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SPECIAL EDITION—MARIJUANA USE AND ABUSE

Introduction to Special Issue on Marijuana Use and Abuse

Samuel Knapp, Ed.D., ABPP
Director of Professional Affairs

Many Americans smoke or eat marijuana either for recreation or for medical purposes. Those who use marijuana may claim that, while it can be misused, marijuana has effects no worse than alcohol or other legal drugs. Furthermore, they may claim that it or its extracts have proven to be effective in treating some medical disorders and that it promises to be an effective drug for other disorders. On the other hand, skeptics of marijuana claim that it is gateway drug to even more pernicious drugs. They may also claim that most of its medicinal qualities are unproven or exaggerated. All would agree, however, that attitudes toward marijuana are changing. Both the recreational and medicinal use of marijuana has increased substantially in the last 15 years (Schauer et al., 2016). A recent poll showed that 59% of Pennsylvanians, including Auditor General Eugene DePasquale, support legalizing marijuana (Deto, September 21, 2017). In addition, through Act 16 of 2016 (Medical Marijuana Act), Pennsylvania has legalized the use of marijuana for medicinal purposes. More and more of our patients will be using marijuana. I wrote these articles to help psychologists better understand the changing health care issues surrounding marijuana use.

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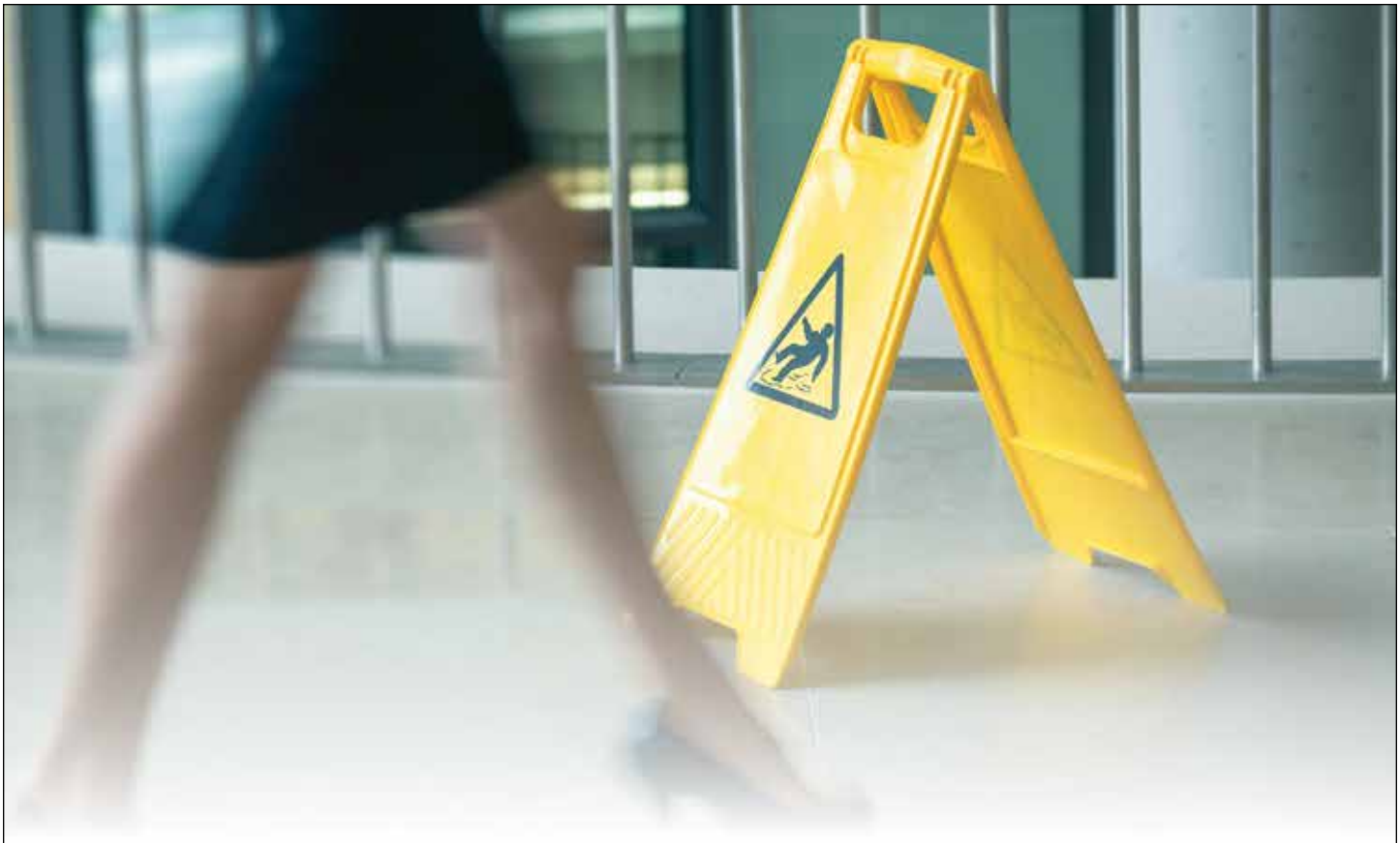

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Medical Uses of Marijuana

Samuel Knapp, Ed. D., ABPP
Director of Professional Affairs

The cannabis plant is commonly classified into three major species and the most common one, Cannabis sativa, has been cultivated to produce many varieties with different biochemical properties.[1] Marijuana refers to the dried leaves, stems, seeds, or flowers from the cannabis plant. Cannabinoids refer to the class of biochemical agents within marijuana that have physical or psychological effects on humans. Scientists have identified more than 500 constituent parts of Cannabis sativa, including more than 100 cannabinoids. The most widely known cannabinoid, tetrahydrocannabinol (THC), produces many of the well-known euphoric or relaxation effects of marijuana. Another cannabinoid, cannabidiol (CBD), has many of the same therapeutic benefits of THC without its euphoric side effects. Scientists are also studying the pharmaceutical applications of other lesser known components of marijuana.

Marijuana is considered a Schedule I drug, which means that it is believed to have harmful qualities leading to a likelihood of addiction with serious health consequences. However, few scientists believe that the evidence warrants this classification. The Schedule I classification means that researchers must register with the Drug Enforcement Administration (DEA) of the Department of Justice, a process that involves substantial delays and administrative burdens, including a requirement that the Food and Drug Administration (FDA) must approve the research protocol.

Pennsylvania's Medical Marijuana Act allows health care professionals to prescribe marijuana when a patient has a terminal illness ("A medical prognosis of a life expectancy approximately one year or less if the illness runs its normal course"), or when a patient has a diagnosis of any of the following serious medical conditions: cancer, HIV, Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), Parkinson's disease, multiple sclerosis, epilepsy, inflammatory bowel disease, neuropathies, Huntington's disease, Crohn's disease, Post-Traumatic Stress Disorder, intractable seizures, glaucoma, sickle cell anemia, autism, spinal cord damage, and severe neuropathic pain where conventional treatments are contraindicated or ineffective.

Pennsylvania's Medical Marijuana Act establishes tight controls over the production and distribution of marijuana. One of the criticisms of Pennsylvania's law is that the cannabinoid extracts permitted by Pennsylvania's law will cost substantially more than marijuana that is typically sold on the street. This raises the possibility that many patients will attempt to self-medicate using marijuana obtained illegally.

The strength of the evidence on the effectiveness of marijuana-based treatments on the medical conditions listed in Pennsylvania's Medical Marijuana Act varies considerably. One disorder is included where the evidence of efficacy is very weak, and other disorders are excluded where the evidence of efficacy is promising.

The FDA has approved THC-based medications for the treatment of nausea for patients undergoing chemotherapy for cancer and to simulate appetite in patients experiencing wasting syndrome secondary to AIDS. Other applications for cannabis-based treatments have been approved in other countries or are currently undergoing clinical trials in the United States, even if the FDA has not yet approved them. Strong evidence also shows that marijuana can reduce chronic pain and spasms associated with multiple sclerosis (Alexander, 2016). Cannabis also shows promise in reducing non-cancer nausea and vomiting, although available medications do well here. It is likely that cannabis can be used as a drug for those who have not responded well to other anti-nausea drugs. Finally, evidence suggests the possibility that cannabis can be used to treat cancer, stress and anxiety, epilepsy, and glaucoma (Alexander, 2016).

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Pennsylvania's Medical Marijuana Act allows health care professionals to prescribe medications for autism, perhaps in response to advocacy efforts by Mothers Advocating for Medical Marijuana for Autism (MAMMA; https://www.mammausa.org/) and other groups. However, the supporting data consists primarily of anecdotes or single case studies. A review by Hadland et al. (2017) concluded that "none of these studies provide sufficient, high-quality data to suggest that cannabis should be recommended for treatment of ASD" [Autism spectrum disorders], p. 120). The American Academy of Pediatrics reached the same conclusion. Although they recognized the demonstrated and potential benefits of cannabinoid treatments for adults with specific medical conditions, they concluded that the lack of data and the dangers of marijuana use argue against recommending marijuana-based treatments for children or adolescents (Ryan & Ammerman, 2017).

Pennsylvania's Medical Marijuana Act does list PTSD among the approved medical conditions. In addition to anecdotal reports, several studies suggest that marijuana can reduce many of the symptoms associated with PTSD, although these studies had many methodological shortcomings such as uncontrolled designs, non-representative

Continued on page 4

[1] Biologists argue about whether the cannabis plants are separate species or variants of one single species.

Continued from page 3

samples, or small sample sizes. But the evidence is not altogether favorable. Veterans with PTSD who have a history of heavy marijuana use tend to have poorer outcomes when given traditional treatments for PTSD. Experts remain divided on whether to recommend cannabis for PTSD (Cannabis, 2016), although all recognize that any treatment does run the risk of some negative consequences and that more research is needed (Steenkamp et al., 2015; Walsh et al., 2017).

Many psychologists will encounter many patients with PTSD or other anxiety disorders who are taking marijuana to self-medicate and sometimes these patients will become quite invested in it and reluctant to discontinue using marijuana.

At this point I suggest that psychologists consider these three conclusions: (1) some patients with PTSD may find meaningful symptom reduction from using marijuana; (2) some patients with PTSD could reduce symptoms much better if they took traditional medications with a proven track record for reducing symptoms; (3) marijuana use can harm some patients, especially those who have a history of substance abuse; and (4) I would recommend marijuana for the treatment of PTSD symptoms only if traditional treatments have failed to provide symptom relief and the patient has no history of substance abuse.

Anxiety is not listed among the disorder for which Pennsylvania physicians can prescribe marijuana. Despite some supportive evidence from uncontrolled studies or anecdotal reports, the effectiveness of marijuana in reducing anxiety is unproven. Turna et al (2017) concluded that "no recommendations can be made on the clinical utility of cannabis as a treatment for these conditions" (p. 1012).

Research Issues

The self-reported benefits of self-prescribed and self-administered marijuana are hard to evaluate for several reasons. The cannabis based drugs vary considerably in their composition and concentration of THC or CBD even in states where it is legal. In addition, the concentration of THC within marijuana purchased illegally has increased steadily over time. In 1980 the average THC concentration in marijuana was 3%, although by 2009 it was 13% and sometimes as high as 37% among some marijuana extracts.

Individuals respond differently to marijuana both in terms of the therapeutic benefits and the side effects. Responsiveness to drugs often vary according the unique biological characteristics of the patient as well as their age, ethnicity, or gender.

Individuals respond differently to marijuana both in terms of the therapeutic benefits and the side effects. Responsiveness to drugs often vary according the unique biological characteristics of the patient as well as their age, ethnicity, or gender.

Furthermore, it is hard to distinguish the medical and recreational benefits of marijuana (Ryan & Sharts-Hopko, 2007). Although Pennsylvania's Medical Marijuana Act restricts prescriptions to cannabidiols which lack the euphoria of THC, many patients will use marijuana obtained illegally. For them it may be difficult to tease out the medical benefits of marijuana from the euphoric or relaxing side effects of the drug. For example, patients may report a reduction in their perception of pain, but that reduction may only occur because of the euphoric side effect of the drug; not because of any inherent pain reduction quality to the drug (Ryan, & Sharts-Hopko, 2017). On the other hand, for many patients the side effects of cannabis have been negative, such as hallucinations and depersonalization.

The mode of administration may influence responsiveness to the drug. Cannabis has been administered through smoking, eating, or even topical applications. Smoked or vaporized cannabis allow a more rapid metabolizing of its psychopharmacological agents. One of the issues that biomedical researchers need to consider how the mode of administration of the drug influences its impact on human physiology.

Practical Implications for Health Care Professionals

The evidence supporting medical marijuana has not kept pace with the popular enthusiasm for it. The public is often interested in using marijuana to replace or supplement the traditional medications that they are already taking. Many physicians will have patients tell them that they are taking marijuana that they obtained illegally to alleviate a muscle spasms, reduce pain, or address another medical condition. Piper et al. (2017) found that three fourths of the patients who started marijuana use reported decreases in medications for pain (including opioids), anxiety, sleep, and depression. Often the patients in Piper's study had not informed their physicians that they were supplementing or substituting marijuana for the prescribed medications.

Medical marijuana laws can place physicians in a difficult position. Patients may ask physicians to prescribe marijuana based on limited scientific information on the effectiveness on many of the conditions listed in Pennsylvania's Medical Marijuana Act. Physicians must consider the preferences of their patients, the evidence behind the treatment, the availability of better treatment options, and the potential for the misuse of marijuana.

Ordinarily physicians would prefer to prescribe FDA medications with evidence for their effectiveness and only prescribe marijuana if the traditional medication fails to produce its desired results. But their prescription patterns will certainly be influenced by the public demand of marijuana based treatments. Many patients who had previous experience with marijuana as a recreational drug feel more positively about it as a medicinal drug. Other patients prefer marijuana because they consider it natural, and thus healthier than more traditional medications. Whether medical marijuana is more natural than other medications is a source of dispute, however.

Also, even proponents of medical marijuana recognize that it needs to be used responsibly. Although the public perceptions of the dangerousness of marijuana have decreased in recent years, using marijuana does involve some health risks. Pennsylvania's Medical Marijuana Act requires physicians to engage in an informed consent process with

their patients that includes potential harmful effects of the medication. In addition, the Act requires a warning label that states:

> This product is for medicinal purposes only. Women should not consume during pregnancy or while breastfeeding except on the advice of the practitioner who issues the certificate and, in the case of breastfeeding, the infant's pediatrician. This product might impair the ability to drive or operate heavy machinery. Keep out of the reach of children.

Physicians need to address several issues with patients. First, they need to inform patients that if it is smoked regularly it can cause bronchitis or other lung diseases. This is less of a problem for legal marijuana in Pennsylvania which restricts the dispensing of dry leaf or plant forms.[2] Second, it can worsen the course of psychotic illness and may precipitate psychoses in a few persons who have a vulnerability to it. Many users of marijuana may experience brief psychotic reactions that last only for the period of intoxication. However, teenagers who use marijuana heavily show an increased risk of psychosis emerging later in their lives (Ranganathan et al., 2016). The reasons for this connection is still in dispute. However, genetics may play a role. Daily smokers who had a specific variant of genes related to the dopamine reward system have risk of developing psychosis that is seven times higher than those who did not smoke marijuana or who smoked it infrequently (DiForti et al., 2012).

Furthermore, marijuana use has been linked to developmental disorders in children who were exposed to cannabis in utero. Pregnant and breast-feeding women should not use it unless under medical direction. The public needs more education on this issue as one study found that almost 4% of pregnant women had used marijuana in 2014, twice the rate of pregnant women who used it in 2002 (Brown et al., 2017).

In addition, patients who have caregiving responsibilities or who have employment that requires substantial cognitive efforts should be advised that marijuana may influence their cognitive abilities in the short-term. Also, marijuana use can cause acute driving impairment. Edible cannabis presents a health risk for children in the household who may view it as a treat or a form of candy. Finally, a minority of marijuana users may develop cannabis use disorders.

[2] The Act gives a Medical Advisory Board the authority to issue regulations permitting dispensing dry leaf of plant forms of marijuana. No such regulations have yet been promulgated, however.

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A Brief Historical Note on Marijuana

Samuel Knapp, Ed.D., ABPP
Director of Professional Affair

Varieties of cannabis in the form of hemp have been found in human settlements dated around 4000 BCE. One variety of cannabis, now called industrial hemp, was used to make clothing, ropes, and other domestic products. It is not known when humans began to use the varieties of cannabis with psychoactive properties for recreational or medicinal purposes, although Sanskrit and Hindi literature referenced its medicinal qualities as early as 1400 BCE. The prominent Greek physician Claudius Galen (131-201 C.E.) had described a sense of well-being that comes from smoking marijuana. Marijuana was not commonly used in American medicine until 1839 when British physician William O'Shaughnessy publicized its usefulness as an analgesic and muscle relaxant after learning about it from South Asian physicians in Calcutta, India. Afterwards, marijuana extracts were regularly marketed through the early 1900s, especially to treat migraine headaches, insomnia, nausea and other disorders.

Nonetheless, following the end of prohibition, anti-drug campaigners within the United States began to associate marijuana use with mental deterioration and crime. Older readers may recall the propaganda film, *Reefer Madness,* which was used to promote awareness of the evils of drugs abuse (it is available on You-Tube). Some historians believe that another factor was the desire of industrialists invested in nylon and other synthetic fibers to cut out competition from growers of industrial hemp. The Marihuana Tax Act of 1937[1] imposed heavy taxes on those who prescribed marijuana and by 1942 marijuana was entirely removed from the formulary of approved drugs. In 1970 Congress classified cannabis as a Schedule I drug, a classification reserved for drugs with a high potential for abuse, although many scientists disagreed with this categorization. During this time, research into the medical benefits of marijuana was limited.

Studies in the 1980s led to the discovery of the human's endocannabinoid system and the presence of cannabinoid receptors in the human body. Both the central and the peripheral nervous systems contain components of the endocannabinoid system which influences many physiological processes including inflammation, appetite regulation, and pain perception.

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Current research suggests that the use of marijuana as a medical agent in the 19th and early 20th century may have some science behind it. Many states, relying on empirical and anecdotal information, now allow its use for medical purposes and several states have lifted criminal sanctions against recreational marijuana use. Currently, marijuana has a quasi-legal status. It is banned at the federal level, legalized for recreational use by several states, and allowed for medicinal purposes by almost half the states. In many states where it is still illegal, law enforcement agencies put its enforcement as a low priority. However, public statements from United States Attorney General Jeff Sessions in January indicate that the federal government may be looking to increase enforcement of its marijuana laws.

In recent years, illegal manufacturers have produced synthetic cannabinoids which produce physiological and psychological responses far greater than ordinary marijuana and which are linked to numerous overdoses. Even though many of the dire warnings of the harmful impact of marijuana have been exaggerated, those warnings do appear appropriate for the new synthetic varieties.

[1] The law used a now archaic spelling of the word marijuana.

Save the Date! PPA's ECP Day will be held on Saturday, March 3, 2018.

What Should Practicing Psychologists Know about Marijuana?

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Director of Professional Affairs

Most professional psychologists will encounter patients who are using marijuana either recreationally or medically. Almost 8% of Americans reported using marijuana in the last 30 days with men (9%) reporting more use than women (about 5.5%). About 14% of younger adults (aged 18-24) reported marijuana use compared to 5% of older adults (50 or older). Most users smoke marijuana in a joint, water pipe, or bong, although 16% used it through edibles and 8% used it through vaporizers. Compton et al. (2016) reported that the rate of using marijuana increased by 30% from 2002 to 2014, although another study using a different methodology claimed that its usage doubled in the same period. The data is inconclusive as to whether the increase in marijuana consumption is accompanied by a decrease in alcohol consumption (Guttmannova et al., 2016).

Marijuana users vary widely in the why, how, frequency, and consequences of their use. Most adolescents and young adults use marijuana to experiment with the experience, to relax or socialize, or to help them cope with daily stressors (Patrick et al., 2016). Among all marijuana users about 16% of marijuana users said that they used it for medicinal purposes only, 53% for recreational use only, and 36% for both medicinal and recreational purposes (Schauer et al., 2016). Most users smoke marijuana infrequently and experience few negative effects from it (Pearson et al., 2017). However, the 12-month prevalence of cannabis use disorder (CUD) was around 2% (3.5% for men and 1.7% for women; Kerridge et al., 2018).

Marijuana use can become clinically relevant in several situations. Some patients may have or be at risk of developing CUD. Those who use marijuana to cope with problems or to relax are more likely to end up abusing it (Patrick et al., 2016). I would recommend that psychologist direct these patients to manage their anxiety through more traditional behavioral or medical interventions.

The heavy use of marijuana by teenagers increases the risk that they may develop cannabis dependence, become a school drop-out, or experience a psychotic episode (Van Ours, et al, 2013). The risk of developing a CUD increases when teenagers start using marijuana at an early age. Evidence for marijuana as a gateway drug is mixed. On the one hand marijuana use is likely to precede the use of other illegal drugs, and adults who used marijuana were more likely to abuse alcohol in the future. In addition, some research with non-human animals suggest that early exposure to marijuana may heighten the brain's response to other drugs later in life. On the other hand, most persons who use marijuana do not go on to use other illegal drugs nor do they develop CUD.

The diagnostic criterion for CUD include a deterioration of the quality of daily life, such as neglect of work, family relationships, or hygiene and an inability to reduce its use voluntarily. Patients at an increased risk for CUD tend to come from families with greater instability, lower SES, and a history of substance abuse disorders. The reason for the relationship between CUD and SES is unclear. Perhaps persons from lower SES use marijuana to cope with life stressors; perhaps the use of marijuana reduces an individual's ability to do well in school or work; or perhaps both factors are in play (Kerridge et al., 2018). CUD is associated with an increased risk for other substance abuse disorders, depression, generalized anxiety disorder, PTSD, and antisocial, borderline, and schizotypal personality disorders (Kerridge et al., 2018).

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Research supports the effectiveness of behavioral interventions, such as cognitive-behavior therapy or contingency management treatments in treating CUD. The FDA has not approved any medications for CUD, although research is on-going in this area and some medications may help alleviate symptoms associated with marijuana withdrawal. Since relatively few psychologists have experience treating drug disorders, it would be necessary to refer such patients to a specialist. A recent study by the Association of State and Provincial Psychology Boards found that only 14% of licensed psychologists claimed an expertise in treating substance abuse disorders (Pearson, 2016).

As with other drug related problems it can be difficult to motivate patients to accept the benefits of behavioral change. Motivational Interviewing may be indicated here. It "is an empirically supported interviewing strategy and delivery style based on the premise that when an individual is adequately motivated, change is likely to occur" (Steinkopf et al., 2015, p. 350). It "is primarily concerned with helping clients to make a decision to change" (Moyers, 2014, p. 358). It involves two elements: the relationship and then promoting change talk. Change talk is more likely to occur after open questions and reflections and less likely

to occur after giving information or asking closed questions. Motivational Interviewing can be used as a stand-alone technique, incorporated into other modalities, or used as a pre-treatment intervention.

In summary, I recommend that psychologists routinely screen patients for their substance use. Although most casual users of marijuana experience few long-lasting problems from its use, I urge psychologists to pay special attention when patients who use marijuana are teenagers, engage in heavy use, or use marijuana to self-medicate. In addition, I strongly discourage the use of synthetic cannabinoids which present serious medical risks. Finally, a subset of marijuana users will develop psychotic symptoms that last longer than the period of intoxication. If necessary, referrals for specialized services should be made for patients who have CUD.

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February 12 at 12:00 pm
Ending the "Silent Shortage" in Pennsylvania through RxP

This webinar will briefly review the extent of the lack of psychiatric resources in Pennsylvania, review how prescribing psychologists are trained and how they would help to bridge the gap between supply and demand, and briefly discuss the pros and cons pursuing RxP in Pennsylvania. Join us and earn 1 CE credit.

February 21 at 1:00 pm
ABPP: An ECP Account During The Board Certification Journey (non-CE)

The American Board of Professional Psychology (ABPP) is the primary organization for specialty board certification in psychology. Julie Radico Psy.D. will share her experience in pursing board certification in Clinical Health Psychology and general information on the process of applying for ABPP. This will include information on: specialty areas, completing the general and specialty credentials review, submission and often resubmission of a written practice sample, and expectations for the oral exam, which she is scheduled to take in March, 2018. The information to be presented about the ABPP process has been reviewed by three ABPP Board of Trustees Members, including the president and Early Career Representative.

Marijuana Overdoses and Suicide

Samuel Knapp, Ed.D., ABPP
Director of Professional Affair

Studies have consistently found a link between marijuana and an increased risk of suicide. For example, Rasic et al. (2013) found that the use of marijuana was linked to depression, suicide ideation, and suicide attempts among high school students. Also, Kimbrel et al. (2017) found that Iraqi-Afghanistan-era war veterans who use cannabis had an increased risk of a completed suicide, even after holding other common risk factors constant.

But cannabis is a weaker predictor of suicidal behavior than many other variables (Delforterie et al., 2015). Several factors may explain this weak cannabis/suicide connection. First, patients who seek treatment for the misuse of marijuana tend to have less overall psychopathology than patients seeking treatment for misuse of other drugs. Perhaps this explains why patients who seek treatment for marijuana alone are less likely to have had a suicide attempt than those who sought treatment for other drugs. In addition, patients who used two or more drugs or who injected drugs had risks of suicide or unintentional overdoses that were 4 or 5 times higher than those who received treatment for marijuana use alone (Bohnert et al. 2011). Borges et al. (2016) found no link between acute marijuana intoxication and suicide, but did find a link between chronic marijuana use and suicide. Among chronic users, the risk of suicide appears especially high for those who have a high intensity and frequency of marijuana use (van Ours et al., 2013).

A reasonable question to ask if suicidal ideation increased the likelihood that patients would use marijuana; if marijuana increased the likelihood that patients would develop suicidal ideation, or if both marijuana use and suicidality were caused by some common factor. The self-medication hypothesis holds that patients use marijuana to help control unpleasant emotions. The functioning hypothesis holds that marijuana use impairs an individual psychologically to the point that suicide becomes an option. A final theory holds that marijuana use co-occurs with suicidal ideation without any causal link between them. Instead, both cannabis use and suicidal behavior are caused by a similar set of risk behaviors. Delforterie et al. (2015) favored the last interpretation, although they acknowledged that the data is mixed.

The argument is that marijuana could be so effective in reducing physical pain or emotional distress that sufferers would have generally improved health and one less precipitant of suicide.

Some argue that the legalization of marijuana would decrease suicide rates. The argument is that marijuana could be so effective in reducing physical pain or emotional distress that sufferers would have generally improved health and one less precipitant of suicide. However, the evidence that marijuana can reduce suicides is mixed. Rylander et al. (2014) found that suicide rates in Colorado did not change following the legalization of marijuana, while Anderson et al. (2014) found that suicide rates for men fell in those states that legalized marijuana. The trend for women was in the same direction but failed to reach statistical significance.

Lethal overdoses from marijuana alone almost never occur. Although traces of marijuana have been found in less than 10% of all completed suicides, it almost always occurs in the presence of other drugs as well (Borges, 2016). However, synthetic cannabinoids present a serious health risk. For example, in the summer of 2017, emergency services in Lancaster, PA responded to 102 crises in a three-day period in July due to overdoses linked to synthetic marijuana (CNN, 2017). By the end of the week there were 158 crises. Synthetic cannabinoids, sometimes called Spice or K-2, are developed by spraying or painting artificial chemicals on plants so that they can be smoked like marijuana. Often, they are mixed with actual marijuana plants. The effects of these drugs are unpredictable, but they can produce hallucinations, psychosis, violent behavior, or lead to unconsciousness (National Institute on Drug Abuse, 2015).

References

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2018 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2018, we are looking to expand these options—we hope you'll join us for one or more of these programs!

Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

February 12, 2018
PPA Webinar Series - Ending the "Silent Shortage" in Pennsylvania through RxP
Anthony Ragusea, PsyD, MSCP
12:00 - 1:00 pm

February 21, 2018
PPA Webinar Series - ABPP: An ECP Account During The Board Certification Journey (non-CE)
Julie Radico, PsyD
1:00 - 2:00 pm

February 23, 2018
PPA Regional Advocacy Day
Philadelphia College of Osteopathic Medicine

March 3, 2018
ECP Day
PPA Office
Harrisburg, PA

April 13, 2018
PPA Lunch & Learn
PPA Office/Virtual Webinar
Harrisburg, PA

April 19, 2018
Regional Advocacy Day
Sheraton Station Square
Pittsburgh, PA

April 19, 2018
PPA's Day of Self-Reflection
Sheraton Station Square
Pittsburgh, PA

April 20, 2018
PPA Spring Continuing Education Conference
Sheraton Station Square
Pittsburgh, PA

May 11, 2018
PPA Lunch & Learn
PPA Office/Virtual Webinar
Harrisburg, PA

June 13–16, 2018
PPA2018—PPA's Annual Convention
Doubletree Valley Forge
King of Prussia, PA

Home Study CE Courses

Act 74 CE Programs

Assessment, Management, and Treatment of Suicidal Patients—1 CE

Older Adults at Risk to Die From Suicide: Assessment Management and Treatment—1 CE

Assessment, Management, and Treatment of Suicidal Patients (Extended)—3 CEs

Assessment, Management, and Treatment of Suicidal Patients (Podcast)—1 CE

Patients at Risk to Die From Suicide: Assessment, Management, and Intervention (Webinar)—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Record Keeping for Psychologists in Pennsylvania—1 CE

Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each

*Introduction to Ethical Decision Making**—3 CEs

*Competence, Advertising, Informed Consent, and Other Professional Issues**—3 CEs

*The New Confidentiality 2018**—3 CEs

This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.

For all Home Study CE courses above, contact: Judy Huntley, 717-232-3817, judy@papsy.org.

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit papsy.org.

Registration materials and further conference information are available at papsy.org.