Dilworth Center
UNLOCK YOUR RECOVERY

Patient Handbook

Adult IOP

2240 Park Road
Charlotte, NC 28203

p. 704.372.6969
f. 704.335.0176

www.dilworthcenter.org
info@dilworthcenter.org

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Welcome to the Dilworth Center!

On behalf of Dilworth Center's Staff and Board of Directors, it is my pleasure to welcome you to our Adult Intensive Outpatient (IOP) Treatment Program. I appreciate you entrusting Dilworth Center with your treatment needs. All of us here at the Center will do our best to provide the direction and support needed to start your successful journey towards recovery.

I understand that this may be a time of uncertainty, fear and confusion for many patients. It is my hope that you will begin to feel that you are in good hands with us as your recovery process begins. We have assembled an exceptionally talented and experienced team of treatment professionals dedicated to supporting and advancing your treatment and recovery goals. I would encourage you to approach the staff with any questions or concerns you may have throughout your time here with us.

I would like to invite you to take time to familiarize yourself with this handbook. We have attempted to organize the information we feel is most important in clarifying the overall treatment experience, as well as your roles and responsibilities in this productive and exciting process. Recovery is indeed a process, not an event. It will evolve over time and can be continually enhanced or encumbered by the choices you make on a daily basis. Good treatment is about making the choices necessary to maximize the chances of successful, long-term sobriety.

Once again, welcome to Dilworth Center's Adult IOP Treatment Program.

Sincerely,

Charles A. Odell, MSW, MAC, LCAS
CEO and President

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Charlotte, NC 28203

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Mission Statement

The Mission of Dilworth Center is to provide effective and affordable treatment services for individuals and families affected by alcoholism and drug addiction.

Our goal at Dilworth Center is to provide treatment programs that maximize the chances for long-term recovery for all our patients. We consider it out responsibility to assist our patients and their families in effectively treating alcoholism and drug addiction and helping them structure positive support systems.

We Believe….

- Recovery from alcoholism and addiction must begin with complete abstinence from all mood-altering chemicals.
- People who suffer from this disease deserve to be treated with the same dignity and quality of care as those who suffer from any other disease.
- Sustained recovery takes place in Twelve Step Programs such as Alcoholics Anonymous and Narcotics Anonymous.
- Treatment is about discovery; learning about the disease and the tools needed for recovery.
- Outpatient treatment represents a proven and effective level of care for initiating enhancing recover.
- Alcoholism and drug addiction seriously affects family members and loved ones. They should be offered compassionate understanding and help towards recovery.

Created: 1991
Revised: 2019

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Organizational Chart

Board of Directors

Martin Godwin (Chair), Peter Browning (Treasurer), Reggie Willis (Secretary)
Tim Ignasher, Gay Boswell, Steve DeGeorge, Becky Headen, Fred Oates, Will Sparks

CEO
Charles Odell

Auditor
C. DeWitt Foard & Company

Controller
Angie Leckie

Director of Development and Marketing
Cynthia Sims

Chief Operating Officer
Tammy Hanson

Medical Director
Christopher Lord, MD

Director of Business Development
Margaret Larrea

Administrative Team

Manager of Administrative Operations
Christina Melber

Patient Accounts Representative
Corinne Freer

Data and Information Coordinator
Jake Allen

Clinical Case Coordinators
Marsha Jackson
Amy Catchpole,

Clinical Team

Clinical Supervisor
Kelly Little

Counselors
Gail Courtright, Abier Thornton, Cori Trotman, Michael Hatley, Jennifer Kline, Todd McLean

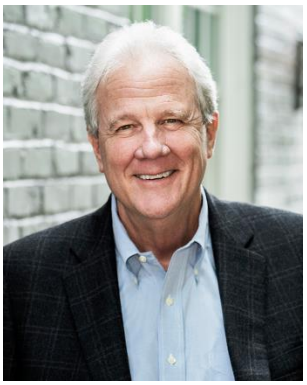
Family Counselors
Diane Frederick, Jordan Tadlock, Laura Wesson

Treatment Facilitators
Dakeita Staton, Peter Hirsch

Laboratory Scientist
Justine Gleason

Created: 1992
REV: 02/2020

Executive Team



Charles Odell

CEO and President

MSW, Master Addiction Counselor (MAC), Licensed Clinical Addictions Specialist (LCAS)

"I believe that Dilworth Center's treatment team is the most competent and talented group of people with whom I've ever worked. It is my privilege to be a part of it. Our patients and their families could not be in better hands."

Mr. Odell has been with Dilworth Center since 1995.

Tammy Hanson

Chief Operating Officer

MSW, Licensed Clinical Social Worker (LCSW), Master Addiction Counselor (MAC), Licensed Clinical Addiction Specialist (LCAS), & Certified Clinical Supervisor (CCS)

"The biggest problem I see that keeps those suffering from addiction from getting help is fear of the unknown. I wish I could show every patient a look into "a crystal ball," so they could see what their life could be without the weight and shroud of addiction."

Ms. Hanson has been with Dilworth Center since 2001.

Margaret Larrea

Director of Business Development

BA,

"There is a lack of understanding that alcoholism/drug addiction is a disease and people who are suffering are not bad people trying to get good—they are sick people trying to get well. They deserve to be treated with care, respect and dignity."

Ms. Larrea has been with Dilworth Center since 2007.

Cynthia Sims

Director of Development and Marketing
JD

"By reaching out for help I now am living my best life. Recovery continues to give me the gifts of joy, peace and gratitude. I want to help extend this gift to others who have lost their way."

Ms. Sims has been with Dilworth Center since 2016.

Angie Leckie

Controller
CPA

"Working at Dilworth Center provides me the opportunity to use my talent for a purpose and mission much larger than myself."

Ms. Leckie has been with Dilworth Center since 2005.

Clinical Team

Dr. Christopher E. Lord

Medical Director
MD, Diplomate, American Board of Psychiatry and Neurology,

"The biggest problem I see that keeps those suffering from addiction from getting help is that they succumb to their distorted beliefs regarding the perceived futility of seeking help. Regardless, they should try anyway."

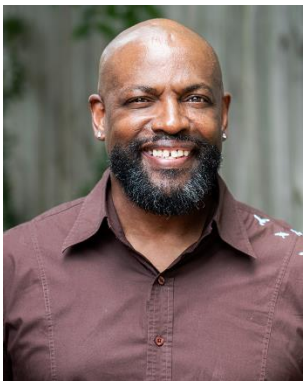
Dr. Lord has been with Dilworth Center since 2009.

Kelly Little

Clinical Supervisor
MSW, Licensed Clinical Addiction Specialist (LCAS), Certified Clinical Supervisor Intern (CCS-I)

"I do this work because I love people. I am honored every day that my patients and their families trust me to be a part of their recovery journey."

Ms. Little has been with Dilworth Center since 2013.



Cori Trotman

Lead Counselor

BA, Certified Alcohol and Drug Counselor (CADC), Advanced Certified Relapse Prevention Specialist (ACRPS)

"I have enjoyed helping people for over 35 years in the field of human services and I believe that there is nothing more important in this world than helping mankind."

Mr. Trotman has been with Dilworth Center since 1997.

Abier Thornton

Lead Counselor

M.Ed., Licensed Clinical Addictions Specialist (LCAS)

"Nothing is more inspiring to me than when former patients reach out to me to show me their Chips and to update me on how their lives improved since being in recovery."

Ms. Thornton has been with Dilworth Center since 1999.

Jordan Tadlock

Counselor

MA, Licensed Marriage and Family Therapist (LMFT).

"I want my work to make an impact. Our pain can feel so isolating but the only way out is through. I make a point to try to connect with others and validate their process."

Ms. Tadlock has been with Dilworth Center since 2011.

Todd McLean

Counselor

AA, Certified Alcohol and Drug Counselor (CADC)

"Recovery is real and it works. And yes, you can have fun! Lots of it! I did not get clean and sober to be pissed off and miserable."

Mr. McLean has been with Dilworth Center since 2012.

Gail Courtright

Counselor

MS, Licensed Professional Counselor (LPC), Licensed Clinical Addiction Specialist (LCAS)

"Nothing is more inspiring to me than seeing someone set a goal, work hard and achieve it."

Ms. Courtright has been with Dilworth Center since 2017.

Jennifer Kline

Counselor

MA, Licensed Professional Counselor Associate (LPCA), Licensed Clinical Addiction Specialist Associate (LCASA), National Certified Counselor (NCC)

"I am someone who strives to be authentic in every moment, and I am not afraid to compassionately challenge in-authenticity as it appears."

Ms. Kline has been with Dilworth Center since 2018.

Diane Frederick

Lead Counselor

BS, Certified Alcohol and Drug Counselor (CADC)

"My "aha" moment came when I realized people can and do recover!"

Ms. Frederick has been with Dilworth Center since 2003.

Michael Hatley

Counselor

MA, Licensed Clinical Addiction Specialist (LCAS)

"The best advice I have received was cloaked in the form a personal wish from a mentor. He said, "My wish for you is that one day you will honor and bless the path you have taken."

Mr. Hatley has been with Dilworth Center since 2017.

Laura Wesson

Counselor

MA, Licensed Professional Counselor Associate (LPCA), Licensed Clinical Addiction Specialist (LCAS), National Certified Counselor (NCC)

"There is nothing braver in my book than being willing to really get to know the most important person in your life… YOU!"

Ms. Wesson has been with Dilworth Center since 2017.

Dakeita Staton

Treatment Facilitator

BA, Pursuing a Masters in Clinical Mental Health

"The best advice I've ever received was that being brave is not the absence of fear but rather the strength of moving forward despite the fear."

Ms. Staton has been with Dilworth Center since 2017.

Nancy Willis

Counselor

MA Ed., Licensed Clinical Addictions Specialist (LCAS), Certified Clinical Supervisor (CCS).

"Ya'll, I love counseling, as long as there's heat, I'll be here!"

Ms. Willis has been with Dilworth Center since 2012.

Peter Hirsch

Treatment Facilitator

BS, Certified Alcohol and Drug Counselor (CADC-R), NC Peer Certified Peer Support Specialist (NCCPS)

"Nothing is more inspiring to me than to know I've connected with someone on the deepest, most meaningful level and can make a difference."

Mr. Hirsch has been with Dilworth Center since 2019.

Justine Gleason

Laboratory Scientist
BS, MSE

"My aha moment came when I saw how many alumni Dilworth Center has and how the work they do here actually is impacting a lot of lives for the positive."

Ms. Gleason has been with Dilworth Center since 2014.

Intake Team

Christina Melber

Manager of Administrative Operations
BA

"Nothing is more inspiring to me than a person who puts aside their ego and asks for help. My heart melts."

Ms. Melber has been with Dilworth Center since 1990.

Amy Catchpole

Clinical Case Coordinator
BA

"Nothing is more inspiring to me than being a witness to someone's journey to finding genuine happiness in sobriety."

Ms. Catchpole has been with Dilworth Center since 2013.

Marsha Green

Clinical Case Coordinator
MA

"I've quickly realized that addiction is not a moral issue, it is truly a disease. This disease does not choose who it effects, rich, poor, or color. I knew at that moment this is where I'm supposed to and be doing with my life. Helping others in their journey. I have never looked back or regretted that decision."

Ms. Green has been with Dilworth Center since 2016.

Corinne Freer

Patient Accounts Representative

"My mission is to help as many people as I can, by not letting money stand in the way of treatment."

Ms. Freer has been with Dilworth Center since 2013.

Jake Allen

Data & Information Manager

"Nothing is more inspiring to me than perseverance in the face of crushing adversity. I'm a sucker for the humble underdog."

Mr. Allen has been with Dilworth Center since 2019.

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ADULT TREATMENT CONTRACT
PRELIMINARY TREATMENT PLAN

1. I agree to abstain from all mood/mind altering chemicals, including alcohol. If I am on any prescribed medications that meet these criteria, written documentation from my physician regarding my use of this medication will be required and prior approval must be obtained by the Director of Clinical Services and/or Medical Director.

2. I agree I may be asked to submit a urine sample for the purpose of drug screening prior to my admission to treatment. I further agree I may be asked to submit to random drug screens and/or breathalyzer testing anytime during the treatment process. I understand screens may be observed as deemed necessary by DC Staff.

3a. I agree if I should come to a treatment session under the influence of any mood/mind altering drug, including alcohol, I will not be eligible for treatment. I understand intoxicated patients are required to leave their vehicle keys with DC Staff and obtain alternative transportation to their residence. At my request, DC Staff will call a taxi service and pay for a one-way trip to my residence - the cost of which will be billed to my account. If I refuse to find alternative transportation and attempt to drive my vehicle, DC Staff will call the police and provide them with vehicle information.

b. I understand if my urine screens demonstrate abnormal validity readings or are positive for mood/mind altering drugs, I may be discharged from the treatment program and referred to a more appropriate level of care, at the discretion of DC Staff. I understand if I am discharged from Dilworth Center program, I may reapply for admission at any time. However, decisions to readmit patients require approval from the clinical team.

4. I agree I will attend a minimum of three (3) meetings of Alcoholics Anonymous or Narcotics Anonymous each week that I am in the treatment program. I agree I will acquire a sponsor from these meetings within the first eight weeks of my treatment program. I understand documentation of attendance and sponsorship will be required. Note: Treatment session, lectures, and groups that you participate in at Dilworth Center are not AA or NA and do not count as the AA/NA meetings that you are required to attend. I understand failure to comply with this part of my treatment contract will result in my discharge from the program.

5. I understand no information concerning my treatment will be released by Dilworth Center Staff without my expressed written consent except in the enforcement of this agreement, or except in the case of an emergency or as required for compliance with Federal and/or State Laws.

Over

6. I agree to attend each of the treatment sessions and to be on time. I understand should I arrive after a treatment session begins, I will be required to repeat the session. The treatment session must be made up before I can complete the program.

7. I understand the schedule is as follows:

Level 1 (8 weeks)

Tuesday 6:00 pm – 9:15 pm

Thursday 6:00 pm – 9:15 pm

Saturday 9:00 am – 12:15 pm

Level 2 (8 weeks)

Tuesday 6:00 pm – 7:45 pm

Thursday 6:00 pm – 7:45 pm

8. I agree if I must miss a treatment session because of an emergency, I must call Dilworth Center at 704-372-6969 and notify a staff member as soon as possible. I understand that failure to do so may result in my termination from treatment. I understand that missing treatment sessions for any reason is strongly discouraged and could place the success of my treatment in jeopardy.

9. I agree to invite my family and/or significant others to participate in the family portion of the treatment program.

10. I hereby authorize Dilworth Center to provide treatment services for chemical dependency, consisting of the items outlined in this treatment contract, as well as any other services deemed appropriate by my treatment team and myself. At any point, my treatment team may modify treatment requirements as necessary to ensure the highest level of patient care.

11. I acknowledge that I have been provided a copy of the statement of patient rights, which will also be included in my patient handbook.

12. I have read and fully understand all of the criteria in my preliminary treatment plan and agree to abide by all parts of this contract. I further understand failure to comply with any of the above may result in my discharge from the treatment program.

_____

PATIENT SIGNATURE **DATE**

_____

STAFF/WITNESS **DATE**

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Adult Intensive Outpatient Treatment Program

Our Philosophy

Dilworth Center supports the American Medical Association's definition of a substance use disorder as a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often both progressive and fatal. It is characterized by impaired control over chemical use, preoccupation with the drug, use of the drug despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

Dilworth Center believes that recovery from substance use disorder must begin with complete abstinence from all mood-altering chemicals. We believe that the best single mechanism for ensuring long-term recovery is active participation in mutual-help groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Dilworth Center believes that throughout the treatment process our patients, as well as their families, deserve the same dignity and quality of care as those suffering from any other disease.

The Treatment Program

The adult, 40-session treatment program offered by Dilworth Center is designed to deliver effective and intensive substance use disorder treatment in a manner that allows participants and their families to continue their work and home routines.

The goal of treatment is to establish abstinence from alcohol and other drugs with an emphasis on continuous recovery as a means of moving towards a well integrated life.

Each patient participates in an intake session prior to beginning treatment. An assessment is performed, a preliminary treatment plan developed, and an orientation to the treatment process is delivered. Spouses, significant others and other family members of the patient may participate in this session if possible. Following the intake session are four basic interwoven components of the treatment process:

1. *Intensive Outpatient (IOP)* - Intensive Outpatient consists of two evening sessions and one Saturday morning session per week for a minimum of eight weeks. Each of these sessions lasts three hours.

    - 6:00 PM - 9:15 PM Tuesdays and Thursdays
    - 9:00 AM - 12:15 PM Saturdays

    All treatment sessions have two primary components, an educational presentation and a

group therapy session. The educational presentations cover such topics as "The Disease of Addiction", "Denial", and "The Family Illness". Lectures centered on each of the first four Steps of Recovery are provided as well. Because denial is a major symptom of substance use disorder, these educational presentations and lectures are designed to enable the participants to confront their disease and recognize and admit their addiction. This process not only instructs, but also involves the patient in the recovery process. Group therapy provides a climate where bonding with other recovering people can take place. New learning and behaviors are tested, and feelings are shared.

2. *Continuing Care* - Continuing Care consists of 16 group therapy sessions over 8 weeks; twice a week for 8 weeks. Based on the goals and objectives of individualized treatment plans, some participants may be involved in Continuing Care beyond 12 weeks. These group sessions are scheduled Tuesday and Thursday evenings and last ninety minutes.

    - 6:00 PM – 7:45 PM Tuesdays and Thursdays for eight weeks

    The purpose of Continuing Care is to facilitate a continuity of care as the patient moves away from Intensive Outpatient treatment. Continuing Care is more than just the provision of a structured transitional experience. It provides an opportunity for patients to capitalize on the gains made during Intensive Outpatient. It is a means by which patients can continue to work on issues derived from their treatment plans. It is continuing reinforcement for the necessity of ongoing involvement in Alcoholics Anonymous or Narcotics Anonymous. It is also an environment in which patients may learn relapse prevention strategies.

3. *Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)* - From the beginning of Intensive Outpatient and throughout Continuing Care, each patient is required to participate in meetings of Alcoholics Anonymous or Narcotics Anonymous. The frequency of meeting attendance is determined by each patient's individualized treatment plan.

4. *The Family Program* - Family participation in treatment is encouraged, and at times, required at the Dilworth Center. Family members and significant others are involved in educational and group therapy on Saturday mornings, Tuesday evenings, or Thursday evenings for eight consecutive sessions. Additionally, involvement in Al-Anon or Nar-Anon is expected and encouraged.

    - 9:00 AM - 12:15 PM Saturdays for eight weeks

      OR
    - 6:00 PM – 9:15 PM Tuesdays & Thursdays for eight weeks

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Treatment Rules

1. Possession of, or use of alcohol or illegal drugs on the property may result in dismissal from the program.
2. Acts of violence, or threats of violence, are grounds for immediate discharge from the program.
3. Weapons are not allowed on the property, either in cars, on the grounds, on the porch, or in the building. Weapons include, but are not limited to, guns, knives, pocketknives, and pepper spray.
4. Borrowing, lending or giving of money or any personal items whatsoever between patients are not allowed while enrolled in treatment at Dilworth Center.
5. No verbal abuse of staff or other patients is allowed.
6. Smoking or the use of smokeless tobacco products are allowed in designated areas only.
7. Patients must attend all scheduled group sessions, unless excused by group and staff. Excessive absenteeism may result in dismissal from the program.
8. Patients are to be on time to all scheduled sessions, any tardiness may result in session extensions.
9. Be respectful of the group process and the facilitator's role. Any disruptive/inappropriate behavior may result in dismissal from the program and, if applicable, reported to their referring source.
10. All treatment assignments are to be completed timely, as requested by counselor. Failure to return paperwork may result in session extension.
11. Patients are responsible for their behavior, and are expected to communicate, cooperate, and show respect to other patients and staff.
12. All visitors must be approved by staff and be willing to abide by HIPAA laws.
13. Cell phones, tablets, headphones and other electronic devices must be turned off while in lecture and in group sessions.
14. Pairing-off between patients is not allowed. Pairing-off is when two patients are alone together, either on or off Dilworth Center property.
15. Any information in regard to the patients and/or group discussions is to be kept within the group. Sharing of patient/group information outside of the group may result in dismissal from the program.
16. Any illegal drug use, whether using or selling in or around facility premises shall be dealt with according to the law. Drinking of any alcoholic beverage during participation in the program is prohibited.

Knowledge and awareness of all rules is expected. When you do not know what to do, please do not assume … ask a staff member

If I bring drugs/weapons onto the property, break any rules, or act out in any way (violent, verbally and/or physically) I will be discharged from Dilworth Center. Behavior that undermines treatment rules and expectations will not be tolerated. Violations of these rules may result in consequences, including dismissal from the program. Illegal activity is subject to criminal prosecution. Dilworth Center's program rules have been explained to me so that I understand them and I have received a copy of these rules.

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Consent for Treatment

CONSENT FOR TREATMENT

I give my consent to voluntarily participate in Dilworth Center treatment program. I have the right to refuse services, and to have the consequences of such refusal explained to me. I agree to follow all program rules and guidelines, and I understand that failure to do so may result in my discharge. I agree to provide an accurate medical history, mental health history, and submit to ongoing drug screening.

CONSENT FOR ALCOHOL AND OTHER DRUG TESTING

I understand that I may be asked to provide a urine, breath or saliva sample at any time so that it may be tested for the presence of unauthorized drugs and alcohol. This testing is done to assist in treatment planning and verify compliance with treatment rules. When asked to provide a urine sample, I may be observed by a staff member of the same gender to insure the integrity of the sample. This request may be made at random, or as the result of a reasonable suspicion that I may have used alcohol and other drugs. I understand alcohol and drug use may result in discharge from Dilworth Center.

PATIENT SAFETY

I understand and will follow the instructions for patients regarding emergency evacuation procedures. I agree to hold Dilworth Center, its staff and Leadership Team, harmless in the event of any loss and/or injury to my person and/or property while in treatment or on the premises of Dilworth Center.

FINANCIAL AGREEMENT

I understand that I am responsible for payment of my treatment and drug screen fees incurred while a patient at Dilworth Center. The fees for treatment have been fully explained to me. Drug Screens may not be included in these fees. Payment arrangements are made prior to admission.

COMMUNICABLE DISEASE REPORTING

I have been informed of my need to report communicable diseases. I understand that Dilworth Center must comply with requirements regarding the reporting of certain communicable diseases with which I may be diagnosed.

EMERGENCY MEDICAL TREATMENT

In the event that I have a medical emergency while in treatment at Dilworth Center, I consent to be transferred to the nearest hospital and to receive emergency medical treatment as is deemed appropriate by medical personnel. I agree to hold Dilworth Center, its staff and the Leadership Team, harmless in the event of the need for such transfer or treatment.

PATIENT PHOTOGRAPHS AND VIDEO RECORDINGS

I give my consent to be photographed for the purpose of medical record identification. This photograph is protected as part of my clinical record.

Created: 03/21/13
Revised: 2020

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It is the policy of the Dilworth Center that possession of alcohol or illegal drugs by staff or patients is strictly prohibited.

1. If in the event patients are discovered to be in possession of alcohol or illegal drugs on the Dilworth Center property, they will be immediately discharged from treatment.

2. If in the event patients are in possession of illegal drugs on the Dilworth Center property, they will be immediately reported to the police.

3. If in the event patients are suspected or confirmed to be under the influence of alcohol or drugs, they will be requested not to drive a motor vehicle. If they refuse the request and drive anyway, they will be immediately reported to the police.

4. All reasonable efforts will be made to refer patients and staff members in possession or under the influence of drugs or alcohol to the appropriate referrals including treatment services.

5. The appropriate use of legally prescribed drugs and/or non-prescription medications is not prohibited by Dilworth Center, but does require that its use is pursuant to a doctor's orders, that the doctor has advised that the substance does not adversely affect the person's ability to safely function and it is on the list of approved medications (see patient handbook). For the purposes of this policy a legally prescribed drug means the individual has a prescription or other written approval from a physician for the use of a drug in the course of medical treatment. It must include the patients name, the name of the substance, quantity/amount to be taken, and the period of authorization.

6. The CEO and the Director of Clinical Services will be made immediately aware of any of the above violations of Dilworth Center policy and will have the final authority in enforcing these procedures.

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Revised: 2020

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Transition Guide

Patient Name: _____ Patient # _____

The following are the types of transitions you might experience while in treatment at Dilworth Center.

Advancing to Level II/ III/ Continuing Care: At the completion of Intensive Outpatient treatment, you will transition to Level II/ III/ Continuing Care. You will then attend treatment two to three treatment sessions per week, as outlined in your treatment contract.

Completion: When you reach your treatment goals and meet all program requirements, you will have successfully completed the program.

Referral for Therapy: If you experience mental health symptoms co-occurring with your substance abuse problem, you may be referred to a counselor or therapist in the community.

Treatment Contract Extension: In the event you have difficulty reaching your goals or adhering to program requirements, the recommended length of your treatment program may be extended to give you more time to reach your goals. **Please note: Additional charges will be incurred.**

Referral to a Higher Level of Care: If your substance dependence problem is determined to be more advanced than initially assessed, if you are unable to establish or maintain abstinence, or if you are under the influence of substances at Dilworth Center, you may be referred to one of the following more intensive levels of care:

- Detoxification
- Inpatient/Residential Program

Returning to a Previous Phase of Treatment: If you are having significant difficulty meeting your goals or adhering to program requirements while in Level II/ III/ Continuing Care, you may be referred back to the Intensive Outpatient phase of treatment. Please note: Additional charges will be incurred.

Clinical Discharge ("At Staff Request"): If it is determined that you have received the maximum benefit from treatment or are not benefitting from the treatment program; you may be notified that you are to be discharged. Your counselor will then work with you on needed referrals. Evidence of lack of benefit includes, but not limited to, continued substance use, repeated absences or tardiness, and/ or failure to submit to drug screens or breathalyzer tests, or overall lack of progress.

Administrative Discharge ("At Staff Request"): In the event that you present with inappropriate, disruptive, threatening or violent behavior, you may be notified that you are to be discharged. Your counselor will then work with you on needed referrals. Examples of this type of behavior include sexual relations with other patients, threatening other patients or staff, damaging property, or exhibiting violent behavior.

Conflict of Interest: If it is determined that there is a conflict of interest between two patients being in treatment together at the same time (ex. family members or friends), the person who began treatment last will be offered referrals to other facilities.

Self-Discharge ("Against Medical Advice"): In the event you discharge yourself before you have successfully completed.

When you experience any transition while receiving services at Dilworth Center, your counselor will meet with you to discuss your:

- ❊progress
- ❊goal achieved
- ❊reason for your transition
- ❊your transition or aftercare plan
- ❊recommendations for your transition
- ❊referrals needed to address your ongoing needs

Patient Signature: _____ Date: _____

DC Staff Witness: _____ Date: _____

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Revised: 2020

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Dilworth Center Dress Code

All clothing should *respect* the purpose of the group, which is to work together to help each other remain clean and sober. Clothing that distracts from this purpose is therefore inappropriate. Dilworth Center has established the following rules regarding clothing worn by all patients while on the premises:

1. Clothes shall be worn as they are designed – pants secured, belts buckled, no underwear as outerwear, no underwear showing. No jeans hanging down the backs of legs so underwear can be seen.
2. Bare midriffs and bare sides should not show even when arms are extended above the head.
3. Clothing that is too tight or too revealing is unacceptable.
4. Garments and/or jewelry which display or suggest sexual, vulgar, drugs, alcohol or tobacco related word/graphics shall not be worn (including tie-dye clothing, rock band shirts, Harley Davidson shirts, etc.).
5. Gang paraphernalia, jewelry, tattoos or other insignias shall not be displayed.
6. Patients are not allowed to wear hats, caps, visors, sunglasses or bandanas, while inside Dilworth Center.
7. Hemlines, shorts, dresses, and skirts shall be no shorter than mid-thigh length.
8. All blouses and shirts must have sleeves at least four fingers wide at the shoulder. No "spaghetti strap" tanks are to be worn alone.
9. Cell phones must be turned off while in lecture and in group sessions.

Further questions about appropriate clothing should be directed to the staff at Dilworth Center. Please note that these rules will be strictly enforced:

- First time violations of the dress code will result in a warning along with the patient required to fix the offending clothing immediately.
- Second time violations will result in the patient being sent home and required to repeat the treatment session.
- Further violations may result in discharge from Dilworth Center.

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PATIENT LATE ATTENDANCE POLICY

POLICY:

Dilworth Center's policy is that all patients will be ready to begin treatment at the designated start time of treatment.

PRACTICE:

1. Treatment begins with assembly promptly at 6:15pm on Tuesday and Thursday, and 9:15am on Saturday. Once assembly begins at 6:15pm on Tuesday and Thursday and 9:15am on Saturday, the auditorium doors will be closed and anyone arriving after that time will be considered "late" and not be allowed into auditorium until after assembly is completed.

2. All drug screens, paperwork, and financial matters MUST be completed prior to the start of assembly. Patients should plan to arrive up to 15 minutes early to complete any required drug screens or financial matters. Any patient who has not completed their drug screen, paperwork, or financial transaction prior to assembly is considered late.

3. If a patient is late, he/she will be required to repeat the treatment session. Generally, patients are not charged for the additional session, however, patients who are repeatedly late or do not attend a treatment session are subject to discharge.

Dilworth Center
UNLOCK YOUR RECOVERY

ACCESS TO AFTER-HOURS SERVICES

POLICY:

Dilworth Center's policy is to provide emergency, after-hour services.

PRACTICE:

1. In the event of an after-hour emergency, patients may call Dilworth Center's main telephone number, 704-372-6969, for instructions for paging the staff member on duty.

2. Patients are encouraged to dial 911 in the event of a life threatening emergency.

POLICY TITLE: Patient Rights and Responsibilities	POLICY # PR-01

I understand I have the right to:

- be treated with dignity, respect, and consideration at all times. I will not be subject to humiliation, abuse and/or neglect of any form. I understand that Dilworth Center does not use seclusions or restraining devices. Emergency interventions using NCI techniques will be used in response to assault, aggression, and threatening and/or violent behavior.
- services that are responsive to age, gender, social supports, cultural orientation, psychological characteristics, sexual orientation, physical situation, spiritual beliefs, genetics, medical history, race, ethnicity, nationality, mental or physical disabilities and will not be denied services based solely on these issues.
- obtain from staff the complete information concerning my diagnosis, treatment, and/or prognosis in terms I can reasonably be expected to understand.
- be assigned an individual counselor responsible for my care and will be informed of the composition of the clinical team.
- receive sufficient information necessary to give informed consent prior to the start of any treatment procedure, as well as the treatment team composition.
- refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
- privacy and to be free from any search of my person or property without just cause.
- have my presence in treatment and all records pertaining to my care protected under federal and state law.
- confidentiality and informed consent to release any such information.
- be involved in all aspects of my care and services, including participating in the formulation of my individualized treatment plan, and review of this plan on a regular basis.
- access the most appropriate, least restrictive level of treatment based upon my needs and best interest.
- participate in activities designed to enhance my self-esteem and support, including mutual help.
- quality services suited to my needs, administered skillfully, safely, humanely, and with full respect for my dignity and personal integrity.
- communicate freely and privately with other persons, within the guidelines of the program policies.
- be informed of the program rules and expectations for patient behavior.
- be fully informed of the services, including the cost of those services. I have the right to examine and receive an explanation of my bill and be free from financial exploitation.

- request to see my record, except in some situations described by law.
- continuity of care, including the right to know in advance any appointment times and when clinical staff are available, and the right to be informed of my continuing care needs following discharge.
- expect a reasonable response to my request for services, within the program's capabilities and responsibilities, with access to information within sufficient time to facilitate my decision making.
- be informed of the relationship of this program to other healthcare and educational institutions as related to my care.
- be informed of any research projects or experimentation affecting my care, and I have the right to refuse to participate.
- access legal counsel, at my expense, within the structure and schedule of the program, as well as standard legal rights.
- members of my family having the same rights to consideration, respect, informed consent and confidentiality regarding treatment service records that I have as a patient.
- a copy of my discharge plan that contains recommendations about other services I may need.
- file a grievance if I believe that my rights as a patient have been violated and to expect a prompt and appropriate response to that grievance. I have the right to be informed of the procedure of filing such a grievance and I will not be retaliated against for filing a grievance. I understand that my counselor and the Director of Clinical Services have been identified as my patient advocates. They will assist me in the grievance process, if I would like assistance. They can be reached at 704-372-6969.

My rights as a patient have been fully explained to me. I understand that if I have any questions, I may ask any staff member for further explanation.

_____ _____

Patient Signature Date

_____ _____

DC Staff Witness Date

More about Patient Rights and Responsibilities

YOU HAVE THE RIGHT TO CONFIDENTIALITY

Your right to confidentiality about your treatment is protected by law. Except in a few limited circumstances, your records and other information about you will not be shared with other agencies or persons without your signed permission. You can withdraw your written permission at any time. You can ask that only certain parts of your record be shared. Sometimes the law may require Dilworth Center to share information about you and the services you receive.

- The court may order us to release your records.
- DC staff members are required by law to report suspected abuse or neglect of children, teens, older or disabled adults.
- Our attorney may need to see your record in special legal situations.
- In an emergency, a doctor, nurse, or counselor who is treating you may see your records.
- If you seem to be a danger to yourself or to others, or if we believe that you are likely to commit a crime, we are required by law to tell the police or a judge (for example, in a commitment situation).
- Special confidentiality rules may apply if you have a legal guardian, are under age 18, or are receiving treatment for drugs and/or alcohol.
- When a child is receiving services and his/her parents are divorced, both birth parents may have access to their child's record unless their parental rights have been taken away.
- If you go to jail or prison, we may share your files with prison officials, if they believe you need mental health or substance abuse services, or support for a developmental disability.
- In special situations, if a family member is involved in your treatment or service, they may be allowed to know some information about your services.
- A patient representative or other advocate may review your record when he or she is asked to work on your behalf.

If you feel that your right to confidentiality has been violated, you have the right to complain to the **Director of Clinical Services at (704) 372-6969**.

YOU HAVE THE RIGHT TO KNOW THE RULES OF THE PROGRAM

- When you begin treatment, you have the right to learn about the rules you are expected to follow and what the consequences will be for not following the rules. You should expect to be provided with a copy of a temporary treatment contract outlining expectations and a copy of patient rights before beginning treatment.
- In the event that the services at Dilworth Center do not meet "medical necessity," or program rules are not followed, you and your counselor may decide you need a different level of service.

More about Patient Rights and Responsibilities

YOU HAVE THE RIGHT TO KNOW YOUR RESPONSIBILITIES

You have responsibilities as a patient. The following are ways you can be a responsible patient:

- Avoid missing treatment sessions.
- If it is unavoidable that you miss a treatment session, make sure to submit a plan to your group and get it approved by group members and your counselor.
- Give us all the facts about the problems you are experiencing.
  Bring a list of all doctors providing care for you.
- Tell us about any other problem for which you are being treated.
- Be very involved in developing and reviewing your treatment plan.
- Talk to your counselor often about your needs, preferences, and goals, as well as how you think you are doing in regards to meeting your goals.
- Ask for information about your problems.
- Follow your treatment plan once you have agreed to it.
- Keep all appointments or call us 24 hours before an appointment, if you cannot come in.
- Let us know about changes in your name, insurance, address, telephone number, or finances.
- Pay your bill or let us know about problems you have in paying.
- Treat staff and other patients with respect and consideration.
- Follow the rules of the program.
- Let us know when you have a suggestion, comment, or complaint so we can help you find an answer to the problem.
- Respect the confidentiality and privacy of other patients.

Failure to meet your treatment responsibilities may result in treatment extensions and/or dismissal from the program.

YOU HAVE THE RIGHT TO MAKE A COMPLAINT

- Please talk to Dilworth Center staff about your problems first to give them a chance to help solve it. If you are dissatisfied with a service or feel you have not been treated fairly, you have the right to make a complaint at any time. You may ask any staff you choose to help you make a complaint. Then, if you are not satisfied, contact the Director of Clinical Services at (704) 372-6969.
- You have the right to appeal decisions made by the Director of Clinical Services to the CEO at (704) 372-6969.

Date Created: 06/19/2013
Revised/Reviewed Date: 1/14/2020

Dilworth Center
UNLOCK YOUR RECOVERY

Dear Patient:

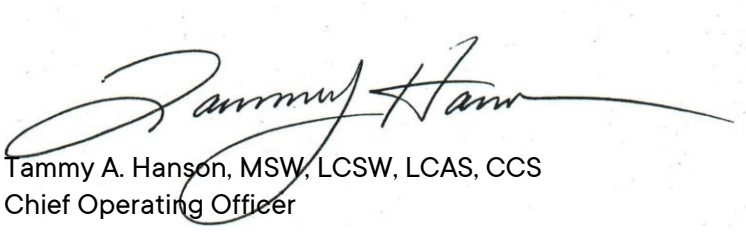
The hope is that the following medication guide will help you make wise decisions regarding over the counter medicines or medications you may be prescribed. Dilworth Center is an abstinence based treatment center; therefore, the drugs in Class A of this guide should never be used, while in treatment. The drugs listed in Class B can only be used if approved by DC psychiatrist and/or DC medical director.

If you become ill while in treatment with a cold, flu, etc., please check this list before taking any medications, to ensure they will not threaten your recovery or treatment experience by testing positively on drug screens. This guide categorizes medications according to their safety and is critical for the identification of substances that should be avoided, carefully evaluated, as well as those that are acceptable for use in recovery.

Please remember this guide is only intended as a quick reference and never a substitute for the advice of your physician, addictionologist and/or psychiatrist. Make sure to let DC treatment team know about any medication changes you may experience, while in treatment. It is also imperative you inform all of your personal physicians, dentists and other health care providers of your substance use disorder history, so medications can be prescribed safely and appropriately when they are deemed necessary. NEVER discontinue or make any changes in the doses of medication you may have been prescribed without the direction of a physician. Doing so may result in unexpected problems, which in some cases may be life-threatening.

If you have any questions regarding the information contained in this guide, please contact your counselor for more information. Your counselor can also help facilitate appointments with our psychiatrist and/or medical director.

Sincerely,



Tammy A. Hanson, MSW, LCSW, LCAS, CCS
Chief Operating Officer

2240 Park Road
Charlotte, NC 28203

p. 704.372.6969
f. 704.335.0176

www.dilworthcenter.org
info@dilworthcenter.org

How to use this medication guide:

There are many types of medications that may present a hazard to a person beginning the journey of recovery from chemical dependency. These include prescription and over-the-counter medications. The danger is not always that a recovering addict may develop a new addiction (though this certainly can happen), but that one can be led back into dependence on their drug of choice. The latest scientific research has proven that all the dependence producing drugs act on the brain in the same way to produce addiction, despite having different effects or a different kind of high when taken. Therefore, it is very important for a recovering person to learn about the different types of medications and drugs, as well as which ones present a special risk to continuing recovery and sobriety. The commonly available medications and drugs are divided into three classes – A, B and C – to indicate three levels of risk.

Class A drugs must be avoided completely, as they are well known to produce addiction and are the most dangerous of all. Only under very unusual conditions can Class A drugs be taken by a recovering addict or alcoholic, and only when given by a physician or dentist and with the consent of the addiction medicine physician that follows your care. These exceptional circumstances can include severe illness and injuries, including major surgery, car accidents and other trauma, and tests or procedures that can only be done under sedation or anesthesia. Medication treatments for certain psychiatric conditions are in this category as are medications used for dug detoxification. The street names for relevant drugs are also included in Class A.

The medications in **Class B** are potentially dangerous, especially when taken by recovering persons without the guidance of a physician or another health care professional. However, under certain circumstances, the Class B group can be taken safely under a physician's care. We strongly urge you to have an addiction medicine specialist follow your treatment when you are prescribed these medications.

Class C medications are generally safe from the point of view of addiction recovery. However, overuse of any medication, even the common over-the-counter remedies, can result in unwanted side effects. People who have struggled with drug addiction or alcoholism must remain aware of the tendency to look for external solutions for internal problems and should avoid taking any of these medications on their own in order to medicate emotions and feelings. The tools of recovery, including participation at 12-Step fellowship meetings, working the Steps, or talking with a sponsor, counselor or doctor, provide safe and healthy ways to deal with the strong feelings that can come up at any time in early sobriety.

The three classes of medications that appear on the following pages include both the brand name (i.e. Valium), as well as the generic name (i.e. diazepam), as the majority of prescription bottles are labeled with the generic name. On the following pages, look for the brand name listed first, followed by the generic name in parentheses. For street drugs, the common name is listed first, and the chemical name or street name is in parentheses. For each drug group in Class A and B, there is a brief explanation of the dangers associated with taking the medication or street drug.

This drug use guide for safe and sustained recovery was adapted from Talbott Recovery Campus. The guide is divided into three sections and is based on the drug classification system developed nearly 20 years ago by Dr. Paul Earley and recently expanded on by Bruce Merkin, M.D., Renee Enstrom, Nicholas Link and the staff at Glenbeigh hospital.

Class A Drugs

Absolutely Avoid

Alcohol:

Ale
Beer (including "non-alcoholic" forms)
Brandy
Liqueur
Malt Beverage
Whiskey
Wine
Wine Cooler

Alcohol consumption reduces social inhibitions and produces pleasure and a sense of well-being. It is a stimulant (raises blood pressure and heart rate) and a depressant. Alcohol affects the brain's reward pathways and appears to be related to interactions with dopamine, GABA, serotonin, opioid and NMDA neurotransmitter systems. The "non-alcohol" or "NA" forms of beer should not be consumed because there is a small amount of alcohol present and research shows that smell may be enough to trigger cravings and a subsequent relapse among certain alcohol- ics. Please note that there is a variety of cough and cold preparations that contain alcohol and that medications which can be taken in tablet form will not contain ethyl alcohol. Certain topical products, soft-gels and capsules contain ethyl alcohol and should be avoided. Please refer to the table at the end of the document for a list of alcohol-containing products to avoid.

Antitussives/Expectorants:

Ambenyl (codeine/bromodiphenhydramine)
Duratuss HD (hydrocodone/dextromethorphan)
Guiatuss (codeine/pseudoephedrine/guaifenesin)
Hycodan Tablets (hydrocodone/homatropine)
Hycodan Syrup (hydrocodone/homatropine)
Hycomine (hydrocodone/chlorpheniramine/ phenylephrine/acetaminophen/caffeine)
Hycotuss (hydrocodone/guaifenesin)
Hydromet (hydrocodone/homatropine)
Mytussin (codeine/pseudoephedrine/guaifenesin)
Nucofed (codeine/pseudoephedrine/guaifenesin)
Phenergan with Codeine (codeine/promethazine)
Robitussin AC (codeine/guaifenesin)
Tussionex PennKinetic (hydrocodone/chlorpheniramine)
Vicodin Tuss (hydrocodone/guaifenesin)

Any cough medications containing narcotics such as codeine or hydrocodone should not be used. These medications bind to opiate receptors in the central nervous system, altering the perception of and response to pain and produce generalized central nervous system depression and may alter mood or cause sedation.

Barbiturates:

Amytal (amobarbital)
Barbita (phenobarbital)
Butisol (butabarbital)
Donnatal (phenobarbital/atropine/hyoscyamine/ scopolamine)
Esgic (acetaminophen/butalbital/caffeine)
Fioricet (butalbital/acetaminophen/caffeine)
Fiorinal (butalbital/aspirin/ caffeine)
Nembutal (pentobarbital)
Seconal (secobarbital)

These medications can produce central nervous system depression ranging from mild (sedation) to hypnotic (sleep induction). As the dose is increased, coma and death can occur. These medications can also lead to an unusual excitatory response in some people.

Class A Drugs

Absolutely Avoid

Benzodiazepines:

Ativan (lorazepam)
Centrax (prazepam)
Dalmane (flurazepam)
Doral (quazepam)
Halcion (triazolam)
Klonopin (clonazepam)
Librium (chlordiazepoxide)
Restoril (temazepam)
Serax (oxazepam)
Tranxene (chlorazepate)
Valium (diazepam)
Versed (midazolam)
Xanax (alprazolam)

These medications can produce an immediate change in mood or affect and can cause central nervous system de- pression (dose related) resulting in sedation, dizziness, confusion or ataxia, which may impair physical and mental capabilities. Abrupt discontinuation or a large decrease in dose can lead to seizures, coma or death.

Hallucinogens:

Cannabis (grass, green marijuana, pot, weed)
DMT (dimethyltryptamine)
(special K)
LSD (acid, blotter, paper, sunshine, window pane)
Marinol (dronabinol)
MDMA (E, eckies, ecstasy, love drug, X, XTC)
Mescaline (peyote)
PCP (angel dust, phencyclidine) Ketamine
Psilocybin (magic mushroom, 'shrooms)
2-CB
5-MeO-DIPT (foxy methoxy)
STP (DOM)

Hallucinogens act in the central nervous system. Using these substances can possibly lead to memory disturbances, psychosis and vivid hallucinations. Marinol is the psychoactive substance in marijuana and may cause withdrawal symptoms if stopped suddenly.

Inhalants:

Aerosols (hair sprays, deodorants)
Airplane Glue
Amyl Nitrate (poppers)
Butyl Nitrate (room deodorizer)
Gases (ether, chloroform, nitrous oxide, butane lighters, propane tanks, whipped cream dispensers)
Nail Polish Remover (acetone)
Paint (butane, propane, toluene)
Solvents (paint thinner, gasoline, glue, correction fluid, felt tip marker)
Varnish (xylene, toluene)

Inhalants are central nervous system depressants. Use of inhalants can cause sedation and loss of inhibitions possibly leading to liver, kidney, nerve, heart, brain, throat, nasal and lung damage up to and including coma and death.

Class A Drugs

Absolutely Avoid

Opioids:

Actiq (fentanyl oral transmucosal)
Buprenex (buprenorphine)
Combunox (oxycodone/ibuprofen)
Darvocet (propoxyphene napsylate/acetaminophen)
Darvon (propoxyphene hydrochloride)
Demerol (meperidine)
Dilaudid (hydromorphone)
Dolophine (methadone)
Duragesic (fentanyl transdermal)
Endocet (oxycodone/acetaminophen)
Heroin (down, H, horse, smack)
Kadian (morphine sulfate)
Lorcet (hydrocodone/acetaminophen)
Lortab (hydrocodone/acetaminophen)
Methadose (methadone)
MS Contin (morphine sulfate)
Norco (hydrocodone/acetaminophen)
Nubain (nalbuphine HCl)
OxyContin (oxycodone)
OxyIR (oxycodone)
Percocet (oxycodone/acetaminophen)
Percodan (oxycodone/aspirin)
Roxanol (morphine sulfate)
Roxicet (oxycodone/acetaminophen)
Roxicodone (oxycodone)
Soma Compound with Codeine (codeine/carisoprodol/aspirin)
Stadol (butorphanol)
Suboxone (buprenorphine/naloxone)
Subutex (buprenorphine)
Talacen (pentazocine/acetaminophen)
Talwin (pentazocine lactate)
Tylenol #2, #3 or #4 (codeine/acetaminophen)
Ultram (tramadol)
Vicodin (hydrocodone/acetaminophen)

Opioids bind to opiate receptors in the central nervous system causing inhibition of ascending pain pathways and altering the perception of and response to pain. Generalized central nervous system depression is also produced. Tolerance or drug dependence may result from extended use. Buprenorphine binds to mu receptors in the brain leading to a suppression of withdrawal and cravings but also feeling of euphoria. Most of the drugs in this class have the potential for drug dependency and abrupt cessation may precipitate withdrawal.

Gastrointestinal (Anti-Diarrheals):

Lomotil (atropine/diphenoxylate)
Motofen (atropine/difenoxin)

Diphenoxylate is a member of the opioid class of drugs. Atropine is added to discourage abuse for recreational purposes. At recommended doses, the atropine causes no effects but in larger doses, unpleasant symptoms are ex- perienced. These medications should not be used because high doses may cause physical and psychological depen- dence with prolonged use.

Other Central Nervous System Depressants:

GHB (G, gamma-hydroxybutyrate, everclear)

This category depresses the central nervous system possibly leading to confusion, psychosis, paranoia, hallucinations, agitation, depression, seizures, respiratory depression, decreases in level of consciousness, coma and death.

Class A Drugs

Absolutely Avoid

Other Sedative-Hypnotics:

Ambien (zolpidem)
Doriden (glutethimide)
Librax (chlordiazepoxide/clidinium)
Lunesta (eszopiclone)
Midrin (acetaminophen/dichloralphenazone/ isometheptene)
Miltown (meprobamate)
Noctec (chloral hydrate)
Placidyl (ethchlorvynol)
Quaalude, Sopor (methaqualone)
Soma (carisoprodol)
Soma Compound (carisoprodol/aspirin)
Sonata (zaleplon)

These drugs act on the central nervous system and have the potential for drug dependency and abuse. Withdrawal symptoms can be seen if stopped suddenly.

Stimulants:

Adderall (amphetamine/dextroamphetamine)
Adipex-P (phentermine)
Cocaine (blow, coke, crack, rock, snow, white)
Concerta (methylphenidate)
Cylert (pemoline)
Dexedrine (dextroamphetamine)
Fastin (phentermine)
Focalin (dexmethylphenidate)
Meridia (sibutramine)
Metadate (methylphenidate)
Methamphetamine (crank, crystal meth, glass, ice, speed)
Methylin (methylphenidate)
Preludin (phenmetrazine)
Ritalin (methylphenidate)
Tenuate (diethylpropion)

Stimulants cause physical and psychological addiction, impair memory and learning, hearing and seeing, speed of information processing, and problem-solving ability.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Addiction Treatments:

*****NOTE: Although the medications listed in this *Addiction Treatments* section are specifically intended to be taken for prevention of relapse to dependence upon one or more drugs, none of them are habit-forming or addictive themselves and should therefore be considered safe for recovering people to take. However, their proper use in the context of a recovery program requires monitoring by a health care professional, and it is for this reason that we place them in Class B.*****

Antabuse (disulfiram)
Campral (acamprosate)
Catapres (clonidine)
Chantix (varenicline)
Revia (naltrexone)
Symmetrel (amantadine)
Zyban (bupropion)

Naltrexone may precipitate intense withdrawal symptoms in patients addicted to opiates. Clonidine acts via autoreceptors in the locus coeruleus to suppress adrenergic hyperactivity there that is involved in the expression of the opioid withdrawal syndrome. Disulfiram is dangerous if taken with alcohol. Amantadine can cause decreased mental alertness or altered coordination. Chantix and Zyban are medications to help with nicotine (cigarettes, cigars, chewing tobacco, snuff) addiction.

Cough and Cold Preparations:

Antihistamines (Sedating)

Atarax (hydroxyzine hydrochloride)
Benadryl (diphenhydramine) OTC
Chlor-Trimeton (chlorpheniramine) OTC
Dimetane (brompheniramine) OTC
Efidac (chlorpheniramine) OTC
Periactin (cyproheptadine)
Polarmine (dexchlorpheniramine)
Tavist (clemastine) OTC
Teldrin (chlorpheniramine) OTC
Vistaril (hydroxyzine pamoate)

Sedating antihistamines should be used with caution because they have the potential to alter judgment and cause fatigue or sedation.

Antitussives/Expectorants

Benylin Cough (dextromethorphan) OTC
Comtrex (dextromethorphan) OTC
Contac (dextromethorphan) OTC
Delsym (dextromethorphan) OTC
Mucinex DM (dextromethorphan/guaifenesin) OTC
Nyquil (dextromethorphan/alcohol) OTC
Phenergan DM (promethazine/dextromethorphan)
Robitussin DM (dextromethorphan/guaifenesin)
Vicks Formula 44D (dextromethorphan) OTC

Any preparation containing dextromethorphan should be used with caution because dextromethorphan acts on opioid receptors in the brain. Respiratory depression and perceptual distortions can also be seen in those people taking large doses.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Decongestants (Many are Combination Products)

Actifed (pseudoephedrine/triprolidine) OTC
AH-chew D (phenylephrine) OTC
Alavert D (loratadine/pseudoephedrine) OTC
Allegra D (fexofenadine/pseudoephedrine)
Benzedrex Nasal Inhaler (propylhexamine) OTC
Bromfed (phenylephrine/brompheniramine)
Bromfed DM (pseudoephedrine/ brompheniramine/dextromethorphan)
Cardec DM (pseudoephedrine/ carbinoxamine/dextromethorphan)
Clarinex D (desloratadine/pseudoephedrine)
Claritin D (loratadine/pseudoephedrine) OTC
Deconamine SR (pseudoephedrine/ chlorpheniramine) OTC
Dimetapp (pseudoephedrine/brompheniramine)OTC
Duratuss (pseudoephedrine/guaifenesin)
Entex LA (phenylephrine/guaifenesin)
Entex PSE (pseudoephedrine/guaifenesin)
Humibid DM (pseudoephedrine/ dextromethorphan/ potassium guaiacolsulfonate)
Mucinex D (pseudoephedrine/guaifenesin) OTC
Nalex-A (phenylephrine) OTC
Novafed (pseudoephedrine) OTC
Profen (pseudoephedrine) OTC
Prolex-D (phenylephrine) OTC
R-Tannate Pediatric (phenylephrine/ chlorpheniramine/pyrilamine)
Rondec (phenylephrine/chlorpheniramine)
Rondec DM (phenylephrine/chlorpheniramine/ dextromethorphan)
Rynatan-S (phenylephrine/chlorpheniramine/ pyrilamine)
Semprex-D (pseudoephedrine/acrivastine)
Sinutuss DM (phenylephrine) OTC
Sudafed (pseudoephedrine) OTC
Tussafed-EX (phenylephrine) OTC
Zyrtec D (cetirizine/pseudoephedrine)

Decongestants should be used with caution because they are stimulating and can trigger relapse.

Nasal Sprays

Afrin (oxymetazoline) OTC
Astelin (azelastine)
Dristan (oxymetazoline) OTC
Flonase (fluticasone)
Nasacort AQ or HFA (triamcinolone)
Nasonex (mometasone)
OTC
Neo-synephrine (phenylephrine) OTC
Nostrilla (oxymetazoline) OTC
Rhinocort Aqua (budesonide)
Vicks Nasal Inhaler (desoxyephedrine) OTC
Vicks Sinex (phenylephrine) OTC
4-Way Nasal Spray (phenylephrine)

All OTC nasal sprays should be used for a short period of time. If used for a long period of time symptoms may worsen. Use for a maximum of 5 days. Intranasal corticosteroids (non-OTC) may cause a reduction in growth velocity in pediatric patients.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Muscle Relaxants:

Flexeril (cyclobenzaprine)
Norflex (orphenadrine)
Parafon Forte (chlorzoxazone)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Zanaflex (tizanidine)

Muscle relaxants can cause central nervous system depression (sedation, dizziness), which may impair physical or mental abilities.

Neuropathic Pain:

Lyrica (pregabalin)

Lyrica acts in the central nervous system as a depressant and can lead to withdrawal symptoms upon discontinuation. It also produces euphoria in certain individuals.

Sleep Aids:

Excedrin PM (diphenhydramine) OTC
Nytol (diphenhydramine) OTC
Sleep-eze (diphenhydramine) OTC
Sominex (diphenhydramine) OTC
Tylenol PM (diphenhydramine/acetaminophen) OTC
Unisom (diphenhydramine) OTC

Sleep aids act in the central nervous system and can alter judgment and cause sedation.

Others:

Asthma

Primatene Mist (epinephrine) OTC
Seroquel (quetiapine)

Primatene Mist can cause nervousness, restlessness, sleeplessness, palpitations, tachycardia, chest pain, muscle tremors, dizziness and flushing.

Steroids

Decadron (dexamethasone)
Deltasone (prednisone)
Medrol (methylprednisolone)

It is important to take steroids exactly as directed. Long term use requires a taper off of the drug. Steroid use can decrease the immune system leading to increased infections. Insomnia, nervousness and a variety of other side effects are also common.

Class B Drugs

With Addiction Medicine Specialist/Doctor Approval Only

Asthma/COPD/Pulmonary (Inhaled Corticosteroids/Long-Acting Beta 2 Agonists)

Advair Diskus (fluticasone/salmeterol)
Azmacort (traimcinolone)
Flovent (fluticasone)
Pulmicort (budesonide)
Serevent Diskus (salmeterol)
QVAR (beclomethasone)

Particular care is required when patients are transferred from systemic corticosteroids to inhaled products due to possible adrenal insufficiency or withdrawal from steroids, including an increase in allergic symptoms. Regular use may suppress the immune system. Orally-inhaled corticosteroids may cause a reduction in growth velocity in pediatric patients. Advair and Serevent can cause central nervous system excitement.

Gastrointestinal (Constipation)

Dulcolax (bisacodyl) OTC
Ex-Lax (senna) OTC
Senokot (senna) OTC

Continued use of laxatives can lead to dependency for colon function. Use for only a short period of time.

Gastrointestinal (Nausea/Vomiting)

Compazine (prochlorperazine)
Phenergan (promethazine)
Tigan (trimethobenzamide)
Zofran (ondansetron)

These medications affect the central nervous system and can cause sedation.

Vertigo/Motion Sickness

Antivert (meclizine)
Dramamine (dimenhydrinate) OTC
Transderm Scop (scopolamine)

These medications affect the central nervous system and can cause dizziness, drowsiness or blurred vision.

Class C Drugs

Generally Safe to Take

Alzheimer's:

Aricept (donepezil)
Exelon (rivastigmine)
Namenda (memantine)
Razadyne (galantamine)

Analgesics (Migraine):

Amerge (naratriptan)
Axert (almotriptan)
Frova (frovatriptan)
Imitrex (sumatriptan)
Maxalt (rizatriptan)
Relpax (eletriptan)
Zomig (zolmitriptan)

Analgesics (Other):

Tylenol (acetaminophen) OTC

Anti-Convulsants (Also Mood Stabilizers):

Carbatrol (carbamazepine)
Depakote (divalproex sodium)
Dilantin (phenytoin)
Keppra (levetiracetam)
Lamictal (lamotrigine)
Neurontin (gabapentin)
Tegretol (carbamazepine)
Topamax (topiramate)
Trileptal (oxcarbazepine)
Zonegran (zonisamide)

Antihistamines (Non-sedating):

Alavert (loratadine) OTC
Allegra (fexofenadine)
(cetirizine) Clarinex (desloratadine)
Claritin (loratadine) OTC
Zyrtec

Antibiotics/Antivirals:

Amoxil (amoxicillin)
Augmentin (amoxicillin/clavulanate)
Avelox (moxifloxacin)
Bactrim (sulfamethoxazole/trimethoprim)
macrocrystals) Biaxin (clarithromycin)
Ceclor (ceflacor)
Ceftin (cefuroxime)
Cefzil (cefprozil)
Cipro (ciprofloxacin)
Cleocin (clindamycin)
Diflucan (fluconazole)
Doryx (doxycycline)
Duricef (cefadroxil)
E-Mycin (erythromycin)
Flagyl (metronidazole)
Keflex (cephalexin)
Ketek (telithromycin)
Levaquin (levofloxain)
Lorabid (loracarbef)
Macrobid (nitrofurantoin monohydrate/macrocrystals)
Macrodantin (nitrofurantoin
Minocin (minocycline)
Omnicef (cefdinir)
Pen-Vee K (penicillin)
Relenza (zanamavir)
Sporanox (itraconazole)
Sumycin (tetracycline)
Tamiflu (oseltamavir)
Tequin (gatifloxacin)
Valtrex (valacyclovir)
Vantin (cefpodoxime)
Vibramycin (doxycycline)
Zithromax (azithromycin)
Zovirax (acyclovir)

Class C Drugs

Generally Safe to Take

Anti-Parkinsonians:

Mirapex (pramipexole)
Requip (ropinirole)
Sinemet (carbidopa/levodopa)

Antitussives/Expectorants:

Humibid LA (guaifenesin/potassium guaiacolsulfonate)
Mucinex (guaifenesin) OTC
Tessalon Perles (benzonatate)

Asthma/COPD/Pulmonary:

Accolate (zafirlukast)
Atrovent (ipratropium)
Combivent (albuterol/ipratropium)
Proventil/Ventolin (albuterol)
Singulair (montelukast)
Spiriva (tiotropium)
Theo-24 (theophylline)
Xopenex (levalbuterol)

Benign Prostatic Hypertrophy (Also Cardiovascular):

Cardura (doxazosin)
Flomax (tamsulosin)
Hytrin (terazosin)
Proscar (finasteride)

Cardiovascular (Antihypertensives, Anticoagulants, Antiplatelets, Cholesterol Lowering, Diuretics):

Accupril (quinapril)
Aldactone (spironolactone)
Altace (ramipril)
Aspirin
Atacand (candesartan)
Avalide (irbesartan/hydrochlorothiazide)
Avapro (irbesartan)
Benicar (olmesartan)
Betapace (sotalol)
Bumex (bumetadine)
Calan (verapamil)
Cardizem (diltiazem)
Coreg (carvedilol)
Coumadin (warfarin)
Cozaar (losartan)
Crestor (rosuvastatin)
Demadex (torsemide)
Diovan (valsartan)
Dyazide (hydrochlorothiazide/triamterene)
Heparin
Hydrodiuril (hydrochlorothiazide)
Hyzaar (losartan/hydrochlorothiazide)
Imdur (isosorbide mononitrate)
Inderal (propranolol)
Isordil (isosorbide dinitrate)
Lanoxin (digoxin)
Lasix (furosemide)
Lipitor (atorvastatin)
Lopid (gemfibrozil)
Lopressor (metoprolol)
Lotensin (benazepril)
Lotrel (amlopidine/benazepril)
Lovenox (enoxaparin)
Monopril (fosinopril)
Niaspan (Niacin)
Nitro-Bid (nitroglycerin)
Norvasc (amlopidine)
Plavix (clopidogrel)
Pravachol (pravastatin)
Prinivil (lisinopril)
Sular (nisoldipine)
Tenormin (atenolol)
Tricor (fenofibrate)
Vasotec (enalapril)
Vytorin (ezetimibe/simvastatin)
Zestril (lisinopril)
Zetia (ezetimibe)
Zocor (simvastatin)

Class C Drugs

Generally Safe to Take

Diabetes Mellitus:

Actos (pioglitazone)
Amaryl (glimepiride)
Avandia (rosiglitazone)
Diabeta (glyburide)
Glucophage (metformin)
Glucotrol (glipizide)
Humalog (insulin lispro)
Humulin L,N,R,U (insulin)
Lantus (insulin glargine)
Novolin 70/30, N or R (insulin)
Novolog (insulin aspart)

Erectile Dysfunction:

Cialis (tadalafil)
Levitra (vardenafil)
Viagra (sildenafil)

Gastrointestinal (Antacids, Anti-diarrheals, Anti-Spasmosdics, Anti-Ulcers, Constipation, Nausea/ Vomiting):

Aciphex (rabeprazole)
Bentyl (dicyclomine)
Colace (docusate sodium) OTC
Emetrol (phosphorylated carbohydrate) OTC
Imodium (loperamide) OTC
Kaopectate (bismuth subsalicylate) OTC
Maalox OTC
Mylanta OTC
Nexium (esomeprazole)
Pepcid (famotidine) OTC
Pepto-Bismol (bismuth subsalicylate) OTC
Prevacid (lansoprazole)
Prilosec (omeprazole) OTC
Protonix (pantoprazole)
Reglan (metoclopramide)
Simethicone OTC
Tums OTC
Zantac (ranitidine) OTC

Genitourinary:

Detrol (tolterodine)
Ditropan (oxybutinin)

Glaucoma:

Alphagan P (brimonidine)
Azopt (brinzolamide)
Cosopt (dorzolamide/timolol)
Lumigan (bimatoprost)
Timoptic (timolol)
Travatan (travoprost)
Trusopt (dorzolamide)
Xalatan (latanoprost)

Gout:

Zyloprim (allopurinol)

Nasal Sprays:

Atrovent (ipratropium)
Ayr (saline) OTC
HuMist (saline) OTC
NaSal (saline) OTC
NasalCrom (cromolyn) OTC
Ocean Spray (saline) OTC

Class C Drugs

Generally Safe to Take

Non-Steroidal Anti-Inflammatory Drugs:

Advil (ibuprofen) OTC
Aleve (naproxen) OTC
Anaprox (naproxen)
Cataflam (diclofenac potassium)
Daypro (oxaprozin)
Indocin (indomethacin)
Lodine (etodolac)
Mobic (meloxicam)
Motrin (ibuprofen) OTC
Naprosyn (naproxen)
Orudis (ketoprofen)
Relafen (nabumetone)
Toradol (ketorlac)
Voltaren (diclofenac sodium)

COX-2 inhibitors:

Celebrex (celecoxib)

Osteoporosis (Calcium Metabolism):

Actonel (risedronate)
Boniva (ibandronate)
Evista (raloxifene)
Fosamax (alendronate)

Psychotropics:

Abilify (aripiprazole)
Buspar (buspirone)
Celexa (citalopram)
Clozaril (clozapine)
Cymbalta (duloxetine)
Depakote (divalproex sodium)
Desyrel (trazodone)
Effexor (venlafaxine)
Elavil (amitriptyline)
Eskalith (lithium)
Geodon (ziprasidone)
Haldol (haldoperidol)
Luvox (fluvoxamine)
Pamelor (nortriptyline)
Paxil (paroxetine)
Prozac (fluoxetine)
Remeron (mirtazapine)
Risperdal (risperidone)
Serzone (nefazodone)
Sinequan (doxepin)
Strattera (atomoxetine)
Wellbutrin (bupropion)
Zoloft (sertraline)
Zyprexa (olanzapine)
Lexapro (escitalopram)

Sleep Aid:

Rozerem (ramelteon)

Thyroid:

Armour thyroid (thyroid desiccated)
Levothroid (levothyroxine)
Levoxyl (levothyroxine)
Synthroid (levothyroxin

Addiction is a Brain Disease

ALAN I. LESHNER, Ph.D.

Chief Executive Officer, American Association for the Advancement of Science
Executive Publisher, Science
Former Director, National Institute on Drug Abuse

A core concept evolving with scientific advances over the past decade is that drug addiction is a brain disease that develops over time as a result of the initially voluntary behavior of using drugs. (Drugs include alcohol.)

The consequence is virtually uncontrollable compulsive drug craving, seeking, and use that interferes with, if not destroys; an individual's functioning in the family and in society. This medical condition demands formal treatment.

- We now know in great detail the brain mechanisms through which drugs acutely modify mood, memory, perception, and emotional states.
- Using drugs repeatedly over time changes brain structure and function in fundamental and long-lasting ways that can persist long after the individual stops using them.
- Addiction comes about through an array of neuro-adaptive changes and the lying down and strengthening of new memory connections in various circuits in the brain.

The High jacked Brain

We do not yet know all the relevant mechanisms, but the evidence suggests that those long-lasting brain changes are responsible for the distortions of cognitive and emotional functioning that characterize addicts, particularly including the compulsion to use drugs that is the essence of addiction.

It is as if drugs have high jacked the brain's natural motivational control circuits, resulting in drug use becoming the sole, or at least the top, motivational priority for the individual.

Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease:

This brain-based view of addiction has generated substantial controversy, particularly among people who seem able to think only in polarized ways.

- Many people erroneously still believe that biological and behavioral explanations are alternative or competing ways to understand phenomena, when if fact they are complementary and integrative.

Modern science has taught that it is much too simplistic to set biology in opposition to behavior or to pit willpower against brain chemistry.

- Addiction involves inseparable biological and behavioral components. It is the quintessential bio-behavioral disorder.

Many people also erroneously still believe that drug addiction is simply a failure of will or of strength of character. Research contradicts that position.

Responsible For Our Recovery
However, the recognition that addiction is a brain disease does not mean that the addict is simply a hapless victim. Addiction begins with the voluntary behavior of using drugs, and addicts must participate in and take some significant responsibility for their recovery.

- Thus, having this brain disease does not absolve the addict of responsibility for his or her behavior.

But it does explain why an addict cannot simply stop using drugs by sheer force of will alone.

The Essence of Addiction
The entire concept of addiction has suffered greatly from imprecision and misconception. In fact, if it were possible, it would be best to start all over with some new, more neutral term.

The confusion comes about in part because of a now archaic distinction between whether specific drugs are "physically" or "psychologically" addicting.

The distinction historically revolved around whether or not dramatic physical withdrawal symptoms occur when an individual stops taking a drug; what we in the field now call "physical dependence."

- However, 20 years of scientific research has taught that focusing on this physical versus psychological distinction is off the mark and a distraction from the real issues.

From both clinical and policy perspectives, it actually does not matter very much what physical withdrawal symptoms occur.

- Physical dependence is not that important, because even the dramatic withdrawal symptoms of heroin and alcohol addiction can now be easily managed with appropriate medications.
- Even more important, many of the most dangerous and addicting drugs, including methamphetamine and crack cocaine, do not produce very severe physical dependence symptoms upon withdrawal.

What really matters most is whether or not a drug causes what we now know to be the essence of addiction, namely

- The uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences.

This is the crux of how the Institute of Medicine, the American Psychiatric Association, and the American Medical Association define addiction and how we all should use the term.

It is really only this compulsive quality of addiction that matters in the long run to the addict and to his or her family and that should matter to society as a whole.

Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease:

- A condition caused by persistent changes in brain structure and function.

This results in compulsive craving that overwhelms all other motivations and is the root cause of the massive health and social problems associated with drug addiction.

The Definition of Addiction
In updating our national discourse on drug abuse, we should keep in mind this simple definition:

- Addiction is a brain disease expressed in the form of compulsive behavior.

Both developing and recovering from it depend on biology, behavior, and social context.

It is also important to correct the common misimpression that drug use, abuse and addiction are points on a single continuum along which on slides back and forth over time, moving from user to addict, then back to occasional user, then back to addict.

Clinical observation and more formal research studies support the view that, once addicted, the individual has moved into a different state of being.

- It is as if a threshold has been crossed.

Very few people appear able to successfully return to occasional use after having been truly addicted.

The Altered Brain - A Chronic Illness
Unfortunately, we do not yet have a clear biological or behavioral marker of that transition from voluntary drug use to addiction.

However, a body of scientific evidence is rapidly developing that points to an array of cellular and molecular changes in specific brain circuits. Moreover, many of these brain changes are common to all chemical addictions, and some also are typical of other compulsive behaviors such as pathological overeating.

- Addiction should be understood as a chronic recurring illness.
- Although some addicts do gain full control over their drug use after a single treatment episode, many have relapses.

The complexity of this brain disease is not atypical, because virtually no brain diseases are simply biological in nature and expression. All, including stroke, Alzheimer's disease, schizophrenia, and clinical depression, include some behavioral and social aspects.

What may make addiction seem unique among brain diseases, however, is that it does begin with a clearly voluntary behavior- the initial decision to use drugs. Moreover, not everyone who ever uses drugs goes on to become addicted.

- Individuals differ substantially in how easily and quickly they become addicted and in their preferences for particular substances.

Consistent with the bio-behavioral nature of addiction, these individual differences result from a combination of environmental and biological, particularly genetic, factors.

In fact, estimates are that between 50 and 70 percent of the variability in susceptibility to becoming addicted can be accounted for by genetic factors. Although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict.

- Over time the addict loses substantial control over his or her initially voluntary behavior, and it becomes compulsive. For many people these behaviors are truly uncontrollable, just like the behavioral expression of any other brain disease.

Schizophrenics cannot control their hallucinations and delusions. Parkinson's patients cannot control their trembling. Clinically depressed patients cannot voluntarily control their moods.

Thus, once one is addicted, the characteristics of the illness- and the treatment approaches- are not that different from most other brain diseases. No mater how one develops an illness, once one has it, one is in the diseased state and needs treatment.

Environmental Cues
Addictive behaviors do have special characteristics related to the social contexts in which they originate.

- All of the environmental cues surrounding initial drug use and development of the addiction actually become "conditioned" to that drug use and are thus critical to the development and expression of addiction.

Environmental cues are paired in time with an individual's initial drug use experiences and, through classical conditioning, take on conditioned stimulus properties.

- When those cues are present at a later time, they elicit anticipation of a drug experience and thus generate tremendous drug craving.

Cue-induced craving is one of the most frequent causes of drug use relapses, even after long periods of abstinence, independently of whether drugs are available.

The salience of environmental or contextual cues helps explain why reentry to one's community can be so difficult for addicts leaving the controlled environments of treatment or correctional settings and why aftercare is so essential to successful recovery.

- The person who became addicted in the home environment is constantly exposed to the cues conditioned to his or her initial drug use, such as the neighborhood where he or she hung out, drug-using buddies, or the lamppost where he or she bought drugs.
- Simple exposure to those cues automatically triggers craving and can lead rapidly to relapses.

This is one reason why someone who apparently overcame drug cravings while in prison or residential treatment could quickly revert to drug use upon returning home.

In fact, one of the major goals of drug addiction treatment is to teach addicts how to deal with the cravings caused by inevitable exposure to these conditioned cues.

Implications
It is no wonder addicts cannot simply quit on their own.

They have an illness that requires biomedical treatment.

- People often assume that because addiction begins with a voluntary behavior and is expressed in the form of excess behavior, people should just be able to quit by force of will alone.
- However, it is essential to understand when dealing with addicts that we are dealing with individuals whose brains have been altered by drug use.

They need drug addiction treatment.

We know that, contrary to common belief, very few addicts actually do just stop on their own.

Observing that there are very few heroin addicts in their 50s or 60s, people frequently ask what happened to those who were heroin addicts 30 years ago, assuming that they must have quit on their own.

- However, longitudinal studies find that only a very small fraction actually quit on their own. The rest have either been successfully treated, are currently in maintenance treatment, or (for about half) are dead.

Consider the example of smoking cigarettes: Various studies have found that between 3 and 7 percent of people who try to quit on their own each year actually succeed.

Science has at last convinced the public that depression is not just a lot of sadness; that depressed individuals are in a different brain state and thus require treatment to get their symptoms under control. It is time to recognize that this is also the case for addicts.

The Role of Personal Responsibility
The role of personal responsibility is undiminished but clarified.

Does having a brain disease mean that people who are addicted no longer have any responsibility for their behavior or that they are simply victims of their own genetics and brain chemistry? Of course not.

Addiction begins with the voluntary behavior of drug use, and although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict.

This is one major reason why efforts to prevent drug use are so vital to any comprehensive strategy to deal with the nation's drug problems. Initial drug use is a voluntary, and therefore preventable, behavior.

Moreover, as with any illness, behavior becomes a critical part of recovery. At a minimum, one must comply with the treatment regimen, which is harder that it sounds.

- Treatment compliance is the biggest cause of relapses for all chronic illnesses, including asthma, diabetes, hypertension, and addiction.
- Moreover, treatment compliance rates are no worse for addiction than for these other illnesses, ranging from 30 to 50 percent.

Thus, for drug addiction as well as for other chronic diseases, the individual's motivation and behavior are clearly important parts of success in treatment and recovery.

Alcohol/ Drug Treatment Programs
Maintaining this comprehensive bio-behavioral understanding of addiction also speaks to what needs to be provided in drug treatment programs.

- Again, we must be careful not to pit biology against behavior.

The National Institute on Drug Abuse's recently published Principles of Effective Drug Addiction Treatment provides a detailed discussion of how we must treat all aspects of the individual, not just the biological component or the behavioral component.

As with other brain diseases such as schizophrenia and depression, the data show that the best drug addiction treatment approaches attend to the entire individual, combining the use of medications, behavioral therapies, and attention to necessary social services and rehabilitation.

- These might include such services as family therapy to enable the patient to return to successful family life, mental health services, education and vocational training, and housing services.

That does not mean, of course, that all individuals need all components of treatment and all rehabilitation services. Another principle of effective addiction treatment is that the array of

services included in an individual's treatment plan must be matched to his or her particular set of needs. Moreover, since those needs will surely change over the course of recovery, the array of services provided will need to be continually reassessed and adjusted.

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