Approved: 3-13-00
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Sandy Praeger at 10:00 a.m. on March 2, 2000 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
Lisa Montgomery, Revisor of Statutes
Hank Avila, Legislative Research Department
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Mary Beth Gentry, Assistant Dean for External Affairs, KU School of Medicine
Jasjit S. Ahluwalia, M.D., Vice Chair, Director of Research, KU School of Medicine
Amy O'Brien-Ladner, M.D., Associate Professor of Medicine, KU School of Medicine
Phyllis Gilmore, Executive Director, Behavioral Sciences Regulatory Board
Ronald Eisenbarth, Kansas Alcoholism and Drug Addiction Counselors Association

Others attending: See attached list

Presentation on: KU Mini Medical School

Mary Beth Gentry, Assistant Dean for External Affairs, KU School of Medicine, briefed the Committee on the University of Kansas School of Medicine Mini Medical School which opened on September 14, 1999. She noted that the philosophy behind a Mini Medical School was to encourage the interested, yet relatively uninformed public, and the skeptical, perhaps out-of-touch scientists, to meet together in an intimate setting to help break down the barriers. The goal of the program is to help the students, upon completion of the course, to know the basic concepts needed to understand news reports and medical research, know how to improve their health and have an understanding of the ongoing role research plays in medicine. (Attachment 1)

Two of the instructors in the Mini Medical School, Jasjit S. Ahluwalia, M.D., Vice Chair, Director of Research, KU School of Medicine, briefed the Committee on "Tobacco Use: A 21st Century Pandemic" (Attachment 2), and Amy O'Brien-Ladner, M.D., Associate Professor of Medicine, KU School of Medicine, briefed the Committee on her research on "Iron Lung". (Attachment 3)

Hearing on SB 398 - Addiction counselor licensure act

Phyllis Gilmore, Executive Director, Behavioral Sciences Regulatory Board, addressed the Committee as an informational and neutral conferee on **SB 398** which would create graduated licensure for drug and alcohol counselors under the Behavioral Sciences Regulatory Board. Ms. Gilmore noted that BSRB is neutral as to a recommendation on the bill, however, should the Committee decide to move forward, the Board does have what it considers to be a friendly amendment relating to the issue of confidentiality and privileged communication which was attached to her written testimony. (Attachment 4)

Ronald Eisenbarth, Kansas Alcoholism and Drug Addiction Counselors Association, testified before the Committee in support of **SB 398**. Mr. Eisenbarth gave a brief history of KADACA and his involvement with addiction counselor credentialing in Kansas. He noted that KADACA appeared before the Legislative Task Force on Providers of Mental Health Services in 1999 at formal hearings to present a licensure concept for addiction counselors. He felt such licensure would provide both practice and title protection, as well as protection to the consumer of counseling services in Kansas. Mr. Eisenbarth provided testimony from the task force hearings along with his written testimony. (Attachment 5) During Commission discussion on **SB 398** the following concerns were discussed: scope of practice issue, credentialing process, program standards and turf battles.

Other testimony in support of **SB 398** was received from Craig Collins, J.D., KADACA Executive Director, (Attachment 6); Daniel Lord, Ph.D., Marriage and Family Therapy Representative on BSRB, (Attachment 7); and Harold D. Price, LMSW, Director of Program Services, Family Life Center, Columbus, (Attachment 8).

There were no opponents to **SB 398**.

Approval of Committee Minutes

Senator Salmans made a motion to approve the Committee minutes of February 21, 22, 2000, seconded by Senator Lee. The motion carried.

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for March 6, 2000.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2 March 2000

NAME	REPRESENTING
Sharon Cormack	MATTC / Think Tank
Dawna Marie Covington Kent	Addiction Circle Think Tank
Theresa M. Seyfouw	SRS: Mental Health / Substance Abuse
Susan Lenz	KS Psychological Assoc
Katrina Hull	University Daily Kansan
Amy O'Brien Laane	University of Kansas, School of Med.
Jayjit S. Ahluwalia	" " "
Mary Beth Gentry	Univ of Kansas School of Medicine
Marty W Turner DDS	Dr of Dairy
Ann Kellogg	KNASW
LARRY BUENING	BD OF HEALING ARTS
Jim Deegan	Kommco -
Richard Hannon	UMB Bank
Marla Rhoden	KDHE
Jesse Gabriel	ASAP Coordinator

KU School of Medicine
Mini Medical School- 1999
Program Overview

We believe a profound crisis is facing our nation's biomedical research community. The public is experiencing a declining confidence in, and understanding of, science. One of the reasons behind this decline in public confidence and understanding is that the members of the scientific community have not been effective at communicating the significance, complexity, excitement and hope embodied in biomedical research. Yet, ironically, the public expresses a genuine interest in science and the medical field in general. That is why we have developed the KU School of Medicine Mini Medical School.

The philosophy behind a Mini Medical School is to encourage this interested, yet relatively uninformed, public and the skeptical, perhaps out-of-touch, scientists to meet together in an intimate setting to help break down the barriers. The public will be able to participate in an engaging, informative, and fun program that not only gives them specific information on medical topics, but also gives them a chance to learn about what scientists do from the scientists themselves. The scientists learn ways of reaching out to the public and learn the importance and value of doing so.

We have established the following goals for our Mini Medical School:

1. Educate the community about clinical and basic biomedical sciences and the latest advances in research and healthcare delivery.

2. Create a partnership among individuals for their personal health and the health of their community

3. Build a positive public awareness for academic medicine's role in the nation's health.

The KU School of Medicine will host an eight-week Mini Medical School, with the last week being a graduation ceremony for the students. Tuition of $75.00 will be assessed, with limited scholarships available.

Senate Public Health & Welfare
Date: 3-2-00
Attachment No. 1

The KU School of Medicine's
1999 Mini Medical School

On Sept. 14, 1999, the University of Kansas School of Medicine presented its first Mini Medical School to community members seeking a stronger understanding of diseases, diagnoses, preventive measures, and advances in medical research.

Each Tuesday evening for eight weeks, 250 individuals packed the Wahl East auditorium to hear presentations by School of Medicine faculty, either basic scientists or physician scientists. Topics by a total of 16 speakers ranged from tobacco use to the reproductive system and from skin cancer to the development of a vaccine against HIV and AIDS.

Interest in the program was overwhelming with enrollment filling the class by noon on the day the Kansas City Star announced the upcoming program. As a result, 150 people were placed on a waiting list.

Individuals of all professions and ages were attracted to the Mini Medical School. High school and college students, pharmaceutical representatives, bankers, attorneys and homemakers enrolled. The youngest student was 9 years of age and the oldest was 85 years young.

The goal of the program was to help the students, upon completion of the course, to know the basic concepts needed to understand news reports about medical research, know how to improve their health and have an understanding of the ongoing role research plays in medical practice.

Today, more than 45 medical schools nationwide and the National Institutes of Health offer similar education programs. The program has been endorsed by the Association of American Medical Colleges as an important tool in helping the public understand academic medicine's role in the health of the nation.

KU's next Mini Medical School will begin September 5, 2000 in the larger Battenfeld Auditorium and enrollment is expected to increase by at least 100.

Future plans are in the works for an advanced "Post Doctorate" course in spring 2001 for students who have completed the Mini Medical School and desire a more intensive, hands-on experience. In addition, efforts are underway to develop a model of this program that can be delivered to interested individuals throughout Kansas, especially those in rural communities where access to health information is often less available.

#1-2

1999 Mini Medical School Schedule

September 14	Tobacco Use: A 21st Century Pandemic Jasjit S. Ahluwalia, M.D., M.P.H., M.S.
September 14	Iron Lung: Consequences of Polluted Air Amy O'Brien-Ladner, M.D.
September 21	The Male Reproductive Function: What Makes a Man George Enders, Ph.D.
September 21	Infertility: It's Not Just Sperm and Eggs Valerie Montgomery Rice, M.D.
September 28	Complementary Medicine: Simple Things To Do In Complicted Times Jeanne Drisko, M.D.
September 28	Cancer: What Is It and How Can We Cure It Or Prevent It? William Jewell, M.D.
October 5	Sedatives and Hypnotics: Benefits and Dangers Salvatore J. Enna, Ph.D.
October 5	What Are Diseases and Why Do We Get Them? Examples from the History of Medicine Christopher Crenner, M.D., Ph.D.
October 12	Progress on Development of a Vaccine Against HIV and AIDS Opendra Narayan, D.V.M., Ph.D.
October 12	X-Ray Vision: Looking Inside Your Body Louis H. Wetzel, M.D.
October 19	The Kidney: The Body's Filter in Good Times and Bad Billy G. Hudson, Ph.D.
October 19	Sunlight: The #1 Environmental Carcinogen J. Michael Casparian, M.D.
October 26	Age and Our Memory: When Is It Normal To Forget? Charles DeCarli, M.D.
October 26	Heartburn: Frequently Not an Innocent Problem Norton Greenberger, M.D.
November 2	Why Your Headaches Make Your Head Ache Kenneth Michael Welch, M.D.

The University of Kansas Medical School

M i n i M e d i c a l S c h o o l

Jasjit S. Ahluwalia, M.D., M.P.H., M.S.
Vice-Chair, Director of Research and
Associate Professor of Preventive Medicine,
and Associate Professor of Internal Medicine
University of Kansas School of Medicine

Dr. Ahluwalia received his B.A. degree at New York University where he was a University Scholar for four years. He then completed a combined four year M.D./M.P.H. program at the Tulane University Schools of Medicine and Public Health in 1987. At the University of North Carolina at Chapel Hill, he completed a three year Internal Medicine residency. He then spent two years at the Harvard Medical School General Internal Medicine fellowship program studying clinical epidemiology and completing a M.S. degree in Health Policy from the Harvard School of Public Health.

From September 1992 to June 1997, Dr. Ahluwalia was an Assistant Professor of Medicine at Emory University School of Medicine, with a joint appointment in the School of Public Health as an Assistant Professor of Health Policy. At Emory, he was a practicing Internist, taught medical and public health students, and conducted clinical research.

In July, 1997, he joined the faculty at the University of Kansas School of Medicine as Vice-Chair, Director of Research, and Associate Professor of Preventive Medicine and Internal Medicine. Dr. Ahluwalia has received more than $3.0 million in funding over the past 5 years. He currently holds a $1.5 million grant from the National Cancer Institute titled, "Does Buproprion Help African American Smokers Quit." He has also received $240,000 for the four year Robert Wood Johnson Foundation Generalist Physician Faculty Scholars program.

He has been active in a number of national organizations, including the Society of General Internal Medicine, The Society for Nicotine and Research, and the American College of Preventive Medicine. He has served on planning committees for national meetings, served on organizational panels, and has been a reviewer for the National Institutes of Health. He speaks extensively on a number of topics to regional and national medical audiences, as well as nonmedical audiences. Until 2003, Dr. Ahluwalia will serve on the National Advisory Committee of the Robert Wood Johnson Foundation's new initiative on Addressing Tobacco in Managed Care.

Tobacco Use: A 21st Century Pandemic

I Objectives

At the end of this session the learner will be able to:

1) Trace the history of tobacco use in the U.S.
2) Describe the health effects of smoking
3) Understand the physical changes that occur as a result of smoking
4) List methods used to help smokers quit

II Background

History of Tobacco

Despite a long history of tobacco use in the world, the first half of the 20th century will be notable for a tremendous increase in the consumption of tobacco along with tragic increase in the number of people suffering from diseases associated with tobacco. Mayan stone carvings suggest that tobacco was used as early as 900 AD. Early methods of use included puffing, chewing and snorting tobacco. It was not until the early 1800's that tobacco was produced in a form that could be inhaled. Lighter strains of tobacco were developed and flue curing was discovered which produced a tobacco that was milder and less irritating to the throat. It was at this time that shredded tobacco began to be rolled by hand in paper and smoked by inhaling - the first cigarettes.

The production of cigarettes soared when, in 1881, James Bonsack of Virginia designed a machine that could produce 70,000 cigarettes a day. Production in the U.S. continued to

increase and reached 10 billion cigarettes during 1913. World War I helped spread the use of cigarettes by the inclusion of cigarettes in soldiers' rations. This practice was continued during WWII and in 1949 approximately 393 billion cigarettes were produced.

Filters were first introduced in 1930. When the health risks of smoking began to be recognized in the 1950's, production of filter cigarettes increased with unfounded claims of safety. By 1960, approximately 50% of all cigarettes produced had filters. In 1964, the first low tar, low nicotine cigarette was produced, just shortly before the Surgeon General's first report on the health effects of smoking. Today the dominance of cigarettes as the primary method of tobacco use in the U.S. continues. According to the U.S. Department of Agriculture, the United States alone produces approximately 689 billion cigarettes annually with the production capacity of over one trillion annually. In addition, recent years have seen increases in the production and use of cigars and smokeless tobacco.

Types of Tobacco Commonly Used Today

	CIGARETTES	PIPES/CIGARS	SMOKELESS TOBACCO
Consumption/Production	Comprise 95% of all tobacco products	Cigars – 4.6 billion produced in 1996, highest level of production since 1980	Usage increasing, especially among teenage males - 15.8% in 1997
Method of nicotine delivery	inhaled smoke, nicotine absorbed in alveoli (lungs)	puffed, nicotine absorbed through buccal mucosa (lining of the mouth)	placed between cheek and gum, nicotine absorbed through buccal mucosa
Characteristics	- Shredded tobacco wrapped in paper - With or without filters - 20 in pack	Pipes - Loose, shredded tobacco Cigars - Rolled tobacco leaves or shredded tobacco wrapped in tobacco leaf - One large cigar can equal one pack cigarettes	Moist snuff - Powdered tobacco Chewing tobacco - Leaf tobacco in pouch - Plug tobacco in brick form

Prevalence

Since 1965, the prevalence of adult smoking steadily declined to 25% in 1990 and has remained steady since then. Although men have consistently had higher rates of smoking than women, the decline in smoking from 1965 to 1995 was greater for men than women, from 52% to 27% for men vs. 34% to 23% for women.

Percent of adults who were current smokers in 1995 – United States

Total population	25%
Gender	
Male	27%
Female	23%
Ethnicity/Race	
White	25%
Black	26%
Hispanic	18%
Education	
≤High School	30%
≥ College degree	14%

Source: National Health Interview Survey: 1995.

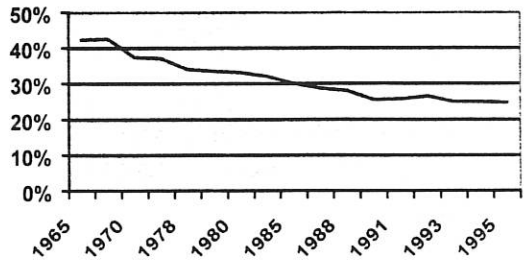
There are some differences in smoking rates among various ethnic populations. Although whites and African Americans have similar overall smoking rates, African Americans average fewer cigarettes per day and fewer quit. Hispanics have a lower overall smoking rate than African Americans or whites. The most dramatic differences in smoking rates are seen across educational levels, with the percent of smokers increasing as level of education decreases.

Initiation of smoking most often occurs in the teenage years and prevention of initiation could have a dramatic impact on smoking rates. The rate of adolescent smoking declined during the 1970's and 1980's but began to increase again in the 1990's. In 1997, among persons 12-19 years of age, 42.7% reported using tobacco products during the previous 30 days, 32% more than in 1991 (MMWR, 1998). This may explain why smoking rates have not continued to decline but rather have remained stable for the overall population.

Policy

As early as 1954 published reports of health effects of smoking began to appear. In 1964 the first Surgeon General's report was released; it concluded that smoking is a cause of lung cancer and chronic bronchitis. During the next 30 years there has been increasing activity to reduce the prevalence of tobacco use. Many of the policies, such as package labeling, put the onus on the consumer to voluntarily reduce consumption of tobacco. Few have had a major impact on the tobacco industry itself.

Prevalence of Smoking in the U.S.: Adults 1965-1995



Years of Tobacco Policies

54	First Surgeon General's report
56	Warning labels
71	Cigarette ads on the radio and television banned
73	Airlines urged to offer no smoking sections on commercial flights
75	Military discontinues cigarettes in rations
32	Congress doubles federal cigarette excise tax
37	Department of Health and Human Services bans smoking at its facilities
38	Smoking banned on domestic flights of less than two hours
90	In-flight smoking ban extended to 6 hour domestic flights
	EPA issues preliminary report on the dangers of secondhand smoke
92	Legislation requires states to adopt and enforce restrictions on tobacco sales to minors
	EPA strengthens its preliminary report and classifies secondhand smoke as a carcinogen

During the past 30 years Congress has considered over 1,000 tobacco control bills while at the same time accepting campaign money from the tobacco industry lobby. It is not surprising that few bills have passed. The Federal Trade Commission has failed to take significant action regarding advertising by tobacco companies, and more recently Congress refused to grant the Federal Drug Administration jurisdiction over nicotine as a drug.

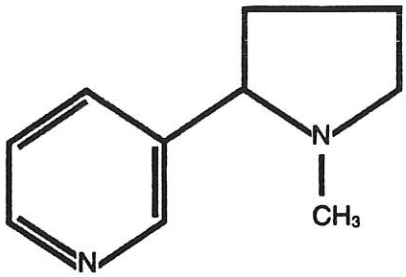
III Smoking or Health

Tobacco Components

Tobacco smoke is made up of over 4,000 compounds including nicotine, tar, carbon monoxide and irritants. About 45 of these chemicals are known carcinogens, tumor accelerators or co-carcinogens. Nicotine is a powerful and toxic drug. It is an alkaloid that is easily dissolved in water or liquid, and absorbed into the body across membranes in the lungs or mouth, depending on the type of tobacco used. Cigarettes con-

tain about 8 mg of nicotine with 1-2 mg per cigarette delivered to the smoker. This is true of all brands except ultra-low nicotine cigarettes, which are heavily ventilated. The large number of minute air holes in these cigarettes increases the air and reduces the smoke that is inhaled. Nicotine and carbon monoxide are the primary causative agents in cardiovascular diseases while tar contributes to cancers and lung disease.

Nicotine levels vary greatly in smokeless tobacco (spit, chew etc.) depending on the brand. Smokeless tobacco contains many of the same compounds, but since the tobacco is not burned some are not released. Health effects of smokeless tobacco include bad breath, gum disease and abrasion of the teeth. Carcinogens contained in smokeless tobacco present the most significant health risk causing various forms of oral cancer.

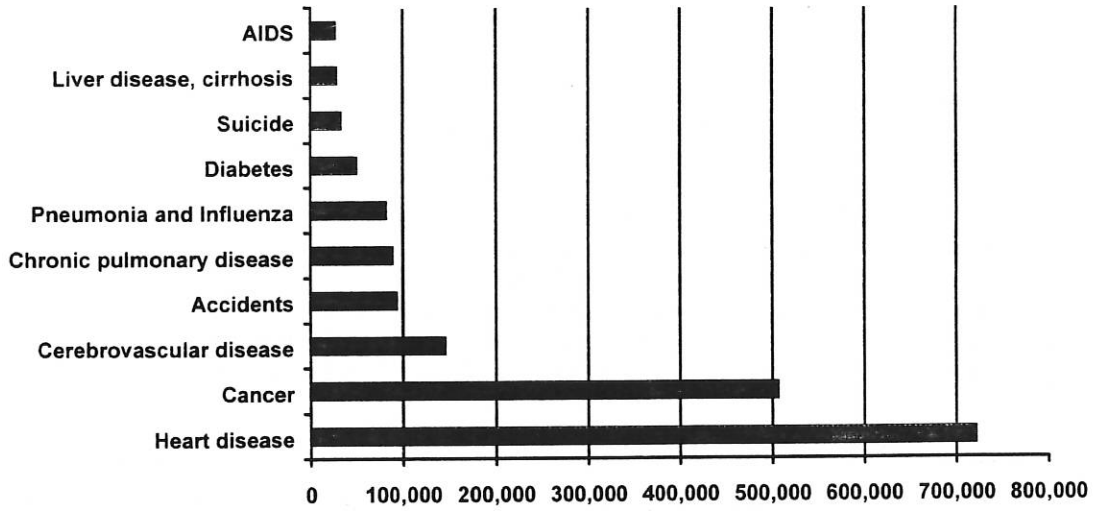


Structural formula of nicotine

Health Risks

Lung cancer was considered an extremely rare condition in the beginning of the 20th century and was not listed as a cause of death in the vital statistics of the United States until 1930. However, just since 1964 there have been more than 2 million deaths from lung cancer in the United States (CDC's TIPS). Among women, lung cancer has surpassed breast cancer as the leading cause of cancer death. In addition to lung and other cancers, smoking contributes to cardiovascular disease and respiratory disease, resulting in more than 400,000 deaths annually.

The 10 Leading Medical Causes of Death



Source: National Center for Health Statistics; 1990

Respiratory System

Inhaling cigarette smoke into the lungs is a very effective way to deliver nicotine to the body. The nicotine is absorbed into the blood stream through the alveoli, small air sacs deep in the lungs. The tar that is present in cigarettes gets deposited in the alveoli and is a concentration of many of the chemicals that are present in cigarette smoke.

In healthy lungs there is an efficient system for dealing with foreign substances and irritants. Lungs produce mucous as a way of trapping material, and tiny hair like structures called cilia are in constant motion to move the mucous out of the lungs. Consistent smoking results in several noticeable changes in this system. An increased production of mucous along with dysfunction of the cilia lining the lungs results in a decreased ability to clear the lungs. This produces an

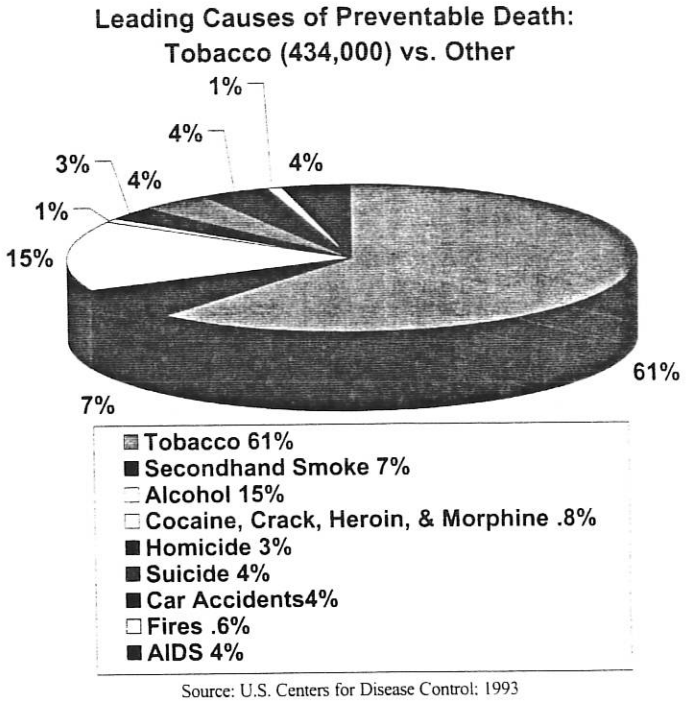
increased, often chronic, cough. It is the tar that is present in cigarette smoke that is responsible for the development of lung cancer, emphysema and chronic bronchitis. Approximately 90% of all lung cancer and 85% of all chronic obstr[illegible] pulmonary disease (COPD), which includes emphysema and chronic bronchitis, is directly attributable to smoking.

Cardiovascular system

More than 400,000 people die from tobacco related diseases each year and 25% of those deaths are from heart disease. Smoking has many effects on the cardiovascular system. Nicotine causes increased blood pressure and heart rate, resulting in the need for increased oxygen for the heart muscles. Although smoking is not considered a causative factor in chronic hypertension, it greatly increases the risk of heart disease. The carbon monoxide that is present in cigarette smoke replaces oxygen in the blood requiring increased blood flow to supply the body with needed oxygen, another stressor for the heart. Smoking increases levels of LDL cholesterol (bad cholesterol) and decreases levels of HDL cholesterol (good cholesterol), thereby increasing the risk of atherosclerosis, the narrowing of arteries. In addition, the blood of smokers has a higher viscosity, which leads to a greater risk of developing blood clots. These effects result in increased risk for many cardiovascular diseases and conditions such as chronic heart disease, heart attacks, stroke, and reduced circulation to extremities.

Central Nervous System

The persistent nature of smoking is due in part to the addictive properties of nicotine and its effects on the central nervous system. Smoking a cigarette delivers nicotine to the brain very quickly, within 7-10 seconds, and affects mood and cognitive functions. The effects on mood can vary greatly from mild euphoria and stimulation to feelings of relaxation and stress relief. Smokers also report increased attention and ability to concentrate. These affects appear to be controlled by altering the number and frequency of cigarettes smoked as well as the length and depth of inhalations. The addictive properties are evident in the need for consistent dosing, development of tolerance to nicotine and the presence of withdrawal symptoms when the smoker is abstinent. Most smokers state they would like to quit, yet few succeed, and the relapse rate is high.



Source: U.S. Centers for Disease Control: 1993

Benefits of quitting

Cessation of smoking decreases the risk of many diseases. Carbon monoxide levels begin to drop almost immediately and within a few weeks cough and sputum production begin to subside. Risk for heart disease decreases sharply in the first year of cessation and after 10 years is the same for non-smokers. The risk of cancers gradually decreases and deterioration due to lung disease slows.

IV Treatment strategies

Over the past 30 years there have many methods promoted as effective in assisting with smoking cessation. Included among early methods were techniques such as the use of mild electric shock and other aversion techniques. Acupuncture and hypnosis may be helpful for some individuals but the few studies conducted suggest these methods are no more effective than placebo.

Annually, approximately 4% of smokers quit, most with little or no assistance. There are, however, a variety of options available to smokers to assist with cessation, both behavioral and pharmacological. Behavioral options range from educational pamphlets, self-help books and internet programs to telephone support and to more intensive methods such as group or individual treatment.

Behavioral Treatment Options

Description & Examples	Pros & Cons
Group Programs Freedom From Smoking (American Lung Association) Fresh Start (American Cancer Society) Smokeless Smoke Stoppers Also offered by many hospitals, medical facilities and by voluntary agencies.	**Pros** • Supportive, encouraging environment • Includes help with changing smoking behaviors **Cons** • Meeting schedule may not be flexible enough for some • A group may not be available when you need it • Cost may be a barrier
Individual Counseling From Healthcare Provider Health care providers may offer individual assistance with smoking cessation. This should include information on skills and relapse prevention	**Pros:** • Flexible • Personalized to your needs • Help with changing smoking behaviors **Cons:** • No opportunity for peer support, sharing • Usually requires an appointment • Cost may be a barrier
Books, Manuals, Audiotapes, Videotapes, and Internet Resources May be a starting point for additional help. These should be educational, informative and discuss the key parts of a comprehensive plan for quitting.	**Pros:** • Flexible and private • Suits people who enjoy working on their own **Cons:** • Success depends on continued use • May not cover all necessary skills
Telephone Counseling Many health providers and worksites offer telephone counseling to provide assistance in developing and following through with a plan for quitting.	**Pros:** • Flexible and private • Suits people who enjoy working on their own • Provides personal support **Cons:** • Phone counselor may vary • Coordination of calls may be erratic

Pharmacological methods include nicotine replacement, in a variety of forms, and buproprion, as currently approved and effective methods. Nicotine replacement therapy aids with cessation by replacing the nicotine the person has been receiving from tobacco products and therefore helps control withdrawal symptoms. Buproprion however affects different areas of the brain. While the exact mechanism is not clear it has been shown to be effective. Combining behavioral and pharmacological methods increases effectiveness of either method used alone

Pharmacological Aids to Cessation

Description & Examples	Pros & Cons
Non-nicotine medication Bupropion sustained release (Zyban) (prescription required) Begin therapy at least one week prior to quit date. Only non-nicotine medication considered effective for smoking cessation.	**Pros:** • Easy to use • Pill form • Few side effects • Can be used in combination with nicotine patches **Cons:** • Should not be used by patients with eating disorders, seizure disorders or those taking certain other medications • May cause insomnia and dry mouth • Must be taken on a regular schedule
Nicotine Inhaler Nicotrol ® Inhaler (prescription required) Mouthpiece containing a replaceable cartridge delivers nicotine when puffed on, not actually inhaled. The inhaler delivers nicotine into the mouth, not the lung, and enters the body much more slowly than the nicotine in cigarettes.	**Pros:** • Flexible dosing • Most similar to hand-to-mouth behavior of smoking • Few side effects • Faster delivery of nicotine than the patches **Cons:** • Requires frequent use during the day to obtain adequate nicotine levels • May cause mouth or throat irritation
Nicotine Nasal Spray Nicotrol ® NS (prescription required) Delivers nicotine through the lining of the nose when squirted directly into each nostril.	**Pros:** • Flexible dosing • Can be used in response to stress or urges to smoke • Fastest delivery of nicotine among currently available products • Reduces cravings within minutes **Cons:** • Nose and eye irritation is common, but usually disappears within one week • Requires frequent use during the day to obtain adequate nicotine levels
Nicotine Patch NicoDerm ®CQ (over-the-counter) Nicotrol ® (over-the-counter) Habitrol ® (prescription required) ProStep ® (prescription required) Patches deliver nicotine through the skin in different strengths, over different lengths of time.	**Pros:** • Easy to use • Only needs to be applied once a day • Some available without a prescription • Few side effects **Cons:** • Less flexible dosing • Slow onset of delivery • Mild skin rashes and irritation
Nicotine Polacrilex (nicotine gum) Nicorette ® (over-the-counter) This gum-like substance containes nicotine which is released after brief chewing. "Gum" is then parked between cheek and gum. The nicotine is absorbed through the lining of the mouth.	**Pros:** • Convenient • Flexible dosing • Faster delivery of nicotine than the patches **Cons:** • May cause problems for people with dental problems and those with temporomandibular joint (TMJ) syndrome • Acidic food or drink decreases absorption of nicotine • Frequent use during the day required to obtain adequate nicotine levels

Conclusion

We have traced the history of tobacco and described the epidemiology and prevalence of smoking. We have covered the health effects of smoking and the benefits for quitting. Most importantly, we have learned methods on how to help smokers quit both through behavioral interventions designed to address the psychological addiction and the habitual aspects of smoking. In addition, we have covered the pharmacotherapy available to help smokers quit smoking.

Cigarette smoking remains the number one cause of death in this country. It leads to one out of three deaths in the United States. While infectious diseases are conquered by treatments and vaccines, cigarette smoking will unfortunately play an increasing role in death and disability in developing countries. It will take a multi-pronged, interdisciplinary approach to curb the rising deaths from tobacco. Ultimately, the manufacturer of tobacco, the tobacco industry, should be held liable.

Acknowledgement: Credit must be given to Denise Jolicouer, MPH one of my best graduate students, and now colleague.

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The University of Kansas Medical School

M i n i M e d i c a l S c h o o l

Amy O'Brien-Ladner, MD
Associate Professor of Medicine
Department of Medicine
Division of Pulmonary/Critical Care
University of Kansas School of Medicine

Dr. O'Brien-Ladner attended the University of Kansas as a Kansas Scholar and received her B.S. degree in Physical Therapy where she was the Ruth G. Monteith award recipient for the outstanding student in her class. She, then completed her MD degree at the University of Kansas School of Medicine, graduating as a member of Alpha Omega Alpha in 1984. She continued at the University of Kansas with a three year Internal Medicine residency and an additional year as chief resident spent under the guidance of Chairman, Dr. Norton Greenberger. She then entered into the Pulmonary/Critical Care fellowship program and completed in 1991. During her final year of fellowship, she spent a year in the laboratory with Dr. Lewis Wesselius studying the effects of oxidant stress on macrophage function and received the Young Investigator Award from the American College of Chest Physicians.

Dr. O'Brien-Ladner joined the faculty in July 1991 is currently an Associate Professor of Medicine at the University of Kansas School of Medicine. She is a past winner of the Student Voice Award for teaching. Her research has been funded by the American Lung Association, American Heart Association and is currently funded by the National Institutes of Health. Dr. O'Brien-Ladner's current research investigates the dysfunction of the alveolar macrophage secondary to oxidant stress and iron in smoking-related lung disease. She is board certified in Internal Medicine, Pulmonary Medicine and Critical Care Medicine and is the Director of the Medical Intensive Care Unit at KU Medical Center.

"IRON LUNG: Consequences of Polluted Air"

OBJECTIVES

At the end of this session, the student will be able to:

- Understand the basic roles of iron in health and disease
- Explain the concept of oxidant stress and the role iron plays
- Describe the lung disease processes in which iron may contribute
- Understand the basics of macrophage function
- Define DNA, RNA and "gene transcription"

I. Introduction: Iron

Iron is one of the transition metals located in the Periodic Table. It is the most abundant transition metal in the body (approx. 4.5 grams). It is absolutely required for all human cell function but is potentially lethal in excess. The treatment of human disease with iron is said to date back to 2735 B.C. in China and 1500 B.C. in Europe, probably to the detriment of those individuals treated. The importance of iron in the health of humans was recognized in the 18th century when iron was described at an important constituent of blood. Nobel laureate, Christian deDuve, hypothesizes that iron was essential for the origin of life on earth in his book, Blue-print for a Cell. The importance of iron in cell function is related, at least in part, to its association with the production of reactive oxygen species (ROS) or free radicals. ROS species are charged, unstable compounds capable of activating, injuring or even killing cells. In order to generate ROS, it is important to understand the concept of *catalytic iron* or that *that is immediately available for chemical or biologic reactions.* The majority of iron is stored bound to proteins in cells throughout the body leaving it unable to participate in the generation of ROS.

The generation of reactive oxygen species is demonstrated by the Fenton reaction (Fig. 1). Iron mixes with hydrogen peroxide (or just oxygen) and forms the potent hydroxyl radical, the most potent of ROS

$$Fe(II) + H2O2 \longrightarrow Fe(III) + OH + OH-$$

Fig. 1 **FENTON REACTION**

ROS are pivotal in the maintenance and activation of all cells within the human body. In excess, however, iron catalyzed ROS can induce oxidant stress. Oxidant stress occurs when the bodies protective mechanisms, antioxidants, are overcome by the amount of ROS and result in injury to cells and tissue. Every cell has an elaborate, inducible protective mechanism against oxidant stress. Primarily, biologic systems handle iron by careful storage to avoid excess generation of ROS. However, the human being does not have a mechanism to rid the body of excess iron. Thus, if increased amounts of iron are ingested and inhaled, the body must handle this excess load internally. And, when protective mechanisms become overwhelmed, iron can be directly injurious to humans, such that it destroys cell structures and leads to cell mutations and/or cell death. There is building evidence, however, that iron may have a more subtle effect on cell function prior to overt injury. Iron may actually control, at least in part, the stability of DNA and transcription of RNA. DNA is that substance within the cell that contains the "potential" pool of genes that controls transformation of a cell into a cancer fighting or infection-fighting cell. The RNA is that substance, derived from DNA, that serves as the " message" to the cell that functions should be activated or altered. The signals to the cell by RNA, through transcription, is required for activation of human defense mechanisms against a variety of insults, including cancer and infection. Our lab is investigating the effect of excess iron on the cells' capacity to activate itself and surrounding cells to recognize and fight cancer and infection within the lung.

II. Iron and the Lung

Iron accumulates in lungs with the normal aging process. Furthermore, occupational exposure, for example in steelworkers, and cigarette smoke and urban air pollution escalate the accumulation of iron within lung. This is a particular problem in the lung because the lungs are the only organ (except the skin) to be exposed to high concentrations of oxygen. This can be dangerous because oxygen facilitates the generation of ROS when iron is in excess.

Cigarette smoking increases the accumulation of iron in the lung by a variety of mechanisms, including the delivery of iron particles and ROS in the smoke that is inhaled. Notably, our research group has observed an increase in lung iron in smokers that demonstrates regional variation in accumulation of iron. Upper lobes, the segments of lung at the top of the chest, accumulate more iron than those in the lower lobes. Interestingly, the diseases related to smoking, primarily emphysema and cancer, both have a predilection for the upper lung region. It is not clear that there is a cause-and-effect relationship between iron and smoking-related disease. However, this has to be considered, because iron exerts influences over a number of mechanisms that can lead to both emphysema and cancer.

Emphysema is the destruction of lung air spaces that are involved in oxygen exchange in emphysema. The walls of these delicate structures are destroyed and form large hyperexpanded bullae similar to the expansion and trapping of air within a balloon (Fig. 2). Bullae serve no functional purpose and displace functional lung.

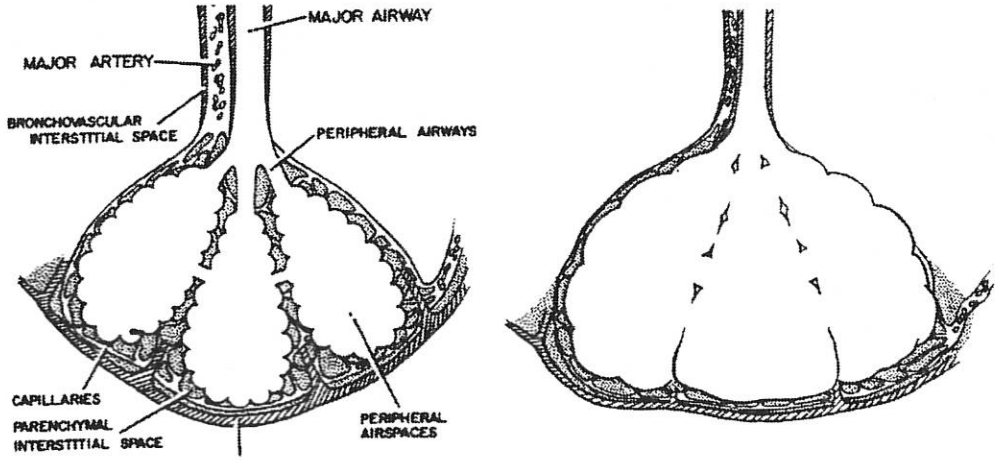

Fig. 2 **The destruction of alveoli (air spaces) in the lung**

Emphysema leads to chronic disability in the 5th and 6th decades of life and certainly smoking is the primary cause of this disorder. An imbalance between the oxidants and antioxidants have been proposed as the cause of emphysema and our data supporting greater iron concentrations in the very areas involved in the disease suggests possible correlation.

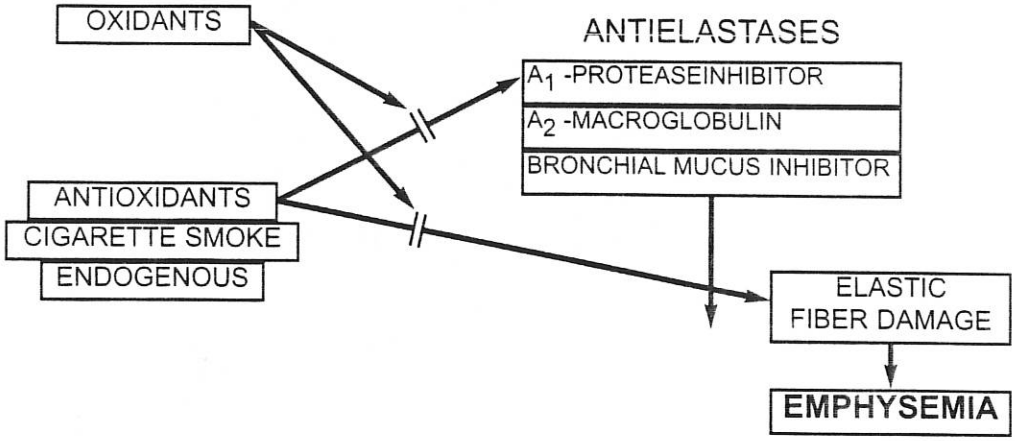

Fig. 3 **Oxidants and Emphysema**

Regarding the association of cancer and iron, studies demonstrate that societies with populations with increase body iron stores are associated with an increased risk of cancer and an increased overall death rate. Two lines of evidence provide a rationale for these phenomenon. First, iron catalyzes the production through oxidant species which is a chronic stress on the cells that leads to mutation (DNA damage) and subsequently to cancer. Secondly, iron can increase the chances for some cancer cells to survive by increasing the antioxidant capacity of cells. Interestingly, cancers involving not only the lung are associated with increased iron levels but also the liver and colon.

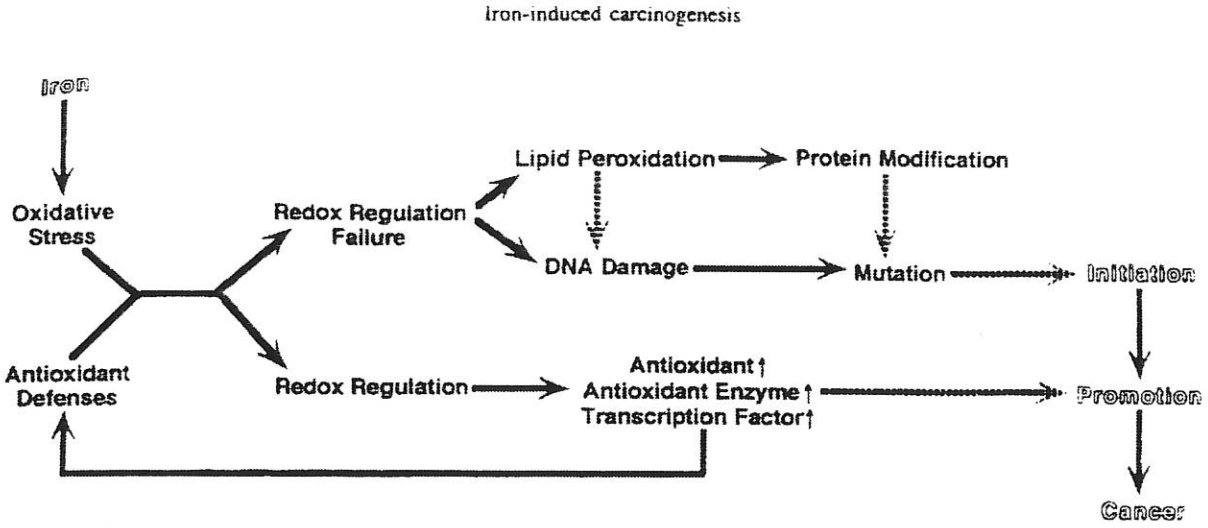

Fig. 4 **Iron and Cancer**

Smoking is an ideal model in which to investigate the effects of iron overload. Smoking-related disease is a major health care burden, yet, the mechanisms by which smoking causes disease within the human lungs are not entirely clear. As one possibility, it is known that smoking causes many alterations in the functions of resident macrophages, cells that are the "housekeepers" of the lung air spaces. The macrophage actually ingests debris from the air inhaled (Fig. 5), including iron delivered by smoking. The macrophage is responsible for surveillance throughout the lung which results in early recognition of the early stages of lung cancer or infection. This surveillance is important because the inherent defense mechanisms against these precesses are very good if problems are "caught in time". Our lab investigates the role that increased iron has on altering the ability of this macrophage to activate defense mechanisms that protect the lung should malignant or infectious agents present themselves. Our data suggests that iron lowers the ability of the macrophage to remain alert and activate in the time of greatest need.

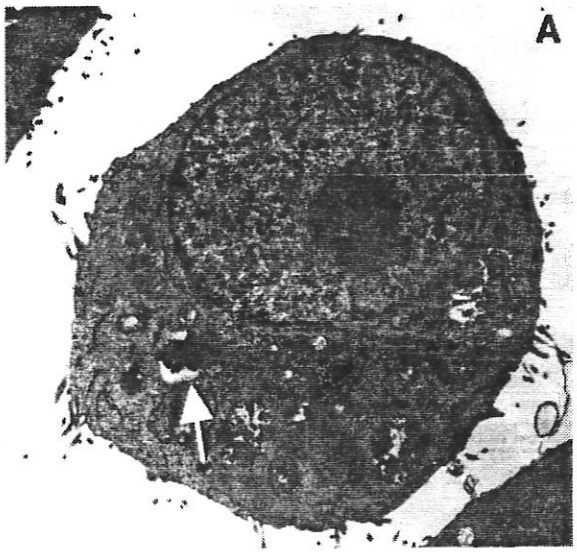

Fig. 5 **MACROPHAGE WITH IRON INCLUSIONS (SEE ARROW)**

III. Damage Control

Treatment for iron-overload is at an investigational level, except in extreme cases of hereditary disorders or ingestion that are clearly "poisoning" the body. The current treatments available include 1) phlebotomy, the removal of blood from the body. The majority of the iron within the body is contained in blood, or 2) iron chelation where iron is bound to a substance that is circulated throughout the body and then eliminated. Both treatment options are sub-optimal. In regards to smoking-related iron, at this time, smoking cessation is our only option. However, it is not clear that iron accumulated with smoking will, in fact, be redistributed or eliminate by the body. Cancer risk from smoking continues long after smoking stops, whereas, the risk of emphysema ceases with smoking cessation. We are planning an investigation where we determine the affect of smoking cessation on the increased iron burden of the lung. At an investigational level, trials of antioxidant therapy and iron chelation are treatments in experimental stages.

STATE OF KANSAS

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SENATE TESTIMONY
PUBLIC HEALTH AND WELFARE COMMITTEE

March 2, 2000

Madam Chair and Committee Members:

Thank you for the opportunity to testify regarding SB 398. I am Phyllis Gilmore the Executive Director of the Behavioral Sciences Regulatory Board.

The BSRB is the licensing board for most of the state's mental health professionals, the doctoral level psychologists, the master level psychologists, the bachelor, master and clinical level social workers, the master level professional counselors, and the master level marriage and family therapists. Additionally, some of the drug and alcohol counselors are registered with us, although most of them are registered with SRS at the present time.

Since licensure is a legislative decision, the BSRB is neutral as to a recommendation on SB 398. However, should you decide to move forward in this discussion, the board does have what it considers to be a friendly amendment relating to the issue of confidentiality and privileged communication. The amendment is attached to my testimony.

Also, should you decide to pass SB 398, please know that the BSRB would heartily welcome the addiction counselors and feel that we can serve them without any additional FTE's. The addition of a board member representing addiction counseling is also not a problem.

Thank you for the opportunity speak to you this afternoon. I will be happy to stand for questions.

Senate Public Health & Welfare
Date: 3-2-00
Attachment No. 4

SENATE BILL No. 398

By Senator Salmans

1-7

AN ACT enacting the addictions counselor licensure act; amending K.S.A. 1999 Supp. 74-7501 and 74-7507 and repealing the existing sections; also repealing K.S.A. 65-6601 through 65-6606.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. Sections 1 through 13, and amendments thereto, shall be known and may be cited as the addictions counselor licensure act.

New Sec. 2. As used in the addictions counselor licensure act:

(a) "Addiction counseling" means the evaluation, assessment, education and counseling of individuals within the context of alcohol or drug usage or both, including but not limited to the requirements of subsection (c) of K.S.A. 8-1008, and amendments thereto. Addiction counseling includes the diagnosis and treatment of addiction disorders as authorized under the addictions counselor licensure act.

(b) "Licensed addictions counselor technician" means a person who is licensed under this act and who engages in the practice of addictions counseling for compensation only under the supervision of a licensed addictions counselor II, a person licensed to practice medicine and surgery, or a person licensed by the board and whose licensure allows for the diagnosis and treatment of mental disorders in independent practice, except that the licensed addictions counselor technician is not authorized to engage in services that evaluate, diagnose or plan treatment for persons with addictions disorders.

(c) "Licensed addictions counselor I" means a person who is licensed under this act and engages in the practice of addictions counseling for compensation except that the licensed addictions counselor I may evaluate, diagnose or plan treatment for persons with addictions disorders only under the direction of a licensed addictions counselor II, a person licensed to practice medicine and surgery, or a person licensed by the board and whose licensure allows for the diagnosis and treatment of mental disorders in independent practice.

(d) "Licensed addictions counselor II" means a person who is licensed under this act and engages in the independent practice of addictions counseling for compensation including the diagnosis and treatment

Proposed Amendment
2/2/00

4-2

formation to any other person.

(f) Nothing in this section or in this act shall be construed to prohibit any licensee from testifying in court hearings concerning matters of adult abuse, adoption, child abuse, child neglect, ~~or other matters pertaining to the welfare of children or from seeking collaboration or consultation with professional colleagues or administrative superiors, or both, on behalf of the client~~ or

New Sec. 11. (a) The board shall fix by rules and regulations and shall collect the following fees:

(1) For application for licensure, not to exceed $150;

(2) for original licensure, not to exceed $175;

(3) for examination, not to exceed $275;

(4) for renewal of a license, not to exceed $175;

(5) for reinstatement of a license, not to exceed $175;

(6) for replacement of a license, not to exceed $20; and

(7) for late charges, not to exceed $5 for each 30 days of delay beyond the date the renewal application was to be made.

(b) Fees paid to the board are not refundable.

(c) The board may require that fees paid for any examination for licensure be paid directly to the examination service by the person taking the examination. If the board is unable to contract with an examination service, the board may establish an examination fee or charge the examination fee and an additional amount that would allow for the collection of the fee that is required to be deposited in the state general fund pursuant to K.S.A. 74-7506, and amendments thereto.

New Sec. 12. Proceedings under the addictions counselor licensure act shall be conducted in accordance with the Kansas administrative procedure act. Judicial review and civil enforcement of agency actions under the addictions counselor licensure act shall be in accordance with the act for judicial review and civil enforcement of agency actions.

New Sec. 13. (a) Upon application, the board may issue a temporary license as an addictions counselor technician, addictions counselor I or addictions counselor II after the application has been reviewed and approved by the board and the applicant has paid the appropriate fee set by the board pursuant to section 11, and amendments thereto, for issuance of new licenses.

(b) A temporary license issued by the board shall expire at such time as final action on the application is completed or 12 months after the date of issuance of the temporary license.

(c) No person may work under a temporary license except under the supervision of a licensed addictions counselor II, a person licensed by the behavioral sciences regulatory board authorized to diagnose and treat mental disorders in independent practice or a person licensed to practice

March 2, 2000

TESTIMONY
In Support of SB 398

TO: Senate Public Health and Welfare Committee
Sandy Praeger, Chairperson

FROM: Ronald Eisenbarth, Legislative Chairperson
Kansas Alcoholism and Drug Addiction Counselors Association (KADACA)

I want to thank you for the opportunity to appear before you today in support of licensure of alcoholism and drug addiction counselors as proposed in SB 398.

I am presenting this testimony on behalf of KADACA, an association of approximately 500 certified addiction counselors. In 1999, KADACA celebrated it's 25th anniversary as a statewide alcoholism and drug addiction counselor association. As a founding member, I have been involved in counselor credentialing with KADACA since 1976 when the association established a counselor certification testing process which still exists today. Since 1980, the KADACA credentialing process has been affiliated with the National Association of Alcohol and Drug Abuse Counselors and when the national test was implemented in 1990, KADACA began utilizing this test and continues to do so today. Through utilization of the national association's test, KADACA certified members are also eligible for national certification.

As the fledgling field of alcohol and drug addiction counseling developed and continued to grow in the 1970s and 80s, the need of a state approved credentialing process was becoming more apparent as insurance companies were beginning to recognize addiction as an illness, which the American Medical Association (AMA) and the World Health Organization (WHO) had done in the 1950s. As a result, some insurance companies were requiring state-approved credentialing of counselors providing services.

KADACA approached several legislators to seek support for a state-approved credentialing process. We were encouraged to seek approval for this by making a request to the Department of Health and Environment to go through the credentialing review. We completed the Department of Health and Environment credentialing review in 1991 and were approved to develop a legislative proposal for registration of alcohol/drug counselors to be under the jurisdiction of the Behavioral Sciences Regulatory Board (BSRB). This proposal was developed and the Registration Bill was introduced in the 1992 session of the Kansas Legislature. During the legislative process, language was also added to the bill which mandated that the Department of

Social and Rehabilitation Services (SRS) develop minimum qualifications (standards) for counselors working in state-licensed facilities as certified alcohol and drug abuse counselors. This legislation, SB 458, was passed into law and became effective January 1, 1993.

Since that time, (7 years), there have been three credentialing processes available and in place for alcohol/drug counselors. Two of these credentials, ADAS, now SATR since May 1999 (see Attachment 1A) and the registration credential are provided by state law. One of these credentials (SATR) is mandatory for counselors working in state-licensed facilities as alcohol/drug counselors, while the other BSRB registration is a voluntary process. Neither of these credentials offer a career ladder. The third credential is the KADACA certification process (Attachment 1B). This process is not formally recognized by the state, although several programs prefer or require KADACA certification for their counselors. The KADACA process does offer a career ladder for counselors as well as a credential that is recognized by the National Association of Alcohol and Drug Abuse Counselors.

In Review:

SATR (formerly ADAS) Credential - This credential is mandatory for counselors working in state licensed or certified programs. These represent the vast majority (probably 95%) of the working alcohol/drug addiction counselors in Kansas. These are minimum standards and as required by law had to be less than requirements for BSRB registration. Through July 1, 1999, there are approximately 1,500 counselors in the SATR process of which 1,285 are credentialed counselors and the remaining are classified as trainees.

BSRB - Registration - This voluntary process was established by law in 1992. Currently, approximately 100 counselors are registered by BSRB. This number has been fairly consistent since 1996.

KADACA - This peer group certification is a voluntary process and is not currently officially recognized by the state. This certification process includes both written tests as well as a case presentation process and review has been in place since 1976. The process has been updated periodically to maintain state-of-the-art credentials which comply with national standards. Unlike the two previously mentioned credentials, the KADACA process offers a career ladder with three levels of counselor certirfication.

Through January 1, 2000, the following figures are counselors certified by KADACA.

CADC I	-	200
CADC II	-	176
CADC III	-	113
TOTAL	-	489

The inconsistencies in these three separate credentialing processes are obvious.

These inconsistencies are why we approached the Legislative Task Force on Providers of Mental Health Services in 1998. In hopes of establishing a process that could be recognized by the state, insurance companies and reciprocity organizations, KADACA was invited to present a proposal to this Task Torce and as a result alcohol/drug counselor licensure was approved as a formal agenda item by this Task Force for 1999.

KADACA appeared before the Task Force at a formal hearing in July 1999 to present a history of alcohol/drug programs and counselor credentialing in Kansas (Exhibit 1) and to present a licensure concept for addiction counselors in Kansas. Concerns were presented and questions arose from that hearing. KADACA representatives met with SATR staff and representatives to address those concerns and presented a draft licensure plan to the Task Force at its September meeting. Further revisions were made after that meeting and we appeared again at the November meeting of the Task Force. At that time leadership of the Task Force asked Dr. Dan Lord, a member of the Task Force and a Licensed Marriage and Family Therapist, to work with KADACA representatives to help ensure that language in the KADACA proposal is compatible with other disciplines licensed by BSRB. This was accomplished and on December 10, 1999, we presented our final draft to the Task Force. After examination and deliberation the Task Force voted in favor of submission of the Alcohol/Drug Counselor proposal to the 2000 session of the Kansas Legislature.

The proposal contained in SB 398 provides for combining of the above-addressed credentialing processes that will provide both practice and title protection and as a result provide protection to the consumer of counseling services in Kansas. Craig Collins, KADACA Executive Director will now provide a brief overview of benefits of the licensure proposal contained in SB 398.

DATE: July 9, 1999

TO: Chairwoman and Members
of the Task Force on Providers of Mental Health Services

FROM: Ronald Eisenbarth, Legislative Chair, Kansas Alcoholism and Drug Addiction Counselors Association (KADACA)

SUBJECT: History of Alcohol and Drug Programs and
Counselor Credentialing in Kansas

I want to thank you for this opportunity to provide you with a brief history of drug and alcohol programs and counselor credentialing in Kansas. I feel very close to this topic since I have effectively been involved in the alcohol and drug treatment field in Kansas since the late 1960s. I am also a founding member of KADACA, which celebrates its 25th anniversary this year.

Prior to the late 1960s, treatment efforts in Kansas for alcoholics or persons who abused alcohol were largely confined to state mental institutions where the accepted practice was to admit and house them in psychiatric wards. They were usually labeled with some form of mental disorder. In this era, alcoholism on its own was rarely a diagnosis, even though a decade earlier, in the 1950s, the American Medical Association and the World Health Organization had already identified and classified alcoholism as a disease.

Alcoholics treated in the mental health institutions rarely received any type of treatment that is utilized today. Those efforts were generally ineffective. One notable exception was a separate unit to treat alcoholics at the VA Hospital in Topeka that began in the late 1940s. Even this program utilized mostly psychiatric treatment instead of the 12-step philosphies that are prevalent in alcohol/drug treatment today. In cases where recovery was initiated, it was often due to a physician, nurse or a mental health professional knowing and contacting a person in Alcoholics Anonymous (AA) and getting that person to guide the client into the AA program.

Unfortunately, most alcoholics entering treatment in the 1960s were chronically addicted, 40 or older, male, and often in poor to very poor health. Most needed intensive medical treatment as well as strong affiliation with self-help groups like AA.

In the late 1960s, the State of Kansas appointed a committee on alcoholism comprised mainly of alcoholics in recovery and medical professionals who had become interested in alcoholism as a medically treatable illness. This committee made little progress because it had little direction and

practically no funding. The State Division of Institutional Management did have a designated staff person whose title was Consultant on Alcoholism, however, the consultant's role was primarily directed toward the state's mental hospitals.

In 1967, a group of concerned citizens led by Dr. William Leipold, a psychologist, founded Valley Hope, a treatment center for alcoholics, in Norton in northwest Kansas. This program adopted much of the Minnesota Model from Hazelden, a world-renowned, Minnesota-based addiction treatment and research organization, which addressed alcoholism as an identifiable disease and utilized the 12-step model of recovery. Valley Hope was the first program in Kansas to identify alcoholism as a family disease and provided treatment for the family members as well as the alcoholic.

Monumental changes took place nationally when Congress passed the Alcoholism Intoxication and Treatment Act of 1970. This bill was designed and authored by Sen. Harold Hughes of Iowa, himself a recovering alcoholic. It brought sweeping changes in the philosophy, treatment and funding for alcohol abuse and alcoholism. With the passage of the Act, funding became available to develop statewide programs with initiation and development grants awarded to states to assist in establishing regional programs to identify and provide treatment for alcoholics.

As programs were developing in Kansas due to this new funding, the service base also increased, making it necessary to increase professional staffs to work with alcoholic clients. National data indicated eastern and western states as well as Canada and Minnesota were employing persons, most of whom were recovering, and giving them job titles of "alcoholism counselor." By this time, week-long summer schools on alcoholism had begun at the University of Nebraska and Utah. Some other states were also developing similarly focused training programs, including Kansas where agencies used these educational offerings to provide training for their counselors. The state hospitals were used in some cases as training sites for newly employed counselors. Valley Hope Center began offering a six-month counselor training program which was utilized by other agencies in the early 1970s.

By 1974, there were several counselors employed by various agencies and programs that had opened after 1970. St Francis Hospital in Topeka started the first hospital detoxification program in Kansas in 1971 and Valley Hope began it's Atchison program in 1972. St. John's Hospital in Salina and Menninger in Topeka both started 30-day, inpatient programs in 1974.

Meanwhile, information was being received from Washington, D.C., that groups of counselors were forming in several states to form counselor associations. In April 1974, an exploratory movement toward an association was started in Kansas when a group of 20 counselors from Atchison and Topeka met to discuss possible benefits of having a state counselor organization.

This discussion resulted in a follow-up meeting in July at which 45 persons enthusiastically endorsed the forming of a state counselor association. The formal organizational meeting was held in September at which time the Kansas Alcoholism Counselors Association (KACA) came into being..

After two years of extensive work, education and investigation of other state associations, KACA established a counselor certification testing process. In 1976, a grandparenting process was initiated and the test was given to about 140 persons who had joined KACA by that time and had met some experiential requirements.

It was also at this time that KACA had joined with several states to form The National Association of Alcoholism Counselors, and in 1976 KACA hosted the first national membership meeting in Topeka. Sen. Hughes from Iowa was the keynote speaker.

KACA, striving to improve it's certification process, initiated an oral test which included presenting a case to a panel of peers. Passage of the written test, the oral test and documentation of three years of experience were required for counselor certification. Counselors-in-training and others with some experience in the field were brought into the association as associate members. That same year the state of Kansas, which by now had developed separately both alcohol and drug abuse units, began working with programs to develop program standards. Prior to this, there were no criteria for programs and anyone that wanted could basically offer services. Some services for drug abusers were being offered around the state so separate standards were developed for drug abuse. It should be noted that in the late 1970's, alcoholism and drug abuse were seen as two completely unrelated conditions. Terms such as chemical dependency and substance abuse, which are common today, were seldom used then. By 1978, the standards were adopted and programs had to be licensed in order to provide services. To be licensed, a program had to meet a host of specific criteria. Even though counselor was referred to throughout the standards, the only specifics for an alcoholism counselor were those of KACA, which was an association credential and not officially recognized.

By 1980, the National Association was very involved with counselor credentialing. KACA worked with the National Association and other states within NAAC to make certain the KACA certification process remained state-of-the-art. That continued to be a priority of KACA, and through the years KACA and later KADACA has been viewed nationally as a leader in the area of counselor credentialing, as well as several other alcohol/drug issues which have a national focus.

In the late 1970s, a group of drug abuse counselors formed in Kansas, and although much smaller than KACA, this association began to try to develop some of the same services for its members. By 1979, patient/client profiles in both the alcoholism and drug abuse fields were beginning to

indicate that many persons were addicted to both alcohol and other drugs. In 1980, the State of Kansas combined alcohol and drug abuse units and encouraged programs and counselors to both work toward doing the same. By this time NAAC was also considering adding drug abuse to it's scope of responsibility. After many lengthy debates, NAAC changed it's name to National Association of Alcoholism and Drug Abuse Counselors (NAADAC).

At it's annual meeting in 1981, Kansas alcoholism counselors were beginning to talk about a merger with drug counselors. There was much resistance to this on both sides. However, with client profiles showing clients were often the same—with the basic difference in many cases being simply whether alcohol or another drug was the drug of choice for the client. Counselors began to work together and after two years of work and discussion the Kansas Alcoholism and Drug Addiction Counselors Association was formed in 1984. At the time of the merger, the combined membership totaled approximately 300 certified alcohol and drug counselors.

A small group of midwestern states in the early 1980s developed reciprocity standards so counselors could transfer certification from one state to another. This concept grew as counselor mobility throughout the states became an important issue in credentialing. KADACA in 1985 became one of the first states to join this consortium that came to be known as the National Corsortium for Reciprocity of Counselors (NCRC but now the International Consortium for Reciprocity of Counselors (ICRC). NAADAC in late 1989 had developed a similiar reciprocity process and in 1990 KADACA did a thorough investigation of both national groups to see to see which would best serve our membership. After much study of these two processes, KADACA, on a vote of its membership, changed its affiliation to NAADAC because it was felt that it was the strongest of the two. This was in 1990, and KADACA has maintained its reciprocity affiliation with NAADAC since that time. It should be noted that the two national groups have been involved in merger discussions for several years. It has appeared on at least two occasions that merger of the two national organizations would take place, but each time the attempts failed. It seems that both groups want the upper hand and are unwilling to compromise when the decision has to be made as to who will be responsible for reciprocity. Kansas again has to evaluate its position as more of our neighboring states are now affiliated with ICRC (new name) than NAADAC. This issue certainly needs to be put to rest at the national level permanently as there will be no true reciprocity among states until there is one recognizable system throughout the U.S.

In the mid 1980s, KADACA began talking with legislators as well as key SRS officials, primarily the ADAS commissioners of that era, regarding licensure. KADACA had long been aware that unless its certification process was formally recognized by the State it would never receive widespread recognition by insurance companies. By 1990, we had support both from key legislators and the ADAS Commissioner to develop a credentialing law. We also learned in our correspondence with NAADAC that the trend in 1990 (which continues even stronger today) is that

licensure is the credential of the future. KADACA then began formulating a licensure plan and began work with two key legislators and legislative staff to move licensure forward. We also met with the director of the Behavioral Sciences Regulatory Board (BSRB) who indicated this credentialing process would be administered by BSRB if passed into law. The BSRB director also indicated that since our plan did not include a masters level criteria it would not qualify for licensure and we would have to settle for registration. After much discussion with our sponsoring legislators, members and other supporters, KADACA decided to draft legislation which was introduced in the 1992 session of the legislature. The bill was amended several times during the legislative process and when it finally passed near the end of the 1992 session it was our current registration law which went into effect January 1, 1993.

The bill which was passed and became law also included provision that gave SRS/ADAS the authority to develop standards for personnel working in licensed alcohol/drug programs, so long as those standards (see attachment A) are less than those required for registration. ADAS developed those standards which are now in place and serve primarily as required standards persons need to meet to work in the alcohol/drug field and enter the alcohol/drug counseling profession. KADACA supported this legislation in its passage, even though it was not the licensing law which we felt was needed. Our legislative sponsors advised we support this measure as a means of getting a credentialing law, with the prospect of applying for licensure at a later date.

This is why KADACA appears before this task force today. Six and a half years after implementation of this legislation, we have three different alcohol/drug counseling credentials available to counselors. Two of these credentials, ADAS (now SATR) and the registration credential are provided by state law. However, one of these credentials (SATR) is mandatory for a counselor working in a licensed alcohol/drug program, while the other (registration) is a voluntary process. Neither of these credentials offers a career ladder. The third credential available is the KADACA certification process. This process is not formally recognized by the State, although (attachment B) several programs prefer or require KADACA certification for their counselors. The KADACA process offers a career ladder for counselors. The inconsistencies, however, in these credentials is obvious. We need one licensing standard in Kansas for alcohol/drug counselors which provides for entry level, clear criteria for advancement and a recognizable career ladder to serve as an incentive for persons to move upward.

Later today Craig Collins, KADACA executive director, will present testimony on a counselor licensing concept that is currently being developed. I again want to thank you for the opportunity to provide you with a history of substance abuse treatment development in Kansas. For much of my adult life it has been my privilege to be a part of the profession and, I hope, in some small way have helped further its development.

TOWARD A DRUG-FREE KANSAS

SRS/ALCOHOL AND DRUG ABUSE SERVICES CERTIFICATION OF COUNSELORS

On January 1, 1993, the Secretary of the Kansas Department of Social and Rehabilitation Services was directed by the passage of SB 458 to adopt rules and regulations and standards for counselors working in licensed and certified alcohol and drug abuse treatment facilities. The requirements for counselors are listed below.

Individuals can be "grandparented" as a certified alcohol and drug abuse counselor if they can provide documentation of either #1 or #2:

1. Documentation of 1000 hours of alcohol and drug abuse counseling experience two years prior to January 1, 1993.
2. Documentation of 3000 hours of alcohol and drug abuse counseling experience 10 years prior to January 1, 1993.

If an individual cannot meet the requirements to be "grandparented" as a certified alcohol and drug abuse counselor, the individual must complete 18 hours of culturally appropriate post-secondary academic credit. The 18 college credit hours must be alcohol and drug abuse specific. Listed below are the areas that must be completed:

1. Screening and intake
2. Orientation and assessment
3. Treatment planning and counseling
4. Case management and crisis intervention
5. Education and referral
6. Reports and recordkeeping and consultation with other professionals
7. Multi-cultural and individual differences
8. Individual and professional ethics
9. Medical aspects and health related issues of alcohol and drug abuse, including emphasis on Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STD'S)

Counselors-in-Training must complete the 18 college credit hours within a three-year period beginng January 1, 1993, or, within a three-year period after the individual was hired by the program.

CONTINUING EDUCATION HOURS

The licensure/certification standards require alcohol and drug abuse programs to document the completion of 60 hours of continuing education activities for alcohol and drug abuse counselors every two years. The 60 continuing education hours should be acquired from activities which enhances the skills of the alcohol and drug abuse counselor. The documentation of the 60 hours of continuing education activities for alcohol and drug abuse counselors shall be kept in the program's personnel files. Programs will need to submit to ADAS a list of continuing education hours obtained by each counselor for the purpose of recertification.

Counselors-in-Training are not required to obtain the 60 hours of continuing education units.

GUIDELINES FOR LEVELS OF KADACA MEMBERSHIP

GENERAL MEMBERSHIP - Is non-voting and includes nurses, doctors, agencies, court service workers, etc.
STUDENT MEMBER: Is non-voting in KADACA but is a voting member in NAADAC. Includes counselors-in-training (ADAS applicants in training, i.e., completing the 18 required college hours), must be full-time student working toward a degree in an addictions related field.
PRECERTIFIED COUNSELOR: Is non-voting in KADACA but is a voting membership in NAADAC. Must be employed in the alcohol/drug field in a counselor-in-training capacity. Must also be working toward certification.

Benefits from these categories include membership in the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) the *Counselor* publication from NAADAC and the *KADACA Newsletter*, KADACA membership directory, and workshop fees at member or student rate. Annual dues are one-half of certified membership dues.

CADC I - Applicants must meet the following criteria:

1. Documentation of High School diploma or GED.
2. Successful completion of ADAS standards for employment:
   A. 18 hours of culturally appropriate post-secondary academic credit in the area of alcoholism/drug addiction counseling; and
   B. Ongoing documentation of 60 clock hours every two years of approved education.
3. Pass a KADACA-approved written examination.

CADC II - Counselor must meet the following requirements for one of two tracks:

1. Successful completion of CADC I requirements;
2. Passage of KADACA-approved ORAL test;
3. Have three years of paid, supervised work experience in a recognized substance abuse treatment and rehabilitation program with job duties assisting clients in the recovery process; and
4. Have attained a minumum of 270 CEUs of counselor education appropriate to the A/D treatment field.

OR....

1. Hold a bachelor's degree in a health related field, which includes 18 credit hours of alcoholism/drug addiction counseling;
2. Passage of KADACA-approved oral and written testing; and
3. Documentation of 500 hours of practicum in a recognized A/D facility.

CADC III - Counselors must:

1. Be either a Registered Alcohol and Other Drug Abuse Counselor (RAODAC) or eligible for registration with Behavioral Sciences Regulatory Board (BSRB);
2. Successful completion of KADACA-approved written test;
3. Documentation of 500 hours of practicum; and
4. Have five (5) years of employment in the A/D field; and
5. Hold a bachelor's degree in a health-related field, including 18 hours of A/D addiction studies.

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RETIRED MEMBER - A certified counselor who is no longer employed in the alcohol/drug field, has submitted a formal letter of request for retired status. Retired members attend KADACA workshops at no charge.

INACTIVE MEMBER - A certified counselor who is not currently working as a counselor and has submitted a formal letter of request for inactive status. Educational requirements are 60 CEUs every two years.

Benefits for both Retired/inactive members are a voting status, reduced dues, *Counselor* magazine, *KADACA Newsletter*, KADACA directory. An official letter of request is required to reactivate.

OTHER PROVISIONS - Any administrator/teacher/trainer is eligible to maintain their level of certification provided they meet the criteria of that level. Otherwises, such persons will be returned to general membership status. Anyone who has reverted to general membership status will be required to meet the criteria for their prior level in order to regain that status. As an example, a counselor serving in an administratve capacity may have failed to keep the continuing education requirements current for his or her level of certification and was placed in the general membership category for that omission. This provides a means for the counsleor to regain his certification level, using procedures for CEU catch-up previously approved the KADACA board.

MAINTAINING CERTIFICATION:

1. Payment of annual dues
2. Documentation of 60 hrs of ongoing continuing education every two years (same recertification cycle as ADAS).

TESTING FEES:

1. Written test - $75, Administrative fee - $25; total - $100
2. Re-test written - $75
3. Oral Test - $60

TESTIMONY FOR SB 398
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
Submitted by Craig Collins, J.D.
KADACA Executive Director
Thursday, March 2, 2000

TO: Chairperson Praeger and Committee members

Thank you for this opportunity to appear and present testimony on behalf of SB 398, the Addiction Counselor Licensure Act. My name is Craig Collins and am the Executive Director for the Kansas Alcoholism and Drug Addiction Counselors Association (KADACA). KADACA is a statewide association with approximately 500 members who are alcohol and drug addiction counselors or have strong interest in the alcohol and drug field. KADACA also provides services to non-member counselors by way of workshops, newsletters and other informational mailings.

The background of the licensure bill will be presented by Ron Eisenbarth, Chair, KADACA's Legislative Committee, so my presentation will focus on the key benefits of the SB 398. A proposed bill must meet the public need, which this bill fully does.

Do to the brevity of time today, my testimony will be succinctly presented. Additional information may be submitted subsequently for clarification or supplementation.

The following are key points for consideration of SB 398:

1. **UNIFORM STANDARDS:** Creates uniform standards for qualifications for those performing alcohol and drug counseling to Kansans. Currently, standards for various credentials are diverse.

2. **ACCOUNTABILITY:** Allows for a mechanism to hold individuals accountable for those performing alcohol and drug counseling to Kansans. Since there is not licensure at the present time, there is no manner by which the state can enforce action in situations of malpractice or to prohibit the counselor from continuing to practice.

3. **PROTECTS PUBLIC:** Protects Kansans by providing assurances that licensed addiction counselors have met qualifications to possess a level of competence not presently available in Kansas. As with licensing of all professions by the state, the public will know that a licensed addictions counselor has met certain standards. It is only through licensure of addiction counselors can standards be established as to professional competency.

4. **RECOGNIZABLE STANDARDS:** Would allow various Kansas agencies and departments, such as Department of Corrections and Social and Rehabilitation Services, to have a recognizable license for use in providing services.

5. **DUI STATUTES:** Would allow existing statutes to be amended to fulfill the Legislature's intent in the area of DUI, specifically, K.S.A. 8-1567 and 8-1008. This important area is without guidance for the sentencing judge as to competency of those performing evaluation and providing treatment which are mandatory requirements.

6. **PRIVILEGE:** Would create the protection, for individuals in addiction counseling, of privilege verse mere confidentiality which is currently in effect from disclosing information obtained during the counseling process subject to certain limitations. SRS currently requires questionnaires to be completed by individuals receiving state funds for counseling which in many situations would violate constitutionally protected 5th Amendment rights.

Due to the enormous impact of alcohol and drug abuse to the Kansas economy and to Kansans individually, licensure for addiction counselors is necessary. KADACA has worked very closely with other stakeholders in the development of SB 398. We seek your support of this very needed legislation.

Kansas would be well served with the passage of SB 398. I stand for any questions.

TESTIMONY FOR SB 398
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
Submitted by Daniel Lord, Ph.D.
March 2, 2000

Senator Praeger and Members of the Committee,

Thank you for considering my testimony today on behalf of SB 398, the Licensed Addictions Counselor Act. I am Dr. Dan Lord and I have been involved with this proposed legislation in two roles. Since July 1996, I have served as the Marriage and Family Therapy Representative on the Behavioral Sciences Regulatory Board. In this role, I have had opportunity to observe the workings of Kansas' present credentialing act for addictions counselors, the Registered Alcohol and Other Drug Abuse Counselors act, known as RAODAC. Secondly, I served on the Mental Health Service Providers Task Force for the past two years, chaired by your former colleague Phyllis Gilmore, which drafted and recommended this act for your consideration. In my daily life, I am the director of the Marriage and Family Therapy graduate program at Friends University.

In the short amount of time you have today, I want to present what I see to be the compelling reasons for your serious consideration of SB 398.

- ***Increasing prominence of addictions treatment.*** At all levels of government—local, state, and federal—the struggle against substance abuse continues to be a high priority. Funds for education, research, and treatment amount to a major social investment to alleviate the human and financial costs of addictions.
- ***Large numbers of treatment providers.*** In Kansas, over 1600 individuals are credentialed as substance abuse counselors and reimbursed through both government and private medical programs for substance abuse treatment services. Approximately 1500 of these persons are certified by Kansas SRS, while about 100 are registered as RAODACs through the BSRB.
- ***Ineffectiveness of the Legislature's 1992 RAODAC act.*** Following completion of the credentialing process for addiction counselors in 1992, the Legislature opted for a volunteer registration act rather than a licensure act. As a volunteer credential, only a few substance abuse treatment providers have chosen to meet the minimum standards then established for the sake of public protection. Instead, most have opted to meet the much weaker requirements set by SRS for reimbursement as a certified substance abuse counselor.
- ***Present SRS certification as de facto licensure.*** Reimbursement of substance abuse treatment services is tied to SRS certification, making these standards Kansas' de facto licensure credential. As such, they now represent the lowest educational standard of any treatment provider so broadly recognized for professional services of such a major treatment population and need.
- ***Timeliness for revision of addictions counseling credential.*** The education and training standards of the RAODAC act are essentially a decade old. Even the construction of the act itself contains numerous implementation problems. SB 398 revises the 1992 RAODAC act with a structure consistent with the licensing acts of other professions regulated by the BSRB. More importantly, it incorporates the emerging educational standards identified at a national level (Center on Substance Abuse Treatment, 1998).

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- ***A workable framework for a diverse profession.*** Along with progressive education and training standards, SB 398 is designed to accommodate the importance of persons with various educational levels serving as substance abuse treatment providers. The three levels of licensure in this act begin with the current minimum standards of the Kansas SRS certification, and progress through a workable framework of increased competence and scope of practice in first a bachelors prepared level and then a masters prepared licensure category.

The issue of addictions counselor regulation received a great deal of attention and effort by the Mental Health Service Providers Task Force in its second and final year of work in 1999. Within this effort, significant input was received from SRS personnel, from the Kansas Alcohol and Drug Abuse Counselors Association, and from the Kansas Association of Community Mental Health Centers. Additionally, the concepts of the bill were reviewed by BSRB members during the Task Force's deliberations, allowing for input addressing weaknesses of the present RAODAC act. These elements combined to create a most unique and effective context for drafting regulatory legislation. As legislators, you can be assured that this act was drafted with the best interests of the Kansas citizenry clearly in mind, and not the self-interests of a single professional group.

Because of these matters, I believe that SB 398 represents a very positive improvement in the regulation of substance abuse treatment providers in Kansas. I urge you to give it your careful attention this legislative session. Thank you for receiving my testimony. Please know that I will be glad to appear before you in person if you would like further discussion or clarification of what I have offered.

TESTIMONY

To the
Senate Public Health and Welfare Committee

By
Harold D. Price, LMSW CADC II
Director of Program Services
Family Life Center
Columbus, Kansas

March 1 2000

Introduction:

Kansas, like many other states, is faced with an epidemic of alcohol and other drug addictions. The majority of health and human service providers that must treat the multiple problems associated with this plague are under educated, under trained and under credentialed to do the job. The Kansas Legislature can do a great deal to correct this deficit. It can approve a measure that will set the stage and initiate the action that will motivate educators and providers to improve their knowledge and ability to treat addictions. That measure is the addiction counselors licensing bill in front of you today.

Scope of Addiction Disorders

The number of people negatively effected by addiction is probably larger than those hurt by all of the other mental and emotional disorders put together. Substance related disorders comprise the largest diagnostic category in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. The DSM IV describes some 125 substance related disorders in just under 98 pages. Substance related disorders frequently coexist with the other 15 diagnostic categories in the DSM IV. Addiction exacerbates the symptoms of mental and emotional disorders and presents serious barriers to recovery. The number and type of substances that people become addicted to are increasing exponentially. Addiction is synonymous with high-risk behavior. Addiction is a major contributor to school and job failure, family breakdown, domestic violence, child neglect and abuse, crime and other debilitating physical and mental disorders. A primary predictor for mental, emotional social and legal problems of children and adolescence is the existence of addiction in the family. Addiction is the equal opportunity disorder. It effects people without regard to age, race, gender, education, sexual preference, socioeconomic status or religious affiliation. Treatment resources are identifying addicted persons who are not yet in their teens. Our elderly represent one of the fastest growing addicted populations.

Scope of Providers:

Because of the scope of addictions and the absence of practice regulation representatives of every human service delivery group are treating addictions, with huge variance in competence, qualification and consequence. Elementary, secondary and college educators deal with addiction and/or its effects daily. School counselors are expected to work with addicted children and parents. Ministers, family physicians, nurses, emergency personnel, human relations specialists and employers are engaging in alcohol and drug counseling. Law enforcement officers, correctional employees, court services, CASA, attorneys, judges and probation and parole

officers are counseling people with alcohol and other drug problems. SRS and private foster care providers are often confounded by work demands related to addiction. Mental health centers, often seen as the lead agencies for addiction expertise and service have psychiatrists, psychologists, social workers and counselors confronting addictions with little or no training and supervision designed to established qualifications or competency in the field.

Current State of Kansas Credentialing:

Currently physicians can voluntarily seek addictions practice specialty through the American Society of Addiction Medicine. The American Psychiatric Association recognizes addictions as a subspecialty and allows its members to voluntarily demonstrate proficiency through a national examination and experience in the field in order to present themselves as Addictionologists. Members of the American Psychological Association may voluntarily acquire a specialty in addictions if 5 out of the last 7 years of their practice have been in addiction counseling and they have passed a national examination. The National Association of Social Workers has a current proposal to provide voluntary certification in an addiction specialty.

SRS funded agencies who treat addictions are required to have addiction counseling employees who have a high school degree, are in the process of acquiring 18 college hours in addiction counseling and are being supervised by a person who has already been credentialed by SRS. The Behavioral Science Regulatory Board provides voluntary registration for alcohol and other drug abuse counselors. The Kansas Alcoholism and Drug Addiction Counselors Association provides for voluntary certification. **Currently there is no means for requiring competency for counselors of individuals with alcohol and other drug disorders. Kansas has no means for protecting the victims of addiction, including the addict's parents, spouses and children, from incompetent and unethical providers.**

Scope of Education:

In a July 1997 national addiction counselor competency survey report to the Substance Abuse and Mental Health Services Administration the Northeast Regional Education Laboratory stated, "The study suggests that a substantial discrepancy exists between actual and needed levels of proficiency among entry level counselors on each of 121 addiction counselor competencies." The study involved a survey of addiction counselors and their supervisors in 19 states of which Kansas was one. Counselors who were judged by their supervisors as "least experienced," and those who were rated as the "most proficient" were asked to rate their needed proficiency and actual proficiency in 15 knowledge and practice areas at the time they started counseling. Their supervisors were asked to rate each of them in the same manner. The areas included *understanding addiction, treatment knowledge, clinical evaluation, treatment planning, implementing the treatment plan, consulting, continuing assessment and treatment, planning, individual counseling, group counseling, counseling with families, couples and intimate dyads, client, family and community education, and professional and ethical responsibilities. Kansas* counselors and supervisors who responded to this survey indicated a job entry level difference between actual proficiency and needed proficiency that ranged from 44% (treatment planning) to 55 % (professional readiness). A summary of the study states, "Although non-supervisory counselors provided higher ratings of actual proficiency, (than supervisors) all three groups displayed large discrepancies between actual and needed competency levels. If that is the case, then considerable need exists for collaboration between faculty who prepare entry-level counselors and treatment supervisors who review their work on the job." **Anecdotal and actual data suggests that our addiction counselors are not being well prepared to enter the field."**

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Summary

- **Addiction is the most pervasive and damaging disorder Kansas must address today.**
- It, more than any other disease effects every aspect of the lives of citizens, from health to safety to economic security.
- **Health and human service providers generally admit they are under educated, under trained and under regulated in the treatment of addictions.**
- Kansas does not require the same level of expertise of addiction counselors that it does of all of the other counseling professions.
- **Kansas has no means of protecting individuals, families, employers and communities from incompetent and unethical addiction counseling providers.**
- Currently our colleges and universities are not motivated to improve addiction treatment education to health and human service providers.
- **Setting standards and regulating practice through the licensure of addiction counselors is the most effective and efficient means of improving the prevention, early intervention and remediation of addiction.**
- Licensing will not only improve the education and competence of alcohol and other drug counselors it will help bring insurance and managed care money for treatment into the state.
- **Licensing will also increase Kansas' competitiveness for federal prevention and treatment funds.**
- Licensing from the consumer's view is a no-lose proposition.
- **From the providers view whatever minor inconvenience it may cause will be offset by improvement in effectiveness and efficiency, improved clinical outcomes and reduction in legal liability.**

Please commit yourself to successful implementation of Addiction Counselor Licensing today.

Harold D. Price is a 53-year-old licensed social worker and certified addictions counselor with 27 years in the community mental health field. He has treated hundreds of mentally, emotionally and addiction disordered clients and hired trained and supervised hundreds of psychologists, social workers, nurses and counselors in three states. He is the Director of Program Services for the Family Life Center, 201 West Walnut, Columbus Kansas, 66725. (316) 429 1860

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