Journal of the Monroe County Medical Society • Seventh District Branch, MSSNY

The BULLETIN

May/June 2022

ADDICTION

National Council on Alcoholism and Drug Dependence – *Rochester Area*

Just the facts, know the risks...

Using marijuana while driving **is illegal in NYS** for **the driver and passenger(s)**.

Impaired or drugged driving jeopardizes the safety of all who travel on NYS roads and highways!

After alcohol, marijuana is the most commonly identified drugs in deadly crashes.

Driving while impaired is illegal, no matter what substance is being consumed.

Legal does not equal safe.

Marijuana is an addictive drug.

- Marijuana is only legal in NYS for those 21 and older.
- Did you know marijuana is often first drug teens try, but not the last!?
- Did you know marijuana is often the #1 reason teens seek treatment?

The potency of marijuana has increased dramatically in the last several decades. THC, the cannabinoid producing the high, is at 20 percent or more in many states where it has been legalized. With concentrates, THC potency often exceeds 75-85 percent or more! As the potency of marijuana increases, the potential for addiction also increases.

ncadd-ra.org

www.facebook.com/NCADDRA/

DEPAUL

The BULLETIN

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ADDICTION

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In Every Issue

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Monroe County Medical Society

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Patients Are Our Number One Priority

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Letter from the
Chief Executive Officer

Dear Members & Friends of the MCMS Family,
March 20, 2022 was the official start of Spring and I hope that, by the time you receive and read this edition of The Bulletin, the weather will be much warmer so that you may enjoy the beauty and wonder that surrounds us in Upstate New York!

The Monroe County Medical Society (MCMS) has been hard at work this year through its partnership with MSSNY, payors, hospital systems and other key community partners.

We continue to work diligently to support:

- Telehealth Services and Payment Equity for Physicians
- Enhanced Insurance Coverage
- Prior Authorization (PA) Reform
- Physician Wellness
- Mental & Behavioral Health
- Substance Abuse/Addiction

Lucia Castillejo, MS
Monroe County Medical Society
Chief Executive Officer
lcastillejo@mcms.org

This edition of The Bulletin is devoted to addiction and substance abuse. Many of the authors in this edition not only have the needed training, knowledge and skillset but many years of experience in treating those who are afflicted with any form of addiction (i.e., gambling, over-spending, binge eating, alcohol, substance, and many more).

For over 20 years, the MCMS has regularly convened a group of professionals in the psychiatry, mental & behavioral health fields. The MCMS Medicine Addiction Committee, chaired for many years by Dr. Gloria Baciewicz and now by Dr. Sahar Elezabi, serves to drive systemic change, to improve the quality of care to those suffering with addictions and to share best practices. This is a long-standing and respected committee which you are invited to join.

If interested, please email me at: lcastillejo@mcms.org.

Additionally, the MCMS supports the efforts of our State Medical Society, MSSNY, who serves as a member of the AMA's Substance Use and Pain Care Task Force. This Committee is focused on helping to end the nation's drug-related overdose and death epidemic. According to MSSNY, the task force developed recommendations for actions that physicians can take as well as those policymakers and public health officials must take. This includes broad efforts to remove barriers and improve access to evidence-based care for patients with pain, a substance-use disorder (SUD) or mental illness.

MSSNY is also actively working to increase physician awareness and leadership to combat the opioid and pain crisis. New York State physicians are increasing the prescribing of Medicated Assisted Treatment (MAT) and are seeking to encourage the use of naloxone by patients and family members. The MCMS and MSSNY are keenly aware that, to drive change in this space, it is critical to develop a strong infrastructure to support patients with pain and/or mental illness by developing an evidence-based, sustainable and resilient infrastructure and health care workforce.

The MCMS will continue its support of local and State advocacy efforts in this area. I invite you to read on!
I wish you and your families a safe and healthy Spring/Summer!

Editor's Page

Neha Pawar, MD,
Co-Editor
The Bulletin

Chronic Pain and Addiction

We cannot reliably measure pain. Pain is subjective and can be broadly classified into Acute Pain and Chronic Pain. Acute pain occurs due to an injury, illness, or surgical procedure that causes tissue damage. Chronic pain is without apparent biological value that has persisted beyond the average tissue healing time (usually taken to be three months)

Often, providers evaluating patients with the dual problem of pain and addiction ask, "Is this pain or addiction?" However, the contracted focus on chronic pain and substance use disorders as distinct treatment entities often miss the intricacy of the whole individual who suffers from the two conditions." (Ajay Manhapra 1, 2018).

These patients may also have a high psychiatric and medical illness burden and use multiple substances or medications to manage their symptoms. In a nutshell, the issue of "pain and addiction" is integrated and thus demands a multidimensional, therapeutic approach.

The current opioid crisis highlights an urgent need for a better standard for preventing and treating chronic pain and addiction. Neurobiologically, pain chronification involves neuroplasticity. "Such neuroplasticity causes changes in several domains related to pain, including perception, cognition, attention, emotion, learning, memory, and motivation. "Preexisting psychiatric comorbidities are among the critical drivers of pain chronification, and pain, in turn, worsens the psychiatric status." (Ajay Manhapra 1, 2018)

Sole focus on a single issue or limited issues like pain and substance use disorder without coordinated treatment of multiple comorbidities is unlikely to lead to sustained benefit. We as a community need to continue to recognize the need for multidimensional approaches to successfully managing patients with such complex clinical conditions.

Treatment with buprenorphine or methadone is associated with reduced mortality in patients with opioid use disorder. Provider education is of utmost importance in this relentless opioid epidemic for safe and effective pain control in patients with dual diagnoses of chronic pain and substance use disorders. Structured opioid therapy and procedural interventions for pain management also enable patient engagement.

Categorizing patient problems and treatment options in a multidimensional model can help patients and physicians engage in more effective treatment.

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Mathew Devine, DO
President
Monroe County Medical Society

President's Page

To Our Health and Wellness

Greetings and I hope that all are well! It is at this time of the year that I am reminded as to how much I love Upstate New York and the four seasons! Thinking of seasons of change we all know that sometimes winter here seems to move along slower and longer than others. I am still not confident to guarantee anymore snow this year, but I am seeing new growth and increased temperatures that tell me we are on the right track for summer! Making predictions in these turbulent times has become really hard but I will make another attempt, with the evolution and time passing I am hopeful that we are now moving to the other side of the pandemic. There is still a lot of work to be done in health care as we now find ourselves in the phase of looking for the lessons learned from the pandemic and how to make lasting and positive changes in our patient's lives and workplaces.

While we have been understandably laser focused on combatting this lethal virus, addiction has continued its path of destruction and a lot of the great efforts we were making on this prior to the pandemic have been lost. So the time is now to regroup and to reconnect with our colleagues and peers to address addiction and to get back to those improvements that we had made prior to the pandemic. Sadly when it comes to addiction, it has no season and has been ever present in our society on a continual basis. It is a disease that spares no profession and all humans are at risk of varying degrees of addiction.

From a national standpoint, the CDC's National Center for Health Statistics recently reported that over a 12 month period from April 2020-April 2021 there were an estimated 100,306 drug overdose deaths in the United States. This is an increase of 28.5% from the 78,056 deaths during the same period the year prior. Overdose deaths from synthetic opioids and psychostimulants increased in the 12-month period ending in April 2021. Cocaine deaths also increased, as did deaths from natural and semi-synthetic opioids (such as prescription pain medication). From data from the Monroe County Health Department for the 2020 year there was an estimated total of 238 deaths related to overdoses. This was higher than the national percentages at an increase of 31.5% from the 181 overdoses fatalities that occurred in 2019. The 238 total surpassed the previous peak of fatalities that was back in 2017 (220 deaths were attributed that year). Both 2018 and 2019 saw decreases from 195 to 181 prior to the spike in overdoses during the year of the pandemic. From 2017 to 2019 we saw a 17.8% decrease in fatalities and we have many community collaboratives that work together aimed at helping to get the challenges of addiction under better control. These committees are now re-emerging to get back to work on shifting these numbers again in a more favorable direction. So in summary as we move ahead I would just like to end with stating how proud I am of all of our communities resources and focus on the treatment and improvement of addiction. The Monroe County Medical Society also has an Addiction Medicine Committee that includes area physicians, clinical staff, and community based mental health staff collaborating on prevention programs and current treatment options for patients with addiction and chemical abuse diagnoses. The Addiction Medicine Committee meets 5 times each year (2nd Thursday of January, March, May, September, and November). We are always looking for champions to help with this and if you are interested in joining this high yield committee please let us know!

We have a great line up of locally, nationally recognized writers for this Bulletin. Please enjoy the issue and the season!

A *TIME LINE* FOR *THE EVOLUTION OF* ADDICTION TREATMENT

BY GLORIA BACIEWICZ, MD AND NEHA PAWAR, MD

Addiction is a chronic, relapsing disorder marked by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain. (NIDA, 2018)

What is the difference between Dependence and Tolerance?

Physical dependence occurs with the regular use of any substance, legal or illegal. The body adapts to chronic exposure to the substance, and when the substance is taken away, it leads to the craving for the drug to relieve the withdrawal symptoms. (NIDA, 2018)

Tolerance is the need to take higher doses of a drug to get the same effect. It goes hand in hand with dependence, and it is often challenging to distinguish the two. (NIDA, 2018)

Addictive substances attack the brain's reward system by flooding the circuit with dopamine. Dopamine is a neurotransmitter that helps regulate movement, emotion, cognition, motivation, and reinforcement of rewarding behaviors. Imaging studies of the brain from people with substance use disorders drugs show physical changes in parts of the brain that are crucial for judgment, decision-making, learning, memory, and behavior control. (NIDA, 2018)

In this article, we have attempted to outline the evolution of addiction management over the years ranging from the mid-18th century to the present time.

The 1700s

1750–Early 1800s (ASAM Principles of Addiction Medicine 6th ed Addiction Medicine in America: Its Birth, 2018).

• Alcoholic mutual aid societies and sobriety circles provided early recovery from 1750 to the early 1800s. These groups comprised various Native American tribes that used native healing practices to treat alcoholism.

The 1800s

• The first inebriate homes which opened in Boston were patterned after state-operated insane asylums. New York State Inebriate Asylum opened in 1864 in Binghamton, NY and was the first addiction treatment center in the U.S. and is considered the first alcohol rehab center.

• Isolation of morphine from opium.

• Introduction of the hypodermic syringe.

• Rise of availability of patent medicines.

• Freud recommended cocaine to treat alcoholism and morphine addiction (the 1880s). Freud and other American physicians used cocaine to treat alcoholism and morphine addiction. However, in the last of Freud's writings, he backed off his former defense of using cocaine to treat morphine addiction.

• Frederick Douglass "takes the pledge". He writes about how liquor and slavery are related in Narrative of the Life of Frederick Douglass, American Slave (1845).

• Poorly evaluated clinical therapies, ethical abuse, economic depression, stigma, de-medicalization, and criminalization of alcohol/drug problems led to the shutting of inebriate homes and the first generation of addiction treatment in the 1890s. After inebriated homes and asylums closed , alcoholics are sent to city drunk tanks, public hospitals, and insane asylums.

The 1900s

1900–1950 (ASAM Principles of Addiction Medicine 6th ed Addiction Medicine in America: Its Birth, 2018).

• New York City substance abuse hospital opened in 1901, treating affluent alcoholics with belladonna elixir.

• The Oxford Group was a Christian institution founded by the American Lutheran minister Frank Buchman in 1921, who believed that the root of all problems was the personal problems of fear and selfishness. The co-founders of Alcoholics Anonymous (AA), Bill Wilson and Robert Smith, met in 1935 through the Oxford Group and listed most of its principles in AA, the first Twelve-step program.

• State laws called for the sterilization of the mentally ill, developmentally disabled, and alcoholics and addicts in 1910's. The legislation granted the medical supervisors of asylums and prisons the authority to "asexualize" a patient or inmate if such action would improve their physical, mental, or moral condition.

• Morphine maintenance clinics were created (1919-1924) to treat people with morphine addiction.

• The first federal narcotics farm was opened in Lexington, Kentucky, in 1935. It provided free treatment to addicts and alcoholics.

• Alcoholics Anonymous was formed (1935).

• Minnesota Model was created (1948-1950) with focus on sobriety and behavioral change.

• Disulfiram was used to treat alcoholism (1948-1950). Other medications used to treat alcoholism included barbiturates, amphetamines, and LSD.

1950–2000 (ASAM Principles of Addiction Medicine 6th ed Addiction Medicine in America: Its Birth, 2018).

• The reach of A.A. membership grew exponentially, and in 1951, A.A. won the Lasker Award from the American Public Health Association.

• American Medical Association defines alcoholism (1952) as primary, chronic disease with genetic, psychosocial, and environmental factors influencing the condition's prognosis.

• Veterans Administration establishes alcoholism treatment units (1957).

• Halfway House Association was founded (in 1958). They provide safe, recovery, and rehabilitation-focused housing for individuals suffering from substance abuse disorders.

• The insurance industry begins to reimburse treatment of alcoholism (1964-1975).

1970 onwards : Strong Organizations like ASAM, AAAP, AATOD, NIDA and NIAAA come into existence.

• Addiction Medicine exam (through American Board of Preventive Medicine) and fellowships.

• Medications FDA approved for treatment of Substance abuse disorder.

»Tobacco: NRT, varenicline, bupropion.

»Alcohol: Disulfiram, acamprosate, naltrexone, IM naltrexone.

»Opioids: methadone, buprenorphine, buprenorphine/naltrexone, buprenorphine monthly injection, naltrexone, IM naltrexone.

• The Controlled Substances Act passed (1970) and placed all regulated substances into five schedules or classifications based on the substance's medical use, the potential for abuse, and dependence liability.

• FDA approves Narcan (1971). It was first available as an injectable solution but is now available as a nasal spray

• Cocaine Anonymous was founded (in 1982). Cocaine Anonymous (C.A.) adopted the 12-step philosophy embraced by Alcoholics Anonymous.

• Rational Recovery. Secular Organizations for Sobriety and Rational Recovery was founded (1985-1986). These programs emphasize rational decision-making, not spirituality.

• American Medical Association calls all drug addictions diseases (1987).

• Drug Addiction Treatment Act passed (1999) with strict enrollment requirements for providers who prescribe narcotic drugs in Schedules III, IV, or V for maintenance and detoxification treatment.

• The opioid epidemic can be outlined in three prominent waves. The first wave began in the 1990s, leading to an increase in overdose deaths involving prescription opioids. (Centers for Disease Control and Prevention, March 2021).

The 2000s

2000–Present (ASAM Principles of Addiction Medicine 6th ed Addiction Medicine in America: Its Birth, 2018)

• The second wave of the opioid epidemic led to rapid increases in overdose deaths involving heroin in 2010 (Centers for Disease Control and Prevention, March 2021)

• The third wave began in 2013, with sharp increases in overdose deaths involving synthetic opioids, particularly those involving illicitly manufactured fentanyl. To date, the market for illicitly manufactured fentanyl continues to change, and it can be found in combination with heroin, counterfeit pills, and cocaine. (Centers for Disease Control and Prevention, March 2021).

• The insurance companies and group health plans provide similar benefits and services for behavioral and substance use treatment and other medical care types under the Mental Health Parity and Addiction Equity Act (MHPAEA)


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which was passed in 2008.

• Addiction treatment is covered by The Affordable Care Act (ACA) (2010).

• In light of the relentless opioid and national addiction epidemic, the AMA petitioned to drop vital sign number 5 (pain) as a professional standard of medical care, a statute first implemented in early 1990.

• In 2021, due to the unprecedented Pandemic of COVID 19 and the already raging opioid epidemic, federal guidelines removed requirements to obtain training course to prescribe buprenorphine. A large number of providers can now prescribe buprenorphine.

• December 2021, New York City became the first U.S. city to officially open supervised injection sites or an overdose prevention center (OPC). In this facility, people can use injectable drugs like heroin, cocaine, and other substances in a clean and safe environment. Chemical dependency rehabilitation resources are also provided.

• Addiction treatment programs have made significant progress over the years and continue to grow as new research, and scientific evidence emerges. Trauma is an invisible force that shapes our lives. (Mate) In a trauma-informed society, we are not concerned with labeling and judging but seek to understand the need for a comprehensive treatment model that aims to help individuals and families strike a balance while treating the whole person.

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Dr Gloria Baciewicz has specialized in the treatment of addiction. In her current role as medical director of Strong Recovery in the University of Rochester's Department of Psychiatry, she works in education, administration, and clinical care. She is certified in addiction medicine by the American Board of Preventive Medicine and board certified in psychiatry, with added qualifications in addiction psychiatry. Dr. Baciewicz is a co-principal investigator for the University of Rochester's Recovery Center of Excellence.

Dr. Neha Pawar has specialized in the treatment of Addiction and Pain Medicine. She completed her residency in psychiatry and fellowships in Pain Medicine, Department of Anesthesiology and Addiction Medicine /Psychiatry, and Department of Psychiatry at the University of Rochester Medical Center. She joined as a senior instructor at Strong memorial hospital in Oct 2021 and works at the Cancer Pain Center at Wilmot Cancer Center and Chemical dependency outpatient clinic, Strong recovery.

THESE *PANDEMIC* CIRCUMSTANCES

BY MARK A. HEAD, LCSW, ACSW

COVID has become "the leader of the landslide" in regards to exposing the truculent impact that the pandemic has had upon hospital health and mental health systems across this country. Most of the publicity regarding overutilization, and frazzled systems review has been focused upon hospital systems, and other inpatient institutions, due to their diminished capacity to adequately respond to the ginormous uptick in demand for acute/ critical care services in response to the pandemic.

The area that has not received the same widespread attention, is the state of outpatient mental health services during this same pandemic period. I have been an outpatient provider of psychiatric services in the greater Rochester area for close to thirty five years. During this timeframe I have witnessed upticks in client need for services coinciding with catastrophic world events (most notably during 9/11).

Uncertain times punctuate the need for support services for traditional outpatient mental health clients. In the tense, and potentially fatal atmosphere, that the pandemic created, this need ratcheted up the demand for services astronomically. Changes in comforting routines,increased isolation and the ever growing loss scenarios, dramatically raised anxiety, bereavement and depression outcomes. COVID lethality fears and uncertainty created a mushroom cloud of need and a greatly challenged response from within the ranks of outpatient mental health providers and client systems alike.

In addition to these manifest liabilities there also existed a polarized, overarching, caustic antagonism that grew out of the partisan divide between political parties,and within client family systems regarding base beliefs and practices as to how to go about providing safety and protection for self and others. These fractured loyalties served to further complicate medical protocol and dissemination of information. There has never been a more challenging time to be a client or a provider.

I have never witnessed the drought of providers accepting new client referrals that exists in this pandemic environment. I used to pride myself in being able to easily facilitate a ready referral for clients that I couldn't service personally.This pride collapsed into incredulous disbelief when I became unable to line-up services for a family member in need of grief counseling.

Clients whose calls for service I answered at my practice, expressed gratitude that I personally responded to their call. Their predominant experience was to be ghosted by potential providers, never to receive a call back after their original query.

Mind you, this occurrence was not an isolated event. I heard it repeatedly like never before. I myself experienced this same phenomenon when I called two highly reputable providers to seek services for a bereaved family member. I waited for two weeks to receive a return call regarding my query about their availability in seeing my relative as a potential client. Meanwhile my relative suffered in silence. It is impossible to convey adequately the abject powerlessness of these pandemic circumstances.

I waited patiently for two weeks for the return call that never came. In frustration I made a second call to each of these providers, chiding them for not returning my first call. To this day I have not heard back from them either.

I did not read this "no response" response as a matter

of callous disregard on the part of fellow providers.I interpreted this not as a personal slight, but rather as overwrought colleagues, besieged by too much work due to the frenzied need for services caused by the pandemic.

In the scant confines of this article I did not have time to address the matter of telehealth services that dramatically increased due to safety concerns and the watering down of services, out of necessity, due to volume and safety concerns,and the isolating impact upon well being.

When I think of clients calling potential providers for clinical services only to be ghosted I feel saddened. I think that patient demands for service superseded our capacity to respond, similarly to how it happened with hospital services during the pandemic. Our obligation as providers is to afford clients courtesy, compassion and dignity. The simplest way of doing this is by acknowledging their call, even if it means that we have to visit our overgrown demand and our personal powerlessness ourselves.

Mark Head is a graduate University of Buffalo School of Social Work. He worked at Hillside Children's Center Residential Treatment Center, Park Ridge Chemical Dependency, inpatient and outpatient services. He was awarded Youth Advocate of the Year for Monroe County in 1987. He spent 27 years on Special Assignment. Drug and Alcohol Coordinator for Rush Henrietta Central Schools Social Worker. He also established 'The Center for Self Enhancement' and has had his private social work practice since1987. When not working he coached Varsity Ice Hockey and was Awarded Coach of the Year Section Five Varsity Ice Hockey Monroe County in 1988. He is married with three children, three grandchildren, and twin grandkids due in June 2022.

Stop Calling It Behavioral Health!

Does the term cause stigma and discrimination?

This article written by Robert Kent and Dr. Charles Morgan was reprinted with permission from the 11/12/2015 issue of theFix.com https://www.thefix.com/stop-calling-it-behavioral-health

When somebody is treated for smoking cessation, the care will probably be provided within the behavioral health system. If that person is later diagnosed with lung cancer that will be treated over in physical health. If she becomes depressed, that'll be managed back over in behavioral health. But if the depression causes digestive problems, that aspect of the patient's health and health care will be treated…you get the picture. Many "behavioral" issues are driven by biological or hereditary conditions, and yet physical and behavioral health are frequently organized, paid for and managed in two entirely different systems. Two key figures at OASAS, which oversees one of the largest addiction treatment systems in the country, argue that the divide between physical and behavioral health, and the term itself, can lead to stigmatization and discrimination against people with "behavioral disorders." Robert Kent, J.D., the general counsel at the NYS Office of Alcoholism and Substance Abuse Services (OASAS), leads OASAS's work to implement health care and insurance reform for the Substance Use Disorders system in New York. Charles Morgan, MD, is the medical director of OASAS and a physician who has devoted over three decades to working with people and families affected by addiction. They both want you to "STOP CALLING IT BEHAVIORAL HEALTH!"… Richard Juman, PsyD.

We believe that it is time to stop calling substance use disorder and mental health "behavioral health." We are unabashed advocates and supporters of the substance use disorder (SUD) treatment, prevention and recovery system. We are regularly amazed by the stories of people who are now able to live their lives in recovery because of the work done by the people in our system. We need to talk about these disorders in a language that reflects their true nature; they are medical conditions, the origins of which lie in the person's brain, and the effects of which extend into every part of that person's life, and as with other illnesses, virtually always into the lives of the people who are touched by the patient.

The term "behavioral health" is imprecise, since it doesn't indicate whether one is talking about a mental health condition or a substance use disorder. More importantly, the concept of "behavioral health" as separate from the rest of health care has allowed insurance and managed care companies to create rules for managing services which have denied people access to needed services. If you follow the logic of using the term "behavioral health," then people with type 2 diabetes, heart disease and asthma could very accurately be identified as having a "behavioral health" issue, as their chronic medical condition is aggravated by their behaviors. But we would never do that with those disorders.

Constellations of behavior manifest from many chronic medical conditions, some of which are construed as "medical" and others as "behavioral." The bifurcation is as illogical as it is stigmatizing. People aren't expected to be able to shrink their own tumors or cure their own infections, but they are expected to control their own behavior. Consequently, calling psychiatric and substance use conditions "behavioral" puts the onus on the patient, often to his tragic detriment in the form of discrimination in housing and employment or the realm of criminal prosecution.

An individual with a substance use disorder has a natural, predictable disease course, one that is responsive to treatment, allowing for recovery. While we obviously do not want these symptoms to continue, blaming a person for their "behavioral health" issues, rather than treating them, is as counterproductive as blaming a person with epilepsy for falling down when they have a seizure, or blaming the person who is allergic to bees for disrupting the annual family reunion picnic because s/he needs emergency care when s/he is stung. Since we do not want such problems to continue or to be ignored, being judgmental or pejorative about them is harmful because it impedes treatment. In the case of the person with a bee allergy, we would instead encourage him to carry an EpiPen, and we would work to remove any barriers that might prevent him from doing so. We would also remove the bees' nest!

With regard to the methods and rules used by the insurers and managed care companies that operate in "behavioral health," some of our recent initiatives provide ample proof of the impact of using the term. Thanks to the leadership of New York Governor Andrew Cuomo, we now have a state law that requires insurance and managed care companies to have the decision-making criteria they use to manage substance use disorders reviewed and approved by OASAS. Our review of the criteria being used revealed that SUD level of care decisions were being significantly influenced by a person's past failures or relapses, by whether they had "failed first" at a lower level of care before they sought a higher level of care, and by their "motivation" to seek help. Some insurers, and even some providers of care, use the term "motivation" to exclude people from treatment. This is in contrast to the concept of motivation as described by the stages of change model, or in motivational interviewing technique, where a patient's level of motivation is understood in order to allow for effective treatment. These types of rules would never be allowed for other chronic medical conditions like diabetes, heart disease, and asthma. Would we deny a diabetic their insulin because they ate chocolate cake the night before? Would we deny the person with heart disease medications because they ate chicken wings and french fries? Of course not, because we do not think of those other chronic medical conditions as behavioral in nature. Unfortunately, there is a bias towards thinking of SUDs as behavioral, and then allowing the punishment of the behaviors that are symptomatic of the condition.

Finally, and most importantly, we believe use of the term "behavioral health" plays a major role in the continued stigmatization of those with an SUD. Such terminology reflects a misunderstanding of SUD, and allows us to perpetuate the myth that the illness is volitional rather than based in biology. Critics of our stance tell us we are absolving people of responsibility for their actions, when in fact we are doing quite the opposite. By delineating the true nature of the illness, we can allow patients to get proper treatment for their illness. Blaming people for addiction would be like blaming people with irritable bowel syndrome for the symptoms of their disease. Acknowledging the disease of IBS allows for proper treatment, which then allows people to be more functional and self-actualized in a way that allows them to take responsibility for their recoveries and to get relief of debilitating symptoms. Similarly, when we treat SUD rationally in this way, rather than as a series of "volitional behaviors" that those afflicted should be able to stop if they were properly motivated, people affected by SUD can then take responsibility for their illness and get effective treatment.

With regard to the stigmatization of people with SUD, researchers estimate that only one in 10 people who have an SUD actually seek help. While we know there are many reasons people do not seek help, we know that the stigma associated with SUD has a significant inhibitory impact.

We should listen to the experts.

The American Society of Addiction Medicine (ASAM) defines addiction as follows:
Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Michael Botticelli, the director of the White House Office of National Drug Control Policy (2015), has talked recently about the language we use impacting whether people seek help for an SUD and he has encouraged us to use different language. We know that some will disagree with our viewpoint and some will dispute the basis used for making it. We also know that we can only change what we do, and we can hope others will do the same.

Continued on page 17

Problem Gambling: *The Hidden Addiction*

BY JENNA HOTALING, CHES, FINGER LAKES PROBLEM GAMBLING RESOURCE CENTER

For most, gambling is an entertaining pastime. But when does something harmless turn into a problem?

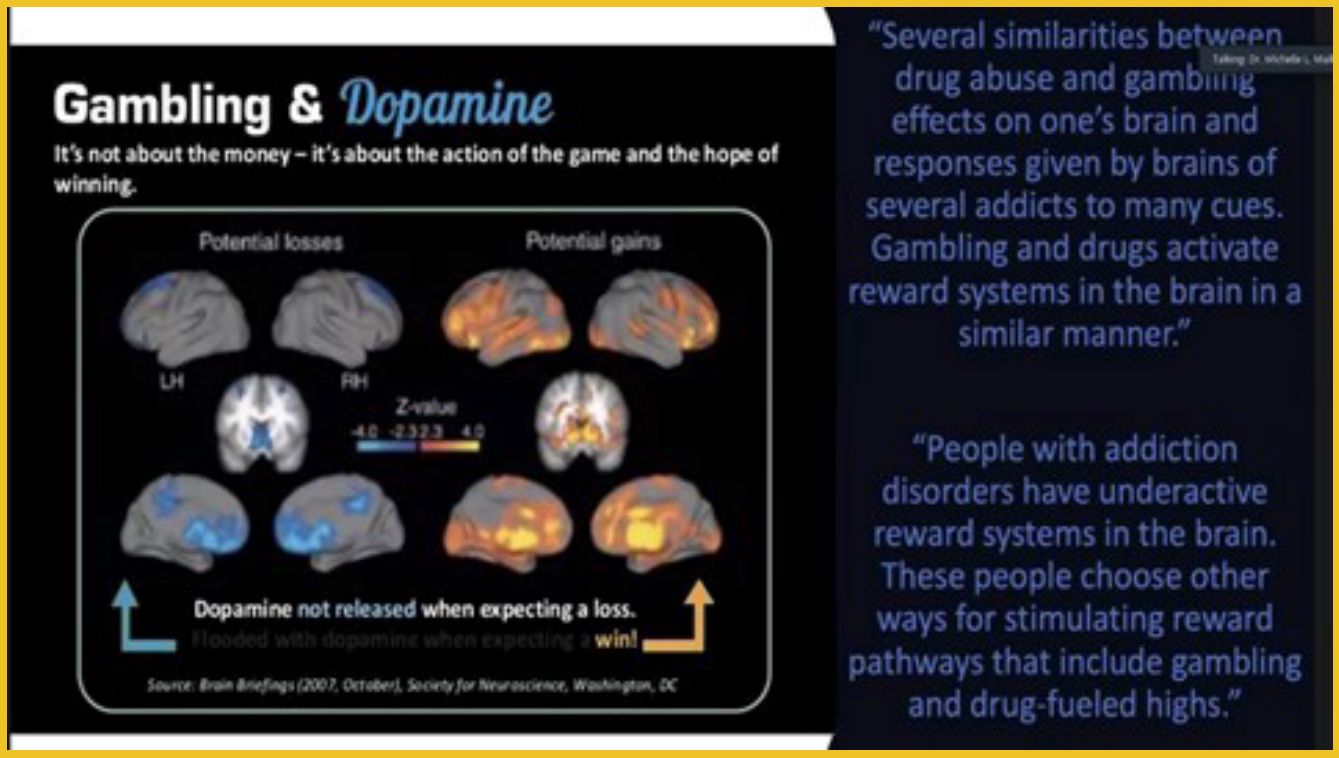
Problem gambling can be defined as anytime gambling causes a problem in someone's life. This can include financial issues, relationship conflicts, stress and anxiety, or distraction from school or work. A common societal view is that gambling problems are the result of a moral failing or lack of self-discipline. However, problem gambling and gambling disorder have a significant impact on a person's physical, mental and social well-being.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) classifies Gambling Disorder as a Substance-Related and Addictive Disorder. A common misconception about gambling is that it is dissimilar to drugs and alcohol because a person does not ingest anything into the body. However, through things like Positron Emission Tomography (PET) scans and other tests, we understand that gambling causes a release of dopamine in a similar manner as with the use of drugs and alcohol. It is no surprise, then, that there is a high rate of co-occurrence between gambling and alcohol and/or drug use.

The 2020 NYS Problem Gambling Prevalence study by the Office of Addiction Services and Supports found that although adults experiencing gambling problems represented 4.3% of the general NYS population, they represented 14.7% of those experiencing an alcohol, tobacco, or other drug problem. Among those experiencing gambling disorder, over 73% also have an alcohol use disorder, over 60% have a nicotine dependence, and over 38% have a drug use disorder .

Further, repetitious exposure to gambling activities can also change brain function, and individuals can experience urges or cravings to gamble, irritability or agitation when unable to gamble, and even physical withdrawal symptoms.

Irritability is not the only impact that gambling can have on one's mental well-being either. In some cases, issues like loss, grief or other life events can lead to gambling as an escape from trauma and depression. In others, the negative consequences of gambling can cause stress, depression and anxiety. Two out of three people with a gambling problem reported that their mental health suffered as a result .



If left unchecked, these struggles can lead to an increased risk of suicidality. Nearly half of people with gambling disorder experience suicidal ideation, or thoughts of suicide. One in five people with a gambling problem or gambling disorder will attempt or die by suicide – the highest rate of any addiction.

The harm from problem gambling and gambling disorder are not exclusive to just the person gambling. It is estimated that each person with a gambling problem directly impacts about 10 other people in a variety of ways, physically, emotionally, financially, and more[2]. With about 600,000 New Yorkers experiencing a gambling problem, that translates to about six million people across the state being negatively impacted by gambling. Nearly all the affected others (91%) surveyed experienced emotional distress with more than half (57%) experiencing some kind of mental ill health[3].

Problem gambling is often described as a hidden addiction. Gambling itself can be easily hidden. Many of the harms associated with gambling can be hidden as well. Some indications that gambling might have become problematic could include being absent from activities with friends or family because of gambling; feeling stressed or anxious when not gambling; low school or work performance due to preoccupation with gambling; inability to pay for regular expenses or needing to borrow money; or lying to family and friends about how much money and time is spent on gambling.

The Finger Lakes Problem Gambling Resource Center (PGRC) is here to help anyone who is looking to reprioritize their lives and overcome the problems that gambling has caused, whether they are gambling themselves or have a loved one who is. Private-practice counselors, behavioral health and treatment facilities, recovery groups and other community services throughout the Finger Lakes region make up a vast referral network. When people call (585) 351-2262 or email FingerLakesPGRC@NYProblemGambling.org, they confidentially connect with a knowledgeable PGRC staff person who will listen to and connect them with the resources that best meet their needs. Whether you are ready to get help, or you are just curious about your options, call us today. We're here to help.

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Jenna Hotaling is a recent addition to the problem gambling field. Since the fall of 2018, she has been leading the Finger Lakes Problem Gambling Resource Center (FL-PGRC) team through outreach efforts, community education, and raising awareness on problem gambling. She has conducted numerous problem gambling training sessions for agencies across the region. Jenna has a Bachelor's Degree in Community Health and a background in health education.

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It is essential that we start thinking of substance use disorders and describing them by using the same language that we use when we describe other chronic medical conditions. The language is critical here: Let's change the world by changing the way we think about, and talk about, the medical conditions formerly known as "behavioral health."

Rob Kent JD is the General Counsel for the White House Office of National Drug Control Policy, and former Chief counsel for NY OASAS

Charlie Morgan MD, FASAM, FAAFP, DABAM is the retired Medical Director of OASAS and formerly the Medical Director of the John L. Norris Clinic. He has worked in the field of Addiction Medicine for over three decades and is a Fellow of both the American Society of Addiction Medicine and the American Academy of Family Medicine. Dr. Morgan has expertise in all modalities of patient and family healthcare.

SOBER LIVING THROUGH FITNESS

BY JONATHAN WESTFALL, CRPA, CRPA-F, CARC, EXECUTIVE DIRECTOR, ROCOVERY FITNESS

That's our tag line… Or mantra… or "pitch" I guess. Whatever you want to call it, that is what the organization promises, and for me, I can say that it delivered just that—IN SPADES! I can honestly say it saved my life, without overstating the matter or even running the risk of being melodramatic about the whole thing. It is a fact, based on historical experience and one brief look at my life can prove it. In fact, I am 100% certain that it would not take much digging on the internet to dredge up some dirt on me (having spent more than a night or two in handcuffs riding to the sub-station for processing).

What CEO gets to write this publicly and invite anyone and everyone to investigate his/her past? One who regularly and openly shares his story to uniquely qualify himself to fill a position in a field where these experiences, and transcendence from them can be used as a point of shared experience with those whom he means to serve. My name is Jonathan Westfall, and I am a person in long-term sustained recovery from alcohol and substance use disorder (SUD). I am also the Executive Director/CEO of a community-based, non-profit organization called ROCovery Fitness in Rochester, NY. We are a sober active community of individuals brought together to create and foster a sober, safe, and inclusive environment of healing and recovery. All our classes, events and programs are 100% free to ANYONE with at least 48-hours of continuous sobriety, whether substance use is part of their journey or not. Participants are encouraged to rediscover their inner strength and resilience through fun, fitness, and sober social connection.

I will save you the time and energy it takes to Google someone's history and just tell you right off, it has been pretty ugly since I was 12 or 13 years old right on up through my 40's. Certainly I had my share of successes in life as well, being born with a certain level of privilege (coming from a white middle class background) you are bound to catch more than a few breaks in life and skate by where others may not get the same opportunity. But to be sure, eventually I would squander any chances I was given and throw away a promising and rewarding future, career, relationships, and family (as my aforementioned encounters with the criminal justice system would indicate). With every consequence of my active use, I would invariably be mandated to some type of formal treatment or community service, and I would swear that "this is the last time" and would genuinely mean it. At times it would stick too, at least for a few months—6-9 months at the most, and I would be right back to where I started. Maybe not right at first, but eventually and sometimes very quickly. It wasn't until I reached the age of 47, and I started to see some of my own behaviors playing out in a couple of my children who were starting to experiment in their teen years that I decided I needed to make some real and lasting changes in my life. I realized that, although I wasn't getting into trouble like I used to when I was younger, I was still far from a good role model for them. So, I decided to get sober (again). This time though, something different and unexpected happened. I met the co-founder of this amazing organization and was surrounded by a different kind of community and connection. One that provided me with a deeper more intense sense of service to others and took my love of fitness and made it relatable to my recovery. Coincidentally, I also made this connection about 6 months into my latest journey into recovery, at a time when I would traditionally start to drift and return to my well-worn paths. Instead, though, I found something that I could truly connect with, and it deepened my recovery. That word alone—RECOVERY, was a game changer for me. Instead of wearing the stigmatizing labels traditionally used for people like me, I was shown the beauty of identifying as someone who was in recovery! This was so much more positive, strength-based and forward focused than anything I had ever heard before. And there was this community of people who also identified as being in recovery and doing these fun and amazing, ACTIVE things that I like to do! And some new things also that I hadn't even tried yet, but my new friends encouraged me and believed in me enough (more than I did) to get me to try them. Some of them I loved and I kept doing and brought others along with me, including my own children, many of whom now continue to connect with the organization, classes and events. So, I began volunteering with ROCovery many hours each week in 2017 prior to being hired as the

Peer Support Program Manager & Outreach Coordinator full-time in July of 2018. In addition to my paid position, I continued to volunteer as a boxing coach, leading outdoor hikes and runs as well as weekend camping excursions, and started a kettlebell class. In January of 2021 I became the Interim Executive Director of the organization as the previous CEO and co-founder, was stepping away from her role. In July 2021 the Board of Directors named me as permanent Executive Director of ROCovery Fitness. Just recently, this past February I celebrated 5 years in recovery.

My reason for telling you all of this and going into some level of detail about my own recovery is not to make it all about me. My motivation is to illustrate how someone like myself, who faced years of suffering in active addiction and a repeating pattern of maladaptive coping skills, could still have hope for finding recovery and spread that hope to others through this amazing organization and to show what it gives to those of us desperately seeking a better way to live. We don't believe there is "one way to recover" but believe in the power of multiple pathways of recovery, and that each person intrinsically knows what will work for them. It is our hope to be able to be a bridge for those seeking recovery to whatever pathway they find most beneficial to them and help facilitate the pursuit of that endeavor by walking alongside and providing support and encouragement along the way.

Our programs, events and classes are free and available to those with at least 48-hours of sobriety, 7 days a week. They include our open gym and community center, outdoor hikes, trail runs, camping, backpacking, park workouts, bicycling, kayaking, group fitness, yoga, meditation, boxing, kettlebell, strength & conditioning, barbell 101, flag football, wellness workshops, board game club, poetry & writing, art group, music/jam nights, outdoor education workshops, mutual aid meetings, holiday dinners and social events, and so much more! We also offer peer recovery support services through our Outreach & Engagement Specialists to give additional support to those who request it. These connections help individuals self-identify areas of need as they relate to 8 dimensions of health and wellness and reveal their self-determined motivation to change in any given area, along with a few strategies to act and make those changes. We believe that everyone has the answers within themselves to live their best, self-directed life in recovery.

Additional information, including our current schedule of classes and events can be found on our web site at www.rocoveryfitness.org or on our Facebook and Instagram accounts @RocoveryFitness. We can also be contacted via email at mail@rocoveryfitness.org or by phone at 585-484-0234. Our outreach center is open from Monday through Thursday 8am – 7pm and Friday and Saturday 8am – 1pm and is located at 1035 Dewey Avenue in Rochester.

Jon has been involved with ROCovery Fitness since 2017. He started as a volunteer engaging in Wayne County expansion project, at the forefront of the community/street level outreach pilot project "Find Your Path" and the annual ROCovery 5k fundraising event. In July 2018, he started full-time with the organization, which allowed him to marry his love of fitness with his passion for community service. Jon has become a cornerstone of the peer recovery movement in the Rochester region. He is heavily involved in community outreach programs, grassroots recovery community organizations and advocacy groups/events. In his time in the human services field, he has served as a Peer Navigator with Catholic Charities Community Services and the Addiction Recovery Program Manager at Open Door Mission. Jon also serves as ROCovery's Boxing & Conditioning Coach, IKFF CKT Level 1 Certified Kettlebell Instructor and Outdoor Program Team Lead. Jon is a NY State Certified Recovery Peer Advocate (CRPA), CRPA-Family, Certified Addiction Recovery Coach (CARC), and a CCAR curriculum trainer. Jon is also a proud father of four, a long-time fitness enthusiast, graphic designer and artist.

THOUGHTS FROM THE SUBSTANCE USE TREATMENT TRENCHES

BY GARY HORWITZ, MD, CHUCK MONTANTE, MS, CASAC II, LMHC, RICHARD BRIGGS LMHC, CASAC

There have been some major developments in the field of treatment of substance use disorders.

• The opioid epidemic- What started as an attempt to develop better ways to manage pain evolved into a tragic example of greed by pharmaceutical companies and miscalculation by regulators. We lose over 100,000 lives in the US every year due to overdoses. No amount of money being clawed back from the pharmaceutical industry will ease the pain of those losses, but if used to fund research and treatment it could improve access to prevention and care in the future.

• Though for the last 2 years COVID-19 and the loss of almost one million Americans seemed to eclipse all other health issues, tobacco and alcohol remain 1 and 2 on the list of drugs that kill. A recently released NIAAA report shows that in 2021 deaths directly attributable to alcohol rose 25%.

• There have been remarkable improvements in substance use care in our community. 24-hour access to care, medications like naltrexone, acamprosate, and suboxone have been of immense help and are available not only in specialty clinics but to practitioners in the wider medical community. Naloxone to reverse opioid overdoses is widely available to the public. Outreach services after overdoses, peer services, and cooperation between law enforcement and interventionists like recovery navigators are reaching some of the most troubled individuals in our community.

• A positive outcome of the COVID-19 epidemic is that the treatment field has implemented and refined telehealth services.

There is a core of things that remain at the heart of good care for individuals with substance abuse disorders.

1.Individualized treatment- No two people progress into this condition the same. Helping people find their unique path to recovery should be an essential part of treatment. While some see "harm reduction" as a novel idea, providers have long known that each person with this condition deserves the respect and support of caregivers to design a treatment plan that informs them of the nature of their condition and offers them tools to change their life in accordance with their goals.

2. Family based care- We are social creatures and everyone in the family is affected by chemical use issues. There are many pressures to see the locus of the symptoms to be solely on the substance user, but everyone in the family needs and deserves the opportunity to address their own symptoms. Working with whole families offers them the chance to grow closer and may even arrest the multigenerational transmission of the disease.

3. Comprehensive teams that work together to treat the disease- Medicine in Rochester has the distinction of being the creator of bio-psycho-social medicine. Treatment service providers are responsible for linking patients to a network of care that considers each of these dynamics in a balanced and progressive way. The presence of co-occurring mental health, physical illnesses, and family symptoms makes it important to have integrated care to meet the evolving needs of patients as they progress through care. This is being accomplished internally by comprehensive providers or by collaborative services among providers in the community.

4. Care that respects the developmental nature of both the condition and the recovery- Most people enter care

with short term goals of alleviating pain that the condition is causing. Physical symptoms, legal issues, marital complaints, and job issues because of alcohol or other drug use may be the initial reason for a person to consider care, but it is likely they will eventually want to address the underlying challenges they have been unaware of when using. Length of care is a strong correlate with successful outcomes.

New York State and the Rochester area in particular has a comprehensive prevention and treatment network that delivers a wide range of community-based peer support services, school located prevention and early intervention services, community-based outpatient care, hospital-based treatments, and long term residential care that works to serve the needs of those experiencing substance use disorders. Those needs have evolved, and so have our providers.

Rick Briggs, MA, CASAC, LMHC currently serves as Clinical Director at Westfall Associates. He provides direct services in addition to providing supervision to other clinical staff. He especially appreciates facilitating Men's Issues Recovery groups. Previous roles include being the Director of Chemical Addiction Recovery Services (CARES inpatient unit) at Benjamin Rush Center, Director of the EAP of WWS Counties in Glens Falls NY and several leadership roles at The Health Association to include Director of EAP, Deputy Director of Community Programs and Executive Director. In 2019 he received the Charlotte Hegedus Award for Service to the Field from the NCADD-Rochester area. He is married to Mary Sanderson, and he has two sons, Taylor (with wife Erin) and Nathan who reside in Chicago.

Charles Montante is President of Westfall Associates. Chuck, along with nine psychiatrists and a business partner, established the practice in 1985 to meet the specialized needs of those individuals with the dual challenges of mental illness and substance use disorders. Chuck has 45 years' experience in the chemical dependency and mental health fields, having worked in schools, community based agencies, inpatient facilities and outpatient treatment agencies. In addition to the administrative responsibilities as the President of Westfall Associates, Chuck continues to see adults along with their families in clinical practice. Intervention services are a large portion of his clinical care. Chuck is the past president of the Region II Consortium of Alcohol and Substance Abuse Services, having served in 1981-83 and again in 1999-2000. He has served on the advisory board of Project Intervention, the National Council on Alcoholism and Drug Dependency-Rochester Area, serving as the chairman. In 2003 he received Counselor of the Year recognition from the Region II Consortium, and in 2003 received the Charlotte Hegedus Aware for Service to the Field from the NCADD. He was named a Health Care Hero in 2021 by RBJ. Chuck served on the Board of Directors for East House from 2009 to 2020, was the Program Committee Chair, and Board Chair in 2019. Chuck and his wife Suzanne have three children, Carrie, Danielle, and Jonathan, are graced with their spouses as additions to their family, along with 3 grandboys. . The Montantes split their residences between their home in Rochester and their cottage on the St. Lawrence in Clayton, New York.

As Medical Director of Westfall Associates, Dr. Horwitz has been assisting people whose lives have been hijacked by their enhanced responsiveness to drugs and alcohol since 1986. He is an Associate Clinical Professor of Psychiatry with the University of Rochester and has a private practice and forensic practice of psychiatry.

INSURANCE AND ACCESS TO CARE- *YOU ARE COVERED, RIGHT?*

BY GARY HORWITZ, MD

Where can you send your patients for treatment of alcohol or drug use disorders? If a family member needed help, where would you send them? If you or a colleague needed help, what resources would be available in our community? Would you be concerned if the only options available were publicly funded programs which are chronically underfunded? Are you aware that the nearest independent inpatient treatment program, Tully Hill which is south of Syracuse, had put a hold on admissions due to staffing issues related to low funding? It is hard to fathom that such questions arise at a time that substance use disorders are at an all-time high with extraordinary death rates compared to historical norms. In contrast to assurances that windfalls from suits against pharmaceutical companies for their part in the opioid epidemic will be available to fund more treatment and assertions by our political leaders that such treatment is a priority, at this time programs are facing critical financial pressures. The problem of financial instability affects not only publicly funded programs, but also those that are not receiving public funds. Some programs rely entirely on health insurance payments. Inadequate funding from insurance is also squeezing programs out of existence. This may be related to structural discrimination against people with mental health and substance use disorders.

It is now fourteen years since The Mental Health Parity and Addiction Act of 2008 (MHPAA) became law. If you talk with anyone who provides care to these patients, you will learn that enforcement of that law has been minimal. Prior to the law it was common to have quantity limits of a maximum of twenty days of inpatient treatment and similar limits for outpatient treatment as well. There were discrepancies in co- pay amounts compared to primary care settings. Such obvious and blatant quantitative discriminatory practices have subsided. Now discrimination is underfunding to the point of unsustainability of the programs.

In 2021 congress furnished the departments in the federal government with new tools to enforce MHPAA in the Consolidated Appropriations Act. Now the insurance industry must provide comparative analyses of their "non-quantitative" treatment limitations. It is the Department of Labor that is involved in enforcement of the private sector. This is to ensure that benefits to employees, including health insurance, is bona fide. If providers cannot be found, it is a bogus benefit. In this year's Report to Congress about the 2008 Parity Act, they note that:

For far too long, people with MH/SUD conditions and their loved ones have faced stigma, discrimination, and other barriers inside and outside of the health care system. These biases and discriminatory practices can often operate as an impediment to even seeking MH/SUD treatment in the first place. And once individuals attempt to seek care, they often find that treatment for their mental health condition or substance use disorder operates in a separate, and often very disparate, system than treatment for medical and surgical care, even under the same health coverage.

An example of this is right on our doorstep. A major health insurance provider in our region has not increased rates to a non-publicly funded program for nine years. Attempts to renegotiate for more reasonable and sustainable reimbursement has been stonewalled. In effect, this is abdication of responsibility for care of this population. If it continues, the only option will be publicly funded programs which are also currently facing existential financial problems.

Now for some good news. With the current administration there is an increased commitment to enforcement. The New England and Upstate New York Region of the Department of Labor (617-565-9600) is interested in examining specific cases of such discriminatory practices. Now is the time of greatest need for equity and parity and now is the time for enforcement. Let's end stigma and structural discrimination. Send them cases and let our representatives know your concerns. How do you want your children and grandchildren treated?

As Medical Director of Westfall Associates, Dr. Horwitz has been assisting people whose lives have been hijacked by their enhanced responsiveness to drugs and alcohol since 1986. He is an Associate Clinical Professor of Psychiatry with the University of Rochester and has a private practice and forensic practice of psychiatry.

LEGALIZATION OF MARIJUANA AND IMPLICATIONS FOR HEALTH

JUST THE FACTS, KNOW THE RISKS!

BY JENNIFER FARINGER, MS.ED, CPP-G, DIRECTOR, DEPAUL'S NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE-ROCHESTER AREA

New York State enacted the Marijuana Regulation and Taxation Act (MRTA) at the end of March 2021, legalizing and regulating the use and possession of cannabis for adults ages 21 and older and paving the way for an influx of marijuana dispensaries and marijuana lounges throughout the state of New York. While this is being promoted as an opportunity for new businesses, it is important to recognize the potential risks and impact on our communities, families, and youth. It is important to have the facts and know the risks.

Legal does not equal safe. Marijuana remains an addictive drug.

While we continue to focus on the devasting opioid epidemic with needed and ongoing efforts to address barriers and turn the tide around tragic overdoses, opioids are rarely a teens first experience with drug use. Alcohol, nicotine (in the form of vaping) and marijuana are the top three drugs that most significantly places young people at risk. Marijuana is often the first drug teens try, but not the last! Data has shown that as the perception of risk of marijuana declines, marijuana use increases. These two data points illustrate an inverse relationship. Legalization has increased access and further decreased the perception of risk.

One of the primary issues of concern for youth and young adults is marijuana's impact on cognitive abilities. Marijuana has been shown to decrease IQ by as much as six to seven points with early, regular use. Early use has also been shown to alter the structure of the developing brain, increasing, or exacerbating vulnerabilities to mental health conditions. Teens sometimes self-medicate, using marijuana to cope with anxiety and depression, but studies have found that using marijuana makes dealing with both conditions that much more difficult. Smoking or vaping marijuana damages lung tissue just as tobacco does. During this time of COVID and our heightened awareness of the value of a healthy immune system, we know that marijuana decreases the body's ability to fight infection, thus weakening the immune system.

Despite legalization or medicalization, marijuana remains an addictive drug! The THC (Tetrahydrocannabinol) potency in marijuana has increased considerably over the last several decades from one to four percent the 1960's to 20% currently in several states. With upwards of 80 to 90 percent THC in concentrates, edibles have become of particular concern.

Increasing instances of pediatric poisonings have been cited by the Upstate Poison Control Center due to children ingesting a variety of edible products. Available in a wide variety of forms, from candies and chips to ice cream and soda, edibles are packaged in such a way to make them not only tempting for children but are often indistinguishable from actual food products. With marijuana products being purposely bred for higher and higher THC content, it is not a surprise that the risk of becoming addicted has also increased. Nor is it a surprise that marijuana is often the number one reason teens seek treatment.

The risk lies in the fact that when edibles are ingested, the effects are not felt as quickly as when THC is smoked or vaped. This delayed reaction or response time, more often than not leads to an individual ingesting more in order to feel the expected effect. With children, this can and does too often result in pediatric poisoning incidences. Effects range from drowsiness or lethargy, loss of muscle

coordination, agitation, or irritability. More critically, children under three are prone to comas, respiratory depression, and single or multiple seizures because of accidental ingestion of THC edible products.

The use of marijuana during pregnancy is an additional cause for concern. A growing number of women are being ill-advised to treat their morning sickness with marijuana. Marijuana use during pregnancy poses serious risks to the unborn child. Similar to advice around the risks of drinking alcohol during pregnancy, there is no amount of marijuana that has been proven to be safe to consume during pregnancy. The American Academy of Pediatrics advises women who are both pregnant and nursing to avoid marijuana use. THC as well as the hundreds of other chemicals found in marijuana may be transmitted to the baby through breast milk which may increase the baby's risk for impaired cognitive development.

Studies have found that marijuana use during pregnancy may be harmful to the health of the baby. Marijuana use during pregnancy increases the chances of stillbirth and pre-term birth and has been linked to lower birth weights. Most significantly, there are mounting studies that show there may be long-lasting effects to the cognitive development of the child including effects on memory, learning and behavior, as well as a potential increase in vulnerability to substance use and misuse in their adolescent years.

Another concern is the predictable increase in drugged driving rates, which has been noted in prior Monroe County STOP DWI Reports. Driving while impaired is illegal no matter what substance is being consumed. The NYS Cannabis Control Board has made it clear that driving while intoxicated from marijuana is illegal. It is also illegal for any passengers in the vehicle to be using marijuana. The individual using marijuana is often unaware of their level of intoxication. They have the perception that they are in control and focused. The reality is that they have a fixation of focus, a decrease in peripheral vision, and a slower reaction time, all of which contribute to marijuana being one of the most identified drugs in deadly crashes, second only to alcohol. Impaired or drugged driving jeopardizes the safety of all who travel on NYS roads and highways.

For more information and a wide range of resources for parents and the community, visit our website awareness page at: https://ncadd-ra.org/resources/awareness-campaigns/marijuana/.

Jennifer Faringer is the director of DePaul's NCADD-RA (National Council on Alcoholism & Drug Dependence - Rochester Area) Jennifer has worked in the field of substance use prevention and education for over 30 years. She has been involved in the development of both professional and community education and awareness programs. She serves on the Executive Committee of the Finger Lakes Consortium of Alcoholism and Substance Abuse Services, also serving as Public Policy chair. She serves on the statewide Board of ASAP (Association of Substance Abuse Providers) of NYS as Vice President, also serving as Co-Chair of the ASAP Prevention Committee. Additionally, she serves on the Council on Addictions of New York State Executive Committee, serving as Chair of Membership and Past President. Jennifer received her Bachelors from Syracuse University and her Masters in Health Education from SUNY Brockport. Jennifer also holds the NYS OASAS Credential for Prevention Professionals with a specialty in problem gambling. Jennifer was awarded the Outstanding Contribution to the Field from Finger Lakes CASAS and the Eileen Penzer Victory Award from NYS ASAP. She presents frequently at regional, state-wide and national conferences on a variety of addiction related topics.

PUNISHMENT *VS. TREATMENT* *Substance Use Disorder (SUD)*

BY MARGARET CORBIN

As a psychotherapist and a health educator, I have been working in the field of substance abuse disorder known as addiction for more than 40 years. I have been asked to write about punishment vs. treatment in the field of Substance Use Disorder or SUD. My experience started when working with juvenile offenders in the Monroe County Hall of Justice, then moved on to classes for motorists arrested and convicted of Driving While Impaired. Also, in private practice counseling with individuals and family members affected by addiction. Then while living and working in London, worked with hospital staff teaching about Family Issues in recovery.

In the 1950's, the American Medical Association formally recognized addiction as a disease. Diseases have a specific set of symptoms, are chronic, progressive, and potentially fatal if left untreated. Substance Abuse Disorder is a preventable disease with a genetic predisposition; with environmental influencers.

Taking opportunities to train with the greats like Father Joseph Martin, Dr. Timen Cermak, Virginia Satir, Dr. M. Scott Peck and others who taught in person and believed that individuals addicted to alcohol and other substances could reclaim their lives. The disorder addiction, is not a badness but a biochemical difference like other diseases. This concept is not fully accepted and/or believed both socially and medically. New studies have developed these early beliefs and recolonize a brain disease disorder. R. Nora Volkow of the National Institute on Drug Abuse is the leading psychiatrist and pioneer in the field. The medical language is changing to show the way.

However, to reclaim your life, one needs to get education about individual needs and reactions to substances, foods, chemicals, environmental irritants, exposures, social surroundings and family pre-dispositions. Similar biological imbalances are diabetes, allergies and genetic proclivities. As we learn how our bodies react to certain foods we eat, air we breathe, skin contact, we must limit and/or avoid substances others have no problem with. When the reactions are life threatening, we need support to avoid, abstain and protect ourselves from these stimuli or irritants to carry on our lives.

Some substances are life threatening. Not really an option. Not "a take it or leave it choice", for some toxic and life threatening, substances. Despite the lack of in-depth research on cannabis, the government has legalized public use. Therefore, leaving use and abuse of an uncontrolled, addicting substance up to the public. The depths of the threat are often not realized by those who do not experience life-threatening responses. By the 1980's alcohol/other drug addictions' impact on the family, other loved ones, becomes a movement that recognizes and addresses the health issues experienced as a direct result of cumulative, chronic stress. Max Schneider, M.D., Internal Medicine, Gastroenterology, left a legacy in addiction medicine. Dr. Schneider, as an instructor, served as a Member of Faculties at Harvard, Buffalo Schools of Medicine and California/Irvine College of Medicine, teachings on aspects of Co-Dependency. He observed how family members were seeking medical care for many of the same conditions as their loved one and that medical issues/costs increased with untreated substance addiction. This included children.

The public, including law enforcement, are left to determine how to evaluate behaviors caused by substances that are not controlled and affect users in many and sometimes dangerous ways.

The majority of adults in our culture can use a small amount of alcohol, it makes one relax and one can stop using easily. Research has shown that nine out of ten people who use alcohol can stop using when they chose to. However, one out of ten cannot. Because the vast majority can choose, it is difficult for the majority to believe that everyone does not have the same choice/reaction to using alcohol. The belief of choice leaves our society to punish those who do not comply to self-control and reject the concept of Substance Use Disorder as a treatable disease.

There are many other substances that are more addicting and once started are even more difficult to not continue to use even if one wants to. The method of controlling misuse, out-of-control behavior activities, caused by abuse of the drug, by the public, is punishment. Public view sees abuse as a choice. The punishment includes: fees, fines incarceration, public control, public shaming. Medical treatment is beginning to be accepted. Treatment, however, is not accepted through insurance plans and medical support. Until the patient is: completely out of control, has multiple "incidents", has injured themselves or others, been incarcerated and rejected by their family members, has irreputable deadly diseases, the patient/ family cannot afford and/or receive treatment.

As an example of disease acceptance, fifty plus years ago it was commonly thought that cancer was brought on by some negative attribute of the patient. The disease was commonly whispered as the "C" word. Good people didn't get the disease of cancer. So, we use isolation as a solution rather than seeking treatment for a disorder rather than a treatable disease. There were no treatments available at the time.

What does the belief system of wrong doing cost us? Police and courts, then jails. We could have screening, referrals, insurance, treatment, hospitals and inpatient and/or outpatient with support/education. The list must start with research, training, medical education in medical schools, public education about the disorder, affordable clinics and support for patients and families. These steps are needed before the tragedies of family break-ups, children trained in fighting rather than treatment and education. Inpatient treatment before it is too late. The fatal car crash, anger, violence, abandonment. Job loss, lifetime family breakup. The next generations repeating the cycle.

Many challenges continue to impede the adoption of interventions into routine clinical care, including competing time demands and priorities, a focus on acute care, and insufficient specialized training of providers in risky alcohol/other drug use interventions. Intervention models that maximize efficiency and relieve clinician burden may offer a solution.

Research has shown that 25% of doctor visits are related to addiction/disorder and lack of personal and medical recognition. The list: falling, hitting, hurting oneself or others under the influence, neglect of supervision of a child or elder, car crashes and other vehicles, poor nutrition, dental/vision issues, sleep irregularities, digestive interference, untreated early-stage diseases, psychological upsets of all family members, job loss or dissatisfaction, overall neglect.

Drug courts have begun and have helped. Yet the greater public, most law enforcement and medical treatments, lack of insurance, are not based on a disorder theory but punishment, fees, fines and incarceration. Beliefs still prevail that "punishment is deserved and this negative situation would not have happened in the first place if this was a good person." The medical disorder model does not prevail.

The new, less expensive model could be early diagnosis including major patient education required for recovery about this brain disorder we call addition. The understanding of the genetic predisposition, how to take care of oneself, seeking support from survivors, educating the family, focus on recovery including all related health issues.

Psychotherapist and health educator. Margaret believes that individuals, families and communities must be empowered in all areas of their lives. "As people learn to care for themselves, they prevent serious illness and gain self-respect." Margaret has a Masters degree from Goddard College, VT and a Bachelors degree from SUNY Empire State College, NY earning both interdisciplinary degrees while raising three children and working part-time. A former SUNY Faculty Member in Health Sciences and Human Services Ms. Corbin has developed and published articles, books and curriculum on chemical abuse, communications, Family Court of NYS, human development, children with special needs, parenting skills, training interns and volunteers. She has taught on and off campus in urban and rural locations, also inside Attica Prison. An independent contractor for over 35 years, Margaret currently directs a New York State DMV Impaired Driver Program. With her staff and interns, 25,000 motorists convicted of alcohol/drug related offenses, have been educated, screened/referred and monitored. She has presented papers in NY State, nationally and internationally and published internationally on driver rehabilitation. She is a founding member of the Monroe County Medical Society Addictions Committee and a founding member of the New York State, Impaired Driver Directors Association. Margaret serves on the United Nations Association of Rochester Executive Board and on the Board of the World Affairs Council of Rochester. Margaret has an international family background and has traveled worldwide for business and pleasure. Ms. Corbin is currently working with international programs for youth and adults.

Ask An Attorney

BY DAVID FITCH, ESQ.

Q: I am concerned about the increase in opioid abuse by patients over the last two years due to the Covid-19 pandemic. What are some options to assist these patients?

A The National Institute on Drug Abuse reports that there has been a noted increase in substance use and drug overdoses in the United States since March 2020, when the Covid-19 pandemic was declared a national emergency. The Centers for Disease Control and Prevention announced in November 2021 that annual drug overdose deaths in the United States had topped 100,000 for the first time for the 12-month period ending in April 2021, which was more than a thirty-percent increase from the pre-pandemic level.

In response, the New York State Department of Health (NYSDOH) has increased efforts to combat addiction, lower deaths due to drug overdose, and assess state and local programs, including: obtaining and sharing data between agencies and affected communities; implementing training for health care providers on addiction, pain management, and treatment; making the prescription drug monitoring program easier for providers to access and use; providing resources to help communities at the local level combat the opioid epidemic; and coordinating community and statewide programs to improve the effectiveness of drug prevention efforts.

Due to the Covid-19 pandemic over the last two years, NYSDOH has highlighted approaches that can be put in place by care providers to meet the needs of people with opioid use disorder (OUD) including telehealth, extended prescriptions or take-home medications, and reducing the frequency of drug testing. However, clinical priorities for in-person visits include patients who request to be seen in-person, are new to OUD treatment, have experienced a recent overdose, are at high risk for overdose, are a persistent concern for diversion, or have an unstable medical or mental health illness.

Health care providers who prescribe opioids are reminded that since 2017 the New York State Department of Health has mandated accredited continuing medical education (CME) for all opioid prescribers. In addition, the Center for Disease Control and Prevention issued opioid-treatment guidelines for health care professionals and patients. Under New York State's "I-STOP" law, prescribers are required to review the state's Prescription Monitoring Program Registry within 24 hours of issuing a prescription for a controlled substance. A physician's failure to complete this CME and follow required guidelines can lead to discipline from the New York State Office of Professional Medical Conduct.

As opioid-related overdoses and abuse have increased in New York State during the pandemic, prescribers of controlled substances must be aware of and follow the legal requirements in an effort to keep their patients safe. It is essential for care providers to conduct an initial physical exam and obtain a thorough history from the patient, order the appropriate diagnostic testing to identify the existence and source of the patient's pain complaints, implement alternate treatment for pain management when indicated, and only prescribe the amount and dosage of medication that is supported by the provider's exam and testing of the patient.

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IN MEMORIAM

Dr. Douglas Edward Johnstone, Sr.

Highland Beach - Dr. Douglas Edward Johnstone, Sr. passed away peacefully at the age of 101 on March 22, 2022, at his home in Highland Beach, Florida. He was born on November 17, 1920, in Utica, New York, to Alfred L. Johnstone and Lillian (Jones) Johnstone. Dr. Johnstone was predeceased by his wife of 76 years, Maxine Louise (Krohn) Johnstone, who died in March 2021 at the age of 100. He was also predeceased by his son Douglas E. Johnstone, Jr. He is survived by four children, Jeffrey Johnstone (Martha), Judith Smith (Robert), Erika Beauvais, and Maxine Komitzer, as well as seven grandchildren and three great grandchildren. Dr. Johnstone was a graduate of Colgate University, where he majored in chemistry and was a member of the honor societies of both Phi Beta Kappa and Sigma Xi. He attended Cornell Medical College in the V-12 Navy College Training Program, after which he served as a medical officer in the U.S. Navy. He later received specialized training in pediatrics, allergy and immunology. For many years Dr. Johnstone divided his time between private practice and the University of Rochester Medical School, where he lectured, served as Director of the Pediatric Allergy Clinic, and also conducted laboratory research. He retired in 1992 as a Professor of Pediatrics Emeritus. He was on officer or founding member of many medical societies, including the American Academy of Allergy, Asthma and Immunology; the American College of Allergy, Asthma and Immunology; and GAA-Interasma Global Asthma Association. He authored chapters in medical textbooks and numerous articles in medical journals. Private arrangements will be at the convenience of the family. Donations may be made in Dr. Johnstone's memory to a charity of one's choice.

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