest Valley Chamber of Commerce  
 Teakwoods Tavern & Grill  
 United Studios of Self Defense

### Community Leaders

Mayor Joan Shafer, Surprise  
 Mayor Keno Hawker, Mesa  
 Mayor Mary Manross, Scottsdale  
 Mayor Steven Berman, Gilbert  
 Mayor Wallace Nichols, Fountain Hills  
 Vice Mayor Claudia Walters, Mesa  
 Vice Mayor Steve Leal, Tucson  
 Former Vice Mayor Phillip Westbrooks, Chandler  
 Councilmember Betty S. Lynch, Avondale  
 Councilmember Brenda Holland, Goodyear  
 Councilmember Carol West, Tucson  
 Councilmember Donna Wallace, Chandler  
 Councilmember Ginny Dickey, Fountain Hills  
 Councilmember Greg Stanton, Phoenix  
 Councilmember James Norris, Casa Grande  
 Councilmember Jini Simpson, Paradise Valley  
 Councilmember Joe Severs, Apache Junction  
 Councilmember Kara Kelty, Flagstaff  
 Councilmember Kris Sippel, Apache Junction  
 Councilmember Richard Monzon, El Mirage  
 Councilmember Steven Frate, Glendale  
 Councilmember Tom Simplot, Phoenix

# Stopping Smoking During Pregnancy: One of the Most Important Things You Must Do

## Immediate Results Benefit the Mother and Baby

By Dottie Schell, BS, RN, NCTAS



The evidence is clear, when a woman quits smoking during pregnancy, her chances of having an uncomplicated pregnancy and healthy baby are dramatically increased. Should she continue to smoke, she is at risk for a miscarriage, ectopic pregnancy, placenta previa (where the

baby's placenta implants in the wrong part of a woman's uterus) or abruption of the placenta (where the placenta separates before the baby is born). The baby is at greater risk for being born low birth weight, dying from Sudden Infant Death Syndrome (SIDS) and having other medical problems after birth. Most of this is from the restricted blood flow to the placenta, increased carbon monoxide in the mother's blood system resulting in a reduction in oxygen, as well as the effects of over the 4,000 other chemicals in cigarette smoke on the mother and fetus.

As drug and alcohol counselors and other health care professionals, we must step up and help pregnant women quit smoking. It's important to do everything we can to help her quit. One tool that can be used is the five A's of intervention. This is a brief counseling cessation method that clinicians may use with tobacco users or recent quitters of any age, including those who are not interested in quitting, tobacco users who are interested but not ready, and those who are ready to quit.

The five A's are:

1. **Ask** about tobacco use at every patient visit.
2. **Advise** the tobacco user to quit in a clear, strong and personalized manner.
3. **Assess** the tobacco user's willingness to make a quit attempt.
4. **Assist** in the quit attempt through counseling and/or pharmacotherapy.
5. **Arrange** follow-up contact to monitor the patient's progress.

When time is very limited the program encourages providers to use the two A's and R—an abbreviated version of the five A's. Patients are **Asked** about tobacco use, **Advised** to quit and then **Referred** to the Quitline (1-800-Quit-Now) and/or community resources.

Studies indicate that by following these methods, clinicians can help up to 20% of pregnant smokers quit. Providing more intensive interventions will give even higher quit

rates. While higher quit rates are desired, these are positive results from an initial intervention. By addressing the issue of smoking in pregnant women, we are conveying the message that smoking in pregnancy is a major concern and it is possible for her to quit. We have to work with her, help her find the motivation to try and support her in all her efforts to quit.

Supporting pregnant patients in their efforts to quit includes helping to develop a treatment plan to assist her in her quit attempt. In addition, experts in the field recommend a comprehensive strategy that seeks to:

1. Utilize evidence-based quit smoking counseling by properly trained and motivated clinicians providing direct patient care.
2. Change office staff behavior to promote quit smoking messages by clinicians and non-clinical personnel.
3. Facilitate system change by supplementing these clinical approaches by medical record and clinician reminder systems, patient self-help materials, and pharmacotherapy, as medically appropriate.
4. Offer community based support services (e.g. Quitline, and/or intensive counseling and a state-wide media campaign to promote smoking cessation services).

A valuable resource for those looking help in treating nicotine addicted pregnant mothers is the Smoke Free Families' National Partnership to Help Pregnant Smoker's Quit. The Smoke Free Families website ([www.helppregnantsmokersquit.org](http://www.helppregnantsmokersquit.org)) provides an abundance of information. For further training, programs like Clean Air for Healthy Children and Families in Pennsylvania ([www.cleanairforhealthychildren.org](http://www.cleanairforhealthychildren.org)) can provide training on counseling and information on integrating the five A's into the course of your routine services or care. Click on the Resources and Links to learn about many tobacco use treatment and dependence resources and training programs. Finally, you can learn how to help your pregnant and reproductive aged patients quit smoking and stay quit with an easy-to-use, interactive, virtual clinic. The free virtual clinic can be downloaded from the Dartmouth Interactive Media Library at <http://iml.dartmouth.edu/education/cme/Smoking/install.html>.

The positive trends and results that result from the interventions of clinicians make the effort worth it.

*Dottie Schell, BS, RN, NCTAS, is the Program Director for Clean Air for Healthy Children and Families supported by Pennsylvania Chapter American Academy of Pediatrics. She can be contacted at [dschell@paaap.org](mailto:dschell@paaap.org) or 1-800.375.5217.*

# NAADAC Celebrates National Recovery Month

## Celebration, Recognition a Big Part of Recovery Month

By Donovan Kuehn, NAADAC News Editor

NAADAC was pleased to partner with its affiliates around the nation and the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) in hosting Recovery Month events throughout the nation. The events spanned the range of activity, from a recovery walk, and state-wide proclamation of Addiction professionals Day, dancing in the streets and an open house at the NAADAC offices in Alexandria, Virginia.

Below is a list of selected 2006 events that took place throughout the nation.

### August 25th

Peggy Beltrone, Chairperson of the Cascade County Commission in Cascade County, Montana, proclaimed National Alcohol and Drug Addiction Recovery Month, in celebration of Recovery Month, thanks to the hard work of NAADAC Past President Roger Curtiss, NCAC II, LAC, and the Montana Association of Alcoholism & Drug Abuse Counselors (MAADAC).

### September 7th–10th

NAADAC, the Association for Addiction Professionals, and its Massachusetts affiliate MAADAC (Massachusetts Association for Alcoholism and Drug Abuse Counselors), brought the message of community outreach and stressed the importance of Workforce Development to one of the nation's most renowned conferences on addiction—the Cape Cod Symposium on Addictive Disorders in Cape Cod, Massachusetts. NAADAC participants included Mary R. Woods, RNC, LADC, MSHS, President of NAADAC, and MAADAC's President Peter Crumb and Treasurer Linda Mullis.

### September 8th

Speaking on Workforce Development: Challenges for the Future at the Journey Together 2006 conference in Nashville, Tenn., was NAADAC Executive Director Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP. The Journey Together



**On-field recognition at the September 17, 2006 baseball game at RFK Stadium in Washington, DC. 26,000 fans saw representatives from NAADAC, the Johnson Institute, Faces and Voices of Recovery and the Central East Addiction Technology Center recognized for their contributions.**

conference brought together professionals working with substance abuse prevention and treatment. At the conference, participants explored a variety of topics related to the medical, psychological and familial aspects of the disease of addiction and shared knowledge, expertise and resource networking. The 2007 conference will be co-hosted with NAADAC.

### September 12th–13th

Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, Execu-

tive Director of NAADAC, the Association for Addiction Professionals, spoke on current challenges facing the addiction professional workforce at the premier training event for North Dakota addiction professionals—the 2006 North Dakota Alcohol & Substance Abuse Summit sponsored by the North Dakota Department of Human Services, Division of Mental Health & Substance Abuse Services.

### September 15th

The Wellness In Nenana Coalition presented Dancing in the Street with a parade, community dinner and sober street dance. NAADAC, the Association for Addiction Professionals, and its Alaska affiliate, the Alaska Chemical Dependency Counselor Association (ACDCA), brought the message of celebration and recovery to the community celebration and provided unique community outreach materials. The event was co-organized by ACDCA President Traci Wiggins.

### September 17th

At a pre-game celebration before a Washington Nationals baseball game, NAADAC, the Association for Addiction Professionals, the Johnson Institute and the Central East Addiction Technology Transfer Center joined together to celebrate Recovery Month in front of a crowd of 26,000 people at RFK Stadium. The on-field recognition included Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, NAADAC Executive Director and Johnny Allem, Executive Director of the Johnson Institute (see picture above).

**(Recovery, continued on page 16)**

(Recovery, continued from page 15)

### September 17th

NAADAC, the Association for Addiction Professionals, and its Nebraska affiliate, the Nebraska Association of Alcoholism & Drug Abuse Counselors, joined with the Nebraska Recovery Network to bring a message of celebration and recovery to the community and provided unique community outreach materials. The Walk for Recovery was held at the Nebraska State Capitol and NAADAC Regional Vice President Jack W. Buehler, MA, LADC, LMHP, NCAC II, SAP addressed the crowd of 200 (see pictures below).

### September 20th

NAADAC celebrated Addiction Professionals' Day by hosting an open house as part of the national celebration of Recovery Month. The NAADAC office serves 85,000 addiction professionals throughout the United States and the world. NAADAC speakers included Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, Shirley Beckett Mikell, NCAC II and other members of the NAADAC staff.

### September 20th

Members of the Tennessee Association of Alcoholism & Drug Abuse Counselors (TAA-DAC) gathered in Chattanooga to celebrate Addiction Professionals' day. NAADAC speakers included David Cunningham,

LADAC, NCAC I, QSAP and former President of TAA-DAC Cindy Black.

### September 20th

The Hon. Jim Doyle, Governor of Wisconsin, proclaimed September 20th Addiction Professionals Day, in celebration of Recovery Month, thanks to the hard work of J. Wolfgang Wallschlaeger, President of the Wisconsin Association of Alcohol & Drug Abuse Counselors (WAADAC) and the members of WAADAC.

### September 20th

The Hon. Dona Stebbins, Mayor of Great Falls, Montana, proclaimed September 20th Addiction Professionals Day, in celebration of Recovery Month, thanks to the hard work of NAADAC Past President Roger Curtiss, NCAC II, LAC, and the Montana Association of Alcoholism & Drug Abuse Counselors (MAADAC).

### September 20th

David Harris, President of the Chemical Dependency Professionals of Washington State (CDPWS), worked in partnership with the Asian Community of Recovery Network (ACORN) to talk about NAADAC and its initiatives at ACORN's Recov-

ery Information and Education Fair. The Fair targeted the Asian Pacific American community and had tables on community resources for those in recovery and provided an opportunity for peers, their family members and the broader community to mingle and celebrate together in a safe environment.

### September 22nd

The National Recovery Month Event "Responding to Addiction, New Treatment Methodologies" was sponsored by Long Island Recovery Advocates (LIRA) and Nassau Community College and supported by NAADAC, the Association for Addiction Professionals and its New York affiliate the Association for Addiction Professionals of New York (AAPNY). The event, held at Nassau Community College, featured a special screening of the NAADAC video "Imagine Who You Could Save." NAADAC Regional Vice President Edward L. Olsen, LCSW, CASAC, SAP spoke at the event.

### September 29th

Henry Lozano from the President's Advisory Commission on Drug-Free Communities, White House Office of National Drug Control Policy, California Assembly member Hector de la Torre and Warren Daniels, CADC II, NCAC I, ICADC, President of the California Association of Alcoholism & Drug Abuse Counselors spoke at the CAADAC reception, which was a part of the NAADAC, CAADAC and NALGAP annual conference.



People gather at the Nebraska legislature in Lincoln to celebrate Recovery Month with a walk and moment of silence, July 17, 2006. At the event, NAADAC Regional Vice President Jack W. Buehler (right) addresses the crowd.





# Job Opportunities!

## Selections from the NAADAC Career Classifieds

*For more information on this program, visit [www.naadac.org](http://www.naadac.org) and click on "Employment."*

### MARYLAND

#### Clinical Director – Adolescent Residential Treatment (posted September 28, 2006)

Mountain Manor Treatment Center is a 70-bed facility providing residential treatment for substance abuse and co-occurring disorders. Program tracks are adolescent, young adult and a long-term step-down group home for girls. Our continuum of care includes outpatient services, a special education school and a mental health clinic. In addition, there are teaching opportunities, an active research program and the opportunity to work with an enthusiastic and dedicated multi-disciplinary team.

The preferred candidate will be a master's or doctoral level clinician with a strong record of adolescent program leadership and evidence based treatments. Minimum Maryland certification of CCS or LCADC.

Our Baltimore City location provides easy access to both the city and the surrounding communities, as well as to the Philadelphia and Washington metro areas and to mountain and seashore vacation destinations.

Full details at [www.naadac.org](http://www.naadac.org) or for immediate consideration, please email your resume with salary requirements to N. Craig Cutter, Corporate Director, Human Resources at [nraigc@msn.com](mailto:nraigc@msn.com) or fax to 410.233.4290. EOE.

### NEW JERSEY

#### Female Counselors for Long-Term Residential Addiction Treatment (posted September 28, 2006)

Strong clinical background in counseling, behavior management and case management of alcoholic/drug addicted women. Understanding of disease of addiction, principles of recovery, behavioral management and dual diagnosis is required. Must be able to build and sustain a therapeutic relationship, possess solid communication skills with an ability to operate in confrontational manner when necessary. Understanding and or experience with AA/NA fellowships. Treatment services clinically driven—not subject to managed care restrictions.

Minimum requirements—bachelor's degree, CAC, LCADC or equivalent credential.

- Salary – competitive salary based on experience
- Benefits – fully funded by foundation
- 8–10 patient case-load
- 7–11 month average length of stay
- Relevant addiction documentation (not JCAHO or insurance driven)
- In-residence family program
- Separate programming for males and females
- Excellent multi-disciplinary staff of ASAM certified psychiatric, medical and psychological staff

Full details at [www.naadac.org](http://www.naadac.org) or e-mail [jeannetteg@alinalodge.org](mailto:jeannetteg@alinalodge.org)

### CALIFORNIA

#### County of Santa Barbara, Alcohol, Drug and Mental Health Service Coordinator (posted September 22, 2006)

The ADMHS Dept. of Santa Barbara County is looking for a ADMHS Service Coordinator based in the beautiful city of Santa Barbara. This position will pay approx. between \$3,856–\$4,708 per month, DOE.

In this position you will:

- assess existing needs for and oversee the development, implementation, monitoring, and evaluation of community-based alcohol and drug abuse prevention and treatment programs and services;
- provide best practice guidance and technical consultation to colleagues, local communities, contract service providers, and public sector agencies;
- conduct data analysis and prepares system-oriented reports; performs related duties as required.

You will work within a system of interdisciplinary departmental teams and/or contract service agencies providing assessment, prevention, intervention, treatment, and related ancillary support services via an integrated service delivery system to people with alcohol and other drug-related problems, mental illness, and/or co-occurring conditions.

To qualify, you need to meet the following standards:

1. possession of a bachelor's degree in the behavioral or social sciences or a closely related subject and three years of experience coordinating an organization's prevention or treatment efforts or supervising client-related services to persons experiencing alcohol or drug dependency; or,
2. possession of a master's degree in the health or social sciences or a closely related field and two years of experience coordinating an organization's prevention or treatment efforts or supervising client-related services to persons experiencing alcohol or drug dependency; or,
3. one year of experience performing duties equivalent to an Alcohol and Drug Service Specialist with Santa Barbara County; or,
4. combination of training, education, and experience that is equivalent to one of the employment standards listed above and that provides the required knowledge and abilities.

Full details at [www.naadac.org](http://www.naadac.org) or to apply visit [www.sbcountyjobs.com](http://www.sbcountyjobs.com)



# NAADAC

THE ASSOCIATION FOR  
ADDICTION PROFESSIONALS

www.naadac.org

901 N. Washington Street, Suite 600  
Alexandria, Virginia 22314-1535  
1-800-548-0497 • 703-741-7686  
Fax 1-800-377-1136 • 703-741-7698

**“Earning the title of ‘professional’ carries responsibilities as well as privileges. As a member of NAADAC, I have enjoyed both. The responsibilities include keeping current with issues about the profession through my national organization. Membership allows me to have a voice when decisions are made about my career, my profession and my legal and ethical responsibilities. NAADAC is the ONLY organization representing the addiction profession at the table in Washington, DC. Let it be your voice as well as mine. Join today.”**

—Sharon Morgillo Freeman, PhD, APRN-CS, NAADAC President

## NAADAC NEW MEMBER APPLICATION

PLEASE PRINT CLEARLY.

**MEMBER INFORMATION**  Ms.  Mr.  Dr.

NAME \_\_\_\_\_

HOME or  WORK ADDRESS (preferred address for all association mailings)

CITY/STATE/ZIP \_\_\_\_\_

\*E-MAIL (E-mail address is required to receive NAADAC's bi-monthly newsletter, NAADAC News.)

YES! Sign me up for the e-LAN (e-mail Legislative Alert Network; an e-mail address is required.)

WORK PHONE \_\_\_\_\_

HOME PHONE \_\_\_\_\_

FAX \_\_\_\_\_

NAADAC RECRUITER'S NAME AND MEMBER # (not required for membership)

**MAIL YOUR APPLICATION WITH CHECK TO:**  
NAADAC

901 N. Washington Street, Suite 600  
Alexandria, VA 22314-1535

**FAX YOUR APPLICATION WITH CREDIT CARD INFORMATION TO:**  
800/377-1136 or 703/741-7698

### 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  \$200  \$300  Other \$ \_\_\_\_\_

**Total Amount Enclosed** \$ \_\_\_\_\_

\*\*If you are paying NAADAC dues by company check, you must enclose 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

CREDIT CARD NUMBER \_\_\_\_\_ EXP. DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

Please send me more information.

DUES RATES	Full	Student (Proof of status MUST accompany application)
Alabama:	\$110	\$57.50
Alaska:	\$120	\$67.50
Arizona:	\$120	\$47.50
*Arkansas:	\$85	\$42.50
California:	\$210	\$67.50
Colorado:	\$135	\$57.50
Connecticut:	\$135	\$57.50
Delaware:	\$85	\$50
District of Columbia:	\$135	\$57.50
Florida:	\$135	\$57.50
Georgia:	\$145	\$62.50
Hawaii:	\$105	\$42.50
Idaho:	\$110	\$42.50
Illinois:	\$115	\$47.50
Indiana:	\$135	\$67.50
Iowa:	\$115	\$47.50
Kansas:	\$180	\$57.50
Kentucky:	\$110	\$47.50
*Louisiana:	\$85	\$42.50

DUES RATES	Full	Student (Proof of status MUST accompany application)
Maine:	\$115	\$50
Maryland:	\$125	\$62.50
Massachusetts:	\$130	\$54.50
Michigan:	\$140	\$60.50
*Minnesota:	\$85	\$42.50
Mississippi:	\$130	\$65
Missouri:	\$98	\$40
Montana:	\$115	\$47.50
Nebraska:	\$117	\$54.50
Nevada:	\$115	\$55
New Hampshire:	\$115	\$47.50
New Jersey:	\$135	\$52.50
New Mexico:	\$115	\$47.50
New York:	\$145	\$62.50
North Carolina:	\$120	\$49.50
North Dakota:	\$115	\$52.50
Ohio:	\$120	\$57.50
*Oklahoma:	\$85	\$42.50
Oregon:	\$120	\$67.50

DUES RATES	Full	Student (Proof of status MUST accompany application)
Pennsylvania:	\$110	\$57.50
Rhode Island:	\$125	\$57.50
South Carolina:	\$120	\$52.50
South Dakota:	\$110	\$52.50
Tennessee:	\$105	\$42.50
Texas:	\$145	\$62.50
Utah:	\$130	\$57.50
Vermont:	\$135	\$62.50
Virginia:	\$135	\$52.50
Washington:	\$125	\$42.50
West Virginia:	\$120	\$50
Wisconsin:	\$125	\$42.50
*Wyoming:	\$85	\$42.50
Other:	\$85	Not available

\*State affiliate membership not available in Arkansas, Louisiana, Minnesota, Oklahoma and Wyoming.

Dues subject to change without notice. 10/06

56 of your membership dues have been allocated to the magazine and this amount is non-deductible. NAADAC estimates that 8% of dues payment is not deductible as a business expense because of NAADAC's lobbying activities on behalf of members. Dual membership required in NAADAC and state affiliate. You will receive services upon receipt of application and payment; please allow 4-6 weeks for initial receipt of publications. Membership in NAADAC is not refundable. From time to time, we share our members' postal addresses with other companies who provide services that we feel are a benefit to the addiction professional. We carefully screen these companies and their offers to ensure that they are appropriate and useful for you. NN10/06

# NAADAC Bookstore Top Picks

## So Much to Document, So Little Time

By Misti A. Storie, MS, Education and Training Consultant

Working within the addiction services profession requires a great deal of documentation, and it is no secret that addiction counselors spend at least 50 percent of their day immersed in paperwork. As the title implies, *The Addiction Counselor's Documentation Sourcebook: The Complete Paperwork Resource for Treating Clients with Addictions, Second Edition*, by James R. Finley and Brenda S. Lenz, is a one-stop resource for clinical documentation. This *Documentation Sourcebook* includes over 70 forms for every aspect of treatment ranging from referral, intake and assessment, treatment planning, and discharge. It also includes specific templates for informed consent, behavioral contracts, group therapy progress notes, client encounter summary log sheet, treatment termination warning/notification, disclosure tracking log, and many more.

To make the integration easier, *The Addiction Counselor's Documentation Sourcebook* includes a CD-ROM with each standardized form in a Microsoft Word format so that it is quickly customizable and editable. The CD-ROM also includes comprehensive psychoeducational PowerPoint presentations concerning addiction treatment, as well as unique handouts, exercises, and facilitator guides for use in individual and/or group therapy.

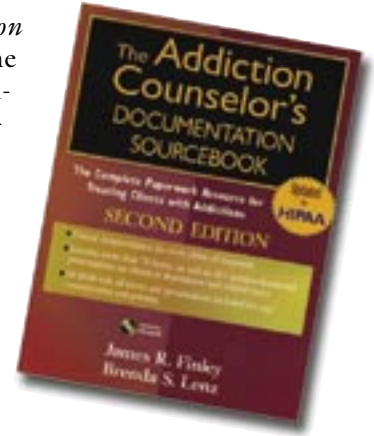
*The Addiction Counselor's Documentation Sourcebook* is ideal for any addiction counselor, private practice, or treatment center struggling to comply with HIPAA, JCAHO, and/or CARF regulations, while still managing a full

caseload. The *Documentation Sourcebook* aims to reduce the amount of time spent on repetitive documentation and to ensure complete record keeping. With its help, more time can be spent on patient treatment, instead of documenting previous interactions.

*The Addiction Counselor's Documentation Sourcebook: The Complete Paperwork Resource for Treating Clients with Addictions, Second Edition* is available for order through NAADAC's Education and Training Center at [www.naadac.org](http://www.naadac.org) or by calling 800.548.0497.

Regular Price: \$50.00

**Member Discounted Price: \$38.50**



NAADAC is constantly searching for the best resources available to help educate professionals about the varying facets of addiction. If you have developed or use a product that has been remarkably helpful to your practice and the patients we serve, NAADAC would like to know about it. Please email [mstorie@naadac.org](mailto:mstorie@naadac.org) with a brief description to initiate a review.

## NAADAC Adolescent Counselors Endorsement to Launch in 2007

By Shirley Beckett Mikell, NCAC II, SAP, NAADAC Deputy Director

The NAADAC Adolescent Committee, in conjunction with the NAADAC National Certification Commission (NCC) plan to release the NAADAC Adolescent Counselor Endorsement (ACE) early in the new year. This endorsement is intended to promote credentialed and licensed counselors whose primary practice is with youth and adolescents. A new set of criteria, educational and training requirements and examination are in the final stages of development.

Members of the NAADAC Adolescent Committee: Chris Bowers and Denise Pyle Hall of Richmond, Virginia, Tiffany Howard of Salisbury, Maryland, Steven Durkee of Crestview Hills, Kentucky, and Margie Tabor



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[www.naadac.org](http://www.naadac.org)

of Marion, New York, have been the primary contributors to this process. These names may be familiar to readers of the *Addiction Professional* magazine, as all of them have contributed columns on adolescents.

These members have donated a great deal of their time, energy and expertise and are all engaged in adolescent treatment.

The endorsement is intended to promote credentialed and licensed counselors whose primary practice is with youth and adolescents.

Look for a formal announcement on the NAADAC website at [www.naadac.org](http://www.naadac.org) and in future editions of the *NAADAC News*.

**YEAR 2006****November 17-18 State of Nevada Association of Addiction Professionals**

New Challenges in the Field of Addictions  
UNLV campus, Las Vegas, Nevada  
More details 702.243.0686 ext 2,  
adrienneft@cox.net, j\_landero@hotmail.com or  
register on-line at www.snapp.net.

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

**YEAR 2007**

**January 25-27 NOVA 2007 Conference**  
25.5 Continuing Education Credits available  
Dallas, Texas  
More details at <http://dallasnova.bravehost.com>.

**February 1-March 1 Nominations Open for NAADAC RVP Elections**  
More details at [www.naadac.org](http://www.naadac.org) or contact NAADAC  
at [naadac@naadac.org](mailto:naadac@naadac.org) or 1-800.548.0497.

**March 4-7 NAADAC Public Policy Conference**  
Doubletree Hotel Crystal City-National Airport  
Arlington, Virginia  
More details at [www.naadac.org](http://www.naadac.org) or contact NAADAC  
at [naadac@naadac.org](mailto:naadac@naadac.org) or 1-800.548.0497.

**March 8-15 NCAC I/ NCAC II/ MAC Exam**  
The Professional Testing Corporation (PTC) provides  
NAADAC approved certification testing.  
More details at www.ptcny.com.

**April 1-30 Voting period for the 2007 NAADAC Elections**  
More details at [www.naadac.org](http://www.naadac.org) or contact NAADAC  
at [naadac@naadac.org](mailto:naadac@naadac.org) or 1-800.548.0497.

**June 7-14 NCAC I/NCAC II/MAC Exam**  
The Professional Testing Corporation (PTC) provides  
NAADAC approved certification testing.  
More details at [www.ptcny.com](http://www.ptcny.com).

**June 21-23 2007 TAAP State Conference**  
Omni San Antonio Hotel  
San Antonio, Texas  
More details at [www.taap.org](http://www.taap.org).

**September 5-8 NAADAC Annual Conference held in association with the Tennessee Association of Alcoholism & Drug Abuse Counselors (TAADAC)**  
Nashville, TN  
More details at [www.naadac.org](http://www.naadac.org) or contact NAADAC  
at [naadac@naadac.org](mailto:naadac@naadac.org) or 1-800.548.0497.

**September 6-3 NCAC I/ NCAC II/ MAC Exam**  
The Professional Testing Corporation (PTC) provides  
NAADAC approved certification testing.  
More details at www.ptcny.com.

**October 3-7 California Association of Alcoholism & Drug Abuse Counselors**  
27th Annual Conference  
Sacramento, CA  
More details at [www.caadac.org](http://www.caadac.org).

**December 6-13 NCAC I/NCAC II/MAC Exam**  
The Professional Testing Corporation (PTC) provides  
NAADAC approved certification testing.  
More details at www.ptcny.com.

**YEAR 2008**

**September 2008 NAADAC Annual Conference held in association with the Kansas Association of Addiction Professionals (KAAP)**  
Overland Park, KS  
More details at [www.naadac.org](http://www.naadac.org) or contact NAADAC  
at [naadac@naadac.org](mailto:naadac@naadac.org) or 1-800.548.0497.

Have an event we should know about?  
Contact 1-800.548.0497, ext. 125 or e-mail [dkuehn@naadac.org](mailto:dkuehn@naadac.org).

**NAADAC News**

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