

CONNECTIONS

The Newsletter for Addiction Professionals



President's Message

By Ron Chupp

IF YOU ARE NOT TREATING TRAUMA, YOU ARE NOT TREATING ADDICTION

That is a pretty bold statement, but the evidence backs me on this issue. When in graduate school, I chose to research co-occurring Posttraumatic Stress Disorder (PTSD) and addictions due to the prevalence of these issues in my practice as a substance abuse professional. I witnessed high rates of PTSD among my clients with addictions, but had had little training in treating clients with PTSD. Many in our profession have labeled as "resentments" what I believe are PTSD symptoms. This results in clients who cannot stop reliving or re-experiencing their traumas being viewed as "unwilling to let go of their resentments." Whereas this may be the case for some of our clients, I believe that many people are being unfairly blamed for their inability to "let go" of their serious mental health symptoms that are not being adequately identified or treated. I believe it is imperative for substance abuse professionals to be able to adequately and appropriately identify and treat PTSD among clients with addictions.

A 1995 study by Wendle, Wendle, Scheidt, and Miller investigated the adult psychiatric correlates of childhood abuse among 481 male and 321 female alcoholic inpatients aged 19-57 years. The prevalence of reported childhood abuse was 59% for women and 30% for men. Forty-nine percent of women and 12% of men reported sexual abuse without physical abuse, 33% of women and 24% of men

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reported physical abuse without sexual abuse, and 23% of women and 5% of men reported dual abuse. Family history of alcoholism was associated with higher levels of physical and sexual abuse. Abuse status, especially dual abuse, was associated with higher rates of PTSD, generalized anxiety disorder, depression, antisocial personality disorder, and suicide attempts among both women and men.

Michael DeBellis (2002) reported on the findings of a study of comorbidity of PTSD and Addiction in a community sample of adolescents. The sample included 384 male and female adolescents from predominantly white working or lower-middle class families. The data were drawn from a longitudinal, community based study that traced the psycho-social development of a single-age cohort since age 5 in 1977, focusing on the date collected when the children were 18 years old in 1990. He concluded that early childhood traumatic experiences, such as childhood maltreatment, are associated with an enhanced risk of adolescent and adult addictions. He focuses on the role of maltreatment on the dysregulation of major biological stress response systems including adverse influence on brain development. Dysregulation of the biological stress response systems may lead to an enhanced risk of PTSD and depression.

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These negative affect disorders may put a child at increased risk for adolescent or young adult onset addiction. He concludes that studies in developmental traumatology may prove to be crucial in establishing a link between maltreatment-related PTSD and the neurobiology of addiction, which has implications for prevention and treatment.

In 1991, Swett, Cohen, Surrey, and Compaine surveyed 189 new female patients at an adult out-patient psychiatric clinic. 27 women reported a history of heavy alcohol consumption measured by scores of 10 or more on the Michigan Alcohol Screening Test (MAST). Women with a self-reported history of sexual and/or physical abuse had significantly higher MAST scores than women without childhood sexual abuse (CSA) or physical abuse histories. When the first abuse occurred before age 18, and there was no recent abuse reported, the association of CSA and/or physical abuse and high MAST scores persisted, suggesting that early physical or sexual abuse may be associated with the etiology of addiction.

In 1994, Schwarz and Perry focused on the neurobiology of survival and "malignant memories" in trauma and PTSD. They identify the complex set of interactive processes in the brain that play a critical role in regulating arousal, vigilance, affect, behavioral irritability, locomotion, attention, the response to stress, sleep, and the startle response. They state that, due to the biological processes involved in trauma, nearly 100% of children who are exposed to sudden, unexpected, man-made violence will develop PTSD, along with other Axis I and II psychiatric disorders. They also warn that trauma in childhood increases risk for future psychopathology rather than inoculating against it.

Brady (2001) reviews the extent of comorbid PTSD and Addiction in both epidemiological and treatment-seeking samples. He discusses theoretical issues concerning the relationship of these disorders, and their effect on the presentation, course, and outcome of treatment for addictions. He clarifies the biological connection between these disorders as being mediated through the catecholaminergic system and the hypothalamic-pituitary-adrenal axis. He reports that many individuals with a history of trauma have PTSD before the onset of addiction, supporting the hypothesis of self-medication as one avenue in developing co-morbidity of the disorders. He reports on the success of Exposure Therapy for PTSD and addiction, which was previously thought to be contraindicated. He reports on recent developments in pharmacotherapy for these disorders, especially selective serotonin reuptake inhibitors and other anti-depressants.

Tracy Simpson (1999) examined evidence that women with addictions report markedly higher rates of childhood sexual abuse than women in the general population. She investigated the frequent postulate that a history of CSA is a critical mediator of the development of both addiction and relapse among women with addictions. Four groups of women were assessed regarding the functional roles of their alcohol consumption and their treatment histories: women with and without histories of CSA seeking treatment for addictions, and non-addicted women with and without histories of CSA. She reports that CSA is a significant risk in the development of PTSD, and on the functional roles that addictions play for female victims of CSA.

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Stephanie Covington (2004), a keynote speaker at the 2011 NCAD Conference, explored the prevalence of addictions, childhood trauma, and mental health problems among women who are incarcerated. Covington cites Bureau of Justice statistics showing 8 out of 10 female offenders with a mental illness were physically or sexually abused, approximately 22% were diagnosed with PTSD, and a 1994 New York prison study found that 60% of incarcerated women reported sexual abuse. Furthermore, 74% of those with addiction were CSA victims and 72% reported emotional abuse. A survey of female pre-trial detainees found that more than 80% met DSM-IV criteria for PTSD. Covington uses these examples of proof that effective programs for female offenders need to be developed to aid their reintegration into the community when released from jail or prison.

It appears clear from the research that PTSD plays a significant role in the development of addictions and that co-occurring PTSD/Addiction are very prevalent among individuals seeking treatment for either problem. I believe that unresolved PTSD is a primary reason for the high relapse rates (67%) among people with addictions. Treating PTSD in conjunction with addictions counseling should lead to a reduction in recidivism in the addicted population, reduce stigma attributed to their "unwillingness to let go of resentment", and offer them the opportunity for a better quality of life. I believe the research also supports my hypothesis that addictions are affective, rather than cognitive, disorders and should be treated with affective therapies. Let's move addiction treatment into the 21st Century.

Only our best!

 LCAC, LCSW

Ron Chupp, LCSW, LCAC, NCAC-II, ICAC-II
IAAP President

Volunteer for NAADAC Annual Conference 2012 – Indianapolis, IN



Volunteers Needed!

Do you want to attend the national conference for free?
Volunteers can apply for scholarships!
Space is limited, so register today!

Find out more:
www.naadac.org

NAADAC Annual Conference 2012 – Indianapolis, IN

Partners

Part of what makes this conference unique is the depth and breadth of partnerships that NAADAC has developed. NAADAC is proud to have joined with ten national and local partners, including the:

Indiana Department of Mental Health and Addiction Services



Substance Abuse and Mental Health Services Administration (SAMHSA)



National Institute on Drug Abuse (NIDA)



National Addiction Technology Transfer Center (ATTC)



International Coalition for Addiction Studies Education (INCASE)



Indiana Association for Addiction Professionals (IAAP)



NALGAP: The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies



National Association for Children of Alcoholics (NACoA)



National Asian Pacific American Families Against Substance Abuse (NAPAFASA)



National Association of Recovery Residences (NARR)



National Addiction Studies Accreditation Commission (NASAC)



State Associations of Addiction Services (SAAS)

NAADAC Annual Conference

Come to Indianapolis for a Unique Educational Experience

August 12 – 15, 2012

Indianapolis, Indiana

JW Marriott Indianapolis Downtown



Leading the Way

The NAADAC annual conference, *Leading the Way*, will be held from August 12 – 15, 2012, at the JW Marriott in downtown Indianapolis, Indiana. NAADAC, the Association for Addiction Professionals, represents the professional interests of more than 75,000 addiction counselors, educators and other addiction-focused health care professionals in the United States, Canada and abroad.

Education You Need

Leading the Way will include workshops addressing prevention, trauma, legal concerns of addiction-focused professionals, co-occurring disorders, current research and outcomes, ethics, special populations, workplace/management issues, clinical techniques, alternative therapies, faith based approaches, clinical supervision and professional development.

Earn Over 30 Continuing Education Credits

Leading the Way will include ■ keynote speakers, ■ daily plenary sessions and breakout seminars. ■ August 11 will feature several all-day, pre-conference seminars. The conference will also feature an ■ Awards Lunch which will honor outstanding addiction-focused professionals from around the nation and an ■ evening event for the NAADAC Political Action Committee (admission by donation). Also included will be optional ■ evening events, to allow you to earn more education credits or to enjoy your time in Indianapolis.

Explore Indianapolis!

Indianapolis hosted the 2012 Super Bowl and is an amazing center of sporting and cultural life. The conference site is blocks from three museums, Victory Field, the NCAA Hall of Fame, White River State Park, Lucas Oil Stadium, the Indianapolis Zoo and the heart of downtown. The city also boasts the Indianapolis Motor Speedway and a Children's Museum. It's a great spot for one last family vacation before the kids head back to school. For more information on attractions and events in Indy, check out the Indianapolis Convention and Visitor's Association (www.visitindy.com).



Scholarships

Scholarships are available. All scholarship applications must be received 60 days before the first day of the conference (June 12, 2012). Download a scholarship form by visiting www.naadac.org/education.

White House Drug Policy Focuses on Treating Addiction

The U.S. government's drug strategy should focus more on treating addiction and less on imposing harsh prison sentences, the White House said in April. "outdated policies like the mass incarceration of nonviolent drug offenders are relics of the past that ignore the need for a balanced public health and safety approach to our drug problem," Gil Kerlikowske, director of the Office of National Drug Control Policy, said in a statement. The office's annual report to Congress suggests a "new national approach" that includes criminal justice system reforms aimed at stopping "the revolving door of drug use, crime, incarceration, and re-arrest," officials said in a statement. "The policy alternatives contained in our new strategy support mainstream reforms based on the proven facts that drug addiction is a disease of the brain that can be prevented and treated and that we cannot simply arrest our way out of the drug problem," said Kerlikowske, who is known as the nation's "drug czar."

Since President Barack Obama tapped him for the job in 2009, Kerlikowske has made it clear that the U.S. needs to do a better job of treating addicts to try to reduce the demand for narcotics. April's report builds on an approach administration officials have promoted since 2010, Kerlikowske, U.S. Attorney general Eric Holder and U.S. Secretary of Health and Human Services Kathleen Sebelius said in a joint statement on the White House website. "It outlines ways to break the cycle of drug use, crime, incarceration, and arrest by diverting nonviolent drug offenders into treatment, bolstering support for re-entry programs that help offenders rejoin their communities and advancing support for innovative enforcement programs proven to improve public health while protecting public safety," the statement said.

Overall drug use has "dropped substantially" over the past 30 years, the policy office said. Cocaine consumption in the U.S. has decreased 40% from 2006 to 2010, and methamphetamine use has dropped 50% in that same period, the office said. But in the report, President Obama said "serious drug-related challenges remain," including prescription drug abuse and the large number of people who need treatment for substance abuse and do not receive it. "Young people's perceptions of the risks of drug use have declined over the past decade, and research suggests this often predicts future increases in drug use," Obama wrote.

The report's release came two days after the end of the Summit of the Americas in Cartagena, Colombia, where Western hemisphere leaders agree that the Organization of American States would begin a study examining alternatives for fighting drug-fueled organized crime. The "war on drugs" drew some of the sharpest criticism among leaders at the two-day gathering, where leaders debated how to address drug trafficking and violence in the hemisphere. Several leaders called for new approaches—something Obama said he was open to, though he closed the door on legalization.

--from CNN U.S. online

Save the Date!
IAAP Fall Conference 2012
October 12th - 13th

Should Addicts Be Sterilized?

Project Pregnancy thinks so, and for years it's been paying poor, addicted women not to procreate. Now, with money from the far right, it's going global. "Don't let pregnancy ruin your drug habit," the slogan on the fliers reads. Another says, "She has her daddy's eyes...and her mother's heroin addiction." Then: "Get birth control, get ca\$h." These are posters that show up nationwide in homeless shelters and methadone clinics, in AA and NA meeting rooms, and near needle exchange programs, distributed by volunteers for Project Prevention. Formerly called Children Requiring a Caring Kommunity (CRACK), the controversial nonprofit pays \$300 to either undergo sterilization or use a form of long-term, "no responsibility needed" birth control.

"What makes a woman's right to procreate more important than the right of a child to have a normal life?" Project Prevention founder Barbara Harris told *Time* magazine in 2010. The question is purely rhetorical: her self-professed mission in life is to zero out the number of births to parents who use illegal drugs, particularly crack cocaine. "Even if these babies are fortunate enough not to have mental or physical disabilities, they're placed in the foster-care system and moved from home to home," she said. The California foster mother, age 59, started the program in 1997 following her failed effort to get the Prenatal Neglect Act through the California state legislature. The bill would have made it a crime for a pregnant woman to use illegal drugs. Shifting tactics, the homegrown activist then began her campaign for a less punitive, if more final, solution to the "problem" of drug-addicted mothers bringing children into the world: pay them not to procreate.

Critics argue that Harris' campaign deprives women who are addicted, poor, and vulnerable of reproductive choice even as it feeds their drug habit. Some opponents say that, since the financial incentive is tantamount to giving addicts money to buy drugs, Project Prevention should be illegal. Others say that if addicted women are not viewed as responsible enough to have a baby, they should not be viewed as responsible enough to give informed consent to having a serious and irreversible medical procedure in exchange for drug money. Still other say that Harris is stuck in the past by targeting the wrong drugs: currently, more babies are born dependent on OxyContin and other legal opiate painkillers than on cocaine or heroin, according to a report published last week in *JAMA*. Many critics have called the payment a bribe, and some have even called it a revival of the eugenics movement.

Though based in North Carolina, Project Prevention mainly targets major cities, especially poor and minority communities—"drug areas" in Harris' words. Harris originally offered \$300 for sterilization and only \$200 for contraception, but the ensuing bad press, mainly charges that the program incentivized addicted women to choose an irreversible decision about reproduction, put an end to that practice. Since its inception, Project Prevention has paid 4,077 people to get tubal ligation, an IUD, implanon, Depro-Provera, or vasectomies for men. Those numbers are not overwhelming considering the project is in its second decade. Yet, with its goal to "save the welfare system and the world from the exorbitant cost to the taxpayer for each drug-addicted birth", Project Prevention has sparked a firestorm of opposition.

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The outrage stems as much from what Harris says as from what the project does. In the considerable press she has generated, Harris typically characterizes her target population less as drug-addicted women than as breeding machines, spitting out a baby a year. "I became more angry at the system that allows them to drop babies off yearly at the hospital with no consequences. If there is a scale, and it is between her never having any more babies and her having five more babies who may be damaged, then what's more important? For me it's the children. And if she can't have any more children, then that is just the consequence of her actions, like getting AIDS or something."

Another of her favorite comparisons that results in outrage is her comparison of the women to dogs. "We don't allow dogs to breed," she said. "We spay them. We neuter them. We try to keep them from having unwanted puppies, and yet these women are literally having litters of children." Given a chance to distance herself from this statement on 60 Minutes, she doubled down saying, "It's the truth—they don't just have one and two babies, they have *litters*."

Harris says she relies on the discretion of the doctors not to give birth control procedures to women who have not already had a child, and says that most of the women have had "at least three children, and as many as *a lot*", despite the fact that she does not collect this data. She told the British press, "The last 20 women who underwent sterilization had been pregnant a total of 121 times and had 78 children in foster care." A 2004 review of the data that Project Prevention does collect on its clients (an incomplete and unscientific data set) reveals that their average birth rate was 3.5, which is above the national average but not "*a lot*" or "*a litter*."

--from The Fix

Addiction Diagnoses May Rise Under Guideline Changes

In what could prove to be one of their most far-reaching decisions, psychiatrists and others specialists who are rewriting the manual that serves as the nation's arbiter of mental illness have agreed to revise the definition of addiction, which could result in millions of people being diagnosed as addicts and pose consequences for health insurers and taxpayers. The revisions to the manual, known as the Diagnostic and Statistical Manual of Mental Health Disorders or DSM, would expand the list of recognized symptoms for drug and alcohol addiction, while also reducing the number of symptoms required for a diagnosis, according to proposed changes posted on the website of the American Psychiatric Association, which produces the book.

In addition, the manual for the first time would include gambling as an addiction, and it might introduce a catchall category—"behavioral addiction—not otherwise specified"—that some public health experts warn would be too readily used by doctors, despite a dearth of research, to diagnose addictions to shopping, sex, using the Internet, or playing video games. The broader language involving addiction, which was debated last week at the association's annual conference, is intended to promote more accurate diagnoses, earlier intervention and better outcomes, the association said. "The biggest problem in all of psychiatry is untreated illness, and that has huge social costs," said Dr. James H. Scully Jr., chief executive of the group.

--NYTimes.com

The Pitiful State of LGBT Substance Abuse Treatment Availability

It's been more than a decade since the Substance Abuse and Mental Health Services Administration released "A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals," which recommended, "A commitment should be made at every level of the program, from the board of directors to the direct line staff, to design and deliver services in a manner sensitive to the needs of LGBT individuals" (p. 123).^[i] A 2009 study offers evidence as to the continued importance of this recommendation: 180 lesbian, gay, and bisexual participants were asked about their past substance abuse treatment experiences (both inpatient and outpatient), including overall satisfaction with their experiences, ability to be open about their sexuality in the program, and the amount of support they received from staff. The author concluded that "LGBT specialized treatment was the only program treatment factor that was a statistically significant predictor of current abstinence" (p. 190).^[iii]

How available is specialized treatment for LGBTs? A 2007 study presents a chilling snapshot. The researchers made telephone contact with 854 substance abuse treatment agencies promoting themselves as having specialized programs for LGBTs in the National Survey of Substance Abuse Treatment Services. Each facility was presented with the same question: "Hi, I am calling because your agency is listed in the SAMHSA directory as one that provides special programs or groups for gays and lesbians, and I am interested specifically in what those programs are. Could you tell me more about them?" (p. 166).^[iii]

The results?

- Although all 854 agencies had indicated they provided LGBT-specific services, at the time of the phone contact 605 (70.8%) acknowledged no specialized programs existed.
- Sixteen of the agencies (1.9%) reported they had offered those services in the past but no longer did so.
- 79 (9.3%) programs described themselves as "non-discriminating" (sample response: "We offer the same thing we offer straight people. . . we don't discriminate.") and 34 (4%) as "accepting" (sample response: "We don't have special services for gays and lesbians, we just allow them in our groups.").
- Only 62 (7.3%) of agencies indicated specialized LGBT programming and almost half were in New York and California.

62 programs in the entire country offer specialize treatment for LGBTs? We obviously have a lot more work to do. The Joint Commission, an independent not-for-profit organization that accredits and certifies more than 19,000 health care organizations and programs in the United States, concluded that the "8.8 million lesbian, gay, and bisexual people now estimated to be living in the United States experience disparities not only in the prevalence of certain physical and mental health conditions, but also in health care due to lack of awareness and insensitivity to their unique needs."^[iv] Lambda Legal's 2010 release "When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV" found that 56 percent of respondents had experienced some form of mistreatment when accessing services and that its report likely *understated* the barriers to health care experienced by LGBT people.^[v] Similarly, The Human Rights Campaign's 2011 report "Healthcare Equality Index 2011" concluded that many LGBT people often decline to seek healthcare in times of need, out of fear of discrimination and poor treatment by healthcare professionals.^[vi]

Substance abuse treatment is typically uninformed and insensitive in regards to LGBTs. Recognizing this, *Addiction Professional* asked the Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies (NALGAP) to create a blog addressing LGBT substance abusers and the treatment providers who work with them. With this, our inaugural posting, we begin a collaboration spotlighting the needs, challenges, and complexities inevitably encountered in the treatment of LGBTs with substance abuse issues, concerns that the studies and references aforementioned in this posting have made abundantly clear.

^[i] A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals (Rockville, Maryland: Substance Abuse and Mental Health Services Administration, 2001).

^[ii] Senreich, E. (2009). Demographic, background, and treatment factors that affect gay and bisexual clients in substance abuse programs. *Journal of LGBT Issues in Counseling*, 3, 177-197.

^[iii] Cochran, B.N., Peavy, K.M., & Robohm, J.S. (2007). Do specialized services exist for LGBT individuals seeking treatment for substance misuse? A study of available treatment programs. *Substance Use & Misuse*, 42, 161-176

^[iv] Facts About Patient-Centered Communications (Joint Commission, 2011).

^[v] When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV (New York: Lambda Legal, 2010). Available at www.lambdalegal.org/health-care-report

^[vi] Healthcare Equality Index 2011 (Washington, DC: Human Rights Campaign Foundation, 2011).

Tools and Strategies to Bolster Behavioral Therapy

October 2010

NIDA Director, Nora D. Volkow, M.D.

Through skillfully administered behavioral therapy, recovering drug abusers can learn to resist cravings and avoid situations that trigger relapse. Many long-term abusers, however, experience memory and cognition impairments that impede their progress in this life-saving educational process. To remedy this problem, NIDA-funded scientists are investigating whether certain medications might strengthen patients' understanding and memory retention. They are also studying the potential of computers and other technologies to extend the reach of therapy and improve followup care.

The principle of using medication to enhance behavioral therapy has already shown promise in several nondrug contexts, including, for example, the treatment of patients with a morbid fear of heights. In a preliminary trial, 60 percent of patients who received D-cycloserine (DCS) prior to two behavioral therapy sessions reported that they were "much improved" when fear of heights was assessed 1 week and 3 months after treatment; only 20 percent of patients given a placebo reported such progress. DCS has also shown positive results in people with social anxiety and obsessive-compulsive disorder.

NIDA-supported investigators are initially focusing on cognitive enhancers to help people quit methamphetamine and other stimulants, drugs that cause some of the most debilitating cognitive impairments during early abstinence. One medication currently under study is modafinil, a mild stimulant that appears to have positive effects on executive function—planning, setting goals, regulating behavior—and impulsivity. The study will measure whether modafinil helps patients progress in cognitive-behavioral therapy (CBT). Researchers suggest that cognition-enhancing medications might permit clinicians to reduce the number of CBT sessions required to counter addiction and thereby reach more people in need of therapy.

Technology—computer software, Web sites, even telephones—may enhance the potency, reach, and cost-effectiveness of behavioral treatment. Patients who cannot or will not attend live therapy sessions may benefit from computer software designed to teach relapse-avoidance skills. Similarly, booster sessions delivered via telephone or the Web might reinforce abstinence. Some providers may offer in-person treatment sessions early in a patient's therapy and then shift to telephone or computer delivery of treatment. These technologies should be particularly beneficial for patients who live in remote areas or have limited mobility.

Cognitive enhancers and computers have great potential to augment patients' acquisition of behavioral therapy's skills and lessons. Technology also promises to provide therapists with new, cost-effective tools to help their patients maintain behavioral changes they achieve during treatment. NIDA is committed to ushering these innovative approaches smoothly and efficiently through the stages of discovery and into the Nation's clinics.

Source URL: <http://www.drugabuse.gov/news-events/nida-notes/2010/10/new-tools-strategies-to-bolster-behavioral-therapy?device=desktop>

2012 Counselor of the Year nominations are now being accepted.
Members wishing to nominate another member from their respective Region may
do so by contacting their Regional Board representative.

IAAP NOMINATION FORM - 2012 General Board/Officer Nominations Criteria:

1. This form shall be completed and returned along with the nominee's bio to IAAP Central Office with a postmark date or faxed NO LATER than August 1, 2012.
2. Candidates for all positions shall be a member in good standing and agree to abide by the bylaws and ethical standards of IAAP and have a strong commitment to the vision, mission, and purposes of IAAP.
3. Candidates shall have resided in the region they represent for a minimum of one (1) year prior to their election and reside in this region for their entire tenure as a Board Officer or Regional Representative.
4. All candidates shall be licensed as LCAC or LAC.
5. Self-nomination is not permitted.
6. Board /Officers may not belong to any other addiction counselor membership organizations.

*Per IAAP Bylaws and Policy and Procedures, each respective Board Member or Officer shall meet the following additional qualifications:

For the Office of President-Elect:

- 1) *Shall possess the ability to satisfactorily perform and fulfill all duties and functions of the President of IAAP as enumerated and described in the IAAP Bylaws.*
- 2) *Shall possess a minimum of a Master's degree in a Human Services or Behavioral Science field.*
- 3) *Shall have served a minimum of one (1) full term of service on the IAAP Board of Directors as a Director or an Officer.*

For the Office of Secretary:

- 1) *Shall possess the ability to satisfactorily perform and fulfill all duties and functions of the Secretary of IAAP as enumerated and described in the IAAP Bylaws.*
- 2) *Shall possess a minimum of a Bachelor's degree in a Human Services or Behavioral Science field.*

For the Office of Treasurer:

- 1) *Shall possess the ability to satisfactorily perform and fulfill all duties and functions of the Treasurer of IAAP as enumerated and described in the IAAP Bylaws.*
- 2) *Shall possess a minimum of a Bachelor's degree in a Human Services, Behavioral Science, Accounting, or Finance field.*

For Regional Director:

- 1) *Shall possess the ability to satisfactorily perform and fulfill all duties and functions of a Regional Director as enumerated and described in the IAAP Bylaws.*
- 2) *Shall possess a minimum of a Bachelor's degree in a Human Services or Behavioral Science field.*

**** PLEASE NOTE NOMINATIONS ARE ALSO BEING ACCEPTED TO FULFILL THE VACATED PRESIDENT-ELECT OFFICE. THIS TERM ENDS DURING THE ANNUAL MEMBERSHIP MEETING HELD IN OCTOBER 2012.**

All nominations must be postmarked by August 1, 2012.

Please mail to: IAAP Central Office, PO Box 24167, Indianapolis, IN 46224

PH: 317-481-9255 - Fax: 317-481-1825

IAAP NOMINATION FORM - 2012

Signature of person submitting

nomination: _____

Name of person submitting nomination (please print or type):

Address:

City/State/Zip:

Please circle Region of Indiana residence: **NE** **NW** **SE** **SW**

E-mail: _____ Phone: _____

I am submitting a nomination for the following position:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> President-Elect (Fulfill remainder of term until Oct. 2012) | <input type="checkbox"/> Treasurer |
| <input type="checkbox"/> President-Elect (Term from Oct. 2012-Oct. 2014) | <input type="checkbox"/> SE Board Rep |
| <input type="checkbox"/> Secretary | <input type="checkbox"/> SW Board Rep |

Name of Nominee: _____

Age: _____ Gender: F / M Ethnicity: _____

Address: _____

City: _____ Please circle Region of Indiana residence: **NE** **NW** **SE** **SW**

ZIP _____ Home Phone: _____ Work

Phone: _____

E-mail: _____

Employer: _____ Yrs. as Addiction Professional: _____

Current job responsibilities and/or related employment:

Education:

Professional affiliation(s), certification(s), and/or license(s):

Relevant leadership experience:

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Save the Date!

Annual Fall Conference
October 12-13, 2012
Indiana Wesleyan University
www.iaapin.org

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.