IAAP
The Indiana Association for Addiction Professionals
A NAADAC Affiliate

September 2013

CONNECTIONS
The Newsletter for Addiction Professionals

Presidents' Message

By Albert Alvarez

I do hope that each of you is enjoying your summer. Again, may I remind you, during this summer season, that many of our bachelor and master level students need your sponsorship and mentorship. Have you taken that extra helpful step and sponsored that aspiring young addiction recovery professional in training? Have you paid her or his membership fee for IAAP and NAADAC? The only way we will grow our addiction recovery profession is by each of us willing to step up to the plate to sponsor and mentor an addiction recovery professional in training. Please be generous and help us grow. As we grow, so does the service we provide to the individuals needing addiction recovery. I thank you for your willingness to sponsor and mentor.

As your president, I want to continue to encourage mentoring as a very important piece of professional rapport development. At our most recent IAAP Board Meeting, the Directors asked me to speak to you about mentoring. So what is mentoring? Let me begin by explaining what I don't do in my mentoring. It is not scheduling a time for the mentee or mentor to have a clinical therapy session for mental health or recovery issues, nor is it clinical supervision of any current cases of the mentee's practice, nor is it tutoring of a particular academic college course, and nor is it supervising internship practice of any core functions of the mentee's internship. Okay, if mentoring is not clinical therapy or academic tutoring, then just what is it? And who is qualified to mentor? And does one need a contract and/or an agreement between the mentor and mentee?

Let's look at the old Merriam Webster dictionary, in which Webster says:"2a: a trusted counselor or guide; 2b: tutor, coach." Yes, mentoring is more akin to the new para-professional practice of "life coaching," however, in our addiction recovery profession, mentoring is practiced by a qualified addiction recovery professional. And what is meant by qualified addiction recovery professional? In the case of mentoring, it means being an LCAC and/or MAC.

In regards a contract, it may not be legally necessary to have a written and signed contract to mentor, however, ethically and professionally, the mentor and mentee should have at least a verbal or written understanding of what is expected in this mentoring and stay within the professional limits and boundaries agreed upon (example: set day and time to meet, length of session, outline of discussion, etc.). I have never charged a fee for mentoring, since I view this as part of my community service and growing of our addiction recovery professionals. Please remember that many of our students are very limited on funding. However, the mentee must be responsible in the mentoring process, if not, I will drop the mentee (this is part of the agreement up front).

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INSIDE THIS ISSUE

President's Message continued.

As an example of mentoring, please allow me to share some of my mentoring. I believe it is important to use several outlines available to all of us in mentoring (these will be very effective and instructional documents for the addiction recovery professional in training to digest and make part of her/his practice). The IAAP/NAADAC Code of Ethics, TAP #21, The academic requirements found in the Indiana Code 25 for the Licensing of Clinical Addiction Counselors, plus any of the other TIP and TAP series that address core functions and skills of the addiction recovery professional. Based upon the IAAP/NAADAC Code of Ethics, I take an holistic approach to mentoring as I "coach" "guide" the mentee to be aware of her/his healthy mental, emotional, physical and spiritual life in the practice of an addiction recovery professional. I never sugar coat and I keep the mentoring focused and real.

At our Spring Conference, many of you promised me you would sponsor and mentor students. Please, I ask you to take this as a very serious commitment to grow our profession; and, thereby, fulfilling the increased need for professionals to provide a service to the recovering community. And I thank each of you for your help to our profession and to IAAP. Just as it has been said that it takes a village to raise a child; in my experience, it takes many addiction recovery professionals to raise effective and experienced addiction recovery professionals.

Only Our Best,

C. Albert Alvarez LMHC, LCAC, MAC, CGP.

Albert, your President
Albert Alvarez, LMHC, LCAC, MAC, CGP.

P.S. Don't forget that our committees could use your expertise. Just a few hours a few times a year will continue to keep IAAP an effective and professional association to all our members (new and old) and further the cause of our valued professional rapport. Please be generous and volunteer today. Many Thanks!

2013 Spring Conference Kits Available!

Did you miss our conference, *Romancing the Brain into Recovery - Conflict Resolution in Recovery and Relapse Prevention*, but want to get the materials you missed? Discounted workshop kits are available through our offices. Kits include: lecture notes and homework as well as client set up information, almost 400 power points and one Client Handbook as well for reference and training. Kits are offered to IAAP Members at a discounted rate of $100.00 per kit (regularly $180.00), plus $5.00 shipping.

For More Information email: stephanie@centraloffice1.com
Questions? (317) 481-9255

Tots Who Sleep Less Have More Behavior Problems, Study Finds

July 10, 2013 — Four-year-olds with shorter than average sleep times have increased rates of "externalizing" behavior problems, new research finds. The study appears in the July *Journal of Developmental & Behavioral Pediatrics*, the official journal of the Society for Developmental and Behavioral Pediatrics.

The researchers analyzed parent responses from a nationally representative study of about 9,000 children, followed from birth through kindergarten age. When the children were four years old, nighttime sleep duration was estimated by asking the parents what time their child typically went to bed and woke on weekdays. **The average bedtime was 8:39 pm and wake time 7:13 am, giving a mean nighttime sleep duration of about 10½ hours.** Eleven percent of children were considered to have "short sleep duration" of less than 9¾ hours (calculated as one standard deviation below the average). On a standard child behavior questionnaire, parents rated their child on six different "externalizing" behavior problems such as anger and aggression. (Externalizing behavior problems are outward behaviors, distinguished from "internalizing" problems such as depression and anxiety.) The relationship between sleep duration and behavior scores was assessed, with adjustment for other factors that might affect sleep or behavior.

On the child behavior questionnaire, 16 percent of children had a high score for externalizing behavior problems. Behavior problems were more common for boys, children who watched more than two hours of television daily, and those whose mothers reported feeling depressed.

After adjustment for other factors, "**Children in the shortest sleep groups have significantly worse behavior than children with longer sleep duration,**" Dr Scharf and colleagues write. The effect was greatest for aggressive behavior problems, which were about 80 percent more likely for children with nighttime sleep duration of less than 9¾ hours.

Shorter sleep times were also associated with 30- to 46-percent increases in rates of the other externalizing behaviors studied, including overactivity, anger, impulsivity, tantrums, and annoying behaviors. **In a linear analysis, as sleep duration increased, troubling behaviors decreased.**

THIS RAISES QUESTIONS FOR THE ADDICTION PROFESSIONAL: HOW MUCH SLEEP WOULD CHILDREN, OF OUR ADDICTED CLIENTS, GET? Should our Family Programs address parenting issues? Should we include it in our AC Groups? Wouldn't it be of benefit to give the TOOL of "earlier to bed for preschoolers" for parents struggling through the aftermath of addiction? I hope you will put it n your toolbox to pass along.

Source: The above story is based on materials provided by **Wolters Kluwer Health: Lippincott Williams & Wilkins**, via Newswise.

Note: Materials may be edited for content and length. For further information, please contact the source cited above.

Journal Reference:

1. Rebecca J. Scharf, Ryan T. Demmer, Ellen J. Silver, Ruth E.K. Stein. **Nighttime Sleep Duration and Externalizing Behaviors of Preschool Children**. *Journal of Developmental & Behavioral Pediatrics*, 2013; 34 (6): 384
DOI: 10.1097/DBP.0b013e31829a7a0d Submitted by B. Kay Bontrager, Cert Chair.

Administration's Public Health Approach to Addiction Begins to Take Hold

Early in his tenure as director of the White House Office of National Drug Control Policy, R. Gil Kerlikowske told a reporter he no longer wanted to use the term "war on drugs" to describe drug control policy. When asked what "bumper sticker" phrase he would use as a replacement, Kerlikowske responded he thought the American public was "ready for a greater dialogue and discussion about our drug problem than a bumper sticker answer."

Kerlikowske shared this anecdote at a forum on 21st Century Drug Policy Reform hosted by the Urban Institute, where he and other speakers emphasized prevention and treatment of substance abuse. "We have to approach drug policy from a public health standpoint, not just the criminal justice standpoint," said Kerlikowske, emphasizing that programs and policies should be based on a foundation of science. He added that although his office has advocated this approach for four years, he's only seen it begin to take hold in the past six months.

Kerlikowske cited numerous statistics on the pervasiveness of drug addiction, such as findings from the national Arrestee Drug Abuse Monitoring Program (ADAM II) that showed more than half of male arrestees tested positive for illegal drugs. He also referenced a California study showing that inmates who participated in drug treatment in prison and completed an aftercare program were half as likely to return to prison. Kerlikowske, who was formerly the Chief of Police for Seattle, Washington, said that although law enforcement plays an important role in addressing violent drug-related crime, he and his colleagues across the country "know we aren't going to arrest our way out of the problem."

Re-entry services for offenders are also vital. Kerlikowske said, "…if you don't spend the time, and frankly if you don'e spend the money to help them reintegrate…[it is no surprise] that people would re-cycle back through the system." He also lauded veteran's courts, drug courts, and other alternatives to incarceration, saying "…if you've been to a drug court and seen what your taxpayer dollars can do and you're not moved…you've probably got a heart of stone."

Kerlikowske closed his formal remarks by discussing drug addiction's impact on young people, saying that "we must also keep that very protective eye on this next generation, the young people who are…going to be the leaders and the innovators of this country." He explained that drug use inhibits young people's ability to achieve their full potential and said "we owe our youth our full and steadfast support," and must "prevent drug use from limiting our children and our nation's future."

The forum also included a panel discussion on marijuana use, prescription drug abuse, and synthetic drugs, as well as a discussion of addiction's disproportionate impact on minorities. Panelist Thomas manger, Chief of Police for Montgomery County, Maryland, spoke against legalization of marijuana but supported decriminalization of drugs in some circumstances. Manger said that his county's School Resource officers find marijuana in students' lockers every day, and while they are "horrified" by the impact of marijuana on kids, none think that the solution is to charge them criminally.

Speaking after the event, panel moderator Nancy La Vigne, director of the Justice Policy Center at the Urban Institute, said that the forum's focus on prevention and treatment of drug addiction is essential for youth in the juvenile justice system. "It's critical that we focus on youth who are engaging in substance abuse or in danger of doing so," said LaVigne, noting that "the best approaches are comprehensive, involving schools, youth, and other community entities, and focusing on early intervention and community awareness.

Submitted by Ron Chupp *from Lisa Pilnik, JD, MS in JJIE*

Rule Change on Painkillers Looms

A new law targeting "pill mills" may change the way doctors throughout Indiana treat patients with chronic pain by putting new protocols in place for prescribing opioid-based drugs. The state's medical Licensing Board is considering an emergency set of rules, triggered by the new law, that calls for drug testing of pain-medication patients and more screening and monitoring of patients by doctors to detect drug addiction and abuse. If adopted, the emergency rules would go into place in December and likely be the basis for more permanent prescribing rules. "This would be a sea change for providers who are used to writing out 'scrips and just walking out the door" said Dr. Amy LaHood, an Indianapolis family physician and member of the Prescription Drug Task Force, which supports the proposed new rules.

In April, the Indiana General Assembly passed a new law dubbed the "pill mill bill", that gives Attorney general Greg Zoeller new authority to crack down on what he's called the thinly regulated pain-management clinics around the state. It gives the attorney general's office more access to medical records maintained by pain clinics and requires every pain management clinic in Indiana be owned and operated by someone who holds a valid registration to prescribe controlled substances. But the law goes much further, potentially impacting every doctor who prescribes addictive narcotics such as Oxycontin, Percocet, and Vicodin to patients with chronic pain. The law mandates that the Medcial Licensing Board adopt a set of rules for how doctors prescribe morphine and opioid-based drugs and how they monitor those patients. The board got a look at a draft of the proposed rules recently and heard from task force members that called them "sweeping" in scope but critical to reducing the number of drug overdoses in Indiana from prescription painkillers.

Dr. Deborah McMahon, the Allen County Health Commissioner and task force chair, said the proposed rules will require doctors to take a "more thoughtful and intentional approach" to prescribing pain drugs. "Doses (of pain drugs) are being escalated without any real thought," McMahon told the board. The proposed rules are aimed at curbing dependence on pain-killing drugs and their illegal sale to drug abusers. They would only apply, for example, when a doctor writes a prescription for more than 60 opioid-containing pills in a month or a morphine-equivalent dose og 15 milligrams a day for three months. The proposed rules would require doctors to do more screening of patients before prescribing the drugs, including the use of the state's online database that tracks prescriptions for controlled substances. It also requires patients undergo a urine or saliva drug-monitoring test before they get a prescription and additional drug tests while they're on the painkillers to determine the presence of other prescription or illicit drugs.

During the board hearing, LaHood said a similar drug-monitoring test is already in place at a family practice clinic in Indianapolis run by St. Vincent health for patients who are prescribed pain-killing drugs. The test results showed that about half of those screened either had an additional pain-killing drug in their system, or showed that they weren't taking their prescribed pain medications at all. McMahon and other task force members said the proposed rules intentionally exclude patients who are suffering from a terminal illness and receiving large doses of pain-killing medication.

Some representatives of the nursing home industry asked that adoption of the prescribing rules be delayed to give them time to figure out how they would impact their patients. A representative from Indiana Academy of Family Physicians also asked for a delay until March to give doctors time to understand the new rules. But Steve Huddleston, chairman of the Medical Licensing Board, indicated that a delay was unlikely. "The legislature said this was an emergency," Huddleston said. "I don't see how we can duck that obligation."

Submitted by Ron Chupp *from Maureen Hayden in The Goshen News, 25 July, 2013*

College Women Exceed NIAAA Drinking Guidelines More Frequently Than College Men

May 18, 2013 — In order to avoid harms associated with alcohol consumption, in 2009 the National Institute on Alcohol Abuse and Alcoholism issued guidelines that define low-risk drinking. These guidelines differ for men and women: no more than four drinks per day, and 14 drinks per week for men, and no more than three drinks per day, and seven drinks per week for women. A study of how well college students adhere to these limits has found that female college student drinkers exceed national drinking guidelines for weekly drinking more frequently than their male counterparts.

Results will be published in the October 2013 issue of *Alcoholism: Clinical & Experimental Research* and are currently available at Early View.

"Recommended drinking limits are lower for women than for men because research to date has found that women experience alcohol-related problems at lower levels of alcohol consumption than men," explained Bettina B. Hoeppner of the Massachusetts General Hospital Center for Addiction Medicine, an assistant professor of psychology at Harvard Medical School as well as corresponding author for the study.

"It is always important to take gender into account when studying health or risk behaviors," added Melissa A. Lewis, associate professor in the department of psychiatry and behavioral sciences at the University of Washington. "Even if you hold weight constant, there are differences in terms of how alcohol affects men and women. For example, men have more of an enzyme in the stomach -- a gastric alcohol dehydrogenase -- that lowers the amount of alcohol that makes it into the bloodstream. Also, women have less blood going through the bloodstream than a man at the same weight, so alcohol gets more concentrated in the bloodstream."

For this study, Hoeppner and her colleagues asked 992 college students (575 females, 417 males) to report their daily drinking habits on a biweekly basis, using web-based surveys throughout their first year of college.

"We found that female college-student drinkers exceeded national drinking guidelines for weekly drinking more frequently than their male counterparts," said Hoeppner. "Weekly cut-offs are recommended to prevent long-term harmful effects due to alcohol, such as liver disease and breast cancer. By exceeding weekly limits more often than men, women are putting themselves at increased risk for experiencing such long-term effects."

"In addition," said Lewis, "men's weekly drinking declined over time whereas women's weekly drinking did not. This finding is concerning. If women continue to exceed weekly drinking recommendations over time, it puts them at greater risk for health issues, such as liver or heart disease and certain forms of cancer."

"These findings contribute to our understanding of how populations adhere to national drinking guidelines," said Hoeppner. "Specifically, it examines college student drinkers, where adherence to weekly drinking limits has not been examined before. Generally, 'binge drinking' receives more attention when examining college student drinking, however, for long-term health, it is also important to examine the establishment of drinking patterns that may lead to long-term harmful effects, not just short-term effects."

"These findings highlight the need for prevention efforts to focus on both daily and weekly limits to reduce harm from short- and long-term negative consequences related to alcohol use," said Lewis. "Current preventative interventions often do not focus on weekly drinking recommendations, which is important and a warranted area of future research.

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Hoeppner agreed. "Our results might motivate clinicians to address weekly drinking limits and the potential for long-term alcohol related harm with their patients," she said. "The reasons that many college students exceed these weekly limits are unclear. It is possible that lack of awareness of the guidelines and possible consequences of exceeding them contributes to these high rates. If so, clinicians might reduce harm by educating their college-student patients about the guidelines and the harm they seek to prevent, especially their female patients. Similarly, researchers and clinicians designing prevention/intervention programs might find it useful to address weekly drinking limits in their programs, both to reduce incidence rates thereof, and to identify the reasons for exceeding these guidelines."

Source: The above story is based on materials provided by via ScienceDaily.
Submitted by B. Kay Bontrager, Cert Chair

DID YOU KNOW? A Risk Gene for Cannabis Psychosis

Nov. 14, 2012 — The ability of cannabis to produce psychosis has long been an important public health concern. This concern is growing in importance as there is emerging data that cannabis exposure during adolescence may increase the risk of developing schizophrenia, a serious psychotic disorder. Further, with the advent of medical marijuana, a new group of people with uncertain psychosis risk may be exposed to cannabis.

For these reasons, it would be valuable if a biological test could be developed that predicted the risk for developing cannabis psychosis. This test could be used to advise people who abuse cannabis or to inform marijuana-prescribing decisions by physicians.

Recent research has implicated a variation in the gene that codes for a protein called RAC-alpha serine/threonine-protein kinase (Akt1) in the risk for cannabis psychosis. However, independent verification of these findings is critical for genetic associations with complex genetic traits, like cannabis-related psychosis, because these findings are notoriously difficult to replicate.

Led by first author Dr. Marta Di Forti at King's College London's Institute of Psychiatry, genetic researchers carried out a case control study to investigate variation in the AKT1 gene and cannabis use in increasing the risk of psychosis.

Di Forti said, "We studied the AKT1 gene as this is involved in dopamine signaling which is known to be abnormal in psychosis. Our sample comprised 489 patients with their first episode of psychosis and 278 healthy controls."

They performed genotyping on all volunteers, and assessed their use of cannabis. They found that AKT1 genotype influences the risk of psychotic disorders in cannabis users, which confirmed the prior report.

"We found that cannabis users who carry a particular variant in the AKT1 gene had a two-fold increased probability of a psychotic disorder and this increased up to seven-fold if they used cannabis daily," explained the authors. "Our findings help to explain why one cannabis user develops psychosis while his friends continue smoking without problems."

Source: The above story is based on materials provided by via ScienceDaily.
Submitted by B. Kay Bontrager, Cert Chair

Cocaine Vaccine Passes Key Testing Hurdle

May 10, 2013 — Researchers at Weill Cornell Medical College have successfully tested their novel anti-cocaine vaccine in primates, bringing them closer to launching human clinical trials.

Their study, published online by the journal Neuropsychopharmacology, used a radiological technique to demonstrate that the anti-cocaine vaccine prevented the drug from reaching the brain and producing a dopamine-induced high.

"The vaccine eats up the cocaine in the blood like a little Pac-man before it can reach the brain," says the study's lead investigator, Dr. Ronald G. Crystal, chairman of the Department of Genetic Medicine at Weill Cornell Medical College.

"We believe this strategy is a win-win for those individuals, among the estimated 1.4 million cocaine users in the United States, who are committed to breaking their addiction to the drug," he says. "Even if a person who receives the anti-cocaine vaccine falls off the wagon, cocaine will have no effect."

Dr. Crystal says he expects to begin human testing of the anti-cocaine vaccine within a year.

Cocaine, a tiny molecule drug, works to produce feelings of pleasure because it blocks the recycling of dopamine -- the so-called "pleasure" neurotransmitter -- in two areas of the brain, the putamen in the forebrain and the caudate nucleus in the brain's center. When dopamine accumulates at the nerve endings, "you get this massive flooding of dopamine and that is the feel good part of the cocaine high," says Dr. Crystal.

The novel vaccine Dr. Crystal and his colleagues developed combines bits of the common cold virus with a particle that mimics the structure of cocaine. When the vaccine is injected into an animal, its body "sees" the cold virus and mounts an immune response against both the virus and the cocaine impersonator that is hooked to it. "The immune system learns to see cocaine as an intruder," says Dr. Crystal. "Once immune cells are educated to regard cocaine as the enemy, it produces antibodies, from that moment on, against cocaine the moment the drug enters the body."

In their first study in animals, the researchers injected billions of their viral concoction into laboratory mice, and found a strong immune response was generated against the vaccine. Also, when the scientists extracted the antibodies produced by the mice and put them in test tubes, it gobbled up cocaine. They also saw that mice that received both the vaccine and cocaine were much less hyperactive than untreated mice given cocaine.

Source: The above story is based on materials provided by via ScienceDaily.
Submitted by B. Kay Bontrager, Cert Chair

IAAP Marketing Committee Update

The Marketing Committee continues to gather email addresses for specific contacts at Community Mental Health Centers throughout the state. This is an interesting, though time consuming task. One we believe will make our communication with the mental health centers more efficient.

As the Marketing Committee develops this list of Community Mental Health Provider's, we keep our focus on the goal of increasing current education for the IAAP members. We want to heighten members expectations of their need for on-going professional education. Several pieces need to be in place to aid each of us to be our best in the clinical settings. Most of us are involved in individual or group therapy. Many of us include psycho-education for clients and their families. Some of us do supervision and consultation of other professionals. In these varied clinical areas in which we choose to work, we have the personal obligation to continue our education in this field. We all have our favorite publications that help us broaden and clarify our thinking, on-line education sources, and we may have a blog we follow.

IAAP accepts the responsibility to provide educational opportunities to help each of us gain the professional knowledge we need to best serve our clients. The benefits of our Spring and Fall conferences not only have presenters with up-to-date information but just as important the opportunity is there for us to network with other professionals in the field. However you learn best, you will find these conferences will be of excellent help.

Jeanne Hayes
IAAP Marketing Chairperson

IAAP Academic and Workforce Development Committee

The Academic and Workforce Development Committee is Chaired by Angela Hayes. The Academic Committee assists higher education institutions develop course work which is consistent with NAADAC standards and Indiana Licensure. We are currently seeking members to sit on the committee.

The Workforce Development Committee approves organizations seeking CEU's for conferences or other educational workshops they may sponsor. There is an application process which is typically renewed annually by the organization. The committee must determine if the conference/workshop meets CEU requirements established by NAADAC and then determines the number of CEU's that would be awarded for the conference/workshop. We are currently seeking members to sit on this committee.

This committee is still currently seeking volunteers. For anyone interested in sitting on the Academic and Workforce Committee, please contact Angela Hayes at Ahayes58@ivytech.edu. Angela is based in the southwest region (Terre Haute area) however, the committee can conduct meetings via conference calls or web based conferencing.

Angela Hayes
IAAP Academic and Workforce Development Chairperson

Wellness and Health for the Addiction Professional

Addiction professionals spend so much of their time, energy and thought to helping the impaired person. What is often missing in our schooling, training and conferences is education on taking care of ourselves. Addiction Professionals are skilled in identifying disorder. They will enhance their skills and personal life by spending more time in wellness. In fact, the more you know and live wellness, the easier it is to identify disorder. We teach our clients to be in the solution rather than the problem. How effective are we at practicing what we teach? Many unethical actions can be found originally rooted in unhealthy decisions and unhealthy living. Here is a brief summary to help stimulate your thoughts and interests in applying it to your skill.

Creating and Taking Personal Action. Start doing and taking action because it makes things happen. Make the choice and it must be for you.

Take Control of Your Life. You have control over your thoughts and actions. You do not have control over people, places, things or situations. List the benefits of taking control of your life and the way you think. List what is keeping you from doing the things you need to. Restoring is gradual.

Establish Values. The quality and depth of your self-worth is a key indicator; you must be clear about your values because they reveal who you really are.

Getting Good Health Care. Get good health care. Access health care. Improve your use of health care professionals.

Lifestyle, Priorities, and Balance. Establish balanced time management. Balance in time with work, rest, relaxation, recreation, leisure. Balance in caretaking and self-care. Balance in having just what you need and the management of it.

Home. Establish living arrangement that is safe and secure. Privacy and respect with support from house-mates. Establish a home where health care providers and wellness activities are accessible. Establish plan for upkeep.

Relationship/Love/Friendships. Support and care toward others builds wellness. Receiving support, love and care builds wellness.

Career. Establish fulfillment in employment. It is crucial to connect talents with interests and passions. Establish enjoyable work and develop skills to enhance it.

Diet. Establish healthy diet and maintain it. Improve diet, avoid overeating, obesity and under eating. Live within Body Mass Index.

Exercise. Establish regular exercise and maintain it. Explore new protocols.

Light. Increase the light in your life by increasing outdoor activities. Add supplemental light.

Sleep. It is essential to establish good sleep. Develop interventions to conduct routine and balanced sleep. Proper sleep restores body and brain functioning and allows for repairs.

Simple Tasks to Improve Quality. Increase your exposure to colors. Arrange for more music in your life. Increase exposure to art. Increase exposure and activity with water (live near it, swim, hot tub, etc.).

Integrity. Integrity produces vitality. Integrity comes from keeping the promises you make to yourself and others.

Spirituality. It is the experience of life within the relationship with God, and the maintenance of it that provides daily purpose, meaning, reprieve and satisfaction.

These are 15 categories to use for guiding one on a Wellness journey. For the purpose of a newsletter, they are but brief postings to aid in your efforts. Your health and wellness are primary to who you are and your profession.

Submitted by Steve Stone

IAAP Mission & Purpose

1. The Mission of the Indiana Association for Addiction Professionals is to advocate for competent, professional addiction counseling services, regardless of the type of addiction, the person's ability to pay for services, or the person's race, gender, ethnic and cultural identity, sexual orientation, religious beliefs, veteran's status, or physical or mental impairment.
2. The Purposes of IAAP are:
    a. To foster public awareness of addictions as treatable diseases;
    b. To promote and advocate for legal and medical reforms in the treatment of addictive diseases;
    c. To advance the science of addictive diseases through research, study, and scholarship;
    d. To elevate and maintain the standards of education for licensure and/or certification required to counsel people with addictive diseases;
    e. To offer educational and training opportunities to addictions-related professionals by offering and promoting trainings, conferences, and other educational forums.
    f. To elevate and maintain the standards of ethical and professional conduct in the provision of addiction services;
    g. To elevate and maintain the standards of honor, dignity, and integrity of addiction service providers;
    h. To engage in any such activities as may be desirable or required to fulfill the mission and purposes of IAAP.
3. IAAP may cooperate with other professional associations at the state or national level, and pay dues required from its treasury.
4. IAAP may cooperate with any official or voluntary health, welfare, educational, or rehabilitation agency concerned with the prevention and treatment of addictive diseases and related health public issues.
5. IAAP and its members will not engage in any activities that actively promote potentially addictive behaviors. Examples include, but are not limited to, the sale of alcohol, tobacco, or illicit drugs, gambling, and the pornographic portrayal of sexual activity.
6. IAAP will admit members, and levy and collect dues and associated fees for membership from individuals and organizations who are eligible for membership pursuant to the qualifications set forth in Article 3.
7. IAAP will engage in the certification of addiction professionals, and may create all such Boards, Committees, or other governing bodies deemed necessary to discharge this function pursuant to the Bylaws of this organization.

IAAP
The Indiana Association for Addiction Professionals
A NAADAC Affiliate

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SAVE THE DATE!
IAAP 10th Annual Fall Conference
September 27th & 28th
TOPIC: Pharmacology and Synthetic Drugs
Registration information coming soon!

BENEFITS OF NAADAC/IAAP MEMBERSHIP

- 33 free CE's via NAADAC's web-site: www.naadac.org - *(Medication Management for Addiction Professionals: Campral Series* and *Blending Solutions)*.
- Free access to NAADAC's online Career Center at www.naadac.org.
- Assistance with referrals concerning ethical or legal questions or complaints and two free hours of help on a Legal Assistance Hotline provided by NAADAC's liability company with malpractice insurance available through the Van Wagner Group.
- Free subscription to NAADAC's official magazine, *Addiction Professional*, which is published six times annually.
- Peer support and network opportunities through national and state conferences and workshops.
- Reduced rates for continuing education including the qualification course for the U.S Department of Transportation's Substance Abuse Professional.
- Reduced rates for publications such as the *Basics of Addiction Counseling: A Desk Reference and Study Guide*, used by experienced professionals and as a guidebook for preparation for certification exams.
- Access to the *NAADAC News*, the association publication only available to NAADAC members.
- Substantially reduced rates for professional Certification and re-certification as National Addiction Counselor (NCAC) or Master Addiction Counselor (MAC). *Please note that certification is not included in NAADAC membership but is a separate process. (Certification is not a requirement of membership in NAADAC.)*
- New avenues for job opportunities and advancement with higher levels of certification.
- A 20 percent discount on all Hazelden Publishing and Educational Services (PES) resources.