

# INFORMED CONSENT

**INFORMED CONSENT IS AN ONGOING PROCESS; IT IS NOT INTENDED TO BE A ONE-TIME ACT.**

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## Connecticut Certification Board Conference and Annual Awards Celebration 2022 Held at Saint Clements Castle

After a 2 year wait because of the COVID-19 pandemic, the CCB held its Spring Conference and Awards on July 2 at the Saint Clements Castle in Portland, Connecticut. Approximately 150 in-person and 100 virtual guests started the day with a welcome from former Fox 61 news anchor and 2012 Summer Olympics Bronze Medalist Margaux Farrell and ended it with incredible enthusiasm and energy from Dr. Brandee Izquierdo of the SAFE Project in metro Washington, DC. The location was perfect, the list of speakers all brought their A-games, and there was plenty of time built in to the schedule for catching up with friends and colleagues and networking with new ones. Award winners Dr. Albert Young (David Powell Lifetime of Service) and Paul Concordia (Joseph Sullivan Young Professional) had their families in attendance and offered words of wisdom, kindness and humility. Some of the comments from those in attendance include:

*"Thank you so much for giving me the opportunity to carry the message"*  
Dr. Brandee Izquierdo

*"The conference was so good. I would definitely attend again. You guys did an amazing job!"*  
Joyce Garcia, LPC

*"Thank you, I thoroughly enjoyed the opportunity to attend the conference and awards ceremony. It was very inspiring and motivating for me as a clinician to see that I can further explore opportunities for my career. I learned so much from each of the presentations. I would love to participate in more events!"*  
Raisa Dirienzo, MS

We appreciate all who were involved, attendees, sponsors, venue staff...time to get started on next year's event!

***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*

The 2022 conference is in the books and quite honestly, it's still a bit hard to believe since we started this process in 2020 with several postponements before finally cancelling. We have received lots of positive feedback and more than one "pat-on-the-back", however the real stars of the show were the venue and the speakers. I offer a heartfelt thank you to Margaux Farrell, Dr. Jaquel Patterson, Andrew Kessler, JD, Jana Wu, Brigadier General John Quintas (USAF-Retired), Colonel Kevin Brown (US Army-Retired), Cinthia Johnson, JD, Vince Santilli, and the always entertaining and informative Dr. Brandee Izquierdo. I am also grateful to see and hear the humility of both award winners, Dr. Albert Young and Paul Concordia, who represent the best of the history and future of our field. The staff at Saint Clements Castle represented the incredible venue quite well. There was no shortage of appreciation for the beautiful location!

Our main article in this edition comes from the New York Times and covers an effective yet entirely controversial treatment for PTSD, and we use it as the focus to remind us to be open-minded and pay attention to our own biases, so that they do not become a hindrance to doing good work in the community. We need not, in our private opinions, approve of a certain pathway or intervention, we simply need to trust the evidence and accept that they may be beneficial to others. Criticizing pathways or encouraging clients away from things we personally disapprove of is not only problematic, they are stigmatizing, discriminatory, and violations of a client's autonomy as well as our Code of Ethical Conduct. For more information on how our biases can be mitigated, you can listen to a recent podcast interview that I did with Donald McDonald, LCSW of North Carolina on our [Scope of Practice website](#).

Speaking of our podcast, I continued to be amazed with those we are able to have as guests. We have been able to secure some outstanding experts in our field as well as people doing some amazing things. I recently spoke with Dr. Carol Falendar of UCLA and Pepperdine University, who is probably the pre-eminent expert of clinical supervision in the world today and Dr. Robert Weiss, who has published several texts on relationship and intimacy disorders and whose latest book challenges the commonly accepted theory of codependency. We have other tremendous guests on the horizon including the Chief Medical Officer of Hazelden, Dr. Alta Lash, who will talk about opioid use disorder treatment for pregnant women. Our podcast is always free to listen and available from our hosting site, Podbean, but also Amazon, iTunes or wherever you listen to your favorite podcasts. We are always looking for new ideas and guests, so we'd love to hear your recommendations.

On July 2, the CCB and the University of Bridgeport Graduate Program in Clinical Mental Health Counseling are sponsoring an event on the UB campus, the only Connecticut stop on the nationwide [Living Undeterred Tour](#). Living Undeterred is a series of events across the country designed to raise awareness about substance use and mental health disorders and most importantly, fight the stigma associated with the disorders. The day includes some words from the tour's founder, Jeffrey Johnston, an Iowa native who is committed to changing the landscape after the loss of his oldest son to an overdose in 2016, a local keynote, and a panel discussion - all of whom have lived experience and are thriving. Bridgeport Mayor Joseph Ganim will welcome the tour and all the guests to his city. Interested in attending? Reach out to me directly for more information, seating is limited for this free event and pre-registration is required. Don't forget to check out our new website! The address remains <https://ctcertboard.org/> but it more modern, easier to navigate and updated regularly. Happy summer everyone!



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# The New York Times

## **A Balm for Psyches Scarred by War MDMA-assisted treatment for post-traumatic stress disorder “represents real hope for long-term healing,” health experts say.**

Nigel McCourry removed his shoes and settled back on the daybed in the office of Dr. Michael Mithoefer, a psychiatrist in Charleston, S.C.

“I hadn’t been really anxious about this at all, but I think this morning it started to make me a little bit anxious,” Mr. McCourry said as Annie Mithoefer, a registered nurse and Dr. Mithoefer’s colleague and spouse, wrapped a blood pressure cuff around his arm. “Just kind of wondering what I’m getting into.”

Mr. McCourry, a former U.S. Marine, had been crippled by post-traumatic stress disorder ever since returning from Iraq in 2004. He could not sleep, pushed away friends and family and developed a drinking problem. The numbness he felt was broken only by bouts of rage and paranoia. He was contemplating suicide when his sister heard about a novel clinical trial using the psychedelic drug MDMA, paired with therapy, to treat PTSD. Desperate, he enrolled in 2012. “I was willing to do anything,” he recalled recently.

PTSD is a major public health problem worldwide and is particularly associated with war. In the United States, an estimated 13 percent of combat veterans and up to 20 to 25 percent of those deployed to Iraq and Afghanistan are diagnosed with PTSD at some point in their lives, compared with seven percent of the general population.

Although PTSD became an official diagnosis in 1980, doctors still have not found a surefire cure. “Some treatments are not helpful to some veterans and soldiers at all,” said Dr. Stephen Xenakis, a psychiatrist and retired U.S. Army brigadier general. As many as half of veterans who seek help do not experience a meaningful decline in symptoms, and two-thirds retain their diagnosis after treatment.

But there is growing evidence that MDMA — the illegal drug known as Ecstasy or Molly — can significantly lessen or even eliminate symptoms of PTSD when the treatment is paired with talk therapy.

Last year, scientists reported in *Nature Medicine* the most encouraging results to date, from the first of two Phase 3 clinical trials. The 90 participants in the study had all suffered from severe PTSD for more than 14 years on average. Each received three therapy sessions with either MDMA or a placebo, spaced one month apart and overseen by a two-person therapist team. Two months after treatment, 67 percent of those who received MDMA no longer qualified for a PTSD diagnosis, compared with 32 percent who received the placebo. As in previous trials, MDMA caused no serious side effects.

Mr. McCourry was among the 107 participants in earlier, Phase 2 trials of MDMA-assisted therapy; these were conducted between 2004 and 2017 and sponsored by the Multidisciplinary Association for Psychedelic Studies, or MAPS, a research group that has led such studies in the United States and abroad. Fifty-six percent of Phase 2 participants no longer met the criteria for PTSD after undergoing several therapeutic sessions with MDMA. At least one year after participation, that figure increased to 67 percent.

A decade later, Mr. McCourry still counts himself among the successes. He had his first MDMA session in 2012 under the guidance of the Mithoeferes, who have worked with MAPS to develop the treatment since 2000. He shared the video of that session with *The New York Times*. “I was suffering so badly and had so little hope, it was inconceivable to me that doing MDMA with therapists could actually turn all of this around,” he said.

The second Phase 3 trial should be completed by October; FDA approval could follow in the second half of 2023.

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“We currently deal with PTSD as something that needs to be managed in an ongoing way, but this approach represents real hope for long-term healing,” said Rachel Yehuda, a professor of psychiatry and neuroscience at the Icahn School of Medicine at Mount Sinai in New York.

“What makes this moment different from 20 years ago is the widespread recognition that we should leave no stone unturned in identifying new treatments for PTSD,” said Dr. John Krystal, the chair of psychiatry at Yale School of Medicine, who was not involved in the research.

Although data from the second Phase 3 trial are needed, he says, the results so far are “very encouraging.”

### **A need for new treatments**

Mr. McCourry, 40, lives in Portland, Ore., and comes from a military family. He joined the Marines in 2003 because he wanted to make a positive difference, he said: “When I went over to Iraq, I felt like we were there because it was for the overall good.”

But he soon became disillusioned. Rather than fighting for freedom, he guarded convoys of oil. He regularly saw civilians killed. He survived an explosion that knocked him unconscious, and he suspected it may have caused lasting traumatic brain injury. He never received a diagnosis because the symptoms of traumatic brain injury — problems with thinking, sleeping and mood — overlap with those of PTSD, and the Army lacks tests that can objectively distinguish between the two conditions, Dr. Xenakis said.

“I just felt like I put my life in harm’s way really for nothing,” Mr. McCourry said. “I watched friends die really for nothing.”

Two months into his deployment, Mr. McCourry was caught in a firefight. Amid a hail of bullets and mortar rounds, he spotted a white truck approaching from the opposite direction. Despite signaling the truck to stop and firing a warning shot, it kept approaching.

Mr. McCourry began shooting at it. Later, he learned that the people in the truck were a father and his two daughters. The father survived, but the girls did not. “The death of those girls, it haunted me,” Mr. McCourry said.

In 2005, between tours of duty, Mr. McCourry sought help from a battalion medical officer for his sleep and anxiety issues. When the doctor dismissed his concerns, “I kind of lost my mind and started yelling at him,” Mr. McCourry said. Shortly after, he was honorably discharged on the basis of a personality disorder — a diagnosis that was not legitimate grounds for discharge and that Mr. McCourry vehemently disputed.

At first, Mr. McCourry felt overjoyed to be home, but he soon noticed that something felt off. He was tense around friends and family. He was easily offended by any hint of perceived disrespect and found it increasingly difficult to control his anger. When he learned that nearly his entire former squad had been killed by a roadside bomb, he felt an unsettling mixture of numbness and guilt. “At that point, things spiraled,” he said.

Veterans frequently struggle with the readjustment process after returning from war, but they often do so quietly. “By and large, soldiers don’t like to reveal that they have any problems, so they tend to minimize their symptoms,” said Dr. Elspeth Cameron Ritchie, the chair of psychiatry at MedStar Washington Hospital Center and a specialist in military and veterans’ issues. “Many don’t like to talk about their feelings.”

Some veterans, including Mr. McCourry, also experience a phenomenon called moral injury, which frequently occurs alongside PTSD and can complicate treatment. According to Dr. Robert Koffman, a psychiatrist and retired U.S. Navy captain, moral injury develops in service members who feel responsible for perpetrating or for failing to prevent an act that violates their deeply held beliefs. The result is often intense feelings of shame and guilt.

For years, vivid nightmares and paranoia prevented Mr. McCourry from sleeping properly, and he began having suicidal thoughts. Eventually, he sought help at a Veterans Affairs clinic. He received a diagnosis of severe PTSD, and the doctors recommended conventional treatments including therapy and medications.

These treatments bring relief for some patients with PTSD, but they are not effective for all, said Paula Schnurr, executive director of the V.A.’s National Center for PTSD: “My take on the literature is that there is room for improvement.”

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Some research indicates that conventional therapy for PTSD tends to be less effective for active duty military and veterans, around 40 percent of whom drop out of treatment. “With PTSD, a pathological avoidance of triggers — which can include psychotherapy — is a core feature of the disorder,” said Dr.

Joseph Pierre, a professor of psychiatry at the University of California, Los Angeles.

Mr. McCourry tried therapy, but it “didn’t help at all,” he said. The medications he was prescribed only complicated his symptoms by causing serious side effects, including disorientation and drowsiness — a common experience.

For those who do not find relief through available treatments, PTSD can become chronic, debilitating and even life-threatening. On average, 17 veterans die by suicide every day, Dr. Koffman said.

“I just remember wanting the suffering to end,” Mr. McCourry said. “I didn’t see any hope, and there didn’t seem like there was any path to improving. I just really wanted to die.”

### **Finding the inner healer**

When Mr. McCourry first heard about MDMA-assisted therapy, he doubted it would make a difference. He met with the Mithoefers for three 90-minute preparatory sessions designed to establish trust and provide guidance on how to respond to difficult memories and feelings that might arise during treatment.

The experimental sessions would last eight hours. Although Mr. McCourry knew he would be taking MDMA, under the study’s double-blind protocol he and the Mithoefers did not know what dose he would be randomly assigned. Possibilities ranged from a very low 30 milligram dose to a relatively high 125 milligram dose. Mr. McCourry’s fell in the middle, at 75 milligrams.

On the day of Mr. McCourry’s appointment in 2012, as he sought to relax, Dr. Mithoefer reassured him. “We talked about not having an agenda about what should happen,” he said. “But some people find it nice to have an overall intention.”

Mr. McCourry’s voice wavered. “If I had an overall intention, it’s basically just to have greater depth of understanding of mental processes and why I think the things I do,” he said. “To try to understand myself better.”

Then, he swallowed the pill with a swig of water, put on eye shades and lay back. Melodic, chanting music filled the room.

After about an hour, a warm sensation began to wash over Mr. McCourry in intermittent waves, and the music sounded more beautiful than before. He felt himself relax, even as he began to worry about where things were going.

Soon, though, the tone of the music no longer felt inviting but ominous. Mr. McCourry considered removing the eye shades and asking the Mithoefers to stop the music. “But then I remembered that if anything uncomfortable came up, I was supposed to breathe into it versus run away from it,” he recalled. The sense of inner conflict mounted and tightened into a knot in his chest. He began remembering with embarrassment all the times he had pushed friends away when they had tried to be kind to him, and he wondered why he had behaved that way. He suddenly felt more connected to Dr. and Ms. Mithoefer and was open to exploring those questions with them.

He removed the eye shades and described “this new hardness” he had developed since returning from Iraq.

“What if you just let people be nice to you?” Ms. Mithoefer gently asked.

“I’d have to give up control of my life in some situations,” Mr. McCourry said.

“How would that look, giving up control? If someone’s trying to be nice to you?”

“It could be a good experience, but I don’t even consider it before I put up these walls between me and people,” Mr. McCourry said.

Trauma can result in enduring changes in genes, hormones and the brain, according to Dr. Yehuda of Mount Sinai. People with PTSD often show exaggerated levels of stress hormones, for example, and tend to have heightened activity in the amygdala, the brain region associated with processing threats and danger. That negative experiences can alter the body so significantly, however, leaves room for the possibility that equally powerful positive experiences could do the same. For many people, MDMA-assisted therapy seems to provide such a transformational reset, Dr. Yehuda said.

But taking MDMA on its own, like a traditional medication, does not automatically alleviate PTSD. Rather, when paired with therapy, the drug seems to catalyze a patient’s innate capacity for psychological healing. Dr. Mithoefer likened this process to the way immunotherapy helps to fight cancer. “We’re stimulating the body’s own capacity for defense and healing,” he said.

Scientists still do not fully understand how MDMA catalyzes healing. Evidence in mice indicates that the drug opens what neuroscientists refer to as a “critical period,” a window that typically occurs during childhood in which the brain is more malleable and better able to learn.

“This critical-period explanation really offers a different way of thinking about it,” said Dr. Gül Dölen, a neuroscientist at Johns Hopkins University

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and senior author of the findings, which were published in *Nature* in 2019. “MDMA is allowing you to do a cognitive reappraisal and reformulate all of the personal narrative you’ve written around the trauma.” In the Mithoefer’s office, Mr. McCourry realized that the reason he was shutting people out was because permitting them to get close would require trusting them — and trusting them would mean surrendering control. In Iraq, extreme self-reliance and distrust of others had been protective mechanisms that had helped to keep him alive. Now, those tools had become detractors. “That’s what PTSD is, really,” Dr. Mithoefer said as the three of them talked through these revelations. “You know you’re back, but there’s parts of you that haven’t taken that in yet.”

### **Different paths to healing**

Not everyone’s experience with MDMA-assisted therapy is as straightforward as Mr. McCourry’s. While serving in Vietnam, John Reissenweber sustained major injuries in a mortar explosion and accidentally killed a 2-year old boy. He came home a different person: always on edge and with “one of the most acid tongues there were,” he recalled recently. Like Mr. McCourry, he felt a constant need for control, and he turned to alcohol for solace.

Mr. Reissenweber, now 73, never considered that PTSD might have explained his feelings and behaviors. His previous mind-set held that “to have PTSD, you’re weak.”

In 2017, Mr. Reissenweber’s wife convinced him to see a psychiatrist, who diagnosed him with PTSD. Despite regular appointments, his mental health did not improve. In 2019, he enrolled in the Phase 3 MDMA-assisted therapy trial.

Entering the first of three sessions with MAPS-trained therapists in San Francisco, Mr. Reissenweber worried that the drug would cause him to “really come undone.” But in the weeks after the session, he felt more connected to himself and others, he said. The second session also went well.

“I could take a walk outside and feel the air against my skin,” he said. “I could focus on somebody and imagine what they were thinking.”

But in the third and final session, Mr. Reissenweber resolved to directly face his trauma, which took the form of a black pit. “You can’t shy away from it anymore,” he told himself, and jumped in. But rather than passing through the pit into the light, as he expected, he became stuck in the darkness and was terrified. Mr. Reissenweber could not sleep for over a week afterward, and he sometimes began shaking inexplicably. Eventually, his therapist helped him realize that the pit had represented his anger and hurt. “I’m still processing from that thing,” he said.

Despite the difficulty, Mr. Reissenweber said his experience with MDMA-assisted therapy significantly changed his life for the better. He now finds traditional therapy to be productive and has been able to deeply connect with others, including his spouse, who he calls his guardian angel.

“It made me realize there was a reason for my hurt and my fears, and that I could change the outcome,” he said.

Mr. McCourry emerged from his first session of MDMA-assisted therapy with what he described as an aerial map of his mind. “It’s just been so tangled up, I didn’t even know where to start,” he told the Mithoeferes.

He slept soundly that night, and his sleep problems never returned.

In one of his later sessions with MDMA, he revisited the memory of the two girls he had accidentally killed and saw that he had been harboring a tremendous amount of self-loathing for the person he had become in Iraq. He was able to replace the contempt he felt toward “Nigel the Marine,” as he put it, with compassion.

Mr. McCourry recently became a father and — after a nearly 10-year long bureaucratic struggle — successfully convinced the Navy to correct his reason for discharge to combat-related PTSD, instead of passive-aggressive personality disorder.

He still sometimes becomes overwhelmed in stressful situations and “just starts to mentally shut down,” he said. But he is now able to recognize when this is happening and to better manage his feelings.

“It’s really important for me that these experiences I’m sharing are used to show people that there is hope,” Mr. McCourry said. “I’ll keep doing what I can to support this therapy until it’s legalized.”

<https://www.nytimes.com/2022/05/29/health/mdma-therapy-ptsd.html>



# Hartford Courant

## **Experts: Firefighters' drug problems illustrate larger-scale need to help first responders**

Don Stacom –Hartford Courant, May 23, 2022

While excessive drinking is still vastly more common in the fire service than drug addiction, the sort of Adderall, marijuana and fentanyl use that allegedly took place in New Britain's fire department isn't entirely uncommon, experts say.

Nationwide, as many as 29% of firefighters use alcohol excessively and up to 10% are misusing prescription drugs, according to the federally funded National Survey on Drug Use and Health. "Firemen are human beings. And in their careers, they're going to deal with very disturbing stuff. Whether that causes them to turn to something like this, well, some people can handle it better than others," said Mike Healy, a veteran substance abuse counselor, former Central Nyack, New York, fire chief and retired clinical director of the New York City transit workers union's member assistance program.

Healy and other fire service authorities last week said a key to preventing - or at least minimizing - alcohol and drug use in the emergency services is to have a capable, genuinely confidential employee assistance program. Another is openly acknowledging that at some point, firefighters, EMTs and police are likely to need help facing extraordinary pressures.

"Our line of work takes a toll on somebody. Over the last five years, talks about mental health and well-being have taken a forefront like cancer screening and prevention," said Chief Mark Worsman of the New Hartford Fire Department, who is president of the Connecticut Fire Chiefs Association.

"It's very critical that we offer services to all (fire department) members. It not only affects the firehouse or the ambulance or the police station, it also affects their family."

"It seems in the last five to six years that the mental health and well-being of (first) responders had become more of a subject that people are paying attention to, and addiction is part of that," said Chief Robert Duval of the Atwood Hose Fire Company in Plainfield. "Addiction is an offshoot of people struggling."

As the immediate past president of the Connecticut Fire Chiefs Association, Duval said stress among fire responders has risen since early 2020.

"The pandemic didn't help. The workload has ramped up. For some, it doubled overnight. People are struggling," Duval said. "They're asked to do a lot more but don't have the relief that someone working from home does."

Firefighters around Connecticut were shaken by news last week that seven veteran New Britain Fire Department members had been demoted and reassigned because of cliques that were allegedly trading drugs - and sometimes using them - at firehouses.

The demotions came after the city fired a lieutenant who it concluded had lied about illegally providing Adderall and other drugs to Firefighter Matt Dizney, who died Jan. 26 of an apparent overdose. Dizney, 36, left two children.

Mayor Erin Stewart was meeting Friday afternoon with union leaders to try to advance a long-stalled policy for mandatory drug testing.

Jeff Dill, director of the Firefighter Behavioral Health Alliance, said that only very recently has the country's fire service become more willing to talk about drug misuse. Excessive drinking is still vastly more prevalent, he said, and more fire chiefs, city leaders, insurers and others are open to seeing misused prescriptions and illegal drugs as a problem, too.

"I founded this in 2010, and early on we got bashed. People were saying we made up the suicide statistics. They were saying 'PTSD is only a military thing,'" Dill said, a licensed counselor and

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retired Illinois fire captain. “I don’t know why this catches people by surprise. In addition to the stressors on the job, firefighters can have stress in the family and personal lives.

“Drugs are not the leading aspect of what we deal with. The number one reason for suicide is marital and family relations, but addictions are in the top 10. Of course there’s alcohol, then you look at gambling or prescription drugs, now heroin or cocaine.

“It all falls back to cultural brainwashing: We’re supposed to act brave, strong, courageous; we don’t seek help; we handle our issues; we don’t let anyone see our pain.”

As chief of the behavioral health service for Las Vegas Fire & Rescue and its 700 firefighters and civilian workers, Dill has concluded that one of the best things a community can do for its fire service is provide a strong EAP and meaningful rehabilitation when people need it.

“We’re starting to see treatment centers specific to first responders. That’s important. We didn’t used to have that,” he said. “I’m a firm believer in rehabs for drugs or alcohol that provide 60 to 90 days. You need that to get them off those addictions.

“If you go in for 30 days, you could need eight to 10 just to detox. That leaves just 20 to get at the problem and change the behaviors. I think we’re setting up our people to fail if we have insurance that only covers 30 days.”

Worsman emphasized that a solid EAP — with guaranteed confidentiality — is also crucial.

“For that system, the expectation has to be that what someone says (to a counselor) doesn’t go out of the room,” Worsman said.

“We want police and fire departments to know they can’t let it build up until someone snaps, causes an accident or something worse. We need to tell our people, ‘We’re here for you. We want to support your brothers and sisters. We have a great organization, but we can’t have it without great people.’”

<https://www.courant.com/news/connecticut/hc-news-connecticut-new-britain-firefighters-adderall-20220523-pcihgthvnamxmzc7l24zqwdce-story.html>



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# Does it come from tobacco? Young adults' interpretations of the term “tobacco-free nicotine” in a cross-sectional national survey sample

## ABSTRACT

### *Background*

Tobacco-free” nicotine (TFN) e-cigarettes and nicotine pouches containing synthetic nicotine are increasingly available. The term TFN may lead to reduced risk perceptions and increased use intentions relative to tobacco-derived nicotine products. Effectively communicating messages about TFN may depend on the public’s ability to differentiate TFN from tobacco-derived nicotine. Our goals were to examine knowledge about the source(s) of nicotine in commonly used products and beliefs about what TFN means.

### *Methods*

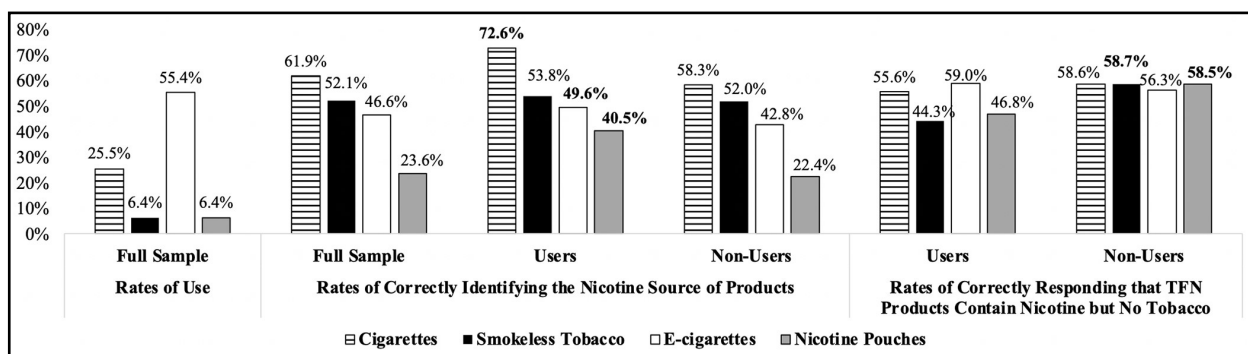
In 2021 we surveyed 2464 young adults (18–25 years) online. Participants reported whether cigarettes, smokeless tobacco, e-cigarettes, and nicotine pouches contain nicotine that comes from tobacco (always, sometimes, never). Correct responses were “always” for cigarettes/smokeless and “sometimes” for e-cigarettes/pouches. Participants also reported “what [they] think TFN e-cigarettes/vapes contain” (nicotine only; tobacco only; both nicotine and tobacco; neither nicotine nor tobacco). We ran unadjusted and adjusted models examining correct responses for nicotine source and TFN contents by past-month product use status (cigarettes, smokeless, e-cigarettes, pouches).

### *Results*

Rates of correctly identifying nicotine source were modest (23.6% pouches—61.9% cigarettes). Except smokeless tobacco, using a given product was associated with identifying its nicotine source correctly in unadjusted models. Participants reported “TFN” means a product contains nicotine only (57.8%), tobacco only (10.8%), both (14.1%), or neither (17.1%)

### *Conclusions*

There is confusion about the source of nicotine in products, and many young adults incorrectly interpreted TFN to mean something other than containing nicotine but no tobacco. Regulatory efforts may be needed to restrict using the term “tobacco-free nicotine” on product labeling and advertising.



Morean ME, Bold KW, Davis DR, Kong G, Krishnan-Sarin S, et al. (2022) Does it come from tobacco? Young adults' interpretations of the term “tobacco-free nicotine” in a cross-sectional national survey sample. PLOS ONE 17(5): e0268464. <https://doi.org/10.1371/journal.pone.0268464>.



## **Bipartisan lawmakers target addiction crisis by boosting non-opioid pain management**

Joseph Guzman

As drug overdose deaths in the U.S. continue to skyrocket, advocates and lawmakers are working to pass key legislation to help prevent opioid addiction before it starts.

Tens of millions of Americans are prescribed opioids like hydrocodone, oxycodone and fentanyl each year to treat moderate to severe pain for patients following surgery or injury. But the powerful drugs run the risks of addiction, abuse and overdose.

Up to 29 percent of people who take prescription opioids misuse them, and 3 million Americans have had or currently suffer from an opioid use disorder. The overwhelming majority of heroin users report misusing prescription opioids before starting heroin use.

With nearly 108,000 overdose deaths reported nationwide in 2021 alone, a bipartisan group of lawmakers in Congress is trying to slash the number of opioids prescribed to patients with the Non-Opioids Prevent Addiction in the Nation Act, or the NOPAIN Act.

Sens. Rob Portman (R-Ohio), Jeanne Shaheen (D-N.H.), Shelley Moore Capito (R-W.Va.) and Joe Manchin (D-W.Va.) introduced the NOPAIN Act in the Senate in March 2021. In the House, the legislation was introduced by Reps. Terri Sewell (D-Ala.), David McKinley (R-W.Va.), Ann Kuster (D-N.H.) and Brian Fitzpatrick (R-Pa.) two months later in May.

The measure would expand access to Food and Drug Administration-approved, non-opioid pain management treatments, such as nerve block injections, to those enrolled in Medicare who undergo an outpatient surgery.

Currently, Medicare does not provide a separate reimbursement for these alternative treatments like it does for prescription drugs, creating what advocates call an “inadvertent” incentive for physicians to prescribe opioids. The NOPAIN Act would remedy the “outdated federal reimbursement policies” by directing the Centers for Medicare and Medicaid Services to provide a separate reimbursement for non-opioid treatments used to manage pain.

“A lot of attention in Congress and in previous administrations has been focused on the opioid crisis in this country, however, relatively little of that attention has focused on opportunities to prevent opioid addiction before it begins,” Chris Fox, executive director of Voices for Non-Opioid Choices, a group rallying support for the bill, told Changing America.

“We know that for many, the path toward opioid use can start after being exposed to a prescription opioid, which can start after a surgical procedure. The vast majority of surgery patients in this country have their pain treated via prescription opioid pills despite the availability of other safe and effective non-opioid pain therapies that are out there,” Fox said.

Alternatives include a multimodal approach, utilizing a combination of medications from different drug classes to control acute pain effectively, including long-acting nerve blocks and nonsteroidal anti-inflammatory drugs administered through an IV, among others.

“The Non-Opioids Prevent Addiction in the Nation Act would create a level ball field. It would say that we’re going to put all pain treatment options on the table,” Fox said.

The bill has robust support in Congress, with more than 135 members of both chambers backing the measure, including nearly 50 percent of the Senate. Major medical associations, including the American Medical Association, and leading patient and recovery groups have also endorsed the legislation.

Among the groups of supporters is the Will Bright Foundation, a nonprofit based in Alabama that operates a transitional next step living facility for those exiting rehab and advocates for families with loved ones struggling with addiction issues.

Lisa Bright, the group’s founder, started the nonprofit in 2014, just two years after her 25-year-old son Will Bright died from a heroin overdose.

*Continued on next page*

### *News Brief*

## **Drug use severity in adolescence affects substance use disorder risk in adulthood**

People who reported multiple symptoms consistent with severe substance use disorder at age 18 exhibited two or more of these symptoms in adulthood, according to a new analysis of a nationwide survey in the United States. These individuals were also more likely, as adults, to use and misuse prescription medications, as well as self-treat with opioids, sedatives, or tranquilizers.

You can read the full article at

<https://www.sciencedaily.com/releases/2022/04/220401122203.htm>

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“Will was the baby of the family so he was a happy kid who played sports, Cub Scouts, enjoyed wrestling and football, and was active in church activities. Pretty much just a normal type of child. He got into those junior high years where you’re a little unsure of yourself and got involved in some drug activity there,” Bright said.

Lisa said her son entered multiple rehabilitation centers from California to Alabama during his college years and would do well in recovery but would relapse when he was released. He then hurt his back while working at a local grocery store and was prescribed OxyContin for the pain.

“That’s where the opioids started to come in. Those were prescriptions given to someone who already had addiction issues, so it was a double-whammy for him,” she said.

“They monitor opioid use the best they can through prescriptions. But when you reach that max, you’re going to go looking for something else because of the addictiveness. That’s when you go to heroin, because an opioid is basically synthetic heroin.”

While Will Bright was not on Medicare, which is for adults 65 and older and younger adults with disabilities, Lisa Bright noted opioid misuse is a growing problem among older Americans who are likely to undergo surgeries such as hip and joint replacements and experience chronic pain. One study published earlier this year found nearly 80,000 Americans ages 55 and older died of an opioid overdose from 1999 to 2019. Yearly numbers of deaths increased over time, from 518 in 1999 to 10,292 in 2019.

Both Fox and Bright said they were optimistic the measure would pass through the House and Senate this year. Capito, who sponsored the bill in the Senate, told Changing America lawmakers are continuing to build bipartisan support for the bill, as West Virginia has been “ground zero for the opioid crisis.”

“I’m hopeful this commonsense legislation gets across the finish line so we can prevent more families from losing sons and daughters to the scourge of addiction,” Capito said.

<https://thehill.com/changing-america/well-being/prevention-cures/3499959-bipartisan-lawmakers-target-addiction-crisis-by-boosting-non-opioid-pain-management/>





July 2, 2022  
John Cox Student  
Center  
University of Bridgeport  
244 University Avenue  
Bridgeport, CT 06604  
11:30 am - 3:00 pm  
**FREE EVENT**

## **CHANGING THE NARRATIVE**

### ***ON MENTAL HEALTH AND SUBSTANCE USE***

Mental health, substance abuse, and addiction are issues that are impacting millions. Each year more people are struggling, and we are losing lives at an alarming rate. When we say our goal for this tour is to change the narrative, we are not claiming to have all of the answers.

What we do want to accomplish is to:

- End the stigma around these issues.
- Start the conversation with those who are struggling or have struggled, those who have lost loved ones, and those who are working in the mental health, substance abuse, and addiction fields.
- Begin to build a collective of resources and find alternative solutions to work toward a better future.

•

The CCB and the University of Bridgeport are sponsoring the only Connecticut stop on this national tour.

Join the conversation on July 2nd as Jeffrey Johnston tells his story of rebounding from tragic loss to fight the stigma associated with mental health and substance use disorders.

With a panel discussion and presentation by our local advocate and keynote, [Yvette Bonilla, LMSW](#), founder of Suicide Care Consulting Services. Special welcome from city Mayor Joe Ganim.

Join us and  
**LIVE UNDETERRED**

Pre-registration required: [jquamme@ctcertboard.org](mailto:jquamme@ctcertboard.org)

<https://www.livingundeterred.com/>



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**BESTLIFE**

## **4 Signs You're Addicted to Marijuana, Experts Warn**

**THESE RED FLAGS COULD MEAN YOU'VE LOST CONTROL OVER YOUR CANNABIS USE.**

With recreational marijuana use now legal in many states, many people are enjoying cannabis safely and guilt-free. But while many people use this popular psychoactive drug without any adverse effects, a study published in the Dec. 2015 issue of JAMA Psychiatry estimated that three in 10 people who habitually use cannabis have "marijuana use disorder," and a 2011 study found that frequent users have a 10 percent chance of becoming addicted to the drug.

Could your cannabis use be creating problems without you even realizing it? Read on to find out what behaviors and symptoms signal marijuana addiction, and how it could be impacting your quality of life.

### **1. Lack of interest in activities you once enjoyed.**

Marijuana use disorder can cause a depressed mental state, including apathy, lack of motivation, irritability, loss of interest in daily activities, inability to concentrate, and feelings of isolation, according to the National Institutes of Health (NIH). "One of the strongest signs that a patient is addicted to marijuana is if their use gets in the way of their normal activities," says Andrea Paul, MD, a medical advisor at Illuminate Labs. "This could be as severe as a job loss, but it could also be [more minor] things like choosing to socialize less with certain friends who don't use marijuana."

The drug rehabilitation and education organization Narconon lists lack of motivation, enthusiasm, and poor decision-making as common signs of marijuana use disorder. As a result, activities that demand quick thinking and focus may no longer seem appealing and users may abandon them altogether. In extreme cases, the lack of initiative stemming from frequent marijuana use may progress to unemployment and missed work opportunities, negatively impacting your life. If this sounds like you, it may be time to reconsider your marijuana use.

### **2. Difficulty maintaining your relationships.**

Do you have conflicts with family members about your drug use? Have you lost friends over marijuana? If you continue to get high despite the deterioration of your social life and close relationships, you may be on a path to addiction, according to the Centers for Disease Control (CDC). Not surprisingly, the lack of interest associated with marijuana can cause people to put little to no effort into maintaining or developing relationships - especially if the people in those relationships disapprove of cannabis.

A Feb. 2020 study found that heavy marijuana use can cause difficulties with emotional awareness in some adolescents, characterized by a lack of empathy and an inability to connect with others emotionally. This is of particular concern to parents, since the health and development of children are dependent on the deep connection and emotional bond forged between parent and child. If you're a parent and often find yourself too high to be emotionally available to your child, it's time to make a change.

### **3. Inability to focus and trouble remembering things.**

The side effects of marijuana use disorder include impaired short-term memory, difficulty learning, decreased motor function, inattentiveness, and increased risky behaviors, such as driving while high and unprotected sex, according to the NIH. And according to Narconon, prolonged marijuana use can result in adverse mental conditions, such as anxiety, depression, poor memory, short-term psychosis, paranoia, and suicidal thoughts.

Any type of drug abuse causes a lack of awareness, so you may not even know the degree to which marijuana is affecting your mental state. If you notice a decline in your mental health, memory, or cognition, it may be time to seek help.

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#### **4. Experiencing withdrawal symptoms.**

If you use marijuana daily, or almost daily, for at least two months, you may experience withdrawal symptoms when you stop. Heavy marijuana users may experience three or more of the following symptoms when not using, according to the NIH: Irritability, anger, or aggression; nervousness or anxiety; sleep issues such as insomnia or disturbing dreams; decreased appetite or weight loss; restlessness; depression; fever or chills; and headache. In addition to these withdrawal symptoms, heavy marijuana users may experience severe adverse effects, such as stomach pain, nausea, lung irritation, panic attacks, shakiness/tremors, and hallucinations.

If you experience these symptoms but continue to use, that's a strong indication your marijuana use may be a problem. However, Paul explains, a qualified health professional is needed in order to make that call. "Ultimately, only a doctor or medically-credentialed addiction specialist can diagnose a marijuana addiction, and it cannot be diagnosed from symptoms alone," he says. "I'd recommend that patients who suspect they're addicted to marijuana speak with a medical expert about the best way to proceed."

[4 Signs of Marijuana Addiction, According to Experts — Best Life \(bestlifeonline.com\)](http://bestlifeonline.com)

*Publisher's note: Although this article will seem remedial to our readers, it is included for the simple fact that a media outlet directed at the general population takes a thoughtful and nonjudgmental stance when talking about the commonly argued and misunderstood topic of cannabis dependence. Supporting effective community discussion instead of coming from a place of fear is all of our responsibility.*



## **Reporting Unethical Behavior of Certified Professionals**

A copy of the CCB Code of Ethical Conduct, Ethics Complaint form and Disciplinary Procedures are available on the CCB website at

<https://ctcertboard.org/ethics>

Not sure if something rises to the level of an ethics complaint? We are happy to discuss any behavior that concerns you and helps you decide the best route to ensure the safety of those we serve.

## The CCB is actively seeking qualified candidates to serve on our volunteer Board of Directors.

The Connecticut Certification Board, Inc. (CCB) is a 501(c)(3) organization dedicated to ensuring the protection of Substance Use Disorder Prevention, Treatment, and Recovery clients through legally defensible competency-based credentialing of professionals. Established in 1980, the mission of the CCB is to *cultivate and maintain the highest standards of professional practice in the recovery field*.

Our board members champion the importance of verification of the identified psychometrically valid and reliable competencies of individual practitioners through an established voluntary process, as well ensuring ethical practice with a standardized investigation process of ethical complaints, developed under the direction of legal professionals.

### Position

Volunteer Board of Directors Member

### Experience

No prior board service experience necessary; organizational leadership experience is required

### Role Function

Organizational advocacy and sustainability

### Role Description

The CCB Board of Directors comprises leaders from the nonprofit and for-profit sector who are dedicated to the organization's mission. Serving on the Board of Directors of the CCB is an extraordinary opportunity for an individual who is passionate about strengthening the SUD workforce.

Board members are expected to have the financial acumen to read and understand the CCB's financial statements and to otherwise help the board fulfill its fiduciary responsibilities.

Board members are expected to attend six meetings of the full board per year. Board members are also expected to serve on one or more committees of the board and to actively participate in committee work through monthly one-hour meetings. They are expected to read board materials in advance of board meetings and to come prepared to ask questions and participate in discussions. Serving on the Board of Directors is not simply an advisory position as directors hold the fiduciary duties of care, loyalty and obedience\*. The total time commitment is 1-3 hours per month.

The CCB receives limited public funding, so board members are expected to play an active role in securing the financial resources necessary for the CCB to achieve its mission. Board members are expected to leverage personal relationships and connections to help the Board and staff identify and solicit potential funders. Although the Board may agree to a minimum financial liability for all members, directly investment in the CCB's work via an annual personal contribution is not currently required.

Board members are expected to responsibly represent the CCB's mission to their respective communities and to advocate for the CCB's mission, programs, and services as appropriate.

Board terms last for three years and board members can serve to two consecutive terms.

### Desired Skills and Expertise

We are currently recruiting for diverse and established leaders with expertise in the following areas:

Operational Expertise

Resource Development

### More Information

Contact Executive Director Jeffrey Quamme at [JQuamme@ctcertboard.org](mailto:JQuamme@ctcertboard.org).

*\*Duty of Care: Take care of the CCB by ensuring prudent use of all assets, including facility, people, and good will;*

*\*Duty of Loyalty: Ensure that the CCB's activities and transactions are, first and foremost, advancing its mission; Recognize and disclose conflicts of interest; Make decisions that are in the best interest of the CCB; not in the best interest of the individual board member (or any other individual or for-profit entity).*

*\*Duty of Obedience: Ensure that the CCB obeys applicable laws and regulations; follows its own bylaws; and that the nonprofit adheres to its stated corporate purposes/mission.*





A potentially lifesaving drug that reduces overdose risk is prescribed to less than half of Americans treated for opioid addiction, a new study finds.

This underuse of buprenorphine is "equivalent to giving those with advanced cancer a less aggressive treatment," said senior investigator Dr. Laura Bierut. She is a professor of psychiatry at Washington University School of Medicine in St. Louis.

"It seems obvious to many of us that we should be giving the most aggressive and effective treatments to those who are most seriously ill," Bierut added in a university news release.

For the study, Bierut and her colleagues analyzed health insurance data on about 180,000 people nationwide treated for opioid use disorder from 2011 to 2016. Only 47% of them were prescribed buprenorphine, and the rate was even lower (about 30%) for opioid users who also misuse other substances such as alcohol, methamphetamine, benzodiazepines or cocaine.

The study was published online May 10 in JAMA Network Open.

"It's concerning that the majority of people misusing multiple substances don't appear to be getting the lifesaving medication they really need," said study co-author Dr. Kevin Xu, a resident physician in the university's psychiatry department.

"While the data we analyzed predates COVID-19, the pandemic saw an escalation in overdoses, yet we're still not seeing many eligible patients get buprenorphine prescriptions," Xu noted.

The data the researchers analyzed are a few years old, Bierut said. "But we think this information can be extrapolated to what's happening now because even more people using opioids — or using opioids as well as other substances — are showing up in emergency departments today. The problem has only gotten worse during the COVID-19 pandemic," she added.

Nearly 107,000 people in the United States died of drug overdoses from early 2021 through early 2022, compared with 70,237 drug overdose deaths in 2017, according to the U.S. Centers for Disease Control and Prevention.

There are a number of possible reasons for the low rate of buprenorphine prescriptions among people treated for opioid addiction, according to Xu.

Buprenorphine itself is an opioid, which may make doctors hesitant to prescribe it to people with opioid addiction. Buprenorphine can be taken at home and does not require daily trips to a clinic, but that lack of supervision could also affect decisions about prescribing it. Another reason may be insufficient data about the drug's effectiveness in those who misuse multiple substances.

But such concerns appear to be unfounded, Xu said.

"Buprenorphine appears to be a safe opioid," he noted. "It's specifically designed to be different from other opioid drugs in that it won't cause a user to stop breathing, which pretty much every other type of opioid will do. That means it can be taken safely at home, which is very helpful, even essential, to recovery."

<https://www.usnews.com/news/health-news/articles/2022-05-13/too-few-people-treated-for-opioid-use-get-anti-overdose-med>



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THANK YOU ALL FOR  
COMING!



WE LOOK FORWARD TO SEEING  
YOU NEXT YEAR!

