A PUBLICATION OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION • JUNE 2019

monitoron

GST# R127612802

Innovative research, interand more are improving preven

> How Social Relationships Protect Us

> > PAGE

New Guid for Practice Girls and Wo

Into **E**



SPECIAL REPORT

NEW SOLUTIONS FOR THE OPIOID CRISIS

States had substance use disorders related to prescription opioids, and 652,000 had a heroin use disorder, according to the National Institute on Drug Abuse. That year, more than 47,000 Americans died from opioid overdoses—six times as many as in 1999. Now, psychologists are implementing new solutions to overturn these grim statistics. Armed with fresh research, interventions, assessment tools, training and more, the field is escalating its efforts to prevent and treat opioid use disorder. Here's how.

HOW PSYCHOLOGISTS IMPROVE CARE

Medications have been the gold standard for treating opioid use disorder, but behavioral interventions can improve treatment for opioid addiction and address the comorbid conditions that go along with it

BY KIRSTEN WEIR

n an average day in the United States, 130 people die from an overdose of opioids, including prescription pain medications, heroin and synthetic opioids such as fentanyl. "The numbers are staggering," says R. Kathryn McHugh, PhD, a psychologist who studies substance use at Harvard Medical School and McLean Hospital. "Opioids touch pretty much every part of society, and the scope of the problem requires an all-hands-on-deck approach from the health-care field." ¶ Yet many health-care providers, including psychologists and other mental health professionals, don't realize the role they could play in addressing the epidemic,

says Kathleen Carroll, PhD, a psychologist and principal investigator at the Center for Psychotherapy Development at Yale University School of Medicine, a National Institute on Drug Abuse (NIDA)-funded center devoted to studying behavioral therapies for addiction. "A lot of people don't believe opioid use disorder is treatable, and it clearly is."

Researchers are still determining how best to design and offer behavioral treatments for people with opioid use disorder, and there's a lot of room for psychologists to contribute to that research. In the meantime, clinical psychologists can get involved by educating themselves and

their patients about opioid use disorder, supporting family members of those who are struggling with the disorder and getting comfortable asking patients about their drug use. (See "How You Can Make a Difference" on page 39.) "It's rare that there's a family in the United States that isn't touched in some way by the opioid crisis," Carroll says. "We must pay attention."

THE CURRENT TREATMENT LANDSCAPE

A 2015 report in Forbes magazine valued the drug treatment industry at \$35 billion. As the opioid crisis has grown, so have inpatient treatment facilities for opioid use disorder. But critics

note that there are no federal standards for drug rehabilitation programs, and little regulatory oversight. The quality of care in those treatment programs varies widely. In some cases, patients are released after detoxification without ongoing care—putting them at increased risk of relapse and overdose. "The worst thing that can happen is for people to get detoxed and then released without medication. It's heartbreaking," Carroll says.

Indeed, the medication Carroll refers to is the backbone of treatment: methadone, buprenorphine and naltrexone. Those medications are prescribed to block the effects of other opioids and prevent cravings and withdrawal symptoms.

"There is strong evidence that these medications save lives, and that they're effective across different ages, genders, ethnicities and social classes," says Carroll.

But 80 percent of people in the United States who need them don't get them, says Carroll, pointing to a new National Academies of Sciences, Engineering and Medicine report that she helped to write.







The report identifies several factors keeping these drugs from more widespread use, including inadequate training for professionals who work with people who use substances, the fragmentation of health care that often leaves people without the means to pay for treatment, and the misconception that substance use is a moral or purely behavioral problem,

"People totally misunderstand the nature of addiction, let alone its treatment," says Alan Leshner, PhD, a psychologist and former director of NIDA, who chaired the committee that authored the report. "None of the barriers are new. It's just that we haven't made any real progress against

them." (To read the full report, go to www.nationalacademies. org/OUDtreatment.)

Regulations also impair access. Buprenorphine is a controlled substance, and physicians. must complete extra training and receive a waiver from the Drug Enforcement Administration to prescribe it. Methadone, also a controlled substance, is available only through specially licensed clinics. While naltrexone can be prescribed by any physician, patients must complete a full detoxification before they can begin using it. On top of the prescribing difficulties, there's a lack of knowledge-among physicians, insurers and society at large—about using medications

More psychologists are needed to provide addiction treatment services and conduct research on new behavioral approaches.

for substance use disorders, as well as a stigma attached to their use, McHugh says.

A study by Ramin Mojtabai, MD, of Johns Hopkins University, and colleagues found that just 36 percent of U.S. treatment centers offered at least one of the medications approved to treat opioid use disorder, and a mere 6 percent provided all three (Health Affairs, Vol. 38, No. 1, 2019).

Of course, medication is just one component of treatment, Often, treatment programs combine prescription medications with counseling or other behavioral therapies. But the quality of behavioral treatments varies considerably, says Tom

Horvath, PhD, ABPP, a clinical psychologist in San Diego who specializes in addiction treatment and recovery. "In some states, you can get a drug counseling certificate without a college degree," he says. "Unfortunately, psychologists are highly underutilized in addiction treatment."

One big reason: The health-care system is designed around fee-for-service, and reimbursement is an issue. Drug treatment programs often can't afford (or aren't willing to pay) psychologists or other professionals such as licensed social workers, he says. "The whole system would benefit from more psychologists, but it's hard for them to work their way into the existing system."

BEHAVIORAL THERAPIES FOR OPIOID USE DISORDER

That's a missed opportunity, experts argue, since evidencebased behavioral treatments used in concert with medication have the potential to make a real difference in long-term recovery. "Substance use is not just about biology. When someone comes into treatment for opioid use disorder, there's a lot of history that predates that, and a lot of things that happened when they were engaged in drug use," says Sharon Walsh, PhD, a professor of behavioral science at the University of Kentucky College of Medicine who studies opioid use disorder and its treatment. "It's critical for people to also have behavioral interventions as needed. You need to treat the whole person to get them well."

While medications can help reduce cravings and decrease overdose risk, they do not reduce people's reactivity to stress, for example. And they don't address comorbid conditions that often go hand-in-hand with opioid use disorder, such as anxiety, depression, post-traumatic stress disorder and chronic pain—all of which can lead people to relapse back into addiction despite medication. "We need to think about how we target everything that's left over after treatment with medication," McHugh says.

In a review of research on behavioral interventions with buprenorphine treatment, Carroll and Roger Weiss, MD, recommend a steppedcare model for buprenorphine treatment that focuses on what they describe as the "Five A's" of successful treatment: adherence to medication, abstinence from illicit drugs, attendance at treatment appointments, alternative activities to drug use and accessing support. For patients who struggle with those efforts, Carroll and Weiss recommend more intensive behavioral interventions (American Journal of Psychiatry, Vol. 174, No. 8, 2017).

One behavioral strategy supported by some of the strongest data so far is contingency management. "One of the difficulties of substance use is that the benefits come immediately, but the costs come after a time lag," McHugh notes. If someone uses opioids today, they satisfy a craving and prevent withdrawal symptoms. The costs—losing a job, alienating family—exist in a hazy, far-off future. Contingency management aims to flip the script.

"Contingency management moves the reinforcer for absti-

THE THREE WAVES OF THE OPIOID EPIDEMIC

An estimated 300,000 Americans have died during the crisis, which has been characterized by three waves:

The problem started in 1991 with a surge in opioid prescriptions for pain. At the time, prescribers thought there was a low risk for addiction.

By 2010, efforts to curb opioid prescriptions led people to use heroin, an inexpensive and widely available, albeit illegal, drug.

In 2013, an increase in the use of synthetic opioids, like fentanyl, led to an increase in deaths.

nence closer to the behavior," McHugh explains. When a person provides an opioid-free urine test, attends scheduled therapy sessions or meets other behavioral goals, he or she receives a reward: a raffle ticket for an inexpensive prize, easing of behavioral restrictions (such as extending curfew for an adolescent being treated for opioid misuse) or a social reward (such as a special dinner).

In one review of the use of contingency management for treating various substance use disorders, Stephen Higgins, PhD, of the University of Vermont, and colleagues found that such programs are effective during treatment, though their effects weaken after treatment ends (*Preventive Medicine*, Vol. 92, No. 1, 2016).

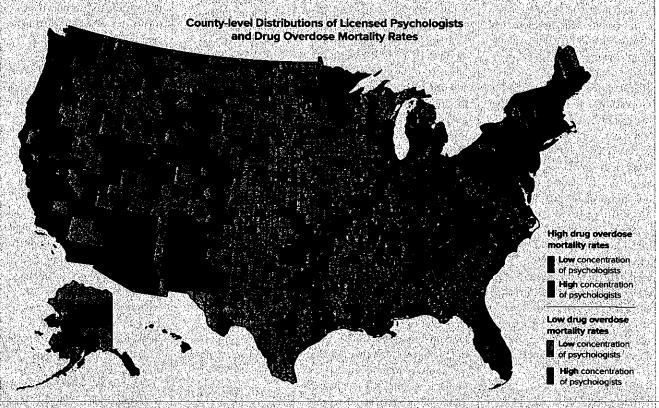
Improving retention rates in treatment programs may be one of the most important targets for behavioral interventions. About half of people drop out of medication treatments by the six-month mark, putting them at increased risk of relapse and overdose. "Behavioral treatments could play a role in bringing up that response rate, and that's a goal a lot of us are working toward," McHugh says.

COGNITIVE-BEHAVIORAL TREATMENTS

To bring more evidence-based treatment to people with opioid use disorder, Carroll and her colleagues developed a computer-based training for cognitive-behavioral therapy (CBT4CBT). The self-guided web-based program teaches coping skills and is intended to

Where Are More Psychologists Needed to Address Overdose Deaths?

Data on the geographical distribution of psychologists and of overdose deaths can shed light on where more psychologists are needed and where training psychologists in substance use issues may have the greatest impact. When examined at the county level, the Southwest and parts of the Midwest, Southeast and Appalachian Mountain regions have higher drug overdose mortality rates and lower concentrations of licensed psychologists than average. The Northeast and parts of the West Coast and Rocky Mountain regions have higher drug overdose mortality rates and greater concentrations of licensed psychologists than average.



By Karen Stamm, PhD, Luona Lin, MPP, Jessica Conroy, BA, and Peggy Christidis, PhD

For an interactive version of this map, visit https://www.apa.org/workforce/data-tools/geographic-distribution. Questions? Contact cws@apa.org.

Source: American Psychological Association. (2019). Distribution of licensed psychologists and drug overdose mortality rates. Washington, DC. Author.

Counties were classified by concentrations of licensed psychologists and drug overdose mortality rates higher or lower than the national mean at the county level

be used as one piece of a comprehensive treatment program for people with alcohol and substance use disorders who are under the care of a qualified psychologist, physician or other trained health professional.

Several clinical trials have found that CBT4CBT is effec-

tive for a variety of substance use disorders. In a 12-week randomized pilot study of the program tailored to patients receiving buprenorphine, 91 percent of patients in the CBT4CBT group had negative urine screens for opioids at the end of the trial, compared with only 64 percent

of the control group (Substance Abuse, online, 2019).

The program is now being used for alcohol and substance use disorders in 25 states and Canada but is available only through health-care providers, including psychologists and psychiatrists as well as primary care

physicians. "We want to make sure there's a clinician who can assess the individual and make sure the level of care is appropriate," Carroll says.

Horvath has also taken steps to reach more people with substance use disorder, using a mutual aid group model. Some 12-step programs, such as Narcotics Anonymous, promote total abstinence and may not welcome people taking medications for opioid use disorder, he says. To. offer a more inclusive alternative, Horvath was a founding member in 1994 of Self-Management and Recovery Training (SMART Recovery), which now offers more than 2,500 local meetings worldwide for people with alcohol and substance use disorders. The evidence-based program is centered on CBT and motivational interviewing, and often addresses co-occurring problems such as depression and trauma (Journal of Groups in Addiction and Recovery, Vol. 7, No. 2-4, 2012). Importantly, he adds, it can be personalized to meet the needs of each participant.

INVESTING IN TREATMENT RESEARCH

Researchers—including many psychologists—are developing new treatments to help more. people recover from opioid use disorder. The National Institutes of Health's Helping to End Addiction Long-term (HEAL) initiative was launched in the spring of 2018 to address the opioid public health crisis. To date, much of the research funded through HEAL focuses on pharmacology, including efforts to develop vaccines to

prevent opioid use disorder, medications to treat it and new, safer drugs to treat pain. But the initiative is supporting some behavioral studies as well, including projects aimed at identifying patient characteristics associated with retention in treatment programs and efforts to explore cultural attitudes that can create barriers to taking medications for opioid use disorder.

The HEAL initiative is just one part of the effort by NIDA and other institutes within NIH to support opioid treatment research in a variety of areas, from basic science to clinical trials. For example, Mark Smith, PhD, a psychologist at Davidson College in North Carolina, has NIDA funding to study the behavioral effects of opioids in rodent models. Animal models naturally play an important role in the development of new medications and the identification of neurobiological mechanisms of drug dependence. But they also have a lot to tell us about behavioral interventions, he says. He's found, for instance, that rats that get vigorous exercise self-administer significantly less heroin than their more sedentary counterparts, and also show changes in gene expression in the brain's opioid and dopamine receptors (Psychopharmacology, Vol. 235, No. 4, 2018).

Many psychologists don't realize how basic science research contributes to the field of substance use disorders, Smith says. "Psychologists are outstanding at developing animal models of pathological behavior. We can use those models to develop behavioral and nonbehavioral

ADDITIONAL READING

Randomized **Clinical Trial of** Computerized and Clinician-Delivered CBT in Comparison With Standard Outpatient Treatment for Substance Use Disorders: Primary Within-**Treatment** and Follow-Up **Outcomes** Kiluk, B.D., et al. American Journal of Psychiatry, 2018

The Role of **Behavioral** Interventions in Buprenorphine Maintenance Treatment: A Review Carroll, K.M., & Weiss, R.D. American Journal of Psychiatry, 2017

The Opioid Guide: A Resource Guide for Practicing **Psychologists** APA, 2018

> **APA Div. 50:** Society of Addiction **Psychology** https://addiction psychology.org/

interventions to both prevent and treat drug use."

Of course, psychologists are also doing important work on the human end of the spectrum. NIDA's Clinical Trials Network extends across 13 geographic "nodes," with hundreds of affiliated clinical study sites nationwide to test new treatments in a variety of treatment settings. Carroll's work on CBT4CBT, for example, was developed at the Clinical Trials Network site she oversees at Yale University. Through the network, she says, she hopes researchers will begin to answer some of the important open questions around opioid use disorder and its treatment: What is the optimal duration of treatment? What factors make people stick with it? How can interventions for co-occurring conditions such as depression and chronic pain be integrated into treatment for opioid use disorder? And what recovery support services can help sustain long-term remission of opioid use disorder? "There are more questions than answers," Carroll says.

Those questions are also a call to action, adds McHugh. "The relative lack of behavior therapy studies for opioid use disorder further highlights how important it is for psychology to get more involved."

A CALL FOR PSYCHOLOGY

The opioid crisis isn't just a problem for researchers to solve. Experts in substance use disorders argue that clinical psychologists can do more in their everyday practices. For starters, they should get in the habit of





asking all patients about their substance use, McHugh says. If they're not comfortable treating such patients, they should make efforts to refer them to providers who are. "Substance use disorder is often separated from mental health care," she says. "But you

cannot be in the mental health field without running into substance misuse."

Unfortunately, too few psychologists get sufficient training to help people with addiction (see article on page 58). John Norcross, PhD, at the University The SMART Recovery program-a mutual aid group model-offers more than 2,500 local meetings for people with substance use issues.

of Scranton, and colleagues surveyed clinical psychology doctoral programs between 1999 and 2017 and found that fewer than a third offered specialty training in addiction (American Psychologist, Vol. 72, No. 7, 2017). "We need to be doing a better job from graduate training through continuing education to make sure psychologists are getting the training that they need to work with folks with substance use disorders," McHugh adds.

"This is an incredibly complex public health problem," adds Walsh. "We need as many smart people as we can find to help solve it.".

 Interested in learning more about how psychologists are reimbursed for their services related to oploid treatment? Look for an article in the summer issue of APA's Good Practice magazine at www.apaservices.org/ practice/good-practice.

IMPROVING CARE HOW YOU CAN MAKE A DIFFERENCE

linical psychologists who lack specific training and experience in treating substance. use disorders often don't know how to get involved. Here are some places to start.

- Educate yourself on the basics and stay current as research opens up new avenues for treatment. Treatment for opioid use is evolving all the time.
- Ask all patients about their history of opioid and other substance use, no matter what they look like or why they are seeking treatment. Not sure how to ask? Ask them what substances they enjoy.
- Provide patients with information about safe medication storage and disposal, so that prescription opioids don't wind up in the hands of adolescents or others who might misuse them.
- Reach out to physicians who provide medical management for opioid use disorder to let them know you're available for referrals or willing to provide behavioral treatment as part of a team.
- If you're not comfortable treating opioid use disorder, connect with experts who are so you can refer patients as needed.
- Help clients with opioid use disorder and their family members understand

which treatments are evidence-based. ■ Learn about how best to support family members of people with substance use disorder.

- Encourage psychology students and trainees to seek out experience in treating substance use disorders.
- Get involved in local or national advocacy efforts. (See page 60),
- Take a deep breath—and dive in. "To feel competent working with a new population, you have to get in there and do it," says substance use researcher R. Kathryn McHugh, PhD. "The earlier you can get started, the better."

LIFE-SAVING SUPPORTS

Psychologist-designed programs that include housing, work and family interventions for people with opioid use disorder show promise

BY STEPHANIE PAPPAS

evin Scott was in his early teens when he began using drugs and alcohol. Since that time, he's experienced homelessness and has struggled with chronic pain from back, neck and head injuries. ¶ Now 48, Scott has secured a stable footing in life, in part because he now has a home. He won't lose his apartment in Seattle's Plymouth Housing program if he does drugs; in fact, Scott is not entirely substance-free. But now that he is free from the stress and uncertainty of the streets, Scott has been able to reduce his use dramatically, participating in a combined behavioral and pharmacotherapy program through the Harm Reduction Research and Treat-

ment (HaRRT) Center and Harborview Medical Center. The program has helped him switch from hard drugs like heroin and methamphetamines to cannabis, and limit his alcohol use. He participates in vocational rehabilitation, has an emotional support dog and volunteers to cook community meals for others in his housing complex. "It's been my anchor," Scott says.

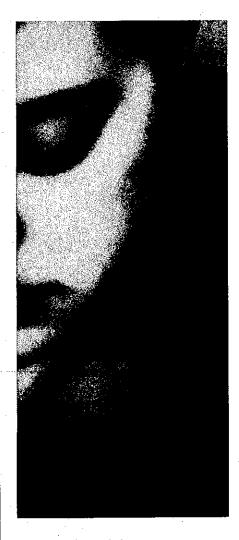
His case is just one example of how psychosocial supports can change lives. Opioid addiction is unique in that there are very effective medications that block opioid receptors to reduce cravings and even save lives in the event of overdose. But some people are reluctant to use medications or are unable to stick to a medication plan because of instability in their lives. Others want to taper off medications over time or need to relearn how to be in the world without substances, says Katie Witkiewitz, PhD, a professor of psychology at the University of New Mexico Center on Alcoholism, Substance Abuse and Addictions, Psychosocial support programs focused on getting substance users into stable housing, bringing together their family members and loved ones, addressing their employment problems and dealing with legal problems stemming from their drug use can make sticking with a broader treatment plan possible.

KEY POINTS

Many people
with opioid use
disorder struggle
to start or stay in
treatment because
of challenging life
circumstances.

Getting individuals into safe housing and providing them family therapy or employment support can make treatment more effective and address issues that lead to substance use.

Effective evidencebased programs exist, but access to these programs lags behind need.



"A lot of the work focuses on the underlying issues that brought people to addiction in the first place," says Witkiewitz.

For someone struggling with an opioid use disorder, these supports can make all the difference.

A SAFE HARBOR

Traditionally, housing programs have asked people with substance use disorders to "prove" themselves before receiving housing, says clinical psychologist Susan Collins, PhD, the co-director of the HaRRT Center at the





University of Washington School of Medicine in Seattle. They might have had to commit to substance use treatment programs or provide negative drug tests before they were considered "housing-ready."

But that philosophy is amiss, Collins says. "What agencies were finding was that the most stable parts of the homeless community were getting housing. But the folks who were struggling the most—and were the most marginalized—were not," she says.

Will Williams, a member of the community advisory board for the HaRRT Center, was once reluctant even to try to get permanent housing because he knew he would "screw it up" if he had to abide by rules like not smoking cigarettes or marijuana.

"You might be surprised how harmful being told that you can't do something is to a person who already feels they've been pushed around, pushed around, pushed around," Williams says.

In response, the philosophy of "housing first" was born. Hous**Psychosocial** support programs can help substance users stick to an effective treatment plan.

ing First programs, the first of which was established in 1988, aim to get homeless people, whether they use substances or not, into housing with few strings attached.

"We know that housing forms the basic platform that folks need in order to even begin to think about how to heal." says Karen DuBois-Walton, PhD, a clinical psychologist and president of the Elm City Communities/Housing Authority of New Haven, Connecticut.

Many cities across the United States now have Housing First programs, funded through a variety of federal subsidies, resident rent payments, grants and donations. The funding perpetually lags behind the need, DuBois-Walton says, especially because home prices and rents have risen faster than income over the past several decades, putting affordable housing in increasingly short supply.

For those who do gain a spot in them, Housing First communities provide an entryway into treatment, with services ranging from on-site case management to behavioral health treatments. Being late on the rent won't trigger eviction proceedings. Rather, DuBois-Walton says, late rent is seen as a first sign that someone might be relapsing or otherwise in need of help. Many of these supportive housing communities that serve people with opioid use histories distribute naloxone (also known as Narcan) to residents and staff and hold trainings on how to use the kits in case a resident overdoses.

Research on using the Hous-

ing First approach with opioid users is relatively sparse compared with research on its use with alcohol or polysubstance users. However, polysubstance use is the norm for people with opioid use disorder, Collins says, and the available evidence suggests the intervention works similarly across substance use disorders: People don't miraculously become abstinent as a result of getting housing, but they don't start using more, as some critics have worried. Overall, they appear to experience fewer negative health outcomes and have a better chance of getting treatment.

One study led by Philip Appel of the New York State Office of Alcoholism and Substance Abuse Services examined a Housing First program in New York and found that about half of homeless, mentally ill methadone patients who secured housing were adhering to their methadone treatment three years later, compared with just 20 percent of the same population who did not receive housing (Journal of Addictive Diseases, Vol. 31, No. 3, 2012).

Another study led by Sara Miller-Archie of the New York City Department of Health and Mental Hygiene found that among polysubstance users in the city, those placed in supportive housing were hospitalized less, used emergency departments less, and were more likely to initiate substance use treatment than those not given such housing (Annals of Epidemiology, in press).

However, a study of homeless adults receiving methadone FURTHER READING

Family Therapy and Systemic Interventions for Child-Focused Problems: The Current Evidence Base

Carr, A.
Journal of Family
Therapy, 2018

Seattle's Law
Enforcement
Assisted Diversion
(LEAD) Program:
Within-Subjects
Changes on
Housing,
Employment and
Income/Benefits
Outcomes and
Associations With
Recidivism

Clifasefi, S.L., et al. Crime & Delinquency, 2017

Opioid Crisis:

No Easy Fix to Its Social and Economic Determinants basgupta, N., et al.

Dasgupta, N., et al. American Journal of Public Health, 2018 maintenance treatment in Vancouver, Canada, by Simon Fraser University clinical psychologist Julian Somers, PhD, and colleagues found that Housing First programs didn't increase methadone treatment adherence any more than treatment as usual, leading the authors to conclude that housing supports were not in themselves sufficient to improve treatment adherence (International Journal of Drug Policy, Vol. 56, 2018). That study did not examine other outcomes like hospitalizations.

HELP AT WORK

For many people who use opioids, struggles with stable work go hand-in-hand with housing struggles. But there are few direct workplace supports for people who use opioids, says Kenneth Silverman, PhD, a professor of psychiatry and behavioral services at The Johns Hopkins University School of Medicine. Silverman and his colleagues run a work program for people with substance use disorders who are chronically unemployed. The program takes a contingency-management approach: Participants are paid to do data entry, and to earn maximum pay, they must also submit substance-free urine samples regularly. The key for achieving abstinence seems to be a combination of workplace incentives and medication treatment, the team has found, an example of social support and medical treatment working in tandem (Drug and Alcohol Dependence, Vol. 197, 2019). Employees aren't fired for relapsing, as they might be in a typical workplace.

"Our people need more than a second chance," Silverman says.

Silverman says his program, which is funded by federal grants, would be hard to reproduce in most employment settings. At most companies, employees with substance use problems who aren't simply fired are likely to get treated through employee assistance programs, which are often limited to short-term counseling and referrals.

But some employers are getting interested in providing more support and second chances. Belden, a computer and telecommunications hardware company, has a "Pathways to Employment" program that lets job applicants who are rejected because of a failed drug screening participate in rehabilitation and try again. Contractors such as American Substance Abuse Professionals Inc. work with employers to develop treatments for employees who have failed drug screenings, particularly in jobs with high safety standards, such as transportation and nuclear energy.

Silverman and his team are in the midst of a study that recruits participants to work in their data-entry business for 90 days and then engage with an employment specialist for a year to find paid work outside the study. As long as they remain abstinent during this time, they receive a stipend.

"You need high-magnitude incentives, and you need to maintain those for long periods of time," Silverman says. "That's one of the motivations for using employment because employment can involve high-magnitude incentives, long-term."





FAMILY THERAPY

Loved ones can also be a potent force in supporting the recovery of people with opioid use disorder. Family therapy can help families create a healthy environment around a member who is using drugs, help repair relationships fractured by drug use and help families support their loved one's recovery.

"Whether you're a teenager or a young adult or you're 40 years old, you have family, and the family can support recovery

or they can undermine it," says Gayle Dakof, PhD, a clinical psychologist and professor of public health at the University of Miami and director of MDFT International.

Often, patients come to treatment still enmeshed in relationships with other substance users, says Hortensia Amaro, PhD, a psychologist at Florida International University who founded a long-standing residential substance use treatment program for Latina

Housing First programs help substance users find stable housing without needing to first "prove themselves" by remaining entirely abstinent from substance use.

"WE KNOW THAT HOUSING FORMS THE BASIC PLATFORM THAT FOLKS NEED IN ORDER TO EVEN BEGIN TO THINK ABOUT HOW TO HEAL," SAYS KAREN DUBOIS-WALTON, PhD.

mothers, called Entre Familia, in Boston. Those patients have to reconstruct their social circles and find ways to navigate or disengage from toxic relationships, Amaro says.

Family involvement is especially important for adolescents who use substances, says Kimberly Kirby, PhD, a professor of psychology at Rowan University in New Jersey, and programs have been developed to help even when a loved one is resistant to treatment. Community Reinforcement and Family Training (CRAFT) is a program that teaches families to interact with a substance-using member by using positive reinforcement and improving communication and other relationship skills. This approach has been shown for decades to move more people with substance use problems into treatment than other family support options like Al-Anon and Nar-Anon or traditional interventions, according to research by Hendrick G. Roozen, PhD, of Erasmus University Medical Centre in Rotterdam (Addiction. Vol. 105, No. 10, 2010).

Kirby and her team have found that one particular aspect of CRAFT—treatment entry training, or training families to look for the fleeting moments when loved ones may be open to treatment and teaching them how to phrase their requests to get help-can be effective on its own in increasing treatment entry rates (Psychology of Addictive Behaviors, Vol. 31, No. 7, 2017).

Other effective familyoriented approaches include multisystemic therapy (MST)



and multidimensional family therapy (MDFT). Both programs differ from CRAFT in that they focus on directly treating substance use as well as building family relationships. There are differences between the programs, MST, for example, focuses on treating adolescents in their homes, schools and neighborhoods, and always includes parents in counseling sessions with youth. MDFT is implemented in community settings as well as inpatient facilities and prescribes solo counseling with youth as well as joint sessions with parents. But both ultimately focus on healing the family and enhancing positive social supports. MST has been shown to be one of the most effective interventions for teenagers who use substances and have conduct problems (Substance Abuse:

Research and Treatment, Vol. 6, 2012). MDFT, which is Dakof's treatment focus, is also highly rated for efficacy, as shown in a meta-analysis by Thimo van der Pol of Leiden University and colleagues (Journal of Child Psychology and Psychiatry, Vol. 53, No. 5, 2017). One particularly meaningful aspect of MDFT for opioid-using teens is the sessions in which they and their families meet to discuss an overdose prevention and safety plan.

"The idea is to stimulate an emotional conversation about drugs and about overdose and about death and life, and so on, to get people motivated to help each other," Dakof says.

These programs have high success rates, but a persistent problem is that they're not available everywhere and that families don't know about them, Kirby Several forms of family therapy are successful in helping repair relationships fractured by drug use.

says. Access to these familyfocused therapies for substance use is "really not great," she says.

SUPPORT, NOT PUNISHMENT

Instead of accessing effective treatments, people who use drugs often land in the criminal justice system. With the deepening of the opioid crisis, police, district attorneys and the courts are increasingly playing the role of lifeline rather than disciplinarian.

The problem is serious. Some 58 percent of state prisoners and 63 percent of sentenced jail inmates met the criteria for drug use or dependence, as of 2009 (Bureau of Justice Statistics, 2017). Jails and prisons aren't drug-free zones; a few years ago, Seattle's Scott says, he was jailed. He came out hooked on methamphetamines.

"Jail isn't a good place for addicts," he says.

For people with opioid use disorder in particular, imprisonment and its aftermath can be life-threatening. One meta-analysis found that among this population, overdose deaths increase three- to eightfold within the first four weeks of release from prison, because if they aren't using regularly while incarcerated, people with opioid use disorder lose their tolerance to heroin and other opioids (Merrall, E., et al., Addiction, Vol. 105, No. 9, 2010).

Another meta-analysis found that offering medications for addiction treatment may help methadone, buprenorphine or naltrexone treatment during incarceration increase substance use treatment entry, and methadone also reduces opioid use after release (Moore, K.E., et al., Journal of Substance Abuse Treatment, Vol. 99, 2019).

States are slowly taking notice: Rhode Island started screening every inmate for opioid use disorder and offering counseling and medication in 2016. California's Department of Health Care Services is funding the expansion of medication treatment for opioid addiction in the corrections system in 22 counties. The federal prison system is gradually coming around, too. In December, President Donald Trump signed the First Step Act, a criminal justice reform bill, into law. The law includes a mandate that the federal prison system expand evidence-based treatment for opioid dependence, including both medication and what the law calls "holistic" approaches.

A more well-established route is to usher people with substance use disorder out of the regular court system and into drug courts, where a judge supervises every aspect of treatment and recovery, These courts are popular because they reduce recidivism and cost less than the standard court-andcorrections process, Dakof says. The first drug court was established in Miami in 1989, and there are now more than 3,000 nationwide.

But drug courts don't always implement the best evidence-based treatments, Dakof says. Very few, for example, implement MDFT or MST for juveniles, even though those approaches have some of the best evidence for the longestlasting effects.

Because high-quality service is key to a successful drug court, psychologists can play important roles in them, and not just in treatment, says Richard Wiener, PhD, a professor of psychology at the University of Nebraska-Lincoln.

"It's getting to the point now where people are thinking about accountability issues and professionalization in drug courts. There is a major role for psychologists, and in fact, the organizational and research role may be the most prominent," Wiener says.

Wiener is now involved in drafting standards for Nebraska's mental health courts, an expansion of the drug-court model. Besides writing standards, he says, psychologists can help teach lawyers, who are trained to defend their clients, to instead think about the best way to get them treatment and services.

"There is an effort to look at things like education, housing, employment, social support, social security and insurance," Wiener says. "It's not just the substance use problem and mental health problems. It's a social service agenda of things people need in order to be successful."



Your trusted partner for integrated addiction and mental health treatment.

> We're working toward the same mission. Let's work together.

877-238-5958

How we invest in mental health professionals

Conferences

White Papers

Recovery Unscripted **Podcast**

Free Educational Webinars

For More Information: Foundations Recovery Network.com

THE STIGMA THAT UNDERMINES CARE

Psychologists are working to tear down the stereotypes and biased language that foster discrimination against those with opioid and other substance use disorders

BY ZARA GREENBAUM

n paper, Robert Ashford, MSW, has a bright future: He's a doctoral student in health policy and a graduate research assistant at the Substance Use Disorders Institute at the University of the Sciences in Philadelphia. In reality, he has had to overcome many obstacles and continues to face many more. As a person in recovery from a substance use disorder since 2013, Ashford has faced housing discrimination and barriers to accessing and financing his education.

¶"All of my research and advocacy work draws on my lived experience with a substance use disorder and the discrimination and bias I've faced over the last six years," he says.

These and other discriminatory practices are rooted in stereotypes of people with opioid use disorder. This population is often seen as criminals, poor employees and lacking a moral compass. Not only do such biased attitudes fuel unfair treatment toward people who use substances, they can also undermine health-seeking behaviors (Brener, L., *Drug and Alcohol Review*, Vol. 29, No. 5, 2010).

"People who feel more stigmatized are less likely to seek treatment, even if they have the same level of addiction severity," says John Kelly, PhD, founder and director of the Recovery Research Institute at Massachusetts General Hospital in Boston and associate professor of addiction medicine at Harvard Medical School. "They're also more likely to drop out of treatment if they feel stigmatized and ashamed."

As part of a broader effort to spread destigmatizing messages, psychologists are studying stigmas among various populations, getting involved with policy efforts and educating the public about addiction. "There are roughly 22 million people in recovery for substance use disorders in the United States, but you may not even know that your colleague or neighbor is one of them because of the high degree of stigma," Ashford says. "We shouldn't have to live in a

society where people can't disclose their history of addiction."

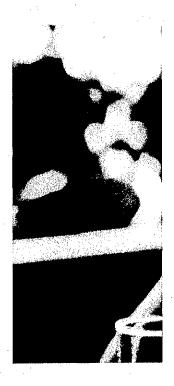
LANGUAGE, IDENTITY AND STIGMA

The stigma against substance use runs deep. It's embedded even in the language we use to describe it, which is often medically inaccurate and can do more harm than good (see sidebar on page 48).

For example, the commonly used terms "drug abuse" and "drug abuser" carry an implicit association with physical, sexual or emotional abuse.

"This gives rise to the idea that people with addiction are willfully and maliciously engaging in substance misuse, when in reality they have lost the choice of use," says David Eddie, PhD, clinical psychologist and research scientist at Massachusetts General Hospital's Recovery Research Institute.

In a study, Kelly found that physicians and clinical psychologists exposed to the term "substance abuser" in a vignette were more likely to blame a hypothetical patient for his or her condition than were those exposed to the phrase "having a substance use disorder." Clinicians



People who feel more stigmatized are less likely to seek treatment and also more likely to drop out of treatment, research finds.





in the first group were also more likely to say that punishment was required as opposed to treatment (International Journal of Drug Policy, Vol. 21, No. 3, 2010).

"Words matter—the words we use convey what's normal and frame how clinicians, health professionals and society at large view a problem," says Howard Koh, MD, MPH, a professor in Harvard's T.H. Chan School of Public Health and former assistant secretary for health at the U.S. Department of Health and Human Services, "If we don't choose our words carefully, we perpetuate bias, cloud understanding and end up distancing ourselves from the people we want to help."

As a result of research by Kelly and others, Michael Botticelli. director of the White House Office of National Drug Control Policy during the Obama administration, initiated changes in language use at the federal level. In 2015, the International Society of Addiction Journal Editors also agreed to remove the terms "abuse" and "abuser" from addiction journals around the world, and in 2017, the Associated Press recommended that journalists use nonstigmatizing language when reporting on substance use disorders.

Other research has explored how stereotypes about addiction interact with racial, gender and other biases to affect different

FURTHER READING

Changing the Language of Addiction Botticelli, M.P., & Koh, H.K. JAMA, 2016

The **ADDICTIONary** Recovery Research Institute, 2016

groups in different ways, For example, Kimberly Goodyear, PhD, and colleagues conducted a nationwide survey of more than 2,600 people, using vignettes to measure stigmatizing attitudes, and found that males and individuals who started using opioids not prescribed by their doctors were rated more negatively (Drug and Alcohol Dependence, Vol. 185, 2018).

Stigma even exists within the recovery community. Compared with those in abstinence-based recovery programs, people who rely on safe injection sites or medications such as methadone and buprenorphine in their treatment are viewed by others in recovery as not being truly sober, says Kelly, even though such treatments significantly reduce overdoses and cravings and increase the chances of remission.

HOW PSYCHOLOGISTS CAN HELP

Studies also indicate that the public understanding of addiction, while not entirely accurate, may be more nuanced than previously thought. A survey of 1,300 community college students and administrators. conducted by Ashford and his colleagues, found that many Americans believe that addiction is both a disease and a moral failing (Substance Use & Misuse, in review). "We need to better understand how people conceptualize this problem so we can develop health messaging that can both reduce stigma and support evidence-based practices," Ashford says.

Moving forward, psychologists can continue to study—and use—medically accurate language around opioid use disorder. They can also promote the use of nonstigmatizing language among health-care providers, politicians, journalists, law-enforcement officers and other groups involved with the opioid crisis.

More extensive education in medical schools and psychology doctoral programs around the genetic and neurobiological bases of addiction can also increase compassion, reduce blame and cut back on discriminatory practices among health-care providers, Kelly says. For example, research shows that genetics account for roughly half of a person's addiction risk, while chronic exposure to opioids leads to measurable changes in brain activity and structure.

And perhaps most important, psychologists—especially those who work with people recovering from addiction—can help redefine what recovery looks like by providing what Kelly calls "personal witness" to addiction and recovery. This

may include inviting people in recovery to speak to faculty, staff or patients or partnering with a national anti-stigma effort such as Faces and Voices of Recovery, which uses online networking to strengthen the recovery community.

"To fight these stigmas, we first need to normalize the process of recovery, providing positive examples of what recovery looks like," Kelly says. "When people see that up close, their stereotypes begin to break down."

PREVENTING STIGMA HOW TO TALK ABOUT ADDICTION

sychologists who study stigmas around opioid use say that the scientific community can help dismantle unfair stereotypes by correcting language in clinical and research settings.

"Language that's medically accurate will ultimately trickle down into mainstream media and popular culture," says David Eddie, PhD, clinical psychologist and research scientist at the Recovery Research Institute at Massachusetts General Hospital in Roston.

Here are examples of stigmatizing language to avoid and alternative terms to use.

■ "Drug abuse" and "drug abuser".

Research by John Kelly, PhD, founder and director of the Recovery Research Institute, suggests that clinicians show increased bias toward patients described as "drug abusers." Instead, Kelly recommends using the terms "substance use" and "person with a

substance use disorder."

"We don't speak this way about other health conditions, so we shouldn't speak this way about addiction," he says. For example, we refer to people with eating-related problems as having an eating disorder rather than being food abusers.

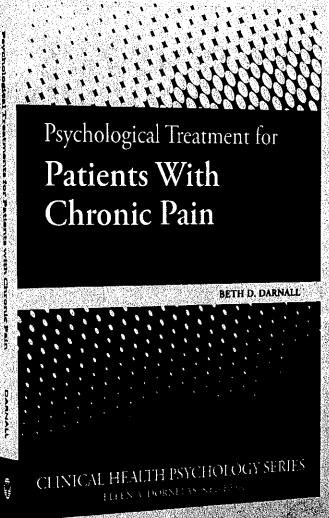
■ "Addict," "alcoholic" and "user"
The terms "addict," "alcoholic" and
"user" define people solely by their
behavior around substances, implying
that other aspects of their identities
are insignificant. Psychologists should
avoid these words and instead use
person-first language to describe
patients or research participants. Terms
such as "person with a substance use
disorder" or "person in recovery" are
less stigmatizing and more accurate.

"Clean" and "dirty"

For decades, clinicians have used the words "clean" and "dirty" to describe both individuals and the results of their

drug screen tests. Howard Koh, MD, MPH, a professor in Harvard's T.H. Chan School of Public Health, urges providers to forgo such language. Drug screens should be described as "positive" or "negative" and patients as "in recovery," "abstinent" or "resuming use of a substance."

■ "Medication-assisted treatment" Even the term *medication-assisted treatment," which describes rehabilitation involving medications such as methadone and buprenorphine, is often misinterpreted and can worsen stigmas around opioid use, says Kelly. The use of such language to describe treatment for addiction—but not for the thousands of other health conditions treated with medications-reinforces the misconception that those who rely on such treatments have simply developed a "replacement addiction." A good alternative is to refer to these substances as "medications for addiction treatment."



Get FREE domestic shipping when you order from the APA online bookstore, plus an exclusive 25% discount for APA members

Clinical Health Psychology Series

Psychological Treatments for Patients With Chronic Pain

Beth Darnall

This book provides a comprehensive overview of using evidence-based therapies to treat patients with chronic pain. Taking a multidisciplinary approach, Darnall shows mental health professionals how to utilize mindfulness interventions, hypnosis, and biofeedback. She also addresses comorbid problems such as depression, anxiety, and insomnia. Included are compelling case studies, and resources for clinical and patient training.

2019 | 193 pages | Paperback ISBN 978-1-4338-2942-0 | Item # 4317497 List \$54.99 / APA Member \$41.24

PREVENTION AS THE FIRST LINE OF DEFENSE

By teaching people to manage pain without opioids, psychologists are helping to prevent those at risk from sliding into misuse

BY ZARA GREENBAUM

mericans make up less than 5 percent of the world's population but consume nearly one-third of the global opioid supply, according to an expert group affiliated with the United Nations, the International Narcotics

Control Board. Much of that consumption is misuse: Data from the U.S. Substance Abuse and Mental Health Services Administration show that 11.8 million Americans currently misuse opioids. ¶ Often, that misuse stems from patients seeking to relieve physical pain by taking more medication than prescribed by their physicians, taking someone else's medication or purchasing substances on the black market, according

to the 2016 National Survey on Drug Use and Health. But physical pain alone does not predict opioid misuse—and other common reasons for misuse include using drugs to relieve tension, to feel good or to help with negative emotions, according to the survey.

"When we compare people who misuse opioids to people who take them as prescribed, there's no significant difference in their physical pain levels," says Eric Garland, PhD, LCSW, director of the Center on Mindfulness and Integrative Health Intervention Development at the University of Utah. "What does discriminate these patients is their emotional pain. That's what seems to be driving this problem."

In fact, the biggest predictors of opioid misuse are existing mental health issues, which is one reason the scientific literature has dubbed opioid use disorder a "disease of despair." People who have experienced trauma, received a depression or anxiety diagnosis, or have a personal or family history of substance use disorder are at greatest risk. Other predictors include being younger, heavy tobacco use and engaging in risk-taking behavior, according to research by Lynn R. Webster, MD (Anesthesia & Analgesia, Vol. 125, No. 5, 2017).

Those findings point to the essential role psychologists can play in preventing opioid misuse, not only by diagnosing and

U.S. OPIOID USE BY THE NUMBERS

11.8 million
Number of
Americans who
misuse opioids

17
Percentage
of the U.S.
population that
was prescribed an
opioid in 2017

One-third
The amount of
the world's opioid
supply used by
Americans, even
though they make
up only 5 percent
of the global
population

treating mental health issues that precede what some providers call "chemical coping," but also by offering nonpharmacological strategies for treating physical pain. A growing body of research supports psychological interventions that are less expensive than, less risky than and often just as effective as opioids for treating pain.

Unless we embrace the prevention approach, the opioid crisis will persist, says Howard Koh, MD, MPH, a professor in Harvard's T.H. Chan School of Public Health and former assistant secretary for health at the U.S. Department of Health and Human Services. "Although we've seen more attention on the opioid epidemic in recent years, there's still very little focus on prevention," he says.

That's why psychologists are working to promote and expand their roles in the opioid crisis by developing, testing and administering pain management strategies that reduce reliance on opioids.

UNDERLYING ISSUES

Opioid use disorder (OUD), which affects 2.1 million Americans, involves chronic opioid The greatest predictor
of opioid misuse is
mental health issues,
particularly among those
who have experienced
trauma, received a
depression or anxiety
diagnosis, or have
a personal or family
history of substance use
disorder.

misuse and is marked by physical tolerance of the drug, withdrawal symptoms when usage is stopped, and the disruption of daily life, according to the Diagnostic and Statistical Manual of Mental Disorders, OUD has two distinct etiologies, each with its own implications for prevention, according to research by Daniel Bruns, PsyD, a clinical health psychologist in Greeley, Colorado, who studied drug risk in more than 3,000 community members and patients in treatment for pain across 36 states (BHI 2 Medical Intervention Risk Report Manual, 2016).

One at-risk group follows what Bruns calls a more traditional pattern of substance use—they are more likely to have engaged in illegal behavior, show greater impulsivity and have a high likelihood of having experienced childhood trauma. These individuals are more likely to use illicit substances or to obtain prescription medications illegally. For this group, a key path to prevention requires psychologists to help patients address underlying mental and behavioral health issues before they begin to self-medicate with substances, says Bruns.

The second at-risk group Bruns identified is patients who have coped badly with a painful illness or injury. "In this case, the opioid use of these high-risk patients has been sanctioned by society," he says. "These patients are often stunned when they become dependent on opioids after simply following the instructions of a physician."

Preventing misuse and addiction among this second

COGNITIVE-BEHAVIORAL THERAPY IS BEING USED SUCCESSFULLY TO HELP PEOPLE MANAGE PAIN WITHOUT OPIOIDS AS WELL AS TO WEAN PEOPLE IN PAIN OFF OPIOIDS.

group—which Bruns says contributes a substantial portion to today's opioid problem—requires a better understanding of which patients can benefit from opioids, which are at risk for misusing them and alternative methods for treating pain.

Opioids block pain signals, which is useful for treating acute pain, but the drugs become less effective over time as patients build up tolerance. With an estimated 50 million Americans living with chronic pain—defined as pain lasting more than three months—U.S. physicians have relied heavily on opioids, prescribing them to more than 17 percent of the U.S. population in 2017, according to the Centers for Disease Control and Prevention.

One of the ways psychologists are advancing prevention of opioid misuse is by creating and administering psychological assessments that predict which patients are at risk for misuse and addiction.

"There are huge individual differences in how people perceive, react to and handle pain, which is why it's important to evaluate patients before we start prescribing opioids," says Robert Jamison, PhD, professor of anesthesia and pain management at Harvard Medical School and

KEY POINTS

.1 .wt

People who have experienced trauma, received a depression or anxiety diagnosis, or have a personal or family history of substance use disorder are at greatest risk for opioid use disorder. Other predictors include being younger, heavy tobacco use and risk-taking behavior.

One of the ways psychologists are advancing prevention of opioid misuse is by creating and administering psychological assessments that predict which patients are at risk for misuse and addiction.

Psychologists are deploying new outreach strategies and technologies to reach more people at risk of opioid misuse.

a pain psychologist at Brigham and Women's Hospital's Pain Management Center. He and his team have developed a series of validated risk assessment scales that are now widely used in studies and pain clinics around the country (see article on page 56 for more on these assessments).

Patients who "catastrophize" about pain, or ruminate on and magnify it, are particularly at risk because they may use opioids to manage their mood as well as the pain itself, says Jamison.

Psychologists can help by teaching people how to reduce that catastrophizing.

"If people are very fearful about pain, if they're saying things to themselves like, 'My life is over, I can't do anything because of pain,' that fear sets off alarm systems in the brain," says Jeannie Sperry, PhD, a pain psychologist at the Mayo Clinic's Pain Rehabilitation Center in Rochester, Minnesota.

To help reduce pain catastrophizing, Sperry provides psychoeducation about pain to patients who enter the clinic's three-week intensive outpatient program. She teaches people with chronic pain from conditions such as fibromyalgia, amputations and Parkinson's disease that their experience of pain does not correlate



with actual tissue damage.

Psychological interventions can help people treat pain without medication because of the way the brain processes pain signals: When a person is injured physically, sensory signals travel from the body to the thalamus and are then sent to several other brain areas associated with the subjective experience of pain. But the prefrontal cortex can modulate how the thalamus relays such signals, changing the way pain is perceived.

"By stimulating top-down control from the prefrontal cortex, psychological interventions can improve people's ability to cope with pain," says Garland. "When effective, these therapies can even decrease the pain itself."

The most commonly usedand best studied—psychological

treatment for pain is cognitivebehavioral therapy (CBT), which practitioners like Bruns and Sperry use to help wean patients off opioids and prevent others from taking them in the first place. Cognitive therapy addresses how people think about their pain, for instance by teaching them to use noncatastrophizing language, while behavioral strategies help patients interrupt negative thought patterns and encourage them to resume activities they may previously have avoided, such as climbing stairs after a back injury.

Research shows that CBT improves mood and positive function, with numerous studies demonstrating its ability to reduce both pain and catastrophizing (American Psychologist,

Opioids treat pain by blocking pain signals, but the drugs become less effective over time as patients build up tolerance.

Vol. 69, No. 2, 2014). One study by David Seminowicz, PhD, and his colleagues at the University of Maryland, Baltimore's Center to Advance Chronic Pain Research even indicated that CBT can lead to increases in the volume of the prefrontal cortex and other brain regions involved with modulating the experience of pain (Journal of Pain, Vol. 14, No. 12, 2013).

Other psychological interventions shown to be effective for pain management include acceptance and commitment therapy, a variation of CBT that incorporates acceptance of pain and commitment to behavior change; biofeedback, which helps patients gain a better understanding of their physical state; and hypnosis. Jamison is even starting to design interventions that employ virtual reality,

gamification and voice and facial recognition to better assess mood and teach patients to relax.

Psychologists are also increasingly using mindfulness therapies to treat chronic pain. Building on his research on emotional regulation deficits in people who misuse opioids, Garland developed Mindfulness-Oriented Recovery Enhancement (MORE), a series of eight two-hour sessions to help treat pain and reduce dependence on opioids.

"The labeling of OUD as a 'disease of despair' in the scientific literature isn't just a metaphor," Garland says. "Chronic pain patients who misuse opioids actually have abnormally high rates of anhedonia—their brains and bodies are blunted to the experience of natural pleasure, joy and meaning in life."

MORE teaches patients coping strategies such as practicing three minutes of mindful breathing before each dose of opioids. The intervention has been shown to increase physiological responses to natural pleasure, including heart rate variability and electrophysiological response, which predict decreases in opioid cravings and misuse (Journal of Behavioral Medicine, Vol. 38, No. 2, 2015).

OUTREACH AS PREVENTION

Beyond administering psychological assessments and interventions in the clinic, psychologists are deploying new outreach strategies and technologies to reach more people at risk of opioid misuse.

"Tens of millions of Americans live in isolated areas without ADDITIONAL READING

Psychological Treatment for Patients With Chronic Pain Darnall, B.D. APA Books, 2018

Neurobiologic Advances From the Brain Disease Model of Addiction Volkow, N.D., et al. New England Journal of Medicine, 2016

Contributions of Psychology to the Understanding and Treatment of Chronic Pain: Why It Matters to ALL Psychologists Jensen, M.P., & Turk, D.C. American Psychologist, 2014

Managing Chronic Pain: How Psychologists Can Help With Pain Management APA, 2013 access to pain psychologists," says Robert Edwards, PhD, associate professor of anesthesia at Harvard Medical School and a pain psychologist at Brigham and Women's Hospital's Pain Management Center. "We can reach many more people if we make our assessment tools and interventions available via telepsychology and smartphone applications."

Edwards and Jamison developed a five-question self-report scale, delivered daily to patients via a mobile application, that can identify people at risk for misusing opioids in just five days (see assessments article on page 56). The instrument helps fill a data gap on how patients are faring.

"Patients may see their provider periodically, but we often lack information about their moods and behaviors between visits," Jamison says.

Cross-disciplinary collaboration among health-care providers is also key for effectively treating pain, says Sperry. The pain management program at the Mayo Clinic, for instance, is staffed with an addiction psychiatrist, a pain psychologist, a physical therapist, an occupational therapist, a nurse, a pharmacist and a chaplain. Patients practice Tai Chi, yoga and relaxation each day in addition to attending several hours of rehabilitation and pain management classes. This sort of integrative care helps pain patients learn long-term coping strategies and taper off high doses of opioids, and has been shown to reduce depression and pain catastrophizing (Journal of Pain, Vol. 19, No. 6, 2018).

Integrative chronic pain

management programs that include psychologists are not only more effective than solely medical approaches; they also save money. After Bruns helped develop and pass the Colorado Chronic Pain Guidelines, statewide regulations for treating pain in workers' compensation cases, he measured the results of regularly replacing surgery with psychological interventions.

"Compared to certain spinal surgeries for pain, studies show that CBT is equally effective, while surgery is much riskier and costs about 168 times more," Bruns says. Colorado's annual medical costs for workers' compensation dropped as much as \$859 million after the pain guidelines were implemented in 1992 (Rehabilitation Psychology, Vol. 57, No. 2, 2012). And an analysis of the Mayo Clinic's pain rehabilitation program. in Jacksonville, Florida, by Christopher D. Sletten, PhD, and colleagues, revealed a 90 percent drop in health-care costs 18 months post-treatment (Pain Medicine, Vol. 16, No. 5, 2015).

CULTURAL SHIFT

As helpful as psychological interventions are for preventing opioid misuse, experts say widespread adoption of such treatments requires a broader cultural shift toward a biopsychosocial treatment model.

"If you watch TV, it looks like there's a pill for everything," Sperry says. "Instead of promoting drugs to treat pain, unhappiness or sleep problems, we should be teaching people how their brains and bodies work together from a young age,"





via teachers, pediatricians and parent education.

More extensive education is also needed for both psychologists and physicians, who currently receive no systematic training in pain management. In a national survey, more than half of psychology practitioners polled said they did not have adequate training to treat individuals experiencing pain (Pain Medicine, Vol. 17, No. 2, 2016).

"When therapists don't feel competent in a certain area, they avoid it," says Beth Darnall, PhD, clinical professor in the department of anesthesiology, perioperative and pain medicine at Stanford University and lead author of the study. "Psychologists aren't going to ask people about their pain if they feel they have nothing to offer," which is

problematic because a high percentage of patients seeking help for mental health issues are also experiencing pain.

To help train psychologists in pain management, APA published Darnall's book "Psychological Treatment for Patients With Chronic Pain" and is developing an online continuing-education module in pain psychology, Darnall also created a single-session pain psychology class (Journal of Pain Research, Vol. 7, 2014) and offers certification workshops to clinicians who hope to gain foundational knowledge and training in the area.

As researchers continue to amass data on opioid misuse, pain and treatment approaches, psychologists and other healthcare providers can develop tools Integrative pain care is an important alternative to opioids. Patients at the Mayo Clinic, for instance. participate in Tai Chi, yoga and relaxation each day as well as rehabilitation and pain management classes.

to prescribe personalized interventions for managing pain.

"Using a combination of brain imaging, genetics and patient self-reports, we can begin to create algorithms that prescribe each patient the optimal combination of treatments as quickly as possible," Edwards says, which may include medications, psychological treatments or a combination of both. Ultimately, this personalized, integrative approach can reduce dependence on opioids, especially in cases where they're likely to be misused.

"When we know that pain is multidimensional and multidetermined, to only prescribe one modality is doomed to fail," says Sperry. "Prescribing only medication for chronic pain is highly likely to be ineffective."■.

WHO NEEDS OPIOIDS?

Psychologist-developed screening instruments help determine which pain patients should receive opioids and which are at risk for misuse

BY REBECCA A. CLAY

ust five days' worth of data collected via a new smartphone app is all it takes to identify people who "catastrophize" their pain and may thus be at risk for future opioid misuse, says Robert Jamison, PhD, chief psychologist at the Pain Management Center at Brigham and Women's Hospital (BWH). ¶ In a study conducted by Jamison and colleagues, participants used the BWH PainApp each day to rate their moods, the intensity of their pain, whether it interfered with activity or sleep, and whether their situations had improved, gotten worse or stayed the same over the past 24 hours (Journal of Pain, Vol. 20, No. 3, 2019). That last question is an extremely effective way to identify

people who indulge in recurrent worries about what might happen, says Jamison. "These people tend not to do well despite any attempts to help their pain," he says. But thanks to the app's two-way messaging feature, psychologists or other providers can intervene with relaxation exercises, cognitive-behavioral therapy or other approaches to pain management.

While the BWH PainApp is an example of a new tool psychologists have developed to assess risk of opioid misuse, psychologists are also using classic assessments in new ways to respond to the opioid epidemic. For example, the Minnesota Multiphasic Person-

ality Inventory-2-Restructured Form (MMPI-2-RF) and the Millon Behavioral Medicine Diagnostic (MBMD) can help assess whether patients are psychologically ready for potentially painful procedures, such as spinal or bariatric surgeries. In addition, Pearson's Battery for Health Improvement 2 (BHI-2) can identify factors that may impede recovery from pain.

"Depression, for example, can very much affect a person's recovery," says Paul Williams, PsyD, a health-care solutions analyst at Pearson Clinical Assessment. "If you're already depressed, go through a procedure and come out even more depressed because now you're

SOME KEY ASSESSMENTS

Screener and Opioid Assessment for Patients in Pain

or Patients in Pail
Helps determine
whether opioid
therapy is
appropriate

Minnesota Multiphasic Personality Inventory-2-Restructured Form and

Millon Behavioral Medicine Diagnostic

Help determine whether patients are psychologically ready for potentially painful procedures

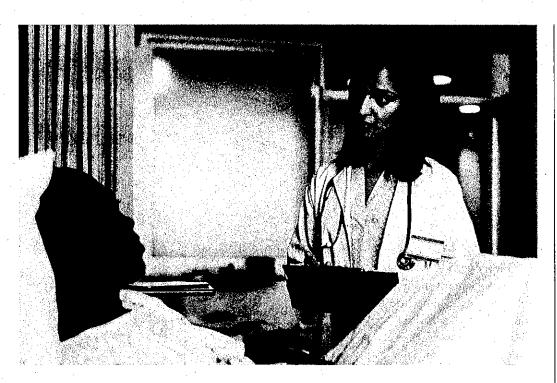
Pearson's
Battery for Health
Improvement 2
Can identify factors
that may impede
recovery from pain

in pain, the symptoms of depression—pessimism, loss of interest and drive, low energy, low appetite—aren't good for recovery." Other issues that may warrant presurgical intervention by a psychologist include anxiety, a tendency to avoid problems, sedentariness that may prevent physical therapy and a lack of social support, he adds.

Another widely used assessment, the Screener and Opioid Assessment for Patients in Pain (SOAPP)—and an updated version called the SOAPP-Rhelps physicians and psychologists determine whether opioid therapy is appropriate. Developed by psychologist Stephen Butler, PhD, Jamison and colleagues, the assessment evaluates patients' mood-related traits, such as mood swings, tension in the home and boredom, and looks at past behaviors that might hint at potential opioid misuse, such as running out of medications early or having had previous legal problems or arrests. A sister survey, the Current Opioid Misuse Measure (COMM), assesses risky behaviors over the past month, such as how often the patient struggled to control his or her anger.

Psychologists and physicians can use the SOAPP and the COMM, along with a patient's personal and family history of mental health issues, to determine when it is safe to prescribe opioids. These tools also help ensure that objective assessment data rather than physicians' own biases drive decision-making when it comes to treating patients in pain and deciding when, to whom and how to





prescribe opioids, says Butler, now a consultant to Inflexxion, an integrated behavioral health company that offers free, webbased versions of the SOAPP and the COMM as part of a clinical evaluation system for pain patients. (The system is available at www.paincas.com/ Account/RegisterFreeOrg.)

These often-unconscious biases can leave some populations undertreated for their pain, says pain specialist Beverly E. Thorn, PhD, ABPP, a professor emerita of psychology at the University of Alabama, who explains that physicians often "bump down" patients' selfreported pain if they've had the pain for a long time or are members of certain groups. "For African Americans, the bias is they're going to misuse medications or they're going to sell their medications," says Thorn.

"For women, the bias is that women are more hypochondriacal and more complaining, And people have said to my Hispanic patients, You're not going to be able to afford these medications, so I'm not going to prescribe them for you."

Once patients are prescribed opioids, Jamison's Opioid Compliance Checklist can help clinicians monitor their patients' adherence to their prescribed regimens and identify patients who may be misusing opioids or be at risk of misusing them in the future (Journal of Pain, Vol. 17, No. 4, 2016). The checklist asks whether patients have lost their medication, missed medical appointments or used illegal substances, for example.

Other assessment tools focus on patients who have already developed problems with opioid misuse, including Too often. providers do not use any assessments. a problem psychologists are working to fix.

the Substance Abuse Subtle Screening Inventory (SASSI-4), which can identify even clients who are unable or unwilling to acknowledge that they have a problem, And Pearson's Quality of Life Inventory (QOLI) can help clinicians and patients track progress in such areas as health, self-esteem, relationships and overall well-being, "It's not looking for deficits like pain or anguish; it's on the positive psychology side," says Williams. "It's very motivating."

Unfortunately, many clinicians don't use any assessments, says Butler. Whether the problem is clinicians' reliance on their own instincts or a reluctance to change work flows, "we've found it can be really difficult to get doctors and their nurses to use these assessments," he says. To help overcome that challenge, Butler and other psychologists are working to shorten and computerize assessments. A new version of the SOAPP developed by Butler, Tamison and other researchers, for instance, reduces the number of questions from the original 24 down to just eight without losing its effectiveness (Pain Medicine, Vol. 19, No. 10, 2018).

But there are still major gaps in the research on pain assessment, psychologists say. There's no way to differentiate between someone whose pain is genuinely undertreated and someone who just wants drugs, for example. Another ongoing dilemma is how to measure outcomes when it comes to chronic pain, "Almost by definition, chronic pain is not expected to get better, so, what does a good outcome look like?" asks Butler.

TRAINING FRONT-LINE PSYCHOLOGISTS

Want to help address the opioid epidemic but need more expertise? Here's where to update and expand your skills.

BY REBECCA A. CLAY

hen psychology interns and postdoctoral fellows show up to work with R. Kathryn McHugh, PhD, an associate psychologist in McLean Hospital's substance use disorders division, she's often surprised by how little preparation they've received to work with the patients they'll be seeing. ¶"It's not unusual to see people who are done with most of their training but still haven't seen a single person with substance use disorder," says McHugh, who's also an assistant professor of psychology at Harvard Medical School. "That's not OK." ¶ For most psychologists, says McHugh, training on substance use disorders consists of a single lecture in an abnormal psychology class.

In programs where several faculty members focus on addiction, however, students typically get a good grounding in the topic as a routine part of their training. According to Katie Witkiewitz, PhD, a past president of APA's Div. 50 (Society of Addiction Psychology), schools offering top programs in this area include the University of New Mexico; the University of Missouri; Syracuse University; the University of California, San Diego; San Diego State University; the University of California, Berkeley; the University of Washington; Arizona State University; the University of California, Los Angeles; and

the University of Florida. Other excellent training programs include those at the University of California, San Francisco, and Johns Hopkins University, adds Nancy A. Piotrowski, PhD, Div. 50's federal advocacy coordinator.

While training for the next generation of psychologists is still catching up to the realities of the opioid epidemic, continuing education (CE) is an important avenue for bringing the existing workforce up to date. Div. 50 offers several CE options for psychologists who want to know the latest evidence-based practices as well as how to screen for problems, says Jessica L. Martin, PhD, who chairs the

division's Education & Training/ CE committee.

To help those practitioners, Div. 50 typically offers CE courses at APA's Annual Convention, which will take place this year Aug. 8–11 in Chicago (go to https://convention.apa.org).

Div. 50 also holds its own annual meeting each spring: The Collaborative Perspectives on Addiction meeting offers CE programs on the latest clinical advances and scientific research across the addiction field (see www.addictionpsychology.org/cpa for more information).

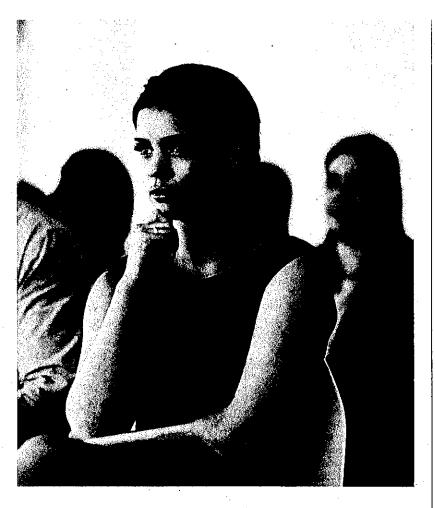
In addition, the division offers clinical teleconferences on cognitive-behavioral approaches to opioid use disorders as well as other topics (see www.addictionpsychology.org/education-training/conference-calls).

APA offers its own CE options on opioid use and other addictions. Topics include treating opioid use disorders and preventing overdoses, identifying and managing patients with co-occurring chronic pain, and more general overviews of substance use disorders and treatment. (To



Psychologists can get CE on opioid prevention, screening and treatment through APA and Div. 50 (Society of Addiction Psychology.)





access them, go to www.apa.org/ education/ce/topic and click on "addiction.")

In addition, APA offers CE programs on non-opioid treatment of pain (go to www. apa.org/education/ce/topic and search for "pain").

For psychologists who want to demonstrate that they already have proficiency in treating substance use disorders, NAADAC, the Association for Addiction Professionals, offers a master addiction counselor certification program. Designed to help psychologists and other practitioners position themselves as

specialists and thus boost their salaries and potential career advancement, the credential recognizes expertise gained via graduate-level coursework and supervised work experience. Among other requirements, the credential requires a minimum of 6,000 hours of supervised experience in substance use counseling, 500 hours of education and training on substance use disorders and a passing score on the National Certification Commission for Addiction Professionals exam or an equivalent. (See www.naadac.org/mac for details.) ■

ADDICTION TREATMENT **EDUCATING OTHER PROVIDERS**

sychologists are also helping to ensure that today's nonpsychologist addiction workforce is up to date on evidence-based practices. Among them is Rachel Winograd, PhD, a research associate professor at the Missouri Institute of Mental Health, University of Missouri-St. Louis.

With a project called Missouri Opioid-Heroin Overdose Prevention and Education, Winograd is combating myths about naloxone, including the belief that it encourages opioid use. The curriculum Winograd and her team created for emergency responders, social service providers and the public replaces the traditional focus on abstinence with a focus on harm reduction.

In another project, Winograd is promoting a Medication First model that seeks to eliminate barriers to rapid access to medications for addiction treatment. Her team has already trained 15,000-plus counselors, social workers, case managers, peers, physicians, nurses and administrators and treated 4,000 individuals. According to preliminary data, clients served by such professionals are more likely to get medication and stay in treatment longer. Median monthly treatment costs are down 19 percent.

Other psychologists are investigating the best way to train the addiction workforce. As director of the Substance Abuse and Mental Health Services Administration-funded New England Addiction Technology Transfer Center, Sara Becker, PhD, trains psychologists, social workers, physicians and other addiction treatment providers with a model she calls the Science to Service Laboratory. This approach to training layers ongoing support including leadership coaching and performance. feedback—on top of didactic workshops.

Research by Becker and colleagues suggests that providers receiving this more comprehensive training are more likely to adopt evidence based interventions than are those who receive workshops alone (Substance Abuse, Vol. 37, No. 1, 2016).

CHANGING OPIOID POLICIES AND PRACTICES

Advocacy by APA and individual psychologists is tackling the opioid epidemic at the federal, state and local levels

BY REBECCA A. CLAY

ore funding for research on opioid addiction and improved prevention and treatment programs are among psychologists' advocacy priorities at the federal, state and local levels. ¶ At the federal level, advocates have won some major successes, including the launch of the National Institutes of Health's HEAL (Helping to End Addiction Long-term) initiative. The effort, which incorporates psychological approaches into its research plan, has nearly doubled funding for pain and opioid research, from \$600 million to \$1.1 billion, over two years. Advocates also secured expanded access to treatment, thanks to the enactment

of the SUPPORT (Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment) for Patients and Communities Act last fall. The SUPPORT Act requires state Medicaid programs to cover methadone and all other medications used to treat opioid use disorder beginning in 2020 and expands Medicare coverage to include telehealth services for substance use disorders. It also requires the Centers for Medicare and Medicaid Services to develop guidelines on non-opioid pain management for participating hospitals and state Medicaid programs. And it authorizes a demonstration project aimed at increasing

the number of substance use treatment providers through improved reimbursement rates and training.

Psychologists can play a key role in implementing the new law and making sure it fulfills its potential (see sidebar on page 62), says Nancy Piotrowski, PhD, federal advocacy coordinator for APA's Div. 50 (Society of Addiction Psychology). "There are lots of opportunities for psychologists to establish lines of funding for research, training and clinical services that address some of the systemic gaps that have existed in the health-care system," says Piotrowski. These new funding streams and programs also create opportunities

RECENT ACTION BY APA

Advocating to nearly double funding for pain and opioid research at the National Institutes of Health

Working to implement a new law that will expand treatment for opioid use disorder

Providing input to the President's Commission on Combating Drug Addiction and the Opioid Crisis for psychologists to use their skills in translating research findings for use in real-life settings and in evaluating outcomes.

APA has also been successful in nominating psychologists to serve in advisory roles in federal groups addressing the opioid epidemic and related issues. Mary Meagher, PhD, of Texas A&M University is now a member of the federal Pain Management Best Practices Inter-agency Task Force, which will develop recommendations for better addressing acute and chronic pain, for example. APA also provided input to the President's Commission on Combating Drug Addiction and the Opioid Crisis.

Meanwhile, raising awareness of the issue of substance use disorders among members of Congress and their staffs is a key priority for researcher Sandra Comer, PhD, public policy officer for the College on Problems of Drug Dependence, an organization for scientists focused on understanding addictive disorders and finding new treatments for them

"They often don't have a clear understanding of what substance





users face and what challenges they have," says Comer, a research scientist at the New York State Psychiatric Institute and professor of neurobiology at . Columbia University.

Another priority is convincing legislators to remove cumbersome barriers for researchers who study drugs of abuse. For example, last year the Drug Enforcement Agency changed the classification of illicit fentanyl analogueswhich, unlike fentanyl itself, have no known medical use-to Schedule 1. While this action was appropriate for protecting public health, says Comer, it makes it more difficult for scientists to study these compounds.

"That's a problem because it is critical that we understand the pharmacology of these drugs," says Comer. "We're trying to figure out more streamlined ways for scientists to do the research while at the same time ensuring proper controls on these substances."

Research with nonhuman primates is also critical, Comer told policymakers and staff at a congressional briefing APA co-sponsored with the Supporting Truth About Animal Research Coalition in March. "The Food and Drug Administration would never in a million years allow me to give synthetic fentanyl to human research volunteers," says Comer. "To

On the local level. psychologists are working with physicians to help ensure that only patients who truly need opioids get prescriptions for them.

understand how these drugs work, we have to rely on preclinical research."

At another congressional briefing sponsored by the Patient-Centered Outcomes Research Institute, psychologist Beth Darnall, PhD, a clinical professor of anesthesiology, perioperative and pain medicine at Stanford University School of Medicine, focused on what she calls "the dual crises of pain and opioids in America." Darnall described her research, which uses behavioral treatments to help pain patients taper their opioid use.

Other psychologists are advocating for change at the state level. In Connecticut, Traci Cipriano, JD, PhD, is taking several approaches in her advocacy. In addition to educating psychologists and physicians, she is working to ensure that the state's workers' compensation system follows its protocols for both medical and psychosocial treatments for chronic pain. Many physicians didn't know the protocols existed, says Cipriano, a private practitioner and an assistant clinical professor of psychiatry at Yale University School of Medicine, who is an adviser to the state's Workers' Compensation Commission. "My work is trying to get the word out," she says. In addition, Cipriano is working with policymakers, insurers and the Connecticut State Medical Society to explore policy options to improve interdisciplinary care for patients with opioid use disorder in ways that also reduce costs.

In Maryland, Carlo DiClemente, PhD, ABPP, a professor emeritus of psychology at the University of Maryland, Baltimore County, is among those urging the governor's Opioid Operational Command Center to distribute naloxone for treating overdoses and incorporate other harm-reduction strategies, such as offering clean needles.

Collaborating with other health-care professionals at the state level is key, says Paul Korte, PhD, the Missouri Psychological Association's federal advocacy coordinator. The association is working with physician groups and others to urge legislators to enact a statewide prescription drug monitoring program to help reduce misuse of drugs. "Missouri is the only state in the union that still doesn't have one," says Korte, explaining that such programs help prevent "doctor-

shopping" by those seeking inappropriate access to drugs. "It's just one more tool to help control prescription opioids," says Korte.

Access to health care more broadly is another priority in the states. The Ohio Psychological Association, for example, is fighting to protect the state's Medicaid expansion, which now covers almost 630,000 of the state's most vulnerable residents, including those with substance use problems. "For many of them, it's the first time they've had coverage of any type," says Michael Ranney, the association's CEO.

At a more local level, Aaron Weiner, PhD, ABPP, is advocating for change within Linden Oaks Behavioral Health, part of Edward-Elmhurst Health, a large integrated health-care system in Illinois, where he is

director of addiction services. By tracking opioid prescriptions, he found that physicians were overprescribing the drugs and that surgeons weren't customizing prescriptions. "I had one surgeon say, 'Whether it's a hip or a knee, a 110-pound woman or a 300-pound man, I give 160 tablets of narcotics post-operatively," says Weiner.

To ensure that physicians are writing prescriptions only for those who truly need opioids, Weiner worked with two dozen physicians to develop prescribing guidelines, drawing on those of the Centers for Disease Control and Prevention.

"A lot of what's going on with the epidemic right now focuses on the demand side for opioids," says Weiner. "From a health-care perspective, we need to take a hard look at the supply side."

CHANGING OPIOID POLICIES HOW YOU CAN GET INVOLVED

ant to get involved in opioid-related advocacy? Scott Barstow, director of congressional affairs for APA Services Inc., recommends that psychologists:

■ Learn more about what pain management and opioid treatment look like in your own community. Are there enough inpatient and outpatient treatment slots? Do patients have access to psychological services and the full range

of medications used for addiction treatment? Does Medicaid or private insurance cover such treatment?

- Start calling city council members, state legislators and other decision-makers after identifying gaps in treatment availability.
- Contact members of Congress to ask them to fund the programs established in last year's SUPPORT for Patients and Communities Act in this

year's appropriations bill.
"Only about one in four
Americans struggling with
opioids gets decent treatment, and many experts
believe new federal spending on the order of \$10
billion to \$20 billion per year
for the next several years is
needed to adequately ramp
up treatment," says Barstow.

■ Act locally, "A lot of the action is going to happen at the state level," says Barstow. State Medicaid agencies and substance use disorder agencies will be the focus of much activity, including decision-making regarding the use of any increases in federal funding of treatment, prevention and recovery programs, Barstow predicts. Also, 14 states have yet to implement Medicaid expansion, which has increased access to opioid use treatment significantly in the states that have adopted it, he says.

For more information, visit www.apa.org/advocacy/ substance-use.



Earn CE Credits at

APA2019

CHICAGO AUGUST 8-1

Choose from over **70** half-day (4-hour) or full-day (7-hour) CE Workshops that will add to your professional development and broaden your network.

11th Annual Distinguished Workshop Series

CBT FOR WEIGHT LOSS AND MAINTENANCE

Judith S. Beck, PhD

FRIDAY, AUGUST 9 6:00-8:50 p.m.

Demonstrate how to help dieters make changes to their thinking so they can maintain fundamental and long-lasting changes in their eating behavior.

Hors d'oeuvres and light refreshments will be served before the 3-credit workshop.

CONVENTION.APA.ORG/CE

For details and a full list of CE opportunities at APA 2019, see our CE Workshops brochure in May's APA *Monitor*.

CE workshop enrollment and CE session credits are priced separately from each other and from the convention registration fee.

Special 2019 Social Justice Track

The 2019 **Social Justice Track** features nine workshops dedicated to building bridges between **social justice**, **research**, and **practice**.





RESOURCES FOR PSYCHOLOGISTS

APA's cross-divisional resource guide offers practical advice to help psychologists respond to the opioid crisis

BY KIRSTEN WEIR

or clinicians who haven't trained in substance use disorders, it can seem overwhelming to figure out how to address the issue when it comes up with patients. In response, three APA divisions have developed a resource guide to help clinical psychologists respond to the opioid crisis. APA's "The Opioid Guide: A Resource Guide for Practicing Psychologists" was written by a cross-divisional task force of representatives from APA's Div. 12 (Society of Clinical Psychology), Div. 28 (Psychopharmacology and Substance Abuse) and Div. 50 (Society of Addiction Psychology). The guide is meant to be a practical handbook, says R. Kathryn McHugh, PhD, a psychologist

in the substance use disorders division at McLean Hospital, assistant professor of psychology at Harvard Medical School, and a co-author of the resource guide. "So many psychologists want to know, 'What do I do when...?" she says. "We wanted to create a really practical primer to help psychologists as they work with this population."

The guide covers a lot of ground, from understanding different types of opioids and recognizing their misuse to identifying evidence-based treatments and resources for family members of those with opioid use disorder. Here are some key takeaways from the guide.

■ Recognizing overdose risk.

"Opioid use disorder is highly fatal," says Sharon Walsh, PhD, a professor of behavioral science at the University of Kentucky College of Medicine and a co-author of the guide. "People can come into care and be doing well, and just one slip can be fatal." Risk factors for overdose include decreased tolerance due to recent reductions in use, mixing drugs, a history of overdose, physical illness, using different opioids that vary in strength, switching to injecting opioids and using drugs alone. Naloxone is a medication that reverses opioid overdose. It has no abuse potential and few side effects. In some locations, a prescription is

required for the drug. Clinicians should consider formal training in the use of naloxone, and counsel family members of opioid users to get training themselves (see article on page 58).

- Identifying misuse. Misuse of prescription opioids often leads to opioid use disorder. The earlier that opioid misuse is identified, the better the long-termprognosis. The guide's authors recommend that clinical psychologists ask all patients about opioid use with a simple screening question: "How many times in the past year have you used an illegal drug or a prescription medication for nonmedical reasons (for example, because of the experience or feeling it caused)?" Anyone who says they have done so even once should then be given a detailed screening to assess for problematic substance use.
- Evidence-based treatment programs. Outpatient treatments that include the medications buprenorphine, methadone or naltrexone are the most effective for opioid use disorder, Behavioral treatments



At a minimum, clinical psychologists should be able to identify opioid use disorder and know where to send people for evidence-based treatment. "The Opioid Guide" can help.





such as contingency management and cognitive-behavioral therapy, used in addition to medication, may improve medication adherence and address problems not treated by medication, such as interpersonal difficulties and stress. Psychologists who identify opioid misuse should refer patients to a substance use disorder treatment specialist, who can help to determine the right level of care based on the patient's needs and the severity of the problem. Higherquality treatment programs offer medication-assisted treatment, provide family support and are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by the Joint Commission or the Commission

on Accreditation of Rehabilitation Facilities. The guide offers resources for locating and evaluating local providers and programs.

■ Resources for families.

Research shows that involving family members in treatment can be helpful for people with substance use disorders, but accessing family-based services can be a challenge. Whether or not a person with opioid use disorder seeks treatment, his or her family members can suffer greatly. Psychologists can help them manage difficulties such as guilt, anger, shame, fear, financial challenges and confusion about setting limits. Psychologists can also help family members connect with support groups.

TO **DOWNLOAD**

The Opioid Guide: A Resource Guide for Practicing **Psychologists** www.apa.org/ advocacy/substance-use/ opioids/resources/ index

■ Social support groups. Mutual help groups may be useful for people with opioid use disorder. These groups can provide social support, reinforce recovery goals, teach skills that support recovery and provide structure and drug-free activities. However, some groups aren't welcoming to patients receiving medicationassisted therapy, since the use of the medications themselves is often stigmatized. By familiarizing themselves with support groups in their region, psychologists can help direct patients to groups that are most likely to be a good fit.

■ Cultural competencies.

Health-care disparities have implications for the assessment and treatment of opioid use

disorder. To address interactions among race, ethnicity, socioeconomic status, cultural context and geography, psychologists must first develop a working knowledge of possible treatment barriers among racial/ethnic minorities, with consideration of health-care system, provider and patient factors. Second, clinicians should assess patients' beliefs and expectancies regarding treatment for opioid use disorder. Finally, clinicians should deliver culturally appropriate care for opioid use disorder.

■ Misuse by adolescents.

Youth who misuse prescription opioids have a high risk

of transitioning to heroin use. The American Academy of Pediatrics recommends that all youth with a severe opioid use disorder be offered medication treatment in addition to behavioral therapy. Ideally, their families should be included in the treatment plan.

■ Managing chronic pain.

Millions of people are prescribed opioids for chronic pain. Several opioid risk assessment tools assess the risk of opioid misuse and dependence. These tools should be used with patients with chronic pain who are considering long-term opioid therapy. Nonpharmacological treatments are also recommended for people with chronic pain. The most widely studied and efficacious interventions for chronic pain include cognitive-behavioral therapy, acceptance and commitment therapy, exposure to feared movements, exercise, physical therapy and interdisciplinary rehabilitation.

■ Critical skills for clinicians.

Many clinical psychologists receive minimal training in substance use disorders, McHugh says, so it's not surprising that they may feel wary about treating people who are struggling with opioid misuse. Clinicians don't

need to be experts to make a difference, however. "It's unrealistic to think that the whole psychology workforce will specialize in this area or feel competent to offer these treatments themselves," she says.

But at a minimum, anyone working in mental health should be able to do two basic things, McHugh adds. "It's critical that people know how to identify opioid use disorder, and that they know where to send people for evidence-based treatments, if they can't manage it themselves. If we can check those two boxes, that would be a huge improvement over where we are now."

