Is This the Future of Treatment?

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Editor’s Note
Looking Forward
Every so often, it’s nice to be able to sit back and reflect on what it is that we do and how we can stay focused on our goals. One of those times for me was at the recent NAADAC conference in San Diego. It was an amazing event, with over 1,000 people attending. There is something dynamic about having so many people together who share a common purpose. You can read the recap of the conference on page four, and find out more about the two professionals and one program that were honored this year. Also in this issue is an interesting article by David Oshman, describing the international option that has taken him to a treatment center based in Thailand. He has some lessons that could be adopted by other treatment centers and his article raises the issue of outsourcing and treatment.

Finally—NAADAC has taken a stand against medical marijuana. You can read why the association thinks this is bad medicine. I hope you enjoy the issue.

Donovan Kuehn
Editor, NAADAC News
The Opportunity of a Lifetime!
Getting Involved in the Profession of Addiction Counseling
Kevin M. Large, MA

“We’ve all heard that we have to learn from our mistakes, but I think it’s more important to learn from successes. If you learn only from your mistakes, you are inclined to learn only errors.”
– Norman Vincent Peale

Who We Are
The people who compose the addictions treatment profession are a diverse group. We have come from varied life experiences, which have often been our greatest teacher. We have come from various academic backgrounds, ranging from little or no college through doctoral level training. We have worked in a variety of treatment settings. No matter what the degree is behind our name, no matter what the professional title or license/certification that we may hold, we have something in common!

What we have in common is specialty background that both brings us together and makes us valuable. It is our diversity that is inherently reflective of our varied backgrounds that makes us such an interesting group!

Why We Become Involved
There are many individuals who have become addictions counselors as a result of their own personal journey to recovery. Many people who choose a career of counseling individuals and families that are dealing with alcoholism and drug addiction have themselves come from a family with a history of alcoholism and/or drug addiction. And there are many professionals who have come to be interested and involved in the treatment of alcoholism and addiction based upon the needs of the clients they work with on a daily basis.

Ways of Getting Involved in Support of the Profession
The greatest thing we do is providing care and counseling to our clients, their families and the community. In addition, I would suggest some other ways to get involved:

- **Write an article**—or even develop and write a column—for a local newspaper.
- **Write an article** for publication in a professional magazine or for an association newsletter.
- **Volunteer to serve** on a committee or in a leadership position with a membership association at the local, state or national level.
- **Develop a lecture** presentation on a topic related to alcoholism and/or drug addiction, and work in conjunction with a teacher or professor that could utilize your experience and knowledge in making a presentation to a class.
- **Teach a course** on alcoholism and drug addiction counseling at a local school, college or university.

- **Contribute to the NAADAC Political Action Committee** (PAC). For more information, go to www.naadac.org and click on the tab for Advocacy and then PAC. Your contribution to the NAADAC PAC helps to support legislation favorable to the cause of the treatment of alcoholism and drug addiction at the national level.
- **Write to your congressperson and senator**, urging them to support legislation favorable to addictions treatment. For more information, go to www.naadac.org and click on the tab for Advocacy, and you will find a wealth of information, links, and resources.
- **Volunteer in your community**. For example, participate in a community-wide panel on substance abuse prevention and/or treatment.
- **Volunteer your time as a mentor** for a new professional who is just starting his or her career. Your advice could help new professionals avoid some of the pitfalls many people face in their career.

Where Do We Go From Here?
We will always be specializing in one area of treatment or another. We will always be searching for different ways of engaging our difficult clients. We will always be searching for some new tools for our counselor’s “tool box” and seek out some rest and relaxation for ourselves along the way.

So, let us not forget who we are and what we are here for! We are dedicated professionals, committed to caring for others whose lives have been strangled by the throes of addiction, and seeking to warn those that would suffer the same fate and attempt to help them steer their lives on a different course.

To paraphrase a couple of familiar quotations:

“Ask not what your organization can do for you, but what can you do for your organization.” “Now is the time for all great addictions counselors to come to the aid of their profession!”

I thank each and every one of you for what you do for both our clients and our profession. It is through our long days and many years that we have helped those that have been able to pull their lives back together and hopefully enjoy a more stable and meaningful existence.

Kevin Large works as a clinician in southwestern Michigan.
S
an Diego was at the center of
some of the most interesting
discussions on addictions in Sep­
tember. Host of the NAADAC
national conference, some of the
best minds focused on addiction preven­
tion, intervention and treatment gathered
with over 1,000 participants to address
the issues of the day.

Here are some of the highlights of the
proceedings.

Jerry Moe
The National Director of the Betty
Ford Center Children’s Programs, ad­
dressed the issue of parental recovery and
its impact on children.

Moe asked the profession to be pro­
active: “I want to see a study on recovery
and how it affects families, not more on
how kids are affected by addiction.”

Moe, pulling from his sometimes heart­
breaking experiences at the Betty Ford
Center, had a simple point for clinicians.

“Kids don’t care about how much you
know until they know about how much
you care,” he said.

Dr. H. Westley Clark
During his presentation, titled Does
Health Information Technology Have a
Place in Addiction Treatment?, H. West­
ley Clark, MD, JD, MPH, CAS, FASAM,
Director of SAMHSA’s Center for Sub­
stance Abuse Treatment, asked the
pointed question: “How many of you are
using electronic health records?”

The response was underwhelming.

Dr. Clark said too many treatment
providers still haven’t implemented elec­
tronic health records (EHRs) despite the
“need to have the ability to document
what they do.”

“People want to know what they are
getting,” said Dr. Clark. “Stories are not
enough; we need data, a sense of quality.
Otherwise, how are we supposed to learn
that people are getting better?”

While pointing out that health infor­
mation technology is “supporting behav­
ioral health aspects of the EHRs based on
standards in the system,” he added that
data collection, privacy and confiden­
tiality will also be a key components of
the new process.

“These are all issues concerning infor­
mation practices. But these issues are not
peculiar to behavioral health; they are not
specific to substance abuse,” Clark said.
“They are general. And all of us will have
to deal with these issues.”

President Obama
The President sent a message to partici­
pants that was read out at the conference.

“Substance abuse and addiction affect
millions of Americans and their families,
straining relationships, communities, our
economy and our health care system. As
a Nation, we must do more to address
these challenges. Though long-term re­
covery is a reality for everyone struggling
with addiction, with the help of dedi­
cated professionals, we can aid recovering
addicts in breaking the cycle of abuse and
rebuilding their lives.”

Dr. Stephanie Covington
In her Sept. 20 plenary session, women’s
treatment expert Stephanie S.
Covington, PhD, noted how the approach
to the issues of violence and sexual abuse
with patients has evolved.

Twenty-five years ago, “[Clinicians]
were saying their clients were not ready.
What they were really saying was they
were not ready [to address these issues],”
said Covington, co-director of the Insti­
tute for Relational Development and the
Center for Gender and Justice.

Dr. Covington spoke about how
changes have created a more supportive
environment for addressing all of the is­
suess clients need to resolve, and the need
to create a safe and approachable space.

She asked the participants to consider
their treatment centers. “When someone
comes for help, does it feel like a safe
place?” she asked.

Integrated Recovery Initiative
Several leading organizations in mental
health and addiction treatment an­
ounced that they have joined forces to
advance a model of integrated treatment.

The effort, which began on September
14th, was rolled out at the conference in
San Diego.

Focus on Integrated Recovery, a col­
laboration between Hazelden, Dart­
mouth Psychiatric Research Center,
NAADAC, the Association for Addiction
Professionals, the National Associa­
tion of Addiction Treatment Providers
(NAATAP), the National Council for
Community Behavioral Healthcare and
Westbridge Community Services, has set
out to address the 5.6 million clients
who have co-occurring addiction and
mental health disorders.

The group has taken action to define
the model for integrated treatment
delivery and provide information and
resources for its successful implementa­
tion across treatment organizations.

Cynthia Moreno Tuohy, Executive
Director of NAADAC, the Association
for Addiction Professionals said, “It is
vital in this new era of integrated services
with addiction and mental health that
our professionals are educated and in­
formed of the technologies related to
coccurring disorders. This partnership
in integrated treatment brings the best of
educational technologies, resources, and
outreach to addiction and other helping
professionals.”

Educational information, events and
resources are available at the website,
www.integratedrecoverynow.org.

In addition to the plenary sessions and
over 70 workshops, NAADAC presented
its awards on September 20 — Addic­
tion Professionals Day.

The award winners and highlights of
their accomplishments are laid at right.

As the number of colleges that offer
true recovery support services and hous­
ing grow, Rutgers stands out as a pioneer.

Watch out for information on the 2012
conference at www.naadac.org.
Mel Schulstad Professional of the Year
The Mel Schulstad Professional of the Year award was created in November 1979 and is named after the first President of NAADAC. The award recognizes an individual who has made outstanding and sustained contributions to the advancement of the addiction counseling profession.

Rocio Del Milagro Woody, MSW, is the 2011 Mel Schulstad Professional of the Year. The primary area of interest for Ms. Woody in the clinical field is the impact of linguistically appropriate and culturally sensitive health care in the treatment needs of children, adolescent and adult patients suffering of psychiatric disorders. In 1995, she founded the Road to Recovery, Inc., the first fully multilingual and multicultural professional counseling clinical practice for behavioral health and substance abuse services and is the only private, minority owned clinical practice to have been awarded local, state and federal contracts to provide DUI, drug court behavioral health services and psychological counseling for minors.

Woody serves in the Drug Court Advisory Committee of the Georgia Supreme Court, is a member of the Board of Visitors of Grady Health Systems and is on the Advisory Board of the Southeast Addiction Technology Transfer Center at Morehouse School of Medicine. She also serves in the community as a Founder of the International Family Center, a non-profit organization dedicated to the prevention of domestic abuse in the Latino community is a former Council Member of the General Consulate of Peru in Miami, Florida and is the immediate past President of the League of Women Voters of DeKalb County, Georgia. Woody is originally from Lima, Peru. She proudly became a citizen of the United States of America on November 13, 1987.

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

Thomas A. Peltz, CAS, LADC I, has worked in the mental health field as both a counselor and an administrator since 1973. In his private practice in Beverly Farms, he works with adults, and offers individual, couples and family treatment. Peltz leads group sessions and lectures in the community and has supervised clinical staff and intern students since 1980 in both Massachusetts and Southern Vermont. He has published multiple professional articles, and has been involved with a number of the U.S. Department of Health and Human Services, SAMSHSA Treatment Improvement Protocol (TIP) publications. His selection as Counselor of the Year was endorsed by many professionals, including David Mee-Lee, MD, Chief Editor of the ASAM Patient Placement Criteria and Senior Vice President for the Change Companies, stated that the longer clinicians work in the profession the more they can succumb to a been there, done that perspective. Peltz stands out because he has avoided this pitfall and has always demonstrated a professional humility and admirable thirst for improving knowledge and skills in counseling. These qualities help explain the clinical excellence he strives for and delivers to the people he serves.

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.

The Rutgers University Alcohol & Other Drug Assistance Program (ADAP) in New Jersey, is the winner of the 2011 NAADAC Organizational Achievement Award. The program, one of the first in the nation, focuses on building ties with the community and support students in the university community. ADAP strengthens these ties by training psychiatrists, psychologists, social workers, interns and graduate students both inside and outside of the Rutgers system. In 2011, over 300 individuals were trained. ADAP has helped support recovery housing, with 28 students in New Brunswick and three more in Newark. Students in recovery housing maintain a higher Grade Point Average than the average Rutgers student.

With the support of ADAP, students in the program speak at hospitals, detox centers, rehabs, correction facilities, other universities and high schools. This is done for free, and not part of any other 12-step work that they do. ADAP also offers free training and advice to other university campuses, either in person, via email or on the phone.

Accepting the award on behalf of Rutgers was Frank L. Greenagel, LCSW, LCADC, ACSW.

Know a person or program that deserves recognition?
Check out the NAADAC awards online at www.naadac.org/about/recognition-and-awards.
“What is this?” my disturbed client questioned. “I hate board games!” another grumped. We were playing Blokus. Clients were obviously frustrated.

I smiled as I placed one of my plastic shapes on the board. “Let’s just keep working our way toward the middle. And start thinking about the parallels to life.”

“The WHAT?” Miss Disturbed exclaimed.

“Think of the ways that this game imitates our daily lives,” I explained. Someone moaned.

I’d moved these Intensive Outpatient (IOP)/Moderate Outpatient (MOP) participants into a game. And I always know that they’ll be a bit resistant to my atypical style of teaching—at first. After all, most all of us don’t like to step out of our comfort zones.

Though I use the Courage to Change curriculum, I like to change it up. I encourage what is best described by the much-abused term, “out-of-the-box” thinking. Though my topic of the day was “recognizing your warning signs,” the group had tired of discussing their interactive journaling answers.

Several years ago, I began introducing games like Blokus, Quirkle and Jenga to emphasize the day’s topic. At first clients are resistant. I’ve come to expect that. Many are used to glazing through lectures offering minimal input.

I have found that games provide a venue for exploring topics in greater depth. Jenga is a game many are familiar with; some clients will comment that they’ve never played this game sober. When this is brought up, we discuss it: How does it feel to participate in something that formerly was only enjoyed drunk? Are you experiencing cravings? How can you deal with these cravings? Other group members often have excellent ideas, so I don’t hesitate to stop the game and allow everyone to share. In fact, I often interject more questions as we go.

Jenga provides an opportunity to discuss how use and abuse have affected various spheres of individuals’ lives. After the game is set by stacking the blocks as indicated in the game directions, I’ll begin play by suggesting something like loss of a job promotion or stress with spouse as a way to get group members thinking. This is a particularly apt way to emphasize topics such as stress related to use/abuse or family issues related to dependency.

Often in the first hour of IOP I’ll cover these topics in a more traditional fashion and then move into a game for emphasis during the second hour. Each person in the group is expected to share something when they pull a block and set it on top. What’s interesting to me is observing how many persons will share at a much deeper level while playing a game. It’s as though they processed the topic at hand intellectually during the earlier lecture or worksheet time, but are able to personalize and share from the heart as they interact with one another during the game.

Recognizing that sometimes there are individuals that experience shaking hands for a variety of reasons, I stress that if the tower falls we will simply say “ooops” and rebuild it. When this happens, I often offer the group members the option of playing the second round or watching—however they are not exempt from sharing something when it is “their turn.” They must remain involved by interacting verbally...
even though they are not pulling out and replacing blocks.

Games provide a means for the involvement of everyone. And if I can reposition person’s thinking by this totally different learning framework, I’ve succeeded. What I’ve found most intriguing is how much clients learn and retain—even though it certainly wasn’t their personal agenda.

“This is ridiculous! It’s pointless!” Miss Disturbed grouched. “I don’t know what this has to do with anything!”

Again I smiled, encouraging clients to keep playing. Blokus is one of those games that seem pointless at first. Individuals place their “Tetris-like” colored pieces on a plastic grid and are encouraged to move toward the middle of the board from their corners. For several rounds nothing seems to happen. Furrowed brows are common; many sit and stare. Some get agitated.

However, it wasn’t more than a minute or two later that both of these frustrated individuals changed their tune. Once clients reach a point in the game where it’s no longer easy to place their pieces on the board, they are stuck. They immediately see pieces they’ve laid that they regret putting in specific spots.

“I’m seeing a parallel here; I see some regret,” I comment.

“Yeah, like I never expected to get arrested for a DUI!” Mr. ‘I-Hate-Board-Games’ interjects.

“Or paying for all these fines and classes!” someone added.

Others look closely at the remaining pieces in their trays. Some realize there were better choices.

Another adds, “Next round I’d know more!”

I comment on life’s parallels (especially relating to gaining insight in group) as they continue.

“I can’t play anywhere!” Miss Disturbed moans.

“What about this?” I suggest. Since she’s sitting to my right, I point out her single yellow square. I place it so that she has a whole new region of the board into which to venture.

“Gosh, I didn’t see that!” she smiles.

“What’s the parallel to life?” I encourage.

“I get lonely. I have a pity party. I drink.” Miss Disturbed squirms.

I nod. “So if you can identify your negative self-talk, what might happen?”

“I could stop it before I go out, right? I could walk on my treadmill or do something else.”

“You got it! There’s a new path in watching your warning signs,” I reply…

Later Mr. ‘I-Hate-Board-Games’ interjects, “I like THIS game. I learned something!”

Tedious topics can spring new life during a simple game. And best of all, clients are not even aware that they are processing what’s new—on a whole different level.

Yvonne Riege currently works as a counselor for Addictions Recovery in Northern Indiana. She emphasizes in behavioral and cognitive methods including modeling, shaping and re-shaping thoughts and changing risky self-talk to positive self-talk. Spiritual elements are also included based on her former experience of serving several local congregations as pastor. Riege has keen interest in utilizing Howard Gardner’s Multiple Intelligences and the Enneagram in group work.
As a practicing drug and alcohol counselor for over 25 years, I’ve seen and experienced many changes in treatment since I began.

I remember with great fondness the famous “Minnesota Model,” and how that became the standard for many treatment programs. Based on the philosophy and experience of traditional behavioral modification treatment, along with valid Alcoholics Anonymous (A.A.) principles and application, how could it miss? Unfortunately, it can, and did.

This does not make this treatment approach obsolete, in any way. Many people truly benefit and blossom in such a treatment modality. But what about the people who don’t? Where can they go?

The additional problem is cost. I remember when the typical (forgive that word!) 28-day treatment program set the suffering alcoholic or addict back possibly $4,000. Nowadays, the sticker price for a primary stay in a treatment program (imagining that 28 days might be just the right amount of time) is easily exceeding $30,000.

In response to this, there are what are best described as “alternative treatment programs” popping up all over the world. I’m privileged to work with one in Koh Samui, Thailand!

Infinite Horizons

One such program that is worth noting, and has been developing a quite novel, and apparently effective approach, is Infinite Horizons in Koh Samui.

You might say “Koh Samui? Is this a resort disguised as a treatment center?” No, it is actually a treatment center disguised as a resort!

The first question is why would someone travel such a long distance to receive treatment for a disease that can be treated close to their home? Frankly, it comes down to costs. Support staff and even clinical staff, are available at a more reasonable cost. And other elements such as food and materials are much cheaper in Thailand.

Then there is the therapeutic value of moving the alcoholic or addict out of his home environment. Well, how more removed can you get than moving the client overseas?

Finally, and probably most important, there is the progressive and creative approach to therapy and recovery that can be implemented in a center such as Infinite Horizons.

A Modern Treatment Philosophy and Approach

Infinite Horizons views its program as an enhanced recovery program. Many of our clients have chemical dependency issues. But, interestingly, some do not. We have found that the recovery process, and the need for inner peace and balance, is universal and not something unique to alcoholics and drug addicts. So we view the events that led up to our clients’ “surrender” or need for help as precipitants, not the main problem.

There is certainly a “Buddhist flavor” in our team’s treatment approach. The objective, always, is to eliminate internal conflict, and thus internal suffering. This aligns completely with A.A. principles, especially the spiritual axiom from the Big Book “any time we are disturbed, there is something wrong with us.” The acknowledgement and application of this truth, throughout treatment, empowers our clients to find the inner peace and acceptance that was attempted by their prior often self-destructive choices and behaviors.

Long-term sobriety, and recovery, depends on a person’s ability to remain undisturbed. Focusing on this eliminates the “dry drunk syndrome,” and allows our clients to actually feel the benefits of recovery, not just the loss of chemical and behavioral distraction and relief. This approach often lessens the occurrence of relapse.

At the Helm

As Program Director, I was chosen from a number of candidates because of my background. Besides my years of experience, I have been recovering from very severe drug addiction and alcoholism for over 27 years. This means two things: I have remained abstinent from all mood-altering chemicals (a very important, and often overlooked, component of successful recovery), and I have lived life with possibilities and passion that I was never able to experience before. As Program Director, I am leading a dedicated group of professionals who want to offer this gift to our clients.
I lead a diverse and professional group. Imagine a treatment team consisting of a classic psychotherapist, a well-trained drug and alcohol counselor, a nutritionist, a yoga instructor, a full-time certified nurse, a physical trainer, a spa and massage expert, a reiki master (reiki is a Japanese technique for stress reduction and relaxation that also promotes healing), a homeopathic physician, a medical doctor and a dog named “Black.” Diverse? Yes? Unique? Possibly. Effective? It certainly has been.

The holistic approach mandates that I allow the professionals to just do their jobs. This eliminates the need to micromanage them, and frees me up to spend more time with clients, and less time with the staff. And since our maximum population is seven patients at any particular time (yes, seven), I get to know and offer guidance and therapy to them. And, for me, that’s the greatest joy of being a psychotherapist and counselor.

A Different Approach

Quite often, rehabs and treatment centers throughout the world, well-meaning as they are, merely offer an overwhelming series of meetings and 12-step based lectures. This can be productive, but quite often fails to adequately acknowledge, address and effectively resolve internal and external issues that have a severe impact on the ability to maintain a successful and comfortable sobriety.

In our program, we take a very different approach. Instead of repeating the same information over and over again, we feel it is much more effective to assist our clients in regaining long-term health and balance of body, mind and spirit. This approach is completely supported by the 12 steps of A.A. and other self-help groups. The difference is that our clients experience a tremendous amount of growth and change within treatment, and are much more prepared to succeed and live a full and meaningful life when they complete treatment.

We merge many different proven techniques in a manner that is effective in empowering people to regain control of their lives. We offer classic psychotherapy, spiritually centered (not religious) counseling and education, medical assessment and support. While all of this intensive healing is taking place, we offer a concurrent program of healing for the body, spirit and soul with yoga meditation, personalized physical training, reiki healing, hydro and aroma therapies, naturopathic consultations and more.

Every person is complex, and unique in their own way. So the standard “cookie cutter” approach to treatment is dismally ineffective. We treat our clients as individuals and devise and implement a treatment plan that is specifically designed to support growth and richness of life. And, using a concept that is unheard of in most treatment programs, we empower our clients by inviting and encouraging them to take an active role in formulating and implementing that plan. They truly become an active part of the solution.

All of our clinicians agree that abstinence and sobriety is inadequate if not combined with happiness, contentment, a richness of life, and an ability to function and improve the quality of their lives at all levels. If anhedonia (the inability to experience pleasure from activities usually found enjoyable) is the problem, we feel that our clinic is the answer!

Co-Occurring/Dual Diagnosis

It is difficult for clinicians to accurately assess when patients presenting for drug addiction or alcohol addiction treatment are actually also experiencing dual diagnosis, also known as co-occurring disorders. Clients with co-occurring disorders are defined as individuals experiencing both an addiction and a mental health condition, such as mood or anxiety disorders. Often, they are failed by the current system. Accurate evaluations and assessments are often not utilized, and the patient becomes categorized as either suffering primarily from a mental health condition or an addiction as opposed to a co-occurring disorder. This dramatically impacts the patient’s subsequent quality of care and course of treatment. To ensure the client receives appropriate care, we have implemented an intensive intake process that helps to accurately identify clients with co-occurring disorders and aggressively treat individuals who are deemed as having dual diagnosis or co-occurring disorders.

Statistically, substance abuse and mental health conditions are intrinsically linked. Frequently substance
abuse arises as a symptom of underlying psychiatric diagnoses and most individuals seeking assistance are in fact dual diagnosis patients. Compelling peer reviewed research, recently published in the Journal of Psychiatric Services, states that the overwhelming majority of patients are, in fact, experiencing co-occurring disorders. This population is also growing at an alarming rate, and are often mis-categorized due to an ongoing lack of proper diagnostic techniques. Epidemiological data suggests a co-occurring disorders rate of 79 percent in patients initially presenting for substance abuse treatment. Unfortunately, only 8 percent of these individuals receive the necessary simultaneous treatment for both their addiction and co-morbid psychiatric conditions (Kessler et al., 1996). This demonstrates a shocking gap in health care delivery systems for dual diagnosis patients who are suffering from their co-occurring disorders worldwide.

Treatment Centers and Co-occurring Disorders

Treatment centers are actively addressing this gap for clients with co-occurring disorders through a comprehensive evaluation processes, including highly extensive psychiatric and psychosocial assessments, that accurately diagnose patients who have co-occurring disorders and then create an appropriate treatment program to meet their unique needs. The initial assessments conducted by the clinical team at Infinite Horizons take into account the possibility of dual diagnosis or underlying psychiatric conditions, and are vital for the formulation of a comprehensive and appropriate plan to simultaneously treat these conditions with maximum clinical value.

Instead of having our clients thrown into sessions that are not appropriate to their treatment progress, we have developed a five phase system to insure that all elements are effective and properly timed.

**Phase 1: Balancing and Regeneration**

**Phase 2: Introspection**

**Phase 3: Processing and Resolution**

**Phase 4: Internalization and Integration**

**Phase 5: Real Life Re-Entry**

During Phases 1 through 3, all activities and elements are considered an integral and vital part of the program and so are not optional. However, Phase 4 and 5 allows the client to make responsible decisions about the activities and elements that are most productive for them. This supports empowerment and reinforces the message that ultimately each person needs to take responsibility for their recovery and their life.

It is important to note that these phases are not pre-determined and are adjusted according to the needs of every client individually. Generally, Phase 1 runs from three to seven days. The length of Phases 2 through 4 depends entirely on the needs of the client. Phase 5 runs three days.

Therapeutic decisions regarding the phase movement is never punitive. It is always with a complete sensitivity to the needs of each client and a willingness to address those needs in an effective and loving manner, that these decisions are made.

This is one of many approaches that has made our program so effective.

Length of treatment ranges from 35 to over 90 days, and this is reassessed by clinical staff on a continual basis. We are not insurance driven, but rather rely on self payment and a hefty grant fund.

**Family Program**

Substance abuse and co-occurring disorders affect not only individuals, but their families as well. To deal with this reality, Infinite Horizons has developed a fully comprehensive program to address the unique difficulties faced by families and loved ones in the aftermath of addiction. We incorporate a family therapy program into each client’s treatment. Family therapy provides a greater level of understanding between client and family, repairs relationships and creates a positive support system to help promote ongoing sobriety and stability.

Relationships can be destroyed by the power of addiction and related behaviors. Our goal is to educate families about their loved one’s addiction, re-introduce and reunite loved ones who have been alienated by negative behaviors and fully incorporate supportive family members into the recovery process. Families and relationships are composed of individuals, but interact and behave as systems.

Research shows that an individual’s chances at succeeding are linked to family interventions and the quality of support systems. This serves to ease the transition from treatment to home environment and foster the emotional bonds necessary for continued healing and recovery. Infinite Horizons includes in it program this very special Family Therapy program hosted on the client’s last three days of treatment.

We are truly passionate about recovery. Our programs focused on individualized care, unique locale and integrated treatment team increase our ability to help our clients in finding their own path of joy and fulfillment.

David Oshman, CADAC, is the Program Director for Infinite Horizons. He can be reached at +66 813618448.

**Resources**

- Co-occurring Disorders: Substance Abuse & Mental Health Services Administration, www.samhsa.gov/co-occurring/default.aspx
- Thailand: Background: U.S. Department of State www.state.gov/r/pa/ei/bgn/2814.htm
The organization that speaks out for 75,000 addiction-focused professionals has made it clear: marijuana is not medicine.

Issuing a position statement on the issue, NAADAC, the Association for Addiction Professionals states, “Marijuana should be subject to the same research, consideration and study as any other potential medicine, under the standards of the U.S. Food and Drug Administration (FDA).”

NAADAC came to this conclusion because marijuana “has a high potential for abuse, has no currently accepted medical use in treatment in the United States and has a lack of accepted safety for use under medical supervision.”

NAADAC represents the professional interests of addiction counselors, educators and other addiction-focused health care professionals in the United States, Canada and abroad.

Voters in many states have approved the concept of “medical marijuana” in referenda across the nation. While NAADAC supports the right of citizens to participate in the democratic process, it does not support legislative or voter ballot initiatives to legalize marijuana for medical use.

“NAADAC recognizes the supremacy of federal regulatory standards for drug approval and distribution. NAADAC recognizes that states can enact limitations that are more restrictive but rejects the concept that states could enact more permissive regulatory standards. NAADAC discourages state interference in the federal medication approval process,” reads the position paper.

“The name ‘medical marijuana’ is false. Marijuana is marijuana, with a negative impact on the health of the user, the community that needs to police the use and sale of the drug and the negative impact that comes from the manufacture and sale of this illegal product,” said Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, Executive Director of NAADAC.

“People who use marijuana are endangering their health,” she added.

### NAADAC Position Statement on Medical Marijuana

**Summary**

NAADAC, the Association for Addiction Professional does not support the use of marijuana as medicine. Marijuana should be subject to the same research, consideration and study as any other potential medicine, under the standards of the U.S. Food and Drug Administration (FDA). Further, NAADAC does not support legislative or voter ballot initiatives to legalize marijuana for medical use.

**Background**

- Marijuana is listed in Schedule I of the Controlled Substances Act (CSA), the most restrictive schedule. The Drug Enforcement Administration (DEA), which administers the CSA, continues to support that placement, and FDA concurred because marijuana met the three criteria for placement in Schedule I under 21 U.S.C. 812(b)(1) (e.g., marijuana has a high potential for abuse, has no currently accepted medical use in treatment in the United States, and has a lack of accepted safety for use under medical supervision).

- Marijuana should be subject to the same research, consideration, and study as any other potential medicine. The U.S. Food and Drug Administration (FDA) is the sole Federal agency that approves drug products as safe and effective for intended indications. The Federal Food, Drug, and Cosmetic (FD&C) Act requires that new drugs be shown to be safe and effective for their intended use before being marketed in this country. FDA’s drug approval process requires well-controlled clinical trials that provide the necessary scientific data upon which FDA makes its approval and labeling decisions. If a drug product is to be marketed, then disciplined, systematic, scientifically conducted trials are the best means to obtain data to ensure that drug is safe and effective when used as indicated. Efforts that seek to bypass the FDA drug approval process would not serve the interests of public health because they might expose patients to unsafe and ineffective drug products. FDA has not approved smoked marijuana for any condition or disease indication. NAADAC recognizes the supremacy of federal regulatory standards for drug approval and distribution. NAADAC recognizes that states can enact limitations that are more restrictive but rejects the concept that states could enact more permissive regulatory standards. NAADAC discourages state interference in the federal medication approval process.

- There is currently sound evidence that smoked marijuana is harmful. A past evaluation by several Department of Health and Human Services (HHS) agencies, including the Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute for Drug Abuse (NIDA), concluded that no sound scientific studies supported medical use of marijuana for treatment in the United States, and no animal or human data supported the safety or efficacy of marijuana for general medical use. There are alternative FDA-approved medications (i.e., Oral THC) in existence for treatment of many of the proposed uses of smoked marijuana. NAADAC rejects smoking as a means of drug delivery since it is not safe.

- A growing number of states have passed voter referenda (or legislative actions) making smoked marijuana available for a variety of medical conditions upon a doctor’s recommendation. These measures are inconsistent with efforts to ensure that medications undergo the rigorous scientific scrutiny of the FDA approval process and are proven safe and effective under the standards of the FD&C Act. Further, voter or legislative initiative does not meet the scientific standards for approval of medicine. Voter and legislative passage of marijuana-as-medicine laws may actually inhibit good medicine because they shortcut the necessary step of researching the marijuana plant and the chemicals within that may have legitimate medical applications. NAADAC does not support legislative or voter ballot initiatives to legalize marijuana for medical use.

Approved by the NAADAC Executive Committee: January 2011.
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CE Quiz

Earn continuing education credits by taking this quiz on the articles from pages 8 to 10 of this issue. A grade of 70% or above will earn you a Certificate of Completion for three nationally certified continuing education hours. This is an open-book quiz. After reading the article, complete the quiz by circling one of the answers for each question. Please give only one response per question. Incomplete or multiple answers will be marked as incorrect. The quiz is worth three continuing education (CE) credits.

Send a photocopy of this page along with your payment of $35 for three CEs (NAADAC members) or $50 for three CEs (non-members).

Please complete the information sections below and print clearly.

I certify that I have completed this quiz without receiving any help in choosing the answers.

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NAADAC, The Association for Addiction Professionals, CE Quiz, 1001 N. Fairfax Street, Suite 201, Alexandria, VA 22314

1. Which of the following statements about the Minnesota Model of treat are true?
   a. The treatment mode is obsolete.
   b. It can only be used with patients from the Mid-West of the United States.
   c. It lacks cohesive principles and application.
   d. It is an appropriate treatment model for some, but not all patients.

2. Why would a client choose to get treatment overseas?
   a. Treatment is more affordable.
   b. There is a therapeutic value to treating clients in away from his or her home environment.
   c. There are innovative treatment approaches that can be implemented in overseas clinics.
   d. All of the above.

3. Diverse treatment teams are referred to as:
   c. Dual diagnosis.
   d. Long overdue.

4. What is the best way to address the unique needs of each individual in treatment?
   a. Adopt a “cookie cutter” approach that applies to all patients.
   b. Reduce the input of patients.
   c. Devise and implement a treatment plan in consultation with the patient.
   d. Only accept compliant patients into treatment programs.

5. Epidemiological data suggests a co-occurring disorders rate of 79 percent in patients initially presenting for substance abuse treatment. What percentage of these patients receive appropriate treatment?
   a. 1%  c. 35%
   b. 8%  d. 79%

6. Which of the following is NOT a benefit of incorporating families into treatment modalities?
   a. Repairing family relationships.
   b. Creating a a greater level of understanding between client and family.
   c. Friends and family discounts.
   d. Creating a positive support system to help promote ongoing sobriety and stability.
The Automation Quandary
Understanding Where to Start With Clinical Technology

Paul H. Le

Nothing is wrong with paper and pencil. There, I said it, after more than 10 years of helping addiction and mental health professionals assess technology needs and feasibility. I admit that paper and pencil may tip the scales on technology for cost. Arguments can be made on both sides for convenience, transportability and practicality. But when it comes to efficiency, technology is hard to top.

Efficiency is critical in most clinical settings—for good or bad. Ensuring everyone’s on the same page regarding client treatment plans, schedules, etc., is important. It ranks right up there with making sure the coffee station is stocked.

Clicking a button and having instant access to a client’s treatment plan—to know progress or anything else, anytime—has value. Technology enables clinical staff to perform certain tasks with more efficiency. It doesn’t guarantee success, of course, but the right “solution” used the right way leads to good things.

So the question really isn’t whether technology can be helpful. More often, I find people asking what technology would work best for them. Whether for a counselor assessing clients from a small office in an outdoor strip mall, or for an entire county of treatment providers, there is something out there that can work. But to make matters frustrating, today there are about as many technology options as there are choices in the salad dressing aisle.

Help is here. I’m not selling a be-all, end-all method for selecting the right technology, but I am willing to share what has helped me and many others: keep…it…simple.

In order to figure out what technology suits you or your organization’s needs:

1. **WRITE IT OUT**—what you have, want and need.

2. **UNDERSTAND THE OPTIONS**—what’s out there and how do I know its right for me?

**Write it Out**

Write out what you already have, what you want and what you need—for documentation, tracking, planning, scheduling, reporting and so on. You may already have a Clinical Management System, use MS Word, or paper and pencil.

Again, keep it simple. Are you dissatisfied? Write out the reasons and then push yourself to answer—honestly—if they justify change. Most likely, some will and some will not. The following are just some examples.

- “I already have a solution/system in place, but it doesn’t seem to do what I want.”
  
  Does the solution really fall short, or do you not understand its capabilities? And is what you want, really what you need? Be honest before upgrading or swapping.

- “I’m fine with using paper/pencil to work with clients. I’m sure software would help, but I doubt I can afford it.”
  
  Embrace the golden rule: if it ain’t broke, don’t think you have to fix it. However, if you think “software” equals “better services for my clients” then it may be worth looking into. Especially if it can be more cost-effective. There are numerous programs out there (web-based specifically) that only cost a small monthly fee. Think of it this way: If you assess only one client a month, that cost alone could easily pay the monthly fee and more. And yes, quality systems at that cost do exist.

- “We’re forced to use a system for state/federal/contract funding which is critical, but it lacks clinical relevance. So we use another system to handle our case management.”
  
  Another all-too-common, legitimate complaint among addictions professionals. Work with the software vendor and the state on interoperability solutions. Most state/federal systems have the capability to work with third-party vendor software systems, which may allow you to reduce a lot of duplicate data entry. And remember, technology people love to solve problems, innately.

- “My facility doesn’t use any software system at all, how can I expect to purchase and implement a full Electronic Health Record (EHR)?”
  
  Not everyone needs to implement an EHR, at least not right away. Legislation still will go through modifications and regulations will change. However, it’s only natural that other payors will start requiring some form of technology be used in the years to come. But for now, even if you can start with a small system that fits your needs now, it can get you prepared for the future.

- “The only way I’ll purchase a system is if it’s a CCHIT-certified EHR system.”
  
  Keep in mind, the core of CCHIT requirement is based on Medicaid/Medicare billing. If you don’t bill for these clients, it may not affect you, at least for now. You may be a counselor that contracts with the court house to conduct assessments and refer. However, there is a chance that insurance companies and other third-party payors will follow federal guidelines. It is estimated that by 2014, Medicaid/Medicare will no longer pay providers for services if they are not using a certified system. So, unless you plan on operating solely on serving self-pay clients, you may want...
to consider looking for systems that are modular, fully or in development to meet CCHIT certifications. If you are not billing for Medicaid/Medicare, just keep a close eye out for changes that continue to take place in healthcare that will impact how you bill for services. Even though CCHIT certification was originally intended for medical based practice, there are now specific requirements for behavioral health EHRs.

Wants are “nice-to-haves.” And while they aren’t necessities, they are important. “Wants” (like needs) should be prioritized. Make them known, up front, because you will be frustrated if—after a long and costly implementation—you’re disappointed to realize you’ve gotten what you need…but not what you want. Put them out there, but be clear and honest with yourself: “These are wants…not needs.”

Many times I have been approached by providers with the same technology quandary. “Paul, I saw 10 different vendors (at a conference) selling (automation) systems from $500 to $500K, but I don’t know what’s right. I’m in private practice with a few other clinicians and we know we can improve workflow and documentation, but I’m not sure which system fits us best.” I encouraged her to write out her goals, follow the steps already outlined in this article, and then helped her prioritize what they need.

Confusion is natural when what we know to be our needs doesn’t match what others say our needs must be. This could be consultants, trainers, regulatory entities, parent companies, peer organizations, friends, family, and yes, even software vendors. “No one knows my needs better than me.” Pile on more confusion if technology experts are combining “need” talk with technology mumbo jumbo. Technology is meant to provide benefit, not headache.

So let’s get back to basics. Ask yourself: what areas about your practice can/should improve—administration, billing, tracking, treatment efficacy, staff efficiency, etc.? Then, prioritize, to know whether or not each of those areas-of-improvement is a “need” or a “want.” You don’t have to have formal statements. It’s more important to be honest and realistic.

Examples of some needs statements are:

• “I need a system that I can just log in to, and find a client’s treatment plan quickly, so I don’t have make a visit to that dreaded file cabinet.”
• “I need to know how many clients admitted in the last six months have thought about or attempted suicide.”
• “I need to reduce the time it takes my staff to document their work because it is decreasing their productivity and even morale.”
• “I need to know if our cultural treatment model is really helping improve the lives of the kids we see and how it impacts the community.”
• “I need to start billing for Medicaid, but I’m not sure where to get started, much less what software I need.”

Understand the Options

After coming up with your list of haves, wants and needs, proceed to discovering the best method for improving things. Start researching your options, and where you fit in. Talk to professional peers, other organizations, consultants. Surf the ’net, get quotes, talk to vendors about different solutions. Keep in mind that your prioritized needs are the litmus test by which every “solution” must pass.

Just beware of software that’s decked out with features that make it really “cool.” Cool may mean more expensive, harder to support, and less likely to use. I always go back to, “What do you need?”

Regardless of your clinical needs, however, the one thing I find everyone needs in a technology solution is simplicity or usability. Simple software gets used.

A few other factors to consider outside of simplicity of use are scalability (Will it grow with me or my organization?), cost efficiency (Does the cost outweigh the benefit? Is it worth paying more for wants vs. needs?) and flexibility (Can it adapt to work with and support our clinical workflow?).

Usability ➤ Adopt ➤ Benefit

In my 12-plus years of consulting on technology implementation, the biggest “X” factor (which I refer to as an “S” factor) in my mind when it comes to looking for a technology solution is service. No matter how easy to use the software is, no matter how “cool” the technology appears, and no matter how cheap or expensive the solution is, a huge factor resulting in the end user’s overall satisfaction is the level of service it receives with the technology.

When searching or evaluating a software solution (or one you currently use), ask yourself: Does the vendor provide you with the proper training, consultation and personal attention you need? Is it aware of health reform and how it affects the addiction field? Can I trust it to have my organization’s best interest at heart?

Of course I understand that need is different for everyone. For some, a 20-minute orientation on the software will have them off and running and they will never need help again unless they forget the password. But maybe you need a full program evaluation with custom development, on-site training and follow-up consulting, plus project management throughout implementation. Regardless of what support you need, it is important that you know that your technology vendor understands what you need and is responsive when needed.

I’ve seen many technology vendors enter the behavioral health market, offer “cool” technology, and then fail after a two-year stint because they couldn’t provide adequate support. That doesn’t breed trust.

Automation, cont. on page 16
Automation, from page 15

To be fair, sometimes the end users don’t always convey their “needs” and “wants” clearly. Or they are not always sure of what they want or need. And there’s always the possibility of the end user changing its mind, during or after implementation. Otherwise known as “feature creep,” this type of behavior can pose a major hurdle during implementation, possibly causing unnecessary delays and costs. This goes back to the earlier message of knowing what you need and want, then keeping it simple.

Large or small, there can always be barriers that impede our progression to automation. Here are some common issues that stop professionals/facilities in their tracks:

- **Affordability.** EHRs and technology have tons of buzz these days, often creating the misconception that it’s too expensive. Like anything else, there are functional and cost options—small, medium and large. Many smaller systems, which offer true solutions, are now being offered at a daily cost less than that of a run to the coffee shop.

- **Technology aversion.** There are people who don’t like technology and might even say it doesn’t belong in practice. This doesn’t apply only to the older generation. I’ve seen a lack of knowledge on computers result in fear and, well, aversion.

- **Resistance to change.** A lot of people don’t like change in general. Clinicians know this all too well. When faced with changing from paper to point-and-click, people often show major resistance.

- **Resources.** This could be an individual counselor trying to see enough clients to make ends meet, or a facility not even having its own company e-mail, much less high-speed Internet.

- **Leadership.** Owner adoption is a major factor. How many times have you been positively motivated or negatively influenced by your supervisor’s actions? Many times I’ve seen the attitude of, “If they aren’t bought into using this system, why should I?”

- **Realistic goals.** Be realistic with goals and expectations. Yes, technology can do just about anything. But that doesn’t equate to, “It should be easy for you to add these 20 questions to the software.” Some things take time, and having realistic goals with open and honest communication between you and your provider of technology solutions will pay off in the end—even if it means that the extra “bells and whistles” don’t make the next software update.

Some software programs are complete systems that can help you with many areas of the clinical process. But it can be a major task to automate everything you do. What I recommend to many providers, big or small, is to separate implementation into phases. Maybe just start doing intake/assessments and progress notes for the first three months, and then introduce treatment plans and follow-ups over the next three months, etc.

Once you’ve selected a vendor for technology solutions, work with it to come up with an implementation plan. It doesn’t need to be long, just useful. The key is that you know what to expect during implementation. That could be as simple as your signing off on the purchase of the software license, your installing or getting set up with the software, then starting to use the software after a quick initial orientation. Or it could mean a full five months of developing specs, customizing the system, training of staff, etc.

Finally, after you have written out your needs and priorities, selected a system, and started using it for, say, three months, did you achieve what you wanted? Have you reached your goals? And if not, what are you and your software partner going to do to make it better?

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Heroin chic was a perverse and twisted fashion trend that resulted in the exploitation of vulnerable young minds. The look, promoting emaciated features and androgyny, was a marketing strategy to seduce young women ever closer to the flame. Called the “dead look,” the “waif look,” and later “junkie chic,” the trend became properly known as the more-sophisticated “heroin chic.” It was a fashion statement, a bizarre alternative in direct contradiction to the healthy, vibrant look of models such as Christy Brinkley, Cindy Crawford, Claudia Schiffer and Heidi Klum.

Thin, white-skinned models, lips painted in black or pale hues, stared vacantly into nothingness. Their exaggerated red eyes were fixed—highlighted with green and hyper blue shadows to emphasize the blank, hollow stare of the junkie. Associated with the look of lifeless and empty drug addicts, heroin chic was an American cultural anomaly that lasted roughly six years. It was intended to be the next new thing, the hot “in look,” but, in the end, it was only a ghoulish fad.

Synonymous with the decadence of the 1990s, heroin chic’s roots sprang from two unique decades of exciting British culture. The first was the London fashion scene of the 1960s. London was the birthplace of numerous artistic trends that reflected the incredible energies of Beatlemania, the English Invasion, the James Bond craze and Carnaby Street fashion. London-based designers, artists and models created trends, such as Dr. Martens and Mary Quant designs, that resonated around the globe. Heroin chic also mimicked punk fashion, developed in the waning days of the late 1970s. It echoed the hard street culture of the drugged-out London underground, individuals who sported colored, spiked hair, leather jackets and safety-pin pierced ears.

A unique aspect of feminine beauty also emerged during this period. Lesley Hornsby, aka Twiggy, was a salon shampoo girl who rapidly became a global celebrity after her photo was featured in a Daily News article titled “This is the face of 1966.” Standing at 5’6½” with a 91-pound pubescent figure, Twiggy was acknowledged as the world’s first supermodel. The 17-year-old Twiggy exemplified the mod look—androgynous, anorexic and hip—that set the dubious standard that continues to this day. Twiggy altered the ideal of beauty and created an irrational image that bordered on near-starvation. A 1967 article in Newsweek noted: “Whatever her ultimate influence on fashion, Twiggy is a radical departure from the past.”

Still, there were voices of protest against the unrealistic expectations being imposed on young women, voices such as Gillian Bobkoff, a British model in the ’60s, decrying the movement: “It was dreadful. [Twiggy] started a trend, and you had to be just the same. I had my hair cut and started killing myself, taking a million slimming pills. I had bulimia. It was a nightmare, trying to keep up.” Anna Greer, editor of the feminist Wo! Magazine, charged that “Eating disorders are a huge problem for especially teenage girls, and I think the impossible body ideals imposed on them by the fashion industry and media and pop culture is obviously a huge contributor to this.”

It is difficult to comprehend anorexia as a fashion concept, yet the macabre trend endured. Twiggy, first in a parade of emaciated models, promoted the extreme look in the 1960s and, three decades later, Kate Moss, the “Twiggy of the ’90s,” was recruited to promote heroin chic.

Heroin chic was the basis of a 1993 Calvin Klein advertising campaign that featured Kate Moss and actor-film director Vincent Gallo. Later, in 1997, Klein released a notorious set of print ads that again used junkie-like models, this time to promote his new perfume cKbe. Some of the sickly models appeared to be in the throes of withdrawal. All were young, drastically underweight, and conveyed that lost, spaced-out look.

Chic, cont. on page 18
Heroin, a morphine derivative, was a likely choice for those working in the fashion industry. As a drug that suppressed the appetite, heroin allowed models enough euphoria and energy to work long, strenuous hours under the lights and in front of the cameras. But it was also dangerous and raised scattered voices of concern. In 1996 the Los Angeles Times argued that the fashion industry had “a nihilistic vision of beauty” reflective of drug addiction.

U.S. News and World Report called the heroin chic movement a “cynical trend.”

After a revealing New York Times article on photographer Davide Sorenti’s fatal heroin overdose, President Bill Clinton accused the fashion industry of portraying heroin use as a glamorous, fashionable drug and an attempt at promoting clothing lines. On May 21, 1997, in an address organized by the United States Conference of Mayors, Clinton addressed a group of 35 mayors. The White House meeting was intended to discuss issues of drug control in major American cities, but Clinton used the opportunity to attack the destructive heroin chic. He stated, “In the press in recent days, we’ve seen reports that many of our fashion leaders are now admitting—and I honor them for doing this—they’re admitting flat-out that images projected in fashion photos in the last few years have made heroin addiction seem glamorous and sexy and cool. And as some of those people in those images start to die now, it has become obvious that this is not true. You do not need to glamorize addiction to sell clothes.”

“American fashion has been an enormous source of creativity and beauty and art, and frankly, economic prosperity for the United States, and we should respect that. But the glorification of heroin is not creative, it’s destructive. It’s not beautiful, it is ugly. And this is not about art; it’s about life and death. And glorifying death is not good for any society. Society can’t take a tough attitude toward illegal drugs and on the other hand send a very different message every time there might be a little money to be made out of it.”

Even the comments from a standing American President held little sway as the emphasis on the waif look translated into more photo shoots and financial gain. Perhaps the tipping point occurred after the terrible 2006 deaths of two Latin American models who starved themselves to death.

On August 2, 2006, Luisel Ramos died soon after stepping off the Montevideo, Uruguay, Fashion Week runway. Ramos, a 22-year-old Uruguayan model, fainted on the way to her dressing room and suffered “heart failure caused by anorexia nervosa.” Medical personnel were unable to revive her. According to her father, the model had gone “several days” without eating and, for a three-month-period, had existed on a starvation diet of salads, greens and Diet Coke. At the time of her death she stood 5’9” and weighed 98 pounds. Her body mass index (BMI) was only 14.5.

One immediate consequence of Reston’s death emanated from the Spanish Association of Fashion Designers, who banned underweight models on the basis of their BMI. As of September 18, 2006, rail-thin models with a BMI below 18 were rejected from the Madrid catwalks and offered medical treatment for their anorexia. The Madrid group explained that it wanted to promote a more positive and healthy aesthetic of feminine beauty for teenagers to follow. That mindset was not lost on Spain’s Association in Defense of Attention for Anorexia and Bulimia, which threatened to have the government legislate to ban stick-thin models if designers...
refused to cooperate with the voluntary restrictions.

Italy’s fashion industry followed in December 2006, as it, too, implemented a code of conduct to battle anorexia. The self-regulatory code was intended to ban models younger than 16 and called for fashion collections to add larger sizes. The code, drawn up in cooperation with the Italian government, also required models to provide medical proof that they did not suffer from eating disorders. It has been estimated that about three million individuals suffer from eating disorders in Italy. The Italian fashion code aimed to redefine feminine beauty and to promote “a healthy, sunny, generous Mediterranean model of beauty.”

Yet despite the controversy, the outrage and the deaths, there were some in the industry who definitely were not convinced. In their 2006 U.S. Autumn collections the Banana Republic and Nicole Miller group introduced, for the first time, “sub-zero” sized fashions for American women.

Why have we allowed individuals like Twiggy—with a skeletal BMI of 14.7—to redefine our standard of beauty? Starvation, as explained by the Food and Agricultural Organization of the United Nations, is a “severe reduction in vitamin, nutrient and energy intake,” and is the most extreme form of malnutrition. In humans, prolonged starvation (in excess of one to two months) causes permanent organ damage and will eventually result in death.

What began with “the Twiggy look” was generally ignored for the next three decades, but then, that deliberate look of death found a new home in the 1990s. Heroin chic became an example of a purposeful and deliberate act of self-destruction, on the part of fashion designers, that exploited a vulnerable group of individuals. Young women need a dramatic alternative, a paradigm shift, away from the images that are being bombarded at them. As a caring and protective society we must provide our youth with appropriate role models who project positive values and body images. The physical destruction and celebration of addiction, as reflected in heroin chic, has endured long enough, both on and off the catwalk.

Maxim W. Furek, MA, CADC, ICADC, is Director of Garden Walk Recovery, an organization promoting wellness through drug prevention and education. His book The Death Proclamation of Generation X: A Self Fulfiling Prophesy of Goth, Grunge and Heroin is currently being utilized at Penn State University as “recommended reading” for “Introduction to Abnormal Psychology” and “Health Psychology.” He is a member of NAADAC and can be reached at www.maximfurek.com.
November 4, 2011
Sign the Petition Supporting Drug Prevention
Tell the White House that prevention needs more support.
More details at http://wh.gov/2Yh.

November 12 –18, 2011
NAADAC Professional Exchange
Havana, Cuba
For more details contact Cynthia Moreno Tuohy at cynthia@naadac.org.

Monday, November 14, 2011
HIV, Meth and Engagement in Care: What Clinicians Need to Know
Yuma, AZ
This free continuing education workshop is available to physicians, physician assistants, nurse practitioners, nurses and other providers serving the impacted patient populations.
More details at http://cabhp.asu.edu/events.

November 15, 2011
Promoting Awareness of Motivational Incentives (PAMI)
Salem, OR
4-hour Workshop (4 CE Hours)
Principles, history, research and suggestions for overcoming implementation barriers of Motivational Incentives will be discussed.
Details at www.attcnetwork.org/regcenters/trainingevents.asp?rcid=10&ViewType=1.

Wednesday, November 16, 2011
HIV, Meth and Engagement in Care: What Clinicians Need to Know
Yuma, AZ
This free continuing education workshop is available to physicians, physician assistants, nurse practitioners, nurses and other providers serving the impacted patient populations.
More details at http://cabhp.asu.edu/events.

November 17, 2011
Webinar – Change is Coming: New Regulations in 2012 for Diagnosis Codes and Claim Submission
Earn 2 continuing education credits
Noon EST
More details at www.naadac.org/education.

November 18 – 19, 2011
Free Workshop: Treatment of TB, STDs, HIV, Hepatitis C and Substance Abuse on the Border
Bisbee, AZ
Continuing education hours through NAADAC and NASW will be awarded.

November 28 – December 6, 2011
Train-the-Trainers in the Foundations of Addiction Practice, Conflict Resolution and SBIRT
Majuro, Republic of Marshall Islands
For more details contact Cynthia Moreno Tuohy at cynthia@naadac.org.

November 30, 2011
Hawai‘i Association of Addiction and Drug Abuse Counselors Monthly Meeting
More details at www.cchono.com/~fratzke.

December 4 through December 11, 2011
Exam Dates for the Winter NCAC I, NCAC II, MAC, ASE, Nicotine Dependence Specialist and Basic Exams
For credential descriptions, please visit www.naadac.org.
The Professional Testing Company administers testing for the NAADA Certification Commission. For more information on the exam, visit www.ptcny.com/clients/NCC.

December 15, 2011
Webinar – Clinical Supervision: Keys to Success
Time: Noon–2pm EST (includes live Q&A at the end of the presentation)
Full details at www.naadac.org/education.

MARK YOUR CALENDAR FOR 2012 EVENTS!
March 12–14, 2012
Advocacy in Action Conference
Washington, D.C.
Meet with lawmakers and learn about trends impacting on the workforce.
For more information, visit www.naadac.org/advocacy.

NAADAC Workforce Development Summit
Creating, Sustaining and Retaining the Addiction-Focused Workforce
Washington, D.C.
For more information, visit www.naadac.org.