ARMS ACRES
75 SEMINARY HILL ROAD, CARMEL, NY 10512

Main Telephone #: (845) 225-3400
Admissions/Intake: (888) 227-4641

Please visit our WEBSITE at www.armsacres.com
Co-Occurring Disorders
Trends + Treatment - 2013

Dr. Frederick Hesse
Medical Director, Arms Acres, Inc.
www.ArmsAcres.com(800) 989-2676
Liberty Management.com
Arms Acres is a private health care system providing the highest quality professional treatment to those suffering from chemical dependency, co-occurring medical and mental health disorders and to those whose lives are impacted by the disease of addiction. Services are provided to diverse populations using the latest innovations in evidence based practices in a caring and respectful environment. Exceptional customer service, community education and fiscal responsibility are our priorities.

Arms Acres is managed by Liberty Behavioral Management Corp., a leader in Behavioral Health Care Management. For more information about Liberty Behavioral Management Corp. and it's other treatment facilities please visit our website.

Additional Links

Conferences & Education

E-Mail Patients

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Click HERE for details on our Alumni Sober Cinco De Mayo Family Gathering.

ARMS ACRES IS NOW ON FACEBOOK!
Click HERE to visit and receive updates!

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Forget past mistakes. Forget failures. Forget about everything except what you’re going to do now - and do it.
- William Durant

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Recovery is within “ARMS” reach...
Providing Inpatient and Outpatient Services to Adolescents experiencing Emotional disturbances, Psychiatric symptoms and/or Substance Abuse Issues

Arms Acres, Conifer Park, and Holliswood Hospital have been leaders in treating Adolescent Issues for over 20 years. Providing both inpatient and outpatient treatment to adolescents 11-17 years old, we are able to provide a true continuum of care throughout the New York City Region, the Hudson Valley, and the Upstate Regions. We also service New Jersey, Connecticut, and Vermont.

Adolescent Substance Abuse & Psychiatric Treatment

The Holliswood Hospital Inpatient Adolescent Program offers therapeutically intensive, coordinated clinical services for adolescents who may be experiencing an emotional disturbance and/or psychiatric symptoms that seriously limit their ability to function adequately with their family, school and community.

Arms Acres and Conifer Park offer inpatient and outpatient treatment to substance abusing adolescents by treating the disease of chemical dependency with the goal of rehabilitating the adolescent’s physical, mental and spiritual life. The treatment program is multidisciplinary in scope and individualized in approach.

Arms Acres, Conifer Park and Holliswood Hospital realize that not all adolescents are equally motivated to make the necessary changes to ensure continued health and success post-treatment. With this in mind we utilize two evidenced based treatment approaches to engage adolescents in the treatment process despite cognitive, developmental and motivation deficits. We utilize both Motivational Enhancement and Cognitive Behavioral therapeutic approaches in engaging, educating and treating adolescents to safely transition to the next level of care. Patients identify and address the direct negative consequences resulting from chemical use.

Anger Management
Special focus given regarding significant issues related to mismanagement of anger and other related emotions as a means of stabilizing and arresting behaviors that could result in direct injury to self or others.

Dual Focus
Special focus given to coexisting issues ranging from ADHD, Mood Disorder and substance induced mental health issues/symptoms. Includes strategies for symptom management as well as evaluation/medication management.

Internally Motivated
Utilizing a CBT approach, patients are educated regarding the abstinence model of recovery, exposed to the 12-step framework and develop a community based sober support network.

Contact one of our locations listed on the back cover for more information about our programs.
Prescriptions now biggest cause of fatal drug overdoses

By Liz Szabo, USA TODAY

Debra Jones didn't begin taking painkillers to get high.

Jones, 50, was trying to relieve chronic pain caused by rheumatoid arthritis.

Yet after taking the painkiller Percocet safely for 10 years, the stay-at-home mother of three became addicted after a friend suggested that crushing her pills could bring faster relief. It worked. The rush of medication also gave her more energy. Over time, she began to rely on that energy boost to get through the day. She began taking six or seven pills a day instead of the three to four a day as prescribed.

"I wasn't trying to abuse it" says Jones, from Holly Springs, N.C., who has since recovered from her battle with addiction. "But after 10 years, I couldn't help what it did to my body or my brain. It was hard to work without it."

Addiction to prescription painkillers — which kill thousands of Americans a year — has become a largely unrecognized epidemic, experts say. In fact, prescription drugs cause most of the more than 26,000 fatal overdoses each year, says Leonard Paulozzi of the Centers for Disease Control and Prevention.

The number of overdose deaths from opioid painkillers — opioid-like drugs that include morphine and codeine — more than tripled from 1999 to 2008, to 13,800 deaths that year, according to CDC statistics released Wednesday.

In the past, most overdoses were due to illegal narcotics, such as heroin, with most deaths in big cities. Prescription painkillers have now surpassed heroin and cocaine, however, as the leading cause of fatal overdoses, Paulozzi says. And the rate of fatal overdoses is now about as high in rural areas — 7.8 deaths per 100,000 people — as in cities, where the rate is 7.5 deaths per 100,000 people, according to a paper by

FATAL OVERDOSES

Big spikes in overdose rates have coincided with increases in the use of street drugs, such as heroin in the 1970s. Year and rate per 100,000:

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
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<tbody>
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Ads by Google
Drug deaths now outnumber traffic fatalities in U.S., data show

Fueling the surge are prescription pain and anxiety drugs that are potent, highly addictive and especially dangerous when combined with one another or with other drugs or alcohol.

September 17, 2011 | By Lisa Girion, Scott Glover and Doug Smith, Los Angeles Times

Propelled by an increase in prescription narcotic overdoses, drug deaths now outnumber traffic fatalities in the United States, a Times analysis of government data has found.

Drugs exceeded motor vehicle accidents as a cause of death in 2009, killing at least 37,485 people nationwide, according to preliminary data from the U.S. Centers for Disease Control and Prevention.

While most major causes of preventable death are declining, drugs are an exception. The death toll has doubled in the last decade, now claiming a life every 14 minutes. By contrast, traffic accidents have been dropping for decades because of huge investments in auto safety.

Public health experts have used the comparison to draw attention to the nation’s growing prescription drug problem, which they characterize as an epidemic. This is the first time that drugs have accounted for more fatalities than traffic accidents since the government started tracking drug-induced deaths in 1979.

Fueling the surge in deaths are prescription pain and anxiety drugs that are potent, highly addictive and especially dangerous when combined with one another or with other drugs or alcohol. Among the most commonly abused are OxyContin, Vicodin, Xanax and Soma. One relative newcomer to the scene is Fentanyl, a painkiller that comes in the form of patches and lozenges and is 100 times more powerful than morphine.

Such drugs now cause more deaths than heroin and cocaine combined.

“The problem is right here under our noses in our medicine cabinets,” said Laz Salinas, a sheriffs commander in Santa Barbara, which has seen a dramatic rise in prescription drug deaths in recent years.

Overdose victims range in age and circumstance from teenagers who pop pills to get a heroin-like high to middle-aged working men and women who take medications prescribed for strained backs and burn knees and become addicted.

A review of hundreds of autopsy reports in Southern California reveals one tragic demise after another: A 19-year-old Army recruit, who had just passed his military physical, took a handful of Xanax and painkillers while partying with friends. A groom, anxious over his upcoming wedding, overdosed on a cocktail of prescription drugs. A teenage honors student overdosed on painkillers her father left in her medicine cabinet from a surgery years earlier. A toddler was orphaned after both parents overdosed on prescription drugs months apart. A grandmother suffering from chronic back pain apparently forgot she already taken her daily regimen of pills and ended up double dosing.

Many die after failed attempts at rehab — or after using one too many times while contemplating quitting. That’s apparently what happened to a San Diego woman found dead with a Fentanyl patch on her body, one of five she applied in the 24 hours before her death. Next to her on the couch was a notebook with information about rehab.

The roots of the problem were planted more than a decade ago by well-meaning efforts by doctors to mitigate suffering, as well as aggressive sales campaigns by pharmaceutical manufacturers. In hindsight, the liberalized prescription of pain drugs “may in fact be the cause of the epidemic we’re now facing,” said Linda Rosenstock, dean of the UCLA School of Public Health.

In some ways, prescription drugs are more dangerous than illicit ones because users don’t have their guard up, said Los Angeles County Sheriff’s Sgt. Steve Opferman, head of a county task force on prescription drug-related crimes. “People feel they are safer with prescription drugs because you get them from a pharmacy and they are prescribed by a doctor,” Opferman said. “Younger people believe they are safer than illegal drugs.”
Deaths From Painkiller Overdose on the Rise, Says CDC

A new report from the Centers for Disease Control and Prevention found nearly 40 Americans die per day -- about 15,000 per year -- from overdoses of painkillers such as Vicodin and OxyContin, linking the epidemic of chronic pain to the epidemic of drug deaths.

By KIM CAROLLO
Nov. 1, 2011
## Arms Acres Opiate Diagnoses

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</tbody>
</table>
Prevalence of Opioid Dependence

Over 2 million people* in the US are opioid dependent
More than 80% are dependent on prescription opioid pain relievers

*Aged 18 or older, 2009

Reference
Substance Abuse and Mental Health Services Administration. Office of Applied Studies, HHS Publication No. SMA 09-4434; 2009.
Drug overdose death rates have increased steadily in the United States since 1979. In 2008, a total of 36,450 drug overdose deaths (i.e., unintentional, intentional [suicide or homicide], or undetermined intent) were reported, with prescription opioid analgesics (e.g., oxycodone, hydrocodone, and methadone), cocaine, and heroin the drugs most commonly involved (1). Since the mid-1990s, community-based programs have offered opioid overdose prevention services to persons who use drugs, their families and friends, and service providers. Since 1996, an increasing number of these programs have provided the opioid antagonist naloxone hydrochloride, the treatment of choice to reverse the potentially fatal respiratory depression caused by overdose of heroin and other opioids (2). Naloxone has no effect on non-opioid overdoses (e.g., cocaine, benzodiazepines, or alcohol) (3). In October 2010, the Harm Reduction Coalition, a national advocacy and capacity-building organization, surveyed 50 programs known to distribute naloxone in the United States, to collect data on local program locations, naloxone distribution, and overdose reversals. This report summarizes the findings for the 48 programs that completed the survey and the 188 local programs represented by the responses. Since the first opioid overdose prevention program began distributing naloxone in 1996, the respondent programs reported training and distributing naloxone to 53,032 persons and receiving reports of 10,171 overdose reversals. Providing opioid overdose education and naloxone to persons who use drugs and to persons who might be present at an opioid overdose can help reduce opioid overdose mortality, a rapidly growing public health concern.

Overdose is common among persons who use opioids, including heroin users. In a 2002–2004 study of 329 drug users, 82% said they had used heroin, 64.6% had witnessed a drug overdose, and 34.6% had experienced an unintentional drug overdose (4). In 1996, community-based programs began offering naloxone and other opioid overdose prevention services to persons who use drugs, their families and friends, and service providers (e.g.,
Naloxone OD Antidote

Naloxone: The Second Chance Drug

Naloxone (also called Narcan) is the antidote that reverses an opioid overdose. It has been used in ambulances and hospitals for decades to reverse overdose. It’s legal and has been approved by the Food and Drug Administration (FDA). It works by neutralizing the opioids in your system and helping you breathe again. Naloxone only works if a person has opioids in their system; the medication doesn’t work on other drugs. You can’t get high from it and it is safe for nearly everyone. It has been used in programs all over the world to effectively reverse opioid overdoses. It’s a lifesaver, there’s no doubt about it.

There are two kinds of naloxone, one that you can squirt up someone’s nose and another that can be injected through clothing into a muscle.

Project Lazarus provides naloxone for FREE through Brame Huie Pharmacy in North Wilkesboro.

The Centers for Disease Control and Prevention (CDC) reports more than 10,000 reversals of overdoses with naloxone by non-medical bystanders!

Naloxone is also an important tool for empowering communities to protect their health. Reviving an overdose victim can be a very powerful motivator to help people change their behaviors. This fact sheet on naloxone shows examples of how naloxone is empowering.

Check out these great resources from the Harm Reduction Coalition, including educational materials, manuals, best practice documents, case studies, research and more.

Naloxone is a prescription medication. Visit your doctor to get a prescription. Medicaid, Medicare and most health insurance covers it. If your doctor isn’t familiar with naloxone, then direct them to PrescribeToPrevent.org or print out these few pages that explain how to prescribe it.
Comprehensive Alcohol Dependence Treatment

Limbic Region
Role: Drive Generation
Intervention: Pharmacotherapy

Cortex
Role: Decision Making
Intervention: Counseling
There are three main choices for medication.

The most common medications used in treatment of opioid addiction are **methadone** and **buprenorphine**. Sometimes another medication, called **naltrexone**, is used. Cost varies for the different medications. This may need to be taken into account when considering treatment options.

Methadone and buprenorphine trick the brain into thinking it is still getting the problem opioid. The person taking the medication feels normal, not high, and withdrawal does not occur. Methadone and buprenorphine also reduce cravings.

Naltrexone helps overcome addiction in a different way. It blocks the effect of opioid drugs. This takes away the feeling of getting high if the problem drug is used again. This feature makes naltrexone a good choice to prevent **relapse** (falling back into problem drug use).

All of these medications have the same positive effect: they reduce problem addiction behavior.
AN INTRODUCTION TO EXTENDED-RELEASE INJECTABLE NALTREXONE FOR THE TREATMENT OF PEOPLE WITH OPIOID DEPENDENCE

The U.S. Food and Drug Administration (FDA) approved extended-release injectable naltrexone (Vivitrol) in October 2010 to treat people with opioid dependence. This medication provides patients with opioid dependence the opportunity to take effective medication monthly, as opposed to the daily dosing required by other opioid dependence medications (i.e., methadone, buprenorphine, oral naltrexone). Extended-release injectable naltrexone was approved by FDA in 2006 to treat people with alcohol dependence.

Treatment of opioid dependence remains a national priority. According to the 2010 National Survey on Drug Use and Health, approximately 359,000 individuals reported either dependence on or abuse of opioids in the past year.

What Role Can Extended-Release Injectable Naltrexone Play in the Treatment of Opioid Dependence?

Extended-release injectable naltrexone is another pharmacological tool that is approved for treatment of people with opioid dependence. Over the years, medications have been successful in treating many patients with opioid dependence. Methadone has been used to treat patients for decades and has been proven effective. However, methadone must be dispensed to the patient at a Substance Abuse and Mental Health Services Administration (SAMHSA)-certified opioid treatment program (OTP) facility—with daily doses administered by a trained professional. This may not be feasible for many individuals. Extended-release injectable naltrexone offers a possible alternative for those who are not able to comply with daily dosing.
This article examines a proposal to offer depot naltrexone to nonviolent opiate-addicted criminal offenders in exchange for release from incarceration or diversion from prosecution. This "negative-reinforcement" behavioral paradigm could have a better chance of success than what has been attempted with drug-abusing offenders. Although positive reinforcement can be more efficacious, it has often been strenuously resisted on the ground that it is inequitable to reward antisocial individuals for doing what is minimally expected of most citizens. Negative reinforcement steers between these hurdles by avoiding the iatrogenic effects of punishment, while also being palatable to stakeholders.

The current proposal provides an excellent platform for conducting this research because the target intervention (depot naltrexone) is demonstrably efficacious, nonpsychoactive, and has few, if any, side effects. Therefore, use of this medication would be unlikely to invoke the same types of legal and ethical objections that have traditionally been levied against the use of psychoactive medications with vulnerable populations of institutionalized offenders. Specific recommendations are offered for questions that must be addressed.

Treatment Research Institute, University of Pennsylvania, dmarlowe@tresearch.org
Girls Keeping Up With the Boys at Bars

Despite Sobering Statistics, Girls' Binge-Drinking Is a Growing Problem on Campuses

March 10, 2006 — Drinking to excess has always been a tradition and a problem among college men. But now college women are a growing concern. They're binge drinking in alarming numbers — and not just on spring break. They're out in public, staggering in the streets, falling down drunk, and becoming easy targets for sexual assault.

"They are not only drinking more than their male peers, but they are now more likely to drink more heavily than their male peers," said David Jernigan, executive director at the Center for Alcohol Marketing and Youth at Georgetown University.

Of particular worry are the drinking patterns of women under the age of 21. "There has been a huge amount of effort to stop underage drinking in this country in the last 10 years. It's made some impact with the boys. We are not getting anywhere with the girls," said Jernigan.

Koren Zailckas was one of the many girls who didn't get the message about the dangers of drinking. A bright, happy child born into a stable, affluent family outside Boston, she was a star student at the local high school, but she lost much of her girlhood to the foggy haze of alcohol abuse.

"My friends were all drinking at that time. I was afraid of being excluded from them. ... I think that is where peer pressure is. I think we are drawn to alcohol because there is a problem of
Models and Opiates

DRUG TRAIN
About Drugs People & Popular Culture

Heroin Chic

The term was used to describe a set of pictures in 1997 featuring Kate Moss and advertising Calvin Klein clothes. It was dubbed heroin chic because the model's look was typified by emaciated and waif-like appearance with sunken and glazed eyes and came under a lot of criticism for promoting drugs and drug use.
Yves Saint Laurent perfume 'drug simulation' ad ban

An Yves Saint Laurent (YSL) perfume advert has been banned for appearing to show a woman simulating drug use, the Advertising Standards Authority said.

The TV advert for Belle D'Opium showed a woman running her finger along the inside of her forearm and lying on the floor as a voiceover said: "I am your addiction. I am Belle D’Opium."

It prompted complaints from 13 viewers who said it simulated drug use.

YSL said its research showed consumers had not interpreted the ad in that way.

The company also said it had not intended to use drug imagery.

The Advertising Standards Authority (ASA) said it was concerned that the woman's behaviour could be seen as simulating drug use.

Related Stories

Stansted train time poster banned
Pregnant nun ice cream ad banned

Top stories

Confusion over Gaddafi son’s fate
Eight dead in California shooting
Apple wins Samsung Australia ban
Salvage crew returns to NZ ship
Deadly storm hits Central America
Monitoring The Future - MTF 2011

Prescription and Over-the-Counter Medications Account for Most of the Commonly Abused Drugs: Past Year Use Among High School Seniors

Percent

Marjuana/Hashish  Synthetic Marijuana  Vicodin  Adderall  Salvia  Tranquilizers  Cough Medicine  MDMA (Ecstasy)  Hallucinogens  OxyContin  Sedatives  Inhalants  Cocaine (any form)  Ritalin

Illicit Drug
Non-medical Use of Prescription Medication

Categories are not mutually exclusive
Source: University of Michigan, 2011 Monitoring the Future Study
Areas of Concern

- While marijuana use declined in the late 1990s and early 2000s, 5-year trends are showing significant increases among 10th and 12th graders for daily, current and past year use. This year, 12.5% of 8th graders, 28.8% of 10th graders, and 36.4% of 12th graders reported past-year use.

Source: The Monitoring the Future study, the University of Michigan, 2011
Teens who smoke pot at risk for later schizophrenia, psychosis

POSTED MARCH 07, 2011, 11:03 AM
Ann MacDonald, Editor, Harvard Health Publications

Teenagers and young adults who use marijuana may be messing with their heads in ways they don't intend.

Evidence is mounting that regular marijuana use increases the chance that a teenager will develop psychosis, a pattern of unusual thoughts or perceptions, such as believing the television is transmitting secret messages. It also increases the risk of developing schizophrenia, a disabling brain disorder that not only causes psychosis, but also problems concentrating and loss of emotional expression.

In one recent study that followed nearly 2,000 teenagers as they became young adults, young people who smoked marijuana at least five times were twice as likely to have developed psychosis over the next 10 years as those who didn't smoke pot.

Another new paper concluded that early marijuana use could actually hasten the onset of psychosis by three years. Those most at risk are youths who already have a mother, father, or sibling with schizophrenia or some other psychotic disorder.

Young people with a parent or sibling affected by psychosis have a roughly one in 10 chance of developing the condition themselves—even if they never smoke pot. Regular marijuana use, however, doubles their risk—to a one in five chance of becoming psychotic.

In comparison, youths in families unaffected by psychosis have a 7 in 1,000 chance of developing it. If they smoke pot regularly, the risk doubles, to 14 in 1,000.

For years, now, experts have been sounding the alarm about a possible link between marijuana use and psychosis. One of the best-known studies followed nearly 50,000 young Swedish soldiers for 15 years. Those who had smoked marijuana at least once were more than twice as likely to develop schizophrenia as those who had never smoked pot. The heaviest users (who said they used marijuana more than 50 times) were six times as likely to develop schizophrenia as the nonusers.

So far, this research shows only an association between smoking pot and developing psychosis or schizophrenia later on. That's not the same thing as saying that marijuana causes psychosis.

This is how research works. Years ago, scientists first noted an association between cigarette smoking and lung cancer. Only later were they able to figure out exactly how cigarette smoke damaged the lungs and other parts of the body, causing cancer and other diseases.

The research on marijuana and the brain is at a much earlier stage. We do know that THC, one of the active compounds in marijuana, stimulates the brain and triggers other brain chemicals known to influence mood.

Links- Risk of mental illness and drug use
In New York - No More Mr. Nice Guy?

Just Buy Online
Organic Spice.com and more...

Buy Spice Online
Now offers FREE SHIPPING on all Items
Orders over $50 - Free Priority Shipping 2-3 Business Days.
Orders over $125* - Free Express Shipping 1-2 business days.

All of our products are of the finest potpourri aroma blends.

New Arrivals

- Abomination Exotic Skin Treatment Bath Salt
- Salvia Divinorum 30x Extract (1 Gram)
- Judgement Day

...and more.
NIDA Info Facts - Spice

• Analyses of seized spice mixtures revealed-
• Synthetic (or designer) cannabinoid compounds
• JWH-018 and HU-210
• Bind to the same cannabinoid receptors in the body as THC (delta-9-tetrahydrocannabinol)
• CB1 receptor vs. CB2
• Abused mainly by smoking also mixed with marijuana or in liquid for drinking.
NIDA Info Facts - Spice Health Effects

- No large-scale studies of effects on human health or behavior.
- Cannbinoids in Spice bind to the same receptors as THC
- Some of them bind more strongly to the receptors [CB1 vs. CB2]
- Could lead to more powerful and unpredictable effects [physical + psychiatric]
- May experience withdrawal and addiction symptoms.
Bath Salts - NIDA Alert 2011

• "Bath Salts" - Emerging and Dangerous Products
• NIDA Director Nora Volkow February 2011
• Amphetamine-like chemicals, as methylenedioxypyrovalerone (MPDV), mephedrone and pyrovalerone
• Typically taken orally, by inhalation, or by injection
• Contents of "bath salts" are largely unknown
• Labeled as "not fit for human consumption."
NIDA Info Facts - Salvia Adol Use

• NIDA’s Monitoring the Future Survey of 8th, 10th, and 12th graders
• Salvia abuse in 2009—5.7 percent of seniors reported past-year use (greater than the percent reporting ecstasy use).
• Latest MTF figures reported by 8th, 10th, and 12th graders unchanged from 2010 to 2011, with 1.6 percent of 8th graders, 3.9 percent of 10th graders, and 5.9 percent of 12th graders reporting past-year abuse.
• Abuse is likely driven by drug-related videos and information on Internet sites.
Old Opiate Threats

OxyContin Litigation

Representing Victims Of OxyContin Addiction

OxyContin has emerged as one of the most addictive prescription drugs ever. OxyContin is very similar to morphine, and is used to treat moderate to severe pain. The extended-release form of this medication is for around-the-clock treatment of pain. OxyContin can become habit-forming and should be used only by the person it was prescribed for. OxyContin should never be given to another person, especially someone who has a history of drug abuse or addiction. Each pill is designed to release the drug slowly over a 12-hour period, so taking two tablets each day can provide continuous relief for chronic pain. OxyContin pills come in 10mg, 20mg, 40mg, 60mg and 160mg dosages. OxyContin also comes in capsule or liquid form.

Dangerous side effects or death can take place when alcohol is combined with a narcotic pain medicine. Check your food and medicine labels to be sure these products do not contain alcohol. Never take more than your prescribed dose of OxyContin. Tell your doctor if the medicine seems to stop working as well in relieving your pain. OxyContin can cause side effects that may impair your thinking or reactions. Be careful if you drive or do anything that requires you to be awake and alert. Do not stop using OxyContin suddenly, or you could have unpleasant withdrawal symptoms. Talk to your doctor about how to avoid withdrawal symptoms when stopping the medication.

Purdue Pharma L.P. first introduced OxyContin onto the market in 1995. In January 2004, congressional investigators stated that Purdue Pharma delivered promotional videos to physicians making unsupported claims that minimized the dangers of the pain-relief drug. In January of 2003, Purdue Pharma agreed to...

Source- Mark & Associates, P.C.
New Opiate Threats

U.S. DEPARTMENT OF JUSTICE

EWS Report 000011  
May 19, 2011

This SENTRY Watch is based on source materials that have not been validated and/or researched by the National Drug Intelligence Center (NDIC). It is intended to serve as an immediate alert to law enforcement and public health officials of potential substance abuse.

Law enforcement and public health officials throughout the country are reporting that oxymorphone abuse is increasing. Oxymorphone is most commonly known by the brand name Opana®. The deaths of at least nine Louisville area residents between January and April 2011 have been linked to polydrug abuse of oxymorphone in combination with alprazolam and/or alcohol; more oxymorphone-related deaths are expected to be confirmed as toxicology testing is completed on other decedents. Since January 2008, oxymorphone-related deaths also have been reported in California, Colorado, Connecticut, Florida, Michigan, New Mexico, North Carolina, Ohio, South Dakota, Tennessee, and Washington (see map). Additionally, in March 2009, Newport (TN) law enforcement authorities reported that oxymorphone resulted in five fatal overdoses within a 3-month period.

Oxymorphone is a Schedule II controlled substance typically prescribed to treat moderate to severe pain. Oxymorphone tablets are available in both immediate-release and extended-release forms. The abuse potential of oxymorphone is similar to that of other opioid analgesics, including morphine. Primary oxymorphone abusers are Caucasian young adults aged 18 to 25; female abusers slightly outnumber male abusers. These demographics mirror those of other opioid abusers. Street names for oxymorphone include biscuits, blue heaven, blues, Mrs. O, octagons, stop signs, and The O Bomb.
Afghan opium production 'rises by 61%'
compared with 2010

Opium production in Afghanistan rose by an estimated 61% this year compared with 2010, according to a UN report.

The increase has been attributed to rising opium prices that have driven farmers to expand cultivation of the illicit opium poppy by 7% in 2011.

Last year opium production halved largely due to a plant infection which drastically reduced yields.

Afghanistan produces 90% of the world’s opium - 5,800 tonnes this year - the main ingredient of heroin.

Analysts say that revenue from the drug has helped fund the Taliban insurgency.

Farmers who responded to the survey described economic hardship and lucrative prices as the main reasons for the increase.

Nearly 80% of the opium grown in Afghanistan is being produced in provinces in the south, including Helmand and Kandahar, which are among the most volatile in the country.

The UN says this demonstrates that there is a clear link between insecurity and opium cultivation.
### Prevalence of Alcohol Dependence Among NESARC Respondents With Psychiatric Disorders

<table>
<thead>
<tr>
<th>Index Disorder</th>
<th>% (SE)</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar I disorder (12 Month)</td>
<td>17.8 (1.83)</td>
<td>5.9 (4.6–7.7)</td>
</tr>
<tr>
<td>Bipolar I disorder (Lifetime)</td>
<td>40.5 (1.78)</td>
<td>5.2 (4.5–6.1)</td>
</tr>
<tr>
<td>Any personality disorder (12 Month)</td>
<td>10.2 (0.51)</td>
<td>4.0 (3.6–4.6)</td>
</tr>
<tr>
<td>Histrionic PD (12 Month)</td>
<td>21.3 (1.88)</td>
<td>7.5 (6.0–9.4)</td>
</tr>
<tr>
<td>Antisocial PD (12 Month)</td>
<td>19.2 (1.29)</td>
<td>7.1 (6.0–8.4)</td>
</tr>
<tr>
<td>Dependent PD (12 Month)</td>
<td>19.1 (3.93)</td>
<td>6.1 (3.6–10.1)</td>
</tr>
<tr>
<td>Major depressive disorder (12 Month)</td>
<td>8.2 (0.78)</td>
<td>2.4 (1.9–3.0)</td>
</tr>
<tr>
<td>Major depressive disorder (Lifetime)</td>
<td>21.0 (0.78)</td>
<td>2.1 (1.9–2.3)</td>
</tr>
<tr>
<td>Social anxiety disorder (12 Month)</td>
<td>8.6 (1.16)</td>
<td>2.3 (1.7–3.1)</td>
</tr>
<tr>
<td>Social anxiety disorder (Lifetime)</td>
<td>27.3 (1.39)</td>
<td>2.7 (2.4–3.2)</td>
</tr>
</tbody>
</table>


OR = odds ratio;  
PD = personality disorder.
Management of Psychiatric Disorders and Comorbid Alcohol Dependence

Screen
Routinely evaluate patients with psychiatric disorders for alcohol use disorders

Treat
Integrate addiction and mental health services

Facilitate abstinence from alcohol
- Psychosocial interventions
- Pharmacotherapies

Stabilize psychiatric symptoms

Individualize therapeutic interventions to the patient’s particular problem set

Roadblocks to Recovery

Psychiatric Symptoms Can Impede Efforts to Treat Comorbid Alcohol Dependence

Mood symptoms
Hinder patients’ active involvement in treatment

Anxiety symptoms
Impede ability to take part in group therapy or attend AA meetings

Antisocial symptoms or behaviors
Hamper patient recovery and/or that of other patients

SAMHSA TIP Series 42
Substance Abuse Treatment for Persons With Co-Occurring Disorders - Jan. 2007

- Treatment Improvement Protocols
- Vast List of Treatment Issues
- Free
- www.Samhsa.gov
Overview of Mental Disorders and Diagnoses

- Personality Disorders
- Mood Disorders and Anxiety Disorders
- Schizophrenia and Psychotic Disorders
- Attention-Deficit/Hyperactivity Disorder (AD/HD)
- Posttraumatic Stress Disorder (PTSD)
- Eating Disorders
- Pathological Gambling
Suicide and Substance Abuse

• Abuse of alcohol or drugs is a major risk factor in suicide, both with COD and for the general population.

• Alcohol abuse associated w/25 to 50 percent of suicides. Between 5 and 27 percent of all deaths of people abuse alcohol are suicide, with the lifetime risk for suicide among people who abuse alcohol estimated to be 15 percent.

• Strong relationship between substance abuse and suicide among young people.
Suicide and Substance Abuse

- Comorbidity of alcoholism and depression increases suicide risk.
- Association between alcohol use and suicide when alcohol removes inhibitions, leading to poor judgment, mood instability, and impulsiveness.
- Substance intoxication associated with violence, both toward others and self.
DSM-IV categorical classification system

• Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, and schizophrenia.

• Common Axis II disorders include borderline personality disorder, schizotypal personality disorder, antisocial personality disorder, narcissistic personality disorder, and mild mental retardation.
Mood and Anxiety Disorders

- Older adults may be the group at highest risk for combined mood disorder and substance problems. Mood disturbances increase in frequency with age. Older adults with mood and substance use disorders tend to have more mood episodes as they get older, even when their substance use is controlled.

- Both substance use and discontinuance may be associated with depressive symptoms.

- Acute manic symptoms may be induced or mimicked by intoxication with stimulants, steroids, hallucinogens or polydrug combinations.

- Withdrawal from depressants, opioids, and stimulants mimic anxiety symptoms.
Mood and Anxiety Disorders

- Some preference for those with depression to favor stimulation and those with anxieties to favor sedation.
- Use of alcohol, is available and legal, is ubiquitous. Less control, permitting relapse.
- It is now believed that substance use is more often a cause of anxiety symptoms rather than an effort to cure these symptoms.
- Since mood and anxiety symptoms may result from substance use disorders, and not an underlying mental disorder, careful and continuous assessment is essential.
5/2005 - Dr. Kyle M. Kampman and colleagues at the University of Pennsylvania School of Medicine and VAMC in Philadelphia treated 40 crack-cocaine-smoking outpatients, Dr. Kampman's team gave topiramate to 20 study participants, and placebo to the other 20. To avoid potential topiramate side effects, including sedation and slurred speech, they initiated treatment with 25 mg/d and increased it by 25 mg/d every week to 200 mg/d. They maintained this maximum dose during weeks 8 through 12, then tapered to zero during week 13. The patients also received cognitive behavioral coping skills therapy twice.

Almost 60 percent of patients taking topiramate attained 3 or more weeks of continuous abstinence from cocaine compared with 26 percent of those taking placebo. All 40 patients showed improvement from week 1 to week 13, as reflected by lower Addiction Severity Index.
Effects of Acute Alcohol on Other Neural Circuits

**GABA and Glutamate Systems**

- Increases the effects of GABA, the major inhibitory neurotransmitter in the brain
- Inhibits the effects of glutamate, the major excitatory neurotransmitter in the brain
- Contributes to decreased anxiety and increased sedation during acute alcohol intake

Manic Episode

- Distinct period with an abnormally and persistently elevated, expansive, or irritable mood. Must last at least 1 week (or less if hospitalization is required).
- The manic episode must be accompanied by at least three additional symptoms including inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences.
- Mood may be irritable (rather than elevated or expansive), at least four of the above symptoms must be present.
Schizophrenia and Psychotic Disorders

- Lasts for at least 6 months and includes at least 1 month of active-phase symptoms (i.e., two or more) of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms flat, slow.
- Schizophrenia subtypes (paranoid, disorganized, catatonic, undifferentiated, and residual)
- Schizoaffective Disorder, Mood Disorder, Autistic Disorder or Pervasive Developmental Disorder With Psychotic Features have been ruled out
Drug-Induced Psychosis

• Psychedelic, hallucinogenic, and stimulant drugs can produce reactions with psychotic features, especially in clients with co-occurring schizophrenia and bipolar disorders.

• People who use phencyclidine (PCP) and who experience one psychotic episode are “more likely to develop another with repeated use”

• In addition, withdrawal from substances, especially alcohol, can produce states that can mimic psychosis.
Attention Deficit/Hyperactivity Disorder (AD/HD)

- **Hyperactivity** - Often fidgets with hands or feet or squirms in seat, leaves seat in classroom or in other situations in which remaining seated is expected. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness). Often has difficulty playing or engaging in leisure activities quietly; is often “on the go” or often acts as if “driven by a motor” talks excessively.

- **Impulsivity** - Often blurts out answers before questions have been completed. Often has difficulty awaiting turn. Often interrupts or intrudes on others (e.g., butts into conversations or games).
Attention Deficit/Hyperactivity Disorder (AD/HD)

- Substance-dependent AD/HD clients may be able to take abusable stimulants in highly monitored clinics, much as opioid-dependent clients take methadone in highly controlled clinics, this approach should not be attempted by other substance abuse treatment clinics.

- When medication is indicated, bupropion, tricyclics such as desipramine, or other antidepressants should be used. These medications are about as effective as stimulants, but are not abusable and have little if any street value.

- The substance abuse treatment counselor helps to monitor compliance, asks about side effects, and communicates any clinical responses to the prescriber.
Posttraumatic Stress Disorder (PTSD)

• Among high-risk individuals (those who have survived rape, military combat, captivity, or ethnic or political internment and genocide), the proportion of those with PTSD ranges from one-third to one-half.

• Among clients in substance abuse treatment, PTSD is two to three times more common in women than in men.

• Among people with substance use disorders is 12 to 34 percent; for women with substance use disorders, it is 30-59%.

• Women with substance abuse problems report a lifetime history of physical and/or sexual abuse ranging from 55 to 99% Most women experienced childhood physical and/or sexual abuse.
Counseling a Client With PTSD

• Proceed slowly with a client who is diagnosed with or has symptoms of PTSD. Establish trust.

• Consider the effect of asking trauma history on the client's current emotional state, such as increased fear or irritability. Respond more to the client's behavior than her words.

• Limit questioning about details of trauma.

• Recognize that trauma injures an individual's capacity for attachment. The establishment of a trusting treatment relationship will be a goal of treatment, not a starting point.

• Develop a plan for increased safety where warranted.
Eating Disorders

• Substance abuse is more common in bulimia nervosa than in anorexia nervosa.

• Individuals with eating disorders are significantly more likely to use stimulants and less likely to use opioids than other individuals undergoing substance abuse treatment who do not have a co-occurring eating disorder.

• Many individuals alternate between substance abuse and eating disorders. Alcohol and drugs such as marijuana can disinhibit appetite (i.e., remove normal restraints on eating) and increase the risk of binge eating as well as relapse in individuals with bulimia nervosa.
Eating Disorders

• Use adjunctive strategies such as nutritional consultation, the setting of a weight range goal, and observations at and between meal times for disordered eating behaviors.

• Psychiatry Eval for meds may reduce binging and compulsion

• Incorporate relapse prevention strategies to plan for a long course of treatment and several treatment episodes.
Topiramate (Topamax) - Helps Outpatients Abstain From Cocaine
Pathological Gambling

- Persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits.
- Co-occurrence of pathological gambling among people with substance use disorders has been reported as ranging from 9 to 30 percent and the rate of substance abuse among individuals with pathological gambling has been estimated at 25 to 63 percent.
- Among pathological gamblers, alcohol has been found to be the most common substance of abuse. At minimum, the rate of problem gambling among people with substance use disorders is four to five times that found in the general population.
Pathologic Gambling

• It is important to recognize that even though pathological gambling often is viewed as an addictive disorder, clinicians cannot assume that their knowledge or experience in substance abuse treatment qualifies them to treat people with a pathological gambling problem.

• It often is essential to identify specific triggers for each addiction. It is also helpful to identify ways in which use of addictive substances or addictive activities such as gambling act as mutual triggers.

• Gamblers may use drugs or alcohol as a way of celebrating a win or relieving depression. A common pattern seen clinically is sequential addictions, that someone who has had a history of alcohol dependence—often with many years of recovery and AA attendance—develops a gambling problem.
Axis II
Personality disorders [PD-NOS]

- Antisocial PD [ASPD]
- Borderline PD
- Dependent PD
- Histrionic PD
Axis II
Anti-Social Personality Disorder

- Prevalence of antisocial personality disorder and substance abuse is highest %
- Much of substance abuse treatment is targeted to those with APD, and substance abuse treatment alone has been particularly effective for these disorders.
- Most people diagnosed as having APD are not true psychopaths—that is, predators who use manipulation, intimidation, and violence to control others and to satisfy their own narcissistic needs.
Anti-Social Personality Disorder

• Differentiate true antisocial personality from substance-related antisocial behavior by looking at how the person relates to others through the course of their life.

• Persons with this disorder have evidence of antisocial behavior preceding substance use and even during periods of enforced abstinence.

• Important to recognize that people with substance-related antisocial behavior may be more likely to have major depression than other typical personality disorders [Treatable, may stop or slow progression]
There are three main choices for medication.

The most common medications used in treatment of opioid addiction are methadone and buprenorphine. Sometimes another medication, called naltrexone, is used. Cost varies for the different medications. This may need to be taken into account when considering treatment options.

Methadone and buprenorphine trick the brain into thinking it is still getting the problem opioid. The person taking the medication feels normal, not high, and withdrawal does not occur. Methadone and buprenorphine also reduce cravings.

Naltrexone helps overcome addiction in a different way. It blocks the effect of opioid drugs. This takes away the feeling of getting high if the problem drug is used again. This feature makes naltrexone a good choice to prevent relapse (falling back into problem drug use).

All of these medications have the same positive effect: they reduce problem addiction behavior.

Source - SAMSHA 2012
Patients abstinent for 7 days prior to treatment initiation
Data on file. Alkermes, Inc.
Comparing and Combining Naltrexone and Acamprosate in Relapse Prevention of Alcoholism (n=160)

Figure 3. Curves of the survival probabilities toward the event “first alcohol intake” (lapse) for each of the treatment groups (Breslow test: \( t_3 = 29.25, P < .001 \)). Significant differences emerged between naltrexone and placebo \( (P = .03) \), between acamprosate and placebo \( (P = .04) \), and between the combined medication and placebo \( (P = .002) \). In addition, the combined medication was significantly more effective than acamprosate \( (P = .04) \).
Depot naltrexone (Vivitrol) in lieu of incarceration: A behavioral analysis of coerced treatment for addicted offenders

- This article examines a proposal to offer depot naltrexone to non-violent opiate-addicted criminal offenders in exchange for release from incarceration or diversion from prosecution. This "negative-reinforcement" behavioral paradigm could have a better chance of success than what has been attempted with drug-abusing offenders. Although positive reinforcement can be more efficacious, it has often been strenuously resisted on the ground that it is inequitable to reward antisocial individuals for doing what is minimally expected of most citizens. Negative reinforcement steers between these hurdles by avoiding the iatrogenic effects of punishment, while also being palatable to stakeholders.

- The current proposal provides an excellent platform for conducting this research because the target intervention (depot naltrexone) is demonstrably efficacious, nonpsychoactive, and has few, if any, side effects. Therefore, use of this medication would be unlikely to invoke the same types of legal and ethical objections that have traditionally been levied against the use of psychoactive medications with vulnerable populations of institutionalized offenders. Specific recommendations are offered for questions that must be addressed.

- Treatment Research Institute, University of Pennsylvania, dmarlowe@tresearch.org
Topiramate (Topamax) - Helps Outpatients Abstain From Cocaine
HIV risk behavior in treatment-seeking opioid-dependent youth: Results from a NIDA Clinical Trials Network multi-site study

Christina S. Meade, PhD,1 Roger D. Weiss, MD,2 Garrett M. Fitzmaurice, ScD,2 Sabrina A. Poole, MS,3 Geetha A. Subramaniam, MD,4 Ashwin A. Patkar, MD,1 Hilary S. Connery, MD,2 and George E. Woody, MD3

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4National Institute on Drug Abuse, Bethesda, MD

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Abstract

Objective
To assess baseline rates of and changes in HIV drug and sexual risk behavior as a function of gender and treatment in opioid-dependent youth.

Methods
150 participants were randomly assigned to extended buprenorphine/naloxone therapy for 12 weeks (BUP) or detoxification for 2 weeks (DETOX); all received drug counseling for 12 weeks. HIV risk was assessed at baseline and 4-, 8-, and 12-week follow-ups. Behavioral change was examined using generalized estimating equations.

Results
Baseline rates of past-month HIV risk for females/males were 51%/45% for injection drug use (IDU) (ns), 77%/35% for injection risk (p<.001), 82%/74% for sexual activity (ns), 14%/24% for multiple partners (ns), and 68%/65% for unprotected intercourse (ns). IDU decreased over time (p<.001), with greater...
Relapse Rates for Drug Addiction are Similar to Other Chronic Medical Conditions

### Medications Used For Preventing Relapse

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Acamprosate (Campral)</td>
</tr>
<tr>
<td></td>
<td>Naltrexone (ReVia, Vivitrol®)</td>
</tr>
<tr>
<td></td>
<td>Topiramate (Topamax)</td>
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<tr>
<td></td>
<td>Disulfiram (Antabuse®)</td>
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<td></td>
<td>Kudzu</td>
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<td></td>
<td>Ibogaine</td>
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</table>

Effects of buprenorphine on μ-opioid receptor availability
Risk Evaluation and Mitigation Strategy (REMS)

Ensuring SUBOXONE Film is used safely and correctly requires coordination and communication between the patient and the healthcare team. Patients with opioid dependence who are using buprenorphine-containing medications need to be educated about the proper use of these medications. Healthcare teams must also continually monitor patients for misuse, abuse, and diversion so that issues can be addressed and treatment can be adjusted as necessary.

REMS is a set of tactics designed to help promote the appropriate and safe use of buprenorphine, which is especially important as the number of patients in treatment for opioid dependence rises. REMS will help protect the in-office treatment of opioid dependence to ensure patients have continued access to the in-office treatment that has given so many the opportunities to successfully overcome their dependence and rebuild their lives.

The REMS program includes various materials and processes developed to assist in achieving the following 2 goals:

- Mitigate the risk of accidental overdose, misuse, and abuse
- Inform patients of the serious risks associated with SUBOXONE Film

As a healthcare provider, you can take an active role in implementing REMS, which will help to:

- Ensure the safe and proper use of SUBOXONE Film
- Maintain office-based treatment as a viable alternative for treating opioid dependence
- Monitor patients for misuse, abuse, and diversion
VIVITROL® Pharmacokinetics

- VIVITROL delivers medication continuously over the approved dosing interval\(^1\).

- The recommended dose of VIVITROL is 380 mg, delivered every 4 weeks or once a month\(^1\).

- Further details about administration will be provided.

- Compared to daily oral dosing with naltrexone 50 mg over 28 days, total naltrexone exposure is 3- to 4-fold higher following administration of a single dose of VIVITROL 380 mg\(^3\).

References
Complete abstinence from Weeks 5–24 was sustained by 36% of patients treated with VIVITROL compared with 23% of patients receiving placebo.
<table>
<thead>
<tr>
<th><strong>Patients</strong></th>
<th><strong>Healthcare Professionals</strong></th>
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**Alcohol dependence is one of the most serious health issues of our day.** It takes a heavy toll - not only on the person who drinks too much, but also on the family, friends, community, medical and legal systems, and society as a whole. If alcohol dependence touches your life, whether you are one of the hundreds of thousands of people in treatment, you know or suspect you have a drinking problem, or you're worried about a family member or friend, you've come to the right place for information.

**With VIVITROL, there’s hope that your patient will be able to say, “I am recovering.”** As a component of a comprehensive management program that includes psychosocial support, such as counseling, VIVITROL can help you reach your patients' treatment goals.
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Admissions/Intake: (888) 227-4641

Please visit our WEBSITE at www.armsacres.com
Please don’t hesitate to contact us

www.drugabuse.gov

You may order publications through the National Clearinghouse for Alcohol and Drug Information at:
1-800-729-6686
Historical Perspective

• 1800’s America was “A drug fiend’s paradise”

• 1878 survey of 1,313 opiate users in Michigan, for example, found that 61.2 percent were female, average age 39

• widespread medical custom of prescribing opiates for menstrual and menopausal discomforts, and the many proprietary opiates advertised for "female troubles”

• alcohol-drinking by women was frowned upon may also have contributed... Husbands drank alcohol in the saloon; wives took opium at home.

• Harrison Narcotic Act 1914, the sex ratio in addiction altered drastically. By 1918 a "Special Committee on Investigation" report that "drug addiction is about equally prevalent in both sexes... the sex ratio continued to change. Estimates during the 1960s indicated that males outnumbered females among known addicts by five to one or more.

• *The Consumers Union Report on Licit and Illicit Drugs*

• *by Edward M. Brecher and the Editors of Consumer Reports Magazine, 1972*
Limbaugh admits addiction to pain medication

Friday, October 10, 2003 Posted: 10:52 PM EDT (0252 GMT)

(CNN) -- Rush Limbaugh announced on his radio program Friday that he is addicted to pain medication and that he is checking himself into a treatment center immediately.

"You know I have always tried to be honest with you and open about my life," the conservative commentator said in a statement on his nationally syndicated radio show.

"I need to tell you today that part of what you have heard and read is correct. I am addicted to prescription pain medication."

Law enforcement sources said last week that Limbaugh's name had
Rush Limbaugh Arrested On Drug Charges
Conservative Radio Commentator Turns Himself In But Claims Innocence

WEST PALM BEACH, Fla., April 28, 2006

(CBS/AP) Rush Limbaugh and prosecutors in the long-running prescription fraud case against him have reached a deal calling for the only charge against the conservative commentator to be dropped without a guilty plea if he continues treatment, his attorney said Friday.

Limbaugh turned himself in to authorities on a warrant filed Friday charging him with fraud to conceal information to obtain prescriptions, said Teri Barbera, a spokeswoman for the Palm Beach County Jail. He and his attorney Roy Black left about an hour later, after Limbaugh was photographed and fingerprinted and he posted $3,000 bail, Barbera said.

Prosecutors' three-year investigation of Limbaugh began after he publicly acknowledged being addicted to pain medication and entered a rehabilitation program. They accused Limbaugh of "doctor shopping," or illegally deceiving multiple doctors to receive overlapping prescriptions, after learning that he received about 2,000
MICHAEL J. FOX WAS EITHER ACTING OR OFF HIS MEDS...

ON THE AIR

UH, RUSH... THAT'S NOT YOUR MIKE... IT'S YOUR BOTTLE OF OXYCONTIN.

13 reasons to vote Republicans
Historical Perspective

The Consumers Union Report on Licit and Illicit Drugs
by Edward M. Brecher and the Editors of Consumer Reports Magazine, 1972

3. What kinds of people used opiates?

Several characteristics of opiate use under nineteenth-century conditions of low cost and ready legal availability will strike contemporary readers as strange.

First, most users of narcotics in those days were women. An 1878 survey of 1,313 opiate users in Michigan, for example, found that 803 of them (61.2 percent) were females. An 1880 Chicago study similarly reported 235 habitual opium eaters, 169 were found to be females, a proportion of about 3 to 1. An Iowa survey in 1885 showed 63.8 percent females.

The use of opiates by prostitutes did not fully account for this excess of women in the user population. Thus the Chicago report noted: "Of the 169 females, about one-third belong to that class known as prostitutes. Doubt is still have among those taking the different kinds of opiates, 2 females to 1 male.

The widespread medical custom of prescribing opiates for menstrual and menopausal discomforts, and the many proprietary opiates advertised for "female troubles," no doubt contributed to this excess of female opiate users. Tennessee survey, which found that two-thirds of the users were women, noted also that two-thirds of the women were between twenty-five and fifty-five. "The first twenty years of this period," the survey report commented, "is the age when the stresses of life begin to make themselves felt with women, and includes the beginning of the menopause period. Nineteenth-century women, on the average, reached menopause somewhat earlier than do men."

The extent to which alcohol drinking by women was frowned upon may also have contributed to the excess of women among opiate users. Husbands drank alcohol in the saloon; wives took opium at home.

After passage of the Harrison Narcotic Act in 1914, the sex ratio in addiction altered drastically. By 1918 a "Special Committee on Investigation" appointed by the Secretary of the Treasury could report that "drug addiction is equally prevalent in both sexes. Thereafter the sex ratio continued to change. Estimates during the 1960s indicated that males outnumbered females among known addicts by five to one or more.

A second remarkable fact about the nineteenth-century use of opiates in the United States was the age of the users. The 1880 Chicago survey showed an average age for males of 41.4 years and for females of 39.4 years.
Tackling Afghanistan's opium problem

BY Alastair Leithead
BBC News, Helmand province

The lush fields of Helmand's river valley flash by from the vantage point of an open back door of a British military Chinook transport helicopter.

But the greenery clinging to the river banks is an oasis for the farmers and the smugglers who are producing more opium poppies than ever this year, and making more heroin for Britain and Europe.

There is guerrilla war waging in the province, but there is still plenty of time to harvest the gum from the poppy bulbs and set the traffickers in motion.

Britain has the lead in Afghanistan for dealing with the drugs problem - liaising with the government to bring the production levels down.

But in the south it has never been as bad - in the next few weeks Helmand province is expected to harvest more poppies than the rest of the country combined, making it the biggest opium producing area in the world.

Growing alternatives
Increasing Drug Overdoses

In recent years, deaths from drug overdoses have risen sharply. Abuse of prescription painkillers grew in the late '90s:
Increasing Drug Doses

More pills, more deaths

The recent increase in fatal overdoses is due largely to rising use of opioid painkillers. The rising mortality rates from drug overdoses parallels the growth in sales of opioid painkillers (milligrams/U.S. resident):
In October 2010, at least 188 local opioid overdose prevention programs that distributed naloxone existed. During 1996–2010, these programs in 15 states and the District of Columbia reported training and providing naloxone to 53,032 persons, resulting in 10,171 drug overdose reversals using naloxone (Narcan). However, many states with high drug overdose death rates have no opioid overdose prevention programs that distribute naloxone.
From 1990 to 2008, drug overdose death rates increased threefold in the United States, and the number of annual deaths increased to 36,450. Opioids (including prescription opioid medications and heroin) are major causes of drug overdose deaths. Naloxone is the standard of care for treatment of potentially fatal respiratory depression caused by opioid overdose.
Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010

Weekly
February 17, 2012 / 61(06);101-105

Drug overdose death rates have increased steadily in the United States since 1979. In 2008, a total of 36,450 drug overdose deaths (i.e., unintentional, intentional [suicide or homicide], or undetermined intent) were reported, with prescription opioid analgesics (e.g., oxycodone, hydrocodone, and methadone), cocaine, and heroin the drugs most commonly involved (1). Since the mid-1990s, community-based programs have offered opioid overdose prevention services to persons who use drugs, their families and friends, and service providers. Since 1996, an increasing number of these programs have provided the opioid antagonist naloxone hydrochloride, the treatment of choice to reverse the potentially fatal respiratory depression caused by overdose of heroin and other opioids (2). Naloxone has no effect on non-opioid overdoses (e.g., cocaine, benzodiazepines, or alcohol) (3). In October 2010, the Harm Reduction Coalition, a national advocacy and capacity-building organization, surveyed 50 programs known to distribute naloxone in the United States, to collect data on local program locations, naloxone distribution, and overdose reversals. This report summarizes the findings for the 48 programs that completed the survey and the 188 local programs represented by the responses. Since the first opioid overdose prevention program began distributing naloxone in 1996, the respondent programs reported training and distributing naloxone to 53,032 persons and receiving reports of 10,171 overdose reversals. Providing opioid overdose education and naloxone to persons who use drugs and to persons who might be present at an opioid overdose can help reduce opioid overdose mortality, a rapidly growing public health concern.

Overdose is common among persons who use opioids, including heroin users. In a 2002–2004 study of 329 drug users, 82% said they had used heroin, 64.6% had witnessed a drug overdose, and 34.6% had experienced an unintentional drug overdose (4). In 1996, community-based programs began offering naloxone and other opioid overdose prevention services to persons who use drugs, their families and friends, and service providers (e.g.,
911 Good Samaritan Law

Some individuals may fear that police will respond to a 911 call and that there will be criminal charges for themselves or for the person who overdosed. Those fears should NEVER keep anyone from calling 911 immediately. It may be a matter of life or death.

In September 2011, the 911 Good Samaritan Law went into effect to address fears about a police response to an overdose. This law provides significant legal protection against criminal charge and prosecution for possession of controlled substances, as well as possession of marijuana and drug paraphernalia. This protection applies to both the person seeking assistance in good faith as well as to the person who has overdosed. Class A-1 drug felonies as well as sale or intent to sell controlled substances are not covered by the law.

Posters (English (PDF, 1MB, 1pg.); Spanish (PDF, 1MB, 1pg.)) and palm cards (English (PDF, 150KB, 2pg.); Spanish (PDF, 137KB, 2pg.)) which highlight the 911 Good Samaritan Law and which provide instructions on how to respond to an overdose may be ordered using this form:

- Microsoft Word format
- PDF format (PDF, 105KB, 1pg.)

New York State's Opioid Overdose Prevention Programs

A life-saving law took effect on April 1, 2006, making it legal in New York State for non-medical persons to administer Naloxone to another individual to prevent an opioid/heroin overdose from becoming fatal. Naloxone (Narcan) is a prescription medicine that reverses an overdose by blocking heroin (or other opioids) in the brain for 30 to 90 minutes.

Programs must register with the New York State Department of Health to operate an Opioid Overdose Prevention Program. Eligible providers are licensed health care facilities, health care practitioners, drug treatment programs, non-profit community-based organizations and local health departments. These programs train individuals how to respond to suspected overdoses including the administration of naloxone. There are more than 80 programs currently throughout the State.

For more information on opioid/heroin overdose prevention, or to register as an Opioid Overdose Prevention Program, please contact the New York State Department of Health, AIDS Institute at (212) 417-4770.

Overdose Prevention Program Resources

- Fact Sheet
- Directory of Registered Programs - Updated 11/2012
- Section 80.138 Regulations
- Registration (PDF, 52KB, 2pg.)
- Guidelines for Policies and Procedures (PDF, 80KB, 6pg.)
- Guidelines for Training Providers (PDF, 94KB, 8pg.)
Directory of Registered Opioid Overdose Prevention Programs

The addresses below do not necessarily reflect sites at which opioid overdose prevention services are provided.

- **820 River Street, Inc.**  
  108-30 Sutphin Blvd.  
  Jamaica, NY 11435  
  **Program Director:** Monica Leiter (718) 526-3803

- **ACASA/Trapping Brook House**  
  3084 Trapping Brook Road  
  Wellsville, NY 14895  
  **Program Director:** Tina Wilson (585) 593-1920 Ext 701

- **Addiction Institute of NY**  
  St. Luke’s Roosevelt Hospital  
  1000 10th Avenue  
  New York, NY 10019  
  **Program Director:** Rachel Chernick, LCSW (212) 523-6166

- **Addiction Medicine**  
  SUNY Upstate MEd University  
  750 E. Adams St.  
  Syracuse, NY 13210  
  **Program Director:** Brian Johnson, MD (315) 464-3130

- **Addiction Treatment and Research Corporation**  
  22 Chapel Street  
  Brooklyn, NY 11201  
  **Program Director:** Dr. Monica Joseph (718) 260-2931

- **After Hours Project**  
  1232 Broadway  
  Brooklyn, NY 11221  
  **Program Director:** Fernando Soto (718) 249-0755

- **AIDS Center of Queens County**  
  175-61 Hillside Avenue, 4th Floor  
  Jamaica, NY 11432  
  **Program Director:** Christina Wolf (718) 233-6564

- **AIDS Community Health Center (formerly Community Health Network, Inc.)**  
  87 N. Clinton Avenue, 4th Floor
INSTRUCTIONS FOR HEALTHCARE PROFESSIONALS: Prescribing Naloxone

Naloxone is the antidote for an opioid overdose. It has been used for decades to reverse respiratory depression associated with toxic exposure to opioids. Naloxone is not a controlled substance and can be prescribed by anyone with a medical license. Take-home naloxone can be prescribed to patients at risk of an opioid overdose. Some reasons for prescribing naloxone are:

1. Receiving emergency medical care involving opioid intoxication or overdose
2. Suspected history of substance abuse or nonmedical opioid use
3. Starting methadone or buprenorphine for addiction
4. Higher-dose (>50 mg morphine equivalent/day) opioid prescription
5. Receiving any opioid prescription for pain plus:
   a. Rotated from one opioid to another because of possible incomplete cross-tolerance
   b. Smoking, COPD, emphysema, asthma, sleep apnea, respiratory infection, other respiratory illness
   c. Renal dysfunction, hepatic disease, cardiac illness, HIV/AIDS
   d. Known or suspected concurrent alcohol use
   e. Concurrent benzodiazepine or other sedative prescription
   f. Concurrent antidepressant prescription
6. Patients who may have difficulty accessing emergency medical services (distance, remoteness)
7. Voluntary request from patient or caregiver
Naloxone OD Antidote

Naloxone: The Second Chance Drug

Naloxone (also called Narcan) is the antidote that reverses an opioid overdose. It has been used in ambulances and hospitals for decades to reverse overdose. It’s legal and has been approved by the Food and Drug Administration (FDA). It works by neutralizing the opioids in your system and helping you breathe again. Naloxone only works if a person has opioids in their system; the medication doesn’t work on other drugs. You can’t get high from it and it is safe for nearly everyone. It has been used in programs all over the world to effectively reverse opioid overdoses. It’s a lifesaver, there’s no doubt about it. There are two kinds of naloxone, one that you can squirt up someone’s nose and another that can be injected through clothing into a muscle.

Project Lazarus provides naloxone for FREE through Brame Huie Pharmacy in North Wilkesboro.

The Centers for Disease Control and Prevention (CDC) reports more than 10,000 reversals of overdoses with naloxone by non-medical bystanders!

Naloxone is also an important tool for empowering communities to protect their health. Reviving an overdose victim can be a very powerful motivator to help people change their behaviors. This fact sheet on naloxone shows examples of how naloxone is empowering.

Check out these great resources from the Harm Reduction Coalition, including educational materials, manuals, best practice documents, case studies, research and more.

Naloxone is a prescription medication. Visit your doctor to get a prescription. Medicaid, Medicare and most health insurance covers it. If your doctor isn’t familiar with naloxone, then direct them to PrescribeToPrevent.org or print out these few pages that explain how to prescribe it.
Where to look for more info:

- www.DrugAbuse.gov [NIDA]
- www.SAMHSA.gov
- www.theAntiDrug.org
- www.Drugfree.org
- www.HBO.com Addiction Series
- www.Vivitrol.com
- www.Campral.com
- www.Topamax.com
- www.ArmsAcres.com (888) 227-4641
Women at Higher Risk

- Women use significantly more prescription drugs than men
- They also use significantly more prescription drugs with addictive properties
- National Medical Expenditures Survey showed women are 48 percent more likely than men to use a prescription drug that can be abused (Simoni-Wastila 2000).
- NSDUH 2003 survey found that 55 percent of new people who used Vicodin, Lortab, Lorcet, Percocet, Percodan, Tylox, hydrocodone products, OxyContin, and oxycodone products were female (SAMHSA 2004).

Source - TIP 51, SAMHSA 2004
Patterns of Substance Abuse in Women

- Narrowing of the Gender Gap- Comparing male and female rates of alcohol over 10 years, there is significant evidence of the gender gap narrowing. (Grant et al. 2006)
- Younger adult females are more likely to mirror male patterns of alcohol and illicit drug use than older females.
- Shrinking gender gap for alcohol and drug use has been noted across ethnic groups, especially among younger women.

Source - TIP 51, SAMHSA 2004
Patterns of Substance Abuse in Women

• People of Introduction and Relationship Status: Women are more likely to be introduced to and initiate alcohol and drug use through significant relationships including boyfriends, spouses, partners, and relatives.

• Females are often introduced to substances in a more private setting (2003). In addition, marital status plays an important role as a protective factor in the development of substance use disorders. -National Center on Addiction and Substance Abuse and Columbia University (CASA)

• Source - TIP 51, SAMHSA 2004
Patterns of Substance Abuse in Women

- Responsibilities and Pattern of Use: Women are more likely to temporarily alter their pattern of use in response to caregiver responsibilities.
- Women are likely to curtail or establish abstinence of alcohol and illicit drugs while pregnant (SAMHSA 2004), even though they are as likely to resume use later on.
- Some women report that they use stimulants to help meet expectations associated with family responsibilities (Joe 1995).

Source - TIP 51, SAMHSA 2004
Patterns of Substance Abuse in Women

- Progression and Consequences of Use: Women experience an effect called telescoping, whereby they progress faster than men from initial use to alcohol and drug-related consequences even when using a similar or lesser amount of substances. (Piazza et al. 1989)

- Research (Hernandex-Avila et al. 2004; Ridenour et al. 2005) supports a similar pattern of rapid progression for illicit drugs.

- Women have a greater biological vulnerability to the adverse consequences of substance use, it is important to note that variations in progression and the biopsychosocial consequences of substance use may also be linked to socioeconomic status, racial/ethnic differences, and age (Johnson et al. 2005). As an example, African Americans generally begin regular alcohol use later than most population groups yet demonstrate more rapid transition from initiation of use to abuse. *Source - TIP 51, SAMHSA 2004*
Patterns of Substance Abuse in Women

Figure 2-4
Percentages of Past-Year Abuse of or Dependence on Alcohol or Any Illicit Drug Among Women Aged 18 or Older by Age Group: 2003

HIV risk behavior in treatment-seeking opioid-dependent youth: Results from a NIDA Clinical Trials Network multi-site study

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See other articles in PMC that cite the published article.

Abstract

Objective
To assess baseline rates of and changes in HIV drug and sexual risk behavior as a function of gender and treatment in opioid-dependent youth.

Methods
150 participants were randomly assigned to extended buprenorphine/naloxone therapy for 12 weeks (BUP) or detoxification for 2 weeks (DETOX); all received drug counseling for 12 weeks. HIV risk was assessed at baseline and 4-, 8-, and 12-week follow-ups. Behavioral change was examined using generalized estimating equations.

Results
Baseline rates of past-month HIV risk for females/males were 51%/45% for injection drug use (IDU) (ns), 77%/35% for injection risk (p<.001), 82%/74% for sexual activity (ns), 14%/24% for multiple partners (ns), and 68%/65% for unprotected intercourse (ns). IDU decreased over time (p<.001), with greater decrease in IDU among BUP than DETOX, and higher levels of sexual risk among females.

Links
- Compound
- PubMed
- Substance
HEALTH RISKS OF OPIATES

- Scarred and collapsed veins, Overdose
- Bacterial infections of blood vessels and heart valves, abscesses, cellulitis.
- Liver disease Hepatitis B and/or Hep C
- Menstrual abnormalities, particularly amenorrhea or an irregular menstrual cycle (Abs et al. 2000; Santen et al. 1975;)
- Abuse, physical and sexual

Source - TIP 51, SAMHSA 2004
HEALTH RISKS OF OPIATES

• It can take up to a year for regular menstrual cycles to resume after drug use is stopped. (Smith et al. 1982).

• Change in sexual desire and performance are also consequences of heroin use (Smith et al. 1982). Probably are related to the lower levels of luteinizing hormone, estradiol, and progesterone (Abs et al. 2000).

• Amenorrhea and other symptoms often make women believe they are permanently sterile, but may have unexpected pregnancy. Source - TIP 51, SAMHSA 2004
PREGNANCY RISKS OF OPIATES

• Lack of prenatal care, STDs, HIV, malnutrition
• Complications include spontaneous abortion, premature labor and delivery, premature rupture of membranes, preeclampsia (high blood pressure during pregnancy), abruptio placentae, intrauterine death.
• Fetal risk of morbidity and mortality because of episodes of maternal withdrawal (Kaltenbach et al. 1998). lower birth weights than unexposed fetuses and
• Neonatal abstinence syndrome (NAS) at birth. NAS is a generalized disorder characterized by signs and symptoms of central nervous system irritability, gastrointestinal dysfunction, respiratory distress, and vomiting.

Source - TIP 51, SAMHSA 2004
PREGNANCY RISKS OF OPIATES

• Methadone-exposed infants through age 2 function well within the normal range of development

• Methadone-exposed children between ages 2 and 5 do not differ in cognitive function from a population that was not drug exposed and was of comparable economic and racial background (Kaltenbach 1996).

• Data suggest that such psychosocial factors as environment and parenting can have as much of an effect on development as prenatal exposure to opioids (Johnson et al. 1987; Lifschitz et al. 1985).

• Timely treatment for HIV/AIDS can virtually eliminate the chance of a pregnant woman passing the infection to her fetus, all women with substance use histories should have an HIV/AIDS evaluation at the first sign of any possible pregnancy.

Source - TIP 51, SAMHSA 2004
• Reviews of several studies recommend methadone maintenance treatment (MMT) as the only treatment for the management of opioid dependence during pregnancy.

• When methadone is provided within a treatment setting that includes comprehensive care, obstetric and fetal complications, including neonatal morbidity and mortality, can be reduced (Jarvis and Schnoll 1995; Kaltenbach et al. 1998).

Source - TIP 51, SAMHSA 2004
PREGNANCY RISKS OF OPIATES

• Buprenorphine treatment [Suboxone, Subutex] has been examined as an alternative to maintenance therapy for opioid dependence during pregnancy.

• Research is limited and only two randomized, double-blind studies have been conducted comparing methadone with buprenorphine, cannot be determined as safe alternative to date. (Fischer et al. 2006; Jones et al. 2005; Kayembe-Kay’s and Lacyde 2003; Raburn and Bogenschultz 2004).

Source - TIP 51, SAMHSA 2004
TIPS for treatment

• Remember that women are socialized to be other-focused. Just because they may not have attended to some of their responsibilities during active substance use does not mean that they will not be focused on these responsibilities upon entering treatment.

• Rather than pushing the idea that they need to “get their head into treatment and not be so focused on outside issues,” use their ability to be other-focused as a tool in developing motivation for recovery.

• Assuming that a woman is resistant to treatment because she is other-focused in the program is a form of gender bias. Women are socialized to think about others.

• Source - TIP 51, SAMHSA 2004
**TIPS for treatment - 2**

- Assess risk factors or potential triggers for relapse, don’t underestimate that the initial reasons for use may be the same reasons for relapse, even if initial use occurred many years ago.
- It is important to prepare for a premature termination of treatment and establish an intervention plan tailored to address these initial reasons for use.
- More times than not, women generally will underestimate the risks associated with these issues. For example, women who initiated use due to a relationship will often deny that relationships are a current risk factor.

*Source - TIP 51, SAMHSA 2004*
TIPS for treatment - 3

• The counselor should not immediately follow the client’s self-assessment but rather proceed with creating roleplays that simulate possible scenarios to provide practice in how to handle relationship issues before they actually occur in treatment; i.e. roleplay a telephone call from a boyfriend who believes that the client does not have a problem and begs her to come home.

• Other women in the treatment group have a better handle on the actual scenarios that are high risk for each other.

Source - TIP 51, SAMHSA 2004
TIPS for treatment - 4

• Because substance abuse tends to run in families, a woman’s parents and children as well as her partner need to be considered in planning treatment.

• A woman needs to be aware of the influence of substance abuse in her family. Using a family geneogram or family tree to mark who has used substances can be a valuable tool in assessing the degree of influence in her family.

Source - TIP 51, SAMHSA 2004
TIPS for treatment - 5

• A partner’s substance use and attitudes toward substance use can influence a woman’s substance use. A woman who uses illicit drugs is more likely to have a partner who also uses illicit drugs.

• The counselor should work with all individuals who have influence on the client so that each person develops attitudes and behaviors that will be supportive of the client’s recovery.

• Remember to assess for personality traits that are more conducive to substance abuse among women, especially sensation-seeking.

Source - TIP 51, SAMHSA 2004
TIPS for treatment - 6

- Trauma is both a risk factor for and a consequence of substance abuse.
- Women with histories of trauma may be using substances to self-medicate symptoms.
- Interventions should be immediately put into place to help build coping strategies to manage strong affect, including relaxation training and other anxiety management skills. [Acupuncture, yoga, EMDR]

*Source - TIP 51, SAMHSA 2004*
TIPS for treatment - 7

• Start skills-building immediately rather than waiting for an incident to occur. It is far more difficult to manage symptoms when they are heightened than when they are at lower levels of intensity.

• From the outset, counselors need to be aware of the potential and common occurrence and impact of co-occurring disorders among women with substance use disorders especially mood, [depressive and bipolar] anxiety, eating disorders, and PTSD.

Source - TIP 51, SAMHSA 2004
TIPS for treatment - 8

• State law requires substance abuse treatment providers to report individuals for child abuse and neglect and to supersede Federal confidentiality laws that cover substance abuse treatment.

• It is critical, therefore, that admissions staff, program materials, and counselors clearly present and discuss the limits of confidentiality as regulations require.

• Without this explicit discussion, women in treatment may have questions and feel uneasy with regard to mandated reporting.
TIPS for treatment - 9

- Without this explicit discussion, women in treatment may have questions and feel uneasy with regard to mandated reporting.
- When counselors intervene to protect a client’s children, this may seem contradictory to the client and raise questions about confidentiality.
- A great barrier to treatment for women is fear of losing their children, a fear that engenders intense mistrust on the part of clients who are mothers.

Source - TIP 51, SAMHSA 2004
TIPS for treatment - 10

• Therapeutic alliance and trust are vital to the treatment process, yet treatment providers must protect children. [Mandated]

• To resolve this, women must understand that although providers will report their concerns for the safety of children, providers are advocates for the women and their families.

• (CSAT 1996; Lopez 1994; U.S. Department of Health and Human Services, Office for Civil Rights 2002).

Source - TIP 51, SAMHSA 2004
TIPS for treatment - 11

• Children in residential treatment programs

• For many women, having their children with them in treatment is essential to their recovery and removes a barrier to treatment entry.

• Research suggests that allowing children to accompany their mothers to a residential program has a positive effect on engagement, retention, and recovery (Lungren et al. 2003; Szuster et al. 1996).

Source - TIP 51, SAMHSA 2004
TIPS for treatment - 12

- Residential services for pregnant women
- Acknowledging the urgency of treating women who are pregnant, Federal law requires that pregnant women receive priority admission into substance abuse treatment programs, allowing them to bypass waiting lists and gain immediate admission.

Source - TIP 51, SAMHSA 2004
used to be

this is your brain on drugs.
Comprehensive Alcohol Dependence Treatment

Limbic Region
Role: Drive Generation
Intervention: Pharmacotherapy

Cortex
Role: Decision Making
Intervention: Counseling
Opioids attach to the mu receptors, dopamine is released, causing pleasurable feelings to be produced.

VIVITROL and Brain Reward Pathways

- Ventral Tegmental Area
- Nucleus Accumbens
- Arcuate Nucleus

Dopamine
Opioid Peptides
VIVITROL
The VTA–nucleus accumbens pathway is activated by all drugs of dependence, including alcohol.

This pathway is important not only in drug dependence, but also in essential physiological behaviors such as eating, drinking, sleeping, and sex.
Effects of Acute Alcohol on Reward Circuits

Dopamine and Opioid Systems

• Indirectly increase dopamine levels in the mesocorticolimbic system
  – Associated with positively reinforcing/rewarding effects of alcohol

• Indirect interaction with opioid receptors results in activation of opioid system
  – Associated with reinforcing effects via µ-receptors

Relapse Rates for Drug Addiction are Similar to Other Chronic Medical Conditions

- Drug Dependence: 40 to 60%
- Type I Diabetes: 30 to 50%
- Hypertension: 50 to 70%
- Asthma: 50 to 70%

Undertreatment of Alcohol Use Disorders

SAMHSA, Office of Applied Studies. Substance Dependence, Abuse and Treatment Tables; 2003
IMS - MAT March 2006
When should I consider prescribing medication for an alcohol use disorder?

All approved drugs have been shown to be effective adjuncts to the treatment of alcohol dependence.

Thus, consider adding medication whenever you are treating someone with active alcohol dependence or someone who has stopped drinking in the past few months but is experiencing problems such as craving. “Or slips”
An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence

The U.S. Food and Drug Administration (FDA) approved extended-release injectable naltrexone (Vivitrol) in October 2010 to treat people with opioid dependence. This medication provides patients with opioid dependence the opportunity to take effective medication monthly, as opposed to the daily dosing required by other opioid dependence medications (i.e., methadone, buprenorphine, oral naltrexone). Extended-release injectable naltrexone was approved by FDA in 2006 to treat people with alcohol dependence.

Treatment of opioid dependence remains a national priority. According to the 2010 National Survey on Drug Use and Health, approximately 359,000 individuals reported either dependence on or abuse of opioids.

What Role Can Extended-Release Injectable Naltrexone Play in the Treatment of Opioid Dependence?

Extended-release injectable naltrexone is another pharmacological tool that is approved for treatment of people with opioid dependence. Over the years, medications have been successful in treating many patients with opioid dependence. Methadone has been used to treat patients for decades and has been proven effective. However, methadone must be dispensed to the patient at a Substance Abuse and Mental Health Services Administration (SAMHSA)-certified opioid treatment program (OTP) facility—with daily doses monitored to prevent diversion and abuse.
## Exhibit 1: Key Differences Between Medications Used To Treat Patients With Opioid Dependence

<table>
<thead>
<tr>
<th>Prescribing Considerations</th>
<th>Extended-Release Injectable Naltrexone</th>
<th>Buprenorphine</th>
<th>Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of Administration</strong></td>
<td>Monthly</td>
<td>Daily</td>
<td>Daily</td>
</tr>
<tr>
<td><strong>Route of Administration</strong></td>
<td>Intramuscular injection in the gluteal muscle by healthcare professional.</td>
<td>Oral tablet or film is dissolved under the tongue. Can be taken at a physician’s office or at home.</td>
<td>Oral (liquid) consumption usually witnessed at an OTP, until the patient receives take-home doses.</td>
</tr>
<tr>
<td><strong>Restrictions on Prescribing or Dispensing</strong></td>
<td>Any individual who is licensed to prescribe medicine (e.g., physician, physician assistant, nurse practitioner) may prescribe and order administration by qualified staff.</td>
<td>Only licensed physicians who are DEA registered and either work at an OTP or have obtained a waiver to prescribe buprenorphine may do so.</td>
<td>Only licensed physicians who are DEA registered and who work at an OTP can order methadone for dispensing at the OTP.</td>
</tr>
<tr>
<td><strong>Abuse and Diversion Potential</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Additional Requirements</strong></td>
<td>None; any pharmacy can fill the prescription.</td>
<td>Physicians must complete limited special training to qualify for the DEA prescribing waiver. Any pharmacy can fill the prescription.</td>
<td>For opioid dependence treatment purposes, methadone can only be purchased by and dispensed at certified OTPs or hospitals.</td>
</tr>
</tbody>
</table>
## Medications Used For Preventing Relapse

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>• Acamprosate (Campral)</td>
</tr>
<tr>
<td></td>
<td>• Naltrexone (ReVia, Vivitrol®)</td>
</tr>
<tr>
<td></td>
<td>• Topiramate (Topamax)</td>
</tr>
<tr>
<td></td>
<td>• Disulfiram (Antabuse®)</td>
</tr>
<tr>
<td></td>
<td>• Kudzu</td>
</tr>
<tr>
<td></td>
<td>• Ibogaine</td>
</tr>
</tbody>
</table>

Patients quit pills too early

By Carla Johnson
ASSOCIATED PRESS

CHICAGO — Many patients stop taking their medicine far sooner than they should, researchers say, and that decision can be deadly when the drugs treat heart disease or diabetes.

It took only one month after leaving the hospital for 1 out of 8 heart attack patients to quit taking the lifesaving drugs prescribed to them, a study of 1,521 patients found.

"One month is very surprising," said study co-author Dr. Michael Ho of the Denver Veterans Affairs Medical Center.

The heart patients who stopped taking three proven drugs — aspirin, beta blockers and statins — were three times more likely to die during the next year than patients who stayed on the pills.

The study didn’t examine why people stopped taking their medicine, but the patients who quit were more likely to be older, single and less educated.

They’re in good company: Former President Bill Clinton — a younger, married and well-educated patient — was prescribed a statin for high cholesterol when he left office. But he stopped taking it at some point. And at age 58, he had to have quadruple bypass surgery because of severely clogged arteries that doctors said put him danger of a heart attack.

The study of heart patients appears in Monday’s Archives of Internal Medicine. The issue features an AP story on the study, which is linked from a related story on the AP web site: www.ap.org.
Acamprosate (Campral ®)
Has been used to treat alcohol dependence in Europe for more than a decade and was approved in the United States for established, it may work by reducing symptoms of protracted abstinence such as insomnia, anxiety, and restlessness. Acamprosate’s efficacy in increasing the proportion of dependent drinkers who maintain abstinence for several weeks to months has been demonstrated in multiple studies, a finding confirmed by a meta-analysis of 17 clinical trials. In most positive studies, patients were fully withdrawn from alcohol for at least several days to weeks prior to initiating use.
Medications Used For Preventing Relapse - Opiates

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opiates</strong></td>
<td>• Methadone</td>
</tr>
<tr>
<td></td>
<td>• Naltrexone Oral (ReVia®)</td>
</tr>
<tr>
<td></td>
<td>• Naltrexone Injection (Vivitrol®)</td>
</tr>
<tr>
<td></td>
<td>• Buprenorphine/Naloxone (Suboxone + Subutex)</td>
</tr>
</tbody>
</table>

Opiate Receptors
- Natural Endorphin Stimulation

Opioids attach to the mu receptors, dopamine is released, causing pleasurable feelings to be produced.

“As opiates leave the receptors, pleasurable feelings fade and Negative Signals, withdrawal symptoms (possibly cravings) begin.”

“Opiates continue leaving the mu receptors until the patient is in a mild-to-moderate state of withdrawal. At this point, SUBOXONE therapy can begin”

“SUBOXONE (buprenorphine) attaches to the empty opioid receptors, suppressing withdrawal symptoms and cravings. As a partial opioid agonist, SUBOXONE works by controlling withdrawal symptoms and cravings and produces a limited euphoria or "high."

“Buprenorphine attaches firmly to the receptors. *[High Affinity]* At adequate maintenance doses, buprenorphine fills most receptors and blocks other opioids from attaching. Buprenorphine has a long duration of action”

Source: Reckitt &Co. [www.suboxone.com/patients/suboxone/how_suboxone_works.aspx](http://www.suboxone.com/patients/suboxone/how_suboxone_works.aspx)
Commonly Used Opioids

- Morphine (MS Contin, Oramorph)
- Diacetylmorphine (Heroin)
- Hydromorphone (Dilaudid)
- Meperidine (Demerol)
- Hydrocodone (Lortab, Vicodin)
- Oxycodone (OxyCotin, Percodan, Percocet, Tylox)
- Oxymorphone (Opana)
Commonly Used Opioids (Continued)

- Fentanyl (Sublimaze, Actiq)
- Propoxyphene (Darvon)
- Methadone (Dolophine)
- Codeine
- Opium
Physical Signs of Opioid Overdose

- Unconsciousness
- Pinpoint pupils
- Very shallow/slow respirations (↓ 10 p/m)
- Very slow pulse rate (↓ 40 p/m)
- Coma
Full Agonists

• Bind to receptors
• Fully turn them on
• Key fits the lock and opens the door all the way
• Full euphoria
• Examples: morphine, heroin, methadone, oxycodone
Perfect fit – Maximum Opioid Effect.

No Withdrawal Pain                             Euphoric Opioid Effect
Antagonists

• Also bind to opioid receptors
• But instead of activating they block the receptors
• Key fits but door does not open and no other key will fit
• Examples: naltrexone and naloxone
Partial Agonists

- Possess some of the properties of both antagonists and full agonists
- Bind to receptors and activate them but not to the same degree as full agonists
- Examples: Buprenorphine
Imperfect Fit – Limited Opioid Effect
High Affinity

- Sticky
- Blocks effects of other opioids
- Full agonists cannot displace it
- This effect is dose related
Safety: Accidental Ingestion & Overdose

• Low potential due to poor GI bioavailability
• One-fifth as potent when swallowed vs sublingual
• Ceiling effect also adds to safety in overdose situation
Side Effects

- Similar to other Mu opioid agonist
- Headache (36% vs 22% placebo)
- Withdrawal (25% vs 37% placebo)
- Pain (22% vs 19% placebo)
- Nausea (15% vs 11% placebo)
- Insomnia (14% vs 16% placebo)
- Sweating (14% vs 10% placebo)
Effects of buprenorphine on μ-opioid receptor availability

MRI

Bup 0 mg

Bup 2 mg

Bup 16 mg
1-year retention and social function after BUP-assisted relapse prevention treatment for heroin dependence in Sweden

Johan Khakko, et al

Sweden
Primary Efficacy Point

• Retention in treatment was significantly better in the Buprenorphine group than placebo (75% vs 0% respectively).
Opiate Health Risks

HIV risk behavior in treatment-seeking opioid-dependent youth: Results from a NIDA Clinical Trials Network multi-site study

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Abstract

Objective
To assess baseline rates of and changes in HIV drug and sexual risk behavior as a function of gender and treatment in opioid-dependent youth.

Methods
150 participants were randomly assigned to extended buprenorphine/naloxone therapy for 12 weeks (BUP) or detoxification for 2 weeks (DETOX); all received drug counseling for 12 weeks. HIV risk was assessed at baseline and 4-, 8-, and 12-week follow-ups. Behavioral change was examined using generalized estimating equations.

Results
Baseline rates of past-month HIV risk for females/males were 51%/45% for injection drug use (IDU) (ns), 77%/35% for injection risk (p<.001), 82%/74% for sexual activity (ns), 14%/24% for multiple partners (ns), and 68%/65% for unprotected intercourse (ns). IDU decreased over time (p<.001), with greater...
There's no substitute for the right treatment.
See how treatment with SUBOXONE Film helped Amber.

Could Treatment HELP YOU?
Watch real stories from people who've worked to turn their lives around.

SUBOXONE Film is here
LEARN HOW TO TAKE IT
Watch the SUBOXONE Film video

Get valuable FREE SUPPORT
Treatment is so much more than medication. The Here to Help® Program can make a difference.

Why choose SUBOXONE Film?

SUBOXONE Film is a prescription medication indicated for the treatment of opioid dependence, available only by prescription, and must be taken under a doctor's care as prescribed. It is illegal to sell or give away your SUBOXONE Film.

Opioid dependence is a challenging and complicated condition, but it can be treated. If you're working to overcome opioid dependence, you know the experience can sometimes be overwhelming. That's why the formulation of your medication should help make your experience convenient.

Patients have shared their concerns about taking SUBOXONE® (buprenorphine and naloxone) sublingual tablets (SLB), such as:
- The time the tablets take to dissolve
- The difficulty of traveling with them
- Their taste

For some patients, these concerns can interfere with being able to focus on their daily treatment and work toward their treatment goals.

SUBOXONE Film, a new formulation of SUBOXONE, may improve your daily treatment experience. And clinical trial patients tell us they prefer SUBOXONE Film to the SUBOXONE Tablet.

Not in treatment yet?
FIND A DOCTOR
A certified to treat opioid dependence in the privacy of his or her office.

SAVE UP TO $45*
A month on your SUBOXONE Film copay

More Search Options
Click for other details
Other Fine Products by Reckitt-Benckheiser
Important Safety Information

SUBOXONE® (buprenorphine and naloxone) Sublingual Film (CIII) is indicated for maintenance treatment of opioid dependence as part of a complete treatment plan to include counseling and psychosocial support. Treatment should be initiated under the direction of physicians qualified under the Drug Addiction Treatment Act.

SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate sublingual tablets) (CIII) is indicated for the treatment of opioid dependence.

SUBOXONE Sublingual Film and SUBOXONE Sublingual Tablets should not be used by patients hypersensitive to buprenorphine or naloxone.

SUBOXONE Sublingual Film and SUBOXONE Sublingual Tablets can be abused in a manner similar to other opioids, legal or illicit. Clinical monitoring appropriate to the patient’s level of stability is essential.

Chronic use of buprenorphine can cause physical dependence. A sudden or rapid decrease in dose may result in an opioid withdrawal syndrome that is typically milder than seen with full agonists and may be delayed in onset.

SUBOXONE Sublingual Film and SUBOXONE Sublingual Tablets can cause serious life-threatening respiratory depression and death, particularly when taken by the intravenous (IV) route in combination with benzodiazepines or other central nervous system (CNS) depressants (ie, sedatives, tranquilizers, or alcohol). It is extremely dangerous to self-administer nonprescribed benzodiazepines or other CNS depressants while taking SUBOXONE Sublingual Film or SUBOXONE Sublingual Tablets. Dose reduction of CNS depressants, SUBOXONE Sublingual Film and SUBOXONE Sublingual Tablets, or both when both are being taken should be considered.

Liver function should be monitored before and during treatment.

Death has been reported in nontolerant, nondependent individuals, especially in the presence of CNS depressants.
Risk Evaluation and Mitigation Strategy (REMS)

Ensuring SUBOXONE Film is used safely and correctly requires coordination and communication between the patient and the healthcare team. Patients with opioid dependence who are using buprenorphine-containing medications need to be educated about the proper use of these medications. Healthcare teams must also continually monitor patients for misuse, abuse, and diversion so that issues can be addressed and treatment can be adjusted as necessary.

REMS is a set of tactics designed to help promote the appropriate and safe use of buprenorphine, which is especially important as the number of patients in treatment for opioid dependence rises. REMS will help protect the in-office treatment of opioid dependence to ensure patients have continued access to the in-office treatment that has given so many the opportunities to successfully overcome their dependence and rebuild their lives.

The REMS program includes various materials and processes developed to assist in achieving the following 2 goals:

- Mitigate the risk of accidental overdose, misuse, and abuse
- Inform patients of the serious risks associated with SUBOXONE Film

As a healthcare provider, you can take an active role in implementing REMS, which will help to:

- Ensure the safe and proper use of SUBOXONE Film
- Maintain office-based treatment as a viable alternative for treating opioid dependence
- Monitor patients for misuse, abuse, and diversion
The National Alliance of Advocates for Buprenorphine Treatment (NAABT) is a non-profit organization with the mission to:

- Educate the public about the disease of opioid addiction and the buprenorphine treatment option.
- Help reduce the stigma and discrimination associated with patients with addiction disorders.
- Serve as a conduit connecting patients in need of treatment to qualified treatment providers.

If you would like to be kept informed about buprenorphine treatment, click here to add your email address to our newsletter mailing list.
Endogenous Opioid Blockade and Impulsive Responding in Alcoholics

• The opioid receptor antagonist naltrexone (NTX) is one of few approved treatments for alcoholism, yet the mechanism by which it reduces drinking remains unclear. In rats, NTX reduces morphine-induced impulsive choice bias.

• Here, we used a modified delay discounting procedure to investigate whether NTX improves decision-making or inhibitory control in humans. We measured the effect of acute NTX (50 mg) on choice between smaller sooner (SS) and larger later monetary rewards and response errors (motor mismatch) in a high conflict condition in a group of abstinent alcoholics (AA) and healthy control subjects (CS). We previously reported that AA selected the SS option significantly more often than did CS.

• If the choice bias of AA is due to enhanced endogenous opioid signaling in response to potential reward, NTX should reduce such bias in the AA group.

• Found that NTX did not reliably reduce impulsive choice in the AA group; however, NTX's effect on choice bias across individuals was robustly predictable. NTX's effect on choice bias was significantly correlated with scores on Rotter's Locus of Control (LOC) scale.

• In addition, we found that NTX significantly enhanced control of motor responses, particularly within the CS group. These results suggest that endogenous opioids may impair response selection during decision-making under conflict, and that NTX's effects on explicit decision-making are personality-dependent.

• Neuropsychopharmacology online publication, 18 October 2006
Alcohol dependence is one of the most serious health issues of our day. It takes a heavy toll - not only on the person who drinks too much, but also on the family, friends, community, medical and legal systems, and society as a whole. If alcohol dependence touches your life, whether you are one of the hundreds of thousands of people in treatment, you know or suspect you have a drinking problem, or you're worried about a family member or friend, you've come to the right place for information.

With VIVITROL, there's hope that your patient will be able to say, "I am recovering." As a component of a comprehensive management program that includes psychosocial support, such as counseling, VIVITROL can help you reach your patients' treatment goals.
Alleviating Challenges of Oral Dosing

- VIVITROL utilizes a delivery system which
  - Overcomes the limitations of daily oral dosing
  - May enhance adherence due to its once-monthly administration
  - Helps maintain more consistent and measurable plasma levels over the month

- Intramuscular route of administration leads to reduction in first-pass hepatic metabolism
This article examines a proposal to offer depot naltrexone to non-violent opiate-addicted criminal offenders in exchange for release from incarceration or diversion from prosecution. This "negative-reinforcement" behavioral paradigm could have a better chance of success than what has been attempted with drug-abusing offenders. Although positive reinforcement can be more efficacious, it has often been strenuously resisted on the ground that it is inequitable to reward antisocial individuals for doing what is minimally expected of most citizens. Negative reinforcement steers between these hurdles by avoiding the iatrogenic effects of punishment, while also being palatable to stakeholders.

The current proposal provides an excellent platform for conducting this research because the target intervention (depot naltrexone) is demonstrably efficacious, nonpsychoactive, and has few, if any, side effects. Therefore, use of this medication would be unlikely to invoke the same types of legal and ethical objections that have traditionally been levied against the use of psychoactive medications with vulnerable populations of institutionalized offenders. Specific recommendations are offered for questions that must be addressed.

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Source: NIDA 2006
Title: “Stress Brain”
Please don’t hesitate to contact us
www.drugabuse.gov

You may order publications through the National Clearinghouse for Alcohol and Drug Information at:
1-800-729-6686
For TIPS manuals, esp. TIP 51 go to -

www.kap.samhsa.gov/products/manuals/

It’s free!

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