Hello, IAAP Members:

As we celebrate Memorial Day and the 70th Anniversary of D-Day 1944, I reflect on my Dad and every man and woman of the greatest generation who preserved the freedom we enjoy today. This also helps me remember all the past addiction recovery professionals who preserved the freedom from addiction for so many individuals and paved the way for us in the current profession. We are so grateful to those who went before us championing the cause of freedom and recovery. One of those professionals, Ms. Becky J. Powell, of Anderson, died last month. Our gratitude and condolences goes out to her family and clients. I never take for granted our freedom from addiction and living a new life of recovery. It is because of wonderful professionals like Becky and all of you who make the miracle of recovery possible.

I am also grateful to all of you who participated in the (March) to membership and spring (April) into membership. We did not double our membership as I had hoped, however, we did have some new and old members join. I welcome you and encourage you to join one of our IAAP committees. During the membership drive, we were fortunate to have a most fantastic Spring Conference on Group Therapy conducted by Drs. Don Osborn and Mita Johnson.

Continued on page 2 see PRESIDENT
PRESIDENT Continued

I want to also send a very special thank you to the speakers, and to Peggy Payonk and her Conference and Educational Training Committee. And a special thanks to Amanda who was at the front desk during the conference and did so much behind the scenes work. It was during this conference some of you heard my plea for much needed committee members for two IAAP committees: the Membership Committee and the Preparation and Testing for Licensure Committee. I am very grateful for those who volunteered and signed up. I will be contacting each of you personally to thank you. Each of these two committees are only half filled and we still need you to volunteer for just a two year term on the committee.

I am continually grateful to all of you mentoring students and sponsoring student membership. Some of you asked me for a brief brochure on IAAP mentoring (which is included in a separate column in this newsletter).

So this Memorial Day, I have so much in which to be grateful. Most of all, I thank each of you, the terrific IAAP professionals, who maintain that miracle of recovery.

Only Our Best,

Albert, your President
Albert Alvarez, LMHC, LCAC, MAC, CGP.

Advertisement Opportunities

New opportunities are now available to advertise in the IAAP electronic newsletter! If you would like to place an ad or if you want more information on how to advertise with us in our electronic newsletters, please contact Stephanie by email at stephanie@centraloffice1.com.

2014 IAAP Events Calendar

· IAAP Ethics Course – more information coming soon!
  July 11, 2014
· IAAP Annual Fall Conference
  October 10–11, 2014

Next Certification Committee Meeting:
June 21, 2014
**Kudos To:**

**KUDOS - DEFINITION:** Praise and honor for an achievement.

WOW! HUGE KUDOS from Kay Bontrager, Editor in Chief to Stephanie Waddell, Managing Editor at IAAP’s Central office for her dedication and efforts to help produce this electronic newsletter.

The new electronic format takes a tremendous amount of time along with great editing skills to assure content is clear, accurate and polished.

If you see or talk to Stephanie, be sure to thank her for her excellent work.

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**A SOBER CHUCKLE**

... Rx: LAUGHTER

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**NAADAC VP for the Mid-Central Region**

Dear IAAP membership,

I would like to introduce myself as your new NAADAC Regional Vice President for the Mid-Central Region.

As such, I look forward to working with you. If you have any questions or needs with regards to your membership or certification with NAADAC, please feel free to contact me. In addition to my service as a representative of NAADAC, I am here to help serve your needs, both as individual addiction counselors, as well as helping to support IAAP in its operations and service to you, the members of IAAP.

If you need to reach me, please feel free to call me at 269-330-6981, or send me an email to klarge@alumni.kzoo.edu.

Sincerely,

Kevin M. Large, M.A., LCSW, MAC
Regional Vice President
NAADAC Mid-Central Region

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**IAAP 2nd QUARTER NEWSLETTER 2014**

**Connections**
Elections Committee

On May 8th, 2014, the Elections Committee met at Charis House, Ft. Wayne, Indiana. The committee consists of Toni Lovell, Warren Gray, Tony Guy, George Scott, and Brent Stachler (Chairperson). The committee reviewed essential points as we prepare for the 2014 election. Specifically discussed were timeframes, nomination process, qualifications for offices, and which offices/regions were open for election.

In 2014, IAAP will be seeking nominations for President-Elect, Treasurer, and Secretary, and Board representatives from Regions 2 and 3. Region 2 is NE quadrant of Indiana, and Region 3 is SE quadrant of Indiana. Region 2 is defined as east of US 31 from the Michigan-Indiana state line and south to US 40 from Indianapolis to the Indiana-Ohio line. Region 3 is defined as east of I-65 to the Indiana-Ohio state line and south of US 40 to the Indiana-Kentucky state line. Nominations for Regional representatives need to be solicited from the same respective region. As an example, an IAAP member in Region 2 may nominate a Region 2 member and not a member from any of the other regions. Further, no member may nominate him or herself.

Nomination forms will be included in this edition of the IAAP Newsletter and will be posted on the IAAP website no later than June 30, 2014. Any and all nominations need to be mailed to the IAAP Central Office to the attention of the Election Committee Chairperson, Brent Stachler. Any and all nominations must be received in the IAAP Office by August 1, 2014, and any received after this date regardless of the postmark date will be voided by the Committee. All nominations are then reviewed by the Elections Committee to determine if qualifications and criteria have been met for the respective position. Upon completion of this process, ballots will be mailed by September 15, 2014, and all ballots must be received by October 9, 2014. Results of the election are announced at the Annual membership meeting on Fri., October 10, 2014 during the Annual Fall Conference.

The Elections Committee encourages each and every member to utilize his or her voice and exercise your privilege to nominate and vote. IAAP is your membership organization. We look forward to having a busy late summer and early fall to review your nominees and tally your votes.

Only our best,

Brent Stachler, LCAC, LMFT, MAC, ICCS
Elections Committee Chair and Past President

Marketing & Communications Committee

The Marketing and Communication committee has continued to focus on developing contact lists for folks throughout the state with whom we have a shared interest in the work we do. We have a developed list for state wide Community Mental Health Centers. We are now working on a contact list for Recovery Houses in Indiana. The list appears strong for the Indianapolis area, but rather weak for the rest of the state. Please send info for any houses you are aware of to jeannehayes10@gmail.com. We ask that the info you send includes name of house, address, and phone number. These lists not only help us to share the work of the IAAP Board, but also allow us to assist our members with resource information.

At this time we want to encourage anyone who wishes to may advertise as part of our emailed and post office mailed Newsletter. For more information on advertising, please email Stephanie at stephanie@centraloffice1.com. A perfect opportunity to advertise your private practice, counseling center, and/or related products.

Jeanne Hayes
LMHC, LCAC, ICACII
Chairperson, IAAP Marketing & Communications Committee

Words of Wisdom

“Even a blind mouse occasionally finds the cheese.” Anonymous

“I try to maintain courage of my doubts as well as my convictions, in this world of dangerous and passionate certainties.” Eric Sevareid (November 26, 1912-July 9, 1992) was a CBS Journalist from 1939 to 1977.
IAAP NOMINATION FORM - 2014

Board/Officer Nominations Criteria:

1. This form must be completed and returned along with the nominee’s bio to IAAP Central Office with a postmark date or faxed date or email time stamp NO LATER than August 1, 2014.
2. All candidates for each position must be IAAP members in good standing, licensed by the IPLA, and agree to abide by the IAAP Bylaws and Code of Ethics.
3. All nominee(s) submitted must be willing and able to serve for the required terms (2 years for officers and 3 years for board members).
4. Self nomination is not permitted.
5. Board/Officers may not belong to any other addiction counselor membership organizations.
6. Presidential nominees must have served as an IAAP Director or Officer to be nominated for President.
7. All nominees must be Indiana residents.

Signature of person submitting nomination: ____________________________________________

Name of person submitting nomination (please print or type):
________________________________________

E-mail: ___________________________________ Phone: ____________________________

I am submitting a nomination for the following position:

☐ President Elect         ☐ NE Board Member (Region 2)
☐ Secretary             ☐ SE Board Member (Region 3)
☐ Treasurer

Name of Nominee: ________________________________________________________________

Address: ____________________________________________________________

City: ________________________ ST: _________ ZIP __________

Current job responsibilities and/or related employment:

Education:

Licensure:

Professional affiliation(s) and/or national certifications:

All nominations must be postmarked by August 1, 2014

Please mail to:  IAAP Central Office
Attention Election Committee Chairperson, Brent Stachler
3125 Dandy Trail, Suite 110 ~ Indianapolis, IN 46214
PH: 317-481-9255 ~ Fax: 317-481-1825
New APS Guideline on Safe Use of Methadone
Medscape Medical News
by Megan Brooks May 22, 2014

Measures can be taken to promote safer user of methadone, including better physician education and patient counseling about methadone safety and cardiac monitoring to identify patients at high risk for these problems, a new Clinical Practice Guideline on Methadone Safety from the American Pain Society (APS) concludes.

The safety of methadone, a synthetic opioid narcotic used to treat opioid addiction and chronic pain, has been questioned in recent years, as deaths from methadone overdoses have jumped from 800 in 1999 to 4900 in 2008, the authors note. The increase in deaths has been substantially higher than for any other opioid medication and is attributed to a sharp rise in prescribing methadone for chronic pain, they point out.

"The guideline was prompted by serious concerns about the great increase in number of methadone-associated overdose deaths," lead author Roger Chou, MD, from the Oregon Health & Science University in Portland and head of the APS Clinical Practice Guideline Program, told Medscape Medical News.

"The unique properties of methadone — including its long and variable half-life, and association with QTc prolongation and ventricular arrhythmias — can make it difficult to use, and the guideline is meant to help clinicians prescribe more safely," he said.

"Although there are some other guidelines out there, all of them focused on the arrhythmia issue, even though it is probably responsible for only a small minority of deaths," he said. "This guideline also addresses safety issues related to dose initiation, titration, follow-up, and monitoring to prevent accidental methadone overdose. It is also the first guideline on methadone safety to be sponsored by professional societies related to pain (the American Pain Society) as well as addiction (the College on Problems of Drug Dependence, CPDD)," Dr. Chou explained.

The guideline is published in the April issue of The Journal of Pain.

Toward Safer Prescribing

The new document is based on a systematic review of the evidence on methadone safety performed by an interdisciplinary panel, commissioned by the APS and CPDD, in collaboration with the Heart Rhythm Society, under the direction of the Oregon Evidence-based Practice Center.

The panel identified "numerous research gaps" and note that most recommendations are based on low-quality evidence and none are based on high-quality evidence.

Among the key recommendations:

- Patient assessment: Perform an individualized medical and behavioral risk evaluation to assess risks and benefits of methadone. Use the results to stratify patients according to their risk for substance abuse and consideration that the long and variable half-life of the drug could cause reactions with other prescription medications and possible arrhythmias. "Proper patient selection is critical when considering the use of any opioid, whether for chronic pain or treatment of addiction," the authors say.

- Education and counseling: Counsel patients about potential risks and benefits before initiating methadone therapy. Advise patients to take methadone as prescribed and comply with recommended follow-up and monitoring. Notify caregivers about risks for respiratory depression; include instructions to withhold additional doses of methadone and contact the prescriber if signs of respiratory depression or somnolence occur.

- Baseline electrocardiogram (ECG): Obtain an ECG before initiating methadone therapy in patients with risk factors for prolonged corrected QT interval (QTc), any prior ECG demonstrating a QTc greater than 450 ms, or a history suggestive of prior ventricular arrhythmia. Consider obtaining an ECG before starting methadone in patients not known to be at higher risk for prolonged QTc. Recent data suggest that methadone is the most common drug-related cause of ventricular arrhythmia, the panel notes.

- Alternative medications: Consider buprenorphine as an option for patients being treated for opioid addiction who have risk factors for prolonged QTc.

- Low beginning dose: Start methadone at low doses (no more than 30 to 40 mg daily) and titrate slowly. This recommendation is based on the drug’s long and variable half-life, which can be as long as 120 hours. Slow titration may reduce the risk for unintended drug accumulation and accidental overdose, the panel says.

- Urine drug testing: Perform urine drug testing before starting methadone therapy and at regular intervals for patients treated for opioid addiction. "The take-home message," Dr. Chou told Medscape Medical News, "is that methadone needs to be prescribed cautiously and that clinicians need to understand its unique properties.

"There are steps that can be taken to mitigate risks of methadone—like assessing for risk factors for QTc prolongation, doing ECG screening, using low starting doses and titrating slowly, close follow-up, and considering alternative opioids—and it is important for clinicians to be knowledgeable about this medication and how to prescribe it safely before using it," he added.

The authors have disclosed no relevant financial relationships. J Pain. 2014;15:321-337. Abstract

Submitted by Kay Bontrager
Posttraumatic Stress Disorder and Substance Abuse

TRAUMA is defined as “any psychologically distressing event or series of events outside the range of normal human experience, that a person experienced, witnessed, or was confronted with that involved actual or threatened death or serious injury, or a threat to the physical integrity of the person or others, and the response to that experience included intense fear, horror, or helplessness” (DSM-IV-TR). PTSD (Posttraumatic Stress Disorder) is a result of incomplete healing of the trauma, has identifiable symptoms, and is treatable. Events that cause PTSD include military combat; childhood sexual abuse; physical abuse; emotional or verbal abuse; rape; domestic violence (victim or witness); car wrecks; criminal victimization (burglary, robbery, assault, etc.); divorce/separation; death of a loved one (especially suicide); overdose; serious illness, injury, and/or surgery.

PTSD Symptoms include re-experiencing the trauma through feeling or acting as if the trauma was reoccurring (distressing memories or dreams of the trauma, dissociative flashback episodes); intense psychological and physical distress when exposed to triggers that resemble an aspect of the trauma; emotional numbing (avoiding triggers associated with the trauma; avoiding thoughts, feelings, or conversations about the trauma; social isolation); depersonalization (feelings of detachment; unable to have loving feelings; does not expect to have a career, marriage, children, or a normal life span); persistent emotional distress (difficulty falling or staying asleep; irritability or anger outbursts; difficulty concentrating; exaggerated startle response). Some common PTSD symptoms that may not meet diagnostic criteria, but are often present include numerous somatic (physical) complaints; substance abuse or dependence; unnecessary risk-taking behaviors (unsafe sex, gambling, thrill-seeking); moving often (relocating, “geographical cure”); relationship problems or conflicts at work or home; fear of crowds; always watching your back. PTSD symptoms re-emerge when clients experience emotional or environmental triggers, undergo routine life stresses, reach a new developmental stage, or let their guard down because they feel safe.

Due to the intense and erratic emotions, PTSD symptoms are often misidentified by clinicians as Bipolar Disorder, Major Depression, or Generalized Anxiety Disorder. In rare cases, the flashbacks are misidentified as hallucinations and the person is diagnosed with Schizophrenia. Mislabling of PTSD has negatively affected the addiction profession and our clients. AA and many addiction counselors with recovery backgrounds have labeled PTSD symptoms as “resentments”, which has resulted in the view that clients with PTSD are “holding on to resentments” rather than actually re-experiencing traumas. This has resulted in people with co-occurring PTSD and Substance Use Disorders (SUD) being unfairly blamed for their inability to “let go” of serious mental health symptoms that are not being adequately identified and treated. It is vitally important for all addiction counselors to be trained in the symptoms and treatment of PTSD to ensure accurate diagnosis and treatment.

Numerous studies have been conducted into the long-term effects of childhood trauma on a person’s psychological functioning. A 1995 study of 481 males and 321 females who were treated for alcoholism at an inpatient setting found that 59% of the women and 30% of the men reported childhood abuse. 49% of women and 12% of men reported sexual abuse, 33% of women and 24% of men reported physical abuse with no sexual abuse, and 23% of women and 5% of men reported both physical and sexual abuse. In 2004, Stephanie Covington explored the prevalence of SUD, childhood trauma, and mental health symptoms among incarcerated women. She cited U.S. Bureau of Justice statistics reporting that 8 out of 10 female offenders with a mental illness were sexually or physically abused as children. She also found that 60% of all incarcerated females reported childhood sexual abuse, and 74% of those with SUD reported childhood sexual abuse.

The Centers for Disease Control and Prevention in Atlanta conducted a long-term longitudinal study on the effects of Adverse Childhood Experiences (ACEs) on adults. The study found that ACEs are more common than previously thought: 27% of children grew up in homes with parental substance abuse, 23% experienced parental separation/divorce, 28% experienced childhood physical abuse, 21% (1 in 5 children) experienced childhood sexual abuse, and 13% witnessed their mother being battered. The study found that cortical development is almost entirely experience-dependent, and ACEs result in chronically elevated stress hormones (cortisol and adrenaline), which are toxic to healthy immune system and brain development. The study showed that three to four ACEs dramatically increased the incidence of heart disease, stroke, chronic respiratory illnesses, diabetes, and hepatitis.

The study also found that ACEs dramatically increase the incidences of mental health problems: Children with no ACEs have a 10% rate of depression as adults and 15% in females. Children with four or more ACEs have rates of depression as adults approaching 60% for females and 30% for males. Children who have six or more ACEs die on average 20 years earlier than those with no ACEs from complications of chronic illnesses. How many of our clients have fibromyalgia, lupus, endometriosis, allergies, COPD, migraines, etc.? Children with no ACE had a 2% rate of alcoholism as adults where children with four or more ACEs had a 16% rate of alcoholism as adults. These numbers are too significant for us to continue to ignore.

Continued on next page.
In 2001, Kenneth Brady clarified the neurobiological connection between both PTSD and SUD as being mediated through the catecholaminergic system in the hypothalamic-pituitary-adrenal axis in the brain. Since both sets of disorders are mediated by the same pathways, and because people with a history of trauma often have PTSD symptoms prior to the onset of an SUD, Brady supports “self-medication” as a valid hypothesis for explaining the development of comorbidity between these two sets of disorders. He also reported on the success of Exposure Therapy for comorbid PTSD and SUD, which was previously thought to be contraindicated.

Both the literature and clinical experience support the hypothesis that childhood traumas play a significant role in the development of PTSD which, in turn, plays a significant role in the development of SUD. Research clearly shows that co-occurring PTSD and SUD are prevalent among people seeking treatment for either disorder. The lack of identification and treatment of PTSD in people with SUD is probably the main reason for high relapse rates among people being treated for SUD. I believe that treating PTSD in conjunction with SUD treatment will lead to a reduction in recidivism in the SUD population, reduce the stigma of their “unwillingness to let go of resentments”, and offer them an opportunity to develop and sustain a better quality of life.

Thankfully, there are numerous resources for clients with co-occurring PTSD and SUD. “Seeking Safety” by Lisa Najavits is an excellent program that is easily adapted to our SUD treatment efforts. “Trauma Resolution Therapy” by Jesse Collins and Nancy Carson is more involved, but easily adapted as well. “Stop Treating Symptoms and Start Resolving Trauma!” by R. Denice Adcock is another excellent resource for learning how to help others heal from their traumas. “Treating Addicted Survivors of Trauma” by Katie Evans and J. Michael Sullivan is also helpful and includes sections on working the 12 Steps for trauma survivors. “Psychological Trauma and Addiction Treatment” has a heavy focus on the neurobiology of trauma and addiction, which some may find helpful. And, finally, anything by Stephanie Covington is highly recommended for the treatment of co-occurring PTSD and SUD. Remember, if we are not treating trauma, we are not treating addiction.

Only Our Best,

Ron Chupp, LCSW, LCAC, NCAC-II, ICAC-II

IMPORTANT NEWSLETTER UPDATE:

In order to help the association GO GREEN, the IAAP newsletter is going to become electronic!

Beginning with this issue of the IAAP newsletter, members will now see their newsletter in their email inbox! If you would prefer to receive a printed copy, please contact Stephanie by email at stephanie@centraloffice1.com.

Thank you for showing IAAP your electronic support!
In Fight with Opiate Overdoses, N.J. County Issues Antidote to Police

Reuters Health Information
By Daniel Kelley April 28, 2014

(Reuters) - Police in coastal Ocean County in New Jersey, faced with a doubling in deaths from drug overdoses in the past year, have issued all police officers an anti-opiate drug in a pilot program aimed at combating deaths tied to painkiller addiction.

Police have already saved six people from overdoses since launching early this month a test of the anti-opiate drug naloxone, which helps restore breathing in people who have overdosed on opiate drugs.

"We're on a roll," said Al Della Fave, a spokesman for the county prosecutor's office, which led the effort. "We've heard from all the officers. In almost every case, their first comment is how great it will be to do something except stand there."

The county, home to about 583,000 people, saw 112 overdose deaths in 2013, more than double the 53 recorded in 2012, Della Fave said. That rise was fueled by an epidemic of prescription painkiller abusers who have turned to heroin because it is cheaper.

States across the country have cleared the path for first responders to carry the rescue drug, which goes by the brand name Narcan and can restore breathing in two to five minutes. Municipalities in New York and Massachusetts are conducting similar tests and New York State officials earlier this month laid out plans to equip every officer in the state with the antidote.

Earlier this month the U.S. Food and Drug Administration approved a portable device to treat overdoses that people without medical training can use.

Della Fave said there are plans to roll out the program across the state from the coastal county about 50 miles (80 km) east of Philadelphia.

Last year, New Jersey enacted a law that allowed drug users to call for emergency medical assistance without fear of prosecution for minor drug crimes.

"New Jersey has been hard hit," said Daniel Raymond, policy director at the New York-based Harm Reduction Coalition. "They've really gotten on board with preventing overdose deaths. We're already seeing a difference."

States including Maine and Connecticut are mull- ing similar measures.

The first city to begin using Narcan, Quincy, Massachusetts, reversed 221 overdoses since requiring first responders to carry the drug in 2010. First responders in Suffolk County, New York used Narcan 564 times in 2013, and say they saved the life of all but one who received it, according to officials there.

Source: Medscape Medical News, 2014-4-28
Submitted by Kay Bontrager
New ICD-10 Transition Date Set for 2015
Medscape Medical News
by Ken Terry May 02, 2014

The Centers for Medicare and Medicaid Services (CMS) announced yesterday that it would require the use of the International Classification of Diseases, 10th Revision (ICD-10), set of diagnostic codes starting October 1, 2015. That is 1 year later than the ICD-10 transition date that was in effect until recently.

The brief statement read, “the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require [Health Insurance Portability and Accountability Act (HIPAA)] covered entities to continue to use ICD-9-CM through September 30, 2015.”

The CMS announcement, eagerly anticipated in the healthcare industry, was a response to Congress’ passage in late March of a bill that prohibited the agency from setting a deadline for ICD-10 any earlier than October 1, 2015. That provision was part of legislation that also prevented a 24% reduction in physicians’ Medicare payments.

At the time that Congress mandated the ICD-10 delay, it was unclear when the new deadline would be, and industry groups, especially hospitals, pressured CMS to set a new one quickly, asserting that the uncertainty was causing disruptions and costing money. The announcement this week allows providers to recalibrate their plans for moving to the new diagnostic code set, Edward Hock, managing director of revenue cycle solutions for The Advisory Board Co, told Medscape Medical News.

In addition, he said, “It also reconfirms CMS’ commitment to ICD-10,” because October 1, 2015, was the earliest date the agency could have legally chosen.

Mixed Reactions
The American Health Information Management Association (AHIMA), the group that has lobbied the hardest for the ICD-10 transition, applauded CMS’ move in a statement posted on its Web site. Noting that the “industry has already invested considerable time and money in [ICD-10] implementation,” AHIMA recommended that the industry keep the momentum going on its transition efforts.

The Medical Group Management Association (MGMA), which has fiercely criticized CMS’ approach to ICD-10, was less positive. In an e-mail responding to a Medscape Medical News request for comment, Robert Tennant, MGMA’s senior policy adviser, said, “We believe that the process of implementation has to be revisited if the industry is to move forward with ICD-10. It is clear from the multiple delays that have already been issued that widespread industry coordination has simply not occurred.

“Physician practices must rely on external trading partners such as software vendors, clearinghouses, and health plans in order to make the transition to this more complex code set. If any one of these links in the chain is not ready, then the practice itself cannot be ready. We will continue to monitor the readiness level of our member practices and continue to communicate our concerns directly to the government.”

Although the American Medical Association (AMA) had not commented on the new deadline as of press time, it previously issued a report that estimated it would cost small physician practices between $56,639 and $226,105 to comply with the ICD-10 mandate. That amount includes the cost of new software as well as expected losses in productivity.

In an earlier interview, Tennant told Medscape Medical News that one of the missing ingredients in CMS’ transition plan was end-to-end testing of ICD-10 claims submission and payment. Last winter, CMS announced it would do end-to-end testing with only a select group of providers in July. That has changed.

In its statement, CMS said the July end-to-end testing is being cancelled, and “additional opportunities for end-to-end testing will be available in 2015.”

Regardless, Hock said he hoped that CMS would expand those tests with its intermediaries and that all payers would do adequate testing with providers, now that they have sufficient time to do it. “We hope this gives the entire industry an opportunity to really do this right, so that the ICD-10 transition is a nonevent for everyone from payers to large providers to small physician practices.”

Will the New Date Make a Difference?
In a recent MGMA survey, less than 10% of physicians said they had made significant progress toward preparing for ICD-10. Hock acknowledged that physician resistance to the switchover continues to be a major problem, and he pointed out that it is possible that that will not change in the next year.

“For the organizations that hadn’t prepared for ICD-10 when we were 6 months away from the original deadline, I don’t think this announcement is likely to change their calculus,” he said.

However, Hock noted, renewed pressure on Congress to again postpone the transition is less likely next year simply because the momentum of all parties toward the new deadline may create a critical mass that will be difficult for any lobbying group to stop. “If the industry as a whole starts to reach a tipping point where we’ve gone so far toward ICD-10, it’s going to be harder to push this back again,” he said.

Submitted by Kay Bontrager
Industrial Hemp in Indiana

From West Lafayette, IN, in an AP news article, the following was reported:

“On Saturday, April 15, 2014, Indiana’s seed commissioner is seeking federal approval for the state’s farmers to begin growing industrial hemp under a newly passed state law. Seed Commissioner, Robert Waltz, said Thursday that he’s asked the US Drug Enforcement Administration and the US Department of Agriculture to grant the state permission to allow hemp to be grown for crops and research purposes.

Although the General Assembly approved a measure during its recent session allowing hemp to be grown in Indiana, the state still needs the federal agencies approval. “We are now in a waiting period. Without federal approval, nothing will happen.” Waltz told The Times of Munster. Waltz said the approval process could take several months, but he noted in letters he sent last week to the DEA and USDA that federal farming legislation enacted in February encourages the development of hemp as an industrial product.

Hemp is marijuana’s non-intoxicating cousin and can be made into rope, clothing, linen, fuel and other items. But federal regulations treat industrial hemp similar to marijuana and it cannot be grown under federal law without permission. Industrial hemp contains low levels of the psychoactive drug compound, tetrahydrocannabinol, or THC, that makes marijuana popular among users. State Sen. Karen Tallian, D-Ogden Dunes, co-sponsored legislation permitting the cultivation of industrial hemp in Indiana under the guidance of the state seed commissioner and federal regulations. “This could be the biggest jobs bill all session,” she said.

The industrial hemp legislation passed the House, 92-6, the Senate, 45-0, and was signed into law March 26 by Gov. Mike Pence.

Submitted by Kay Bontrager
NAADAC: Helping Addiction Professionals Treat the Nation’s Addiction Epidemic

Addiction Profession Workforce Profile
(Bureau of Labor Statistics, 2013)

- Over 85,500 professionals work as Addiction Focused Professionals
- Between 2010 & 2020 the workforce is expected to grow by 27% (Nearly 2X the average growth)
- “Growth expected as more minor drug offenders are increasingly sentenced to treatment rather than jail time”

Advancements through Advocacy

- Promoting the addiction workforce for 40 years through NAADAC’s government relations department
- Hosting and participating in state and national Advocacy and Public Policy Conferences over the past 27 years
- Writing authoritative position papers and a Situational Analysis of the addiction profession
- Working to build awareness and education through state affiliates on important national advocacy efforts
- Partnering with other associations and organizations including: Recovery Month Partners, Addiction Leadership Group, National ATTC/NIAAA, National Council for Behavioral Health, NORC at the University of Chicago, Hispanic and Latino ATTC, National Center for Responsible Gambling, ICRC, SBIRT ATTC, and many others

Creating Identity for Addiction Professionals

- Imagine Who You Can Save recruitment video and packet
- NAADAC’s 47 State Affiliates provide technical support and professional services
- NAADAC publications for Addiction Professionals:
  - Advances in Addiction & Recovery, the official publication of NAADAC and a quarterly magazine, focuses on providing useful, innovative and timely information on trends and best practices in the profession that are beneficial for practitioners
  - Addiction & Recovery eNews, a free bi-weekly eNewsletter, delivering trending and breaking news, innovations, research and trends impacting the addiction-focused profession
  - Professional eUpdate, a free weekly eNewsletter, delivering the latest news from NAADAC and partner organizations, including educational events, trainings, resources, and career opportunities
- Offering student and new professional mentoring
- Building a social media presence through Twitter, Facebook, and LinkedIn
- Providing resources through NAADAC’s new website, www.naadac.org

Setting Standards

- Working with Addiction Studies programs at academic institutions to set curriculum standards
- Establishing scopes of practice and setting the national career ladder
- Standardizing training providers and Training of Trainers (TOT)
- Incorporating Code of Ethics updates to include new challenges in tele-counseling and electronic communication

NAADAC & NCC AP Endorsements, Qualifications, Certifications, & Certificate Programs

- Professional (SAIP) Qualification
- Masters Addiction Counselor (MAC)
- National Certified Addiction Counselor I & II (NCAC I & II)
- Nicotine Dependent Specialist
- Nationally Certified Adolescent Addictions Counselor
- Peer Recovery Credential
- Nationally Endorsed Clinical Supervision for Substance Use Disorders Professionals
- Nationally Endorsed Student Assistance Professional
- Co-occurring Disorders Proficiency Certificate
- See www.naadac.org/certification for additional programs

Delivering Quality Education

- Over 35,000 participants trained through the webinar series since 2012
- Over 70 Webinars addressing co-occurring disorders, ethics, ASAM Criteria, brain neurochemistry and much more
- Innovative homestudy and face-to-face trainings
- Nationwide state affiliate training
- National Annual Conference
- NAADAC is growing our training services to include more online training products and certificate programs. Look for those in the Spring of 2014.
- International training and credentialing in over 30 countries
Dear Policymakers and Advocates,

NAADAC, the Association for Addiction Professionals, is pleased to offer you our Guide to Addiction Policy. NAADAC represents the professional interests of more than 85,000 addiction counselors, educators and other addiction-focused health care professionals in the United States, Canada and abroad. This guide seeks to educate you on the foremost policy issues facing the counselors, social workers, nurses, psychologists and other prevention, intervention, treatment professionals and recovery support specialists who create safer and healthier communities through the delivery of alcohol, tobacco and other drug services.

NAADAC is the premier organization serving the addiction counseling profession. Our mission is to lead, unify and empower addiction-focused professionals to achieve excellence through education, advocacy, knowledge, standards of practice, ethics, professional development and research.

NAADAC advocates at the federal level for sound policies that will reduce the number of Americans who suffer from substance use disorders. There are countless public policy areas where addiction professionals play a meaningful advocacy role. This booklet outlines several ongoing federal priorities issues. These include:

1. Ensuring that both the Affordable Care Act (ACA) and Wellstone-Pete Domenici Mental Health Parity and Addiction Equity (Parity) Act are fairly and effectively implemented for substance use disorders.
2. Growing and developing the addiction professional workforce in the 21st Century, and
3. Increasing federal and state funding levels for addiction treatment and research programs.

Addiction will not disappear on its own. NAADAC looks to Congress to lead our nation into a 21st century that is healthy, substance use free and safe. Addiction counselors need your support and are optimistic that together we can create a healthier, more functional and a safer America. We hope that this briefing booklet will provide you with insight regarding policy issues affecting addiction professionals and their clients.

For further information, please visit NAADAC’s website at www.naadac.org or contact at 800.548.0497.

Sincerely,

Robert C. Richards, MA, NCAC II, CADC III
President, NAADAC

Cynthia Moreno Tuccy, NCACII, CCDC III
Executive Director, NAADAC
Helping Clients Cope with Large Feelings

Feelings are the emotions we experience in response to happenings and thoughts. Feelings are what give the happening and the thoughts meaning and connection. Though it seems that the primary emotions we know well are fear and joy, they are all too frequently hidden by anger and happy.

In response to our anger we get mad. Mad gives many of us focus and energy and happy is fun and easy. These are wonderful emotions. They are what we can think of as surface feelings, ones easily available to us. The feelings we want to connect to and increase awareness of are those beyond the surface.

For example after some thought or happening we may identify fear as directly behind anger, and possibly behind the fear we feel resentment. Now, we can see, maybe even feel, the difference when we respond to a happening with anger and when we acknowledge that our response really brings resentment to our gut.

When we respond to an important happening and say we are so very happy as we stand there with tears in our eyes. Upon reflection we may come to understand that behind the happy feeling is truly a spiritual sense of connection beyond words, a feeling we may know as joy.

We have on occasion found that feelings cause an emotional numbness that surprises us. We become speechless, and believe no one can or will hear us; if we do try to speak. In some quiet corner of our brain we know it may help to say it out loud. Shame stills our voice and we speak the pain into a pillow or the ear of a pet. Until we find the human ear we trust, we tell ourselves that our wrongness is unacceptable. When we find a person brave enough to hear with empathy our story repeated, we might begin to let go of numb and reach in to the feelings behind the numb. With another’s help of listening, we may find the feeling beyond the numbness is not as paralyzing as the lack of feeling. Even if the feeling is strong and powerful, we are surprised to feel something helps, while feeling nothing keeps us chained in a secret of our making.

Feeling can also be physical with strong emotional connections. The wind blowing softly on our face on a spring day; may surface a feeling of contentment. The feeling of being well fed, may lend a strong sense of security and comfort. The feeling of stomach pain from laughing hard with others gives us a smile that is almost too big, and an excellent feeling of connectedness to others.

Feelings of guilt and shame are among our most controlling emotional experiences. Shame is the message we hear from others, guilt is when a happening goes against our own conscience.

As we have noted, shame can still our voice because it is a judgment from another, and we may believe that our response of anger is not acceptable. More than our response, we actually come to believe we ourselves are not acceptable.

Guilt is readily available for us to bring to the surface. It is the message we give ourselves that we did not make our best decision. We feel embarrassment and we allow that feeling to stay easily accessible in our bank of emotional memories. When the emotion of guilt surfaces, we may tend to honor it, as being more fact than feeling. We then accept guilt not as feeling, but as a fact of great honesty. Once we replace the feeling with fact we have a very difficult time putting it in perspective.

For some feelings are huge. So huge, that the feeling overtakes the thinking process. This is the moment when we want to increase our awareness. We want to shift from feeling to thinking. When we have this experience we usually take note and bring the emotion back to a normal range. This can commonly happen with the giggles, and it may take some time to get back to allowing our thoughts to be in control again, but in this situation time can be measured in minutes. While feelings of guilt and shame may if unattended last indefinitely.

When humor overwhelsms us it is usually fun and socially acceptable. It is when feelings of sadness take over our thinking that we may open the door to being anxious with the belief that we cannot cope with the effect of our sadness. When this occurs, many of us seem to be at a loss as to what to do in response. It is often helpful to acknowledge the feeling and accept the reality of it, then go to the intellect and turn the feeling over to thinking. You see, for the benefit of personal mental, emotional, and spiritual safety; we can mentally learn to control our response to feelings.

Many of us do this rather naturally, and many of us have great difficulty with this process. Often it is too great a challenge to sort out feelings from fact, because our belief in that feeling gives energy to the severity of the real, unreal, or partially real fact.

The process to consider is how to use our intellect to manage our feelings. Life has taught us that unmanaged feelings take control of us physically, mentally, and, spiritually. It is as though the emotion becomes who we are and begins a long path of impaired and unhealthy thinking and being.

There is a saying we may be familiar with. It is written as a fraction one over e. This tells us and reminds us that as emotions begin to grow and they start to become unmanageable, we gain manageability by focusing on our thinking. Something as relatively simple as the giggles in church can be managed by physically leaving. The immediate mental response is the realization that simply states, “Wrong place, wrong time”.

When stronger feelings, especially the more negative feelings, wash over us the process to use mind over emotions becomes a greater challenge.

It is for many as though they live in response to unbidden feelings. We may experience life as though afloat without an anchor. We bounce through our days at the mercy of our emotional moment.

Continued on next page.
IAAP Student Mentoring

Dear IAAP Member:

Besides history and information and our website newsletter I sent you already, allow me to summarize and put in a brief outline of what we do here with IAAP.

1.) Make sure your academic and workforce committee or your board reaches out to all your human services depts. of your state colleges/universities to offer mentoring, involvement on their advisory boards, and promotion of appropriate addiction recovery profession academic courses in line with your state licensure.

2.) Make sure your state membership knows how to mentor students who are interested in the addiction recovery profession (offer training or refresher through newsletter or workshop), and how to obtain a student to mentor.

3.) Have lower student fee to join state affiliate/NAADAC and give students some incentive to attend state workshops and conferences (all of our workshops and spring and fall conferences are free to our students who are members of IAAP /NAADAC).

4.) Strongly encourage your addiction recovery professionals to pay for the student fee to join state affiliate/NAADAC for the student he/she is mentoring.

5.) Strongly encourage your addiction recovery professionals to each sponsor and mentor a student (and try to stay with that one student through associates, bachelor’s and master’s level of academics and the licensure levels).

6.) Have student members (must be members in good standing of state affiliate/NAADAC) representing regions of the state be full voting members on the state affiliate board of directors (with elections and term limits).

IAAP Member, this is all in place in our state and is still growing and in process. I would like to see more student involvement on our IAAP committees.

Please keep in contact and I would be interested in comments, suggestions, critiques you can offer us. I hope to meet you face to face in Indianapolis this year for our Fall Conference.

Only Our Best,

C. Albert Alvarez, LMHC, LCAC, MAC, CGP.

Albert, president of IAAP
C. Albert Alvarez, LMHC, LCAC, MAC, CGP

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This is often the experience of those who struggle with Post Traumatic Stress.

When a past traumatic event is recalled through a smell, a song, a word, a touch or any other reminders, it is experienced again through what we call emotional memory. This brings about an almost immediate, unanticipated emotional and often physical response. That over takes the person and sets them into panic mode. The process of assisting that person to stay in the moment is slow, challenging, though frequently successful.

First, the victim of these strong emotional events identifies someone they can talk with. Someone who will listen over and over again, as the story is told. This person may be a professional, but may also be a family member or friend, a caring person in our life. The role of the listener is to listen with patience, kindness and the absence of judgment, while helping the one in emotional pain to remain in the here and now while remembering their past experience.

The telling and re-telling of their story allows them to slowly over time shift from believing they are a victim to a position of being safely vulnerable. Vulnerable may sound as though it is weakness, but in fact, allowing self to be vulnerable gives courage--Courage to face the invisible and real demons of the past, by believing to our core that they happened in the past.

When an emotional memory occurs, it comes into our here and now. Yes, it happened in the past, but emotionally it is experienced right now. Being vulnerably aware of that feeling acknowledges its realness. Though it is a difficult feeling, our intellect reminds that it happened in another time and place. Not now. It was another time and place, when we were different than we are today. This is the thinking that keeps us into day and away from emotional remunerating.

Sometimes the flood of emotional memory allows us to feel. For some of us we have shut down feelings and opted for numbness. This flood of emotional memory gives us a kind of energy, powered by feeling. Even though it is fear filled, we also know it has life to it. A sense of energy that is comfortable. We mistakenly seize the energy as a sign of life, and we allow the remuneration to begin and to become part of us. Now we can recognize what is happening and interrupt this process by stepping away from feeling and stepping into thinking.

This is the beginning of the healing process. It is a process that may be repeated many times over a period of time. Each time we visit the pain or sadness it decreases its power to overwhelm us emotionally, mentally, physically, and spiritually.

This journey over time delivers us to an emotionally safer life as we increase our serenity and wisdom.

Jeanne Hayes
LMHC, LCAC, ICACII
Chairperson, Marketing & Communications Committee
BENEFITS OF NAADAC/IAAP MEMBERSHIP

- 33 free CE’s via NAADAC’s web-site: www.naadac.org - (Medication Management for Addiction Professionals: Campral Series and Blending Solutions).
- Free access to NAADAC’s online Career Center at www.naadac.org.
- Assistance with referrals concerning ethical or legal questions or complaints and two free hours of help on a Legal Assistance Hotline provided by NAADAC’s liability company with malpractice insurance available through the Van Wagner Group.
- Free subscription to NAADAC’s official magazine, Addiction Professional, which is published six times annually.
- Peer support and network opportunities through national and state conferences and workshops.
- Reduced rates for continuing education including the qualification course for the U.S Department of Transportation’s Substance Abuse Professional.
- Reduced rates for publications such as the Basics of Addiction Counseling: A Desk Reference and Study Guide, used by experienced professionals and as a guidebook for preparation for certification exams.
- Access to the NAADAC News, the association publication only available to NAADAC members.
- Substantially reduced rates for professional Certification and re-certification as National Addiction Counselor (NCAC) or Master Addiction Counselor (MAC). Please note that certification is not included in NAADAC membership but is a separate process. (Certification is not a requirement of membership in NAADAC.)
- New avenues for job opportunities and advancement with higher levels of certification.
- A 20 percent discount on all Hazelden Publishing and Educational Services (PES) resources.