President's Column

What to think about e-cigarettes?

Sherry McKee, PhD

Have you been asked this question, by clients, by colleagues? What do you think about e-cigarettes?

Do they represent a safer alternative to cigarettes, a means to quit smoking? Or has the past 50 years of successful tobacco control efforts led the tobacco industry to support the next generation of nicotine delivery devices? What are the short and long-term health effects of e-cigarettes? What are the consequences of nicotine use, in and of itself, including nicotine-related toxicity? How should e-cigarettes be regulated—as a tobacco product or as a medical device? Will e-cigarettes counteract successful tobacco control efforts by making cigarettes more acceptable? What effect does e-cigarette use have on vulnerable populations, such as adolescents or the mentally ill? What effect do they have on other drug use? These, and more, are just some questions that come to mind when I think about e-cigarettes.

E-cigarettes are available for retail and internet sale in the United States, unlike other countries which have banned their use (e.g., Australia, Canada, Mexico, and Switzerland). The e-cigarette market is currently estimated at $3 billion and positioned to increase to $10 billion within the next couple of years. Of concern, major tobacco companies (Altria Group, Reynolds American, and Lorillard) are heavily involved in the e-cigarette industry, supporting national advertising and lobbying efforts. Although television
ads for cigarettes have been banned since 1971, ads for e-cigarettes are currently legal. E-cigarettes are also heavily advertised on social media highlighting flavorings and celebrity endorsements—likely appealing to young users.

Epidemiological data documents the recent exponential increase in e-cigarette use among adults. Data from the 2014 National Health Interview Survey found that 13% of all adults had tried e-cigarettes (14% of men, 11% of women), with use highest in 18-25 year olds (21.6%) and declining with age. About 4% of all adults were current e-cigarette users, primarily comprised of current or former tobacco smokers. Data from the 2014 Tobacco Products and Risk Perceptions Survey found that 50% of cigarette users had tried e-cigarettes with 21% continuing their use. Additionally, 22% of e-cigarette users were former cigarette smokers and 10% of e-cigarette users had never smoked cigarettes.

Adolescents appear similarly receptive to e-cigarettes. The 2014 Monitoring the Future survey found that 17% of high school seniors and 16% of 10th graders reported e-cigarette use in the prior month. Of particular concern, data from the 2011-2013 National Youth Tobacco Survey found that e-cigarettes facilitated transitions to cigarette use. Overall, the odds of trying regular cigarettes in the past year were twice as high among e-cigarette users, and this rate increased by 400% in 11-13 year olds. Currently, there is insufficient data to understand how early exposure to nicotine as delivered by e-cigarettes affects development in adolescents, as well as transitions to other drugs of abuse. The e-cigarette device is being used as a discreet delivery device for other drugs of abuse (e.g., marijuana, various synthetic concoctions), the effects of which are often not known.

Proponents of e-cigarettes identify that they represent a harm reduction approach to quitting smoking. Every morning during my commute into the office, I pass a billboard stating “Quit Smoking. Vape”—but is this true? There is no question that cigarette smoking remains the leading cause of mortality and morbidity in the United States. Each year 556,000 adults die prematurely from something that is completely preventable. The costs of cigarette smoking to the US economy are staggering, exceeding $289 billion dollars annually. While significant strides in tobacco control have been made, approximately 1 in 5 adults still smoke cigarettes leading to the question—are e-cigarettes a safer alternative?

Unfortunately, there is very little data to evaluate whether e-cigarettes are a safe alternative in the short or long term. Studies to date identify that inhaled vapor may contain toxic metals (e.g., lead, nickel, and chromium), tobacco-specific nitrosamines (as nicotine is derived from tobacco), formaldehyde, and other known carcinogens. Overall, it appears that exposure to toxic agents is lower in e-cigarettes than cigarettes, but it is unknown whether these lower levels are safe. Another factor to consider is second-hand vapor exposure. While exhaled vapor does not contain smoke particles containing tar, or carbon monoxide, it does contain nicotine—exposing those in the environment to unwanted nicotine exposure detectible by urine analysis. The liquid itself also possesses a toxic and potentially fatal health risk to those refilling cartridges and to children who may consume the liquid.

With regards to quitting, recent data fails to support the use of e-cigarettes to assist in quitting smoking. Meta-analytic results of studies randomizing smokers to e-cigarettes containing nicotine or to placebo e-cigarettes, find no differences in quit rates (9% versus 5%). Further, there appears to be no advantage of e-cigarettes in helping smokers to quit smoking in comparison to other forms of nicotine replacement, such as the patch. In working with clients who wish to quit smoking, it will be important for providers to educate smokers about effective methods to quit smoking (e.g., FDA-approved medications in combination with counseling) and to educate them about the current state of knowledge regarding e-cigarettes. I also question how smokers approach the use of e-cigarettes as a cessation aid—and whether use is time-limited (as in the case of nicotine patch) or whether it’s viewed as a long-term maintenance solution to smoking. Surveillance data identify that e-cigarette use is most commonly used in current and former smokers; it will be important to identify how e-cigarettes influence transitions in and out of cigarette smoking. The recently released Population Assessment of Tobacco and Health (PATH) Study will be invaluable in this regard.

At this point in time many questions remain regarding e-cigarettes. Significant federal resources have been directed to increase our knowledge about e-cigarettes, which is rapidly changing. The lessons learned regarding tobacco control can help to facilitate and expedite regulation and health policy regarding e-cigarettes. As researchers and clinicians with expertise in addiction we can and should contribute to these efforts.

Sources / Additional Reading

- [http://circ.ahajournals.org/content/130/16/1418.full.pdf+html](http://circ.ahajournals.org/content/130/16/1418.full.pdf+html)
Editor’s Corner

Bettina B. Hoeppner

Welcome to the Spring 2016 issue of TAN!

Once again, the spring issue is packed with important SoAP announcements: the candidate statements for this year’s SoAP elections, and the official announcement of our SoAP 2016 Award Recipients! Please join me in congratulating these highly deserving and inspiring award winners, and in thanking our SoAP candidates for running for office and sharing their vision.

More closely to “home,” I also have a special TAN announcement: Please join me in welcoming our incoming TAN editor, Mateo Pearson, who will start his 3-year term with the Fall/Winter 2016 issue of TAN. Mateo hails from the Center on Alcoholism, Substance Abuse, and Addictions at the University of New Mexico, and will help Hillary and I wrap up our editorial term with the next issue of TAN. Meanwhile, Mateo is looking to explore new directions with TAN, and is hoping for your feedback. That’s right, YOUR feedback! To this end, he has created a quick 20-item survey. It would be wonderful if you could take a few moments to complete it by going to: https://www.psychdata.com/s.asp?SID=170107. From time to time, we get some informal feedback on TAN, which is always much appreciated—and never fails to make me smile. 😊 Mateo would like to get more comprehensive feedback, so that he has a better understanding of the features in TAN you value versus the things you’d like to see less of. It would be great if you could take the 5 minutes to answer the survey.

In addition to exciting announcements and the exploration of bold new visions for TAN, this issue of TAN is also the biggest issue TAN has published to date. Our call for articles on the topic “Perspectives on the Opioid Epidemic” has resulted in a record number of articles for TAN, 11 articles in total. It is clear that this topic strikes close to home. In these articles, our authors (including TAN’s very own Hillary Howrey!), provide comments on the context of the current opioid epidemic, including attitudes towards drug use and harm reduction, share personal and clinical experiences, describe the difficulties in providing appropriate pain relief in the midst of the opioid epidemic, and share views of ways in which we can respond to the opioid epidemic through meaningful legislative changes, improved drug education, and increased access to naloxone. I am grateful to these authors for taking the time to share these ideas and thoughts with us, and have greatly enjoyed reading them—as I hope you will!

In the next issue of TAN (June 1 deadline), we will focus on: “Impact of Social Networks on SUD Treatment and Recovery.” To this end, we invite you to submit an article on your research, clinical work, thoughts and/or ideas on this topic. Articles can take any approach to this general topic, including, for example, articles that examine how social networks function in specific populations, how they impact substance use and recovery, and how they could be leveraged to improve SUD outcomes. Thoughts on the special barriers to consider in either leveraging social networks to promote recovery or simply studying them are also greatly appreciated! Keep in mind that articles are short (1,200 word limit), fairly informal, and take many shapes (e.g., opinion pieces, descriptions of pilot or small studies, short reviews)—all factors, hopefully, that will make it easy for you to share your thoughts. We also invite you to submit an article on a topic of your choosing. In fact, if there is a topic you’d like to be explored in a future issue of TAN, please be sure to suggest this topic to us: We are happy to receive any and all ideas!

Happy reading!

Bettina Hoeppner
TAN Editor

Hillary Howrey
TAN Grad Student Mentee

Mateo Pearson
Incoming TAN Editor

Hope to see you!
The American Psychological Association Practice Organization (APAPO) holds its annual State Leadership Conference (SLC) in Washington; February 30 through March 1, 2016. The theme of the meeting this year, according to Dr. Katherine Nordal, Executive Director of APAPO, is *Expanding the Practice Spectrum*. Nordal reported that the Multistate Summit on Delineating Alternative Practice, Legal, and Financial Models for Integration helped to shape the meeting planning. Dr. Nordal anticipated that “...psychologists will continue to evolve their practices to meet technological, economic, legal, and regulatory challenges.” As such, the meeting will have a variety of continuing education sessions on the basic steps of integration, new practice models, and collaborating with insurers and other health professionals to advance integration.

I will be attending this meeting in my role as your Federal Advocacy Coordinator (FAC). I will report on the meeting sessions in the next issue of TAN. If any other members (students or otherwise) plan to attend the meeting, please let me know so that we can coordinate a visit during the meeting. If this sounds of interest and you might want to try to attend this “by invitation only” meeting in the future, let me know and I will provide some suggestions for how you may do this. Also, if you are a student interested in advocacy issues, please be in touch with me.

The anticipated legislative priorities for 2016 continue to focus on Medicare. Rates, supervision rules, and methods of funding technology requirements are important issues needing advocacy. For example, reimbursement rates for psychologists continue to be important because as these rates go down, fewer and fewer practitioners can afford to serve Medicare clients. A lack of providers has public health impact, especially for elders seeking services. Independent practice by psychologists serving Medicare clients also is important. Specifically, it is a priority to reduce unnecessary physician supervision. The fact is that if you have two clients with different insurance, one being on Medicare, and another not, they face different barriers to treatment. Psychologists serving the Medicare clients generally face requirements for physician signoffs and supervision simply because of Medicare rules, where those treating clients with the exact same conditions, but different insurance do not. This creates a bottleneck for services in areas where there is a shortage of physicians under Medicare, so this harms clients. Finally, the push of technology infrastructure as a necessary condition to serve Medicare clients’ needs attention really requires that psychologists be eligible for HITECH Act Incentives. This is because there are substantial costs that are well beyond what most practitioners can afford on their own. So, given all this, you are likely to hear more about how these issues move forward this year. Watch TAN, watch the listserv, and be sure to visit Practice Central for more information on these issues ([http://www.apapracticecentral.org/advocacy/index.aspx](http://www.apapracticecentral.org/advocacy/index.aspx)). The best way to reach me for follow up on any of these items is via napiotrowski@yahoo.com.

**Resource Information**

New Member Spotlight: Elizabeth R. Aston, PhD

Jennifer E. Merrill
Early Career Representative

Please welcome to SOAP a new member, Elizabeth Aston! Dr. Aston is currently an Assistant Professor in the Center for Alcohol and Addiction Studies (CAAS) in the Brown University School of Public Health. She completed her PhD in the Neuroscience Program at Wake Forest School of Medicine in Winston-Salem, North Carolina under the instruction of Dr. Anthony Liguori. Her graduate training focused on laboratory models of alcohol administration among heavy episodic drinkers. After completing her degree, she came to CAAS to complete a postdoctoral fellowship under the mentorship of Dr. Jane Metrik. There, she transitioned to studying marijuana use behavior and laboratory models of marijuana administration.

What are your research interests?
I am interested in the behavioral economics of marijuana. I have been studying marijuana demand, or relative value, via use of a marijuana purchase task. Specifically, I am investigating the influence of marijuana demand on marijuana purchase and escalation of use, and hope to use behavioral economics to inform marijuana taxation policy and evaluate potential pharmacotherapies for cannabis use disorders. I recently received a K01 award from NIDA to study demand in marijuana users over two phases. I am currently working on the first phase, which includes conducting qualitative research with recreational and medical marijuana users to understand their perceptions and knowledge surrounding marijuana use. I am also obtaining feedback on our current marijuana purchase task and plan to incorporate suggested changes into a new version. After the next version of the purchase task is finalized, I plan to validate it in the second phase of this research using cue reactivity and marijuana administration during a laboratory study.

How did you get interested in addictive behaviors?
My desire to study addictive behaviors began as an undergraduate student at Purdue University. As a psychology major, I took a course with Dr. Robert Meisel entitled “Drugs and Behavior.” I began to understand that addiction is complicated and pervasive, and I became committed to conducting research that would further our understanding of trajectories of substance use and the progression into addiction.

How did you hear about the Society of Addiction Psychology (Division 50) and what motivated you to join?
I heard about the Society of Addiction Psychology from several mentors and colleagues. I was eager to join as there are so many benefits related to professional and career development in belonging to this division, including mentorship, training, and targeted programming. I am looking forward to the many opportunities available for collaboration and networking in this community of amazing scientists. I am excited to attend the Collaborative Perspectives on Addiction Conference in San Diego this March. I am looking forward to learning about new research and ideas for addressing current problems in addiction from top scientists in the field.

What interests do you have outside of work?
I started snowboarding last year in order to have something to look forward to during the winter months in Rhode Island so I have been spending a lot of time practicing on the weekends! I spend the rest of my time hanging out with my dachshund, Pretzels.
Student and Trainee Perspectives

Megan Kirouac
Noah Emery

In this edition of Student and Trainee Perspectives we would like to highlight some things to look to. First, we discuss the division’s midyear meeting and speak to some programing that students and trainees planning to attend should drop into their calendars. Second, we would like to introduce a rising star in addiction psychology as part of our inaugural Student Expert section. This, and future iterations of the Student Expert, will showcase the efforts of a student whose exemplary work aligns with the topic of that issue of The Addictions Newsletter.

The 2016 Collaborative Perspectives on Addiction Meeting

SoAP’s midyear meeting Collaborative Perspectives on Addiction (CPA) is back for its fourth installment, this time in sunny San Diego, CA. The 2016 meeting will have a series of opportunities for students that we would be remiss not to mention.

First, students and trainees of all levels will want to take advantage of the free preconference workshop on Friday, March 18th from 10am-12pm, titled: “A Look Inside the Funding Process at NIAAA” by Dr. Anita Bechtholt, Program Director, Division of Treatment and Recovery Research, NIAAA. This workshop is intended to detail how the funding process really works at NIAAA. There will be a formal presentation followed by an open-ended discussion with attendees.

Also on the CPA agenda are two networking events directed toward students and early career professionals. These informal gatherings are intended to facilitate new professional relationships. Light food will be provided and a cash bar will be available. These social events will be held on the evenings of Thursday, March 17th and Friday, March 18th. Further details will be provided in an invitation sent to student and early career affiliates via email. So, please RSVP and take full advantage of this special event. Hope to see you in San Diego.

Introduction to the Student Expert

Tessa Frohe is a first-year graduate student in the Department of Health and Human Performance at the University of Florida emphasizing in Behavior and Addictions. She completed her undergraduate degree in Psychology, Magna Cum Laude, at the University of New Mexico where she completed an emphasis in Addictions Counseling. Ms. Frohe has a strong background in research and public service that parallels her impressive academic record. She has demonstrated particular knowledge in the research and treatment for alcohol as well as opioid misuse. As student representatives for the Society of Addiction Psychology, we are excited to have Tessa Frohe as the inaugural “Student Expert” for this issue of The Addictions Newsletter and to hear her insight on “The Opioid Epidemic.”

From Tessa Frohe: The Opioid Epidemic

Growing up in New Mexico played a large role in how I initially became interested in the current opioid epidemic. New Mexico has been ranked one of the highest states for opioid overdose-related deaths for many years and most recently, in 2015, it had the second highest rate in the U.S. (United Health Foundation, 2016). Over the past decade there have been immense shifts in how the public, policy makers, and health care providers view painkillers or prescription analgesic medication. Most people are aware that pain relievers are within the same class of drug as heroin, all of which are opioids. From 1997 to 2002, medical use for opioids to treat pain within the US increased rampantly with the highest being oxycodone at a 403% increase (Gilson et al., 2004). As physicians first began prescribing opiates, many assumptions were made and the weight of addiction that came with them was not well understood (Ballantyne & LaForge, 2007). The most dangerous, addictive method of ingesting opioids is when they are crushed and then snorted or injected, as well as when they are combined with other pills, drugs, or alcohol (Volkow, 2014). The combination of increased prescriptions with aberrant behavior led to a 124% increase in unintentional overdoses within the U.S. between 1999 and 2007 (Bohnert et al., 2011).

Since then, many safeguards have been put into place in an attempt to reduce this colossal occurrence. In 2010, OxyContin was recoded, which made it more difficult to crush and dissolve. This was done to deter any aberrant behavior and to reduce the experience of an immediate high (Dryden, 2012). Green and colleagues (2015) found that this alteration shifted national patterns of prescription opioid use from 2009 to 2011. Prior to 2010, increased opioid use over time predicted “abuse;” however, after 2010 the trend stabilized and the initiation of heroin increased (Green et al., 2015). These trends reflect what has been described as a Medusa Effect—in that when you cut off a source at one point, another is almost inevitably going to appear somewhere else (Tucker, 2016). From 2011 to 2013 heroin use increased and...
the overdose deaths nearly doubled in the U.S. (CDC, 2015a). Dr. Tucker (2016) explained further that looking at this subsequent shift in terms of behavioral economics allows all parties involved to see the pattern alterations on a larger scale. Given that the sale and resale of drugs, both legal and illicit, becomes an industry, cutting off one source will not eliminate the demand; it merely shifts the market. As a new member in this field, I find trending data and unintended effects like these to be incredibly important as we consider future approaches for such public health concerns. As students who will shape the future of this field, coming to recognize patterns like these are particularly valuable in addressing the opioid epidemic.

Since the shift in prescription opioids, Mexican cartels have increased their importation of cocaine, heroin, and meth to the U.S. (Winslow, 2015). In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) conducted a national survey on drug use and health. They found an increase of availability has shifted the common market of heroin consumers to demographics that have never had such easy access to these products, such as non-Hispanic white, men, 18- to 25-years old (SAMHSA, 2015). Furthermore, SAMHSA (2015) goes on to report that heroin use has spread among women, individuals with higher incomes, and people with private health insurance over the past decade. The National Drug Early Warning System (NDEWS) annual project report found a border-related difference in patterns of use among students located near the Mexican border (i.e., higher use of marijuana, cocaine, and heroin), while non-border students reported higher use of methamphetamine (Maxwell, 2015). In the same report, a warning was published that heroin users have become younger and the amount of heroin seizures on the western part of the border have increased by over 350% within the last ten years (Maxwell, 2015). Furthermore, SAMHSA (2015) found that 21.5 million Americans (ages 12 and older) were diagnosed with a substance use disorder (SUD). From that population, 1.9 million reported an SUD involving prescription pain relievers and 586,000 reported an SUD involving heroin (SAMHSA, 2015). The number of overdose death rates involving both prescription pain relievers and heroin accounted for 63% of lethal drug overdoses in 2014 (CDC, 2015b). This ever-growing epidemic has gained national recognition and recently the White House Administration (2015) held a press release to propose investments that tackle the prescription drug and heroin epidemic by addressing multiple facets of the issue; the main two being prescriber training and improving access to treatment. This epidemic seems to be reaching all demographics, which makes it especially pertinent to young people as we educate our peers and further disseminate the information to others as we discover more, going forward.

As a student in this emerging field, it is clear that multidisciplinary efforts are necessary to address these concerns. Substance abuse treatment services for opioid abuse or dependence are being offered larger endorsements to work with Medicaid and other insurance companies as well as in community settings (CDC, 2015a). Additionally, local policy that will allow it, is ensuring that people have access to integrated prevention services, such as access to sterile injection equipment (CDC, 2015a). Grants are being offered for large trainings for Naltrexone administration, which can help combat opioid overdose (CDC, 2015a). Vast opportunities lie within these services to aid those in need. For students, the timing is just right to attain proper resources to do so. Going forward, taking a harm reduction, systems approach seems to be the most promising in that we can utilize multiple theories from diverse disciplines in order to find the most appropriate treatment outcomes for each group or individual. Approaching this topic with as many stakeholders as possible appears to be the most beneficial way to tackle such a widespread problem. The Medusa Effect will remain; however, the future of the field has the opportunity to keep this in mind while making further plans. Being aware of what resources we cut off and attempting to predict safeguards that reduce negative consequences over solely reducing use may be the best option for the widespread and heterogeneous patterns of use in this current opioid epidemic.

References


Substance Abuse and Mental Health Services...


Bruce Liese

Those who know me know how passionate I am about Division 50. I am among the founding members and haven’t wavered in my commitment to the Division since joining back in 1993. I served as Editor of our Division 50 Addictions Newsletter for 10 years (1993-2003) and received the Division 50 President’s Citation for my work in that role. I have been Division 50 Membership Chair for the last two years and as a result, have gotten to work closely with a terrific committee and great Division 50 officers. About a year ago I initiated monthly Nationwide Division 50 Conference Calls for students and post-docs and, with lots of help from the Membership Committee, these calls have been going strong—with an average of 25 individuals participating in each call, each month. And as a supplement to these calls, I have designed a website (www.cbtaddictions.com/d50) where you can download and listen to any of these archived conference calls. Last year at the APA convention in Toronto, our Division gave me an award for Distinguished Career Contributions to Education and Training. While involved in the Division, I have been a Professor at the University of Kansas, where I’ve taught in the departments of Psychology, Psychiatry, and Family Medicine for more than 30 years. As you might guess, my teaching, research, practice, and other scholarly activities have all revolved around addictive behaviors. For more than 30 years Division 50 has given so much to me that I can’t imagine a better way of giving back than serving as President-Elect and then President of our Division.

Lori Eickelberry

I am a Board Certified practicing psychologist and graduate psychology instructor. As owner of two clinics that serve patients with addiction issues, I am well-versed in the clinical areas of need in our field. With your support, my major focus will be on important areas that are barriers...
2016 Award Recipients for the Society of Addiction Psychologists (SoAP)

Kim Fromme, Chair Fellows and Awards Committee
Members: Thomas Brandon, Gerard Connors, and Tamara Wall

The SoAP Fellows and Awards Committee is pleased to announce the following 2016 Award Recipients.

Linda Carter Sobell: Distinguished Scientific Contributions to the Application of Psychology Award

Dr. Linda Sobell is the 2016 recipient of the Distinguished Scientific Contributions to the Application of Psychology award. Dr. Sobell is a President’s Distinguished Professor in the College of Psychology at Nova Southeastern University and Co-Director of the Guided-Self-Change Clinic, in the Community Mental Health Center at Nova. She has been the recipient of a long and prestigious list of awards and honors, including a Lifetime Achievement Award from the Association for Behavioral and Cognitive Therapy, the Distinguished Scientific Contributions to Clinical Psychology Award from Division 12 of APA, the Presidential Citation from APA, and the Jellinek Memorial Award for outstanding contributions to the advancement of knowledge in the addiction/alcoholism field. Dr. Sobell was also elected to the APA Board of Scientific Affairs in 2015.

Dr. Sobell’s long and extremely productive career has made numerous important contributions to addiction science, and to the alcohol field specifically. She is internationally recognized for multiple areas of research, including the development and validation of the Time-line Follow-Back assessment, which has become the gold standard for the measurement of self-reported alcohol consumption. Dr. Sobell has also been at the forefront of discovering and documenting the processes of natural recovery from substance abuse, finding for example that life events often accompany, but are not causally associated with, changes in drinking behavior. With support from the National Institute on Alcohol Abuse and Alcoholism, Dr. Sobell designed and evaluated the first controlled study of natural recoveries, involving individuals who had recovered without treatment and others who had similarly severe problems but had not recovered nor been in treatment. From the innovative program of research which grew out of this initial study, Dr. Sobell concluded that natural recoveries are much more prevalent than had been previously thought, and that the primary precipitant of recovery is a cognitive evaluation process (i.e., weighing the cost and benefits of change).

Dr. Sobell continues to demonstrate her leadership as a researcher and innovator in the alcohol field through randomized clinical trials of cognitive behavioral treatments for problem drinkers and the use of smartphone applications to facilitate self-change. Dr. Sobell’s impressive and important body of work has expanded our understanding of the process of change in addictive behaviors, and made enduring contributions to the application of psychological knowledge to addiction science in the areas of assessment, treatment, treatment outcome evaluation, and technological advances.

Joseph William Ditre: Distinguished Scientific Early Career Contributions Award

Dr. Joseph Ditre is the 2016 recipient of the Distinguished Scientific Early Career Contributions award. Dr. Ditre received his PhD in clinical psychology in 2010 from the University of South Florida and completed his pre-doctoral internship at the James A. Haley VA Hospital. He then accepted his first Assistant Professor position in the Department of Psychology at Texas A&M University (2010-2012). Dr. Ditre is currently an Assistant Professor in the Department of Psychology at Syracuse University, as...
well as an Adjunct Assistant Professor in the Department of Medicine at Upstate Medical University, and an Affiliated Scientist in the Center for Integrated Healthcare at Syracuse VA Medical Center. His primary research activities are in the areas of Health Psychology and Behavioral Medicine, with an emphasis on the intersection of addictive behaviors and comorbid medical disorders. More specifically Dr. Ditre’s research examines how the use of substances may influence the onset and progression of comorbid medical disorders, and how the symptoms of chronic medical conditions influence the use/misuse of addictive substances.

Using a multi-methods approach, Dr. Ditre has established a productive program of research to study complex interrelations among pain, affect, comorbid psychopathology, and the onset or maintenance of addictive behaviors. He has 31 peer-reviewed publications that have appeared in top tier psychology, pain, and addiction journals, including Psychological Bulletin, Journal of Abnormal Psychology, and Psychology of Addictive Behaviors. Dr. Ditre is currently supported by two R21 grants from the National Institute on Drug Abuse (NIDA) which address novel aspects of the association between smoking and pain. Dr. Ditre is at the cutting edge of research that has both theoretical and practical significance at the intersection of substance abuse and chronic and acute pain.

Cora Lee Wetherington: Outstanding Contributions to Advancing the Understanding of Addictions Award

Dr. Cora Lee Wetherington is the 2016 recipient of the Outstanding Contributions to Advancing the Understanding of Addiction award. Dr. Wetherington joined NIDA in 1987 as a program officer, and in 1995 she assumed the role of NIDA’s Women and Sex/Gender Differences Research Coordinator, aimed at advancing and infusing the study of females and sex/gender differences into all areas of drug abuse research. Dr. Wetherington is being recognized for her advocacy efforts to help ensure that the examination of sex and gender differences remains at the forefront of NIDA’s research mission. Dr. Wetherington serves on the Trans-NIH “Sex as a Biological Variable” Working Group and is NIDA’s representative to the NIH Coordinating Committee of the Office of Research on Women’s Health (ORWH). Dr. Wetherington’s advocacy efforts have helped to advance policies and practices which ensure that sex/ gender differences are addressed in all NIH grant submissions.

2016 APA Convention

Lara Ray & Christian Hendershot
2016 APA Convention Program Co-Chairs

The 2016 APA Convention will be held in Denver, Colorado from August 4th-7th. We’ve got a fantastic program scheduled for this year, featuring SoAP (Division 50)-sponsored symposia and poster presentations that will be of broad interest to clinicians, policy makers, research scientists, and students. A diverse range of addictive behaviors will be covered, including alcohol and marijuana use, smoking, and other drug problems, as well as disordered gambling and internet addiction.

Our theme this year is “Application of Precision Medicine to Addiction Science.” Topics covered include: addiction phenotypes presented within a research domain criterion (RDoC) framework, clinical studies of addiction neurobiology and genetics, development and application of biomarkers, the use of technology to encourage health behaviors, and new targets for treatment and prevention.

Our president, Sherry McKee, will be presenting a talk entitled “Precision Medicine in Addiction Science and Treatment: Factoring in Sex and Gender Differences.” Dr. Ken Leonard will present an invited talk entitled: “The emerging importance of intimate relationships as antecedents and consequences of excessive alcohol use.”

Division 50 has collaborated with Division 28 (Psychopharmacology and Substance Abuse) to co-sponsor a symposium entitled: “Nicotine metabolism and smoking using precision medicine to optimize smoking cessation.” In addition, we have sessions covering integrated care for substance abuse and PTSD, “Does integrated substance abuse and PTSD treatment impact suicidal behavior in veterans.” A session entitled “Imaging the human male and female brain: Implications for precision medicine” will strengthen the overall theme for the division.

As in previous years, the SoAP and Division 28, with generous support from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA), will co-sponsor an Early Career Social Hour and Poster Session, during which early career members will have the opportunity to present their work and meet other SoAP members. This is an opportunity to see the work of some of the newest members of the field, and the quality of the work is outstanding. In addition, we are planning two invited NIAAA R13-supported sessions, one on mobile technology in research and interventions, and another focusing on brain-based approaches to treatment. We encourage all of our SoAP members to attend!

Details about the specific times and locations of these events will be published in the Summer issue of TAN and in the Convention Program.

2016 Convention Facilities include the Colorado Convention Center. ATTENDEE REGISTRATION BEGINS APRIL 15, 2016.

Last but certainly not least, we would like to thank all of the reviewers who provided expedient and thoughtful reviews. Their feedback was critical for making difficult decisions as we
developed this outstanding program. Reviewers include Anita Cservenka, Christian Hendershot, Christine Grella, Cinnamon Bidwell, Daniel Roche, Dana Litt, Denis McCarthy, Golfo Tzilos, Greg Homish, Hayley Treolar, James Murphy, Jeffrey Wardell, Jen Read, Jennifer Merrill, Jodi Gilman, Joel Grube, Jordan Braciszewski, Kaston Anderson-Carpenter, Kelly Courtney, Kristine Marceau, Laura MacPherson, Lorraine Collins, Lynn Hernandez, Mark Myers, Marya Schulte, Matt Martens, Matthew Keough, Matthew Kirkpatrick, Megan Yardley, Melissa Lewis, Raina Pang, Rebecca Houston, Rebecca Schacht, Roisin O’Connor, Sara Blaine, and Suzy Gulliver. We look forward to seeing you there! In addition to the Annual Convention, Denver boasts numerous cultural and outdoor attractions, and myriad forms of family entertainment. These include the world famous Rocky Mountain National Park, Museum of Nature and Science, Botanic Gardens, Denver Center for the Performing Arts, Denver Art Museum, Coors Field, the Denver Zoo, the historic Larimer Square, or Civic Center Park, which lies in the heart of Denver, and many shops and restaurants on 16th Street, which runs through the city center.

Future Convention Dates: Aug. 3-6, 2017 in Washington, DC, and August 9-12, 2018 in San Francisco, California.

Education and Training Committee

William R. Corbin, PhD
Member of the SoAP Education & Training Committee
SoAP Representative to APA ELC

Every fall, the APA Education Leadership Conference (ELC) in Washington, DC provides an opportunity for psychologists to convene to discuss educational issues that are critical to the advancement of the field. In addition to providing continuing education from leading scholars and opportunities to come together with valued colleagues, the ELC engages APA membership in legislative advocacy issues that are of concern to the psychological community. This year, the theme of the ELC was “Translating Psychological Science to Educational Practice, Policy and the Public.” Our SoAP was among a total of 60 organizations represented, including APA Divisions, Psychology Education and Training organizations, other Psychology organizations, APA Groups, and invited speakers. ELC attendees also visited Capitol Hill to
advocate for restoration of graduate student eligibility for the Federal Direct Subsidized Loan Program. It was my pleasure to serve as the Division 50 representative to the ELC once again, and I am happy to report back to the SoAP regarding my experiences at this year’s conference.

On October 18 and 19, distinguished speakers presented plenary sessions on a wide variety of issues related to the translation of psychological science to education and policy. On Sunday morning, Dr. Dan Willingham, author of “Why Don’t Students Like School?,” and “Raising Kids Who Read,” gave a thought provoking presentation on the application of psychological science to classroom teaching. Dr. Willingham argued that teacher education is often too abstract and focused on theories that cannot be easily translated into practical application. He suggested that “empirical generalizations,” or findings that have been shown to be consistent across a variety of contexts and topic areas are of greater value than abstract theories. Examples in a learning context are that learning requires attention and practice, and that probing memory improves retention of new information.

Dr. Willingham argued that learning these empirical generalizations and how to correctly apply them in educational settings could substantially improve the quality of education. The Honorable Brian Baird, former U.S. Congressman and a clinical psychologist by training, followed with an informative and entertaining talk about conflicts between what lawmakers need to know and what psychologists typically provide.

Later in the morning a distinguished panel of presenters continued the discussion of applying psychological science in the schools. Dr. Tim Kirby of George Mason University discussed findings from a national Kindergarten survey noting an apparent disconnect between the skills that teachers want to see and those that are stressed in Pre-K programs. In particular, Kindergarten teachers valued social-emotional skills as much or more than academic skills. Dr. Roseanne Flores of Hunter College followed with information about characteristics of high quality early education programs and how parents can identify programs that will deliver quality education. Dr. Rena Subotnik of the APA Education Directorate closed out the symposium with an overview of “Assessing and Evaluating Teacher Preparation Programs,” a project sponsored by the Coalition for Psychology in Schools and Education and the Board of Educational Affairs. Dr. Subotnik highlighted the challenges of the process and described some key principles on which there was consensus including the need to: use multiple methods and time samples; standardize implementation; train higher education faculty and staff on data collection and analysis; and support the continued development of better measures to evaluate teacher preparation.

Dr. Elana Newman of the University of Tulsa and Research Director of the DART Center for Journalism and Trauma closed the morning with an engaging discussion of the challenges of using psychological science to inform journalism. She outlined the many challenges of working at the interface of psychological science and the media in the context of her work on trauma, and stressed the critical importance of working with journalists to educate the public about mental health problems and approaches to treating them.

We spent most of the afternoon on our first day in break-out groups, with each group addressing a particular area in which psychological science may be applied to education or policy. I was part of a group discussing the application of psychological science in schools. We spent the majority of our time focusing on how to make the application of psychology to Pre-K-12 education a priority in APA’s new strategic plan. The consensus within the group was that people do not see APA as a key source of information on Pre-K-12 education despite the many materials that are already available on APA’s website. Thus, we felt that a key issue was informing the public about the availability of these resources to facilitate broader dissemination. It was a lively discussion and debate and it was rewarding to be able to reach consensus within the group about next steps for facilitating application of psychological science in the schools.

We closed day one with an overview of the legislative issue we would be going to Capitol Hill to promote the following day. Karen Studwell of the Education Directorate provided us with a history of the Federal Direct Subsidized Loan Program and the loss of this program for graduate students with the passing of the Budget Control Act of 2011. We were shown data on the growing debt of graduate students in psychology and we were also able to hear the very personal stories of students in the audience who were directly impacted by this policy change. These stories were compelling and provided valuable insight as we prepared for our visits to the Hill the following day.

Returning to our theme of translating psychological science to education, Dr. Stephen Chew kicked off the morning session on Monday, October 19. Dr. Chew was engaging and entertaining, using a variety of his own teaching strategies as he led us through the challenges of engaging in evidence-based teaching. He noted our tendency to rely on intuition, biases, and assumptions in our teaching despite our knowledge of research on learning strategies. It certainly made me stop and think about the many things I know from learning science but do not always implement in my own classroom. Dr. Chew noted that part of the problem is that what we know from learning science is not presented in a way that is digestible for teachers. Dr. Chew closed by presenting some key principles from learning science that can be directly applied to teaching and by stressing the importance of formative assessments. He also provided information about publicly available materials that can aid in applying what we know from psychological science to teaching. I plan to use some of the materials that he has made available on the Society for the Teaching of Psychology web page (http://www.teachpsych.org) when I prep my next course.
After the Education Advocacy Awards Luncheon during which the Education Advocacy Distinguished Service Awards were given, we dedicated our efforts to final preparation for the Hill visits, led by members of the APA Education Directorate and Soapbox Consultants. We learned the specifics of the proposed legislation as well as the language necessary to communicate effectively with our state senators and congresspersons. We also learned the importance of having a compelling and personal story. Luckily, given the importance of graduate education to everyone in the room, we were able to easily develop personal anecdotes regarding the importance of this particular legislative issue. We also discussed the budgetary issues that would challenge our state senators and congresspersons as we asked them to support allocation of limited federal budgetary resources to this particular cause. The leaders from Soapbox Consulting did an amazing job in helping us learn how to communicate effectively to bring the issue to life for our state representatives, and they got us excited about our opportunity to make a direct difference through our advocacy efforts. We also practiced our presentations while Federal Education Advocacy Coordinators (FEDACs), played the role of Congresspersons, giving pushback as we argued for their support for restoration of graduate student eligibility for the Federal Direct Subsidized Loan Program.

On Tuesday, October 20th, advocacy teams from each state visited the Congressional offices of our Senators, and met with the staff of the Representatives for whom we are constituents. As the only representative from our state I was on my own. Having been through this process once before gave me a bit more confidence and thinking about the stories of graduate students from my own department provided all of the passion necessary to advocate on their behalf. As was true during my first visit, I had a great time meeting with the incredible staff members of my state senators and the congresswoman from my district. For many of the staff members, the issue was one with which they were quite familiar as they were still working to pay off their own student loan debt. One staffer even told me that the congresswoman from my district was still paying off loans from graduate school. In the end, I was excited to have made a small contribution to the advocacy process. In November 2015 I was thrilled to learn that Representative Judy Chu (CA-27) introduced legislation that would amend the Higher Education Act to restore the eligibility of graduate students to the Federal Subsidized Loan Program. This outcome was at least partly a product of the efforts of the members of the ELC.

In summary, the ELC was a great learning experience for me, and a wonderful opportunity to make a real difference through legislative advocacy. I hope that this report helps inspire others to take an active role in promoting legislative issues of importance to our field. For more information about the ELC, please go to the APA website. Many of the presentations from the conference are freely available for download at http://www.apa.org/ed/governance/elc/. Finally, I would like to thank the SoAP for their support in making it possible for me to attend the Education Leadership Conference. I hope I will get the opportunity to serve in this role again in the future.

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**NIAAA-sponsored Symposium at the 2016 APA Annual Meeting**

We are pleased to present the topics and titles of this year’s NIAAA-funded symposia at the APA convention, funded by NIAAA’s R13 award to SoAP (PI: Buckman):

**Symposium #1: “Screening and Brief Intervention across Settings, Patient Populations, and Providers”**
Chair: Robert B. Huebner, PhD, National Institute on Alcohol Abuse and Alcoholism

Presenters:
- Stacy Sterling, DrPH(c), MSW: “Adolescent SBIRT in Pediatric Primary Care: Implementation Outcomes from a Randomized Trial in an Integrated Health Care Delivery System”
- Thekla Brumder-Ross, PsyD: “Large-scale implementation of alcohol SBIRT in adult primary care in an integrated health care delivery system: lessons from the field”
- Derek D. Satre, PhD: “Hazardous drinking among patients in depression treatment: Brief intervention outcomes and impact on psychiatric symptoms”

**Symposium #2: “Interactive Alcohol Research and Clinical Practice: Mobile Technology for Every Occasion”**
Chair: Anita Bechtholt, PhD, National Institute on Alcohol Abuse and Alcoholism

Presenters:
- Brian Suffoletto, MD: “An interactive text-messaging (SMS) program to reduce alcohol consumption”
- Reid Hester, PhD: “CheckupandChoices.com: An integrated web application for people with alcohol and drug problems”
- Marsha E. Bates, PhD: “Smartphone apps to measure and intervene in real-time physiological responses to triggers for relapse”
- Kathy Jung, PhD: “A wearable alcohol biosensor: Benefits and challenges”
Evaluation of Knowledge and Confidence Following Opioid Overdose Prevention Training: A Comparison of Types of Training Participants and Naloxone Administration Methods

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There has been a substantial increase in the number of opioid overdose deaths in the United States (US) from 1999 to 2012 (Warner, Hedegaard, & Chen, 2014). Naloxone education and distribution is a prevention strategy that has been used more recently to reduce risk among individuals who use opioids. Naloxone is an opioid-antagonist that can be safely administered to prevent overdose-related deaths (Boyer, 2012). Given these benefits, states have passed legislation to increase naloxone availability to laypersons and non-medical providers (e.g., friends and family members of individuals who use opioids). Training programs have been developed to increase the distribution of naloxone to the public and to enhance general public awareness of the dangers of opioid overdoses (Enteen, Bauer, McLean et al., 2010).

Studies have indicated that opioid overdose or “reversal” trainings increase participant knowledge about recognizing overdose situations and using naloxone (Strang, Mayet et al., 2008; Tobin, Sherman, Bilenson, Welsh, & Latkin, 2009). Despite having and retaining knowledge following these trainings, many participants continue to use non-recommended or incorrect strategies when responding to an overdose situation (Clark, Wilder, & Winstanley, 2014). One potential explanation, based on theories of health behaviors (Bandura, 1977; Rosenstock, Stecher, & Becker, 1988; Ryan & Deci, 2000), is that individuals may lack confidence in their abilities to recognize and respond to overdose situations.

There is little research examining the extent to which opioid overdose trainings affect confidence in one’s ability to intervene during an overdose situation. In addition, the confidence of training participants may vary as a function of how naloxone is administered. Both intramuscular injections and intranasal sprays of naloxone can be administered safely and effectively; however, targeting confidence as a training outcome is another important indicator in examining the utility of each.

To help address these gaps in the literature, this study examines the effect of an opioid overdose training program on participants’ knowledge about overdoses and confidence to recognize and respond to an overdose situation. We also examine the impact of route of naloxone administration and participant type (i.e., friend/family member, healthcare provider, or another category such as public safety officer) on knowledge and confidence scores.

Over a one-year period (4/2014-4/2015), participants were recruited from a mid-sized metropolitan area in the northeastern United States via medical campus flyers, email blasts, word-of-mouth, and snowball sampling. The majority of training was completed on the campus of a university-based medical center; however, trainings in the community were also available. Pre-training knowledge was assessed by seven true-false items about signs of an opioid overdose, typical contexts of overdose situations, mechanisms of action, and legal repercussions associated with opioid overdose situations. We used an adaptation of the Perceived Competence Scale (Williams & Deci, 1996) to assess participants’ confidence with regard to their abilities to recognize and respond to overdoses using a seven-point rating scale (1 = “Not at all true,” 7 = “Very true”). An interdisciplinary addiction team led a 20-45 minute didactic presentation, which described the epidemiology and physiology of opioid overdoses and the potential benefits of naloxone in the context of overdose prevention. There was also a skills training component to demonstrate appropriate administration of the naloxone. Participants then received the post-training assessments and were given a take-home naloxone kit.

A total of 428 participants were included in the analysis after excluding 90 individuals for not completing all assessment measures. Trainings that instructed participants how to administer naloxone through an intranasal spray (n = 274) occurred from August 2014 to April 2015; trainings for intramuscular injections (n = 154) were conducted from April 2015 to July 2015. Participants were asked to select one of the following: “Patient” (n = 3; excluded from the analysis) “Provider” (n = 93), “Family Member/Friend” (n = 14
Overall knowledge and confidence increased significantly from pre- to post-training (ps < .001). There was no significant association between knowledge and route of administration or participant type. Knowledge significantly increased from pre- to post-training in all participant types and in trainings with both routes of administration (ps < .001). Confidence improved significantly from pre- to post-training across both routes of administration (ps < .001). However, confidence was higher among those who were trained to use the intranasal naloxone compared to those who were trained using the intramuscular injection naloxone at pre- (p = .011) and post-training (p < .001). Confidence increased from pre- to post-training in each of the participant types (ps < .001). Post-hoc tests revealed that post-training confidence was higher among providers and friends/family members compared to “other” participants, such as first responders (p < .05).

The results of the study were consistent with other research demonstrating that opioid overdose training increases knowledge and confidence (Sherman, Gann, Scott, Carlberg, Bigg, & Heimer, 2008). This study demonstrates that the content of the training can be disseminated in a way that knowledge about this topic can be achieved across a variety of participant types. Additionally, this was the first study to our knowledge that used quantitative measures of confidence and a broad recruitment strategy that included a large, diverse sample. Furthermore, this study demonstrated that confidence varied both as a function of participant type and the route of administration on which the participant was trained.

There may be several reasons why we found that confidence was higher in providers and friends/family compared to “other” participant types and among those trained on the intranasal spray versus intramuscular injection. One reason for enhanced confidence among providers may be due to their familiarity with biomedical situations and crisis response. Similarly, friends/family members may have more first-hand experiences dealing with opioid-related negative consequences. Confidence may be higher among those who were trained using intranasal naloxone because this route of administration circumvents needle-stick injuries which could occur when administering naloxone intramuscularly. Intranasal spray avoids the potential for fearing needles and potential exposure to blood-borne diseases.

Generalizability across settings, by different trainers, and to patients requires further research. Additionally, a long-term follow-up examination would be needed to assess if participants retained their knowledge and confidence. Despite these limitations, this study demonstrates that this training was brief, easily transferrable and understandable, and can increase participants' knowledge and confidence to respond appropriately in opioid overdose situations. Future research using longitudinal designs could test the degree to which knowledge acquisition and confidence is related to effective naloxone administration in hypothetical and/or actual overdose situations.

**References**


Falling Down the Rabbit Hole: Perspectives of Chronic Pain and the Opioid Epidemic from the Field

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Introduction

Evaluation and treatment of chronic, non-cancer pain (>3 months or past time of normal healing) as part of a multidisciplinary treatment program often places psychologists and other mental health providers at the intersection of managing both patient and medical providers’ expectations regarding the use of opioid medications. As the economic, mental health, and medical consequences of prescribing opioid medications have mounted, the prevailing logic regarding the usefulness of prescribing opioids for chronic pain (CP) has shifted (Centers for Disease Control and Prevention (CDC), 2013; Ives et al., 2006). In fact, the CDC recently released proposed guidelines aimed at curbing inappropriate pain medication prescriptions (Dowell, Haegerich, & Chou, 2016).

Clearly, both CP and opioid misuse are problems of great public health significance. Chronic pain affects about 100 million Americans (Institute of Medicine, 2011) and adequate pain control has been described as a human right (Hall & Boswell, 2009; Lohman, Schleifer, & Amon, 2010). However, some CP patients have perceived that “right” to mean entitlement to opioid analgesics for prolonged pain control (Zgierska, Miller, & Rabago, 2012). As a result, physicians may feel pressured to continue prescribing opioids—thereby reinforcing the patient’s beliefs and reliance on medication (Dorflinger, Kerns, & Auerbach, 2013). The widespread dissemination of opiates and the lax safety measures placed on their storage has also led to an increase in non-medical use. In 2012, more than 2 million people in the US used prescription drugs non-medically for the first time, and between 29-60% of individuals with opioid use disorders also reported moderate-to-severe CP (National Survey on Drug Use and Health, 2015; Peles, Schreiber, Gordon, & Adelson, 2005; Potter, Shiffman, & Weiss, 2008; Rosenblum et al., 2003; Sheu et al., 2008). Given the high level of comorbidity between opioid use disorders and CP, mental health providers’ decisions about how to address treatment with patients who may have or who have been diagnosed with substance use disorders (SUD) are often complex.

A rabbit hole, in a metaphorical sense, is a long and winding exploratory path with many connections and offshoots. The field of CP management has undergone a circuitous adventure, but we have learned a lot throughout the last two decades. Traditional, “biomedical” methods used to treat acute pain have proven unacceptable in the treatment of CP; additionally, single modalities of treatment—whether pharmacological, interventional, physical, psychological, rehabilitative, or an alternative modality—rarely have been found to be sufficient (Turk, Wilson, & Cahana, 2011). Governing agencies now suggest that CP patients should be approached using the “bio-psycho-social” method, which requires that the pain provider not only identify biomedical factors, but also encourages providers to focus on the psychological, social, and spiritual elements believed to be responsible for the persistence of the pain (Turk & Okifuji, 1998). Biopsychosocial methods tend to utilize comprehensive psychosocial diagnostic strategies, are long-term, assess effects of pain, and define pain as a complex problem requiring treatment of the whole person, including mind, body, and spirit.

New Guidelines for Opiate Prescriptions

Despite some opposition from various stakeholders, the new CDC guidelines for initiation, selection, and assessment of opioid therapy risk indicate that non-opioid and non-pharmacological (i.e., behavioral) strategies should be the first option for the treatment of CP (Dowell et al., 2016). Moreover, the CDC reiterates the limited evidence supporting the notion that the benefits of long-term opioid use outweigh the risks or improves functionality and quality of life in CP patients. Conversely, long-term opioid therapy is associated with higher rates of opioid addiction, mortality, overdoses, falls/accidents, cardiovascular events, endocrine complications, and has been found to be no more efficacious than other therapies (Keller, Hayden, Bombardier, & van Tulder, 2007). The new guidelines will require mental health providers, in particular, to assess for risk of overdose or development of a SUD, and to be keenly aware of their patients’ pain levels and pain management strategies when working as part of a system where opioid medications may be prescribed.

Role of Mental Health Providers Working with Individuals with Chronic Pain

Although it is likely helpful for all CP patients, behavioral management of pain should be strongly considered for individuals in treatment for any SUDs. Behavioral management of pain (e.g., Acceptance & Commitment Therapy, Cognitive-Behavioral Therapy, hypnosis, biofeedback, etc.) has been shown to have small-to-moderate effects on CP and psychosocial functioning (Cosio, 2016; Dowell et al., 2016). These effects are similar to those for exercise therapy and interventional pain management (i.e., epidural analgesics for prolonged pain control (Centers for Disease Control and Prevention (CDC), 2013; Ives et al., 2006). In fact, the CDC recently released proposed guidelines aimed at curbing inappropriate pain medication prescriptions (Dowell, Haegerich, & Chou, 2016).

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injections), and outcomes are improved when treatment modalities are combined to create comprehensive pain management plans. Currently available research indicates that common factors—a traditional psychological concept—may have a role in pain management, a concept endearingly termed a “Manumea effect” (Cosio, 2016). The Manumea is a cousin to the Dodo bird, and this “effect” references the “Dodo Bird effect,” or that all psychotherapies are effective and therefore useful based on their common factors (Wampold et al., 1997). Furthermore, the facilitation of common therapeutic factors such as provider empathy, therapeutic alliance, validation that a patient’s pain is genuine, and supporting positive expectations about multidisciplinary pain treatment are likely to be key aspects of a mental health provider’s role in helping patients with CP self-manage (Cosio, 2014, 2016).

**Patient and Provider Pain Education**

Pain education programs based on the bio-psycho-social approach to pain management emphasize the individual’s responsibility for self-management and should include pain education, wellness principles, and sound interventions. Thus, patients must be self-efficacious, have access to information about pain and pain management, be receptive to adopting a self-management approach, and be willing to participate in education efforts. The “Pain Education School” is offered within VISN-12 of the Department of Veterans Affairs (Cosio, Hugo, Roberts, & Schaefer, 2012) and is an educational program open to all Veterans and their caregivers. It is a comprehensive program that introduces patients to different modalities for self-management of CP, and includes modalities focusing on “lifestyle imbalance” (e.g., nutrition, recreation, sleep), rather than or in addition to the usual “chemical imbalance.” Past studies have shown that “Pain Education School” decreases pain intensity, improves pain knowledge, changes beliefs about pain and subjective pain experiences, and creates positive change on depression measures (Cosio & Lin, 2013). Mental health providers may also be able to assist patient outcomes by facilitating provider education and training (de Haes & Teunissen, 2005). Provider education and communication interventions, specifically appropriate boundary setting, may improve outcomes in pain management.

**Setting Boundaries**

When falling down the rabbit hole, an individual sets off on the path with a goal, gets sidetracked by various events and changes direction several times along the way, eventually ending up somewhere unexpected, typically without having satisfied the original purpose of the quest. For mental health providers working in addiction treatment, in particular, boundary setting with CP patients is essential. Boundaries are simply rules or limits that individuals create to identify reasonable, safe, and permissible ways for others to behave around them—and to determine how they’ll respond when someone oversteps these boundaries (Walters, 2014). Boundaries are not a threat or an attempt to control others’ behavior, rather, appropriate boundary setting will improve therapeutic relationships. Establishing appropriate boundaries is a skill that requires a lot of thought and practice, yet many providers have learned little about it in medical school or clinical training. There are four steps involved in setting appropriate boundaries (Learning & Violence, 2014):

1. Name or describe the behavior that is unacceptable
2. Express what you need or expect from the other person
3. Decide what you will do if he or she does not respect the boundaries you’ve established
4. Validate your actions by recognizing that setting boundaries is an important skill

Mental health providers are uniquely equipped to provide behavioral interventions, to improve patient motivation for change, to assist other providers with multidisciplinary pain management plan adherence, and to monitor for SUDs and overall risk. When working with patients who have comorbid SUDs and CP, embracing an educational, bio-psycho-social, and appropriately bounded approach to pain management will help prevent a fall down the rabbit hole.

**References**


The Twenty-First Century Opioid Epidemic: What Is Happening and What Can Be Done?

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Introduction

The early years of the twenty-first century have seen what we have previously described as a large-scale natural experiment in opioid provision (Darke & Farrell, 2015). We briefly examine what has occurred, and implications for addressing the problem.

Prescribing of Opioid Analgesics

The past decade has seen an unprecedented increase in the prescribing of pharmaceutical opioids (Berterame et al., 2016; Bohnert et al., 2011; Dart et al., 2015, Maxwell, 2011).

Globally, between 2001 and 2013, the number of utilized opioid doses doubled (Berterame et al., 2016). This phenomenon is most prominent in North America, where utilization of opioids increased from 2.4 billion to 5.3 billion defined daily doses, representing 72% of the world’s opioid doses (Berterame et al., 2016). Utilization, of course, reflects prescribing. In the US, between 1999 and 2008, dispensed prescriptions of opioid analgesics increased by 300% (Centers for Disease Control, 2012). More recent data showed prescriptions increased from 47 million in the first quarter of 2006 to 62 million at the end of 2012 (Dart et al., 2015).

Significant increases in consumption, and prescriptions, also occurred in western Europe and Australasia (Berterame et al., 2016). This is, however, very much a first world problem, with 96% of utilized opioid doses occurring in North America, western Europe and Australasia (Berterame et al., 2016).

While opioid analgesics are essential medicines (Berterame et al., 2016), such dramatic increases are unlikely to reflect unmet need. Indeed, the large increase in prescribing of these drugs is reflected in concomitant increases in their non-medical use (Darke, Duflou, & Torok, 2011; Dart et al., 2015; Giraudon, Lowitz, Dargan, Wood, & Dart, 2013; Rintoul, Dobbin, Drummer, & Ozanne-Smith, 2011). In the US, for instance, there was a 20% increase between 2002 and 2009 in the number of people who had recently used opioid analgesics for non-medical reasons (Substance Abuse and Mental Health Services Administration, 2010). Similar increases have been seen in western Europe and Australasia (Darke et al., 2011, Giraudon et al., 2013; Rintoul et al., 2011).

Mortality

As with all psychoactive substances, more widespread use is associated with higher levels of harm. In the US, pharmaceutical opioid overdose deaths have tracked prescriptions (Bohnert et al., 2011; Dart et al., 2015; Hedegaard, Chen, & Warner, 2015; Maxwell, 2011), increasing from some 1.5 per 10^4 in 2000, to approximately...
from 28 to 89 per 105, hydrocodone involving oxycodone increased rates of emergency room visits in the and use, between 2004 and 2009 Paralleling the increase in prescribing & Pearson, 2012; Rintoul et al., 2011). Importantly, the toxicology of these cases mirrors those of other opioids, including heroin, in that they overwhelmingly involve the concomitant use of other CNS depressants (Darke et al., 2011; Hall et al., 2008; Ogle et al., 2012; Rintoul et al., 2011).

Paralleling the increase in prescribing and use, between 2004 and 2009 rates of emergency room visits in the US involving oxycodone increased from 28 to 89 per 105, hydrocodone visits rose from 27 to 67 per 105, and unintentional overdose deaths rose by 124% (Maxwell, 2011).

Who is dying? Cases comprise two distinct groups: established injecting drug users (IDU), and chronic non-cancer pain patients (Carise et al., 2007; Darke et al., 2011; Hall et al., 2008; Ogle et al., 2012; Rintoul et al., 2011). The first two weeks of treatment appear to have the highest level of risk (Miller et al., 2015). Moreover, the introduction of long-acting preparations appears to have increased the risk of overdose (Dhalla et al., 2009; Miller et al., 2015). Importantly, in as many as half of cases the drug was not prescribed to the decedent (Carise et al., 2007; Darke et al., 2011; Hall et al., 2008; Ogle et al., 2009).

The increased use of opioids by IDU has implications for mortality beyond drug toxicity. Many IDU crush and inject such preparations (Darke, Duflou, & Torok, 2015). No matter how finely crushed, the injection of tablets leaves deposition of insoluble bulking agents in the pulmonary vasculature, that can cause pulmonary hypertension and right sided heart failure (Darke et al., 2015; Karch, 2009). This is a problem that will take a long time to emerge and impact on clinical settings, with long term complications.

Finally, we must not forget heroin-related death. Since 2010 heroin toxicity deaths in the United States have increased markedly (Dart et al., 2015; Hedegaard et al., 2015). Indeed, the use of pharmaceutical opioids appears to be a new entry point to heroin use (Cicero, Ellis, Surratt, & Kurtz, 2014).

What Can Be Done?

Given the direct relationship between supply and mortality, prescribing practices appear to be the most salient means of reducing harm. We must bear in mind, however, that opioid analgesics are an essential medicine, and availability for pain relief must be ensured (Berterame et al., 2016). As noted above, however, it is exceedingly unlikely that the need for such medications doubled in the United States. Medical schools and governing bodies could play a major role. It may well be necessary to change the scheduling of some of these substances. Ultimately, however, it will come down to the individual decisions of medical practitioners. Practitioners need to be cautious where younger polydrug users are engaging in high dose pain control regimes. Such approaches need careful and systematic auditing.

The attraction of these drugs to existing opioid users must also be borne in mind in prescribing, particularly given the apparently high rates of diversion.

A realistic determination of what is an appropriate population rate of prescribing also needs to be identified. We need to find a better balance between provision within the high consumer countries of the USA, Europe and Australia and develop better treatment access for the majority of the world’s population who are currently underserved by the current system.

The toxicology of pharmaceutical opioid overdose is strikingly similar to that of heroin-related death. Numerous public health campaigns have been directed at heroin users warning of the role of polysubstance use. To our knowledge, no such targeted campaign has been aimed at pain patients. This is crucial, as CNS depressants (e.g. diazepam) are frequently co-prescribed. Doctors clearly have a direct role in warning patients of the risks of polypharmacy, and of the risks of using alcohol with opioids. The first two weeks of treatment appear to be particularly risky (Miller et al., 2015), and post-prescribing monitoring would appear wise.

Opioid overdose is eminently reversible using the opioid antagonist naloxone. Serious thought should be given to the co-prescription of naloxone with opioids, especially for those with a higher risk profile. Naloxone is the opioid antagonist used to reverse acute toxicity, and can be administered by intravenous, intramuscular, subcutaneous or intranasal routes. The direct provision of naloxone to heroin users has been successfully trialled in the US, Europe and Australia, is available as an over the counter drug in some (e.g. Italy, Australia) (Darke, 2011; McCauley, Aucott, & Matheson, 2015). This would not save all lives. In cases where others are present, however, the use of such a drug may reduce the risk of anoxic brain damage and death. Finally, the introduction of new formulations of drugs such as oxycodone that are more difficult to crush and inject may well reduce this specific harm (Cicero, Ellis, & Surratt, 2012).

Conclusions

The marked increases in opioid prescribing has been associated with a substantial increase in morbidity and mortality. Addressing these problems will require behaviour changes from the users of these drugs and, most importantly, from those who prescribe them.

References

Reducing Overdose Risk by Increasing Access to Naloxone

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Background

Opioid overdose has reached epidemic levels in the United States. Over 28,000 Americans died of an opioid-related overdose in 2014, a 14% increase over the previous year and a more than six-fold rise since 1980 (Rudd, Aleshire, Zibbell, & Gladden, 2016; Warner, Chen, Makuc, Anderson, & Minino, 2011). This dramatic increase in opioid-related death was originally driven mostly by prescription painkillers (Hedegaard, Chen, & Warner, 2015), but heroin deaths have recently increased dramatically as well (Rudd et al., 2016).

Opioid overdose occurs when opioids, either alone or in combination with other drugs, cause respiration to slow to the point that insufficient oxygen is available to the brain and other vital organs (White & Irvine, 1999). Opioid-induced respiratory depression can cause irreversible cell death within minutes and, if untreated, can lead to hypoxia, unconsciousness and death (Michiels, 2004; Pattinson, 2008). This respiratory depression can be reversed by administration of naloxone, a pure opioid antagonist that displaces opioids from the brain receptors to which they bind, reversing their effects and restoring normal respiration (Chamberlain & Klein, 1994).

Naloxone is a prescription medication but not a controlled substance. Although it is stocked by nearly every inpatient medical facility, it has not traditionally been prescribed for outpatient use. This is rapidly changing. Because people who use drugs (PWUD) and their friends and family members are often already “on the scene” of an overdose, they are an obvious source of overdose rescue, and programs that distribute naloxone to laypeople began operating in several cities in the United States by the early 2000’s (Clark, Wilder, & Winstanley, 2014; Galea et al., 2006; Maxwell, Bigg, Stanczykiewicz, & Carlberg-Racich, 2006). As of 2014, over 140 such programs had dispensed naloxone to over 150,000 laypeople, with more than 26,000 overdose reversals reported (Wheeler, Jones, Gilbert, & Davidson, 2015).

Increased access to naloxone does not appear to encourage or increase drug use, and the distribution of naloxone to heroin users has been determined to be robustly cost-effective (Coffin & Sullivan, 2013; Doe-Simkins et al., 2014). It is almost certain that the practice reduces overdose mortality and morbidity. For example, a recent study found that communities in Massachusetts with higher access to naloxone and overdose training had significantly lower opioid overdose death rates than those that did not (Walley et al., 2013).

Legal Changes to Increase Naloxone Access

Despite the demonstrated benefits of providing naloxone to laypeople, a number of legal barriers have traditionally limited the practice. Chief among these are liability concerns on the part of prescribers combined with state medical practice laws that require a provider-patient relationship for the prescription of medication (Beletsky et al., 2007; Davis, Webb, & Burris, 2013). Additionally, people present at the scene of an overdose often fail to call 911 because they fear being arrested or charged with a crime, particularly when they are using illegal drugs or using prescribed medication other than as prescribed (Enteen et al., 2010; Tobin, Davey, & Latkin, 2005).

In the past few years, states have made great strides in modifying law and regulations to reduce these barriers. At the beginning of 2010, only four states had amended their laws to improve naloxone access. By September 2015, all but seven states (AZ, IA, KS, MO, MT, SD, WY) had passed legislation to make it easier for people who might be in a position to assist in an overdose to access the medication and, in most cases, to encourage overdose witnesses to become “Good Samaritans” by summoning emergency assistance (Davis & Carr, 2015).

Naloxone Access Laws

Thirty seven states now permit individuals otherwise authorized to prescribe naloxone to prescribe the medication not only to their own patients, but also to family members, caregivers, and others who are likely to be in a position to assist in the event of an overdose, a practice termed third party prescribing. Twenty seven states also permit naloxone to be prescribed via standing order, in which a prescriber issues a prescription for naloxone to be provided to any person who meets certain criteria, as opposed to a named individual. Twelve states also permit designated laypeople to distribute naloxone as directed by a physician or other prescriber. Nearly all naloxone access laws provide limited immunity to medical professionals who prescribe and dispense naloxone as well as lay people who administer it.

Although harm reduction organizations pioneered naloxone programs and continue to be the primary source for laypeople to obtain the medication, pharmacies are an increasingly important venue for naloxone access (Green, Dauria, Bratberg, Davis, &
Walley, 2015). Indeed, laws in 38 states now permit people to receive naloxone from a pharmacist without first seeing another practitioner, although in most states the naloxone must be dispensed via a standing order or collaborative practice agreement. Three states (CT, ID, and NM), however, permit some or all pharmacists to prescribe naloxone on their own authority, and six states (CA, IL, NV, OH, OR, and VT) permit pharmacists to dispense naloxone under a statewide protocol issued by one or more professional boards. As more medical professionals become familiar and comfortable with writing standing orders for naloxone and prescribing it directly to their patients, the amount of naloxone being dispensed from pharmacies is likely to increase dramatically over the next several years.

**Good Samaritan Laws**

As of September 2015, 35 states have passed laws to encourage bystanders to summon emergency assistance, typically referred to as medical amnesty or overdose Good Samaritan laws. Most provide a person who summons emergency responders in good faith protection from prosecution for minor drug possession, and nearly half (16) also protect the caller and victim from being arrested for those crimes. Twenty-two states also provide protection from prosecution for paraphernalia possession, with 13 providing protection from arrest for that crime. Sixteen Good Samaritan laws also provide protection from probation or parole violations, while six provide protection from other drug-related crimes. While these laws likely encourage some people to call 911 who otherwise would not, research focused on people who use drugs is necessary to determine if they are sufficient to overcome fear of arrest and prosecution among people who witness overdose events.

**Conclusion**

The outpatient prescription and dispensing of naloxone is formally supported by nearly every national clinical organization, and most states have modified state law to help ensure that naloxone is available when and where it’s needed. Prescribing clinicians should be aware of the laws in their state, and should be knowledgeable regarding when a naloxone prescription is indicated. In states that permit third party prescriptions, they should also consider prescribing naloxone to the friends and family members of people at risk of overdose as appropriate. Current naloxone access and overdose Good Samaritan laws can be found at [lawatlats.org](http://lawatlats.org). The website Prescribe to Prevent (prescribetoprevent.org) provides useful information for clinicians regarding appropriate naloxone prescribing and dispensing.

Naloxone is not a magic bullet; it reverses overdose but does not address potential underlying conditions such as addiction or poorly managed pain. Rapid scale-up of efforts to reduce inappropriate opioid prescribing, increase access to evidence-based treatment, and modify punitive, counterproductive criminal justice approaches to addiction are urgently needed as well. However, increasing naloxone access is an easy and cost-effective way for every prescriber to help reverse the overdose epidemic.

**References**


Understanding Opposition to Heroin-Related Harm Reduction: The Critical Role of Perceived Controllability

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The current heroin epidemic in the U.S. is especially acute in some regions, including the rural and urban Appalachian areas encompassing much of Kentucky, Ohio, and West Virginia. In northern Kentucky, heroin overdoses treated in local hospitals have more than quadrupled since 2011, reaching 1168 in 2015 (DeMio, 2016). In March, 2015, a coalition representing public health, law enforcement, and family members affected by the epidemic persuaded the Kentucky state legislature to pass a sweeping heroin bill; it was immediately signed into law by the governor (Wynn, 2015). Among other provisions, the law expanded access to naloxone, funded more treatment (including medication-assisted treatment [MAT]), and legalized syringe services programs (SSPs), pending local approval. Despite the groundswell of support for the new law, implementation has faced constant opposition. For example, few local physicians have become certified to prescribe buprenorphine (DeMio, 2016), many treatment programs are reluctant to accept MAT patients, and elected officials have yet to approve any SSPs in northern Kentucky (DeMio, 2015).

Because overdose prevention, MAT, and SSPs aim to mitigate harm associated with heroin use without requiring abstinence from all drugs or medications, we view them as forms of heroin-related harm reduction. To understand the opposition to these practices, we measured attitudes toward them and conducted two studies to explore theoretically relevant predictors of these attitudes.

Study 1

We developed multiple-item 5-point Likert scales assessing attitudes toward overdose prevention, MAT, and SSPs (1 = strongly negative and 5 = strongly positive attitudes); Cronbach’s α’s for all scales were moderate (.74 to .87). In an online study, a sample of 94 college students (Mage = 21.78, SD = 7.46; 71% female) completed these scales, along with scales assessing their beliefs about the extent to which heroin addiction is under individuals’ control (perceived controllability) and is a biological disease (disease model beliefs). Participants’ political identity (strongly liberal to strongly conservative) and feelings of anger and disgust toward heroin use were also assessed.

Of the three harm reduction practices, overdose prevention was viewed most favorably (M = 3.80, SD = .87); MAT was next (M = 3.71, SD = .73), and SSPs were viewed least favorably (M = 3.33, SD = .81). Next, we conducted three multiple regression analyses, using mean favorability ratings of...
each harm reduction practice in turn as the criterion and simultaneously entering perceived controllability, disease model beliefs, anger and disgust toward heroin use, and political identity as predictors. In each case, the regression was significant ($R^2$’s ranged from .39 to .48, all $p$’s < .001). Both perceived controllability and disease model beliefs significantly predicted attitudes toward each of the three harm reduction practices; $p$’s for perceived control ranged from .006 to <.001, and $p$’s for disease model beliefs ranged from .007 to .002. No other predictors were significant. Thus, opposition to heroin-related harm reduction was strongly associated with greater perceived controllability of heroin addiction and lesser convictions that heroin addiction is a biological disease.

**Study 2**

To replicate and extend the results of Study 1, we conducted a laboratory study of predictors of attitudes toward heroin-related harm reduction. The wording of some of the items in the scales was altered slightly, but the multiple-item scales maintained moderate internal consistency (Cronbach’s α’s: .65 to .84). Compared to the Study 1 sample, the 201 college students in Study 2 were younger (M age = 18.99, SD = 3.25), and slightly more (77%) were female. After completing scales assessing the Study 1 variables (perceived controllability, disease model beliefs, anger, disgust, and political identity), Study 2 participants also completed established or adapted measures assessing other variables we hypothesized to be relevant: the Social Value Orientation (SVO) Scale (Van Lange, De Bruin, Otten, & Joireman, 1997), a measure of preference for individualistic, competitive, or prosocial interactions; the Interpersonal Reactivity Index (Davis, 1980), a measure of empathy; the Essentialist Beliefs Scale (Bastian & Haslam, 2006), a measure of belief in the immutability of human characteristics; and the Perceived Dangerousness of Heroin Users Scale, adapted from Link, Cullen, Frank, and Wozniak (1987).

Like Study 1, overdose prevention was rated most positively ($M = 3.72$, $SD = .68$), followed by MAT ($M = 3.49$, $SD = .69$) and SSPs ($M = 3.09$, $SD = .73$). Next, we conducted three multiple regression analyses, using mean favorability ratings of each harm reduction practice in turn as the criterion and simultaneously entering perceived controllability, disease model beliefs, anger and disgust toward heroin use, political identity, SVO, empathy, essentialism, and perceived dangerousness of heroin users as predictors. In all cases, the regressions were significant ($R^2$’s ranged from .29 to .39, all $p$’s < .001). Perceived controllability of heroin addiction significantly predicted attitudes toward each of the three harm reduction practices (all $p$’s < .001). SVO predicted attitudes toward overdose prevention and MAT ($p$’s ≤ .039), but not SSPs. Greater perceived dangerousness of heroin users predicted opposition toward MAT and SSPs ($p$’s ≤ .021), but not overdose prevention. Essentialist beliefs predicted opposition toward MAT ($p = .030$) but not the other forms of harm reduction; no other predictors were significant.

Because the perceived controllability of heroin addiction was the most consistent and robust predictor of attitudes toward all harm reduction practices in both studies, we conducted exploratory multiple regression analyses to identify significant predictors of this variable. With Study 1 data, we treated perceived controllability as the criterion and simultaneously entered disease model beliefs, political identity, anger, and disgust as predictors. The overall regression was highly significant, $R^2 = .54$, $p < .001$. Each of the predictors except anger was significant ($p$’s ≤ .002), but disease model beliefs made the strongest contribution ($p < .001$); stronger beliefs in the controllability of heroin use was associated with weaker beliefs in the disease model, greater political conservatism, and stronger disgust toward heroin use. Using Study 2 data, we again found a significant overall regression, $R^2 = .33$, $p < .001$. Disease model beliefs were most significant ($p < .001$); SVO and perceived dangerousness were also significant ($p$’s ≤ .038), but the other variables were not. Like Study 1, participants who believed more strongly that heroin use is under individuals’ control had weaker beliefs in the disease model, were more pro-self than prosocial in their value orientation, and were more likely to believe people who use heroin are dangerous.

**Discussion**

Across two studies, we demonstrated that all heroin-related harm reduction practices are not equally acceptable: Overdose prevention training was more acceptable than syringe services programs, and MAT was in between. In addition, we showed that perceiving heroin addiction to be within individuals’ control was the strongest predictor of harm reduction opposition. In turn, believing that heroin addiction is a biological disease was the strongest predictor of perceived uncontrollability in both studies.

Our studies are limited by our use of college students, rather than representative samples of community residents, but our results nevertheless have theoretical and practical significance. Our findings are consistent with Weiner’s (1980) theory of responsibility attributions, in that people exhibit more blame and reduced helping intentions toward stigmatized conditions they see as controllable. Our results further suggest that, despite controversies surrounding the disease model of addiction (e.g., Reinarman, 2005), the model has utility for reducing stigma (Volkow, Koob, & McLellan, 2016). Understanding the roots of opposition to heroin-related harm reduction is an important step, but more work is needed to determine how to increase the persuasiveness of the disease model and build public support for life-saving harm reduction practices.

**References**

Addressing Overdose Will Require All Hands—and Shared Vision

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Almost daily we awaken to shocking and sensationalized news. Whether political statements, world events, weather calamities or human injustices we might fairly ask, “how much more can this planet take?” Lost inside this sense of powerlessness is something we can do since we created it and we can address it—today’s opioid epidemic.

Two major clinical indicators of an individual’s drug dependence are denial and rationalization. An experienced clinician’s reading of these can be as reliable as any toxicology screen.

At the societal level, denial and rationalization have contributed to our national lack of a unified Vision on substance use. Substance use can be seen as anything from a moral failure to a crime, as a necessary corollary of pain management to the consequence of sought anhedonia, or as illness with physical and psychological components on to itself. For many it is also an alternate economy and source of income in hard times. This income comes at a cost of lost quality of life and harm to others. For this reason, the absence of a unified Vision on substances, means that to address it will require our best efforts and an understanding of proven practices in distinct populations with various clinical presentations—augmented by the full local community participation, oversight and action, i.e., all hands.

Recent CDC data reported over 47,000 deaths in 2014 alone to drug overdose. This was a 14% increase over 2013. From 2000 to 2014 nearly half a million Americans have died from drug overdose (CDC, 2015). Since 2002 deaths have increased each year with no predictable end in sight, bringing the CDC to proclaim this an American “epidemic” (ONDCP, 2011). To put this into context, since entering combat in Iraq and Afghanistan we sadly have lost 7,402 of our military since 2001. We lost 58,209 American soldiers in total from 1954-1975 in the Vietnam Conflict (Statistic Brain Research Institute, 2016).

What Must Change?

It seems our society is a drug based society. While we comprise less than 5% of the world’s population we consume 80% of the opioids, 99% of the hydrocodone and 2/3 of the illegal drugs—worldwide (World Drug Report, 2011; Volkow, 2014). In 2014...
1.9 million people had a prescription opioid use disorder while over 100 million Americans were treated for pain (Volkow, 2014). Some 259 million prescriptions for opioids were written in 2012—enough for every adult American to have a personal month’s supply. Only 15% of those using non-prescribed opioids obtained them from drug dealers (CDC, 2014). Opioid overdoses are now the leading cause of unintentional deaths in the U.S. (CDC, 2015)—and yet pills alone can never solve life’s deeper issues nor alone offer true solutions.

Given this prevalence we must ask, “how prepared are we psychologists to screen, evaluate and treat substance use and dependence and sustain personal recovery?” In examining medical school curricula, I found that only 30% of US and Canadian medical schools provide any training in opioid use and pain management; moreover, only 10% offer training specific to the treatment of addiction (Morley-Forster, Pergolizzi, Taylor, Axford-Gatley, & Sellers, 2013). 50-80% of graduating physicians reported feeling unprepared to manage pain or treat addiction (Miller, Sheppard, Colenda, & Magen, 2001). And how about psychology? Today’s science and best practices suggest psychologists can play a major role in prevention, early intervention, family and individual treatment, building and sustaining recovery, pain management, research, community leadership, etc. How many courses in these were available to you? We must be better prepared and continually abreast of the nature of the illness, its treatment and the recovery from it.

Truth be told, if every person meeting clinical criteria (DSM or ICD) for substance use sought treatment the specialty substance use treatment system could handle no more than 10%—at full capacity (ONDCP, 2014). Receiving care from other more generalist, competent clinicians—and peers—is our only hope to reach the needs of today’s 24 million Americans who meet clinical criteria for substance dependence, let alone the millions working toward it with problematic use (SAMHSA, 2014).

Oh, many won’t want treatment—it’s the nature of the illness—but many might and leaving this treatment gap unaddressed and its subsequent $450 billion dollars of annual cost to society (McAllister, French, & Fang, 2010)—not to mention the human loss cannot be sustained. There is enough denial and rationalization to go around on this issue. Treatment capacity and skills must grow in all specialty and non-specialty practices.

What We Can Do?

Beyond the above foundational issues there are many short term things we can do. Throughout 2015 under a directive from President Obama the U.S. Department of Justice and the White House Office of National Drug Abuse Policy gathered 25 Federal agencies involved in the issue and produced an encompassing document known as the “National Heroin Task Force—Final Report and Recommendations” (US DOJ, 2015). This group reviewed each state’s actions, best science and practices, and roles for persons in recovery, families and communities to join with law enforcement in forming a “360-degree approach” to the solutions. By “360 degree” they mean a joint approach by law enforcement-researcher-coroner-physician-clinician-policy maker-person in recovery and family member united at the local level and armed with the best knowledge each can bring. Beside urging more available naloxone access for all with a history of opioid dependence and their families, they encourage community education, increased prevention, earlier intervention, more treatment—especially with medication support, more linkage to peer supports, comprehensive community and practitioner education and more competent practice including suggesting a review of each and every local overdose to better assess failed intercept points and while building safer communities. Highlighting effective programs in specific states, this report will offer twenty-three pages of specific recommendations with grounding citations within an “all hands” collaborative recovery focused model for each state and community. Another conceptual plan offered by Kolodony, Courtwright, Hwang, Kreiner, Eadie, Clark, & Alexander (2015) also builds a local “prevention” based approach for each level of overdose intervention.

The Substance Use and Mental Health Services Administration has promulgated a free Opioid Overdose Prevention Tool Kit (SAMHSA, 2016). The National Institute on Drug Abuse along with national professional associations such as the American Association on Addiction Medicine and the American Association for Pain Management have developed sound “practice guidelines” for both pain and/or substance dependence treatment using opioids. Several managed care companies (e.g., U. of Pittsburgh Medical Center Community Care Behavioral Health Organization) have developed locally relevant and practice guidelines (see: http://www.ccdbh.com/providers/phealthchoices/bestpractice/index.php) to use when addressing opioid treatment and medication assisted treatment. States, too, are now developing guidelines that can align with local laws and needs. Checking out any of these resources can prove helpful both for patient safety and sound, enhanced practice.

Our own American Psychological Association continues to offer specific credentialing in substance use via a Certificate of Proficiency from the School of Professional Psychology. Sadly, too few currently attain it. Expanding this number will instill new learning and consumer confidence in our profession as would gathering the many APA divisions that are touched by substance use in practice, addiction, pharmacology, community health, aging, special populations, teens, criminal justice ... all divisions to proclaim a priority to identify and address substance use in their division focus area. It touches all. Perhaps APA might also develop general practice guidelines for all psychologists addressing substance use and dependence.

At the heart of any solution is the will to do it. Psychology certainly can’t do
it alone but we must be willing to do more. We must be willing to cross the barriers of guilds and peers and unite in an “all hands” respectful, prioritized collaboration. This would bring a 21st century approach that defines a “new medical model” inclusive not only of best science but of broadened scopes of practice and enhanced involvement with the community and each family for a partnered accountability.

No one ever overcame an addiction in their therapist’s office—ever. We have nothing to lose and everything to gain. In its original Latin derivation addiction or “ad dicere” meant to give oneself up to a (negative) power or force other than oneself. 24 million Americans currently suffer from SUD, 40 million more are struggling with problematic use and headed toward SUD, 67% of all American families are now affected. (Center for Behavioral Health Statistics and Quality, 2015). It’s time. All hands on deck.

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The Opioid Epidemic: Can We Safely Manage Chronic Pain Patients with Opioids?

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The usefulness of opioids in the treatment of acute and cancer-related pain has been confirmed by several studies (Kelso et al., 2004), but worry over use of prescription opioids for chronic noncancer pain remains. Over the past decade, there has been a steady increase in use of prescription opioids in the United States, which has been the main contributing factor to the sky-rocketing incidence of opioid abuse. The number of opioid prescriptions written for pain in 1991 was 76 million and in 2012 reached an estimate of 259 million (Frenk et al., 2015). This increase has paralleled the increase in opioid-related overdoses and hospitalizations (Centers for Disease Control and Prevention, 2012). In fact, patients in the U.S. consume 80% of all opioid prescriptions worldwide and prescription drug abuse is perceived to be the fastest growing drug problem in America (National Institutes of Health, 2014). Due to the increased availability of prescription opioids there have been more deaths related to opioid abuse than cocaine and heroin combined. Now, more than ever, health care providers who treat persons with pain are concerned about adverse effects, tolerance, and addiction associated with prescription opioids, particularly among those with chronic noncancer pain (Bhamb et al., 2006).

Despite the need to identify misuse of opioids and to limit inappropriate prescribing, practitioners also struggle with providing appropriate pain relief for those patients who present with legitimate pain problems (Ballantyne & LaForge, 2007). In the U.S., there are many chronic pain patients who have failed surgeries and have not benefited from injections, rehabilitation approaches, or non-opioid medication. Although opioids may be the most effective treatment for pain, most clinicians are not adequately prepared to closely monitor patients with chronic pain who are prescribed opioids. Greater efforts by health care providers to improve identification of abuse and diversion of controlled substances have been strongly recommended by the US Department of Justice (Department of Justice, 2006). In particular, those individuals who seek prescriptions from multiple providers, use illicit drugs, snort or inject medications, sell and divert prescription drugs, and use drugs in a manner other than the way they were intended have been identified as particularly problematic.

A number of regulatory and professional organizations have released recommendations and guidelines related to the use of opioids among patients with chronic pain (Chou et al., 2009; Furlan et al., 2010). These guidelines emphasize the importance of opioid risk assessment before initiation of long-term opioid therapy. In addition to obtaining a thorough medical history, reviewing past medical records, and performing a medical examination, it is recommended that providers conduct an opioid risk assessment using validated screening tools. Structured interview measures based on DSM-V criteria have been useful in assessing alcoholism and substance use disorders (First et al., 2012), but often these measures lack validation with persons with chronic pain. Using traditional substance abuse measures increases the likelihood that tolerance and physical dependence will be identified when no abuse may exists.

Our group has been involved in developing and validating a number of opioid risk assessment tools. The Screener and Opioid Assessment for Patients with Pain—Revised (SOAPP-R) is a self-administered 24-item screening tool developed and validated for those persons with chronic pain who are being considered for long-term opioid therapy (Butler et al., 2008). The SOAPP-R was designed to predict aberrant medication-related behaviors. This questionnaire includes subtle items that identify certain behaviors that are positively correlated with opioid misuse, yet are not perceived to lead to reprisals. This screening tool has been found to identify over 90% of those who will eventually misuse opioids. It has been cross-validated in over 600 patients across the United States (Butler et al., 2009) and its reliability and predictive validity were found to be highly significant.

A related questionnaire to the SOAPP-R, The Current Opioid Misuse Measure (COMM), was developed and validated for patients who have already been prescribed opioids for chronic pain (Butler et al., 2007). Unlike the SOAPP-R that is a trait measure, the 17-item COMM is a state measure that can be repeated and helps to identify those patients who are currently misusing their prescription opioids. Other reliable opioid risk assessment tools also exist including the Opioid Risk Tool (ORT; Webster & Webster, 2005), the DIRE (Belgrade, 2006), the PADT (Passik et al., 2004) and the SISAP (Coambs et al., 1996).

Urine toxicology screens are particularly useful in determining a patient’s adherence to their prescribed opioid medication. Immunoassay urine screens can be helpful in determining
a particular class of drug present in the urine, but gas chromatography/mass spectrometry (GC/MS) is the most sensitive and specific type of urine screen and is particularly helpful in quantifying a particular prescription medication. GC/MS screens are also helpful in determining creatinine levels used to identify possible drug tampering or adulteration as well as presence of illegal substances and/or absence of prescribed medications. Objectively documenting compliance by obtaining a urine screen on every patient on opioid therapy at least yearly is recommended (Reisfield et al., 2007).

Prescription Drug Monitoring Programs (PDMPs) monitor and analyze electronic prescription data transferred from pharmacies and practitioners. PDMPs are one facet of a universal precautions approach that has been implemented clinically over recent years. Universal precautions assume a degree of risk for each patient and include risk assessment strategies as well as close patient monitoring in order to initiate and modify therapy in a safe and controlled manner (Gourlay et al., 2005). For instance, if a patient is screened and deemed to be at higher risk for opioid misuse, more frequent follow up may be indicated as well as signing an opioid treatment agreement, prescribing fewer doses of opioids per prescription, requiring frequent urine screening, using pill counts, and regularly checking the PDMP.

What can be done for those high-risk patients with chronic pain? We conducted a longitudinal randomized study to examine the benefits of close monitoring and cognitive behavioral motivational counseling to improve compliance with prescription opioid use among noncancer back pain patients at high risk for opioid misuse (Jamison et al., 2010). The results of the study showed that compliance training paired with very careful monitoring of high-risk patients can be successfully incorporated into a multidisciplinary pain program. Additionally, opioid compliance among high-risk patients could be improved to that of low-risk patients. This encouraging study demonstrated the value and importance of risk assessment, frequent monitoring with monthly urine screens and opioid compliance checklists, and motivational counseling to help improve compliance with opioids. In summary, prescription opioids are perceived to be a particular problem in the US due to increased availability and potential diversion. A number of strategies can help reduce opioid misuse. The recommended gold standard of care for all patients considered for chronic opioid therapy includes a comprehensive assessment with a thorough history and physical, a mandatory opioid agreement, and regular monitoring. For those patients at greatest risk for misuse of their medication, more frequent visits with urine toxicology screens, use of a compliance checklist, motivational counseling, and pill counts, if indicated, would be recommended (Jamison & Edwards, 2013). Even though risk of opioid misuse and addiction remains, greater focus on risk screening and documentation of outcome will help to mitigate the misuse of prescription opioids and ultimately reduce concerns associated with the opioid epidemic (Jamison et al., 2013).

References


The Epidemic of Nonmedical Opioid and Heroin Use in the US: A Result of Poor Drug Education

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We’re experiencing a heroin epidemic in the US, which is largely a result of addiction to opioids such as Vicodin and Oxycontin. Many of us blame doctors and others blame pharmaceutical companies (Gounder, 2013), but we tend to forget about another important factor—our lack of drug education in the US.

Prevalence of nonmedical opioid use is actually decreasing in the US (Miech, Johnston, O’Malley, Bachman, & Schulenberg, 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a); however, treatment admissions, overdoses, emergency department visits, and deaths related to use have increased (Chen, Hedegaard, & Warner, 2014; SAMHSA, 2013, 2014b). Aside from the potential for adverse health outcomes related to use, alarmingly, many users who are dependent are now transitioning to heroin as it tends to be less expensive and more freely available than opioids (Cicero, Ellis, Surratt, & Kurtz, 2014). In fact, my colleagues and I recently found that over three quarters of high school seniors in the US who reported heroin use also reported lifetime nonmedical use of opioids, and more frequent nonmedical opioid use robustly increased one’s risk of using heroin (Palamar, Shearston, Dawson, Mateu-Gelabert, & Ompad, 2015). Prescription drug monitoring programs and training to reverse opiate-related overdose have become more widespread to address increasing diversion, dependence, and deaths related to opioid/heroin use; however, we’re still way behind with regard to proper drug education in the US.

The Epidemic Can Affect Any of Us

I have been researching “party drug” use for some 15 years. My fascination with the drug ecstasy (MDMA, now commonly referred to as “Molly”) is what got me into my research and party drug use continues to be my main research interest as an epidemiologist. In all honesty, I’ve never been interested in studying addiction. However, in recent years, the public health issue of nonmedical opioid use has gotten so out of hand that I felt I had to begin to conduct some research of my own and speak out to the public about this important issue (for my recent opinion-editorial on the stigma toward heroin addiction, see: Palamar, 2015). Many of us have been touched by this epidemic—many of us know someone who is addicted to opioids and/or heroin, or we know someone whose family member or friend is suffering from such addiction.

For me, what hit closest to home was the death of my little sister, Tara.

Similar to the common trends described in the recent epidemiological literature, Tara’s dependence on opioids/opiates began with nonmedical use of Vicodin. Like many individuals in their late teens and early 20s, she had a history of dabbling with party drugs such as ecstasy. I was never really worried because I knew it was just recreational use. However, the day I discovered my prescribed Vicodin and Percoset missing I began to worry. I knew this was a problem because I knew she lacked the proper education to know the pills she began to take regularly (for recreation) could be physically addicting. Within a few years she progressed to Oxycontin, and then to heroin. Many people who have recently progressed to heroin say they only sniff and would never inject, and next thing they find themselves injecting. By this point it is usually a full-blown addiction that is extremely
difficult to treat—in part, due to the stigma associated with heroin use and addiction (Palamar, 2015).

**We are Poorly Educated**

Tara, like most other children a couple of decades ago, was taught that all illicit drugs are equally dangerous. For example, many of us have been taught that marijuana is as dangerous as heroin, and the chief of the Drug Enforcement Administration only recently admitted that “heroin is clearly more dangerous than marijuana” (Berenson, 2015). My sister and I, like many other teens, learned that marijuana is in fact not as dangerous as most illicit drugs out there. However, we learned this through experience and from friends. What many individuals do not know, however, is that opioid pills have a completely different set of risks than most recreational drugs and party drugs. What many users don’t realize is that these pills can be physically addicting. (And I stress “physically addicting” as in “classically” addicting—unlike many other drugs that may lead to other forms of dependence). Yes, plenty of people use opioids a couple of times and remain unscathed, but a lot of people find themselves caught in a habit, and by then it’s too late—they’re often physically addicted.

Many people who become dependent on opioids have simply been ill-informed about drugs. As aforementioned, many have been taught that all drugs are equally dangerous. Therefore, when they use other drugs such as marijuana and figure out that they have been lied to, they often no longer believe other anti-drug messages put forth by teachers or the government. Not only are most individuals at risk for use ill-informed about drugs in general, but many simply don’t realize that these “legal” government-approved pharmaceutical-grade pills can be even more dangerous than your typical “street” drugs. Many teens think, “If it is government-approved and mommy and daddy get it prescribed, then how can it be so bad?”

**Our Educators Need Better Drug Education**

Our kids need truthful, realistic information about drugs. Reasons why people use different drugs tend to be noticeably absent from most drug education. Likewise, many drugs tend to be simplistically categorized together with little to no differentiation with regard to effects or potential harms associated with use. In my opinion, the scariest part about our drug education situation is that many teachers have such a severe lack of drug education themselves that it is the students who often know more about them—and this is often from experience or exposure.

Most authority figures in general know very little about drugs. In recent years, I’ve conversed with teachers, parents, priests, police officers, and (sadly) even doctors who know very little about drugs. Just within the last few weeks I’ve been asked, “Is there a difference between cocaine and heroin? Doesn’t trying marijuana make you go crazy? How can pills be so dangerous if doctors prescribe them? Isn’t alcohol safer than other drugs like marijuana because it’s legal?”

Considering that most teachers know very little about traditional drugs, teachers likely don’t know very much about all the new drugs that have emerged in recent years. In 2014 alone, 101 new street drugs were discovered, and most of these are synthetic cannabinoids (e.g., “Spice”, “K2”) and synthetic cathinones (“bath salts”) (European Monitoring Centre for Drugs and Drug Addiction, 2015). So we now have to worry about use of (often “legal”) drugs like NBOMe and “Spice,” and we also now have to worry about smoking trends rebounding in the form of hookah and e-cigarettes.

As new drugs continue to emerge, educators are presented with many challenges. We can’t properly educate our kids if we don’t know even the basics about psychoactive drugs. No teen should disbelieve or be unaware that nonmedical opioid use can be very dangerous and addicting. We can blame doctors and pharmaceutical companies for this epidemic, but I, personally, think we need to blame our drug education. Drugs will always be available and our kids need to have enough information in order to make safer decisions. Our drug education methods need a desperate revamping and very quickly in order to save lives.

**References**

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Responding to the Opioid Epidemic: Vermont’s Hub and Spoke Model as a System of Care

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The Opioid Use Problem in Rural America: The State of Vermont

Over the past decade, rates of opioid use disorders (OUDs) have increased significantly, in parallel to the increased availability of prescription opioid medications (Han, Compton, Jones, & Cai, 2015). Opioid use has been of particular concern in rural states. For instance, in Vermont, opioid-related overdose death rates rose by over 85% since 2002, while state-funded treatment programs had an eight-fold increase in the number of patients seeking treatment for OUDs (Rossen, Bastian, Warner, Khan, & Chong, 2016; Simpatico, 2015). The increase in demand for long-term medication-assisted treatments (MAT), primarily methadone and buprenorphine, contributed to long waitlists for treatment throughout the state (Sigmon, 2014). While any DEA-waivered physician can prescribe buprenorphine, rural physicians had concerns about complex regulations, limited access to treatment for co-occurring psychiatric disorders, the adequacy of remuneration for buprenorphine prescribing, and a lack of training in treating OUDs (DeFlavio, Rolin, Nordstrom, & Kazal, 2015). Although a sizable number of physicians in Vermont were waivered to prescribe buprenorphine (Knudsen, 2015), those providers were only prescribing to a median of one patient (Blueprint for Health, 2014).

An Innovative Model

To increase the state’s capacity for treating OUDs, the Vermont Department of Health, the Blueprint for Health, and the Department of Vermont Health Access developed an integrated system-wide approach, called the Care Alliance for Opioid Treatment. This approach used a chronic disease management model in which opioid addiction was treated like other chronic conditions, including the development of patient registries, and the creation of practice guidelines (McLellan, Lewis, O’Brien, & Kleber, 2000; Moses & Klebonis, 2015). Vermont’s “Hub and Spoke” system integrated this chronic disease management model with the goals of increasing patients’ access to MAT, while providing quality, comprehensive care, and overcoming barriers to the widespread implementation of MAT in general medical practices (Moses & Klebonis, 2015; Simpatico, 2015).

Launched statewide in 2013, the Hub and Spoke system allows patients to flexibly transition from higher to lower levels of care based on their acuity, while providing access to community health teams and an established medical home (Department of Vermont Health Access, 2015). The rural state set up two types of opioid treatment programs: Hubs and Spokes. Hubs are specialty opioid treatment programs (OTPs) that traditionally dispensed methadone, though state Medicaid and third-party insurance companies initiated reimbursement rates to cover buprenorphine. In addition, Hubs provide intensive services addressing other substance use, psychiatric and medical conditions (Department of Vermont Health Access, 2013).

Spokes are office-based opioid treatment (OBOT) programs that provide buprenorphine and other services to less complex patients, who are sometimes existing patients in the practice. Currently, the majority of Spokes are family practice, obstetrics/gynecology (OB/GYN), psychiatry, or pain management practices (Department of Vermont Health Access, 2015). In addition to Medicaid and...
Not Only Access to Care, But Acceptable Quality of Care is Critical

Improving access to evidence-based treatment for OUDs is life-saving, but emphasis on the quality of care is critical. Substandard care is potentially dangerous, and may result in high rates of diversion and medication misuse. Of particular importance is reducing provider burnout and making this work emotionally sustainable and rewarding in a rural setting where practices are geographically dispersed and often isolated. Learning collaboratives are one strategy to address these issues, and typically include educational presentations, practice-based learning through case presentations, and the collection of common quality improvement (QI) measures (Institute for Healthcare Improvement, 2003). Over the past three years, Vermont utilized a learning collaborative strategy to foster adherence to guidelines, lead practice-based case consultation, reduce practice variation, and offer support to OBOT physicians and their practice teams. More than 6 cohorts of practices have participated, including over 34 physicians and 100 members of their practice teams. The effects on reducing practice variation and improving care quality were significant (Nordstrom et al., in press). Across practices, variation decreased on eight QI measures. Additionally, practices had significant increases in the percent of patients receiving monthly urine drug screens and improved utilization of the prescription monitoring system. Significant improvements were also found in the percent of unstable patients seen weekly and in the rates of adequate OUD documentation.

Measurable Impact

Over the past 5 years, a four-fold increase in the number of patients receiving MAT has occurred. Across Vermont, the Spokes were treating 1,837 Medicaid beneficiaries in the first quarter of 2013. By the final quarter of 2014 this number rose to 2,132 patients (Department of Vermont Health Access, 2015). Within these Spokes, 62 physicians were prescribing buprenorphine to ten or more patients (Department of Vermont Health Access, 2015).

More Work To Do

Coordinating care between physicians and community services is a critical component of managing OUDs under the chronic disease management model (McLellan et al., 2014). To improve care coordination, we are working to develop a Patient Centered Medical Home/ Neighborhood (PCMH/N) framework to address the multiple service needs of patients with OUDs (Laudet & White, 2010). The neighborhood concept acknowledges the needs of patients across a range of agencies and services. This requires methods of care coordination, communication, standardization of information exchange, and common measures and metrics. Activities are underway to support the development of PCMH/N approaches within the major regions of Vermont. The Hubs, or OTPs, serve as the center-point for the PCMH/N, just as a hospital might for other chronic conditions. In establishing PCMH/Ns, healthcare and other service providers are challenged to consider patients as “ours,” not “mine” or “yours.” These considerations align with population health strategies used to deliver truly patient-centered and not provider-centered services.

Finally, addiction medication is one piece to the care and recovery of a person with an OUD. Integrating the value of recovery into the conversation for providers, patients and the larger systems continues to be critical. To date, there is no pill or medication that offers a cure to the multifaceted disease of addiction.

References

Responding to Opioid Overdose Deaths in the US: Opportunities for Expanded Overdose Education and Naloxone Distribution

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Overdose Education and Naloxone Distribution (OEND) in the US

For nearly 20 years, overdose education and naloxone distribution (OEND) programs in the US have provided naloxone to people at risk for opioid overdose death, their friends, and family members. Over 600 OEND programs have provided naloxone rescue kits to 152,283 individuals, who reported using naloxone 26,463 times to respond to witnessed overdoses (Wheeler et al., 2015).

Over a decade of research has shown that OEND can lead to increases in opioid overdose knowledge and response competency, with few adverse outcomes (e.g., Bennett, Bell, Tomedi, Hulse, & Kral, 2011; Doe-Simkins, Walley, Epstein, & Moyer, 2009; Enteen et al., 2010; Green, Heimer, & Grau, 2008; Jones, Roux, Stancliff, Matthews, & Comer, 2014; Maxwell, Bigg, Stanczykiewicz, & Carlberg-Racich, 2006; Tobin, Sherman, Beilenson, Welsh, & Latkin, 2008). Several studies have also shown unanticipated benefits in terms of reduction (or no increase) in illicit drug use and increases in drug treatment participation (Galea et al., 2006; Seal et al., 2005; Wagner et al., 2010).

More importantly, research shows that when communities make naloxone available, overdose death rates decline. After the implementation of a comprehensive overdose prevention program in Wilkes County, North Carolina including naloxone prescription, community coalition building, and changes to prescribing practices, the overdose death rate dropped from 46.6 per 100,000 in 2009 to 14.4 per 100,000 in 2011 (Albert et al., 2011; Haegerich, Paulozzi, Manns, & Jones, 2014). Communities in Massachusetts that implemented naloxone distribution to laypeople from 2004-2006 had significantly reduced overdose death rates compared to those that did not (Walley et al., 2013).

Legislation has been enacted in all but 10 US states to expand access to naloxone (Davis, Webb, & Burris, 2013; Network for Public Health Law, 2015). While these laws vary, they typically: (1) provide authority for prescribers to write standing orders to authorize distribution of naloxone by non-medical personnel, (2) provide authority for prescribers to write prescriptions to friends, family members and other persons in a position to rescue a person experiencing an overdose, and (3) provide liability protections (usually civil, criminal, and professional) for those who prescribe and/or administer naloxone in good faith.

Missed Opportunities

Despite these legislative efforts, and the concomitant rapid expansion of OEND programs, to date most OEND programs have been primarily located in settings focused on providing services to people who inject drugs (PWID), such as syringe access programs. To have the greatest effect on reducing the increases in overdose-related deaths, OEND must continue these efforts while also expanding in scope and
reach. This is particularly important given the evolving nature of the opioid overdose epidemic in the US. Many studies have found that a substantial portion of heroin users/injectors initiated opioid use with prescription opioids, but it appears that only a small percentage (perhaps less than 5%) of prescription opioid users initiate heroin use (Compton, Jones, & Baldwin, 2016). Overdose deaths due to prescription opioids increased fourfold from 1999 to 2009 (Calcaterra, Glanz, & Binswanger, 2013; Chen, Hedegaard, & Warner, 2014; Rudd et al., 2014). Many prescription opioid users have no reason to visit a syringe access program (nor would we necessarily encourage them to do so), and may therefore not have access to OEND services in those settings.

While the dramatic increase in prescription opioid deaths may be leveling in more recent years, heroin overdose deaths have continued to rise across all demographic groups (Rudd et al., 2014). Changes in the illicit heroin market, including increases in purity and decreases in price, appear to be driving increases in heroin use in populations that may not be as educated about the risks associated with heroin use and injection, including overdose death and blood borne virus transmission (Compton et al., 2016). Providing OEND services to PWIDs should be broadly supported, since overdose is the leading cause of death among PWIDs (Tyndall et al., 2001). However, if OEND programs remain limited only to settings that cater to PWIDs, they will fail to engage PWIDs who live in areas that are not well-served by programs for drug injectors, who face barriers to engaging with such programs, or who are forced to conceal their drug injection due to stigma, discrimination, or other social/legal factors. They will also miss opioid users who do not inject. Identifying venues for OEND in addition to programs for PWIDs will be critical to reaching the larger population at risk.

In our recent research we identified opportunities for providing OEND that could expand access for individuals most at risk for opioid overdose death. In a study among 573 PWIDs in San Diego, California, receiving care in a hospital and being arrested for drug possession were both significantly associated with elevated odds of having a recent overdose (Wagner et al., 2015). While some of those hospitalizations could have been related to the overdose itself, only half of the 45 individuals who reported an overdose said they had been taken to a hospital as a result of this overdose—leaving 50% who had received hospital care for other reasons. Research in Australia found that individuals with a history of being attended by ambulance for multiple non-fatal overdoses had more than seven times the odds of dying from overdose over five years of follow-up (Stoove, Dietze, & Jolley, 2009). More recently, a retrospective study in the US found that 91% of individuals who presented in an emergency department with a non-fatal prescription opioid overdose received another prescription for opioids after that overdose, most (70%) from a provider who had cared for them before the overdose, and 7% had a repeated overdose (Larochelle, Liebschutz, Zhang, Ross-Degnan, & Wharam, 2016). Finally, extensive research shows the weeks following release from incarceration or discharge from abstinence-oriented substance abuse treatment are associated with a substantial increase in risk of overdose death among opioid users due in part to loss of tolerance (Binswanger, Blatchford, Mueller, & Stern, 2013; Ødegård, Amundsen, Kielland, & Kristoffersen, 2010).

## Strategies for Expansion

Taken together, these studies highlight several opportunities for expanding OEND into settings where people at risk for overdose death seek care. Both emergency and routine care settings provide an opportunity for providing brief education on overdose risk and naloxone prescriptions to individuals at risk for overdose death. Health care providers in hospitals, emergency departments, emergency medical services, mental health clinics, substance abuse treatment facilities, pain management clinics, criminal justice venues, and primary care settings are likely to care for patients with current or recent histories of medical or non-medical use of illicit or prescription opioids, whether or not opioid use is the primary complaint. We recommend several strategies for the inclusion of OEND in these practice settings: (1) implementing a brief opioid use screening interview into clinical assessments in hospitals, primary care, and mental health care settings to help identify patients at risk for overdose, (2) co-prescribing naloxone along with any prescriptions for chronic, high doses of prescription opioids (especially long acting opioids), (3) including OEND in emergency department and hospital discharge procedures for any patients presenting with non-fatal opioid overdose, (4) including OEND in jail and substance abuse treatment discharge planning, and (5) disseminating OEND information through public health campaigns, general education and health care professional training programs, and materials included in opioid medications distributed by retail and mail order pharmacies. These strategies employ venues where individuals at risk for overdose death interact with health care providers who can prescribe and/or dispense naloxone. But this is just a starting point. Identifying additional such points of contact will be critical to scaling up national, state, and locally based efforts to expand access to naloxone and stem the growing epidemic of opioid overdose deaths.

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A Clinician's Effort to Improve Opioid Dependence Research

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When I arrive every day on campus as a graduate student in Northeastern University’s Applied Psychology doctoral program, I walk through neighborhoods in Boston served by my employer prior to entering the program: an outpatient treatment center for opioid dependence. Before entering my doctoral program, I worked for two years as a staff clinician at a methadone clinic in Boston which serves approximately 800-1000 patients per day. Seeing a line of people out the door for daily dosing or group therapy on a snowy Boston weekday was at once disheartening and inspiring. Our patients weathered a constant, unforgiving storm, using courage, persistence and a limitless stream of hope to fight addiction every day. Accompanying them on their journey, as a therapist, brought me equal parts adversity and joy.

Perhaps the most valuable lesson I learned in my time serving those suffering from opioid dependence was that someone’s experience of addiction is a highly personal, ever-changing phenomenon that should be recognized and treated as such. In other words, I believe that treatment should focus, whenever possible, on addressing the biopsychosocial needs of a given individual and should avoid “top-down” or “one-size-fits-all” approaches to care. As a therapist who worked in the highly structured setting of methadone maintenance treatment clinic, I consider the ability to use interpersonal skills the bridge between the systematic and personal elements of substance abuse treatment.

The experience of serving others as a behavioral health professional on the front lines of a national public health epidemic reinforced my belief that healthcare providers in this field—from doctors and nurses to therapists and social workers—need every bit of available support in combatting opioid dependence. The scope of the opioid epidemic in the United States underscores the urgency of this need. Data from the Center for Disease Control and Prevention indicate that as of 2013, more injury related deaths in the United States came from drug overdose than any other cause (Hedegaard et al., 2015; Center for Disease Control and Prevention, 2015). Moreover, this recent CDC data indicate that nationally, heroin-related deaths nearly tripled between 2010 and 2013 (Hedegaard et al., 2015). Locally, the statistics are similarly sobering: Public health officials recorded 1,099 confirmed unintentional opioid-related deaths in 2014, up from 911 deaths in 2013 (Massachusetts Department of Public Health, 2016).

Mental health professionals treating those suffering from opioid dependence—specifically when it concerns heroin use—have the unique opportunity to save lives by helping heroin users seek treatment options providing safer alternatives to daily heroin use (Bart, 2012). Seizing this opportunity appears both timely and necessary, as opioid addiction indiscriminately affects families and communities across the United States at an alarming pace.

My advocacy for providing additional support to fellow healthcare professionals inspired me to pursue doctoral study at a program which emphasizes the use of applied research to support the local community. I plan to focus my research on ways to disseminate evidence-based addictions treatments to real life settings to improve the treatment of opioid dependence—within particular focus on identifying and understanding what aspects of treatment are most useful and trainable to health professionals, including behavioral health practitioners. I have a passionate interest in understanding how motivation affects drug treatment careers and clients’ responses to treatment, which I am investigating under the mentorship of Dr. Lee. Her programmatic research, funded by NIAAA (R01021136) has focused on disseminating motivational interviewing (MI) to reduce hazardous drinking and negative consequences among health disparities populations with poor mental health (Lee et al., 2015) and understanding how chronic social stressors influence treatment response and outcomes. (Lee et al., 2015).

I work with Dr. Lee as part of the Motivational Interviewing Health Disparities Lab in the Department of Applied Psychology, within the College of Health Sciences at Northeastern University. I hope to create innovative approaches to empirically measuring readiness to change in an opioid-dependent population—measures that could readily assist clinicians in the field with assessment and treatment planning. I also hope...
to use my experience to educate healthcare providers about modern treatments used to combat opioid dependence, including medication-assisted treatments such as methadone and buprenorphine/naloxone (e.g., Suboxone®). I consider the intersection of behavioral health and medical methodologies not only the frontier of opioid dependence research, but also an indication of a larger, emerging integrative healthcare model of substance abuse treatment and research.

I believe that the behavioral health field would benefit from knowing more about how to respond to the physiological and psychological challenges inherent to opioid dependence. Today, opioid dependence treatment often involves integrating medical and behavioral health resources to support the patient in navigating their personal recovery process. My work as a scientist-practitioner in counseling psychology is to continue the battle with opioid dependence in the academic research setting, with clear intentions to disseminate my findings to my peers, dutifully supporting the local opioid recovery community—face-to-face, every day. I hope my efforts will contribute to ridding Boston and beyond from affliction and needless suffering, making the neighborhood walk nicer for us all.

References


SoAP Clinical Conference Call

SoAP sponsors a monthly conference call focusing on clinical issues in the treatment of addictive disorders. It’s held the second Friday of the month at 1PM Eastern Time. Past topics have included SMART Recovery (Tom Horvath), Group Therapy (Dennis Wendt) and Cognitive-Behavioral Therapy (Bruce Liese). Membership in SoAP is not required, and all interested parties are invited to participate. Please contact Mark Schenker at mschenker@navpoint.com for inclusion in the distribution list, access to the call-in numbers, and to receive copies of any relevant slides for the presentation.
Abstracts


This study developed and tested a moderated-mediation model of work stress and alcohol use based on the biphasic pharmacological effects of alcohol and self-medication and stress-vulnerability models of alcohol use. The model proposes that exposure to work stressors can increase both negative affect and work fatigue, and that both negative affect and work fatigue can motivate the use of alcohol in an effort to regulate these two sources of strain. However, the relations between the intervening variables (negative affect and work fatigue) and alcohol use are conditional on the joint moderating effects of specific alcohol outcome expectancies and gender. Data were collected from a national probability sample of 2,808 U.S. workers. Supporting the model, the results indicated that work stressor exposure was conditionally related via negative affect to heavy alcohol use among both men and women holding strong tension reduction alcohol expectancies and to after work alcohol use among men holding strong tension reduction alcohol expectancies. Also, work stressor exposure was conditionally related via work fatigue to both heavy alcohol use and workday alcohol use among men holding strong fatigue reduction alcohol expectancies.


Background: As opioid overdose rates continue to pose a major public health crisis, the need for naloxone treatment by emergency first responders is critical. Little is known about the views of those who administer naloxone. The current study examines attitudes of health professionals on the social media platform Twitter to better understand their perceptions of opioid users, the role of naloxone and potential training needs. Methods: Public comments on Twitter regarding naloxone were collected for a period of three consecutive months. The occupations of individuals who posted tweets were identified through Twitter profiles or hashtags. Categories of emergency service first responders and medical personnel were created. Qualitative analysis using a grounded theory approach was used to produce thematic content. The relationships between occupation and each theme were analyzed using Pearson chi-square statistics and post-hoc analyses. Results: A total of 368 individuals posted 467 naloxone-related tweets. Occupations consisted of professional first responders such as emergency medical technicians (EMTs), firefighters, and paramedics (n = 122); law enforcement officers (n = 70); nurses (n = 62); physicians (n = 48); other health professionals including pharmacists, pharmacy technicians, counselors, social workers (n = 31); naloxone-trained individuals (n = 12); and students (n = 23). Primary themes included burnout, education and training, information-seeking, news updates, optimism, policy and economics, stigma, and treatment. The highest levels of burnout, fatigue and stigma regarding naloxone and opioid overdose were among nurses, EMTs, other health care providers and physicians. In contrast, individuals who self-identified as “naloxone-trained” had the highest optimism and the lowest amount of burnout and stigma. Conclusions: Provider training and refinement of naloxone administration procedures is needed to improve treatment outcomes and reduce provider stigma. Social networking sites such as Twitter may have potential for offering psychoeducation to health care providers.


Background and Aims. Dysfunction of physiological regulation systems may underlie the disrupted emotional and self-regulatory processes among people with substance use disorder (SUD). This paper reviews evidence as to whether or not respiratory sinus arrhythmia (RSA), as a psychophysiological index of emotional regulation, could provide useful information in treatment-outcome research to provide insights into recovery processes. Methods. We reviewed the use of RSA in clinical research and studies on SUD treatment. Search terms for the review of RSA in clinical research included respiratory sinus arrhythmia, heart rate variability, vagal, cardiac vagal control, psychophysiology, intervention, treatment, mindfulness, mind-body, mental health, substance use, chemical dependence, regulation and emotion regulation. For the review of RSA in intervention studies, we included only those that provided adequate description of psychophysiological methods, and examined RSA in the context of an intervention study. Results. RSA appears to be able to provide an index of self-regulatory capacity; however, it has been little used in either intervention or treatment research. Of the four intervention studies included in this review, all were mindfulness-based interventions. Two studies were with substance-using samples, and both showed pre-post increases in RSA and related improved substance use outcomes. Two of the three studies were randomized controlled trials (RCTs), and both showed significant increases in RSA in the experimental compared to comparison condition. Conclusion. Respiratory sinus arrhythmia may be a useful index of emotional regulation in people with substance use disorder, and a potential measure of underlying mechanisms for SUD treatment studies, particularly mindfulness-based interventions.
Announcements

JSAT Editorial Fellowship Program
Call for Applications

Applications are now being accepted for the JSAT Editorial Fellowship Program. Supported by Elsevier and JSAT, this is a one-year experience to begin in June 2016. We seek two fellows for this year. The compensation is modest ($1000), but the experience accrued will be excellent.

The fellows will participate in bi-weekly phone calls with the Editor-In-Chief and Managing Editor, and bi-monthly phone calls with the Associate Editors. During these calls, the focus will be on manuscript review, the ethics of authorship and review, and how to combine and synthesize conflicting reviews into a constructive decision. Each fellow will be expected to advance twelve to fifteen papers thru the submission to review to decision process. The work should not be longer than 1 to 2 hours per week. The fellowship should result in a superb knowledge of contemporary electronic scientific publication and also produce improved writing skills and manuscript preparation. Both of which will be useful in a research career. Furthermore, there are several models for the fellowship leading to roles on the JSAT Editorial Board.

The ideal applicant would be a person in an early phase of his or her academic or research career, with a track record of a commitment and achievement to substance use treatment research. Those interested should email Mark P. McGovern, Editor-In-Chief, directly with questions (mark.p.mcgovern@dartmouth.edu). Applicants should email a one- to two-page letter to the JSAT Managing Editor, Chantal Lambert-Harris (chantal.a.lambert-harris@dartmouth.edu) expressing interest in the fellowship and describing how it will fit into career plans. Please enclose a curriculum vita. Applications will be accepted through March 2016. Final decisions will be made by the editorial team and announced in JSAT, with a June 2016 start.

Interprofessional Advanced Fellowship in Addiction

The U.S. Department of Veterans Affairs Interprofessional Advanced Fellowship in Addiction Treatment provides two years of post-residency or post-doctoral research, education, and clinical learning opportunities to eligible physicians and associated health professionals such as psychologists, pharmacists, social workers, and nurses. Fellows spend approximately 75 percent of their time in research and educational activities and up to 25 percent in clinical care at one of the seven selected VA sites. Mentors of national stature provide guidance to fellows in rich learning environments focused on training in reducing the burden of alcohol and other drug use in the Veteran population. Graduates are expected to be role models and change agents in leading, developing, conducting, and evaluating innovative research, education, and clinical care in health issues pertaining to Addiction Treatment. Visit the fellowship coordinating center website to learn more about all seven sites: www.pittsburgh.va.gov/Trainee/ATF

Postdoctoral Scholars

Two-year NIH/NIDA-funded positions as postdoctoral scholars in drug abuse treatment and services research are available in a multidisciplinary research environment in the Department of Psychiatry, University of California, San Francisco. Applications will be considered until all slots are filled. Scholars work with a preceptor to design and implement studies on the treatment of drug dependence, and select a specific area of focus for independent research. Training of psychiatrists, women, and minorities for academic research careers is a priority. Send letter or interest, CV, research statement, samples of work, and two (2) letters of recommendation to:

Postdoctoral Training Program in Drug Abuse Treatment/Services Research
University of California, San Francisco
1001 Potrero Avenue, Bldg 20, Ward 21, Rm 2130
San Francisco, CA 94110-3518;

For more information please visit http://addiction.ucsf.edu/education/postdoctoral-training or contact Rebecca Cook via e-mail: rebecca.cook@ucsf.edu or phone: 415-206-3051.

Clinical Psychology Post-Doctoral Residency

Located in Boca Raton, Florida, Caron Renaissance/Ocean Drive has been an innovator in addiction treatment and behavioral healthcare for 30 years. We have a full-time opening for a paid Post-Doctoral Residency in Clinical Psychology emphasizing neuropsychological assessment beginning September 2016.

Our Clinical Philosophy utilizes treatment interventions that address emotional, behavioral and psychological components of addiction and personality disorders for adults with dual diagnosis. Our treatment focuses on process addictions related to trauma, body image, eating disorders, gambling, etc.

Responsibilities:
- Complete comprehensive assessments in intelligence, neu-
psychological functioning, academic, personality, etc.
• Assist with diagnosis, treatment planning, interventions and recommendations
• Complete rotations throughout the clinical milieu

Education Requirements:
• PhD/PsyD in Clinical Psychology
• Completion of an APA accredited Pre-Doctoral internship

Applicants should send a cover letter, curriculum vitae, sample report and 3 letters of recommendation to sfischer-wylie@caron.org.

EOE M/F/D/V

Clinical Psychologist

Caron Treatment Centers internationally recognized for excellence in Behavioral Health and Addictions treatment is seeking a Clinical Psychologist. Caron’s clients have primary addiction disorders, but most also experience co-occurring mental health issues that require treatment concurrently with addiction treatment.

This position provides psychological services including evaluations, psychotherapy and training to respective clinical staff across Caron’s continuum.

The ideal applicant would be enthusiastic and have a desire to participate fully in a collaborative and creative treatment environment with psychologists, counselors, and physicians. Applicants should have experience treating adolescents and adults. We are looking for someone who values and uses evidence-based treatment approaches, in particular CBT and 3rd Wave CBT treatments. It would be a plus for the applicant to have experience treating eating disorders and/or trauma/PTSD and some familiarity with 12-Step recovery principles. For more details and to apply on-line go to www.caron.org/careers.

Book Announcement

A free digital edition of my latest book on alternative psychological treatment options for patients dealing with various addiction issues including alcohol, drugs, and other behavioral addictions is now available for my colleagues in Division 50. This self-help book (iCope: Alternatives to a 12-Step Program: A Path to Recovery) emphasizes the behavioral and cognitive coping skills needed to get into a good recovery and practical steps for relapse prevention. The book is ideal as an adjunct to individual or group therapy.

If you would like a free digital copy of the full book, send me your email address and I will send you a Coupon Code and instructions on getting the book in whatever format your digital reader requires (e.g., for Apple, Kindle, PDF, or other formats). You can also view a sample of the book at Amazon.com. My email is TCiminero@aol.com.

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The general listserv is maintained by the division. You may join it once you are a Division member by sending an email to the SoAP Membership Chair and requesting to be added to the listserv, or by visiting the listserv URL at http://mailman.yale.edu/mailman/listinfo/apadiv50-forum and entering a subscribe request to the moderator. Instructions on how to post to the listserv are also located at the listserv URL. This listserv is graciously provided by our member Robert F. Leeman, PhD.

The announcements-only listserv is one upon which your email address is automatically added if you provide one to APA and give APA permission to send you email. The APA Division Services Office staff updates the list as members join the division, or as individuals need to make adjustments to any email address or listserv subscriptions on file. The acting SoAP President is the only one who can approve announcements on this listserv. Generally, announcements from this listserv are high priority time-sensitive messages from the Division President, Division Board, APA, or other entities expressing information of key importance to members. You may join or update your subscription through http://listserv.apa.org/.

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