President’s Message
By Stewart Ball

Giving Back
Many faiths consider December their primary season of giving. Is it “…more blessed to give than to receive?” The founders of Alcoholics Anonymous (AA) and Al-anon would likely agree! Step twelve of AA records “…having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs”. Sharing a message of hope, and even more, sponsoring a newly recovering addict or their family member, provides additional reasons to stay sober and work our own program.”

Saint Paul records “…let us consider how we may spur each other on…” As the New Year approaches, I challenge each of us (i.e. myself included) to consider how we might give back. For some, rediscovering sponsorship will bless the benefactor (sponsee) and the sponsor. A colleague of mine in private practice, gives back, by allowing 10% of his clients to pay the amount they can afford with some of his clients paying as little as $10.00. Sylvia Kolida, my former co-worker, gave back several years ago by preparing me for the former Certified Alcohol and Drug Abuse Counselor (CADAC) exam and case presentation; enabling me to pass on the first try.

Continued on the next page, see PRESIDENT.

IAAP NEEDS YOU!
Look Inside this Issue for Exciting Leadership and Advocacy Opportunities to Gain Skills and Support Addiction Professionals.
In an effort to increase our clinical supervision skills, and ultimately give back, IAAP will provide low cost clinical supervision training on the 9th of February (2018). As mentioned in previous messages, IAAP will be providing regional trainings next year at a minimal cost as well.

The health and success of IAAP depends on each of us giving back. Committee participation, which requires relatively minimal time and effort, is a practical way to do so.

May each of us consider how we might give back in this season of giving and throughout the upcoming year.

Only our best,

Stewart B. Ball, LCAC, LMFT, LCSW
President
Certified Clinical Supervisor Renewal Training

Date: February 9, 2017
Cost*: IAAP/NAADAC Members $100.00/Non Members $125.00 *If registering on or after February 1st add $10.00

Title: Clinical Supervision: New Technologies; Proven Approaches - Presented by Thomas Durham, PhD, LADC

Tom has been involved in the field of addiction treatment since 1974. As Director of Training at NAADAC, he is responsible for the assessment, coordination, curriculum development and delivery of training to professionals in the field of addictions treatment. Prior to joining NAADAC he worked in government contracting under SAMHSA and the Department of Defense. He also served as the Executive Director of The Danya Institute and Project Director of the Central East Addiction Technology Transfer Center. From 2004 to 2017 Tom was an adjunct faculty member at Northcentral University where he taught graduate courses in psychology.

Tom has been conducting training for over 25 years on a variety of topics on the treatment of addictions. Tom holds a PhD in Psychology from Northcentral University, a Master of Arts degree in Counseling Psychology from Adler University, and a Bachelor of Arts degree in psychology from DePauw University. He is also a Licensed Alcohol and Drug Counselor.

Workshop Description: February 9th
Clinical supervision remains an essential ingredient for treatment programs in today's environment. Successful programs appreciate and promote the availability of growth-based clinical supervision of staff. This workshop will demonstrate the processes of supervision that make it an essential component in effective clinical care. Topics covered include ethical issues for supervisors; relational and cultural considerations; performance monitoring and goal development; modalities and methods; direct observation; and technology-based supervision. The workshop will be interactive and comprise a combination of didactic presentations, class discussions, and small group experiential exercises.

Learning Objectives:
- Review relational and cultural considerations of supervision.
- Analyze ethical obligations and ethical decision making of the supervisor
- Explore modalities and methods of supervision such as observation and live supervision.
- Integrate the process of performance monitoring with the development of career development plans
- Discuss key benefits of using technology to extend the reach of supervision

Schedule:
- Registration Opens: 8:30am
- Session: 9:00am - 12:00pm
- Lunch on your own: 12:00pm - 1:15pm
- Session Conclusion: 1:15pm - 4:30pm

Location:
Indiana Wesleyan University - 3777 South Priority Way South Drive - Indianapolis, IN 46240

Certified Clinical Supervisor Renewal Training Registration

Name: ____________________________
Address: ____________________________
CSZ: ____________________________
Email: ____________________________
Phone: ____________________________
Certification Number: ____________________________

Method of Payment:
__________________________ Check (Checks payable to IAAP)
__________________________ Credit Card (add $5 convenience fee)

Registration Fee ________
Late fee on/after FEB 1st ________
Convenience Fee ________
Total Amount Paid $ ________

Refund Policy: Refunds will be issued, minus a $15 service charge, if requested on or before 2/1/2018.

Credit Card Information: Card # ____________________________ CVV Code ________ Exp. Date ________
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Marijuana Use May Not Aid Patients in Opioid Addiction Treatment: Symptoms Harder to Manage

Science Daily - December 4, 2018

But new research led by Marian Wilson, Ph.D., of the Washington State University College of Nursing found that frequent marijuana use seems to strengthen the relationship between pain and depression and anxiety, not ease it.

“For people who are using cannabis the most, they have a very strong relationship between pain and mood symptoms, and that’s not necessarily the pattern you’d want to see,” Wilson said. “You would hope, if cannabis is helpful, the more they use it the fewer symptoms they’d see.”

The research, recently published in the journal Addictive Behaviors, involved 150 patients being seen at an opioid treatment clinic. Previous studies have shown that nearly two-thirds of patients receiving medication-assisted treatment for opioid addiction also have chronic pain, and many experience depression and anxiety.

About 67 percent of the clinic patients surveyed by Wilson and her team said they had used marijuana in the past month.

“Some are admitting they use it just for recreation purposes, but a large number are saying they use it to help with pain, sleep, and their mood,” Wilson said. “We don’t have evidence with this study that cannabis is helping with those issues.” In fact, the relationship between pain and depression and anxiety increased with the frequency of marijuana use.

In most cases, people reported they were self-medicating with marijuana, Wilson noted, yet only a small number had a medical marijuana card.

The study noted that opioid overdose rates have more than tripled in the past two decades and are now the second-leading cause of accidental death in the United States. There are many questions about the relationship between marijuana use and opioid addiction and treatment -- such as why opioid death rates are 25 percent lower in states that have legalized medical marijuana -- but the primary purpose of Wilson’s study was to see whether cannabis use affects the relationship between pain and depression and anxiety.

Patients believe using marijuana helps them with their symptoms, but the study’s results could indicate the opposite is true for those in addiction treatment -- that by strengthening the connection between feelings of pain and emotional distress, it makes it harder for them to manage their symptoms.

“The effectiveness of cannabis for relieving distressing symptoms remains mixed and requires further research,” the study concludes.

Source:
Materials provided by: Washington State University.

https://www.sciencedaily.com/releases/2017/12/171204091144.htm
Gender and Use of Substance Abuse Treatment Services
By Carla A. Green, Ph.D., M.P.H.

Women are more likely than men to face multiple barriers to accessing substance abuse treatment and are less likely to seek treatment. Women also tend to seek care in mental health or primary care settings rather than in specialized treatment programs, which may contribute to poorer treatment outcomes. When gender differences in treatment outcomes are reported, however, women tend to fare better than men. Limited research suggests that gender-specific treatment is no more effective than mixed-gender treatment, though certain women may only seek treatment in women-only programs. Future health services research should consider or develop methods for (1) improving care for women who seek help in primary care or mental health settings, (2) increasing the referral of women to specialized addiction treatment, (3) identifying subgroups of women and men who would benefit from gender-specific interventions, and (4) addressing gender-specific risk factors for reduced treatment initiation, continuation, and treatment outcomes.

In the 1970s and 1980s, practitioners and researchers began to call attention to how little was known about providing appropriate care for women with substance abuse problems, particularly alcoholism (Schmidt and Weisner 1995). Research traditionally had focused on how men fared in substance abuse treatment, and treatment programs were ill-equipped to help women. In response, government organizations began to support research and treatment for women, and significant numbers of researchers and practitioners focused on understanding and addressing gender differences in treatment access, treatment provision, and outcomes (Schmidt and Weisner 1995). Researchers began examining the characteristics and social circumstances of women with substance abuse problems, identifying factors that interfered with detecting and diagnosing women who needed help. They also studied the barriers that prevented women from entering treatment and gender-specific issues related to women’s success in treatment. These efforts have resulted in a large body of research addressing gender differences in treatment-seeking, access to care, retention in care, and treatment outcomes.

Over this same period, many treatment programs also began to pay greater attention to the women in their programs and their special needs. Today many (although not all) treatment programs offer gender-specific or gender-sensitive services, such as gender-matching with counselors, mixed-gender treatment groups led by male and female co-leaders, gender-specific treatment groups, and gender-specific treatment content. Many programs also provide ancillary or wraparound services, such as child care and parenting groups, which facilitate women’s treatment entry and continuation. In addition, significant numbers of treatment programs serve women only, target pregnant women or adolescent girls, or offer specialized parenting services for women and their children.

These profound changes in research and treatment programs have occurred at the same time as other important social changes in the United States, such as women’s increased participation in the workforce, greater similarities in men’s and women’s patterns of substance use, and increased public knowledge about substance-abuse-related problems and their treatment. As a result, health services researchers who study gender and substance abuse treatment are finding it difficult to know whether findings from earlier research are still applicable in current settings. Consequently, the following review sometimes specifically distinguishes earlier research findings (i.e., from the 1970s and the 1980s) from more recent research findings.

This article examines gender differences in the prevalence of substance use and related problems, the identification of such problems, treatment-seeking and access, retention in treatment, and treatment outcomes.

GENDER AND THE PREVALENCE OF SUBSTANCE USE AND SUBSTANCE-RELATED PROBLEMS

Research on how gender influences substance use and substance-abuse-related problems has established clear differences between women and men in several important areas. Women typically consume less alcohol than men when they drink, drink alcohol less frequently, and are less likely to develop alcohol-related problems than men (Fillmore et al. 1997). Similarly, women are less likely than men to use illicit drugs and to develop drug-related problems (Greenfield et al. 2003a).

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Conversely, when women do develop substance abuse problems, they tend to develop them faster than men do. For example, although women tend to be older than men, on average, when they begin a pattern of regular drunkenness, women’s drinking-related problems (e.g., loss of control over drinking, negative consequences of drinking) appear to progress more quickly than those of men (Randall et al. 1999). This faster progression also means that women experience shorter intervals than men between onset of regular drunkenness and first encountering the negative consequences of drinking, which include physical problems, interpersonal difficulties, negative intrapersonal changes (such as in personality or self-esteem), poor impulse control, and reduced ability to maintain normal social roles and responsibilities. Women also experience shorter intervals between first loss of control over drinking and onset of their most severe drinking-related consequences, and shorter intervals between onset of regular drunkenness and treatment-seeking (Randall et al. 1999). Women report more severe problems and experience more health-related consequences from substance use (Bradley et al. 1998), and their substance-related problems interfere with functioning in more life domains compared with men (Fillmore et al. 1997).

Recent narrowing of the differences in men’s and women’s substance use patterns and attitudes (McPherson et al. 2004) raises additional concerns because of women’s greater susceptibility to substance-related problems. Based on recent U.S. prevalence estimates, women make up about one-third of people with alcohol problems and slightly less than half of those who have problems with other drugs (Greenfield et al. 2003a).

AT A GLANCE
THE NATURE OF WOMEN’S SUBSTANCE ABUSE PROBLEMS
- Women are less likely than men to use illicit drugs and develop drug-related problems (Greenfield et al. 2003a).
- Women drinkers tend to drink less alcohol less often than men do and are less likely than men to develop alcohol-related problems (Fillmore et al. 1997).
- When women do develop substance abuse problems, they report problems of greater severity and experience more health-related consequences (Bradley et al. 1995).

- Women’s problems related to substance abuse interfere with functioning in more areas of life than men’s do (Fillmore et al. 1997).
- Women are older than men are when they begin drinking to intoxication, but once they develop a pattern of regular intoxication, they:
  - Encounter drinking-related problems more quickly than men (Randall et al. 1999)
  - Lose control over their drinking more quickly than men (Randall et al. 1999).
- Recent research shows that women’s and men’s substance use patterns have become more similar in the past few years (McPherson et al. 2004).
- Women make up about one-third of the population with alcohol problems and slightly less than half of those who have problems with other drugs (Greenfield et al. 2003a).

GENDER AND THE IDENTIFICATION OF SUBSTANCE ABUSE PROBLEMS

A person’s gender has the potential to affect several critical junctures along the pathway to seeking substance abuse treatment. Identification of a problem is the first step toward treatment, whether by the person needing treatment, or by a family member, health care professional, employer, or government agency. The likelihood that a person’s substance abuse problem will be identified appears to differ by gender in some settings. For example, compared with men, substance abuse problems among women, particularly older women (National Center on Addiction and Substance Abuse 1998), are less likely to be identified in health care settings (Brienza and Stein 2002). Women with substance abuse are more likely than men to be identified through contacts with child protective services (Fiorentine et al. 1997; Grella and Joshi 1999). Women also are less likely than men to be referred for substance abuse treatment by their employers or schools (Morgenstern and Bux 2003) and are more likely to have family members, friends, and partners who use drugs and support their substance use (Bendtsen et al. 2002; Grella and Joshi 1999; Center for Substance Abuse Treatment 1994; Kelley et al. 1996; Kline 1996).

Effective Treatments for Opioid Addiction
National Institute on Drug Abuse

Opioid Use Disorder Affects Millions
Over 2.5 million Americans suffer from opioid use disorder which contributed to over 28,000 overdose deaths in 2014.

Use of opioids, including heroin and prescription pain relievers, can lead to neonatal abstinence syndrome as well as the spread of infectious diseases like HIV and Hepatitis.

Effective Medications are Available
Medications, including buprenorphine (Suboxone®, Subutex®), methadone, and extended release naltrexone (Vivitrol®), are effective for the treatment of opioid use disorders.

- Buprenorphine and methadone are “essential medicines” according to the World Health Organization.
- Medications should be combined with behavioral counseling for a “whole patient” approach, known as Medication Assisted Treatment (MAT).

MAT Decreases opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission. After buprenorphine became available in Baltimore, heroin overdose deaths decreased by 37 percent.

MAT Increases social functioning and retention in treatment. Patients treated with medication were more likely to remain in therapy compared to patients receiving treatment that did not include medication.

Treatment of opioid-dependent pregnant women with methadone or buprenorphine Improves Outcomes for their babies; MAT reduces symptoms of neonatal abstinence syndrome and length of hospital stay.

Science Driven Solutions
Improving Medications
In November 2017, the U.S. Food and Drug Administration approved Sublocade™, the first once-monthly buprenorphine injection for moderate-to-severe opioid use disorder in adult patients who have initiated treatment with the transmucosal buprenorphine-containing products. This medication, in addition to Probuphine®, an implantable buprenorphine formulation approved in May 2016, eliminate the need for daily dosing and improve treatment retention. Read the Director’s blog - Probuphine: A Game-Changer in Fighting Opioid Dependence.

Reaching Patients in Need
The emergency department (ED) provides a prime opportunity to screen patients for opioid use disorder and initiate MAT. Patients who initiate MAT in the ED are more than twice as likely to remain engaged in treatment compared to patients referred for treatment. Read the JAMA article - Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence.

A recent study found treatment with extended-release naltrexone reduced relapse rates among criminal justice involved adults with a history of opioid dependence. Read the NEJM article Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders.

Medications are Not Widely Used
Less than 1/2 of privately-funded substance use disorder treatment programs offer MAT and only 1/3 of patients with opioid dependence at these programs actually receive it.

- The proportion of opioid treatment admissions with treatment plans that included receiving medications fell from 35 percent in 2002 to 28 percent in 2012.
- Nearly all U.S. states do not have sufficient treatment capacity to provide MAT to all patients with an opioid use disorder.

Continued on the next page.
Addressing Myths About Medications
Methadone and buprenorphine DO NOT substitute one addiction for another. When someone is treated for an opioid addiction, the dosage of medication used does not get them high—it helps reduce opioid cravings and withdrawal. These medications restore balance to the brain circuits affected by addiction, allowing the patient’s brain to heal while working toward recovery.

Diversion of buprenorphine is uncommon; when it does occur it is primarily used for managing withdrawal. Diversion of prescription pain relievers, including oxycodone and hydrocodone, is far more common; in 2014, buprenorphine made up less than 1 percent of all reported drugs diverted in the U.S.

Solutions Driven Science
New Treatments
Vaccines currently under development target opioids in the bloodstream and prevent them from reaching the brain and exerting euphoric effects.

Researchers are exploring the potential of Transcranial Direct Current Stimulation, a novel, non-invasive brain stimulation technique, for treating opioid use disorder.

Improving Treatment Delivery - Researchers are exploring how the health care system can reach more people in need of treatment and helping providers understand which treatments will be most effective for which patients.

Reaching Justice-Involved Youth - NIDA-funded research is aimed at identifying the most effective strategies for improving the delivery of evidence-based prevention and treatment services for youth through our Juvenile Justice Translational Research on Interventions for Adolescents in the Legal System (JJ-TRIALS) initiative. Read more about Justice System Research Initiatives.

Source:
Veterans and Military Families

SAMHSA leads efforts to ensure that American service men and women and their families can access behavioral health treatment and services.

Overview

There are an estimated 23.4 million veterans in the United States, and about 2.2 million military service members and 3.1 million immediate family members.

- The demanding environments of military life and experiences of combat, during which many veterans experience psychological distress, can be further complicated by substance use and related disorders. Many service members face such critical issues as trauma, suicide, homelessness, and/or involvement with the criminal justice system. Approximately 18.5% of service members returning from Iraq or Afghanistan have post-traumatic stress disorder (PTSD) or depression, and 19.5% report experiencing a traumatic brain injury (TBI) during deployment.
- Approximately 50% of returning service members who need treatment for mental health conditions seek it, but only slightly more than half who receive treatment receive adequate care.
- Between 2004 and 2006, 7.1% of U.S. veterans met the criteria for a substance use disorder.
- The Army suicide rate reached an all-time high in 2012.
- In the 5 years from 2005 to 2009, more than 1,100 members of the Armed Forces took their own lives, an average of 1 suicide every 36 hours.
- According to an assessment by the Departments of Housing and Urban Development (HUD) and Veterans Affairs (VA), nearly 76,000 veterans experienced homelessness on a given night in 2009. Some 136,000 veterans spent at least one night in a shelter during that year.
- Mental and substance use disorders caused more hospitalizations among U.S. troops in 2009 than any other cause.
- A recent Treatment Episode Data Set (TEDS) report, Twenty-one Percent of Veterans in Substance Abuse Treatment Were Homeless (PDF | 488 KB) states that about 70% of homeless veterans also experience a substance use disorder.

Research also shows the negative impacts that deployment and trauma-related stress can have on military families, particularly wives and children:

- Cumulative lengths of deployments are associated with more emotional difficulties among military children and more mental health diagnoses among U.S. Army wives.
- Children of deployed military personnel have more school-, family-, and peer-related emotional difficulties, compared with national samples.

Although active duty troops and their families are eligible for care from the U.S. Department of Defense (DoD), a significant number choose not to access those services due to fear of discrimination or the harm receiving treatment for behavioral health issues may have on their military career or that of their spouse. National Guard and Reserve troops who have served in Iraq and Afghanistan (approximately 40% of the total) are eligible for behavioral health care services from the VA, but many are unable or unwilling to access those services. Many National Guard, Reserve, veterans, and active duty service members as well as their families seek care in communities across this country, particularly from state, territorial, tribal, local, and private behavioral health care systems, often with employer-sponsored coverage.

Military families have a culture and unique behavioral health needs that may not be understood within the greater community. SAMHSA supports the behavioral health needs of America’s service men and women—active duty, National Guard, Reserve, and veterans—along with their families, by leading efforts to ensure that community-based services are accessible, culturally competent, and trauma-informed. Reintegration is the primary goal.

Please visit the following pages for more detailed information on each:

- SAMHSA’s Efforts to Support Veterans and Military Families
- Critical Issues Facing Veterans and Military Families
- At-Risk Populations among Veterans and Military Families
- Reintegration into Civilian Life
- Grants Related to Veterans and Military Families
- Publications and Resources on Veterans and Military Families

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