Volume 1, Issue 2

NOTCa

National Opioid Treatment Clinicians Association

MEETING THE CHALLENGES OF OPIOID TREATMENT

www.notca.com

September 2004

EXECUTIVE BOARD

Terry Willis,
President, GMPC

J. Paul Connell,
Vice President, GMPC

Ned Etherington
Treasurer, GMPC

Joelyn Alfred
Secretary, GMPC

Melissa Ragsdale
Parliamentarian, GMPC

Elaine Tophia
Executive Director, NOTCA

BOARD OF APPEALS

Everett L. Blake, Chair
Wanda Diann Henry
Jerry Love

ETHICS BOARD

Victor K. Hollings, Chair
Ola Leslie Green
Deirdre K. Wilhoite
Kimberly Hosey

BOARD OF EXAMINERS

Larry Hardy, Chair
Jill Loveridge
Elaine Tophia

President's Editorial
So, What's In A Name?
GMPC or OTPG
By Terry Willis

Are you one of those individuals in our field of expertise that hesitates to mention the words methadone treatment when asked what your professional line of work is?

Hesitate no more. There has recently been a movement afoot that lends itself to the aforementioned question. So, what's in a name? For years, our noble profession has been referred to as methadone treatment. It has appeared to me over the past fifteen years I have been affiliated with methadone treatment that many professionals in our field are reluctant to use the word methadone when given the opportunity to express to others their chosen profession. Society has placed such a negative connotation in relation to methadone treatment that even I, one who has witnessed first-hand the remarkable impact methadone treatment has had on the lives of patients and their family, find myself from time to time describing my chosen profession with terms that do not include the words methadone treatment. I'm positive, if the truth be told, many of us throughout the United States and abroad have a similar dilemma.

This enigma, we in the methadone profession find ourselves confronting over and over again, has been given full consideration on the national, international, state and local levels. After a careful and longitudinal review of this phenomenon, it became obviously apparent for all concerned that a change in name is needed to sustain the credibility and affirmative momentum our profession has garnered over the years.

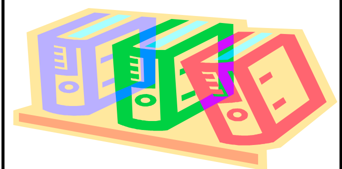
So, what's in a name? Our national and international organization the American Methadone Treatment Association (AMTA) is no longer referred to as such. To follow recommendations for a name change, AMTA is now known as the American Association for the Treatment of Opioid Dependence (AATOD). This new moniker, as you will probably agree, carries less negative baggage than its' predecessor. To follow suit, our own Georgia Methadone Providers Coalition has decided to relinquish our attachment with the reference 'methadone' by now being officially known as Opioid Treatment Providers of Georgia.

So, what's in a name? To be sure, a name is that which distinguishes persons, places or things with an individual identity. This identity can reflect positively or negatively. Which identity do you prefer? The concept of being identified positively as opioid treatment professionals is unequivocally more politically and socially correct and it serves to free all of us in the field of the negatively, whether justified or not, associated with the words methadone treatment.

In conclusion, for those of us who have had difficulty in the past communicating our chosen profession to others, the change from methadone treatment to opioid treatment is a refreshing and welcome change. The challenge for us all is to use this opportunity for renewal to let go of all negative practices associated with methadone treatment and fulfill all of the positive promise of opioid treatment.

If there are opioid treatment professionals that would like to offer feedback concerning this editorial, please feel free to do so. I look forward to seeing you soon.

"Education is key"



Remember:

You are the only person on earth who can use your ability and only those who risk going too far will ever know how far they can go.

Join our rank of professional clinicians and proudly wear the bars of an Opioid Treatment Clinician.

For additional information regarding our certification programs and/or training schedules and to contact us, please visit our Website at:

www.notca,com

Volume 1, Issue 2

Supervision As A Catalyst To Quality Patient Care

Counselors all across the country attend numerous trainings throughout the year with the hope of perfecting or improving their capabilities in patient care. But in many instances the training looses it effectiveness once it gets to the treatment environment because it is not reinforced on the practical level. This is one of the reasons why supervision is so important.

Supervision provides realistic accountability for both the counselor and the supervisor in the areas of knowledge and skills, learning style, conceptual skills, suitability for work setting and motivation. It is an evaluative process that builds a collaborative relationship between counselor and supervisor. According to David J. Powell in his book *Clinical Supervision in Alcohol and Drug Abuse Counseling,* he states that for every 20 hours of direct client contact, a counselor should receive one hour of clinical supervision. According to one of our accrediting bodies, supervision should be an ongoing process and should be documented as such. Counselors should not only be proficient in the 12 Core Functions, e.g. screening, intake, orientation, assessment, counseling, case management, treatment planning, consultation, crises intervention, client education, referral and report and record keeping, but skills should include professional ethics, supervision, dual diagnosis, incest, codependency, other addictions, transference, counter-transference and working with various populations.

An important component of this process is that the supervisor must have confidence in self. He/she must realize that an assessment of the counselor is also an indirect assessment of how

(Continues on page 3)

The Ethical Benefits of not knowing By Shannon D. Kelly

People laugh at me when I tell them that it was an accident that I ended up with my job—as though I were kidding them or perhaps being a little sarcastic! Because when I arrived at work that day, as a counselor at a newly opened OTP, I was expecting to see a few clients, do some charting, and finish arranging my office. I had been an employee for exactly 63 days. My plan in life was to continue my studies in an obscure form of psychoanalysis and philosophy so that I could teach; not worry over urine screens, plan staff meetings, and endlessly create forms! So when I closed the door behind my first appointment and asked her how she thought we could help her, I was totally unaware that when I opened the door for that client to leave I would find myself in charge of running an opioid treatment clinic. And so there I was, or more truthfully, here I am, program director of an opioid treatment program with, now, 136 days of experience to utilize as a clinical and managerial tool. And so I maintain that it was an accident—although it has been pointed out that I could have said no.

I'm not so sure that I can describe the week following that day, when the program director suddenly resigned and I inherited a confused and worried (but devoted and diligent) staff, a clinic full of patients who were completely unaware, a pile of paperwork larger than I could have imagined, and a truer understanding of why someone might choose to do a few lines rather than deal with life. And so, at the end of an emergency consultation (which would have been more appropriately titled "Teaching Shannon What Her Job Is") when the executive director of NOTCA looked at me very seriously and asked me if I was in therapy, I promptly replied, "of course" and started laughing.

Since that day, I have hired and trained four new staff members and an intern, added 25 pages of extra information to our client handbook, instituted new dosing hours, new intake procedures, moved the chart room, attended what seem like 60 hours of HIV/EIS training, suffered through a state inspection, prepared for a CARF inspection, and, of course, continued to see the 23 patients on my caseload. And I am, of course, still in therapy. And I still, thankfully, have no idea what I'm doing.

I say "thankfully" because the one thing my experience and education did provide requires an element of ignorance. If you assume knowledge, even when you have it, you become unable to listen, or to hear something new in another's speech. So, when I was asked to write this article about what it was that allowed me to cope with a situation that was, and still is, entirely overwhelming, my first thought was—I assume that my knowledge is insufficient to sustain an environment that involves a number of other unique individuals. Or, in other words, I had no idea what I should do so I asked people what they wanted. Because what I did quickly figure out was that outside of the laws and rules that I cannot avoid, there lies an infinite number of possibilities for change. Additionally, by listening to people's thoughts and ideas without assuming that I already knew the "right" way to do things, I was able to avoid some of the more damaging aspects that accompany positions of power. And, equally important, I was able to allow people to assume responsibility for their desires—both for the patients in their own treatment, as well as for the staff in the performance of their job. I cannot staunchly uphold policy or procedure, or even tradition to support my reasoning or my decisions in any situation—I haven't been around long enough and there's too much I don't know!

It becomes a problem of ethics when one assumes that they have the answer and that their answer is the only one, or the right one. Because the implicit statement in that response is that everyone else is wrong or at least second best. And when people are forced to act on the demand of someone who fails to consider their input, they do not act with the responsibility that accompanies autonomy and choice. Alternatively, the one who fails to recognize that s/he may not have all the answers also fails to act with responsibility—instead imagining that it is a matter of acting in accordance with "The Right Way" rather than a matter of acting in accordance with "my way." allowing a bit of difference, of "other ways," allows power to be distributed throughout rather than collected in one place or in one person.

People come to us because they made a choice which has serious consequences. They also come because they have made an additional choice to address those consequences. We expect them to be responsible for both of those decisions. In fact, we insist that they be responsible and we try to create a place where they can learn how to take on this responsibility. Often times, however, people arrive for treatment without knowledge of why they made the choice to use drugs. They believe instead that we know—that we not only know how to fix them but that we also know something about why this happened to them in the first place. But, in much the same way that I couldn't have assumed that I knew

The Ethical Benefits of Not Knowing (Continues from page 2)

everything about my new job, we cannot assume that we know everything about our patients, despite how much education, or training, or experience we have with "addicts." if we do this, we become ineffective—we allow patients to continue to believe that someone else can answer for them, when in fact they can only answer for themselves.

I maintain that it was an accident that I ended up with my job, just as it may have been an accident for many of our patients who found themselves addicted to opiates. What I do not maintain, what I cannot ethically maintain is that I had no choice. I made a choice by not saying no and I am the only one who can answer for that decision despite that I accept my inability to predict the future while understanding that my decisions today will have some impact on what happens next. So, when I hear a patient say it was an accident—they didn't know they would get addicted—not only can I believe them, I can also provide a place for them to begin to accept a decision that could have only been theirs. After all, I didn't know either! What it is, then, that has allowed me to cope with this overwhelming situation, is precisely the recognition that nobody "knows" and, more importantly, that everyone wants to know something! Such a desire to understand can only be maintained in the presence of a failure, or a lack in knowledge—the possibility for accidents to happen.

Shannon D. Kelly is the program director at Covenant Treatment Center in Carrollton, Georgia. Ms. Kelly is responsible for 10 staff members. The facility was officially opened November 1, 2003 and is owned by Bill Duncan.

NOTCA invites members of the Opioid Treatment Providers of Georgia, NOTCA Trainers and certified members to submit articles to be published in this newsletter. Submission must be sent to:

Elaine Tophia, Executive Director, NOTCA, 209A Swanton Way, Decatur, Georgia 30030 or you may send it via email at elaine@notca.com.

NOTCA 2005 TRAINING SCHEDULE

January

The Process of Addiction

Planning Treatment for Women in Opioid Treatment

February

Pharmacology in Opioid Treatment

Pharmacy/Medical Procedures

Medical Issues of Opioid Treatment Patients

March

Developing Cultural Competency

Counseling Theories

Men and Violence in Opioid Treatment

April

Management/Administration

Families and Addiction

Ethics

May

Clinical Practices in Opioid Treatment

Enhancing Group Facilitation Skills

Clinical Supervision in Opioid Treatment

June

Preparation for Oral Examination

Preparation for Written Examination

Confidentiality in Alcohol and Drug Treatment

July

A Spiritual Approach to Recovery

Written Examination

Oral Examination

September

NOTCA ANNUAL CONFERENCE

October

Preparation for Oral Examination

Preparation for Written Examination

December

Written Examination

Oral Examination

**Training locations and dates may be found at our Website: www.notca.com or you may visit our parent organization Website at www. otpga.org.*

New Certified Members

Certified Master Opioid Treatment Clinician (CMOTC)

Elaine Tophia

Nils Chandler

Supervision As a Catalyst To Quality Patient Care

(Continued from page 2)

well he/she selected and trained the counselor. Not only should the counselor be evaluated by the supervisor, but the supervisor ***should also*** *be evaluated by the counselor. This provides for a more balanced relationship and is much needed in our treatment environments.*

The work that we do in opioid treatment settings is critical to the lives and well-beings of others. The effectiveness of our counselors can determine the progress or no progress of our patients and can be the bedrock of winning and losing a legal case. Therefore, this is a plea to all Clinical Supervisors in Opioid Treatment Settings to provide the type of supervision that is going to enhance the services provided to our patients so that we are able to stand up against any evaluative process and continue to grow strong in our field as professional opioid treatment clinicians.

Elaine Tophia, LMSW, CMOTC, SAM
Executive Director, NOTCA

ACKNOWLEDGEMENT

The National Opioid Treatment Clinicians Association take this opportunity to thank the Georgia Department of Human Resources Addictive Diseases Division (Bruce Hoopes and Anthony McClarn) for their unwavering support during this 2004 training year.

YOU ARE THE BEST!