Informed Consent

Informed consent is an ongoing process; it is not intended to be a one-time act.

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Quarterly Newsletter of the Connecticut Certification Board, Inc.
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Board of Directors Approves Counselor Magazine as the Official Publication of the Connecticut Certification Board

THE MAGAZINE FOR ADDICTION & BEHAVIORAL HEALTH PROFESSIONALS
COUNSELOR

In their November meeting, the Board of Directors of the CCB discussed and approved a motion to make Counselor Magazine the Official Publication of the Connecticut Certification Board.

The overall quality of the publication, its distinguished editorial board and its availability both online and in print were the determining factors in the decision. The magazine also offers guest columns and the affiliation will allow access for Connecticut professionals to submit their own writings for consideration. It also allows Connecticut providers to reach a national audience through advertising opportunities. Jeffrey Quamme, CCB Executive Director, will also contribute to each issue with a column that covers issues and important updates related to the SUD/COD workforce entitled "Counselor Concerns." The first submission, entitled "The Counselor's Role in Combatting NIMBYism," is scheduled for the upcoming issue.

The annual subscription cost (6 issues) is $25.00 - 55% less than the original cost of $54.95 - and is available directly from the CCB. The direct link to subscribe is https://ctcertboard.org/counselor-magazine.

There are no secrets to success. It is the result of preparation, hard work, and learning from failure. ~ *Colin Powell*

From the Desk of the Executive Director

As the year nears its end and we are in the midst of the holiday season, I reflect on what has been a difficult year for so many with no immediate end in sight. I doubt if any of us are personally untouched by COVID-19, and I know that is has affected us all professionally. So many have had interruptions in, or even lost, employment, and for those of us lucky enough to still be working, the face of that is like nothing we have seen before. We have all been forced to learn to new skills to be successful in caring for those who seek our assistance. Substance use, mental health, and co-occurring disorders continue to take their toll, often increasing the difficulty in seeking help. I am grateful to all of you out there who continue to fight the good fight for a very vulnerable group of individuals.

This year marked the 40th anniversary of the Connecticut Certification Board, and it was certainly an eventful celebration for the organization, although not the way we had envisioned it. We had scheduled (and twice rescheduled) a conference, until deciding to cancel instead of going virtual. So many events at that time had already gone virtual that the Board decided that cancelling was a better option—and as someone whose work life revolves around virtual contact, I couldn't have agreed more.

There were positive changes for us as well, including the election of a new slate of officers for the Board of Directors: Amy Sedgwick (President), Joanna Crowell (Vice President), Jennifer Kolakowski (Secretary) and Art Mongillo (treasurer). All four are brand new to each position and have injected new energy to continue the leadership of that last group. Our immediate past president, David Borzellino, has worked hard to help with a smooth transition. They year also has us looking into the future of the organization and has led us to reassess and update our mission and vision statements. The new mission of the CCB is to "cultivate and maintain the highest standards of professional practice in the recovery field," and the vision of the CCB is to "strive to be the standard bearer for the recovery workforce through training, credentialing, and ensuring ethical practice." We, as an organization, feel these more accurately represent our role to the Connecticut workforce.

In January, we launched our first ever podcast entitled "Scope of Practice" with an interview with expert Dr. Juline Koken of the City University of New York, who spoke about issues related to sexuality and recovery. We intentionally started with what was once considered a taboo and misunderstood subject in order to get such difficult conversations started. We continued on with many other subjects and experts, and had some individuals who were once very much in the public eye (French Open tennis champion Murphy Jensen and Michigan State All-American and 1990 second overall NFL draft pick Tony Mandarich) talk about their difficulties with substance use disorders and subsequent journeys in to long-term recovery. I am lucky enough to now refer to these two gentlemen as friends (Special thanks to Scott Gorman, CPRS, for his assistance).

Most recently, our organization has launched a partnership with the California Consortium of Addiction Professionals and Programs (CCAPP) that is still taking shape. CCAPP is one of the largest certification boards in the country with over 16,000 certified professionals. Our initial efforts include sharing professional development opportunities to help build stronger workforces on each coast. It is also noteworthy that CCAPP initially reached out to us for the partnership based on the quality of our workforce and Board. We should all be proud of this.

Finally, Counselor Magazine, one of the most respected and largest trade publications aimed at the SUD/MH/COD workforce is now the Official Publication of the CCB. We are excited to be affiliated with the magazine, which is published bi-monthly online and in print. Beginning with the next issue, I will also author a column focused on issues specifically related to the workforce entitled "Counselor Concerns." The first article is on effective ways to combat NIMBYism in our communities, so that those we serve have opportunities to seek services in their own communities. Counselor also accepts submissions from guest writers, and our association with the magazine can make that process easier. Additionally, if you are a service provider seeking a national reach, we can assist with advertising in the publication to reach its audience of 48,000 professionals. Subscriptions are available through the CCB.

In closing, here's hoping for a smoother 2021!

Stay safe and healthy for yourself and for others.

Pointers from Portugal on Addiction and the Drug War

(Austin Frakt, The New York Times)

Decriminalization involves trade-offs, but treating addiction as a disease yields a clear gain, research suggests.

Many people point to Portugal as an example for the United States to emulate in dealing with illicit drugs. But Portugal's experience is often misunderstood. Although it decriminalized the use of all illicit drugs in small amounts in 2001, including heroin and cocaine, that's different from making them legal. And it did not decriminalize drug trafficking, which would typically involve larger quantities.

Portugal's law removed incarceration, but people caught possessing or using illicit drugs may be penalized by regional panels made up of social workers, medical professionals and drug experts. The panels can refer people to drug treatment programs, hand out fines or impose community service.

A lot of the benefits over the years from Portugal's policy shift have come not from decriminalization per se, but in the expansion of substance-use disorder treatment. Such a move might bring the most tangible benefit to the United States.

After decriminalization, the number of people in Portugal receiving drug addiction treatment rose, according to a study by Hannah Laqueur, an assistant professor in the Department of Emergency Medicine at the University of California, Davis. Moreover, as of 2008, three-quarters of those with opioid use disorder were receiving medication-assisted treatment. Though that's considered the best approach, less than half of Americans who could benefit from medication-assisted treatment for opioid addiction receive it.

"Most accounts of the Portugal experiment have focused on decriminalization, but decriminalization was part of a broader effort intended to encourage treatment," Professor Laqueur said.

In turn, the country made financial investments in harm reduction and treatment services. Research in the United States shows a dollar spent on treatment saves more than a dollar in crime reduction.

Opioid overdose deaths fell after Portugal's policy change. So did new cases of diseases associated with injection drug use, such as hepatitis C and H.I.V. This latter change could also be a result of increases in needle exchange programs in the country. Those programs often meet opposition in the United States, but a cost-effectiveness analysis published in 2014 replicated the research of others in finding that a dollar invested in syringe exchange programs in the United States saves at least six dollars in avoided costs associated with H.I.V. alone.

Harm reduction through needle exchanges and greater treatment availability are among the reasons for the wide disparity in drug overdose deaths between the United States (with a rising and staggering total of nearly 72,000 last year) and European countries like Portugal (which typically has well below 100 such deaths a year). These reflect a different mind-set on addiction; in Portugal, it's treated strictly as a disease.

Not everything got better immediately after Portugal's shift. One study found an increase in drug experimentation after the law. But this was a transient effect - most experimentation did not lead to regular drug use.

Murders increased by 41 percent in the five years after the drug reform law (after which they fell), and drug trafficking grew. These could be related.

"Any change in the drug market can bring about violence," said Keith Humphreys, a professor of psychiatry and behavioral sciences at Stanford University. "Drug traffickers may have incorrectly understood the Portuguese law as a sign the country was a safe place to expand their business, leading to clashes among them and between them and the police."

One way much of the United States is similar to Portugal is that penalties for cannabis use have fallen. Portugal's regional panels typically impose no penalties for cannabis use, the most-used illicit drug in Portugal. In the United States, most states have legalized medical marijuana, and some have legalized it for recreational use.

One consequence of ending incarceration as a penalty in Portugal is that prison overcrowding decreased. The same would be expected to occur in the United States.

It's important to note that we don't know what would have happened in Portugal had the 2001 drug reforms not occurred, so findings should be taken with a grain of salt. Some of the observed changes could result from trends predating the change in laws. For example, even before the 2001 law, those convicted of drug use were typically fined, not incarcerated. In each of the eight years before the 2001 law, the number of people incarcerated for drug use was no higher than 42 and was as low as four. (Portugal's population is roughly that of the Chicago metro area, about 10 million.)

https://www.nytimes.com/2020/10/05/upshot/portugal-drug-legalization-treatment.html

You can hear these, as well as future episodes at www.scopeofpractice.podbean.com

List of Episodes

- Sexuality and Recovery: Dr. Juline Koken, City University of New York
- COVID-19 and Problem Gambling: Art Mongillo, Connecticut Council on Problem Gambling
- The Incredible Bulk, the Incredible Bust to the Incredibly Blessed: Michigan State All-American Offensive Tackle Tony Mandarich
- A Discussion with Ruth Riddick, Certified Addiction Recovery Coach (NY)
- Born to Serve: Grand Slam tennis and Recovery Champion Murphy Jensen (WA)
- The View from Washington, DC: Andrew Kessler JD, Slingshot Solutions (DC)
- Fitness as a Recovery Pathway: Lisa Nichols, ROCovery Fitness (Rochester, NY)
- The Unique Needs of Women in Recovery, A Three-Part Series, Tenesha Grant MS, Director of Women's Services, Community Renewal Team (Hartford, CT)
    1. *A Discussion on Gender Specific Programming*
    2. *Trauma*
    3. *Stigma: It Rests Heavier on the Shoulders of Women*
- The Unique Needs of Transgender Individuals in Substance Use Disorder Treatment: A Special Two-Part Series, Dr. Frederick Dombrowski, University of Bridgeport (CT)
    1. *An Understanding of Terms and Concepts*
    2. *The Treatment Environment*
- Suicide Facts and Prevention: Lisa Coates, LCSW, Bristol (CT) Hospital
- Counselor Magazine: A Discussion with Publisher Pete Nielsen
- A Holistic Approach to Recovery: Dr. Jaquel Patterson, ND, MBA, Fairfield Family Health (CT)
- The Cochran Review of Alcoholics Anonymous: What Does the Research Actually Say?: Kapil Nayar MS, Grand Canyon University (AZ)
- A Different Kind of Cultural Competence: A Discussion of Veteran Reintegration Into Civilian Society: Colonel Kevin Brown (US Army - Retired) and Captain Lisa Moon (USAR)
- Uprooting Addiction: An Interview with Film Producer Hope Payson, LCSW
- Gratitude and Recovery: Alex Fidalgo and Paul Alves, Choice Recovery Coaching (MA)

Have an idea for an interesting podcast? Contact Jeff directly at JQuamme@ctcertboard.org

Affordable per-episode sponsorship available. Contact Executive Director Jeffrey Quamme for more information.

Relational Models of Addiction Treatment: Recipient or Participant?

William White

Since the late 1990s, I have advocated a radical redesign of addiction treatment—one that extends the prevailing acute care model of addiction treatment to one of sustained recovery management (RM) nested within larger recovery oriented systems of care (ROSC). RM moves beyond providing brief episodes of biopsychosocial stabilization to assuring sustained recovery support across six stages of long-term recovery: precovery, recovery initiation, recovery maintenance, enhanced quality of personal and family life in long-term recovery, and efforts to break intergenerational cycles of addiction and related problems. RM models differ across many dimensions, including approaches to treatment attraction, access, assessment, engagement, service components, service relationship, involvement of family and community, and the nature and duration of post-treatment recovery support services.

I am often asked the extent to which addiction treatment in the U.S. reflects this RM and ROSC orientation. Answering this question with current data across all RM and ROSC elements is beyond the scope of a short blog, but a just-published study does inform the present status of one critical RM element.

Traditional acute care models of addiction treatment is based on an expert relational model of service delivery. A professional expert screens, assesses, and diagnoses a substance use disorder and any co-occurring conditions present in the patient/client. The expert then formulates and implements a treatment plan and monitors the progress of treatment using measures defined by the expert. The expert also makes the ultimate decision when and under what conditions the service relationship is terminated—all in an ever-briefer time due to current funding constraints. In short, the individual being treated is considered a recipient of the services and expertise of the professional in a relationship not unlike having a broken arm treated by a physician within a hospital emergency room.

RM relies on a partnership relational model in which the person seeking recovery guides their own recovery process with professionals, family members, and peers in recovery serving as recovery consultants who offer guidance as needed and requested. The client role in co-creating and directing their own recovery processes involves an active role in problem definition and problem resolution with acknowledgement of many pathways and styles of long-term personal and family recovery that differ considerably across clinical populations and cultural contexts. This philosophy of choice is central to the RM approach to treatment and counseling. In mainstream medicine, this personalized model of service delivery is widely advocated as "patient-centered care."

Park and colleagues have just published an analysis of 2017 data on the degree to which U.S. addiction treatment providers practice patient-centered care. Based on a national sample of 730 addiction treatment programs, only 23% of programs involved clients within clinical decision-making processes. Clinics treating a majority of clients with alcohol or opioid use disorders were most likely to offer a standard, minimally personalized treatment protocol and least likely to involve clients in clinical decision-making.

In a recent blog, Bill Stauffer and I offered a renewed call for the inclusion of people seeking and in recovery into the decision-making venues that affect their lives. Such ideal representation surely includes the active involvement in clinical decision-making of patients undergoing addiction treatment. Based on the Park study, the addiction treatment field has a long way to go in achieving the involvement of its most important constituents. It is long past time for that to change.

References

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White, W. L. (2008b). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia, PA: Philadelphia Department of Behavioral Health & Mental Retardation Services.

http://www.williamwhitepapers.com/blog/2020/10/relational-models-of-addiction-treatment-recipient-or-participant.html

Recovery Homes Build a Following, but There's Plenty of Room to Grow

William Glanz, National Council on Behavioral Health

Korey McCreery knows exactly how much time he spent in a recovery home.

"Thirteen months and one day," he said.

He also knows spending more than a year at the Canton, Ohio, home operated by Phoenix Recovery Support Services did much more than keep his alcoholism and substance use disorder under control. It kept him alive.

"If it wasn't for the clean, safe, sober living environment provided by the recovery house, I would not be talking to you today," McCreery said. "The recovery house helped save my life."

Stories of recovery like McCreery's are less common than they could be because widespread adoption of the recovery housing model among state governments remains elusive.

The homes – peer-run or peer-managed drug and alcohol-free supportive housing for people in recovery from substance use disorders (SUD) – have slowly gained traction in the U.S. as a crucial element of treatment and recovery because they help residents access outpatient treatment and peer support services. While people in recovery can voluntarily choose to live in recovery housing, many end up in the homes after receiving a referral from a treatment provider or the criminal justice system.

"Some states really get it," said Dave Sheridan, executive director of the National Alliance for Recovery Residences (NARR), which establishes standards for recovery homes and works with state agencies to ensure those homes are recognized by state health departments. "If a state agency understands they need to support treatment and recovery through support for recovery homes, that helps people in recovery. But some states are behind the curve and have yet to adopt this more expansive vision to support recovery."

Sheridan and a group of others – including the National Council's Tom Hill – began their efforts to formalize standards for recovery homes 10 years ago, at a meeting in Atlanta in May 2010. They were motivated by the firm belief that people in recovery had too few options, which in turn led them to experience relapses, recidivism, and other life-threatening pitfalls. They were also motivated by the understanding that substance use disorders are a chronic condition that require long-term treatment.

Relying on short-term inpatient care does not allow a person to overcome a substance use disorder, Hill said.

"The growth in the number of recovery homes in the U.S. matches the realization that this is a necessary service," he said.

In states including Ohio, West Virginia and Oklahoma, state health directors understand the value recovery homes provide to people and communities. The National Council – in partnership with NARR – has prepared an extensive resource, Building Recovery: State Policy Guide for Supporting Recovery Housing, to help states develop the policies to ensure development of recovery housing.

Ohio officials embraced recovery homes soon after a 2013 study demonstrated the demand the homes would meet. Elected officials in the state approved formal language in 2016 to define recovery housing and established a requirement that communities include the homes in required community plans as a way of responding to the opioid crisis.

The state also has leveraged both federal and state resources to support recovery homes, providing funding that covers everything from planning, to construction or renovation, to operational and technical costs. That funding also provides support for Ohio Recovery Housing, the non-profit group that certifies recovery homes and is a NARR affiliate.

Few states have had such a progressive response.

"We have a long way to go," said Danielle Gray, executive director of Ohio Recovery Housing. "But every time I talk to people in other states, I realize how lucky we are. We have made so much progress in Ohio."

In 2017, 93 certified recovery houses in Ohio had 1,012 clients.

Today, 225 certified recovery houses in the state have 2,076 clients.

In Ohio, as in other states, the number of people who would benefit from a recovery home far exceeds the space to accommodate people in recovery.

See Recovery Housing on following page

Recovery Housing, continued from previous page

"There's more demand than available housing," Gray said.

With the nation's opioid crisis surging – overdoses and overdose deaths are on the rise – demand continues to grow.

"These homes support recovery," said Mike Maddox, director of the Oklahoma Alliance for Recovery Residences, which formed this year and affiliated with NARR.

Oklahoma's nascent support for recovery housing has received a big boost from the state's Department of Mental Health and Substance Abuse Services, which has set aside $500,000 for vouchers to subsidize housing costs for clients, and the number of recovery homes in Oklahoma will grow from seven at the beginning of October to 21 – with an estimated 450 residents – by the end of the month as Maddox races to license homes throughout the state.

Inpatient treatment alone is not the answer. There should be a continuation of services once inpatient treatment is completed – recovery housing and outpatient treatment," Maddox said. "Levels of care are vital to recovery. Our state has helped us legitimize recovery housing, and now we're trying to make sure we have them throughout Oklahoma because there's a huge need."

And NARR continues its efforts to increase the number of licensed recovery homes nationwide. Estimates vary widely, but one study published this year in Alcoholism Treatment Quarterly determined there are 17,943 recovery homes in the country. But the absence of a single, agreed upon national standard for recovery home standards and oversight means the number of homes varies depending on which organization is doing the counting. The study counts 1,470 homes affiliated with NARR. Intervention America, a California-based drug and alcohol treatment resource that publishes a directory of recovery homes, includes more than 14,000 residences.

The discrepancy illustrates the problem with an absence of standards and conflicting criteria about what constitutes a recovery home, Sheridan said.

What's more important, is the number of people who rely on the recovery homes. Just 1.2 percent of people with a substance use disorder use recovery homes, according to the authors of the study published in Alcoholism Treatment Quarterly, despite the finding that "recovery homes are an important and widespread post-treatment recovery resource."

Recovery homes also have proved crucial for people who don't require treatment, Sheridan said, which demonstrates that there are many pathways that lead people in recovery to the homes.

The winding path McCreery took began with a litany of arrests and culminated in the understanding that he had to commit to his recovery or risk more time in incarceration.

"I said to myself 'you're not going to make it in prison'," he recalls. "I knew I needed to find a way not to drink."

When he left the program in 2010, he emerged with first-hand knowledge of the value of the homes and the programs they provide people in recovery. Now he delivers that message every day because McCreery, a former recovery home resident, serves as the chief operating office at Phoenix Recovery Support Services.

"I wouldn't be the person I am today if it wasn't for the peer services provided by the recovery house," he said. "Recovery happens in these homes."

https://www.thenationalcouncil.org/BH365/2020/10/13/recovery-homes-build-a-following-but-theres-plenty-of-room-to-grow/??

Korey McCreery (center, with helmet), COO at Phoenix Recovery Support Services, in Canton, Ohio, poses with a group of military veterans from the program's intensive outpatient program residence at the Pro Football Hall of Fame.

For information on recovery homes that meet the NARR standards, contact the Connecticut Alliance of Recovery Residences (CTARR) at info@ctrecoveryresidences.org
Or visit their website at https://ctrecoveryresidences.org/

Remember, you represent not only yourself, but your colleagues, your agency, our Connecticut system of care and the profession as a whole.
Professionalism Matters

If you think you can do it, that's confidence; If you do it, that's competence
-Unknown

Need hours for initial certification or renewal? Check out our CCB Approved Training Providers page on the CCB website: *https://www.ctcertboard.org/approved-training-providers*

im·por·tant (imˈpôrtnt/)
adjective: of great significance or value; likely to have a profound effect on success, survival, or well-being.

Credential Renewal Reminders Are Sent Via Email 90 Days Before The Due Date As A Courtesy.

Please Make Sure That We Have Your Updated Email Address So That The Information Reaches You.

It Is Important To Note That Each Certified Professional Is Responsible To Ensure That Their Materials Are Submitted To The CCB In A Timely Fashion. You Can Verify Your Renewal Date By Checking Our Website At https://www.ctcertboard.org/verify-credentials

Reporting Unethical Behavior of Certified Professionals

As certified professionals, we hold the responsibility for many things, with the two most important being the protection of the clients we serve and the public, followed by protection of the field of SUD prevention, counseling and recovery. This responsibility is not simply aspirational, being something that we aim for, but we also must take an active role. We cannot be satisfied by simply managing our own behavior, we must also be aware of the behavior of others, and when they behave in an unethical fashion, make a formal report to the CCB Ethics Committee. It is your duty, and you agreed to do such when you agreed to abide by the CCB Code of Ethical Conduct with your credential.

Not reporting unethical behavior makes you complicit in the potential violation and makes you subject to sanctions, up to and including permanent revocation of all credentials. This is not stated in a threatening manner, simply to underscore the importance of our ethical responsibilities. Often times clients will not report things out of fear of retribution, and we can (and must) be their voice. A copy of the CCB Code of Ethical Conduct, Ethics Complaint form and Disciplinary Procedures are available on the CCB website at https://www.ctcertboard.org/ethics.

UNADDRESSED AND UNREPORTED ETHICAL VIOLATIONS DAMAGE THOSE WE SERVE AS WELL AS THE FIELD AS A WHOLE.
SILENCE IS COMPLICITY!

A Groundbreaking New British Drug Offers Hope to Opioid [Dependent Persons]

Nina Bardwaj, Business Insider

A groundbreaking new drug is the latest development in the fight against opioid [dependence] offering new hope to drug users.

Buvidal, an injectable form of Buprenorphine, acts as a slow-release drug and blocks the opioid receptors in the brain which stops the patients from having withdrawal symptoms.

It only has to be administered once a week or once a month, making it a good alternative to methadone which is often prescribed to wean users off of heroin and other opioids.

Methadone users frequently have to visit the pharmacy on a daily basis which can be difficult for [those dependent on opioids] with a job, those living in rural areas, or people whose local pharmacies do not provide support.

Dr Arun Dhandayudham, Medical Director for Westminster Drug Project, told Insider: "Buvidal completely steadies blood levels and blocks any highs from of heroin so those who stop using gain a sense of stability and a new lease for life.

"It is of most benefit to those who are working because they no longer need to visit the pharmacy every day but it generally helps by completely unhooking the system so people are not meeting other users who they can be tempted by.

The scheme was first introduced to the UK through a partnership between London's Redbridge Council, Redbridge Clinical Commissioning Group, Camrus, P&S Chemist, and the Westminster Drug Project last year.

"Around 10% of the caseload in Redbridge are on Buvidal or have used it in the past and its success has meant that there are plans to roll out the program across 30-40% of London," said Dr Dhandayudham.

A pilot program for Buvidal was also launched in Glasgow last year with 14 patients, all of whom remained engaged in recovery six months after the trial had finished, according to the BBC.

Scotland's drug fatality rate is three times higher than the UK collectively but only 40% of those with drug problems are currently in treatment, according to the National Drug Treatment Monitoring System (NDTMS).

Research from the Scottish Drugs Forum found that 18% of the Scottish population has been prescribed at least one opioid in 2018 in the same year, they were responsible for or implicated in 86% of the 1,187 drug deaths.

Meanwhile, methadone also contributed to or was implicated in 560 or 47% of drug fatalities in 2018 but now over 100 people in Glasgow are being prescribed Buvidal instead.

There are also plans to roll out Budival in Northwest England to help control the country's growing rates of opioid use.

A 2019 report from West Sussex NHS Trust, in Southeast England, found that the UK is now heading towards an American-style crisis with five people every day dying from opioid overdoses.

In the USA, 71,000 Americans died from drug overdoses last year - 50,000 of which involved opioids, according to the Centers for Disease Control and Prevention.

The opioid mortality rate has contributed to three consecutive years of decline in life expectancy between 2015 and 2017, the most dramatic decrease since the 1960s.

https://www.businessinsider.com/groundbreaking-new-drug-that-could-help-tackle-the-opioid-epidemic-2020-10

Be on the lookout for our monthly virtual training options, addressing topics not often covered by our training partners. We began in November with "Emotional Intelligence As Self Care" to a capacity cohort. Reviews were positive with more to come!

Certification by the Connecticut Certification Board

- Shows the public and employers that you have met high international standards for education, training, and experience that are transferable to other states, regions and countries.
- Enhances your professional reputation and credibility.
- Offers both you and your clients the protection of an enforceable, legally defensible *Code of Ethical Conduct*.
- Demonstrates your commitment to continued professional development and skills expansion.
- Increases your opportunities for career advancement.
- Provides opportunities for you to contribute to advocacy efforts for the profession.
- Makes you part of a 50,000+ network of professionals certified by the IC&RC, the largest organization for substance use and co-occurring disorders prevention, treatment and recovery professionals in the world.
- Affords you an opportunity to be selected as a subject matter expert and/or item writer for credential and examination updates that impact the profession internationally.
- Hold a credential that maintains a focus on public protection and the needs of those served, and is not subject to change based upon the whims of the state legislature or groups whose advocacy puts the needs of clients behind the desires of counselors or agencies.

  While licensure through the Department of Public Health provides your permission to practice, certification verifies that you are competent to practice. Having BOTH is the gold standard.

The Certified Peer Recovery Specialist credential, available through the Connecticut Certification Board:

1. Designed for the protection of the service recipient.
2. Created through a strict psychometric process to guarantee the validity and reliability of the knowledge, skills, and abilities required for effective practice.
3. Legally defensible standards if one's competence is ever challenged in a court of law.
4. Appropriate for assisting individuals with co-occurring substance use and mental health disorders.
5. Allows for the candidate to choose their own path of training, supervision and work experience to meet the identified standards.
6. Standards are updated by subject matter experts (including experienced peer support practitioners and individuals in recovery) regularly to ensure they reflect the profession accurately.
7. The credentialing process is 100% objective and does not rely on the subjective opinion or rating of one's ability to practice.
8. Reciprocal to many other states and countries.
9. Currently held by over 5,000 practitioners across the United States and the world.
10. The most complete peer support credential available, without exception. The CPRS has no equal.

https://www.ctcertboard.org/files/pdfs/CPRS%20Application.pdf

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Events/Advertisements (in rotating banner)	$100/$50 First month/ Each additional

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