SCAADAC News

South Carolina Association of Alcoholism and Drug Abuse Counselors

Spring 2006

From the President

by Donny Brock, BS, NCAC II, CAC II

Many of you have provided feedback to SCAADAC regarding inadequate clinical training available to sustain a competent work force. Perhaps the most important initiative SCAADAC has been involved with over the last year is the development of a new state-wide training system to solve this problem. Although this project is not yet complete we have made strides and I believe you will begin to see how this coordinated effort will pay dividends. I would like to provide you a brief overview of our progress and what I believe you can expect in the coming months.

If you are like me you have heard about the budget cuts to the Department of Alcohol and Other Drugs Abuse Services *(DAODAS)* over the past few years. Somehow DAODAS seems to re-shape itself and the work gets done. However, it became clear that training was a function that could no longer be delivered as it has been in the past. Many organizations came together to solve the problem. About a year ago representatives from various stake holders including Behavioral Health Services Association *(BHSA, the Association of County AOD Directors)*, Southeastern Addition Technology Transfer Center *(SATTC)*, the National Institute of Drug Abuse, Clinical Trials Network – South Carolina Node *(NIDA CTN)*, DAODAS and a hand full of counselors working in public sector agencies met to develop a training system from scratch. The group that has resulted from this is the South Carolina Substance Abuse Training Consortium. The Consortium's first task was to produce last year's SC School of Alcohol and Other Drug Studies. A work group was set up to organize the event and develop a system to coordinate future SC AOD Studies Schools. Another work group took on the task of designing basic clinical skills training that could be delivered on a regional basis.

That brings us to where we are today. Jimmy Mount of DAODAS put it best when he said, "While there is a definite need for comprehensive training of substance abuse professionals in South Carolina, it has become clear that we can only create such opportunities with input from all the 'players' in our field. By bringing together representatives of DAODAS, the County Alcohol and Drug Abuse Authorities *(BHSA)*, such vital groups as SCAADAC and the South Carolina Addiction Prevention Professionals Association *(SCAPPA)* — and other organizations — the South Carolina Substance Abuse Training Consortium will be able to effectively design and implement events that address the full range of our field's educational needs." The Training Consortium is now an organized working committee whose function is to provide ongoing strategic planning to address the ever-changing training needs of the State. Sub-committees are working on specific areas that include: SC School of Alcohol and Other Drug Studies, Clinical Services Training, Prevention Training, Board Seminar, and Management/ Administrative Staff Training. I need to pause briefly to thank the leadership of BHSA and DAODAS. Their cooperation, financial support, and leadership have been the key to making this system possible.

"Sound good but what can I expect?" you might ask. This summer you will see what I believe to be the best SC School we've had in years. The details should be released soon and I'm sure you will be impressed. We will begin to roll out our regional basic training skill events in the fall. Each new training topic is being developed and taken on a trail run to "work out the bugs." Then, each topic will rotate to a location in the see them Upstate, Midlands, and Lowcountry. Topics to look for this year include: AITP *(Assessment, Interviewing, and Treatment Planning)*, Group Counseling, Pharmacology, Ethics, and Case Management. I hope you will be pleased with the product.

SCAADAC continues to be in the forefront of issues that face you, the professional addictions counselor. We are dedicated to advocating for your needs and the needs of your clients. As we near the end of the current term of our officers and committee chair persons, I would like to personally invite you to run for a Board Position or volunteer to work on an issue that you believe is important to the field. ***Come***

Note from the Editor

By Ed Johson, MAC, CAC II

Included in this issue are three articles pertaining to the three "Best Practices" which are currently being implemented in those Addiction Treatment Facilities under the purview of the South Carolina Department of Alcohol and Other Drug Abuse Services (SC DAODAS) or in the case of CBT in the Outpatient Program at WJ McCord have been implemented. These articles are included to provide SCAADAC members more information about the basics of these three modalities and hopefully to show why they are considered "Best Practices".

To the Membership of SCAADAC

By Frank Sheheen, MS, CAC II
Nominating Committee Chair and
Immediate Past President of SCAADAC

That time rolls around very quickly. And here it is again. We are now in the cycle of nominations and awards. This summer we will select the Leadership for SCAADAC for the next two years.

We have had a progressive and hard working Board for the last number of years. Great advances have been made and our membership remains strong. To continue this type of leadership for our members, we are preparing to elect new officers for the upcoming two-year term. I ask that you nominate viable candidates that are members in good standing of SCAADAC.

Please think of someone you know professionally who will be a willing voice of the Addictions Professional. To serve on the Board is gratifying and helps ensure that our mission continues to be carried out.

We are also asking for nominations for Counselor and Professional of the year. These are folks who have contributed to our field in the previous year in a manner that should be recognized at the highest level of service.

Enclosed please find the Board of Directos nomination forms or visit our website at www.scaadac.org.

I thank you in advance for your nominations.

CBT in a Nutshell

By Nancy Inman, M.Ed., LPC. LPCS
Director Outpatient Services, W. J. McCord Center

Cognitive-Behavioral Therapy *(CBT)* is a clinically and research proven treatment approach. CBT is "evidence-based", being consistently "proven" to be effective through rigorous clinical trials and solid empirical support. It has been proven effective in the treatment of numerous disorders, including substance use disorders.
CBT has also been proven effective for most populations and age groups, which makes it essentially an effective *universal* treatment approach.

CBT was pioneered in the 1960's by Aaron Beck and Albert Ellis. Since that time, a number of well known therapists have expanded and further developed this approach. These include but are not limited to Donald Michenbaum, David Burns,
Maxie Maultsy, and Aldo Pucci.

In a nutshell, CBT is a form of therapy based on the premise that maladaptive *(faulty, distorted)* thinking patterns cause maladaptive behavior and negative emotions. During life we develop cognitive "mindsets" *(schemas)*, which determine our patterns of behavior. When these schemas include dysfunctional and irrational beliefs, the result is negative thinking and behavior, including maladaptive coping strategies. CBT integrates the cognitive restructuring approach of cognitive therapy with the behavior modification techniques of behavior therapy. Treatment focuses on changing the individual's thoughts *(cognitive patterns)* in order to change his or her behavior and emotional state.

CBT is based on logic and belief in the power of the individual to take charge and change their negative thoughts, feeling and actions. It utilizes a very direct, action-oriented, collaborative process. This approach validates and empowers the individual. Treatment is tailored to meet the specific needs and goals of the individual.

Through various interventions, the CBT therapist *teaches* the client to identify and analyze the dysfunctional patterns of thinking and acting. The therapist, through several CBT strategies, instructs the client how to challenge and restructure their thinking and behavior to reach client desired goals.

Some of the better known interventions utilized in CBT include, but are not limited to: cognitive rehearsal, validity testing / challenging irrational beliefs, self-monitoring, thought stopping, relaxation training, systematic desensitization, conditioning, and modeling.

A huge benefit of CBT success is that the client has gained the knowledge and skills to address future problems without the need for returning to formal treatment again and again.

Effective Drug Abuse Treatment Approaches The Matrix Model

Courtesy of the National Institute of Drug Abuse

The Matrix Model (Rawson et al., 1995) of outpatient treatment was developed during the 1980s in response to an overwhelming demand for stimulant abuse treatment services. The intent was to create an outpatient model responsive to the needs of stimulant-abusing patients while constructing a replicable protocol that could be evaluated. Treatment materials draw heavily upon published literature pertaining to the areas of relapse prevention (Marlatt and Gordon,1985), family and group therapies, drug education, self help participation and drug abuse monitoring. The clinical materials have been selected as a result of a behavioral analysis of the type of problems encountered by cocaine and methamphetamine users as they proceed through a period of cocaine abstinence.
Over 5000 cocaine addicts and over 1000 methamphetamine users have been treated with the method. The experience of these patients has been the source of the data used in developing and modifying this integrated therapeutic model. The treatment model has been extended to address the clinical needs of alcohol users and opiate dependent individuals.

The goal of the Matrix Model has been to provide a framework within which stimulant abusers can achieve the following: (a) cease drug use, (b) retain in treatment, (c) learn about issues critical to addiction and relapse, (d) receive direction and support from a trained therapist, (e) receive education for family members affected by the addiction, (f)become familiar with the self-help programs, and (g) receive monitoring by urine testing.

The Matrix model requires that the therapists use a combination of skills required to function simultaneously as teacher and coach. The therapist fosters a positive, encouraging relationship with the patient and uses that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct but not confrontational or parental. Therapists are trained to view the treatment process as an exercise that will promote self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is a critical element for patient retention.
The treatment materials contained in detailed treatment manuals include work sheets for individual sessions, family educational groups, early recovery skills groups, relapse prevention groups, conjoint sessions, urine tests, 12 step programs, relapse analysis, and social support groups. A pilot study comparing the Matrix outpatient model with an inpatient hospital treatment program produced preliminary support for the clinical

utility of the model for the treatment of cocaine dependence (Rawson et.al, 1986). A number of NIDA-funded projects have demonstrated that participants treated with the Matrix model demonstrate statistically significant reductions in drug and alcohol use, improvements in psychological indicators and reduced risky sexual behaviors associated with HIV transmission (Rawson et al,1995, Shoptaw et al, 1994, Shoptaw et al 1997). These reports, along with evidence suggesting comparable treatment response between methamphetamine users and cocaine users, *(Huber, et al, 1997)* and demonstrated efficacy in enhancing naltrexone treatment of opiate addiction *(Rawson et al, under review)* provides a body of empirical support for the use of the model.

The fact that the Matrix model materials have been manualized into systematic treatment protocols with instructions for use, has tremendously facilitated the dissemination of this approach. Currently, projects are being conducted in 12 states and 4 countries employing this approach in treatment settings for stimulant, opiate and alcohol users.

Save the Date
November 5-7, 2006
SCAADAC's Fall Conference in North Charleston, South Carolina at the Embassy Suites Airport/ Convention Center

Motivational Enhancement Therapy

By Lynn McKnight, LPC/S, CCS, MAC, ATR
Clinical Supervisor, Charleston Center

Motivational Enhancement Therapy (MET) is a systematic intervention approach for evoking change. It is based on principles of motivational psychology, and is designed to produce rapid, internally-motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own change resources. It may be delivered as an intervention in itself, or may be used as a prelude to further treatment.

MET may be particularly useful in situations where contact with clients is limited to one or a few sessions. Treatment outcome research strongly supports MET strategies as effective in producing change in individuals experiencing substance use disorders.

The MET approach begins with the assumption that the responsibility and capability for change lie within the client. The therapist's task is to create a set of conditions that will enhance the client's own motivation for and commitment to change. MET focuses explicitly on motivation as the key factor in triggering lasting change (Miller & Rollnick, 1991). In the absence of motivation and commitment, skill training is premature.

Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the client's inner resources, as well as those inherent in the client's natural helping relationships. MET seeks to support intrinsic motivation for change, which will lead the client to initiate, persist in, and comply with behavior change efforts. *(Miller and Rollnick, 1991)* have described five basic motivational principles underlying such an approach:

1. Express Empathy
2. Develop Discrepancy
3. Avoid Argumentation
4. Roll with Resistance
5. Support Self-Efficacy

MET is well-grounded in theory and research on motivation for change. It is consistent with an understanding of the stages and processes that underlie change in addictive behaviors. It draws on motivational principles that have been derived from both experimental and clinical research. This motivational approach is well supported by clinical trials with alcohol problems: its overall effectiveness compares favorably with outcomes of alternative treatments, and when cost-effectiveness is considered, an MET strategy fares well indeed in comparison with other approaches.

The NAADAC/ICRC are in the due diligence phase and a formal offer has been made by NAADAC to the ICRC Board. Details are posted on line an the NAADAC web site www.naadac.org. Please check it periodically if you want to keep abreast of the progress.

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2006 Written Exam Schedule:

Exam Date	Application and Fee Deadline	Materials Deadline
July 29	May 30	May 17
November 18	September 29	September 18

2006 Oral Interview Schedule:

Interview Date: July 13-14
Request Letter and Fee Deadlines: June 20

Interview Date: October 12-13
Request Letter and Fee Deadlines: September 20

Look Who's Certified!

Congratulations to Newly Certified Addictions Counselors:

Allison Carrington of Charleston – CAC 1
Robin Nickerson of Camden – CAC II
Keith Rivers of Burton – CAC 1
Latash Robinson of Orangeburg – CAC 1

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NAADAC Members Bring their Voice to Capitol Hill

Equal treatment, Methamphetamine Critical Issues for Addiction Services Professionals

NAADAC, the Association for Addiction Professionals met with legislators and their staffs on March 22-23, 2006 to ensure that addiction prevention, intervention and treatment are considered in the nation's agenda. NAADAC's Advocacy Action Day focused on legislative issues affecting the addiction professional. NAADAC members, and NAADAC's partners in the addiction health services, plan to discuss the federal government's workforce development agenda, parity for addiction and other health related insurance, plans to secure adequate and consistent funding, changes to the Medicaid program and the methamphetamine epidemic.

NAADAC's members heard from top officials and experts on making an impact on the national legislative process.

"This year, NAADAC's members addressed several critical issues, including workforce development, the growing epidemic of methamphetamine addiction and substance abuse treatment parity," said Andrew Kessler, NAADAC Director of Government Relations. "by meeting one on one with national decision makers, we can make a real difference in people's lives."

Regulation Ammendments

The Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists is amending Regulations 36-01, 36-04 through 36-09, 36-12 through 36-15; adding 36-07.1, 36-08.1, 36-10.1, 36-22, and 36-23; and deleting Appendix A, B, C and D. Major changes are being proposed with regard to Licensed Professional Counselor and Licensed Marriage and Family Therapy supervision. To view the document go to *http://www.scstatehouse.net/regs/3012.doc*

SCAADAC
2006-07 Officer Nomination Form

Candidate: ______________________________ Phone: ______________________

Address: ____

Employer: ______________________________ Membership #: _________________

Office: ____

Eligibility: Must be a member in good standing of the NAADAC and the SCAADAC, who has been actively engaged in the field of alcohol and other drug dependence and abuse Counseling, Prevention, or Administration for at least two years immediately prior to nomination.

Please state your qualifications for the office:

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Summary of SCAADAC Activities:

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Philosophy statement regarding the future of SCAADAC:

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Please attach black and white photo.

I agree to run for the SCAADAC office listed above and, if elected, to serve the Association to the best of my ability.

Candidate's Signature: ______________________________

Nominated by: ______________________________

Return to: Chair, Nominations and Elections Committee
1215 Anthony Avenue
Columbia, SC 29201

(Note: This form is designed as a return self-mailer—fold, tape and mail)

Nominations must be received no later than August 1, 2006

(fold, tape and mail)

South Carolina Association of Alcoholism and
Other Drug Abuse Counselors
1215 Anthony Ave
Columbia SC 29201-1701

Chair, Nominations and Elections Committee
1215 Anthony Avenue
Columbia, SC 29201

NAADAC's 2006 Advocacy Action Day and Workforce Development Summit Recap

Summit Faces Challenges Affecting the Addiction Workforce

The NAADAC Workforce Development Summit held in late March helped NAADAC members assess the challenges facing the addiction services profession and work towards planning for the future. The summit, the second of its kind hosted by NAADAC, brought together many different partner organizations including the Center for Substance Abuse Treatment (a part of SAMHSA), Partners for Recovery, the Addiction Technology Transfer Centers (ATTCs), the Institute for Research, Education and Training in Addictions (IRETA), the Institutes of Medicine, the National Association for Addiction Treatment Providers (NAATP) and the International Certification and Reciprocity Consortium (IC&RC).

NAADAC's President, Mary Woods, was pleased with the concept and execution of the conference.

"This is the first NAADAC conference to address the way addiction professionals can take leadership roles to benefit their careers, other professionals and the clients they serve," she said. "The focus on Workforce Development: the ability to find, keep and compensate the people who work in the addiction profession is critical to our collective success."

Participants heard from critical voices in the addiction profession, including George Gilbert, J.D., Acting Deputy Director of the Center for Substance Abuse Treatment, SAMHSA, who spoke on workforce development issues. Gilbert outlined the trends facing the addiction workforce, including:

- Insufficient workforce/treatment capacity to meet demand;
- Changing profile of patients/clients;
- A shift to increased public financing of treatment;
- Provision of services in generalist and specialist settings; and
- Discrimination associated with addictions

CSAT research discovered that there is a shortfall in skilled employees in the addictions profession and even greater shortages are anticipated in the near future. Gilbert asserted that even a modest 10% increase in treatment capacity would require 6,800 clinicians above the annual number to replace those leaving the field.

Gilbert also felt that the addictions profession lags behind other industries in its ability to access and use information technology. In a 2003 study, it was found that twenty percent of the 175 counseling centers studied had no information systems, voice-mail or e-mail access (source: McLellan et al., 2003). This has a huge impact on simple issues like managing caseloads and paperwork, not to mention keeping clinicians current on best practices and cross-professional communication.

Poor infrastructure, coupled with a $28,510 median income for substance abuse counselors was (according to the U.S. Department of Labor, 2003) and a lack of benefits for a significant number of clinicians (30% had no medical coverage, 40% had no dental coverage and 55% were not covered for substance use or mental health services) may be leading to he Bureau of Labor Statistics estimates that there will be 3,000 unfilled positions for addictions counselors by 2010 *(Landis et al., 2002)*. Individuals are reluctant to enter the field because of low salaries, minimal benefits, negative perceptions of the field, low professional status and stressful working conditions *(according to the U.S. Department of Labor, 2003)*.

CSAT has targeted employee retention, national accreditation and standards and the development of leadership capacity as its priorities for workforce development.

Linda Kaplan, M.A., also presented on issues in the addiction workforce, explaining that the lack of national standards has resulted in less recognition for and lower status of the certification process. Citing an aging population and few new entering into the profession, Kaplan presented on the additional issues of recruitment and retention.

Kaplan stressed the need to recruit more diverse staff; to focus on new marketing strategies and work with colleges and universities, particularly historically black colleges and universities (HBCUs) and other minority schools to recruit staff; Provide intensive orientation to new staff, to provide ongoing clinical and administrative supervision to new staff and to ensure adequate in-service training and support for ongoing continuing education.

Kaplan revealed that turnover rates in the addiction services workforce are higher than for most other fields and range from 17-33%. These numbers are high, but people are not necessarily leaving the field. Often they are "churning" – going to another agency – for as little as $500-$1,000 a year salary increase.

Kaplan felt that employers could adopt several management practices to improve employee retention, including providing clinical supervision; providing staff development and/or training, providing more job autonomy, recognizing and rewarding staff for strong job performance and encouraging better communication between management and staff.

Many more influential speakers took part in the conference, including Jack B. Stein, Ph.D., Deputy Director, Division of Epidemiology, Services & Prevention Research, National Institute on Drug Abuse who focused on evidence based practices; Faye Calhoun, DPA, Deputy Director of the National Institute on Alcohol Abuse and Alcoholism; Jeff Hoffman, Ph.D., President, Founder, & CEO, of Danya International who reported on Succession and Transition Planning; Anne Helene Skinstad, Ph.D., Director, Prairielands Addiction Technology Transfer Center who presented on the Workforce Development Survey; and Robyn Marks, Public Relations Manager, Associated Treatment Providers Management Services Network.

The sessions featured an update on the merger discussions between NAADAC and IC&RC, featuring Jeff Wilbee, CAE, President of the International Credentialing and Reciprocity Consortium; discussions with Ronald J. Hunsicker, D.Min, FACATA, President & CEO of the National Association for Addiction Treatment Providers (NAATP) and with Mary Beth Johnson, MSW, Director, National Addiction Technology Transfer Center.

The Summit also presented the world premiere of the Workforce Development Video, produced in partnership by NAADAC, the Northeast Addiction Technology Transfer Center (NEATTC), IRETA and the Central East Addiction Transfer Technology Center. The purpose of the video, *Imagine Who You Could Save*, is to promote career opportunities in the addiction profession while dispelling preconceived notions and/or stereotypes typically associated with the addiction/ substance use disorder field. The premise of the video centers around the word "addiction" and the horrific toll it takes on substance users, their jobs, their families, and their lives- regardless of age, race, sex or persuasion.

The Summit was well received by those who participated and generated energy, enthusiasm and knowledge for people to share on Workforce Development issues. The challenges of recruitment, retention and rewards still face the addiction profession, but the Summit was a powerful step forward in resolving these issues.

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South Carolina Association of Alcoholism and Drug Abuse Counselors

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SCAADAC Office:

Administrator: Marie B. Queen, marie.queen@queencommunicationsllc.com

What SCAADAC Region Am I In?

The following is a listing by County of the four SCAADAC Regions and the Regional Representative. The e-mail addresses of the Regional Representatives are listed with those of the other members of the Board of Directors.

Region I – Regional Representative: David Martinson
Anderson, Cherokee, Greenville, Oconee, Pickens, and Spartanburg

Region II – Regional Representative: TBA
Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda, Union and York

Region III – Regional Representative: Lewis N. Foster
Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter and Williamsburg

Region IV – Regional Representative: Lindsey C. Hamilton
Aiken, Allendale, Beaufort, Bamberg, Barnwell, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg