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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, that we realize the true extent of their addiction.

I know that many of you who are reading this now are frantic that their loved one has been arrested. No parent ever wants to see his or her child 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.

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As an addiction psychiatrist, I have been working directly with individuals who have co-occurring conditions (formerly known as “dual diagnosis”) and their families for over 30 years. I have also directly managed almost every kind of program imaginable that has provided service to individuals with co-occurring conditions. I have worked directly providing training, technical assistance and consultation to all kinds of clinicians, programs, agencies, provider organizations, managed care organizations, and county and state systems all over the country. I want to share with you some of the most important things that I’ve learned (and taught) about how people with co-occurring conditions can make progress toward what we can call “dual recovery”.

**Recovery:** Many people automatically associate the term recovery with “recovery from addiction”. However, in the past few decades, the concept of recovery has expanded dramatically. We talk about recovery for people with serious mental illness, trauma, and chronic physical conditions as well as recovery in relation to traumatic life events like divorce and loss of a loved one. As this concept has evolved, so has our understanding of recovery.

Recovery is not recovery “from” a condition, but recovery of a human being who may have one or more serious and persistent conditions. Conditions may be medically diagnosed like addiction, bipolar disorder and diabetes, or, conditions may refer to other painful and persistent life circumstances. Recovery is a process, not an event, during which the person “recovers” pride, self-worth, hope, dignity, and meaning, even though the condition may persist, symptoms (e.g. cravings, mood swings) and disabilities may persist, and the need for continued treatment and support may persist. Recovery happens over time and is ongoing, so the person is engaged in a continuing spiritual process that brings greater meaning and serenity to his or her life over time.

_in this regard, anyone with any condition, and anyone with many conditions, can experience the hope and promise of recovery._

**Most people have many conditions!** If we look at epidemiologic data, as well as the experiences of most people who are struggling with addiction or anything else, most suffer from “co-occurring conditions”. That is, “Co-occurring conditions are an expectation, not an exception.” People struggling with addiction are more likely to struggle with co-occurring mental health conditions than people in the general population. These conditions can precede the addiction or sometime emerge during the course of the addiction but nonetheless, they persist indefinitely once sobriety has been attained. These conditions may include serious mental illnesses such as bipolar disorder, schizophrenia, major depression, anxiety disorders, PTSD, and ADHD, as well as the general effects of trauma (emotional, physical and sexual abuse as well as stressful life events), personality disorders, cognitive challenges, and a wide variety of other challenges. If you are suffering with two or more co-occurring MH and SA conditions- you are not alone. You can get better and achieve a happy, meaningful and successful life!

Below are some very basic principles and suggestions that you can apply in your own life or to help someone you love. These principles are designed to make your journey “simpler” (though there is no shortcut to recovery).

**The Principles of Dual Recovery**

1. **Welcoming:** “Co-occurring” is an expectation, not an exception. Welcome yourself into the recovery process, exactly as you are.

One of the challenges you may face as a person with co-occurring conditions is feeling like a “misfit” in both the mental health world and in the substance abuse world. This feeling may lead to strong feelings of shame and failure, feelings of being uniquely screwed up, often combined with an undercurrent of self-blame for being so sick in the first place. Many co-occurring mental health conditions, as well as substance use issues are related to past and present experiences of “trauma” (emotional, physical, and/or sexual abuse). This sense of self-blame becomes a continuation of the abuse, this time in your own thoughts which make it hard for you to feel that you are even worthy of getting well. This is why “welcoming yourself” is such an important step.

Welcoming may sound corny, but it really works. Find your own welcoming speech and say it over and over to yourself: You are an amazing person who has had the courage to recognize that you have BOTH mental health and substance problems. This is very common, and you deserve credit for showing up- exactly as you are - to try to make changes. You deserve as much or more help as anyone else because you are likely to be having a very hard time. Don’t worry…. you are in the right place and you can begin making progress toward addressing all your issues slowly over time in order to have a happy, hopeful, beautiful and meaningful life.

2. **Hope:** Hope fuels the journey. Identify your most important vision for a happy, successful meaningful life, and use that vision every day.

The starting place for hope is recognizing that people with any condition can experience the promise and hope of “recovery”. This further means that even though you may have two or more conditions that can be “chronic” or “lifelong”, you have every ability to achieve a happy, meaningful and successful life that can be even more spiritually rewarding than a life led by someone who has neither mental health nor substance use issues.

Write down your vision of a happy life. Keep that vision in front of you and use it to energize your own “integrated recovery” plan. Write what you really hope for and shoot high: “I want to feel like a person who is proud of who I am when I look in the mirror”. “I want relationships with friends and family that are loving and meaningful, where I value both what I give and what I receive.” "I want to engage in meaningful work or other activity”. “I want a place to live that feels like home”.

3. **Strength-based:** Supersize your strengths by focusing on what you have done right.

When you have more than one type of issue it is likely that your story will include many ups and downs. It is natural to want to focus on your failures and to feel like you have to “confront” yourself in order to make progress. This “deficit-based” approach becomes progressively less helpful as you face more challenges. Instead, you need to be “strength-based” in order to energize your existing capacities to make progress. How do you do this? **Remember the following:**

a) The more challenges you have, the more strength it’s taking you to ever live your life, as well as to make progress.

b) In a strength based framework, there is no such thing as a
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John Giordano DHL, MAC, CAP is a thirty-year veteran of clinical addiction treatment. Mr. Giordano is the founder and former owner of G & G Holistic Addiction Treatment Center, a 62 bed JCAHO accredited facility located in North Miami Beach, Fl. and has contributed to sixty-five papers on addiction and its treatment published in peer-reviewed scientific and medical journals and is considered by Research Gate to be one of the top researchers in the country.

Dr. Kenneth Blum, a researcher on neuropyschopharmacology and genetics and the co-discoverer of the first confirmed Reward Gene; aka/the addiction gene, the alcoholic gene. He is one of the world’s foremost experts on addiction and its treatment. Dr. Blum retired as a full professor in the Department of Pharmacology, University of Texas, where he was also chief of the Division of Addictive Diseases, chief of the Division of Substance and Alcohol Misuse, and director of the Laboratory of Pharmacogenetics at the University of Texas Health Science Center (San Antonio, Texas) and has written over five-hundred papers on addiction and its treatment published in peer-reviewed scientific and medical journals.

We are appreciative of the politicians who have recognized that addiction is a biological and genetic based disorder and not a moral failing, that America is in a raging and deadly opiate/opioid epidemic and their efforts to turn this force around. The purpose of this letter is to shine a light on critical facts that need to be considered in the planning and decision making process of any drug/addiction treatment policy proposal. We believe that to have an open, honest and informed discussion on how to resolve America’s second opiate/opioid epidemic, it becomes imperative that we put all the facts on the table.

A Brief History on both of America’s Opiate/Opioid Epidemics – And the Policies That Successfully Ended the First

America’s first opioid epidemic resulted from Chinese immigrants’ opium smoking habits that spread beyond their culture and the extensive use of morphine in the civil war. In 1898 the German drug company Bayer introduced Heroin in the United States as a non-habit-forming medicine that could and would cure opium and morphine addiction.[1]

Over 100 years ago America’s first drug czar, Dr. Hamilton Wright, was the subject of an op-ed for the New York Times with the shocking headline: “UNCLE SAM IS THE WORST DRUG FIEND IN THE WORLD” [2]. In this explosive exposé, Dr. Wright revealed that per capita, American’s were the biggest consumers of raw opium and opium based products such as morphine, heroin, laudanum, over the counter medicines and patented medicines in the world. His efforts led to a series of Federal laws that restricted the importation, distribution and prescription of opiates and opioids; effectively ending the first American opiate/opioid epidemic.

In the 60’s many soldiers returning from Viet Nam brought home with them their heroin addiction. The growing number of heroin addicts caused President Nixon to pass legislation (The Narcotic Addict Treatment Act of 1974) allowing Methadone Clinics to open across the country in an effort to combat heroin abuse.

The birth of America’s second opiate/opioid epidemic coincides with the aggressive marketing tactics of a pharmaceutical company’s launch of a powerful new and highly addictive painkiller in the late 90’s. Doctors were paid by pharmaceutical companies to prescribe narcotics – and they did; enough to keep every American adult high for a month. Opioid prescriptions nearly quadrupled in less than fifteen years. Responsible, hard working, non-drug abusing Americans became addicted to the Oxycodone they were prescribed by their doctors for pain resulting from sports injuries and minor and major surgeries; giving rise to the infamous pill mills and pain clinics. Today we find ourselves in a full blown opiate/opioid epidemic that if not addressed, promises to keep expanding.

America Has an Opiate/Opioid Epidemic – Not Just Heroin

If we are to have an honest discussion, it is consequential we frame the issue correctly. To say America has a heroin epidemic would be disingenuous and misleading. The facts below paint a clear and vivid picture of a country hooked on opioid painkillers – the most prescribed drugs in America today.

An “opiod” is any synthetic narcotic not derived from opium. Opiates are analgesic alkaloid compounds found naturally in the opium poppy plant Papaver somniferum. One main source fueling America’s opiate/opioid epidemic that continues to expand its boundaries is the over-prescribing of addictive opioid painkillers. Admissions of babies addicted to opiates and opioids (prescription and illicit) at birth to U.S. neonatal intensive care units nearly quadrupled from 2004 through 2013 and continues to rise. [3] Everyday in America, 2,500 youth (12 to 17) abuse a prescription opioid painkiller for the first time. [4] Twice as many people die from prescription painkillers than from heroin. [5] A study conducted by Express Scripts found that nearly half of patients who took opiate/opioid painkillers for more than 30 days in the first year continued to use them for three years or longer. [6] Almost half of chronic opioid users took only short-acting medications – rather than longer-acting formulations – thus increasing their risk for addiction. [6] Anywhere from 45% to 75% of heroin addicts surveyed said they were first addicted to opiate/opioid painkillers then moved to heroin. [7-8] Quoting from Journal of American Medical Association Psychiatry (JAMA Psychiatry July 2014) “Although the “high” produced by heroin was described as a significant factor in its selection, it was often used because it was more readily accessible and much less expensive than prescription opioids.” [7]

More Facts:

- Americans, constituting only 4.6% of the world’s population, have been consuming 80% of the global opioid supply and 99% of the global hydrocodone supply, as well as two-thirds of the world’s illegal drugs. [9]
- Since 1999, the amount of prescription painkillers prescribed and sold in the U.S. has nearly quadrupled (272%) to nearly 207 million in 2013 [10]
- Enough to medicate each American adult every four hours for an entire month [11]
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Did you know that scientists believe there is a black hole at the center of our Milky Way galaxy? For those of you who don’t know, the Milky Way Galaxy is our home in the universe and the mother galaxy for which our Solar System is a child of. You can look at the Milky Way Galaxy as being mother Earth’s great grandparent to our grandmother, the Sun. The theory is that the Milky Way Galaxy was born from this intense and immensely large black hole. But what does this mean to us little humans running around on planet earth? Why would I, a behavioral therapist, be writing a scientific blog about a black hole? The reason is very simple: personal growth.

As a behavioral therapist whose hobby and interests are quantum physics, string theory and just about anything related to science and the universe, I have always found it interesting and exciting that what happens out there in the stars is a direct reflection on human behavior, and even more specifically with the ways in which human beings can learn to self-heal and strive for personal growth. So, let’s take our black hole analogy into the realm of the human condition and human spirit.

Out of the darkness of a black hole came the light of the galaxy which produced a billion stars in the universal sky. Stars are fire and light that heat and bring life into the solar system. They bring life into our hearts, life to us! As above…so below!

So many of us are fearful of the darkness; fearful of going into the pain and the dark recesses of our hearts and minds, that we miss the opportunity for serious spiritual growth, and therefore our souls begin to rot like withered grapes in an eternal cold winter snow. But it is through the darkness that we manifest the light, the light within ourselves, our hearts and our minds. It’s where we find peace, love, and evolution. If a species doesn’t evolve it goes extinct.

It’s like that one thing that’s been holding you back; that one behavior you just can’t tackle that has made all the difference, and that one behavior you just couldn’t modify before all hell rained down on you. That’s the darkness, that’s the black hole, and to get through it you must face it head on with patience and discipline.

These are a few of the aspects of spiritual growth therapy- learning to face the darkness and building the courage, strength and conviction through spiritual growth to do so. This is how personal growth is achieved along a stratospheric timeline.

There are things that are done to us, things we do to ourselves, things we have witnessed and things we do to others. Overtime, it builds and builds adding to an ever growing wall of shit, hell, and darkness keeping us isolated inside a shrinking prison until we suffocate and explode. But these walls become what we know, become what we trick ourselves to believe is our identity. But nothing is further from the truth. If you believe it to be true, it will be. If you believe you can change it, you will. The light comes from the change, from breaking through the wall to take on a new you, a new identity, and a new belief system with the foundation that you are all powerful and can achieve all your mind wants and desires, with grace and peace.

I see so many people fail in their endeavor for change and personal growth, not because they are afraid of the darkness, but because they are afraid of the light. They have grown accustomed to the darkness, comfortable with where and who they are and are truly fearful of the change because of a misperceived notion that they lack courage and conviction to push through the wall and break free. I feel very strongly that psychotherapy today needs to change to reflect the therapists’ position as a guide through the darkness while incorporating and teaching their patients how to find the light through the practices of spiritual growth therapy. I’ve seen too many therapists keep patients in therapy for years and years without end, a practice that is catastrophically counterproductive in all of its goals. There is no reason for this when patients can be treated by learning spiritual practices with the help of the therapist and support systems. But before anything begins we must not be afraid to face the darkness because this darkness is the father of the light.

As above…so below! As we are connected to each other, connected to nature and the life that exists on this planet, so are we connected with the universe, portraying all of its mysteries, wonders, and beauties within our own hearts. Find your light within the darkness and manifest yourself in a place of wonder and amazement in everything you do in your life, and you will find your spiritual and personal growth!

Paul D. Alleva is the founding owner of Lifescape Solutions and Evolve Mental Health which he opened in December of 2011, based on a new model of healing and psychotherapy called Spiritual Growth Therapy. His newest book Let Your Soul Evolve: Spiritual Growth for the New Millennium 2nd edition describes the model.

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When most people think about alcoholism or drug addiction they think only of the alcohol/drug-based symptoms and forget about the sobriety-based symptoms. Yet it is the sobriety-based symptoms, especially post-acute withdrawal, that make sobriety so difficult. The presence of brain dysfunction has been documented in 75-95% of the recovering alcoholics/addicts tested. Recent research indicates that the symptoms of post-acute withdrawal (PAW) are associated with alcohol/drug-related damage to the brain which may contribute to many cases of relapse.

Post-Acute Withdrawal (PAW)

Post-Acute Withdrawal (PAW) is a group of addiction symptoms that occur as a result of abstinence from addictive chemicals. In the alcoholic/addict these symptoms appear within seven to fourteen days into abstinence, after the person has stabilized from the acute withdrawal.

- **Post** means- after.
- **Acute** means- immediate or severe; short-term
- **Post-Acute Withdrawal**: Symptoms that occur after acute withdrawal.

Post-acute withdrawal is a bio-psycho-social syndrome. This means that the symptoms are caused by the combination of damage to the brain and nervous system (Bio), difficulty thinking clearly and managing feelings and emotions (Psycho), and problems with relationships (Social). The PAW symptoms get worse when you are under stress. During periods of low stress they are very mild or not present at all.

Recovery causes a great deal of stress. Many chemically dependent people never learn to manage stress without using alcohol and drugs. The stress aggravates the brain dysfunction and makes the symptoms worse. The severity of PAW depends upon two things:

1. The severity of the brains dysfunction caused by the addiction.
2. The amount of psychosocial stress experienced in recovery.

The symptoms of PAW typically grow to peak intensity over three to six months after abstinence begins. The damage is usually reversible which means the major symptoms go away in time if proper treatment is received. So there is no need to fear. With proper treatment and effective sober living, it is possible to learn to live normally in spite of the periodic episodes of PAW. The brain does heal, but it doesn’t happen quickly. Recovery from damage to the nervous system usually requires from six to 24 months with the assistance of a healthy recovery program. Recent research is showing that for some recovering people the symptoms of PAW occur. This will be the subject of next month’s article.

Fortunately, there are ways to manage PAW symptoms when they occur. This will be the subject of next month’s article.

**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. Terence is the Director of The National Certification School for Relapse Prevention Specialists.**

~ Terry Gorski Blog: www.terrygorski.com
~ Terry Gorski, via www.facebook.com/GorskiRecovery
~ Gorski Books: www.relapse.org

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**SYMPTOMS OF POST ACUTE WITHDRAWAL**

How do you know if you have PAW? There are six major symptoms to look for:

1. **Difficulty Thinking Clearly**: You have difficulty organizing your thoughts and you can’t solve usually simple problems. You feel confused and don’t understand what is going on.
2. **Difficulty Managing Feelings and Emotions**: This includes both emotional overreaction, where little things set off a big stress reaction, and emotional numbness, where it seems like you can’t feel anything. You can also swing from overreacting to feeling numb for what seems like no reason at all.
3. **Difficulty Remembering Things**: Something happens and you feel like you won’t forget it. But in a few moments you can’t remember exactly what happened. This is because your brain recognizes what is happening in the moment but has problems storing these immediate memories into your long-term memory.
4. **Sleep Disturbances**: You have difficulty sleeping restfully. You can’t fall asleep. When you do sleep you’re fitful and often have bizarre dreams. When you wake up you don’t feel rested. You tend to sleep during the day and are agitated and awake most of the night.
5. **Physical Coordination Problems**: You feel clumsy and have problems with hand-eye coordination. This can cause you to become accident-prone.
6. **Stress Sensitivity**: During periods of high stress the symptoms get worse. When you are having a stressful day or wake up after a restless night of sleep the symptoms get worse.

These PAW symptoms can make you start feeling crazy, incompetent and embarrassed. You can swing in and out of depression as you move in and out of the stressful situations that activate PAW. Low self-esteem and the fear of failure interfere with your ability to live a productive and challenging life. The problems are more severe if you were raised in a dysfunctional family, because as a child you never learned how to effectively manage stress.

**PATTERNS OF POST ACUTE WITHDRAWAL**

PAW is not the same in everyone. Some people experience certain symptoms; some people have other symptoms; some people have none at all. Over a period of time, PAW may get better or it may get worse, it may stay the same or it may come and go. If it gets better with time we call it *regenerative*. If it gets worse we call it *degenerative*. If it stays the same we call it *stable*. And if it comes and goes we call it *intermittent*.

Just knowing about PAW makes most people feel better. Fortunately, there are ways to manage PAW symptoms when they occur. This will be the subject of next month’s article.

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**Image**: Post-Acute Withdrawal (PAW): What it is and why you should care! By Terence T. Gorski.
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If truth be told, I struggle to sustain affirming thoughts for my son who is now into his 20th year of addictive illness. I love him deeply but often do not like or trust him. He is a tiger in my life; menacing, powerful and strategic with the occasional playful, warm and fuzzy side. However, just as I would not want a tiger in my milieu because of my respect for his predatory nature, I also would not hate the tiger even if he were to menace me. The tiger, just like you and me, is a highly strategic animal hard-wired to get through his tiger day watered and fed.

My son is currently drug-free but only this past Sunday evening, while “popping by” for a visit from his sober living, ten dollars of change that was handed to my husband at the supermarket went missing. Needless to say, we all danced around the elephant in the living room; you know, the one that seeps into our psyche like ink into a white rug; “I wonder if our son stole the money?” Our mothers taught us the old saying, “Once burned, twice shy.” A tragic hint of contempt permeates the room pulling in old memories of long-lost pieces of jewelry or family silver. It is notable that my son goes out of his way to find the lost cash. He goes into the trash and riffles through the shopping bags. He appears almost manic in an effort to locate the lost money. He joins the dance of avoidance; he knows that we suspect him and he desperately rushes around the house eager to prove us wrong. The money is not found and there is a dark, hopeless fog of blame lying heavy in the room. The painful truth is that we have no idea where the money is; it might have fallen onto the pavement in the supermarket parking lot. Yet sadly, those old intrusive doubts and fears run like a cruel tickertape under our narrative.

This business of being a parent of an adult child with addiction is very hard. I hear from my clinical colleagues that more and more research supports a view that addictive illness is highly co-morbid with antisocial personality disorder. That being said, many core features of one’s personality arrives with us when we are born. There is an esteemed Oxford longitudinal study that examined personality in a cohort of people over a lifetime. In the study, the subjects were videotaped regularly from the age of 12 months for over sixty years. The outcome is impressive: we folks do not change much. We arrive on earth hard-wired to manifest ourselves in some patterned way. I have audio-fooage of me talking to Santa Claus at age 3. Santa asked me what I wanted to be when I grew up and there was not a second of hesitation, “Santa, I want to be a teacher.” LOL: here I am hard-wired after all of these years working hard to temper some of my know-it-all wish to teach and teach and teach some more. I have been trying to edify people for almost 70 years. If we are born as vigilant, scrupulous children, we remain vigilant and scrupulous our whole lives. If we are born with a high degree of goal-directed curiosity; we remain passionate our whole lives to understand how things work. If we demonstrate an early tendency towards risk-taking; we will be life-long risk-takers. Thinking of the Oxford study, I am then reluctant to tag my son as pre-morbidly anti-social as I recall his youthful acts of empathy, kindness, concern for others and his capacity to mirror. There was nothing grossly strategic about my son’s actions when he was a child. He was no tiger-baby; he was a kitten.

So what to make of the high degree of comfort people have linking antisocial behavior with addictive illness? Well, no mystery here. Addicts do steal things and they often lie. They do these things strategically to assure that they are rewarded. The addicted brain knows well what it wants. It has no interest in my antique ring. Sadly, the ring can be pawned and the monies spent on a moment of peace and chemical resonance. It wants heroin or alcohol or Xanax. The craving brain is not a brain that thinks about social mores. The craving brain does not think about the future. It is the brain of a hunter; it is hard-wired to do all that it can to achieve its end to gratify; to gratify hunger, emotional peace and satiation. The craving brain does not project internal visual footage about consequences. For example, if a child saw a $5 bill sitting on his unattended teacher’s desk, the tiger brain might just say “go for it” because there is no internal visual display of being called into the principal’s office or of receiving a dressing down from one’s angry father. For the craving brain there is no past (no regrets, no guilt about past injuries and harms) and no future (no concerns about consequences or outcomes). No, the craving brain is all about the present moment and about seeking immediate gratification or relief from pain in that present moment.

While many people believe that addictive illness and antisocial behavior are dance partners, I more often than not find the opposite to be true. For the past several years, I have run a weekly CBT for an Anxiety Group at UCSD. Imagine my surprise to have over half of my anxiety group patients secretly approach me requesting to be transferred into my newly formed Clinical Strategies for Recovery Group. These highly anxious, scrupulous and self-auditing good citizens are also struggling with drug and alcohol addiction. These folks are the opposite of persons who are anti-social. These are no tigers; these are worker bees. These are the folks who care too much about what others think; who devote their lives to resolving problems. Who knew? Of course, it makes a huge amount of sense to me that people who are chronically anxious would be attracted to either alcohol which would dampen down the anxiety or to stimulants which would distract the person from anxiety.

Finally, while I embrace and celebrate the teachings of Buddha and the import of being mindful, I find it ironic that there is currently almost what could be called a form of fad-infused “guilting” of people to live more in the present. This makes sense for the excessively future-oriented anxious addicts who worry chronically about dissonance; about things out of place. They might need alcohol and Xanax less if they moved into the present and had more acceptance and self-compassion. That being said, the tiger lives his whole life in the present. He thinks nothing of the future or of the past. The tiger does not self-audit. He is simply a biological strategist. Sadly, this present-focus often finds the tiger reviled and imprisoned. We must have compassion and love for both the tiger and the addict. They both walk with Buddha.

Caroline Ridout Stewart is a clinical supervisor, instructor and psychotherapist in the Department of Psychiatry at UCSD. After teaching anthropology for ten years both in Canada and at Cuyamaca College in San Diego, Caroline retrained to become a Licensed Clinical Social Worker specializing in the treatment of anxiety disorders, infertility and addictive illness. Caroline’s eldest adopted son suffers from addictive illness, prompting Caroline to become the President of the board of A New PATH (Parents for Addiction Treatment and Healing.) Caroline has worked tirelessly for the past 15 years to promote a more clinically-informed understanding of addiction. She runs the Clinical Strategies for Recovery Group at UCSD Outpatient-Hillcrest. Caroline is a writer, artist and poet who enjoys exploring the Southwest desert.
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SNAPCHAT ISN’T THE ONLY APP TEENS USE FOR CYBERBULLYING
By Mendi Baron, LCSW

“You should die,” “Why don’t you go kill yourself,” “Why are you still alive?” “You’re ugly,” “Drink bleach and die,” “Can u die please?” “You haven’t killed yourself yet.” “Go jump off of a building.”

These are only some of the harassing and hateful texts that 12-year-old Rebecca Ann Sedwick continuously received on her cellphone from several middle school classmates who bullied her for nearly one year. On September 9, 2013, Rebecca jumped to her death from a platform at an abandoned cement factory, instead of going to school. While the cause of Rebecca’s suicide cannot be attributed to any one or all those “mean girls” who tormented her online and through text messages, the case, which made national headlines, continues to illustrate how teens today are using the Internet and cellphones to send relentless, hateful electronic messages known as cyberbullying. Cyberbullying is defined as: someone who is tormented, threatened, harassed, humiliated, embarrassed or otherwise targeted by another person using the Internet, interactive and digital technologies, or mobile phones. Cyberbullying is a very real problem among teens. In fact, nearly 43 percent of teens admit to having been bullied online and 1 in 4 say they have experienced it more than once.

It’s incomprehensible that anyone, let alone young people, could send such hateful messages as the girls who tormented Rebecca Ann Sedwick. However, these dangerous hateful messages are all too real and becoming more commonplace. Teens have access to newer, lesser-known social applications like Ask.fm and Kik, which are not only free, but can be used anonymously or by creating a fictitious identification, allowing teens to spew hateful comments behind a veil of anonymity. Most parents of teens are familiar with social networking sites like Facebook, Twitter, and Instagram. Some parents have even heard of Snapchat, where teens can send a photo, video, or comment that disappears almost as quickly as it’s sent. However, there are many other apps at your teens’ disposal that put the ability to victimize—or be victimized, literally into the palm of their hand. If you’re scratching your head when you hear or read about Burnbook, Voxer, Kik, YikYak, Tinder, Tumblr, Ask.fm, Poke, Vine, Whisper, Secret, or Snapchat, then it’s time to educate yourself and read up on the trendy new social media apps teens are using. These are the latest apps tweens and teens are flocking to these days. Many of the above-listed apps are being used for cyberbullying. Anonymous cyberbullying is a rising trend on the Internet, as teens are increasingly turning to pseudonymity to abuse others, so that the targeted victim may or may not know who is harassing them. When it comes to online safety, only being your teen’s “Friend” on Facebook is like letting them drive a car with a seatbelt but no working brakes. You need to be more than just familiar with all your teen’s social media apps.

Knowing “cyber lingo,” as well as which app does what, will keep you in tune how teens are communicating with each other. From a teen’s perspective today, texting is the equivalent of talking. They don’t speak face to face - they text, even when they are sitting next to each other. Start the conversation…Ask your teen which apps he or she is using and how they work? It’s not possible to join every site or app and monitor your teen’s every move online, nor should you. It’s more important that you build trust, start the conversation, and keep it ongoing. There will always be some new platform that your teen will find and you won’t know about it yet. Rather than being a “helicopter” parent and hovering or completely barring your teen from downloading social media apps all together, start a conversation about “common sense” social media etiquette, safety, and cyberbullying.

CYBER-ETIQUETTE OR DIGITAL CITIZENSHIP
Parents consistently reinforce being a good citizen, having proper manners, and etiquette like saying, “please,” and “thank you” and of course, the Golden Rule -- “Do unto others as you would have them do unto you.” However, how many parents and/or teachers talk to teens about how to use good manners when leaving a comment on a blog post? The rules are the same; we call it “cyber-etiquette” or “digital citizenship.” Helping teens be smart, safe, respectful citizens online should be part of every child’s education both at home and in school. Some parents like to say, “If you wouldn’t be proud to share it with grandma, then don’t share it online.” The number one rule for online behavior is, “If you wouldn’t say it or use those words in person, then don’t put it online.” Teaching proper social media behavior empowers teens to make a difference and end online negativity. Instead of allowing them to wrap themselves in the cloak of anonymity, let’s teach our teens to use social media in a positive way.

CYBERBULLYING
It’s almost impossible to prevent cyberbullying altogether, but what you can do is educate your teen and minimize the chances that they will be a victim of cyberbullying or harass someone else online. Teens can use smartphones and computers to harass other teens by sending malicious text messages, uploading embarrassing photos or videos on websites, taking over someone’s social media profile, or creating a new profile. First, educate yourself about cyberbullying. Next, get to know how your teen uses his/her computer and smartphone. Find out what they are doing online when not working on homework? Then, start the conversation about cyberbullying and its various incarnations. And finally, teach your teen what information they can share with others online and what they can’t, such as telephone numbers, addresses, their full name, and school. Remind them that they should never send any information they don’t want the general public to see. It is important to acknowledge that nothing on the Internet or sent in a text is truly private.

What should you do if Your Teen is Being Bullied Online?
Keep the lines of communication open and ask your teen to let you know if someone is hurting him/her or making them feel uncomfortable online, even if the person is acting anonymously. Let them know that not every cyberbully needs a response. If they receive a hateful message or inappropriate picture, don’t respond, but also don’t ignore it. Ask your teen to try and get a screenshot, especially if it’s something like Snapchat where communications quickly disappear. Sometimes, bullies are just trying to get a rise out of them. However, if it persists, it is important that you encourage and help your teen document the bullying behavior. Involving school administrators, if the source of the bullying is a schoolmate, is the next step, as cyberbullying will have an impact on your teen’s social life and ability to learn.

If you haven’t established certain online and social media rules already, and the words cyberbullying and cyber-etiquette have not been discussed, don’t wait! Start the conversation today and you will be prepared for tomorrow.

Mendi Baron, LCSW, is the founder and CEO of Evolve Treatment Centers, a treatment Center for teens struggling with mental health and addiction issues, based in Southern California. A passionate advocate for teens in the field of mental health and addiction, Mendi is a go-to expert to start the conversation on critical issues that impact teens and their families. For more information go to www.evolvetreatment.com or email Mendi at Mendi@evolvetreatment.com
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At my treatment facility, I was taught that addiction is like a “Great Eraser”. It erases everything that matters in your life. The first tier of “The Great Eraser” is the financial eraser. It erases money spent on alcohol, pills and drugs. At first, it is a slow trickle of money to feed the addiction, but later, it is like a fire hose pumping money into the addiction monster. The addict or alcoholic will lie, manipulate, steal and connive on ones so they can stay in their addiction. I have witnessed two young teen age boys who ran up tens of thousands of dollars on their mother’s credit card. Later, they pawned their autistic sister’s jewelry to feed their addiction. These young lads would never have dreamed of such horrendous acts while they were sober. This is what addiction leads to. Many family members have paid large sums of money for substance abuse treatment which erases money from their retirement funds. Also, as the addict or alcoholic gets older, it becomes harder and harder to find a job because of their checkered employment history. The financial Great Eraser will cause them to lose everything – jobs, homes, apartments, cars- erase, erase, erase. This is why more than 60% of the homeless population has substance abuse issues.

The second tier of “The Great Eraser” is the relationship eraser. The reality is that the alcoholic or addict hurts the ones that love him or her the most. In the Alcoholic Anonymous book, it says “The alcoholic (addict) is like a tornado roaring his way through the lives of others”. I have been in 2 tornados while living in Oklahoma. They are very centric, very powerful and very destructive… just like the alcoholic and addict. My experience with dealing with 800+ men at is that the younger the men are, the more forgiving the family is. As the alcoholic or addict gets older, the family loves them from a distance and does not want to be sucked into the toxic tornado. They pray and hope by some miracle, that their addicted family member reaches their bottom and starts living a sober life. The alcoholic or addict feels that their family has deserted them – when in fact, their addiction is center of their life – not their family. They live each day, each week, each month, and each year in almost total isolation. The relationship Great Eraser will cause the alcoholic or addict to lose his relationship with his family, friends and God and live in almost total isolation... erase, erase, erase.

The third tier of “The Great Eraser” erases hope, self-worth and finally life. Because of self-destruction and low self-esteem, the alcoholic or addict feels like their life is a waste and they are worthless. They have attempted many times to stay sober and clean but have failed miserably after each relapse. Since substance abuse is a progressive disease, their self-confidence spirals downward. They have lost hope. Some die because of suicide, some die very quickly of overdose and some die slowly of liver and kidney disease. This is the final eraser.

So what is the solution? The solution is TIME. The longer an alcoholic or addict is sober and clean, the better their chances are that they will stay sober and clean for the rest of their life. Over time, the mental urges to drink and drug will diminish if they stay sober and clean. To think that after 30 days of treatment an alcoholic or addict will get cured or recovered is ludicrous. They are typically thrown back into the same environment … with all the problems and triggers still there 30 days later. I would recommend 6 to 12 months of an “in patient” program. This will allow the alcoholic or addict to unlearn compulsive behaviors and to deal with life on life terms without using alcohol and drugs. I would also recommend an After Care program that will slowly allow them to live an independent lifestyle. The After Care Program should be a detailed road map that has an action plan that can be monitored. The real joy is seeing the alcoholic or addict reunited with their family and staying sober and clean for the rest of their life. The miracle can happen, if you let time heal all the wounds.

Brent Burmaster is the Executive Director of Soul's Harbor Treatment Center located in Dallas, Texas. Brent has a Bachelor of Science from the University of Oklahoma.
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Robert completed inpatient treatment a few weeks ago. While there, he learned about addiction, explored some of the thoughts and feelings surrounding his substance use, and worked on improving a few important relationships. Despite having a comprehensive discharge plan, Robert was terrified because he’d done this many times before, only to relapse within the first few months. By now, he knew all those fundamental truths of recovery, like Hungry Angry Lonely Tired (H.A.L.T.) and One Day at a Time, but his relapses seemed to arise from out of nowhere; even though he wanted to resist his urges, he didn’t see them coming.

In recent years, there has been a growing wave of research into the practice of mindfulness. Diverse groups including elementary school children, corporate executives, and prisoners have all been the focus of mindfulness-focused studies. Indeed, the February, 2014, cover of *Time* magazine that proclaimed a “Mindful Revolution” attests to the popularity of mindfulness as a potential solution to the problems of modern life. The application of mindfulness has extended into the field of addiction treatment as well, and the results have been promising.

A 2006 study in *Psychology of Addictive Behaviors* examined mindfulness meditation as an alternative to traditional substance abuse treatment for people in jail who had histories of drug and alcohol abuse. The researchers found a significant decrease in the frequency of substance use for those who participated in the mindfulness meditation training following their release compared to the control group. Participants also reported feeling more optimistic and in control of their using behavior. This study was followed up with a 2009 pilot project that measured the influence of 8-week mindfulness training on relapse rate, craving, impulse control, and acceptance in 168 adults who had recently completed substance abuse treatment. As with the first study, the research team found positive results: participants had significantly lower relapse rates, decreased cravings, and increased feelings of acceptance in the 4 months following discharge from treatment. These findings resulted in the development of *Mindfulness Based Relapse Prevention* (MBRP), a structured program designed to teach substance abusers these skills (www.mindfulrp.com).

While there is no universally accepted definition for mindfulness, many people refer back to the founder of *Mindfulness-Based Stress Reduction* (MBSR), Jon Kabat-Zinn’s, description: “Mindfulness means paying attention in a particular way: on purpose, in the present moment, and non-judgmentally.” Now, some might be intimidated by this vague and flowery language, conjuring up images of monks sitting in lotus position on a mountaintop, far removed from our “real” world. Others might dismiss mindfulness outright as some unscientific new age spiritual practice. However, neither of these reactions is based on a fair depiction. To see how and why mindfulness meditation benefits people in recovery from addiction, let’s take a closer look at this definition.

What does it mean to really pay attention? As you hold this magazine, notice what is happening. How do the pages feel in your hands? Where has your mind drifted while reading this article? Is your breathing deep or shallow? Are you relaxed or tense? Paying attention means actively using all of our senses. Very often, we go about our days on autopilot. Like driving along the road to a well-known destination, we tune out. The problem with this for those in early recovery is that they fail to notice the warning signs passing them by, barreling past the “ROAD OUT AHEAD” sign and over the cliff. Tension builds up slowly – a worry about money, an argument with a family member, a missed meal – until finally exploding into relapse. Mindfulness practice means attending to these sensations in order to appropriately respond to them as they arise.

The next component of mindfulness involves intention. Just as we would commit to regular exercise in order to strengthen our bodies, training our mind’s ability to withstand the powerful forces of thought and emotion requires intentional practice. This is the “on purpose” part of mindfulness. We cannot expect to be effective at tasks we don’t practice on a regular basis. Skills don’t magically appear in the midst of a crisis, when we most need them. Reaping the benefits of mindfulness takes consistent, conscious practice on a daily basis. This means we have to take the time to sit in silence, go for a long walk, or participate in any other form of mindful reflection. It is simply another type of daily hygiene.

Mindfulness also requires us to be present. Remaining in the present moment is a common theme in addiction recovery. Whether it is communicated through slogans like “first things first,” “one day at a time,” or “the present is a gift,” people are told to avoid dwelling in the past or projecting into the future. Being present allows us to pay attention. Thus, being mindful also means being in the here-and-now and allowing ourselves to experience sometimes uncomfortable thoughts or sensations.

The last part of Kabat-Zinn’s definition of mindfulness – non-judgmentally – may be the most difficult for some people in early recovery to achieve. Substance abuse often results from feelings of shame, anger, and doubt. Moreover, addiction breeds even more of these negative, harsh self-criticisms because of the types of activities it involves and the long-term damage to which it leads. “This time will be no different,” “I’ll always be a [junkie, crack head, drunk, etc.].” “No one would accept me if they really knew me.” “I’ve ruined my life.” Such automatic thoughts constantly run in the background for those who have struggled with addiction. It is only by remaining still and tuning into our minds and bodies that we uncover these hidden messages. And it is only through knowing they exist that we can accept and eventually let go of them.

It is easy to see why mindfulness practice would be helpful for someone like Robert. Of course, it is no guarantee against relapse; cultivating these skills simply provides additional traction on the road towards peace. One happy result of the growing popularity of mindfulness is that there are now seemingly endless resources available to those who want to begin their own mindfulness practice. Try it for yourself: find a quiet space and sit in a comfortable position. Set your phone timer for 3 minutes. Close your eyes. In this time, breathe consciously and easily. In and out. Clear your mind, anchoring yourself with your breath. If you find your mind starts to wander and some of those automatic thoughts pop up, let them float by like passing clouds – without judgment or resistance.

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America currently has a fulminating heroin/opioid epidemic and there are at least ten reasons for this; which I will discuss in a series of articles in Sober World Magazine. The reasons include:

1. War in Afghanistan
2. Injudicious Prescribing by MD’s
3. Patient Expectations
4. Internet Sale of Pain Pills
5. OxyContin Reconstitution
6. NIMBY
7. Supply & Demand - “War on Drugs”
8. Physician Training and Biases
9. Mental Health Treatment
10. Public Officials

Yes, there is plenty of blame attributing to the heroin/opiate epidemic and the changing demographics of today’s heroin user, which has migrated outside of our major cities to suburban and rural America. But before we engage in a detailed explanation of who/what to blame and to better understand the complexity of the issue, let’s review the biological, psychological and sociological aspects of the disease of addiction. Then, we can better understand the reasons why this scourge to society has spread so widely and present some viable solutions.

What is heroin? Heroin is actually diacetylmorphine which was synthesized by C.R. Wright in 1874 by adding two acetyl groups to the molecule morphine, which is found naturally in the opium poppy. This alteration of the morphine molecule makes heroin two to four times more potent than morphine with a faster onset of action. In 1898 Bayer Pharmaceutical of Germany marketed a heroin which has migrated outside of our major cities to suburban and rural America, found its way into suburban and rural America, and was marketed diacetylmorphine under the name of heroin. Illicit forms of heroin can be injected, snorted or smoked. Purity has increased so much over the past decade one no longer needs to inject heroin to get the rapid euphoria (“high”). Snorting the drug works quite well!

**Biological:**
To understand the biological aspect of the disease of addiction, let’s look at it from the viewpoint of genetic predisposition. Years ago, Scandinavian studies demonstrated that your biological parents are the predominant factor whether you would develop the disease of addiction. The study followed identical (monozygotic) twins who were adopted into different families. The results demonstrated that the children most likely to develop addictive behavior were those from birth parents with the disease of addiction. Although environmental factors were also shown to be important, the predominant factor on whether determining who would develop the disease of addiction was most highly correlated with parents and genetic predisposition.

Metabolism is another example of a biological component that influences addiction. There is a segment of the Japanese population that rarely drinks alcohol and they also commonly lack an enzyme called alcohol dehydrogenase. In most of us, alcohol dehydrogenase is the predominant substance that breaks down alcohol in to metabolites, which are then excreted by the body. A small amount of alcohol is metabolized by an alternative pathway. However, if one lacks the enzyme alcohol dehydrogenase, the majority of alcohol is metabolized by the alternative pathway. The alternative pathway produces a toxic metabolite which can make one extremely ill.

The symptoms and effects of the toxic metabolite can range from mild nausea and dizziness to losing consciousness from low blood pressure, seizures, heart attacks or other significant consequences. Individuals who lack the enzyme alcohol dehydrogenase typically avoid these unpleasant effects by not drinking alcohol. In fact, the medication called disulfiram (Antabuse) is prescribed to some patients who wish to stop drinking. Antabuse blocks the enzyme alcohol dehydrogenase forcing alcohol to be metabolized by the alternative pathway, thus producing toxic byproducts. This type of aversion therapy using medication and recommended counseling can be effective albeit it does carry a risk if patients are not compliant.

**Psychological:**
Many substance users consume alcohol or drugs in order to eliminate or minimize feelings, fears, or symptoms. Unfortunately, medical services are not easily obtainable for many people suffering from mental health related illnesses, and they may self-medicate with alcohol or illicit drugs. In addition, people commonly fear the effects of withdrawal and this psychological response continues to drive addictive behavior. There seems to be a relationship between anxiety disorders and alcohol; depression and cocaine or other stimulants; bipolar illness and opiates; and ADHD and marijuana. Treating underlying mental illness is an important component to curb inappropriate substance use. There have been reports that as many as 50% of patients with substance use disorders have underlying mental illness.

**Sociological:**
Where we live and how we live makes a difference in our choices. If we live in an environment where there is no alcohol or drugs then we are unlikely develop a substance use disorder, even if we have genetic predisposition or underlying mental illness. If we reside where drugs and alcohol are readily available and dependency is developed and then we wish to stop using, it is more difficult to refrain if we return each and every day to this same neighborhood with the same sociological cues. This is a major factor why Vietnam war veterans who became addicted to heroin abroad tended to do much better in recovery when they returned home, having left sociological cues behind in Vietnam; and why it is more difficult for a drug user to change his/her habits if living with another user of alcohol or drugs.

In a recent article published in the New York Times on April 17, 2015 entitled, Serving All Your Heroin Needs (http://nyti.ms/1Th5jDX), two quotes are extremely revealing:

“… selling heroin across the United States resembles pizza delivery.”

“… a new home for heroin is in rural and suburban Middle America …”

To better understand why pizza delivery of heroin works and how it found its way into suburban and rural America, there are three related terms that are essential to understand:

- **Tolerance**
- **Dependency**
- **Addiction**

Tolerance refers to not getting as much bang for the buck. In medical terms, it is the body’s adapting to a drug which then necessitates consuming more of the drug to achieve the same effect.

Dependency refers to the state of having symptoms in the absence of the drug. Examples of withdrawal symptoms are the “shakes” after a heavy drinker stops drinking; or the chills, nausea, vomiting, abdominal cramping, etc. when a heroin addict is deprived of his/her next “fix”.

Addiction is the drug seeking behavior of an individual. However, a person who is dependent may not necessarily be addicted. Since the disease of addiction has bio-psycho-social...
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The mental health/substance abuse field is an extremely complicated one. There are an immense amount of professionals with all kinds of credentials and initials. And there are all kinds of levels of care provided for our loved ones. We thought it would be very informative to explore what all of those initials, letters, and levels of care really mean.

The very top of the mental health/substance abuse arena is the physician (medical doctor or osteopathic physician). These individuals have attended and completed medical school in addition to internships and residency. And the very top of the physicians in the mental health/substance abuse realm would be the psychiatrist. These individuals are physicians (having completed medical school) and specialize in treating disorders of the mind most often utilizing prescription medication. Although most any physician is permitted to write a prescription for most any medication, the psychiatrist is the expert. Of all psychiatrists, the board certified individuals are rigorously trained and further tested in order to establish their bona fides as a real authority in this arena.

Next down the ladder would be the psychologist. The psychologist has a doctorate (doctorate of philosophy, Ph.D., or doctorate in psychology, Psy.D.). These individuals are highly trained in assessment instruments (intelligence tests, personality tests, etc.) and therapy. In most states, these individuals complete an American Psychological Association (A.P.A.) doctoral program in addition to an A.P.A. internship. The difference between the Ph.D. and the Psy.D., is that the Ph.D.’s are trained in research design (the ability to plan and conduct research for publication) and the Psy.D. is often referred to as a “practitioner” degree with the individual not learning research design, but spending more time in clinics perfecting their therapeutic techniques.

Working with the physicians under the highly structured medical model are nurse practitioners, physician assistants and nurses. Nurse practitioners (A.R.N.P.) are nurses who have a license as a registered nurse, a bachelor’s degree, and have earned a master’s degree. They can diagnose, order laboratory tests, and write prescriptions. Physician assistants may be responsible for the general health of patients; meaning they care for the needs of the patient outside of psychiatric requirements. They may have bachelor or master’s degrees and are specialists in general health. Medically, nurses within mental health/substance abuse programs, whether they be Registered Nurses (R.N.) or Licensed Practical Nurses (L.P.N.), provide the bulk of the direct care required by patients. They will monitor medications and vital signs to assure the proper health of the patient on a day to day basis.

The next level of licensure encompasses individuals with master’s degrees who provide clinical care. These individuals are often identified as counselors, marriage and family therapists, and social workers. In addition to completing their education, they must also complete years of internship before they can even sit for their respective licensure examinations. These individuals often conduct groups and provide direct, one to one therapy.

Some confusion does occur with individuals who have acquired their master’s degrees (and the respective license) and then go on to earn a doctorate in a related field. Some of the fields may include counseling, counselor education, program assessment, education, and the like. They have earned a doctorate (Ph.D.) and at the same time have earned a license to practice therapy. They are indeed “doctors,” but are not psychologists.

However, as the field develops, other professionals are now part of the team. Addiction professionals are individuals that have acquired some level of education (both formal and informal), some amount of internship experience, in addition to eventually sitting for an exam (which may permit recognition on a state and/or national level). Behavioral Health Technicians (B.H.T.) are often the individuals that have direct control and responsibility for patients for the bulk of the day. In some locales, it is required they have some education (approximately forty hours) in addition to some work experience. These individuals often supervise patients as they move around the program property. They provide direct care and observation in residences. They truly spend the most time with patients and have a pivotal role in assisting patients to acquire and maintain their new found sobriety. Other professionals decide to become sober life coaches. These contracted individuals often shadow someone in new recovery in order to assist them in making the right decisions.

Now, to really solidify this information, we will briefly discuss the levels of treatment. The most basic level of care could be considered outpatient (O.P.). These services are often covered rather liberally by insurance providers and are often comprised of time with a licensed professional, usually a psychotherapist. Visits are two to three visits per week for more acute diagnoses and once stable, once per week.

A higher level of care from outpatient is intensive outpatient (I.O.P.) services. This usually encompasses approximately nine hours per week at an appropriately licensed facility. The bulk of the service at this level is often group therapy (three hours per week, three times per week). This level of service may be approved by the insurance provider for several weeks.

The next higher level of care from I.O.P. is partial hospitalization (P.H.P.) services. This level of care is still mostly often comprised of group therapy but may also include access to a psychiatrist. Hours included in this program include at least twenty-five hours per week often assigned as several hours per day Monday through Friday. (Some insurance carriers may require a more intense regimen up to thirty hours plus during that same week.) Insurance carriers often only allow this level of service for a week to ten days.

Beyond P.H.P., we usually enter the realm of inpatient services. This can range from inpatient facilities (which may utilize up to forty-five days of service) to inpatient detoxification (which usually encompasses approximately seven days of services). Most states also have statutes and regulations that permit an involuntary commitment for psychiatric evaluation. This service is provided within a locked unit and is often built upon a seventy-two hour commitment before more court involvement is required. The criterion for this very intense level of care is usually a credible threat to harm oneself or others. Law enforcement is often required to implement this level of care.

Obviously, this is a very brief oversight of both the professionals and the levels of care offered and there can be a wide continuum of services offered within your locale. Consult with both your insurance carrier and the professionals in your area for the absolute most accurate information.


Dr. J. De Gaglia is a licensed clinician, addictions professional, paramedic, and researcher. He is presently working with individuals struggling with addiction in the South Florida area.

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AN OPEN LETTER TO ALL AMERICANS: WE CANNOT PRESCRIBE OUR WAY OUT OF AMERICA’S OPIATE/OPIOID EPIDEMIC WITH SUBOXONE AND METHADONE

By Dr. Kenneth Blum and John Giordano DHL, MAC, CAP

Continued from page 8

• The CDC reports that there has not been an overall change in the amount of pain that Americans report in the same time frame. [10]
• Centers for Disease Control and Prevention (CDC): Many states report problems with for-profit, high-volume pain clinics (so-called “pill mills”) that prescribe large quantities of painkillers to people who don’t need them medically. [12]
• CDC: Overprescribing leads to more abuse and more overdose deaths. [10]
• CDC: The number of drug-poisoning deaths in 2013 was 43,982, the number of drug-poisoning deaths involving opioids (prescription painkillers) was 16,235 (45 people a day), and the number of drug-poisoning deaths involving heroin was 8,257 (23 people per day). 1,342 deaths involved both opioid analgesics and heroin. [13]

In summary, Americans, who have not reported any more pain in the 14 year period starting in 1999 and ending in 2013, were prescribed – by the doctors they trusted their health to – nearly 300% more prescription opiate/opioid painkillers in the same time period. Also in 2013, nearly twice as many people died from prescription opiate/opioid painkillers as compared to those who died from heroin overdoses. Moreover, studies clearly show a trend of addicts migrating from the opiate/opioid painkillers they started their addiction with, to the more accessible and less expensive heroin – a fact that in our opinion, clearly distinguishes prescription opiate/opioid painkillers as a gateway drug to heroin.

We cannot prescribe our way out of America’s Opiate/Opioid Epidemic

The kitchen sink is full. Water is gushing over the edges flooding the floor below. It would be simply incredible to believe we could resolve this plumbing issue by adding more water; and equally as fantastical to believe we can end America’s opiate/opioid epidemic by prescribing more opioids specifically methadone, buprenorphine, Subutex Suboxone and ZubSolv. It is our opinion, based on the mountains of unbiased empirical data, that all the policies related to addiction treatment will not end this epidemic if we don’t first shut off the tap. We believe that shipping away at key parts of the Harrison Narcotics Act of 1914 (HNA) – legislation resulting from Dr. Wrights efforts that played a significant role in ending America’s first opiate/opioid epidemic – as suggested by the drug/addiction treatment policy plans published by presidential candidates can have major negative consequences that simply cannot be ignored.

To be clear, we recognize the desperate situation we find ourselves currently in and accept that this opiate/opioid epidemic requires actions to bring it to its end that perhaps might seem counterintuitive under less precarious circumstances. However, we do not condone actions that satisfy the short term while ignoring the serious and unavoidable long-term consequences, no matter how well intended, as we strongly suspect can occur from what we’ve been able to glean about these proposed policy plans through media reporting. We also acknowledge that there are people who are experiencing chronic pain that require narcotics for relief. We also accept that some addictions are so extreme that narcotics are the only answer. It is our intention to make sure these people get all of the medications they need.

There are a few commonalities between the presidential candidates’ drug/addiction treatment policy proposals that we would like to comment on. Of the plans on record, presidential candidates are proposing federal financial assistance to states that provide a plan that meets certain criteria. We believe the criteria requires more detail and contains unintended consequences that are likely to minimize their desired effect. Below you’ll find the criteria with our observations and comments on how the standards can be upwardly adjusted so that the presidential candidates’ plans can meet the goal of ending America’s opiate/opioid epidemic.

Both presidential candidates’ drug/addiction treatment policy proposals include the expansion of medically assisted treatment (MAT)

From our experience and observations, MAT, in practice, is the use of FDA approved medications – most of which are opioids – for the treatment of opiate/opioid addiction. The two primary opioids used to treat opiate/opioid addiction are methadone and buprenorphine which is up to 50 times more potent than morphine. Subutex is a name brand buprenorphine. Suboxone is a name brand opioid that consists of 4 parts buprenorphine and one part naloxone, a pure opioid antagonist often used as an antidote for opiate and opioid overdoses. Zubolv, a dissolvable tablet which combines the drugs buprenorphine and naloxone and treats opioid dependency and addiction. It is our understanding through reports in the media that the published drug/addiction policy plans include a component allowing for greater availability and use of buprenorphine naloxone combinations (Suboxone/Zubsolv) in addiction treatment.

Buprenorphine (Subutex) is a partial agonist, meaning that it partially blocks the brain’s opioid receptors. They also block Dopamine receptors. They work by tricking the opioid receptor into thinking it has been satisfied with opioids without producing strong feelings of euphoria, the effects are long acting and they eliminate the withdrawals associated with addiction. They also have a ‘high’ or ‘buzz’ ceiling, a characteristic not shared with methadone. Buprenorphine (Subutex) is thought to be safer that methadone and distributed to patients by prescription while methadone can only be dispensed daily at a clinic with few exceptions. These narcotics are reported to be safe when used as directed; but isn’t that the point? Addicts don’t take opiates and/or opioids as directed.

All of the narcotics mentioned above that have FDA approval for use in opiate/opioid addiction treatment are habit forming, addictive just like any other opiate or opioid, potentially just as deadly and subject to the same abuse as any other prescription or illicit narcotic. Quoting from the manufacturer’s own website: SUBOXONE Sublingual Film can cause serious life-threatening breathing problems, overdose and death, SUBOXONE Sublingual Film can be abused in a manner similar to other opioids, legal or illicit. [14] ZUBSOLV contains an opioid that can cause physical dependence. ZUBSOLV can cause serious and life-threatening breathing problems. It can cause death or harm. [21]

A study lead by Drs. Edward Hill and Charles Moehs along with Dr. Blum and Mr. Giordano and others from MIT found that long-term Suboxone use lead to blunted emotional responses in its users. They had less self-awareness of being happy, sad, and anxious. In layman terms, over time Suboxone has a zombie like effect. They had less self-awareness of being happy, sad, and anxious. In layman terms, over time Suboxone has a zombie like effect on its users. The paper titled ‘Long Term Suboxone™ Emotional Reactivity as Measured by Automatic Detection in Speech’ was published July 9, 2013 in the peer-reviewed journal PLOS one. [15]

Deaths directly attributed To FDA Approved MAT opioids

In 2004, USA Today reported: Methadone was cited in nearly 13% of all the overdose deaths reported in the USA in 2004, up from about 4% five years earlier. [16] According to the Centers for Disease Control and Prevention (CDC) as reported by CBS News in 2012: Methadone to blame for one-third of U.S. painkiller deaths. CDC says – Methadone accounts for only 2 percent of painkiller prescriptions in the United States - but the drug is behind more than 30 percent of prescription painkiller overdose deaths. The report showed that deaths from the drug have been on the rise for years as more prescriptions have been filled. [17] According to the CDC, in 2012, there were 41,502 deaths due to drug poisoning (often

Continued on page 42
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Approximately 100 million people annually may experience difficulty with some aspect of sleep. Population studies have shown the magnitude of the negative impact of poor sleep on the nation. In fact, insomnia causes great economic, social, physical and psychological problems. This translates into billions of dollars lost in poor job performance, traffic accidents and ill health. Without sleep, health is lost.

There are gender differences in sleep habits. While women may complain more about sleep problems, several scientific studies imply that sleep in men is often of a lower quality than in women. So, just what is sleep? For the most part, the general public still regards sleep as a state of stupor or quiescence where inactivity prevails. But in reality, sleep is actually a state of wakefulness for the brain.

Sleep is a process of major activity within the body where the brain is involved in much turbulent activity. There are arousal mechanisms in the brain and it is the activation of these arousal mechanisms rather than the inhibition of brain functions that are involved in sleep. Sleep can be considered a form of modified consciousness. Stress, poor nutrition, excessive fatigue and environmental pollutants definitely impact the brain’s sleeping and waking mechanisms. There are many pharmaceutical agents that will help an individual to sleep but these same drugs carry disadvantages and limitations.

The pharmacological revolution of the 20th century has overshadowed the value of natural nutritional support for the promotion of healthy sleep. The popular prescription drugs presently available for sleep have short term benefits with long term disadvantages because the brain is not so easily fooled by a simple chemical that may focus on a relatively distinct and small number of tissue receptors. The premature or indiscriminate use of prescription drugs, or OTC drugs is not only unwise but potentially dangerous. Frequently, clinicians prescribe antipsychotic medications for sleep based on their side effect profile and often utilize medications “off label” to treat certain maladies. In 2013, however, the APA advised clinicians to carefully evaluate patients before prescribing antipsychotics to ensure they were clinically warranted.

The issue of achieving that elusive sleep seems to be a particular problem for those struggling with substance abuse. As we know, substance abuse is the exact antithesis of sleep; and the drugs of abuse interfere with the normal functions of the brain that control sleep. There is a pervasive push in the rehab culture to utilize various medications for sleep that have a sedation side effect profile. One such medication is Seroquel. This medication can cause movement disorders, chronic metabolic problems, and can be very difficult to discontinue once used for sleep. The bottom line is that the FDA has not approved the use of any antipsychotic for the first line treatment of major depressive disorder or insomnia, or any atypical antipsychotic for the first line treatment of anxiety disorders. And yet, we see a lot of this application in the addiction arena.

The CDC recently completed a study estimating how many adult ER visits were made each year in the U.S. because of adverse events from such medications as Haldo, Risperdal and Seroquel. Using data from all ER visits for 2009-2011 at 63 randomly selected U.S. hospitals, it was estimated that there were more than 20,000 visits to the ER for adverse events associated with these medications each year. It was noted that antipsychotics as a class caused 3 times more visits to the ER for adverse drug events than sedatives and anxiolytics, 4 times more visits than stimulants and 5 times more visits than antidepressants. Antipsychotic medications have great benefits for those with serious mental illness, however, they carry risks and sometimes potentially harmful side effects.

Melatonin is also frequently used in the addiction arena to recalibrate sleep in higher doses than is physiologically warranted. Melatonin is a hormone. Humans usually make 0.5-1 mg a day naturally. When melatonin is given in supraphysiological doses, it ultimately causes reduced serotonin. People on long term high dose melatonin become depressed. In addition, it can cause anxiety at high doses. When you alter one neurochemical, you are affecting another. They work in symphony and in balance.

It would seem that avoiding the use of these medications for sleep in favor of other options that are less likely to cause adverse events may be particularly appropriate when considering the treatment of insomnia and anxiety in those struggling with substance abuse issues. In my opinion, when we as clinicians put our patients who are already struggling with addiction issues on medications like Seroquel for sleep, we do a great disservice to them. Frequently, patients leave the rehabs on these type of medications and they are reluctant to “give them up” because they now can’t sleep without them. The inability to sleep and the related anxiety surrounding this particular issue, frequently fuel the relapse journey of the best intended. Thus, it may behoove us as clinicians to try a more benign approach to a patient’s sleep issue. These issues are usually multifactorial even when not complicated by addiction. For example, one of the main culprits could be elevated cortisol.

A discussion about sleep would be incomplete without talking about cortisol. Cortisol, released in response to stress, is mainly produced by the adrenal gland. A full examination of the role and function of cortisol is beyond the scope of this article; however, suffice it to say that elevated cortisol levels can impede sleep. You might ask, “Who has elevated cortisol levels?” Probably a majority of the population who are living beyond the scope of this article; however, suffice it to say that elevated cortisol levels can impede sleep. You might ask, “Who has elevated cortisol levels?” Probably a majority of the population who are living.

Magnesium is one such agent. It is a cofactor—a molecule that binds to and stimulates an enzyme—that is involved in the activation of over 300 enzymes in your body. It acts as a natural tranquilizer and can help induce sleep. It relaxes muscles, relaxes electrical impulses and facilitates calmness. The glycinate form is a highly absorbable magnesium chelate.

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“chronic relapser”. There are only people like all of us who are recurrently successful. Start by thinking about the periods of time (even if short) in which you did well. What strengths did you use every day for all of your issues to be successful? Write down all the things that you did right, and all the things you are doing right at the present moment. You will begin to realize how much you actually have to work with and will start feeling stronger. The next steps involve building your current strengths so that you do better in the future, rather than tearing yourself down.

4. Time: Progress occurs slowly for both types of issues, one day at a time.

The process of recovery for people who have multiple co-occurring conditions takes time. There is a tendency for people to seek a “program” that will address all their co-occurring issues in a few weeks or months. However, this is more often than not disappointing. While a program may be helpful in getting you started, many people get started without such an intervention. In either case, the “real” work is making small steps of progress for each issue over time. It is important to celebrate your actual progress “one day at a time” for each issue, rather than constantly being upset because you haven’t been “fixed” yet. There is a lot to learn, and no one can possibly learn it all at once.

5. Partnering for Progress: Identify a helpful team that will work with you on all your issues.

Now that you are in the right frame of mind for your recovery journey, you need to start pulling your team together to help you along the way. You need a team that can work with you as partners, help you with all your issues in small steps, and hang in there with you in a way that is empathic, hopeful, and strength based over time. Who should be included? Start with the most positive people you can find in your environment – family members and friends, as well as anyone you can find who has lived and experienced recovery (especially dual recovery) and who is willing to support you on your journey. Next, look for professionals who can help you as well. Find at least one counselor who is comfortable working with you as a partner to help you figure out how to manage ALL of your issues. Even though they may not be expert in all, they should be willing to work with you to seek the best possible input on each issue to guide your progress. I often recommend that people start not by committing to a program, but by finding the best local expert in the field of co-occurring addiction and mental illness and getting an excellent assessment along with recommendations for ongoing care. Recognize that using medication is appropriate to help your mental illness, but even when medicine works; it rarely works perfectly or instantly and still requires you to learn how to manage “normal” painful feelings, as well as ongoing symptoms of your illness. You need good partners to help you find the right approaches. Also, recognize that medications (anti-craving agents such as naltrexone or acamprosate, for example) are increasingly used as helpful interventions to support sobriety, along with other types of treatments and self-help recovery programs. Work with your teammates to explore all the available tools and decide which ones are best for you over time.

6. Integrated Recovery Planning: Develop your own personal “recovery plan” to guide your progress.

It is helpful to have some structure to organize your recovery journey. I recommend a template in which you begin by writing down your hopeful vision. List all of the issues (e.g. Substance use, mental health, health, relationships, job etc.) that affects your progress toward your vision and then identify all the strengths you have been using to do at least something right for each issue. Then you ask yourself, “What is the next baby step I need to take for each issue in the next month in order to make a little more progress?” Then for each issue, write down your “baby step” objective, the help you will need to learn how to take that step and how to recognize when you’ve actually accomplished it. This forms your integrated “plan” that will keep you focused over the next month or so.

The following principles guide the content of the plan and the work that you need to do.

7. Integrated Primary Treatment: All your issues are primary. The key to success is to take the best small next step for each issue at the same time.

Many people with co-occurring conditions get “stuck” trying to figure out which problem is “primary”. Am I drinking to cover up my depression? Am I depressed because of my drinking? What we have learned is very simple and important: it doesn’t matter how the problems got there…it only matters that they are there, they are persistent, and they need attention. Success is built on treating each issue as “primary” - that means that each issue (whether it is a “diagnosis” or a more tangible problem like “finding a job”) is important in its own right. It means that the best intervention for people with multiple issues is the best next small step for each issue at the same time. Find the small step that you can and will do for each issue. If it feels too overwhelming or confusing, take a smaller step!!!

8. Stage-matching: The correct intervention for each issue must be matched to your stage of change for that issue.

Most people are familiar with the concept of stages of change:

- Pre-Contemplation -Don’t bug me about that.
- Contemplation -I’m willing to think about whether to change but I don’t want to change.
- Preparation - I need to find a small step to start.
- Early Action - I’m taking some steps, but not following all the recommendations.
- Late Action - I’m working as hard as I can to be stable and successful, but I need help to be more consistent.
- Maintenance - I’m stable and trying to stay that way.

What you are probably less familiar with is the application of stages of change to people with multiple issues.

If someone asks you, “What stage of change are you in?” the correct answer is always “For which issue?” Stage of change is issue specific, not person specific. The best next step and outcome for each issue has to be stage matched.

So in your plan, write down which sentence best works for you for each issue, and then think about how to move a little bit forward in that stage. You may be “Late Action” for sobriety, in that you are trying all the recommendations you have been given, but you need to learn how to apply what you have learned more consistently, while you may be in “Early Action” for depression, where you are just realizing that you might need antidepressants, but are not sure it’s the right decision, so you agree to try medication just for a few weeks. You may be in “Pre-Contemplation” to quit smoking, where the challenge is to just make it easier for you to even think about smoking (Contemplation), by considering questions like: “What is the right amount of smoking for me right now?” and “How well is my current smoking plan working for me in helping me achieve my goals?” These are examples of stage matched interventions for each issue.

In your recovery plan, write your “stage of change” next to each issue, so you can be sure that your intervention and plan is “stage-matched”.

9. Skill Building: Progress comes through learning new skills. Learning requires practice, rehearsal and repetition in small steps with lots of support over time.

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HEROIN EPIDEMIC IN AMERICA
By Steven Kassels, M.D.

Continued from page 32

In order to become more profitable with a surplus of product, heroin distribution expanded its market and started finding its way to suburbs and rural areas. Also, because the purity of heroin has increased as much as 60%, it is not necessary to inject (“shoot up”) the drug. Snorting heroin can now give the same “rush” that in the past was only possible by using needles. No needles has resulted in more people willing to try it, contributing to the heroin epidemic and its wide spread use.

There are so many misperceptions that encourage the inappropriate classification of some drug addictions as “bad” (heroin or cocaine) and some as “tolerable” (alcohol or nicotine). In actuality, there are no “good” drug addictions. In order to demystify and destigmatize addiction, we must educate our neighbors, our politicians and our family members and we must find “novel” approaches to reach them. That is why I wrote Addiction on Trial and why I hope you will help to spread the word that the disease of addiction, like diabetes and other chronic illnesses, may not have a cure but can be put into remission, allowing many to live productive lives.

Dr. Kassels has been Board Certified in both Addiction Medicine and Emergency Medicine. He serves as the Medical Director of Community Substance Abuse Centers. He is the author of “Addiction on Trial”, written as a murder mystery/legal thriller to reach and educate a wide range of readers. The book is available at: Amazon www.amazon.com/Addiction-Trial-Tragedy-Downeast-Maine/dp/1491825316 and free author book club presentations and educational meetings (in person or using Skype) can be arranged at: www.addictionontrial.com/author-events/.

THAT ELUSIVE SLEEP
By Teresa Boland, ARNP, LMFT, PhD, ABD, FAARM

Continued from page 32

inhibition responsible for REM sleep atonia and a decreased core body temperature associated with sleep. In another study, glycine enhanced sleep quality, sleep onset time and day time alertness. There are a number of herbal and amino acid proprietary blends that are useful in managing cortisol levels and facilitating sleep as well. In a recent study, Sensoril, ashwagandha extract, promoted relaxation and maintained healthy cortisol levels and C reactive protein levels. Maintaining a proper vitamin D level supports normal cortisol production and phosphatidylserine is also known to blunt cortisol.

So when you are wired and tired, you might find adaptogens to be useful. Inositol is yet another agent that when compounded at high doses (9-12 gm) calms mind chatter and minimizes the number of sheep you count till sleep. This listing is certainly not exhaustive. It is vitally important to speak with a qualified, trained clinician to explore these and other options.

Teresa Boland is a Fellow of the American Academy of Anti-Aging/Regenerative Medicine. She is a Psychiatric Advanced Registered Nurse Practitioner and a Licensed Marriage and Family Therapist. In addition she holds a certificate in Sports Nutrition as well as a Diploma for Dietary Supplement Counselor (Dip. DSC). Teresa is certified in Critical Incident Stress Debriefing, in Clinical Hypnotherapy and as a Trauma and Loss Specialist and Consultant. She is presently completing Certification in Addiction Medicine.

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Early in 2013, the Florida Association of Recovery Residences (FARR) raised the alarm regarding certain unethical and potentially illegal practices resulting from an absence of oversight of licensed behavioral healthcare providers. One impact of these practices was to pollute the recovery housing pool, attracting unethical operators to a space that had previously been occupied exclusively by persons, themselves in long term recovery, who were legitimately motivated to help those entering recovery. This predecessor group had earned a solid national reputation, developed over decades of quality service, as providers of safe, clean, alcohol and drug free, recovery-oriented housing. Up until 2010, drug urinalysis screening, while conducted by recovery-oriented housing providers as a condition of residency, had never been treated as a “revenue center”. Drug testing had always been absorbed as cost of business. Typically, sober home operators tested randomly and “for cause” by utilizing multi-panel point of care tests (POCT) that provided reliable results for multiple drug classifications. When a POCT produced a positive result for a particular drug classification and the resident adamantly denied having used drugs, then the provider would forward the sample to an independent laboratory for qualitative confirmation. Qualitative testing by sober homes was a rare event, even for 200 bed operators prior to 2010.

In 2010; an enterprising businessman in the real estate investment sector discovered a little known pathway provided under the Clinical Laboratory Improvement Amendment (CLIA) protocol that permitted unlicensed sober home operators to apply for a CLIA Waiver. This waiver allowed operators of sober homes to submit claims to healthcare insurers for reimbursement as the “collection site”. The CLIA waiver established a legitimate opportunity for sober homes to generate revenue above and beyond rent. Early on, this practice held great promise. Ethical operators viewed this additional revenue as a means to fund enhancements to properties, hire trained staff and improve upon services offered. Regrettably, the attraction of insurance reimbursement for drug urinalysis opened the flood gate of opportunists who rushed into the space. These opportunistic, poorly trained individuals, with little or no experience, and motivated chiefly by the promise of instant wealth, flocked to the SUT and Recovery Support Services sectors in great numbers. The CLIA waiver approach has since morphed through numerous iterations as payers were forced to decline all claims originating from housing providers, requiring drug screening tests to be ordered by a physician as being medically necessary. This payer response led to an explosion in Intensive Outpatient (IOP) license applications that continue to overwhelm the Department of Children and Families (DCF) Substance Abuse (SA) licensure staff. So called “sober homes” then popped up in communities throughout South Florida to provide housing for consumers enrolled in these licensed outpatient programs. Subsequently, the “Gold Rush” has resulted in a dramatic rise in patient brokering and insurance fraud; now considered by many to be systemic throughout the space from Dade to Indian River Counties.

The State Law Enforcement Agency (SLEA) commenced an investigation in South Florida in 2013. FARR has channeled documented evidence of patient brokering and insurance fraud to this law enforcement agency steadily since their arrival. This relationship has contributed to high-profile FBI raids on DCF Licensed Behavior Healthcare providers who also operated complimentary housing (sober homes) for clients enrolled in their clinical platforms. It is our understanding that federal indictments will soon be announced alleging criminal activities perpetrated by a gallery of co-conspirators including healthcare providers, sober homes, confirmatory laboratories, billing companies and marketers. We further understand that the investigation has opened hundreds of files of over the last several years and that these initial indictments will likely be followed by yet others.

FARR’s chief mission is to protect the consumer of recovery support services in Florida. While we are grateful for the diligent work of this investigation and certainly applaud the commitment of resources the State of Florida and Federal Agencies have invested to date, we are concerned that soon after the initial fervor surrounding upcoming indictments has subsided, it will be back to business as usual. This frightens us for many reasons, not the least of which is the fact that providers are shooting themselves in the foot. South Florida’s national reputation couldn’t be any lower. Surely these indictments will be an opportunity for those addicted to the promise of quick riches to seek change. Wouldn’t it be exciting if we refocused on services that promote wellness rather than instant wealth? The opportunity is now and the need is great for all stakeholders, including those who have most contributed to the problem.
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the issues that you struggle with. Often, you will recognize that these recommendations are helpful and you may be pretty good at repeating what you have been told: “Don’t drink. Go to meetings. Ask for help” “Take your medication as prescribed” However, even though the recommendations may seem deceptively simple, the real challenge for people with co-occurring conditions is to learn a whole new set of skills for managing multiple conditions. I call this “Learning the skills you need to succeed.”

Learning occurs through practice, and usually the practice has to occur for you with a lot of attention to detail and a willingness to work with your team of partners to support your continued learning and practice. Be aware that nothing you have to learn is all that simple…. so give yourself a break, and be willing to learn in small steps.

One set of skills are called “Self-management skills” – Things you do on your own to help yourself deal with a particular challenge. For example, if you are supposed to take medication regularly, how do you organize yourself to do that, knowing that no one is perfect at taking medication? Or, if you are supposed to “not drink”, what skills do you use to refuse offers of alcohol or drugs from other people? How do you practice and improve any set of skills- through trial and error, in small steps over time.

For each issue that you are taking action on in your recovery plan, think about how your “action step” can identify one or two new skills or behaviors, and then practice them in various situations over the next period of time.

10. Accelerating Assistance: The better you get at asking for help sooner rather than later, the faster you will make progress.

For managing each issue you face, there are skills you will learn relatively easily, and others in which you will need help to make progress. It is important to remember that asking for help is a skill, and there is no easy way to master that skill effectively for multiple conditions. When managing multiple conditions, you need to learn to ask for help in many ways. First, you have to learn to ask for help for each issue you face. Second, for each of those issues, you are likely to need to learn to ask for help from professionals (including prescribers), friends, family, and peers (as in 12 step programs).

As part of your recovery plan, think about where you are very good at asking for help already, and then identify next “baby steps” to practice new learning. Common examples include:

- Developing a great partnership with your prescriber to work on identifying over time the right medication for you, with the fewest side effects: How do you learn to really share what is going on and ask for what you need?
- Asking for help with each issue when you are in trouble: How do you practice calling and asking for help and support when you have cravings? How quickly can you tell someone if you “pick up” and get help to stop?
- Asking for help to manage uncomfortable feelings or MH symptoms: How easily can you share with counselors, family, or peers (or sponsor) when you are having a hard time with MH symptoms, to get support through the day?
- Finding a support system that is “co-occurring friendly”: How do you develop a core support system of people who are comfortable with your having both issues? How can you find Dual Recovery meetings – or “co-occurring friendly meetings” - in your community?

11. Rounds of Applause: Reward is the best way to support ongoing change.

The journey of recovery can be painfully slow and frustrating. It will be easy for you to expect more of yourself than you can possibly achieve all at once. Remember, even though you may have a long way to go, you are still making progress. Be sure to encourage each tiny baby step of progress by giving yourself a big round of applause.

If you have ever taken a course in psychology, you were taught that “reward is a more effective way to support learning than punishment.” Yet, even though we know this, we tend to try to punish ourselves into success…which often pushes us backwards. The framework of “positive contingent learning” is a “best practice” for people with multiple serious challenges. In fact, it is one of the core elements of 12 Step recovery programs – you get a round of applause from a room full of people for being sober just one day.

Think about applying that approach to every area of progress - you figured out how to take your medication a bit more consistently - round of applause. You asked your prescriber a tough question about why the medications doesn’t seem to work well – round of applause. You asked someone for help for the first time when you were having cravings – BIG round of applause.

12. Continuing the Journey: Maintaining forward progress when you run into a wall.

You have a lot of opportunity to work your way down the list, starting with welcoming and hope, identifying your strengths, engaging your partners, and putting together a recovery plan. You have made some progress and you have worked pretty hard, but suddenly you find yourself slipping backwards. Maybe you relapse on drugs or alcohol or your medication for mental illness isn’t working as well. You get really frustrated because you feel like you have not made as much progress as you wish. Your goals seem a long way off and impossible. You encounter a loss or disappointment. What do you do?

When you get discouraged, it is tempting to abandon the principles and try to find a short cut or quick fix to pull you out of the doldrums, but generally that’s not going to get you where you need to go. The key recommendation is this:

When you feel that the principles aren’t working, it’s time to go back and apply those principles even more vigorously.

- Go back and welcome yourself for being such an amazing person.
- Put your hopeful vision in front of your eyes.
- Think about all the amazing strengths you have been using to make progress for each and every issue.
- Recognize that progress occurs slowly, and focus on smaller and easier steps.
- Think about your partners and how important they are to helping you.
- Review and update your recovery plan.
- Find an easy small step for each issue that is strength-based, stage-matched, and involves learning a new skill for either self-management or asking for help.
- Give yourself a big round of applause for taking those next steps.
- Keep on going.

You are an amazing human being who is making enormous progress in the face of multiple challenges. You deserve to be happy and to get all the help you need to achieve your goal of a beautiful and meaningful life. You are a miracle.

Kenneth Minkoff, M.D. is a board-certified psychiatrist and is currently a clinical assistant professor of Psychiatry at Harvard Medical School. He is a senior systems consultant for ZiaPartners in San Rafael, CA. Kenneth is recognized as one of the nation’s leading experts on recovery oriented integrated services for individuals and families with co-occurring mental health, substance use, and health conditions, plus other complex needs, and has published dozens of articles in this field. Along with his partner, Christie A. Cline, MD, MBA, Dr. Minkoff has developed a framework for integrated systems and services development, and a toolkit to help programs and clinicians to make progress. Dr. Minkoff and Dr. Cline have provided integrated system consultation in over 40 states, 7 Canadian provinces, and 4 states in Australia.
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referred to as drug-overdose deaths) in the United States, of which 16,007 involved opioids and 5,925 involved heroin. [18]

The numbers provided by the CDC indicate that in 2012; 5282 people died from an accidental overdose of methadone, while 5,925 died from heroin, a difference of 643 people. Yet in spite of the empirical data that clearly shows a pattern of increases deaths directly attributed to methadone and the slim margin between methadone deaths and heroin deaths – deaths we were told methadone would prevent – the FDA approved MAT narcotic is still prescribed, widely available and considered safe by the FDA and advocates for treating opiate/opioid addicts with opiates/opioids.

Deaths attributed to Buprenorphine/Subutex/Suboxone/Zubsolv are harder to track. According to a New York Time report in 2013: the Centers for Disease Control and Prevention does not track buprenorphine deaths, most medical examiners do not routinely test for it, and neither do most emergency rooms, prisons, jails and drug courts. The addiction drug was a “primary suspect” in 420 deaths in the United States reported to the Food and Drug Administration since it reached the market in 2003, according to a Times analysis of federal data. [19]

**Two lives gone another ruined.**

Courtney Howell, a 27 year old, was sentenced to 30 years in prison on 08/26/2015 after pleading guilty to manslaughter and exposing a child to a controlled substance, both felonies. Howell, who had a prescription for FDA approved methadone, put the narcotic in her 17-month-old daughter’s bottle so that she would fall asleep. Howell was offered little sympathy from most of her family who said she knows how powerful methadone is. The baby’s father died of an accidental methadone overdose a few months before the baby was born. [20]

These are just a mere few of the thousands of heartbreaking stories of how FDA approved MAT opioids are tearing apart the moral and social fabric of America. Just because an addict is in a MAT program doesn’t mean that they have stopped abusing opiates, opioids and/or other dangerous drugs. We encourage you to search online and see for yourself just how vast and devastating America's opiate/opioid epidemic has become.

Also please see: Systematic evaluation of “compliance” to prescribed treatment medications and “abstinence” from psychoactive drug abuse in chemical dependence programs: data from the comprehensive analysis of reported drugs.


In America's first MAT program, albeit it wasn’t called that in the late 1800’s and early 1900’s, doctors prescribed heroin – promoted by it’s German manufacturer, Bayer, as a “cure for opium and morphine addictions” [1] – to opiate and opioid addicts from their office. And we all know how that turned out. We’ve learned through our own history that adding more opiates/opioids into an already over-served market with lax oversight mechanisms in place through the convenience of a doctor’s prescription – no matter how well intended – only adds more Americans to rolls of addiction with, in our opinion, the potential to extend America’s second opiate/opioid epidemic into perpetuity.

Dr Hamilton Wright's efforts in the early 1900’s lead to the Harrison Narcotics Act of 1914 that proved to be an integral part in bringing America's first opiate/opioid epidemic to a close by restricting the flow of opiates/opioids. We agree with the Centers for Disease Control and Prevention (CDC) findings that overprescribing leads to more abuse and more overdose deaths. [10] We believe that the path charted by Dr. Wrights is the correct course to end America's second opiate/opioid epidemic.

While we agree that in the short term MAT (possibly from detoxification to less than 12 months) especially methadone or Buprenorphine/naloxone (Suboxone/Zubsolv) may have important benefits in terms of preventing unwanted opiate/opioid withdrawal. Moreover, these potent narcotics can induce patient stability ultimately leading to reinstatement of a patient to enter into the work force again and become a so called “productive member of society,” Understanding the real facts and the neuropharmacology of MAT and the mechanism of action involving dopamine function whereby their blocking action of dopamine provides a certain degree of abuse prevention due to “psychological extinction” [why use if the thrill is gone], is in our opinion an inflated and not cost effective way to combat America’s second opiate/opioid epidemic. This will be covered in greater detail in next month’s issue of Sober World in our second installment of: An Open Letter to All Politicians Developing a Drug/Addiction Treatment Policy.

Deleon’s Film –The American Epidemic

Smith’s Film – American Addict

References:

The real cost in starting a High Complexity LC-MS lab is the opportunity cost if you don’t do it right.
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Addiction affects the whole family.

Our treatment programs offer a small, gender specific setting that encourages individuals and families to focus on core characteristics for recovery.

Men’s Addiction Treatment Center • Women’s Addiction Treatment Center
Sylvia Brafman Mental Health Center

To learn more about our residential and outpatient programs, please call 866-756-HOPE or visit www.destinationhope.net