Over the past several months, I have updated NAADAC members in the President’s section on the changes now happening, and those anticipated in the addictions profession. NAADAC has been responsible to members in providing not only needed information on these changes, but more importantly in several instances, NAADAC has shaped and provided the foundation for these changes. If you were not at the recent National Addictive Disorders Conference, January 1, 2014 was certainly a side discussion of the attendees.

Several of the attendees and our members expressed their appreciation to NAADAC for the communication, and NAADAC being at the forefront in setting new and needed standards. Much appreciation was given to NAADAC as a consistent and reliable source where such information could be found, and referred colleagues to NAADAC. As an aside, while at the conference those who were not members of NAADAC when they arrived at the conference, were members when they left. This speaks to the continued evidence of NAADAC’s efforts as the leader and voice for the addiction profession and the clients we serve.

So why January 1, 2014?

There are several reasons for this date. The first is the Patient Protection and Affordable Care Act (PPACA), or two terms you may be familiar with, “health care reform” and “Obamacare,” named after the President. Full implementation will be on January 1, 2014. Before going any farther it must be acknowledged that while some small portions of the PPACA are now enacted and some celebrate the PPACA, there are challenges ahead.

The PPACA is being challenged by more than 20 state Attorneys Generals with regard to the constitutionality of the PPACA. The question here is “Can the U.S. government force citizens to buy a particular product?” My personal conclusion is no, no more than the government can tell me what kind of car to buy. The PPACA has already had two other setbacks, in that two Federal Courts have already ruled against some portion, or all of the PPACA being enacted, for the very reason I just pointed out. Recently funding sources for the PPACA have been curtailed which speaks to a larger question, “How are we going to pay for the PPACA?” The issue of taxes being raised is one avenue, yet there is a smaller number of persons paying taxes, and a larger number who do not pay taxes. Some argue that the U.S. has reached imbalance in the tax burden. Further, the U.S. Supreme Court will hear the cases for and against the PPACA and will answer the question of whether the legislation is constitutional.

My sources in Congress inform me that it is possible that Congress may not fund the PPACA. This would also be connected to the upcoming 2012 election should the President or members of Congress that belong to the President’s party not be elected.

For the addiction profession, the PPACA has changes in the Title V section of the bill. Here there is a new term for you to become familiar with. The term Integrated Behavioral Health Care (IBHC) is used to describe the delivery model and how individuals will gain access to care.

Title V

Here I would like to give you a brief overview of the current Title V, as I have analyzed that section related to the impact on the addiction profession. Title V will, in part, be connected to the workforce and workforce development as related to IBHC. IBHC will be considered two areas: Substance Abuse/Addiction and Mental Health. Persons seeking services will enter the system through a Physical Health Provider in a Community Health Center.

New positions and new titles in the workforce will emerge that will require academic degrees from associate thru PhD. The plan at this time is to recruit and train 60,000 new counselors. Up to $500 million has been established to recruit and train those counselors including scholarship and loan repayment. New titles and degree designation include Behavioral Health Technician needing an associate or bachelor degree, Peer Specialists needing a bachelor degree, Care Managers needing a master’s degree, and finally, Consulting Behavioral Care Experts/Consultants needing a master’s and/or doctoral degree. Currently 32 states now have or will soon move forward with peer specialists connected to Medicaid payments.

Some of those states include Kansas, Michigan, Pennsylvania, Tennessee and Wisconsin. Oklahoma has gone so far as to enact state legislation requiring service providers to hold a master’s degree in addictions. History was made in Indiana with the state’s now popular addiction counseling licensure bill. The licensure consists of a two tiered system of a bachelor’s and master’s degree holders, with a one-time-only grandfathering. The licensure was historic in that it contained the first-ever addiction specific courses and hours needed from higher education establishing a scope of practice. The “Indiana Model” was featured on the cover and in an article of an earlier edition of this magazine. (Addiction Professional, March/April 2011, Vol. 9, No. 2).

Regarding patient treatment, a new and evolving model of care will emerge, referred to as Stepped Behavioral Health Care (SBHC). SBHC levels are designated as Minimal, Basic at a distance, Basic on site, Close partially integrated, and Close fully integrated. Some treatment facilities, whether PPACA becomes a reality or not, have begun the transition to this model of care and the addiction professional qualification to provide clinical services. What can be ascertained is that should PPACA not be fully enacted, the professional provider structure connected to academic preparation is likely to go forward for reimbursement in the new addictions workforce. This is evidenced by not only legislation, but the changing qualifications of government and third party payers of who can provide addiction services.

The addiction profession is now at a time where higher education and educational standards will dictate certification and licensure standards. To this end, the National Addiction Studies
Substance abuse treatment providers:
Act now to get ready for health care reform

Treatment providers will start seeing a broader spectrum of patients

By Thomas E. Freese, PhD

The Affordable Care Act, which will extend health care coverage to currently uninsured Americans, will dramatically change how substance use disorders treatment is funded, and the types of services that are reimbursed. Substance abuse treatment providers must start making changes now so they are ready when the Act is implemented in 2014.

Under the new system, funding for many services that previously came primarily from block grants will now come through Medicaid and the private health insurance system. One of the more immediate and practical challenges will be the major changes that will need to be made to billing systems, so that providers can bill for Medicaid-related services. Instead of focusing on filling beds in their programs, providers will have to track and bill by the specific services they provide.

Another major change will be that substance abuse treatment providers will be seen as part of the larger health care system. Both substance abuse treatment providers and primary care providers will need to look for ways to be more integrated and collaborative with one another.

Substance abuse treatment providers will need to become much more familiar with the other medical problems that their clients often face, such as diabetes, high blood pressure and asthma. When they see clients who are exhibiting symptoms of these diseases, they will need to link them back to primary care for evaluation and treatment.

Primary care providers will need to become much more comfortable in giving screening and brief intervention for patients at risk of substance abuse, and in knowing where to refer patients who need further help at all levels of risk. This will mean that substance abuse treatment providers will start seeing a broader spectrum of patients — not just those with full-blown addiction, but also those with milder issues that nonetheless need treatment.

Both primary care providers and substance use disorder service providers will need to better integrate their services for medication-assisted treatment for substance abuse as well, in order to ensure that patients who are receiving medication for opioid or alcohol dependence are also receiving the behavioral services they need.

Health care reform will allow patients to have a much broader choice of providers for substance abuse treatment. They will begin to ask why they should choose Agency X over Agency Y. As a result, substance abuse treatment providers will have to engage and motivate clients to choose them, using data to measure success. They will have to become more visible and competitive in the health care field they will now be a part of, instead of the specialty realm of addiction treatment services.

By starting now to look at billing, integration with health care providers, and how to demonstrate program efficacy to attract patients, substance abuse treatment providers will be better equipped to navigate the new health care system, and to provide their patients with a more comprehensive, better quality of care.

Thomas E. Freese, PhD, is Director of Training for UCLA Integrated Substance Abuse Programs and Principal Investigator and Director of the Pacific Southwest Addiction Technology Transfer Center. He can be contacted at tfree.se@mednet.ucla.edu. This article was reprinted with permission by Join Together online (www.drugfree.org/join-together).
Accreditation Commission (NASCA) will be in the lead for our profession. NASAC will function to ensure the quality of higher education, as addiction study programs will now systemically connect to the national scope of practice, certification and state licensure standards. The changes mentioned are not something that is yet to happen, the changes are already here.

In the future, I will address Medicaid, private insurance, the place of higher education, and the new professional scope of practice. Addiction professionals will also come understand the changing role and existence of certification giving way to the impact of licensure.

Let’s Build Upon a Heritage and Leave a Legacy,
Don

Donald P. Osborne serves as the President of NAADAC, the Association for Addiction Professionals. To contact him directly, please e-mail dposborn@hotmail.com.
He served as a colonel in the U.S. Air Force. He was an addiction counselor at a time when society didn’t know what that meant. He co-founded the professional association for addiction counselors. And he was an advocate for people suffering with substance use disorders and the professionals who serve them.

Colonel Mel Schulstad (retired) was the co-founder and past-president of NAADAC, the Association for Addiction Professionals, a co-author of two significant books Under the Influence (1984) and Beyond the Influence (2000) and lent his name to the award that recognized professional excellence.

He was born in Duluth, Minn., in 1918, as Louis Melvin Schulstad. The youngest of 10 children, he spent most of his youth in Reynolds, N.D.
Schulstad’s last address to NAADAC

2008 NAADAC conference presidents dinner

Thank you Cynthia for that warm welcome.
I consider it an honor to have been invited to these annual get-together occasions and I consider it an honor to be able to speak to you in particular who are working so hard in this field.
I want to say at the start of my remarks three things to all of you who are gathered here —
three things:
I respect you,
I honor you,
And I love you.
You might say, why is that?
Because you have had the courage to take on this new, wonderful, and unique profession, the profession of giving counseling, healing, recovery and new life to addicts and alcoholics who come to you for help. You perform miracles.
I have learned and I believe that you will find that you are most effective in healing your patients when you give them of your love!
There is very real and magical healing power in the act of giving love when given by one human being to another. You know that deep down in your heart.
You and I share a common understanding — which is that we all share the belief that people are all pretty much alike especially at birth.
At that time we all were given a physical body, a brain with a mind and a soul. What is the soul, we ask?
The soul is the essence of life in every human being because it contains the spark of divine spirituality, which is implanted at birth in every human being.
Please remember that.
And I believe that the soul is the basic element in every human being, including especially the addict and the alcoholic. The soul has the greatest need for nurture, for healing, for renewal and recovery.
We know that addicts and alcoholics despise themselves. This spite and this disgust for the life they are leading and living tears at the roots of the mind and the body and that soul. And you reach them where they need help the most by giving them your empathic understanding, your compassion, and your God-given love.
Pretty corny stuff, huh?
The greatest gift you can give, I repeat, is your compassion, your understanding and your love. It is my hope that you leave here with an understanding, perhaps even a new understanding, that the belief that you already have within you — and you already have within you the power which they need the most — your own God-given love.
In order to do this you must first come to forgive yourself, respect yourself, and honor yourself as I do. And yes, come to love yourself. Then and only then I believe will you be prepared to give away with God’s healing grace the ability for your patients to learn to love themselves. And there is the secret, and in that way they will find a new life. A new life which they can and will enjoy as long as they continue to give their love to others.
This is the real deep down secret of sobriety and recovery.
Take it home with you.
I expect that this well may be my last attendance at a NAADAC conference at least on an official basis. I may sneak in the back door when you’re not looking. But at my age flying across country and all that entails is not the fun it used to be 34 years ago when we first gathered in a hotel someplace, all 27 of us, to decide what to do next. So I bid you with a warm heart a fond farewell and I repeat as my farewell message to you a message I began with — I respect you, I honor you, and from the bottom of my heart I tell you I love you. Thank you.

— Mel Schulstad
Help us find the best professionals
NAADAC award nominations accepted until April 30

By Donovan Kuehn, NAADAC Director of Operations

“Don’t aim for success if you want it; just do what you love and believe in, and it will come naturally.”
David Frost (1939–present), British journalist and writer

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

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

Over 80 groups, individuals and organizations have received recognition from NAADAC in the 30 years since it began its awards program. Very select company considering that NAADAC has 8,000 members and the addiction profession encompasses over 86,000 clinicians.

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

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

In a profession where interventions can have life or death consequences, choosing outstanding addiction professionals can be a difficult job. NAADAC, the Association for Addiction Professionals, recognizes the work of addiction professionals, organizations and public figures who work above and beyond to make a difference.

NAADAC honored two professionals and one program in 2011. They are highlighted on the next page.

2012 Awards Nominations
Who will be the new professionals recognized for their excellent work? You may have a hand in telling that story.

Nominations for the 2012 awards must be received by the NAADAC Awards Committee no later than April 30, 2012. For full descriptions of NAADAC’s awards, please visit www.naadac.org and go to “About NAADAC” and then “Recognition & Awards.”

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

Donovan Kuehn serves as the Director of Operations and Outreach for NAADAC, the Association for Addiction Professionals. While serving as Editor of the NAADAC News, the publication won an Apex Award for Communication Excellence in 2008. In 2010, Kuehn won a Rising Star Scholarship from the Angerosa Research Foundation, a nonprofit organization established in 2003 to conduct industry research to benefit the association publishing and marketing professions.
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 from 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, Massachusetts, 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, SAMHSA 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. As the number of colleges that offer true recovery support services and housing grow, Rutgers stands out as a pioneer.
As a person in recovery and a science journalist, I look forward to 2012 as the turning point. Let this be the year that marks a transformation in our culture’s lagging understanding of where the science and practice of the addiction recovery profession have finally brought us. What follows is an excerpt from my new book, A Lethal Inheritance, A Mother Uncovers the Science Behind Three Generations of Mental Illness.

When spoons began to disappear from my mother’s silverware drawer in the late 1960s, neither my mother nor I suspected my younger sister Rita’s dope use. It didn’t dawn on us that heroin had been mixed with water and cooked over a flame before it was injected. At that time, my friends and I smoked pot regularly, and, we had also tried psychedelics, mushrooms, and acid — tried being the operative word. Rita went farther and did it much faster, and more overtly. She flew through pot and discovered barbiturates, speed, and cocaine. Heroin was too pricey without help from an older boyfriend, but by the time she was 16, it had nonetheless become Rita’s drug of choice. She started stealing to get it: Mom’s wedding band was one of the first casualties; soon, cash could no longer be left in a drawer or purse. This was before drug rehab as a concept had entered the American cultural lexicon, certainly that of the suburban northeast, leaving my mother baffled and ashamed at the behavior of her prettiest, once the easier of her two daughters.

When President Richard Nixon declared his war on drugs in 1971 — a war that has been hopelessly lost in the four decades since — it did one constructive thing by creating a new and favorable climate for addiction. Another look at the science of addiction could help change and improve these antiquated public perceptions.

The long road to understanding self-medication

It is time to change and improve our perceptions

By Victoria Costello

The idea that human psychological vulnerabilities had anything to do with addiction was a brand-new piece of the puzzle, and it reflected Khantzian’s psychoanalytic background as much as his clinical work at the Cambridge Clinic. As a clinician, he saw the important roles played by what he called the damaged “ego and self structures” in his addicted patients. He then identified the following four common areas of psychological problems that led his patients to addiction: a lack of self-esteem, inability to form and maintain relationships, and lack of self-care.

Decades later, Khantzian’s hypothesis is accepted medicine within the mental health field. Psychiatrist Allen Frances, in his review of a 2009 textbook edited by Khantzian (in the American Journal on Addiction) titled “Finding Hope Behind the Pain,” referred to the “simplicity and beauty of the self-medication hypothesis,” and “its usefulness in the clinical situation.” While Khantzian’s theory is accepted by his peers, a broader cultural understanding of the implications of this theory for individuals with undiagnosed mental disorders who may be self-medicating has lagged far behind, not unlike broad stubborn resistance to the idea of addiction as a disease over which the addict has little or no control without treatment — and, sadly, not unlike continuing resistance to the robustly established precept that treatment for addiction is effective. Another look at the science of addiction could help change and improve these antiquated public perceptions.

Which comes first?

Is it the chicken or the egg: the mental illness or the addiction? This fundamental question remained unanswered up until the 1990s. As always, there were some pioneers who caught on well before their peers — because they had to. In the 1970s, one group of clinicians and researchers at the Philadelphia Veterans Administration Methadone disorders. The concept had come originally from Freud, in 1884, after he noted the antidepressant properties of cocaine.

This theory immediately caused a storm of controversy because it challenged views then held by the medical community and law enforcement that attributed drug abuse to peer pressures, family breakdown, affluence, escapism, and lax policing. For the first time, the nation’s newly minted white middle class drug addicts (typified by my sister) were joining their less affluent urban counterparts, who were already populating U.S. jails and hospitals. Junkies — hippies, rich and poor, black and white, addicts and alcoholics — constituted an equal-opportunity mental health crisis for public health doctors on the front lines of treatment in big-city hospital emergency rooms.

The father of the self-medication hypothesis is Edward J. Khantzian, a founding member of the Psychiatry Department at Harvard’s Cambridge Hospital. Khantzian, writing in 1985, believed addicts weren’t victims of random selection but instead had a drug of choice: a specific drug affinity dictated by “psychopharmacologic action of the drug and the dominant painful feelings with which they struggle.” For example, he observed the energizing effect of heroin and other stimulants in response to the depletion and fatigue of addicts dealing with preexisting depression. In his patients who abused opiates, Khantzian noted the calming effect of heroin on the addict’s typically problematic impulsivity.

Is it the chicken or the egg: the mental illness or the addiction? This fundamental question remained unanswered up until the 1990s. As always, there were some pioneers who caught on well before their peers — because they had to. In the 1970s, one group of clinicians and researchers at the Philadelphia Veterans Administration Methadone
Clinic evaluated the effect of an antidepressant given to heroin addicts who were also diagnosed with depression and anxiety. After a year, their results showed a significant reduction of symptoms and less drug use for the addicts whose treatment included the use of the antidepressant. In subsequent follow-up studies, they found that the additional use of psychotherapy added even more significantly to their patients’ recovery rates. In the mid-1980s, the Philadelphia V.A. staff said that 80 to 85 percent of their heroin-addicted patients were comorbid; today they’d be called “dual diagnosis.” More than half were afflicted with major depression. Other common diagnoses included antisocial personality disorder; a history of alcohol dependence; anxiety disorders; and other disorders of mood, such as manic depression (now known as bipolar disorder).

In 1992, with a first-of-its-kind national survey of the state of the nation’s mental health called the National Comorbidity Survey (NCS), scientific understanding of comorbid addiction and mental illness went mainstream. The NCS evaluated 8,098 average Americans, ages 15 to 54, interviewed in face-to-face home settings by trained laypersons — making them far less able to lessen or deny symptoms and patterns. Among the striking results of the NCS survey: 45 percent of those people with an alcohol-use disorder and 72 percent with a drug-use disorder also had at least one other mental disorder. Perhaps more important at a time when the self-medication theory was still under attack, the NCS survey provided a concrete and comprehensive answer to the chicken-and-egg question about addiction and mental illness.

**So which is it?**
The NCS showed that when an alcohol disorder accompanied another mental disorder, the alcohol abuse began after the individual was suffering from symptoms of the other mental disorder; usually a year or more after. Not including other forms of substance abuse, the most common preexisting mental disorders reported among those interviewed were anxiety, depression, and, for men, conduct disorders.

When an updated NCS survey was done with a new group of ten thousand people in 2002 (called the NCS-R, for “replicated”), its findings were strikingly similar to the first. Faring worst by age group in the 2002 numbers were 36- to 44-year-olds, among whom 37 percent had anxiety disorders and 24 percent had mood disorders in addition to their alcohol abuse issues. Depressed women in their 30’s and 40’s have a 2.6 greater risk for heavy drinking, compared to those without major depression. It occurred to me as I read these numbers that age 30 to 44, when comorbid disorders are highest, are also women’s prime childbearing years.

**Too late for so many**
My sister Rita died at 38, a year after a heroin overdose left her in a coma for several days. While packing for a move not long ago, I found a letter I’d received from Rita, written during her first stint in Rockland County Jail for robbery a decade earlier, dated March of 1982:

> I should have known I was heading for trouble again. I was having black outs from small amounts of liquor (small amounts for me). But I went on another drinking binge and now I’m back here again. I guess I’ve hit the pits this time. I just finished speaking to a woman from the jail ministry. She’s quite sure that God brought me back here to save my life or try again. She may be right. I just feel really bad now that I won’t be home for Easter when you come. So much for all that. Meanwhile pray for me, forgive me for letting you all down, try to talk to Mom for me and take care of my beautiful nephew. Love, Rita.

I didn’t have any inkling of the unequal effect of alcohol and drugs on different people back in the ’60s when my friends and I started experimenting with whatever we could get our hands on. Back then, I suppose I went no farther than thinking that Rita and others like her were weaker than I was in some fundamental way. Science now illuminates the finer points of the unequal inheritance of predispositions to addiction even in the same family, as well as the debilitating effects on those who carry the heaviest genetic load of growing up in a culture of self-medication. Simplifications like personal weakness simply don’t cut it anymore. It’s time for the culture to catch up with the science and practice of recovery.

Victoria Costello is an Emmy Award winning science writer, a blogger for PsychologyToday.com and Recoverynow.com. As an advocate for a prevention approach to mental health, she leads workshops for parents and providers around the U.S. Her book, A Lethal Inheritance, A Mother Uncovers the Science Behind Three Generations of Mental Illness, from which this article is drawn, is available in January 2012, from Prometheus Books. 

Amazon link above:
www.amazon.com/o/ASIN/1616144661?tag=betteraddons-20
Addiction-focused professionals can create positive change

Mark March 19–21, 2012, in your calendar

By Donovan Kuehn, Director of Strategic Planning and Outreach

This spring, addiction professionals will leave their group therapy sessions and paperwork behind for a new client: the nation’s lawmakers.

NAADAC, the Association for Addiction Professionals, will host the Advocacy in Action conference from March 19–21, 2012, in Washington, D.C.

NAADAC’s Advocacy in Action conference, its first advocacy meeting since 2010, is designed to educate addiction professionals about current public policy issues in Washington, D.C., and bring their day-to-day experiences and stories decision-makers at all levels of government.

The conference will provide the opportunity to meet face-to-face with the nation’s lawmakers and help re-shape how they view addiction. Participants will receive training on advocacy strategies to promote effective prevention, treatment and recovery policies and to help them become active, year-round advocates back in their home communities.

If members of Congress do not know that addiction is treatable and that people can and do recover, they have no reason to address the problem. This is why active participation and advocacy are essential, especially from the professionals who, on a daily basis, help combat a disease that affects over 23 million Americans.

“As addiction professionals, we have a responsibility to educate the public — including those we’ve elected to Congress — about treatment and recovery. Advocacy in Action is so important because it gives us the tools and training to ensure that we are heard and valued by decision-makers,” says Gerry Schmidt, Public Policy Committee chair.

The sessions in Washington, D.C., are geared to new and returning participants with an introduction to advocacy issues, tips on how to communicate effectively with lawmakers and mentoring sessions for those new to the legislative process.

“For many treatment professionals this is their first encounter with their lawmakers. The excitement for most professionals is that they are at the heart of the legislative process, can see events unfold in front of them and become an active participant in the process,” said Schmidt.

NAADAC will be partnering with other governmental and national associations speaking to the latest information regarding the workforce and the implementation of health care reform and parity.

“The Advocacy in Action conference is so important to addiction professionals because it gives us the tools to ensure we are heard and understood by decision-makers in government,” added NAADAC Executive Director Cynthia Moreno Tuohy.

“We’re the experts on what works and what doesn’t, and we need to educate our representatives.”

More details about the 2012 Advocacy in Action conference, including the agenda, speakers and registration costs can be found at www.naadac.org/conferences/advocacy-conference.
2012 Advocacy in Action Registration Form
March 19 – 21, 2012
Holiday Inn Hotel & Suites Alexandria-Historic District
625 First Street, Alexandria, VA 22314
www.holidtownalexandriahotel.com
(enter the group code of N2A when booking online)
877.504.0047 (toll free reservations) • 703.548.6300 (front desk)

REGISTRATION FEES

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For non-members to receive the member rate for the conference, join NAADAC by calling 800.548.0497 or visit www.naadac.org/join.

REGISTRANT INFORMATION (Please print clearly)
NAADAC Member #______________________ (if applicable)
Name: __________________________________________________________________________________
Address: ________________________________________________________________________________
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Phone: (____) ___________________________ Fax: (____) ____________________________________
E-mail: ________________________________________________________________________________

CONFERENCE FEES

_____ Conference Fees (see fee schedule above)

_____ Ticket for the NAADAC Political Action Committee (PAC) reception on March 19, 2012. $35 suggested donation. Corporate checks or credit cards cannot be used to pay for tickets.

_____ Guest Ticket for the Legislative Update Lunch on March 19 or the Legislative Awards Lunch on March 20. $50 per guest. Lunch is included in participant registration.

_____ Guest Ticket for the Breakfast Briefing on the Hill on March 21. $30 per guest. Breakfast Briefing on the Hill is included in participant registration.

_____ TOTAL AMOUNT ENCLOSED

Please send me additional information about membership.

PAYMENT OPTIONS & INFORMATION
Please return check or money order by mail to:
NAADAC
1001 N. Fairfax Street, Suite 201
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FEATURE ARTICLE

Know when to refer out
A practical guide for the private practice professional
By Beverly Berg, PhD

This is the first of two articles by Beverly Berg on client services and referrals.

We have entered an age where the marriage between the field of addiction treatment and the field of mental health treatment has finally been consummated. The 1980’s brought sweeping ideological change to the world of alcoholism treatment, including the discovery and subsequent delineation of “co-existing disorders” as a growing problem facing treatment institutions. When the movement began, “traditional mental health approaches tended to view alcohol problems as symptomatic of underlying mental disorder, best treated by psychotropic medications; in direct opposition was the traditional alcohol treatment perspective which focused on how emotional problems stem from underlying addiction, calling for total drug abstinence. (Schmidt and Weisner, 1993 p. 383). This article is going to offer ways to recognize when private practice psychotherapy becomes secondary and not primary treatment.

According to reports published in the 2011 Journal of the American Medical Association:

1. Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse.
2. 37 percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness.

Each private practice clinician needs to have a built-in criterion that they use to assess clients with co-morbid disorders. This is whether they are sitting with a client they are treating for a mental health disorder with untreated addiction, or the reverse. Statistics on dually diagnosed adults in the United States are limited, but growing stronger each year. According to the 2002 SAMHSA Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders, the best data on the existence of dual diagnosis comes from the Epidemiological Catchment Area (ECA) Survey and the National Comorbidity Survey (NCS) (SAMHSA Report to Congress, 2002, Ch. 1, p.3, Reiger et al., 1990, Kessler et al., 1985).

Every well-trained clinician today needs to have multiple lenses through which to assess and evaluate his or her clients. The days of clinicians who work purely within one model of treatment may not be over, but it is for the clients you see that are struggling with both mental health and addiction issues. For those clients, if you really want your clinical work to be masterful and pristine, then you need to be eclectic and flexible in your treatment methods. Having a large array of clinical skills to offer is not only for the purpose of giving your client the best treatment, but it is also to protect you from burnout, or worse yet, from being sued for malpractice. To succeed at this, you must be willing to know when you are working within your scope of treatment and when you aren’t, and helping the client get what they need, even if it isn’t from you.

The Gold Standard

• The ability to gain strong rapport with your client
• Know the difference between a mental health patient, an addiction patient or a patient who is both
• Knowledge of the difference between primary addiction, secondary mental health and dual diagnosis
• To have the capacity to create a treatment plan with fact-based evidence that it is working within the scope of your treatment with your client
• A Rolodex of referrals at your fingertips for specialists you can call upon who treat what is out of your scope of treatment.
• Utilizing midstream assessment to account for new information that adds to the diagnostic profile
• The ability to use your rapport with your client to agree to go to outside treatment when necessary and not expect your office to be the one stop shopping for all needs
Midstream re-assessment

What does it mean to utilize midstream re-assessment? Midstream re-assessment allows for the clinician to change his or her mind at any point of treatment a client’s diagnosis or original treatment plan that was created from initial intakes. For example, the way most interns are clinically trained starts at the reception desk making appointments for prospective clients, and then doing intakes with prospective clients in person. During those times, clinicians are not only getting a full history on the client, but they are also evaluating how the client presents this information in order to assess which modality of treatment might seem optimal. Any ethical intern-training environment will come to expect from the intern that he or she learn how to come to conclusions fairly quickly in order to have an idea of how to orient around the client’s specific needs, but it also serves the purpose of gaining diagnostic and treatment-planning skill. This is all well and good, and typical of training protocol, but when do interns learn that they can make course corrections along the way? It needs to be accepted as commonplace occurrence that when clinicians get to know their clients more intimately, and information gets revealed, or becomes more transparent, that they can change their treatment plan, throw it out completely, or even, refer their client to other treatment!

As an intern in 1982, I felt scared and ashamed when I had to do a course correction in my treatment approach during a client’s treatment. I would slap myself in the head and think, “Whoa, how did I not see this from the start?” or “Whoa, this person is in deeper trouble than I thought” or “Uh-oh, now I’m not sure what I’m looking at all.” It was at that point I had to swallow my pride and admit that there was more at play with my client than what my eyes initially met.

For the record, in 1982 the treatment of alcoholics and the treatment of mental health disorders were at odds. If further complications arose when trying to diagnose a person with separate, primary disorders of mental health problems, we were all apt to put them under the umbrella of symptoms of addiction. If secondary disorders from substance abuse or other addictions emerged, we were all apt to put those under the umbrella of symptoms of the mental health issue. An obvious example is when an alcoholic client experiences depression due to their alcoholism, or when a client with a mental health disorder will abuse alcohol, drugs and other addictions to self-medicate their disorder. (Pary, Lippman and Tobias, 1988, p. 1530.) Back in 1982, addiction and co-morbid disorders were in their embryonic phase, and the idea of looking at addiction as being anything more than addiction was too confusing and complicated for most clinicians to have to juggle. Those of us in the field of addiction made abstinence the goal, and the steps and meetings the treatment. Tragically, the client was blamed and stigmatized if their depression was still present, or their anxiety too high, or if a merry-go-round of other addictions cropped up, like food or sex or gambling. We just didn’t know any better. And we couldn’t understand why the relapse rate was so high. We have come a long way since that time, but we still have a long way to go until we get to the most pristine treatment that is possible for our dually diagnosed clients. So, whether you are a clinician that has therapist denial from not seeing addiction, or a therapist that has therapist denial from not seeing co-morbid disorders, know your bias! Even today the question of which came first, the chicken or the egg, is still very confusing, even to the most seasoned clinicians. It didn’t take long, although somewhat baffled and ashamed, before I realized the need to go back and make a midstream re-assessment of my client simply from the mere fact that I knew them better and had more intimate information. What do I do with the client who reveals addiction when I have been treating their anxiety with cool meditation techniques? How do I convince the addict that the 12 steps is not going to cure the clinical depression that they, and their entire family tree, have been suffering with? While I was more interested in being an ethical clinician than trying to look like a smarty pants, surrendering to exposing my confusion and reaching out for help in re-evaluating clients who I thought I had my finger on the pulse of, made treating these clients much less anxiety provoking or entrapping.

I think the need for midstream re-assessment should be a given. It’s always been needed, but hasn’t always been taught. I no longer view it as my dirty little secret, or shame myself with self-critical thoughts, but have realized that it is the nature of the beast. My job is now to take my midstream assessment, re-evaluate my treatment plan, and recognize whether the next layer of what is being revealed to me might need outside help from my therapy office and inside help from an inpatient facility, outpatient facility or a psychiatrist who prescribes medication.

I believe that a hearty midstream re-assessment should be part of every single internship teaching, and the allowance for it should be seen as intelligent and not a sign of initial negligence or lack of clinical aptitude on the part of the intern. Seasoned clinicians also need to incorporate this idea into a philosophy of what effective treatment really means. At the risk of sounding self-righteous, isn’t the responsible and ethical clinician made up of a combination of humility, ethics and healthy fear? Having relationships with other effective clinicians, and a handful of admissions people at different rehab centers that will help your clients when they need more than what you can give them in private practice puts you in the gold standard of treatment. Without these variables in your toolbox, you are working at a deficit, and you are putting your client and your reputation at risk.

Beverly Berg, PhD, has worked in private practice since 1982, working with individuals, couples and families dealing with both mental health and addiction issues. She has worked with top addiction specialists, including UCLA professor Dr. Harvey Sternbach, Dr. Garrett O’Connor (Betty Ford’s head psychiatrist) and Dr. David Sack (founder of Promises and Elements).

References

Recommended Reading List
The Dual Diagnosis Recovery Sourcebook: A Physical, Mental, and Spiritual Approach to Addiction with an Emotional Disorder (2001). Author: Dennis O’rtman, PhD. Publisher: Contemporary Books
The Van Wagner Group has been providing comprehensive insurance solutions to the Addiction Treatment and Counseling field for over 25 years. The agency began services in 1985 by partnering with N.A.A.D.A.C., the National Association of Addiction Professionals, to provide low cost, comprehensive coverage to their member drug and alcohol counselors.

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Counselor commemorations
Looking back at those who have passed away

By Donovan Kuehn

While looking forward to 2012 and the opportunities it presents, NAADAC also casts a look back at the previous year, and the counselors who are no longer with us. Below is a brief write-up on counselors who have passed away in the last year.

Is there someone you know who passed away and deserves to be remembered? Please send information and a high resolution photo (100 KB minimum) to Donovan Kuehn at dkuehn@naadac.org. Submissions may be edited for editorial or space requirements.

Eugene N Crone, PhD, 82, died Wednesday, June 22, 2011. He was born on April 17, 1929, in Newton Falls, Ohio. He earned a bachelor’s degree in education at Ohio University, a master’s degree in education from Columbia University in New York City and received his PhD from the National University of Graduate Studies in Dallas.

Dr. Crone served in the U.S. Army during the Korean Conflict with the 101st Airborne and was a member of the American Legion. He was an active supporter of the NAADAC political action committee and was an outspoken advocate for the deaf and hard of hearing.

Nimal G. Fernando, 47, of Fort Wayne, Ind., passed away on Dec. 30, 2010. Born on July 12, 1963, he was the son of Albert Fernando, and Nelig Fernando. He was not only an asset to the field of addictions treatment, but also a fellow brother in recovery for many, many years. He is survived by his devoted wife, Shanthinnie Fernando; and his loving sons, Nathan Fernando and Nelig Fernando.

Samuel L. Foggie Jr., former President and Founder of Allied Addiction Services, LLC, and a well respected mental health professional, who departed this life surprisingly a year ago on Friday, Oct. 9, 2009. “Sam” as he was respectfully called, took great pride in his work and service toward others; he made tremendous efforts to focus on his own journey of recovery as well as empowering others to focus on their recovery. Foggie spent the last 20 plus years of his life dedicated to his personal cause of being sober right until his last breaths. He died ‘fighting’ and he died sober.

Roman Frankel, PhD, CCS, NCAC II, CBIS, CEAP, CCGC, passed away on March 4, 2011. Dr. Frankel was the 2008 recipient of the Mel Schulstad Professional of the Year Award, an honor created in November 1979 and named after the first President of NAADAC. Dr. Frankel was a “…passionate teacher, insightful scholar and a steadfast and ardent promoter of the counseling profession,” said Madeline Dupre, one of the people who nominated him for the award.

Askew Jackson, Jr., NCACII, CACII, CCS, past President of Georgia Addiction Counselor Association (1990–1992), passed away on June 1, 2011. He was instrumental in affecting the lives of many including professionals and clients alike. His passion was helping others in their own path of sobriety, always giving to others that enriched their life. They would say it was he who helped them; but Jackson always lived his life that in helping others he was blessed.

Fern Kappelle was not only an asset to the field of addictions treatment, but also a fellow brother in recovery for many, many years. I knew Fern for many years and he was a mentor of mine when I was fairly new in the addictions field. I will never forget Fern’s legacy of the clinical drama — “Mr. Alcohol.” How many times, I co-facilitated that exercise with him while working with him at Castle Medical Center. We always had outstanding results. Now he is up in the Meeting in the Sky, and the Lord will no doubt continue to use Fern. His legacy lives on through all of us he took the time to teach and mentor.

John Keenan. It is with such sadness that I pass this message along. John, Frances, Kathy, and John Rollins were amongst the first I met in this profession. John was so instrumental in my involvement with MTAADAC. We spent many hours talking about spirituality, God and motorcycles. His sarcasm and sometimes dark humor made him dear to me. A bright light in my life has been dimmed in this realm, though I know he shines on the other side.

Suzanne Arlein Kerner, 67, of Jacksonville, Fla. died April 3, 2011 at the Hadlow Center for Caring. She was born on Feb. 27, 1944 in Cleveland, Ohio. She graduated from the University of Dayton where she received her BA in Social Work. She married Thomas Kerner in 1966 and they raised their family in Ohio. Kerner was a well respected counselor and EAP program director in New Hampshire until her retirement in 2005. She and Tom moved to Florida in 2006 to be with family. She belonged to and participated in many community and professional organizations which shared her passion for helping others. She focused on her beloved 12-step work for over 40 years.

Brad Killian dedicated much of his adult life to helping others. And in his final act, the 58-year-old addictions counselor provided Eugene police a crucial assist, helping them nab a man suspected of breaking into vehicles near Killian’s office. Minutes after police arrested the suspect Friday morning, Killian suddenly collapsed and died. Killian’s wife of 36 years said her husband’s death came as a complete surprise. Deborah Killian said she has contacted her husband’s clients, and hopes they continue to get the help they need to overcome addictions.

“I think (his death) is going to leave a hole for a lot of people,” she said. “Some of (his clients) have told me that he saved their lives. I just hope they can take what they got from Brad and keep going.”

By Jack Moran writing in the Register-Guard

COMMEMORATIONS, continued on page 18
Valerie Michelle “Micki” Knuckles passed away on Dec. 29, 2010. She was born on Nov. 4, 1948, in Oakland, Calif., and grew up in Albany, Ore. She worked as an addiction counselor and eventually became director of treatment and then executive director at Willamette Family Treatment Services in 2009. She was an active member of Alcoholics Anonymous for 30 years.

In Sept. 2010 she was the recipient of the Thomas R. Dargan Award presented to her by the Oregon Department of Human Services, Addictions and Mental Health Division, for her outstanding leadership in the area of alcohol and drug abuse prevention and treatment. Formal recognition was acknowledged for her unselfish efforts over the years which have inspired others to maintain their commitment to making the community a wholesome and thriving place. Notably, she was nominated by her peers in the profession.

James Lamar “Jim” Screws, Jr., 50, died on Feb. 10, 2011 at his residence following an extended illness related to pancreatic cancer. He was a native of Waycross, Ga., was raised in Patterson and had made his home in Waycross for the past 20 years. He was the 1978 Valedictorian of Patterson High School and had attended Valdosta State College. He was a Certified Addictions Counselor with Satilla Community Services and also contracted counseling services to the Department of Corrections and the Parole Office in Waycross. He was a member of Alcoholics Anonymous where he had been actively involved since Nov. of 1982. He was also a member of Patterson Baptist Church.

A woman who brought hope and recovery to women all over the Mid-South has died. Sharon Trammell died Nov. 4, 2010 after a long battle with cancer. But her life will go on in the thousands of women whose lives she saved. “She had a real passion for what would help women be more empowered, and be more of what they could truly be. She had just an infinite amount of love and caring for the women,” said Elaine Orland, a Clinical Director at Grace House. Trammell was the Executive Director of Grace House, the last remaining long-term, residential, alcohol and drug treatment center in Tennessee specifically designed for women. Grace House began in 1976 as a “safe house” for alcoholic women who were trying to get sober. Trammell helped transform Grace House into comprehensive treatment program that focuses on all aspects of recovery for women. Grace House has served more than 5,000 women, and more than 80 percent of them remain clean and sober.

Details courtesy of wmc.tv.com

The TAADAC Board voted unanimously to have a tree planted at Grace House in Ms. Trammell’s memory. There will also be a plaque installed at the base of the tree.

HUMBLE HERO (for Mel*)

he was quick to laugh
unashamed to cry
always inspiring others
surrounded by love and warmth
by forgiveness and understanding
always quick to say ‘i love you’

he was a giant of a man
a humble hero
unselfish and benevolent
who took what he was given
and gave it all away
a man of true and constant wonder

he had stories to tell
from his days in north dakota
and his service to our country
to the gift of spirituality
as the key to his recovery
he was an ambassador of wit and wisdom
of truth and love
of compassion and understanding

he became an instant friend
 to everyone he met
leaving behind a million memories
imprints on those he loved
his big norwegian smile forever remembered
by those of us who were honored
to call him a friend
his heartprints are on my life
he was my mentor
he was my hero
he was my friend

neilscott 1-15-12

(See article Remembering Mel Schulstad beginning on page 6.)

Neil Scott is a national media and special projects consultant, working with non-profit organizations on media related projects and issues. He is the producer and host of RECOVERY – Coast to Coast, a two-hour nightly national radio talk show dealing exclusively with addiction, with a focus on recovery.
“For more than 30 years, NAADAC has been the leading advocate for addiction services professionals. Our association’s purpose is to help develop the skills and enhance the well being of professional alcoholism and drug abuse counselors.”


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