DYING IN VEIN
DISCUSSION GUIDE
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“Now it’s our turn. Make a difference. Help change the way people perceive those battling substance addiction. Tell them they can make new choices, ones that will help them win the battle. Tell them there IS hope”

- Dave Saxton, Chase’s Father

This discussion guide is designed for high school and university students, parents, teachers, healthcare professionals, and policy makers. It is created to work in conjunction with the film Dying in Vein, The Opiate Generation, to provide additional information about addiction/substance use disorders, discussion questions, and action items for communities.

The statistics are distressing. The US represents 5% of the world’s population and consumes 80% of the prescription opioids (pain pills). Every day in the US, 44 people die as a result of prescription opioid overdose. The majority of IV heroin users begin by misusing prescription pain pills. Opiate misuse costs between $30-50 billion each year due to health care, criminal justice costs, and lost productivity in the workplace. The numbers illustrate the urgent need to work together to take action, create change, and turn these numbers around.

We hope that the film and discussion guide bring understanding to opiate use disorder, from prescription pain pills to heroin, in order to break down limiting stigmas and misconceptions. Informed communities, professionals, and individuals can use this information to make changes that will save lives by:

- Raising awareness about this national public health problem.
- Breaking down stigmas and misconceptions about addiction/SUD through leading scientific information.
- Providing information that guides communities, professionals, families, and individuals on how to facilitate productive conversations about this issue.
• Providing resources for communities, professionals, families, and individuals on how to help themselves or someone they know who might be struggling with addiction/SUD.
• Providing resources for communities, professionals, families, and individuals on how to deal with stress, difficult emotions, and change in positive and productive ways that may help recognize and preclude addiction/SUD.
THE MAKING OF DYING IN VEIN
A PERSONAL STATEMENT FROM THE DIRECTOR, JENNY MACKENZIE

Addiction is a deeply personal issue. We have several people in our family who struggle with addiction. We are fortunate; no one in our family has died of an overdose. I have a brother who has been sober for 9 years, a stepmother who has been sober for over 40 years, and a daughter who is happy and successful in her life after experiencing drug misuse in high school and college.

My husband Chip and I have three remarkable daughters. Our middle daughter Anna started misusing prescription opioids in high school after her 3rd sports injury. We caught her at just the “right” time. She actually WANTED to be in treatment, and we had the financial means to send her to an excellent treatment program, away from her home community (the people that she used with). It was a very difficult and stressful time for our family. I wondered every day if Anna would get through it, if she would relapse, and how our family could help her to get well. I knew then that I wanted to make a film about addiction, and the devastating impact it has on families.

After 7 months of treatment Anna went to college. She hit some bumps in the road, but overall she did well. In February of her sophomore year, she called sobbing because a boy she knew from high school had died from a heroin overdose. Anna sent me his obituary. I was struck by how open and brave the family was about his addiction. That night (3 days after they had lost their son), I emailed the parents. I shared my deepest sympathies, said that Anna knew Chase in high school, and that she had been in treatment. I said that if they felt like sharing their son’s story, I believed it could impact many other families. There is nothing more powerful than witnessing a loving family bury a child. This disease kills people. It robs families of a lifetime with a loved one. Chase’s family responded that evening. The next day we met and talked about the potential filming process. Four days before his funeral, we started filming, and that was the beginning of Dying in Vein.

At Chase’s funeral, I met his good friend Matt, who, at the time had been clean for over 2 years. A few weeks after Chase’s funeral, Matt and I did our first interview. Matt talked about his life, getting into heroin, his friendship with Chase and his concern about two other friends who were still actively using heroin. We realized that both Matt and Chase were important characters: similar backgrounds, getting into drugs together, one clean & sober, and one dead from an accidental overdose. What would happen to their friends who were still using? Would they live or would they die? That question guided our work. We approached two other friends’ of Matt and Chase. They declined to participate.
Two months later we were finishing a successful Kickstarter fundraising campaign, and received a private message on our Dying in Vein Facebook from an a 22-year-old who was still using:

Hello my name is Madeline, my mom told me about your documentary and if there is any way I can help or if you’d like to look into the life of a using addict feel free to contact me. I am not clean right now, but I don’t wish this life on anyone and would love to share my experience if it would just stop one person from going down the same road as me.

After responding to Maddy’s message, and talking at length with her and her girlfriend Page, I realized we had found our final subjects. These two young women were in the throes of addiction, wanting to get clean, but not yet able to navigate their way out.

We all learn by connecting with another human being’s experience, and I am deeply grateful to each of our brave subjects for opening their hearts and sharing their stories so that others may learn and grow. It isn’t easy to tell such a personal story on film, and it is especially difficult to tell a story about heroin addiction, because judgment, shame and stigma continue to exist. Matt has been sober for over five years, Maddy and Page for almost two, and the Saxton family thinks about Chase everyday.

Dying in Vein took three years to complete, and now, as it reaches communities, schools, festivals, and health care organizations, we hope it will be a catalyst for conversations about addiction. We want to bring this disease out of the closet, and take away the shame and blame, so that individuals, families, and communities can heal and grow.

Talk about addiction. It’s a disease.
ADDICTION/SUBSTANCE USE DISORDER
SUD 101: RECOGNIZE AND UNDERSTAND ADDICTION/SUD

“When I was in my addiction I acted outside of my morals and values in order to get drugs. I tried time and time again to exercise my will power to stop and I just couldn’t do it.”

– Maddy Cardon

HISTORY
Until recently, the medical community had an incomplete understanding of addiction/substance use disorders. It was common to perceive alcohol use disorder or other addiction/SUDs as moral failings, and previous medical standards significantly limited treatment because of the perception that a patient’s condition was hopeless. The recent scientific information defining “addiction” as a “substance use disorder” and as a disease has helped support struggling individuals and their families.

CURRENT SCIENTIFIC FACTS
Addiction/SUD is a progressive and chronic disease. Progressive diseases worsen over time if they aren’t treated, and similarly to cardiovascular disease and many cancers, addiction typically advances unless it is treated. Addiction/SUD is considered a chronic illness because brain changes in people who suffer from addiction often appear to be permanent, and in cases where they are not, the predisposition for addiction/SUD typically remains throughout a person’s life. Studies on flies, mice, and monkeys with inflicted addictions demonstrate that sensory input, memories, and stress can cause intense drug-seeking behavior, even after long periods of being deprived of the drug. Human studies have shown that even after years of abstinence, people suffering from addiction respond to triggers – sights, sounds, smells, and even emotions that they associate with drugs. The persistent possibility of relapse is a hallmark of addiction/SUD, which is why a lifetime of monitoring and treatment is often required.
POTENTIAL SIGNS
*This list is not intended to be used as a “check list” to identify a disorder.
  • Consuming larger amounts of a substance than intended
  • Desire to control or failed attempts to control substance use
  • Significant time spent obtaining, using, or recovering from the substance
  • Craving for the substance
  • Obligation failure (work, school, home, etc.)
  • Social and interpersonal problems
  • Reduced or abandoned activities (social, occupational, recreational)
  • Physically hazardous use (e.g., driving, swimming, etc., while under the influence)
  • Physical or psychological problems caused by use

POTENTIAL RISK FACTORS
*Even individuals who do not have or exhibit the provided risk factors can develop an addiction/SUD. Addiction/SUD is an equal opportunity destroyer.

  • **Poverty:** People living below the poverty line are 50% more likely to use and 100% more likely to misuse or develop a disorder than those with incomes 200% over the poverty line.
  • **Trauma:** 55% of individuals with an alcohol use disorder have a history of childhood trauma.
  • **Dysfunction in Families:** In a household where one or both parents misuse alcohol or drugs, a child’s chances of substance misuse increases two to three times.
  • **A Family’s Substance Disorder Cycle and Genetics:** It is estimated that 8 to 10% of people have a genetic predisposition to an addiction/SUD. Studies of twins have indicated that genes account for 50% of the risk factor for an addiction/SUD.
  • **Learning Disabilities:** About 20% of school-aged children (K-12) in the U.S. – about 11 million – have learning disabilities; these have been shown to increase the risk of drug and alcohol misuse.
  • **Behavioral Disorders, Mental Illnesses (such as depression, attention deficit disorder, anxiety, etc.):** A SAMHSA study found that people who experienced mental health problems were more than 3 times as likely to have drug problems. Reinforcing this, 6 out of 10 individuals suffering from an addiction/SUD have at least one co-occurring mental disorder.
DISCUSSION QUESTIONS

ADDITION/SUBSTANCE USE DISORDER

• What differences or similarities did you observe between Maddy, Page, Chase, or Matt in regards to accepting and addressing the reality of their addiction/SUD?

• According to the characters, what led to their addiction/SUD?

• What made them vulnerable to misusing drugs?

• What did Shelley (Chase’s mother) discover about Chase when she read his journals about his opiate use disorder? What were his reflections?

• How has your perception of Addiction/SUDs, and the conditions that make people vulnerable to Addiction/SUDs, changed since viewing the film?
THE CHEMICAL CONNECTION BETWEEN PRESCRIPTION OPIATE PAIN PILLS AND HEROIN

Structurally, prescription painkillers and street heroin are nearly identical chemical substances. The misuse of prescription opiate painkillers such as Oxycontin produces a very similar high to heroin.

As a result, legally obtained prescription pills can lead to opiate abuse, and most people who use heroin start by misusing prescription pain pills. If addiction/SUD forms from a legally obtained opiate prescription, acquiring additional prescription pain pills illegally can be costly. Therefore, heroin becomes a cheaper alternative for someone who is misusing opiates.

“And he came over and he had heroin, and he’s like, “You want to try some?” I said no for about two minutes, I think, cause I still just had this impression that it was worse than the pills”
– Matt Waljie

THE OPIATE CRISIS: A PILL FOR EVERY ILL

“And unfortunately a lot of people bought - a lot of institutions bought - we all bought that life should be without an ounce of pain. And if there is pain, we take a pill.”
– Jennifer Plumb M.D.

TIMELINE

1803: Friedrich Sertuerner of Germany synthesized morphine for the first time.

1853: The hypodermic syringe is invented. The inventor’s wife is the first to die of injected drug overdose.

1898: Bayer chemist invents diacetylmorphine and names it heroin, from the German word for ‘heroic.’ Heroin was considered a highly effective medication for cough and the discomfort of tuberculosis. This effect was important because pneumonia and tuberculosis were the two leading causes of death at that time, prior to the discovery of antibiotics.

1906: Pure Food and Drug Act passed, requiring pharmaceutical companies to label their patent medicines with the complete contents. As a result, the availability of opiate drugs in the U.S. significantly declined.

1909: Congress banned the import of opium.

1914: Congress passed the Harrison Narcotics Act, which aimed to curb drug abuse and addiction. It requires doctors, pharmacists, and others who prescribed narcotics (cocaine and heroin) to register and pay a tax.

1924: Heroin production, importation, and possession is made illegal.
THE GROWING PROBLEM

From 1980 to 2000, the prescribing and use of opioids changed dramatically.

In the early 1980s, providers and pharmaceutical companies began to promote the use of opioid medications as safe and non-addictive for the treatment of chronic, non-cancer related pain.

In the 1990s, the American Pain Society (funded in part by Purdue Pharmaceuticals, manufacturer of Oxycontin) advocated for “pain as the 5th vital sign,” meaning pain was to be evaluated not as a symptom but as part of basic patient care, alongside temperature, blood pressure, respiratory rate, and heart rate.

In 2001, The Joint Commission - an independent, not-for-profit group in the United States that administers accreditation programs for hospitals and other healthcare-related organizations - published a document promoting that pain be treated as “the 5th vital sign.” The document stated, “Some clinicians have inaccurate and exaggerated concerns about addiction, tolerance, and risk of death. This attitude prevails despite the fact there is no evidence that addiction is a significant issue when persons are


1951: Arthur Sackler from Purdue Pharma revolutionizes drug advertising by promoting drugs with adds in radio, t.v. and medical journals.

1960: Arthur Sackler’s campaign for Valium makes it the industry’s first drug to bring $100 million in revenue.

1972: Contin (a controlled drug-release system) is developed.

1980: The New England Journal of Medicine publishes a one paragraph letter to the editor known as “Porter and Jick” that states, “addiction is rare in medical patients with no history of addiction.”

Early 1980’s: First Xalisco migrants set up heroin trafficking business in the San Fernando Valley of Los Angeles, CA.

1984: Purdue releases MS Contin, a timed-release morphine painkiller marketed to cancer patients.


Early 1990’s: “Xalisco boys” heroin cells begin expanding beyond San Fernando Valley to cities across the western United States. Their pizza-delivery style system evolves.

1990: Dr. Lynn Webster founds Life Tree Pain Clinic in Salt Lake City, UT. He becomes one of the leaders on pain medicine in the medical world, and has lectured extensively on preventing opioid abuse in chronic pain patients. However, some 20 deaths have been associated with his aggressive pain prescriptions.

1996: Purdue releases Oxycontin, timed-released oxycodone, marketed largely for chronic-pain patients, advertised as having lower abuse potential than immediate-release oxycodone because of its time-release properties, despite there being no scientific evidence backing that conclusion.

1996: Dr. David Procter’s loose prescribing practices at his clinic in South Shore,
given opioids for pain control.” Given this information and encouragement, physicians felt compelled to change their prescribing practice and embrace opioid medications as “good medicine.”

Simultaneously, financial incentives towards measured patient satisfaction were introduced, and provider compensation was tied with positive satisfaction scores - scores that were affected by the physician’s attention to pain management.

The climate was ripe for the escalation of opioid prescribing: experts were informing providers that the risk was minimal, institutions were encouraging more aggressive treatment of pain, and providers were getting paid more to make patients happy. Not surprisingly, a sharp increase in overdose deaths followed. According to the CDC, from 2000 – 2014, the rate of deaths from drug overdoses increased 137%. This included a 200% increase in the rate of overdose deaths involving opioids.

In an environment where opiates were fully trusted, many developed a complacent attitude to prescription opiates. It was not uncommon to keep pills in the medicine cabinet, or give an opiate to a friend or relative that was not prescribed the medication, and hold onto a prescription medication when it was no longer needed. A typical first misuse occurs when an individual takes more than the prescribed dose, or a curious friend or family member accesses the pills because they were not properly and safely stored.

Kentucky, is presumed the nation’s first “pill mill”.


1998-99: Veterans Administration and JCAHO adopt idea of pain as the 5th vital sign.

2000: Operation Tar Pit targets Xalisco heroin networks as the largest joint DEA/FBI operation and first drug conspiracy case to stretch from coast to coast.

2001: Washington was the first state to recognize the growing number of opiate overdose deaths in injured individuals receiving workers compensation.

2001: JCAHO: Joint Commission for Accreditation of Health Care Organizations issues a new standard requiring hospitals to regularly ask patients about pain and to make treating pain a priority.

2001: JCAHO publishes a guide sponsored by Purdue Pharma that states: “some clinicians have inaccurate and exaggerated concerns regarding addiction, tolerance and risk of death. This attitude prevails despite the fact that there is no evidence that addiction is a significant issue when persons are given opiates for pain control”.

2002: Dr. David Proctor pleads guilty
THE TIPPING POINT

“There’s enough opiates out there for every single American adult to have their own, personal, private bottle at this time any given moment.”

- Jennifer Plumb. M.D.

The change in physician perceptions about opiates, the introduction of pain as the 5th vital sign, and the financial ties between patient satisfaction and physician compensation all contributed to the steady increase of opiate misuse; and the subsequent use of heroin, a cheaper alternative to prescription opiates. Today, in the United States, overdose is the number one reason for accidental deaths.

As individuals, families, and communities continue to experience the devastating impact, thousands die each year, and many are taking action. In 2007, Purdue was required to pay a multi-million dollar settlement for fraudulent marketing, and much of that funding has gone to prevention education. Recognizing an increasing stream of opiate dependent individuals, doctors have begun to decrease their opiate prescribing practices, and look for new ways to help their patients. In 2016, the AMA recommended removing pain as the 5th vital sign, due to the opiate crisis. Some legislators have supported legislation promoting needle exchange programs, healthcare reform, and increased access to Naloxone - a drug that reverses the effects of opiates and can halt an overdose. Research institutions and organizations are educating providers and the public about the appropriate use of opioids, what safe alternatives exist, and how we can evolve our perception of pain and pain management.

to drug trafficking and conspiracy and is sentenced to serve eleven years in federal prison.

2004: The Federation of State Medical Boards calls on state medical boards to make the under-treatment of pain punishable for the first time.

2007: Purdue pleads guilty to misleading the public about Oxycontin’s risk of addiction, and agrees to pay $600 million in one of the largest pharmaceutical settlements in U.S. history. Its president, legal counsel, and former chief medical officer plead guilty as individuals to misbranding charges - a criminal violation - and agree to pay a total of $34.5 million in fines.

2008: Drug overdoses, mostly from opiates, surpass auto fatalities as leading cause of accidental death in the United States.

2008: Actor Heath Ledger dies from an Oxycontin Overdose.

2009: Dr. Warren R. Stack is sentenced to 8 years in prison for conspiracy to commit distribution of a controlled substances from his Murray UT office.

2011: Dr. Dewey McKay is sentenced to 20 years in prison for illegally prescribing pain pills from his Brigham City Office, UT.

2012: New England Journal of Medicine publishes a study that found: “76 percent of those seeking help for heroin addiction began by abusing pharmaceutical narcotics, primarily OxyContinen”.

2014: Actor Philip Seymour Hoffman dies from a heroin overdose.

2015: On October 4, 2007, Kentucky officials sued Purdue because of widespread Oxycontin abuse in Appalachia. Eight years later, on December 23, 2015, Kentucky settled with Purdue for $24 million.

2016: Prince dies from a Fentanyl overdose.

2015: Officers from the DEA dismantled a pill-manufacturing operation in Cottonwood Heights, UT. It is found to be responsible for distributing hundreds of thousands of deadly counterfeit pain pills, including fake Fentanyl, across the United States. *

* Time line provided in part by Sam Quinones in his book “Dream Land, The True Tale of America’s Opiate Epidemic.”
DISCUSSION QUESTIONS
THE OPIATE CRISIS

• Who are the various players responsible for the opiate epidemic? How are they involved in the problem? What were their motives?

• What has changed in regard to your understanding of the prescription pill to heroin pipeline since viewing this film?

• How did the inclusion of pain as the 5th vital sign change our expectations of managing pain? How did this pressure doctors’ prescribing practices?
INDIVIDUALIZED TREATMENT
We begin by treating addiction as a chronic, relapsing brain disease. Detoxification may be a first step, but it is only the beginning. As with diabetes, hypertension, and asthma, the appropriate treatment for addictions/SUDs includes long-term lifestyle modification and the opportunity for ongoing support and treatment.

Successful treatment holistically addresses the complex, multifaceted needs of an individual, meeting the participant’s specific symptoms and situation. It is variable in duration, and based upon the severity of symptoms and the individual response to the intervention. The intensity of the intervention is based on careful and ongoing assessment to determine whether treatment interventions should continue, terminate, decrease, increase, or be resumed after a period of stabilization.

Adolescents are a particularly vulnerable group. Studies by the Treatment Research Institute show that successful treatment of adolescents includes: family participation, developmentally and trauma informed practices, attention to co-occurring mental health conditions, and skill based, active participation.

OUR PATH FORWARD
CURING DISEASE, CURING SOCIETY

“There is a baseline level of care that we feel is due to everyone for any medical condition. It isn’t translating in the world of addiction, and the resources are not getting dedicated to it.”

– Jennifer Plumb, M.D.
OVERCOMING MISCONCEPTIONS

It is in the interest of rehab facilities and insurance companies to present patients who have completed a 28-day detox as cured, and equipped to rebuild their lives. Similarly unrealistic are expectations on addicts to “quit cold-turkey”. These expectations perpetuate myths that addiction/SUD is a moral failing, or a choice that can be discontinued at any time. Such myths often prevent those living with an addiction/SUD from receiving the long-term, evidenced based care necessary to fully stabilize their condition.

Another misconception is that relapse signifies ineffective treatment. In fact, relapse does not indicate failure; as with other chronic conditions, a relapse of symptoms is expected. Relapse rates following addiction treatment are comparable to reoccurring evidence of diabetes, hypertension, and asthma.

Finally, the use of medications in opioid treatment is another area of misconception. Research demonstrates that medication assisted treatment will not only reduce risk for relapse and overdose, but also reduce the transmission of infectious disease and help individuals to stabilize and achieve an improved quality of life; in effect reducing many of the symptoms that prevent recovery.

MEDICAL TOOLS

Medication-Assisted Treatment (MAT) for opiate withdrawal and dependence has been used effectively for decades. As with chemo treatment for cancer or maintenance treatment for diabetes the “right” medication is different for different individuals. If one method doesn’t work for you, try another. It is also important to use MAT as prescribed and under close observation of healthcare providers and professionals. Finally, while MAT can be effective, it is MOST effective when combined with additional forms of treatment such as individual counseling and group support.

NALOXONE

Naloxone is an opiate antagonist that stops or reverses the effects of any opioid. It is administered by injection or is sprayed into the nose. When administered, naloxone binds to the opiate receptor cells in the brain and temporarily “kicks out” the opiate. It can save a person from a deadly opiate overdose, while at the same time precipitating a painful opioid withdrawal.

Historically, naloxone has been written off as a “parachute” or a “safety net”, and some argue that its use perpetuates addiction/SUD. This is a misconception. Emergent research demonstrates that naloxone does not encourage continued use of a drug; it does provide a person experiencing an overdose with a second chance at life and sobriety.
An increasing number of doctors are prescribing naloxone as a partner prescription to any opiate prescribed. An increasing number of legislators are working to increase access to Naloxone, including making it legal for any individual to administer it. Many in the health care arena recommend keeping Naloxone nearby as a life-saving medication.

**NALTREXONE**
Prescriptions like Vivitrol and Revia use the active drug naltrexone to block opioids in the brain. Similar to naloxone, naltrexone acts as an opioid antagonist that prevents receptors in the brain from absorbing any opioid that may be in the system. These MAT’s can be taken orally to reduce relapse and maintain sobriety. However, it is recommended that patients participate in counseling and social support groups while using any naltrexone prescription.

**METHADONE**
Medication-Assisted treatment programs have been using methadone for decades. By altering how the brain responds to pain, it can decrease the symptoms of opiate withdrawal, and block the euphoric effects of opiates. Methadone can be addictive, but is only prescribed for opioid treatment through a federally licensed methadone clinic to prevent misuse. Effective treatment plans usually include case management, counseling, and group support participation.

Overtime, methadone is given in smaller doses. This prevents withdrawal symptoms, and has been shown to effectively keep heroin users in treatment programs for longer periods of time, increasing opportunities to address the addiction/SUD and other areas of struggles. The process must be done gradually and under the supervision of a healthcare provider so that withdrawal symptoms and relapse are prevented.

**BUPRENORPHINE**
In 2002, buprenorphine medication became the first medically assisted treatment that could be easily obtained through a healthcare prescriber’s prescription. However, like methadone, these medications are highly regulated and doctors must obtain specialized training and a waiver prior to prescribing.

Suboxone, Bunavail, Zubsolv, and Subutex can help opiate dependent individuals experience limited cravings or withdrawals. Many of these medications are chemically composed of a combination of naloxone and buprenorphine. Buprenorphine acts as an opioid partial agonist and naloxone acts as an opioid antagonist; and the two work together to provide an opiate dependent individual decreased potential for opiate misuse, decreased physical dependency symptoms like cravings and painful withdrawals, and increased overdose safety.

While buprenorphine medications can be effective medication-assisted treatments for opiate addicted individuals, they do have the potential to be misused. It is critical that these medications be used in conjunction with a treatment program that includes counseling, and social support group participation.

**NAD IV TREATMENT**
Nicotinamide Adenine Dinucleotide (NAD) therapy involves IV infusion of the NAD mixture on a daily basis for approximately 10 days. This mixture of metabolic co-enzymes helps with withdrawal symptoms by assisting the body in replenishing depleted enzymes, improving cellular metabolism and aiding in brain restoration.

Though it was pioneered in the 1960s, NAD IV treatment has only recently begun to be utilized on a broader basis for addiction. It has been shown to help individuals overcome painful opiate withdrawal, and it normally resolves cravings for addictive substances. This therapy is most effective when accompanied by additional treatment that addresses the psychological aspects of addiction.
AREAS FOR REFORM

HEALTH CARE REFORM
Inclusive Health Care Reform provides access to health insurance for all individuals, and guarantees that the benefit they receive provides parity for behavioral health care, including addiction/SUD treatment. Insurance benefits that limit the number of sessions or days of treatment fail to recognize the nature of a chronic, relapsing condition.

REMOVAL OF FINANCIAL BARRIERS
There is great variation between publicly funded rehabilitation programs and luxurious private treatment facilities. Publicly funded programs frequently have waiting lists that prevent access to care when symptoms are most severe. Private programs are frequently beyond reach due to cost that can exceed insurance benefits.

COMPREHENSIVE TREATMENT
There is an expectation among Insurance companies and the general public that treating addiction/SUD demands acute care, i.e. detox and limited rehabilitation. Current research shows that long-term comprehensive care is the more successful approach when operating under the scientific conclusion that addiction is a disease.

REDUCTION OF STIGMA
The stigma associated with opiate abuse prevents individuals from seeking help. The Surgeon General’s Report on Alcohol, Drugs, and Health (2016) states:

Removing stigma will “require a major cultural shift in the way we think about, talk about, look at, and act toward people with substance use disorders. Negative attitudes and ways of talking about substance misuse and substance use disorders can be entrenched, but it is possible to change attitudes. This has been done many times in the past: Cancer and HIV used to be surrounded by fear and judgment, now they are regarded by many as simple medical conditions.”

Stigma from family, communities, and society perpetuates addiction/SUDs; education and normalization of the understanding that addiction is a disease helps reduce this stigma.

DISCUSSION QUESTIONS

OUR PATH FORWARD

• What is your understanding of how to treat addictions/SUDS? Has it changed since viewing the film? If so, how?

• What kind of treatment did the characters in the film receive? What kind of treatment could Chase have benefitted from? What made the difference in Maddy and Page’s treatment options?

• How would you support friends or families who might be struggling with substance use disorder?

• What are your misconceptions about people who have an addiction/SUD? How might those misconceptions limit your ability to help them?

• Discuss the potential of Naloxone, the judgment surrounding it, and how it could help people.
WHAT YOU CAN DO
The vast majority of individuals with an opiate use disorder begin by abusing prescription pills. In recognizing this, a new approach to how we incorporate these medications in our lives can begin to take shape.

Below are changes you can make to reduce the influence of prescription pain pills in your own life:

• Restrict your use of opiates to injuries and conditions that involve severe pain. Not all injuries and painful conditions require opiates. Some of the very best medication is ice, elevation, and rest.
• Ask your doctor about other non-addictive medications and pain management alternatives that might benefit you.
• Clear your home and medicine cabinet of any unused prescription pain pills and dispose of them safely.
• Talk openly with your family about the potential dangers of having opiates in the house, and how to dispose of them properly when they are no longer needed.
• Be informed. Know your family history and risk for addiction/SUD. Know the dangers of opiate medications and discuss these with your family.
• Recognize unhealthy coping mechanisms that you or family members employ in stressful circumstances. Reach out to others for help.
• Share your knowledge of this epidemic with others.

WHAT WE CAN DO
DOCTORS, LEGISLATORS, AND COMMUNITIES
MAKING A DIFFERENCE

“I want something that I can get up every morning and be excited to go to. I just wanna be happy. I don’t know what that means, I don’t, I don’t know what that entails. I just want to be happy.”

- Page Warren

WHAT YOU CAN DO
The vast majority of individuals with an opiate use disorder begin by abusing prescription pills. In recognizing this, a new approach to how we incorporate these medications in our lives can begin to take shape.

Below are changes you can make to reduce the influence of prescription pain pills in your own life:

• Restrict your use of opiates to injuries and conditions that involve severe pain. Not all injuries and painful conditions require opiates. Some of the very best medication is ice, elevation, and rest.
• Ask your doctor about other non-addictive medications and pain management alternatives that might benefit you.
• Clear your home and medicine cabinet of any unused prescription pain pills and dispose of them safely.
• Talk openly with your family about the potential dangers of having opiates in the house, and how to dispose of them properly when they are no longer needed.
• Be informed. Know your family history and risk for addiction/SUD. Know the dangers of opiate medications and discuss these with your family.
• Recognize unhealthy coping mechanisms that you or family members employ in stressful circumstances. Reach out to others for help.
• Share your knowledge of this epidemic with others.
WHAT DOCTORS CAN DO

Unknowingly, our physicians have played a significant role in our current opiate epidemic. The development of the 5th vital sign, pain, perpetuated the overprescribing of opiate pain medications. Pharmaceutical companies downplayed the addictive risk of these medications with false marketing and poorly executed research, resulting in over 260 million annual prescriptions for opiate pain medications. Hospitals and insurance companies continue to use patient satisfaction surveys that ask patients if their pain was properly treated. Many of these surveys tie directly to physician reimbursement. A process with perverse incentives has been created in our current healthcare culture to treat pain as if it is a malignancy that has to be rid from the body. It is only recently that physicians have come to grasp the enormity of the problem created by the overprescribing of opiate medications.

Primus non nocere, a Latin phrase meaning “first, do no harm,” is one of the fundamental guiding principles among physicians and medical providers throughout the world. One interpretation implies that in some situations it may be better to do nothing than to risk inflicting more harm. As the negative effects of opiate use and abuse come to light, physicians are recognizing the epidemic level of harm caused by the excessive prescribing of opiates, and the risks of attempting to completely eradicate pain.

With knowledge comes action. Recognizing their role on the front lines of this epidemic, Emergency Physicians together with Intermountain Healthcare in Salt Lake City, UT have begun to pioneer small research studies to develop new medical standards to change the way physicians address pain and prescribe opiate pain medications. By analyzing the number of prescription opioid pills patients actually used by patients, these physicians have been able to reduce the number of pills in each prescription by up to 50%.

Physicians can do more to solve this epidemic:

• Initiating bedside conversations with patients facing painful conditions regarding the risks, benefits, and alternatives to opioid prescriptions.
• Recognizing that conditions like low back pain, headaches, and recurring abdominal pain often do not respond to chronic opiate treatment. These conditions have other types of management strategies that have proven more effective, such as physical therapy, exercise, and meditation.
• Enhancing medical training by requiring more comprehensive education about when to prescribe opiates, what they are for, and how they are useful.
• Understanding treatment modalities and options that have proven to be effective for opiate addicted patients.
• Prescribing Naloxone as a partner to any opiate prescription.

WHAT LEGISLATORS CAN DO

States and local governments have the ability to initiate large-scale change with addiction/SUD prevention, education, and outreach. Their scope is broad and can have profound effects on the outcome of this crisis.

In 2016 Obama signed the Comprehensive Addiction and Recovery Act (CARA). It increased the availability of Naloxone, strengthened prescription drug monitoring programs, and expanded prevention and educational efforts with teens and other adult populations. In 2016, Legislators in Utah passed an uncontested, jointly sponsored bill that permitted Naloxone to be dispensed without a prescription, and introduced a needle exchange program. Communities across the country, supported by their local governments, have utilized tactics like jail diversion programs, drug drop boxes, and public service and education campaigns.
Legislators can do more to solve this epidemic:
• Hold pharmaceutical companies responsible through tougher regulatory sanctions.
• Support law enforcement efforts to shut down the illegal production and distribution of opiate prescription pills and heroin.
• Initiate criminal justice reform by responding to research that indicates that addiction/SUDs are chronic and progressive medical disorders; criminalizing the disease will not cure it.
• Address the funding inequalities for substance abuse treatment programs, and increase the options available in communities.
• Encourage and support community-wide efforts such as Naloxone programs or Needle exchange programs.
• Push for increased and affordable access to Naloxone, and the legal ability for anyone to administer it.
• Push for healthcare reform, including more available, consistent, and science-based resources for those struggling with an addiction/SUD.
• Push for an increased level of support from insurance companies for detox, rehab, and continued care.

DISCUSSION QUESTIONS
WHAT WE CAN DO

• What kind of reform is needed in our medical community around pain and prescription practices?

• What can doctors do in their practices to help their patients address pain, and educate them against the potential dangers of opiate prescription pills?

• Discuss our society’s unrealistic expectations for a pain-free life. How could society shift its perspective on pain, and managing pain?

• How can Naloxone programs and needle exchange programs positively impact the opiate epidemic? What historical misconceptions have prevented us from seeing these public health tools as beneficial?

• How can we create larger awareness campaigns in high schools, universities, and communities?
Our hope is that Dying in Vein will raise awareness through informative, thoughtful, and well-intentioned conversations in communities. Talking directly and openly about addiction/SUD is the first step towards bringing it “out of the closet”. Active dialogue allows us to understand misconceptions, change stigmas, break down barriers, and stimulate change. Moving beyond the shame and blame that exists around addiction to a place of compassion will help families and communities heal and grow. This section includes some additional information for families and communities about opiate addiction, healthy communication guidelines, and discussion prompts to initiate conversations.

COMMUNICATION AND STRESS MANAGEMENT 101:
Stress, difficult emotions, and a general resistance to change are natural elements of our human existence. Our early ancestors responded to fear, sadness, and anger with a “fight or flight” response to survive the threat of predators and dangerous environmental influences. Changes in their environment often meant instability and uncertainty in their lives, and triggered emotional responses.

Technologies enabled us to dominate many of those early stressors. However, that evolutionary response did not disappear with the saber-tooth tiger. We still feel stress, difficult emotions, and a reluctance to change, and with the world changing so quickly, many struggle to find positive coping skills to tackle these responses.
Here are a few examples of what stress can look like:
• Fear and anxiety for the future
• Reduced interest in usual activities
• Desire to be alone
• Loss of appetite
• Irregular sleeping patterns

Matt Waljie, a character in the film, recalls “I just remember like my parents are getting divorced and I don’t know what to do… I didn’t have the tools to understand. Just the way I internalized it and how it was relative to my life was really devastating.” Matt’s inability to positively process the stressors, difficult emotions, and changes that came from his parents’ divorce may have made him more vulnerable to his heroin use.

Learning how to respond to these negatively perceived emotions and situations in a productive way has the potential to positively influence your life. As Chase Saxton said during his struggle, “Only through hard times, change, struggles, etcetera, will you grow.”

Here are some tips & ideas on how to process stress, difficult emotions, and change in positive ways:

Take care of yourself
• Eat healthy
• Exercise regularly
• Get consistent sleep

Talk to others
• Take a break
• Be able to ask for help

HELPING SOMEONE WITH AN ADDICTION/SUD
Addiction/SUDs take patience and persistence to overcome, but recovery is possible. It can be extremely difficult for someone struggling with opiate addiction to recover on their own. Often, internalized shame prevents someone from seeking help, despite a desire to receive it. Detox is the first step to overcoming addiction/SUD, but continued personalized treatment is necessary to fully recover.

If you know or suspect someone you love might be struggling with addiction/SUD, here are a few things you can do initially to help:
• Educate yourself
• Remember that addiction has hijacked your loved one’s brain, and thus their personality
• Seek treatment: Help is out there. Look for the options in your community
• Understand that relapse is part of treatment
• Get your family involved with treatment
• Don’t punish yourself for not having seen it right away
• Don’t blame yourself
• Fight the stigma

PEER–TO–PEER ENGAGEMENT
HIGH SCHOOL AND COLLEGE STUDENTS
The transition into adolescence and young adulthood is marked with changes, new experiences, and challenges. The skills you develop to cope with these pressures will have a significant impact on your future. These discussion questions can be used to talk in open and supportive ways with your peers, parents, or guardians. Here are few guidelines on how you can support yourself, your peers, and your parents or guardians during this transitory time.
INFORMATION
Being an adolescent or a young adult in today's world can be challenging. There are additional pressures that come from school, family, and social media. Navigating the teenage years can be complicated. No one is perfect, and all we can do is our best each day. Sharing and discussing issues and problems openly and directly with peers, teachers, and family members can often be a way to bring an issue “out of the closet” and realize that you are not alone.

TIPS & IDEAS
• Talk with your peers and parents or guardians about the realities of drugs.
• Try not to be emotionally reactive – when expressing concerns or engaging in difficult conversations.
• Use reflective listening and assertive communication (rather than strong or abrupt emotional reactions).
• Know the facts, and be able to educate those who do not.
• Develop positive coping skills like exercise or meditating, and share them with others.
• Initiate a peer-mentoring program in your school – mentors can be a lifeline when you feel like you can’t turn to friends and family for help.
• “It’s either deal with it and get sober or, like, die eventually, you know. I don’t like thinking about it. It stresses me out.” – Maddy.
Discuss stressors in your life. What are healthy vs. unhealthy ways to deal with that stress?

• Talk about what might have made either Maddy, Page, Matt, or Chase vulnerable to substance use disorder? Are there any personal characteristics that make you vulnerable to addiction/SUD?

• Chase’s mother and sister both wish that “Chase had shown us his journals as he was writing them.” What changes need to occur in the way we think about substance use to allow kids to share this kind of information more openly? If you were misusing opiates or using heroin how do you think you would approach your parents, family, or friends?

• How do you feel supported by the adults in your life – by teachers, parents, counselors, etc.?

• “It started to become less about like a social thing, and more of like our little group, our little fucked-up friend group, just doing a bunch of drugs together.” – Matt. Please discuss peer relationships that you might be concerned about. How can you and your peers support each other when there may be pressure to do negative/harmful things?

• At 15 years old, Maddy was at a party and took Oxycontin without knowing what it was. Realistically, what do you think you would do in that situation?

• When did you feel most sympathetic to one or more of the characters in the film? Why?

• When did you feel most frustrated with one or more of the characters in the film? Why?

• What would you do differently if you were concerned about a friend’s substance use as a result of seeing this film?
PARENT–TO–PARENT ENGAGEMENT

INFORMATION

Being a parent has never been easy. In today’s world it may seem more difficult than ever. No one is perfect. All we can do is our best each day. With Internet availability, there are few limitations on what kids can access. It’s never too late to start talking about drugs with your family. Providing accurate information and an open space for dialogue may help you and your child connect over the facts. Patience, empathy, encouragement, and effective communication will set the stage for your family’s success. You play a crucial role in your child’s life.

TIPS & IDEAS

- Increase your awareness – of yourself and of your child.
- Use “I feel statements” to share your thoughts and feelings. Encourage your child to do the same.
- Let your child know you are listening – STOP TALKING when your child expresses themselves, and then use reflective listening to help your child feel heard and validated.
- Take care of yourself – After all, you must put the oxygen mask on yourself before you can help another person. Model to your children that self-care is a crucial part of living.
- Perfection is a myth, and does not exist in parenting. Recognize and move on from your limitations.
- Make time for your kids – Scheduled and unscheduled time.
- Commit, as a family, to take turns doing activities that others enjoy.
- Keep open lines of communication with your kids.
- Be willing to have difficult conversations in your family.
- Work together! Let your children know that you don’t have all the answers, but are willing to find them together.
• How do you currently bring concerns to your child? After watching this film, do you think you would do anything differently? Why?

• Matt calls his mom asking for help after being jailed, released, and unable to shoot up due to a bent needle. If this happened to your child, how would you handle it?

• Chase used a journal to express his problems. What strategies do you and your child have to work through problems? Can you find ways to work together?

• “Chase is probably gonna die. And I’m not gonna feel guilty about it because we did the best that we knew how to do, and I’m no expert, and I’m sure that we did all, not all the wrong things, but a lot of wrong things. And I, I look back and think, oh, I should have done this, and I should have done that. And then I, also, think, I don’t know if it would have mattered.” –Shelley, Chase’s Mom. How might you reconcile your limitations as a parent if faced with a life-threatening situation or disease?

• Chase, Matt, and Maddy all came from what appeared to be happy and supportive families with financial resources, and still became addicted to opiates. Understanding that no family is immune, how can you recognize and address vulnerabilities within your own family?

• Explore how you talk with your child about tough topics. Discuss ways in which you could initiate conversations, actively listen, and positively problem-solve with your child?
Substance use disorder can feel crippling to those who are afflicted or have loved ones struggling. Here are a few ways you can help yourself or someone you know.

ACCESS NALOXONE
Currently, many states have laws in place that enable anyone to administer Naloxone in the event of an overdose, and most first responders now carry it as part of a standard kit. If you feel that you or a loved one could benefit from having Naloxone on hand, here are resources on how to read your state’s laws and access the drug.

• To check your state’s laws and availability, visit this website: http://lawatlas.org/datasets/laws-regulating-administration-of-naloxone

“I did actually tell my husband, “You know what, Chase is probably gonna die. And I’m not gonna feel guilty about it because we did the best that we knew how to do, and I’m no expert.”

- Shelley Saxton, Chase’s mom
HOST A SCREENING
Thank you for sharing this film’s story and urgent message with your community. The following information includes how to book a screening of Dying in Vein, and some tips on how to make your screening successful:

• To get started, connect with the Dying in Vein Outreach team to obtain the legal rights for the film. Contact Jorden at: Jordenhackney@gmail.com
• Consider, who is your target audience, specifically? Pick a date, time, and venue that would be most accessible for them.
• Prepare for your target audience. Select resources or design a discussion panel based on the needs or preference of your audience.
• Partner with community partners who can help host and facilitate a screening, or be involved in a post-screening panel discussion. Active, focused, and inclusive discussions can provide the impetus for change.
• Use social media, community partners, and other resources to market your screening. The film’s trailer and Facebook page may be a good place to start: Dyinginveinmovie.org.
• Stay in touch! Ask your audience to connect with the film via Facebook, Instagram, and Twitter, or via our website.

Mental health issues and Substance Use Disorders carry stigma and shame for many. A screening is a powerful place to start the conversations that can eliminate those limiting beliefs. A safe and respectful atmosphere is essential to ensure that your audience feels comfortable enough to share their experiences or ask difficult questions. Here are a few tips on how to establish a supportive environment for your audience during a post screening discussion:

• Before screening the film, let your audience know that the film includes scenes and subject matter that may be potentially triggering.

• Start your post screening discussion with an acknowledgement of the difficulties of the subject matter, and add the reassurance that everyone’s opinions will be respected and honored.

• Be sure that your moderator is able to guide discussions that are focused, informative, and supportive to your audience.

• Provide post-screening outlets with whom your audience can connect if they are struggling, like a mental health counselor.

CONTINUE AUDIENCE AND COMMUNITY ENGAGEMENT
For many with an addiction/SUD and their families, the experience can be isolating. Coming together as a community for a film screening might be the first step an individual takes to address the problem. Keep the momentum going, and provide ways for your audience to engage after they leave the screening:

• Connect with our social media campaign #talkaboutaddiction #addictionisadisease

• Engage with Nation Overdose Awareness Day: http://www.overdoseday.com

• Share links to organizations who are leading the way in spreading awareness and advocacy: http://shatterproof.org

ADDITIONAL INFORMATION AND RESOURCES

NCADA – General information about drugs and addiction: http://ncada-stl.org/about-us/

National Institute on Drug Abuse – Information and resources for parents, teens, teachers, etc.: https://www.drugabuse.gov

Helpguide.org – “Trusted guide to mental, emotional, & social health”: http://www.helpguide.org


The National Center on Addiction and Substance Abuse – General information about drugs and addiction: http://www.centeronaddiction.org/?gclid=CjwKEAiAr4vBBRCG36e415-_1wS-JAAatJZzESrPrpzkXhfaZ4rkiE9pfkeRGT34-_Zb0moex_shoCoJLw_wcB

BOOKS
“Clean – Overcoming Addiction and Ending America’s Greatest Tragedy”. By David Sheff
“Dream Land – The True Tale of America’s Opiate Epidemic”. By Sam Quinones
“The Journey of the Heroic Parent”. By Dr. Brad M. Reedy
ADDICTION TERMINOLOGY:

5th Vital Sign: The evaluation of pain not as a symptom but as part of basic patient care, along-side temperature, blood pressure, respiratory rate, and heart rate.

Addiction: (now referred to as Substance Use Disorder): A chronic diseases that often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Chronic Disease: A disease or condition that persists for 3 months or more.

Heroin: An illegal opioid developed in 1898. When smoked, snorted, or injected it can give the user a euphoric feeling. Dependence can happen quickly, and withdrawals can be extremely painful.

Opiate: Natural substances that bind to receptors in the brain that inhibit pain.

Opioid: Synthetic substances that bind to receptors in the brain that inhibit pain.

Opioid Use Disorder: Physical and psychological dependence to a natural/synthetic or legal/illegal opioid and an inability to discontinue use despite negative consequences.

Overdose (also referred to as an “OD”): Consumption of a dose much larger than that either habitually used by an individual or a dose larger than that used for treatment of an illness; likely to result in a serious toxic reaction or death.

Physical Dependence: When the body adapts to a drug, requiring more of it to achieve a cer-tain effect.
**Psychological Dependence:** A subjective sense of need for a specific psychoactive substance.

**Rehabilitation:** Restoration of optimal state of health by medical, psychological, and social means for a person with a substance use disorder.

**Relapse:** Recurrence of signs and symptoms of active addiction in an individual who has established abstinence or sobriety.

**Remission** (also referred to as Recovery): Abatement of signs and symptoms that characterize active addiction.

**Sobriety:** Sustained abstinence with a clear commitment to and active seeking of balance in the biological, psychological, social, and spiritual aspects of health and wellness that were previously comprised by active addiction.

**Tolerance:** State in which exposure to a drug results in diminution of drugs effects over time.

**Treatment:** A treatment system for substance use disorders comprised of multiple service components including but not limited to: Individual and group counseling, inpatient and residential treatment, intensive outpatient treatment, partial hospital programs, case or care management, medication, recovery support services, 12-step fellowship, and peer supports.

**Withdrawal:** Two or more symptoms present between a few hours to a few days of substance cessation or reduction

**Unhealthy use:** Use that increases the risk or likelihood for health consequences or has already led to health consequences.

**COMMUNICATION TERMINOLOGY:**

**Aggressive Communication:** Communication style that is in violation of others rights by expressing thoughts, feelings, and opinions in a way that is physically or emotionally abusive.

**Assertive Communication:** Communication style that is respectful of others but clear and firm in intent.

**“I Feel Statements”**: A communication skill that breaks down feelings into digestible parts.

- I feel… (emotion)
- I feel this way when… (description of event)
- I feel this way because…(beliefs/interpretations/perceptions)
- What I hope that is within my control is…
- What I hope that I cannot control is…

**Passive Communication:** Communication style that avoids expressing/experiencing one’s own thoughts, feelings, and opinions.

**Passive-aggressive Communication:** Communication style that indirectly expresses thoughts, feelings, and opinions.

**Reflective Listening:** Communication skill where what is said is repeated back in order to ensure validation and demonstrate understanding or empathy. The sender shares their “I feel” statement. The receiver’s job is simply to paraphrase it back to them, without interpretation, reaction, negation, or minimizing anything; it is simply reiterated it without judgment.
REFERENCES
THIS DISCUSSION GUIDE WAS CREATED WITH INPUT FROM THE FOLLOWING SOURCES


GENERAL REFERENCES
American Society of Addiction Medicine
http://www.asam.org

Centers for Disease Control and Prevention
https://www.cdc.gov

Diagnostic and Statistical Manual of Mental Disorders – 5
https://psychiatry.org/psychiatrists/practice/dsm

National Institute on Drug Abuse
https://www.drugabuse.gov

Substance Abuse and Mental Health Services Administration
https://www.samhsa.gov

GRAPHICS PROVIDED BY
CDC: Center for Disease Control
NIDA: National Institute on Drug Abuse
SAMHSA: Substance Abuse and Mental Health Association

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