INFORMATION BOOK

Some things you should know about
Medication Assisted Treatment for Opioid Addiction.

MEDICATION ASSISTED TREATMENT FOR OPIOID ADDICTION SAVES LIVES

stigma

STOP STIGMA NOW

STOP STIGMA NOW (SSN) is a public information group of dedicated drug treatment professionals determined to eliminate the stigma against medication assisted treatment for opioid addiction. Perpetuated by a misinformed public as well as professionals in the fields of medicine and nursing, this stigma directly impacts anyone taking methadone and other medications used to treat opioid addiction.

Our mission is to inform the general public, the court systems, medical, nursing and counseling professions, public officials and the media about the overwhelming scientific evidence supporting the success of medication assisted treatment for opioid addiction.

Today in this country there are millions of people suffering from an addiction to opioids.
We are experiencing a national epidemic of opioid overdose deaths in the tens of thousands yearly ... driving up the overall death rates among Americans in the prime of their lives in virtually every racial and ethnic group in almost every state in the nation ... and increasing exponentially, with no end in sight.

We must eliminate the stigma which undermines the efficacy of medication assisted treatment for opioid addiction.

Won't you please join us?

For more information about Stop Stigma Now,
or to become a member or make a contribution, go to our website

www.stopstigmanow.org

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A BRIEF HISTORY of MEDICATION ASSISTED TREATMENT for OPIOID ADDICTION

We owe a great deal to the three medical pioneers who recommended medication as a long-term approach to treating the life-threatening problems of opioid addiction. It was Drs. Vincent Dole, Marie Nyswander, and Mary Jeanne Kreek who did this work at Rockefeller University in New York City more than 40 years ago.

Their task was made difficult by two things:
First, the medication used in treating opioid addiction was Methadone, itself an opioid. There was, and still is, a huge task in educating people to the fact that patients treated with medication would not be getting high on their medication.

Second, from the very beginning it was felt that successful addiction treatment required long-term treatment, even life-long treatment. That was a bitter pill for the patients to swallow. But that assumption has been proven to be true time and again by the high relapse rate for those stopping treatment, a relapse that hovers between 80 and 90%.

Long-term medication assisted treatment for opioid addiction is the most successful treatment of any life-threatening illness in our country.

The Dole-Nyswander-Kreek landmark research began with a group of six patients, carefully chosen for having had a well-established addiction for many years. Treatment was begun with a variety of injectable opioids including morphine and heroin. While some improvements in the patients were seen with regard to their health and welfare, most of their time was spent waiting for their next dose of these short-acting drugs. It was known from studies done at Lexington KY that there existed a long-term opioid medication that could be administered by mouth. That medication was methadone.

What happened next was dramatic. Taking methadone just once a day, patients were no longer hanging around waiting for their next dose. They became active and interested in their lives and their families. Even a return to school or a job was now possible. With an epidemic of heroin addiction occurring, especially in New York City, the favorable results of the Dole-Nyswander-Kreek study resulted in the setting up of many methadone clinics.

Millions of patients are currently in medication assisted treatment for opioid addiction in this country and around the world. The overwhelming majority of these patients are grateful for the chance to improve their health, their finances, their relationships with family and friends, and most of all, to regain their self-respect, something that had disappeared a long time ago.

OPIOID ADDICTION

What are opioids?

Opioids are medicines often used to relieve pain or diarrhea. Opioids usually are safe when used correctly, but some people can become addicted to them. Opioid drugs include morphine, codeine, fentanyl, oxycodone, hydrocodone, heroin, methadone and buprenorphine.

What is addiction?

Addiction is a disease that affects your brain and your behavior. At first, you have control over your choice to start using drugs. Over time, with changes in your brain, you develop a powerful physical hunger or craving.

What are signs of opioid addiction?

The most important sign of addiction is the inability to stop using when it is harming your life, you are aware of that harm, and still unable to stop. Other signs of addiction include increased drug tolerance and drug dependance.

What is drug tolerance?

When your body, over time, gets used to a drug, you may need to take more of it to get the same effect. If you stop using an opioid for a period of time, your tolerance will begin to fade. Resuming the opioid at the same dose may be dangerous, resulting in an overdose.

What is drug dependence?

After taking a drug for a long time, when you stop you may have withdrawal symptoms. Withdrawal from opioids, includes sweating, nausea, vomiting, chills, diarrhea, shaking, pain, depression, insomnia, and fatigue.

What is the difference between drug tolerance, drug dependence and addiction?

Drug tolerance and dependence are a normal part of taking any opioid for a long time. You can be tolerant of, or dependent on a drug and not be addicted to it. Addiction, however, is not normal. You are addicted when neither your body nor your mind can function without the drug, causing you to obsessively seek out the drug, even when using it is destroying your health, your finances and your relationships.

OPIOID ADDICTION and THE BRAIN

Patients informed about the brain origins of addiction can benefit from knowing they have a disease ... that being addicted does not mean they are “bad” people. Changes in the brain from continuous use of heroin and other opioids are long lasting and can produce cravings that lead to relapse months or years later. Treatment with methadone or buprenorphine can reverse brain changes associated with an addiction disease. They are very effective treatments, rather than substitutes for the addictive opioids.

Origins of Drug Addiction
When heroin or any other opioid travels to the brain, it attaches to the ‘mu’ opioid receptors on the surfaces of brain cells. This triggers feelings of pleasure. Over time, using opioids builds tolerance and withdrawal.

Opioid Tolerance and Withdrawal
Repeated exposure to opioids alters the brain so it only functions normally when the drugs are present. The more a person develops opioid tolerance, the greater the need to take higher dosages to achieve the same effect. Opioid tolerance occurs because opioid receptors gradually become less responsive to opioid stimulation. Opioid withdrawal comes from the production of a body chemical, noradrenaline. When opioid molecules link to those ‘mu’ receptors on brain cells, they reduce the release of noradrenaline. With repeated exposure to opioids, neurons adjust by increasing their level of noradrenaline. When opioids are not taken the neurons release excessive amounts of noradrenaline, triggering withdrawal with jitters, anxiety, muscle cramps and diarrhea.

Methadone
Methadone stimulates brain cells much like heroin and other opioids, but methadone has a very different effect because of its long duration of action and steady influence on the ‘mu’ opioid receptors. Methadone eliminates craving and compulsive drug use. Methadone also corrects hormonal changes found in addicted individuals. For example, it reduces the stress response that increases the danger of relapse in stressful situations. Methadone reduces relapse rates and helps patients to concentrate on life’s tasks, repairing relationships, and holding down a job.

Methadone is administered in federally regulated methadone programs where careful monitoring of patients and regular drug counseling are important. Relapse is common among patients who discontinue methadone and many patients have benefitted from lifelong methadone maintenance.

Buprenorphine
Buprenorphine is an opioid partial agonist. This means it produces effects such as euphoria or respiratory depression. But with buprenorphine these effects are weaker than drugs such as heroin and methadone. Unlike methadone treatment, which must be performed in a highly structured clinic, buprenorphine may be prescribed in physician offices, significantly increasing treatment access. Qualified physicians can offer buprenorphine in an office, community hospital, health department, or correctional facility. Buprenorphine is best prescribed as part of a comprehensive treatment plan that includes counseling and social support programs.

Naltrexone
Naltrexone is in a class of medicines known as opiate antagonists. Available as a tablet and a long-lasting injection, it works by blocking the effects of narcotic drugs. Naltrexone, when used to help people addicted to alcohol or opioids, should also include lifestyle changes, counseling, and support.

Summary
Opioid dependence and addiction are medical disorders, like high blood pressure and diabetes. Like those other diseases, a cure for drug addiction is unlikely. But long-term treatment can limit the disease's serious problems and improve daily functioning.

MEDICATION TREATMENT of OPIOID ADDICTION

Most people cannot just walk away from opioid addiction. Quitting “cold turkey” has a poor success rate. Medication treatment, like using medication to treat any other illness such as heart disease, asthma or diabetes, is widely accepted. Taking medication for opioid addiction is not the same as substituting one addictive drug for another. Medications make it possible for a person to regain a normal state of mind, free of withdrawal, cravings, and the drug-induced highs and lows of addiction. The most common medications used in the treatment of opioid addiction are methadone, buprenorphine, and naltrexone.

Methadone

Methadone has been the standard form of medication treatment for opioid addiction for more than 40 years. Methadone suppresses opioid withdrawal, reduces cravings, and blocks the effects of other opioids. Methadone for the treatment of opioid addiction is only available from federally regulated clinics. Participation in a methadone program improves both physical and mental health, and decreases mortality (deaths) from opioid addiction.

Buprenorphine (Suboxone)

In 2002, the Federal Drug Administration approved the use of buprenorphine for the treatment of opioid addiction. Buprenorphine has some advantages over methadone. Treatment does not require participation in a highly regulated federal program such as a methadone clinic. As a partial opioid agonist, its abuse potential is lower than methadone. A partial opioid agonist produces less of an effect than a full opioid when it attaches to opioid receptors in the brain. Another benefit of buprenorphine is the ‘ceiling effect,’ meaning if buprenorphine is taken in an overdose there is a less suppression of breathing than that resulting from a full opioid.

Naltrexone

Naltrexone is an opioid blocker. It blocks the effects of heroin and other opioids. Naltrexone does not produce physical dependence. But unlike methadone and buprenorphine, it has several disadvantages. It does not suppress all cravings for opioids. It cannot be started until a patient is off all opioids. Many patients are unable to maintain abstinence during the waiting period. Also, once patients have started on naltrexone the risk of overdose is increased. If relapse occurs, the tolerance for opioids has been sharply reduced and the usual dose of drug now becomes an overdose.

METHADONE and BUPRENORPHINE

What is Methadone?

Methadone is a synthetic drug that suppresses the need for opioid drugs by eliminating painful withdrawal symptoms. Methadone stops cravings, breaking the addiction cycle and allows a person to build a healthier life. Unfortunately, methadone has the most extensive mythology surrounding any form of treatment.

BUPRENORPHINE (*Suboxone, Subutex, Buprenex, Bunavail)*

What is Buprenorphine and How Does it Work?

Buprenorphine is a medication widely used in the treatment of opioid addiction. It suppresses the withdrawal symptoms and cravings associated with opioid addiction. Buprenorphine, in combination with counseling and behavioral therapies, provide a whole-patient approach to the treatment of opioid dependency. Unlike methadone which can only be used in a clinic setting, buprenorphine may be prescribed by any qualified physician, one who has taken an eight hour course of study.

Why is Buprenorphine a 'Partial Opioid Agonist?'

A 'partial opioid agonist' produces less than a full opioid effect when it attaches to opioid receptors in the brain. Morphine, heroin, and methadone are examples of 'full opioid agonists.' A major benefit of buprenorphine is the 'ceiling effect,' meaning there is less suppression of breathing when an overdose is taken.

Why is an 'Opioid Antagonist' Added to Buprenorphine?

Naloxone is an opioid antagonist often added to buprenorphine. When the medication is taken by mouth, the naloxone is not absorbed into the bloodstream to any significant degree. But, if the combination of buprenorphine/naloxone is crushed and snorted or injected, the naloxone will trigger a rapid and severe withdrawal symptom. Naloxone has been added for only one purpose: to discourage people from snorting or injecting buprenorphine.

ONCE-MONTHLY INJECTABLE BUPRENORPHINE (Sublocade)

There is an urgent public health need for new treatment options for patients suffering with opioid addiction. An average of four people die of an opioid overdose every hour of every day. We will all be watching the introduction of a new treatment option, a once-monthly injectable buprenorphine.

Who is eligible for this new treatment?

Patients who have initiated treatment with buprenorphine for a minimum of seven days. A once-monthly injection removes the need for patients to remember to take their medication every day, allowing for a greater focus on counseling support. There is no maximum duration of maintenance treatment as patients may continue indefinitely. In the beginning, injectable buprenorphine will have a limited distribution to limit the risk of harm that could result from intravenous self-administration.

VIVITROL (Naltrexone injection)

Naltrexone injection is used to help those who have stopped using any opioid to stay drug-free. It is not a cure for addiction. It is used as part of an overall program that includes counseling and group meetings.

Is Naltrexone an opioid?

It is not an opioid. Naltrexone works by blocking the effects of any opioid. It will not produce any physical dependence. A nurse or other health provider gives this medicine as an injection into the buttocks muscle. It is usually given every 4 weeks. Because naltrexone is not an opioid, craving for opioids may be experienced by many on Vivitrol treatment. There may also be a risk of overdose while on Vivitrol. In an attempt to get high, users could end up using much more than they normally would.

What happens after treatment?

When treatment with Vivitrol ends, your body will be more sensitive to opioids. If you use an opioid in the future, you will need to use less than before Vivitrol treatment. Using the same amount you used in the past could lead to overdose or death. It is recommended to wear a medical alert tag stating you use Vivitrol. Any medical care provider who treats you should know you are receiving this medication. If you need surgery, tell the surgeon ahead of time that you are receiving Vivitrol injections.

MORE METHADONE FACTS

Methadone is a synthetic drug that suppresses the need for opioid drugs by eliminating painful withdrawal symptoms. Methadone stops cravings, breaking the addiction cycle and allowing a person to return to a normal life.

Does Methadone make you high?

No. Methadone doesn't have the mind-altering side effects of heroin and many other opioides. Methadone treatment allows individuals in recovery to manage other responsibilities, including holding down a job. Most people get on methadone because they are exhausted, fed up, desperate, can't keep a heroin addiction going and can't keep themselves together anymore.

Is Methadone safer than Heroin?

Like any drug, methadone does have side effects. Methadone can cause a person to sweat more and experience some constipation. A dose that is too high can trigger drowsiness. When used as addiction treatment, methadone is taken by mouth as a liquid, eliminating the dangers associated with needles. It is dispensed in a medical facility, making it far safer than cruising alleys or back roads to hunt for a dealer. Exposure to disease, attacks on the street, and overdoses are eliminated. The death rate, arrest rate, and illness rate all drop during methadone treatment.

Will Methadone damage my body?

The correct dose of methadone will not cause any harm to your body. Methadone doesn't damage the liver, the heart, the lungs, the kidneys or the immune system. The health status of patients on methadone has probably been studied with greater depth than any other medication. Dr. Mary Jeanne Kreek from The Rockefeller University concludes, "The most important medical consequence of long term methadone treatment is the marked improvement in general health and nutrition."

Will Methadone rot my teeth?

It is common for drug addicts to ignore personal hygiene while in the throes of addiction. Such neglect weakens their gums as well as the bones that hold their teeth in place. As a result, many suffer dental problems that linger long after they begin their addiction treatment.

Once on Methadone, will I be addicted to it?

Methadone treatment is not an addiction, but a life saving treatment. Because the relapse rate is so high when anyone stops treatment, the safest thing is to continue methadone for the long term, even if that means for a lifetime.

THE METHADONE CLINIC

Is the methadone clinic a place I want to be receiving my care?

The methadone clinic is a mixed blessing. Most important, it offers a way out of the life destroying activities of opioid addiction. No more finding street drugs every day - and pay a lot of money for those drugs. No more being subject to the dangers of violence, disease and incarceration resulting from the street life. Should you need medical care, many methadone programs now have onsite, primary medical care. Treatment in the methadone program allows you to regain a bit of financial security and renew relationships with friends and family. It is an opportunity to regain that sense of self respect that was lost a long time ago.

What problems could I face in the methadone clinic?

First - the transition to methadone many be uncomfortable during the first weeks. Doses of methadone will start slowly and it is likely to feel withdrawal during that time - but each day will be more comfortable and a proper maintenance dose is usually achieved in less than two weeks.

Second - you will be required to attend the clinic every day (or six days a week) for at least the first few months. Hopefully, as you stop using street drugs, the program will arrange take home doses of methadone.

Third - you will be standing on line in order to get your daily methadone dose. Fourth, urine testing for street drugs is required for all patients and this is done randomly. You never know which day you will be asked to submit a urine specimen.

Last - now that you are no longer involved with drugs, the only time you meet persons involved with drugs is at the clinic.

Must I deal with a drug counselor in the program?

You want to get support from the staff member assigned to be your counselor. Methadone programs have substantially improved supervision and credential requirements for counselors, including training in cognitive behavior therapy and motivational interviewing. Group and family counseling can also be very helpful. Your counselor will also give you feedback on your urine tests, ask what problems you are having with methadone and most important, what problems you are having in your life. There is personal support, vocational support and legal support for you in this counseling relationship.

What if my counselor wants me to reduce my dose or to taper?

Be careful. Many counselors were initially trained in the abstinence model of treating addictions and do not favor using methadone which they may view as a crutch. However, we know that addiction to opioids has changed the brain in a way that makes it important to continue the methadone medication.

Should I look forward to the time when I can be "drug free?"

That is really hard to answer. Most patients in the methadone program have the idea of eventually tapering off of medication. The problem is the high relapse rate, perhaps as high as 80%. Tapering is not something that experienced methadone professionals promote. Yet, there are people who are able to do it successfully. The final decision is always up to you.

Should I consider buprenorphine in place of methadone?

When starting medication treatment for the first time, there are good reasons to consider buprenorphine. You will not have to attend a methadone clinic. Instead, you go to a private medical office - and you do not have to be there every day. However, it is not likely you will have the close monitoring and support from a drug counselor. Many people prefer the daily structure of the methadone clinic. But, changing from methadone to buprenorphine is a problem. Buprenorphine quickly replaces methadone at the opioid receptor sites of brain cells. It does this more quickly than its own effects, meaning a person must be free of methadone before starting buprenorphine. Otherwise, they will have a severe withdrawal problem on taking the first buprenorphine dose. All of this means one has to taper off methadone before starting buprenorphine, not an easy task or one without the danger of relapse.

THE MEDICAL PROFESSION and TREATMENT of PAIN

Opioid addiction and methadone maintenance are not well understood by the medical profession. The Harrison Narcotic Act of 1914 did not consider opioid dependence a legitimate medical condition and doctors were forbidden to offer treatment. Over the years, the medical profession's early experience with the Harrison Narcotic Act evolved into "stay away from addicts," they are nothing but trouble and addiction is not a doctor's domain. This attitude became prevalent in medical schools with physicians receiving little or no training in addiction, a situation which remains something of a problem to this day.

THE OPIATE-DEPENDENT PERSON AND PAIN

Methadone patients who are hospitalized with painful conditions are at high risk for receiving inadequate medication for relief of pain. First, many health professionals incorrectly believe that methadone patients will obtain pain relief from their single dose of methadone. Second, attitudes of the medical staff about illicit drug use may overwhelm the need to provide adequate pain relief. Complaints from the patient are perceived as manipulations to receive opioids for other than pain relief. Third is the failure of the medical staff to recognize tolerance in methadone-maintained patients. Methadone maintained patients may need more pain medication, not less.

Some hospitalized methadone patients have reported their methadone doses were lowered in the hospital. As a result they experienced withdrawal symptoms while hospitalized. Some patients were even told to taper off methadone prior to surgery. In the medical office, methadone-maintained patients can and should be treated for severe pain which may result from neuropathy, severe arthritis or cancer.

METHADONE and BUPRENORPHINE DURING PREGNANCY

Methadone for pregnant women has been studied for more than 40 years and is considered the “gold standard” of treatment for pregnant women with opioid addiction. Neither methadone nor buprenorphine cause birth defects. Many babies born exposed to methadone or buprenorphine have withdrawals and the hospital has medications and/or cuddling therapy to help the baby stay comfortable. During pregnancy, it is a good idea to meet with the medical staff at least once per month. They will check to make sure the pregnancy is going smoothly.

What is Fetal Alcohol Spectrum Disorder?

Fetal Alcohol Disorder is caused by drinking alcohol during pregnancy. Symptoms may be a mild learning disability, but alcohol can also result in severe learning disabilities, abnormal facial features, and disorders of the central nervous system. There is no “safe” amount of alcohol for pregnant women.

What about tobacco?

Nicotine found in tobacco products can cause problems for your baby. Smoking reduces the blood flow to the fetus. This means the baby is not getting all the nutrients and oxygen it needs. Smoking may cause the baby to not grow as big as it should.

What if I want to taper off methadone?

Tapering is not recommended while a woman is pregnant as it increases the chances of a miscarriage or premature birth. Also, many people relapse as they taper, which put both mother and child in danger.

What about breastfeeding?

It is safe to breastfeed while you are taking your methadone. It isn’t safe if you are using street drugs or HIV positive. Your baby will receive a very small amount of your medication, but the nutritional benefits and bonding of breastfeeding are so important that breastfeeding is a good idea. Breastfeeding is a personal choice. Not every woman decides it is right for her.

Will Child Protective Services take my baby?

Not if you are in treatment and follow your treatment plan, stay away from street drugs, and have a safe home environment. Some families have a home visit by a public health nurse who will check the safety of your home and make a recommendation for a parenting class.

What about my dose...should I try to stay on a reduce dose?

There is no connection between a mother’s dose and withdrawal symptoms in the baby at the time of birth. It might seem that the more milligrams a mother is taking, the worse the withdrawal symptoms will be. But this is not the case. The most important thing is a dose of medication that will keep the mom from withdrawals or cravings. Because of the changes in the body during pregnancy, it’s not uncommon for women to need an increase in their methadone during the third trimester and return to the pre-pregnancy dose after delivery.

DRUG COURTS

ADULT DRUG COURTS

An adult drug court is a court specially designed to reduce criminal acts and increase successful rehabilitation of those suffering from drug addiction. Early, continuous, and intense treatment is an effective component of drug courts. In drug courts, prosecution and defense counsel use a cooperative approach. The program includes periodic drug testing, community supervision and appropriate sanctions all of which are supervised by the court. Drug courts significantly reduce crime and substance abuse while lowering the cost to the public by reducing or eliminating incarceration.

FAMILY DRUG COURTS

Unlike adult drug courts, where the incentive might be the avoidance of incarceration, the principal goal in Family Drug Court is family reunification. Failure may result in long-term foster care for the dependent children. When a child must be taken from the home, they should be placed in a relative foster care home, and if not in a nonrelative foster home. In Family Drug Courts children spend less time in foster care, there are lower arrest rates for the parent and costs are lower due to less use of child welfare resources. Being treated with respect by the judge and being empowered by the judge to engage actively in their own recovery produces the greatest achievements.

DRUG COURT ISSUES

While many people have benefitted from the drug courts, a number of questions have been raised. The person in court may not have any choice to accept or refuse treatment; many times it is a judge making the decision on what treatment is offered, not a doctor or drug professional; the drug courts have traditionally refused to accept medication treatment of opioid addiction; the “sanctions” applied if someone is not doing well in treatment could result in their incarceration, sometimes for longer period than would have resulted from their initial criminal charge.

WHAT IS FENTANYL?

Fentanyl is a powerful synthetic opioid similar to morphine but 50 times more potent. It is used to treat severe pain or to manage pain after surgery. When prescribed by a physician, fentanyl is administered by injection, skin patch, or in lozenges.

FENTANYL OVERDOSE

Overdose deaths involving fentanyl have skyrocketed at a rate that outpaces deaths from any other opioid, including heroin, hydrocodone, and oxycodone. The fentanyl associated with recent overdoses is produced in illegal laboratories. This non-pharmaceutical fentanyl is sold as a powder, or mixed with heroin or cocaine. Since fentanyl is so much more potent than other opioid painkillers, drug traffickers only need to pack their drugs with small amounts of it to provide users a powerful punch. But a tiny bit too much can be deadly.

The powerful synthetic opioid fentanyl is now the deadliest drug in America, causing an estimated 19,000 fatal overdoses in 2016. The DEA says most of the illicit fentanyl comes from China, either shipped directly to U.S. consumers through the mail or mixed with heroin that is smuggled across the southern border by Mexican drug cartels.

At New York City's JFK airport, the point of entry for about 60 percent of the country's international mail packages, seizures of fentanyl by Customs and Border Protection agents increased from 7 in 2016 to 84 in 2017. All of the packages came from China. Nationwide, fentanyl seizures by CBP increased from 459 pounds in 2016 to 1,296 pounds last year.

In New York City, the DEA seized a record 193 kilos of fentanyl in 2017 — enough to kill the city's population 11 times over. James Hunt, special agent in charge of the DEA's New York field division, said it's virtually impossible to stop the flow of fentanyl.

"The southwest border of the United States is porous," Hunt said. "There's thousands of miles of border. Thousands of trucks stop every day at the border. There's millions and millions of parcels coming into the country every day, you can't search them all. And traffickers know that."

WHAT IS NALOXONE?

Naloxone is an opioid receptor antagonist that reverses opioid overdose and restores normal breathing. Overdoses of fentanyl should be treated immediately with naloxone but may require multiple doses to successfully reverse the overdose.

Overdose and Naloxone

Naloxone (also known as Narcan®) is an "opioid antagonist" used to counter the effects of opioid overdose. Naloxone only works if a person has opioid overdose; it has no effect on any other drugs or alcohol. Although traditionally administered by emergency personnel, naloxone can be administered by anyone. Naloxone may be injected or sprayed into the nose. Most important - it is a temporary drug that wears off in an hour.

Risking an overdose - Mixing Drugs

All sedating medications carry overdose risks. But when drugs are combined, the risk is increased. Many overdoses occur when people mix heroin or prescription opioids with benzodiazepines such as Klonopin, Valium, or Xanax.

Speedballing (heroin and cocaine) is another common drug combination. While combining a stimulant and a depressant would seem to balance the different effects, the combination does not cancel out overdose risk. People who speedball are at higher risk because cocaine causes the body to use more oxygen while heroin reduces breathing.

Preventing an overdose

- Use less drug when you haven't used even for a few days. Any decrease in your tolerance can become a fatal overdose!
- Use only one drug at a time.
- Avoid mixing alcohol with heroin or other opioids — this is an incredibly dangerous combination
- If drinking or taking benzos with heroin, do the heroin first to better gauge how high you are. Alcohol and benzos impair judgment so you may not remember how much you've used.
- Have a friend with you who knows what drugs you've taken and can respond in case of an emergency. Develop an overdose plan with your friend or partner.
- Some people sense when they are about to go out. This is not common, but if you are one of these people have naloxone ready.
- Delivering a drug more quickly to the brain is more likely to create an overdose. Injecting and smoking can mean increased risk.

Recognizing Opioid Overdose

Sometimes it can be difficult to tell if a person is just very high, or experiencing an overdose. If you are worried that someone is getting too high, ***it is important you don't leave them alone.*** The following are symptoms of an overdose:

Loss of consciousness
Awake, but unable to talk
Face is pale or clammy
Fingernails and lips turn blue or black
Breathing is slow and shallow, or has stopped

If someone is making unfamiliar sounds while "sleeping" it is worth trying to wake them up. Thinking a person was snoring, when that person was overdosing, may be a missed opportunity to save a life.

Call for Help! Overdose Response

It is rare for someone to die immediately from an overdose. When people survive, it is because someone was there to respond. The most important thing is to call 911 right away. It is important to have trained professional evaluate the person's condition. People who survive an overdose are at risk for pneumonia or heart problems. After you call 911, place the person in the recovery position. Lay them on their side with their face turned to the side. This will keep their airway clear and prevent them from choking if they throw up.

RECOVERY

The term “recovery” has been highly controversial. In past years, it meant someone had recovered from their opioid addiction only when they achieved a state of total abstinence. If a person was prescribed medication treatment with methadone or buprenorphine, they had not achieved “recovery.”

This attitude has recently softened considerably. Many of those who previously insisted on abstinence as the only goal of treatment, now realize many of those suffering from opioid addiction need medication.

If anyone with a history of addiction stops using street drugs, and continues in treatment, they most certainly are in “recovery.” Put simply, recovery is restoring a life that was lost during active opioid addiction. Still, we await the day when all drug treatment professionals understand this.

There are many ways family and friends can help a person suffering from addiction.

- Learn about the disease of opioid addiction.
- Understand addiction is not a problem of poor self-control.
- Learn how easily family members can get drawn into supporting their loved one’s addiction (co-dependency).
- Encourage your loved one to attend and complete treatment.
- Understand you cannot make the addict get better, but you are not helpless. You can make changes that promote recovery for your loved one, and for you.
- Participate in support groups that help the family of the addict recover (such as Al-Anon and Nar-Anon).

We want everyone taking methadone (or similar medications) and their family members to feel proud of what they have accomplished in finding the strength and courage to overcome an addiction to opioids.

The fortunate ones are those who have sought treatment ... who can take a single dose of medication each day to be free of opioid addiction.

Stopping is only the first step. There remains a life to rebuild, a home to establish, children to raise, and medical problems to deal with.

Most of all we hope for each person in treatment to experience a renewed sense of self-respect.

SSN EXECUTIVE BOARD OF DIRECTORS

Sy Demsky
President of Stop Stigma Now (SSN), Sy Demsky is also President of the Board of National Development Research Inc. (NDRI-USA.) He collaborated on eight grants and studies with NDRI. Sy was the Director of The Mount Sinai Hospital's Narcotics Rehabilitation Center from 1970 to 2001 when he retired. From 1975 to 1999 he was the President and CEO of Auto Assess, Inc., a computerized testing company in the field of addiction. He is the owner and President of Sy Demsky & Associates, a Health Care & Consulting Company. Sy was a member of the Governor's Advisory Council on Substance Abuse, and the founder and first President of the New York State Committee of Methadone Program Administrators (COMPA.) He has received many distinguished awards, including the Dole/Nyswander Award for outstanding lifetime service to the addiction field, and the Unsung Hero Award from the notable Carron Foundation.

John Phillips
Mr. Phillips is the founder of Creative Socio Medics Corporation (now Netsmart Technologies) the leading patient information company in Behavioral Health and Addictions, Started in 1968 it is one of the oldest software companies in the world. John was responsible for hundreds of information systems projects over the forty years before his retirement, and is now responsible for systems and automation in STOP STIGMA NOW.

Robert Sage, PhD
Dr. Sage has worked in the field of chemical dependency since 1973. His work with the Addiction Research and Treatment Corporation (ARTC) included serving as a clinician, trainer, and researcher; Coordinator of Mental Health Services; Vice President of Treatment Services; and Senior Vice President. He was responsible for program development and implementation, clinic operations, treatment services, staff training, and compliance issues for ARTC's seven methadone maintenance treatment programs and two medically supervised drug-free programs, serving more than 3,000 patients. Dr. Sage has also been responsible for facilitating the implementation of psychosocial research conducted by ARTC's Research Division. In exercising similar administrative responsibilities for programs managed by ARTC's affiliated agency, the Urban Resource Institute (URI), he also supervised research and evaluation studies for URI's alcoholism treatment program and domestic violence shelters. Dr.Sage also served as a Program Surveyor for CARF, the agency that provides national accreditation for medication assisted treatment programs throughout the United States, and assisted with programs to meet optimal medication assisted treatment standards for opiate addiction treatment. Dr. Sage has presented at numerous local and national conferences and conducts, presented, and published research and evaluation studies.

Joycelyn Woods, **MA, CMA**
Joycelyn Sue Woods has a degree in neuroscience and did some of the early work on opiate receptor mapping. A methadone patient advocate for over thirty years working with the Committee of Concerned Methadone Patients (CCMP), she helped to establish the Association of ex-Drug Addicts for Prevention and Treatment (ADAPT) and the National Alliance for Medication Assisted Recovery (NAMA Recovery). She has served on policy making committees including patient representative for methadone and buprenorphine regulations. She is a recipient of the Richard Lane-William Holden Patient Advocacy Award, and the Drug Information Association (DIA) Fellowship. Joycelyn is the Project Coordinator for the MARS Project and Executive Director of NAMA Recovery where she serves as liaison to STOP STIGMA NOW.

Stephen W. Paul, CPA
Mr. Paul has a professional background in corporate and not-for-profit organizations. The first twenty years of his career were shaped in Accounting and Finance roles at BDO, Pepsico, NBC and GE Capital. He moved to the not-for-profit realm twelve years ago taking leadership roles at Edison Schools (charter school management), Columbia University, Natural Resources Defense Council, and is currently the Chief Financial Officer at the Center for Jewish History. Steve, his wife and their daughter live in New Rochelle, NY.

Ellen Friedman, PhD, LCSW, CASAC
Dr. Friedman's background includes serving as Associate Director of Support Services at Beth Israel MMTP, directing substance abuse programs at St Barnabas Hospital and Greenwich House and most recently implementing and overseeing The New York State OASAS HOPEline for Substance Abuse and Problem Gambling. Dr. Friedman is an Associate Adjunct Professor at NYU Silver School of Social Work and has presented at local, national and international conferences and contributed four book chapters on clinical issues. Dr. Friedman was awarded The Make a Difference Award by the Commissioner of OASAS, is a consultant/supervisor at LESC, and maintains a private practice. Dr. Friedman graduated from Brooklyn College, Hunter Silberman School of Social Work, Metropolitan Institute and New York University.

PROJECT DIRECTOR

Philip Paris, MD
A family physician, Dr. Paris served as the primary physician in the Mount Sinai Hospital Narcotics Rehabilitation Center for more than 20 years. Phil's focus was on the critical health issues, including HIV, Hepatitis C and pain management. As a founding member of STOP STIGMA NOW, he continues to respond to many of the media articles written on the subjects of addiction and fhe medication treatment of opioid addiction.

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