HEALTH REFORM: What it Means for Addiction Professionals
Special Feature
Pages 15–18
The Heat is Rising
“Laws are like sausages, it is better not to see them being made.”

– Otto von Bismarck
First Chancellor of the German Empire.

The temperature of the health care debate in Washington, D.C. has risen, and there has been seemingly endless discussion of health care reform. But what are the implications for addiction professionals as the discussions move forward?

Daniel Guarnera has read through the proposed legislation and looks at what it may mean for addiction professionals. As Bismarck alluded to in his quote above, the final legislation may look different than how it is currently written up, but I believe it is helpful to see what the implications may be for the profession as the new law winds its way through the legislative process.

I hope your holidays are safe and satisfying and wish you the best for 2010. Enjoy the issue!

Donovan Kuehn

NAADAC News Editor
dkuehn@naadac.org

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NAADAC-NAATP Public Policy Committee Co-Chairs
Gerry Schmidt, MA, LPC, MAC
Ken Ramsey, PhD

Because of the heavy workload of NAADAC News, Letters, Comments, and Articles are welcome, not required. All submissions are subject to approval by the editor. Either hard copy or email submissions are accepted. All material submitted for publication must be original and not published elsewhere. NAADAC News reserves the right to edit submissions for content, style, and length. NAADAC News is not responsible for return of submitted material. NAADAC News is published 12 times a year (every second Wednesday). Content deadlines are 2 weeks prior to the publication date.


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Investing in the Future
Your Contribution can Make a Difference

Patricia M. Greer, BA, LCDC, AAC, NAADAC President

It’s hard to believe that 2009 is winding down, and 2010 is just a few weeks away. However, one thing doesn’t change: the rewards and challenges of working in our profession.

The NAADAC Education and Research Foundation (NERF) has worked to help NAADAC’s members through these challenging times in a number of ways:

1. Providing 41 scholarships to new and hard-hit professionals so they could attend the NAADAC Sowing the Seeds of Recovery conference and earn the continuing education credits they need to retain their credentials.

2. Helping disseminate new information on pharmaceutical research, clinical approaches and data about the prevalence of substance abuse keeps flowing to our professionals, in partnership with our business and government partners.

3. Helping new professionals in the United States and overseas understand the core principles of addiction prevention, intervention and treatment practice through mentoring and the establishment of professional training and certification boards.

As we face 2010, our challenge in a difficult economic climate is to sustain our current progress and to develop potential relationships into partnerships. In order to accomplish this, we would like to ask for your help. As a member of NAADAC, you have an important role in the future of the foundation’s efforts. We are asking you to partner with NERF in helping make a difference in the lives of your fellow professionals.

10 for 2010 Initiative
For the upcoming year, we are asking you, the members for a modest, $10 tax-deductible contribution to the NERF.

You may donate over the phone, by calling 800.548.0497, give electronically at our Web site www.naadac.org/give or you can send a check or money order to the NERF at 1001 N. Fairfax Street, Suite 201, Alexandria VA 22314.

We recognize that the economy has hit many people very hard — if you have the ability to give a larger contribution, we would welcome it! Also, the first $1,000 will be matched by a generous donor, so if you are an early contributor, your donation will be doubled.

We thank you for your service to our profession, and welcome your partnership in planning for the future of NAADAC. May your upcoming holidays be filled with joy and gratitude for all of your blessings. Thank you!

What is the NERF?
The NAADAC Education and Research Foundation (NERF) is a registered 501(c)3, non-profit organization focused on the promotion of education and research for the addiction-focused profession. Donations to the NERF are tax-deductible.

In 2008, there were 81 donors who gave a total of $2,596.50 to the NAADAC Education and Research Foundation. The average donation to the NERF was $32.06.

In 2008, the NERF provided $32,000 of scholarship money and facilitated $32,000 of donations to the NAADAC building campaign.

Through cumulative grants and proposals, the NERF also provided $575,000 of funding to national and local education and training programs.
NAADAC Elections Provide the Opportunity to Lead
Participate and Make Something Extraordinary Happen
Roberta Taggart, NCAC II, NAADAC Elections and Nominations Chair

Open Positions
Every two years, members of NAADAC, the Association for Addiction Professionals, have the opportunity to select the officers who will determine the direction of the association. In April of 2010, NAADAC members will be voting on officers of the Executive Committee (President-Elect, Secretary and Treasurer), as well as four Regional Vice Presidents. All positions are for two-year terms.

PRESIDENT-ELECT
Represents all NAADAC members.
The President-Elect becomes the President of NAADAC after serving his or her term and performs the President’s duties if the President is absent or disabled.

Candidates
1. Must be a current member in good standing of NAADAC (Active Membership).
2. Must have been actively engaged in the addiction profession for the past two years.
3. Must have two years of Board of Directors experience on either the NAADAC Board of Directors or a NAADAC Affiliate Board, and chaired a NAADAC committee, or served as a Commissioner on the NAADAC Certification Commission.

TREASURER
Represents all NAADAC members.
The Treasurer shall report on the finances of the association and shall develop and review the fiscal policies, review of the annual budget and serve as Chair of the Finance Committee

Candidates
1. Current member in good standing of NAADAC.
2. Must have been actively engaged in the addiction profession for the past two years.
3. Must have two years of Board of Directors experience on either the NAADAC Board of Directors or a NAADAC Affiliated Board, and chaired a NAADAC committee, or served as a commissioner on the NAADAC Certification Commission.

SECRETARY
Represents all NAADAC members.
The Secretary for keeping and preserving the oversight of meeting records in the books of the Association, and distribution of true minutes of the proceedings

Candidates
1. Must be a current member in good standing of NAADAC (Active Membership).
2. Must have been actively engaged in the addiction profession for the past two years.
3. Must have two years of Board of Directors experience on either the NAADAC Board of Directors or a NAADAC Affiliated board, chaired a NAADAC committee, or served as a Commissioner on the NAADAC Certification Commission.

Nominee/Election Information
Only members in good standing who have been actively engaged in work in addiction counseling or as an addiction professional for at least two years immediately prior to nomination shall be eligible for an elective office with NAADAC.

Nominees for the position of Regional Vice President must represent a state wherein an Affiliated State Association is in place and may only be nominated for a region in which they reside. Candidates can serve two consecutive terms.

The Committee seeks nominations from the membership. All nominations must be submitted no later than February 15, 2010.

For more information on NAADAC’s elections, to find job descriptions for the NAADAC executive positions or to download a nomination form, please visit www.naadac.org. For more specific information, please call 800.548.0497, ext. 125 or e-mail dkuehn@naadac.org. Please put “NAADAC Elections” in the subject line.

Roberta Taggart, NCAC II, serves as the NAADAC Elections and Nominations Chair.
Campaigning Guidelines

Information on candidates will appear in the April issue of the NAADAC News and the NAADAC website, www.naadac.org. There should be no other campaign activities by the candidates. Any written materials, except materials produced and distributed by NAADAC, are prohibited. This includes self-initiated articles for publication in state or local professional publications or editorial comments submitted in any of those publications as well. All ballots are sent directly to an independent auditor.

The Auditor counts ballots and notifies a NAADAC designated staff person and the Chair of the Nomination and Elections Committee who has received the most votes for each office. The Chair of the Nomination and Elections Committee must notify all candidates of the results by the deadline below. Election ballots are destroyed 30 days after all candidates are notified of the election results. Any candidate challenging the results of an election must notify the Chair of the NAADAC Nominations and Elections Committee within 30 days of the balloting.

This is an exciting opportunity to get involved in the NAADAC election process and have your voice heard as a national leader. NAADAC’s members are key to the promotion and improvement of the addiction profession.

Nomination Timeline

1. Candidates seeking office must complete an official nomination form and submit it to the NAADAC Nominations and Elections Committee on or before February 15, 2010. It is the responsibility of the candidate to ensure that his or her nomination has been received.

2. Candidates will be notified by the Chair of the Nominations and Elections Committee of the acceptance or rejection of their application.

3. A slate of candidates who meet the specific qualifications of the office they are seeking will be featured in the April 2010 issue of the NAADAC News.

Election Timeline for 2010

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<th>Date</th>
<th>Event Description</th>
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<tr>
<td>April 1</td>
<td>Ballots will be sent to all NAADAC members in good standing.</td>
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<tr>
<td>April 7</td>
<td>Ballot packet arrives in your mailbox.</td>
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<td>April 30</td>
<td>Mailed ballots must be postmarked by this date to be valid. Online ballots must be cast by 11:59 pm.</td>
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<tr>
<td>May 21</td>
<td>The NAADAC President and all candidates will be notified of the election results by the Nominations and Elections Committee Chair.</td>
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<td>June 1</td>
<td>Deadline for appeals to the Nominations and Elections Committee by candidates.</td>
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If you do not receive a ballot packet by April 7, 2010, please contact Donovan Kuehn at 800.548.0497, ext 125 or dkuehn@naadac.org.

Regional Vice Presidents

Regional Vice Presidents provide regional identity and facilitate communication between states and NAADAC. Vice Presidents will be elected for four regions:

Mid-Atlantic Regional Vice President

Represents New Jersey, Delaware, Pennsylvania, Virginia, the District of Columbia, Maryland & West Virginia.

Mid-South Regional Vice President

Represents Arkansas, Louisiana, Oklahoma & Texas.

Northeast Regional Vice President

Represents Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island & Vermont.

Northwest Regional Vice President


Candidates

1. Must be a current member in good standing of NAADAC.
2. Live in the region represented.
3. Have two years of experience on either the NAADAC Board or a NAADAC Affiliate (State/Chapter/International Association) Board.
4. Must have been actively engaged in the profession of addiction for the past two years.
In September 2010, the NAADAC Annual Conference and the SECAD Conference will merge to form The National Conference on Addiction Disorders. A first conference of its kind, it will provide an opportunity for addiction professionals from around the country to collaborate, exchange ideas, and network with their peers.

With over 60 sessions ranging from addiction and counselor specific topics to administrative, technology, and infrastructure programs, this conference will tackle the most critical issues in treatment programs and facilities.

Join the most influential organizations in the addiction field, and learn about cutting-edge treatment facilities, programs, and best-practices. So, mark your calendar and don’t miss this industry-changing event!

www.NCAD10.com will be coming soon!
Bachmeier Honored

Will Bachmeier, a Lutheran Social Services (LSS) of North Dakota Gamblers Choice counselor in Minot, was named “Counselor of the Year” by the North Dakota Addiction Counselor Association and the North Dakota Addiction Treatment Coalition during the Substance Abuse Summit in Bismarck.

The award was given in recognition of Bachmeier’s outstanding contributions to the addiction profession and his dedication to helping people in North Dakota.

Bachmeier began working at LSS in January of 2005. He is a nationally certified gambling and addiction counselor and has served on numerous state and national boards including the North Dakota Addiction Counselors Association, NAADAC, the Association for Addiction Professionals, the North Dakota Treatment Providers Coalition and the North Dakota Council for Compulsive Gambling.

Congratulations Will, we appreciate your dedication to helping problem gamblers and their families.

TAADAC Winners

TAADAC announces its annual award winners (from the TAADAC Newsletter. For more info, contact taadac@gmail.com).

TAADAC
Counselor of the Year Anita Wilson
Professional of the Year Lori Martin
President’s Trophy Dennis Riddle
Lifetime Achievement Award Martha Rogers-Hornsby

ETAADAC
Counselor of the Year Keith Farrar
Professional of the Year Lori Martin
Lifetime Achievement Award Martha Rogers-Hornsby

MTAADAC
George M. Allen Counselor of the Year Anita Wilson
Professional of the Year Alex Leonard
Lifetime Achievement Award Dr. Anderson Spickard

SETAADAC
Counselor of the Year Darcey Nevin
Professional of the Year Jean Davis
Bob Barr Lifetime Achievement Award Yvonne Findley

New SAMHSA Web Site Provides Tools to Help Address Co-Occurring Disorders and Homelessness

The Substance Abuse and Mental Health Services Administration (SAMHSA) today announces the availability of a new Web site to help SAMHSA grantees, health professionals and the public address problems of homelessness and co-occurring substance abuse and mental health disorders. The site, http://chab.samhsa.gov features an on-line library of tools that are designed to advance the field and improve the effectiveness of prevention, treatment and recovery programs operated by SAMHSA’s Co-Occurring and Homeless Activities Branch (CHAB) and other service providers.

The new CHAB Web site provides a platform for creating an interactive community of providers, consumers, policymakers, researchers, and public agencies at federal, state, and local levels working to prevent and treat homelessness and co-occurring substance abuse and mental disorders.

“Persons who are homeless often have to contend with a wide range of issues including medical, pharmacological, and psychiatric issues, substance use, and other disabling conditions,” said SAMHSA Acting Administrator Eric Broderick, D.D.S., M.P.H. “The CHAB Web site provides valuable new tools to develop more comprehensive and effective means for serving this population.”

Nationally, the CDC recorded approximately 45,000 traffic-related deaths and 39,000 drug-related deaths. The 16 states with the highest drug fatalities are Colorado, Connecticut, Illinois, Maryland, Massachusetts, Michigan, Nevada, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Utah and Washington.

It’s not clear why those states have seen such a shift, but experts said certain drugs may be more of a problem in some states than in others.

While cocaine and heroin continue to be significant killers, most of the increase is attributed to prescription opiates such as the painkillers methadone, Oxycontin and Vicodin.

From 1999 to 2006, death rates for such medications climbed sevenfold, according to the CDC.

Using death certificate data, CDC researchers counted more than 45,000 U.S. deaths nationwide from traffic accidents in 2006, and about 39,000 from drug-induced causes.

About 90 percent of those drug fatalities are sudden deaths from overdoses, but the count includes people who died from organ damage from long-term drug use or abuse.

Full details on the CDC report, visit www.cdc.gov/NCHS.

North Dakota

CDC Report Finds Drug Deaths Outnumber Traffic Deaths in 16 States

In 16 states and counting, drugs now kill more people than auto accidents do, reports the Centers for Disease Control and Prevention (CDC).

Experts said the startling shift reflects two opposite trends: Driving is becoming safer, and the legal and illegal use of powerful prescription painkillers is on the rise.

For decades, traffic accidents have been the biggest cause of injury-related death in the U.S., and they are still No. 1. But drug overdoses are pulling ahead in one state after another.

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Full details on the CDC report, visit www.cdc.gov/NCHS.
Clinicians often wrestle with how they might best engage, motivate, and prepare clients for the change process. In time, our attention often turns to helping clients develop necessary attitudes and skills for relapse prevention and recovery. Ideally, we see our clients building a new sense of themselves as individuals who are capable of on-going recovery in the context of a supportive community. We celebrate our clients’ transformation and their new life, which includes a desire to be a lifelong learner and a bridge of hope for the hopeless.

In this regard, there are many parallels between clinicians and teachers as well as clients and students. As teachers, we ask many of the same questions as clinicians: How can I get students interested in the work of change (learning)? Are the course assignments really meaningful to them? Are they learning anything new — and will it stick? As students, much like clients, we ask ourselves can I really do this — become an addictions counselor? Will it be worth it — can I make a life this way? What do I have to offer others?

Motivational-Experiential Learning
I’ll never forget our conversation with Michael. My students and I were visiting a halfway house in Chicago and Michael was serving as our tour guide. Michael was sharing about how he and his peers were giving back in the community. He commented, “I used to hang out on the corner and parents told their kids to stay away from me. Now, I’m helping elementary students and at the school everyone calls me Mr. Johnson.” It was an inspirational moment for me. I was reminded in a profound way — which reached deep into my soul — of my desire to be a part in this sort of transformation. And, this is what I want for my students as well.

Several months later our university unveiled a revised mission statement, which included the phrase, “(a) community committed to changing the world by developing students in character, scholarship, and leadership.” At first, I found the phrase rather presumptuous. However, I soon found the calling of the mission hard to shake. I was captured by the message as were my colleagues and my students. Maybe Goethe was right when he said, “Dream no small dreams, for they have no power to move the hearts of men.” I also found the mission statement rather convicting…what difference was I really making in my world? I could talk the talk but was I walking the walk?

What followed by providence and the encouragement of peers was a new vision for my teaching. It started with a question,
“How could I possibly find the time to make a difference in my own community (world)?” I soon found myself thinking about the upcoming semester and our capstone course for seniors, Addictions Programs and Professional Development.

**Motivational-Experiential Teaching**

One of the assignments my students would typically complete for the capstone course has been the development of a treatment program, addressing a variety of considerations and informed by course readings, discussions, and research. My conversation with Michael and our new mission statement had me thinking about doing something different. When our local jail chaplain called me about the need for a local halfway, I saw an opportunity for my students to become more actively engaged in the learning process by addressing a need in our world.

This group of approximately 15 seniors spent most of the semester researching and discussing halfway houses, three-quarter houses, faith-based recovery homes, and residential treatment programs. The project’s potential for practical significance in our community added vitality to our analyses and conversations that semester, as we examined the history and philosophies of addictions treatment, evidence-based practices and multicultural competence, NAADAC’s Code of Ethics, and various professional development themes. The experience culminated with a student presentation in the community to various leaders and stakeholders. This gathering spawned a volunteer steering committee which eventually gave birth to a non-profit organization and a faith-based recovery home, Grace House. Grace House is now in its fourth year of existence. The home has served approximately 50 men in the last two years, with 70 percent of these men demonstrating sustained sobriety and recovery. The current Board President, Reggie Lipscomb — a terrific counselor and advocate for addicted people — was a student in the class who first tackled this project. In recent years, students in the capstone course have prepared a smoking cessation curriculum and addressed best practices in pain management and addictions treatment for area providers.

Craig (1997) has indicated that experiential learning involves learning through observation, simulation, and/or participation that provides depth and meaning by engaging the mind, spirit, and body through activity, reflection, and application. Community problem-solving and other experiential learning activities offer several advantages, which counselors can readily appreciate:

1. Improved student motivation and engagement in the learning process
2. Enhanced retention and other learning outcomes
3. Increased student self-efficacy as helpers
4. Enhanced sense of work as calling for students and faculty
5. Community problem-solving and other experiential teaching methods are less teacher-centered

6. Community problem-solving cultivates virtue and contributes to the common good

Community problem-solving projects and other experiential learning activities are not without their drawbacks. For example, these activities may make it difficult to cover all the usual course content. These projects may also “commit” the teacher to additional projects beyond their time or capacity. Finally, some students will prefer a more traditional pedagogy and others will struggle to carry their weight given the increased autonomy and dispersion of responsibility. In this regard, a few recommendations are in order:

1. **General:** Consider starting small, perhaps with a move toward reading materials that are especially engaging and likely to invite discussions. Assign and rotate students as discussion leaders — have them start by bringing a few thoughtful questions from the readings.

2. **General:** Make considerable use of role-plays, participant modeling, and coaching when teaching about interviewing, relapse prevention, group facilitation, and motivational interviewing.

3. **Community Problem-Solving:** Assist the students in identifying community projects which can reasonably be completed within a given semester. Set and communicate clear limits with regard to your on-going responsibilities and time.

4. **Community Problem-Solving:** Invite the students to consider you as the CEO of a small consulting firm, with the students as the front-line consultants. Discuss how they want to present themselves in the community. Have them start by preparing questions and methods which will assist them in defining the problem. Require them to provide a detailed strategic plan early in the process and revise until approved by the CEO. Build in a means of student accountability — the strategic plan and subcommittees will help with this as will journals/logs and peer feedback. Believe in the students and affirm their hard work as demonstrated by a professional community presentation and associated resources.

I have become increasingly convinced that our students, much like ourselves and our clients, grow and change when the heart as well as the head is engaged. New behaviors are shaped by new thoughts, expectations, and beliefs and new thoughts, expectations, and identities are influenced by new behaviors and experiences — it is a two-way street. Inspiration and personal involvement (engagement, emotion) are common markers of the most significant changes.

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Dr. Doug Daugherty is a licensed clinical psychologist and Professor of Addictions and Psychology at Indiana Wesleyan University. He earned his doctorate from Indiana State University and has published in the area of recidivism and serves as an evaluator for local correctional programs, including the Drug Court. Dr. Daugherty is also the founder of Grace House for Recovery, a Christian recovery home in Marion, Ind. He can be reached at Doug.Daugherty@indwes.edu.
New Study: More Than 1 in 5 Young Adults Need Treatment

Study Also Shows That Less Than 1 in 10 Young Adults Needing This Treatment Receive It

SAMHSA Press Office

Nearly seven million Americans aged 18 to 25 were classified as needing treatment in the past year for alcohol or illicit drug use according to a new national study. The study by the Substance Abuse and Mental Health Services Administration (SAMHSA) also shows that that 93 percent of these young adults did not receive the help they needed at a specialty treatment facility. These levels have remained relatively stable since 2002.

The study also showed that the vast majority (96 percent) of young adults needing, but not receiving specialized treatment for these substance use problems did not perceive their need for help. Even among the 4 percent of young adults who thought they needed specialized help in the past year, but who had not received it — less than one third (32.2 percent) made any attempt to get treatment.

“Substance use disorders are preventable and treatable yet we continue as a Nation to allow the lives of 1 in 5 young people and their families be torn apart by substance abuse,” said SAMHSA Acting Administrator, Eric Broderick, DDS, MPH. “As a nation we must redouble our efforts to prevent substance abuse in the first place and ensure treatment is available to those in need.”

Among young adults, 17.2 percent needed treatment for alcohol disorders in the past year, 8.4 percent for illicit drug disorders and 4.4 percent for a combination of alcohol and illicit drug disorders.

The report reveals substantial differences among young adults receiving specialized treatment in terms of their medical health insurance coverage. Young adults covered by Medicaid/Children’s Health Insurance Program (CHIP) were more than three times as likely to receive treatment for alcohol or illicit drug use in a specialty facility as were their counterparts with private insurance (13.2 percent versus 4.0 percent). Young adults without insurance or with other forms of insurance also received treatment at higher levels than those with private insurance (10.6 percent and 8.7 percent respectively).

Young Adult’s Need for and Receipt of Alcohol and Illicit Drug Use Treatment: 2007 is based on 2007 data drawn from the National Survey on Drug Use and Health, involving responses from 22,187 young people aged 18 to 25.

The full report is available online at http://oasbeta.samhsa.gov/2k9/157/YoungAdultsDrugTxt.cfm. Copies may also be obtained free of charge by calling SAMHSA’s Health Information Network at 877.SAMHSA.7 (877.726.4727) or at http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=18140. For related publications and information, visit www.samhsa.gov.

SAMHSA is a public health agency within the Department of Health and Human Services. The agency is responsible for improving the accountability, capacity and effectiveness of the Nation’s substance abuse prevention, addictions treatment, and mental health services delivery system.

New Online Training—Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Legal Professionals

The National Center on Substance Abuse and Child Welfare (NCSACW) offers free online courses for substance abuse treatment, child welfare, and court professionals. The newest course was developed by NCSACW and the American Bar Association Center on Children and the Law. It is customized to help judges and attorneys gain an understanding of the work that child welfare and substance abuse treatment professionals perform and provides tips on how to engage and retain families in substance abuse treatment. It also highlights judicial and attorney roles and responsibilities and underscores the importance of partnership and collaboration among the three systems.

For more information, visit www.ncsacw.samhsa.gov
Your company has teamed up with Bank of America to bring you an exclusive package of benefits and other services through the Bank of America at Work® program. See below how the Bank of America at Work program can provide you valuable savings on your everyday banking needs and help prepare for your future.

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<td><strong>Money Orders • Cashier’s Checks</strong></td>
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<td>No Purchase Fee</td>
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1. For information about the rates, fees, other costs and benefits associated with these cards, please visit a banking center and speak to an associate.

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The Variable Annual Percentage Rate (APR) is 4.49% (Prime plus 0.75%) for a new home equity line of credit of $100,000 with a combined loan-to-value (CLTV) ratio of up to 70% on a 1 to 4 family owner-occupied primary residence. APR is based on The Wall Street Journal Prime Rate (3.25% as of 9/21/2009) plus or minus a margin, and will vary with changes in the Prime Rate, but will not exceed 24%. APR includes a 0.25% discount for maintaining automatic payment from a Bank of America account, a 0.25% discount for drawing or transferring a balance of $25,000 or more at closing and maintaining the balance for 3 consecutive billing cycles, and a 0.25% discount for maintaining one of the following relationship accounts: Advantage.® Preferred.™ Money Manager, Pima.™ Tiered Interest Checking, FirstChoice Gold.™ Master Relationship Account, Premier Banking,™ Small Business Banking, 1st Mortgage with Bank of America, Bank of America at Work® or Bank of America Direct Benefits.™ (Automatic payment from a Bank of America account is necessary for relationship discount.) Automatic payment and relationship discounts are also available on home equity loans. You are not required to have a relationship to obtain a home equity line of credit or loan at an undiscounted rate. APR will be higher if conditions for discounts not maintained. CLTVs, LTVs, margins, rates and payment amounts may vary based on certain factors such as state, occupancy status, loan amount, property value, debt ratios and credit history and are subject to change. Your actual rate and payment amount may be higher or lower than advertised rates and payment amounts. If the Prime Rate were to change by 0.25%, the APR would also change by 0.25%. Property insurance is required and flood insurance where necessary. Bank of America pays all closing costs on lines and loans of $500,000 or less, and may pay up to $300 toward attorney’s fees in states where attorney closings are required. For loans and loans over $500,000, customers may be responsible for paying closing costs, including attorney’s fees. If you close your home equity line of credit account within 24 months of the opening date, we may require you to reimburse the bank for any third-party fees, which would be your benefit. An annual fee of $75 will be charged to your home equity line account on or after each anniversary date. We will waive this fee if you maintain an average daily balance of $150,000 or more during the preceding 12-month period. Please contact Bank of America for current rate information and other details. Additional Information for Texas Collateral: Lines and loans secured by a primary residence homestead property in Texas for the purpose of obtaining cash, or refinancing a prior Texas (a)(6) lien, are subject to Section 50(a)(6) of the Texas Constitution; and the following exceptions apply: Bank of America cannot use a customer’s homestead equity funds to pay (in part or in full) Bank of America (‘en-us’) non-homestead debt at closing, the minimum advance amount on the line of credit is $4,000, the maximum CLTV is 80% and the maximum LTV for the home equity line is 50%. Bank of America pays all closing costs. The Annual Fee and Early Closure Fee do not apply. Access to the home equity line account using a home equity line visa access card or ATM card is not allowed. Credit and collateral are subject to approval. Terms and conditions apply. This is not a commitment to lend. Programs, rates, terms and conditions are subject to change without notice.

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2. Online Banking service is free, but other account related fees still apply.

3. Discounts and pricing vary depending on the state where the account is opened. Ask an associate at your nearest Banking Center for details.

4. Purchases with rewards or ATM cards are not eligible for matching. We will match 100% of your Keep the Change transfers for the first three months, and 5% thereafter. The maximum total match is $250 per year. Matching funds are paid annually after the avalanche of enrollments on accounts that remain open and enrolled. Eligible savings accounts include Regular Savings, which requires a minimum opening balance of $25 and pays a variable annual percentage yield that is 0.20% as of 9/21/09. Money Market Savings accounts are also eligible. Matching funds will be reported to the IRS on Form 1099. Fees may reduce earnings. Patent pending.

5. This offer applies to new accounts only. You must open a new personal checking account, a new Regular Savings account (referred to as Unlinked Market Rate Savings in ID and WA) and sign up for our Keep the Change® service on the same day. The monthly maintenance fee (referred to as monthly service charge in CA) waxes on your Regular Savings account begins the statement cycle after your first Keep the Change transfer from your new personal checking account to your new Regular Savings account. We may change or terminate this offer at any time. Excess transaction fees on Regular Savings still apply. See our Personal Schedule of Fees for information about these accounts and our Keep the Change service.

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8. This offer is not available in CA. A premium reduction is available in NY. Insurance products are offered through Bank of America, N.A., a licensed insurance agency located at 7455 High Market Street, Sunurst Beach, NC 28468.

9. Information is accurate as of 9/21/2009 Bank of America, N.A., Member FDIC. Equal Housing Lender © 2009 Bank of America Corporation

Claiming your bonus is as easy as 1-2-3.

1. Present this form to a Bank of America associate at your local Bank of America banking center or at a Bank of America event at your workplace (where applicable).

2. Open a new Bank of America personal checking account through the Bank of America at Work program.

3. Have your paycheck direct deposited into your new checking account within 90 days of account opening. Once your direct deposit begins and we qualify your account, we’ll deposit $50 directly to your new checking account within 90 days.

BECAUSE WE KNOW DIRECT DEPOSIT IS THE EASIEST, MOST CONVENIENT WAY TO BANK, FOR A LIMITED TIME WE’RE GIVING YOU $50 TO GET STARTED.

Information is accurate as of 9/21/2009 Bank of America, N.A., Member FDIC. Equal Housing Lender © 2009 Bank of America Corporation

REDEMPTION PROCESS FOR BANK OF AMERICA ASSOCIATES

Offer Code: OBD

IMPORTANT NOTE FOR PERSONAL BANNERS: Please use the Online Redemption Form or call the Redemption Hotline via OneCall to request the offer fulfillment on the customer’s behalf.

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555-53-2004B

AR75936/SXLFBO
Honor Best Practices
NAADAC Award Nominations Accepted Until April 30
Barbara Fox, NAADAC Awards Subcommittee Chair

“An honor is not diminished for being shared.”
– Lois McMaster Bujold, 1986 American Author

Do you know someone who deserves accolades for their work, professionalism and dedication? Perhaps there is an “unsung hero” whose fine example and work should be nationally recognized. Wherever you are, you can submit that person for consideration for a NAADAC national award.

NAADAC established its awards program to identify and honor the outstanding work of addiction professionals and organizations that treat addiction. NAADAC’s program provides a unique opportunity to let others know about the professionalism and expertise exhibited by addiction professionals throughout the U.S. and the rest of the world.

NAADAC has recognized the best practices of addiction professionals since 1979, when it established the Alcoholism and Drug Abuse Counselor of the Year Award (since renamed the Lora Roe Memorial Alcoholism and Drug Abuse Counselor of the Year Award). The first winners, the Counselors of the U.S. Navy alcoholism and drug abuse program, came to prominence after the U.S. Department of Defense revised its policies to encourage voluntary identification and enrollment of those with addictions in treatment programs.

The Navy’s program was the first non-punitive military rehabilitation programs developed with a focus on treatment. The program treated addiction as a disease and ensured that those who volunteered for treatment could not be discharged under other than honorable conditions.

Over 80 groups, individuals and organizations have received recognition from NAADAC in the 29 years since it began its awards program. Very select company considering that NAADAC has 10,000 members and the addiction profession encompasses over 80,000 clinicians.

Nominations for the 2009 awards must be received by the NAADAC Awards Committee no later than April 30, 2010. For full descriptions of NAADAC’s awards, please visit www.naadac.org and click on “About NAADAC” and then “Recognition & Awards.”

To make a submission, or for additional information, please contact Donovan Kuehn, NAADAC Director of Outreach and Marketing, at 800.548.0497, ext. 125, or by e-mail at dkuehn@naadac.org.

NAADAC AWARDS
NAADAC has six awards to recognize excellence in the addiction profession. They include:

Mel Schulstad Professional of the Year
Presented for outstanding and sustained contributions to the advancement of the addiction profession.

William F. “Bill” Callahan Award
Presented for sustained and meritorious service at the national level to the profession of addiction counseling.

Lora Roe Memorial Alcoholism and Drug Abuse Counselor of the Year
Presented to a counselor who has made an outstanding contribution to the profession of addiction counseling.

NAADAC Organizational Achievement Award
Presented to organizations that have demonstrated a strong commitment to the addiction profession and particularly strong support for the individual addiction professional.

Medical Professional of the Year
Presented to a medical professional who has made an outstanding contribution to the addiction profession.

Lifetime Honorary Membership Award
This award recognizes an individual or entity who has established outstanding service through a lifetime of consistent contributions to the advancement of NAADAC, the addiction profession and its professionals.

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American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701 www.americanprofessional.com
Health Care Reform and Addiction Services
How Health Care Reform Affects Addiction Professionals

Daniel Guarnera, NAADAC Director of Government Relations

Background and Status of Health Care Reform
During the 2008 campaign, President Obama named reform of the nation’s health care system as a top priority. Advocates for reform argued that new, comprehensive legislation was needed to lower health care spending, reduce the number of Americans without adequate insurance and improve health outcomes.

President Obama tasked Congress with the job of drafting health care reform bills. Each committee of jurisdiction in the House of Representatives passed similar bills (HR 3200) over the summer, and at 11:15 pm on Saturday, November 7, the full chamber passed a unified version (HR 3962) by a vote of 220-215. All but 39 Democrats voted for the bill while all but a single Republican voted against it.

In contrast to the House, the two Senate committees of jurisdiction each wrote and passed separate, uncoordinated bills. The Health, Education, Labor & Pensions committee approved a health care reform bill in July, and the Finance Committee passed its bill in October. The Senate finally passed a merged bill (HR 3590) on Christmas Eve.

Both the House and Senate must pass identical legislation before it can become law. Over the next few weeks, negotiators from each chamber will meet in private to create a single bill out of the two versions. Because the Senate will require 60 percent support for the bill whereas the House only need a simple majority, it is expected that the Senate-passed legislation will become the final framework.

Current Status of Addiction Treatment Financing
Total spending on addiction treatment is about $20 billion annually, although only about one-tenth of people with a diagnosable substance use disorder receive any specialty treatment. Untreated addiction imposes enormous costs on American society. In 2005, federal, state and local governments alone spent over $465 billion on addiction-related health, social, economic and criminal justice costs (of this amount, less than two percent was spent on prevention and treatment).

Many health insurance plans offer lesser benefits for addiction services than are offered for other kinds of health care. For example, a plan might have a higher deductible and lower lifetime limit on treatment days for addiction services than they have for other types of medical care. The Wellstone-Domenici Parity Act (see page 18) is intended to end this kind of discrimination in most plans. Even when plans offer fair benefits “on paper,” however, restrictive medical management techniques frequently make it difficult for beneficiaries to access clinically appropriate levels of care (with respect to both intensity or duration of treatment).

Due largely to the inadequacies of the private insurance market’s limited coverage of addiction services, addiction is much more likely than most other conditions to be treated in the public health system. Currently, only about 10 percent of addiction treatment is paid for by private insurers. This represents a nearly 20 percent decrease in private insurance payments since the 1980s. Federal, state and local governments have been forced to fill the void—over half of all addiction treatment is paid for by government sources other than Medicaid and Medicare, compared to just an 11 percent level for other health spending.

The Basics of Health Care Reform Legislation
Health care reform legislation can be daunting in its complexity and does not lend itself to simple summarization. At its heart, however, the House and Senate bills focus on the following four ideas:

- Require more businesses to provide insurance and individuals to have insurance, with tax subsidies and other incentives to encourage compliance (and penalties for those who remain uninsured).
- Expand Medicaid to cover low-income people who might be unable to afford insurance otherwise.
- Create state-based health insurance Exchanges that that pool uninsured individuals and small businesses together to allow them to buy insurance at lower rates than are currently available. Plans that participate in the Exchange would be required to meet minimum benefits standards and comply with state laws, as well as offer several levels of

In a Nutshell,

Health Care Reform Would ...
- Increase insurance coverage among the currently uninsured and enable individuals (like those in private practice) and small businesses to buy insurance at lower cost.
- Allow plans to continue to manage benefits much as they do now, with some new requirements.
- Provide for some expansion of workforce development, prevention and screening care programs.

Health Care Reform Would NOT ...
- Require government screening before care could be provided.
- Give the government a new role in determining which providers can be reimbursed for care (if there is a public plan option, it would start out using Medicare reimbursement policies that would later be modified as appropriate).
- Change credentialing systems for addiction professionals.

Health, cont. on page 16

www.naadac.org
Health, from page 15

Many indentations! Legislation is double spaced with repetition and “inelegant” wording. In its defense, the page format for reduction and “inelegant” wording. There is such an option in the House bill, although it does not seem like it will be carried over into the final draft.

A variety of non-insurance-coverage provisions including workforce development initiatives, expanded prevention and public health programs, modifications to Medicare and service integration and delivery system reforms.

A great deal of attention has been given to the potential costs of health reform legislation. The current House bill is estimated to cost approximately $1 trillion dollars over ten years. The draft Senate bill will cost slightly less. The House bill proposes covering this cost largely through increased taxes on high income individuals and savings by reducing waste and abuse, whereas the Senate bill draws much of its funding by taxing health plans that offer particularly expensive plans.

A controversial amendment concerning abortion was added to the House bill a few hours before its passage. The amendment prevents people receiving government subsidies to buy insurance in the Exchange from purchasing a plan that offers abortion coverage. The Senate version includes several measures to prevent federal funds for paying for abortion services (in cases not involving rape, incest, or risk to the life of the pregnant woman) and requires that Exchanges must include at least one plan that offers these abortion services and one that does not.

The Impact of Reform on Addiction Professionals and Their Clients

Although the House and Senate bills are very similar in many ways, there are some important differences. These differences are noted below where they are significant. Once again, it is likely that the final bill will more closely resemble the Senate bill because the Senate bill is more modest in several respects. The bill’s effects are arranged topically. Please note that this proposed legislation is not law. Changes will inevitably be made as Democratic leaders combine the two bills and create legislation that can get the votes to pass. Additionally, many of these reforms would be phased in over time; some aspects would not go into effect until 2014.

**Coverage & Benefits:**

- **Near-universal coverage.** The health reform bills both make efforts to significantly reduce the number of uninsured Americans. They do this by expanding Medicaid eligibility (see below), providing tax credits to low-income individuals and small businesses to purchase insurance, penalizing large employers who fail to provide insurance, and requiring individuals who choose not to purchase insurance to pay excise penalties. Small employers and individuals would be able to purchase insurance from the Exchanges (large employers will be able to participate in 2017, according to the Senate bill).

People with a mental illness or substance use disorder are more likely than the national average to lack health insurance. Similarly, about one-in-four uninsured adults have a mental illness or substance use disorder. Of people who know they need treatment but don’t access it, about 36 percent name prohibitive cost as the reason they do not receive care (it is the single most oft-cited reason for foregoing treatment by people who know they have an addiction problem). Therefore, extending insurance coverage to currently uninsured and under-insured Americans will greatly expand treatment access for this population in need of care.

- **Expanded Medicaid eligibility.** The House bill requires states to increase Medicaid coverage to individuals at or below 150 percent of the federal poverty level ($33,100 for a family of four). The Senate bill would increase Medicaid eligibility up to 133 percent of poverty ($29,300 for a family of four). Additionally, adults without dependent children who meet the financial requirements would be universally eligible for the Medicaid for the first time. The federal government, rather than states, would pay for most of the costs of expanded coverage. Medicaid’s effectiveness in delivering addiction treatment varies significantly by state. The health care reform proposals would not change the Institutions for Mental Disease (IMD) exclusion, which prevents federal Medicaid money from being spent on individuals receiving residential treatment in community-based or other standalone facilities with more than 16 beds, although both bills include a $75 million pilot program for IMDs to provide emergency psychiatric stabilization services for Medicaid beneficiaries.

- **Medicaid managed care plans must be able to meet the needs of people with substance use disorders.** The House bill says that a state will not be allowed to require a Medicaid beneficiary to enroll in a Medicaid managed care plan unless the managed care plan has demonstrated its ability to “meet the health, mental health, and substance abuse needs of such individuals.” The Senate bill requires that Medicaid managed care plans meet parity requirements.

Why are the bills so long? The House health reform bill is 1,990 pages—it’s also written in language that most non-lawyers will find extremely difficult to understand! This is the way that almost every law is written. The “legalese” is intended to reduce the risk of misinterpretation, which leads to a great deal of repetition and “inelegant” wording. (In its defense, the page format for legislation is double spaced with many indentations!)
• **Benefits Reform.** The bills would prevent plans from discriminating based on pre-existing conditions (starting in 2014). The Senate bill also prohibits annual limits on care.

• **Parity as the standard.** Both bills apply the Parity Act to all health plans. This means that plans will not be allowed to offer discriminatory benefits for addiction and mental health services. The Parity Act says that financial requirements (co-pays, deductibles, out-of-pocket costs, etc.) and treatment limitations (limits on the frequency or duration of treatment) for mental health and addiction treatment must be the same as those for other medical services. Out-of-network coverage must also be the same for addiction and mental health services and other medical services. The regulations for the Parity Act, which are scheduled to be released in the next few weeks, will have a significant impact on how the Parity Act will be applied in practice. The Parity Act exempted plans covering fewer than 50 people; the health reform bills require all plans to abide by parity.

• **Addiction and mental health benefits mandatory.** Current proposals require insurance plans in the Exchange to include mental health and addiction services in their minimum benefits packages. Since the Exchanges are expected to become the primary source of insurance for small employers and individuals, this closes the most significant gap (the small employer exemption) in the Parity Act.

**WORKFORCE DEVELOPMENT:**

• **Grants for Mental and Behavioral Health Training.** The House bill includes an amendment by Reps. Green (D-Tenn.), Baldwin (D-Wis.), Murphy (R-Penn.) and Bono Mack (R-Ca.) that would create a grant program to support programs that train mental and behavioral health professionals in interdisciplinary training across a range of health settings (community-based, home-based, institution-based). Health professions schools, hospitals and nonprofit entities may apply for the grants. The grants can be used to create traineeships or fellowships for professionals who participate and plan to teach afterwards. The Senate bill includes a loan repayment program for child and adolescent mental health and addiction professionals working in underserved areas.

• **Creation of Workforce Commissions.** Both bills create commissions to further study the health care workforce in the U.S. and make recommendations to increase its effectiveness.

• **Interdisciplinary care training grants.** The Senate bill includes a Primary Care Extension Program to educate primary care providers about chronic diseases, including substance use disorder prevention and treatment.

**PREVENTION & WELLNESS:**

• **Screening, Brief Intervention and Referral to Treatment (SBIRT).** The House bill creates a $30 million grant program to fund the implementation and research of SBIRT. The Senate does not have a similar provision.

• **Substance Abuse and Mental Health Services Administration listed as an agency to be consulted.** SAMHSA is listed in several places in both bills as an agency which must be consulted as various programs in the health reform bills are implemented.

**MISCELLANEOUS:**

• **Federally Qualified Behavioral Health Centers designated.** The House bill provides this designation for centers providing the extent of screening, treatment, rehabilitation, peer support, outpatient services, primary care and crisis response services covered under their state’s Medicaid laws. For outpatient clinic services for mental health and addiction, it requires that the care meet “evidence based (including cognitive behavioral therapy, dialectical behavioral therapy, motivational interviewing, and other such therapies which are evidence-based).” The centers must also “maintain linkages” with “sub-
The Wellstone-Domenici Parity Act and Its Impact on Health Care Reform

In October 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was signed into law. The Parity Act, which goes into effect in January 2010, requires most health plans to provide the same kind of benefits for addiction and mental health treatment that they provide for other medical services. In particular, benefits must be the same in terms of both “financial requirements” (like co-pays, deductibles, and out-of-pocket expenses) and “treatment limitations,” including lifetime or day limits. Insurance plans will maintain broad authority to “manage” those benefits as they see fit, however.

Regulations implementing the legislation are expected by January 2010 and will provide a much clearer picture of how the law will operate. The Parity Act will go into effect regardless of whether a health care reform bill is passed.

The process of passing parity helped position addiction and mental health prevention, treatment and recovery advocates to positively affect the health care reform process. First, it provided a chance to educate Congress about the importance of addiction and mental health services in the context of the health care system. Secondly, it helped addiction and mental health advocates coordinate their efforts. Thirdly, it helped create a minimum standard or “floor” of inclusion and equality for addiction and mental health that health reform to build upon.

Medicare and Medicaid, and it is something that addiction professionals should watch closely.

This process is still evolving and there may be new and unexpected changes as both the House and Senate must pass identical legislation before it can become law. Over the next few weeks, negotiators from each chamber will meet in private to create a single bill out of the two versions. Because the Senate will require 60 percent support for the bill whereas the House only need a simple majority, it is expected that the Senate-passed legislation will become the final framework. Regardless of how the negotiations evolve over the next few weeks, there will be a new and bracing change to the health care system of the United States. How this change impacts on addiction professionals is the key question for 2010 and beyond.

Daniel Guarnera is NAADAC’s Government Relations Director and is responsible for ensuring the public policy concerns most important to the counseling community — especially insurance parity, federal treatment grants, and workforce development — are heard and addressed by lawmakers in Washington. He can be contacted at daniel@naadac.org or 800.548.0497 x129

For additional information about health care reform, please visit www.naadac.org/advocacy.
Blending Solutions: Integrating Motivational Interviewing with Pharmacotherapy

The Blending Solutions: Integrating Motivational Interviewing with Pharmacotherapy online course is a part of the NAADAC Life-Long Learning Series. The goal of this online course is to educate addiction and other helping professionals of the specific skills necessary for integrating Motivational Interviewing and pharmacotherapy with the Stages of Change model by utilizing live trainer instruction, video clips of counseling interactions and patient testimonials.

Upon successful completion of the course, participants will earn three (3) online continuing education credits and a printable certificate of completion.

Regular Price: $25 | Member Discounted Price: Free

For more information, visit www.naadac.org>Education>Blending Solutions or call 800.548.0497.

Medication Management for Addiction Professionals

The Medication Management for Addiction Professionals online course is a part of the NAADAC Life-Long Learning Series. This online course is specifically designed for addiction professionals and provides valuable information about alcohol dependence, possible tools for professionals addressing alcohol dependence and strategies for counseling patients. Studies on pharmacological interventions, case studies, model treatment plans, a patient update report form and addiction and alcohol dependency resources are also provided.

By watching and completing the online course, participants can earn six (6) continuing education credits and a printable certificate of completion.

Regular Price: Free | Member Discounted Price: Free

For complete course details, visit www.naadac.org/counselingwithmedication or www.naadac.org>Education>Knowledge Center or call 800.548.0497.

These are not the only options for training. The NAADAC Knowledge Center has online courses for addiction professionals. These online courses are free to NAADAC members and accessible for a minimal cost to non-NAADAC members.

For more information, visit www.naadac.org and click on “Education” and then “Knowledge Center.”

Coming Up!

Featured events being hosted by NAADAC in 2010

Conflict Resolution in Recovery Training Session
May 14–15, 2010
Alexandria, VA at the NAADAC National Office

Developed in partnership by NAADAC and the Danya Institute, this is a therapeutic resource that is skilled-based and focused on the brain, how it works in conflict and how to affect the quality of recovery in relationships.

Participants can earn six, 12 or 18 hours of CEs and 18-hour participants are eligible for a certificate program.

Substance Abuse Professional Qualification & Re-Qualification Training
October 21-22, 2010
Alexandria, VA at the NAADAC National Office

Since 2001, NAADAC has certified Substance Abuse Professionals (SAPs), all of whom must renew every three years, as outlined by U.S. Department of Transportation (DOT) regulations. This session will explain new regulations, address common questions faced by professionals and lead participants through the assessment and screening process. This course includes an examination and posting of your name on NAADAC’s qualified SAP online listing.

National Conference on Addiction Disorders
Founded and produced by Vendome Group, LLC and NAADAC, the Association for Addiction Professionals
September 8-12, 2010 • Arlington, VA

Join NAADAC in the nation’s capital for this inaugural event. The National Conference on Addiction Disorders will include presenters from around the nation and from the Substance Abuse and Mental Health Services Administration (SAMHSA); Center for Substance Abuse Treatment (CSAT); the National Institute on Drug Abuse (NIDA); the White House Office of National Drug Control Policy (ONDCP) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). This conference will also include a special advocacy track and meetings with Legislators.
UPCOMING EVENTS

January 15, 2010
Application Deadline for March 2010 NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exam
Across the nation
The Professional Testing Company administers testing for the NAADAC National Certification Commission. For details on fees or to download an application form, visit www.ptcny.com/clients/NCC

February 15, 2010
Deadline for Nominations for NAADAC National Elections
Alexandria, Virginia
For more information, contact Donovan Kuehn at dkuehn@naadac.org or visit www.naadac.org

February 21 – 24, 2010
SECAD 2010
Nashville, TN
Earn 20 CEUs!
More details at www.secad10.com
March 6 through 13, 2010
Exam Dates for the March 2010 NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exam
Across the nation
For credential descriptions, visit www.naadac.org.

March 25 – 26, 2010
U.S. Department of Transportation Substance Abuse Professional Qualification and Re-Qualification Seminars
Alexandria, VA – NAADAC National Office
This session will explain new regulations, address common questions faced by professionals and lead participants through the assessment and screening process. More details at www.naadac.org

April 1 – 30, 2010
NAADAC Election Period
Nationwide
For full details on NAADAC elections, visit www.naadac.org.

April 15, 2010
Application Deadline for June 2010 NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exam
Across the nation
The Professional Testing Company administers testing for the NAADAC National Certification Commission. For details on fees or to download an application form, please visit www.ptcny.com/clients/NCC

April 30, 2010
Deadline for Submissions for NAADAC Awards
Alexandria, Virginia
For more information, visit www.naadac.org

May 14 – 15, 2010
Conflict Resolution in Recovery Seminars
Alexandria, VA – NAADAC National Office
Developed in partnership by NAADAC and Danya International, this is a therapeutic resource that is skill-based and focused on the brain: how it works in conflict and how to affect the quality of recovery in relationships. More details at www.naadac.org

June 5 through 12, 2010
Exam Dates for the March 2010 NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exam
Across the nation
For credential descriptions, visit www.naadac.org.

July 15, 2010
Application Deadline for September 2010 NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exam
Across the nation
The Professional Testing Company administers testing for the NAADAC National Certification Commission. For details on fees or to download an application form, please visit www.ptcny.com/clients/NCC

September 8 – 10, 2010
National Conference on Addictive Disorders
Washington, DC
Sponsored by NAADAC
Visit the nation’s capital, earn over 30 education credits and network with addiction professionals from around the nation. Optional advocacy track provides training and outreach with the nation’s legislators. For more information on the conference, visit www.naadac.org

September 11 through 18, 2010
Exam Dates for the September 2010 NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exam
Across the nation
For credential descriptions, visit www.naadac.org.

October 15, 2010
Application Deadline for December 2010 NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exam
Across the nation
The Professional Testing Company administers testing for the NAADAC National Certification Commission. For details on fees or to download an application form, please visit www.ptcny.com/clients/NCC

Addiction Professionals’ Day
Celebrate the work performed by addiction professionals! Founded in 1992, NAADAC held its first Addiction Professionals’ Day (originally called National Alcoholism and Drug Abuse Counselors Day). This day was established to commemorate the hard work that addiction services professionals do on a daily basis. For more information, visit www.naadac.org

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