

CONNECTIONS

The Newsletter for Addiction Professionals



President's Message

By Ron Chupp

LEADING THE WAY!

I want to personally thank all of you who attended the recent NAADAC National Addictions Conference in Indianapolis, entitled "Leading the Way." Kudos to all of the NAADAC staff and the IAAP staff and volunteers, who worked hand-in-hand to pull together a fantastic conference in such a short period of time, and made it such an overwhelming success. I also want to extend my gratitude to all of our state partners, including FSSA and Kevin Moore for their support, and to Tracy Jones at the Indiana Statehouse for helping to make our Rally for Recovery a rousing success!

The JW Marriott hotel was a perfect venue for the conference, and the hotel staff was the friendliest and most helpful I have ever encountered. The city of Indianapolis is an excellent conference site due to the proximity of great restaurants, museums, a zoo, shopping, Lucas Oil Stadium, Victory Field, the NCAA offices, and White River State Park, all within walking distance of the hotel—and the weather was perfect! The feedback I have received from conference attendees has been overwhelmingly positive, from the caliber of speakers NAADAC provided (Lisa Najavits, Carlo DiClemente, C.C. Nuckols, Dr. Harold Urschel, Rokelle Lerner, to name a few) to the city of Indianapolis, and the experience of Hoosier Hospitality displayed by our volunteers. For years, the IAAP tag line has been "Only Our Best", and I truly believe that the addictions profession was treated to our

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best at this conference. I left the conference with a deep sense of pride in our organization and our membership for providing such a positive experience for our guests.

I was also filled with pride as we filed into the Statehouse for the Rally for Recovery on Tuesday afternoon. I was proud to see the number of people who attended the rally to listen to and support the speakers. I enjoyed hearing Stewart Turner-Ball fire up the crowd. I was pleased to hear the speech from Secretary of State Connie Lawson who, as a Senator, was instrumental in shepherding the licensure bill through to fruition. I was impressed by the speech of David Mineta from the Office of National Drug Control Policy as he discussed changes coming from ONDCP regarding the way we view and treat people with substance use disorders. I was proud to hear Dr. Westley Clark of SAMHSA talk about the future of the addictions profession, and the opportunities that will be available for addictions professionals in the years to come. And I was very proud to hear Dr. Clark affirm what I have been saying for the last two years: *Indiana truly is leading the way in the addictions profession!*

Ten years ago, I sat in a meeting where Don Osborn (then-President of the NAADAC state affiliate in *Indiana*) told us about a conversation with a legislator who told him we would never be licensed because we were a mere field, not a profession.

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A profession, she told him, requires a standardized national curriculum, especially at the clinical level, in order to perform and provide clinically valid therapy. Even hairdressers have a standardized curriculum *and we did not!* Like many of you, I came into the field through my own recovery and certification process, and was confident that was sufficient to be able to perform counseling for addictions. However, after listening to Mr. Osborn and doing some research on my own, I realized that every facet of the counseling profession (Social Workers, Marriage and Family Therapy, Mental Health Counseling, and Addictions) was being pushed in that direction by insurance companies and by litigation issues. I also realized that I lacked the skills to effectively counsel people at the clinical level. So, again like many of you, I “read the writing on the wall” and went to school to gain skills in counseling, graduating with a BSW at age 33. After working in the addictions field for a few years, I returned to school to gain advanced clinical skills, graduating with an MSW at age 45.

Meanwhile, Don Osborn was working with SAMHSA, NAADAC, INCASE, Indiana Wesleyan University and others to *create* a standardized national curriculum from the associate to the *doctoral level in addictions*. He worked with SAMHSA to have the standardized addictions studies curriculum approved for accreditation nationwide. He worked with NAADAC and INCASE to create the National Addictions Studies Accreditation Commission (NASAC), which will oversee implementation of the national addictions studies curriculum in universities across the nation. He worked with the *Indiana* legislature to include the national addictions studies curriculum in our licensure bill, which has become *the* model for addictions licensure across the nation. More importantly, in creating the national addictions studies curriculum, he also created the addictions *profession*, protecting our livelihoods by preventing us from being subsumed into the other counseling professions! Don Osborn of *Indiana* took it upon himself to lead the way in addictions by working collaboratively with others to *create the addictions profession* from the “mere field” in which we were working. Don’s action will have the net effect of creating a multitude of unlimited opportunities in the *addictions profession* for years to come.

I need to be clear in stating that there will always be a place in the profession for recovering counselors. IAAP will still certify Recovery Technicians to fill entry level positions in the profession, of which there will be many. Some individuals will be content with those positions and that scope of practice, and that is fine. However, for those who want to perform clinical work in addictions, we now have the methods and opportunities to make that happen. We now have a career ladder we can climb, from non-degreed recovery technician all the way to doctoral level university professor *in addictions*. We will now gain opportunities for research grants, tuition reimbursement, teaching positions, higher salaries, and maybe—just maybe—some overdue and well-deserved respect for what we do *in addictions*.

Don always says, “Build on a Heritage, and Leave a Legacy.” He has done such a good job of building on our heritage that his legacy will be (as someone has already referred to him) the “Father of the Addictions Profession.” This is the legacy he has left us, and the heritage that we must continue to build upon. I am proud to be riding Don’s coattails, and proud of this opportunity to use my last newsletter as your President to report on what has been happening over the past decade in our profession. I want to take this opportunity to extend my most heartfelt gratitude to my good friend Don for all he has done for us. We all owe Don Osborn a huge debt of gratitude. Write him, call him, email him, or stop him in the street and thank him for all he has done for us, because we will be reaping the rewards for a long time to come.

Only Our Best,

 LCAC, LCSW

Ron Chupp, LCSW, LCAC, NCAC-II, ICAC-II
IAAP President

What Does It Mean to Belong to IAAP?

All people have chose to belong some entity at some point in their life, whether it was an extracurricular team or group, a civic organization, a study group, or an association. Some, who chose to belong, joined for a reason. Perhaps that reason was due to the shared values and purpose and wanting to make a difference in the community or in the profession. However, in order to make a difference, I have to become *active*. Yes, I can choose to support someone else, but I have to rely on that person to hopefully carry-out my vision. But, if it's my vision, then I need to do more.

Much like the legislative system of the United States of America, the Indiana Association for Addiction Professional (IAAP) relies on the representatives of the members. And, I, as a citizen, can contact my representative to share my vision, or I can take a bigger leap and choose run for election and share my vision with countless others. In other words, become an active citizen. So what does this have to do with IAAP, you may ask?

As an answer, I will reflect upon memory lane. Several years ago I joined NAADAC's Indiana affiliate for purposes of networking and gaining certification as an addiction counselor. To fast forward ahead, on the day I was invited to present my case as part of the certification process, more than certification was offered. I was also offered an opportunity to become involved in the association, which I belonged. The order of events went something like this.

There I sat in front of three panelists who were assigned to ask me questions as part of the Oral Case Presentation Method. (For those new to this profession, this was the final step to gain addiction certification and is now replaced by a much better way to measure competency, clinical supervision through internships and practicum.) After completing this anxiety-provoking process, the lead panelist, who has become one of my mentors as well as a very good friend, Albert Alvarez, made the following statement:

"Congratulations! You have passed your case presentation." I thought to myself, "Aah, relief, now I can put that behind me. Wait. He has something else to say." The words that follow made a significant impact upon my life. "Now it's time to become an active member of your association." I thought to myself, "Wait. I just became certified at Level II. What do you mean it's time to become active? Let me have some downtime. And, what do you mean "your association". It's not mine." Or is it?

A statement, which remains relevant today as much as it was relevant in 1961, is the words stated by President John F Kennedy. "And so, my fellow Americans: ask not what your country can do for you—ask what you can do for your country." In a similar manner, this same challenge was targeted towards me by Mr. Alvarez years ago, and it still applies today. 'Ask not what IAAP can do for you, but what you can do for IAAP.'

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IAAP, the NAADAC state affiliate for Indiana, has provided much for its members. I encourage, you, the reader, to review our President's article in this edition of the newsletter. And, through NAADAC, there is so much more. At the NAADAC National Conference in Indy, we were reminded of the countless benefits offered by NAADAC.

And, for those present at the NAADAC Conference, we know the answer to 'what has NAADAC done for you'. But for those not able to attend, let me share the answer with you. ALOT!!

As a debt of gratitude for NAADAC and its state affiliate, IAAP, the proper response is to give back, something many of us have been charged to do through our own recovery experience. One way of doing this is to volunteer to serve on IAAP Committees or to accept a nomination for a Regional Board of Director position. To those who volunteered at the National Conference, "THANK YOU!"

As you know, nominations for the available positions were due August 1, 2012. These positions included President-Elect to fulfill remainder of term until October 2012, President-Elect to fulfill term of October 2012 to October 2014, Treasurer, Secretary, Southeast Board Representative and Southwest Board Representative. The ballots have been tallied and results will be shared soon. Per IAAP Bylaws, "if a Board vacancy occurs, the remaining Directors will appoint a qualified person to serve the remainder of his or her term."

In closing I want to share one of the phrases I have used over the years with those I encouraged. 'You get out of it what you put into it'. What do you want to put into IAAP?

Only our best,

Brent A Stachler, MS, LMFT, MAC

Brent A Stachler, LCAC, LMFT, MAC, NCGC II, ICCS
IAAP Immediate Past President

How PTSD and Addiction Can Be Safely Treated Together

The vast majority of people with addiction have suffered significant previous trauma, and many people who struggle with addiction suffer from post-traumatic stress disorder (PTSD) simultaneously. But the treatment of these people has posed a conundrum: experts have believed that PTSD treatment should not begin until the addicted person achieves lasting abstinence, because of the risk that PTSD treatment may trigger relapse. Yet addicted people with untreated PTSD are rarely able to abstain for very long.

Now, a new study suggests that there may be no need to wait. Researchers found that using exposure therapy—(arguably) the gold-standard treatment for PTSD, which involves exposure to memories and reminders of patients' past trauma—can successfully reduce symptoms of PTSD, even when people with addiction continue to use drugs. And, although exposure therapy requires patients to face some of their worst fears, it does not increase their drug use or prompt them to drop out of treatment more than ordinary addiction therapy, the study found.

"The exciting thing in my view is that [the study] supports people with drug and alcohol problems having access to other forms of psychological interventions, rather than being fobbed off and told to sort out their alcohol and drug problem first," says Michael Farrell, director of the national Drug and Alcohol Research Center of New South Wales in Sydney, Australia, where the research was conducted. The findings could potentially help the majority of those who suffer from addiction and PTSD: one-half to two-thirds of people with addictions suffer from PTSD concurrently, and the same proportions of people with PTSD also have substance use disorders.

The new study involved 103 people with both conditions. Most were addicted to multiple drugs, primarily heroin, marijuana, and alcohol. More than two-thirds of the participants had been traumatized during childhood, with almost half reporting a history of sexual abuse. Researchers randomly assigned half of the participants to simply continue the addiction treatment of their choice, whether it was detoxification leading to abstinence, residential treatment, or maintenance on medications such as methadone and buprenorphine.

The other half received their usual treatment, plus exposure therapy for PTSD, which consisted of 13 one-on-one sessions with a clinical psychologist, meeting about once a week for 90 minutes at a time. The therapy began with education about PTSD and addiction, including instruction on cognitive techniques to address distressing thoughts that could lead to relapse. When patients were ready, they were exposed to reminders of their traumatic experience, which they usually avoided out of fear of flashbacks and intense anxiety by using. Exposure therapy works to reduce or eliminate these PTSD symptoms by breaking the patients' cycle of fear and avoidance.

Patients in the exposure treatment "demonstrated significantly greater reductions in PTSD symptom severity compared with participants randomized to receive their usual treatment alone," the authors wrote. Drug use in the exposure therapy group did not decline any more than in the usual treatment group. Both groups saw a reduction in the severity of addiction, but in each case the majority of participants continued to use drugs. Notably, however, drug use did not increase due to the exposure therapy. "These findings challenge the widely held view that patients need to be abstinent from addiction before any trauma work, let alone prolonged exposure therapy, is commenced," the authors wrote. "Findings from the present study demonstrate that abstinence is not required."

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While the study showed that carefully delivered exposure therapy can help, it did not support the practice of forcing addicts to confront trauma in setting where they do not feel safe. Exposure therapy is designed so that patients do not become overwhelmed or feel helpless. In contrast, coercion by the therapist can re-traumatize patients and worsen both PTSD and addiction symptoms, as previous studies have shown. There is no clear evidence that compelling people with addictions to recall or re-enact traumatic experiences—a commonly used group therapy tactic—actually helps. What the current study shows is that when trained clinical personnel carefully deliver exposure therapy in a tightly monitored trial, they can help reduce PTSD symptoms in people with addictions.

TIME.com/Healthland

Researchers Find a Way to Block Heroin, Morphine Addiction

Opiate drugs, such as morphine and hydrocodone, are frequently prescribed to aid patients in need of chronic pain relief—but they often come at a cost. Opioid addiction can develop for those habitually taking these pain relievers, leading to physical dependence and withdrawal symptoms when their use is stopped abruptly. Now, researchers from the University of Adelaide in Australia and the University of Colorado have found a way to block addiction to opioids like morphine and heroin, while simultaneously increasing pain relief. Their results could potentially lead to a new drug that could not only help people with severe pain, but also help heroin users “kick the habit.” The major breakthrough is part of a paradigm shift in the way to treat drug addiction, according to the researchers. Opioid dependence has become a widespread problem, with approximately 9 percent of the U.S. population abusing opioids—both prescription and illegal—over the course of their lifetime according to the National Institute on Health, with one in five U.S. children experimenting with prescription opioids before the age of 17.

“We know that drugs like morphine drive a reward system that causes elevations of dopamine in the brain,” Dr. Mark Hutchinson, ARC Research Fellow at the University of Adelaide’s School of medical Sciences and the study’s lead author, told FoxNews.com. “Our work suggested [nervous system] pathways are important, but 90 percent of the cells in the brain are glia, which are immune cells. So we hypothesized that the immune system was probably involved in drug rewards as well—and we showed it was.” Current pharmacological treatments for opioid addiction focus mostly on treating the central nervous system. While Hutchinson and his team acknowledged both the nervous system and the immune system play key roles in addiction, they decided to focus solely on the immune system’s response. This led them to the immune receptor Toll-Like receptor-4 (TLR4).

“Our paper shows that opioids bind to this receptor TLR4,” Hutchinson said. “TLR4 is known as the receptor that causes anaphylactic shock. It is designed to recognize E. coli, so it is a bacteria receptor. It also recognizes morphine, and in the brain, this causes the immune cells to hijack the reward pathways and drive pathological rewards to morphine,” ultimately amplifying the drugs addictive properties. If we develop drugs to block TLR4, we can stop drug rewards from presenting themselves,” Hutchinson added.

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Laboratory studies have shown that the drug naloxone selectively blocks the immune response to morphine, shutting down the need to keep taking opioids. Once the TLR4 is blocked, the neurochemistry of the brain changes, Hutchinson said, and dopamine is no longer produced.

Through their research, the scientists discovered another beneficial side effect of blocking TLR4—amplifying the pain relief provided by opioids. “When you block TLR4, you also increase the pain relief you get from the morphine,” Hutchinson reported. “WE might have a treatment for people who are addicted to illicit pain meds, but we also have the opportunity to intervene before this addiction starts in people needing pain relief. Perhaps the future might be a coformulation—morphine providing pain relief and a drug like ours to stop TLR4 activity, modifying pain but also stopping the addiction.”

Hutchinson reports that opioid dependence is continuing to grow at an alarming rate. He hopes this fundamental shift in treating drug addiction—by focusing on the immune response—will help many people in need of pain relief, while avoiding addiction. “People have typically thought about drug addiction (as) being a seedy kind of problem,” Hutchinson said. “We’ve really transitioned away from that because of the availability of prescription opioids. This isn’t a treatment just for drug addicts; this could really have implications for the population’s health, by making better opioid medications—which are great for pain relief—a whole lot better.”

FoxNews.com

How Childhood Trauma May make the Brain Vulnerable to Addiction and Depression.

Childhood trauma has long been known to raise a child’s odds of developing depression and addiction later on in life. Now, a small but intriguing new study links these risks to specific changes in the brain, finding that disruptions in certain neural networks are associated with increased chances of substance use disorders, depression, or both in teens.

Researchers at the University of Texas studied 32 teens, 19 of whom had been maltreated in childhood but did not have a current psychiatric disorder. The researchers defined childhood trauma or maltreatment as any type of significant abuse or neglect lasting six months or longer, or a major traumatic experience like life-threatening illness, witnessing domestic violence, or losing a parent before age 10. The other 13 participants in the study served as the control group, having no history of major childhood trauma or psychiatric problems. All of the teens were followed every six months for an average of three and a half years. During that time, the authors found that five of the maltreated children and one control had developed major depression, and four of the maltreated children and one control had developed substance use disorders. Two of the maltreated children had both a drug problem and depression. This means that nearly half the maltreated children had either a diagnosable drug problem or depression, or both, which was three times the rate seen in the control group.

Using a brain-imaging technique that measure the integrity of the white matter that connects various brain regions, the researchers looked for any differences in the teens’ brains when they were first enrolled in the study, before they had developed any psychiatric problems.

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The scans showed that children who had been maltreated showed connectivity deficits in several brain areas, including the superior longitudinal fasciculus (SLF), which is involved in planning behavior and, on the left side of the brain, in language processing. Another affected region was the right cingulum-hippocampus projection (CGH-R). This tract helps connect the brain's emotional processing regions with those involved in more abstract thought, ideally allowing the person to integrate both types of information and to regulate their responses to emotional stress.

The teens who developed depression had the most significant reductions in white matter in their SLF; those who developed SUDs were more likely to show greater white matter loss in the CGH-R. These changes suggest that depression-specific vulnerability may be linked to rumination and processing of language that is focused on the negative, while addiction susceptibility may be linked to an inability to regulate emotions more generally. Because prior studies have found reduction in different white matter regions among maltreated children—and because this was a small study—more research is required before any firm conclusions can be drawn. But the findings do add to the already voluminous literature suggesting that addictions problems have more to do with people's attempts to manage emotions or flee from emotional pain than their desire to seek pleasure—and that simple drug exposure is not sufficient to trigger addiction.

Understanding how severe stress and trauma can lead to addictions and other mental illnesses should ultimately help lead to more effective treatments. In the meantime, the best prevention is treating all children with love and kindness.

TIME.com/Healthland

The Kratom User's Guide

By Kay Bontrager, Certification Committee Chair

One of the highlights for me at the annual NAADAC conference in Indianapolis recently was the breakout session, EMERGING DRUGS OF ABUSE. One that I had not known of, is named: Kratom. You can research it on the internet but some of the basics follow.

WHAT IS KRATOM?

Kratom is a tree native to Southeast Asia (Thailand, Malaysia, Myanmar [Burma], and elsewhere. Its botanical name is *Mitragyna speciosa*. Kratom is in the same family as the coffee tree. The leaves of Kratom have been used as an herbal drug from time immemorial by peoples of Southeast Asia. It is used in folk medicine as a stimulant (at low doses), sedative (at high doses), recreational drug, painkiller, medicine for diarrhea, and treatment for opiate addiction.

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HOW IS IT TAKEN?

In Thailand, Kratom leaves are often chewed fresh after removing the stringy central vein. Dried leaves can also be chewed, but since they are a bit tough, most prefer to crush them up or powder them so that they can be swallowed. Powdered Kratom can be mixed with fruit juice or applesauce. This partially masks the taste (sounds like a good idea to me!) and allows it to be quickly swallowed. It also can be made into capsules and swallowed. Dried Kratom leaves are often made into a tea that is strained and then drunk (this is the most frequently used method in the West). Kratom can be smoked, but doing so has no advantage over chewing or making a tea from it. The amount of leaf that constitutes a typical dose is too much to be smoked easily. A paste-like extract can be prepared by lengthy boiling of fresh or dried leaves. This can be stored for later use. Small pellets of this extract can be swallowed, or it can be dissolved in hot water and consumed as a tea. Some people like to mix Kratom tea with ordinary black tea, or other herbal teas, before it is consumed. This is done to make it more palatable. Sugar or honey can be added to sweeten it. While now illegal in Thailand, in that country's drug culture, the leaf is sometimes combined with cough syrup and Coke, tranquilizers and marijuana to produce a narcotic drink called "4X100".

WHAT ARE THE EFFECTS?

Kratom is a rather unique drug in that a low to moderate dose will usually, but not always, be stimulating, while a high dose is almost always quite sedating. This is apparently because the active alkaloids have both stimulant and sedative effects. Which predominates probably depends both on blood level and individual differences between users.

The stimulant level: at the stimulant level the mind is more alert, physical energy and sometimes sexual energy is increased, ability to do hard monotonous physical work may be improved, one is more talkative, friendly and sociable. Some people find this level edgy rather than pleasant.

The sedative-euphoric-analgesic level: At this dosage, you will be less sensitive to physical or emotional pain, feel and look calm, have a general feeling of comfortable pleasure, and may enter a pleasant dreamy reverie. You may experience some itching or sweating. Your pupils may be constricted. You may feel nauseated, but if you lie down and relax the nausea should quickly cease. Effects last about six hours. The higher the dose, the stronger the effects, and the longer they last. When taken by some, there is respiratory depression, similar to the effect of opiates like heroin.

Further reports tell us that patients are showing up in Emergency Rooms suffering withdrawal from Kratom. It is being touted as safe and effective for many maladies, while having fewer side effects and being less addictive than narcotics such as oxycodone.

However, Frank LoVecchio, medical director of the Banner Good Samaritan Poison and Drug Information Center in Phoenix, Ariz states: "Every month somebody is trying to get a new 'safe

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high', and Kratom is definitely not safe." While advertisements say it is not addicting, and there have been no fatalities from Kratom, the known risks and dangers of Kratom overdoses include hallucinations, delusions, listlessness, tremors, aggression, constipation and nausea". From the web site, Kratom.com, they list the following in their "dangerous effects" section: "Long term daily high dose of Kratom consumption is reported to induce nervousness, sleeplessness, loss of libido, constipation and the darkening of skin complexion."

Like "Bath salts" and "spice"—drugs that are now illegal but were legal and trendy until law enforcers and medical researchers gathered data on their dangers—Kratom is under scrutiny, having been added to a Drug Enforcement Administration's list of 'drugs and chemicals of concern.'

Legalization is Clear, Simple and Wrong: Our Current Problem is not With Marijuana Laws, but with Marijuana Use.

By Allan Barger, MSW

The journalist H.L. Mencken once observed, "For every complex problem there is an answer that is clear, simple and wrong." Several clear, simple arguments for legalizing marijuana have gained traction with the public. Proponents assert it is less harmful than alcohol, and it is hypo-critical to market alcohol while marijuana remains illegal. They argue marijuana is already widely available, so legalization will have no impact on use or problems. Moreover, they predict legalization will unburden law enforcement, court and penal systems while creating new tax revenues to fix the budget woes faced in many states. This argument for legalization is attractive, but is legalization the right answer? As one who has spent the past 15 years following the published cannabis research, I am dubious.

Legalization advocates frame the debate as a fairness issue by comparing marijuana to alcohol. "You drink your glass of wine, why can't I smoke my weed?" This is a false analogy equating alcohol in any amount to using marijuana, but the two are not equivalent. Most adults are not impaired on a standard drink consumed in an hour. A more accurate analogy compares marijuana use to drinking to get drunk. A person may have a cold beer after mowing the lawn to enjoy the taste and cool off with no intent to get tipsy; but the purpose of using marijuana is to get high. There is no other reason to use it. This is what distinguishes it from typical alcohol use.

Framing the debate as marijuana vs. alcohol ignores the actual question that must be asked: Is marijuana harmful to those using it? Marijuana proponents argue it causes fewer problems than alcohol, but this is partly because far fewer people use it. The latest figures from SAMHSA show 4.6 million people used 300 or more days in the past year, while those binge drinking alcohol at

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least once in just the past 30 days is 12 times higher at 58.6 million people. If marijuana is legalized, use rates are likely to escalate, especially in our advertising-driven society where billions in corporate profits can be made by promoting its use.

Comparing marijuana to alcohol masks marijuana-specific problems. Marijuana users report it helps them focus, but this is really a loss of ability to rapidly shift attention among multiple tasks. This diminished ability to shift attention is a problem when driving. Research finds those under the influence of cannabis lose the capacity to rapidly attend to the multiple factors required in driving, have impaired perception of time and distance, and slowed response times. These effects create an increased risk for both crashes and fatalities.

While legalization might decrease some social costs, particularly in the legal system, it is likely to increase other costs. Proponents of legalization point out alcohol prohibition caused the rise of organized crime, but fail to note organized crime did not vanish when Prohibition ended. It simply moved to other “businesses.” We may see reduced costs in police, court and detention systems for prosecuting misdemeanor possession charges, and taxes could create new revenue. However, these benefits will be offset by increased regulatory bureaucracy, increased healthcare costs, higher demand for treatment of cannabis dependence, and greater losses in economic productivity.

Marijuana carries its own risks as a significant public health and public safety issue. Our two legal substances, alcohol and tobacco, already incur more costs than they generate in public revenue. Choosing to add another substance to that list, one that serves no function but getting high, invites still more social costs. To argue it does less harm than alcohol is a poor reason to legalize it. Legal marijuana is unlikely to pay its bills, and monetary gains will not undo the health and relationship problems it creates.

Our current problem is not with marijuana laws, but marijuana use. Increased public awareness of the along with tailored prevention and treatment efforts to reduce use are likely to be more cost-effective. Since it would further damage public health, burden healthcare and treatment systems with preventable problems and undermine individual well-being, legalization is an answer that is clear, simple and wrong.

Allan Barger, MSW, is a Research Analyst at Prevention Research Institute. A version of this article originally appeared in the May/June Edition of the NAADAC News.

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- Free access to NAADAC's online Career Center at www.naadac.org.
- Assistance with referrals concerning ethical or legal questions or complaints and two free hours of help on a Legal Assistance Hotline provided by NAADAC's liability company with malpractice insurance available through the Van Wagner Group.
- Free subscription to NAADAC's official magazine, *Addiction Professional*, which is published six times annually.
- Peer support and network opportunities through national and state conferences and workshops.
- Reduced rates for continuing education including the qualification course for the U.S Department of Transportation's Substance Abuse Professional.
- Reduced rates for publications such as the *Basics of Addiction Counseling: A Desk Reference and Study Guide*, used by experienced professionals and as a guidebook for preparation for certification exams.
- Access to the *NAADAC News*, the association publication only available to NAADAC members.
- Substantially reduced rates for professional Certification and re-certification as National Addiction Counselor (NCAC) or Master Addiction Counselor (MAC). *Please note that certification is not included in NAADAC membership but is a separate process. (Certification is not a requirement of membership in NAADAC.)*
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