SIBLINGS
By Louise Stanger Ed.D, LCSW, CIP, CDWF-Candidate & Roger Porter

When Denial Becomes an Affliction: It's OK to Talk about Mental Illness
By Elaine R. Rotenberg, Ph.D.

Marijuana: Heaven or Hell?
By Kenneth Blum, Ph.D.
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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. 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.


Sincerely,
Patricia
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As parents, when we think of substance abuse and mental health issues, we usually think first about the child who is abusing and causing havoc. Rarely do we turn our attention to his or her siblings and the impact the negative behavior has on other family members. This complex sibling relationship and the way parents respond and teach their children are issues that often perplex and baffle us.

We know from research that sibling relationships are complex, multidimensional and often contingent on their relationships with their parents and other caregivers. When siblings band together, they are a force to be reckoned with. The flipside is they can also cause fractured relationships as the Old Testament tale of envious brothers Cain and Abel illustrates.

Older siblings may be heroes by teaching younger siblings how to ride a bike, do math, and make friends. They can also be villains and vixens by fighting with siblings, lying to parents, and exposing their siblings to sex, drugs, alcohol and more. As such, we can’t escape the kinetic pull of a sibling’s life. Brothers and sisters take the good with the bad in familial bonds because through it all, they are the ones who know each other best. If siblings are a snapshot of our identity, then better understand family dynamics. In families that are experiencing a sibling with a substance abuse or mental health problem, the whole family feels the effects of the lone member’s struggle.

Parents often focus their attention around the troubled child, making the other children in the family feel left out. It is important to understand how the family roles may shift. In 1976, Sharon Wegscheider-Cruse adapted the works of Virginia Satir and Claudia Black into a schema titled The Family Trap. The work explains how families unconsciously take on survival roles, which allow them to maintain equilibrium and function with the least amount of discomfort. The pioneering efforts of Wegscheider-Cruse, Satir and Black comprise much of the language we use today when clinicians and health experts look at family dynamics, including the roles of “chief enabler”, “family hero”, “lost child”, “scapegoat” and “mascot. These same behaviors, ways of looking at and reacting to the world may be passed down from one generation to another.

In the recent Time Magazine investigation of siblings, author Jeffrey Kluger reveals that “between the two - parents and siblings - the siblings’ role is often the more influential one.” Why? Because sibling relationships are forged in the trenches together, they know each other’s defenses and denials. “They’re good at the subtler business of gently picking one another’s locks, feeling how the emotional tumblers fall, and opening a sibling up in a way no professional, or even parent, ever could.” So it’s no mistake that clinicians and health professionals study these relationships to aid in the healing process when a family member is experiencing a substance abuse or mental health problem. Think of siblings as the key to unlocking the safe.

A look at sibling relationships shows that negative influences start at a young age and can accelerate quickly. Although there are other factors at play, family dynamics always play a key role. The National Longitudinal Survey of Youth looked at over 11,000 adolescents aged 14 to 22 on the impact smoking cigarettes has on younger or older siblings. “Forty percent of kids whose older sibs smoke take up the habit themselves, compared with 10% of those with nonsmoking sibs.” And the study also found evidence that shows individuals who see their siblings smoke start at a younger age. Finally, the results aren’t limited to older to younger siblings. Evidence also shows the influence freely flows from younger to older siblings and bleeds into drug use, truancy, delinquency and teen pregnancy.

The good news is that the same radical influence an older or younger sibling has on their fellow kind can flow in positive ways. “If it’s true that siblings can steer one another into danger, it’s also true that they can steer one another out of it, playing a role that’s not corrupting or destabilizing but healthy, therapeutic and even wise.” And it’s not just a passive influence - many siblings take on a proactive role to steer siblings away from the harmful effects of alcohol and drug use. In academic studies of older siblings influence on younger siblings, the research shows that “when the sibs do take such initiative, they can do a remarkable amount of good.”

If such a push and a pull exists in a sibling relationship, then it’s important to get the help needed in situations where substance abuse and mental health issues are in play. Sibling relationships, tightly coiled around shared experiences, can make it difficult to say something when a sibling struggles with addiction. The remaining siblings can feel left out and wonder why so much parental attention is being given to the sibling with the addiction issue. This can cause resentment towards the brother or sister with the issue. Therefore, it is important for parents to be aware and address these issues when they come about. Parents must learn about addiction and mental health. They can communicate this knowledge to their children and acknowledge that they have been preoccupied with trying to help the brother or sister with the issue and in doing so have not been as available as they would have liked. Parents need to let their other children know they love them and are proud of them. Here are some ways parents might communicate:

1. Pick a convenient and comfortable time to talk either individually or as a group.
2. Make sure conversations are held in a quiet space with no digital distractions.
3. If it’s a two-parent family, it’s best that both parents talk with the children together. If there is a large age gap between siblings, then talk one-on-one.
4. Make sure that you indicate that the conversation is not secretive. Everyone in the family needs to be on the same page. You want to avoid pitting one sibling against another and make it clear that addiction is a disease that affects the whole family.
5. Ask your children what they have observed about their brother or sister but understand that as siblings, they may be hesitant to share.
6. Ask what their concerns are for the sibling with the addiction.
7. Talk to them about substance abuse and mental health disorders in ways that are age appropriate.
8. Open up the conversation to the whole family, allowing questions, concerns, or even ways they think might help their brother or sister.
9. Make sure that you are not asking them to tattle or tell secrets. If your child comes to you first with news of strange or bad behavior about a sibling, acknowledge their concern and assure them you are addressing the issue.
10. If the house is loud and disruptive because of the fighting and antics, let them know they are not at fault.
11. When siblings bring home good report cards or excel in sports make time to pay attention to them.
12. If your child seems forlorn, make time to talk to them to see what’s bothering them or what’s on their minds.
13. If your children are teenagers, Alateen may be an option.
14. Private Counseling with someone who is skilled in family systems, substance abuse, and mental health is always appropriate.
15. As parents, it is best to try and keep a united front with your family. Sibling splitting or having one child try to curry favor with the addicted sibling can be hazardous toward a joint effort in finding your loved one a path to recovery.”

Continued on page 40
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Our veterans are special in many ways. They have made contributions to our safety and freedom in ways that are impossible to calculate or appreciate. Exposure to the trauma of mayhem and combat creates severe problems because even the best of training cannot prepare mortals for the hell of battle. Combat veterans suffer disproportionately with regard to post-traumatic stress disorder (PTSD) and substance use disorders (SUDs). Although PTSD has been known by various names over the ages, such as “battle fatigue” and “soldier’s heart,” the psychological trauma is the same.

The incidence of SUD in veterans with PTSD is over 20 % which is twice what one would expect to see in the general population. Veterans with PTSD and SUDs tend to be binge drinkers if using alcohol. This is thought to represent the need to self-medicate because of the intensity of the symptoms at any given time. Binge drinking causes its own set of problems with increased problems to the liver and brain.

Opiate use disorder is seen especially in veterans who had suffered wounds or injuries of various types and then had surgeries or were for whatever reason placed on opiate therapy. Many veterans are placed on chronic opiate therapy (COT) because of the severity of their pain and injuries. This increases the chances of addiction because of the increased exposure.

Veterans with PTSD smoke more than age-matched control subjects. Cigarette smoking kills more individuals with addiction than any other substance. Smoking cessation is something that can be minimized in the face of other addictions, but it needs to be addressed with the same intensity as other addiction problems.

What is behind this phenomenon of co-occurring substance use disorder and PTSD? There are a number of factors involved. In this article, I plan to outline what I believe to be the most important issues from both the neurobiological side to the psychological aspects.

From the neurobiological side, addiction has a genetic as well as an environmental side. Not everyone has the genetic makeup for addiction, so some individuals are spared the problems of addiction simply by having the right parents. There are certain changes in the brain that have to take place to develop a substance use disorder. There is a dysregulation of dopamine in the brain’s pleasure center in a part of the brain called the limbic system, which, when triggered, causes the compulsive use of a substance. Use of addictive substances, coupled with the genetic predisposition, causes permanent changes in this part of the brain, setting up the addictive process. When a veteran with PTSD exposes himself or herself to addictive substances, the chances of developing a SUD increases dramatically.

Couple this with trauma. Another part of that same part of the brain that is responsible for addiction is directly connected to the area of the brain called the amygdala, which is the part of the brain that reacts to trauma. In animal models, if the animal is subjected to trauma and the animal’s amygdala is subsequently examined with neuroimaging techniques, that area of the brain will enlarge permanently. The amygdala is sensitized to sights, sounds and smells which bring previous experiences to the forefront of the individual’s consciousness.

In the case of the combat veteran, flashbacks, re-traumatization, or other triggers not only spark a “flight or fight” response, but it also contributes to further dysregulation of that part of the brain that is connected to the dopamine/pleasure/addiction center of the brain contributing to relapse behaviors. The affected individual is merely trying to relieve the stress, but what has occurred is a pathological way of reacting to the stress with alcohol or drugs.

From a psychological standpoint, PTSD is a breakdown of normal defense mechanisms creating chronic stress. This leaves the individual living with PTSD in a state of hypervigilance, anxiety and fatigue. Sleep comes with difficulty. Intrusive emotions interfere with day-to-day life.

Treating PTSD and SUD requires a parallel approach to handle both issues at the same time. The substance use requires detoxification and involvement in recovery programs for rehabilitation. The PTSD requires moving toward a paradoxical position psychologically. It is important for the veteran to get in touch with the feelings of fear and anxiety rather than suppress the emotions. It is the suppression of feelings that prolong and intensify the symptoms of flight and fight. This is called exposure therapy. It is giving the veteran the ability to accept the troubling emotions that drive the engine of tension. Sometimes, but not always, medications are needed to calm the brain enough to be able to engage in treatment. Such medications must be non-addictive. Unfortunately, not all practitioners providing care to veterans are aware of the addictive properties associated with certain medications, such as benzodiazepines, used for the treatment of anxiety, and the treatment can worsen the problem.

The overarching principle of treatment is to allow the veteran to understand his/her self-worth. With self-validation comes the ability to sit with uncomfortable feelings. With the ability to sit with the feelings, the veteran can then move toward his/her values and lead a meaningful life. Continued support in a supportive community is essential for ongoing stability and quality of life for the affected veteran.

The treatment of PTSD and SUDs is not only possible but essential for the survival and well-being of our veterans. They deserve the best possible care we can provide for them. The ability to do so is within our grasp. We need to be there for them as they were there for us.

Joseph Troncale, MD is Retreat’s Medical Director. Over the past 35 years Dr. Troncale has established himself as one of the premier physicians working in the field of addiction. He is both a fellow and a member of the American Society of Addiction Medicine (ASAM) and was named Outstanding Clinician by Addiction Magazine in 2010. He has publications in journals such as The Journal of Addictive Diseases and other peer-reviewed journals.
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WHEN DENIAL BECOMES AN AFFLICTION: IT’S OK TO TALK ABOUT MENTAL ILLNESS

By Elaine R. Rotenberg, Ph.D.

For years, addiction and mental illness were not talked about in the same sentence. They were not considered part of the same family. They were not even treated as distant relatives. The fact is, that in the not too distant past, if someone called a mental health clinic for help, stating that they had depression and anxiety, and also a substance issue, they were often told to “get treatment for their substance issue first, including several months of documented sobriety, and then call back for help with the underlying mental health issue.” Unfortunately, that approach really missed the mark. For in fact, mental illness and substance use disorders often go hand and hand. Further, what they share is the profound veil of denial that accompanies both.

When I think about denial and mental illness, I am reminded of the now often familiar “casserole story.”

It’s the story of two mothers…..each mother running day in and day out to visit her child in the hospital. One child was in the hospital recovering from a serious suicide attempt; the other child was in the hospital recovering from injuries sustained in a near-fatal car accident. The difference between those two mothers can be summed up in one word -- CASSEROLE.

For the mother whose child was in the car accident, there were casseroles and meals, candy and flowers delivered every day.

For the mother whose child was recovering from a serious suicide attempt, there was nothing. No one even knew that that child was in the hospital. No one knew why he had missed school all week. No one knew that that child had a mental illness.

As a society we don’t like to talk about mental illness. We would rather talk about a loved one with cancer, diabetes, or heart disease than talk about bipolar disorder, clinical depression, schizophrenia, or any other mental illness.

Maybe it’s the word “mental?” Maybe its shame, or a belief that this illness is our fault.

Whenever I have the opportunity to discuss Substance Use Disorders, I find myself eager to shine a light on the prevalence of mental illness in our society. Why?

Because regardless of our discomfort and “dis- ease,” with mental illness, there is no avoiding the fact that people with mental illness are more likely to experience an alcohol or other substance use disorder than someone not affected by a mental illness.

The numbers speak for themselves: One quarter adults will experience a mental illness. Of those, 18% have a substance use disorder, compared to 6% who have no mental illness.

And it works the other way too….Among the 20 million adults in the United States who experience a substance use disorder, 50% will have a co-occurring mental illness.

Not talking about mental illness doesn’t make it go away. Not talking about it simply means that people will not get an appropriate diagnosis, and will not be directed to appropriate treatment.

BUT – even if people do not seek treatment, people will still suffer with the symptoms of their untreated illness, and will look for ways to cope. Oftentimes, these individuals will turn to drugs and alcohol to ease the pain of anxiety, depression, or to dull the voices that just won’t go away. And then the cycle has begun, and which comes first does not matter. What matters is the inextricable link between substance use and mental illness.

Unfortunately, so often denial is much easier for communities than addressing the issue of mental illness directly.

Why is that?

• Maybe it’s because by looking away, we can avoid taking responsibility for the lack of affordable services in our communities.

• Maybe it’s because by looking away, we can avoid facing the pain of mental illness that has impacted our own family, and our neighbors.

• Maybe it’s because by looking away, we can continue to pretend that mental illness is someone else’s problem.

By continuing to deny, we continue to perpetuate myths about mental illness. A few examples:

Myth #1: People with mental illness are responsible for most violent crimes in our society

IS THIS TRUE? NO! The fact is - People with mental illness are 10 times more likely to be the victim of a crime than the perpetrator of a crime.

Myth #2: Talking to someone about suicide will increase the likelihood that they will make a suicide attempt.

IS THIS TRUE? NO! The fact is - Talking to someone about suicide can save a life.

Myth #3: Mental illness does not occur in children.

IS THIS TRUE? NO! The fact is - More than 50% of adult mental illness can be diagnosed before age 14. Unfortunately, less than one third of those children ever receive appropriate treatment.

Maybe a first step toward busting myths like these is teaching ordinary citizens, through initiatives like Mental Health First Aid (MHFA) that turning toward not running away from someone struggling with a mental illness or a substance use disorder, can save lives. Mental Health First Aid is an evidence-based educational program that has been taught in the United States since 2008; teaching people how to recognize a potential mental health or substance crisis. Mental Health First Aid teaches a 5 step plan for how to approach someone who is suffering, and explains how to direct that person to appropriate help.

In Palm Beach County, Florida, Alpert Jewish Family and Children’s Service has spearheaded a county-wide coalition of 26 nationally certified instructors, representing 10 local agencies and the school district, who have already trained more than 1200 citizens. Efforts like these will be what it takes to blanket our country with awareness.

Mental illness is an illness, a treatable illness. So, who are the real afflicted? Those who are diagnosed? I think not. That label belongs to individuals and communities that deny, shun, and stigmatize mental illness in the first place, too often shaming individuals from seeking the treatment and support that they so desperately need.

Remember the boy whose mother didn’t receive a casserole? Perhaps had someone recognize his symptoms of anxiety and depression, he never would have wound up in that hospital bed in the first place.

Imagine how much better the lives of the boy, his mother, and our communities might be if we replace our denial of mental illness with affirmation and treatment.

Dr. Elaine Rotenberg has been the Clinical Director of the Alpert Jewish Family & Children’s Service and the Levine Jewish Residential & Family Service for the past 24 years. She is a licensed clinical psychologist, having received her BA degree in psychology and education from Brandeis University and both her Masters and Doctoral degrees in psychology from the University of Denver. Dr. Rotenberg completed her predoctoral fellowship in the psychiatry department of Yale University.
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In Florida, the Marchman Act is a very effective tool to get the necessary help for those whose loved ones are abusing substances. Unfortunately, it has historically been underutilized by families and treatment professionals. More recently, however, many families who fear for their loved ones’ safety are turning more and more to the Marchman Act as a means of securing the substance abuser’s admission into treatment. The existence of a court order requiring the individual’s residency in a treatment center is compelling and persuasive evidence to the substance abuser that he or she is at, or quickly approaching, the end of the road of their active abuse of substances. If the court order for treatment is violated, it will result in the incarceration of the individual. Hopefully, this will compel them to be compliant with the court order.

The first step in triggering the Marchman Act is to request that the court order an assessment of the substance abuser and to stabilize the individual. This is done by filing a petition with the court in the county where the substance abuser is located. The substance abuser does not have to be a resident of Florida. It is enough that the individual is living, even temporarily, in the state. Moreover, the family need not be Florida residents either. Many of our clients are out of state families who are able to suggest to their loved one that they visit Florida under the suggestion that they investigate treatment centers or just to enjoy our beaches and weather. Once the individual is in Florida for whatever reason, the family or friend can file the Marchman Act papers and the Court can enter an order.

It is not difficult to obtain such an assessment order. There has to be a “good faith” reason to believe that the person is substance abuse impaired or has a co-occurring mental health disorder and because of the impairment or disorder:

1- The person lost the power of self-control with respect to substance abuse; and

2- a.) The person needs substance abuse services because his judgment has been so impaired that he is incapable of appreciating his need for such services and of making a rational decision about services; or

b.) Without help, will the person likely suffer from neglect or refusal to care for himself which poses a real threat of substantial harm.

For most people who have been abusing substances for any length of time, the above criteria is not that difficult to establish to the Court in order to obtain an order for the assessment and detox. The family or friend who files the petition must locate a facility which can do the assessment and detox the individual, if needed. It is up to the family or the addicted individual to pay for the services. There are many, very good facilities in South Florida available for these purposes which accept insurance. Typically, the court orders a five day stay in the facility for the assessment although that time can be extended by the filing of the petition for involuntary services. The assessment has to be done by a “qualified professional” which is defined as a physician; a physician’s assistant; a professional licensed under Chapter 490 or 491 (i.e. a LHMC or LCSW); ARNP; or a person who is certified through a DCF recognized certification process for substance abuse treatment services and who holds at least a bachelor’s degree. The last category includes a CAP with a college degree in any area. The assessment report must be reviewed and signed off by a physician.

The next step in the process is the filing of a petition for involuntary services (treatment). The same criteria of the assessment proceeding must be met although now there is a higher burden of proof required to persuade the court to order involuntary services. The family or friend must show the Court by clear and convincing evidence that the person needs treatment services. Services, by
We are the second step to becoming sober. Calling us is the first.
For the aspiring treatment center start-up, gaining and maintaining traction within the marketplace can be daunting. Patient acquisition is the single-most important aspect of owning and operating a program, for without patients, there is no program. However, patient acquisition is also the place filled with landmines. Unlike a typical business, where one can offer a potential customer a coupon, a free ride, almost anything of value to try their services, providing (or even offering) anything of value to a patient to induce their patronage is unlawful.

These actions tend to fall within an area of criminal law referred to as “patient brokering” and generally take one of two forms: one is offering anything of value to a potential client/patient to induce that person to patronize a specific health care provider; the other captures the activity of “bartering” or “selling” of patients to a treatment provider in exchange for a fee, a de-facto “patient delivery service.”

Why are these actions unlawful? As a matter of public policy, we desire for patients to make unbiased health care decisions based upon the quality of the care to be provided, rather than based upon personal benefit received, which are thought to unfairly influence health care decision making. Stated differently — would the patient select treatment center “x” but for the fact that the center offered to pay for the patient’s airfare, or free room and board?

Admittedly, there are numerous instances of persons who are legitimately unable to obtain addiction treatment due to the lack of availability of services, but for the gratuitous “scholarship” provided. However, the overarching reality is that these otherwise altruistic intentions have been corrupted and abused to the point where the current generation of patients has learned how to “game the system. These mostly young adults have started their recovery journey by figuring out they can barter their value, measured in increments of insurance benefits, for cigarettes, gym memberships, and free rent, as well as a host of other various luxuries, so long as they tender their insurance card to the highest bidder.

This is also an area where parents of adult children need to be more engaged. Parents are equally in a vulnerable position. There is an existential crisis occurring which they believe someone is taking care of — and that person is often a “market” under a different title. The enabling actions of a marketer or treatment center in providing free items or services undermines the need for the patient to learn self-help and self-care, which is the only way to sustain sobriety from addiction.

The other form of “patient brokering” is the actual delivery of patients to a facility in exchange for a fee. These salespersons, who label themselves as a “market” or “outreach coordinator,” are in reality no different than any other form of commercial “broker” in any other commercial field — we regularly use and rely upon auto brokers; commodity brokers; insurance brokers; mortgage brokers; real estate brokers; and stock brokers, to guide us in our decision-making process. These actions tend to fall within an area of criminal law referred to as “patient brokering” and generally take one of two forms: one is offering anything of value to a potential client/patient to induce that person to patronize a specific health care provider; the other captures the activity of “bartering” or “selling” of patients to a treatment provider in exchange for a fee, a de-facto “patient delivery service.”

But paying a “market” is unlawful for the same public policy reason — the profit motivation of providers to simply get access to patient insurance benefits tends to compromise how that patient was acquired.

Certainly, providers must be held accountable for the actions of the “marketers” they employ, and to some degree, the law does place a burden upon treatment programs to ensure that their marketing “employees” are not themselves engaged in illegal behavior to secure patients for their employers.

However, the policy to have a patient select his or her own provider based upon the quality of service delivery assumes that patients can readily differentiate between providers, and that facilities are able to fairly compete within the same market space. This also assumes that patient acquisition itself is a fair playing field.

So, the question is posed — has the time come to regulate, and therefore accept, the worst-kept secret in behavioral healthcare? Is it possible to craft a set of rules and guidelines (as well as professional licensing) so that consumers of this health care commodity will be in a better position to be educated and protected from otherwise unscrupulous “patient placement services?” Can regulation actually level the playing field by allowing all providers an equal opportunity to compete for their fair share of the treatment provider service delivery model? By eliminating the underground economy of patient brokering, which has devolved into human trafficking, could we possibly also elevate the very important role that recovery residences have within the treatment continuum by distinguishing them from “boarding houses” which simply warehouse actively using kids until they are placed in treatment programs?

By licensing and regulating marketing activity, we may be in a position to deliver an essential and important public health service of matching patients to appropriate treatment providers.

However, until then, a “market” remains (rightfully or not) akin to one who barters in human misery, no matter how they justify their role in this underground economy. Therefore, this occupation should be scrutinized, regulated, and professionalized with a set of ethics and industry education. Public health policy actually demands this of us, and the future of the American drug and alcohol treatment industry will be defined by our collective ability to deliver quality and cost-effective behavioral health care to the masses.

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To give you a brief history, the use of the cannabis plant dates back to 2,500 B.C. when the Chinese used it as a pain reliever and for its euphoria-inducing qualities. During American colonial times, doctors used it for a variety of medicinal and health purposes, including pain relief and appetite control. In the 1950’s, the U.S. government imposed mandatory jail sentences and fines for the possession and distribution of marijuana. Marijuana was classified as a Schedule 1 substance in the 1970’s placing it on the same level as heroin and cocaine. In the last decade, although there has not been much reform of Cannabis policy—the clamor of debate and controversy continues today. Recently, the US is experiencing real change in the state laws governing marijuana and in the enforcement of Federal legislation that has fueled genuine and heated debate both for and against these changes.

Recreational marijuana use is legal in four states and the District of Columbia. It is also legalized in some form in twenty-five states. In 2012, ballot measures legalized Marijuana in Colorado and Washington. In Alaska and Oregon adults 21 and older can now transport, buy or possess up to an ounce of marijuana in public, six plants in Alaskan homes and eight ounces in homes in Oregon. Voters in Nevada are considering a ballot initiative later this year. Moreover, Louisiana lawmakers amended the state’s existing medical marijuana law permitting doctors to recommend rather than prescribe medical marijuana, which runs counter to the federal legislation. The law also expanded the list of eligible conditions for cannabis treatment. Possession of small amounts of marijuana has been decriminalized in some states while others have passed medical marijuana laws-some broader than others allowing for limited use. The types of medical conditions that allow for treatment vary from state to state. For example, some states have passed laws allowing residents to possess cannabis oil if they suffer from certain medical illnesses. Decades ago, Virginia enacted legislation allowing for the possession of marijuana if individuals received prescriptions from doctors. However, Federal law prohibits doctors from prescribing marijuana, rendering those laws invalid. In April, Pennsylvania became the latest state to legalize medical marijuana.

Mounting concern promoted by an alliance of organizations and individuals named Smart Approaches to Marijuana (SAM) are professionals working in the mental health and public health sector dedicated to a health-first approach. They are bipartisan people who seek a middle road between incarceration and legalization. They are treatment providers, medical doctors, lawmakers, teachers, law enforcement officers and others who believe in a commonsense, third-way approach to marijuana policy, based on reputable science and sound principles of public health and safety. Understandably, professionals in the addiction space want to accomplish fair policies regarding both the medical and recreational use (not abuse) of marijuana. This is more easily said than done! A recent visit to Denver’s legalized dispensary helps one understand the dilemma. While there are many smokable marijuana varieties (having upwards of 24% active Tetrathydrocannabinol (THC) to choose from with an array of names and mood claims, there are also edibles such as gummy squares containing 7 mg of THC per square and some waxes containing from 69-89% THC. With good intentions, the dispensary staff try to help people navigate this array, explaining the possible dangers of over–indulgence and suggesting caution especially about the over consumption of gummies (no more than one or two at a time) and providing careful instructions concerning waxes.

The missing piece is the human condition.

While some believe that legalization is about making a small number of business people wealthy and reducing unwanted incarceration, others are calling for a middle-road approach, primarily seeking only decriminalization, moving us backward. Would this provide the impetus for drug cartels to harvest and illegally sell again? The answer is not so simple. RAND (Research AND Development) Corporation recently reported that drug trafficking groups received a minority of their revenue from marijuana, the big money for them is in human trafficking, kidnapping, extortion, piracy and other illicit drugs.

However, without being long-winded lets lay down some interesting facts—pro and con concerning the utilization of another intoxicant in society.

What is the Scientific Truth?

Clinically, Substance Use Disorder (SUD) is a subset of Reward Deficiency Syndrome (RDS) a framework based on a known hypodopaminergic trait (genetic) further impacted by environmental elements (epigenetic). It is to be understood that the human brain contains not only the natural receptors (cannabinoid-CB1 and CB2) that respond to cannabis but also endogenous substances that act like THC.

Much of the information here can be found at ‘How THC Affects the Brain’ http://headsup.scholastic.com/students/the-science-of-marijuana.

Marijuana’s main active ingredient THC was first identified as delta-9-tetrahydrocannabinol and began the ‘Science of Marijuana’ in the mid1960s. It took twenty years for scientists to identify [cannabinoid (CB) receptors] the sites in the brain and body where marijuana acts. Next, researchers discovered the body’s own natural chemicals [anandamide and 2-AG (2-arachidonoyl glycerol) which also act on CB receptors. This group of chemicals is called cannabinoids, and together with their receptors, make up the endocannabinoid (EC) system. The EC system affects so many different bodily functions because it works in many areas of the brain. Cannabinoids work by regulating how cells communicate—changing how they send, receive, or process messages. See how the EC System operates in the Neurons in the figure below.

Inhaled marijuana, rapidly releases THC that quickly attaches to cannabinoid receptors. THC overwhelms the natural EC system preventing the natural chemicals from doing their job properly and changes the balance of the whole EC system. In doing so, some level of relief from everyday stress is provided by

Continued on page 38
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With all due respect to my colleagues who might feel differently, an opioid is an opioid; period. I believe the vast majority of my colleagues' hearts are in the right place and are genuinely concerned about the wellbeing of addicts. But that sentiment doesn't change the fact that all opioids—including Medication-Assisted Treatment (MAT) drugs, buprenorphine and methadone being the most popular—are highly addictive and affect the same regions of the brain in essentially the same way. They all share the same adverse side effects and withdrawal pain. MAT narcotics are not miracle drugs that cure addiction—they're simply opioids. This just strikes me as a no-brainer, but I feel compelled to repeat it at the expense of sounding redundant to galvanize the point that some of my colleagues want to leave covered in the shaded background.

What many of my colleagues and most people don't realize is that we are actually in America's second opiate/opioid epidemic. In the late nineteenth century it was discovered that Americans consumed more habit-forming drugs per capita than the Chinese who were at the time considered to be biggest drug abusers on the planet. The German Company, Bayer, marketed heroin directly to physicians as a completely safe and non-addictive painkiller for menstrual cramps, migraines, a cough medicine, and a cure for morphine addiction. Is any of this sounding remotely familiar to you?

The epidemic became so perverse that President Roosevelt appointed Dr. Hamilton Wright to the position of United States Opium Commissioner; for all intent and purposes, our first 'Drug Czar.' Dr. Wright was instrumental in the crafting of The Harrison Narcotics Tax Act of 1914. This federal law mandated the regulation and taxation of the production, importation, and distribution of opiates and coca products. It was also interpreted within its framework that doctors could no longer prescribe opiate and/or opioids for the purpose of addiction treatment. There were challenges to this interpretation; but in 1919, the Supreme Court ruled that physicians could not prescribe narcotics solely for maintenance. The Harrison Narcotics Tax Act effectively ended America's first opiate/opioid epidemic.

Fast forward fifty years later when the Narcotic Addiction Rehabilitation Act of 1966 (NARA) pealed away a layer of the Harrison Narcotics Tax Act by opening the door to methadone maintenance. The Comprehensive Drug Abuse Prevention and Control Act of 1970 cut even deeper and helped usher in methadone clinics. The Drug Addiction Treatment Act of 2000 enabled certified physicians to prescribe and/or dispense narcotics for the purpose of treating opioid addiction. An amendment to the Controlled Substances Act in 2005 allowed for certified doctors to prescribe buprenorphine from the privacy of their office to as many as 30 patients per year. Just this summer (July 2016) congress patted themselves on the back as they smiled for cameras in photo-ops seen around the country. Their achievement; passing the Comprehensive Addiction and Recovery Act which allows approved doctors' medical assistants and nurse-practitioners to prescribe buprenorphine. It is expected the White House will up the limit of the number of patient’s doctors can prescribe buprenorphine to, to 275. What could possibly go wrong considering the addiction rate in the medical field is above the national average and has been estimated to be as high as 15%?

The Harrison Narcotics Tax Act of 1914 has been hollowed out; it's a mere shell of what it once was when it kept opioid addiction levels in this country at an all time low. So what is the outcome of destroying the one good piece of legislation that was so effective at protecting us from opioid addiction? We've become the biggest drug abusers on the planet. With less than 5% of the global population, Americans consume 80% of the global opioid supply, 99% of the global hydrocodone supply, as well as two-thirds of the world’s illegal drugs. We now hold the distinction of being the most sedated society in the world.

Having worked in the treatment field for over thirty years and being in recovery myself, I'm more sensitive to the plight of addicts than most; but the numbers are clear. This is not the way forward.

Are we doing a disservice to addicts and robbing them of true recovery by repealing laws to make opioids more readily accessible to them in the form of MAT drugs? Are we actually helping them or merely extending their addiction as Dr. Wright said would happen over 100 years ago?

There are two camps that have emerged on this issue with strongly opposing positions. For this conversation let’s keep it simple and call them the pro-opioid and the anti-opioid camps. I fall into the later and strongly believe we are impairing recoveries and casting these poor people into a life of perpetual addiction. Here are the facts that I base my opinion on.

The common mantra and central guiding principal of the pro-opioid camp goes something like this; ‘Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is the most successful for many people.' To most this sounds impressive enough—it’s catchy and appears to be all inclusive. However it rings hollow to my ears; like an advertising slogan trying to sell something.

Not long ago there was a study published in a peer-reviewed journal that revealed it takes up to three years of abstinence before an opioid addict’s brain chemistry normalizes. I can tell you from my own first-hand experience that treating addicts the first two weeks after detox are fruitless—you might as well talk to a palm tree—you simply can’t get through to them. It takes at least a couple of weeks for any vestige of cognition to reveal itself.

This leads me to question the very foundation of the pro-opioid camp. We know that opioids have a massive negative impact on brain chemistry that leads to impaired cognitive function. Why would anyone expect counseling and behavioral therapies to achieve a successful outcome when you’re feeding addicts opioids that scramble their brain function at the same time? Counseling and opioid use are polar opposites. These are two opposing forces that constantly work against each other. Considering the fact that the longer someone uses opioids, the longer it takes to normalize brain function, the only logical conclusion a rational person can come to is that the MAT program extends peoples’ addictions.

Let me just state this for the record. In over thirty-years of treating addicts, I have never met a single living person who was successfully treated for addiction with an opioid of any kind. Not one. Nor have any of my friends and associates in the treatment field (and I have a lot of them) met one. In fact, we are not aware of any disease, disorder and/or condition that have ever been successfully treated with an opioid. All opioids are highly addictive painkillers and nothing more, they don’t cure anything. With that being said and at the risk of asking the obvious; why on earth would you ever think treating an opioid addict with another dangerous and highly addictive opioid could ever produce a successful outcome?!

Speaking of successful outcomes; there is something else pro-opioid camp mantra left unanswered that needs to be addressed; “How many people are now addicted to buprenorphine and...
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Where compliance is a journey not a destination
Despite America’s obsession with sexuality, vitality and youthful appearance, a study conducted by the University of Chicago disproves several myths about age, quality of life and happiness. Our common misconception is that older individuals, many dealing with age-related aches and pains and the death of loved ones, are in a state of melancholy and depression. The surprising results of the University of Chicago study, however, indicates that the happiest Americans are those who are older and into the proverbial “Golden Years.”

Study author Yang Yang stated that the study was based on periodic face-to-face interviews from 1972 to 2004. Published in American Sociological Review, the study (n=28,000) looked at individuals ages 18 to 88, a nationally representative group. Overall, the probability of being happy increased at a rate of five percent with every ten years of age.

Yang Yang claims that older people, those in their “Golden Years,” are happier because of where they are in life. That is, those who accept their selves and their lot in life no longer struggle with that search for greatness, accomplishment or fortune. Not everyone is successful enough to purchase the proverbial mansion on the hill. And that is OK. Whatever you have, apartment, bi-level, ranch home, mansion, trailer, cabin or tent, is more than enough to allow you to be happy.

Also, older Americans have learned to lower their expectations. They are more content with their achievements and with what they have. They have learned to accept things the way they are. Older adults have been able to put the words of the Serenity Prayer into action. God grant me the serenity to accept the things I cannot change; Courage to change the things I can; And wisdom to know the difference.

Dreaded Lesser Prospect

Even as we value youthful energies and potential, we erroneously view getting older as a sometimes-dreaded lesser prospect. A new study proves just the opposite. Youth may not hold the key to happiness, but often inhabit the realm of depression, uncertainty and hopelessness.

The findings, published in the Journal of Clinical Psychology (August 25, 2016) are based on surveys of more than 1,500 San Diego-area adults. This study represented individuals from ages 19 to 99. The report, as expected, found that old age brings with it physical problems, memory and cognitive issues and feelings of being disregarded. Loneliness and depression are often experienced during this period of life when we experience a lack of usefulness.

Still, older people appear to able to cope with life struggles easier. One reason is that older folks have been able to develop a certain amount of wisdom that helps them cope with life challenges more successfully than do youth. The study found that older adult’s mental well-being being steadily improved as people grown older. Older adults are generally less stressed and happier with their life situation than their younger counterparts.

Yet, too, there is a different system of values between the two dissimilar groups. Youth desperately strive to be accepted and recognized within a group, gauging their status by the number of Facebook “likes” they receive, accumulation of materialistic trappings, as well as, other superficial and adolescent litmus tests.

Not so with adults.

Older Americans are more socially active than their younger counterparts, an activity that is the perfect tonic to stave off depression and loneliness as it enhances socialization and group identity. Being accepted into a group is one of the most important aspects of humanness. Older adults have had decades to connect with a group that shares their interests, beliefs and values. On that score, older adults have gone through the trials and tribulations and those awkward adolescent years of attempting to build confidence and self-esteem and gaining approval. Older adults, most likely, have already climbed that mountain.

Happiness and Longevity

Happiness during the Golden Years seems to be a good predictor of human longevity. A 2011 study published in Proceedings of the National Academy of Sciences found that older people who reported being the least happy died at nearly twice the rate in the next five years as people who reported being the most happy. After adjusting for factors like illness, finances and depression, people who were the happiest still had a 35% lower risk of death.

Another study of older adults found that happier people retained their physical function better than those who weren’t happy; their walking speeds even declined more slowly; a perfect example of the Spartan Mens sana in corpore sano, or sound mind in a sound body.

According to a 2002 Yale University study, men and women older than 50 with more positive self-perceptions of aging lived 7.6 years longer than those with negative perceptions.

Helping people is another possible key to happiness following in the wake of Abraham Maslow and his Hierarchy of Needs, most specifically Transcendence. Another survey, as revealed in the Wall Street Journal, found that when retirees were asked what brought them the most happiness, most said their greatest happiness came from helping people in need rather than focusing on themselves.

The survey found that seniors who volunteer and/or donate money to others were happier (66 percent vs. 52 percent) and healthier (50 percent vs. 43 percent) than those who did not give regularly to others.

Aging provides us with a safe harbor. We experience less of the rollercoaster hormone-spiked drama and uncertainty. And we cultivate more confidence and positive expectation. Still, despite the research and evidence, our society continues to worship the youth culture.

An article by The Huffington Post put it perfectly, “While many cultures celebrate the aging process and venerate their elders, in Western cultures — where youth is fetishized and the elderly are commonly removed from the community and relegated to hospitals and nursing homes — aging can become a shameful experience. Physical signs of human aging tend to be regarded with distaste, and aging is often depicted in a negative light in popular culture, if it is even depicted at all.”

Psychologist Erik Erickson argued that the Western fear of aging keeps us from living full lives. “Lacking a culturally viable ideal of old age, our civilization does not really harbor a concept of the whole of life,” he explained.

Not every society shares those dubious values. Koreans are socialized to respect and show deference to older individuals as well as authority figures. Chinese families traditionally view respect for one’s elders as the highest virtue and adult children are still generally expected to care for their parents in their old age.

Perhaps our society would do well to heed the Asian philosophy of respecting elders, allowing them to mentor us in all things, and especially in the ways of attaining happiness.

Maxim W. Furek is passionately researching the essence of happiness. His rich background includes aspects of psychology, addictions, mental health and music journalism. His book Sheppton: The Myth, Miracle & Music explores the miraculous and supernatural elements experienced by two entombed Pennsylvania miners. Learn more at shepptonmyth.com

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RECOVERY AND FOOTBALL CAN GO HAND-IN-HAND
By Thomas G. Kimball, Ph.D., LMFT

Fall is upon us. School has started and students have descended upon university campuses across the country. The beginning of the fall semester is always full of hope and promise. It is a new school year, a chance to start over, to begin again, or continue the journey toward graduation. Education aside, we can feel the imminent shift from hot to cooler weather and soon the leaves will begin to change. At Texas Tech, as we walk across campus, we hear the famous ‘Goin’ Band from Raiderland’ practicing just behind the Student Union Building. The sounds of music and marching fill the air. In West Texas, Marching band is second in popularity to the long anticipated return of what many refer to as The King of Fall: Football.

By now, college football is in full swing and teams across the country are competing and fans by the millions are filling stadiums or tuning in on their televisions, computers, and smart phones. Surrounding almost every college football game are time honored traditions related to pre, during, and post-game rituals that often involve large quantities of food and an abundant supply of alcoholic beverages. There are plenty of people who partake in the festivities, food, and drink without negative consequences. For people in recovery, the potential consequences of embracing the drinking culture are treacherous and potentially deadly. The good news is many individuals in recovery who love college football have learned how to successfully navigate and participate in the festivities without drinking or partying to extreme.

As we kickoff a new season, here are 3 Things for every college football fan to remember that may prove to be helpful as you cheer for your favorite team.

1. Be a Student of the Game
Football is a highly complicated and beautiful game where multiple strategies are utilized on offenses, defenses, and special teams. A lifetime could be spent trying to fully understand the variety of options that are available to coaches and players on both sides of the ball. Understanding the rules of the game, why and when penalties are called, and why coaches and players make decisions at certain times makes the game come alive. Being a student of the game also means exploring your team’s history and tradition and knowing the strengths and weaknesses of the players and coaches. I believe the full joy of football can only be experienced as a sober student of the game.

2. Host a Sober Tailgate
An emerging trend at many colleges involves students in recovery who organize and gather for sober tailgates. Sober tailgates include all the fun and festivities as other tailgates without the alcohol. Great music, smart football talk, and tasty food set the stage for a successful sober tailgate. The best part is the community and camaraderie of interesting people who come together and share the love and support of their team and the game. Sober tailgates also offer anyone who makes a lifestyle choice to not drink a great setting to get to know people and enjoy the festivities. Sober tailgates should be offered on every college campus across the nation.

3. Create a Student in Recovery Section at the Game and/or Attend with People in Recovery
My students at Texas Tech’s Collegiate Recovery Community attend football games together. They meet at a convenient place and walk together to the game. Imagine 50+ students in recovery sitting smack dab in the middle of the Texas Tech student section enjoying the game and all of its thrills from a sober perspective. It is my experience that students in recovery are just as loud and enjoy the game just as much as the students who are drinking alcohol. Attending games together also solidifies relationships and gives the students opportunities to talk and connect. When people attend together they naturally make plans afterwards to be together extending the recovery support to well after the game ensuring that everyone is safe and has a great time.

Enjoy the football this fall. May your team rise to heights of glory and victory. Becoming a student of the game, organizing and attending sober tailgates, and attending with people of recovery may enhance your football experience and your recovery. Most importantly, may you enjoy the rituals and traditions of football in a sober and safe way.

Dr. Kimball serves as the Director of the Center for Collegiate Recovery Community and holds the George C. Miller Family Regents Professorship at Texas Tech University. He is co-author of the book, Six Essentials to Achieve Lasting Recovery, Hazelden Press. He is also a Clinical Director with MAP Health Management, LLC.
Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who has been exposed to addictive illegal or prescription drugs. Prenatal NAS results from the sudden discontinuation of fetal exposure to substances that were used by the mother during pregnancy. It is often a multi-system disorder that frequently involves the CNS, GI system, autonomic system, and respiratory system.

Symptoms of NAS depend on various factors including the type of drug the mother used, how much of the drug she used, how long she used the drug, and how the mother’s body breaks down the drug.

Maternal substance abuse, the cause of NAS, is a leading preventable illness of mental, physical, and psychological problems in infants and children. Substance use by pregnant women has both medical and developmental consequences for newborns, in addition to the legal, health, and economic consequences for the mother.

Most illicit drugs cause addiction for the mother and dependence in the infant. Dependence or tolerance in the infant is a result of the passage of drugs across the placental barrier. Substances that act on the central nervous system easily cross the placenta allowing a rapid equilibration of drugs between the mother and the developing fetus. They accumulate in the fetus because of the immature systems that are needed for metabolism of the drug. Child birth removes the drug source resulting in withdrawal. The symptoms and timing of the withdrawal depends on the drug, the frequency of maternal use, the last exposure for the fetus and the baby’s ability to metabolize the drug.

The specific effects of illicit substances are complex and depend on the type of substance.

Opiates produce the most dramatic effects on both the mother and fetus because of its short half-life. Heroin withdrawal may start as early as 24 hours after birth and usually peaks within 48-72 hours in 50-80% of infants. Some delayed withdrawal can occur as long as 6 days after birth. Sedative-hypnotics such as benzodiazepines and barbiturates have a longer half-life and withdrawal may not start until after the infant has been discharged from hospital (age 2 weeks).

Methadone maintenance has been an acceptable form of therapy for opiate-addicted pregnant women for more than 20 years. Methadone is currently the recommended treatment for opioid-addicted pregnant women and is considered relatively safe for the fetus. Medically however, it is also associated with NAS, and its effects on the fetus are similar to the effects of heroin. Methadone’s half-life is longer than 24 hours, and acute withdrawal may occur within the first 48 hours after birth and as long as 7-14 days later. The withdrawal can be delayed for as long as 4 weeks after birth, with subacute signs developing as long as 6 months after birth.

Buprenorphine has recently been approved for treating opioid addiction. Buprenorphine and methadone have comparable maternal efficacy although methadone seems superior in terms of retaining patients in treatment. Infants who had prenatal exposure to buprenorphine required significantly less morphine for the treatment of NAS, a significantly shorter period of NAS treatment, and a significantly shorter hospital stay than did infants with prenatal exposure to methadone.

Long-term problems of children exposed to illicit drugs in the womb include adverse neurodevelopmental outcomes. Speech, perceptual, memory and reasoning disturbances have been reported in toddlers who were exposed to opiates. Behavioral problems are also reported in children of mothers who have taken illicit substances in pregnancy. Others reported lower levels of learning and adapting to new situations; higher sensitivity to their environment; resulting in irritability, agitation, aggression, poor social skills; and a lack of imitative play and late emergence of symbolic play. Prognosis widely varies and depends on the family, socioeconomic variables, and whether either or both parents continue to use illicit drugs. Children of mothers ceasing or decreasing their use of substances up to time of the birth delivered healthier babies than the mothers who continued to use substances. In addition, their results indicated that early intervention, including treatment of addiction during pregnancy, prenatal care, and psychosocial support, helped to prevent some developmental defects of newborn children of substance-using mothers. MAT has also been shown to decrease illicit behaviors, improve prenatal care and obstetric outcomes resulting in improved family outcomes.

Pregnant drug-using women should be counseled at the earliest opportunity to abstain completely from all injurious substances, enter into a comprehensive treatment program, be provided smoking cessation options and seek prenatal care. Adequate dietary intake and early supplemental prenatal vitamins with folic acid should be stressed. Ideally, illicit substance use including tobacco should be terminated by women and their male sexual partner before conception. Prevention is the best way to stop NAS.

Dr. Jones is the Founder and CEO of Mango Bay Retreat, a Premier Addiction Facility for Women Specializing in Pregnant Women.

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For many years, treatment of addiction has been focused on providing various treatment modalities to achieve sobriety. As our understanding of substance misuse disorders evolved based upon medical research and scientific data, the treatment community is still struggling with the concept of recovery. Unfortunately, most treatment facilities as well as therapists, see sobriety as an end all-not part of the process. Quite often when a patient relapses, the immediate response by the therapist or the center is blaming the patient. Here are some statements collected from patients: “well you were not going to your meeting regularly,” or “why did you stop calling your sponsor,” and, “you need to come back to the center, obviously you need more therapy.” The before mentioned statement therapists make to patients do not necessarily address or admit why or how previous therapy has failed the patient. Therapist and centers often look at patients as failures; since the established standards in the industry tends to be rigid, “of all or none”, in other words: you are either sober or you are an active addict. In many ways, the bar is set rather high by the therapeutic community-not recognizing the fact that people considering treatment often bring multiple issues to the table. Some examples include: dual diagnosis, multiple addictions, trauma, etc.

The illness of addiction, especially opioid addiction, is complex in many ways and requires multiple therapeutic approaches over extended periods of time. In an ideal scenario, a wide-range of treatment options, including medication-assisted treatments (MAT) would be available to all patients with opioid dependency and other substance use disorders. However, not every person with an opioid misuse issue requires to be treated with MAT. The treatment protocol best suited for a patient should be left to the patient and their healthcare provider. If and when a person and their healthcare provider determine that MAT is the chosen treatment protocol, it should be readily available rather than making the patient jump through multiple hoops to get it. For example, current policies in the criminal justice system, along with under educated judges with limited understanding of opioid addiction, dual diagnosis and recovery, prohibit the use of MAT. They would rather put addicted people behind bars, without a wide range of treatment options, including the use of MAT, then ask themselves: why is there a high recidivism rate and is the criminal justice system financially troubled because of the recidivism.

The insurance companies are not any better. They offer insurance plans that make it more and more difficult to get approval for addiction medications; or plans that exclude methadone maintenance therapy entirely from coverage. The attitude from insurance companies is that the patient must exhaust all available approved treatment modalities and fail before they can receive MAT.

Can you imagine telling a diabetic patient that unless they go into a diabetic coma while receiving other treatments, they will not be able to receive any medications, despite his doctor insisting otherwise. Whether it is the criminal justice system or third party providers, state and local governments are consistently failing to recognize that millions of people who are suffering from opioid misuse can be helped, if these agencies would incorporate some common sense into their agenda. Most of the stigma attached to MAT is created in the addiction field, largely due to ignorance with such statements as ‘medication-assisted treatment is substituting one addiction for another’. Medication-assisted treatment is absolutely not substituting one addiction for another. Many treatment facilities resist suggesting the use of MAT since it conflicts with their philosophy. What ever happened to “do no harm”, and putting the patient’s best interest first, instead of money or philosophy. The field of addiction has advanced in many ways and as health care providers; it is our responsibility to keep up with the changes and to promote best patient care, period. This also includes reducing the stigma that keeps people from seeking help or staying in treatment which is vital to the increased use of MAT.

People need options that can be tailored to their specific treatment needs, just like we try to give them for other health issues. Unfortunately, state and local governments are responsible for providing treatment, prevention, and recovery efforts for substance abuse disorders (a.k.a. addiction). But they have tragically been overlooking a key element that can help millions of people affected by opiate and opioid addiction: prescription medications!

This is the equivalent of telling a cardiac patient that unless he has a heart attack while receiving other treatments, he cannot receive the medications his doctor has said may save his life. Some of these plans exclude methadone maintenance therapy entirely from coverage.

Given the current trends in society, it is time for us as professionals to put down the barriers and provide a responsible and ethical medically assisted treatment for those who are suffering from a chronic illness.

Dr. Casey is renowned as an expert in addiction medicine, psychology and medically assisted treatment (MAT), and in addiction counseling. He is a successful public speaker in this field, speaking nationally and internationally, as well as delivering seminars and providing training. Dr. Casey has been practicing for more than 25 years and is currently serving as the Executive Director at Access Recovery Solutions in Delray Beach, Florida. www.arsdelray.com

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The term “Recovery Residence” was first introduced by the National Alliance for Recovery Residences (NARR) in 2010 to describe recovery-oriented housing compliant with NARR Quality Standards. These thirty-seven (37) standards are organized under four domains:

- Administrative & Operational
- Recovery Support
- Property & Architecture
- Good Neighbor

NARR Quality Standards recognize four distinct support levels. One level is not “better” than another. Rather, support levels reflect intensity of services offered by the program.

**Level I** is best exemplified by the Oxford House model where-in residents democratically elect a peer council and a servant leader to chair that council, collectively agreeing to abide by a set of written house rules and covenants.

**Level II** offers monitored peer support typically empowering senior peers including house managers to maintain order and recovery focus within the residential peer community.

**Level III** residences build atop this platform by providing 24/7/365 supervision generally with oversight by credentialed peer staff, and deliver nonclinical life skills programming.

**Level IV** Residences blend clinical and social model support and are licensable by the DCF as behavioral healthcare providers. Often referred to as Florida Model Treatment facilities, these providers operate community-based housing as a licensed component. At present, only Level IV Recovery Residences are eligible to seek reimbursement from commercial funders (insurers). Funding represents a fundamental challenge for Level I, II & III recovery residences, primarily because they are perceived solely as housing providers.

SAMHSA block grants provision state funding for peer recovery support services. These services include consumer support for employment, recovery, and community integration. While Florida receives over $300 million annually through the SAMHSA block grant program, these funds rarely trickle down to fund services delivered by recovery residences. Though SAMHSA acknowledges the value of recovery-oriented housing as a vital component of the continuum and also recognizes NARR Quality Standards as best practices for the operation of a recovery residence, in the past, SAMHSA referred recovery residences to Housing & Urban Development (HUD) whenever the subject of funding arose. This illustrates that federal agencies perceive recovery residences singularly as housing providers. HUD views recovery residences as falling outside their primary mission. HUD is deeply committed to the Housing First program which does not permit exclusionary criteria such as the NARR requirement that recovery residences maintain an alcohol/illicit drug-free peer community. As a result, Level I, II & III Recovery Residences are forced to fund operations primarily through resident (and family) self-payment. This fact has led operators to appreciate themselves as housing providers. While certified programs deliver considerably more than shelter, operators typically bundle all services including employment, recovery and community integration support, under the single billing category: RENT.

SAMHSA is currently researching recovery-oriented housing from the perspective of peer recovery support services. Certain states including Massachusetts, Ohio, Maryland, Idaho, Indiana, Illinois and Pennsylvania allocate between one to four million dollars in annual funding for recovery housing support. However; even these allocations, though valuable, are framed as “housing support” as opposed to reimbursement for peer recovery support services delivered in a recovery residence setting.

The Florida Association of Recovery Residences (FARR) recently launched a six phase research project in collaboration with Dr. David Best, world renowned recovery researcher from Sheffield Hallam University (SHU) in the United Kingdom. Dr. Best and his team trained peer staff from eight certified recovery residences to support 650 residents in the use of REC CAP, a formal recovery planning instrument designed to map recovery strengths and barriers and to empower self-directed achievement of concrete recovery goals. REC CAP navigators, mentor, monitor and measure resident gains in recovery capital, defined as the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999; Cloud & Granfield, 2004). Now commencing the fourth of six phases, the SHU-FARR REC CAP Research Project continues to exceed expectations. This project will result in presentation of REC CAP to SAMHSA as an evidence-based intervention appropriate for delivery in both clinical and peer environments. Once so positioned, a coherent argument for reimbursement of peer recovery support services delivered through recovery residences certified to be in compliance with NARR Quality Standards can be presented to third-party funders including healthcare insurers, state agencies and EAPs. Consumers who elect to reside in certified programs experience concrete support that facilitates behavioral change vital to sustaining resilience. Recovery residences are currently engaged in demonstrating that those who engage in REC CAP as a peer recovery support service experience measureable gains in recovery capital which, in turn, significantly improves outcomes.

The day when a certified level I, II and III recovery residence becomes eligible for reimbursement for delivery of peer recovery support services may be near, however; the service sector will not achieve this milestone without first evidencing provider compliance with best practices and the delivery of services that are both measured to produce enhanced outcomes. Over the last seven years, much has transpired to erode confidence in the efficacy of recovery housing. Patient brokering, driven by insurance fraud, has greatly polluted our service sector. Multiple state and federal agencies including the Palm Beach County State Attorney’s office, Office of the Attorney General and the Federal Bureau of Investigations have joined forces with community stakeholders to restore order to the “Wild West”. The nexus between some licensed behavioral healthcare and some recovery housing providers lies at the root of system
abuse. Recovery Residence providers who deliver services that positively impact the populations they serve deserve to be well compensated for their continued commitment to excellence. While they exist, it has become increasingly difficult for communities, families and consumers to identify this provider group. FARR will continue to revoke certification when evidence demonstrates willful abandonment of the NARR Quality Standard in pursuit of quick riches. FARR will continue to deny applicants who evidence violation of Florida’s patient brokering statute by offering free or deeply discounted rent in exchange for enrollment in an associated licensed behavioral healthcare program. Conversely, FARR will continue to support ethical, law-abiding providers to achieve certification. Despite public consensus that law enforcement is asleep at the wheel, FARR remains confident that activities are underway to effectively address patient brokering and insurance fraud through a combination of law enforcement and legislative initiatives. In the midst of frequently reported abuses against consumers and funders, a pioneering group of FARR Certified Recovery Residences have set course to improve the recovery paradigm and are supported by some of the most respected recovery advocates and academic researchers in the world. From my vantage point, hope shines bright.
WHY AUTHENTIC FRIENDSHIPS ARE KEY TO GOOD MENTAL HEALTH AND RECOVERY

“A friend is what the heart needs all the time.”
~ Henry Van Dyke

As a person, I learned early on that friendships can prove an asset or a hindrance in this life. Friends are like the pebbles found within the body of a river; while you will tread upon many beautiful stones, it is seldom that we will find a rare and precious gem. Similar to those that we encounter in this life, all friendships have their merits, but it’s unique to find a friendship that is authentic, genuine and unconditional. What truly is the difference? While we may have an abundant number of friends; it’s like the old adage says, “true friends are few and far between.”

Friendships can prove the greatest asset one has in this life. Again it is not about having a vast number of friends on social media like Facebook; rather it’s about establishing a healthy and close connection with another. At the core, friendship is about having an intimate bond and relationship with another human being. It is the unique relationship that can encourage, inspire and transform our way of thinking. However, not all friendships are an asset; sadly, in some cases, friends can prove like an albatross strung around our necks sinking us to the depths of the ocean floor. Therefore, it is critical that we are diligent in connecting with individuals who have a vested interest in our lives and who will prove a positive asset rather than a negative one.

WHAT IS A HEALTHY FRIENDSHIP?

“A friend is someone who gives you total freedom to be yourself.”
~ Jim Morrison

While the onset of a friendship may develop through a family member, or an acquaintance, either way, healthy friendships are a critical ingredient in human survival. “Friends are what make us uniquely human,” says James Fowler, professor of medical genetics and political science at the University of California at San Diego. “There is no other species that interacts so widely with other members of their species. So right away, you know that when you’re studying these relationships with friends, what you’re really doing is studying what makes us unique.”

Healthy verses Unhealthy Friendships

A healthy friendship is driven by mutual respect, admiration, and interest. A friendship is the ultimate partnership designed to enrich and enhance all active participants. An unhealthy friendship is an imbalanced and lopsided relationship. An unhealthy relationship is most commonly disguised as a healthy and genuine relationship, but one or both participants are seeking out the relationship for selfish and self-serving reasons. The nucleus of a self-serving relationship is concern for one’s own welfare and personal interest rather than the interest and welfare of others.

A healthy friendship is supportive, trusting, and nurturing. It is the sort of relationship that recognizes that we are all human, and still willing to stick by our side through the good times and bad times. An authentic friend is always interested in maintaining the strictest of confidentiality, but will not encourage or tolerate unethical or immoral behaviors.

Friendship is a critical ingredient in living an abundant, secure, and fulfilled life. A friend is imperfect, but they recognize your own imperfection with acceptance and an unconditional spirit.

A COMMON REALITY OF ADDICTS

“A real friend is one who walks in when the rest of the world walks out.”
~ Walter Winchell

For many who are struggling with addiction, finding a friend who is an ally, a support and an accountability partner can prove a challenge. Unfortunately, addicts have been portrayed in the media and society as blemished and unworthy, but the truth is, all of humanity struggles with some form of addiction whether it be a thought, a perception, or an ideological perspective. Moreover, we have a skewed perception of addiction because of its orientation to drugs and alcohol, but the truth is drugs and alcohol only account for a small portion of addictive habits.

AN UNCONDITIONAL FRIENDSHIP

As a person, we must adapt an unconditional persona. A person living an unconditional life looks beyond one’s failures and successes and strives to see the authentic person. Unconditional acceptance does not mean that we are to compromise our belief system, ideological perspectives, or ethical slants, but that we are accepting of others despite themselves. An authentic friend remains loyal and accountable during the good times and the bad.

The Keys to a Healthy Friendship are:

1) An authentic friend should avoid tactics that may compromise the integrity of the relationship.
2) Do not allow the sun to go down upon your anger. Allowing anger to fester can prove toxic ultimately destroying the integrity of the relationship.
3) Be willing to share your appreciation and gratitude for others.
4) Develop and maintain healthy boundaries.
5) Be clear with your desires and expectations within the relationship.
6) Regularly practice and maintain a mindful approach to friendship.
7) An authentic friend is readily available.
8) Acknowledge and accept responsibility for mistakes when they occur.
9) Never accept responsibility for the failures or mistakes of others.

10) Respect is the deep admiration and personal regard for another.

11) Continuously work and strive to improve your own person.

12) Never accept any form of abuse from any person at any time.

13) Practice active listening; active listening is a skill, technique, or an inherent trait whereby a person is purposefully and intentionally focusing on the communications being sent by another person or persons.

14) Forgiveness is a purposeful action to move beyond an intentional or unintentional harm. “Psychologists generally define forgiveness as a conscious, deliberate decision to release feelings of resentment or vengeance toward a person or group who has harmed you, regardless of whether they actually deserve your forgiveness.”

15) Authenticity is the ability to be genuinely your own person.

An authentic friendship is the key to developing and maintaining a healthy relationship. Authentic friends are interested in being an advocate, ally, and proponent of your person. Most of all, friendship is the blending of the hearts, minds, and souls of two imperfect individuals into a common cause, a common good, and a common goal. Friendship is an ever-evolving relationship with a similar connection; you.

May you begin living beyond.

Author: Dr. Asa Don Brown, Ph.D., C.C.C., D.N.C.C.M., F.A.A.E.T.S.
Website: www.asadonbrown.com
References Provided Upon Request
The Legalization of Marijuana for medical purposes and now for recreational purposes has become one of the most divisive issues in America. At the same time, it’s the most misunderstood. People state that they are Pro-Marijuana or Anti-Marijuana like it sums up an intelligent and rational position. Saying you’re Pro-Marijuana is like saying you’re Pro-Food. It makes no sense. There are types of food that people dislike and there are even aspects of the manufacturing of food that people dislike. It’s not a black and white argument. Marijuana has not only morphed into a different kind of drug, it resembles very little of what was once known as weed. To say you are Pro-Marijuana says very little about what you’re actually for.

According to a 2015 study by Pew Research Center, most American adults favor marijuana legalization. Roughly 56% think it should be legal, while only 44% believe it should be illegal. The pro-pot sentiment is even higher for those under 35 years of age – 68%. But, what is marijuana? Why isn’t anyone asking that question? Why isn’t anyone asking why we’re still calling it Marijuana? It’s not Marijuana anymore, but when surveys refer to it, when people ask about it, when reporters and marketers cover it, they still refer to it as if it was the same thing it was in 70’s.

Would we survey people’s opinion about crack and call it cocaine? Would we survey people’s opinions about fentanyl and simply call it opioids? Why are we asking people about their opinions of legalization when the product bears absolutely no resemblance to what it’s been since the beginning of time. Why does it matter how many people are in favor of it, when “IT” is not even “IT” anymore! Botanists grew marijuana; now industrial scientists grow it. The 2% to 5% flower that got you high 40 years ago is now a wax or an oil that can be 97% pure THC. Flower marijuana has been genetically modified in labs and is selling as high as 42%. The collective knowledge of man has no idea what the effects are on the human body and brain. This is not only a social experiment gone bad, it is a modern day bait-and-switch.

Would you survey people’s opinion about crack and call it cocaine? Would we survey people’s opinions about fentanyl and simply call it opioids? Why are we asking people about their opinions of legalization when the product bears absolutely no resemblance to what it’s been since the beginning of time. Why does it matter how many people are in favor of it, when “IT” is not even “IT” anymore! Botanists grew marijuana; now industrial scientists grow it. The 2% to 5% flower that got you high 40 years ago is now a wax or an oil that can be 97% pure THC. Flower marijuana has been genetically modified in labs and is selling as high as 42%. The collective knowledge of man has no idea what the effects are on the human body and brain. This is not only a social experiment gone bad, it is a modern day bait-and-switch with the American public. The same play book used by the tobacco industry years ago is being used by an industry hell bent on profits from addiction – especially the addiction of youth.

In late 2014, while I was finishing filming the documentary, “An American Epidemic,” I was in Boulder, Colorado meeting with a man who had lost his daughter to an opioid overdose. While I was walking down beautiful Main Street in downtown Boulder for some B-Roll, I came upon an oversized, gaudy green cross that looked not only out of place on this beautiful strip, but intrigued me to investigate what I had heard so much about. I walked into a head shop on steroids. What I witnessed in that dispensary struck such fear in my heart, that I set out almost immediately to begin to document what was really happening. I saw an industry in the making – a huge, commercialized, industrialized mega-operation that was going to be dependent on addiction.

If people would really get informed and avoid getting their information from biased media, this issue could be looked at objectively. There are over 400 molecules within marijuana and unfortunately not a lot is known about most of them. Most people are for the research and design of true medical marijuana. We know that CBD which is Cannabidiol is the accepted part of marijuana which has shown significant medical benefits. This is where our focus should be and it’s not. In fact, CBD and “medical marijuana” is being used as a ruse by the industry to convince Americans that legalization is all about helping people. It’s not what is happening in the states that have legalized commercial, retail marijuana. We are sliding down the most slippery slope in American history and we are completely forgetting the lessons we learned with Big Tobacco. We are forgetting what a for-profit industry did to this country. Cigarette-related illnesses kill more Americans than any other drugs combined. We don’t need to make the same mistake again.

Until we put our emotions in check and accept that our preconceived ideas about what marijuana once was might not be applicable today, and understand what is actually happening with this product, we will never come together to understand what is really going on. For our children’s sake and the sake of our country, we must become informed. My newest documentary, MarijuanaX is my attempt to do just that – inform. It was more than a year in the making and I hope and trust that it will open some eyes.

One of the most important films of our time, on one of the most misunderstood social issues in our history.

The legalisation of marijuana for medical, and now recreational use, is divisive and controversial; but the truth about this changing product is not being told - until NOW!

It’s Not Marijuana…. It’s MarijuanaX

From the Producer and Director who was the first to address the heroin and opiate epidemic in New Jersey through his film, Kids Are Dying, and who later went on to document the national epidemic in An American Epidemic brings you the most poignant and relevant documentary on marijuana to date. MarijuanaX takes you on a journey of what was promised and what has transpired. This film challenges the mainstream media’s take on marijuana like never before. Meet the people who have been affected by the drug that most people think is harmless. Listen to people in Colorado devastated by all the drug talk and see what is really taking place. Oils and waxes, shatter and budder, concentrates and edibles, youth use escalating, cartel involvement, illegal grows and an exploding black market; it’s all here. This is a film that will make everyone question their positions. However, it will surely make you look at marijuana differently, because it’s NOT Marijuana Anymore!

Michael will be premiering his movie, It’s Not Marijuana… It’s MarijuanaX at the Reel Recovery Film Festival on Friday, Nov 4th and Saturday, Nov 5th.

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Our family didn’t witness the beginning of Jake’s addiction. He was a normal high-school kid, fun and athletic. We were proud of him as he went off to college. When a childhood friend, nearly in tears, shared his concerns about Jake’s risky behavior, his dad and I were shocked. The evidence tumbled in from there—two failed classes Jake’s freshman year, loss of his scholarship, the inability to hold down a job after we stopped funding his education, his skinny body and dark hollow eyes. But the final puzzle piece was an odd smudge of soot on his forehead—Jake was smoking OxyContin.

Abuse of Oxy quickly led him to heroin. How could this happen to a kid raised in a loving family on a quiet street in Silicon Valley? Our entire family became consumed in some wrenching years. I was plagued with self-doubt and crushing guilt. Blame and shame consumed me. Where did I go wrong? What more could I have done? Why didn’t I see this coming? My husband reacted to my son’s addiction with frustration and anger. He threw himself into work which was something he could control. He was angry that our son’s crisis was all we ever talked about and it was true; I was obsessed with saving Jake.

My daughter was a junior in high school when the worst began. She was depressed that her brother had abandoned her and she felt left alone to watch her parents suffer. She rebelled against us as I clamped down, wanting to keep her safe since I hadn’t with her brother. She chose a troubled boyfriend—someone she could save—but then he abandoned her too. I tried to be there for her but she wouldn’t let me in. My son’s drug abuse was greatly affecting us all. Powerful emotions were splintering our family apart. I’ve learned that this is why addiction is called a family disease. One person may use, but the whole family suffers.

The first time I got Jake into rehab, my husband was away on business, my daughter distraught over her boyfriend. I worked alone in exhausted frenzy, making decision after decision, a battered explorer learning a new world. When Jake arrived at the place in Utah, I remember we all felt huge relief thinking, “Great, he’ll be fixed in thirty days and we can all go back to our nice lives, he can get back on track, no one has to know.” It was a devastating realization to learn that addiction is a lifelong disease, that his brain would convince him he didn’t have a problem, so he would likely relapse more than once. On top of that, we learned that if he did become willing to find recovery, it would take a long time for him to learn to live in sobriety and he would need a strong community for support.

Hard as it was for all of us to accept that, and believe me, our son was the last one to accept it. Understanding the science of the brain and sorting out the facts from misconceptions had ultimately helped us in our interactions with Jake. Learning about how his brain was working with the disease of addiction wrapped around it, started to change my thinking and pushed me to figure out better responses to those common symptoms of addiction: manipulation, entitlement, blame, lying, denial. If I viewed my son’s behavior as lazy and bad, I’d get angry. If I recognized those behaviors and actions as symptoms of the disease, it helped me gain compassion. Still, it took me a long time to learn it does no good to get angry at someone who is sick.

In the months that followed, Jake clung desperately to denial, cycling in and out of four different rehabs, as the rest of us struggled with the realities of our reconfigured family, our strained relationships with well-meaning family and friends, and the shame and stigma attached to addiction. I didn’t want to tell because we live in a society full of misperceptions and judgment but it was not a secret I could keep.

An addiction therapist encouraged me to tell my extended family and close friends that Jake was battling addiction; she saw that fear and silence were tearing me apart. She pointed out that telling instead of maintaining secrecy would ultimately help Jake because others could begin to learn about addiction for themselves. At first, I was all mixed-up not wanting to cross a line with Jake’s privacy, and he certainly didn’t want me to tell anybody, but as we feared for his life it got to be bigger than one person or one family could handle.

Breaking my silence began to help. Warmth and wisdom flowed from support meetings. Feeling understood by those who’d experienced the same chaos and heartbeat felt like balm on my roughened soul. I’d been desperately trying to save my son because that’s what mothers of drug addicts do. We try everything within our power to save them until we realize we have no power over our children or their drugs. I was learning the only person I had power over was me. Focusing on changing my own behavior—a slow and sometimes agonizing process—turned out to be the light to follow out of those deep dark woods.

I’ve written Saving Jake: When Addiction Hits Home to tell the story of our family’s battle, the lessons learned, the patterns repeated, the growth and change, the love. My book lets struggling families know they are not alone. Saving Jake is also intended for people with no experience of addiction, because I want everyone to learn more, to raise awareness, to gain compassion for the challenges facing an addict, and empathy for the family who often has to deal with shame and silence. When people hear the words “drug abuse” and “addiction” fear and denial can take over. We can put on blinders, ignore new information and assume that’s someone else’s problem. I did that—until addiction hit home. But I’ve since learned how fear can keep misperceptions firmly in place and how denial can block urgently needed change. Fear and denial together perpetuate the deadly silence surrounding addiction. Our nation’s drug epidemic is impacting every community, taking down tens of thousands just like Jake. Ours is the story of how drug addiction can happen to anyone. And it’s the story of how one family eventually finds their way to a ray of hope.

D’Anne Burwell holds a Master’s degree in education and advocates for families of addicts through radio commentaries, parent mentoring, speaking engagements and her resource-and-information website, www.ASKforFamilyRecovery.com Her commentaries have appeared on the Perspectives series on KQED/NPR. SAVING JAKE is the winner of the 2016 Eric Hoffer Book Award for Memoir and the 2015 USA Best Book Award for Addiction & Recovery. The mother of two young adults, D’Anne Burwell lives with her husband in Silicon Valley. For more information visit www.SavingJakeBook.com
FAMILY SUPPORT

One of the most difficult challenges in life is to try to cope with a loved one who is struggling with an addiction to drugs and/or alcohol. It is so important for families to have support and understanding to help them deal with this heart-breaking situation.

I have started this page for all the families coping with this devastating disease. There are many groups, and my suggestion is to try different ones until you find the one you are most comfortable with. You will also find some online groups. The most important thing you can do for your loved one is to get help for yourself. Together, we can make a big difference.

A New Path
www.newpath.org

Addiction Haven
www.addictionhaven.com

Bryan’s Hope
www.bryanshope.org

CAN- Change Addiction Now
www.changeaddictionnow.org

Changes
www.changesaddiction.org

FAN- Families Against Narcotics
www.familiesagainstnarcotics.org

Learn to Cope
www.learn2cope.org

The Long Island Council on Alcoholism and Drug Dependence
www.licadd.org

Magnolia New Beginnings
www.magnolianewbeginnings.org

Missouri Network for Opiate Reform and Recovery
www.mennonetwork.org

New Hope
facebook.com/New-Hope-Family-Addiction-Support-1682693525326550/
Parent Support Group New Jersey, Inc.
www.psgnjhomestead.com

P.I.C.K Awareness
www.pickawareness.com

Roots to Addiction
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WHAM! USING WHOLE HEALTH ACTION MANAGEMENT TO ADDRESS MENTAL HEALTH AND SUBSTANCE USE CONCERNS

By David Susman, Ph.D.

Over 60 years ago, Dr. Brock Chisholm, a psychiatrist and the first Director-General of the World Health Organization (WHO) said “Without mental health there can be no true physical health.” It’s now universally accepted that mental health and physical health are related and both must be included in any comprehensive personal recovery plan for mental illness or addiction. This combined focus on physical and mental health has been referred to as integrated care, holistic health, and whole health, among other terms.

A great example of an integrated health approach to more effectively manage mental health and substance use issues is WHAM, or Whole Health Action Management, developed by the SAMHSA-HRSA Center for Integrated Health Solutions. According to the authors, WHAM is a science-based health plan, created by peers for peers, to teach individuals how to set and achieve whole health goals via weekly action plans and 8-week support groups. A two day, in-person training teaches interested persons how to lead and facilitate a WHAM program.

In addition, WHAM provides education about the basic health screenings for prevention and it encourages shared decision-making with health professionals. WHAM is based on long-term disease self-management programs such as HARP (Health and Recovery Peer Program) and research-based approaches like the Relaxation Response.

The overall goals of the WHAM approach are to:

1) Write an achievable whole health goal and weekly action plan.
2) Participate in peer support groups to create new health behaviors.
3) Elicit the relaxation response to manage stress.
4) Engage in cognitive skills to avoid negative thinking.
5) Know basic health screenings and how to prepare for them.
6) Complete a shared-decision-making form for more engaging meetings with doctors.

10 Health and Resiliency Factors

The WHAM training model includes 10 health and resiliency factors. As each person develops their own whole health goals and plans, they will look at their current patterns, interests, and strengths in each of these 10 factors:

1. Stress Management
2. Healthy Eating
3. Physical Activity
4. Restful Sleep
5. Service to Others
6. Support Network
7. Optimism Based on Positive Expectations
8. Cognitive Skills to Avoid Negative Thinking
9. Spiritual Beliefs and Practices
10.A Sense of Meaning and Purpose

Outline and Format of WHAM

The WHAM materials are organized as follows:

Session 1: Welcome and Overview – This session includes an introduction to the program, a discussion of the 10 health and resiliency factors, an overview of the person-centered planning process and “5 keys to success.”

Session 2: The Science of Stress – This session describes the stress response, the relaxation response, and stress management techniques.

Session 3: Improving Your Health – This session covers the importance of and strategies for healthy eating, physical activity, and restful sleep.

Session 4: The Power of Human Connections – This session discusses the benefits of providing service to others and developing a strong support network.

Session 5: The Importance of Attitude – This session introduces the value of optimism based on positive expectations and how to use cognitive skills to avoid negative thinking.

Session 6: Connecting With That Which Is More Than Self – This session discusses spiritual beliefs and practices and the importance of finding a sense of meaning and purpose in one’s life.

Session 7: Health Risk, Screening, and Shared Decision-Making – This session covers common health risks, recommended health screenings, how to have effective shared decision-making about health issues with health care providers, and useful health screening resources.

Session 8: Key to Success 1 – This session describes the first of the 5 keys to success, which is setting a person-centered goal. Also included is a review and prioritization of the 10 health and resiliency factors, and applying six “IMPACT Criteria” to maximize the likelihood of achieving the personal goal.

Session 9: Keys to Success 2 & 3 – This session covers the second and third keys to success: having a weekly action plan and a daily/weekly personal log.

Session 10: Keys to Success 4 & 5 – This final session covers the last two keys to success: one-to-one peer support and a peer support group.

Typically, about 6 hours (usually three 2-hour meetings) are required to present the material from the 10 sessions described above. Then, participants will meet once a week for 8 weeks in a peer support group to discuss their progress toward developing and implementing their personal whole health goals and plans.

Learn More about WHAM

WHAM is an innovative program that’s definitely worth a look. The WHAM materials are divided into a participant guide and an implementation manual for group facilitators. If you want to start a WHAM program, you would first need to identify facilitators who would meet and review the provider manual and plan the program for your local area. Here are the links to each of the reference manuals:


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indirectly increasing the release of dopamine via a cascade of neurotransmission within the reward system of the brain. This is the so-called “heaven” sought out by millions daily. In the following figure, the differences between the natural anandamide and THC on brain and behavior are represented. The function of the brain structure that contains high numbers of CB receptors and the altered effect of the THC user are listed.

![Brain Structure](image)

Certainly, the literature is rife with controversy concerning many scientific aspects related to the “heaven” and “hell” effects of marijuana. One could make a case for either by selecting any appropriate literature citation. However, having an honest approach to this complex pharmacological risk compared to benefit inventory seems not only parsimonious but necessary for our lawmakers to vote responsibly. Without endorsing or agreeing with certain scientifically vetted issues on the subject (this would entail an in-depth scientific review) the following represents current thinking to this complex pharmacological risk compared to benefit inventory.

To vote responsibly. Without endorsing or agreeing with certain scientifically vetted issues on the subject (this would entail an in-depth scientific review) the following represents current thinking to this complex pharmacological risk compared to benefit inventory. The following represents current thinking to this complex pharmacological risk compared to benefit inventory. The following represents current thinking to this complex pharmacological risk compared to benefit inventory.

- **Question**: Is Marijuana Addictive?
  **Scientific Response**: There is some evidence that marijuana is both addictive and harmful to the human brain, especially when used as an adolescent. One in every six 16 year-olds (and one in every eleven adults) who try marijuana will become addicted to it. The retort here is that 33% of Americans carry polymorphic genes that provide a high risk for psychoactive drugs to be abused and become addictive.

- **Question**: Can Marijuana produce physical withdrawal not just psychological?
  **Scientific Response**: Different addictions have different symptoms, but whether its food, sex, marijuana, or heroin – your brain knows it wants more of that feeling of pleasure. Unlike alcohol, heroin, cocaine and tobacco, most chronic marijuana users who attempt to stop “cold turkey” will experience a milder array of withdrawal symptoms such as irritability, restlessness, anxiety, depression, insomnia, and/or cravings. Science has shown that 1 in 6 kids who ever try marijuana, according to the National Institutes of Health, will become addicted to the drug. Potentially, one explanation is that today’s marijuana is not your “Woodstock weed” – it can be 5-10 times stronger than marijuana of the past.

- **Question**: Does Marijuana Make you dumb?
  **Scientific Response**: While there is a plethora of data suggesting that short-term memory is impaired, there is also evidence that many successful people have smoked marijuana throughout their careers. However, research shows that adolescents who smoke marijuana once a week over a two-year period are almost six times more likely than nonsmokers to drop out of school and over three times less likely to enter college. Evidence from a large cohort published four years ago found that using marijuana regularly before the age of 18 resulted in an average IQ of six to eight fewer points at age 38 versus to those who did not use the drug before 18.

- **Question**: Marijuana makes you lack satisfaction and motivation?
  **Scientific Response**: While there is evidence that regular marijuana use is associated with lower satisfaction, lack of intimate romantic relationships and referred to as “a-motivational syndrome” surprisingly, a new paper in 2016 showed that when regular heavy daily marijuana users stopped using and were compared to so-called healthy non-users, the measured motivation was similar for both groups. This suggests that marijuana seems different from most other addictive drugs but does not make it safe, especially for adolescents.

- **Question**: Are Marijuana Users Clogging our Prisons?
  **Scientific Response**: Most Americans are unhappy with the fact that illegal possession of small amounts of marijuana should constitute incarceration. It is true that there have been some very unfair cases in the past, whereby people were jailed for only marijuana possession. However, a survey by the Bureau of Justice Statistics showed that 0.7% of all state inmates who were behind bars for marijuana possession only, had pled down from more serious crimes. In total, one tenth of one percent (0.1 percent) of all state prisoners were marijuana-possession offenders with no prior sentences. Other independent research has shown that the risk of arrest for each “joint,” or marijuana cigarette smoked is about 1 arrest for every 12,000 joints. This of course does not mean that self-medicating marijuana users should be arrested.

- **Question**: Is Marijuana a medicine?
  **Scientific Response**: The answer to this question is that more research should be conducted on the 22 alkaloids present in marijuana plants. There is significant growing evidence that certain cannabinoids have potent anti-tumor activity, anti-depressant characteristics, helpful with HIV/AIDS, glaucoma, multiple sclerosis, cardiovascular issues, sleep, anxiety, and anti-nausea. There is also some evidence for improvement in ADHD and focus at lower doses. Understanding this potential does not negate the fact that most states that permit the use of medical marijuana, less than 2-3% of users report having cancer, HIV/AIDS, glaucoma, MS, or other life-threatening diseases.

- **Question**: Does Marijuana cause lung cancer?
  **Scientific Response**: The evidence on lung cancer and marijuana is mixed – but marijuana contains 50% more carcinogens than tobacco smoke, and marijuana smokers report serious symptoms of chronic bronchitis and other respiratory illnesses. However, in some studies, the opposite was found showing that the combination of smoking marijuana with tobacco reduced the incidence of lung cancer. The growing use of vaporizers and edibles should reduce the use of tobacco.

- **Question**: Is Marijuana a gateway drug?
  **Scientific Response**: We know that most people who use Marijuana won’t go onto other drugs, but 95% of people who are addicted to other drugs started with alcohol and/or marijuana. However, regarding some scientific facts in mice, it is now known that THC (not marijuana per se) administered to pregnant females cause epigenetic effects for up to two generations so that the resultant generations have an increased sensitivity for subsequent heroin abuse and addiction. Scientifically, the real gateway drug is nicotine, especially for cocaine abuse.
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Alcohol and Nicotine are legal, why shouldn’t marijuana also be legal?

Scientific Response

Most scientists would agree that both alcohol and nicotine are far worse than marijuana in causing sickness and even death from its abuse. In fact, our currently legal drugs – alcohol and tobacco – provide a good example since both youth and adults use them far more frequently than illegal drugs. According to recent surveys, alcohol is used by 52% of Americans and tobacco is used by 27% of Americans, but marijuana is used by only 8% of Americans. However, with the rise in THC content of current recreational products like wax (up to in some cases 97%) we are being faced with an increase in psychosis and toddler intoxication from edibles.

One important issue brought up by the SAM organization that requires some discussion involves the concept of legalization and the change in the presence of drug cartels in mainstream America. SAM suggests that legalization will not do much to deter the drug cartels presence in America. They suggest that legalization of marijuana will involve unwanted taxes that will, in turn, result in people seeking cheaper tax-free products through illegal means. I find this hard to believe because we have not seen this with the legalization of alcohol in the United States. The boot-legers are gone, and as such this defense seems unfounded.

Based on restrictive marijuana laws regarding research especially in the smoked form, and Marijuana being placed in schedule 1 since the 60s, research on the plant has been almost non-existent. In fact, in one extreme case, a professor at a well-known University in America was fired for suggesting a study for smoked marijuana as an adjunct for PTSD. However, many scientists and some politicians have asked the US government to place marijuana in a lower category than Schedule 1 and are awaiting a response. There are however signs of a possible shift in attitude within the federal government. In May, the D.E.A. issued new rules to increase the government’s production of marijuana for research this year from 21,000 grams to 650,000 grams. At the National Institute on Drug Abuse, records show that at the beginning of this year there were 28 active grants for research into the possible medical benefits of marijuana in six disease categories. Additionally, other National Institutes of Health entities have been supporting marijuana research. As for independently funded marijuana research, the federal government has cleared 16 projects since 1999, 13 of them at the University of California, San Diego.

With the current information, many chronic marijuana users never go on to more ‘heavy-duty’ drugs. However, the use of marijuana is a ‘double-edged sword’ – it can be “Heaven or Hell.” More research is required and is in the pipeline. With that said we have yet to understand how to fully utilize its ‘magical’ properties – and to discover the best way as a society, that we can do with or without it.

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

**Siblings**

By Louise Stanger Ed.D, LCSW, CIP, CDWF-Candidate and Roger Porter

Continued from page 6

Acceptance is key to understanding your sibling’s long-term work to control their addiction. This will help you build trust with your sibling. Once a treatment process for the sibling in need has started, family dynamics will change as new roles and responsibilities emerge. This is normal. As a representative from the SHARC organization points out, “dealing with a brother or sister’s alcohol or drug problem tends to be a continual process, which can be seen as a series of stages.” While the sibling with the substance abuse/mental health disorder gets help through treatment, the other brothers and sisters must also get help, develop their own boundaries, understand their vulnerabilities and evolve their own relationships.

**Dr. Louise Stanger - Speaker, Writer, Teacher.**

Louise Stanger Ed.D, LCSW, CIP CW received her bachelor’s degree in English Literature from the University of Pittsburgh, her Masters in Social Work from San Diego State College and her Doctorate in Educational Leadership from the University of San Diego. Her book *Falling Up: A Memoir of Renewal* is available on Amazon and *Learn to Thrive-An Intervention Guidebook* is available is on her website www.allaboutinterventions.com

**Roger Porter** has two bachelor degrees, film and marketing, from the University of Texas at Austin. He works in the entertainment industry, writes screenplays and coverage, and when he’s not doing that he tutors middle and high school students. As a college alumnus he is committed to being an advocate for public discourse on college campuses.

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methadone?" These narcotics are more addictive than heroin and harder for an individual to get off of. They're also more potent. For example; one milligram of the popular MAT narcotic Suboxone is equal to 40 milligrams of a morphine derivative.

I'd also like to know how many addicts have been weaned off the MAT drugs in the last year. To the best of my knowledge no one is keeping track. Judging from the extremely limited studies I was able to find, I'd speculate a very, very small percentage stopped using the MAT narcotics. If addicts continue to be added to the MAT program and only a handful weaned off of the narcotics, than the pool of addicts using these dangerous drugs is only going to grow exponentially.

That may be great news for the manufacturers, distributors and sellers of buprenorphine and methadone, but it's a sad day for our culture. All that the new addiction related legislation is really accomplishing at this point is opioid replacement. Addicts are being herded away from Mexican heroin and prescription pain killers towards buprenorphine and methadone.

Switching addicts from opioids bought and sold in the streets to a name brand pharmaceutical opioid sold by doctors and calling it evidenced-based science is really lowering the bar. This is merely a word salad intended to make you believe the MAT program is the answer to your addiction issues; and that has strong appeal to an addict's core psyche; always looking for the quick fix. Is this really that much different than the Bayer Company marketing heroin directly to physicians as a completely safe and non-addictive cure for morphine addiction? Sure sounds similar.

None of these recent bills lays out a requisite monitoring program or time-table for weaning addicts off of the MAT narcotics. There is no incentive given for addicts to get off these drugs. No one is asking addicts to take responsibility for their actions – they're just given a free pass and a 90 day prescription to buprenorphine under the guise of compassion.

Isn't this course of action just extending someone's addictions into perpetuity and robbing them of their recovery? Millions of people are living happy and fulfilling lives after freeing themselves of opioids and there is every reason to think others can do it too.

There are other medications that are safer in helping patients overcome opioid addiction by blocking the effects of opioid drugs. Naltrexone was approved by the FDA in 1984 for opioid addiction. In combination with counseling for underlying issues, Naltrexone used for up to six months has shown to be an effective modality and easier to go off of. Buprenorphine has been a hit or miss modality; no one therapy that is effective for everyone. However, I will have more alternative therapies showing great promise in a future article.

Another common refrain from the pro-opioid camp is that MAT helps addicts get reconnected to the people that they used to be and to their loved ones. It enables them to hold jobs and be productive members of society. This is simply balderdash. I contributed to a study lead by my good friend and colleague Dr. Kenneth Blum – discoverer of the addiction gene, also known as the reward gene – where we took a look at the long-term emotional effects of Suboxone. We found that over the long-term, people developed muted emotional responses. They couldn't feel joy or sorrow. They didn't know if they were happy or sad. Sure, they might be able to hold down a menial low paying job as the pro-opioid camp suggests; but they're never going to feel the bliss of a loving relationship or the joy of bringing a new person into the world. For lack of a better term, over time Suboxone turns its users into zombies.

We are better than this. America's Second Opiate/Opioid Epidemic has been grabbing headlines for the last few years, forcing congress to act. As these lobbyist guided lawmakers tend to do, congress turned to a solution with a positive economic impact for major industry; more specifically in this case, PhRMA. What we have today is an addiction treatment model that is being driven by market growth and quarterly profits rather than common sense and effective evidenced-based and scientifically-proven modalities. Profit driven treatment centers are popping up like hamburger joints on every street corner. Buprenorphine centers have begun taking root in our communities. Whether they grow to become the next pill mills has yet to be seen; but not hard to imagine.

The fatal flaw in congress's assessment of this epidemic was not recognizing it as the humanitarian issue that it is rather than an economic one. Their solution is a mere sweeping of the problem under the carpet, out of the headlines and public view. Problem solved. The reality is that congress has done nothing more for addicts than rearrange the chairs on the Titanic for them to sit in and extended the deck size to accommodate the influx of the new group addicted to PhRMA's poison. The manufacturers, middle men and sellers will continue to grow their profits year after year for the foreseeable future from this epidemic while people continue to die from it. Lives will be destroyed, families will continue to be ruined and innocent people are going to continue to be harmed until our government stops flooding the market with opioids.

There is only one way out of this crisis and it doesn’t include more opioids. As Dr. Wright so clearly pointed out over a century ago; using an opioid to treat an opioid addiction only extends the addiction and robs that individual of his recovery.

Primum non nocere – “First do no harm,” A doctor’s creed from the Hippocratic Oath.

John Giordano DHL, MAC is co-host of “Addiction Untreated” with Michael Lohan airing Sundays at 12 noon EDT on WZZR 94.3FM Boca and iHeart Radio nationally, President and Founder of the National Institute for Holistic Addiction Studies, Chaplain of the North Miami Police Department and is on the editorial board of The Scientific Journal of Reward Deficiency Syndrome (JRDS). For the latest development in cutting-edge treatment check out his website: www.holisticaddictioninfo.com

**THE “HOW TO GUIDE” FOR FAMILIES AND TREATMENT CENTERS USING THE MARCHMAN ACT**

By Joseph M. Considine, P.A. Continued from page 12

mental health professionals should have their concerns allayed by the fact that the qualified professional is the only expert in the courtroom; is the only expert who has assessed the individual; and even though lawyers think they know everything, the mental health professional is much more knowledgeable in this instance.

Occasionally, families fear the resulting anger which may come from the substance abuser as a result of filing a Marchman Act case. I was very impressed by the comments of a client, the words of a father, who filed the case notwithstanding that his daughter would be very angry with him. He remarked to me: “I want to know that if her substance abuse kills her, I did everything possible for her to get her help.”

Finally, the Marchman Act proceedings are confidential by law and the contents of the filing are confidential and protected from disclosure both under HIPPA laws and the Marchman Act itself.

Joe Considine has practiced law in South Florida since 1983. His practice is limited to family law and addiction related law including the Marchman Act. Joe has handled over 1500 litigation cases in his career, appearing in courts throughout Florida. Joe works extensively with families whose loved ones have substance abuse and mental health problems as an attorney. He lectures throughout Florida on family law matters including the Marchman Act and other substance abuse related issues.

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