I suspect that most, if not nearly all, counselors unwittingly minimize the toll of spending their days/evenings interacting with clients. Stories of trauma(s), massive denial, frequent hostility and resentments characterize a typical day for many addiction counselors. Unfortunately, we can easily lose awareness of our “dragons” (i.e. counter-transference) which, if left unattended, will likely siphon the energy needed to counsel effectively; let alone impact our own emotional and physical well-being.

Unresolved feelings of helplessness/powerlessness are frequently remnants of our family of origin for some of us. The lack of clarity regarding our limitations (i.e. what you/I can or cannot control) will, invariably, catalyze and perpetuate the aforementioned feelings of helplessness. Failing to effectively manage our fear(s) of disapproval, including challenges to our competency or motivations, results in a great deal of stress for others. Tendencies toward over responsible behavior, including over talking and assuming responsibilities better assigned to our client(s), may well represent our reenactment of our role emanating from our family of origin as well. These roles, despite their apparent benefits, frequently have considerable side effects or negative consequences; well known by family therapists and other clinicians. Over-identification with our client’s suffering which seem similar to our own recovery experiences may, unfortunately, result in pigeon-holing the client and potentially limiting our usefulness.

Regardless of your “dragon,” I encourage you to take care of yourself!

Only our best,

Stewart B. Ball, LCAC, LMFT, LCSW
President
Malcolm started her career working with the elderly and adults with disabilities. She has over 10 years of progressive clinical experience working with the complex diagnoses that often accompany addictions and co-occurring disorders. She started working specifically with addictions in 2006 when she moved to Billings and started working at Rimrock.

She coordinates the continuing education for licensed staff, ensuring they have opportunities to appropriate continuing education units to improve their skills and ability to meet the needs of clients. She also supervises and coordinates the internship program and ensures all learning objectives are met. She also provides educational lectures and workshops to patients and community members and also conducts adjunctive group, family, and individual therapy.

Friday: Earn up to 6 CEUs
Working with Antisocial Personality: Etiology through Treatment Interventions

Saturday: Earn up to 6 CEUs

Location: Indiana Wesleyan University - Indianapolis North Campus

2018 IAAP Events Calendar

Save these Dates!

Ethics Workshop
Friday – July 13th

CCS Training
Saturday - July 14th

Annual Fall Conference
October 26th - 27th
Virtue, Courage, Humility and Character in Ethical Behavior
Rob Morgan, MS, LCAC, NCAC II, ICAC II
Chair, IAAP Ethics Committee

As the ethics chair, I needed to ask myself: what really keeps professionals from finding themselves in potentially unethical circumstances in the first place?

The most serious and first thing that comes to mind is to never engage in personal relationships with our clients to include sexual encounters. This one sits firmly atop the list where it should remain. As I thought about this concept, I recalled the time that I was with my wife at a seminar. I do not recall which conference, they often tend to run together. At this particular conference the speaker talked about the different professions: Social Workers, LMHC’s, LMFT’s and Addiction Professionals and the tendency to be involved with sexual relationships with their clients.

The speaker asked us all if we knew which had the highest incidences of sexual relationships between client and therapist? You guessed it, Addictions! This was the moment my wife slugged me in the arm. As I sat there in pain (not really), but feigning mock irritation at her accusation, I wondered why the addictions profession was at the top of the list. The immediate answer lies somewhere in the unbalanced emotional and ethical world which our clients come from and our own human failings.

So, I asked myself, how do we recognize and minimize our human failings?

No matter how the numbers vary, no one wants to find themselves embroiled in an ethics violation. So, how do we avoid ethical issues as a matter of practice? The problem is that the laws regarding whether an action is ethical or not, are not conventional. For example, an accepted rule is driving on the right side of the road, using a spoon when we eat soup or holding the door for an aged person. I like that one!

The solutions are not evidenced based in the sense that I just stated, they just seem like the right thing to do. I know, it is the law to drive on the right side. My point is that the driver will figure it out rather quickly, that something is amiss and correct their error simply to not have any problems. Avoiding ethical issues is more a subjective matter. Potential ethical problems can be effectively avoided or dealt with if we develop and monitor our personal and professional practices around these four concepts: character, virtue, humility and courage. Let’s explore each of these inner and personal yet learned values separately and then together.

If you want to know what a man is like, take a good look at how he treats his inferiors, not his equals.  J. K. Rowling

Character: This is who we are as in our personality, nature, disposition, temperament among other aspects. These develop because of our choices, thoughts, words, and behaviors all of which help to create our character. This could be simply stated as “what we do in one thing, we do in all things.”

Character is how we are known by our friends, family, co-workers and of course our clients. If you will, this is our word, honesty, integrity, and what those who know us expect from us.

Ability may get you to the top, but it’s character that will keep you there.  A. Lincoln

Virtue: Virtue is an integral part of the inner person. Qualities would be our morality, integrity, honor, dignity and decency. In our actions and reasons, we are responsible for what we do in each situation. Being patient, kind, and generous in a caring and understanding way can be a counselor’s strength and a barrier to our human failings. If we do something for the right reason, the right way, the results will turn out to be right.

It is not thinking less of yourself but thinking of yourself less.  C.S. Lewis

Humility: This is also an inner part of who we are. Humility allows us to do something for someone else or for reasons that do not put us in direct benefit of what we do. I put this to my clients as the ability to shrink my “I.”

Continued on next page.
I minimize my ego’s needs to do for others so not do this action so “I” look good. I do this because it is the correct thing to do. We see humility in our humbleness, modesty, lack of pride and vanity.

One isn’t necessarily born with courage, but one is born with potential. Without courage, we cannot practice any other virtue with consistency. We can’t be kind, true, merciful, generous, or honest. Maya Angelou

**Courage:** This may seem like the easier to recognize, but it is not. It is far above bravery, because it is the right thing to do. Pluckiness, was a word the dictionary used. This describes a person being in the game for the game and not the money. Being unafraid to do the right thing. This part of courage is within ourselves and when mixed with humility and virtue can help us in recognizing the right thing to do because this is our character.

As we contemplate about and apply these concepts into our moral compass, we begin to see the following. That these 4 are all closely related and in fact support each other and cannot exist alone with any effectiveness. Courage to do what is right, even though we prefer to do something else. For example: Wanting out of frustration, to slap a patch of hair off a client’s head who continues to use is not what we should do, but, we’ve all been there. This leads to humility which helps us do the right thing and what is more important, to be known to do the right thing, to never give up and to never punish. These all lead to character or what we known to be as a therapist, parent, grandparent, friend or mentor. We all can benefit from these four characteristics (notice the similarity of the words) to aid in developing ourselves as ethical human beings. This concept by itself (the four as one) will help to shield us from ethical dilemmas no matter what anyone else does, says, feels or threatens. These four, if nurtured, will help us become more effective professionals. Or in the words of Mathew Kelly, founder of Dynamic Catholic; to become the best version of ourselves. This must be done on a daily basis increasing our abilities to make ethical decisions no matter what life or our clients throw our way. Put in another way, these concepts will enable us to remain the captain of our own ship.
Largest Study of its Kind Finds Alcohol Use Biggest Risk Factor for Dementia

Alcohol use disorders are the most important preventable risk factors for the onset of all types of dementia, especially early-onset dementia. This according to a nationwide observational study, published in The Lancet Public Health journal, of over one million adults diagnosed with dementia in France.

This study looked specifically at the effect of alcohol use disorders, and included people who had been diagnosed with mental and behavioral disorders or chronic diseases that were attributable to chronic harmful use of alcohol.

Of the 57,000 cases of early-onset dementia (before the age of 65), the majority (57%) were related to chronic heavy drinking.

The World Health Organization (WHO) defines chronic heavy drinking as consuming more than 60 grams pure alcohol on average per day for men (4-5 Canadian standard drinks) and 40 grams (about 3 standard drinks) per day for women.

As a result of the strong association found in this study, the authors suggest that screening, brief interventions for heavy drinking, and treatment for alcohol use disorders should be implemented to reduce the alcohol-attributable burden of dementia.

"The findings indicate that heavy drinking and alcohol use disorders are the most important risk factors for dementia, and especially important for those types of dementia which start before age 65, and which lead to premature deaths," says study co-author and Director of the CAMH Institute for Mental Health Policy Research Dr. Jürgen Rehm. "Alcohol-induced brain damage and dementia are preventable, and known-effective preventive and policy measures can make a dent into premature dementia deaths."

Dr. Rehm points out that on average, alcohol use disorders shorten life expectancy by more than 20 years, and dementia is one of the leading causes of death for these people.

For early-onset dementia, there was a significant gender split. While the overall majority of dementia patients were women, almost two-thirds of all early-onset dementia patients (64.9%) were men.

Alcohol use disorders were also associated with all other independent risk factors for dementia onset, such as tobacco smoking, high blood pressure, diabetes, lower education, depression, and hearing loss, among modifiable risk factors. It suggests that alcohol use disorders may contribute in many ways to the risk of dementia.

"As a geriatric psychiatrist, I frequently see the effects of alcohol use disorder on dementia, when unfortunately alcohol treatment interventions may be too late to improve cognition," says CAMH Vice-President of Research Dr. Bruce Pollock. "Screening for and reduction of problem drinking, and treatment for alcohol use disorders need to start much earlier in primary care." The authors also noted that only the most severe cases of alcohol use disorder ones involving hospitalization were included in the study. This could mean that, because of ongoing stigma regarding the reporting of alcohol-use disorders, the association between chronic heavy drinking and dementia may be even stronger.

Story Source: Materials provided by Centre for Addiction and Mental Health. Note: Content may be edited for style and length.


Source: https://www.sciencedaily.com/releases/2018/02/180220183954.htm
The Wonder of the Current Shortfall of Treatment
Jeanne Hayes LMHC, LCAC

Now is a time to wonder. Time to wonder how prepared we are as a profession to approach the future. It is easily recognizable that at this time, we as a profession are not capable of meeting the clinical needs of those struggling with Substance Use Disorder. It may be that we have sufficient groups to serve our clients in an out-patient setting. It is not true that we have the clinical ability to serve our clients seeking detox, or those in need and wanting residential treatment. This is a reality that ought to shock each of us, but over time we have become immune to this situation.

We are capable of helping our clients understand that Addiction is a brain disorder. Are we Addiction Professionals capable of understanding this disorder? If so how is it that we accept the lack of treatment available to our clients? This seems to me to be an ethical dilemma for our whole profession.

No one wants to be an addict, regardless of what the addiction is. This disease is a challenge that “hijacks” the brain. The client’s negative consequences increase over time. These consequences block the client’s view that the lifestyle change required is within their grasp. They most often believe that they are alone. Withdrawal or any part of this mental health challenge is not something one ought to be punished for. It seems clinically correct that our clients our family members or maybe we, who struggle with Addiction as well as other mental health issues, ought to be treated by professionals in a clinical setting not punished with incarceration.

The primary reason clients are denied treatment is there are no available beds for those seeking detox or residential treatment, a two to three week wait is not unusual. Often clients are denied treatment for reasons such as: they have not yet failed at previous treatment, or they do not have the ability to pay, even though, we all may believe they are unable to stop using on their own. The Affordable Care Act has decreased the denial of treatment for many, but not for all. The not being able to stop using and stay stopped on their own is a huge component. So where are we with treatment?

If a client is arrested by the legal system due to behavior brought on by this disease, they have violated the law. They will not receive clinically safe and respectful treatment, they will be incarcerated, and they may detox in a holding cell, and/or obtain their drugs illegally in the jails or prisons. Please, please let us not wonder if in the future treatment opportunities will increase, let us today treat this disorder with the professionalism it deserves.

What are we willing to do about lack of residential care? It is not up to the other person, or the next generation this is for us to address today. I invite all Addiction Professionals to challenge their thinking about this issue. I encourage each of us to discuss this frequently in staffing, with clinical and administrative staff. Write letters expressing your perspective about this to IAAP, SAMHSA, elected officials, CARF, JCAHO, letters to the editor, anyone or any group that you think needs to be informed. If we do not raise the issue, who will?

Words of Wisdom

“People often say that motivation doesn’t last. Neither does bathing. That’s why we recommend it daily.”

– Zig Ziglar
Jymmin: How a Combination of Exercise and Music Helps us Feel Less Pain

I chose this article because I have found through the years that a moderate amount of clients in recovery have complained that chronic pain drew them to drink or abuse of their opiates. I believe that chronic pain patients deserve pain relief but has western thought with its focus on “a pill cures all” philosophy in the 20th century appropriately and effectively resulted in the patient achieving pain management? I believe we have failed our patients by offering them a cure that isn’t a cure after all, but just a bandaid to their problem. I hope you will enjoy the article below. (Kay Bontrager, Editor)

Pain is essential for survival. However, it could also slow rehabilitation, or could become a distinct disorder. How strongly we feel it depends on our individual pain threshold. Scientists have discovered that this threshold can be increased by a new fitness method called Jymmin. It combines working out on gym machines with free musical improvisation - and makes us less sensitive towards physical discomfort.

Often, pain emerges as a consequence of disease, injury or intense physical demands. About seven percent of adults in Germany experience chronic pain and feel constrained by it. There are several options to help manage this. A new alternative to painkillers or heat therapy could be Jymmin, a mixture of working out on gym machines and free musical improvisation, jamming, developed by scientists at the Max Planck Institute for Human Cognitive and Brain Sciences (MPI CBS) in Leipzig. They found out that this new fitness technology makes us less sensitive to pain.

In Jymmin, fitness machines are modified in a way that movement strength on the abdominal trainer, pull bar or stepper creates a wide range of sounds. Software for music composition developed at MPI CBS and a related sensor system enable users to produce a unique accompaniment from each fitness machine. The exerciser becomes the composer and the machines their instruments.

We found that Jymmin increases the pain threshold. On average, participants were able to tolerate ten per cent more pain from just ten minutes of exercise on our Jymmin machines, some of them even up to fifty per cent,” says Thomas Fritz, head of research group Music Evoked Brain Plasticity at MPI CBS. From previous studies the neuroscientist already knew that sports in general increases our pain threshold. " Jymmin showed these effects to be even stronger compared to normal workouts,” Fritz states. After Jymmin, the participants were able to immerse their forearm into ice water of one degree Celsius for five seconds longer compared to a conventional exercise session.

Scientists working with Fritz think one of the main reasons for this might be the increased release of endorphins: the higher their level, the more tolerant we are to pain. The combination of physical exertion and making music seems to trigger the release of endorphins in a particularly efficient way.

Interestingly, the effect size was dependent on the individual experience of pain. The scientists had divided the twenty-two participants according to how they rated pain. Indeed, the participants with the highest pain threshold benefitted the most from this training method. This could be due to their already more effective release of endorphins in comparison to those who are more pain sensitive."

There are several possible applications for Jymmin that can be derived from these findings,” the neuroscientist says. It could help alleviate pain in sufferers of acute or chronic pain, for example. These machines could especially deliver valuable support in rehabilitation clinics by enabling more efficient training. “Patients simply reach their pain threshold later.” A current study with chronic pain patients furthermore seems to imply that Jymmin can also reduce anxiety, a contributor to chronic pain.

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On the other hand there are top athletes who strive to achieve highly demanding physical performances and want to increase their pain thresholds. Preliminary investigations on top swimmers in South Korea showed that athletes who warmed up using Jymmin machines were faster than those using conventional methods. In a pilot test, five of six athletes swam faster than in previous runs.

Several former studies have demonstrated that Jymmin has many positive effects on our well-being. They revealed that not only is less effort in sports ad exercise required to reach the same result, but also that personal mood and motivation is improved. Even the music itself - produced by their Jymmin was perceived as pleasant, even if not described as their personal music taste.

Story Source:
Materials provided by Max Planck Institute for Human Cognitive and Brain Sciences. Note: Content may be edited for style and length.

Journal Reference:

Source: https://www.sciencedaily.com/releases/2018/02/180220104107.htm

Words of Wisdom

“What lies behind us and what lies before us are tiny matters compared to what lies within us.”

– Ralph Waldo Emerson

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CFR Part 2 Confidentiality of Substance Use Disorder Patient Records

Learn about 42 CFR Part 2, a federal law governing confidentiality for people seeking treatment for substance use disorders from federally assisted programs.

Federal privacy laws and regulations exist to protect patients’ personal health information. These policies guide healthcare professionals, health IT vendors, and insurance companies to maintain information security and patient confidentiality.

If you or a family member seeks treatment for a substance use disorder, or you are a professional who works with this population, it is important to understand a federal statute called Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) 2, also known as 42 CFR Part 2.

The federal statute governs confidentiality for people seeking treatment for substance use disorders from federally assisted programs.

This law generally requires a federally assisted substance use program to have a patient’s consent before releasing information to others. It encourages people to seek treatment and reassures patient privacy.

Proposed Revisions and the Notice of Proposed Rulemaking (NPRM)

The U.S. healthcare system has changed significantly since 42 CFR Part 2 was last substantially updated in 1987. Over the last 25 years, changes to health care include:

- New models of integrated care for supporting patient care
- An electronic infrastructure for managing and exchanging patient data
- The expansion of prescription drug monitoring programs
- A new focus on measuring performance in health care systems

In February 2016, the Department of Health and Human Services (HHS) published proposed revisions to 42 CFR Part 2. The proposed rule, Confidentiality of Substance Use Disorder Patient Records, was published in the Federal Register on Feb. 9, 2016. HHS recognized the need to update these regulations and used this proposal to suggest changes. Public comments were collected until April 11, 2016 and are available on the Regulations.gov Web site.

SAMHSA hosted a webinar to give an overview of the proposed rule (NPRM):

- Video: Proposed Rule Updating the Substance Abuse Confidentiality Regulations (42 CFR Part 2) (19 minutes)(link is external)
- Webinar slides - 2016 (PDF | 1.5 MB)

Final Rule

SAMHSA issued a final rule to update and modernize the Confidentiality of Alcohol and Drug Abuse Patient Records (now the Confidentiality of Substance Use Disorder Patient Records) regulations and facilitate information exchange within new health care models while addressing the legitimate privacy concerns of patients seeking treatment for a substance use disorder. These modifications also help clarify the regulations and reduce unnecessary burden. On March 21, 2017 the final 42 CFR part 2 rule went into effect.

SAMHSA concurrently issued a supplemental notice of proposed rulemaking (SNPRM) that proposes additional clarifications to the part 2 regulations as amended by the final rule. Questions were raised by commenters on the proposed rule that highlighted varying interpretations of the 1987 rule's restrictions on lawful holders and their contractors and subcontractors' use and disclosure of part 2-covered data for purposes of carrying out payment, health care operations, and other health care related activities. Public comments were collected on the SNPRM until February 17, 2017.

SAMHSA hosted and recorded a webinar (73 minutes) (link is external) that gives a broad overview of the Final Rule and the SNPRM available for viewing.

On January 3, 2018, SAMHSA issued a final rule based on the SNPRM.

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Listening Sessions

In 2014, SAMHSA hosted a public listening session discussing concerns around 42 CFR Part 2 with stakeholders. Comments received during the listening session are posted on the SAMHSA Web site.

In January 2018, as required by Section 11002 of the 21st Century Cures Act, SAMHSA will hold a public meeting to seek input on how Part 2 impacts patient care, health outcomes, and patient privacy.

Transcript of 2018 Listening Session (PDF | 945 KB)
SAMHSA 2018 Listening Session Introductory PowerPoint Slides (PDF | 1 MB)

Other Resources

SAMHSA has worked closely with the Office of the National Coordinator for Health Information Technology (ONC) to develop guidance documents for behavioral health providers on applying 42 CFR Part 2:

- FAQs by SAMHSA & ONC: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE) – 2010 (PDF | 381 KB)
- Applying the Substance Abuse Confidentiality Regulations 42 CFR Part 2 - 2011 (PDF | 57 KB)

SAMHSA is in the process of providing updated guidance to reflect changes made in the 2017 and 2018 rules.

In addition to federal regulations, many states have established regulations to protect health information. In these states, the state- or federal-level regulation that is most stringent is the one that applies. For more information on laws and regulations specific to behavioral health, access SAMHSA’s Laws, Regulations, and Guidelines topic. Last Updated: 03/12/2018

Words of Wisdom

“It’s difficult to believe in yourself because the idea of self is an artificial construction. You are, in fact, part of the glorious oneness of the universe. Everything beautiful in the world is within you.”

– Russell Brand
Opioid Abuse Leads to Heroin Use and a Hepatitis C Epidemic, Researcher Says

Heroin is worse than other drugs because people inject it much sooner, potentially resulting in increased risk of injection-related epidemics such as hepatitis C and HIV, a new study shows. As more people use opioids, many switch to heroin because it’s more potent and cheaper -- a trend that complicates disease prevention as health officials crack down on opioids.

As more people use opioids, many switch to heroin because it’s more potent and cheaper -- a trend that complicates disease prevention as health officials crack down on opioids, said Ricky Bluthenthal, first author of the study and a professor of preventive medicine at the Keck School of Medicine.

Stigmatizing drug use is an ineffective way to address a public health outbreak, he added.

"The market is saturated with opiates. That cat is out of the bag," Bluthenthal said. "At this point, we have to figure out what we're going to do about opioid abuse because the opioid crisis is leading to downstream infectious disease epidemics such as acute hepatitis C."

Published in the journal Drug and Alcohol Dependence on Feb. 15, the study surveyed 776 people in Los Angeles and San Francisco about their drug use. Researchers limited the investigation to heroin, methamphetamine or speed, powder cocaine and crack cocaine.

About 99 percent of participants who used heroin, regardless of demographics, eventually injected the drug -- nearly three times the injection rate of people who used crack cocaine. The second most injected drug was meth or speed, with 85 percent of users reporting that they moved to injection.

Heroin had the shortest incubation period -- about half a year -- from initial drug use to drug injection. It took meth and speed users about twice that time and powder cocaine users nearly five times that length of time to begin injecting.

"Heroin is less expensive than opioids and more potent," Bluthenthal said. "So transitioning to heroin is reasonable. Heroin is much more efficient when injected, and that's why we see this trend."

On the road to a solution

As the nation tries to clamp down on the opioid epidemic, it may inadvertently drive people to heroin more quickly, Bluthenthal said. The real solution, he noted, is to get people better treatment for their opioid addiction.

From 2002 to 2015, there was a six-fold increase in the number of overdose deaths involving heroin, according to the National Institute on Drug Abuse.

Hepatitis C linked to injection drug use has increased three-fold over a 10-year period, the study stated, citing research from the University of Cincinnati Medical Center.

"We want to interrupt people from escalating their drug use from legal prescription opioids to illicit heroin use," Bluthenthal said.

Possible solutions include drug consumption rooms, supervised injection facilities, syringe exchange programs, overdose prevention education and naloxone distribution, Bluthenthal said. Naloxone is an antidote for opioid overdose.

"We're always trailing the epidemic: We don't know there is a problem until the bodies and infections start showing up," Bluthenthal said. "We now know people are moving from opioids to heroin to injection. We missed the opportunity to change that progression, so we need to move more aggressively to reduce opioid abuse and to implement safer venues to consume drugs. The end result will benefit public health."

Daniel Chu and Thomas Valente from the Keck School of Medicine, Alex Kral and Lynn Wenger from RTI International and Philippe Bourgois from the David Geffen School of Medicine at UCLA also contributed to this study.

The study was entirely supported by federal grants amounting to $1,656,797 from the National Institute on Drug Abuse (R01DA027689, R01 DA038965) and the National Cancer Institute (P30CA014089).

Story Source:
Materials provided by University of Southern California. Original written by Zen Vuong. Note: Content may be edited for style and length.

Journal Reference:
Ricky N. Bluthenthal, Daniel Chu, Lynn D. Wenger, Philippe Bourgois, Thomas Valente, Alex H. Kral. Differences in time to injection onset by drug in California: Implications for the emerging heroin epidemic. Drug and Alcohol Dependence, 2018; 185: 253 DOI: 10.1016/j.drugalcdep.2018.01.005

Source: https://www.sciencedaily.com/releases/2018/02/180222162135.htm
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Institute for Alcohol and Drug Studies

PLENARY SPEAKERS

Stefanie Carnes, PhD, CSAT-S
Day 1

Osvaldo Cabral, MA, LPC, LAC
Day 2 and 3

Bari K. Platter, MS, RN, PMHCNS-BC
Day 2 and 3

Wednesday and Thursday, May 16 and 17, 2018
8 a.m.–5 p.m. (CDT)

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Friday, May 18, 2018
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