Letters from Your Leadership

BY JOHN-MIKE NELSON - President - president@nvlpc.org

Dear NVLPC Members,

NVLPC needs your help! As an organization, we are only as strong as our membership. Leadership is still looking for volunteers to join the team and help continue the successful growth of NVLPC. Some of the benefits of volunteering are:

- Networking
- Free training opportunities
- Influencing positive change throughout NVLPC
- Leadership experience in one of the largest counseling organizations in Virginia

NVLPC needs volunteers for events! We are in need of a Events Director and East/West events chairs. You can make a difference in NVLPC! Let us know you’re interested by emailing me at President@NVLPC.org.

We are also planning for the 2015-2016 year and are looking for feedback from our members. Just as your clients need feedback for growth opportunities, so does NVLPC! Have thoughts about event times, locations, topics, anything? Make sure your voice is heard and fill out our anonymous and quick online survey at: https://www.surveymonkey.com/s/P8R8DVK

Speaking of presentations for the upcoming year, NVLPC is opening up a call for presentation proposals! This is an exciting opportunity to present at one of our events in your area of expertise. Look at the membership section of the newsletter for more information!

John-Mike Nelson
NVLPC President

NVLPC Has a New Telephone Number
703-400-0751

Go to www.nvlpc.org and your email for the most up-to-date information before heading to an event!
At my recent Clinical Supervision Training a question was raised asking about the stages of development in a Supervisor. Typically, supervision training concentrates on the stages of counselor/supervisee development and the Supervisor’s role in relation to those counselor stages. So the question prompted a good discussion leading to the following suggestions:

**Beginning Stage**
- Possibly lacking confidence in their supervisory skills
- May be less competent specifically in terms of supervision
- May be concerned about “getting it wrong”
- May be concerned about the ability to build rapport with the supervisee
- May be more likely to act as a therapist rather than a supervisor
- May have difficulty transitioning to the role change
- May be uncomfortable in the “authority” or “expert” role
- May have difficulty balancing between administrative and clinical duties
- May rely more on supervising as they were supervised
- May lack flexibility in technique
- May have more difficulty implementing boundaries
- May concentrate more on the client (as a therapist) than on the supervisee’s development

**Intermediate Stage**
- Increased flexibility
- Increased decision making ability
- More anchored in supervision theory
- Developing a personal style of supervision
- May be more organized regarding planning for supervision
- Increasingly more mindful of process and relationship
- Reduced anxiety about “doing it wrong”
- More comfortable admitting they aren’t the expert
- Increased ability to give constructive feedback
- May be more able to embrace the “expert” role
- Increased confidence
- More likely to use mistakes made as a learning opportunity

**Experienced Stage**
- Confident in the role and able to encourage, accept, and apply feedback from the supervisee
- Knows what they don’t know
- Has developed their own personal model of supervision
- May be set in their ways and less likely to be flexible in using other models of supervision
- Can use past experience as a supervisor to bring greater depth to the supervision process
- Is comfortable in all roles as: teacher, expert, consultant
- Challenges self to keep learning
- May think the supervisee is more capable/experienced than they are
- Willing to experiment and learn from the supervisee
- Demonstrates the ability to allow the supervisee to struggle
- Feels secure in their role as a supervisor
- Feels they are ensuring there will be another generation of competent clinicians

Of course, a supervisor can exhibit any of the above at any time and may even start out as a “competent” supervisor. However, reviewing this list would be helpful for any supervisor in order to self reflect as to where they stand in their own development.
Counseling Asian Americans

BY CAROLINE STRUNK

Have you ever wondered why Asian Americans, despite being one of the largest and fastest-growing minority groups in the United States, have among the lowest rates of mental health service utilization in the country?

Partially to blame is the model minority myth, a popular stereotype that depicts Asian Americans as more academically, socially, and economically successful than other minority groups. Far from being an asset, the image of collective success perpetuated by this myth negates individual experiences and minimizes the mental health needs of Asian Americans.

However, their absence from our mental health system does not have a one-sided explanation. To a certain extent, Asian Americans choose to be invisible. They are taught to mask their discontent and endure hardships without complaint. To protect their families from shame and embarrassment. To avoid conflict and prioritize group harmony, often at great personal cost. These cultural values, along with the strong stigma associated with mental illness, discourage Asian Americans from seeking help, even when they truly need it. I know because I have seen the struggle firsthand.

My own father, a first-generation Korean immigrant riddled with deep emotional insecurities, was a moody, volatile presence in our home. One January afternoon, my mother went to see a doctor about her migraines without seeking my father's consent. When he found out, he flushed her new medication down the toilet in a fit of rage and threw her out of the house, locking the garage door behind her. After enduring his abuse and alcoholism for many years, my mother finally left him. After their divorce it was not relief and liberation that awaited her, but social isolation, vilification by her Korean colleagues, and years of financial hardship.

Her story is not unique. Asian women and children usually adopt Western values faster than men, which often causes marital and other intra-family conflicts. However, many women choose to stay in unhealthy relationships rather than face the cultural stigma of divorce. Other problems that Asian American families frequently encounter as a result of their immigration experience or perceived discrimination include depression, loneliness, anxiety, low self-esteem, and high levels of stress. The more subtle microaggressions that Asian Americans routinely experience, such as being asked, “Where are you really from?” leave them feeling like perpetual foreigners in a country they call home.

While feelings such as anger, sadness, and despair may be universal, it is clear that the resources and means we have to navigate these struggles are not. My experiences as an Asian American woman have imbued me with a heightened sense of cultural awareness and personal responsibility. I want to be the guide, the ally, and the advocate that my mother never had.

I want to adapt approaches such as group therapy, family-focused therapy, and directive, solution-oriented therapy for Asian Americans in a way that draws on the strengths of their culture instead of circumventing it. In other words, by integrating collectivist values rather than pathologizing them. By conducting outreach and interventions in a culturally sensitive manner, I believe we can change the way counseling is perceived within the Asian American community.

Counseling can be an empowering, transformative experience, but there are many who do not have the knowledge or voice to seek it. As counselors, we cannot mistake silence for peace. There is so much more to the community of “model minorities” than meets the eye, and it is critical that we bridge the gap between Asian Americans and mental healthcare, and challenge ourselves to see beyond the myth.
NVLPC Member Receives Recognition for Her Work

AMY F. PARKS, Ph-D Resident, LPC Resident-in-Counseling - Membership Chair - membership@nvlpc.org

Jan Beauregard, PhD, LPC is an addiction and trauma specialist and a long standing member of NVLPC. This spring she was chosen to receive the 2015 Caron Metro DC Award for Addiction Professional of the Year. The committee was most impressed by Jan’s integration of trauma and addiction as well as her extensive work in training other mental health professionals in topics related to chemical dependency, trauma, eating disorders, self-harm, sexual compulsivity and body based interventions to address addictive disorders more effectively.

I had the opportunity to speak with Jan about her journey as a therapist and specifically about this recent award. Jan’s prior career as a chemistry teacher led naturally into an interest in providing educational opportunities and mentoring other therapists as her career as a counselor evolved. Saddened by the recidivism rates for those suffering with addictions, she sought trauma training to help clients better cope with the pre-existing issues that predated their decent into addictive behaviors as a coping mechanism. Because so many clients have trauma histories, she believes good treatment must address both issues simultaneously for clients to be successful. Most recently her workshops have focused on integrating yoga, movement and Sensorimotor Psychotherapy™ into addiction treatment.

When asked about who most inspired her work, she reflected on her participation in a consultation group led by McLean psychiatrist Dr. Mark Lawrence from 1997 until his passing in 2011. Being in this peer group fostered her clinical skills in ego state therapy, EMDR, guided imagery and hypnosis as well as taught her how to work with highly dissociative clients. Although a great fan of Pat Ogden, Steven Porges, Bessel Van der Kolk, Stan Tatkin and Clarissa P. Estes, it was Dr. Lawrence’s kind mentoring and encouragement she will most credit with shaping her as a competent therapist.

Jan has presented many times at NVLPC as well as at the Psychotherapy Networker, ISSTD, SASH and many addiction workshops throughout the United States. In addition to directing a private practice in Fairfax and presenting at workshops nationally, Jan offers both individual and group consultation to both beginning and advanced therapists. Her recent research in the field of addiction is to look at the impact of marijuana and pornography on the teenage brain. She hopes to launch this presentation some time next fall. When she isn't working, she can be seen riding her bicycle happily on the WO&D or hiking in national parks around the country with her husband. To be a good therapist she says, “it is important to enjoy both work and play with equal vigor…..to give both your all!”

We wish Jan continued success in her chosen field and await with much anticipation the results of her latest research work on addiction and its impact on the teenage brain. If you happen to see Jan on the WO&D Trail, hiking in Shenandoah National Park, or presenting again at NVLPC, be sure to congratulate her on this latest professional achievement.
Our Students. Our Future.

BY KATRINA CLAYTON, MA - Student Development Chair - studentdevelopment@nvlpc.org

I’ve had the opportunity to talk to multiple student members at length over the last few months. They always have wonderful suggestions and enthusiasm for our organization. Most recently was at our Student Development Lunch in April. Our student members are the future of NVLPC, which is very exciting.

Students, I challenge you to get involved!

We need your energy, creativity, and enthusiasm to continue to make our organization grow and offer helpful benefits for everyone. We have numerous volunteer positions on our leadership team. (“NVLPC Leadership” on our website, www.nvlpc.org). Maybe start by being a chair of a committee or a committee member. Take a look at all the different committees and consider volunteering. Perhaps there’s something not listed, but you see a need. We are open to hearing from you. Be proactive. This is your local counseling organization and we want it to thrive!

Questions about getting involved? Contact Katrina at studentdevelopment@nvlpc.org.

Student Development Lunch at Mimi’s Café

On April 18th NVLPC had a Student Development Lunch at Mimi’s Café in Sterling. It was a wonderful opportunity for students to meet each other, share ideas about internship sites, and offer encouragement. Katrina asked the students for suggestions as she prepared for the NLVPC strategic planning meeting. Everyone gave wonderful recommendations. We value our students and their insight. Thanks to all who came out to make this a fun and productive event!

Sharon Perrine, Katrina Clayton, Rebecca Hogg and Jamilah Abdul-Wahab
Introduction to Emotionally Focused Therapy for Couples

2 Credit Hours

Who: Robin Cohen, LCSW and LuAnn Oliver, LCSW

When: Friday, May 15, 2015, 9:15 am - 11:30 am

Registration: 9:00 am

Early Registration Cost (on or before May 10, 2015):
$30 - Members, Clinical and General Members
$25 - Members, Residents, Students, and Retired
$50 - Non-Members

Regular Registration Cost (after May 10, 2015):
$40 - Members, Clinical and General Members
$35 - Members, Residents, Students, and Retired
$60 - Non-Members

Where: 1757 Golf Club, 45120 Waxpool Road, Dulles, VA 20166

RSVP: Register online at any time.

Walk-in registrations will also be accepted on the day of the event starting at 8:30 AM.

For additional information contact Tamara Sheridan at eventswest@nvlpc.org.

To cancel, call or email 24 hours in advance or you will be charged. If NVLPC cancels an event, you will be refunded the cost of the event.

About the Event:

Therapist: So what brings you to couples therapy?

Sue: We can't communicate. I feel like we've become roommates. Bill travels for work so most of the household and children responsibilities fall on my shoulders. When he is home, I feel like he's pre-occupied with other things - his work, the kids, the gym. I'm last. I feel taken for granted.

Bill: I work hard so we can have a comfortable lifestyle. I don't think that she appreciates how hard I work. She has it good. We have a nice house and two healthy kids. I just hear complaints. It's never enough.

Welcome to the world of a couple's therapist. How often have we heard this? Where does the therapist start? What is your plan to help this couple? Do you focus on the pattern of communication between the couple, the underlying emotions, or both? Which comes first? How does the therapist begin to unravel key emotions that fuel couples communication patterns? How does the therapist help each partner to “reach” for his/her needs and longings in the relationship? These are some of the questions that will be addressed in this workshop.

Emotionally Focused Therapy for Couples (EFT) provides the therapist with a clear blueprint of how to do couples therapy. What separates EFT form other models is its focus on the emotions that relate to each partner's attachment needs. This workshop will provide a general overview of EFT. It will include a description of attachment theory as it relates to adult love relationships, an outline of the stages of EFT, and a description and video example of some of the interventions.

As Yogi Berra once said, “If you don't know where you are going, you'll wind up somewhere else.” Join this workshop and become clear “where you are going” with your couples.

Earn 2 Contact Hours for attending this event

About the Presenter(s): Robin Cohen is a Licensed Clinical Social Worker who is certified in Emotionally Focused Therapy for Couples. She is in private practice in Herndon, Virginia. Robin completed a post-Master's program in Marriage and Family Therapy at Virginia Tech in 1994. She subsequently was an adjunct faculty member from 2005 to 2009 at Virginia Tech where she supervised graduate students at the university clinic. In addition to her position as adjunct faculty, Robin has participated as a research therapist at Virginia Tech for two different studies with couples, one using a Solution Focused Model with violent couples and more recently a study using an EFT model where one partner has depression. Robin was selected as a “Top Therapist” by Washingtonian Magazine in 2009 and 2012.

LuAnn C. Oliver is a licensed clinical social worker in the state of Virginia and runs a private practice in North Springfield, VA. LuAnn has over 10 years of experience working with couples and individuals. She is certified in Emotionally Focused Therapy (EFT), a highly effective, evidence based method of couples therapy. LuAnn also facilitates Hold Me Tight Workshops, an educational course for couples based on EFT. She currently serves as chair of the Washington/Baltimore Center for EFT Networking Committee.

NVLPC is an NBCC-Approved Continuing Education Provider (ACEPTM) and may offer NBCC-approved clock hours for events that meet NBCC requirements. The ACEP solely is responsible for all aspects of the program.
Working with Transracial Adoptive Families and Individuals: Blending Awareness, Skills & Knowledge

2 Credit Hours

Who: Susan Branco Alvarado, LPC

When: Friday, June 5, 2015, 9:15 am - 11:30 am

Registration: 9:00 am

Early Registration Cost (on or before May 31, 2015):
- $30 - Members, Clinical and General Members
- $25 - Members, Residents, Students, and Retired
- $50 - Non-Members

Regular Registration Cost (after May 31, 2015):
- $40 - Members, Clinical and General Members
- $35 - Members, Residents, Students, and Retired
- $60 - Non-Members

Where: Springfield Golf & Country Club,
8301 Old Keene Mill Road,
Springfield, VA 22152

RSVP: Register online at any time.

Walk-in registrations will also be accepted on the day of the event starting at 8:30 AM.

For additional information contact Susan Young at eventseast@nvlpc.org.

To cancel, call or email 24 hours in advance or you will be charged. If NVLPC cancels an event, you will be refunded the cost of the event.

About the Event: Current estimates indicate that 40% of all adoptive families are transracial with the majority being composed of white parents with children of color. Some research suggests that this group utilizes mental health services at a higher rate than non adopted populations. Mental health and school counselors need to be aware of the unique strengths and challenges that transracial adoptive families and individuals possess in an effort to provide effective services. Working with transracial adoptive persons and their families requires blending skills from multicultural counseling and adoption competencies. In addition to highlighting pertinent American Counseling Association multicultural competencies, this workshop will review individual and family developmental lifespans, describe current theoretical frameworks and models in which to structure treatment, and will discuss ethical treatment and intervention practices.

Earn 2 Contact Hours for attending this event.

About the Presenter(s): Susan Branco Alvarado is a Licensed Professional Counselor and Approved Clinical Supervisor practicing in the City of Falls Church, VA. She has developed her specialty practice focusing on working with adoptive populations including families, individuals, and first parents. She is a doctoral candidate in counselor education and supervision at Virginia Tech’s North Capital Region and is a National Board for Certified Counselors Minority Fellowship Program 2014 Fellow.

Networking Notice: As part of our networking opportunities, we invite all members to bring their marketing materials to display, and/or to introduce themselves during our 2-minute introductions. Please let us know that you are interested when you RSVP.

NVLPC 2015 Calendar of Events

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Event Type</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/12/15</td>
<td>West</td>
<td>Resident in Counseling Support Group Meeting</td>
<td></td>
</tr>
<tr>
<td>5/15/15</td>
<td>West</td>
<td>Breakfast presentation — Where are you going when working with couples? Emotionally Focused Couples Therapy: Techniques to Guide the Way</td>
<td>Robin Cohen, LCSW LuAnn Oliver, LCSW</td>
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<tr>
<td>5/30/15</td>
<td></td>
<td>Student Workshop: Residency Paperwork</td>
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<tr>
<td>6/5/15</td>
<td>East</td>
<td>Breakfast presentation — Working with Transracial Adoptive Families and Individuals: Blending Awareness, Skills, &amp; Knowledge BOARD MEETING</td>
<td>Susan Branco Alvarado</td>
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Our Events and Workshop Chairs are working on finalizing details with presenters and venues for some of the events. As the information becomes available, additional information will be provided through future newsletters and the website. Always check the website for the most updated information and registration links.
# Commonly Abused Drugs

## Acute Effects/Health Risks

<table>
<thead>
<tr>
<th>Substance</th>
<th>Acute Effects/Health Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Stroke; cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, colon, kidney, bladder, and acute myeloid leukemia; adverse pregnancy outcomes; addiction</td>
</tr>
<tr>
<td>Nicotine</td>
<td>Not scheduled/smoked, snorted, chewed</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Not acutely intoxicating; increased heart rate, blood pressure, body temperature, metabolism, feeling of exhilaration; increased energy, increased heart rate, anxiety, hallucinations, memory loss, impaired coordination, addictions (alcohol, lsd, lysergic acid diethylamide, and mescaline)</td>
</tr>
<tr>
<td>Caffeine</td>
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## DEA Schedule/How Administered

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</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Not scheduled; snorted, chewed</td>
</tr>
<tr>
<td>Nicotine</td>
<td>Not scheduled; smoked, snorted, chewed</td>
</tr>
<tr>
<td>Alcohol</td>
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## Examples of Commercial and Street Names

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## Other Compounds

<table>
<thead>
<tr>
<th>Substance</th>
<th>Other Compounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Aspirin, Oxycodone, Diclofenac, Dapsone, Zidovudine, Equine anti-cup, ran, tiane, and nicotine</td>
</tr>
<tr>
<td>Nicotine</td>
<td>Not scheduled; snorted, chewed, applied to skin</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Not acutely intoxicating; increased heart rate, blood pressure, body temperature, metabolism, feeling of exhilaration; increased energy, increased heart rate, anxiety, hallucinations, memory loss, impaired coordination, addictions (alcohol, lsd, lysergic acid diethylamide, and mescaline)</td>
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**Principles of Drug Addiction Treatment**

More than three decades of scientific research show that treatment can help drug-addicted individuals stop drug use, avoid relapse and successfully recover their lives. Based on this research, 13 fundamental principles that characterize effective drug abuse treatment have been developed. These principles are detailed in NIDA’s *Principles of Drug Addiction Treatment: A Research-Based Guide*. The guide also describes different types of science-based treatments and provides answers to commonly asked questions.

1. Addiction is a complex but treatable disease that affects brain function and behavior. Drugs alter the brain’s structure and how it functions, resulting in changes that persist long after drug use has ceased. This may help explain why abusers are at risk for relapse even after long periods of abstinence.

2. No single treatment is appropriate for everyone. Matching treatment settings, interventions, and services to an individual’s particular problems and needs is critical to his or her ultimate success.

3. Treatment needs to be readily available. Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible.

4. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual’s drug abuse and any associated medical, psychological, vocational, social, and legal problems.

5. Remaining in treatment for an adequate period of time is critical. The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment.

6. Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment. Behavioral therapies vary in their focus and may involve addressing a patient’s motivations to change, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships.

7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Also, for persons addicted to nicotine, a nicotine replacement product (nicotine patches or gum) or oral medication (bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.

8. An individual’s treatment and services plan must be assessed continually and modified as necessary to ensure it meets his or her changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation and/or social and legal services. For many patients, a continuing care approach provides the best results, with treatment intensity varying according to a person’s changing needs.

9. Many drug-addicted individuals also have other mental disorders. Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.

10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse. Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification.

11. Treatment does not need to be voluntary to be effective. Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.

12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur. Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual’s treatment plan to better meet his or her needs.

13. Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases. Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Treatment providers should encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations.

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This chart may be reprinted. Citation of the source is appreciated.
ICD-10 Transition and You

BY JACK CHILDERS

On April 16, 2015 President Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA) into law. One of the aspects of this new law is that the Medicare Sustainable Growth Rate formula, which yearly called for unrealistic cuts to physician reimbursement (and needed to be “fixed” at the last minute every year by Congress) has finally been repealed.

Another aspect of MACRA, one that will impact counselors, is that it looks like implementation of version 10 of the International Classification of Diseases (ICD) is finally upon us.

ICD codes are the codes clinicians use to report to (and receive reimbursement for) insurance companies the clinical diagnosis of the client. As a reminder, by contrast Current Procedural Terminology (CPT) codes are the codes used to document the type of service provided (e.g. 90791 for diagnostic interview). CPT codes are not a part of this change, and will remain as before.

The ICD was first published in 1900. In 1948 the World Health Organization (WHO) took over management of the ICD, and uses it for reporting on healthcare utilization worldwide. The ICD-6, also published in 1948, was the first version to include a section on mental disorders. The United States, as a WHO member nation, has been using the ICD-9 for reporting purposes since the late 1970’s.

Nevertheless, the ICD-10 has been around a long time. It was released by WHO in 1992, but the United States has delayed adopting this version. We were supposed to adopt in last year on October 1 (as you may recall), but a last minute action by the United States House delayed the transition for yet another year.

But it looks as if the deadline of October 1, 2015 for clinicians switching to the use of the ICD-10 for reporting diagnostic information to insurance companies is going to really happen. I’ve researched the change, and have come to believe that this change should not be a great source of anxiety for us mental health clinician types.

For the most part, when you code a diagnosis for submitting a claim to a client’s insurance, you are simply going to substitute the corresponding ICD-10 for the ICD-9 code you have been using. For example, say you are treating a client for posttraumatic stress disorder (PTSD) and want to submit a claim to the client’s insurance company for reimbursement. The Diagnostic and Statistical Manual-5 (DSM-5) has already incorporated the new ICD-10 codes. In my copy of the DSM-5, the heading for PTSD is on page 271. Next to “Diagnostic Criteria” is the ICD-9 code (309.81) in bold print. Next to that, in parentheses, is the ICD-10 code: F43.10. After October 1, simply use the new ICD-10 code in place of the familiar ICD-9 code.

The “F” in ICD-10 codes indicates that the diagnosis is a mental, behavioral, or neurodevelopmental disorder. Nearly all the diagnoses counselors will be interested in will be “F” codes.

A couple of things to consider. First: does your billing software (if you use any) support the new ICD-10 codes? You might want to check this out now, before it becomes an emergency. Second: can the new ICD-10 codes be used prior to October 1? Hopefully individual insurance providers will be sending out notices soon regarding when they are set up to receive claims using ICD-10 codes. Keep tuned in for this.

Now, not to stress you out too much, but it is worth noting that WHO is rolling out the ICD-11 sometime this year. I hope it doesn't happen before October 1: that the ICD-10 is not obsolete before we even begin using it. Apparently the ICD-11 will better reflect DSM-5 diagnosing systems, especially in certain areas such as autism spectrum and bipolar disorders. However, given that it took the U.S. 25 years to adopt the ICD-10 from the time it was first published, I wouldn’t be worrying about the ICD-11 anytime soon.

It’s also worth remembering that the ICD code is not the diagnosis itself. The actual clinical diagnosis is from the DSM-5. You are using the DSM to develop a descriptive diagnosis that hopefully adds understanding and treatment direction to your work with your client. The DSM has simply reported on the ICD code that best matches each DSM diagnosis.

Please direct comments or questions to: JackChildersLPC@yahoo.com.

References:


http://www.amhca.org/default.asp?page=Advocate20140201


https://providers.amerigroup.com/Public%20Documents/ALL_ICD10FAQ.pdf
OVERVIEW:

With PLUS Membership, the NVLPC website functions as a fully interactive professional and social networking platform

Designed for those who want to fully utilize their NVLPC membership, PLUS membership offers an array of options beyond the basic NVLPC membership.

PLUS Membership on the NVLPC website offers our members a place to host professional web pages and blogs, and allows a variety of interactive features including expanded social networking and career center access. As an additional perk, members will be able to create a personalized URL to their profile, suitable for including on business card. An extended option for a shorter URL, directed to the NVLPC web page or blog of your choice is also available for an additional one-time fee.

Additional networking benefits of PLUS memberships include the ability to link your NVLPC profile to your outside social networking websites (LinkedIn, Facebook, Twitter, etc.), and access to the NVLPC Career Center, where you can post and review job openings.

PLUS MEMBERSHIP INCLUDES:

- All the standard features of NVLPC membership: a dedicated member profile page, and features including messaging, groups, file uploads, the ability to post your resume, and to make referrals electronically.

- PLUS Features available with NVLPC PLUS Membership:
  - A hosted professional website on the NVLPC website, using the Pages feature:
    - Host up to 10 web Pages per profile (see example link below)
    - Use this option to post photos, files for client forms, practice information to the public, etc.
    - Members can set a URL as ‘nvlpc.org/member/YOURNAME’ – which will go directly to the profile page. Suitable for sharing on business cards, email signature blocks, etc.
      - There is also an option to purchase a more direct URL for $10. The direct URL would be ‘nvlpc.org/YOURNAME’ and can be directed to your primary web Page, your blog, etc.
  - A blog on your NVLPC profile page. You write the blog, and decide if you want to make it interactive (voting, sharing, take comments, etc.).
  - Add direct links to outside Social Networking sites (LinkedIn, Facebook, Twitter, etc.) to your profile.
  - Access to the Career Center where you can post and review career postings.
  - A photo gallery you can upload onto your profile.
  - A fully interactive social and professional networking platform, where you can create Favorites with quick links to important colleagues and contacts.

For an example of what you can do with your web pages on the new NVLPC website, please look at the web Page example set up by Shulamit Widawsky, our Website Chair: https://nvlpc.ym.com/shulamit When the website goes live in April, that URL will shorten to https://nvlpc.org/shulamit
## Membership Comparison Chart

<table>
<thead>
<tr>
<th>Feature</th>
<th>Basic Membership</th>
<th>Plus Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MESSAGING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Send and receive private messages from NVLPC members.</td>
<td>✓ INCLUDED</td>
<td>✓ INCLUDED</td>
</tr>
<tr>
<td><strong>FILES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upload files and create links to your file library.</td>
<td>✓ INCLUDED</td>
<td>✓ INCLUDED</td>
</tr>
<tr>
<td><strong>RESUME</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post your professional resume on your member profile.</td>
<td>✓ INCLUDED</td>
<td>✓ INCLUDED</td>
</tr>
<tr>
<td><strong>GROUPS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Join and form groups on the NVLPC website.</td>
<td>✓ INCLUDED</td>
<td>✓ INCLUDED</td>
</tr>
<tr>
<td><strong>REFERRALS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generate referrals to other colleagues.</td>
<td>✓ INCLUDED</td>
<td>✓ INCLUDED</td>
</tr>
<tr>
<td><strong>PAGES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create your own professional webpage hosted on the NVLPC website.</td>
<td></td>
<td>Not included.</td>
</tr>
<tr>
<td><strong>BLOGS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create a blog hosted on the NVLPC website to post professional articles and career updates.</td>
<td></td>
<td>Not included.</td>
</tr>
<tr>
<td><strong>CAREER POSTINGS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create job postings and review other career postings</td>
<td></td>
<td>Not included.</td>
</tr>
<tr>
<td><strong>SOCIAL NETWORKS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add Social Networking sites, (LinkedIn, Facebook, Twitter, etc), to your profile</td>
<td></td>
<td>Not included.</td>
</tr>
<tr>
<td><strong>PHOTO GALLERY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post photos and create albums on your profile.</td>
<td></td>
<td>Not included.</td>
</tr>
<tr>
<td><strong>FAVORITES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create quick links to important colleagues and contacts on the NVLPC website.</td>
<td></td>
<td>Not included.</td>
</tr>
</tbody>
</table>
Calling All Speakers, Workshop Presenters and Subject-Area Experts!

NVLPC is looking inside our own ranks of distinguished, clinically-trained members to provide many of our educational events for the 2015 - 2016 year! Do you have expertise in a particular area that you would be willing to share with our membership? Friday events are held in East and West locations and are approximately 1.5 hours in length. We typically attract 25 - 30 attendees per event! Some topics might include:

- Trauma
- Court-related work
- Evidence-based practices
- EMDR
- Mindfulness
- LGBT issues
- Substance Use Disorders
- Couples and relationship issues
- Technology
- Practice development/growth

Please submit your name, professional credentials, email address, phone number and topic of interest to eventschair@nvlpc.org. A member of the events team will contact you regarding your proposal to discuss next steps, if selected.

Newsletter Advertising

Are you interested in advertising your practice, services and/or event to our membership of over 350 clinicians throughout Northern Virginia? Business card to Full page ad sizes are available. Email advertising@nvlpc.org for details. Members also have the privilege of a FREE 25-word ad in our newsletter each month!