A Big Year Ahead

2010 is shaping up to be a big year for the addiction profession. First off, the Obama administration issued the long-awaited regulations governing how parity would be implemented in the US (see page 10 for more details and how you can make your voice heard). Then the first draft of the Diagnostic and Statistical Manual of Mental Disorders (DSM) V was released, leaving addiction professionals wondering what the future holds for them.

On top of these issues, NAADAC’s elections are coming in April, with a full slate of candidates for the association executive board. More details are available online at www.naadac.org, and all of the candidates’ bios will be included in the April edition of the NAADAC News.

Finally, don’t forget your opportunity to nominate a deserving candidate. NAADAC Awards is April 30, so don’t delay in nominating a deserving candidate.

Donovan Kuehn
NAADAC News Editor
FEATURE ARTICLE

Mental Health Parity and the Addiction Equity Act

Mental Health and Substance Abuse Services are Key to Health Care Reform

Kathleen Sebelius, Secretary of the Department of Health and Human Services (HHS)

There are a lot of changes happening right now that could have a big impact on behavioral health: parity, health insurance reform, the growing popularity of integrated care models, an increased focus on prevention, huge gains in our understanding of the science behind mental illness and substance abuse.

These changes are creating a lot of potential for progress, but we also know that nothing is guaranteed. The integrated care models that spread could have a strong mental health component. Or they could not. We might find effective ways to apply some of the research we’re doing. Or we might not. In order to get the most out of the next few years, all of us in government, the private sector, and the nonprofit world are going to have to work hard to steer these changes in a direction that benefits our friends and neighbors with mental illnesses and substance abuse disorders.

I think it’s important to start by recognizing how far we have to go. Mental illness and substance abuse are far more common than most Americans realize. About one in five Americans will have a mental illness this year. Almost half of Americans will have a mental illness in their lifetime. And we know that many of these people do not get the care they need. More than ten million adults said they didn’t get the mental health care they needed last year. About twenty million said they didn’t get the substance abuse care they needed.

If ten or twenty million Americans were walking around with open wounds, we’d call it a national crisis. But because mental illnesses and addictions can be harder to see, we don’t feel the same urgency. And yet, the costs of mental illness are right there in front of us. Thirty-two thousand Americans commit suicide each year. People with mental illness make up half of the 700,000 homeless people in America. People with substance abuse disorders account make up four out of five prisoners. The National Academies estimate that mental illness in Americans under 25 alone costs our country almost $250 billion a year.

Given the high price we pay for these gaps in care, the Mental Health and Addiction Equity Act, which Congress passed last year and which will soon go into effect, is a huge step forward. Congress should be commended for passing the bill, especially the late Senator Paul Wellstone and Senator Domenici who fought for it for years. And I also want to commend all of you in the advocacy community for helping to educate members of Congress about this important issue.

Thanks to parity, millions of Americans with mental illness and substance abuse disorders will get the care they need. It’s going to help people afford their medicines. It’s going to make them less likely to put off important care. And it’s also an important symbolic step. For years, we thought about mental illnesses and addictions in terms of its costs for the rest of us who weren’t sick. Then we slowly began to acknowledge, “okay, maybe we can help some of these people.” And it’s only been recently that we’ve contemplated the possibility of full recovery. Parity establishes the principle that as a society, we have just as much of an obligation and interest in treating diseases of the brain as we do diseases that affect the rest of the body.

That said, we need to understand what we mean when we say parity. What we’re really talking about is “parity in reimbursement by private health insurance plans that cover mental health and substance abuse services.” That’s significant, but it’s just a starting point. A broader definition of parity would encompass investments in prevention, investments in health care delivery reform, investments in support services like housing that can affect behavioral health outcomes, and investments in treatment and service system research. And it’s this fuller version of parity that we should be striving for.

One idea we’ve talked a lot about is integrated care. The idea here is that providers deliver higher quality care when they work as a team. So say you have diabetes. Instead of being told, “You
Thanks to parity, millions of Americans with mental illness and substance abuse disorders will get the care they need.

Another idea that we need to borrow from our work to improve our physical health care system is investing in prevention. We know from the latest research that half of all mental illnesses begin by age 14. Three fourths begin by age 24. We also have decades of research showing that the most cost-effective mental health interventions are the ones that prevent or delay the onset of mental illnesses. Part of why these early interventions are so effective is that they can also prevent associated problems like drug use. We know for example that kids between the ages of 12 and 17 who were depressed in the past year were twice as likely to take their first drink or use drugs for the first time as those who did not experience depression.

So there’s a lot to gain by preventing mental illness. And while we still have more to learn about which of these interventions work best, we’re aggressively looking for answers. For example, the National Institute of Mental Health is currently conducting a major early intervention trial for people who have just experienced their first episodes of schizophrenia. What makes this research unique is that we’ve already assembled a working group from three of our agencies including SAMHSA that is thinking about how we could pay for this intervention if the study is successful. Given the benefits of prevention, we want to make sure we’re moving as fast as possible to implement the best ideas we have.

A third idea we need to incorporate into our mental health and substance abuse response are partnerships that go outside the public health community. Just as we understand that our physical health is affected by food we eat and the air we breathe and the physical environment we live in, we need to realize that prescription drugs and counseling are not the only factors that affect our mental well-being.

For example, we know that two of the most effective tools we have to help people recover from mental illnesses or addictions are a home and a job. That’s why my department is working with the Department of Housing and Urban Development on a demonstration project that will combine housing vouchers with behavioral health and other support services to see if this combination can help reduce homelessness for people with severe mental illness or substance abuse disorders. We’ve already seen one study in Chicago where providing housing and case management reduced hospital stays and emergency room visits by 25 percent, and we want to try to build on that success.

We’ve also formed partnerships to help us reach some of the Americans with mental illnesses who may not be getting the services they need. So we’re also working with the Department of Education and the Department of Agriculture to promote behavioral health in schools. We’re working with the Veterans Administration to reach veterans. We’re working with the Department of Labor and other agencies to reach out to families in the cities that have been hardest hit by the economic downturn. And if we’re going to treat mental illness and substance abuse effectively, we’re going to need more of these partnerships, public and private.

Of course, the change that you’re probably most curious about is health insurance reform. And I’m sorry to say, I didn’t come here today to announce a secret deal. As you’re all aware, the House has passed a bill and the Senate is still trying to work out the details on its own bill. We in the Obama administration are continuing to support them any way we can. But while we can’t know exactly what the final reform bill will look like, we do know that any reform bill that meets the President’s basic criteria will have huge benefits for Americans with mental ill-

Parity, from page 3

need to exercise more and eat better. Come back and see me in six months,” you have a team of nurses and dieticians working with you to figure out a diet and exercise plan that you can stick to. And the same approach can work for mental illnesses and addictions. Mental health and addiction professionals can serve as what are called “recovery navigators,” helping to connect patients with health screening, as well as counseling, medication management, housing, and job training.

We know that these integrated care models can be especially effective when they combine behavioral and physical health conditions. That’s because mental illnesses and substance use disorders usually go hand in hand with other physical conditions. We know that the sicker you are, the more likely you are to be depressed: forty percent of older patients with advanced heart failure have major depression. And we also know that when physical and mental health problems come together, they usually make each other worse. For example, the cost of treating a patient a medical problem and comorbid psychiatric condition is twice as high as the cost for a patient with the medical condition alone.

We already have several successful examples of how to provide this kind of integrated care. Health care systems like Cherokee Health, Intermountain Health, and the Veterans Administration have all successfully included mental health into their primary care systems. Now the challenge is to spread these models, especially to smaller practices that may not have the same experience dealing with mental health and substance abuse problems.

And we also need to make integration work the other way. We know that barely half of public mental health centers have the capacity to provide medical treatment for physical health problems either onsite or through referral. We need to do better, and SAMHSA is currently administering a grant program designed to figure out how we can incorporate primary care services into these community behavioral health centers.

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nesses and substance use disorders. Any reform bill will expand access to insurance, which will especially benefit people with mental illnesses who we know are twice as likely to be uninsured. It will prevent insurance companies from calling your substance addiction a preexisting condition and denying you coverage. Through pilot programs and new incentives, reform will encourage the kind of integrated care models and prevention strategies I talked about earlier.

At the same time, we know that even the strongest reform bill will not provide all the services that Americans with the most serious and disabling mental and substance use disorders need. That’s why it’s so important that we continue to work to prevent these conditions from occurring and deliver the services that help Americans with these disorders fully recover and become contributing members of society. To do that, we’ll need your help. As much progress as we’ve made, there is still a long way to go. We need you to be advocates not just for more resources for mental health and substance abuse prevention and treatment, but for smarter use of those resources. We have a better understanding than ever before about the kind of programs that are most effective, and we need to apply that knowledge to get the best results.

Through it all, we need to remember that health is one of the best investments we can make. When people are mentally and physically well, they miss fewer days of work and get more done. They pay more taxes. They can take care of their grandkids. They can play softball. They can volunteer at the town library. They can walk to the grocery store. They can get a good night of sleep.

Kathleen Sebelius is the Secretary of the Department of Health and Human Services (HHS) and leads the principal agency charged with keeping Americans healthy, ensuring they get the health care they need, and providing children, families, and seniors with the essential human services they depend on.

The National Institute on Drug Abuse invites you to join national experts, researchers, policymakers, and colleagues to learn about the latest research in the prevention and treatment of drug abuse and addiction. Designed to narrow the “translational gap”, the 2010 NIDA Blending Conference will highlight the utilization of scientific evidence to support clinical practice with diverse populations and settings.

Conference Highlights include:

Notable keynote/plenary speakers include:

**Nora Volkow, M.D.**
Director, National Institute on Drug Abuse

**William Miller, Ph.D.**
University of New Mexico

**Scott Henggeler, Ph.D.**
Medical University of South Carolina

**Barbara McCrady, Ph.D.**
University of New Mexico

**Donald Warne, M.D.**
Aberdeen Area Tribal Chairman’s Health Board

- Special track focused on Native American/American Indian and Substance Abuse
- 25 Breakout Sessions addressing multiple topics including: promising new vaccines, veterans issues, treatment interventions in criminal justice settings, co-occurring disorders, medication treatment for young adults and SBIRT
- Technical assistance workshop on a NIDA funding opportunity designed to assist service providers to build system capacity to implement evidence-based practices.
Rules on Addiction and Mental Health Parity
Issued by Obama Administration
Rules Impact on How Parity Will be Interpreted

News Feature by Bob Curley, Join Together

New rules for implementing the addiction and mental-health parity law passed by Congress in 2008 are being hailed by advocates, despite their issuance three months after the law actually went into effect.

The interim final regulations (PDF) unveiled on Jan. 29 included detailed guidelines and guidance on implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which took effect in October 2009. “The rules we are issuing today will, for the first time, help assure that those diagnosed with these debilitating and sometimes life-threatening disorders will not suffer needless or arbitrary limits on their care,” said U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius.

The final rules will go into effect on April 5, and will be applicable to insurance plan years that begin on or after July 1. Rep. Patrick Kennedy (D-R.I.), who along with former Rep. Jim Ramstad (R-Minn.) was a key advocate for the Wellstone bill in Congress, said the rules “provide the critical guidance necessary to ensure that this landmark legislation is implemented fairly and justly, and will ensure that insurance companies are no longer allowed to discriminate against those suffering from addiction and mental illness.”

Stephen Gumbley, vice chairman of Faces and Voices of Recovery, an advocacy organization for individuals in recovery from addictions, said the rules had been released “not a moment too soon.”

“Some insurance companies have already put plans in place that fall short of this law’s intent, severely restricting patients’ access to life-saving care,” said Gumbley, who cited United Healthcare and Blue Cross/Blue Shield as examples. “This needs to change, and we encourage individuals and families covered by these plans to ask them to fully implement policies consistent with this new law.”

The Wellstone parity law does not require health plans to cover addiction or mental illness, or any specific types of treatment, but mandates that plans which do include such benefits treat these conditions on par with other illnesses. According to the law, group health insurance plans may not limit benefits or impose higher patient costs for addiction and mental health treatment than those applying to general medical or surgical benefits.

In states that mandate certain addiction or mental-health benefits, the law now requires that they be provided on a parity basis with other health services.

Issued jointly by HHS and the departments of Labor and Treasury, the interim final rule provides an enforcement framework for the Wellstone act. The rules explicitly state that parity applies to both quantitative differences such as higher deductibles or caps on the number of days patients can stay in treatment and qualitative limits such as preauthorization requirements and medical management.

The rule breaks down benefits into six categories: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency care; and prescription drugs. If a plan provides coverage for addiction and/or mental health services in any of these categories, it must be on par with the medical/surgical benefits provided in that category, according to the interim final rule.

The parity law applies only to public and private employer-based plans from companies with 50 or more employees; it also applies to Medicaid managed-care plans, but the interim final rule doesn’t cover Medicaid. Regulations for Medicaid parity will be issued later, according to HHS.

Enforcement of the law will fall primarily on states, which regulate insurance plans, but both HHS and the Department of Labor have established compliance hotlines.

Administration officials estimate than 150 million Americans are covered by employer-provided health plans, 90 percent or more of which currently include addiction and mental-health benefits and thus would be subject to the Wellstone law. Speaking on background, an administration officials said there was “no evidence of companies dropping their benefits in any significant way attributable to parity.”

Under the law (and the interim final rule), all health plans must implement the parity rules. However, they may subsequently opt out if they can prove that parity caused their costs to rise by 2 percent or more in the first year or 1 percent or more in subsequent years. Non-federal government plans also have the ability to opt out of the law.

Rules, cont. on page 9
The first draft of the American Psychiatric Association’s (APA) latest Diagnostic and Statistical Manual of Mental Disorders (DSM-V) eliminates the disease categories for substance abuse and dependence and replaces it with a new “addictions and related disorders” — just one of several major changes to the “Bible” used almost universally to diagnose (and get insurance reimbursement for) behavioral-health problems.

“Eliminating the category of dependence will better differentiate between the compulsive drug-seeking behavior of addiction and normal responses of tolerance and withdrawal that some patients experience when using prescribed medications that affect the central nervous system,” the APA explained in a Feb. 10 press release.

“The term dependence is misleading, because people confuse it with addiction, when in fact the tolerance and withdrawal patients experience are very normal responses to prescribed medications that affect the central nervous system,” said Charles O’Brien, MD, PhD, chair of the APA’s DSM Substance-Related Disorders Work Group. “On the other hand, addiction is compulsive drug-seeking behavior which is quite different. We hope that this new classification will help end this widespread misunderstanding.”

The new category for addictive diseases would include a variety of “substance-use disorders” broken down by drug type, such as “cannabis-use disorder” and “alcohol-use disorder.” Diagnostic criteria for these disorders in DSM-V would remain “very similar” to those found in the current DSM-IV, according to APA. However, the symptom of “drug craving” would be added to the criteria, while a symptom that referred to “problems with law enforcement” would be eliminated “because of cultural considerations that make the criteria difficult to apply internationally,” APA said.

Also new to the DSM-V are diagnostic criteria for “cannabis withdrawal,” which the APA says is caused by “cessation of cannabis use that has been heavy and prolonged,” results in “clinically significant distress or impairment in social, occupational or other important areas of functioning,” and is characterized by at least three of these symptoms: irritability, anger or aggression; nervousness or anxiety; sleep difficulties (insomnia); decreased appetite or weight loss; restlessness; depressed mood; and or physical symptoms such as stomach pain, shakiness or tremors, sweating, fever, chills and headache.

**Battle Over ‘Addiction’ and ‘Dependence’**

The APA has gone back and forth between use of the terms “addiction” and “dependence” to describe alcohol and other drug problems, noted researcher Stanton Peele, PhD. “Every book I’ve written has the word “addiction” in the title, so I’m glad the term will now be recognized,” wrote Peele in the Huffington Post on Feb. 11. “But the change back may make us wonder whether we will have to reconsider every twenty years or so whether it is more beneficial or harmful to use a word loaded with cultural meanings (“addiction”), or a more neutral term (“dependence”).”

In fact, “dependence” made it into the DSM-IV by just a single vote, O’Brien noted in a May 2006 editorial in the American Journal of Psychiatry co-authored by Nora Volkow, MD, Director of the National Institute on Drug Abuse (NIDA), and T-K Li, MD, then-head of the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

“Experience over the past two decades has demonstrated that this decision was a serious mistake,” the trio wrote. “The term ‘dependence’ has traditionally been used to describe ‘physical dependence,’ which refers to the adaptations that result in withdrawal symptoms when drugs, such as alcohol and heroin, are discontinued. Physical dependence is also observed with certain psychoactive medications, such as antidepressants and beta-blockers. However, the adaptations associated with drug withdrawal are distinct from the adaptations that result in addiction, which refers to the loss of control over the intense urges to take the drug even at the expense of adverse consequences.”

**NAADAC Maps Out a Response**

With the draft release, NAADAC’s leadership has sprung into action. NAADAC’s President, Patricia M. Greer, LCDC, AAC, established a committee to draft a response to the new recommendations. The committee, chaired by NAADAC Regional Vice President John Lisy, LICDC, OCPS II, LSW, LPCC, will prepare its response before the April 3 deadline set by the APA.

“The DSM has such a primary place in diagnosing illnesses, including that of addiction,” said Daniel Guarnera, Director of Government Relations for NAADAC. “We have a responsibility to NAADAC members, and to the profession as a whole, to ensure that this DSM-V, cont. on page 9
Mental Health Parity and the Addiction Equity Act
The Government Regulations From the Centers for Medicare & Medicaid Services
Centers for Medicare & Medicaid Services

Introduction
The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that may apply to two different types of coverage:

1) Large group self-funded group health plans (CMS has jurisdiction over self-funded public sector (non-federal governmental) plans, while the Department of Labor (866.444.3272) has jurisdiction over private sector self-funded group health plans.);
2) Large group fully insured group health plans.

Contact your state’s insurance department to find out about whether additional protections apply to your coverage if you are in a fully insured group health plan or have individual market (non-employment based) health coverage. Medicare and Medicaid are not issuers of health insurance. They are public health plans through which individuals obtain health coverage. Medicaid Managed Care plans, however, are subject to the MHPAE requirements. Contact your specific Medicare or Medicaid contractor to discuss your level of benefits.

Employment-related group health plans that provide benefits through insurance are known as fully insured group health plans. Employment-related group health plans that pay for coverage directly, without purchasing health insurance from an issuer, are called self-funded group health plans. Contact your plan administrator to find out if your group coverage is fully insured or self-funded.

MHPAE may prevent your large group health plan from imposing financial requirements and treatment limitations on mental health and substance use disorder (MH/SUD) benefits that are more restrictive than financial requirements and treatment limitations on medical/surgical benefits. MHPAE also may prevent your large group health plan from placing annual or lifetime dollar limits on MH/SUD benefits that are lower — less favorable — than annual or lifetime dollar limits for medical/surgical benefits offered under the plan.

MHPAE does NOT apply to small group health plans or health insurance coverage in the individual (non-employment based) market, but you should check to see if your state law requires mental health parity in such other cases. (Visit www.ncl.org, on the right hand side of the page enter “mental health parity” then select “State Laws Mandating or Regulating Mental Health Benefits” in order to view State specific information.) MHPAE applies to most group health plans with more than 50 workers. According to Federal standards, MHPAEA does NOT apply to group health plans sponsored by employers with fewer than 51 workers.

Summary of MHPAE Protections
The Mental Health Parity Act of 1996 (MHPA) states that a group health plan may not impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical surgical benefits.

MHPAEA preserves the MHPA protections, and adds significant new protections. Although the law requires “parity,” or equivalence, with regard to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does NOT require large group health plans and their health insurance issuers to include MH/SUD benefits in their benefits package. The law’s requirements apply only to large group health plans and their health insurance issuers that already include MH/SUD benefits in their benefit packages.

Key changes made by MHPAEA, which is generally effective for plan years beginning after October 3, 2009, include the following:

- If a group health plan includes medical/surgical benefits and mental health benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- If a group health plan includes medical/surgical benefits and substance use disorder benefits, the financial requirements and treatment limitations that apply to substance use disorder benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- MH/SUD benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan includes medical/surgical benefits and mental health benefits, and the plan provides for out of network medical/surgical benefits, it must provide for out of network mental health benefits;
- If a group health plan includes medical/surgical benefits and substance use disorder benefits, and the plan provides for out of network medical/surgical benefits, it must provide for out of network substance use disorder benefits;
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD, must be disclosed upon request;
- The MHPA parity requirements under existing law (regarding annual and lifetime dollar limits) continue and are extended to substance use disorder benefits.
Exceptions

There are three exceptions to the MHPAEA requirements:

1) MHPAEA requirements do not apply to small employers who have between 2 and 50 employees;

2) Large group health plan sponsors that meet the requirements stated in the MHPAEA download below (Section 512(a)(2) Cost Exemption) and demonstrate that compliance with MHPAEA increases their claims by at least two percent in the first year (one percent in subsequent years) may request exemption from the MHPAEA based on their cost exemption. Subsequently, the plan sponsors may notify the plan beneficiaries that MHPAEA does not apply to their coverage; and

3) A nonfederal governmental employer that provides self-funded group health plan coverage to its employees (coverage that is not provided through an insurer) may elect to exempt its plan (opt-out) from the requirements of MHPAEA by following the Procedures & Requirements posted on the Self-Funded Nonfederal Governmental Plans webpage (see Related Links Inside CMS), then issuing a notice of opt-out to enrollees at the time of enrollment and on an annual basis. Thereafter, the employer must also file the opt-out notification with CMS.

For additional information, e-mail the Centers for Medicare & Medicaid Services at phiq@cms.hhs.gov or visit www.cms.hhs.gov/healthinsreformforconsume/04_thementalhealthparityact.asp.

Rules, from page 6

Rules for determining these exemptions have not been released yet; the Congressional Budget Office estimated that parity would result in a cost increase of 0.2 to 0.4 of one percent for health plans.

“This is an important first step, said Daniel Guarnera, Director of Government Relations for NAADAC, the Association for Addiction Professionals. “Knowing where professionals stand will help us as we move forward, but the regulations miss the mark in a few areas. NAADAC will be a prominent in advocating for changes that help addiction services professionals.”

More than 400 comments on parity were reviewed as part of the rulemaking process. The interim final rule will be published in the Federal Register (PDF) on Feb. 2, after which consumers, insurers, providers and other interested parties will have 90 days to comment on unresolved issues surrounding non-quantitative treatment limits, drug formularies, the scope of benefits and more. Deadline for comments is May 3.

“NAADAC has been at the forefront of the parity debate for years,” said Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, NAADAC Executive Director. “Now that we are so close to seeing the promise fulfilled, we will be tireless advocates to ensure that parity is implemented in the best interests of our members and our clients.”

This article is from Join Together, a service of the National Center on Addiction and Substance Abuse at Columbia University – www.jointogether.org.

DSM-V, from page 7

best reflects the treatment realities faced by members of the addiction profession.”

If you would like to contribute to the NAADAC DSM-V report, please e-mail John Lisy at jlisy@msn.com.

Gambling Addiction Makes the Cut

The proposed DSM-V also would add a new category of “behavioral addictions” which contains a single disorder: gambling addiction. “Internet addiction was considered for this category, but work group members decided there was insufficient research data to do so, so they recommended it be included in the manual’s appendix instead, with a goal of encouraging additional study,” according to an APA press release.

The net effect is that the term “addiction” would now be officially applied to more than alcohol and other drug related disorders. “There is substantive research that supports the position that pathological gambling and substance-use disorders are very similar in the way they affect the brain and neurological reward system,” said O’Brien. “Both are related to poor impulse control and the brain’s system of reward and aggression.”

Peele argues that the APA’s addictions category could be expanded even further to include “life-harming, compulsive” involvement with things like sex and food, which are classified in the DSM-V draft as separate “hypersexuality” and “binge eating” disorders.

The APA also is looking to create a classification for patients who suffer withdrawal symptoms when they stop taking tricyclic antidepressants and selective serotonin reuptake inhibitors, two types of antidepressant medication. These “miscellaneous discontinuation syndromes” fall outside the definition of substance-use disorders, APA said, but share some common traits with use of addictive drugs. “If the substance is abruptly discontinued, in some cases the body responds with a rebound effect that creates unpleasant, and sometimes serious, symptoms of withdrawal,” said O’Brien.

Comments Deadline: April 20

APA is accepting public comments on the DSM-V revisions until April 20. “This is the first complete revision of the DSM since 1994,” said NIDA Director Nora Volkow in a Feb. 11 letter to addiction professionals. “... In light of the advances in research on substance abuse and addiction since the last revision, many suggested changes have been proposed in this revision. Therefore, this is an important opportunity to offer your comments on the new criteria.”

All of the proposed changes and information about submitting comments can be found on the DSM-V Web site at www.dsm5.org. To contribute to the NAADAC DSM-V report, please e-mail John Lisy at jlisy@msn.com.

This article is from Join Together, a service of the National Center on Addiction and Substance Abuse at Columbia University – www.jointogether.org.
Understanding Insurance Parity Regulations

NAADAC Government Relations Director Explains the Implications of the New Parity Rules

Daniel Guarnera, NAADAC Director of Government Relations

On October 3, 2008, the Paul Wellstone–Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was passed by Congress and signed into law by President Bush. There was strong bipartisan support for the bill, which sought to end discrimination by health plans against mental health and substance use disorder (MH/SUD) services. Key legislative champions for this legislation included Reps. Patrick Kennedy (D-R.I.) and Jim Ramstad (R-Minn.) and Sens. Edward Kennedy (D-Mass.), Pete Domenici (R-N.M.) and Chris Dodd (D-Conn).

The bill ultimately passed as part of a larger legislative package that provided $700 billion to rescue the financial services sector. For more information about what the MHPAEA law says, please refer to page 8 in this edition of the NAADAC News.

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The Regulatory Process

The MHPAEA legislative language officially took effect for most plans on January 1, 2010. However, there are two distinct processes involved in making and implementing most public policy. The legislative process ended when parity passed Congress and was signed into law. The regulatory process “operationalizes” the legislation, specifying exactly what health plans must do in order to comply with the law. Regulations provide more detail than legislation regarding how the law applies to the complex real-world situations to which parity must be applied.

The regulatory process takes place in federal agencies. The three agencies with jurisdiction over parity — the Departments of Health & Human Services, Labor, and the Treasury — requested comments from the field in spring 2009 on issues that were left unresolved by the legislative language itself. NAADAC and over 400 other interested parties submitted comments.

On February 2, 2010, the three agencies issued an “interim final rule” on the MHPAEA. Public comments on these regulations will be accepted until May 3, 2010 and can be submitted by following this link: www.regulations.gov/search/Regs/home.html The interim final rule itself, however, is legally binding for health plan years starting after July 1, 2010. In practice, this means that most plans will fall under the MHPAEA interim final regulations on January 1, 2011.

The agencies will be able to use comments submitted as they prepare to issue a “final rule.” However, in practice this process can take years, and it is common for interim final rules to be the final regulatory guidance offered.

Q: What conditions qualify as mental health and substance use disorders?
A: In determining what qualifies as a mental health or substance use disorder benefit, health plans must use criteria that are consistent with generally recognized standards of current medical practice, such as the DSM, ICD or state guidelines.

Q: What scope of services is covered by parity?
A: The regulations do not address what specific scope of services for Substance Use Disorders (SUD)/Mental Health (MH) benefits must be covered by plans. They acknowledge that not all treatments and treatment settings for SUD/MH correspond with medical/surgical ones.

Q: Can insurance companies separate their medical/surgical plans from their SUD/MH plans to evade the parity requirements?
A: No. All medical care benefits offered by an employer, regardless of how they are organized, constitute a single group health plan for the purposes of the regulations.

Q: Do plans need to provide SUD/MH benefits at all?
A: No, unless there is a state law mandating such benefits. Plans do not need to provide any SUD/MH benefits because of the MHPAEA. However, if benefits are provided, they must meet the parity requirements in all the ways discussed above.

Q: Does parity protect state law?
A: Yes. Nothing in the MHPAEA supersedes a state law mandating specific SUD/MH benefits, except to the extent that such state policies prevent the implementation of the MHPAEA.
Example: If a state mandates that insurers offer a minimum dollar amount of SUD/MH benefits, that policy does not prevent the implementation of the MHPAEA and thus it remains in effect.

Q: Which plans does parity apply to?
A: The MHPAEA applies to self-insured group health plans that fall under the Employee Retirement Income Security Act (ERISA). It is estimated that 111 million people are covered by nearly 450,000 ERISA plans.

The parity regulations also apply to public employer group plans sponsored by state and local governments. There are approximately 29 million people covered by about 20,300 public plans. (The Federal Employees Health Benefits Program has had parity since 2000.)

Medicaid managed care plans offering SUD/MH benefits are also covered by the MHPAEA. However, these regulations do not apply to such plans. The Centers for Medicare and Medicaid Services (CMS) will issue separate guidance at a later date.

Many group plans, both ERISA and public plans, use managed behavioral healthcare organizations (MBHOs) or “carve-outs” to manage their SUD/MH benefits. There are an estimated 120 MBHOs.

This is an important first step — knowing where professionals stand will help us as we move forward. However, the regulations miss the mark in a few areas. NAADAC will be prominent in advocating for changes to these regulations that help addiction services professionals.

To provide your thoughts on the regulations, please visit www.regulations.gov/search/Regs/home.html before May 3, 2010.
Malpractice insurance for Addiction Counselors

PREMIUM RATES FOR $1,000,000/$3,000,000 OF COVERAGE START AS LOW AS $90

If you are paying more, Then you are paying too much!

Have questions? Need additional information?

Email our Mental Health Department Supervisor at mentalhealth@americanprofessional.com or visit our website at www.americanprofessional.com

Of course if you prefer to speak with someone you can always call us toll free at 1-800-421-6694

American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701 www.americanprofessional.com
Strategic Planning Guide for NAADAC State Affiliates
Simple Tools to Help Make Your Affiliate More Active

Daniel Guarnera, NAADAC Director of Government Relations

These examples are drawn from the “NAADAC Affiliates and Advocacy” presentation posted at www.naadac.org/advocacy. To discuss these ideas further, please contact Daniel Guarnera, Director of Government Relations, at 800.548.0497 x129 or daniel@naadac.org.

The following are examples of possible advocacy goals for your affiliate with two different timelines.

6–MONTH TIMELINE
1. Form a public policy committee — send an e-mail to all members asking for volunteers and post an announcement on our website and in our newsletter.

2. Begin tracking the news for addiction policy-related stories. Have a public policy member sign up for JoinTogether.com alerts and Google Alerts and check www.naadac.org/advocacy regularly. Every 2 weeks, the volunteer will e-mail the rest of the committee with the most relevant news and information.

3. Submit 3 letters to the editor of local or state newspapers/media about the importance of addiction treatment and addiction professionals (for example, about addiction’s role in health reform). Send copies of these letters to policymakers.

4. Attend one town hall meeting of Representative X. Make a comment about the importance of addiction services in health reform.

5. Schedule a meeting in the district office of a member of Congress to talk about addiction’s role in health reform.

6–12 MONTH TIMELINE
1. Host an advocacy-focused Recovery Month event in our state.

2. Invite a state-level policymaker to speak at an affiliate training/conference (or submit a letter of welcome).

3. Submit written testimony to the relevant state legislature committee about a piece of addiction-related legislation.

4. Work with another health profession to co-host a “Legislative Hill Day” where your members come to the state capital to meet their legislators.

5. Prepare a “one-pager” about our affiliate and its advocacy activities to be delivered to our Representatives and Senators when people from our state attend the 2010 National Conference on Addiction Diseases in Washington, D.C. (Sept. 8–11, 2010).

6. Begin a regular advocacy column in your newsletter or website for your members.

7. Create some method to get the word out to your members when a legislative issue requires fast action.

Institute of Addiction Awareness

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Your source for high quality, low cost courses since 1988. We originated homestudy for the addictions field and online addictions courses.

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Course Titles: Ethics, HIV/AIDS, Alcohol/Drug Detoxification, Domestic Violence, Dual Diagnosis, MET, Senior Treatment, Stimulant Abuse Treatment, Women’s Treatment, Case Management, Cocaine Counseling, Relapse Prevention, Cognitive Behavioral Counseling and more.
Make sure potential clients can find you online with a listing in Psychology Today’s Therapy Directory

Special introductory offer
Gain exposure to those seeking care with new NAADAC partner, Psychology Today and the Therapy Directory.

NAADAC members may register for a professional listing in the directory at no charge for the first six months.

High-profile marketing
The Therapy Directory, with your listing, has top rankings on Google, Yahoo, and more than 20 leading health sites on the Internet.

- update your own profile in real time
- track how many new clients have found you online
- more than 20,000 mental health care providers already use this powerful tool.

Meeting clients’ needs
Potential clients can search for a mental health care professional by state (or Canadian province), zip code, or by selecting from a wide variety of specialty options such as:

- depression
- grief/loss
- relationship issues
- eating disorders
- psychosis
- impulse control disorders
- parenting

The advanced search function allows further specific criteria, such as average session cost, religious orientation, or language spoken other than English.

To take advantage of this six-months FREE program, enter the promotional code NAADAC when prompted. A credit card is required for registration, but it will not be charged unless you remain in the Directory beyond the six-month free period. Once you enter the seventh month, the card will be charged $30 per month.

Your professional listing in the Therapy Directory includes:

- photo
- contact information
- credentials and qualifications
- specialty areas
- treatment preferences
- client focus
- brief introduction

Pop-up information boxes give explanations of credentials and treatment preferences. Learn more and register now by visiting https://secure.sussexdirectories.com/therapist/naadac.php or visit www.naadac.org

NOTE: NAADAC members who already have a listing in the Therapy Directory are not eligible for this six-month introductory program.
One part of the study looked at counselors and what motivated them to select the addiction services profession.

The study’s findings indicated that personal reasons rather than structural or organizational factors were the primary reasons new career addiction professionals entered the profession. Thus, factors such as helping others in their communities, having friends or family with addiction problems, and the challenging nature of the work were of greater importance than salary, benefits or employment opportunities.\(^\text{iv}\) For example, 95 percent indicated that the challenging or interesting nature of the work was influential in their decision and 91 percent indicated that their decision was due in part to their desire to work in a helping profession. In contrast, only 16 percent indicated that salary or benefits were of great or very great influence in their decision. Similarly, only 19 percent were influenced by job availability in the field.\(^\text{v}\)

Relating this to Maslow’s hierarchy, the counselors in the study seem to be motivated less by basic needs and more for something that creates personal fulfillment. Recognizing that people working in the addiction services profession are often motivated by things other than money, there are other rewards that people can receive.

An important way to recognize the critical work performed in the addiction services profession is through the NAADAC recognition program. It is a way to recognize professional excellence, a way to benchmark your performance against other outstanding players in the profession and a chance to pause and celebrate the important work that practitioners do around the nation.

We all work for paychecks, and it is the compensation that helps us survive in society, but the opportunity to thrive and show our best side is an incredibly potent motivator. If you know of someone who deserves national recognition for their work, please nominate him or her for a NAADAC award.

More details are available at www.naadac.org > click on About NAADAC > Recognition and Awards or call 800.548.0497.

Donovan Kuehn serves as the Director of Operations and Outreach for NAADAC, the Association for Addiction Professionals, as Editor of the award-winning NAADAC News and is a recipient of the 2010 Rising Star Scholarship from the Angerosa Research Foundation.

References
\(^2\)Ibid.
\(^3\)Ibid.
\(^4\)Ibid.
\(^5\)Ibid.
\(^6\)Ibid.

So how does this play out in the workplace for addiction professionals? In 2001, NAADAC, the Association for Addiction Professionals, embarked on a three-year program of study funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) called the Practitioner Services Network.
Sharpen Your Counseling Skills
NAADAC is proud to have released an update of its acclaimed Basics of Addiction Counseling. The newest edition has been broken up into three modules that focus on knowledge addiction services professionals need to keep current:

- Pharmacology of Psychoactive Substance Use, Abuse and Dependence
- Addiction Counseling Theories, Practices and Skills
- Ethical and Professional Issues in Addiction Counseling

...and you can earn CE credits!

Purchasers also have the option of enhancing their learning by ordering the Basics of Addiction Counseling Independent Study Course that corresponds to each module. Each course includes the manual and an independent study exam that can be completed and returned to NAADAC for continuing education credits, as well as useful practice that closely resembles NAADAC certification exams. The exams offer a total of 42 continuing education credits or 12, 14 or 16 credits separately, depending on the module.

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.

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 skilled-based and focused on the brain; how it works in conflict and how to affect the quality of recovery in relationships.

For more information, visit www.naadac.org>Education>
Knowledge Center or call 800.548.0497.
$1,000 Scholarship Available From the University of Cincinnati Addictions Studies Program

The Addictions Studies program at the University of Cincinnati has announced a new scholarship program specifically for working professionals. Between now and Summer 2010, any employee currently working in the chemical dependency profession who is accepted into the Addictions Studies program will receive a $1,000 scholarship.

Now offered in an online format, this degree includes a comprehensive 180 credit hour curriculum that fulfills the academic requirements of the Ohio Chemical Dependency Professional Board LCDC III. Applicable transfer credit from accredited universities may be applied to degree requirements.

To see more about the program and application requirements, visit www.ccch.uc.edu and search the A–Z listing for Addictions Studies. For more information about the scholarship program, contact ccch@uc.edu or 888.325.2669.

In the Field of Recovery Artwork Submissions

Southeast, Inc. sponsors Fresh A.I.R. (Artists in Recovery) Gallery to exhibit the works of individuals affected by mental illness and/or substance abuse disorders. The gallery works to break down the stigma of mental illness and substance abuse by bringing focus to the artistic vision. Fresh A.I.R. Gallery’s 32 previous exhibitions have featured works by emerging as well as regionally established artists with serious and persistent mental health disorders, artists with substance use disorders and artists who are family members of consumers.

For Mental Health Recovery Month 2010, Fresh A.I.R. Gallery is exhibiting In the Field of Recovery with artwork created by professionals who work in the behavioral health field. The call for entries provides details about how to submit work for this juried exhibition. Please share this with any colleagues who may wish to participate.

The deadline for submission is March 5, 2010. A jury — comprised of Sandy Stephenson, Director of the Ohio Department of Mental Health, Betsy Nofziger, Senior Program Consultant with the Center for Vocational Alternatives (COVA), consumer & artists Jennifer Eisenhauer, and artist Karen LaValley will select artists and artwork for the exhibit. The show will open with an artists’ reception in the gallery on May 12.

For more information, contact Myken Lint Pullins, 614.225.0980 or lintm@southeastinc.com.

Swedish Parliamentarian Consults with NAADAC

In February, the Swedish embassy contacted NAADAC to set up a meeting between NAADAC staff and Swedish parliamentarian Jan R. Andersson. Mr. Andersson wanted to investigate successful programs for reducing and stopping use of alcohol, tobacco and drugs, with a particular focus on younger populations. He was also interested in lobbying and public affairs programs and how they work on addiction issues in the United States.

SAMHSA Releases Data from the Latest National Survey of Substance Abuse Treatment Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released findings from the 2008 National Survey of Substance Abuse Treatment Services (N-SSATS).

N-SSATS is an annual census of substance abuse treatment facilities that provides data on the location and characteristics of alcohol and drug abuse treatment services throughout the United States. It also provides information on the scope and nature of how these facilities and programs are used.

Throughout the nation, the 13,688 eligible facilities that responded to the survey reported that a total of nearly 1.2 million clients were in treatment in their facilities on March 31, 2008. Private non-profit run facilities made up the bulk of treatment facilities (58 percent) while private for-profit facilities made up 29 percent of these services in 2008. The remaining facilities were operated by local governments (6 percent), state governments (3 percent), the Federal government (2 percent) and tribal governments (1 percent).

The 2008 N-SSATS shows that there were 474 adults in treatment at substance abuse facilities for every 100,000 people in the U.S. aged 18 and older.

The report’s other major findings include:

- The total number of substance abuse treatment facilities remained relatively constant between 2004 and 2008 (13,454 to 13,688), while the number of people in treatment increased slightly (from 1,072,251 to 1,192,490).
- Thirty-nine percent of all people in substance abuse treatment facilities had diagnosed co-occurring abuse and mental health disorders.
- Clients under age 18 made up slightly more than 7 percent of all clients in treatment at the time of the survey.

Copies of this report and all its detailed findings are available on the Web at wwwdasis.samhsa.gov/08ssats/08ssats2k8.pdf. They may also be ordered free of charge by calling SAMHSA’s Health Information Network at 877.SAMHSA.7 (877.726.4727). Request inventory number SMA09-4451.

For related publications and information visit the SAMHSA Web site at www.samhsa.gov.
How To Write a Winning Grant Proposal

Handy Tips for Tapping Into Government Grant Funding

Rebecca A. Clay

Stanley Kusnetz, MSEd, has reviewed hundreds of grant applications in his long career as a senior review administrator in SAMHSA’s Office of Program Services. A few stand out. Take the application from a would-be grantee that didn’t bother to mention the substance abuse problem the organization was hoping to tackle.

“Rather than actually describe the substance abuse problem in the South Bronx, the organization just kept describing itself as Fort Apache — a reference to a movie that was about substance abuse in the South Bronx,” said Kusnetz. “But as far as the review committee was concerned, the South Bronx didn’t have a substance abuse problem, because the organization didn’t describe it.”

Making assumptions is just one of the common mistakes Kusnetz and other reviewers see. They have plenty of advice for those seeking funding from SAMHSA.

Grant Writing Tips

Use the following tips to boost your chances of crafting a winning grant proposal.

• Plan ahead. “Applicants are often scurrying at the last minute,” said Cathy J. Friedman, MA, a public health analyst in SAMHSA’s Office of Policy, Planning and Budget and a former staffer in SAMHSA’s review office. Allow yourself enough time to give a grant application the time it deserves.

Make things easier for yourself by doing as much as you can ahead of time. “Certain parts of a Request for Applications (RFA) are standard, so try to prepare those parts in advance,” recommended Friedman. “Once you’ve put together that information,” she said, “you can re-use it in every SAMHSA application.” If you’ve never applied for a SAMHSA grant before, you can review SAMHSA’s past grant announcements to see what other applicants have done – www.samhsa.gov/Grants/archives.aspx.

• Look for a good match. Don’t apply for grants willy-nilly. Friedman encourages applicants to look for a good match between what the grant program requires and what you can offer. Start by reviewing the Executive Summary on the first page of every RFA, which gives a thumbnail sketch of the award information, program’s purpose, application due date, and other details. Also check to make sure you’re eligible to apply. For some programs, for example, only states are eligible.

And don’t over-promise warned Kusnetz. Before you apply, consider whether you actually have the capacity to do what you propose, including collecting data on outcomes.

• Follow directions. No matter how good your proposal is, it will be screened out if you miss the deadline, exceed the page limit, fail to follow formatting requirements or make similar errors.

Pay special attention to the project narrative section, where you have a chance to explain your proposal in depth. “Write in plain English what you’re going to do, how you’re going to do it, and how you’re going to evaluate it,” recommended Ms. Friedman. “Sometimes people are so convinced that their project is terrific, they just send in something about their program without really responding to the requirements of the grant announcement.”

Be very specific, added Mr. Kusnetz. “A very common mistake is for applicants to give you a list of what they’re going to do without saying how they’re going to do it,” he said. “Lots of ‘whats’ without ‘hows’ don’t work.”

• Don’t make assumptions. Don’t leave things out of your application because you assume the reviewers already know them. “You leave something out at your peril,” warned Kusnetz, explaining that the experts who review grant applications use a structured checklist of criteria to score applications.

Cultural competency is one area that applicants often overlook. “We might get an application from an Indian tribe that doesn’t discuss the cultural competency elements of working with the tribe because they figure, ‘Hey, we’re a tribe, so of course we know these things,’ ” said Kusnetz. “But the reviewers are instructed not to assume anything. If it’s not written in the application, it doesn’t exist.”

• Have someone else read your application. Simply running a spell check isn’t enough. “For some reviewers, it’s hard to get past the technical errors to see the quality of a program,” said Friedman, citing punctuation problems, run-on sentences and inaccuracies in the table of contents or appendices as just a few examples.

Having at least one person who hasn’t been involved in writing the application read it over can save you from more than embarrassing typos: A proofreader can also catch inconsistencies. “So many times we get answers that are contradictory,” said Friedman. “Sometimes organizations have different people write different parts of the application. They need someone to read the finished product and make sure it all hangs together.”

Avoid these key errors and the grant process can reap dividends.

Reprinted from the SAMHSA News, September/October 2009, Volume 17, Number 5

Resources

• SAMHSA’s grants Web page lists announcements of SAMHSA funding opportunities – www.samhsa.gov/grants.

• Developing Competitive SAMHSA Grant Applications is a manual that guides readers through the process of planning and preparing successful applications – www.samhsa.gov/grants/ta/index.aspx.

• Grants.gov lists grant opportunities from all Federal agencies. Search the database or sign up to receive emailed alerts based on subject area, funding agency or other criteria – www.grants.gov.
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!
NAADAC News
NAADAC Education and Research Foundation
1001 N. Fairfax Street, Suite 201
Alexandria, VA 22314

UPCOMING EVENTS

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, please 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, visit www.ptcny.com/clients/NCC
April 23 and 24, 2010
Montana 2010 Conference – Building Skills for Addiction Professionals
Featuring Dr. Carlo DiClemente
Red Lion Colonial Hotel
Helena, MT 59601
Sponsored by the Chemical Dependency Bureau (including Montana Chemical Dependency Center), Addictive and Mental Disorders Division Montana Department of Public Health & Human Services and NAADAC, the Association for Addiction Professionals. For more information, please visit www.naadac.org

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 skilled-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 4, 2010
Ethics for Addiction Professionals Seminar
Alexandria, VA – NAADAC National Office
More details at www.naadac.org
June 5 through 12, 2010
Exam Dates for the June 2010 NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exam
Across the nation
For credential descriptions, visit www.naadac.org.
The Professional Testing Company administers testing for the NAADAC National Certification Commission. For more information on the exam, please visit www.ptcny.com/clients/NCC
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, visit www.ptcny.com/clients/NCC

September 1 – 30, 2010
Recovery Month
Washington, DC
Events Nationwide
For more information on events, please visit www.naadac.org or recoverymonth.gov
September 8 – 11, 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, please visit www.naadac.org
September 11 through 18, 2010
Exam Dates for the September 2010 NCAC I, NCAC II, MAC, ASE, Nicotide Dependence Specialist and Basic Exam
Across the nation
For credential descriptions, visit www.naadac.org.
The Professional Testing Company administers testing for the NAADAC National Certification Commission. For more information on the exam, please visit www.ptcny.com/clients/NCC
September 20, 2010
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
October 15, 2010
Application Deadline for December 2010 NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exam
Across the nation
For credential descriptions, visit www.naadac.org.
The Professional Testing Company administers testing for the NAADAC National Certification Commission. For more information on the exam, please visit www.ptcny.com/clients/NCC

For a complete interactive calendar, visit www.naadac.org > Education > Calendar of Events
Have an event we should know about? Contact 800.548.0497, ext. 122 or e-mail dkuehn@naadac.org.