The Addictions Newsletter

The American Psychological Association, Division 50

www.addictionpsychology.org SUMMER 2015

Contents

President's Column: Wrapping Up!

Alan J. Budney

So my time as President of SoAP is rapidly coming to a close. As expected, re-immersion into the workings of the American Psychological Association has been both rewarding and frustrating. I'd like to take this opportunity to focus mostly on the positives.

Alan J. Budney

First, I offer a few comments about SoAP leadership and those contributing to the Division's governance and operations. This group of professionals and students, whom I have worked closely with over the past 22 months, are a truly remarkable group fully committed to enhancing the science and practice of psychology as it relates to problems of addiction. The time and effort they devote to this mission is not small, it is not compensated, and it is rarely acknowledged outside our Division. And, quite a few of your leaders have been contributing to this operation for an extended period of time, well past initial commitments and expectations. So what motivates this enduring behavior? I have observed at least two factors I think are noteworthy: (1) they truly care about the profession and the people suffering from problems related to addiction, (2) they care about each other and enjoy belonging and contributing to a group with shared values. The reinforcement derived from such intrapersonal and social experiences can prompt much positive behavior, which in this case, affords multiple benefits to our profession and

Division 50 Mid-Year Meeting
San Diego
March 18-19, 2016

those we all work so hard to help. What I have found particularly rewarding during my relatively brief time with this group, is the working synergy between science and practice that seems to come naturally to these dedicated professionals and students. They all seem to "get it"! SoAP will remain in excellent hands and your incoming President, Sherry McKee, promises to infuse the Division with additional perspective and expertise that will further promote its recognition and influence in a field much in need of guidance.

So, if you are looking for somewhere to devote your time, energy, and expertise, please consider volunteering to become an active Division 50 / SoAP member. We have much to do, and many opportunities available that will allow you to participate and contribute! I promise you, the experience will be rewarding and you will enjoy the company of likeminded professionals and students all working to advance a common cause.

So what is it that SoAP does? I'd like to note a few developments and accomplishments over the last year or so relevant to our mission. First, Bruce Liese, our Membership Chair, in concert with a number of our highly active and committed student members, developed a monthly teleconference for students in training to provide an avenue for comradery, activism, education, and career development. To date this has been a huge success, with increasing numbers of trainees participating each month. If you would like to learn more or participate, either as a contributing professional or as a trainee, go to http://cbtaddictions.org/d50/ to listen to prior conferences and see what's up next.

Second, over the past two years we worked to regain the APA Certificate of Proficiency that recognizes a clinical psychologist's expertise and training in the area of Addiction Psychology. This certificate can and is used by many to obtain recognition and reimbursement for clinical services. Psychologists have much to offer when the goal is to develop and deliver the most effective services to those suffering from Substance Use or other types of Addictive Disorders. Unfortunately, we have many times been left off the lists of clinical providers that insurance companies and state agencies designate as those qualified to perform services and receive reimbursement. Now that the Certificate is again available, we need to recruit more psychologists to apply for it to increase recognition of our skills and availability.

This year, SoAP has also taken the first step in renewing the Proficiency status of treatment for addictive type problems within the APA, which outlines the training needed to be proficient and gain certification in this area of practice. We are in the process of revising that application to update the standards of practice and training which reflect the changing science and practice knowledge that has developed over the past 10 years. Last, related to our seeking to increase recognition of psychologists with expertise in the practice of addiction psychology, we have initiated the process to designate it as a Subspecialty under the American Board of Cognitive Behavioral Psychology, which is a specialty area under the American Board of Professional Psychology. This designation would provide another avenue to further achieve certification of expertise in our clinical area, and offer the public additional clear and visible options for seeking help from recognized experts in the field. I'd like to thank John Kelly, Linda Sobell, Ray Hanbury, Mark Schenker, and Nancy Piotrowski for all their efforts to make these things happen.

Third, I want to highlight the tremendous progress that has been made in establishing our mid-year Collaborative Perspectives on Addiction (CPA) conference. Under the leadership of Katie Witkiewitz and Jen Buckman, this year's 2-day conference in Baltimore on the Changing Landscape of Addiction had the highest attendance to date despite a substantial number of last minute cancellations due to the snow. This conference provides an intimate opportunity to get to know your colleagues, and is particularly geared towards students in training and young psychologists. We received rave reviews from attendees, and have already nailed down a venue and theme for the coming year. In 2016, CPA will be in San Diego (March 18-19), and we have recruited APA Division 45, the Society for the Psychological Study of Culture, Ethnicity and Race, to join us in a conference that will focus on reducing Health Disparities through Addiction Science and Practice. Katie Witkiewitz has submitted an internal APA grant to help support the conference and make it a scientific and financial success! With the new year comes a changing of the guard; James Murphy and Robert Leeman will be taking the lead in organizing this year's CPA. I thank them both, and the others on the conference committee for their time and efforts. One final point, the growth and success of CPA is of great importance to SoAP. This year, the conference resulted in a net positive financial gain. Although we are a volunteer organization, the Division requires a substantial budget to get things done and effectively serve our members and our mission. CPA, if successful, is one potential avenue going forward to infuse a modest amount of dollars into our organization. Please consider attending and participating—I promise, you will not regret it.

The last aspect of SoAP activities that I want to mention is the APA convention, and our always successful Division programming. Behind the scenes, a few people work hard each year to make this happen under more and more trying circumstances. This year Kristine Jackson and Suzette Glasner-Edwards have worked particularly hard to recruit, collaborate, and arrange a fantastic addiction related program for Toronto. If you have never been involved with developing the program for a conference, consider volunteering to assist with the APA convention program (or CPA). You will find it both rewarding and trying, and hopefully will gain satisfaction from contributing to the process of providing continuing education to those in our field.

On a final note, I mentioned earlier the finances of SoAP. Although never the most interesting part of an organization's process, careful attention to finances is vital. Fortunately, SoAP has had Jen Buckman, our Treasurer, looking after our interests for many years now. The good news, our finances are stable and the Division is in good shape moving into the next few years! However, this will be Jen's last year as Treasurer. Although I'm sure the incoming Treasurer will do an excellent job, Jen will be missed. It has been a pleasure getting to know her these past 2 years, and I want to thank her for all that she has contributed, not only as Treasurer, but as an active member of the Executive Committee who assists with most of our operations. When you see Jen, please express your appreciation as well!

As you can tell, the theme here is volunteerism. SoAP's success is dependent on the devotion of our members' time and efforts. Above, I neglected to mention Brandon Bergman, our Secretary, and Lauren Hoffman, a student representative, for their concerted efforts to define the roles of our various officers, committees, and liaisons, and to clearly outline the opportunities to get involved in the workings of SoAP. The product of their labor will soon be available on our website, where you can go and learn about how you can become more involved. I offer a big thanks to both of them and the others who have assisted with this process. I am both humbled and grateful to have had the opportunity to work with all of those mentioned above and the many others not acknowledged here. There is much more to do, and I look forward to my coming year as Past-President to continue this work with our incoming president, Sherry McKee, and with you all, existing and new volunteers, to further progress toward SoAP's mission—*to promote advances in research, professional training, and clinical practice within the broad range of addictive behaviors including problematic use of alcohol, nicotine, and other drugs and disorders involving gambling, eating, sexual behavior, or spending*.

See you in Toronto (APA), and then in San Diego (CPA)!ψ

Editor's Corner

Welcome to the Summer 2015 issue of TAN! This issue brings you election results, convention highlights, and rave reviews of our mid-year meeting, the Collaborative Perspectives on Addiction (CPA). I find it particularly impressive that this meeting is emerging as such a tremendous career development experience for our graduate students. A graduate school mentor of mine, Mark Wood, who many of you knew, and who tragically passed away this April, was a great supporter of graduate student conference attendance (in fact, a scholarship is in the process of being set up in his honor at the University of Rhode Island to support graduate student conference travel). And indeed, for me, attending my first conference was career transforming (that's how I learned about F31s). Of course, attending one's first scientific meeting isn't all roses and sunshine—at least, not necessarily. I well remember attending my first scientific conference, and how intimidated and lost I felt. With that experience in mind, I am in awe of CPA for creating such a welcoming and stimulating environment for our graduate students. So, kudos to all of you who are contributing to CPA's success!

Bettina B. Hoeppner

In this issue of TAN, we also have an exciting line-up of articles focusing on **"Continuing Care for Substance Use Disorder."** These articles provide the historical and current context for the need to provide continuing care, describe a diversity of ways in which it can be provided (e.g., Oxford House, emerging technology), and address some of the challenges encountered in providing it. My gratitude goes out to these wonderful authors, who answered our call to provide these informative and insightful articles—NIH deadlines and vacation plans notwithstanding!

In the next issue of TAN (**October 1 deadline**), we will focus on: **"Can Positive Psychology Contribute to Addiction Treatment and Recovery?"** To this end, we invite you to submit an article on your research, clinical work, thoughts and/or ideas on this topic. Articles can take any approach to this general topic, including, for example, articles that examine why continuing care may be necessary / beneficial, what works, what's promising, and what we still need to know. Keep in mind that articles are short (1,200 word limit), fairly informal, and take many shapes (e.g., opinion pieces, descriptions of pilot or small studies, short reviews)—all factors, hopefully, that will make it easy for you to share your thoughts. We also invite you to submit an article on a topic of your choosing. In fact, if there is a topic you'd like to be explored in a future issue of TAN, please be sure to suggest this topic to us: we are happy to receive any and all ideas!

Happy reading!

Bettina Hoeppner
TAN Editor

Hillary Howrey
TAN Grad Student Mentee

Advocate's Alcove

Nancy A. Piotrowski, PhD
Division 50 Federal Advocacy Coordinator

In this column, I have a little information to share with some updates on legislation, and a request to ask of you. I will start with a question that leads to the request. Do you regularly talk to your elected representatives about issues related to the profession? Have you ever visited their offices? Or have you met their local staff? Or perhaps you just know a representative as a neighbor, friend, or old chum from high school? These connections are important because they are opportunities for our representatives to get to know psychologists and learn about the work we do with our clients, our research, and how we can contribute to public health and science more broadly. I mention these relationships, because I would like to get to know more about your experiences and relationships like these. In fact, the American Psychological Association Practice Organization (APAPO) has asked me to send out a mini-survey to gather this information. To this end, I will be sending out a mini-survey soon via email. Please respond to the survey as directed in the email, or feel free to email me back channel at napiotrowski@yahoo.com with any information you might like to share. I thank you in advance for helping!

Nancy A. Piotrowksi

Second, I wanted to update you on a few items related to legislation affecting psychologists and those we serve. First, the State Leadership Convention in March was very successful. Hundreds of psychologists attended meetings in Washington, DC to discuss policy matters affecting our profession, such as the integration of psychologists into the healthcare arena, and varied new emerging practice models. Additionally many psychologists and students met with legislators to help them learn about the work we do. In fact, in March and April, over 13,000 psychologists wrote to their representatives to let them know about difficulties our clients are having with access to care. Informed of such problems, for about the seventh year in a row, our representatives repealed the Sustainable Growth Rate (SGR) formula. This was a very good step forward to help clients keep access to health care, including mental health care. One additional update that we learned recently is that Representative Tim Murphy is reintroducing a request for support for Behavioral Health Information Technology (BHIT). His bill will amend and extend the meaningful use component of current health care information technology incentives to include psychologists, as well as other behavioral health practitioners and facilities. Information about the Medicare changes and more information on BHIT will soon be available at Practice Central. So check the APAPO website for updates over the summer months.

Finally, I am happy to introduce two new students who have volunteered to work with me to learn about advocacy work related to addiction psychology. These students are Robert Teel, III, who is a graduate student at the California School of Professional Psychology in San Diego and Pamela Cornejo, who is a graduate student at the University of Utah. Again, to other students who participated in our advocacy trainings last year, or who are otherwise interested in learning more on these topics, please be in touch! We continue to work on having members (including students!) throughout the states who are well-informed advocates. The best way to reach me is via email (napiotrowski@yahoo.com).

Image courtesy of digitalart/FreeDigitalPhotos.net

Resource Information

American Psychological Association Practice Organization (APAPO) www.capwiz.com/apapractice/issues

New Member Spotlight: Rose Marie Ward, PhD

Allison K. Labbe
Early Career Representative

Please welcome to SoAP a new member, Rose Marie Ward. Rose Marie is a Professor of Kinesiology and Health, and the Special Consultant to the Dean of Students on Alcohol and Other Drugs, at Miami University in Oxford, Ohio. She completed her training at the University of Rhode Island with a focus on Healthy Psychology and Statistics.

What are your research interests?
College student health behavior change—specifically, the overlap between high-risk drinking practices and sexual assault. I have examined the relationship between Thursday drinking and academic related outcomes. Thursday drinking is interesting because students who choose to drink on Thursday don't have a natural "recovery day." Most recently, I am exploring the overlap between alcohol-related blackouts and sexual assault.

How did this become an area of interest to you?
In graduate school, one of my assistantships was with Mark Wood, PhD, who unfortunately passed away this past April. I helped with his bar lab and with the grants he had at the time. My most recent interest stems from my work on Miami University's Appeal board. It seems that alcohol-related blackouts are becoming more acceptable to students. They are less worried when they have a blackout experience.

What are your educational/training interests?
My educational/training interests involve the instruction of statistical and research methods. I enjoy teaching courses in statistical analysis (e.g., power analysis, structural equation modeling) and research methods. My goal is to make these topics interesting and usable. I also supervise masters- and doctoral-level students.

What do you enjoy about supervising students?
I love watching my students become excited about research. Every semester, I watch as they realize that they can create knowledge that contributes

Rose Marie Ward, PhD

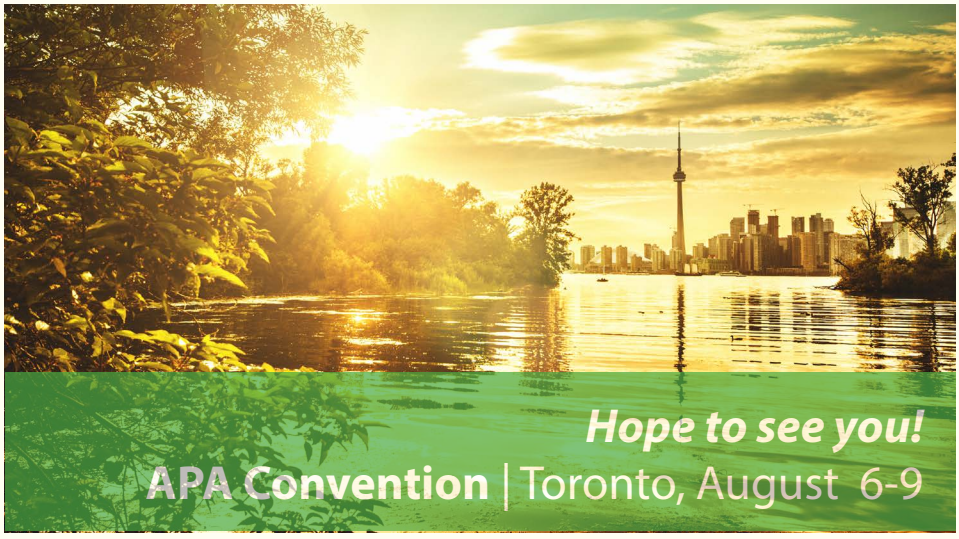
to the field. Every mentor-mentee relationship is an opportunity to improve the field and guide the future leaders of the field.

How did you get interested in addictive behaviors?
In graduate school, I worked with Drs. Wayne Velicer and James Prochaska at the Cancer Prevention Research Center at the University of Rhode Island.

What kind of work did you do with Dr. Velicer and Dr. Prochaska (or, what kind of work were they doing) that got you interested in pursuing addictions-related work?
Drs. Velicer and Prochaska utilize the Transtheoretical Model. They primarily do intervention related studies. In graduate school, I was able to contribute to a large variety of projects (e.g., stress management; smoking cessation; responsible drinking) that influenced my current path. As a graduate student at the CPRC (Cancer Prevention Research Center), I was able to be involved in all aspects of the process from research question generation, to intervention development, to data analysis, to grant writing, to manuscript development.

What motivated you to join the Society of Addiction Psychology (Division 50)?
The community aspect.

What about the community aspect do you like about Division 50?
The division is a great resource to individuals in the addictions field. Specifically, I find that the newsletter is very informative and provides insight into issues that others in the field are facing.ψ



Student and Trainee Perspectives

Noah N. Emery, MA
University of South Dakota
Student Representative

Lauren A. Hoffman, MS
University of Florida
Student Representative

Summer has arrived and we are excited to share what this season has in store for students. In this issue, we highlight promising APA Meeting events, issue a call for Division 50 student leadership applications, and discuss the Division's newest initiative for professional growth and collaboration.

The 2015 APA Annual Convention

The APA Convention is right around the corner and is sure to be a great meeting! This year, the conference will be held in Toronto and has much to offer SoAP's student members, including symposia highlighting innovative research, informative poster sessions, and invaluable networking opportunities.

Student members are encouraged to take advantage of several events. First, be sure to attend the joint NIDA/NIAAA Early Career Investigators Poster Session and Social Hour at Fairmont Royal York Hotel, Imperial Room on Friday, August 7th (4:00 to 5:50 PM). This social hour is open to all convention attendees and will offer great networking opportunities; meet some of the most well-known addiction researchers and enjoy the free food! Also, do not miss the Division 50 Poster Sessions on Addictive Behaviors, which will be held on Saturday, August 8th (12:00 to 12:50 PM & 1:00 to 1:50 PM). Stop by and support the work your fellow students are engaged in!

Mingle with SoAP members at the Division 50 Board and Committee Reception on Thursday, August 6th from 4:00 to 6:00 PM. This event offers a unique opportunity for student members to interact with several senior members who have served on SoAP committees throughout the years. Student affiliates will receive an invitation via email and are encouraged to RSVP and take full advantage of this special occasion. Don't forget to stop by the Division 50 booth, where graduate students will find important information regarding available student positions on SoAP committees. For more information on conference symposia and events relevant to Division 50's interests, see the TAN report by the convention program chairs, Kristina Jackson and Suzette Glasner-Edwards.

Lauren A. Hoffman, MS

Noah N. Emery, MA

APA also offers a wide array of collaborative programing devoted to student career development at this year's convention. Workshop and discussion topics include "Turbo-Charging Your Career—Finding and Keeping a Good Mentor" (Thursday, August 6th, 2:00 to 3:50 PM) and "Hire Me! Seeking Employment in Academia" (Saturday, August 8th, 11:00 to 11:50 AM). Students in the clinical field may want to attend the "Internship Prep Workshop for Rehabilitation, Health, and Neuropsychology Students." For more information on these and other American Psychological Association of Graduate Students (APAGS) hosted events, access the official APA Convention website and navigate to "Programming."

Student Representative Applications

SoAP student members, Division 50 is seeking applications to fill 1 of the 2 student representative positions on the Executive Committee. This position is a two-year commitment and a wonderful opportunity for those interested in becoming more involved with the division and its associated events/policies. Duties include monthly conference calls with the Executive Board, contribution to the division's quarterly newsletter, and collaboration with students on other SoAP committees, such as the membership, advocacy, and social committees. If you are a student member who is currently enrolled in a doctoral program and have at least two years remaining in your program, please send your CV and a brief letter of intent outlining the reasons you would like to serve on the committee to Noah Emery at noah.emery@usd.edu. Applications are due by June 19th, 2015.

National Conference Call for Students and Early Career Professionals

By now, you may be aware that SoAP's Membership Committee has been hosting free nationwide conference calls for students, post-docs, and early career professionals. These calls are 1-hour long discussions held on the last Friday of every month (year-round). They feature guest speakers with diverse experiential backgrounds and address a wide variety of topics (e.g., grants & funding, internship & post-doc positions, etc.). These calls represent the division's commitment to student development and involvement. A unique feature of this conference call is the interactive blog where we encourage attendees to ask questions and contribute to discussion. Additionally, all of our calls are audio-recorded for those unable to be on the call and for anyone who wishes to listen again. The blog and recordings are available at www.cbtaddictions.org/d50. We encourage you to take advantage of this student-focused opportunity! Be on the lookout for announcements for the upcoming calls. If you have yet to receive an announcement and would like to be added to our listserv, feel free to email your student representatives, Lauren Hoffman (lahoffman@ufl.edu) or Noah Emery (noah.emery@usd.edu).ψ

Congratulations to the Newly Elected!

Katie Witkiewitz

Linda Carter Sobell

Jennifer Read

Ty S. Schepis

Brandon Bergman

Submitted by Nominations and Election Committee
Amy Rubin, Robert Leeman, Samantha Domingo (student representative), Sara Jo Nixon

This has been an exciting election year. We had stiff competition for five elected positions. 212 SoAP members (about 25%) voted in the election. So if your candidate didn't win and you didn't vote, you know what to do next year! All full members, fellows, and associate members in good standing for at least 5 years are eligible to vote.

Our **President-Elect** for this coming year will be **Katie Witkiewitz, PhD**. Katie is an Associate Professor at the University of New Mexico in Psychology and an important force in organizing the Mechanisms of Change satellite conference of RSA every year, as well as Co-Chair of the Collaborative Perspectives on Addiction meeting. Her goals for SoAP will be to increase membership involvement in SoAP initiatives and activities, as well as to increase the reach of SoAP through collaborating with other APA Divisions and other professional societies.

Linda Sobell, PhD, ABPP has been re-elected to the position of **Council Representative (Science).** Linda has an impressive resume of accomplishments in the fields of addictions and psychology. It would take the entire issue of TAN to list all her accomplishments! Linda is Professor of Psychology at Nova Southeastern University, former President of Division 12 (Clinical Psychology), has served in a number of positions for Division 50, and is a passionate and enthusiastic advocate for practice and research in addictions. She plans to continue to promote the division's influence and strengthen the visibility of the division in the whole of APA's governance structure.

Our new **Member at Large (Science)** will be **Jennifer Read**. Jen is Professor in Psychology at the University at Buffalo, State University of New York, and has an adjunct appointment with the Research Institute on Addictions (RIA). Jen serves on the editorial boards of *Psychology of Addictive Behaviors*, and the *Journal of Abnormal Psychology*. Jen served as Program Chair for SoAP in 2010-2011, and was Group Leader for the Addictive Behaviors SIG of ABCT. Jen sees this position as an opportunity to foster connection and communication between members of the SoAP, other divisions within APA, and the Science Directorate.

Ty S. Schepis will serve as our new **Treasurer.** As a young psychologist, Ty has already made significant contributions to SoAP. Ty served on the website committee of the division in 2010, and coordinated the Presidential One-Hour Mentoring Program that year. Ty's goals as Treasurer are to further the financial standing of SoAP by keeping expenses below or in line with income; continue conservative investment of any unspent earnings to increase the endowment of SoAP; and to increase both awards and travel stipends to the Collaborative Perspectives on Addiction conference, particularly to graduate students and early career professionals.

Brandon Bergman, currently appointed to serve as Acting **Secretary,** has been elected to this position for the next three years. Brandon is a psychologist at Massachusetts General Hospital with a faculty appointment at Harvard Medical School. Brandon plans to continue his work on effective dissemination and implementation of the Certificate of Proficiency and aiding division leadership in obtaining board-certification in addiction psychology. Brandon also plans to develop strategies to use web-based platforms (e.g., the division website, Facebook page, etc.) as organizational and information-sharing tools for division members.

I want to thank Clara Bradizza, Lori Eickleberry, Nancy Haug, Fred Rotgers, Jesse Suh and Aaron Weiner for volunteering to run for office and conducting their campaigns. These are people willing to commit time and energy to support and advocate for the rest of us, and they deserve our thanks. I'm sure we will see all of them serving SoAP in different capacities in the future.

Thank you to Alan Budney for his work as President this past year. Alan will now serve as Past President, advising our new President, Sherry McKee, and the Board.

A special thanks goes to Jen Buckman, whose tireless and creative work over the past 13 years as Treasurer and PI of the R13 conference grant, along with the Finance Committee, led to the Division being in excellent shape financially and able to fund many young professionals in attending conferences to share their work.ψ

APA Annual Convention 2015: Toronto, Ontario August 6 - August 9

Suzette Glasner-Edwards and Kristina Jackson
SoAP 2015 Program Chairs

Join us for this year's APA Convention in Toronto! We have a fantastic program, which includes a variety of symposia as well as social hours and poster sessions! Several of the presentations are focused on this year's theme of the science and treatment of co-occurring disorders, but we feature a wide array of other topics in the prevention, treatment, and public health implications of substance use. Our program covers a wide range of addictive behaviors, including alcohol use, marijuana use, and opioid and other substance use disorders, as well as disordered gambling and internet addiction. As in previous years, we have developed our program in close collaboration with Division 28 (Psychopharmacology and Substance Abuse). They, too, have an outstanding program planned, as do many other divisions who will be sponsoring events that will be directly relevant to SoAP members. Be sure to check out Division 28's events and the many convention events that are co-listed by Division 50 in the APA Program.

We have three poster sessions to tell you about! Division 50 is hosting a poster session on Saturday afternoon from 12-1pm and another on Saturday from 1pm-2pm. These poster sessions are a great way to hear about the ongoing research of premier addictions groups, not to mention to identify future students, interns, and post-docs for your own research efforts. In addition, once again we are holding an *Early Career Investigators Poster Session and Social Hour*, scheduled on Friday from 4-6pm. It is held in collaboration with Division 28 and the National Institutes on Alcohol Abuse and Alcoholism (NIAAA) and Drug Abuse (NIDA). This session showcases the work of rising stars in the addictions field and provides unique networking opportunities for our early career investigators with researchers and clinicians in the field. We encourage established psychologists to attend and mingle. Hors d'oeuvres will be served.

We want to remind you about the annual SoAP Business Meeting (Friday 11am-12pm) where we will discuss the past year's activities of the Executive Board and all SoAP committees. The Business Meeting immediately follows the SoAP Presidential Address given by our esteemed Alan Budney prompting us to answer the timely question, "*How Can Behavioral Science Inform Marijuana Regulation Policy?*" In addition, we invite all student members to join us on Wednesday from 4-6pm at our annual Social Hour where we will be awarding Student Poster Awards, as well as distributing awards to SoAP members who have made outstanding contributions to the field (invitation only).

The full program is listed on the following pages. The wide range of presentations reflect SoAP's longstanding goal of enhancing discussion and dialogue between researchers and clinicians. We hope to see you there!ψ

SOCIETY OF ADDICTION PSYCHOLOGY (Division 50)
2015 APA CONVENTION PROGRAM

Thursday, August 6th

8:00 AM - 9:50 AM: SYMPOSIUM
(Convention Centre Room 705)
Substance Use and Psychiatric Co-Morbidity – Findings, Challenges, and Opportunities
M. Goodman, P. Smith, J. Johnson, C. Bradizza, J. Kelly

9:00 AM - 9:50 AM: SYMPOSIUM
(Convention Centre Room 104B)
Minimizing Pills and Maximizing Skills – Achieving Successful Opioid Cessation in Chronic Pain
J. Hah, R. Prasad

10:00 AM - 10:50 AM: SYMPOSIUM
(Convention Centre Room 201F)
HIV and Substance Use: Using Technology to Understand and Intervene Upon Risk Behaviors
S. Glasner-Edwards, J.Pellowski, D. Hasin, S. Kalichman

11:00 AM - 12:50 PM: SYMPOSIUM
(Convention Centre Room 715B)
Does Intervening With Populations at High-Risk for Substance Abuse Reduce Suicide Risk?
N. Leonard, H. Resnick, D. Walker, J. Sherrill

1:00 PM - 2:50 PM: SYMPOSIUM
(Convention Centre Room 801A)
Brown University's Alcohol Research Center on HIV – Initial Findings
T. Wray, M. Celio, N. Mastroleo, D. Operario, J. Rehm

3:00 PM - 3:50 PM: SYMPOSIUM
(Convention Centre Room 711)
Health-Risk Behaviors Among College Students – Trends and Implications for Research and Practice
L. Buckner, G. Groth, L. Longo, J. Prout, Y. Li, B. Freidenberg

4-6 PM: DIVISION 50 BOARD AND COMMITTEE RECEPTION (Closed)
(Luma Restaurant, 350 King St. W, TIFF Bell Lightbox, 2nd fl)

Friday, August 7th

8:00 AM - 9:50 AM: SYMPOSIUM
(Convention Centre Room 104A)
Marijuana on the Adolescent Brain? Exploring Neurodevelopment and Behavior
S. Gruber, K. Lisdahl, F. Filbey, J. Jacobus, S. Feldstein Ewing

10:00 AM - 10:50 AM: PRESIDENTIAL ADDRESS
(Convention Centre Room 803A)
How Can Behavioral Science Inform Marijuana Regulation Policy?
Division 50 President: Alan Budney

11:00 AM - 11:50 AM: DIVISION 50 BUSINESS MEETING
(Convention Centre Room 803A)
Open to all Division 50 members

4:00 PM - 5:50 PM: NIDA/NIAAA EARLY CAREER INVESTIGATORS POSTER SESSION AND SOCIAL HOUR
(Fairmont Royal York Hotel, Imperial Room)
Open to all convention attendees.

Saturday, August 8th

8:00 AM – 9:50 AM: SYMPOSIUM
(Convention Centre Room 103A)
Technology and substance use disorders: Expanding our methods and improving our science
K. Preston, M. Koffarnus, K. Horvath, E. McClure, S. Sigmon

9:00 AM - 9:50 AM: SYMPOSIUM
(Convention Centre Room 803A)
Novel Nonpharmacological Interventions for Addiction
K. Witkiewitz, C. Hendershot, E. Claus

10:00 AM - 11:50 AM: SYMPOSIUM
(Convention Centre Room 717B)
Exercise as an Adjunct Treatment for Substance Use Disorders
J. Chudzynski, T. Trivedi, S. Alessi, R. de la Garza, R. Rawson

10:00 AM - 11:50 AM: SYMPOSIUM
(Convention Centre Room 202B)
Sex Differences in Marijuana's Effects in Human and Animal Studies--- Equal Opportunity for Abuse?
J. Wiley, L. Fattore, P. Winsauer, T. Franklin, M. Haney

12:00 PM - 12:50 PM: POSTER SESSION
(Convention Centre, Exhibit Halls D and E)
Division 50 Poster Session on Addictive Behaviors

1:00 PM - 1:50 PM: POSTER SESSION
(Convention Centre, Exhibit Halls D and E)
Division 50 Poster Session on Addictive Behaviors

1:00PM - 2:50PM: EXECUTIVE BOARD MEETING (Closed)
(Intercontinental Toronto Centre Hotel, Halton Room)

Predictors and Outcome of Aftercare Participation: Implications for Research and Practice

Simone Arbour & Janice Hambley
Bellwood Health Services, Inc.

Although residential treatment is often a necessary first step on the road to recovery from addiction, research has demonstrated the importance of long-term post-treatment aftercare to help support individuals in realizing and maintaining their recovery goals (Gossop, Harris, Best, Man, Manning, Marshal & Strang, 2003). Because addiction is a chronic disease of the brain's reward, motivation, and memory systems (American Society of Addiction Medicine, 2011), it requires long-term management. Therefore, addiction treatment does not end with the initial program completion. Research has consistently demonstrated that working a strong program in aftercare is one of the best predictors of long-term recovery and behaviour change (Fiorentine & Hillhouse, 2000; Hambley, Arbour, & Sivagnanasundaram, 2010; Moos & Moos, 2007). Given the importance of aftercare in addiction treatment, it is useful to explore and understand factors that may contribute to the likelihood that one may engage in ongoing continuing care.

Importance of Aftercare in Early Recovery

While most holistic residential treatment programs aim to repair the physical, psychological and social damage caused by the addiction, a major outcome of such programming is also to prevent relapse. Throughout their residential treatment, individuals work hard on developing a realistic and meaningful plan for recovery that includes the ongoing engagement in support programs and continuing care or aftercare. Such programs can include, among other things, group-based outpatient programs, individual counselling, and 12-Step programming. This plan for ongoing support is important because research has demonstrated that most relapses occur within the first 3-4 months following treatment (Brown, Vik, & Creamer, 1989; Marlatt & Gordon, 1985; Sannibale et al., 2003).

Early recovery is a time of transition. The brain and body are still in a state of stabilization and repair. In early recovery, individuals are also refining the newly developed adaptive coping strategies to deal with life's stressors. Participation in self-help groups such as Alcoholics Anonymous lends itself to an increase in active coping. By sharing one's story at a meeting, listening and providing feedback to others and seeking advice, the individual is no longer avoiding, numbing, or self-medicating with alcohol and drugs but actively seeking social support or instrumental support to deal with problems head-on. Research has demonstrated that in a 40-year long-term follow-up study of male alcohol abusers, regular AA attendance was associated with longer relapse prevention than any other factor, including demographic and socio-economic variables (Vaillant, 2003). At follow-up, Vaillant found that the men who achieved stable abstinence attended roughly 20 times as many AA meetings as the men who were not abstinent.

We have conducted various outcome research over the years, each with different lengths of follow-up ranging from three months to five years. Across all our studies, we found that the most significant predictor of improvement in clients receiving residential addiction treatment was regular aftercare attendance during the first year of recovery (Hambley et al., 2010 & Hambley et al., 1998). For example, in our most recent study, we found that 83% of individuals who attended at least two forms of regular continuing care were continuously abstinent or achieved at least a 95% reduction in substance use at six-months follow-up (Hambley et al., 2010).

Predictors of Aftercare Engagement

Given the significant association between recovery status and aftercare engagement, it is important to determine factors that may increase an individual's likelihood of participating in such programs. Past research has examined the impact of some demographic variables such as gender or factors like motivation to predict aftercare engagement. Generally speaking, research investigating predictors of aftercare engagement have yielded mixed results.

For this reason, we conducted our own study to identify factors associated with greater post-treatment aftercare participation in 367 adults who completed residential substance abuse treatment at Bellwood Health Services in Toronto, Canada (Arbour, et al., 2011). We used a number of predictor variables to examine engagement in three types of continuing care: 1) 12-Step programming, 2) Individual counselling and 3) Outpatient aftercare programming offered by the institution providing the residential treatment. Predictor variables included: demographic variables such as age, gender, education and marital status, substance use history, concurrent disorder diagnosis, treatment entry motivation, satisfaction with residential treatment and length of residential treatment.

At six-months follow-up the majority of participants (74.1%) reported attending at least one type of aftercare support regularly. Just over half of participants (55%) reported attending 12-Step

programming weekly, 37.3% reported attending some form of regular individual addiction counseling, and 36.9% attended outpatient group-based aftercare offered by Bellwood Health Services at least every other week.

Significant predictors emerged for each of the continuing care programs. Key findings from this research revealed that for 12-Step programming and individual counselling, the length of residential treatment program emerged as a significant predictor of weekly engagement in each of these aftercare supports. In particular, we found that for each additional day spent in treatment, the participant was 2% more likely to engage in regular 12-Step programming or individual counselling at six-months follow-up.

For the structured group-based outpatient programming offered by the treatment facility, satisfaction with the institution emerged as a significant predictor of engagement in the continuing care support. For each unit increase on the satisfaction measure, the participant was 14% more likely to attend Bellwood's structured aftercare program. With the aspiration of integrating research and practice, these findings suggest implications for residential addiction treatment centres.

Implications for Practice and Future Research

If treatment duration is associated with an increased likelihood of engaging in continuing care, then research such as the study outlined above raises questions about the recommended length of treatment for individuals receiving residential treatment for addiction. For example, findings in our study suggest that a mere 10-day increase in residential treatment would increase the likelihood of attending post-treatment individual counselling or 12-Step programming by 20%. Therefore, a longer, more comprehensive treatment program with an introduction to aspects of 12-Step programming and group-based aftercare meetings would be ideal.

At the residential treatment facility in our study, clinicians took the opportunity within the residential program to expose clients to aspects of continuing care. For example, clients were required to attend three 12-Step meetings per week for the duration of their residential stay. In addition, individuals who sign up for the outpatient continuing care are required to begin attending the group-based meetings while in residential treatment. This practice of integrating aftercare components into the residential treatment program most likely contributed to the high rates of continuing care involvement reported by the participants in the study.

Lastly, client satisfaction with the treatment facility predicted engagement in facility's outpatient continuing care. These (somewhat intuitive) findings encourage treatment providers to make quality assurance and client input programs a priority in service delivery. The improvements in programming not only benefit the residential clients, but may also increase the chances that the client attends the facility's outpatient continuing care.

The consistent, significant association between continuing care engagement and long-term recovery reinforces the notion that researchers and clinicians alike should view aftercare engagement at follow-up as an *outcome* variable rather than one that moderates outcome. The idea that the importance of aftercare cannot be overstated, suggests that a successful addiction treatment outcome for clients and clinicians (and one that they should be working towards) is the establishment of the realistic and meaningful long-term aftercare plan.

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Continuing Care for Substance Use Disorders: Oxford House Recovery Homes

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In the US in 2010, approximately 11.2% (2.6 million persons) of the population with substance use disorders received treatment from a hospital, rehabilitation center, or other mental health facility (SAMHSA, 2010).(SAMHSA, 2010b). However, approximately 57% of these clients (1.4 million) had been in treatment at least once prior(SAMHSA, 2010b). These figures suggest that there may be a pattern of substance use, treatment, post-treatment relapse, and subsequent retreatment (Warner & Kramer, 2008), sometimes called the "revolving door" of alcohol and other drug (AOD) treatment (White & Kurtz, 2006). Given that total AOD treatment care costs in the US are estimated to be $12 billion annually, it follows that relapse and re-treatment are significant contributors to the overall costs of AOD problems.

Lack of social support networks and exposure to risky environments are two major factors in AOD relapse (Gossop, Stewart, Browne, & Marsden, 2002; Marlatt & Donovan, 2005; Walton, Reischl, & Ramanathan, 1995). Risk-prone environments are those in which AODs are readily available, where social contacts are friends, family, and others using AODs, and/or environments in which illegal activities which support AOD use is common (McKeganey, Intosh, & Keganey, 2000; Moos & Moos, 2006; Walton et al., 1995). After treatment, many individuals have no alternative other than to return to risky environments.

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Oxford Houses are a model of residential recovery homes that provide both social support and AOD-free housing. Created in 1975 in Maryland, Oxford Houses are self-run, single-gender, non-professional communal recovery homes for people whose goal it is to remain abstinent from AODs. In its most common form, an Oxford House is a rented, single-family house in which 7 to 12 same-gender individuals in AOD recovery live together as a communal entity (Oxford House Inc., 2011a). To be an official or "chartered" Oxford House, residents must adhere to three criteria: 1) the House must be self-run on a democratic basis; 2) the House must be financially self-supporting with all residents paying equal shares for rent and common utilities (this averages to $100 per week across the U.S.); and 3) any resident who drinks alcohol or uses drugs must be expelled immediately (Oxford House Inc., 2011d, p. 5). An umbrella policy is that any recovering individual may live in an OH for as long as he or she wishes. In fact, the first "rule" agreed upon by the OH founders was to remove any restrictions on length of stay (White, 2012).

Oxford Houses share similarities with mutual support groups such as Alcoholics Anonymous, residential recovery homes (half-way and three-quarter houses), and therapeutic communities (TCs) (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998; Polcin & Henderson, 2008). Like a recovery home or TC, OHs provide housing facilities and a structured environment, but differ from these settings because OHs operate without professional or administrative staff and without a maximum length of stay requirement (Harvey & Jason, 2011; Jason, Olson, Ferrari, & Lo Sasso, 2006). Like mutual-help groups, individual Oxford Houses share a recovery philosophy of complete abstinence; OH residents agree to behave according to a common set of operating principles formalized by the umbrella organization, Oxford House World Services, Inc. Although OH principles for recovery suggest that most OH residents attend self-help groups, many residents also obtain psychiatric and therapeutic help of their own choosing, particularly if they have additional psychological problems (Aase, Jason, & Robinson, 2008; Majer, Jason, Ferrari, & Miller, 2011; Oxford House Inc., 2011a).

Unlike a staffed recovery home or TC, living in an Oxford House is not "treatment"; there are no professional or therapeutic staff employed in the house, nor are there services offered or a therapeutic program to follow. Similarly, there is no staff employed at an OH to administer and maintain the house. Instead, five elected house resident-officers (a president, both a treasurer and comptroller to manage finances, a recording secretary, and a chore coordinator) perform all administrative functions and are rotated every six months by house majority vote (Oxford House Inc., 2011a). Thus, every OH resident is involved in maintaining the house, and chore duties and officer positions rotate among all house residents.

Like a residential recovery setting or TCs, OHs provide long-term housing and an immersive, recovery-oriented environment. An obvious, if sometimes overlooked, advantage of residential aftercare is that they provide housing for a population that often experienced chronic homelessness (Des Jarlais, Braine, & Friedmann, 2007). Surveys taken from OH residents in the United States indicate that 63% of residents were homeless prior to living in their OH, and approximately 79% of OH residents have served time in jails or prisons.

Oxford Houses are not licensed, sequestered environments. Most OHs are located in mainstream suburban

and urban communities because these locations offer a full range of services for living and working (Ferrari, Groh, & Jason, 2009). These locations typically have access to public transportation, grocery stores, restaurants, recreation, shopping, and access to paying jobs. Living in ordinary homes without a maximum length of stay restriction allows OH residents to interact with neighbors as members of the community rather than as patients. In addition, OH locations also provide OH residents with choices to attend 12-step meetings, therapy, or other treatments per the discretion of each resident.

Research indicates that Oxford Houses are effective. Groh et al. (2009) summarized that regular treatment and 12-step meetings (e.g. Alcoholics Anonymous, Narcotics Anonymous) produced sobriety rates of 45%, while living in an Oxford House can produce sobriety rates of 87% when combined with treatment and 12-step meetings. In addition, current and ongoing studies also indicate Oxford Houses have a positive impact on reducing aggressive and criminal behavior (Aase et al., 2008). The combination of supportive sober living environments with other recovery resources seems to have a powerful protective effect against relapse. Finally, self-run and self-financed OHs can provide services at much lower costs than professionally run acute- and chronic care facilities, as well as prison-based treatment systems (Olson et al., 2006).

Of Oxford House residents in the USA, three-quarters are male and one-quarter female, and approximately one-third are African American (Oxford House Inc., 2011d). The average age of the residents is 32.5 years. Oxford Houses exist for both men and women with children, there are houses for the hearing impaired, those with serious psychological disorders, Spanish-speaking houses, and houses in both urban and suburban environments (Jason, Davis, & Ferrari, 2007). Half of Oxford House residents come directly from referrals from a detoxification program or treatment center, and word-of-mouth referrals from attending AA, NA, and other 12-step meetings. Oxford House vacancies can be found through the OH website search tools (http://oxfordhouse.org/locate_houses.php).

Importantly, each Oxford House is part of a national network of sober residences following the same principles, and are remarkably similar in structure regardless of location (Ferrari, Jason, Blake, Davis, & Olson, 2006; Ferrari, Jason, Sasser, Davis, & Olson, 2006). By some estimates, the OH model represents the most widely implemented aftercare program for former substance abusers in the world. Currently, there are over 1,700 OHs with over 12,700 residents worldwide (Oxford House Inc., 2012). Each year, Oxford House World Services, Inc. holds an international conference in which hundreds of current and former OH residents, leaders, and professionals attend to exchange experiences, obtain advice on house operations, and for general fellowship and friendship. Although the vast majority of OHs are in the United States, there are OHs in Australia, New Zealand, Ghana, the U.K., and efforts are underway to create OHs in places as diverse as Nigeria and Bulgaria. (Contact the first author if interested in learning more about these international initiatives.)

For more than twenty years, a DePaul University-based research team has been involved in studying Oxford Houses in order to better understand the role they play in substance abuse recovery. Please visit the Oxford House publication page at the DePaul University Center for Community Research website at: http://condor.depaul.edu/ljason/oxford/publications.html for links to many of our research articles on Oxford Houses.

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Recovery Support Services: A New Look at Continuing Care

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Why Continuing Care? A Brief Historical Overview

The use of drugs and alcohol was historically regarded by society as a weakness of will or moral failing, and the medical field treated it as incurable, relegating the 'afflicted' to asylums. The addiction field has undergone two transformative changes in the past twenty years that are changing the way addiction is addressed. A 2000 article put forth that in terms of course and other key features, addiction is a chronic medical disorder, on par with other chronic conditions such as diabetes, hypertension and asthma (McLellan, Lewis, O'Brien, & Kleber, 2000). By definition, chronic conditions cannot be cured but can be managed through self-care, professional and/or social support. With the hope of finding a 'cure' dashed, the goal of treatment became to equip clients with strategies they can use going forward, once treatment has ended.

From Treatment to Recovery: A Paradigmatic Shift

Enters the concept of 'recovery,' a term thus far rooted in 12-step programs such as Alcoholics Anonymous. In that context, 'recovery' went beyond sobriety. Perhaps in response to a growing grassroots movement of persons in recovery, and/or recognizing the costs of the current acute care model of services, SAMHSA set its sights on 'recovery.' The first order of business was to define the construct, a task that started in 2005 with the first national summit on recovery that gathered addiction professionals, persons in recovery and recovery advocates, treatment funders and other stakeholders (Center for Substance Abuse Treatment, 2006). The resulting recovery definition had two implications for services: 1) Since recovery is a process (not an endpoint), it requires ongoing services (i.e., continuing care); and 2) the goal is broader than mere abstinence but rather, includes improvements in other life areas impaired by active addiction.

Informed by these concepts, SAMHSA advanced an organizing framework for recovery support services: the **Recovery Oriented Systems of Care (ROSC)** model (Clark, 2008a, 2008b). ROSC seeks to intervene early with individuals with substance use disorders (SUDs), to support sustained SUD recovery, and to improve health and wellness. ROSC ushered in 'legitimized' recovery support services, a service element that was previously largely absent from the care model as formal aftercare services, while effective (J. R. McKay et al., 2009) are not always available due to treatment programs' financial constraints.

Implementing ROSC requires two paradigmatic shifts in service development and delivery: a focus on wellness promotion rather than symptom management, and a transition from the acute care delivery model to one where stepped down (continuing) recovery support services are available as needed. Such momentous changes in a system take time and resources to implement; US states nationwide are proceeding at different paces according to their size and resources.

At about the same time ROSC was launched, another transformative change occurred in our field that contributed to crystallize the momentum for recovery support services: Following the 2008 presidential election, new leadership at the White House Office of National Drug Control Policy (ONDCP, i.e., the 'drug czar's office') effected drastic changes in the nation's approach to drug use. From a largely punitive approach (i.e., incarceration and 'the drug war'), ONCDP's national drug policy is now squarely rooted in public health, and recovery is promoted through the agency's Recovery branch and various efforts to promote recovery support services (Office of National Drug Control Policy, 2010). This shift is also consistent with the newly implemented Affordable Care Act of 2010 that emphasizes the importance of providing ongoing services for chronic conditions. This convergence of transformative changes in US policy and healthcare delivery has provided a fertile context for recovery support services to develop and become more available.

Types of Continuing Care Recovery Support Services (RSS)

Recovery support services (RSS) can be delivered by professionals and by peers—individuals who have experiential knowledge of recovery (A. B. Laudet & Humphreys, 2013). Delivered by professionals, RSS takes the form of continuing or 'stepped down' aftercare, typically following intensive inpatient or residential treatment, an approach that has been heavily practiced and researched (J. R. McKay, 2009; J. R. McKay, et al., 2009). Other, more recently developed forms of professionally delivered care that have been shown effective include telephone-based continuing care (J. R. McKay, Lynch, Shepard, & Pettinati, 2005) and regular post-treatment **Recovery Management Check-ups** (RMC) that aim to monitor clients' status, minimize relapse risk and to provide linkage to services after relapse to shorten the cycle (C. Scott, White, W., Dennis, M., 2007; C. K. Scott, Dennis, & Foss, 2005).

Peer-based recovery support is a more recent approach. It builds on the 'helper therapy principle' (Riessman, 1965) whereby helping someone else who is going through the same challenge as you helps you as well. The support of peers is consistently cited a key to recovery maintenance across studies and samples (A. B. Laudet, Savage, & Mahmood, 2002; Margolis, Kilpatrick, & Mooney, 2000).

Peer-based recovery support is the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery: Peers assist others in initiating and maintaining recovery and enhancing their overall quality of personal and family life in long-term recovery; peers may be working as volunteers or as paid service workers (Kaplan, 2008). As discussed elsewhere (A. B. Laudet & Humphreys, 2013), peer-based approaches have been implemented extensively to address a range of chronic conditions, including asthma, breast cancer, depression, and diabetes. Unlike professionally delivered services, peer-based RSS can be delivered in a variety of community-based venues such as recovery community centers and homes, faith-based institutions, jails and prisons, other health and social service centers (Faces and Voices of Recovery, 2010).

The following are the most developed forms of peer-based RSS:

- ***Recovery coaches*** mentor persons seeking stable recovery: they assist in setting recovery goals and a recovery plan, and serve as role models. They may also help connect the individual to recovery-supportive resources needed to restructure life (e.g., housing, employment) and serve as advocate and liaison. Recovery coaching has not been evaluated systematically but the approach showed promise in the context of a clinical trial of integrated case management for parents in substance-involved families: the model enhanced access to treatment, resulting in increased family reunification rates compared to standard care (Ryan, Choi, Hong, Hernandez, & Larrison, 2008).

- ***Sober residences*** are homes that offer mutual help-oriented, financially self-sustaining, self-governed, democratic communal-living environments where individuals in recovery can live for as long as they desire after, or as an alternative to treatment (Polcin, 2009). Oxford House (OH) is the most prevalent model of sober housing in the U.S.; it has received strong empirical support across studies with various populations (Jason & Ferrari, 2010) and is also cost effective (Lo Sasso, Byro, Jason, Ferrari, & Olson, 2012).

- ***Collegiate Recovery Programs (CRP)*** are the newest model of peer-based recovery support. CRPs are campus-based, peer-driven communities that aim to allow students in recovery to continue pursuing their educational goals in a safe environment. Started at a few universities in the 1980's, the CRP model took hold a decade ago and has since experienced a 12-fold growth, with some 50 CRPs nationwide. This growth promises to continue with the recent formation of the Association of Recovery in Higher Education. While not yet formally assessed, the model holds great promise based on its site-level reports in terms of both academic and substance use outcomes—i.e., low relapse rates (A. Laudet, Harris, Kimball, Winters, & Moberg, 2015).

Take Home Message

Substance use disorders are for many, a chronic condition that may leave the individual prone to relapse and the resulting costly consequences on all aspects of their lives. When addiction has become chronic, even with the best treatment team available, the time limited aspect of treatment necessitates continuing support after services

end. This relatively new approach to addiction has been used effectively for virtually every other chronic condition. For addiction-affected persons, 12-step programs (e.g., AA) were historically the most used form of recovery support in the U.S. (Kessler, Mickelson, & Zhao, 1997) and the de facto aftercare for most, especially since the fiscal environment makes it challenging for most treatment agencies to offer formal aftercare services.

Several recent transformative changes in policy and healthcare delivery have brought continuing care to the forefront of healthcare services, and recovery as a key goal of addiction services. As a result, a number of models of continuing care delivery have emerged, often referred to as "recovery support services" (RSS). Peer-based services are perhaps the most promising for several reasons including the documented effectiveness of peer support to sustain recovery, but also their relatively low costs and therefore longer duration relative to professionally delivered services. Addiction professionals are well-advised to familiarize themselves with local recovery support services and to discuss these options with their patients with the ultimate goal of maximizing positive recovery and overall health outcomes.

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New Directions in Continuing Care for Substance Use Disorders

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Substance use disorders (SUDs) often have a chronic course, characterized by cycles of abstinence, sporadic use, and heavy use (Hser, Longshore, & Anglin, 2007; McKay, 2009a; McLellan, Lewis, O'Brien, & Kleber, 2000). Wider use of extended continuing care has been recommended to increase rates of sustained recoveries and limit the severity of relapse episodes that do occur (Dennis & Scott, 2007; Humphreys & Tucker, 2002; McKay, 2009a; Miller & Weisner, 2002). Despite the perceived importance of continuing care for

SUD, evidence for the effectiveness of such interventions is actually mixed (McKay, 2009b). A recent meta-analysis generated only modest support for continuing care, finding statistically significant but small positive effects at the end of continuing care and at follow-up (Blodgett et al., 2014).

In our own work to improve the effectiveness of continuing care, we have focused on two issues, service delivery alternatives to traditional clinic-based continuing care, and adaptive interventions and research designs. With regard to service delivery alternatives, we have studied the use of telephones—and more recently text messaging and smartphones—to deliver continuing care interventions. Our first study (McKay, Lynch, Shepard, & Pettinati, 2005) found that for SUD patients who completed one-month intensive outpatient programs (IOPs), 12 weeks of telephone continuing care was at least as effective as 12 weeks of standard group counseling or individual Cognitive Behavioral Therapy (CBT) delivered in the clinic. In a subsequent study, we found that adding an 18 month telephone continuing care treatment, that included a brief assessment at the start of each session followed by coping skills oriented interventions to address the most worrisome issues identified in the assessment, to an IOP produced better alcohol use outcome than the standard IOP only. Subsequent analyses indicated the treatment effect was more robust for women and those with prior treatment episodes, and for those with poor social support or low motivation after a month of IOP (McKay et al., 2011).

Our two most recent telephone continuing care studies have yielded more mixed findings. In a study with 321 cocaine dependent patients (McKay et al., 2013a), we examined the impact of adding low-level incentives for completing continuing care sessions to improve participation rates. As expected, the incentives nearly doubled the number of continuing care sessions attended. However, there were no effects on our primary substance use outcomes. Moreover, extended continuing care (with or without incentives) when added to an IOP did not produce better substance use outcomes than the IOP only. Subsequent analyses indicated that there was a large and highly significant positive effect in participants who were still using cocaine or drinking at intake, or during the first few weeks of IOP prior to randomization. Conversely there were no effects in participants who were abstinent during that period.

We also failed to find a positive continuing care effect in a smaller study, in which IOP plus a combination of individual face-to-face and telephone sessions that included incentives for attendance and began shortly after intake rather than after 3-4 weeks of IOP was compared to IOP only (McKay et al., 2013b). In this study IOP only actually outperformed the continuing care intervention. We speculated that this intervention had relatively poor outcomes because it was not well integrated with the IOP.

Currently, we are conducting an NIAAA-funded study in collaboration with Dr. David Gustafson and University of Wisconsin colleagues, to test the separate and combined effects of counselor delivered telephone continuing care and an automated smartphone recovery support program referred to as ACHESS (Gustafson et al., 2014). Each of these interventions has complimentary strengths. Telephone continuing care provides human contact, a working alliance, and the opportunity to develop improved coping behaviors in collaboration with an experienced therapist; whereas ACHESS provides recovery support, such as GPS-driven linkage to social support, suggestions for coping, and relaxation/distraction exercises, available 24/7. In this study, we are evaluating the effects of each of these interventions individually and both combined, and also conducting cost-effectiveness analyses.

Our other focus is the development and evaluation of adaptive continuing care interventions and research designs. In an adaptive treatment approach, patient progress is systematically monitored, and treatment is modified as needed when a patient is not responding adequately. We have been interested in whether early progress in treatment, prior to the initiation of continuing care, can be used to select optimal continuing care interventions. Our first study in this area found that cocaine dependent patients who failed to achieve remission from cocaine dependence during IOP benefited from individualized CBT continuing care over standard group counseling, whereas there was no treatment effects in patients who stopped using cocaine during IOP (McKay et al., 1999).

Our other continuing care studies, described above, provide further support for this approach. We have consistently found that more intensive or extensive continuing care is most effective for patients who are struggling to achieve the goals of the initial phase of outpatient treatment, including stopping alcohol and drug use, improving social support for abstinence, and increasing motivation for recovery. Conversely, patients who achieve these goals early in treatment derive little if any benefit from extended or more intensive continuing care (McKay et al., 1999; 2005; 2011; 2013). This suggests that by monitoring patient progress in these areas in the first weeks of treatment, counselors could better determine whether extended continuing care should be recommended to the patient.

We are also studying the impact of an adaptive prevention intervention, designed to achieve sustained reductions in hazardous drinking in veterans receiving opioid medication for pain. In this study, veterans on opioid pain medication who screen positive for hazardous drinking are given a brief intervention and monitored for four weeks. Those who reduce their drinking go into a low-level monitoring track, which consists of monthly check-in telephone calls and supportive text messages. Conversely, those who do not reduce drinking are placed in an enhanced prevention condition, which includes more frequent telephone

calls focused on motivation or skills issues and text messages that target specific problems. During the 12-month prevention intervention period, those in the monitoring track who once again begin to drink more heavily are transferred over to the enhanced prevention track until their drinking levels decline again. Similarly, those in the enhanced prevention track who reduce drinking are switched over to the monitoring track.

In summary, the work of our group and of others indicates that continuing care may be more important for some patients than for others, and that it may not help patients unless it is well-integrated with the rest of the treatment continuum. Although adaptive interventions have obvious appeal, they are difficult to implement and present significant challenges. For example, if a client does not respond to one intervention, it is unlikely that she will respond to an alternative unless it works very differently from the first intervention offered, and we do not yet have a wide range of effective interventions with markedly different mechanisms of action. Moreover, our experience suggests some SUD clients who are not responding are unwilling to start the alternative intervention. Instead, they are pulling back, or dropping out altogether. Therefore, although adaptive approaches to continuing care hold considerable promise, more work will be needed to develop a wider range of treatment options with different mechanisms of action and improve methods to retain clients who are struggling.

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Technology to Support Continuing Care for Substance Use Disorders

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Mobile and internet technologies are rapidly transforming our approach to the management of chronic diseases. Individuals with conditions such as diabetes or heart disease can achieve better outcomes when they have access to technologies that can help monitor their symptoms, share data with their providers, and facilitate self-management behaviors (Elbert, van Os-Medendorp, van Renselaar et al. 2014). Emerging evidence suggests that tools for patient self-management and connection to ongoing care may be just as critical to continuing care for Substance Use Disorder treatment, as they are for the long-term management of other chronic health conditions (Quanback, Chih, Isham et al. 2014). For example, a client who is completing an episode of residential treatment will need to stay connected with aftercare providers, monitor progress, engage with supportive peers, and operationalize coping and relapse prevention plans in the context of

real world triggers. This brief article highlights some recent encouraging findings from researchers who use technology to support continuing care, and concludes with some suggestions for increasing the implementation and sustained adoption of these technologies in real world clinical practice.

Readers may have heard about the exciting results of a recent clinical trial published by Gustafson and colleagues in JAMA Psychiatry (Gustafson, McTavish, Chih, et al., 2014). This trial evaluated the A-CHESS (Addiction-Comprehensive Health Enhancement Support System) mobile application. This "comprehensive recovery management system" does it all; outcomes monitoring, connection to social support, self-directed exercises, AA meeting locator, online discussion groups, podcasts, even a feature that allows the user to set up alerts that use GPS to warn them when they are approaching a location that they identified as a trigger for relapse.

One hundred seventy patients in three residential treatment programs were randomly assigned to receive smartphones with the A-CHESS app before discharge. While still in treatment, the counselor helped them to set up their profile, showed them that they could use the discussion board and texting feature, and helped them identify two individuals that they could contact if they pressed the apps "panic" button. Patients completed a weekly outcomes measure, which most (97%) chose to share with their counselors. Time spent by counselors interacting with patients was not tracked, but was reported as being minimal. For the eight months of the intervention, and 4 months of follow-up, patients in the A-CHESS group reported significantly fewer risky drinking days than did patients in the control group, with a mean of 1.39 vs 2/75 days (mean difference 1.37; 95% CI, 0.46-2.27; p=.003).

Another innovative study that used smartphones to support continuing care for SUD was recently published by Alessi & Petry (2013). In this study, a mobile app was used to reinforce alcohol abstinence as part of a Contingency Management (CM) protocol. CM uses tangible incentives to reinforce abstinence, and is among the most efficacious psychosocial treatments for substance use disorders (Lussier, Heil, Mongeon, et al; 2006; Prendergast, Podus, Finney, et al, 2006). Voucher amounts typically escalate for each consecutive negative test to promote sustained abstinence, and vouchers reset when abstinence does not occur.

Participants received a phone, a breathalyzer and training on video-recording alcohol breath tests on their phone, (BrACs) and texting results. Staff texted participants one to three times daily, asking them to send the results of a BrAC within the hour. Participants were randomized to either receive modest compensation for submitting dated time-stamped videos regardless of the results or to a condition that used escalating vouchers for on-time alcohol-negative tests. The percentage of negative BrACs and LDA (Longest Duration (in days) of Abstinence) were greater with CM, and there was an interaction effect on drinking frequency and negative consequences, with decreases over time with CM (p=0.00; effect sizes d=0.52-0.62).

Smartphone capabilities such as GPS and real-time video upload represent exciting new possibilities for enhancing the continuity of care for SUD. Computerized Cognitive Behavioral Therapy (CCBT) interventions that have been optimized for delivery on desktop and laptop computers have also demonstrated their potential for helping SUD clients to remain abstinent (Carroll, 2014). Such programs typically use interactive exercises, streaming media, and some level of conditional logic to personalize the learning experience. Researchers Reid Hester, Kathleen Carroll, and Lisa Marsh, have all been very active in developing, evaluating, and commercializing CCBT interventions for SUD treatment. The results of published clinical trials evaluating these interventions for continuing care have been universally positive, whether using the CCBT intervention as "partial replacement" for treatment services (Marsch, Guarino, Acosta, 2014; Carroll, Kiluk, & Nich, 2014) or as an adjunct to a mutual help program (Hester, Delaney & Campbell, 2011). Published accounts of Hazelden's efforts to implement comprehensive recovery management system MORE – My Ongoing Recovery Experience in their residential treatment system, have been similarly positive (Klein, 2014; Klein & Anker, 2013).

Despite these encouraging findings, evidence-based technologies to support continuing care for SUD are not broadly available to SUD patients in the community. In the interest of scaling up these interventions for maximum reach and public health impact, I offer the following suggestions to researchers in this area; 1) *Embrace the implementation science perspective* (e.g. Damschroder, Aron, Keith et al., 2009) in order to understand the contextual factors that drive an organization's decision to invest in, and maintain a new technology. For example, the Consolidated Framework for Implementation Research (Damschroder et al, 2009) provides a pragmatic structure for understanding the complex, interacting elements of both the inner setting (e.g. clinic or residential program) and outer setting (e.g. health care system). Using the common constructs embodied in the CFIR to report the results of a study can improve the generalizability of findings regarding work with partnering organizations. 2) *Look to research in related areas for best practices in implementing technologies to support sustained behavioral change*. To be sure, continuing care for SUD presents some unique challenges, but that is not to say that we can't learn from colleagues who are working on sustaining other behavioral changes, such as weight loss (Liu, Kong, Cao, et al. 2015), or changing thoughts and behaviors related to depression and anxiety (Bennett-Levy, Richards, Farrand et al., 2011). How are researchers in these areas using

coaching and outcomes monitoring to improve care? What amount of human support, provided by whom, in what medium, is required for people to engage with these programs, and to keep them engaged until they realize some benefit? 3) *Address systems integration issues early and often.* Many promising technologies cannot be brought to scale in large health care systems until they can successfully exchange data with an organization's electronic medical record. Rather than developing proprietary new platforms that require clients to log in to separate systems, investigators are encouraged to partner with health care systems and insurers who have already deployed secure online platforms for patient engagement.

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Developing Home-Based Continuing Care: Exploring Feasibility and Acceptance With Parents and Young Adults

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Nearly 450,000 young adults (YAs; defined as 18-25 years old) enter drug treatment each year; with over 25% entering costly residential treatment programs, which tend to treat individuals with higher severity and relapse risk (SAMHSA, 2011). Despite the development of new continuing care models, most residential programs discharge patients with referrals to outpatient treatment and/or instruction to attend self-help groups. Those who comply tend to have reduced substance use post-treatment, but many do not link to the referred services or participate minimally in them. As such, relapse is common (60-75% at 3 months post residential treatment; e.g., Dennis et al., 2003; Godley et al., 2001; Kennedy & Minami, 1993). One reason for poor compliance may be that many areas served by residential programs do not have age-specific services or self-help groups (Godley et al., 2002). Given the lack of age-appropriate continuing care services and poor engagement by YAs, it is not surprising that many parents

report feeling unsupported and poorly prepared when the YA returns to live with them after residential treatment (Bohrs, 2007).

The Home-based Continuing Care (HCC) Concept

With these statistics in mind, we are developing a Home-based Continuing Care (HCC) program for YAs leaving residential treatment. The model will combine two approaches with proven efficacy. The first, therapist-delivered Telephone-based Continuing Care (McKay, 2009; 2011), has at least two advantages: 1) it is practical for residential treatment programs that treat YAs from a wide geographical area, and 2) it essentially reduces the response-cost for YAs to participate, which may increase their engagement in continuing care. Therapists will contact the YA patient weekly, assessing relapse risk and coaching them on relapse prevention strategies or connecting them with additional treatment. The second approach is parent-delivered Contingency Management (CM; Stanger & Budney, 2010). Parents (biological; adoptive; former guardian or caretaker) will receive training allowing them to partner with the remote therapist, administering home-based urine testing with CM for verified abstinence and for engagement in continuing services. Our goal is to develop an effective continuing care intervention that will prepare parents for the YA's return home without expecting them to become the YA's therapist. We recently interviewed parents and YAs in person and by telephone to collect informed judgments on the acceptability of the proposed HCC procedures and to identify and find solutions to potential barriers to their participation. Specifically, we wanted to know:

- What proportion of YAs live with a parent after discharge from residential treatment?
- Would YAs be willing to involve parents in their continuing care? Would parents do it?
- Would YAs and parents be willing to participate in a program by telephone or internet?
- What features of the program would they like or dislike? Would they agree to urine tests?
- What changes would they need to see in themselves and the other person to make their participation worthwhile?

YAs (*n* = 72) and Parents (*n* = 42)

We recruited participants from residential alcohol and drug treatment facilities, family support groups, and YA recovery support groups. YA participants tended to be representative of YAs in residential treatment in the U.S. (74% male; 79% White, and 93% non-Hispanic), but were unemployed (71%) and using heroin or another opioid (66%) at higher than representative rates. Parent participants were 98% White. After gaining informed consent, we described to participants the proposed HCC program before asking them questions regarding their feelings toward the program. Participants were paid $40.

What proportion of YAs live with a parent after discharge from residential treatment?

The largest proportion of YAs (44%) reported that they had or intended to live with a parent after discharge; an additional 16% indicated that they had or intended to live with a partner or other family member. This suggests that a HCC model might be feasible with about 60% of YAs in residential treatment.

Would YAs be willing to involve parents in their continuing care? Would parents do it?

Most of the parents and YAs (74% of YAs and 71% of parents) indicated that they liked the parental involvement and education components of the proposed program. Nearly half of the participants (30 YAs; 18 Parents) were directly asked if they would participate in the HCC program were it offered: 87% of YAs and 78% of parents responded affirmatively. Several YAs commented that they wanted their parents to better understand the likelihood of relapse and how to react to it.

What features of the program would they like or dislike? Would they agree to urine tests?

Parental involvement was the feature that the YAs most commonly mentioned liking, but, surprisingly, nearly 40% also indicated they liked the urine testing aspect of the program. Only 8% said they disliked it. Unfortunately, 43% of the parents disliked the idea of urine testing the YA at home, while only 10% liked it. Some parents who objected indicated that they didn't think having the parent do the testing was "age appropriate," while others expressed concern about the potential for adulteration. Although a third of the YAs indicated they liked the use of phone sessions, about a quarter disliked it, commenting that it would be easy to deceive the therapist. Parents were more receptive to phone or live web-based sessions, with 36% indicating they liked the idea and only 10% indicating they disliked it. About a third of the parents also reported liking the HCC program because it would address the need for continuing care.

What changes would you need to see in yourself and in the other person to make participation worthwhile?

YAs most frequently identified abstinence (71%) and improved psychological functioning (50%) as the changes they would need to see in themselves to make the program worthwhile to them. Nearly 40% also mentioned improvements in their relationship with their parent. Parents tended to mention the relationship more frequently (50%), with improved psychological functioning of the YA (45%) and YA abstinence (36%) closely following.

With respect to changes in the parent,

YAs responses focused on improving the parent's education or expectations regarding recovery (60%) and improving their interactions (53%) and relationship with them (40%). Parents also wanted to improve their education (38%) and their interactions with the YA (48%). In addition, 50% of parents mentioned improving their own self-care.

Summary

A larger, representative survey would be needed to draw firm conclusions regarding the feasibility and acceptability of the home-based continuing care model, and ultimately a controlled trial will be required to determine if participants will behave as they say. But some of the YA and parent responses were encouraging. First, over half of the YAs had or planned to live with a parent or partner following discharge from residential treatment, supporting the feasibility of a home-based model. Importantly, the majority of YAs and parents indicated that they would be interested in this type of program if asked. Surprisingly, YAs appeared to view home urine testing more positively than did parents. Some parents appeared to have been heavily influenced by the 12-step family approach that encourages detachment and self-care, indicating that home-urine testing and having the YA live at home would be harmful to their recovery. Clearly, HCC will not be for everyone, but results are positive enough to encourage us to proceed to pilot testing. If successful, this program could provide a cost-effective means of supporting YA recovery for extended periods.

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Results of the Nicotine Anonymous Pilot Study: With an Invitation to Practitioners and Researchers

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Gains have been made in reducing the prevalence of tobacco use (DeAngelis, 2014a; DeAngelis, 2014b; Goodwin, Keyes, & Hasin, 2009) but further reductions remain to be made, especially among smokers living in poverty (Glasser, 2010). Further, smoking cessation services are not reaching communities with high rates of smoking, such as homeless populations (Glasser & Hirsch, 2014). One promising inexpensive aid to tobacco cessation and abstinence maintenance that has received relatively little research attention is Nicotine Anonymous (NicA). Nicotine Anonymous is the 12-step mutual support approach that was adopted from Alcoholics Anonymous (AA). As of 2008, there were 600 meetings worldwide with most in the United States (Nicotine Anonymous-a). There are many meetings in the Los Angeles, New York, and San Francisco metropolitan areas. [There are also telephone meetings scheduled every day of the week for a total of 33 different times a week (Nicotine Anonymous-b)]. Attendance at NicA meetings has not been the subject of satisfactory efficacy testing to date.

In contrast, while posing greater challenges for research due to the greater stigma associated with Alcohol Use Disorder, the efficacy of Alcoholics Anonymous has been demonstrated (e.g., Kelly, Stout, Zywiak, & Schneider, 2006; Pagano et al., 2012). In the present study we present descriptive data on 36 NicA members who completed an anonymous survey, as well as a subset based on possible eligibility criteria for a future NicA efficacy study. We also compared NicA meeting attendance frequency in our sample to AA meeting attendance frequency using archival data.

Method: We conducted an anonymous one-page survey at 10 NicA meetings in California, New Mexico, and Connecticut [funded by the Pacific Institute for Research and Evaluation (PIRE)] that were near PIRE Centers in Berkeley, Albuquerque, and Pawtucket, respectively. This survey included items from the AA Involvement Scale (Tonigan, Connors, & Miller, 1996) with NicA replacing AA to assess meetings attended in the last 12 months and over the lifetime. Participants were compensated with $5 cash for completing the survey. A total of 36 respondents (out of 46 attendees) completed the survey. This sample consisted of 47% women, 6% Latino, 6% Native American, 6% Asian, and 83% White participants.

For a proposed prospective longitudinal study on the efficacy of NicA, we suggest the following eligibility criteria: 1) interest in participating in research; 2) low exposure to NicA (operationalized as 20 or fewer NicA meetings in the last 12 months: a balance between constraining prior exposure to NicA while allowing enough attendees to be eligible); and 3) fewer than 365 days since last tobacco use (so participants would be at risk for relapse, and therefore efficacy based on number of meetings assessed longitudinally could be detected). Length of abstinence for those matching this criterion ranged from zero to 330 days.

Results: Eighty-one percent of our anonymous participants indicated in the affirmative that "If there was a study about NicA which compensated you a total of $175 for being interviewed every 3 months for a year, would you be interested in participating?" Thirty six percent had attended 20 or fewer NicA meetings in the last 12 months. (For the entire sample, up to 200 NicA meetings had been attended in the last 12 months, M = 37.2, SD = 41.8, median = 30.) Seventy two percent had smoked at least once in the last 365 days. (For the entire sample, the longest time since smoking was 5960 days, M = 737, SD = 1496, median = 117.) Ten (28%) of the 36 survey respondents met all three of the proposed eligibility criteria. Therefore, the number of meetings attended in the last 12 months was the most limiting of the three proposed eligibility criteria.

Using the data from all the participants, even with the limitations of a cross-sectional design, we did find evidence that the number of meetings attended in the last 12 months was correlated with the number of days since last cigarette: $r(33) = .34$, $p < .05$, providing rudimentary evidence for the efficacy of NicA meetings.

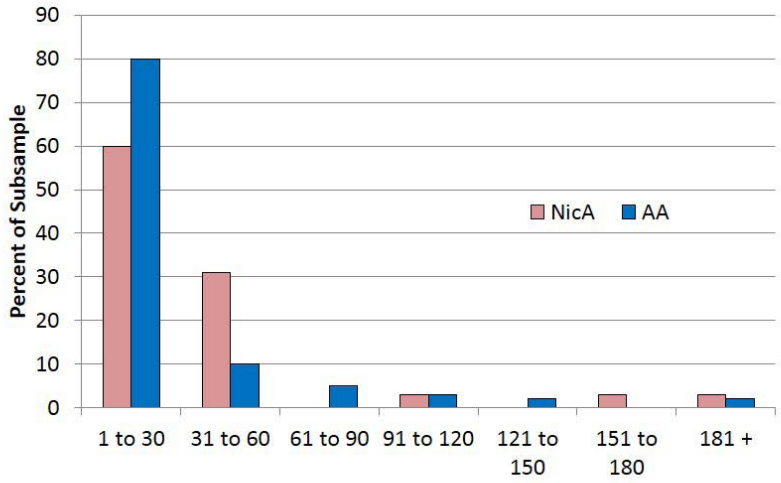
For the subsample of 10 NicA attendees based on the proposed eligibility

criteria, age ranged from 32 to 72, with a mean of 51 (*SD* = 12.3, median = 50). The number of NicA meetings attended in the last 12 months ranged from 3 to 20, with a mean of 11.2 (*SD* = 5.9, median = 10). Time since last tobacco use ranged from less than 1 day to 210 days, with a mean of 64.8 days (*SD* = 69.4, median = 47.5). The majority of the ten attendees (70%) had successfully quit (Shiffman et al., 2006) with at least 24 hours of abstinence (with a range from 20 to 210 days of continuous abstinence). Twenty two percent of the ten had also attended AA meetings. Eighty percent had used nicotine replacement therapy (NRT). None reported using Chantix (varenicline) or other medications besides NRT. [Four of the other 26 survey respondents reported using Chantix (3 participants) and/or antidepressants (2 participants: Wellbutrin and Zyban).]

We reviewed the distribution of the number of meetings attended in the last year for the sample of 36 and compared this to the number of AA meetings attended in the last year at baseline by Project MATCH outpatients (Babor & del Boca, 2003) who had attended at least one AA meeting. (We did not include the aftercare clients since we expected greater severity and greater involvement with AA in the aftercare arm.) We wondered if there would be evidence that members don't "stick" as well to NicA meetings, compared to AA meetings. We did not find evidence of greater attrition in NicA meetings compared to AA meetings, as shown in **Figure 1.**

In fact, our sample attended more NicA meetings (*M* = 37.2, *SD* = 41.8) than the comparison sample attended AA meetings (*M* = 25.1, *SD* = 49.9) as evidenced by a t-test on the square root of this measure $t(42) = 3.02$, $p = .002$. (The square root transformation was conducted to reduce the skewness and transformation of the dependent measure to acceptable levels.) This suggests that the lack of proliferation of NicA meetings relative to AA meetings may stem from other causes. One of these may be the lack of referrals relative to referrals made to AA groups.

Figure 1. Number of Meetings Attended in the Past Year for NicA versus AA



Discussion: We invite substance abuse treatment practitioners to assess smoking status, and refer smoking clients to NicA (meeting times and locations are on the Nicotine Anonymous website). Smoking cessation is not a prerequisite for attendance (just abstinence during the meeting). As indicated in the prior issue of *The Addiction Newsletter*, the prevailing consensus among experts is that smoking cessation should be a goal for those quitting other substances (see e.g., Rohsenow, 2015). It has been reported that patients referred to AA by medical practitioners led to the tremendous growth of AA (Humphreys, 1997). Further, we invite researchers to conduct prospective longitudinal studies to test the efficacy of NicA and to evaluate hypothetical active ingredients of NicA. Additional research questions regarding NicA have been previously suggested by Lichtenstein (1999).

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Observations From Student Division 50 Members Who Attended the 2015 Collaborative Perspectives on Addiction Meeting in Baltimore

Lauren Hoffman
University of Florida

Joseph Clarke
University of South Dakota

Noah Emery
University of South Dakota

The Division 50 Mid-Year Meeting, Collaborative Perspectives on Addiction (CPA), was held in Baltimore, MD on March 6-7, 2015. Despite a terrible snow storm, the meeting was a huge success and the CPA planning committee has received rave reviews of the meeting. One of the highlights of the CPA meeting was the level of student involvement, with over 60 students and early career psychologists in attendance. Here are just a few of the reviews provided by student members in attendance:

Lauren Hoffman, fifth year PhD candidate in the Behavioral Cognitive Neuroscience program at the University of Florida and SoAP student representative to the Executive and Membership Committees: I've attended the CPA meeting since its launch in 2013, and its continued emphasis on the student experience is what makes it my favorite conference of the year. Because CPA is a smaller conference, it provides a more intimate environment and greater opportunity to converse with senior researchers and clinicians. It's particularly encouraging that the meeting hosts so many events that are specifically aimed at the student attendees. This year, I had the opportunity to serve on the panel for the student workshop "Post-Bac to Post Doc: Navigating Graduate School and Beyond." It was really fun to share my advice about graduate school and learn from others about the post-doc application process. I have yet to see a workshop like this one offered at any other conference, which made it a really notable experience. The poster sessions were inspiring, as always. It's exciting to know that there are so many talented young researchers in our field and so much potential for future collaboration! The CPA student social events were especially unique to this conference. Attended by both students and the SoAP executive board, they were a fun way to get to know my peers and converse with senior-career professionals in a less formal environment. It was great to see everyone let loose and just have fun together after a day of amazing symposia. I am undoubtedly counting down the days until next year's CPA meeting!

Joseph Clarke, third year graduate student in the Clinical Psychology PhD program at the University of South Dakota: I try to be involved with organizations outside my University as much as possible to try and round out my experiences in graduate school. One problem for me is that I often find conferences to be very large, intimidating and difficult to navigate. CPA this year had fewer than two-hundred attendees making it feel very comfortable and intimate. There were full days of talks and poster presentations, but no need to sort through a program and choose between which talks you most wanted to attend. I had opportunities to talk with well-established researchers and titans of the field researching exactly what I am interested in. I had a chance to discuss research ideas with peers and often there were more experienced researchers standing next to us who would give their input and help extend the conversation. The whole experience helped to expand my idea of what research could be for me, and helped me realize how beneficial conferences can be to my professional development. On top of all of that, at night we explored Baltimore and had a blast getting to know peers outside of the work atmosphere. My experience in March at CPA was so amazing that I can't wait to go again next year.

Noah Emery, fourth year graduate student in the Clinical Psychology PhD program at University of South Dakota and Student Representative to the Executive Committee of SoAP and the Membership and Social Committees: This conference was easily the highlight of my year. The program was full of intriguing talks and posters representing all areas of addiction research, from clinical trials to marijuana administration studies to research on the neurological basis of substance use. I found this diversity of content to be one of the meeting's greatest strengths. It allowed me to gain exposure to new areas of research, that I would not have normally come across, which has helped me cultivate new ideas for my own work. Also,

it was great to learn about findings from cutting-edge studies in my major research area. Taken together, this made for a perfect blend of breadth and depth that I think is unrivaled. Another unique feature of CPA was the intimate setting that afforded me unprecedented access to senior researchers whose papers my work is based on. As a result, I was able to make inroads and form relationships there that will last for many years to come. Furthermore, it was clear that the meeting was dedicated to making students feel included and my experience there has quickly made CPA a cannot-miss event on my calendar. I cannot recommend this event enough.ψ

Abstracts

Amlung, M., McCarty, K. N., Morris, D. H., Tsai, C. L., & McCarthy, D. M. (in press). Increased behavioral economic demand and craving for alcohol following a laboratory alcohol challenge. *Addiction*. doi: 10.1111/add.12897

Background and aims. Although increases in subjective alcohol craving have been observed following moderate doses of alcohol (e.g., priming effects), the effects of alcohol consumption on behavioral economic demand for alcohol are largely unstudied. This study examined the effects of alcohol intoxication on alcohol demand and craving. **Design.** A between-subjects design in which participants were randomly assigned to either an alcohol (*n* = 31), placebo (*n* = 29) or control (*n* = 25) condition. **Setting.** A laboratory setting at the University of Missouri, USA. **Participants.** Eighty-five young adult moderate drinkers were recruited from the University of Missouri and surrounding community. **Measurements.** Change in demand for alcohol across time was measured using three single items: alcohol consumption at no cost (i.e., intensity), maximum price paid for a single drink (i.e., breakpoint), and total amount spent on alcohol (i.e., O_{max}). Alcohol demand at baseline was also assessed using an alcohol purchase task (APT). Craving was assessed using a single visual analog scale item. **Findings.** In the alcohol group compared with the combined non-alcohol groups, intensity, breakpoint, and craving increased from baseline to the ascending limb and decreased thereafter (*p*s < 0.05; O_{max} *p* = 0.06). Change in craving following alcohol consumption was significantly associated with change in each of the demand indices (*p*s < 0.0001). Finally, the demand single items were associated with corresponding indices from the APT (*p*s < 0.01). **Conclusions.** Alcohol demand increases following intoxication, in terms of both the maximum amount people are willing to pay for one drink and the number of drinks people would consume if drinks were free. Behavioral economic measures of alcohol value can complement subjective craving as measures of moment-to-moment fluctuations in drinking motivation following intoxication.

Rose, G. L., Skelly, J. S., Badger, G. J., Ferraro, T. A., & Helzer, J. E. (2015). Efficacy of automated telephone continuing care following outpatient therapy for alcohol dependence. *Addictive Behaviors, 41*, 223-231. doi:10.1016/j.addbeh.2014.10.022

Background: Relapse rates following cognitive behavioral therapy (CBT) for alcohol dependence are high. Continuing care programs can prolong therapeutic effects but are underutilized. Thus, there is need to explore options having greater accessibility. **Methods:** This randomized controlled trial tested the efficacy of a novel, fully automated continuing care program, Alcohol Therapeutic Interactive Voice Response (ATIVR). ATIVR enables daily monitoring of alcohol consumption and associated variables, offers targeted feedback, and facilitates use of coping skills. Upon completing 12 weeks of group CBT for alcohol dependence, participants were randomly assigned to either four months of ATIVR (n = 81) or usual care (n = 77). Drinking behavior was assessed pre- and post-CBT, then at 2 weeks, 2 months, 4 months, and 12 months post-randomization. **Results:** Drinking days per week increased over time for the control group but not the intervention group. There were no significant differences between groups on the other alcohol-related outcome measures. Comparisons on the subset of participants abstinent at the end of CBT (n = 72) showed higher rates of continuous abstinence in the experimental group. Effect sizes for the other outcome variables were moderate but not significant in this subgroup. **Conclusions:** For continuing care, ATIVR shows some promise as a tool that may help clients maintain gains achieved during outpatient treatment. However, ATIVR may not be adequate for clients who have not achieved treatment goals at the time of discharge.ψ

Announcements

Postdoctoral Scholars

Two-year NIH/NIDA-funded positions as postdoctoral scholars in drug abuse treatment and services research are available in a multidisciplinary research environment in the Department of Psychiatry, University of California, San Francisco. Applications will be considered until all slots are filled. Scholars work with a preceptor to design and implement studies on the treatment of drug dependence, and select a specific area of focus for independent research. Training of psychiatrists, women, and minorities for academic research careers is a priority. Send letter or interest, CV, research statement, samples of work, and two (2) letters of recommendation to Postdoctoral Training Program in Drug Abuse Treatment/Services Research, University of California, San Francisco, 1001 Potrero Avenue, Bldg 20, Ward 21, Rm 2130, San Francisco, CA 94110-3518.

For more information please visit http://addiction.ucsf.edu/education/postdoctoral-training or contact Tuli Cruz via e-mail: gertrude.cruz@ucsf.edu or phone: 415-206-3979.

Addiction Health Services Research Conference (AHSR) 2015

Register now for the Addiction Health Services Research Conference (AHSR) 2015: Navigating a Changing Healthcare Landscape, October 14-16 in Marina del Rey, CA. MDR is adjacent to LAX and easily accessible to other sections of Los Angeles. Plenary speakers include: Dr. Margarita Alegria, Harvard University; Dr. Larry Palinkas, University of Southern California; Dr. Kenneth Wells, UCLA; plus a plenary panel featuring diverse perspectives from the field on implementing addiction health services within the changing health services system. Pre-conference workshops on October 14 include:

- Identifying Effective Treatment and Health Services in Substance Abuse Research Using Observational Data. Presenters
- Using Qualitative Methods to Study Behavioral Health Interventions and Services in Diverse Settings. Presenters
- Strategies for Publishing in Addiction Health Services Research: A Workshop for Early Career (and any other) Investigators

Mentoring activities and travel scholarships will also be available for early career investigators. Please see our website: http://www.uclaisap.org/ahsr.ψ

Follow us to the ...

APA Convention

Toronto, Canada

August 6-9, 2015

more info on pages 8-9

(don't forget your passport!)

Celebrating Achievements in Addiction

Foote, Wilkens & Konsake Receive CPDD/NIDA Media Award

The Center for Motivation and Change (CMC) is proud to announce that CMC co-founders Drs. Jeffrey Foote and Carrie Wilkens, and Director of Family Services Dr. Nicole Kosanke have been awarded the 2015 College on Problems of Drug Dependence (CPDD)/NIDA Media Award for their book, *Beyond Addiction: How Science and Kindness Help People Change*. This award is given to individuals/organizations that have made major contributions through the media that have enhanced the public understanding of scientific issues concerning drug use disorders. Previous award winners include author David Sheff, filmmakers Justin Hunt and Charles Evans, and Partnership for Drug-Free Kids Director of Programs Sean Clarkin.

Beyond Addiction is written specifically for families and friends of people who have a substance use problem. It provides families with a roadmap to understand substance issues, including the most current scientific information about substance effects on the reward centers of the brain and motivation, and how to employ the most effective, evidence based approaches to helping family members, most prominently with strategies from the CRAFT approach. *Beyond Addiction* teaches families to become active, compassionate and effective participants in the change process without detaching, as well as practical advice on navigating the complicated and messy addiction treatment world they may be entering.

More information can be found at http://beyondaddictionbook.com.ψ

COLLABORATIVE PERSPECTIVES on ADDICTION

Division 50 Mid-Year Meeting

Reducing Health Disparities through Addiction Science and Practice

March 18-19, 2016 • San Diego, CA

Call for Proposals will be posted in July 2015, with symposium submissions due in September 2015 and poster submissions due in November 2015. See the CPA website for updates: http://research.alcoholstudies.rutgers.edu/cpa

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