CSAM NEWS

Newsletter of the California Society of Addiction Medicine / Spring 1991, Vol. 18, No. 1

INSIDE

- *Recommendations for Treatment Outcome Measures*
- *Reporting Lapses of Consciousness*
- *Treatment of Intractable Pain*
- *Book Review: Musto on Narcotic Control*

The NEWS is published three times a year by the California Society of Addiction Medicine, a nonprofit professional organization in the state of California with offices at 3803 Broadway, Oakland, CA 94611; (415) 428-9091.

Subscription rate is $25 per year.

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, Inc.

Addiction Medicine in AMA's Masterfile

Steve Heilig, MPH

Almost one year after the AMA House of Delegates voted to add addiction medicine (ADM), how far have we come towards realizing the benefits of getting ADM listed as a self-designated specialty in the AMA Masterfile? It is too early to say, because the process is just getting underway. Furthermore, it appears that not many specialists in addiction medicine have taken the initiative to change their specialty listing to ADM.

A gradual trickle-down

The AMA Physician Masterfile contains records on more than 600,000 American physicians, including listings by specialty. And it is used internally by the AMA for research, planning, credentialing, mailing of publications, and reports to state medical associations. It is also sold to governmental authorities and private researchers. Addiction Medicine was one of 21 new specialties approved for inclusion in this file last year, along with others such as critical care anesthesiology and orthopedic sports medicine. Addiction Medicine was the only new specialty added by AMA House Resolution; the others were approved through the AMA's process of looking for accredited residency programs and ABMS certification. Prior to last year, no new specialties had been added by the AMA since 1986.

What is supposed to happen after addition to the masterfile is a little more complicated. The AMA keeps its massive files updated by continually surveying all physicians, whether AMA members or not. Physician Professional Activities questionnaires (PPA) are sent to approximately one third of all American physicians each year; thus, three years are required for a complete picture of specialty distribution after a new specialty is added to the file—that is if all potentially interested physicians practicing in that specialty are aware of the addition and note the addition of the appropriate code on the AMA survey form.

Following the AMA action in June of 1990, Addiction Medicine was scheduled for inclusion on the new PPA forms beginning in 1991. As of mid-March, the AMA had not yet officially listed it in the AMA Masterfile, sent out any survey forms with the specialty added, or taken any action to alert state and local

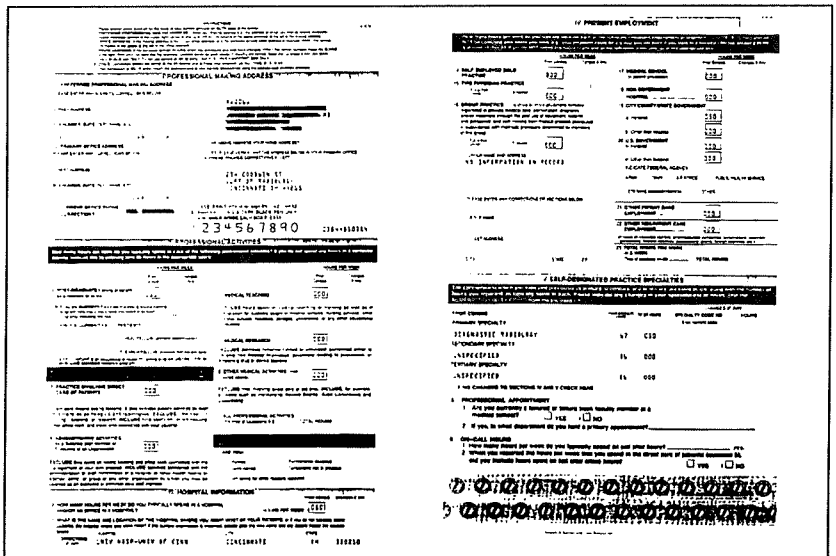
medical associations about the change. AMA staff noted that Addiction Medicine would be added to the next mailing of 140,000 PPA surveys, slated for late April.

With that schedule, the AMA will have the first full national survey completed by the late summer of 1993. Those who do not want to wait for the PPA to come to them may call AMA's Department of Biographic Records at (312) 464-5153, with a request that an addition of the ADM code be made to the record. This might be the simplest and fastest way to make the change.

Those who do not want to wait for the AMA questionaire may call the Department of Biographic Records at (312) 464-5153 and change their specialty designation.

The California Medical Association matches its list of physician specialties with the AMA list in May of each year. Thus, CMA has no official indication yet of the inclusion of Addiction Medicine on the accepted specialty list, and no CMA members are listed under that specialty. CMA staff note that implementation of the AMA action will have to "trickle down" from the AMA survey process, with the only exception to be when *new* CMA members list Addiction Medicine as a specialty on their applications.

Neither AMA nor CMA spokespeople knew of any current or planned actions to educate members about this new option. Even among some active CSAM members, who presumably are more aware and concerned about this issue than the general physician population, indications are that some county medical societies are still waiting to hear from above regarding official listings for Addiction Medicine.



AMA's Physician Professional Activities (PPA) Questionnaire

David Murphy, MD, of Culver City, was told by the Los Angeles County Medical Association that LACMA is waiting for information from the AMA even though they have been receiving calls from other interested members. The Alameda-Contra Costa Medical Association, says Arthur Bolter, MD, of Castro Valley, told him they will be "looking into making the change next year."

There is a certain amount of inertia yet to be overcome.

David Smith, MD, is the only physician listed under Addiction Medicine with the San Francisco Medical Society, although over a dozen CSAM members practice there.

Specialists must make themselves heard

The general feeling is that there is a certain amount of inertia yet to be overcome. Addiction Medicine specialists may need to continue to make their requests heard at various levels. Other than directly calling the AMA to have their specialty listings changed, some ways to help grease the wheels might be for CSAM members to contact their county medical association and the CMA, alerting those organizations to their own interest in being listed with the specialty of Addiction Medicine. Some educational outreach might be mounted to raise awareness among other physicians about the new specialty code on the AMA survey forms—whenever those forms begin to show up in physician offices. □

Reporting Lapses of Consciousness

California's Department of Health Services has begun the revision of regulations to implement a change in the law regarding patients with lapses of consciousness.

The law was changed in 1990 by SB 2328, a bill sponsored by the California Medical Association. The bill was intended to focus primarily on how reporting requirements affected physicians with patients suffering from Alzheimer's disease, but it also covers any diagnosis which involves loss of consciousness. The law requires that a new definition of the conditions be drafted, and that the definition be based "on existing clinical standards" and include related disorders which are severe enough to be likely to impair a person's ability to operate a motor vehicle.

Regulations have been drafted for public review. Gary Levine, MD, suggested that the proposed wording pertaining to alcohol-related disorders be:
"Alcohol-Related Disorders: Persons suffering from dementia associated with alcoholism shall be reportable." In his letter to the DHS, Levine said, "This change would result in greater consistency in the reporting regulations, and would clarify for clinicians who it is that they are required to report."

Proposed regulations are expected to be published in April and be available for comment. For more information, contact the Department of Health Services Epidemiology and Disease Prevention Section, PO Box 942732, Sacramento, CA 94234-7320; (916) 327-4662. □

Intractable Pain Treatment Act

The California legislature has added a new section to the Medical Practice Act, effective January 1, 1991:
"No physician and surgeon shall be subject to disciplinary action by the [Medical] board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain. This section shall not apply to those persons being treated by the physician and surgeon for chemical dependency because of their use of drugs or controlled substances."

The Sacramento-El Dorado Medical Society ad hoc Committee on the Treatment of Pain, chaired by Otto Neubuerger, MD, prepared a report on the historical and emerging views of treatment of pain. The report says, "Physical dependence was once virtually synonymous with addiction, but is no longer," and notes that physical dependence does not inevitably lead to addiction, in the self-destructive sense, for patients in treatment for intractable pain. The report, entitled "The Painful Dilemma," is available from the California Society office. □

Society of Americans for Recovery, Inc

Harold E. Hughes has formed a new, grass-roots national organization of "recovered people and friends of recovery." It is a membership organization with dues starting at $10 for a member.

The mission is "to end the financial, social, legal, and health care discrimination against alcoholics, other drug dependent persons, and their families through mobilization of a powerful political constituency."

For more information, contact SOAR, 1919 Pennsylvania Avenue, NW, Suite 300, Washington, DC 20006. □

CMA Dissolves Committee on Chemical Dependency

The CMA's reorganization plan, adopted by the House of Delegates in 1991, has dissolved several committees, and will rely on Councils – the next larger group in the heirarchical CMA committee structure. Among those disbanded is the Committee on Chemical Dependency which was chaired most recently by Gary Levine, MD.

Issues will be handled by the Council on Scientific Affairs (formerly called the Scientific Board) with help from the specialty advisory panels On some issues, CMA says it will convene technical advisory committees. For more information, contact Gary Levine at 655 Redwood Highway, Suite 332, Mill Valley, CA 94941. □

News About Members

Kevin Olden has been called to active duty with the US Navy and is currently serving at the US Naval Hospital in Oakland as a staff gastroenterologist and consultant to the Alcohol Recovery Unit.

Lloyd Hyndman has left his position as Medical Director of the Alcoholism Service at St. Joseph Medical Center in Burbank and has opened a psychiatry practice in Camarillo.

Jess Bromley was featured in a 15-minute segment called "Physician Intervention in Smoking Cessation" on Lifetime Cable TV's *Physicians' Journal Update*. □

A Book Review

The American Disease: Origins of Narcotic Control

David F. Musto
New York: Oxford University Press, 1987, $13.95 paperback.

Like many professionals working in addiction medicine, Dr. David F. Musto, author of *The American Disease,* came to the field as much by accident as by design. As a young U.S. Public Health Service officer in the 1960's, Musto was serving at a post in Washington, DC, when a superior, knowing of his interest in the history of medicine, asked him to do a bit of background research on an odd question: Why had the AMA opposed the establishment of opiate maintenance clinics in 1919?

For those with any interest at all in the current drug policy debate, this is the primary historical reference.

After his initial protests were declined, Musto hoped to limit the scope of what he regarded as an unrewarding task by requesting Department of Justice records — a request he fully expected would be denied. But Fate intervened. It so happened that the Justice official who received his request also had a question: During his 20 years as a narcotics control officer, he had gone from hero to goat. Since the nature of his work hadn't changed, something else must have. What, he wanted to know, had gone wrong?

Thus did Musto find himself faced with scores of file boxes from the Public Health Service, the Department of Justice, and the Prohibition Unit of the Bureau of Internal Revenue. As his interest grew, he secured the papers of Harry Anslinger (Chief of the Federal Bureau of Narcotics from 1930 to 1962), the Rt. Rev. Charles H. Brent (head of the American delegations to the Opium Commissions), Hamilton Wright (architect of the Harrison Narcotic Act), and Dr. Willis P. Butler (director of the Shreveport morphine maintenance clinic). Later, he was also able to interview both Anslinger and Butler.

Recognizing the value of the materials he had unearthed, Musto devoted the next five years to preparing the first edition of *The American Disease* (1973). Now reprinted as an expanded edition (1987), it remains the definitive text on the evolution of American narcotics control. For anyone who has any interest at all in the current drug policy debate, this is the primary historical reference.

Despite this enthusiastic recommendation, I must caution that it is a dense, scholarly work with nearly 90 pages of footnotes following the main text. This scrupulous attention to detail is a reflection of Musto's aim not to take sides, but rather to present a massive amount of material as factually as possible. Chapter titles reflect both the chronologic sequence of events (e.g., "The Harrison Act," "The Narcotic Clinic Era") and the dominant forces at work (e.g., "Diplomats and Reformers," "The Search for Cures"). If Musto has a thesis, it is an illustration of Santayana's famous aphorism about those who fail to learn the lessons of history: that as a nation, we are caught in cycles of drug use tolerance and intolerance. Each opposing swing of the pendulum seems propelled to new heights by its predecessor, and there, having spent itself, turns to drive the next excess. □

During his 20 years as a narcotics control officer, he had gone from hero to goat. Since the nature of his work hadn't changed, something else must have.

Reviewed by Richard S. Sandor, MD

A (Very) Brief History Of U.S. Drug Policy

Richard S. Sandor, MD

The evolution of American drug policy cannot be understood without considering the larger historical trends of which it was a part. Up to the end of the 19th century, the problems of illness and "doctoring" were primarily family matters. Organized medicine was nothing like the highly regarded profession it is today — many physicians were poorly educated and their methods (not to mention fees!) incurred as much fear and loathing as gratitude. The approved medical practices of the so-called Heroic Age of American medicine — violent purging, bloodletting, amputations — not only drove patients away, they also enhanced the popularity of all kinds of non-physician healers. But everyone had opium.

Since the days of Sydenham, physicians had regarded opium (and later, morphine) as the most useful of all medications. In addition to being the only really effective sedative and anodyne available, it also alleviated the symptoms of dysentery and cholera — endemic and epidemic diseases in 19th century America.

Prior to about 1900, the majority of American opiate addicts were white, upper or middle class women, who received "Dover's Powder" and other such preparations from their physicians. Those who could not afford a doctor found the same relief with over-the-counter patent medicines. Astonishingly, many of these individuals may not have known that the symptoms their medicine held at bay were due to opiate withdrawal. Of course, those who became dependent upon subcutaneous morphine injections (the hypodermic syringe was invented in 1853) must have had a clearer notion of what the real problem was. And not surprisingly, after their patients, physicians themselves represented the second largest population of narcotics addicts. Towards the end of the 19th century, public intolerance of narcotics use was combined with the alcohol prohibition movement to become a potent political force.

The turn of the century also saw the rise of scientific-academic medicine as a sovereign profession. Following the Flexner report, proprietary medical schools were replaced by accredited, university-affiliated institutions where Pasteur's germ theory and Virchow's doctrine of cellular pathology were taught. Practical application of these discoveries, primarily in the form of sanitary municipal water works and waste disposal systems, benefitted the collective health of Americans enormously. The techniques of antisepsis and anesthesia gave birth to modern surgery, and the application of the techniques of organic chemistry to pharmacologic agents made rational and uniform prescribing possible.

Opium was the only really effective relief for the diarrhea of dysentery and cholera.

These advances in medical technology prompted a growing disapproval of physicians who practiced symptomatic treatment; moreover, as more physicians became aware of the addicting properties of the opiates, they became reluctant to dispense them as liberally as their predecessors had — even when they were indicated. But at the same time, as the number of medical addicts declined, an apparently growing number of non-medical or pleasure (or as we would say now, "recreational") narcotics users emerged. By and large, these new addicts were male, urban, and poor — the unsupervised offspring of impoverished immigrant or black laborers. Many of these young men also became involved with various deviant (at least in terms of mainstream values) or criminal enterprises associated with brothels, saloons, and gambling houses. As narcotics use became associated with the criminal subculture, fear among the general population added new fuel to the fires of narcotic prohibition. Racism sentiments, directed against both Chinese (who smoked opium) and Blacks (who were reputed to become "crazed" by cocaine) fanned the flames.

American political aspirations in the international arena also played a role in shaping our narcotics control regulations. Eager to establish the United States as a friend of China, Episcopal Bishop Charles H. Brent and Hamilton Wright (a physician with substantial political ambitions) prevailed upon Theodore Roosevelt's administration to sponsor several international opium conferences aimed at helping the Chinese combat the debilitating importation of Anglo-Indian opium.

But American ambitions at these conferences (Shanghai, 1909, and the Hague, 1912-13) were frustrated by lack of a domestic narcotics policy, so in 1909, Wright developed the Foster Bill and lobbied Congress to adopt it. This first attempt at passing a federal narcotic control law failed, but five years later, resurrected as the Harrison Narcotic Act, it was enacted. Although some legislators (notably the populist William

Jennings Bryan) certainly had narcotic prohibition in mind, the 1914 statute contained specific language protecting the right of the medical profession to prescribe these drugs:

Nothing contained in this section shall apply . . . to the dispensing or distribution of any of the aforesaid drugs to a patient by a physician, dentist, or a veterinary surgeon registered under this Act in the course of his professional practice only.

Nevertheless, within a few years, agents of the Treasury Department, who would soon become responsible for enforcing alcohol prohibition (the Volstead Act, 1920), began to seek out and prosecute physicians who provided narcotics merely to maintain addicts. Several Supreme Court decisions upholding these convictions followed (Jin Fuey Moy, 1915; Webb and Doremus, 1919; Behrman, 1922), and, despite a later reversal of interpretation (the 1925 case against Dr. Charles Lindner), enforcement practices remained unchanged.

Advances in medical technology prompted a growing disapproval of physicians who practiced symptomatic treatment.

In an attempt to preserve medical supervision of opiate addicts, beginning in 1918, public health officials in several cities established narcotics maintenance clinics, but few achieved any real success. Poor organization, lack of a clear purpose, and the pressure of federal harassment eventually undid them all. When the Shreveport facility, under the direction of Dr. Willis P. Butler, stopped maintenance treatment in 1923, it marked the end of an era. Over a period of approximately 25 years, the use of opiates had been transformed from a medically sanctioned response to illness to a despised criminal enterprise.

The idea that treatment of narcotic addiction should be a part of federal policy did not entirely disappear, but without effective medical advocacy, it took the federal government over ten years to build two rehabilitation farms — the first in Lexington, Kentucky (1935) and the second in Houston, Texas (1938). About a quarter of the patients admitted to these facilities were involuntary, and the places were a kind of hybrid between prison and a hospital. The Lexington institution in particular also served as a major training and research center.

Following a 1929 scandal involving the leadership of the Federal Bureau of Prohibition, Congress created the Federal Bureau of Narcotics and assigned it the task of enforcing the continuing prohibition of narcotics — opium, morphine, heroin, and cocaine. Harry Anslinger, its chief from 1930 to 1962, added the prohibition of marijuana to his domain in 1937 and was a masterful manipulator of popular opinion. In a 1953 publication, for example, he wrote,

The bright side . . . is the Lexington story. From 1935 to 1952, 18,000 addicts were admitted for treatment. Of these, 64% never returned for treatment, 21% returned a second time, 6% a third time, and 9% four or more times. These figures should give everyone confidence that the U.S. Public Health Service Hospitals can secure good results in one of medicine's most tremendously difficult tasks.

Anslinger was far too intelligent a man not to have known that the number of addicts not returning to his treatment facilities was a poor measure of "success." In actuality, a properly conducted follow-up of Lexington graduates revealed dismal results: one analysis showed that only 6.6% remained abstinent after discharge, and another found an even lower success rate of 3% .

Narcotic control legislation enacted after World War II has been, for the most part, increasingly punitive and inclusive. The Hale-Boggs Bill of 1951 and the Narcotic Drug Control Act of 1956, for example, established mandatory minimum sentences for narcotics violations with escalating sentences for repeat offenders (including the death penalty for some). While these acts were hailed by law-enforcement professionals, (who could control punishment by manipulating charges) they also severely increased the workload of the judicial system. Without hope of lenient sentencing from a judge, more defendants opted to take their chances with a time consuming and expensive jury trial .

In the early 1960's, California laws had the effect of making addiction itself a crime, but the Supreme Court declared such statutes to be a violation of the Eighth Amendment's prohibition of "cruel and unusual punishment" (Robinson v. California, 1962). The result, in combination with the conclusions of a White House conference on addiction in the same year, was a new interest in civil commitment as treatment. The Narcotic Addict Rehabilitation Act of 1966 called for the development of in- and outpatient treatment in mental health centers under the direction of the National Institutes of Mental Health, but in 1967 another Presidential Commission was critical of both the concept and cost-effectiveness of civil commit-

ment. In time, the idea was abandoned.

The current outline of American narcotics control policy stems from the Drug Abuse Prevention and Control Act of 1970. This law replaced all preceding statutes, proclaimed that federal law superseded all state and local laws, transferred authority for enforcement from the Treasury Department to the Bureau of Narcotics and Dangerous Drugs under the Department of Justice, and divided drugs according (roughly) to their abuse potential. Supervision of treatment programs was shifted to the Department of Health and Human Services in the National Addict Treatment Act of 1974. In the Carter era, many states moved towards the decriminalization of marijuana.

The law and order Reagan "revolution" of the 1980's rededicated government resources to narcotics prohibition. Being against drugs has always been a safe political issue, but currently, with uncontested issues increasingly rare, political leaders seem interested primarily in outdoing one another's toughness on drugs. Thus, the pretentious opening statement of the 1988 Anti-Drug Abuse Act: "It is the declared policy of the United States Government to create a Drug-Free America by 1995."

The history of U.S. narcotics policy reveals it to be a complex and shifting web of contradictory forces: puritanical morality against the credo of individualism, international political ambitions opposing domestic xenophobia, the relentless advance of medical technology countered by the distrust of professionalism, and, lastly, every society's undying need for a scapegoat. Irrespective of the cause, it cannot be refuted that addicts have been at the mercy of a ruthless black market for over 70 years. Although it is a gross oversimplification to assert that prohibitory laws alone are the root of the problem, the criminalization of narcotic use (addictive or otherwise) has played a significant role in the development of many of our current drug problems.

Because an illegal market places a premium on drugs which are most easily smuggled, narcotics traffickers gradually switched from dealing in smoking opium (a bulky product) to the more easily handled and more potent heroin. Initially, the laid-back opium smoker of the early 1900's simply replaced his opium with heroin. For ten or fifteen years after the Harrison Act (1914), heroin was still relatively plentiful, and because it was also fairly pure, snorting was the preferred method of use. However, as the unregulated market developed, unscrupulous suppliers found it increasingly profitable to "step on" (dilute) their wares while at the same time increasing prices. Confronted with "dope" of decreasing potency and increasing expense, most addicts eventually turned to intravenous injection. The weaker the heroin, the more time and effort were required to obtain enough of it to stave off withdrawal, and in this fashion, whatever else the addict might have had time for was abandoned. Legitimate work, family responsibilities, nutrition, personal hygiene, basic human dignity — all were sacrificed in the making of the modern street-hustling, strung-out "junkie."

America's current narcotics control policy stems from the Drug Abuse Prevention and Control Act of 1970.

Other drugs have come and gone over the years: cocaine in the 1920's, amphetamines in the 30's, barbiturates in the 50's, marijuana and the psychedelics in the '60's, and minor tranquilizers in the '70's. Now cocaine is back again, and smokable methamphetamine ("ice") is threatening to become the scourge of the 1990's. And of course, the trade in tobacco and alcohol continues unabated because it is promoted for commercial purposes.

If there is one lesson to be learned from the history of American drug policy, it is that, for better or worse, we are a drug-using culture. Policy has waxed prohibitory and waned permissive, but like a long-running musical, though generations of performers have come and gone, the songs and story have remained the same.

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Proposed Recommendations For Design Of Treatment Efficacy Research With Emphasis On Outcome Measures

Introduction

These recommendations are directed to those interested in treatment efficacy in the field of chemical dependency; that is, comparing one type of treatment with another to assess how effective one is when compared with the other. These recommendations apply to any type of program or treatment for chemical dependency. *Efficacy* of treatment must be distinguished from *outcome, per se*, which is the person's condition at a particular time after starting treatment. Outcome will depend not only on treatment efficacy (if any), but also on all the other factors influencing the person's condition at that time.

These recommendations represent the consensus of over 70 experts polled by the Society.

There are three primary categories of outcome indicators (or variables) to be assessed at follow-up in research on the efficacy of chemical dependency treatment:

- ☐ those which look at the patient's alcohol or drug dependence or use
- ☐ those which look at the patient's physical and psychological health and subjective sense of well-being
- ☐ those which look at the patient's function or role in relationship to society

These recommendations were initially proposed by the Treatment Outcome Committee of the California Society of Addiction Medicine and distributed for review to interested parties. They were published in NEWS in Winter 1989, with a request for comments. The Committee polled experts throughout the U.S.; over 70 submitted responses. Comments received have been evaluated and incorporated if the Committee adopted them. The resulting version was reviewed by two independent experts who focused on the process undertaken to produce the recommendations and the strength of the information which supports them, as well as the document's ability to address the concern which generated the project, namely that generally endorsed guidelines for designing and reporting outcome studies were needed. These experts gave a favorable endorsement. The document is now awaiting action by the Executive Council of the Society.

Recommendations

STRUCTURE OF THE RESEARCH PROJECT

There are nine essential elements of the design of a study. These elements should always be integrated into the communication of study results to the professional community.

1. The Starting Number of Patients

The number of patients who meet the entry criteria at the time of initiation of treatment should be noted. Sample size should be large enough to ensure adequate statistical power for the study.

2. Initial Patient Characterization

Patients should be adequately characterized at the time they enter the study to give a baseline on all variables to be used as outcome measures and all variables known to influence prognosis (e.g., psychiatric diagnoses, demographics, significant relationships, addict's environment, and payment source). The mechanism for characterizing patients and (when appropriate) the validity and interrater reliability of the method should be described. Collateral data is recommended.

3. Comparison of Two or More Groups

Efficacy studies require comparison of two or more groups. The process of group assignment should be described, and should follow recognized research standards (random assignment, when possible) and should control for, or measure, factors affecting the selection of treatment and prognostic indicators in order to minimize bias as much as possible. Inclusion and exclusion criteria should be described and reasons should be given to show why certain patients are excluded.

4. Description of the Treatment Program

The program of treatment should be described in a way that makes clear the important structure and process components as well as the program philosophy. These elements should be described:

a) Setting
b) Level of care: the number of contact hours per day in group and/or individual contact with treatment staff
c) Staff and their level of training
d) Which assessment tools were used
e) Main treatment elements and the duration of each
f) Treatment individualization, the matching of treatment to patient characteristics and patient needs
g) Program philosophy and goals of treatment

5. Continuing Care Compliance, Frequency and Duration

The study should describe the continuing care activities, including percent compliance with recommendations, and actual frequency and duration of the patients' and significant others' participation in outpatient/aftercare/maintenance services. Participation in self-help activities (e.g., Alcoholics Anonymous, Narcotics Anonymous, a church, etc.) should be described.

6. Discharge Category

Each patient who entered the study should be accounted for. For all patients who met the entry criteria, the report of the study should specify the duration of treatment and the patient's condition at the termination of participation in the study, whether planned or unplanned.

7. The Number of Patients Followed Up
The number of patients for whom outcome data are known at the time of follow-up should be specified.

8. The Follow-up Time
The length of time from initiation of treatment to follow-up should be specified. Multiple follow-up points are recommended. Three important time points are 6 months, 12 months and 24 months.

9 Costs
The cost per day of treatment and the method of payment for care should be specified.

VARIABLES TO BE MEASURED
We recommend measurement of the following six variables, listed here in order of priority. We also recommend validation of information received from patient self-report.

1. Substance use
a) Report the status of use of primary drug(s) of dependence
b) Report the status of use of other drugs of dependence, including nicotine

For a) and b) above, report the following:
i) total abstinence since start of treatment
ii) time to first use from start of treatment
iii) time to first use from end of treatment
iv) number of days between last use and follow-up time
v) % days abstinent since start of treatment
vi) days of substance use since start of treatment. Report any use, since the start of treatment, of medications prescribed for their psychotropic action or which have psychotropic side effects (including detoxification medications)

Quantity/Frequency measures such as average drinks per drinking day may be useful for some studies, but may be harder to measure and validate than abstinence measures.

Confirmation of a patient's self-report of substance use or non-use is recommended, by either biochemical measure or corroborative report.

2. Readmission for chemical dependency treatment due to re-use or threatened re-use
Admission may be to chemical dependence or psychiatric inpatient or outpatient facility.

3. Health status
a) Health service utilization
i) Mortality
ii) Hospitalizations since start of treatment
iii) Medical/dental outpatient visits since start of treatment
b) Confirmation of health status is recommended.
i) Appropriate biochemical markers associated with illness
ii) Standardized interviews, psychological tests and rating scales

4. Employment function status
a) Employment status at follow-up
b) Number (or percent) of days worked compared to total days eligible to work after release from inpatient or full-time day treatment

Confirmation by the employer is recommended.

5. Legal problems after release from inpatient treatment (if there was inpatient treatment)
a) DUIs
b) Arrests

Confirmation by checking the public records of arrests is recommended.

6. Evaluation of the patient's relationship with close family and significant others
a) Marital status at follow-up (includes same-sex and opposite-sex partners)
b) Relationship status assessments may include:
i) Satisfaction with relationship at follow-up
ii) Quality of family interactions at follow-up
c) If a parent of minors, custody status of children

Confirmation from family members/significant others is recommended.

THESE AREAS NEED FURTHER STUDY

■ Global Function Assessments
Before we recommend global function as a variable to be measured, we suggest these questions for further study:
a) Have the global function assessment instruments been reported in the chemical dependency literature?
b) Have the instruments been validated appropriately?

■ Emotional Status Assessments
Standardized psychological/psychometric instruments may be able to measure the subjective sense of well-being of the patient and assess the functionality or ability to cope of the patient. This may be a better approach than attempting to measure states of feelings directly.

Questions for further study:
a) What valid instruments or methods assess one's ability to cope with stresses, or the range of affect over time, or the subjective sense of well-being?
b) What valid instruments assess feeling states which are not subject to wide fluctuations?
c) Which of the above have been used in chemical dependency assessments?

■ Assessment of Social Functioning

■ Assessments of Major Life Stressors in the Follow-up Period
Measuring major stressors occurring in the follow-up period would help determine whether two groups were affected by different prognostic variables occurring following treatment. This may help assess the efficacy of specific stress management treatment interventions. There are instruments to assess both stressors and family and work environmental scales, and they should be studied further to identify their validity and their ability to contribute to measurements of the effectiveness of treatment. □

A Review

Audience

The plays of Vaclav Havel, the dissident playwright who was elected President of Czechoslovakia in 1989, are currently playing in New York and a number of theaters around the country. In his one-act play, *Audience*, Havel shows that he has a remarkable grasp of acute alcohol intoxication. One of the two characters, a beer brewmaster in an unspecified, eastern bloc country, summons one of the plant line workers to his office. The worker, it turns out, is also a minor league writer who is under scrutiny by the police.

Over the one hour of the play, the manager consumes one beer after another. At first, he is jolly and friendly and insists that his employee join him for a beer. The employee, who doesn't drink beer, tries unsuccessfully not to drink it, but the manager insists. "Drink up," he commands, refilling his employee's glass. When the manager leaves to go the bathroom, as he does with increasing frequency throughout the play, the employee empties his glass into the manager's. On his return, the manager opens still another beer and refills his employee's glass.

As intoxication progresses, the manager begins to repeat himself episodically, without any apparent recognition that he is doing so (the impairment in short-term memory that heralds a blackout). The employee politely tolerates the manager's insistence that he "drink up," but tries several times to extricate himself to return to the floor of the plant. Each time, however, the manager insists that he stay, and he eventually announces that he intends to promote the writer to an office position within the plant.

The manager's mood becomes progressively more labile, oscillating between euphoric garrulousness and irritability. Suddenly, the manager reveals to his employee that the police have been questioning him and that he has been making up things about him to appease the police. The manager asks the employee to write down some things about himself so that he will have information to tell the police. The employee refuses stating that it is against his principles for him to "fink" on himself. The manager launches into an angry diatribe about intellectuals and their "principles" and how they don't "give a damn" about other people. As his rage subsides, the manager becomes frightened, sad, and remorseful. He pleads for the employee to reveal something about himself before he passes out in his employee's arms.

The play is interesting, in part, because of the skillful way Havel shows, in a compressed time sequence, the range of moods and cognition produced by alcohol intoxication. The play obviously rang true, for many people leaving the theater were discussing the people that they knew who were "just like" the brewmaster.

The compressed time sequence makes obvious the logical gaffs in the intoxicated person's thinking. The cognition of the intoxicated person, and, for that matter alcoholics in early recovery, emulates logical thinking closely, but it is not quite right. Havel's ability to show clearly the evolution of alcoholic thinking in one hour is at once entertaining and instructive.

Reviewed by Donald Wesson, MD

Annual Meeting of the Members

Awards and Installation Ceremony

Friday evening, November 22, 1991 *Hilton Beach and Tennis Resort Hotel, San Diego*

Presentation of the Vernelle Fox Award
Presentation of the Community Service Award
Installation of Kevin M. Olden, MD
as the 9th President of the California Society

Business Meeting of the Members

Saturday, November 23, 1991, at lunch

Applicants For Membership

As part of the California Society's application process, the names of applicants are published in the newsletter and sufficient time is allowed for comments from the members before the Executive Council acts to accept candidates for membership. The first time the name appears in the newsletter, a biographical sketch prepared from information on the application form is included.

If you have comments to bring to the attention of the Executive Council, please contact P. Joseph Frawley, MD, at (805) 687-2411, or write to him in care of the California Society office.

Alan L. Berkowitz, MD, is in the private practice of psychiatry both hospital-based and office-based. He was certified by the American Board of Psychiatry and Neurology in 1990. Berkowitz received his medical degree from the University of Michigan in 1984; and completed his residency in psychiatry at UC San Diego. He was a fellow in psychopharmacology at USCD in 1988-89. His focus is on dual diagnosis. He is Clinical Instructor in psychiatry at UCSD.

John Buehler, MD, is a psychiatrist in private practice. He has been Medical Director of Pacific Recovery Center outpatient chemical dependency program at Ross Hospital since 1982. He graduated from the University of Oregon School of Medicine in 1959, and completed a psychiatric residency at Langley Porter Institute in San Francisco in 1963.

Steven Eickelberg, MD, is an addiction medicine specialist at Kaiser Permanente's Chemical Dependency Recovery Service in Fontana. After graduating from the University of Oregon School of Medicine, he was in a residency in surgery, 1981-82, at Johns Hopkins Hospital and at Massachusetts General Hospital, 1982-844. He was a fellow in addiction medicine at Serenity Lane in Eugene, Oregon, 1988-1989. He was the founding president of the Oregon Society of Addiction Medicine.

Loring Gifford, MD, is the Medical Director of the Alcohol and Drug Program at the El Paso State Center, and the staff psychiatrist at Life Management Center. He received his medical degree from the University of Texas Southwestern Medical School in 1965; he was in a psychiatry residency at the University of Cincinnati's General Hospital, 1966-69.

Michael J. Horne, DO, is the Medical Director at Woodside Women's Hospital in San Mateo. Horne was certified by the American Board of Psychiatry in 1980, and was certified in internal medicine by the Royal Australian College of Physicians. He received his medical degree from the University of Sydney in Australia in 1968. From 1978 to 1990, he was a research fellow in psychiatry at Stanford. He is Assistant Clinical Professor of Psychiatry at Stanford University.

Leonard Schulkind, MD, is the Medical Director of the Alert Unit and the Emergency Department at Villaview Community Hospital in San Diego. He is also the Medical Director at Future Health Care Centre in San Diego. He received his medical degree from the Autonomous University of Guadalajara in 1983, and was in a residency in family medicine at Prince George Hospital Center in Maryland in 1988. He was certified by the American Board of Family Practice in 1990.

Mark A. Souza, MD, is a resident in internal medicine at the VA in Martinez. He received his medical degree from USC in 1988. In July he will begin as a staff physician at Kaiser in Pleasanton where he is slated to become the Medical Director of the Chemical Dependency Program. An appointment as Assistant Clinical Professor with UC Berkeley-UCSF is pending.

Other candidates for membership are:

David Dougherty, MD, Bakersfield
Daniel Glatt, medical student, Millbrae
Said Jacob, MD, Glendora
Samuel Mayeda, MD, Irvine
Catherine McDonald, MD, Oakland
William McDonald, MD, Mountain View
Charles Moore, MD, Sacramento
John Nork, MD, Diamond Bar
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CONTINUING MEDICAL EDUCATION

International Conference on Physician Health

Sponsored by the American Medical Association and the Canadian Medical Association.
Inn on the Park, Toronto
June 6-8, 1991
For information, contact AMA, 1-800-621-8335.

State of the Art in Addiction Medicine

Sponsored by the American Society of Addiction Medicine
Marriott Hotel, Orlando
October 17-19, 1991
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015. (202) 244-8948.

State of the Art in Addiction Medicine

Sponsored by the California Society of Addiction Medicine.
San Diego Tennis & Beach Hotel, San Diego
November 21-23, 1991
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611. (415) 428-9091.

Addiction Medicine Specialist Needed

Physician needed to provide direct care and administrative services to a broad spectrum chemical dependency program in the Sacramento region. Satellite clinics, dual diagnosis and other specialty services in the planning phase. Knowledge of detoxification (inpatient and outpatient) essential. Certification in addiction medicine helpful. 10-hour per week position open, beginning 6/1/91.

Call or write: Roger D. Shafer, MD, Sutter Center for Psychiatry, 7700 Folsom Boulevard, Sacramento, CA 95826; (916) 386-3005.

Psychiatrist Needed

Psychiatrist interested in adolescent and general psychiatry, and chemical dependency needed to take over office and join practice in La Jolla. For more information, send inquires with CV to Administrators, P.O. Box 269, Rancho Santa Fe, CA 92067.