INTERVIEW WITH MITCH WINEHOUSE

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Dear Readers,

I welcome you to The Sober World magazine. The Sober World is an informative award winning national magazine that’s designed to help parents and families who have loved ones struggling with addiction. We are a FREE printed publication, as well as an online e-magazine reaching people globally in their search for information about Drug and Alcohol Abuse.

We directly mail our printed magazine each month to whoever has been arrested for drugs or alcohol in Palm Beach County as well as distributing locally to the schools, colleges, drug court, coffee houses, meeting halls, doctor offices and more throughout Palm Beach and Broward County. We also directly mail to treatment centers throughout the country and have a presence at conferences nationally.

Our monthly magazine is available for free on our website at www.thesoberworld.com.

If you would like to receive an E-version monthly of the magazine, please send your e-mail address to patricia@thesoberworld.com.

Drug addiction has reached epidemic proportions throughout the country and is steadily increasing. It is being described as “the biggest man-made epidemic” in the United States. More people are dying from drug overdoses than from any other cause of injury death, including traffic accidents, falls or guns.

Many Petty thefts are drug related, as the addicts need for drugs causes them to take desperate measures in order to have the ability to buy their drugs. The availability of prescription narcotics is overwhelming; as parents our hands are tied.

Purdue Pharma, the company that manufactures Oxycontin generated $3.1 BILLION in revenue in 2010? Scary isn’t it?

Addiction is a disease but there is a terrible stigma attached to it. As family members affected by this disease, we are often too ashamed to speak to anyone about our loved ones addiction, feeling that we will be judged. We try to pass it off as a passing phase in their lives, and some people hide their head in the sand until it becomes very apparent such as through an arrest, getting thrown out of school or even worse an overdose. I hope this magazine helps you find the right treatment for your loved one.

I know that many of you who are reading this now are frantic that their loved one has been arrested or put in jail, but this may be your opportunity to save your child or loved one’s life. They are more apt to listen to you now than they were before, when whatever you said may have fallen on deaf ears. This is the point where you know your loved one needs help, but you don’t know where to begin.

I have compiled this informative magazine to try to take that fear and anxiety away from you and let you know there are many options to choose from.

There are Psychologists and Psychiatrists that specialize in treating people with addictions. There are Education Consultants that will work with you to figure out what your loved ones needs are and come up with the best plan for them. There are Interventionists who will hold an intervention and try to convince your loved one that they need help. There are detox centers that provide medical supervision to help them through the withdrawal process.

There are Transport Services that will scoop up your resistant loved one (under the age of 18 yrs. old) and bring them to the facility you have chosen. There are long term Residential Programs (sometimes a year and longer) as well as short term programs (30-90 days), there are Therapeutic Boarding Schools, Wilderness programs, Extended Living and there are Sober Living Housing where they can work, go to meetings and be accountable for staying clean.

Many times a Criminal Attorney will try to work out a deal with the court to allow your child or loved one to seek treatment as an alternative to jail. I know how overwhelming this period can be for you and I urge every parent or relative of an addict to get some help for yourself. There are many groups that can help you. There is Al-Anon, Alateen (for teenagers), Families Anonymous, Nar-Anon and more. This is a disease that affects the whole family, not just the parents.

Addiction knows no race or religion; it affects the wealthy as well as the poor, the highly educated, old, young-IT MAKES NO DIFFERENCE.

This magazine is dedicated to my son Steven who graduated with top honors from University of Central Florida. He graduated with a degree in Psychology, and was going for his Masters in Applied Behavioral Therapy. He was a highly intelligent, sensitive young man who helped many people get their lives on the right course. He could have accomplished whatever he set his mind out to do. Unfortunately, after graduating from college he tried a drug that was offered to him not realizing how addictive it was and the power it would have over him.

My son was 7 months clean when he relapsed and died of a drug overdose. I hope this magazine helps you find the right treatment for your loved one. They have a disease and like all diseases, you try to find the best care suited for their needs. They need help.

Deaths from prescription drug overdose have been called the “silent epidemic” for years. There is approximately one American dying every 17 minutes from an accidental prescription drug overdose. Please don't allow your loved one to become a statistic. I hope you have found this magazine helpful. You may also visit us on the web at www.thesoberworld.com.

Have a Safe and Sober July 4th.

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INTERVIEW WITH MITCH WINEHOUSE
By Patricia Rosen

Amy Winehouse was born in London on September 14, 1983 and broke into the music business at the age of 16. Her music was a mix of Jazz, pop, soul and R&B. She won 5 Grammy Awards for her 2006 album Back to Black and many of us remember her song “Rehab”, which was released as the lead single. It won 3 Grammy’s at the 50th ceremony, won record of the year, song of the year, and best Female Pop Vocal Performance. It made the billboard hot 100 list and became Amy’s first and only top 10 hit in the United States. She had a bright future ahead of her, only to lose her life at such a young age to the disease of addiction. Amy died on July 23, 2011, at the age of 27 from a seizure due to a night of excessive drinking.

I had the pleasure of meeting Amy’s father, Mitch Winehouse and interviewing him for The Sober World. Mitch has suffered the greatest loss any parent could- losing his only daughter Amy. It is a heartache that no parent should ever have to endure. Unfortunately, there are families across the globe everyday enduring the same heartache. Mitch hopes through his foundation- The Amy Winehouse Foundation, which he started in Amy’s memory can help young people, especially those in need by reason of ill-health, disability, financial disadvantage or addiction.

Patricia: I want to say how truly sorry I am for your loss.

Mitch: Thank you. You only know too well yourself. It’s something no parent should have to go through.

Patricia: You’re right. We get through it but you never get over it. There probably is not a day that goes by that I don’t think of my son.

Mitch: I understand.

Patricia: Your daughter was so talented, you must have been so proud of her.

Mitch: So proud!

Patricia: Looking back now, with everything Amy accomplished, what do you think about most? Is there anything different you would have done or said to change any of it?

Mitch: Good Question. No, not really. Amy was 27 when she passed away and her downward spiral began when she was 22. We were always encouraging her to get help. At 22 there isn’t a whole lot you can do or say to get them to stop. They are over 18. You can’t court order them because they need to be crazy, Amy wasn’t. Her grandmother could have come down from heaven in a chariot and asked her but she would have said yes, and been back the next day doing the same thing. One time I pretended I had a heart attack. I was in the hospital and she came in, looked at the chart and told me I didn’t have a heart attack. I almost wish I had.

Patricia: That is pretty funny……I remember crazy things I did and said to try to stop my son from using. It’s amazing what we will do.

Mitch: Yes, well what could we do? Amy wasn’t going to stop until she was ready and the thing to remember is Amy had stopped using drugs three years prior to her death. She saw me in an uncomfortable situation. I had a fight with her drug dealer, and I am not a young guy. She also saw her mother very sick and saw the look on her mum’s face and she just knew it was time to stop using drugs. She was very strong willed and when she made up her mind, there was no stopping her.

Patricia: So I guess it’s true when people say when the addict is ready to stop using, they will stop.

Mitch: Yes, what are you supposed to do? Like any other parent you don’t know what to do about it. There is no book written about it. Many people tell you different things. One person talks to you about tough love, another one is telling you to do this or that and one person said to me you have to cut off her money. It’s her money! I had no power to cut off her money. Another person said “you have got to leave her”- how do you do that? It’s my daughter. I couldn’t do that.

Patricia: right… I agree with that too.

Mitch: And ultimately, whatever we did together it worked because she did quit drugs. She never went into rehab per se. She would go into detox. You know not everyone goes into treatment although I personally think rehab is a wonderful thing and that she would have benefitted from it. She never dealt with the underlying problems so yes she stopped using drugs but then she started another addiction. I don’t know if you know London but there is this store Selfridges which is like Saks 5th Avenue and she would go into the store and spend like £40,000 on dresses.

Patricia: So she substituted one addiction for another?

Mitch: Yes, and then I would take them back the next day and she would be like “dad, where’s my dresses, stop taking them” but then we would laugh about it because she knew what I was doing. The store didn’t mind because like 200 people followed her and bought the store out but she never really dealt with the underlying issues of her addiction.
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WHY STAY SOBER IF I’M DYING?
By Terence T. Gorski

I had just completed a workshop on relapse prevention. As I was leaving the conference room, a thin and frail-looking man from the audience approached me. “Mr. Gorski,” he said, “My name is Malcolm. I am recovering from chemical dependence and have been sober for nearly eleven years. I’ve had AIDS now for over two years and I’m beginning to get sicker and I know I will eventually die. A big part of me wants to start drinking to deal with it and, to be quite frank, considering my condition, I can’t think of any good reasons to stay sober. What should I do?”

Alcohol and Drugs Won’t Help!
It is tempting for terminally ill patients to believe the mistaken notion that alcohol and drug use will somehow make their disease easier to cope with. It does not. I ask patients to think back to the times when they were using alcohol and drugs and to remember the quality of their lives.

No matter how painful or debilitating your terminal illness may be, alcohol and drugs will only make it worse. The mental anguish and pain you may be experiencing will increase and your ability to cope with your disease will progressively disappear. At best, alcohol and drugs will provide brief moments of temporary anesthesia, followed by periods of shame, guilt, and dysfunction. As the chemical dependency progresses, and it always progresses, the resultant loss of control will prevent you from responsibly treating your illness, destroy any hope of having quality moments of life, and escalate your movement toward a painful death.

For people who are addicts, alcohol and drugs are never a solution to any of life’s problems, including terminal illnesses. The temptation to believe that alcohol and drugs are a solution is part of the delusional system that accompanies chemical addiction.

The Choices In Facing A Terminal Illness
When facing a terminal illness, we only have three choices:

• We can deny it by pretending everything is fine.
• We can fight it by learning all that we can about our disease, fortifying our sobriety, stepping ourselves in courage and hope, and doing everything we know how to do to increase the duration and quality of our survival time.
• Or we can accept it. We can face the inevitability of our death and surrender to it. By surrendering we can reinvest our energy in finding a sense of dignity and meaning in the experience of our illness and death. We can finish our business here on earth and turn to strengthen ourselves spiritually to face the transition from this life to the next.

Which is the best or correct way? There is none. We each will have to choose which of these alternatives we will embrace at each stage of our movement toward death. At times, it is best to deny our illness and live as if we will live forever. At other times, it is best to steep ourselves for the battle and fight for our lives with everything we have. Yet still at other times, it is best to surrender to the inevitable and face our death for what it is, the final transition of our physical lives.

The bottom line is this -- if we choose to use alcohol and drugs to cope with our illness, none of these alternatives will be available to us. Our addiction will rob us of all of our choices, make our pain worse, and rip us away from ourselves, our God, and those who love us. Alcohol and drugs can never be a solution to anything for people in recovery from addiction.

Reasons To Stay Sober
When Malcolm asked me the question, “Why should I stay sober?” my response was very direct, “Because you owe it to yourself and those around you. Because you are in recovery and you are able to face anything sober and this includes your own eventual death.”

For a moment I became philosophical. “We can all create precious moments in time,” I said, as I leaned forward and looked him in the eyes. “We can, at times, transcend our fear and carve out moments of joy and wonder.” I looked away for a moment as I realized how often I had failed to follow my own advice. Then I continued: “We can choose to laugh when we feel like crying. We can live fully, even in the face of death. This is just true for all of us.”

My mind flashed words of Ernest Hemmingway: ‘All true stories end in death.’ In other words, we are all dying in every moment that we are alive. We are all living in every moment we are dying. We can choose to embrace life and revel in it, or we can choose to embrace death and quake in horror, fear and despair. Many people have told me the most painful thing they faced when confronted with their own impending death was how many moments in their lives they had wasted.

Then my rational brain took charge and I began explaining to Malcolm that there are seven good reasons to stay sober even if you have a terminal illness.

1. There Is Always Hope: Only God decides when we die. In recovery, we learn that we are not God. Although we will all eventually die, the timing of our death is never certain. Many people with HIV will never develop AIDS. Of those who have AIDS, some will have spontaneous remissions and others will live a long and meaningful life before eventually dying. On top of that, there is always the hope of a major medical breakthrough in treatment. Perhaps a cure will be found! Even if such a breakthrough never comes, people are happier and healthier when they live with hope than when they live in despair.

2. Staying Sober Increases The Length And Quality Of Survival Time: Staying sober, eating right, exercising moderately and managing stress (all of the components of a good recovery program for chemical dependence) will increase the length and quality of survival time.

3. Staying Sober Allows Us Connection With A Higher Power: It is only in sobriety that we can experience a deep connection with our Higher Power and contemplate with hope what lies beyond the limits of our physical existence. This is the only true source of comfort when facing our own death.

4. Alcohol and Drug Use Escalates Disease Progression: Alcohol and drug use inhibits the immune system and accelerates the development of AIDS. Alcohol and drug use will also interfere with the effectiveness of many of the new medications and other treatments that slow down the progression of AIDS.

5. Staying Sober Gives Us The Possibility Of Death With Dignity: By staying sober, we can approach our death with dignity and self-respect. We can reflect upon the meaning of our lives, the loves we’ve shared, the experiences we have had and the things

Continued on page 44

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Shame is a complex emotional state which can be difficult to define and understand. Many think of shame as similar to guilt but they are inherently different emotions. A very simple way of understanding the difference is in the way we think and behave in response to these emotions. When we feel guilty about something we’ve done, our self-talk about the situation is usually something like “I feel bad about what I did,” and typically we will move toward the source of our mistake in order to apologize or otherwise repair the misconduct.

On the other hand, when we feel shame we think and behave very differently. Our thinking, or self-talk, is more along the lines of “I am such an idiot” or “I am so stupid” instead of “I did something wrong” or “I made a mistake.” Unlike guilt, however, where we move toward connection in an attempt to restore and repair, when we experience shame we will move away, avoid, or even hide in order to disconnect from others and our feeling of shame.

When trying to understand the role shame plays in addiction, it is further complicated and misunderstood because of the dual nature of shame. Shame is experienced at healthy levels (innate moral shame) and toxic levels (internalized shame). John Bradshaw, in his book *Healing the Shame That Binds You*, does a great job explaining this dual nature of shame with his cholesterol analogy. Just as there are two kinds of cholesterol, HDL (healthy) and LDL (toxic), there are also two forms of shame; healthy and toxic.

Healthy shame keeps us grounded. It is our reminder that we are not superhuman and all powerful (aka God), that we are human, and we make mistakes. Healthy shame points us in the direction of some larger meaning. Healthy shame is the essential foundation for spirituality and the psychological ground for our humility. Healthy shame is good for us and will often be the emotional prompting that encourages individuals to seek help for their addiction. Any true surrender can’t occur without a healthy dose of shame. I can’t tell you how many times I’ve heard people say “I couldn’t stand to even look at myself in the mirror. I was disgusted with the person I had become.” This rings true regarding my own recovery from addiction.

Internalized shame, on the other hand, is like LDL cholesterol. It is destructive and if left unchecked will ultimately kill us. Instead of a momentary feeling of being embarrassed, making a mistake or feeling less than, a person comes to believe that their whole self is fundamentally flawed and defective. We are no longer perfectly imperfect human beings; we are totally and absolutely imperfect. When shame becomes internalized or absolutized, it becomes a state of being. Toxic shame is the most destructive emotional sickness of self a person can have. It is a true soul sickness that serves as both root cause and perpetrator of all addictions. It lethally disgraces us to the point where we literally disown ourselves. This self-alienation requires an elaborate masking or cover-up of the true and authentic self by creating a false self, which is essentially our protection against our felt sense of toxic shame.

The fuel of all addictive behavior is this rupturing of the self, the belief that we are flawed and defective human beings; we are a mistake. Deep, internalized, toxic shame gives rise to distorted thinking where our worth is measured on the outside instead of the inside, “I need something outside myself (alcohol, drugs, sex, money, power, food, etc.) in order to be okay,” which results in acting out on this thinking, followed by more shame over the consequences of our behavior. Addiction in and of itself can quickly turn healthy shame into toxic shame. I see this very often with the young people I work with who are barely out of their teens. The role of addict is the only identity they’ve ever known, with the compulsive cycle of addiction being fueled and regenerated by their identity and shame as an addict.

Healing toxic shame is an essential part of all addiction recovery. Unfortunately, it is an extremely painful process and especially difficult because pain is essentially the very thing we are trying to avoid. The pain comes in having to expose and look at the toxic shame, which is necessary and critical in order to reduce, and ultimately heal internalized shame. Shame thrives in darkness. The more we avoid it, the more it grows and the worse it becomes. We need to bring it out of hiding. Healing internalized, toxic shame requires what Bradshaw refers to as “externalizing” the shame. This can be tricky because there is the risk of premature exposure, or exposing our shame before we are ready, which can, in turn, create more internalized shame. The key to successful externalization is finding a non-shaming intimate person or support group and honestly sharing our innermost feelings.

Brene Brown, in her research on shame, credits this willingness to become vulnerable and exposed as an essential element in the healing of shame. When we trust someone and experience their unconditional love and acceptance, we begin to change our beliefs about ourselves. One of the reasons 12 Step programs are so successful is in their inherent ability to heal toxic shame. The birth of AA was created through the very act of two people coming together (Bill W. and Dr. Bob) and exposing themselves and their pain to each other and then, of course, ultimately, to other suffering alcoholics. Alcoholics Anonymous and 12 Step Recovery has by far been the most successful approach to healing toxic shame. That being said, there is a significant population of individuals for whom 12 Step programs are not appealing and who continue to suffer and struggle because of their reluctance to engage in the healing process. 12 Step recovery affords. And although I am a devoted supporter of 12 Step programs, and credit it with my own personal recovery, I believe it is possible to heal toxic shame without a 12 Step program. Conversely, I have also found that many struggling with toxic shame require more than a 12 Step program in order to fully heal their internalized shame. I am in no way recommending anyone forego 12 Step recovery, but simply acknowledge that it is possible to heal toxic shame through other means. This can be accomplished through an intimate, unconditionally loving, and non-shaming, relationship with a support group, mentor, clergyman or therapist. Whichever the route, however, in order to heal, we must come out of hiding and connect with others. There is virtually no other way.

Karrol-Jo (KJ) Foster is a Licensed Mental Health Counselor, Certified Addiction Professional, Advanced Certified Relapse Prevention Specialist, and Researcher. KJ works as a clinical research therapist at The Treatment Center of the Palm Beaches. She is also a PhD student at FAU researching relapse prevention and the impact of shame on addiction recovery. In addition to her relapse prevention and shame research, KJ is co-author of the research project “Spiritual Competence in Counseling and Supervision” which is currently in progress. She recently facilitated a learning institute on Integrating Spirituality into Counseling at the American Counseling Association Annual Conference in Montreal. KJ is a member of ACA, ASERVIC, FMHCA and President of the Beta Rho Chi Chapter of Chi Sigma Iota Counseling Academic & Professional Honor Society International. She may be contacted at gratitudeflows@gmail.com.
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A group of Harvard Medical Students — who are fed up with the lack of comprehensive coursework on opioid addiction and its treatment — have elected to educate themselves. The group who identify themselves as ‘White Coats for Recovery,’ present their mission statement on their Facebook page; “We represent the changing of the face of medicine, one that addresses addiction with compassionate action, not with judgment or dismissal. To take a stand against stigma and to give our patients and community members a fighting chance at recovery, we are buying and carrying naloxone, a drug that saves lives by reversing opioid overdoses.” One of the organizers who helped initiate the training sessions, John Weems, a fourth-year medical student, said: “What kind of a doctor would I be if I didn’t know how to do this?”

How positively refreshing and it gets better!

There is a large group of healthcare students, “Student Coalition on Addiction,” from Boston University, Harvard University, Tufts University, and University of Massachusetts who are advocates for residents at risk for substance use disorders, including those disadvantaged by homelessness, poverty, racism, and other systemic forces. You can view their website at www.ma-sca.org/

I can’t help but to get excited and encouraged when I see our young future physicians put into clear focus the reality that has plagued us for the last twenty-years. Perhaps it’s a generational thing, but these students get it.

Katrina Ciraldo, a recent Boston University Medical School graduate, has a personal connection to the disease. Her best friend from childhood died of a heroin overdose when she was in her first year of medical school. “She had all of these interactions with the health care system before she died. There were missed opportunities. We could do so much better.” Katrina mentioned the multiple track marks on her friend’s arms — certainly a red flag indicating addiction — that seemed to go unnoticed by medical professionals.

I give a lot of credit to these students who had to rise above and challenge the norms. But I become concerned when, according to Ciraldo, “the doctors who are teaching us medicine have not gotten this education.” This just begs the question what is being taught about addiction and its treatment at our finest universities? If the professors lack the education, than who is teaching our best and brightest? If schools like Boston University and Harvard lack comprehensive coursework on addiction and its treatment, who is teaching it?

Rolvix Patterson, a student at Tufts University School of Medicine, stated that “At the beginning of every lecture that we have when we have a guest lecturer, they always have a slide that says, ‘These are my conflicts of interest.’” Believe it or not this is an improvement. In the past pharmaceutical representatives often made presentations to med students without identifying their business ties to the industry.

While in med school at the University of Toronto in 2004, Doctor Navindra Persaud attended a week-long course on how to treat patients suffering from chronic pain. He felt as though something was missing from the presentation. In his estimation the negative effects of opioids such as deaths, overdoses, and addiction were strongly downplayed while “positive” research that supported prescribing opioids for chronic pain was played up. He stated that he and his peers left the lecture with an “incomplete and partially inaccurate” picture of how to treat patients. It was later found out that the lecturer had been previously paid to speak about pain management on behalf of Purdue Pharma LP, the makers of OxyContin.

Just how much influence does the Pharmaceutical Industry have on our future healthcare professionals has been the source of great controversy and a heated debate going on for quite some time. As early as 1961, Dr. Charles May, editor of the AMA journal Pediatrics and serving on the AMA Council on Drugs, wrote in his article

“Selling Drugs by Educating Physicians” that the “independence of physicians is ... threatened by ... drug manufacturers ... [that] promote their products by assuming an aggressive role in the education of doctors.”

In the April 2016 issue of in-Training Magazine — the agora of the medical student community — was an article titled, “The Pharmaceutical Industry’s Role in U.S. Medical Education.” In it the authors, Rijul Kshirsagar and Priscilla Vu — both medical student at the University of California, Irvine School of Medicine — point out that “Medical students are subjected to a barrage of advertising that inevitably leads to a physician-industry connection that can be harmful to our health care system. Medical students’ exposure to pharmaceutical marketing begins early, growing in frequency throughout their training. Students receive gifts such as free meals, textbooks, pocket texts, small trinkets and even drug samples. Forty to one-hundred percent of medical students report exposure to the pharmaceutical industry, with clinical students being more likely than preclinical students to report exposure. The number of students recalling over 20 exposures to marketing rose from 33.3 percent to nearly 72 percent as students entered their clinical training. Pharmaceutical companies, recognizing the formative nature of the clinical years of medical education, seek to form relationships with medical students’ years before they are ready to independently practice medicine.”

While Rijul Kshirsagar and Priscilla Vu paint a vivid picture of how the Pharmaceutical industry attempts to influence young future medical professionals’ decision making, a few researchers took it to the next level.

Kirsten E. Austad MD (Harvard Lab fellow at the time of publishing); Aaron Kesselheim, Research Associate, Department of Health Policy and Management Harvard; And Jerome “Jerry” Lewis Avorn, M.D., Professor of Medicine at Harvard Medical School and Chief of the Division of Pharmacoepidemiology and Pharmacoeconomics at Brigham and Women’s Hospital conducted a systematic review report according to PRISMA guidelines to determine the frequency and nature of medical students’ exposure to the drug industry, as well as students’ attitudes concerning pharmaceutical policy issues. In their paper titled ‘Medical Students’ Exposure to and Attitudes about the Pharmaceutical Industry: A Systematic Review’ published in the peer-reviewed journal PLoS (May 2011), they concluded that; “undergraduate medical education provides substantial contact with pharmaceutical marketing, and the extent of such contact is associated with positive attitudes about marketing and skepticism about negative implications of these interactions. These results support future research into the association between exposure and attitudes, as well as any modifiable factors that contribute to attitudinal changes during medical education.

Rijul Kshirsagar and Priscilla Vu echoed a similar observation in their article stating that; “In losing their ability to detect bias and analyze pharmaceutical marketing statements objectively, medical students hinder their future ability to practice evidence-based medicine.”

Continued on page 44
We are the second step to becoming sober.

Calling us is the first.
Sons of narcissistic fathers are driven by lack of confidence. Raised by a self-centered, competitive, arrogant father, they feel like they can never measure up or be enough to garner their father’s approval. Their father may be absent or critical and controlling. He may belittle and shame his son’s mistakes, vulnerabilities, failures, or limitations, yet brag about him to his friends. He may boast about inflated versions of his achievements, while disparaging those of his son. A narcissistic father may ruthlessly bully or compete with his son in games, even when the boy is a less-capable child. Similarly, he may be jealous of his wife’s attention to the boy, compete with him, and flirt with his girlfriends or later wife.

Narcissists lack empathy. Many such fathers are authoritarian and rigid about how things should be done, the correctness of their opinions, and getting their way as portrayed by Robert Duval as the father in the movie “The Great Santini.” Franz Kafka articulately describes a literary example of such an imposing intolerance in Letter to His Father (1966):

“What was always incomprehensible to me was your total lack of feeling for the suffering and shame you could inflict on me with your words and judgments. It was as though you had no notion of your power. I too, I am sure, often hurt you with what I said, but then I always knew, and it pained me, but I could not control myself, could not keep the words back, I was sorry even while I was saying them. But you struck out with your words without much ado, you weren’t sorry for anyone, either during or afterwards, one was utterly defenseless against you.”

Arrogant and overly confident, his father listened to no one, but judged everyone without any need to be consistent. His rules and decrees were conveyed in a “frightful, hoarse undertone of anger and utter condemnation… [that] only makes me tremble less today than in my childhood….” The fact that those commandments didn’t apply to him made them all the more depressing to Kafka, who outlines the three worlds he lived in:

“one in which I, the slave, lived under laws that had been invented only for me and which I could, I did not know why, never completely comply with; then a second world, which was infinitely remote from mine, in which you lived, concerned with government, with the issuing of orders and with the annoyance about their not being obeyed; and finally a third world where everybody else lived happily and free from orders and from having to obey. I was continually in disgrace; either I obeyed your orders, and that was a disgrace, for they applied, after all, only to me; or I was defiant, and that was a disgrace too, for how could I presume to defy you; or I could not obey because I did not, for instance, have your strength, your appetite, your skill, although you expected it of me as a matter of course; this was the greatest disgrace of all.”

As a result, Kafka lacked confidence, courage, and resolve. Like other children of narcissists, he internalized guilt and the projected shame of his father. He became so insecure and fearful, he was unsure of everything, “even of the thing nearest to me, my own body,” eventually leading to hypochondriasis.

When narcissistic fathers get involved with their son’s activities, some take over, micro-manage, or are hypercritical. Frequently, narcissists are perfectionists, so nothing their child does—or who he or she is—is good enough. Seeing their child as an extension of themselves, they become overly involved and control their son’s lives, education, and dreams, as did the father in the movie, “Shine.” Alternatively, other fathers may be physically or emotionally remote and wrapped up in their work, addiction, or own pleasures. They act like giving attention to their son’s needs, feelings, and interests or showing up at their games and activities is unimportant and a burden, even though they might provide for him on a material level. In either case, such fathers are emotionally unavailable. Because they deny and distain their own dependency and vulnerability, they often shame and belittle any sign of distress or weakness in their sons.

Kafka suffered predominantly from emotional abuse. He writes that although he rarely got a whipping, the constant threat of it was worse, as well as the guilt and shame he endured when he received a reprieve from one that he “deserved.” Some narcissists are physically cruel. One father made his son dig a swimming pool; another, cut the grass with a razor blade. (See Allen Wheelis’ How People Change.) Abuse makes a child feel helpless, afraid, humiliated, and enraged due to feelings of injustice and powerlessness. As an adult, he may have conflicts with authority and not manage anger well. He turns it on himself or others and becomes aggressive, passive, or passive-aggressive.

Sons, who do not become narcissists themselves, suffer from codependency. The message they’ve received is that they’re somehow inadequate, a burden, and that they don’t measure up to their father’s expectations—basically, that they’re unworthy of love—despite the fact that they may feel loved by their mothers; because children need to feel that both parents accept and love them for who they are. They’re deeply moved receiving an apology or crumbs of love that other people take for granted, as Kafka describes when he was sick. He was overwhelmed with tears when his father merely looked into his room and waved at him. All Kafka wanted was, “a little encouragement, a little friendliness, a little keeping open of my road, instead of which you blocked it for me, though of course with the good intention of making me go another road.” Children of an abusive parent frequently learn to be self-sufficient, guarded, and devalue their dependency and emotional needs, leading to intimacy problems. They may marry a narcissist, abuser, someone cold, critical, or emotionally unavailable.

Sons may be driven to achieve, in an attempt to get validation and the approval of their father but their success feels hollow. It’s never enough—even for themselves. They need to learn to be assertive and to set boundaries in healthy ways that were not modeled and unthinkable growing up.

They also need to value themselves and raise their self-esteem and confidence. Many have suffered from lifelong inner loneliness due to growing up in a family in constant turmoil and/or lacking emotional closeness. However, healing their shame and learning to comfort, accept, and love themselves and receive love are possible.

See Darlene’s books “Narcissist?” and Dealing with a Narcissist: 8 Steps to Raise Self-Esteem and Set Boundaries with Difficult People

Darlene Lancer is a Licensed Marriage and Family Therapist and expert on relationships and codependency. She’s authored two books: Conquering Shame and Codependency: 8 Steps to Freeing the True You and Codependency for Dummies, and six ebooks covering self-esteem, assertiveness, codependency, narcissism, overcoming guilt, and spiritual transformation through the 12 Steps. You can get a free copy of “14 Tips for Letting Go” on her website www.whatiscodependency.com Find her on www.youtube.com, Twitter @darlenelancer, and Facebook. You can contact her at info@darlenelancer.com

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THE FALSE MATCHING OF THE BUPRENORPHINE DOSE TO RESULT RANGES OF URINE DRUG TESTS (ANALYSIS BY LC/MS/MS): BIOLOGIC FACTORS THAT PROHIBIT THIS UNSUPPORTED CLAIM

By Kenneth Blum, Ph.D., Co-discoverer of: The Reward Gene

Faced with a devastating opiate/opioid epidemic the Food and Drug Administration (FDA) has approved some Medication-Assisted Treatments (MATs) for the treatment of alcoholism, opiate, and nicotine dependence, but nothing for psychostimulant and cannabis abuse. These pharmaceuticals are important and have relevance short-term for the acute induction of “psychological extinction,” [taking the drug no longer causes a high]. However, our sense of “well-being” relies on healthy dopamine function and caution is necessary when the chronic (long-term) use of MAT favors blocking dopaminergic function. The two institutions devoted to alcoholism and drug dependence (NIAAA & NIDA) realize that MAT is not optimal and continue to seek better treatment options.

Opioid Substitution Therapy (OST)

From our experience and observations, Medication-Assisted Treatment (MAT), in practice, is the use of FDA approved medications – many of which are opioids – for the treatment of opiate/opioid addiction. The two primary opioids used in opioid substitution therapy (OST) to treat opiate/opioid addiction are methadone and buprenorphine. Buprenorphine is up to 50 times more potent than morphine. These narcotics have FDA approval for use in opioid/opioid addiction treatment, are habit forming, addictive just like any other opiate or opioid, are subject to the same abuse as any other prescription or illicit narcotic, and are potentially just as deadly.

Previous work from our laboratory found that, like opiate use, long-term Suboxone® [Buprenorphine/naloxone] use led to blunted emotional responses in its users. They had less self-awareness of being happy, sad, and anxious. In layman terms, over time, Suboxone® users feel zombie-like. Other work showed that in comprehensive treatment programs, that include talk therapies, compliance with taking OST medication was high, and abstinence rates improved over time. Short-term treatment was successful (psychological extinction).

Although methadone and buprenorphine diversion by patients in OST is a poorly understood phenomenon, recent drug addiction policy plans include allowing for greater availability and use of Buprenorphine/Naloxone combinations in addiction treatment have been published. Despite the problem of expanded office-based buprenorphine opioid dependence treatment being associated with medication misuse and diversion consequences, to help with treatment accessibility, Blum and associates have recently advocated raising the patient limit per doctor to 200. Genetic addiction risk testing and rigorous urine drug monitoring were also recommended. The purpose of this white paper is to discuss and clarify a claim made by some laboratories that result ranges from urine drug screens can predict clinical responses to drugs and quantify diversion.

Can reported ranges from urine drug screens predict clinical response or diversion?

Obviously, a major concern in the United States about the treatment of pain and addiction is the possibility of both street diversion and clinical response to buprenorphine alone or in combination with naloxone. There are also the problems of mortality and even suicidal intent especially in the elderly. Clearly, it would be of benefit to a practicing physician to be able to accurately predict from urine drug screens the actual ideal dose of buprenorphine needed to treat the patient. This would allow the clinical team to determine treatment response, possible diversion, or abuse. However, there is no way to match the quantity of buprenorphine or any drug consumed with the reported range from a urine drug screen, even using sophisticated detection instruments such as LC/MS/MS.

Unfortunately, there is no relationship between Buprenorphine dosage, and the urine drug screen results reported from the laboratory. Many factors can change the urine drug result ranges. Some of the biological factors that would prohibit this unsupported claim are explained below.

Factor one: Genetic defects in metabolism

It is widely known that the cytochrome P450 (CYP450) enzyme system is crucial for the metabolism of some opioids. In fact, many patients who require high doses of opioids may have a genetic defect that can alter their ability to metabolize these agents. There are at least three specific CYP defects—2D6, 2C9, and 2C19. The cytochrome P450 could be called the “drug metabolizing enzyme system.” The CYP450 enzymes are primarily found in the liver, but can exist in the intestine, lungs, brain, and kidney. Many opiates/ opioids are metabolized via the CYP enzymes system. They include codeine, hydrocodone, oxycodone, tramadol (Ultram), fentanyl, methadone, and buprenorphine. Laboratories will identify patients as Extensive Metabolizer (EM; normal enzyme), rapid or Ultra-Rapid Metabolizer (UM; overactive enzyme), Intermediate Metabolizer (IM; underactive), or Poor Metabolizer (PM; inactive or minimally active). The IM and PM have decreased function Buprenorphine is metabolized by P450-3A4 in N-dealkylation in the liver and therefore is subject to varying degrees of metabolism as suggested above. The end products of metabolism measured in the urine drug screen will also vary, for example, the same amount of drug taken at the same time by an EM vs. an IM would produce different amounts of residue in the urine. The results as determined by LC/MS/MS or any other detection methods would differ.

Factor Two – Absorption & Distribution

Oral dosing leads to “first-pass metabolism” in the liver that breaks down both buprenorphine and naloxone preventing good absorption. Additionally, some opioids will act without biotransformation at the opioid receptor, and provide pain relief without being metabolized by the CYP enzyme or glucuronidation system. Together these differences explain the increasing utilization of sublingual, buccal, patch, subcutaneous and intravenous injection, and intrathecal routes of opioid administration since these non-oral routes allow either greater opioid effect or reach the central nervous system (CNS) before entering the liver.

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“Sometimes people let the same problem make them miserable for years when they could just say, So what. That’s one of my favorite things to say. So what.”

Andy Warhol (1928-1987)

Funny, how we always complain about the weather, ranting against the heat, the rain, the cold. Although it is a time-honored tradition it is also a waste of precious time and energy. As opined by American poet Henry Wadsworth Longfellow (1807-1882), “For after all, the best thing one can do when it is raining is let it rain.”

Simple enough, just let it rain! A frequent criticism is that the world, like the weather, is not fair. We argue that the world should operate in a more predetermined and cooperative manner. It is difficult to accept the way things are and accept life on life’s terms. Like children, we shrug our shoulders and stomp our feet. We resist. We rebel. We do not accept life raining on our parade.

Life is not fair
Life is not fair. That basic law needs to be immediately acknowledged. There are numerous “isms” that we encounter during our journey. They are spelled and pronounced differently, but collectively include negative philosophies of racism, sexism, ageism and classism. They are the malevolence philosophies of prejudice and animosity that seek to deny those who are marginalized and different. All of these “isms” are constructs created to keep us in our place, to hold us down, and prevent us from reaching our goals. They are designed by those in positions of influence and authority as a means of retaining their power. Refuse to allow the isms to dictate.

The playing field is not level. Being more qualified may not be enough to trump those who are more beautiful, charismatic or politically connected. Some sell their soul for a handful of gold coins, eagerly discarding principles for economic gain. The widespread culture of “office politics,” unjust and unfair, is an example of the harsh reality of “the way of the world.” Many can identify disconcerting examples of individuals who were promoted, not because of skill and aptitude, but because of nepotism or some other unspoken rule preventing the best qualified individual from grasping the brass ring. It is the classic con, the fum flam; the slick hand dealing under the table.

Bad things happen to good people. Everyone can relate to the evil that surrounds us. Think back to the decade of the 1990’s --- Rodney King and the L.A. Riots, the Oklahoma City bombing, Susan Smith’s horrific murders of her two sons, Andrea Yeates systematic drowning of her five infants. Innocent lives torn apart and destroyed randomly; examples of an evil pattern that emerges in spontaneous and unpredictable form.

Those atrocities are difficult to comprehend and accept as our reality. Thus, we protest. We whine and moan. We carp to anyone who will listen. We mentally list all of the grievances surrounding us. Numerous examples abound. There is a widespread notion that the rich are getting richer. The powerful continue to amass more power and control. Violent crime has gotten worse. Those beliefs leave us feeling frustrated and angry.

As written by ancient Chinese philosopher Lao Tzu, “Life is a series of natural and spontaneous changes. Don’t resist them; that only creates sorrow. Let reality be reality. Let things flow naturally forward in whatever way they like.”

Refusing to accept the way of the world leaves us bitter and frustrated. It does nothing to benefit us. What it does do, however, is allow us to continue a pattern of complaining and ranting about situations that are out of our control. A person who demonstrates anger is, after all, an individual not focused on conflict resolution but on expressing anger as a short-term solution. Anger feels good. It gives us immediate control. It becomes a powerful process addiction with elements of increased tolerance and withdrawal. In a never-ending cycle the anger is repeated over and over again; a process that never finds conclusion.

Mitch Albom, writing in “The Five People You Meet in Heaven,” offers “Learn this from me. Holding anger is a poison. It eats you from inside. We think that hating is a weapon that attacks the person who harmed us. But hatred is a curved blade. And the harm we do, we do to ourselves.”

Immediate Gratification
Continuing to complain that the world is unfair is a negative expenditure of our precious energies. Rather than accepting the challenges set before us and seeking resolution, we wish and hope for a different outcome. We expect that our hard work and focused energies will be immediately met with expected success and applause.

The phrase “immediate gratification” became a cultural buzzword after the youth of Generation X (1965-1978) were introduced. Many X’ers expected to hit the proverbial home run the first time they stepped into the batter’s box. Their expectation was that instant results and cheers of approval would automatically materialize. That magical thinking has engrained itself as a major postulate of the post-modernist era, an ongoing and persistent theme.

Feelhappy.com warns that, “Escapism, or withdrawing from the pressures of the real world into a safer fantasy world, is pervasive in our culture. It comes in many forms, some rather subtle, and prevents us from doing what we need to do to improve the circumstances of our real lives.”

Instant gratification is an unrealistic expectation, a maladaptive fantasy. We dream and fantasize about the possibilities. We create another world, a mental Utopia where magical thinking conjures wonderful accomplishments representing our wishes. But it is a false reality, an unfulfilled promise.

You can level the playing field. A more pragmatic methodology is to observe the way of the world and to understand this intricate and delicate system where things operate in a dynamic give and take. There are ways to open doors. There are ways to create opportunity. Learn and educate yourself. Begin with a cornerstone of knowledge as an initial forward step. Then, learn how successful individuals interact in the real world. Study the behaviors of those who have garnered success. How do people succeed and how do they reach their goals? How do individuals facing huge challenges overcome these obstacles and eventually arrive at what has been defined as success?

One strategy for survival and success is to network. Meet people. Get to know them. Forge relationships. The amount of energy you place into cultivating relationships will be equal to the support and opportunities you receive from these individuals.
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Those of us with a loved one struggling with drug or alcohol addiction are used to them being referred to as an “addict.” In 12-step support groups such as Nar-Anon, Step one begins by stating, “we cannot control our addicts” (Recovery, 2016). But what about our addiction? This may be a real shock to think that as a family member of an addict that we may struggle with problematic behaviors. These behaviors may consist of enabling, co-dependency and unhealthy boundary setting in regards to our addict. Perhaps a new term for you is co-addict. A co-addict can be a spouse, partner or loved one of an addict or alcoholic. Generally these individual’s mean well but can end up doing more harm than good. For the purpose of this article the term co-addict will be used.

Often times, a family with an alcoholic or addict living in the same home experiences stress. The stress experienced typically will change family roles. The role change is generally due to the desire to accommodate the addict or alcoholic. Enabling, co-dependency, and setting unhealthy boundaries are a few ways co-addicts try to deal with the stressful environment experienced when addiction is in play.

Enabling is a form of dysfunctional behavior which is meant to reduce and or eliminate stressful and or problematic situations. Typically, enabling only makes these situations worse. Co-dependency is when a loved one enables their partner or child’s addiction. Lastly, unhealthy boundary settings are when a parent or partner does not reinforce rules which are in place to provide safety and security in a home and or relationships.

I will provide a few examples of each behavior a family member may exhibit when addiction is involved in a family system. For example, a father with a son addicted to heroin would have a strong desire to not see his son struggling through withdrawal. Therefore, he may provide his son with opiates in order to help reduce and or eliminate the aversive symptoms of withdrawal. Or a wife who knows if her husband has a bad day at work and comes home to no beer in the fridge becomes angry or upset. The wife, a co-addict will likely make sure she does not bring any further stress to her husband’s day and will have her partner’s drink of choice ready when he gets home. These are examples of both enabling and co-dependency. An example of an unhealthy boundary would be the parent of a heroin addict allowing their child to stay in their home when they know the addict is using at the residence. A healthy boundary would be telling the child they need to not use in your home, they can go to rehab or they can live somewhere else. This is not an easy step and I respect that it is difficult. Sadly, some parents or partners feel that if their child or partner uses at home it is safer than being on the streets or somewhere else. The bottom line is that setting unhealthy boundaries is not going to help your loved one nor will it reduce the stress and struggles you are experiencing. Only by setting healthy boundaries can positive change possibly happen.

Co-addiction is the family and or loved one’s way of dealing with a loved one struggling with drugs and alcohol addiction. Co-addiction is not a sign of weakness. It is also not something which is avoidable. Even if a wife were to divorce her alcoholic husband the co-addiction would still be present.

Three stages exist for co-addiction. The first stage is called Early Stage. During the Early Stage the family members attempt to problem-solve the behavioral issues which come about when the addict begins using drugs or alcohol. However, the family members are unable to stop the addict and struggle with stress and anxiety.

Stage two is the Middle Stage, during which the family members continue to use the same problem solving skills as in the first stage. The problem-solving attempts continue to fail leaving the members to experience the feeling of self-dejectedness.

The final stage is known as the Chronic Stage. During this stage the family members continue to experience the feelings of self-defeat.

The reason is, the same approach and problem-solving skills which were used in stage one and two are still being used in stage 3 with the same results. They are not working.

You may wonder if you’re aware of these three stages, how they can help. The point of identifying the three stages of co-addiction is not to make the co-addict look foolish but for them to understand that groups such as Nar-anon, Al-anon or other family groups can help. Co-addicts need support just like the addict. This is why 12-step groups exist for both the addict and family.

It is important to note at this point that even once in treatment via 12-step or family groups, relapse can occur. Relapse of a co-addict is behavioral in nature. Behavioral signs of co-addiction may present in the following ways:

**Situational Loss of Daily Routine** - The family member's daily routine is interrupted by the addiction. The family member does not return to their normal recovery program following the addict going into treatment.

**Lack of Personal Care** - Family member takes care of others first and self-second.

**Indecision** - Daily life decisions become more and more difficult to make.

**Lack of Rest** - Restful sleep is not met by the family member.

**Return of Unreasonable Resentments** - Family member reviews addict’s behaviors which have brought hurt, pain and sadness. When reviewing these experiences the family member experiences old emotions attached to these situations.

**Self-Pity** - Co-addict begins to think about current or previous problems and magnifies them. The co-addict may ask themselves “Why do these things always happen to me?”

**Eating Disorders** - Family member loses their appetite or may start to over eat. Both are done in order to feel better.

**Return of Fear or General Anxiety** - Situations which previously did not bring about anxiety or fear do so now. The source of the anxiety may be unknown to the family member.

**Scapegoating** - Co-addicts tend to put blame on other people, places and things to figure out why they feel poorly.

Recovery for co-addiction is all about learning your signs and using supports. Co-addiction is chronic in nature and therefore susceptible to relapse. Personal needs should be met -it is crucial. The co-addict needs to understand they need to come first and that by doing so they place themselves in a position for recovery to happen. Remember, one day at a time is how recovery works and can work for you.

Brian Shrawder is a Therapist at Harbor Counseling located in Wellsboro, PA.

References Provided Upon Request
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We lost another one today. He was 23, young, beautiful and loving but depressed. He OD’d and died. He could help others but couldn’t help himself.

His Grandmother has been a friend of mine for 30 years, this loss shook deep. She came from New York to collect his ashes and have a memorial. She stayed with us- We grieved together.

When the Police called to inform her of her Grandsons death she said to the police officer that she was sorry that he had to call her with sad, sad news. The officer responded “lady thanks, but you are the fourth family member today”. We have had 132 overdoses in Palm Beach County in the first quarter of this year. This is a massive issue for us and all of America.

All of us in the field of drug treatment are fighting a war to save lives. And many of us are exhausted but still fighting. I have been in this field for 40 years and this is the worst it has been. Our children are dying in massive numbers. This is more than a medical issue. It is a deep cultural and spiritual issue. The solution is more than personal. It has to be cultural. Our society is based in the accumulative of money and possessions and not relationships.

We function best as a group. Whether that group is a family or a community we must return to them. The reason that 12 step programs work is that they bring all the members together in to a loving healthy community based in service. All of us must join together as a community again.

We need to join together to make drug using behavior unacceptable. We must arrest the dealers, close unethical halfway houses, fight against the stigma and addiction and call it what it is- a DISEASE! We must educate ourselves and others.

We must take a stand. This death rate is unacceptable. NARCAN is not enough- besides it doesn’t help if other narcotics are mixed with heroin.

We need to begin to protest publically the blain tent misuse of pharmaceutical drugs and hold the drug companies accountable. We also need to hold accountable the insurance companies. They are simply trying to find ways to avoid paying for treatment when patients are truly sick. These patients are being treated in an unethical manner.

If you are reading this magazine you are about drug addiction or probably know someone affected by drug addiction. If you work in the addiction field you know how horrible it has become and how prevalent addiction is. Let’s turn our concern into action. We will begin to develop local strategies to clean this mess up.

Join me in saying we are no longer going to stand by while our children are killed by drugs. We have to become warriors in the war to take our community and our children back. Starting in July we will be holding a community meeting at Lifescape Solutions to develop a strategy of putting an end to the destruction of lives from drugs and alcohol.

Please join Phil Diaz, former member for the White House Drug Czar’s Office and Partner at Lifescape Solutions and Patricia, Publisher of The Sober World Magazine for this open meeting. There are many families affected by drug abuse and we welcome you to attend. Phil Diaz will be chairing the meeting. The meeting will be on Wednesday, July 27th, 2016 at 7:00 pm at Lifescape Solutions & Evolve Mental Health- 4723 W. Atlantic Ave. Delray Beach, FL 33445.
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Extending the care continuum for patients battling chronic illnesses has been well-established as best practice for managing illness and predicting potential relapses. A vital part of extending the continuum of care, the provision of structured, long-term extended support, is critical to successful chronic disease management, particularly when initiated during treatment or in the early stages of recovery.

In regard to addiction treatment, with the chronic nature of the disease of addiction and the myriad challenges of early recovery, the propensity for relapse is high. Generally defined as a return to active use, relapse is acknowledged as a frequent manifestation of the disease. Addiction treatment, whether it is residential or out-patient, is an important initial step toward health and healing. Whether treatment is completed in 28 days or longer, due to the high risk for relapse in the first year, effective addiction treatment (the long-term management of the disease), actually begins at the completion of professionally rendered care.

Population health management has begun to make inroads into the field of behavioral health and this movement has resulted in embracing the individual battling addiction in a comprehensive, holistic way. As treatment teams begin to collaborate, individuals who complete addiction treatment are increasingly positioned to receive extended professional care in order to maintain their health and effectively manage their chronic disease. The decisions for this movement toward extending the care continuum is backed by science and treatment providers have begun to be reimbursed by payers for this extended care.

Extending the care continuum is well established in the management of chronic illnesses such as cancer and diabetes, however it is a comparatively new concept in the field of addiction treatment. In one example, the state of Connecticut has led the way in the development and integration of recovery supports as it relates to behavioral health systems and addiction treatment. The state has noted that recovery has recently emerged as a new organizing paradigm for behavioral healthcare and has begun to invest resources into best practice methodologies for extended support services (including professionals and consumers, e.g., peers) and their effects on short-term and long-term prospects of recovery.

At MAP Health Management, we have recently reported on five years of data collected on individuals who completed addiction treatment and participated in a 12-month extended care program. The science speaks for itself. The propensity for individuals to remain in contact with a post-treatment professional is directly related to their ability to maintain long-term recovery and effectively manage their chronic disease.

Once a novelty, post-treatment recovery support has garnered the respect of the behavioral healthcare and addiction treatment fields. Professionally trained and certified recovery specialists, therapists, and counselors begin to work with their clientele prior to their completion of treatment and the data demonstrates that forming a bond in the transitory phase from treatment to short-term recovery is important.

Sean O’Brien has worked with individuals striving to recover from addiction for close to five years. As Director of Recovery Support Services at MAP, Sean has been through many scenarios with individuals as they transition from treatment to early recovery to long-term recovery. Sean has witnessed the relapse of clients and one-time use events and helped guide them back to health. Once homeless and addicted to heroin, Sean has the lived experience that many of clients are facing. However, we are beginning to discover that extended support can also be delivered by trained counselors and therapists who understand the disease and its many manifestations.
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Domestic violence rarely affects only those directly involved in the abusive relationship. Domestic violence is any behavior involving physical, psychological, emotional, sexual, or verbal abuse. It is any form of aggression intended to hurt, damage, or kill an intimate person.

It is seldom that domestic violence is an isolated episode; rather it is comprised of a number of episodes over an extended period of time. The probability of alcohol and drugs being involved in a domestically violent relationship is considerably high.

**THE DESENSITIZATION OF DRUGS, ALCOHOL, AND OTHER SUBSTANCES**

Reportedly, the consumption of alcohol accounts for approximately 65% of all cases related to domestic violence, versus 5% of all accounts associated with drugs. “Alcohol is a factor in 40% of all violent crimes today, and according to the Department of Justice, 37% of almost 2 million convicted offenders currently in jail report that they were drinking at the time of their arrest.” The probability of the use of alcohol verses drugs stems from the ease of access and the societal acceptability of alcohol. The media is somewhat accountable for the societal acceptance of alcohol and the glorification of drugs. A report published in the Journal Pediatrics, which is the official journal of the American Academy of Pediatrics (APA), analyzes and carefully examines in detail the relationship of alcohol, drugs, and others substances in relationship to the media.

“Although parents, schools, and the federal government are trying to get children and teenagers to ‘just say no’ to drugs, more than $25 billion worth of cigarette, alcohol, and prescription drug advertising is effectively working to get them to ‘just say yes’ to smoking, drinking, and other drugs.” The media’s love affair with the consumption of drugs, alcohol, and other substances has a dire effect upon our society.

“The power of advertising to influence children and adolescents (and adults, for that matter) is incontrovertible. Advertising works; otherwise, companies would not spend billions of dollars on it.” The billions spent marketing to young people is not only perpetuated by the movie and television industry, but with the viral society with which we now live, such media’s are becoming more and more prevalent having an instant impact upon our society.

The Pediatric article also highlighted the fact that many of the current movies and television programming has purposefully sensationalized smoking, drinking, and substance abuse. Whether we are discussing媒体 like Harold and Kumar, Fear and Loathing in Las Vegas, 22 Jump Street, Everything Must Go, or Two and Half Men; the movie and television industries have made use and abuse of cigarettes, alcohol, and other substances morally acceptable. “A content analysis of the top 100 box office hits between 1996 and 2004 revealed that tobacco use was depicted in three-quarters of G-, PG-, and PG-13– rated movies and in 90% of R-rated movies.”

Moreover, the love affair of substances also provides allowances for egregious behaviors of the famous and the infamous such as: the Justin Bieber incident of urinating in the mop bucket of a New York City establishment; or the Charlie Sheen escapade of ranting and binging while working as a cast member of Two and Half Men; or the allowances for domestic violence with figures like the NFL Player, Ray Rice who stated “I blame liquor for elevator attack.” The excuses provide an unwritten tolerance and the lack of accountability for those who have acted egregiously.

**DOMESTIC VIOLENCE**

“Alcohol is often a factor in violence where the attacker and the victim know each other.”

Domestic violence is frequently excused when alcohol and other substances are involved:

- “He isn’t normally like that, he was intoxicated.”
- “Alcohol makes him mean”
- “I just slapped her or punched her, I never forcefully struck her”
- “She provoked me into my anger”
- “She doesn’t know when to just shut up”
- “His lack of help around the house makes me aggressive”
- “She’s normally a very kind and loving person, she didn’t intend on harming me”

Domestic violence is often associated with drugs and alcohol. The majority of those who are domestically violent and use have a greater propensity to be egregiously violent. However, the use of alcohol and other substances is not a guarantee of a domestic violent person, nor is the use of alcohol and other substances an indication of the probability of domestic violence. Nevertheless, perpetrators of domestic violence have a greater probability of increasing their domestic abuse when using substances and alcohol. “Most people who abuse substances don’t abuse their partners, but a substantial proportion of people who abuse their partners also abuse substances.”

“Domestic violence has been described as a hidden face of addiction.” We are a society of excuses, shame, and blame; we avoid accountability and often project our responsibility when involving domestic violence. “The abuser is quite keen for us to believe the cause and effect myth of alcohol and domestic violence - it gives them a ready excuse to deny responsibility for their abusive behaviour.” The lack of culpability of the perpetrator, and his or her transference of blame onto alcohol or other substances only perpetuates the violent behaviors. “...The abuser is quite happy for us to accept that common concept that alcohol and domestic violence are linked by alcohol being the cause of domestic violence. While we believe that, we are likely to concentrate our efforts on helping the abuser aim for sobriety, not challenge his abusive belief system and behaviours.”

“The presence of drug and/or alcohol abuse makes continued offending more likely. Although sobriety may not eliminate the risk for re-abuse, research suggests it may be a necessary ingredient.” However, substance abuse treatment is usually not effective in reducing domestic abuse over the long term. There are four main reasons for this:

- Abusers who use substances are violent and controlling both when they are intoxicated and when they’re not.
- People who want to quit drinking or drugging do not necessarily want to treat their partner better or give up control of them. Most domestic abusers do not choose to examine and change their entitlement attitudes during substance abuse treatment.
- Substance abuse treatment can’t overcome the social context that supports the control of women by men.
- Substance abuse does not cause domestic abuse in the first place.”
WHAT IS A LEVEL 4 TRANSITIONAL CARE HOUSE?

Sunset House is currently classified as a level 4 transitional care house, according to the Department of Children and Families criteria regarding such programs. This includes providing 24 hour paid staff coverage seven days per week, requires counseling staff to never have a caseload of more than 15 participating clients. Sunset House maintains this licensure by conducting 3 group therapy sessions per week as well as one individual counseling session per week with qualified staff. Sunset House provides all of the above mentioned services for $300.00 per week. This also includes a bi-monthly psychiatric session with Dr. William Romanos for medication management. Sunset House continues to be a leader in affordable long term care and has been providing exemplary treatment in the Palm Beach County community for over 18 years.

As a Level 4 facility Sunset House is appropriate for persons who have completed other levels of residential treatment, particularly levels 2 and 3. This includes clients who have demonstrated problems in applying recovery skills, a lack of personal responsibility, or a lack of connection to the world of work, education, or family life. Although clinical services are provided, the main emphasis is on services that are low-intensity and typically emphasize a supportive environment. This would include services that would focus on recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the world of work, education, and family life.

In conjunction with DCF, Sunset House also maintains The American Society of Addiction Medicine or ASAM criteria. This professional society aims to promote the appropriate role of a facility or physician in the care of patients with a substance use disorder. ASAM was created in 1988 and is an approved and accepted model by The American Medical Association and looks to monitor placement criteria so that patients are not placed in a level of care that does not meet the needs of their specific diagnosis, in essence protecting the patients with the sole ethical aim to do no harm.
Most people in our industry know what the Mental Health Parity and Addiction Equity Act (MHPAEA) is, and those who are not aware will probably look at you as if you have five heads! It can be a complex topic, but nonetheless, an important one. In short, “parity” was enacted to make sure there was fairness between mental health and/or substance use disorder (MH/SUD) benefits and medical and/or surgical benefits that are covered by health insurance. The law was enacted in 2008 and does not require a plan to offer MH/SUD benefits; however, if the plan does offer these benefits, it must offer the same benefits as the other medical and surgical benefits it covers. An example of a parity requirement is the frequency of office visits. Under this law, patients are not limited to medically necessary appointments. Under plans that require equal benefits that follow Parity, you can’t limit a patient’s number of office visits for counseling sessions, just as you wouldn’t limit the number of emergency room visits or any other major medical care.

Every treatment center, psychologist, psychiatrist, case manager and counselor should be aware of what this law is and the violations that can occur. The end goal is to work with insurance companies, not report violations and make more work for ourselves. We are already inundated with paperwork and clients to treat. This begs the question, “How do we work together and not against each other?” Here is the bottom line: 1 in 4 people will develop a mental disorder in their lifetime and many of those same people suffer from co-occurring disorders like alcoholism and drug abuse. Patients need access to treatment and they shouldn’t have to suffer at the hands of a faceless insurance representative on the other line telling them what is or isn’t clinically appropriate for them. Of course, I do understand the insurance criteria which needs to make sure that tests and services are “medically necessary” as there are a few bad apples who take advantage of insurance upcoding. This occurs across the entire medical field and not just in the substance use and mental health arena.

Violations and coverage denial should not be commonplace against all treatment centers. Lately, we have seen insurance companies decide to go rogue and stop paying all claims due to “audits.” It’s becoming a big concern amongst patients as well. Treatment centers need to be able to use their cash flow and sustain their business so they can continue to treat patients. By imposing these audits, treatment centers cannot get reimbursed the insurance money that is owed to them. They are left with major problems and essentially have to turn down patients since their insurance cannot be utilized. This then becomes a public health concern.

Are you denied higher levels of care like Residential treatment (RES) or Partial Hospitalization (PHP) because the patient hasn’t already “failed at a lower level of care first?” Are you limited to so many psychiatry sessions per year? Have you been required to obtain pre-authorization for outpatient services? These may be Parity violations.

So what do we do? Here is a link which is a good resource that lists the common violations: www.paritytrack.org/know-your-rights/common-violations

When reporting violations, have your call center document the time, name of insurance representative and what the violation seems to be. It’s always a best practice to record every phone call for accuracy, making sure both parties are aware the call is being recorded.

If the insurance is a state governed plan issued here in Florida, you need to contact the Department of Insurance (www.floir.com). You are encouraged to call the Consumer Helpline 877-693-5236. They prefer to speak with the consumer (patient) since it is a health related issue and even having a Power of Attorney (POA) doesn’t matter. They want to hear it from the patient and they will look into the denial and compare it to what the policy states.

If the plan is governed by federal law—you need to contact CMS and the Department of Health and Human Services in your state.

Allison Seriani is Public Relations and Communications for Destination Hope, Inc.
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Patricia: Do you have any idea of what those issues were?
Mitch: Well, I am only surmising but the 3 major things that happened were: My mother passed away, her big album Back to Black came out at the same time and her boyfriend Blake came back into the picture. Fame didn’t sit easy with her. She had a friend in a group the Artic Monkeys which was a massive group but he wasn’t like Ringo Starr in the Beatles, no one knew who he was. He had all the money and whatever but he could walk down the street and no one knew him. With Amy, everyone knew her. Do you know London? Have you ever been there?

Patricia: No.
Mitch: Well there’s this street Wardour Street, you would start at the top and we would walk down the street and everyone knew her. She would talk to everyone. It was like Adele and Lady GaGa. She was mobbed. Some of the times she was cool with it, she loved the kids but sometimes she was uncomfortable with it. But, who is prepared for stardom? She certainly wasn’t.

Patricia: And not when it’s constant and you have no privacy.
Mitch: That’s right. So as I said, she had these 3 big things, her grandmother passed away, her album was coming out and her boyfriend re-emerged who was a drug addict. He coerced her into drug addiction. He put up his hands and admitted it. So there might have been other underlying issues, I don’t know- one thing I know, it had nothing to do with her family. We were a very close Jewish family who loved and nurtured each other. We were all very close and nothing like this had ever happened in our family.

Patricia: Like many families in the country, in the world really! I say this country, meaning the United States but you’re from London so it’s really reaching people globally. It doesn’t seem to matter, it’s an epidemic and good families are being hurt.
Mitch: That’s right. This preconceived feeling that it can’t happen in my family, it can happen in any family.

Patricia: Any family, regardless of race, income, religion, old, young…it makes no difference. Do you have other children?
Mitch: Yes, a son. He has a little boy.
Patricia: Did Amy always like music? I know you said you are a musician and I heard she had a couple uncles that were Jazz musicians.
Mitch: On her mum’s side.

Patricia: Did she always like music? How did Amy get into music?
Mitch: When she was a little baby like all fathers and mothers, we would sing to her. When she was able talk we would sing and she would put words in, but, I did the same thing with my son, like most families do. When she was 3 or 4 she took ballet and tap lessons. She was a brilliant dancer. She would go to my mother’s apartment and ask “Grandma, can I tap dance on your floor?” and my mother would say “You need to ask Mrs. Cohen downstairs”. My mother had that linoleum flooring and if she didn’t ask, Mrs. Cohen would start banging the broom on the ceiling to stop the noise!

Patricia: lol.
Mitch: So, Amy would run downstairs and ask Mrs. Cohen who said “yes, darling, you can tap dance” and Amy would run back up and tap dance. So, yes… And then as she grew up she went to stage school on weekends, got some dancing and acting jobs but you wouldn’t think she necessarily would have become a singer. One time she asked me and my second wife to come hear her sing in a school show. I said to my wife “she’s singing?” But, ok, I watch my son play soccer so I will go and listen to her sing. So, we went to see her and they were doing the show Annie and she didn’t understand about keys- Do you understand about keys?

Patricia: Me? No, what do I know. You reach a key or you don’t reach the key.
Mitch: It’s Ella Fitzgerald you have to reach the right key, if you don’t she will sound like you- with all due respect. Everything has to be in the right key. So this Annie was in the wrong key. I said to my wife Jane- “Thank god she can dance!”

So the next year she says “I’m singing in the show again.” I said to my wife “oh god, she’s singing again. We have got to go. She sang the Alanis Morissette song “Isn’t it Ironic” and it was in the right key. So, now I know she can sing and now she doesn’t want to go to school anymore. She wants to go to stage school. She said “Dad, I want to go to the Sylvia Young School.” I said she couldn’t. I told her she had to be good for a year and then she could go. She was naughty, no…not really naughty but mischievous. She would sing in class and sometimes disrupt the other children but the teachers and everyone really loved her. So what did she do? Unbeknown to us she applied for a scholarship. I still have the letter.

Fast forwarding a minute, The Amy Winehouse Foundation provided scholarships for 3 children trying to go to the Sylvia Young School who didn’t have the financial means to attend. We sat through over 100 kids just to find 3 who would be accepted into the program. It’s very difficult to get into, much like the Dreyfoos School here. So, I know what kids have to go through to get in and Amy got in!

Patricia: And she did that all by herself.
Mitch: Yes, all by herself. She was very resourceful, very resourceful at such a young age.

Patricia: She knew she wanted it and she went out and did it.
Mitch: Yes. The minute she could go to work, she did, sometimes working 3 jobs!

So anyway this is when we knew she could sing and when she signed her first record deal. I had to sign for her because she was underage. This was the publishing deal and the record deal.

Patricia: Was EMI the first record deal she had?
Mitch: No, Universal was the record deal or Island Records which is part of Universal. Emi were the publishers.

Patricia: So, when this was all happening, how did you feel? Were you excited?
Mitch: Kvelling.

Patricia: Kvelling is right. You must have been so proud.
Mitch: Surreal. Sometimes, what you do is naturally limit your expectations. I remember her first record deal she received an advance of £250,000. At the time they were giving millions to songs and she was only offered £250,000 and she did have offers like that but Amy made all her own decisions. I never made her decisions for her. She said she was going with Island records because Island is not like a pop label. They nurture their artists. She didn’t want to have to bring out an album every 6-9 months. She wanted to relax and take it slow.

Patricia: It really sounds like she had her head screwed on straight.
Mitch: Every decision she made, and the ones I disagreed with always ended up to be the right ones.

Patricia: She sounds very level headed.
Mitch: Yes, but also resolute, she was very resolute. When she made her mind up she was like granite. She didn’t budge an inch. So, back to the £250,000. One of the things is her money wasn’t a good mix. She could have just started blowing it.

Patricia: You’re right, not good for most young person to have that kind of money.
GOLF AND ADDICTION RECOVERY?

South Florida is known globally for golf courses and addiction treatment resources. You would be amazed to know that the same strategies used in your golf game can help in addiction recovery, whether you are a scratch golfer or a beginner.

Emotional mastery and composure, identifying things that you can manage, what you cannot control and being present in the moment are prime examples of techniques that can improve your game and life. Defining oneself not by performance, setting goals that are possible and believing in self can be learned.

If the substance abuser is motivated internally to enter treatment instead of at the urging of loved ones, friends and colleagues, their chance of recovery is so much better. For that reason, addiction programs are dual purpose now. They are designed to engage potential people looking for recovery. Holistic amenities may attract woman, wilderness adventures for young adults or golf swing instruction and play for sports minded boomers and seniors. These added activities make addiction treatment more relevant. For instance, if one was able to improve their golf swing as well as learn to enjoy life sober, one may consider participating.

Of course, solid medical and physiological services are still the basis of treatment. But to some, the addition of golf makes the process feel more like a positive experience than a punishment.

Golf alone is not enough for successful long term recovery, but lessons learned during play can make a big difference in the course of life. Addiction Reach manages the practices of treatment providers that offer customized concierge addiction recovery services for individuals, couples, and families in all stages of recovery, including GOLF THERAPY. For a complimentary consultation call 561-427-1900 or visit www.addictionreach.com

FARR Conference Agenda

Welcome & Introduction (9:00am-9:30am):
Rick Riccardi: Florida Alliance for Recovery Board

Panel 1 - The Process: Voluntary Certification of Recovery Residences (9:30am-10:30am)
This panel presents an overview of certification and compliance protocols and answers questions regarding the FARR Certification Assessment process.
Moderator: Dr. Michael Weiner, PhD, CAP and FARR Board Member

Dr. Weiner received his Ph.D. in Psychology from the State University of New York at Stony Brook, and has taught at the University of North Carolina at Greensboro and the Rochester Institute of Technology. He has also been published in numerous professional journals, and regularly presents at professional conferences. Dr. Weiner serves the FARR Board of Directors.

Panel 2 - Credentialled Peers: The New Frontier (10:45am-11:45am)
This panel discusses the national emphasis on development of a Behavior Healthcare Peer Workforce. Panelist will examine opportunities and challenges associated with embedding peers in recovery oriented systems of care.
Moderator: Neal McGarry, FCB Executive Director

Neal A. McGarry brings more than 20 years of industry experience in professional credentialing, and has served as the executive director of the Florida Certification Board for the past 16 years. He has grown the organization from certifying addiction counselors only to the more than 30 types of credentials offered today. Mr. McGarry sits on numerous boards of directors for addiction service organizations.

Lunch - Alliance Membership: Together, we can transform systems to improve outcomes (11:45am-1:00pm)
Over desert & coffee, Dr. Ahr will present the opportunity for unified stakeholders to promote ROSC principles, engage communities, reduce stigma and improve recovery outcomes.
Presenter: Dr. Paul Ahr, Ph.D., M.P.A

Dr. Ahr chairs the Florida Alliance for Recovery and is President of A House in Town. Dr. Ahr has more than 45 years of experience in the fields of clinical psychology, organizational behavior and leadership. He has held top management posts in the public and not-for-profit sectors, and has consulted with and trained top managers and their staff members from over 100 corporations and other organizations. Dr. Ahr is licensed as a psychologist in Missouri.

Keynote: Mentoring, Monitoring and Measuring Recovery Strengths (1:15pm-2:30pm)
Dr. David Best will discuss Assessment of Recovery Capital as an outcome measurement and present key objectives of the current SHU-FARR REC CAP Research Project involving eight recovery residences and more than 300 residents.

Keynote Presenter: Dr. David Best

Professor of Criminology in the Department of Law and Criminology at Sheffield Hallam University and Associate Professor of Addiction Studies at Monash University, Melbourne. He has an under-graduate degree in psychology with philosophy, a Master’s degree in criminology and a PhD in the psychology of addictions. He has authored three books on addiction recovery and has written more than 160 peer-reviewed publications and around 70 book chapters and technical reports. Previous employers include the Institute of Psychiatry (Kings College London), Strathclyde University, Birmingham University, the National Treatment Agency and the Prime Minister’s Delivery Unit.

Panel 3 - The New Recovery Advocacy Movement - Expanding Advocacy and Recovery Support Service (2:45pm – 3:45pm)
The growing network of recovery community organizations (RCO’s) strives to deliver quality and effective peer-based recovery support services in diverse settings to help more Americans achieve long-term recovery. This presentation will highlight the development of RCO’s and the accreditation of peer recovery support service providers.
Presenter: Patty Metcalf, M.S., Executive Director, Faces and Voices of Recovery

Patty Metcalf, M.S., comes to Faces and Voices of Recovery from the Center for Social Innovation where she served as a Deputy Director of SAMHSA’s Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) initiative. As Deputy Director, she has provided project direction and managed the quality and flow of work for numerous tasks under BRSS TACS. Previously, Ms. Metcalf served for a decade as the Director of Friends of Recovery-Vermont (FOR-VT), a statewide recovery community organization promoting the power of long-term recovery to improve the health and quality of life of Vermonters.

Panel 4 - Recovery: Journey or Destination? (4:00pm-4:30pm)
This presentation discusses Recovery as a life journey and examines challenges rooted in conflicting definitions. John addresses the importance of the definition recovery from legislative and service delivery perspectives.
Presenter: John Lehman, FARR President and Florida Alliance for Recovery Board Member

John has led FARR to achieve its current role as state credentialing entity for voluntary certification of recovery residences. He sits on the NARR Standards & Ethics Committee, Florida ROSC BRSS TACS Policy Academy, and Florida Certification Board Advisory Council. He serves several nonprofit boards. A person in long-term recovery, John is the grateful beneficiary of quality addiction treatment and recovery support services. He is committed to enhancing the recovery landscape in Florida.
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Recovery.... By accident or on purpose?

Pushing those suffering from substance use disorder into treatment is controversial. People say that the “addict” has to want the treatment for it to be successful. It’s very contentious these days to force someone into treatment. Civil commitment is such a divisive issue. Does someone need to want it for it to work? Can someone seek and find it if they’re seeking it for someone else? Does the person have to be ready, willing and able? Good questions. Can we find Recovery by accident? Can it find us? Great questions... I found Recovery on purpose, and I live it with purpose. For me, it’s only with that purpose that I am able to maintain it.

Interpretation of this issue is not the same for everyone. Even the word Recovery means something different to different people. These days, for some, Recovery doesn’t even seem to require living a drug-free life. I was told by a Florida NA meeting chair that he is in recovery from heroin and he smokes marijuana to maintain his “sobriety”. I was told by a guy from New York that recovery from heroin for him was maintained by obtaining anti-depression and anti-anxiety medication from his new doctor — both of which he abused in his addiction. I’m not judging other people or even measuring their recovery. Recovery for them is their recovery. I don’t even know how we define the word anymore. I will just define it for me, and for me, Recovery means more than just abstinence from the drugs and alcohol that destroyed me. It means living Recovery with Purpose.

I don’t want my past to become other people’s future. I don’t want to see the people I am able to reach suffer from the same consequences I endured. I don’t want the pain I endured and the chaos I caused to all be in vain, so I live my life finding purpose in all of it. Teaching my story to other people is the purposeful path I now choose. I have purpose and passion in my life and my passion has met my purpose. So now, in long-term Recovery from my addiction, the purpose in my life has become my life. It’s become a life of purpose.

Eleanor Roosevelt once said, “The purpose of life is to live it, to taste experience to the utmost, to reach out eagerly and without fear for newer and richer experience.” I get that. In fact, I understand it more deeply than I ever have. The experience of addiction cannot be removed from the consciousness of our minds. The heartache and pain caused by addiction in our lives cannot be erased from our memory. It’s there and will always remain there, but we can’t affect our present or our future other than to support it as a reference. A reference to note for ourselves and others as a life not to be lived. We can grow from it, but more importantly, we can help others learn from it, so as not to repeat it. Recovery can unfold in a magnificent way through living this life of purpose. Every aspect of our lives can be positively affected. It’s happened for me. I never could have imagined such a life of purpose, and here I am living it.

Russian Novelist, Fyodor Dostoyevsky came up with the greatest expression for living life, and living a life of purpose. He states, “The mystery of human existence lies not in just staying alive, but in finding something to live for.” This has become my Anthem of Recovery. It’s good to remain clean and sober, and for me, it’s exceptionally good. However, without living this life of Recovery as I do, without teaching my story to others, without looking at Recovery as the specific thing I live for, I wouldn’t really be living to the extent to which God desires me to live. Recovery for me must be LIVED, and it must be lived with PURPOSE. It’s actually become the purpose in my life and of my life. Sharing it with other people becomes the upside of all the downsides of my addiction. I didn’t want it in the beginning but it’s become something I not only want, but can’t live without. Living a life of purpose is extremely rewarding. Living a life of purpose in Recovery is beyond rewarding, it’s actually the meaning of living itself. Purpose drives recovery and recovery enhances life. It allows every day of every year to become that purpose and the life that’s unfolding is beyond my wildest dreams.

Michael DeLeon, director and producer of the films “Kids Are Dying” and “An American Epidemic” is expected to release his third documentary “Higher Power”. Michael is the founder of Steered Straight Inc., a motivational outreach program for youth and young adults reaching over 2 million students nationwide and expanding across 45 states.
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Mitch: So I said to her “what we are going to do with the money is buy you an apartment” so this way we got that out of the way. It cost £160,000 in Camden Sound.

Patricia: She must have been so excited, her first apartment.

Mitch: Yes, she was so excited! This was her place. We paid cash and no one could take it away from her. Actually, I live in that apartment now. Well, I have two apartments. One in the north of London and to get into town with traffic is a real problem. So, when we need to be in town we stay there. It’s a lovely pied-à-terre. She never wanted me to hear her songs because some of them, the lyrics were kind of racy. Do you know some of her songs?

Patricia: Some of them.

Mitch: Well, one of the songs, you will have to excuse me but it says: “The only time I hold your hand is to get the angle right” and I said to her “Why do you have to say that” and she would say “now you know why I don’t read you the lyrics.”

Patricia: I would have probably said the same thing as you!

Mitch: I mean some things were shocking but I would laugh about it too. I started reading some of the lyrics and listening to the songs which she did co-write some of them and I didn’t even know she could read and write music. That doesn’t mean I was a delinquent father.

Patricia: Well, of course not! Sometimes you really don’t know their talent unless it’s always been right in front of you.

Mitch: I said “When you write a song, do you do the music first or…” and she would say “Dad! Don’t you understand……?” The thing is she didn’t think it was a big deal and she didn’t think she had a great talent. Sometimes we could be arguing, like father and daughter do and she would walk out of the room, write it down, come back, ask where we were and that conversation would appear in a song. For instance, Rehab.

Patricia: I was just going to ask you about that song. Did she write that while you were discussing her going to rehab?

Mitch: No, what happened was that day she had a bout with drinking. Now, she never had a drinking problem but like a lot of young people she would sometimes go out and get hammered. She wasn’t drinking every day.

Patricia: So, let’s back up. When she first started out she wasn’t really doing drugs?

Mitch: She was smoking pot.

Patricia: So, in between her first starting to write music and becoming famous, when did she first start using drugs?

Mitch: What sort of drugs?

Patricia: The heroin and all of that

Mitch: Right after Back to Black came out and her boyfriend Blake reappeared.

Patricia: Oh…okay, so now tell me about rehab

Mitch: It was about 2004-2005. She just broke up with her boyfriend and she fell and banded her head. Her manager at the time wanted her to go for help but Amy said she didn’t need help. When she drank, she drank a lot but she wasn’t drinking every day. They came to my house in the country and they said they were taking her to rehab and I said “Amy doesn’t need rehab, she’s fine.” And she puts that in the song- not my daddy thinks I’m ok but the exact words “my daddy says I’m fine”. She ended up going there and came back 3 hours later. They told her she would need to be there for 17 days, and that’s in the song too- I ain’t got 17 days. The guy just wanted to talk about himself. She was able to take a conversation and put it into a song. I didn’t appreciate it until afterwards but I realize now how brilliant she was. She was my little kid and she was really a genius. My ex-wife Janice’s family was all geniuses. I am talking physicists, rocket scientists- brilliant and Amy took after them. Janice, who is now a pharmacist, was studying advanced mathematics when Amy was 10. You know the mathematics with the squiggles. I couldn’t even understand the question and Amy was doing this with Janice.

Patricia: She sounds like she was a very bright girl.

Mitch: Very Bright.

Patricia: I know you’re doing some wonderful things in Amy’s memory. You started the Amy Winehouse Foundation. Can you tell our readers a little about that?

Mitch: Well, after Amy died, I was on the plane coming home from New York. I had in my mind the Amy Winehouse Foundation and kids- Amy loved kids. When I touched down in London I sat down with my ex-wife Janice, my wife Jane, Amy’s brother Alex and the rest of the family and I said we could either pull the covers over our heads or we could do something worthwhile. They were all in agreement. At the start we had no money but I had written my book, and I had income from shows I had done which I still do, so all that money went into the foundation. I think it was like a million and a half pounds which is like 2 million US dollars. That was our seed money. We started helping children’s hospices which is heartbreaking and a lot of music therapy. Amy had an eating disorder so we upgraded a website for an eating disorder charity called Beats.

Patricia: When did she have an eating disorder?

Mitch: During this period as well which obviously exacerbated all the other problems.

Patricia: When she was doing drugs or when she was drinking?

Mitch: When she was drinking it started to simmer down. She started eating better. If you look at pictures in 2010-2011, she looks great. In 2007-2008 she looked awful.

Patricia: What other projects?

Mitch: Amy’s Resilience Program which is a school project. They are in over 100 schools in the UK. It’s a drug and alcohol awareness and prevention program for secondary schools. We received a 4.3 pound grant from the big lottery. There’s nothing like it at all in the UK. It gives young people the information they need and a platform to speak about issues that are affecting them. The program is delivered by people who are in recovery so you’re talking about people they can relate to. It’s not their parents, teachers or grandparents who they wouldn’t feel comfortable opening up to.

The program is evaluated by the University of Bath in the UK and Harvard University in the US. The evaluations have been absolutely incredible. The results show that we have been helping many, many people.

We have a project called Amy’s Yard which is working with disadvantaged children through music, we have Amy’s Place which is the first women only recovery house in London and will be opening shortly. We are very excited for that! We do some strategic grant giving as well. There the Havens Hospice, which is a children’s hospice. Can you believe it’s the only one? They added a new wing and we paid for the music room which will be known as the Amy Winehouse Music Room. Music is very powerful and soothing. We have something similar at the Cerebral Palsy center.

Patricia: Wow, you really are doing quite a lot. Are you doing anything in the United States?
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**INTERVIEW WITH MITCH WINEHOUSE**  
By Patricia Rosen

**Mitch:** I don’t know if many people realize but although Amy was born in the UK, her mother is originally from Brooklyn, NY. She always had an affinity to Brooklyn so we worked with the Brooklyn Conservatory of Music. We awarded them $25,000 to finance scholarships for teenage jazz musicians. The money will go to defray the expenses of needy children accepted into the academy’s Teen Jazz Program. In Florida we are working with the Dreyfoos School of the Arts which is in West Palm Beach, a very affluent area but there are a lot of very needy kids that come from all over South Florida. We are providing the hardship fund which would be used to assist students with lessons and travel to competitions. We had a fund raiser not too long ago and will be presenting them with a check for $50,000.

We would like Amy’s name on one of their buildings. We would like Amy’s name on one of their buildings. We would like a building named after Amy. We would like a building which would be used to assist students with lessons and travel to competitions. We had a fund raiser not too long ago and will be presenting them with a check for $50,000.

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Patricia: Amy loved Florida. She loved Miami. It would mean a lot to her if we the music room to be called the Amy Winehouse Music Center. We would like Amy’s name on one of their buildings. We would like a building named after Amy. We would like a building which would be used to assist students with lessons and travel to competitions. We had a fund raiser not too long ago and will be presenting them with a check for $50,000.

Patricia: And from what I read she loved to do for other people and was quite generous before she passed. I am sure she is smiling down on you now.

**Mitch:** I hope so. I believe in life after death. I have been to Psychics. I went to a Psychic a couple weeks ago. I was told very, very good stuff. Things no one would have known about.

**Patricia:** I have a feeling that Amy is watching over you.

**Mitch:** Of course you have. I have to tell you a brief story. Every now and then I get a feeling she is sitting on my bed and it freaks me out a bit. The night before I went to the Psychic I was lying on my left side in bed and I felt like something came through my window and entered my body. Like an electric drill, not an electric shock. Like my whole body was vibrating and I was awake. I was like, “what is this”? I wasn’t in any pain or anything. So, I went to this Psychic who I had to wait 9 months to see and one of the things she said to me was “Amy wants you to know that she came to you last night while you were in bed at 5:02.”

**Patricia:** Oh my god!!

**Mitch:** My clock didn’t say 5:02; my clock said 5:05

**Patricia:** Oh my god how she knew…..

**Mitch:** She said you would have felt her energy. I said “Well, now let me tell you what happened” and she said “that was Amy”

**Patricia:** That is an amazing story. Tell me, what would be your advice for families trying to cope with a family member in active addiction?

**Mitch:** What can I say? I think you will get contradictory advice from experts. Some will say do tough love, which I couldn’t do. My daughter suffered from an illness. God forbid she suffered from an illness such as cancer, what would you do? Nobody chooses to become an addict.

**Patricia:** It’s a disease.

**Mitch:** That’s right. It’s a disease. We were told about tough love from some of my distant relatives and as I said before, something worked because she was clean of drugs for 3 years before she died. I think you have to take the middle way. You have to let them know they are loved and cared for, but equally you can’t empower them to continue using. You have to let them know how they are affecting the family. You know, you hear stories how kids steal from their parents to buy drugs and alcohol but Amy didn’t have to do that. She had plenty of money that she didn’t need to do that.

**Patricia:** Do you feel that enabled her to do more drugs?

**Mitch:** Yes. People would say “oh, well you just need to stop her money, it’s easy…just stop her money” but you can’t just stop an adult’s money without proving she’s incompetent or incoherent.

**Patricia:** Right. You can’t just take their rights away. It really is a dilemma for parents.

**Mitch:** At one point we tried to have her sectioned but in London she has to be a threat to herself or someone else and you can’t just section them because they take drugs or their high.

**Patricia:** It’s the same way in Florida. I do believe though as a parent there should be something we are able to do.

**Mitch:** I agree, I agree.

**Patricia:** I mean these hippa laws are crazy. If as a parent you know your child is killing themselves with drugs or alcohol, as a parent we should have certain rights.

**Mitch:** Yes, but unfortunately there is little you can do. We couldn’t take her money away or stop it. The truth is, I really don’t have any advice because there really is none. What works for some people doesn’t always work for others. When Amy was struggling with alcohol and I was looking for answers there was no one to help me. The person who gave me the best advice was Amy herself. She said “Dad, remember how it was with the drugs? That’s how it’s going to be with the alcohol.”

There will be long periods when I don’t drink and short periods when I do drink and those periods when I don’t drink will become longer and longer and those periods when I do drink will become shorter and shorter. I’m learning dad” I said “Amy, those seizures you have when you drink too much” and she said “Don’t worry, I am not going to die”. A few months before she died there was a situation where she was on skype with a friend of hers in NY who saw her have a seizure. She was in a hotel and he called me. Had he not called me she would have died then but we were able to get to her and help her.

**Patricia:** What happened the night she died?

**Mitch:** She was in her room at 2 in the morning playing the drums and singing and a security officer said the neighbors were complaining. She wasn’t purposely drinking herself to death like some people thought. You don’t purposely drink yourself to death. You can throw yourself in front of a train but you don’t drink yourself to death. She was having a nice evening and making noise and now it was time to go to sleep. Unfortunately, she had a seizure and didn’t wake up.

**Patricia:** So, it may not have even been the alcohol level…..

**Mitch:** Oh, it was. The alcohol level was extremely high.

**Patricia:** What would you like to say to the other families out there that have lost a loved one through drugs or alcohol?

**Mitch:** Don’t blame yourselves unless it’s your fault. There are people that struggle with drugs and alcohol because they come from an abusive family but that wasn’t my family or your family. Is there anything you could reproach yourself about? What could you have done different or better for your son? Is it your responsibility that your son passed away?

**Patricia:** No, you’re right. We did everything we knew how to do…….. And we did the best we knew how.

**Mitch:** Right, and that’s it. Of course you do the best you could. It’s human nature to wonder what you could have done differently. Did you see the film Amy?

**Patricia:** No

**Mitch:** This guy was doing Q & A’s about what bad parents Janis and I were. He talks about what he would have done.

**Patricia:** Well, it’s very easy for other people to tell you what they would have done. My mother would say you have to tell him this

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A memory from 2 years ago popped up on my timeline this morning. We’d been invited to Palm Desert for a long weekend by clients of my husband. It was always difficult for me to enjoy these trips -what if this was the weekend that something tragic happened to Michael? What if the cops came to the house or tried to call? I considered leaving my cell phone number taped to the front door. I worried myself sick over how we’d politely excuse ourselves if we had to leave, (because surely we couldn’t tell them our son was a drug addict, could we?), and how would I break the news to my husband who’s “head was in the sand” and endure the drive back home.

Michael chose this weekend to lie to his best friend/partner in crime. “E”, who momentarily grew a conscience and decided to send me a series of texts defending himself from what he was sure, was wrongful incrimination, “I know it looks like I stole all those checks, but it’s not how it seems…….” What?? Holy shit…. what?? I knew that I brought every last check with me hidden in my luggage. How did he get in the house? Getting ready to meet our friends for breakfast, “E” fills me in on those checks that come in the mail from the credit card company – you know the ones – inviting you to pay off other debts using their “convenient and complimentary” checks. I quietly checked the credit card on my phone app and sure enough the account was about to be maxed out – checks were hitting as I watched. To make matters worse, this was my husband’s business card. Reading the texts while walking across the street to meet our friends cheerfully waiting on the other side, I seriously considered throwing myself in front of a car.

Shaking like a leaf, holding back tears, stomach in knots, I excused myself and called the credit card company to report it lost. I said nothing about the checks. I was still protecting my son. I lied to my husband and told him the card was compromised and they were sending him a new one. No worries. Cover it up….protect…lie. I was texting Michael under the table to tell him he’s busted…. the checks won’t work…. the account has been closed…. no response. I’m so angry, scared and sad- and I have to sit there and smile, carry on polite conversation and actually try to get food down.

I text “E” – frantic – Where is Michael? Tell him to respond to me ASAP. “E” said he’s probably still trying to get my car back. OMG. I’m going to faint. Smiling, taking a bite of my omelet and gushing over how adorable our host’s grandson looks in his soccer uniform…. I want to die right here and now.

Michael had not only gotten into the house but he took my car using a key that he’d long ago told me was lost and used it as collateral for a buy and to cover money he owed. I was so full of mixed emotions at that moment – knowing the panic Michael must be feeling; it broke my heart….protective mom mode. The anger and fear were making me physically ill. I excused myself once more and called Michael a dozen times. No response. And this went on all weekend.

Well, he did get the car back – this time. He traded our family heirloom- Sterling Silver flatware. It wasn’t pawned – no receipt to try to buy it back – it was traded on the street to a drug dealer. Michael survived the weekend and our hosts didn’t have a clue that anything was wrong. My husband found out about the checks and chose to believe Michael’s excuse that he had a gambling problem – much easier to believe than a heroin addiction which he was fully aware of but refused to acknowledge. He gave that problem to me - handle it - fix it. Whatever works. And me? I went on making excuses and enabling. Michael had already stolen much worse from me, so I let myself believe that the silver was just material stuff – my son’s life was all that mattered.

His addiction was my addiction.

It took another 11 months of attempted rehab, painful detoxes, and death defying binges before he was finally arrested and began his road to recovery. And today I look back on that Facebook memory with disgust…. look at Amy! She’s in Palm Desert! What a great life - all is right with the world! What a load of crap.
(mucosal) lining of the oral cavity. The passage of molecules through the oral mucosa is affected by many factors, like the size of the molecule, the lipid solubility of the molecule, the concentration of molecules, and the pH of the solution. For example, if the pH of the oral mucosa is 6.5 at the time of administration of sublingual Buprenorphine the absorption rate is 55%. Lower pH becomes more acid, and less absorption occurs if the pH becomes more basic more is absorbed. The remaining 46% Buprenorphine will be absorbed through “first pass” metabolism.

While naloxone is poorly absorbed through the mucosa, buprenorphine is better absorbed through this site. However, these and possibly other factors would also influence the ability of buprenorphine to enter through the blood brain barrier. Buprenorphine can also be metabolized in the kidneys. This alternative metabolic system known as glucuronidation may also have an effect on the therapeutic level of buprenorphine. These various types of absorption and distribution influenced by each individual’s metabolic-function ensure that ranges of buprenorphine metabolites will have little to no meaning.

**Factor Three: Opioid Receptor sensitivity**

Opioids can act at the opioid receptor, and provide pain relief without being metabolized. Although this seems like a way to match buprenorphine dosing with urine range, it does not take into account a crucial pharmacologic principle that receptor sensitivity (response to a drug) is altered by the ability of a drug to bind to a receptor. Better opiate receptor(s) availability for drug binding results in better response to the drug. So, for example, if a patient carries a gene variant that influences the brain to produce either higher or lower numbers of opiate receptors the resultant urine range will likewise vary and have little to no relevance to dose response and therapeutic value. Another example is a patient who has the A1 variant of the dopamine, D2 receptor gene (DRD2), will have 30-40 percent fewer D2 dopamine receptors than a patient with the A2 variant. This means that naloxone (the diversion/abuse deterrent) is less efficient because it cannot bind to opiate receptors in many brain regions reducing its ability to regulate opiate activity. Another genetic effect is that carriers of the so-called 9 variant of the dopamine transport gene (involved in rapidly clearing dopamine from the synapse–resulting in low dopamine) respond well to buprenorphine. So knowledge of urine range once again cannot help the clinician predict any useful information related to clinical response or diversion issues.

**Make no dubious claims – first, do no harm**

The claim that Buprenorphine dosage can accurately be determined by urine range is false. The only determination that can be made by a urine drug test is either the presence or absence of the drug. Some clinical laboratories are making these claims proposing that they possess an advantage of their urine drug test compared to other laboratories that do not ascribe to this tactic for sales purposes. Such claims are worthless and false, and worse could confuse the practicing physician and clinical team. Unfortunately, there is no way to match buprenorphine or any other drug with the reported range even using sophisticated detection instruments such as LC/MS/MS.

In summary, based on these and numerous others factors not discussed in this white paper, laboratories claiming that “knowing the drug urine range provides the clinician with an accurate dosage match” are not supported scientifically. With that said I would encourage these laboratories to rethink and change their false claims and “first, do no harm.”

Kenneth Blum, B.Sc. (Pharmacy), M.Sc., Ph.D. & DHL; received his Ph.D. in Neuropharmacology from New York Medical College and graduated from Columbia University and New Jersey College of Medicine. He also received a doctor of humane letters from Saint Martin’s University Lacey, WA. He has published more than 550 abstracts, peer-reviewed articles and 14-books.

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**INTERVIEW WITH MITCH WINEHOUSE**

By Patricia Rosen

and that and sure I have to tell him, but the bottom line is you can’t tell them anything especially when they are actively using. It’s like talking to the wall. They aren’t listening and they will do what they want until they themselves are ready to stop. It’s very easy for people who have no clue to tell you what they think you should do.

**Mitch:** And she was responsible for herself, your son was responsible for himself. When they were ready they would have stopped and it didn’t matter what you said. Amy died from a seizure caused by too much drinking.

**Patricia:** What would you like to see happen in this world regarding addiction?

**Mitch:** That’s a good question. I would like addiction treated as an illness, to be treated like every other disease because it certainly is. In the US you don’t have the National Health Service but in England we do. It’s the finest institution in the world. If you have a heart attack, need a new heart or bypass, there is no problem. You can stay home and recuperate as long as it takes but if you’re a drug addict- forget it. You are left to die. If you can’t pay for it, forget it. We put people through treatment that can’t afford it. There is something like 300,000 people that we know about that need rehab.

There are no beds for them. What are they supposed to do? So, if their drug of choice is heroin they pump them up with methadone for 20 years. They substitute one drug for another.

**Patricia:** Do you agree with that? I know I don’t agree.

**Mitch:** No, of course I don’t agree with it. They need a program for rehabilitation. We have 18 employees, 14 which are in recovery and they are the most resilient people. They do a great job with our school program and are a pleasure to employ. Nobody chooses to be an addict and why they should be stigmatized is terrible. We still have this attitude in the UK and US that it’s shameful to be an addict.

**Patricia:** And that’s why it’s so important for you to keep doing what you’re doing.

**Mitch:** Yes, and you as well. Your magazine is an amazing source of information.

**Patricia:** Thank you. We all need to work together to reduce the stigma. It has been such a pleasure speaking to you.
Join us for the 29th anniversary of one of C4 Recovery Solutions’ premier addiction conferences — the Cape Cod Symposium on Addictive Disorders. CCSAD is dedicated to continuing education and networking in the field of addictions. Last year, CCSAD hosted more than 1,270 professionals from across the country.

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WHY STAY SOBER IF I’M DYING?
By, Terence T. Gorski

Continued from page 8

we have accomplished and contributed. We can bring closure to our lives and our relationships. We can search for and find a deeper meaning to our lives and to our death.

6. Relapse Adds Pain and Problems to an Already Bad Situation: When a chemically dependent person returns to alcohol and drug use, there is a big price to pay. Physically, the booze and drugs rip our bodies apart and make us more vulnerable to the progression of other illnesses and less responsive to treatment. Psychologically, our self-esteem suffers and we develop shame, guilt and anguish. This emotional response accelerates our plunge into depression and eventual despair. Socially, we become isolated and unable to give or receive love. We inadvertently hurt the people we love most and cut ourselves off from one of the few sources of true comfort, the loving embrace of other human beings. Spiritually, we become bankrupt and disconnected from the God of our understanding. We lose conscious contact with our source of courage, strength, and hope.

7. It Is Better To Die Sober than To Die Drunk: I strongly believe that it is better to die sober than it is to die drunk. Using alcohol and drugs is never a solution for anything. Alcohol and drugs cut us off from our inner source of courage, strength, and hope. Addiction destroys our self-esteem and self-respect. And, on top of that, it will make whatever other disease we have worse. In the long run, it will create more pain and misery.

Terence T. Gorski is the Founder and President of The CENAPS Corporation. He is an internationally recognized expert on substance abuse, mental health, violence, and crime. He is best known for his contributions to relapse prevention, managing chemically dependent offenders and developing community-based teams for managing the problems of alcohol, drugs, violence, and crime. He is a prolific author and has published numerous books and articles. www.terrygorski.com www.relapse.org

ACCEPTING “THE WAY OF THE WORLD” OR JUST LET IT RAIN
By Maxim W. Furek, MA, CADC, ICADAC

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Still, the concept of happiness is one that continues to elude us even as we desperately search for it. What is this thing we call “happiness” and can we be happy if we refuse to accept the way of the world?

Happiness needs to be defined individually. It is special and unique. Many of us are unhappy with the way of the world. We hate the violence, poverty and corruption that we see every day. Many of the most creative and productive people are those who actively work to change the world and to make it a better place. Unhappiness begets action that brings about positive change.

Despite the negative energies that exist in the world, it is possible to reject the sorrow and instead choose a positive outlook as the cloak we drape upon ourselves. That is the psychic garment worn into the world, a vestment reflecting our positive spirit, energy and acceptance of the way of the world.

Maxim W. Furek, MA, CADC, ICADAC is passionately researching the essence of happiness. His rich background includes aspects of psychology, addictions, mental health and music journalism. His book Shepton: The Myth, Miracle & Music explores the psychological horrors and miraculous survival experienced by two entombed Pennsylvania miners. Learn more at sheptonmyth.com

References Provided Upon Request

PHRMA U – THE HIDDEN CURRICULUM
By, John Giordano, Doctor of Humane Letters, MAC, CAP

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There is no question that a relationship between Academics and the Pharmaceutical Industry is essential to our current and future wellbeing. What is debatable – and seems to be fluid – is where the line is between a healthy relationship and unethical practices. That line seems to me as being more like a snaking river than the closest distance between two points. With all of this being said I have to ask; with the mountains of scientific evidence at our fingertips, why on God’s green earth are the professors at – of all places – Harvard not educated in the safe prescribing of opioids as their med students claim?! Moreover, why didn’t Dr. Jeffrey Flier, Dean of the Faculty of Medicine at Harvard University, knowing that America is in a full blown opiate/opioid epidemic, institute a comprehensive addiction and its treatment coursework in the school he oversees? How many people have to die before there is any meaningful change on our campuses?

Michael Botticelli, head of the White House Office of National Drug Control Policy, in a recent interview said that “The nation has seen ‘no huge change in prescribing behavior’ around addictive opioid painkillers. Botticelli continued; “there is little to no education within medical education curriculums around addiction and safe prescribing.” In addition, our drug Czar revealed that the number of people who die of overdoses in each state is closely linked to how widely doctors are prescribing opioids.

But don’t despair; there is hope on the horizon. Dr. Joji Suzuki, a Harvard psychiatrist said the current generation of med students shows much more interest in learning about addiction than did their predecessors who are now setting the curriculum. Change is coming!

John Giordano DHL, MAC is a counselor, President and Founder of the National Institute for Holistic Addiction Studies and Chaplain of the North Miami Police Department. For the latest development in cutting-edge treatment check out his website: www.holisticaddictioninfo.com

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PROTECTING CHILDREN

Society has seldom considered the vicarious effects of domestic violence between partners on the lives of children. “A study in Massachusetts found that children who witnessed abuse of their maternal caregiver were 50% more likely to abuse drugs and/or alcohol.” Moreover, studies have found that children who witness abuse are more likely to accept relationships that are abusive. As children, what is the norm within our lives often becomes the norm within our adulthood.

Children who witness abuse are more apt to have a skewed view of relationships; the healthy behaviors within relationships; and a healthy way of interacting with others.

“Many young people who are mistreated by an adult, victimized by bullies, criminally assaulted, or who witness domestic violence react to this violence exposure by developing behavioral, emotional, or learning problems. What is less well known is that adverse experiences like violence exposure can lead to hidden physical alterations inside a child’s body, alterations which may have adverse effects on life-long health.” The repercussions of domestic violence can have a systemic effect on the psychology, biology, and physiology of the human makeup. It is essential that children who are directly or indirectly affected by domestic violence receive psychological care.

RECOVERY

“Of pain you could wish only one thing: that it should stop. Nothing in the world was so bad as physical pain. In the face of pain there are no heroes.” ~ George Orwell

While we understand many of the causations of domestic violence; it is critical that these factors are not overlooked when providing or requesting treatment. The escalation of domestic violence within the home has been shown to increase when the familial environment is unstable. As clinicians, it is of the utmost importance that you consider the following areas when working with a domestically violent couple:

• What is the financial makeup of the home?
• What are the psychological and physiological factors of the familial environment?
• What are the socioeconomic challenges that this family may be facing?
• Are there any academic disparities or challenges within the home?
• What other stressors may be the catalyst for domestic violence?

Domestic abusers and the abused need to develop healthy support systems (e.g. psychological services, familial support systems, domestic violence programs, and treatment programs). “Do not assume that substance abuse treatment will make your partner treat you better. It may be necessary, but it won’t be enough to end the violence.” It is important to understand that domestic violence does not always occur by those that struggle with substances or alcohol. Furthermore, domestic violence occurs at all socioeconomic levels.

1. Be your best proponent, ally, and advocate.
2. Be an informed advocate and support.
3. Always make your familial environment a safe and inviting place.
   a) always allow for healthy and open communication
   b) actively listen, even if you disagree, promote healthy conversations
   c) avoid jokes that are at the emotional expense of your partner, child or others
4. Never allow yourself to be a bystander. Always be a voice and an advocate for others.
5. Prevent an atmosphere of bullying within your own home! (E.g. physical assaults or discipline, yelling, belittling, trivializing, minimizing, downgrading, sneering, or running down your child or others).
6. If you are living in a domestically violent home, time is of the essence.
7. Be aware of children who may be living in a domestically violent home. Inform the proper authority.
8. Always, always do what is necessary to protect yourself and your family from harm.

While domestic violence is always inexcusable, know that there are a number of reasons that someone becomes a domestic abuser or tolerates domestic abuse. It is always important never to judge those who are living in a domestically violent home, rather help them find a healthy support system.

May you begin living beyond.

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References Provided Upon Request

BEGINNING AT THE END

Why Effective Addiction Management Needs to Start at the Completion of Treatment

By Jacob Levenson

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their treatment outcomes which is the collective goal. We all want to improve the treatment outcomes for individuals battling addiction. The data shows that extending the care continuum for individuals following the completion of treatment significantly improves the likelihood of effectively managing the illness and maintaining long-term recovery. Telehealth is proving to be a successful tool in the ability to maintain connections with individuals striving for long-term recovery, making the transition from early recovery to long-term recovery as smooth as possible.

Effective disease management begins at the end of addiction treatment and results with individuals living healthy, meaningful lives in long-term recovery.

Jacob Levenson founded Austin-based MAP Health Management, LLC in 2011, and has served as Chief Executive Officer since its inception. MAP has established itself as the nation’s leader in the provision of a comprehensive, accessible technology platform specifically developed to improve treatment outcomes for individuals treated for addictions and other behavioral health illnesses. Levenson has hired research analysts, clinical directors, recovery advocates, technology professionals and billing experts all dedicated to improving outcomes, empowering treatment providers with data, reducing costs and driving facility revenue. Levenson is a frequent contributor to leading addiction and population management publications. For more information, visit www.ThisIsMap.com.
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