Informed Consent

Informed consent is an ongoing process; it is not intended to be a one-time act.

Volume 6, Number 1 ***Spring 2022***

Connecticut Certification Board Conference and Annual Awards Celebration

June 2, 2022

Saint Clements Castle, Portland, CT

www.ccbevents.org

All of us at the CCB are excited to be able to bring the Annual Awards Celebration back live in late spring. This year we are combining it with a full day conference at one of the most beautiful venues in the state: Saint Clements Castle sits overlooking the Connecticut River in Portland, offering beautiful views in a historic setting.

The conference features speakers national recognition, incredible expertise and enthusiasm about their subject matter. Our keynote is Fairfield, Connecticut-based naturopathic physician Dr. Jaquel Patterson, who has presented all over the country and continent. We are very lucky to have this sought after expert joining us.

We will also have a panel to discuss the specific needs of veterans in recovery that not only features providers with expertise, but 2 highly decorated retired military officers who were raised here in Connecticut: Air Force Brigadier General John Quintas, whose last assignment was with the Joint Chiefs of Staff, currently serving as Director of Military Affairs for Amazon, and Colonel Kevin Brown, whose last assignment prior to retirement was the Garrison Commander at Fort Riley, KS, where part of his responsibility was to provide effective support services for Soldiers and family members assigned to the base.

A familiar face will also be present as our Master of Ceremonies. Margaux Farrell, currently the Marketing Director at the Root Center for Advanced Recovery, will be recognized by many as the former morning anchor at Fox61 in Hartford. She brings her expertise and passion for the field to our conference to keep things moving smoothly.

The event will be hybrid, with a limited number of in person seats, plus a virtual option for those who cannot be there in person. This also allows us to bring the event to people around the country, as there will be significant interest in our presenters. Tickets are available for live seating now or for out of state professionals to register for the virtual option. We will open the virtual option for in-state people on April 15, 2022. We are still actively seeking sponsorship from interested parties.

You can find much more information at dedicated website for the event, **www.ccbevents.org**.

We look forward to seeing you!

Cultivating and maintaining the highest standards of professional practice in the substance use disorder prevention, treatment and recovery industry

From the Executive Director

Jeffrey Quamme, MS, AADC, CCS, CNE, CNC

Just as Spring is a time for growth and change, we are also experiencing that at the CCB. The most obvious and significant transformation is that we are all seemingly turning the corner on the COVID-19 pandemic, which has forever changed the way we all work. The way the behavioral health workforce has adapted is incredible, and has taught us many lessons. I, for one, am tremendously proud of how the field adapted to this never-before seen crisis and kept pushing forward. It is quite remarkable.

Changes are everywhere, and some challenge the status quo: there is a growing school of thought in our field that views addiction as not a disorder of the brain, but as an attachment disorder, with the release of several published items discussing the view. We include some of that in this issue, not to change anyone's beliefs, but to expose our professionals to alternative theories, so that they can be debated and discussed. It is important that we are able to disagree professionally and still respect one another, but it is also just as important to be aware of new ideas and theories, ESPECIALLY if we disagree. It is too easy to dismiss something on its face if it falls outside our belief system, I believe it is much more valuable to us to understand the things that with which we disagree. Quite the opposite of what's happening in our country presently!

The CCB is currently in a partnership with a national training provider to manage our continuing education events. TPN.Health of New Orleans is an organization that aims to develop a nationwide network of clinicians to build a learning community, referral information and professional development activities. Most trainings that they offer are FREE OF CHARGE and cover interesting topics in the behavioral health space. Many live events are available and their library of on demand events is ever growing. All events are approved by the CCB for initial certification or renewal. Check hem out and solve any CE availability concerns that you may have.

I look forward o our upcoming conference and awards presentation in early June, with great speakers and deserving professionals to be honored. Our annual David Powell Lifetime of Service Award winner for this year is Dr. Albert Young, who is not only an exceptional clinician with a thirst to increase his knowledge, but also a long time educator who has contributed so much to the professional development of so many. Dr. Young is the perfect representation of what our long lost friend and mentor, Dr. David Powell, represented. Our Young Professional Award, named after the innovative CEO of MCCA and long time CCB Director and Treasurer, the late Joseph Sullivan, will be awarded to Paul Concordia of Recovery Network of Programs. Nominated by his peers based upon his drive, enthusiasm, passion and performance, we were most touched by his gratitude and humility. Knowing Joe as I did, I am confident that he would notice those traits as well. I offer my sincere congratulations to both, and look forward to seeing them given these awards.

The Conference will have a maximum of 150 live attendees, but technology has allowed us to offer it virtually to anyone who cannot attend for any reason. Technology has made our world smaller, and this virtual option lets us share all of the great things our workforce does with the rest of the country. Check out the website at https://wwwccbevents.org.

Speaking of websites, the CCB website is undergoing major changes to make it more easily navigated and useful for our Connecticut professionals. Be on the lookout for notification when it goes live.

Don't forget to check out our free podcast, Scope of Practice, where we talk about issues that affect our industry not commonly heard elsewhere, even some controversial topics. You can hear our interviews by clicking the link above, or by going to wherever you listen to your favorite podcasts.

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Black overdose death rate exceeds white rate in U.S. for first time in 20 years

OD mortality rates increased in 2020 for all groups studied and were highest among Native Americans

Enrique Rivero

UCLA Newsroom

In 2020, the first year of the COVID-19 pandemic, the rate of drug overdose deaths among Black Americans surpassed that of whites for the first time since 1999 — a sharp reversal of the situation a decade earlier, when rates were twice as high for whites as for Blacks, new UCLA research shows.

Native Americans/Alaska Natives experienced the highest overdose death rate in 2020 and were, along with Blacks and Latinos, among the groups with the largest increase in overdose deaths per 100,000 people over the previous year. Death rates for all four racial and ethnic groups studied, including whites, not only climbed in 2020 but climbed higher than in any single year prior, the researchers said.

The grim statistics, they said, highlight not only the ways in which the pandemic has exacerbated overdose rates but the wide availability of synthetic opioids and other highly toxic drugs.

"Although the overdose crisis has often been represented as a 'white problem,' that has never been further from the truth," said Joseph Friedman, an addiction researcher and M.D. and Ph.D. candidate at the David Geffen School of Medicine at UCLA. "The increasingly dangerous drug supply has disproportionately put Black and Native communities at risk. We need to reverse deep-seated inequalities in access to treatment, harm reduction and services that can help people stay safe. We also know that disproportionate policing and incarceration is playing a key role in creating the instability that leads to overdose."

The study, published today in the peer-reviewed JAMA Psychiatry, draws on the first national data released on overdose deaths by race and ethnicity in 2020.

Yet even before this data became available, Friedman said, there were indications that overdose deaths were increasing disproportionately in the Black community and among other minority groups. In a 2021 study, for instance, he and his colleagues examined emergency medical services records and discovered that in 2020, overdose deaths in emergency settings had increased most rapidly for Black patients. The new study now provides more broad and definitive evidence.

For the current research, the study authors used all available sources from 1999 to 2020 to calculate drug overdose deaths per 100,000 people for Blacks, whites, Latinos and Native Americans/Alaska Natives. They found that:

- Black people had the largest percentage increase in deaths from 2019 to 2020, a jump of 49%, compared with an increase of about 26% for whites.
- Black overdose death rates rose to 37 per 100,000 in 2020, 16% higher than the rate for whites — a reversal of the Black–white overdose mortality gap in 2010, when the rate of 15.8 per 100,000 for whites was double that of Black Americans, at 7.9 per 100,000.
- American Indians/Alaska Natives experienced the highest rates of overdose deaths in 2020, at 41.4 per 100,000, approximately 31% higher than the white mortality rate.

While overdose mortality rates for Latinos were the lowest among the groups studied in 2020, Latinos did experience a 40% surge in the number of these deaths from 2019 to 2020.

Mortality was driven largely by illicit, highly toxic drugs such as synthetic opioids (including fentanyl), benzodiazepines and high-purity methamphetamine, the researchers noted.

The high — and unpredictably variable — potency of the illicit drug supply may be disproportionately harming racial and ethnic minoritized communities for various reasons," the researchers wrote. "Deep-seated inequalities in living conditions, including stable housing and employment, policing and arrests, preventive care, harm reduction, telehealth, medications for opioid use disorder and naloxone, are likely playing a key role."

https://newsroom.ucla.edu/releases/black-overdose-deaths-rates-surpass-whites-rates

The New York Times

GUEST ESSAY

It's Misleading to Call Addiction a Disease

By Carl Erik Fisher

In 2010, a little more than a year after graduating from medical school, I was admitted to a psychiatric ward at Bellevue Hospital after a drinking and Adderall binge.

The first day there, I was finally ready to acknowledge that I had a problem with addiction. After a few days alone on the ward, however, I started calling around to friends, trying to get them to sign on to my newly revised opinion that my problem wasn't that bad after all.

Denial is common for people with substance problems. But in my case, my very idea of addiction was working against me. I thought addiction was an extreme mental illness — a "disease," as I learned in medical school and later, in rehab. I understood addiction as a damaged condition that neatly divided me from the normal population.

Addiction as a disease made sense to me initially, but before long, I realized how harmful that view was.

Annual U.S. overdose deaths recently topped 100,000, a record for a single year, and that milestone demonstrates the tragic insufficiency of our current "addiction as disease" paradigm.

Thinking of addiction as a disease might simply imply that medicine can help, but disease language also oversimplifies the story and leads to the view that medical science is the single best framework for understanding addiction. Addiction becomes an individual problem, reduced to the level of biology alone. This narrows the view of a complex problem that requires community support and healing.

Once I was a few years into my recovery, I began studying addiction medicine, in no small part to make sense of what had gone wrong with me and my family — both of my parents were alcoholics. I found little help from my own field, which is divided into sometimes clashing schools of thought about how addiction works. As a result, I looked beyond medicine and science to history, philosophy and sociology; addiction is an idea with a long, messy and controversial history, dating back more than half a millennium. That history deepened my understanding of addiction and helped me make sense of my own experiences.

Around 500 years ago, when the word "addict" entered the English language, it meant something very different: more akin to a "strong devotion." It was something you did, rather than something that happened to you. For example, an early writer counseled his readers to "addict all their doings towards the attainment of life everlasting." My experiences and those of my patients seem more in line with how 16th- and 17th-century writers described addiction: a disordered choice, decisions gone awry.

Benjamin Rush, a founding father of the United States and one of the most influential physicians in America in the late 18th century, was particularly focused on mental illness. He was famous for describing habitual drunkenness as a chronic and relapsing disease. However, Rush argued medicine could help only in part; he recognized that social and economic policies were central to the problem. It was the later temperance movements of the 1820s and 1830s that emphasized a harder language of disease, insisting that people with drinking problems had been damaged by a sort of reductionist biology, that "demon rum" took you over, as in a possession.

It's imperative to be careful about these types of deterministic stories. Such reductionistic narratives were repeatedly used as a justification for racist, oppressive crackdowns in the United States, on Chinese opium smoking at the turn of the 20th century and on crack cocaine in the 1980s, which was painted as a problem primarily in Black neighborhoods. Today, amid the opioid overdose epidemic, addiction is more likely to be called a disease, but the language of disease has not done away with the misleading notion that drugs hold all the power.

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Not all drug problems are problems of addiction, and drug problems are strongly influenced by health inequities and injustice, like a lack of access to meaningful work, unstable housing and outright oppression. The disease notion, however, obscures those facts and narrows our view to counterproductive criminal responses, like harsh prohibitionist crackdowns.

In contrast, today, descriptions of "brain disease" imply that people have no capacity for choice or self-control. This strategy is meant to evoke compassion, but it can backfire. Studies have found that biological explanations for mental disorders increase aversion and pessimism toward people with psychological problems, including addiction. What's needed now more than ever, with overdose deaths on the rise, is not fatalism or dehumanization, but hope.

I am not saying that addiction is not a real problem, and as a person in addiction recovery, I would never deny that it is a problem of profound challenges with self-control. I know that for some of my peers in recovery and their families, the disease analogy helps them make sense of those struggles and the terrifying breakdown of reason that comes when people cannot seem to change despite their best efforts.

There are innumerable ways to make sense of addiction and many paths to recovery. But the view of addiction as disease fails to capture much of the experience of addiction, and disease language is not necessary to make the point for humane treatment.

Today, I am grateful to be in recovery from addiction. I have made peace with the idea that I am the kind of person who should not drink, at least for today. But I do not need to consider it a disease to do this. I believe that waking up to addiction is a tremendous gift, because it points us toward universal human struggles with self-control and working with our pain. In that sense, addiction is profoundly ordinary, contiguous with all of human suffering. We cannot end it, we certainly cannot cure it, and medicine alone will never save us. But if we drop the idea of disease and open up to a fuller picture of addiction, it will allow for more nuance, care and compassion.

Dr. Fisher is an addiction physician and bioethicist. He's the author of "The Urge: Our History of Addiction."

[It's Misleading to Call Addiction a Disease (ampproject.org)]

AlterNet
www.alternet.org

Addiction is not a disease: A neuroscientist argues that it's time to change our minds on the roots of substance abuse

Laura Miller

The mystery of addiction — what it is, what causes it and how to end it — threads through most of our lives. Experts estimate that one in 10 Americans is dependent on alcohol and other drugs, and if we concede that behaviors like gambling, overeating and playing video games can be addictive in similar ways, it's likely that everyone has a relative or friend who's hooked on some form of fun to a destructive degree. But what exactly is wrong with them? For several decades now, it's been a commonplace to say that addicts have a disease. However, the very same scientists who once seemed to back up that claim have begun tearing it down.

Once, addictions were viewed as failures of character and morals, and society responded to drunks and junkies with shaming, scolding and calls for more "will power." This proved spectacularly ineffective, although, truth be told, most addicts do quit without any form of treatment. Nevertheless, many do not, and in the mid-20th century, the recovery movement, centered around the 12-Step method developed by the founders of Alcoholics Anonymous, became a godsend for those unable to quit drinking or drugging on their own. The approach spread to so-called "behavioral addictions," like gambling or sex, activities that don't even involve the ingestion of any kind of mind-altering substance.

Much of the potency of AA comes from its acknowledgement that willpower isn't enough to beat this devil and that blame, rather than whipping the blamed person into shape, is counterproductive. The first Step requires admitting one's helplessness in the face of addiction, taking recovery out of the arena of simple self-control and into a realm of transcendence. We're powerless over the addictive substance, and trust in a Higher Power, and the program itself, to provide us with the strength and strategy to quit. But an important principle of the 12 Steps is that addiction is chronic and likely congenital; you can be sober indefinitely, but you will never be cured. You will always remain an addict, even if you never use again.

The flourishing of the 12-Step movement is one of the reasons why we now routinely describe addiction as a "disease." To have a disease — instead of, say, a dangerous habit — is to be powerless to do anything .

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except apply the prescribed cure. A person with a disease is unfortunate, rather than foolish or weak or degenerate. Something innate in your body, particularly in your brain, has made you exceptionally susceptible to getting hooked. You always have and always will contain a bomb, the important question is how to avoid setting a match to it. Another factor promoting the disease model is that it has ushered addiction under the aegis of the healthcare industry, whether in the form of an illness whose treatment can be charged to an insurance company or as the focus of profit-making rehab centers.

This conception of addiction as a biological phenomenon seemed to be endorsed over the past 20 years as new technologies have allowed neuroscientists to measure the human brain and its activities in ever more telling detail. Sure enough, the brains of addicts are physically different — sometimes strikingly so — from the brains of average people. But neuroscience giveth and now neuroscience taketh away. The recovery movement and rehab industry (two separate things, although the latter often employs the techniques of the former) have always had their critics, but lately some of the most vocal have been the neuroscientists whose findings once lent them credibility.

One of those neuroscientists is Marc Lewis, a psychologist and former addict himself, also the author of a new book "The Biology of Desire: Why Addiction is Not a Disease." Lewis's argument is actually fairly simple: The disease theory, and the science sometimes used to support it, fail to take into account the plasticity of the human brain. Of course, "the brain changes with addiction," he writes. "But the way it changes has to do with learning and development — not disease." All significant and repeated experiences change the brain; adaptability and habit are the brain's secret weapons. The changes wrought by addiction are not, however, permanent, and while they are dangerous, they're not abnormal. Through a combination of a difficult emotional history, bad luck and the ordinary operations of the brain itself, an addict is someone whose brain has been transformed, but also someone who can be pushed further along the road toward healthy development. (Lewis doesn't like the term "recovery" because it implies a return to the addict's state before the addiction took hold.)"The Biology of Desire" is grouped around several case studies, each one illustrating a unique path to dependency. A striving Australian entrepreneur becomes caught up in the "clarity, power and potential" he feels after smoking meth, along with his ability to work long hours while on the drug. A social worker who behaves selflessly in her job and marriage constructs a defiant, selfish, secret life around stealing and swallowing prescription opiates. A shy Irishman who started drinking as a way to relax in social situations slowly comes to see social situations as an occasion to drink and then drinking as a reason to hole up in his apartment for days on end.

Each of these people, Lewis argues, had a particular "emotional wound" the substance helped them handle, but once they started using it, the habit itself eventually became self-perpetuating and in most cases ultimately served to deepen the wound. Each case study focuses on a different part of the brain involved in addiction and illustrates how the function of each part — desire, emotion, impulse, automatic behavior — becomes shackled to a single goal: consuming the addictive substance. The brain is built to learn and change, Lewis points out, but it's also built to form pathways for repetitive behavior, everything from brushing your teeth to stomping on the brake pedal, so that you don't have to think about everything you do consciously. The brain is self-organizing. Those are all good properties, but addiction shanghais them for a bad cause.

As Lewis sees it, addiction really is habit; we just don't appreciate how deeply habit can be engraved on the brain itself. "Repeated (motivating) experience" — i.e., the sensation of having one's worries wafted away by the bliss of heroin — "produce brain changes that define future experiences… So getting drunk a lot will sculpt the synapses that determine future drinking patterns." More and more experiences and activities get looped into the addiction experience and trigger cravings and expectations like the bells that made Pavlov's dogs salivate, from the walk home past a favorite bar to the rituals of shooting up. The world becomes a host of signs all pointing you in the same direction and activating powerful unconscious urges to follow them. At a certain point, the addictive behavior becomes compulsive, seemingly as irresistibly automatic as a reflex. You may not even want the drug anymore, but you've forgotten how to do anything else besides seek it out and take it.

Yet all of the addicts Lewis interviewed for "The Biology of Desire" are sober now, some through tried-and-true 12-Step programs, others through self-designed regimens, like the heroin addict who taught herself how to meditate in prison. Perhaps it's no surprise that a psychologist would argue for some form of talk therapy addressing the underlying emotional motivations for turning to drugs. But Lewis is far from the only expert to voice this opinion, or to recommend cognitive behavioral therapy as a way to reshape the brain and redirect its systems into less self-destructive patterns.

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Without a doubt, AA and similar programs have helped a lot of people. But they've also failed others. One size does not fit all, and there's a growing body of evidence that empowering addicts, rather than insisting that they embrace their powerlessness and the impossibility of ever fully shedding their addiction, can be a road to health as well. If addiction is a form of learning gone tragically wrong, it is also possible that it can be unlearned, that the brain's native changeability can be set back on track. "Addicts aren't diseased," Lewis writes, "and they don't need medical intervention in order to change their lives. What they need is sensitive, intelligent social scaffolding to hold the pieces of their imagined future in place — while they reach toward it."

Addiction is not a disease: A neuroscientist argues that it's time to change our minds on the roots of substance abuse - Alternet.org

Hartford Courant

What is fentanyl and can touching it kill you? Doctors dispute police warning

Seamus McAvoy

On Jan. 14, Hartford police issued a warning stating they recently recovered fentanyl 50 times more potent than the kind typically tested across New England.

Police did not specify where they recovered the drugs, but the issue of fentanyl was close to mind. A 13-year-old student at Sport and Medical Sciences Academy overdosed on the drug while at school Jan. 13, and later died. The following day, police said a subsequent search of the school revealed nearly 40 small bags of fentanyl packed for street-level sale.

In the warning released Jan. 14, police repeated a claim that has since been widely scrutinized: "The strength and potency of this product can be deadly to anyone coming in contact with it, including absorption through the skin," they wrote.

The latter part of the claim is untrue, according to medical and addiction experts, who fear the circulation of these claims could spread unnecessary fear and negatively impact harm reduction efforts in the future.

"Proving a negative, as in, this could never be a problem, is potentially difficult. But in this situation, it really isn't so difficult," said Dr. Charles McKay, former president of the American College of Medical Toxicology and associate medical director of the Connecticut Poison Control Center.

"I am unaware … of a legitimate, scientifically reviewed, published case report of dermal powder fentanyl exposure resulting in severe toxicity and death," said Dr. Suzanne Doyon, medical director of the Connecticut Poison Control Center.

It's simply not how the drug works, the doctors said.

Fentanyl is a synthetic opioid 50 to 100 times more potent than morphine and typically administered intravenously to treat severe pain, such as for cancer patients or post-surgical patients.

It is cheaper to produce than other opioids, which are usually derived from the opium poppy. Though considered safe in a medical environment, the drug has begun to infiltrate the illicit opioid market, and its potency poses a fatal risk to users.

It's also a larger substance and doesn't absorb well through the skin, McKay said. It is "physically impossible" that one could develop symptoms just minutes after coming into contact with the drug, he added.

Pharmaceutical companies have more recently produced dermal fentanyl patches — but only after more than 10 years of development, Doyon said.

These highly technical patches often contain large quantities of fentanyl in a membrane, and are applied with adhesive and occlusive dressing.

"There's a huge difference between that and someone who gets a little bit of white powder on the hands," Doyon said.

Lt. Aaron Boisvert, the Hartford police spokesperson who wrote the warning, clarified the claim with The Courant on Thursday and reiterated the dangers posed by the highly potent opioid.

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"We've always had training bulletins and things that [said] you're not supposed to touch this stuff because it can be absorbed through the skin. Apparently that is no longer the case," Boisvert said.

"However, if you touch it and touch your eye later, your nose later, then it can potentially kill you. I'm not going to say you can touch fentanyl. This is dangerous stuff."

Ocular ingestion is thought to pose more of a risk than dermal absorption, but medical experts said the dangers are mitigated with basic safety precautions, like handwashing.

"If people come in casual contact with fentanyl, they should wash their hands and avoid touching their face, mouth or nose," until they wash their hands, said Dr. Matt Griswold, chief of the Division of Toxicology at Hartford Hospital.

Experts also questioned the rigorous decontamination process at the Sport and Medical Sciences Academy, which kept the school closed until Wednesday.

School administrators placed the school under a "Code Yellow" alert after learning of the overdose, meaning students and staff had to stay put, and did not distribute lunches to students.

Jason Thody, Hartford police chief, said at a press conference Jan. 13 that students were required to walk through a solution of bleach and OxyClean before leaving the school.

A certified state contractor continued the decontamination process over the weekend in the areas where bags of the drug were found. The direction to treat the school as a "Hazmat situation" came from the Drug Enforcement Administration, Boisvert said.

McKay said the process was "completely unnecessary and benefits nobody." While these chemicals would succeed in degrading the fentanyl, the likelihood of significant quantities of fentanyl-laced powder being tracked out of school on the shoes of the students is slim.

"I suppose if [students] licked their shoes or something, they might get a dose, but that doesn't seem very likely," McKay said. "It would be better to focus people on the problem that does exist, which is the widespread availability and use of very potent opioids with no idea what is in them."

The Sport and Medical Sciences Academy reopened Wednesday with a two-hour delay, with extra support staff on site and resources for students and staff.

Whatever the rationale for closing the school for decontamination, "it would have nothing to do with preventing subsequent exposures," McKay said.

Mark Jenkins, executive director of the Connecticut Harm Reduction Alliance, said he was concerned with the optics of the response. "The message that sends to the community is hysteria," he told The Courant.

Jenkins and other harm reduction advocates worry that spreading claims that fentanyl can kill you just by touching it, or that hazmat suits are needed to decontaminate, spreads stigma around opioids and makes intervention less likely in the future. People who witness an overdose, or first responders, may be hesitant to treat a victim with Narcan, for example.

The decontamination process at the school is not replicated at other scenes where overdoses occur, according to Peter Canning, EMS coordinator at UConn John Dempsey Hospital.

"If you treated every [overdose] scene the way they treat some of these hazmat scenes, you would need to put tape around the city of Hartford," Canning said.

The mistaken belief that fentanyl can be lethal to touch has been particularly pervasive among law enforcement officials as police and other emergency personnel started to respond to more fatal overdoses over the last decade.

In 2016, the DEA released a training video for officers called "Fentanyl: A Real Threat to Law Enforcement" that said dermal contact with the drug could be fatal.

Videos and testimonies of officers claiming to experience overdoses soon began to circulate widely, in part thanks to a plethora of misleading news reports.

Several medical organizations have attempted to counter these claims in the years since. In 2017, the American College of Medical Toxicology and the American Academy of Clinical Toxicology released a joint position statement saying "incidental dermal absorption is unlikely to cause opioid toxicity.

Despite fentanyl's potency, the "risk of clinically significant exposure to emergency responders is extremely low," the statement reads.

As for the testimonies, McKay noted that the symptoms described by first responders "are generally not what you'd expect to see with opioid exposure."

Symptoms like dizziness or an elevated heart rate are more akin to stress or panic attacks, experts said.

Still, these incorrect beliefs have stuck around, and guidance from medical institutions is not always clear.

The Centers for Disease Control and Prevention, for example, in 2020 updated its guidance for first responders when handling fentanyl, but still warns of the dangers of skin absorption on its general fentanyl page online.

It can be hard to correct misinformation once it gets out the first time, Canning said, and deferred to a favored quote from Jonathan Swift: "Falsehood flies, and truth comes limping after it, so that when men come to be undeceived, it is too late; the jest is over, and the tale hath had its effect."

[What is fentanyl and can touching it kill you? Doctors dispute police warning - Hartford Courant]

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You can find us directly at https://scopeofpractice.podbean.com
And Amazon, iTunes, or your favorite podcast host.

We are excited to announce that we will be joined by Dr. Carol Falender of Pepperdine University, author of several graduate clinical supervision texts on clinical supervision in late spring and Connecticut native, Dr. Alta DeRoo, Chief Medical Officer at Hazelden Betty Ford during the summer. Dr. DeRoo will speak with us on her specialty, women with OUDs.

FREE CCB approved training events, both live (virtual) and on demand. Check them out! https://TPN.Health

Medium

Ketamine-Assisted Therapy for Alcohol Addiction Could Save Lives

Findings from the world's first controlled study exploring the use of ketamine-assisted psychotherapy for alcohol addiction has shown positive results

Ruben Bouma, MS

Results from the Awakn Life Sciences' Phase IIa/b study investigating ketamine-assisted therapy for the treatment of alcohol use disorder (AUD) have shown 86% abstinence for six months following treatment. According to the study's lead author, the therapy has the potential to save lives.

The double-blind placebo-controlled clinical trial, which included 96 patients with severe AUD.

The primary and secondary endpoints of the trials were days abstinent and relapse at six-month follow-up.

The study's results have been published in the *American Journal of Psychiatry*.

Psychopharmacology professor Celia Morgan, who led the trial conducted by the University of Exeter, said: "Alcohol Use Disorder is pervasive and persistent public health issue, affecting at least 390 million people globally. Treatment rates are low and relapse rates post-treatment tend to be high. We urgently need new and more effective treatments. "

Ketamine

Ketamine is a dissociative anesthetic drug that acts on the central nervous system chiefly through antagonism of the N-methyl-D-aspartate receptor. Therefore, ketamine is a promising candidate therapy in AUD for several reasons.

Substantial evidence supports the rapid-acting antidepressant properties of subanesthetic doses of ketamine

Ketamine might aid alcohol abstinence by providing a window during which psychological therapies can be more effective via increased synaptogenesis and neurogenesis, known to be disrupted with addiction

Several studies have directly investigated the effect of ketamine on patients with problematic alcohol use and revealed promising results

Study findings

Participants in the trial were randomized into four groups.

- First group, three ketamine infusions plus KARE
- Second group, three saline infusions plus KARE
- Third group, three ketamine infusions plus alcohol education
- Fourth group, three saline infusions plus alcohol education.

Analysis of the results revealed several interesting outcomes.

Primary outcomes

- The first group significantly increased abstinence over all other groups
- The odds ratio of relapse was reduced with the KARE therapy

Secondary outcomes

- Ketamine groups showed increased liver function across several markers
- Ketamine groups saw reduced depression and anhedonia (inability to experience pleasure) at 3 months

Exploratory analysis

- Heavy drinking days were reduced in the KARE (first) group compared to all other groups

Safety

- Ketamine was well tolerated and had a good safety profile, adverse events were predominantly mild and only reported by 8/96 patients. No serious adverse events happened.

Primary outcomes

The findings demonstrated that ketamine combined with proprietary manualized therapy (KARE) resulted in total abstinence in 162 of 180 days in the following six-month period. This was an increase in abstinence from around 2% prior to the trial to 86% post-trial.

Moreover, relapse results at 6 months showed that the ketamine plus KARE group's risk of relapse was 2.67 times less than the placebo plus alcohol education group.

"We found that controlled, low doses of ketamine combined with manualised psychological therapy can significantly increase post-treatment abstinence rates."

Professor Morgan added.

"This is extremely encouraging, as we normally see three out of four people returning to heavy drinking within six months of treatment. With the data we've collected from this study, along with emerging data from other studies of ketamine to treat AUD, they strongly suggest that further trials of this treatment are warranted."

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Secondary outcomes

The secondary outcomes also identified encouraging results.

These include improved liver function across several different markers and a statistically significant decrease in depression after 3 months and a decrease in anhedonia.

Exploratory analysis

There were only 12 heavy drinking days in the KARE (first)group at the 6-month follow-up. This is a steep reduction compared to other trials.

There was also a 10-fold decrease in the risk of mortality. 1 in 8 patients would have died within 12 months without treatment, a number which decreased to 1 in 80 following the treatment.

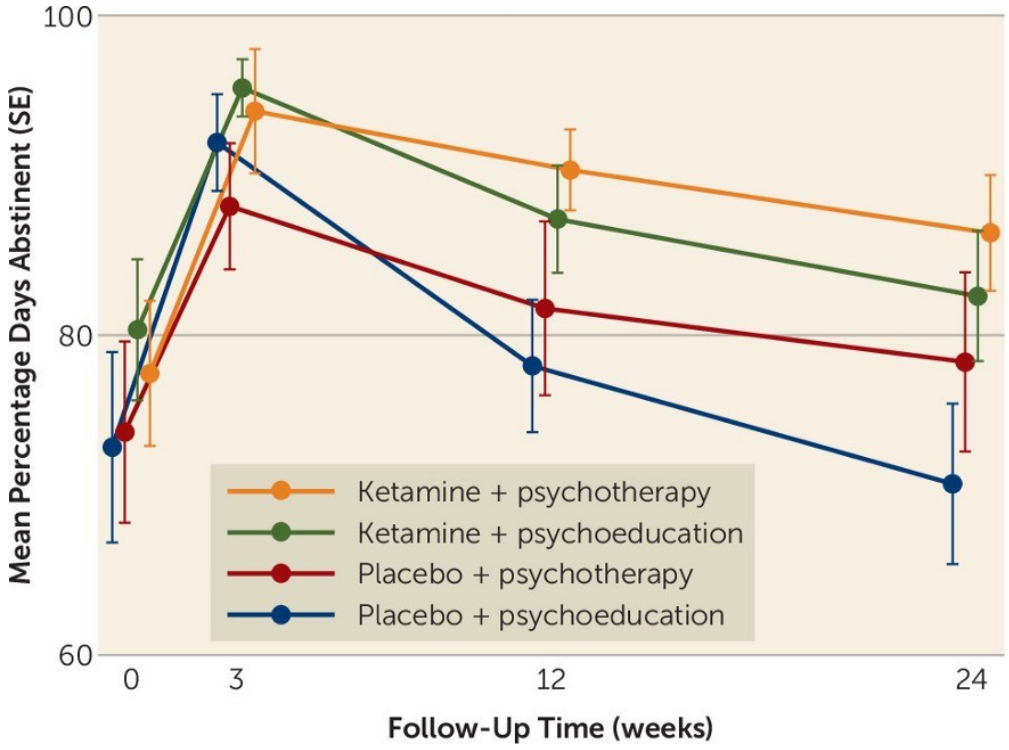
Conclusion

In short, the trial demonstrated that 3 subanesthetic infusions of ketamine support abstinence from alcohol. Moreover, abstinence may be further enhanced when ketamine treatment is combined with therapy. Neurotrophic, modulatory, and even psychological mechanisms have all been proposed to account for the sustained antidepressant effect of a single dose of ketamine. Hence, these downstream effects on diverse neural circuits may have relevance to addiction treatment as well.

"We are so pleased to see such encouraging results in an area of treatment that has been stagnant for so long, leaving so many people with little or sub-par options available to them."

Anthony Tennyson, Awakn's chief executive, commented.

"We will continue to support this research and future clinical trials as we push to bring a radical shift in the alcohol addiction treatment industry."



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THE TIMES OF INDIA

Best Medicine: Why UK doctors now prescribe shot of comedy and laughter to trauma patients

Kirti Pandey

Trauma – severe trauma can cause several illnesses of the body and mind. People who have suffered severe injuries, losses, agony, stress, subjected to abuse etc. are all trauma patients. And guess what the UK medical experts have decided to rope in as prescribed treatment? Laughter. Comedy. Heart-felt fun.. Counselling, cognitive behavioural therapy (CBT), and medication – that is as far as we thought that doctors will go to treat a trauma patient? In the UK, a prescribed comedy course could become a new way to help people recover from trauma.

As per a report in the UK daily The Guardian, Angie Belcher, a comedian in residence at the University of Bristol, has been working with health advisers to develop comedy sessions to help patients recover from trauma. Belcher has worked with health advisors and psychology theories to develop the sessions. Guardian cites that this is not the first time that such an out-of-the-box idea has been thought out about involving comedy in the healing process.

It says that several comedians – such as Russell Brand and Jimmy Carr – have written about mental health in their books.

Take a look at this TED Talk video by Ruby Wax who went even a step further – she not only beat her mental illness but after returning from the mental health institution, she studied psychotherapy, got a master's in mindfulness-based cognitive behaviour from Oxford, delivered a Ted Talk and received an OBE for services to mental health.

And how will it help the trauma patient?

By helping them uproot the stigma, the shame, the guilt around the illness they have battled, and gain a new perspective – a positive outlook. By combining the arts with psychology and looking at "an inner sense of self". Belcher told BBC that all comedy comes from "trauma not the happy bits" and gives people a new perspective on experiences.

Belcher, who holds a master's in psychology, told BBC, "Comedy is a force for good" and people do not realise how much it "can change people's lives… We're all naturally comedians. When I work with young people there's a lot of people experiencing gender dysmorphia, people who have recently come out, issues with family, class and race. We explore those subjects. In the end, people seem six inches taller."

"I'm always saying to people: the more authentic and vulnerable you are on stage, the closer your audience feels to you. The closer they feel to you, the more believable you are. And the more believable you are, the funnier you are," Belcher told the New Statesman.

GPs in Bristol will be able to socially prescribe the pilot course (six-week comedy course to patients who are struggling with trauma) from this month. In fact, Belcher's first series, which has 15 participants and is being run in partnership with the Bristol Wellspring Settlement Social Prescribing Team, started [in] January 2022. Students will come from all walks of life, within a wide range of trauma afflictions – those on suicide watch, also those battling/recovering from addiction, those experiencing gender dysmorphia, depression, anxiety, PTSD or bereavement, etc.

By the end of the course, it's hoped that participants will be able to perform five minutes of stand-up based on their own life. Professional comedians Charmian Hughes and Jack Campbell will help to deliver the sessions.

. Best Medicine: Why UK doctors now prescribe shot of comedy and laughter to trauma patients | Health Tips and News (timesnownews.com)

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Parolees With Opioid Addiction Need Choices, Not a Naltrexone-Only Policy

Doug Johnson

Across the United States, people with opioid addiction who are on parole aren't getting the right medication. In many cases, they might not get any medicine to help them deal with withdrawal or give them a safe alternative to the adulterated illicit supply. In others, courts will preferentially prescribe one drug over another, sometimes ignoring the recommendation of a parolee's health care provider.

Like other people with opioid use disorder, current and future parolees are often prescribed one of three drugs: methadone, buprenorphine or naltrexone (brand name: Vivitrol). The first two medications are full and partial opioid agonists, respectively; they bind to the opioid receptors in the brain. Naltrexone, meanwhile, is an antagonist and does the opposite: It functionally blocks off the opioid receptors and prevents a person from getting high.

Amelia Caramadre, a legal fellow with the Health in Justice in Action Lab, noted that opioid agonists are often stigmatized because some believe that they are just replacing one "narcotic" with another. Yet naltrexone comes with a slew of substantive issues.

Naltrexone is "not the gold standard," Caramadre told Filter. "Methadone and buprenorphine are the gold standards."

In December, a court case in Massachusetts highlighted this issue. The Massachusetts Parole Board was requiring some people to take naltrexone as a condition of their parole—sometimes against their doctors' recommendations on the matter. Under this blanket policy, the Board allegedly failed to conduct individual assessments to see if the antagonist would work for each person, or to consider whether methadone or buprenorphine might be a better fit.

This case, brought forward by the US Attorney's Office for the District of Massachusetts, ultimately ended in an agreement that the parole board would no longer follow these practices, which prosecutors argued contravened the Americans with Disabilities Act (ADA).

"The Parole Board is committed to addressing substance use disorder in the criminal justice system and to supporting parolees in accessing treatment resources," a spokesperson for the parole board told Filter in an email. "The Board worked proactively and in close collaboration with the Department of Justice toward this agreement and is committed to fulfilling its requirements."

The US Attorney's Office did not provide answers to Filter's questions by publication time.

Issues Around Naltrexone

It's not that naltrexone is necessarily worse than methadone or buprenorphine in some cases, according to Joshua Barocas, MD, an associate professor of medicine at the University of Colorado. The compound has been around for a long time, and has often been prescribed for people who are or have been incarcerated because "there's quite a bit of stigma and apprehension about using agonist therapy," he told Filter.

"Naltrexone was kind of the lowest-hanging fruit," Dr. Barocas said, adding that it's always been the easiest sell for institutions.

Early clinical trials showed that it was more effective than prescribing nothing in the short term, he said. Because the drug can, over shorter spans of time, help stabilize a person, it was also beneficial for people living with HIV, he added, as it helped them become more organized and, thus, more likely to take their HIV medications regularly.

However, naltrexone functionally blocks opioid highs. So, in order for it to be effective, the person using it must have already gone through withdrawal, he said. That means it certainly isn't suitable for everyone. For people who do use it, "There's still cravings. There's still some amount of desire for opioids."

In the general population, buprenorphine and methadone tend to perform better than naltrexone, Barocas said. He added that people on naltrexone often discontinue the drug. In these cases, after long stretches of time without taking any opioids, their tolerances to opioids have decreased. If they then use opioids at dosages similar to the ones they used prior to taking naltrexone, they will be at a higher risk for overdose.

For example, a 2015 study involving 1,097 naltrexone patients in Australia, which suggested there may have been 25 to 29 deaths over the course of two years that might not have occurred if patients had received methadone instead. "Large-scale use of oral naltrexone to treat opioid users may not have, as intended, saved lives," the authors wrote.

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"This isn't to say naltrexone doesn't have a place," Barocas said. "I have plenty of patients who, for a number of reasons, say that's what they want. There are people who are successful on naltrexone, but making that the only medication that's available to someone is problematic."

Addressing This Nationwide

To address this damaging, one-size-fits all scenario, the Health in Justice Action Lab has begun a project working to end the practice of preferentially prescribing parolees any one drug over another, and mandating or denying certain addiction medications.

Caramadre, who is part of it, said that in some cases, these meds can be used as "weapons"—if a parolee misses a check-in, for instance, a court might block their access to methadone. Ideally, the project would also stop this practice.

Caramadre is working to find other US jurisdictions where courts have done what Massachusetts was doing, and where parolees may have been harmed. The team will then perform research and groundwork, building a case to hand up to the states' Assistant United States Attorney's Offices (AUSAs) which, the team hopes, will then prosecute. From there, the non-compliant body can either hope to settle, like Massachusetts, or face further consequences, Caramadre said.

According to Caramadre, if the Health in Justice Action Lab—or even plaintiffs who have been hurt by being preferentially prescribed one drug over another—went directly to court over this issue, it's likely the court wouldn't care. That's why the project is turning to various AUSA's in states around the country, planning to present them with legal cases in the hopes that the offices bring the other bodies into compliance with the law—as happened in Massachusetts.

The project is still in its early stages, having begun in November of last year, but Caramadre said the team also hopes to develop a template for cases that they can adjust for specific states and bring to their AUSAs.

While the Massachusetts case used the ADA, the Health in Justice Action Lab project will use a different legal pathway. Though Caramadre declined to say which, she said that it's one that has not been used before.

"We are exploring different legal routes to get the same result [as in Massachusetts] on a larger scale."

https://filtermag.org/parole-opioid-addiction-naltrexone

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theguardian

Rob Davies

Trading is gambling, no doubt about it' – how cryptocurrency dealing fuels addiction

Fears rise over how unregulated trading and promotion of crypto assets are creating a new generation of addicts

Steven has lost more bitcoin than most people will ever own.

Raised on the remote Shetland archipelago, he left school at 13 to become a trawlerman before moving into construction, eventually earning £85,000 a year digging tunnels for Crossrail.

Despite his self-made success, compulsive cryptocurrency trading, alcohol and drug use took over his life.

In the fog of multiple addictions, he lost the "addresses" of between five and 10 bitcoins, rendering his digital buried treasure – worth up to £300,000 today – impossible to retrieve.

Steven spotted the potential of bitcoin early and he had a talent for trading. But even if he had that money now, his addiction means it would soon be squandered.

"Trading is gambling, there's no doubt about it," he says.

"I studied and studied. I taught myself how to be a good trader and tried really hard to manage my accounts and stick to a set of rules.

Now in recovery at the Castle Craig residential treatment clinic in Scotland, Steven fears that legions of young people are being lured into high-risk trading and potentially addiction, based on the same misguided quest for untold riches.

"A whole generation think that with a little mobile phone they can win, that they can … beat the market," he says.

"It scares the bejesus out of me."

Steven's fears are founded partly on crypto's rapid emergence into the mainstream.

When he started investing in 2015, digital currencies meant nothing to most people.

Now, they are being touted as a more democratic alternative to a monopolistic and exploitative global financial system.

As the Guardian revealed on Friday today, crypto firms launched a record-breaking promotional push in London last year, targeting millions of commuters with 40,000 adverts on billboards, at tube stations, in carriages and across the side of double decker buses.

Advertisers included relatively obscure names such as Hex, Kraken and Puglife about whom consumers know little, if anything.

Meanwhile, football clubs and players, not to mention globally recognised celebrities, tout crypto investments on a daily basis via social media.

This week, reality TV star Kim Kardashian West and boxer Floyd Mayweather Jr were named in a lawsuit alleging that they helped promote crypto firm EthereumMax, as it made "false and misleading" statements that left investors nursing heavy losses.

An Instagram post about EthereumMax, to Kardashian's 250 million followers, may have been the most widely seen financial promotion of all time, according to the head of the UK's Financial Conduct Authority (FCA).

Yet despite their ascendancy – and warnings that governments could suffer "limitless" losses – cryptoassets remain unregulated in the UK, pending a Treasury review.

That means that the FCA, the UK's financial regulator, is all but powerless to influence how the industry behaves.

While some trading platforms that offer digital assets are regulated – because they also offer more traditional financial instruments – crypto coins and tokens are not.

Cryptoasset executives do not have to prove that they are fit and proper people to take people's money. The companies they run are not required to hold enough cash to repay investors if they go bust. Nor must they worry about the FCA's stipulation that financial promotions, such as those splashed across public transport in London, are fair, clear and not misleading.

Amid the marketing blitz, the Advertising Standards Authority is the only watchdog that has bared its teeth.

It is investigating one advert by the cryptocurrency Floki Inu and has already banned one for Luno Money.

"If you're seeing bitcoin on a bus, it's time to buy," the Luno advert insisted, contrary to prevailing investment wisdom.

Luno Money told the Guardian it would welcome an "effective regulatory framework".

But in the ongoing vacuum of oversight, experts fear that cautionary tales of addiction, such as the one told by Steven, are being drowned out by powerful, overwhelmingly positive messages.

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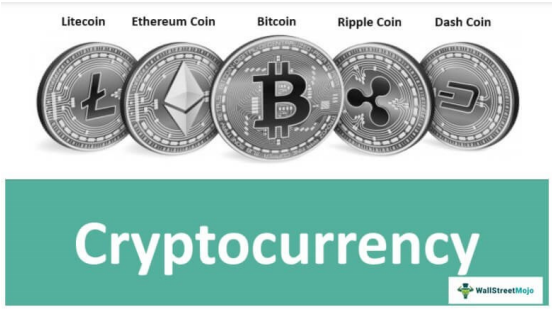

To monitor the type of messaging sent out by marketing teams, the Guardian created an experimental cryptocurrency portfolio – holding a mixture of bitcoin, ether and Shiba Inu.

As bitcoin slumped towards the end of 2021 and into 2022, having reached all-time highs just weeks earlier, the Twitter account of smartphone trading app eToro remained doggedly optimistic.

"Is bitcoin on its way to a new high?," it asked, as the slide began. "We've seen bitcoin rally before. But could this be the one to take it to the MOON?"

The answer, for the time being at least, was "No". But holders of crypto portfolios were encouraged to stay positive.

"Your account gained 1.87% yesterday," one app notification read, as the slump abated. "You had a good day. Share the news with everyone."

No such invitation appeared on the far more frequent days when the value of the Guardian's portfolio went down.

"It's a very strategic marketing ploy," says Dr Anna Lembke, one of the world's foremost addiction experts, professor of psychiatry at Stanford University School of Medicine and author of the book Dopamine Nation.

"They're encouraging you to amplify the wins and ignore the losses, creating a false impression there are more wins."

Asked about this, eToro says that it is "committed to helping retail investors engage with each other and foster an environment of learning and collaboration", adding that its platform is not "gamified".

According to eToro's UK managing director, Dan Moczulski, some users make their account public so that "all investments are visible to others, whether they are profitable or not".

The company said it also provides educational tools, performs know-your-customer checks and encourages long-term, diversified investing.

But Dr Lembke is concerned by the potential for the social media element to fuel compulsive behaviour in crypto trading, an activity she says bears the hallmarks of addictive gambling products but without the acknowledged risk.

"When you mix social media with financial platforms, you make a new drug that's even more potent," she says.

Social media posts pushing crypto frequently refer to *FOMO* – the fear of missing out – fuelling an urge to participate.

"You get this herd mentality where people talk to each other about what the market is doing, they have wins together, losses together, … an intense shared emotional experience."

"We get a little spike in dopamine, followed by a little deficit that has us looking to recreate that state."

This, she says, echoes characteristics of gambling but with a crucial difference.

"It's less stigmatised," she says. "It has this socially sanctioned status as something that maverick smart people do."

Parallels with gambling are becoming harder to ignore.

GamCare, which runs the National Gambling Helpline, said it fields about 20 calls a week related to crypto.

Callers reported trading for 16 hours a day, making huge losses and struggling to cope with the guilt.

As with gambling, where every one addict is estimated to harm seven other people, many were suffering at the hands of someone else's habit.

One recounted how her partner's trading obsession was leading them to spend time away from the family.

Another said their partner had taken to trading while in recovery from alcoholism, spending every waking hour making trades.

GamCare has even dealt with young patients who bought digital coins in a desperate attempt to make enough money to get on to the property ladder, only to lose life-changing sums.

At Castle Craig, where Steven is receiving treatment, the first crypto addict arrived at the clinic in 2016, followed by more than 100 since then.

"More and more people are isolated and are doing this [trading], especially since Covid," says Tony Marini, the senior specialist therapist at the clinic and a recovering gambling addict himself.

"It's tenfold already since 2016, so what's it going to be like in the next five years?"

https://www.theguardian.com/technology/2022/jan/15/trading-is-gambling-no-doubt-about-it-how-cryptocurrency-dealing-fuels-addiction

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