PCB NEWSLETTER

IN THIS ISSUE:

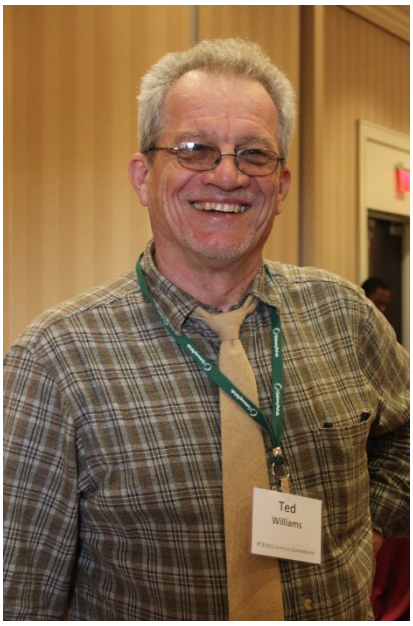
PCB ANNOUNCES 2012 AWARD RECIPIENT

The PCB award was presented during its annual conference held on April 16-17 in Harrisburg. The award recipient was honored at a luncheon on April 16 during which time PCB President, Richard Foster, made the presentation. The award presented was for Certified Professional of the Year. The deserving recipient was:

CERTIFIED PROFESSIONAL OF THE YEAR

Barry Trout, CADC, CCDP
Addiction Counselor, ADAPPT CEC., Reading, PA

Trout (middle) accepts his award with wife, and co-workers.



Williams pictured at the PCB Conference.

FAREWELL TED!!!

The PCB Board of Directors say good-bye to long time board member Ted Williams who is leaving the Board after 22 years. Ted is one of the longest serving board members in PCB history. In his 22 years of service and dedication to PCB, Ted has served as Treasurer and President of the board, as well as chair of or serving on several committees including the Ethics Committee, and he was a trainer for PCB at the annual conferences and the spring and fall trainings and assisted in the development of several credentials.

To say that Ted was an active board member would be an understatement. His dedication to the certification process will have a lasting impact on all who have worked side by side with Ted over the years. We cannot begin to express our thanks and gratitude to Ted for his time, talent, dedication and commitment to PCB. From everyone at PCB, know that you will be missed Ted!

2012 PCB ANNUAL CONFERENCE A SUCCESS

There are so many people to thank for making the 13th Annual PCB Conference a success. A very special thank you is extended to our keynote speakers Barry Duncan, Psy.D. and Neil Capretto, DO, FASAM and to our comedy performer, Tim Grealish.

PCB also thanks its generous co-sponsor, Gateway Rehabilitation Center and to our break sponsor, Seabrook House.

All of the individuals below played a major role in the 2012 conference and deserve our thanks for their participation.

TRAINERS

Pauline Amaismeier, BSN, MS, LPC, RN-BC, DCC
Catherine Chichester, APRN, BC
Christopher Davis, DO, CAADC
Melanie East, M.Ed.
Dotti Farr, CCDP Diplomate, LSW, LADC
Richard Jones, MA, CADC, CCDP, CCS
William Lorman, Ph.D., MSN, PsyNP, CARN-AP
Andrew Nocita, Ph.D., CAAP
Melissa Perkins, M.Ed., CADC
Elizabeth Smull, MRPYC, CADC
Marilyn Stein, M.Ed., CAAP
Carolyn Baird, DNP, MBA, RN-BC, CARN-AP, CCDP Diplomate
Chris Cubero, Ph.D., LPC, CAADC
Erin Deneke, Ph.D., LCPC
Rhona Epstein, Psy.D., CADC
Mark Fuller, MD
Jeffrey Kaufhold, R.Ph.
Amy McCoy, BA
Michael Palladini, R.Ph., MBA, CADC
Deborah Slates-Ciocco, MA
James Snyder, MA, LPC, CAADC
Paula Tropiano, MA, LPC, CCDP Diplomate

EXHIBITORS

Abstinent Living at The Turning Point
Behavioral Health of The Palm Beaches
Caron Treatment Centers
Clarity Way
Colonial House
Community Care Behavioral Health
Eagleville Hospital
Fairmount Behavioral Health System
FamilyLinks
Firetree, Ltd.
Gateway Rehabilitation Center
Gaudenzia, Inc.
Gaudenzia Center for Higher Education
Gaudenzia Training Institute
Highland House, Inc.
INTERLINK Network Systems
IRETA/NortheastATTC
Journeys of Life
Livengrin Foundation
Malvern Institute
New Insights
POWER
Pyramid Healthcare
Retreat at Lancaster County
Roxbury Treatment Center
Seabrook House
Temple
Treatment Trends, Inc.
Turning Point Chemical Dependency Treatment Center
Valley Forge Medical Center & Hospital
Value Behavioral Health of PA
White Deer Run/Cove Forge Behavioral Health System/Bowling Green Brandywine

ADVERTISERS

Abstinent Living at The Turning Point
Caron Treatment Centers
Community Care Behavioral Health Organization
Edinboro University
Fairmount Behavioral Health System
Gateway Rehab Center
Highland House
Turning Point Chemical Dependency Treatment Center
Valley Forge Medical Center & Hospital
Value Behavioral Health of Pennsylvania

Our 14th annual conference to be held on April 22-23, 2013, will be even bigger and better and will again be held at the Sheraton Harrisburg-Hershey. Make plans now to attend! **Call to Present available in July. Information on exhibiting, advertising, and sponsorship available on the PCB website in August. Conference invitation available in January.**

SPECIAL THANKS

PCB extends a huge thank you to the following facilities/organizations for providing space for various PCB functions:

Caron Treatment Centers
Eagleville Hospital
Gateway Rehabilitation Center
Mercy Behavioral Health

Everyone involved in the certification process appreciates the generosity of these facilities and their continued support of our efforts and initiatives.

PREVENTION SPECIALIST SCHOLARSHIP RECIPIENT NAMED

The Pennsylvania Certification Board (PCB) announced recently the recipient of the Maggie Marcopul Prevention Specialist Scholarship. Chris Snyder, Supervisor of Prevention Programs for Beacon Light Behavioral Health Systems in Warren, was awarded the three-year scholarship from PCB marking the second scholarship offered by PCB.

The Maggie Marcopul Prevention Specialist Scholarship was established by PCB in memory of 19-year PCB board member, Maggie Marcopul, who passed away in May of 2008. Maggie's impact on the credentialing process in Pennsylvania and her dedication and commitment to the field of prevention was worthy and deserving of a lasting honor in her memory. PCB felt that this scholarship opportunity was a fitting tribute to a truly remarkable leader in the prevention field.

Mr. Snyder had been in the prevention field for five years and recently was promoted to Supervisor of Prevention Programs. "Being awarded this scholarship would be a tremendous honor and opportunity to better serve the families and citizens reached by our prevention programs around our service area," states Mr. Snyder.

In submitting Mr. Snyder's nomination, Jennifer Gesing, Counselor at Beacon Light Behavioral Health Systems states, "Chris has become the face of prevention in our area and continues to look for new opportunities to educate the community through innovative programming."

The scholarship includes all fees associated with becoming a Certified Prevention Specialist, membership in the Commonwealth Prevention Alliance, attendance at the annual Commonwealth Prevention Alliance Conference, attendance at the annual PCB Conference, and attendance at the National Prevention Network annual conference. The scholarship also requires each recipient to become a mentor to the next scholarship recipient. Sherry Clouser, Prevention Program Specialist for Dauphin County Department of Drug and Alcohol Services in Harrisburg was the recipient of the first scholarship and will be a mentor to Mr. Snyder.

PCB will award the next prevention specialist scholarship in spring of 2015 and details can be found on the PCB website.

PCB NAMES NEW PRESIDENT AND TREASURER

PCB is pleased to announce that effective March 2012, Richard Foster, Ph.D., CAADC, CCS, CCJP began his two-year term as President of the Board of Directors of PCB. Rich has been a member of the board since 2008 and had served as Treasurer prior to being elected President. Currently, Rich is Executive Vice President of Treatment Programs for Gateway Rehabilitation Center. Rich has been in the field since 1991 and is also currently serving as President of the Community Corrections Association of Pennsylvania.

We are also pleased to announce John Massella, Ed.D., CCS, CCDP Diplomate as the new PCB Treasurer. John brings 30 years of experience in the alcohol and drug field and has been a member of the PCB Board of Directors since 1997. Currently, John is Assistant Professor and Clinician, Counseling Center, California University of Pennsylvania and part-time therapist and educator for Gateway Rehabilitation Center. John has provided trainings for PCB's spring and fall trainings as well as the Annual Conference to hundreds of professionals.

We welcome and congratulate both Rich and John to their respective positions.

Rich Foster, PCB President

John Massella, PCB Treasurer

GET HIGH OR DIE TRYING IN THE SUMMER OF 2006

By Maxim W. Furek, MA, CADC, ICADC

The outbreak that began in the summer of 2005 was something that could easily have been an episode of *CSI*. The only thing missing was the primal scream of Roger Daltrey belting out "Who Are You?"

The names were unassuming enough -- *Echo. Monkey. Flatline. Al Capone* --four bizarre names for a street cocktail of deadly heroin. This batch, however, contained a mysterious additive that when combined with heroin's suppression of the central nervous system, triggered irregular heartbeat, breathing difficulty and horrific feelings of suffocation. Systematically, the drug would slow and then, for some, stop the beating of the human heart. Death would come, not in a violent bloodstained spasm, but in a shroud of dark, eternal sleep.

It was fentanyl, authorities determined, that had been added to the lethal heroin. Fentanyl is a powerful narcotic painkiller known to be 50 to 80 times more potent than morphine and is a dangerous drug. It can easily paralyze the chest wall and stop a person from breathing (Graham, 2006). Only 125 micrograms of fentanyl, the equivalent of five or six grains of salt, can kill an adult user (Nordqvist, 2006). A Drug Enforcement Agency (DEA) schedule ll controlled drug, fentanyl is often prescribed medicinally for persons with moderate to severe chronic pain. It is also used as anesthesia for open-heart surgery and for those already physically tolerant to opiates such as morphine.

The heroin-fentanyl mixture was unusual, as U.S. street heroin is typically cut with starch, flour, talc or quinine--cheaper and safer fillers that maximize profits (Leinward, 2006). The addition of fentanyl to the heroin, authorities believed, was a bizarre marketing strategy intended to gain a competitive edge on the streets. For those addicted to heroin, the new killer heroin presented a tremendous opportunity to attain a powerful new high. The promise of a powerful high seemed to dismiss fears of the potential for overdose from this killer concoction.

Officials were concerned, fearing for the worst. Their fears played out in reality, as people began to shoot up and die. The use of the drug mixture spread from the Camden, New Jersey epicenter to Philadelphia, where as many as 100 people died, and then to Harrisburg and Pittsburgh, Pennsylvania, heading west to Illinois. There were as many as 350 overdose deaths across eight states according to the Office of National Drug Control Policy. The Center For Substance Abuse Treatment (CSAT) warned: "In just one week, an estimated 33 individuals in the Detroit area are reported to have died after using this fatal mix of drugs; the same drug combination may have been responsible for over 100 deaths in the same region since last September."

In a special alert to addiction professionals, posted June 2, 2005, H. Wesley Clark, Director of CSAT stated: "As an individual involved in the public health, you need to be aware of this new 'killer drug combination,' and you need to be prepared to alert patients, clients, and others in order to help save lives" (CSAT, 2006). In a specially called forum on July 28, 2005, the White House Drug Policy Office hosted a summit in Philadelphia. Patrick Meehan, U.S. attorney for the eastern district of Pennsylvania, acknowledged that, since April of that year, over 170 deaths and 300 nonfatal overdoses occurred in Pennsylvania, New Jersey and Delaware. ***Continued on page 6***

GET HIGH OR DIE TRYING IN THE SUMMER OF 2006 *CONT.*

Although heroin accounts for about 8 percent of related ER visits, the fentanyl - heroin combination was especially lethal when medical action was not promptly taken. The CSAT warned that suspected overdoses should be treated immediately with a naloxone (Narcan) injection. Naloxone rapidly reverses symptoms that are related to narcotic overdose and a dose of 0.4 to 2 mg intravenously (IV), subcutaneously (SC) or intramuscularly (IM) every 2 to 3 minutes is recommended. Naloxone can also precipitate immediate narcotic withdrawal symptoms as overdose symptoms are reversed but if there is no response after 10 minutes, a different diagnosis should be considered.

The CSAT further warned that fentanyl-related overdoses could result in sudden death through respiratory arrest, cardiac arrest, severe respiratory depression, cardiovascular collapse or severe anaphylactic reaction. Although some labs can test for fentanyl when specifically requested, routine toxicology screens for opiates will not detect the drug. Critical treatment time can be lost because ER personnel may not be aware that fentanyl is undetectable in standard toxicology screens.

As the drug spread across the country the brand names began to change (Fefe. Exorcist. Apollo.) In Pittsburgh it was called Get High or Die Trying (Fuoco, 2006).People died there too. Pittsburgh authorities compiled the grim facts: Users were predominately white males between the ages of 16 and 56 and crossed all socioeconomic lines. The drug was relatively inexpensive, as individual stamps or bags sold for only $10 to $15. The toxic mix may have come from Chicago, believed to be a main distribution point.

On June 22, 2005, three dozen members of the Chicago-based Mickey Cobras gang were charged with running a drug ring and conspiracy to possess and distribute heroin, crack cocaine, marijuana and fentanyl. Their individually packaged fentanyl was variously labeled Max Pain, Lethal Injection, Fear Factor, Drop Dead, and Final Call. On that same date, U.S. and Columbian authorities arrested 56 people in an international drug ring that smuggled millions of dollars of heroin into New York. DEA agents seized more than 112 kilograms of heroin with a reported $25 million street value.

It would seem that we have not learned from past mistakes. Over two decades ago another lethal batch of fentanyl - laced heroin made headlines in Pittsburgh. As documented in Top Cops, "The China White Episode," 18 people died and over 200 overdosed in 1988, after rogue Calgon chemist Thomas Schaefers made up a batch of lethal fentanyl. And in early 1991, over 126 east coast overdose deaths were attributed to chemist George Marquardt, who was manufacturing fentanyl out of his Kansas lab (Mc Cormick, and O'Donnell, 1993). Because of the profit motive it is not difficult to see why fentanyl has emerged on the streets. Harry Avis, in his excellent book Drugs and Life, explained that a meager investment of $2000 in chemicals and glassware can be parlayed into a profit of $2 billion of "China White," the bootlegged street version of 3-methyl fentanyl (Avis, 1990). ***Continued on page 7***

GET HIGH OR DIE TRYING IN THE SUMMER OF 2006 *CONT.*

Authorities pondered where the fentanyl originated. The lethal substance was believed to have been produced in clandestine laboratories and then mixed with or substituted for heroin. On June 5, 2005 U.S. federal officials announced that, working with Mexico, they had shut down a lab in Toluca, Mexico, thought to be the source of the illicit fentanyl.

In the first national tally of the fentanyl deaths, the Centers for Disease Control and Prevention (CDC) reported in July, 2008:

Testing of street drugs found samples consisting of NPF (nonprescription fentanyl) alone and NPF mixed with other drugs. Most of the implicated NPF was mixed with heroin or cocaine, sold as a street drug, and used as an injection. From April 4, 2005 to March 28, 2007, the CDC/DEA surveillance system identified 1,013 NPF-related deaths. The monthly incidence of NPF deaths peaked in June 2006 at 150 cases and decreased to one death in February 2007 and one death in March 2007. Among the 984 decedents whose sex and age were known, 577 (58.6 percent) were aged 35--54 years and 788 (80.1 percent) were male. Among the 984 decedents whose race/ethnicity were known, 545 (55.4 percent) were white, 392 (39.8 percent) were black and 41 (4.2 percent) were Hispanic (CDC, 2008).

Dr. Stephen Jones, author of the CDC report, told Reuters: “I think this is an extraordinary episode of fatal drug overdoses. But it’s got to be recognized as part of the bigger problem of the increasing numbers of drug overdose deaths in the United States” (Akre, 2008).

According to Kenneth Hoffman, MD, MPH, at the SAMHSA/CSAT Division of Pharmacologic Therapies: “Many addicts will want to try the ‘bad’ batch - this is classic and probably defines best the decision making process of someone truly addicted. The dynamics are against the educational message until the person is engaged in treatment” (Hoffman, 2006).

Sidestepping traditional education-prevention strategies, the fentanyl-heroin outbreak was a difficult challenge for law enforcement and addiction professionals. The fentanyl-heroin mix provided an opportunity that many hardcore addicts--unable to get high and using only to keep from getting sick--spend a lifetime searching for. The rationale for ingesting this deadly drug cocktail was a combination of twisted denial and distorted thinking, hallmarks of addiction.

Hoffman believes that treatment is key: “It is my belief that treatment options need to be easily and quickly available for anyone who might consider getting help. This is not easy in many communities and many insurance plans will not cover much of what's needed for the time needed. Some outreach programs that have a high number of recovered addicts as counselors (and have standing in the community) could have the most impact. Successfully treated patients can become your best outreach workers and their insight into the community of users can be the best way you have to reach in with prevention messages.”

In December 2006, federal authorities announced the arrest of individuals believed to be key suppliers of the fentanyl mix. They were discovered in a Pennsauken, New Jersey heroin-processing "mill" was close to a kilogram of heroin. Authorities also found 300 grams of fentanyl, enough to spike 40,000 doses of heroin. Gerard P. McAleer, DEA special agent in charge for New Jersey, stated, “This is probably the biggest threat that I've seen to the public, and I lived through the crack wars. The fentanyl problem is small now, but if it gets any bigger, it will be devastating” (Graham, 2006).

Fentanyl use, both legal and illegal, has been steadily increasing over the years. Fentanyl prescriptions more than doubled from about 2.59 million in 2000 to 7.64 million in 2008. The U.S. Department of Justice says the availability of fentanyl is due to, not only the increase of legal prescriptions but also its many forms. Because of its rapid effects, U.S. medics in Afghanistan pack fentanyl lollipops in their kits to administer to critically wounded soldiers (Grady, 2010). In June 2011, the U.S. Food and Drug Administration (FDA) approved Archimedes Pharma for their fentanyl nasal spray. Lazanda—the first fentanyl nasal spray approved in the U.S.--is a schedule-II controlled substance for patients who are opioid-tolerant and already receiving opioids for persistent cancer pain.

Although the fentanyl outbreak has passed, the potential danger remains. On May 16, 2011, the FDA met with members of the Industry Working Group and other sponsors of long acting and extended-release opioid drugs and warned that “Opioids are at the center of a major public health crisis of addiction, misuse, abuse, overdose and death.”

The FDA has now requested the makers of opioid pain relievers, including the makers of fentanyl patches, to develop a Risk Evaluation and Mitigation Strategy (REMS) to prevent injury to patients. The REMS would educate doctors about pain management and would ensure that only patients who meet certain criteria would be given a prescription for fentanyl. Drugmakers have also been asked to write a medication guide that explains to patients how to use fentanyl safely. ***Continued on page 8***

Fentanyl is often administered through a patch that is placed on the patient's skin. Depending on the fentanyl dose, a patch can last for two or three days. But patients who experience extreme pain may assume that they can use more patches than recommended to increase the therapeutic benefit of the patch. Doing so, however, puts the patient at risk of receiving far more fentanyl than the body can handle, putting him or her into respiratory distress and possibly proving fatal.

Pittsburgh-based Michael Palladini, RPh, MBA lived through the 2005/2006 fentanyl outbreak and experienced the destruction. He cautions: "The absolute strength of this drug and the sheer number of prescriptions being written continue to make fentanyl an extremely dangerous drug on the street. Diversion of fentanyl transdermal patches, the most commonly dispensed and administered formulation of the drug, leads to unapproved methods of use including chewing pieces of the patch, and more dangerously, withdrawing the drug from the patch for intravenous use. Additionally, the use of fentanyl powder to increase the potency of heroin in a growing and competitive market is a continuing and dangerous practice. The potency of fentanyl can be fatal to opiate-tolerant and opiate-naive persons alike, and as was seen in Pittsburgh in 2006, alluring to many seeking an ultimate high.

Maxim W. Furek, MA, CADC, ICADC is Director of Garden Walk Recovery, and a researcher of new drug trends. His book, The Death Proclamation of Generation X: A Self Fulfilling Prophesy of Goth, Grunge and Heroin, is being utilized at Penn State University as "recommended reading" for several courses. He can be reached at www.maximfurek.com

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PCB ETHICS CODE RULE 1.1 REVISED

Effective March 2012, PCB revised Rule 1.1 of its Code of Ethical Conduct. The revised rule is as follows:

Rule 1.1 Once certified, a certified professional shall not be cited, arrested, or convicted for any summary offense, misdemeanor, or felony relating to the individual's ability to provide substance abuse and other behavioral health services or that reflects conduct unbecoming a certified professional as determined by PCB.

Discussion: A certificate of conviction shall be deemed conclusive evidence of an individual's guilt of the felony or misdemeanor for which he or she has been charged. If the citation, arrest, or conviction relates to the individual's ability to provide substance abuse and other behavioral health services or reflects conduct unbecoming a certified professional, as determined by PCB, this shall be deemed a violation of this Rule. Some specific examples within this section include but are not limited to crimes involving violence, use or sale of drugs, driving while intoxicated/impaired, fraud, theft, and sexual misconduct. PCB may choose to allow pending charges against the certified professional to be settled through the judicial system before rendering their decision on the ethics complaint.

PCB CODE OF ETHICAL CONDUCT VIOLATIONS

David Sherman, CADC #6780

Revocation effective 12/16/2011 for violation of Rule 4.1 under Exploitation of Clients and 5.4 under Professional Standards.

Darren Skinner, CADC #4485

Revocation effective 04/10/2012 for violation of Rule 10.1 under Cooperation with the Board.

WANT TO KNOW MORE ABOUT THE CERTIFICATION PROCESS?

PCB will present a free workshop on the certification process at your facility/agency for your staff upon request.

This 1 ½ hour workshop will focus on the requirements for all levels of certification, recertification, and the written exams.

1.5 free PCB education hours will be given to each participant for use toward initial certification or recertification.

You will hear first-hand of any changes to the process, new credentials offered, and have an opportunity to ask questions.

To arrange for a free workshop at your facility/agency for 10 or more individuals, please call the PCB Office at 717-540-4455, extension 103.

WORKSHOPS OPEN TO ANYONE WHO MIGHT WANT TO ATTEND ARE:

September 24, 2012
11:00 am - 12:30 pm

Mercy Behavioral Health
249 S. Ninth St., (Southside)
Pittsburgh

October 15, 2012
10:00 am - 11:30 am

BHTEN
520 N. Delaware Ave., 7th floor conference room, Philadelphia

To RSVP for one of the workshops above, call the PCB Office at 717-540-4455, extension 103 and leave your name and daytime phone number to reserve your spot.

FROM THE DESK OF PCB'S DIRECTOR OF TRAINING & EDUCATION

It's spring! - PCB is excited about all of the trainings available to our certified professionals this season. In an effort to respond to requests for more advanced training options we have two training series on our schedule that will provide more in-depth treatment of important training topics.

The two-day training at Eagleville: **Cultural Competence** promises to be an exciting and informative series that will provide all who participate with a unique workshop experience unlike any other. Marilyn Stein, PCB Board member and Master trainer, never fails to offer a fresh perspective and practical exercises designed to create a more thorough understanding of topics that are essential to the clients we serve.

The **Drugs of Abuse** training series at Mercy Behavioral Health, will thoroughly investigate a critical public health issue that has most recently received much needed attention from federal health agencies. Seasoned expert trainer, Michael Palladini will provide a comprehensive overview of this topic in the initial training and delve deeper in the second training with the focus on drugs of abuse in the co-occurring population.

You can review all of the fine trainings PCB is offering by visiting our website at www.pacertboard.org and clicking on PCB Spring/Fall Trainings.

NEW!! As of 3.21.2012- All PCB sponsored spring trainings are approved for CE hours by NASW-PA providing CE hours to Social Workers, Marriage and Family Therapists, and Professional Counselors.

PCB WANTS YOU TO TRAIN FOR US! **To submit training proposals for our fall 2012 training schedule and beyond, please go to the PCB website and click on Applications. The trainer application is on the bottom of the applications page.**

Why train for PCB?

- Give back to a community hungry for your experience and expertise
- Earn CE hours from PCB and NASW
- Great opportunity to learn from your peers as you teach
- Presenting to professionals is a great way to build your professional credentials and broaden your resume
- Have a positive impact on our profession and your colleagues

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