CSAM news
VOL. 29/NO. 3 • WINTER 2004
THE VOICE FOR TREATMENT
QUARTERLY NEWSLETTER OF THE CALIFORNIA SOCIETY OF ADDICTION MEDICINE

The Narconon Story Or, Why Drug Abuse Prevention Programs Need to Be Education, Not Indoctrination

TIMMEN L. CERMAK, MD

A couple of months ago I was one of several CSAM members (including Peter Banys and David Smith) approached by Nanette Asimov, a reporter for the SF Chronicle, inquiring what I knew about Narconon. As I knew nothing about this organization, she proceeded to describe the following strange scenario.

Several schools in SF were using a drug prevention program provided at no charge by something called Narconon. The Chronicle's investigation of these presentations to students revealed two intriguing, and disturbing, aspects to Narconon. First, much of the "information" they teach is quite questionable scientifically. And second, the ultimate funding source for, and presumably the ultimate control over, Narconon is the Church of Scientology. The intimate connection between Narconon and the Church is not openly revealed in its school drug prevention programs, a fact that could be interpreted either as evidence of its secular independence or deviously cloaking the wolf in sheep's clothing.

As a direct result of the Chronicle's investigative reporting, Narconon's drug prevention efforts have been called into question by the San Francisco school district, the Los Angeles school district, and the California Department of Education. SF school superintendent Arlene Ackerman's quick response to revelations about the drug education program offered to schools by Narconon / The Church of

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Gamma-Hydroxybutyrate (GHB) Update: Use, Abuse, and Treatment of Withdrawal

GANTT P. GALLOWAY, PHARM.D., Haight Ashbury Free Clinics, San Francisco
BASIL L.D. GLEW-GALLOWAY, Haight Ashbury Free Clinics, San Francisco
KAREN MIOTTO, M.D., University of California Los Angeles

Since the last review of gamma-hydroxybutyrate (GHB) in the CSAM newsletter, several events have kept it in the national spotlight, including its use in drug facilitated sexual assault (DFSA), continued widespread use as a drug of abuse, and large numbers of arrests of individuals involving internet sales of GHB from a coordinated law enforcement sweep across the US and Canada. In addition, the FDA approved GHB (sodium oxybate) under the trade name Xyrem for the treatment of cataplexy.

GHB is a simple, four-carbon molecule that was originally synthesized in an effort to find an orally active gamma-aminobutyric acid(GABA)ergic agent. GHB is a naturally occurring metabolite of GABA, an inhibitory neurotransmitter that modulates the sleep cycle. There is a specific GHB receptor (Snead OC 1996, Cash, 1994). GHB has been used as a general anesthetic, to induce seizures in animal models of epilepsy, and, more recently, in the treatment of narcolepsy and alcohol and opiate dependence (Galloway, Frederick-Osborne et al., 2000).

Reports of abuse of GHB date to the early 1990s, though the drug was first tested for its analgesic capacity in 1964. It began to be used by bodybuilders who believed it would increase circulating levels of growth hormones in the late 1980s—a time when the drug's hypnotic and euphoric properties rapidly became apparent and contributed to its popularity. The desired effects of GHB resemble those of alcohol and include relaxation, disinhibition, euphoria, and relief from insomnia. As GHB has caught on in the all-night dance party (rave) scene there has been a marked increase in cases of GHB poisoning in emergency medical centers across the world. GHB typically is sold as "GHB," "G," or "liquid ecstasy." GHB is almost always sold as a salty, aqueous solution. Concentrations of GHB may be prepared and measured inaccurately; this undoubtedly contributes to the high incidence of adverse effects. The Internet has been a source of information promoting GHB, as well as a venue to purchase GHB and GHB analogs. In response to increasing legal restrictions on the sales and purchase of GHB, there has been increasing use of gamma-butyrolactone (GBL) and 1,4-butanediol (BD) both of which are converted to GHB in the body.

GHB has a narrow therapeutic window; users frequently experience

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Looking for an Opportunity to Make a Difference?

The Physician's Diversion Program, a statewide rehabilitation and monitoring program for physicians suffering impairment from chemical dependency and/or mental illness, is recruiting Diversion Evaluation Committee (DEC) Members. The program maintains DECs statewide to determine physicians' appropriateness for participation, terms of participation, and successful completion or termination from the program.

In summary DEC membership eligibility criteria includes:

1. A current, unrestricted medical license for physicians
2. A current, unrestricted license from the Board of Behavioral Sciences, the Board of Psychology or certification as an alcohol and drug counselor/specialist for public members.
3. A minimum of two years of professional experience in the treatment of addictions and mental illness or a minimum of two years of professional experience in physician well-being activities.
4. A minimum of five years of uninterrupted recovery for individuals in recovery.
5. Two years since successful program completion for former diversion program participants.

You can apply to be a DEC member by sending a letter of interest and current CV to: Physician's Diversion Program, 1420 Howe Ave, Suite #14, Sacramento, CA 95825, Facsimile: (916) 263-2607

For further information please call the program at (916) 263-2600.

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PRESIDENT'S MESSAGE

By Donald J. Kurth, M.D., FASAM

Approaching the midpoint of my term as CSAM President, I could not be more proud of the condition of our Society. Financially, academically, and public policy-wise, we are at peak form. I want to thank all of you, our members, and our staff, our friends and supporters, for making our many successes the reality for the California Society of Addiction Medicine.

Donald J. Kurth, MD, FASAM

Financially, we have kept on track and we are soundly in the black. CSAM Treasurer Jeff Wilkins, M.D. has done a yeoman's job of watching over our funds and Membership Chairperson Romana Markvitsa, M.D. has worked diligently on membership development. Her active new member conference calls and other activities have become the standard for all the other ASAM state chapters to try to attain. Finance and membership are just two of the areas that ASAM so often looks to CSAM for leadership and experience.

Academically, President Elect and Education Chair David Pating, M.D. continues to raise the bar. Even after receiving the prestigious Samuel Sherman Award from the California Medical Association (CMA) for innovative CME excellence, we continue to exceed even our own high standards. Our 2004 CSAM Review Course held in LaJolla, CA was the highest attended course CSAM has ever offered. Conference Chairman Sean Koon, M.D. and his committee have outpaced themselves once again this year. Norm Reynolds, M.D. Chair of the Physician Well-Being Committee continued the strong tradition of the Best Practices Series, building on the strength of seasoned veterans like Garrett O'Connor, M.D. and Jim Tracy, D.D.S. with new faces like former flight surgeon Kevin McCauley, M.D. The result has been a series of powerful one-day conferences with standing room only attendance in both Northern and Southern California locations.

In addition, our Committee on Opioid Dependence, chaired by Judith Martin, M.D., this year completed the "Guideline for Physicians Working in California Opioid Treatment Programs." The committee first prepared this in 1998 and this updated edition was completed by Deborah Stephenson, M.D., M.P.H. This committee has been on the forefront on these issues and continues to have a voice on policy issues in Sacramento through Dr. Martin's excellent representation.

The Public Policy Committee, lead by Immediate Past President and Public Policy Chair Gary Jaeger, M.D., FASAM, created yet another successful CSAM Annual Legislative Day in 2004. In planning CSAM's First Annual Legislative Day in 2003, we had to struggle to coax California's legislators for commitments to attend and speak at our public policy session. CSAM's Annual Legislative Day II, however, was a very different story. We actually had uninvited legislators leave their busy offices to attend our session and ask to have a chance to address our physicians! That sort of recognition, my colleagues, is an example of nascent political power.

Our challenge, of course, is to figure out how to effectively build on that foundation. Dr. Jaeger and his Public Policy team are doing that with CSAM Annual Legislative Day III, scheduled for Ground Hog Day, February 2, 2005. CSAM member, Diana Sylvestre, M.D., has organized a grant to help transport health care professionals and patients to Sacramento on CSAM Legislative Day III to join in our public policy efforts. I want to offer my highest kudos to Diana for her initiative and ingenuity! CSAM members who wish to participate on February 2, may apply for the scholarships to attend by registering at: csam-asam.org.

Why have we been so successful? What has made CSAM the addiction treatment beacon for rest of ASAM and for the world? I will tell you why we are so successful. CSAM–our membership and our leaders, past present, and future—have a team with the courage to step forth with new ideas in the public policy arena and to do what we knew was right, even in the face of uncertainty and opposition. Not everyone in this world believes that addiction is a treatable disease, or perhaps more importantly, that persons suffering from addiction deserve the same treatment as any other human beings suffering from any other chronic medical condition.

Public policy changes we effect today will save the lives of millions of patients for many decades to come. We just need the courage to step forward and apply the tools of political science to addiction treatment public policy. As the great anthropologist Margaret Mead once said, "Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it's the only thing that ever has." My friends and colleagues, we are that group and the time for us is right now.

Donald J. Kurth, M.D., FASAM, currently serves as Chief of Addiction Medicine at Loma Linda University Behavioral Medicine Center and as Assistant Professor in the Department of Psychiatry at Loma Linda University. In addition, he is currently a Robert Wood Johnson Foundation Fellow for Developing Leadership in Reducing Substance Abuse and serves on the Board of Directors of the American Society of Addiction Medicine (ASAM).]

Narcanon Story

Continued from page one

Scientology was warranted and wisely measured. Educational programs offered through our schools must be credible, accountable and above board. It appears that Narconon meets none of these standards.

It is ironic that the Church of Scientology, which has opposed the government on a variety of issues, is guilty of creating a drug education program that is flawed in precisely the same way that government efforts have traditionally been flawed. Using fear as a primary tactic, even at the expense of basic factual information, has never produced anything but short term results in changing adolescents' behavior.

For example, the government's initial efforts to reduce the recreational use of marijuana produced Reefer Madness. Now an object of ridicule, this 1936 film aggressively claimed that marijuana inevitably causes violence and insanity. When young people in the 1960's saw that such luminaries as Louis Armstrong and the Beat poets were neither psychotic nor dangerous, and once most who experimented with pot were still able to continue their lives without any major negative consequences, the government's message became untrustworthy. In fact, the government as a whole became a symbol of hypocrisy. Unfortunately, accurate messages about more dangerous drugs, such as "Speed Kills," were no longer believed either.

Fear mongering does not work and has no place in drug education. While it may prevent a few kids from using drugs, they may have been influenced by more reasoned and sound arguments. Research on the impact of DARE programs confirms that we can get youngsters to swear off drugs for a period; but there is little, if any, difference ultimately in the rate of their drug usage over the long run.

When Narconon teaches entirely unproven "facts" about the indefinite storage of all drugs in fat tissue and their slow release during exercise and sweating, leading to cravings, relapses and flashbacks, they are guilty of similar fear mongering. When it describes colored sweat oozing out of drug users and collecting on the floor of saunas or staining their towels, I don't think even the most committed potheads are ever going to actually see this happen. Once adolescents understand that the "facts" Narconon teaches are not true, why should they trust their warnings about the risk of using drugs?

We need to teach reality. Young people need to hear, for example, that our brains are prewired for pot. The THC in marijuana affects us because it mimics natural cannabinoid chemicals already contained in the brain. THC floods areas of the brain that contain these natural cannabinoids and over stimulates them, lowering our capacity for short-term memory, increasing our sense of novelty and hunger. But this flood of THC desensitizes these areas. When the THC disappears, our natural cannabinoids are less effective. The "virtual novelty" experienced when we are high is followed by a period of relative boredom.

Because our brain's normal functions are disrupted by drugs, there are significant risks to using drugs and alcohol. But these risks are not evenly distributed. Not everyone is at equal risk. The younger a person is when beginning any drug use, the more likely addiction will occur, and the quicker addiction can sink its barbed hook into their brain.

Dramatic personal stories of redemption from former drug addicts will always be more powerful than a science lecture. We need two legs to walk, and drug education needs both information and motivation to be effective. Neither alone will be enough.

During the current era of decreased government funding, our schools cannot afford to reject free drug education programs offered by generous community organizations (although the donation of unrestricted funds for schools to choose the drug education program that best fits their specific needs would avoid all hint of impropriety). We would not turn our back on substantive programs developed by the Catholic or Mormon Churches, so we can not off-handedly reject the Church of Scientology's offer.

But we must insist that any appearance of subterfuge, any trace of importing religious concepts as truth, must be scrupulously avoided. I fear that Narconon's reluctance to acknowledge right up front its fundamental relationship with the Church of Scientology is a direct and serious violation of this standard.

Kids hate hypocrisy by adults – and rightfully so. Our responsibility is to present them with as little hypocrisy as possible in their school curriculum. The best tool in working to minimize the devastation that early drug and alcohol use creates in too many teen's lives is the truth - plain and simple.

There is potentially a valuable role for addiction medicine to play in the development of school-based drug abuse prevention programs. Most importantly, the drug prevention field desperately needs a watchdog to guard against pseudoscience and politicalization of the truth. Addiction medicine's evidence-based approach is needed on two levels. First, what is scientifically well enough established to warrant being taught as facts? And second, what prevention strategies have any evidence of effectiveness?

How could CSAM make a positive contribution in this arena? First, our public policy committee would need to explore whether the society would like to take on the task of trying to influence the stake holders in California's school drug prevention programs. Who would need to be influenced, and would it be worth the resources required to develop the means to assert influence?

Second, we need to explore whether there are any standards for what scientific information should routinely

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GBH Update

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adverse effects, including dizziness, nausea, vomiting, decreased respiratory effort, and coma (Chin, Sporer et al., 1998; Miotto, Darakjian et al., 2001). Other sedative-hypnotics, notably alcohol, may act additively with GHB and increase the risk of overdose. GHB users report episodes of loss of consciousness that are more frequent and less predictable than with alcohol use. The half-life of GHB is approximately 20 minutes, and patients can make a surprisingly rapid transition from comatose to alert and eager to terminate medical care.

The major source of media interest of late surrounding GHB has been the trial of Andrew Luster, heir to the Max Factor fortune. Luster was convicted, in absentia, of drugging women with GHB and sexually assaulting them. Two weeks into his trial, Luster fled to Puerto Vallarta, Mexico. He was tracked down in Mexico by a bounty hunter and returned to California to begin serving a 124-year prison sentence. The use of GHB for sexual assault was an important factor leading the classification of GHB in Schedule 1 of the Controlled Substances Act.

Rising reports of the use of GHB by sexual predators and robbers lead the Drug Enforcement Administration (DEA) to coordinate an effort with the U.S. Postal Inspection Service, U.S. Customs Service, Internal Revenue Service, Federal Bureau of Investigation, the Royal Canadian Mounted Police, and the Ontario Police Department to take down websites involved with the sale of GHB called Operation Webslinger. Operation Webslinger was a multi-jurisdictional investigation targeting the illegal Internet trafficking of GHB and its derivatives, GBL and BD (DEA 2002). Most of the Internet sites disguised their sales of GHB, such as the site that sold cleaning agents as Good Household Bargains. The telltale information on such sites would indicate, "somulence will occur if ingested" [sic] or "cherry flavoring" listed as an ingredient in the cleaning products. In all, enforcement operations were conducted in over 80 U.S. cities with drug seizures that could have yielded more than 25 million dosage units, and arrests of 115 individuals in 84 cities across the United States and Canada (DEA, 2002).

Amid this negative press GHB continues to be studied and used as a treatment for several medical disorders. On July 17, 2002 GHB was approved by the FDA as a treatment for cataplexy associated with narcolepsy, under the brand name Xyrem®. In addition to the use of GHB for sleep disorders, GHB is being studied to reduce the pain, fatigue, and sleep abnormalities associated with fibromyalgia. As noted above, GHB appears to have little efficacy in the treatment of alcohol and opiate dependence (FBI, 2002; Nimmerichter, 2000).

In response to concerns about diversion and safety, Xyrem was given a split schedule. For medical use, it has been placed in Schedule III, but as stated, illicit use of this or other GHB products remains punishable under Schedule I. In addition, FDA mandated a controlled risk-management program for Xyrem, named by the manufacturer, Orphan Medical, the "Xyrem Success Program." Under this program, Xyrem is available to prescribers through a single centralized pharmacy. The program also involves other components, such as physician education, patient education, registration, and patient surveillance.

Physical dependence and addiction have been reported with GHB, GBL, and BD (Galloway, Frederick et al., 1994; McDaniel & Miotto, 2001). It is important to note that our knowledge of the nature and treatment of dependence on these drugs comes from a relatively small number of case reports and one survey. Frequent use (that is, at least four times a day) and high dose seem to be required for physical dependence. Patients experiencing severe withdrawal syndromes reported frequencies of use between every 40-60 minutes to once every three hours. Patients reported having used quantities ranging from 5-10 mL of store-bought beverages containing GHB or a pro-drug of GHB to 20-30 capfuls of the same, to as much as 181 g of GHB per day (Hutto, 2000; Migliani, 2000; Mahr, 2001; Addolorato, 1999; Chin, 2001).

The withdrawal from GHB has been compared to that of alcohol, though the onset tends to be more rapid, occurring as quickly as one hour after the last dose, and the autonomic instability can be less severe (Miotto 2001). The withdrawal syndrome may be mild, involving insomnia, agitation, anxiety, and limited sympathetic arousal. Cases of severe GHB withdrawal involve agitation, delirium, and psychosis (McDaniel & Miotto, 2001). Onset of withdrawal occurs within hours and may last up to 2 weeks (Mahr, 2001; Miotto 2001). The severity of withdrawal may progress rapidly, as from mild to severe within 1 hour. Withdrawal does not seem to be a significant issue following therapeutic doses (US Xyrem Group, 2003).

Of the many medications that have been used to treat GHB withdrawal, the most experience is with benzodiazepines, which may need to be given in extraordinarily high doses for severe withdrawal symptoms. One example of high dose benzodiazepines was 507 mg lorazepam and 120 mg diazepam, given over 90 hours, with limited decrease in the symptoms of delirium (McDaniel & Miotto, 2001; Dyer, Roth et al., 2001). In another case, a patient in withdrawal from GHB was treated 10 mg of haloperidol and lorazepam every 2 to 4 hours for 5 days, with no amelioration of withdrawal symptoms. During this time the patient slept and ate very little. She was then given 1,500 mg of chloral hydrate, after which she quickly fell asleep and received two more 1,000 mg doses over the next 24 hours, during which she remained asleep. She awoke fully recovered from the 5 days of delirium and hallucinations from which she had just suffered. Other than a brief, mild recurrence of hallucinations, she did well on 5 days of chloral hydrate and was discharged (Hutto 2000). Some cases may respond to

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Addiction Medicine Review

From the Conference Chair

Dear Colleagues,

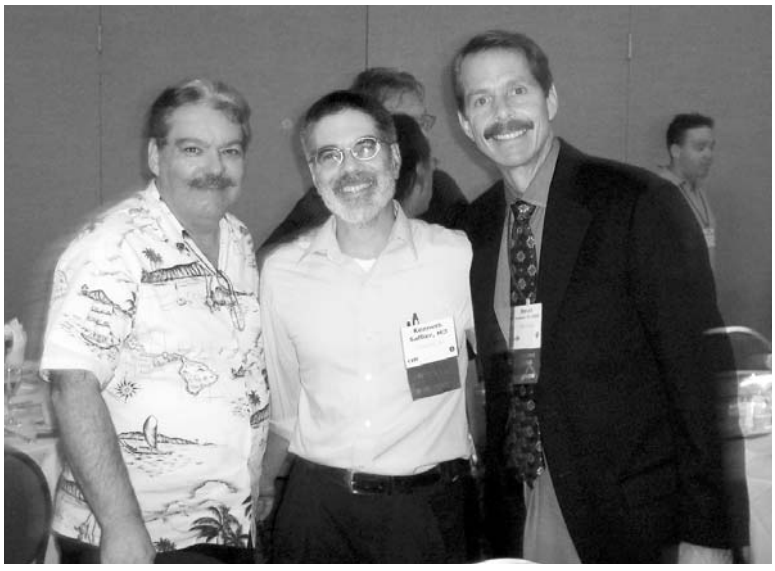
It was great to see some familiar faces at our Addiction Medicine Review Course October 7-9 in La Jolla, California. For those that didn't make it, you were missed!

Our plenary speaker this year was William White, author and addiction treatment historian. He presented a fascinating discussion of the history of addiction treatment in America, followed by a rousing challenge for addictionists to personally engage with the communities we serve. We also heard from Frank Vocci, Mary Jean Kreek, George Koob, Marc Schuckit, and a host of other excellent speakers. As much as possible, we've included all the lectures on our website for easy access and review: http://www.csamasam.org/-2004Presentations.htm

Sean Koon, MD
CSAM Review Course
Chair, 2004

We hope this was an interesting and helpful review of the "Evidence and Art" in addiction medicine. Best of luck to those of you taking the upcoming ASAM Certification exam!

Small group discussions of cases have become a hallmark of the CSAM R
This year's course had 35 such tables



Ernie Vasti, MD, Ken Saffier, MD, and Steven Eickelberg.

Judith Martin, MD, Chair of the CSAM Committee
Review Course promoting use of E

Course 2004 in San Diego

Review Course.

NEEDS A CAPTION
NEEDS A CAPTION

e on Opiate Dependence, at the
Buprenorphine.

Medical Student Brian Hurley and Romana Markvitsa, MD,
Chair of the CSAM Membership Committee

Diana Sylvestre, M.D. Receives Vernelle Fox Award

The Vernelle Fox Award was established by CSAM in 1982 to recognize achievement in clinical, research, education, prevention, or legislation/administration areas of chemical dependence.

By Judith Martin, MD

Diana Sylvestre says that what she does is not unusual, but she's wrong. She's an unusual and outstanding physician. Years from now, when medical historians look back on the terrible needle-related outbreaks of HIV and hepatitis C among heroin users, Diana Sylvestre's name will figure prominently as the person who saw what had to be done, and who brought hepatitis C treatment to the persons who needed it. In 1998, effective treatment of hepatitis C was reported in the medical literature. But hepatologists were refusing to treat the needle users - those who were exposed and who were actually spreading the epidemic. Dr. Sylvestre realized that many of her patients at OASIS* had active hepatitis C, and were not going to get treatment unless she did something to make it happen. (Aptly, the AS in OASIS stands for "achieve solutions.")

Diana Sylvestre, M.D.

Soon she had obtained funding to provide free treatment as part of clinical research. The results of her studies show that patients don't have to be opiate free for six months to benefit from treatment, and her findings directly affected the NIH consensus panel statement in 2002, that treatment for active users should NOT be summarily denied, but individually considered.

She has also been an active grass roots advocate working tirelessly for syringe exchange legislation. She organizes groups of patients to visit Sacramento to have their voices heard on this and other issues pertaining to treatment and support services for the addicted patient. She works with coalitions of organizations to achieve her goals.

Diana is unfettered by ideology, and refuses to be intimidated by bureaucratic barriers. Even though she is an internist, she has an intuitive sense of what kind of psychosocial services are needed with an addicted and underserved population. The weekly education and support groups at OASIS, (held at noon, with lunch served,) have supported and trained hundreds of patients, given them not only facts, but confidence and hope. Patients in the group take charge of their own information, they know about viral loads, genotypes, side effects of interferon, fibrosis.

Dr. Sylvestre's most recent effort is a study treating hepatitis C in patients maintained on buprenorphine, an opiate agonist for treatment of heroin addiction. How many physicians have ever seen a needle exchange site? The commonly accepted notion of needle exchange is that these are the people who 'don't want treatment': all one can do is help reduce risk with clean needles. Dr. Sylvestre has fifty patients so far directly recruited from needle exchange tents around the San Francisco Bay Area. OASIS peer counselors show educational movies and talk about buprenorphine and about hepatitis. Patients are then screened and accepted into a research program. They begin taking buprenorphine to treat their addiction, and eventually, when they are stabilized, they begin the difficult and painful treatment for hepatitis C as well.

In summary, Dr. Diana Sylvestre is a pioneer, an original thinker who sees a way to do what others might consider impossible. We all benefit from her efforts. She has saved and improved many of our patients' lives in the East Bay.

Dr. Sylvestre obtained a BS degree from the University of Florida, and her MD from Harvard Medical School. She trained in Internal Medicine at the Brigham and Women's Hospital in Boston, MA, and underwent fellowship training in Biochemical Genetics at the Sloan Kettering Institute in New York, NY. She is currently an Assistant Clinical Professor of Medicine at the University of California, San Francisco, and Executive Director and Founder of O.A.S.I.S. (Organization to Achieve Solutions in Substance-Abuse), a non-profit organization located in Oakland, CA.

CSAM Honors Henry H. Wheeler, Jr.

The following is the inscription of a award presented to Henry H. Wheeler at the CSAM Review Course on October 7:

The California Society of Addiction Medicine presents A Special Award to Henry H. Wheeler, Jr., whose vision, scientific curiosity, generosity, and personal involvement enables study of the neuroscientific basis for addictive behavior to flourish prominently in California's Universities amid extraordinary cross-disciplinary collaboration. The UCSF Wheeler Center for the Neurobiology of Addiction and the Henry H. Wheeler Jr. Brain Imaging Center at Berkeley presents students, graduates, and seasoned scientists the unique opportunity to iteratively generate and test hypotheses advancing our conceptualization,diagnosis, and treatment of chemically dependent patients

Gretchen Burns Bergman Receives Community Service Award

The Community Service Award was established by CSAM in 1985 to recognize outstanding achievement and contributions to the substance abuse treatment community.

Gretchen Burns Bergman received the 2004 CSAM Community Service Award in recognition of her efforts to put a human face on the problem of addiction. She is a founder and executive director of "A New PATH" (Parents for Addiction Treatment and Healing), an organization of parents, concerned citizens, and community leaders working together to reduce the stigma of substance use in order to increase treatment opportunities and end discrimination. PATH projects include building a self-reflection garden at Donovan State Prison, a "Faces of Recovery" calendar, a resource and referral line, joint events with NCADD and the Mental Health Association, and a parent survival kit. PATH has been a strong proponent supporting Proposition 36, which mandates treatment instead of incarceration for non-violent drug offenders. Burns Bergman served as state chairwoman when the measure was passed by voters in 2001. A New Path has been visionary in bringing together the leaders and policy shapers in San Diego to address the problems of substance abuse and dependence in the community. They have focused their efforts on the task of healing the way society views and responds to these serious public health issues.

DIANA SYLVESTRE, M.D.

CSAM Mission Statement

The specific purpose of the Society is to advance the treatment of alcoholism and other addictions through education of physicians, physicians-in-training, and other health professionals. Additionally, the Society promotes research, prevention, and implementation of evidence-based treatment.

Narcanon Story

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be contained in any drug education program. I submit that, while governmental agencies may claim to provide these standards, and may even provide useful bodies of information, their potential for being unduly controlled by changing political winds makes it impossible to accept them as the final arbiter. We have too often seen liberal or more often conservative perspectives curtail and unduly modify the "information" that governmental agencies try to present to the public.

Third, it is likely that CSAM would have to develop its own mechanism for outlining the core body of scientific knowledge about drugs and drug abuse that should be required of any drug abuse prevention program. This would be a huge task, requiring coordination among experts in a wide variety of different drugs as well as input from child and adolescent developmentalists and educators to determine age appropriate levels of information over wide span of cognitive and emotional capacities (from grade school to early adulthood). Were such an effort to be undertaken, it would certainly be wise to explore interfacing with ASAM in a joint effort.

For the time being, CSAM members would do well to stay current with the Narconon story that is developing throughout California (and potentially nationally) and to be prepared to provide input at the local level when the controversy opens up in your neighborhood. We do have much of value to add to the dialogue about school drug prevention programs. Who else will be the watchdog for scientific findings that can dispel political agendas and move us beyond mere opinion?

Dr. Timmen Cermak serves as Medical Director of the Ohlhoff Recovery Programs and has a private practice of psychiatry in San Francisco and Mill Valley. He is a co-founder of the National Association for Children of Alcoholics, chaired the California Society of Addiction Medicine's Task Force on Medical Marijuana, and is author of Marijuana: What's a Parent to Believe? *(Hazelden Publications, 2003).*

CSAM news

CSAM NEWS is published quarterly by the California Society of Addiction Medicine, a nonprofit professional organization in the state of California with offices at: 74 New Montgomery Street, Suite 230, San Francisco, CA 94105; Phone: 415/927-5730; Fax: 415/927-5731; E-mail: csam@compuserve.com. The California Society is a specialty society of physicians founded in 1973. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine.

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CSAM Opposes Merger of California Mental Health and Alcohol and Other Drug Program Agencies

Shortly after assuming office, Governor Schwarzenegger issued an Executive Order that established a mechanism – the California Performance Review (CPR) – for making government more effective, efficient and responsive. On August 3 the CPR presented its report to the Governor. This review culminated in hundreds of recommendations.

The CPR recommended that California merge its Department of Alcohol and Other Drug Programs with the Department of Mental Health. The PRC claims that the reorganization, known as HHS15, will save approximately $1.8 million per year.

CSAM and other organizations and advocates for drug and alcohol treatment strongly oppose the merger. A CSAM position paper, presented to the Commission stated, "We believe that consolidating the State's Mental Health and Alcohol and Drug Programs agencies would seriously undermine the ability of the State agency to retain a comprehensive and sustained focus on the unique issues surrounding substance abuse and degrade the ability of the State substance abuse agency to collaborate effectively with organizations to address the serious problems of substance abuse confronting Californians." (for the full text of CSAM statement go to csam-asam.org)

A recent study of the organizational placement of State substance abuse agencies, funded by the SAMHSA Center for Substance Abuse Treatment, examined organizational performance of substance abuse agencies in nine States:

The SAMHSA-sponsored study found that organizational placement affects the performance of State substance abuse agencies.

The five largest States in this study kept State substance abuse agencies separate from mental health agencies. Of these states, two have substance abuse agencies at cabinet level and two have agencies closely connected to a "Drug Czar" appointed by Governor. According to the report effective collaboration requires visibility, autonomy and "clout"; these are usually achieved through appointment of substance abuse director by Governor or close relationship to a "Drug Czar" who is appointed by Governor. Substance abuse agencies submerged in lower echelons of State government or merged with mental health agencies appeared to be less effective than others in collaboration and policy specific to substance abuse issues.

Florida recently took the substance abuse agency away from the jurisdiction of the mental health agency, under which agency it had been subsumed, and the Directors of both agencies now agree that the performance and effectiveness of the substance abuse agency has increased as a result. (The full SAMHSA report is also available at csam-asam.org)

Governor Schwarzenegger has not commented directly on the proposals from the CPR. Proposals to restructure state government will be part of the budget submitted by the Governor in January and must be approved by the legislature.

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Wednesday, February 2, 2005
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Your registration will include:

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Schedule

10:00 am – Policy Update
12 noon – Rally at State Capitol
1:00 pm – Visits with Legislators
3:00 pm – Wrap up

Register or apply for a scholarship to cover airfare at http://www.csam-asam.org/LegDay05.htmHelp

GBH Update

Continued from page five

modest doses of benzodiazepines. In one case, withdrawal symptoms disappeared completely after just 2 hours with 20 mg treatment of diazepam. Treatment with diazepam was continued for 6 days, after which withdrawal symptoms did not recur (Addolorato et al, 1999). In addition, limited data suggest that pentobarbital may be effective for the full range of withdrawal symptoms (Sivilotti, Burns et al., 2001). Delirium, psychosis, and use of high doses of benzodiazepines or barbiturates all are indications for inpatient hospitalization.

Antipsychotic medication appears to be less effective and potentially more hazardous than benzodiazepines. Two case reports describe side effects from antipsychotic medications including dystonia and possible neuroleptic malignant syndrome (Rosenberg et al., 2003). In the event of severe agitation and psychotic symptoms associated with GHB withdrawal antipsychotic medications would seem to be an obvious treatment choice. However, it is important to consider that patients appear to be resistant to the sedating effects of antipsychotic medication, and are already at risk for hyperthermia due to agitation.

There have been withdrawal effects from BD and GBL, both of which are converted to GHB in the body. The withdrawal effects are similar if not identical to those of GHB, and patients are responsive to the same methods of treatment. A couple who had been using 16 oz of a store-bought BD solution per day each presented at an emergency department four days after cessation of BD use. Their withdrawal syndrome had started 6 hours after cessation of use of BD. They had tried to detoxify themselves by drinking alcohol, with no amelioration of their symptoms. They responded favorably to treatment with 1 liter of saline, 2 mg lorazepam, and 5 mg diazepam. After 6 hours of observation, they were released with a 5-day supply of lorazepam (Mycyk 2001). Another example involves a man presenting to the emergency room who claimed to have used 5 g of GBL every 2 hours for the six months prior to presentation, and had began to show symptoms of GHB withdrawal including delirium, tremors, and tachycardia approximately 10 hours after last use. He was treated in the emergency department with 2 mg lorazepam and 65 mg phenobarbital. Within an hour, he was less tremulous, delirious, and his heart rate had dropped to 100 bpm (Schneir 2001). Another man in withdrawal from GBL and BD reported agitation, hallucinations, tachycardia, nystagmus, tremor, and diaphoresis. (Schneir 2001).

Patients in GHB withdrawal require careful initial medical monitoring to determine withdrawal severity. The case report literature of severe GHB withdrawal describes intensive care or inpatient management while outpatient treatment of milder cases has also been reported. Guidelines for GHB detoxification and relapse prevention merit further study.

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