CSAM NEWS

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INSIDE

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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.

New Federal Regulations

"Substance Abuse Professionals" Do More than MROs

H. Westley Clark, MD, JD, MPH

Although the Medical Review Officer (MRO) has been around since the Department of Health and Human Services promulgated rules in 1987 for drug testing of Federal employees, it was not until the Department of Transportation regulations of 1989 that the concept achieved widespread utility. The role of an MRO was created out of the recognition that medical information might surface during the course of drug testing, and, therefore, a physician should interview the person being tested to make the determination whether there was a legal medical explanation for the positive drug test.

The 1989 Department of Transportation (DOT) regulations say that the MRO shall be a licensed physician with knowledge of substance abuse disorders. The MRO may be either an employee of a transportation employer or a private physician retained for this purpose (Department of Transportation, Federal Register 54(230):49875; December 1, 1989).

Subsequent to revisions in the alcohol and drug testing rules, the DOT has revised the qualifications of the MRO. The old definition required only one thing, that the MRO have knowledge of substance use disorders. This limited specification of requirements is consistent with the reluctance to have a Federal definition of the qualifications of physicians. However, the 1994 regulations became more specific: An MRO is a medical doctor who not only has knowledge of substance abuse disorders, but who has been trained to interpret and evaluate laboratory test results with an employee's medical history (Federal Transit Administration, Federal Register 59(31):7583; February 15, 1994). Thus, there are now three component parts of the MRO definition which impose a requirement on the physician functioning in this role: (1) knowledge of substance abuse disorders, (2) trained to interpret and evaluate laboratory test results, and (3) interpreting those results in conjunction with an employee's medical history. This new definition is closer to the actual activity of the MRO.

These same new DOT regulations introduced a new category of personnel called the Substance Abuse Professional (SAP). A substance abuse professional can be a licensed physician or a licensed or certified psychologist, social worker, employee assistance professional, or addiction counselor certified by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission. The SAP must

have knowledge of and clinical experience in the diagnosis and treatment of alcohol- and drug-related disorders (Federal Register 59(31)). The SAP may be employed by the employer, may operate under contract with the employer, or may be unaffiliated with the employer.

The generic function which the DOT now requires is to *evaluate* an employee who has tested positive for alcohol or drugs. Regulations require that an SAP make these evaluations:

- to determine what assistance, if any, the employee needs in resolving problems associated with alcohol misuse and controlled substance use.
- to determine through a second evaluation whether the employee has properly followed the prescribed rehabilitation program where offered.
- to determine if the employee also requires drug testing for an alcohol-positive employee or alcohol testing for a drug-positive employee.
- to determine the number and the frequency of the unannounced follow-up testing.

Regarding potential conflict of interest, DOT regulations prohibit SAPs from referring employees determined to need assistance to the SAP's private practice, or to a person or organization from which the SAP receives remuneration, or has a financial interest.

The Federal Railroad Administration expands the required function into the area of psychological assessment, thus raising the issue of dual diagnosis. Its rules (49 CFR 219.04(d)) establish this additional function for the SAP:

- to determine if the employee is affected by a psychological or physical dependence on alcohol or one or more controlled substances or by another identifiable and treatable mental or physical disorder involving misuse of alcohol or drugs as a primary manifestation.

Return to Work

The SAP, thus, is to play a major role in the situation of an employee who has tested positive. In order for a post-positive employee to return to work, there must be an evaluation by an SAP. The employee must have presented a urine sample that tested negative for controlled substances if the subject has violated the sections involving controlled substances, or presented breath for testing that indicated an alcohol concentration of less than .02 if the subject violated the sections involving alcohol. An employee shall be required to present both a urine sample and breath for testing if the SAP determines that it is necessary.

Physicians certified in addiction medicine or addiction psychiatry would be ideally suited for the joint function of MRO and SAP.

Comment

The changes in the DOT regulation clearly de-emphasize the function of the MRO in favor of the SAP. The MRO (who must be a physician) is not involved with alcohol testing. The SAP, who may be a physician, but more likely will not be, is required to be involved in the consequences of both alcohol and drug testing. Thus, physicians who are MROs may want to ask themselves if they could also be SAPs.

It is not necessary to be a physician to be an SAP. An employer could hire a NAADAC-certified counselor to do substance abuse assessments of employees who test positive. A counselor is certainly cheaper than a physician or licensed or certified psychologist or a social worker. A cost-conscious employer may opt for the cheapest personnel possible.

However, in order to enhance efficiency and communications, some companies, already linked with the MRO in the drug testing arena, may be willing to extend the use of the MRO to these newly required functions if the MRO could also qualify as an SAP. Alternatively, the company may wish the MRO had either a collaborative or supervisory relationship with a non-physician SAP.

ASAM-certified physicians or physicians certified in addiction psychiatry would be ideally suited for the joint function of MRO and SAP. Other physicians functioning as MROs who do not have knowledge of and clinical experience in the diagnosis and treatment of alcohol- and drug-related disorders need to become specifically trained in these functions in order to qualify as an SAP.

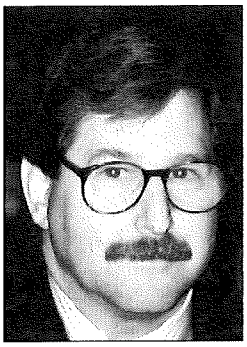
Physicians who do not meet the criteria of an SAP but who hold themselves out as being SAPs create risk management problems for themselves and for the employers who hire them. Issues of public safety and employee rights hang in the balance. Work-related errors caused by employees prematurely or inappropriately returned to work may result in damage awards against the employers.

In the case of dual diagnosis, the SAP who has little knowledge of mental or physical disorders that have misuse of alcohol or drugs as a primary manifestation is at a disadvantage. The MRO who is not an SAP, but who collaborates with an SAP must be concerned with his/her own actions and the actions of the SAP upon whose decisions the MRO, the employer and the employee rely.

There are now more players in the field. Physicians and others concerned about occupational substance abuse should be sensitive to these changing requirements and scenarios. □

Doctor Clark is Chief of Associated Substance Abuse Programs, VA Medical Center, San Francisco; and Assistant Clinical Professor of Psychiatry, UCSF.

President's Column



With this issue of the newsletter, we welcome all the new CSAM members who are joining us by virtue of their membership in the American Society of Addiction Medicine.

It seems appropriate at a time of new beginnings to review where CSAM began and how it became a part of ASAM. The California Society was founded over 20 years ago by a group of physicians who wanted to see care for alcoholics and addicts improved. They felt that a medical specialty society would promote high standards of treatment as well as provide the collegiality and educational activities so necessary for advancing a new field.

CSAM became a state chapter of ASAM in 1989 in order to participate more effectively with a national organization capable of taking up larger issues than a state organization alone would influence (e.g., certification, treatment outcome, patient placement criteria).

After long and careful deliberation, the ASAM leadership decided to implement a unified membership structure for state chapters and the national organization, starting in 1995.

With health care reform taking center stage in national politics, it seems more important than ever that we work together toward common goals that will benefit our patients and our field. The coming year may be a critical time to bring our experience and perspective to the national debate.

Over the next year we will be meeting our new members and learning about their interests, hopes, and needs. We will be welcoming them into activities, dialogue, and decision-making. We hope to hear their voices in our educational projects, in our attempts to influence state policies affecting addicts and alcoholics, and also in our publications.

The most important activities of this organization are the same ones which brought our founding members together in 1973: education, collegiality, and advocacy for our patients. The Executive Council recently identified these five activities as critical to the organization:

- the annual review course or state of the art conference
- the newsletter
- the yearly membership directory which provides a brief profile of each member
- advocacy for statewide issues, such as education in the medical schools, and the workings of the Medical Board of California's Diversion Program for Physicians
- bringing the physician's voice to matters of conscience and public policy

To each of our new readers, a special welcome for the New Year. □

— Richard S. Sandor, MD

WHY SPIRITUALITY?

Richard S. Sandor, MD

Editors' Note: Doctor Sandor spoke on "The Power of Spirituality in the Doctor-Patient Relationship" at the CSAM Annual Meeting in the half-day conference preceding the Review Course. This article is taken from his presentation.

The spiritual aspect of man's nature and the role it plays in the interaction between physician and patient is an enormous and neglected area in modern medicine. It is neglected perhaps because it cannot be quantified and

It is difficult to articulate precisely what spirituality means. Nevertheless, I believe we are obligated to take it up as a serious concern

measured. It is even difficult to precisely articulate what spirituality means. Nevertheless, I believe we are obligated to take it up as a serious concern. Indeed, I want to make the concept of obligation itself the theme of this consideration of spirituality in addiction medicine. For purposes of discussion, I have divided the idea into three aspects: we are obliged to ponder the question of spirituality for the sake of our patients, because we are indebted to our society, and finally because we owe it to ourselves.

First, we are obliged to our patients to be concerned with questions of spirituality. Too many addicts and alcoholics have recovered through the Twelve Step groups for us to disregard what they feel is the most important element of their program. It is true that many people have not been able to receive the help that these fellowships offer; however, that does not negate their beliefs. Beyond citing the empirical evidence of AA's helpfulness, however, there are other considerations. It strikes me as incredulously shortsighted that many clinicians and researchers imagine that we will someday find a "magic bullet" for chemical dependence. Certainly medication can serve as an aid to withdrawal, as adjuncts to recovery, but as a single, simple "cure"? No. Suppose we had such a thing — a pill for addiction. What would it do? How would it work? I once asked a group of patients this question. One bold individual replied confidently, "That's easy! It would make me not want to drink!" "Oh, we've had a pill like that for years," I responded. "It's called Valium!" After a moment's hesitation we all had a good laugh. All of the patients were well aware of how frequently one addiction substitutes for another in the absence of true recovery. I do not want what I am saying to be interpreted as an argument against the use, for example, of methadone. Without question, methadone maintenance has played an important role in recovery from opiate dependence; however (and I think most colleagues who have worked in methadone clinics would agree) merely controlling the chemical dependence does not solve the problems of living that heroin addicts must face if they are to recover genuinely worthwhile lives.

Fifteen years' experience working with addicts and alcoholics has confirmed for me what people in AA have been saying for a long time: people recover from addictions by virtue of having what they call a spiritual awakening. I'm so convinced that I now organize my treatment strategies around the idea of helping people overcome obstacles to that spiritual awakening. Let me explain my rationale for this approach.

When I became a doctor, my father, also a physician, managed to pass on some wisdom to me. He said, "People go to a doctor for only one of two reasons, pain or fear. At least start by trying to figure out which one they're coming for."

It was good advice, but it was incomplete. What he didn't tell me was that the pain and fear could be coming not only from an illness, but also from events — present or past — in people's lives. Perhaps more importantly, he also didn't tell me that I wasn't the only doctor people were going to use. People find all sorts of rapid, reliable

I now organize my treatment strategies to help people overcome obstacles to that spiritual awakening.

(if short-lived) ways of doctoring themselves in order to get rid of pain and fear: drugs, alcohol, sex, sport, gambling, shopping, eating, work all the "ism's." But none of these escapes from pain and fear brings anyone closer to maturity or wisdom (the original meaning of "sobriety"). The ultimate issue addicts of all kinds must face is the loss of the capacity to suffer. Whenever things go seriously wrong in an addict's life, the first thing that emerges, like it or not, and particularly early in recovery, is the urge to use — the urge to escape the discomfort. This powerful memory of a rapid way out of suffering is the terrible liability that remains long after the struggle to "quit" is over.

The continuing (and apparently never-ending) task of recovery from an addiction is to not begin again. And if people do not have a way of making suffering meaningful, why would they choose to stay sober? In fact, in my experience, they don't. Time after time I've heard clinical histories of alcoholics and addicts relapsing after years of sobriety. In virtually all of these cases, at least in my experience, the individual had long ago stopped active engagement in the program of AA. This continuing work towards tolerating suffering — not a bad defini-

tion of spiritual growth, I think — is what the AA program is all about. It doesn't matter what pharmaceutical assistance we develop; if this question is not addressed, then our work with our patients will be inadequate.

Our obligation is to understand something about spiritual awakening in order to work effectively with our patients.

So, our first obligation is to understand something about spiritual awakening in order to work effectively with our patients.

Our second obligation is to our society, both past and future. We owe an enormous debt to our predecessors for all that we are able to do, and yet at the same time we are also obliged to the future to try to correct some of the problems that we have unintentionally created. We have brought forth enormous problems as a result of the kind of unbalanced and aggressive approach to living that has so dominated Western Civilization. I have written about this problem as it is reflected in the field of the addictive disorders previously (CSAM *NEWS* 19 (3):1-3, 1992), and, for the purposes of this article it seems sufficient to summarize the matter with a quote from *The Arrogance of Humanism* by David Ehrenfeld: "The society clever enough to perform sophisticated research on cancer is the society clever enough to invent the sugar substitutes, children's sleepwear ingredients, food coloring agents and swimming pool test kits that may cause it."

Einstein voiced the same thought when he said, "I fear we have created problems from a state of mind which cannot solve those problems." In our own field, for example, our unbridled manipulations have lead us to turn relatively harmless, or even very useful, natural substances into potent toxins — the agents of addictive disorders. People have used mind-altering substances for eons in rituals and traditions that bound a people together and gave individuals very special experiences which they then could share with the rest of society. This was, and is, a very important aspect of living. Coca, for example, has been used in Peru and by the Indians indigenous to the Andes for a long, long time without significant problems. Along comes modern science in 1866, tears the leaf apart and extracts the active ingredient, cocaine hydrochloride. Enter problems with addiction. Correcting this problem isn't a matter of turning back the clock or of imagining that the "final solution" is just around the next technological corner. It's a question of re-awakening a balanced consciousness that can perceive the long-term effects of our actions — another fairly good definition of a spiritual awakening.

If we don't approach this imbalance as a serious spiritual problem and do what we can to correct it, then we're not fulfilling our obligation to our society and to our future.

What about our third obligation — our obligation to ourselves? I suspect that many of us were called to the practice of medicine for reasons that even now we may not fully understand, but which had something to do with the idea of having a meaningful life. Without wanting to sound arrogant, I know of no other human endeavor which puts one squarely, repeatedly, in front of the big questions of life and death. Face to face with the most serious kinds of suffering, how can we not ask ourselves what it means? Are we mere slaves of the evolutionary force of life on earth? Does individuality mean nothing more than being the container for a slightly unique set of human genes?

...re-awakening a balanced consciousness that can perceive the long-term effects of our actions is a fairly good definition of a spiritual awakening.

The ultimate issue which addicts of all kinds must face is the loss of the capacity to suffer.

Of course we forget these questions in the day to day practice of medicine. Absorbed in the technical aspects of our work, we lose sight of the *person* who is sick more often than we care to admit. Sadly, in the process of forgetting this, the spiritual aspect of our work, we risk losing our own personhood. It is salutary to remember that one day we will be the ones who are ill — not the ones trying to help. I hope the doctor assisting me will be sensitive to the dignity and meaning of my suffering.

At the conference, Barry Rosen told us of an inscription on the first page of *Stories of the Spirit, Stories of the Heart* by Christina Feldman and Jack Kornfeld: "In the end, the universe is made not of atoms but of stories."

Such a story came to my mind in preparing for this conference. It's about spirituality as the full and direct acceptance of our humanity. As a junior medical student at the University of Southern California School of Medicine, I spent a month on the Diabetes Service at Rancho Las Amigos Hospital. One day an elderly woman was admitted with her blood sugar wildly out of control. In the process of performing the physical exam, I uncovered her newspaper-wrapped right foot only to discover a four or five centimeter ulcer filled with maggots.

Why Spirituality? *(continued)*

Now, the next morning, I had to present "my case" on teaching rounds. You will all, I'm sure, recall that we were taught not to say things to our colleagues at the bedside which might be frightening or offensive to our patient. You remember the euphemism for cancer, "mitotic disease," for example? Well, there I was, standing at the bedside, all the students and attending gathered around the professor, looking at me. I began the recitation, "Mrs. Brown is a 74-year-old female who was admitted yesterday for blah-bla-blah and so-and-so-and-so-and-on." Eventually, I came to the physical exam. "Inspection of her right foot showed a four centimeter diameter ulcer with ...um ...white ...um ...tubular...uh ..." Acutely aware of my failing speech, the patient herself reared up in the bed and said to me, "Go ahead and say it sonny, MAGGOTS!" In addition to our roles of doctor and patient, we also became good friends — once she taught me to speak clearly and honestly!

Such a story may seem trivial, but it, and dozens of other encounters like it, have brought me wonderful lessons about the purpose of life. For those of us who have the privilege of attending people who speak authentically to us, often in situations which emphasize their humanity all too clearly, it would be an awful waste of a life not to receive those lessons. The attempt to respond to this sense of obligation has made my life in medicine really joyful and satisfying — for me, the indisputable gift of a spiritual awakening. □

Spiritual Health

John N. Chappel, MD

Editors' Note: Doctor Chappel spoke on "A Biopsychosocial Spiritual Approach to Understanding Addiction and Recovery" at the CSAM annual meeting in the half-day conference preceding the Review Course. He is the author of the chapter "Spiritual Components of the Recovery Process" in Principles of Addiction Medicine, published this year by the American Society of Addiction Medicine. This article, a shortened version of his presentation, gives a helpful definition and description of spirituality.

If my physical health is my relationship with my body, my mental health is my relationship with my mind and brain functioning and my social health is my relationship with the people around me, then my spiritual health would have to be my relationship with whatever this creative force is that put our world together.

Characteristics of Spiritual Health

Spiritual health overlaps to some extent with mental health but has separate characteristics and hallmarks. One is humility. This is different from humiliation and is reflected in the statement, "I am a fallible individual who needs all the help that I can get." In comparison with the magnitude of the forces in the universe and the complexity of our own selves and our own brains, humility is a relatively easy concept to grasp. With the experience of humility comes some **honesty with self and others** and an **openness and willingness to accept help**.

Spirituality is not passive. Spiritual health is not a passive state. It's a very **active** one. AA reflects this in its saying that "I learned that my higher power will do nothing for me that I can do for myself."

Having a sense of meaning and purpose is an another indication of spiritual health. Spiritual experience often leads to a greater interest and intention in living. For example, we see it in specific activities such as promoting healing in medical practice or in general activities such as working to improve the quality of life on earth.

Another aspect is a sense of harmony, of **being at one with other people and with the world around us**. With that comes an interest in helping others and in doing things which improve our environment.

Other hallmarks of spirituality are **acceptance** and **tolerance**. One of the evidences for me that Alcoholics Anonymous and the other 12-step programs are spiritual programs is the tremendous acceptance and tolerance which they display, far greater than any church, synagogue or temple that I've known. I belong to a Methodist church in a downtown area. When a drunk comes in, we don't kick him out, but you can always tell where he is because there are empty seats all around him. It is like a penicillin spot in a petri dish. On the other hand, when the same drunk wanders into an AA or NA meeting, somebody comes up, greets him with a big smile, and offers a cup of coffee if he can hold it. If he throws up or spills his coffee, he's still welcome and told to keep coming back. There's a tremendous acceptance there in those meetings which is very helpful to both the giver and the receiver.

...a helpful definition and description of spirituality.

Spiritual health also seems to provide a sense of **inner strength**. The experience of a higher power contributes to a sense of being able to deal with whatever vicissitudes life happens to bring to us, including a variety of catastrophes.

A characteristic which helps the development of spiritual health is the ability to be relatively **flexible in our thinking**. As an example, how often do we refer to our higher power as She? As female? This rarely happens, in my experience, and yet, amongst us human beings, women are demonstrably more capable of nurturing than we men are. If we wanted to postulate a caring, loving God, it would make greater sense to refer to that entity as She rather than as He or as Father. But the fact is we don't know, and therefore some flexibility is really essential in our viewpoints and in our thinking.

Whatever the creator is, we can't understand it. God is incomprehensible to us. If he or she or it were not, he'd be too simple to have created this world. That means basically that there's no true religion and there is no true belief, whatever it may be. All of us are seeking comprehension of what is a caring, loving, accepting, forgiving and tolerant creator.

Paths to Spiritual Health

Spiritual health, like physical health, is achieved by exercise, activities undertaken repeatedly and regularly. It requires both time and effort on our part.

Spiritual health, like physical health, is achieved by exercise.

Prayer is the best known spiritual exercise. It's a conscious attempt to connect with our higher power, whatever this higher power may be. It is characterized by an attitude of openness and willingness to experience whatever comes from the exercise of prayer. We often forget that 50 percent of communication is listening. This may be where meditators have an advantage in developing communication with God as we understand Him/Her. Clearing the mind through meditation may be a way of opening ourselves to the experience of a higher power.

Cultivating an open mind is a useful exercise for moving toward spiritual health. Be willing to learn and to explore new ideas and experiences. Learning may be one of the primary purposes of our brains. If we look at the human brain and the way that it's constructed, it is an organ designed to acquire knowledge and information. To the extent that we do not use it to learn, we may be missing a great deal of our own potential.

Another useful exercise is **discussion** with other human beings and learning from the experience of others. It is fascinating to me how difficult it is to get into a discussion about spiritual issues with people. I found it's easier to talk about these spiritual issues in AA meetings than it is in my own church. The Twelve Step programs, by valuing personal experience and refusing to evaluate or judge anyone's experience, have created a forum where people can be comfortable discussing their spiritual beliefs and experiences or lack of them.

Reading is another exercise through which we can connect with the thoughts and experiences and wisdom of other people and other cultures. Often we see the commonality, the universality of our human nature and our spiritual nature in the great novels, essays, and autobiographies which have been written.

Religious activities and worship services certainly can help but cannot by themselves strengthen our spiritual lives. I'm indebted to Alcoholics Anonymous for helping me understand, in a way I never did before, the difference between spirituality and religion. One of the intriguing aspects of spirituality in addiction medicine is how religions generally have shown so little success in dealing with addiction, whereas the spiritual programs of Alcoholics Anonymous and Narcotics Anonymous have demonstrably shown greater success.

All of these elements can be helpful in fostering our own spiritual nature and helping both ourselves and our patients strengthen our spiritual lives and our spiritual health. □

Suggested Reading:

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Chappel JN (1994). Spiritual components of the recovery process. In Miller N (ed.) *Principles of Addiction Medicine.* Chevy Chase: American Society of Addiction Medicine.

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Khantzian EJ & Mack JE (1989). Alcoholics Anonymous and contemporary psychodynamic theory. In M Galanter (ed): *Recent Developments in Alcoholism.* New York: Plenum Press, vol. 7, pp. 67-89.

Kurtz E & Ketcham K (1992). *The Spirituality of Imperfection: Modern Wisdom from Class Stories.* New York: Bantam Books.

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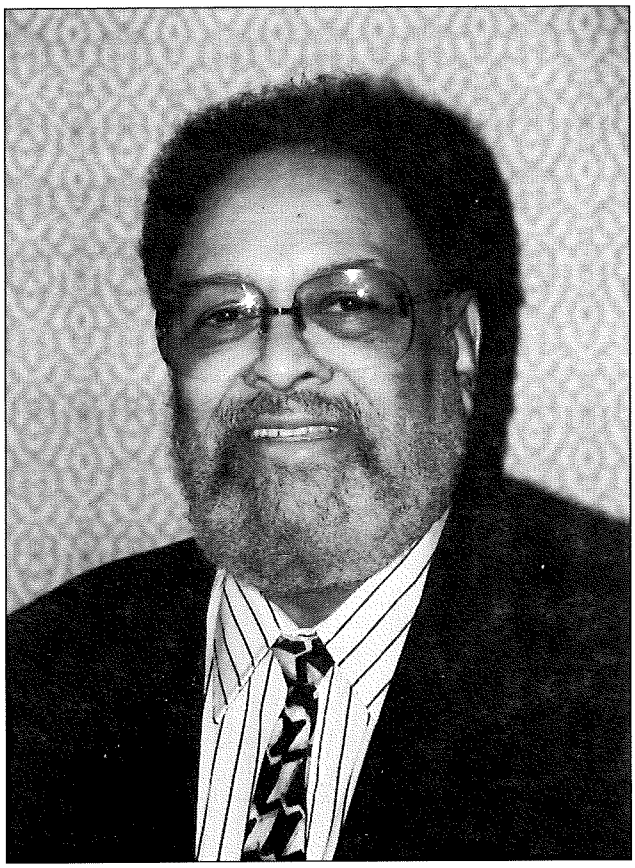
Community Service Award



CSAM

The California Society of Addiction Medicine
presents the

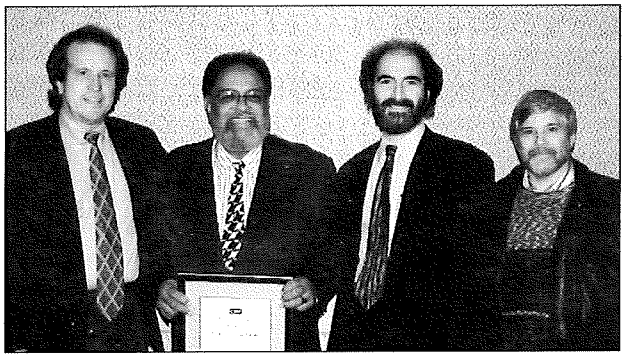
Community Service Award

to

The Reverend Cecil Williams

In recognition of your leadership and example
in making meaningful contributions
to the welfare of people whose lives
have been overtaken by alcohol and drugs.

Your humanitarian efforts are multiplied by
your special gift of evoking and organizing
compassion in others.



Reverend Williams with those who presented the tribute to him: David Smith, Barry Rosen, Tim Cermak.

Two couples honored: Dorothy Gordon, Jack Gordon, Jan Mirikitani, Cecil Williams.

ANNUAL MEETING November 1994 SAN FRANCISCO

Vernelle Fox Award

CSAM

The California Society of Addiction Medicine presents the

Vernelle Fox Award

to

Jack David Gordon, MD

one of the visionary founding fathers of CSAM

- in recognition of the significance of the example he sets by accepting alcoholics as patients with a treatable illness; and
- in tribute to his natural talent as a teacher, and in appreciation of his good humor, warmth, and willingness to share his clinical experience and acumen in the spirit of service to patients and to the community.

Jack Gordon with those who presented the tribute to him: Kevin Olden and William Brostoff.

ANNUAL MEETING November 1994 SAN FRANCISCO

New Members-at-Large on the Executive Council

Joseph Galletta, MD

Lyman Boynton, MD

Gail Shultz, MD

Doctors Joe Galletta, Lyman Boynton, and Gail Shultz were elected to the Executive Council during the business meeting of the members. Boynton is Chief of Addiction Medicine and Medical Director, Chemical Dependency Recovery Program at Kaiser in San Francisco. Galletta is in private practice of addiction medicine and family practice in Hemet. Shultz is Medical Director of the Betty Ford Center.

Photos of all 13 members of the Executive Council are included in this issue. In addition to the three new members above, the Committee Chairs shown below, and the President, Richard Sandor on page 3, are John Lanier, Nicola Longmuir, and Garrett O'Connor.

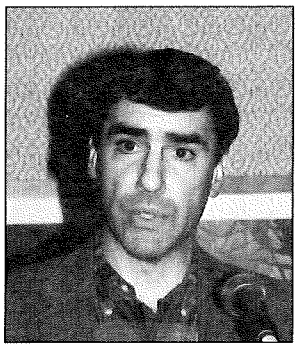
John Lanier, MD

Nicola Longmuir, MD

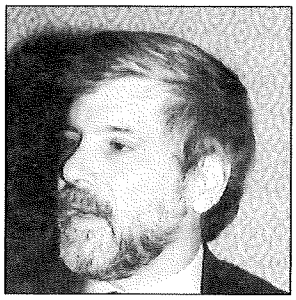
Garrett O'Connor, MD

Committee Chairs Report to the Members

Diane Hambrick, MD, Committee on Membership

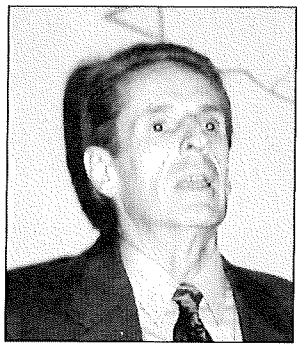


William Brostoff, MD, Committee on Physician Impairment

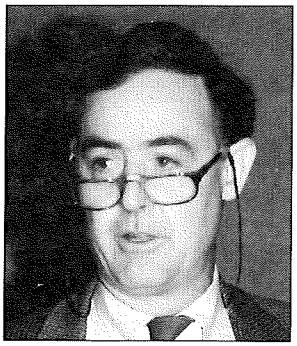


Tim Cermak, MD, Study on Scope of Addiction Medicine

Kevin Olden, MD, Committee on Research



Donald Gragg, MD, Treasurer, and Committee on Education



P. Joseph Frawley, MD, Representative to ASAM

For photographs used in this issue, we thank Richard Merrick and Peter Banys.

ANNUAL MEETING November 1994 SAN FRANCISCO

APPLICANTS FOR MEMBERSHIP

The names of applicants are published and sufficient time is allowed for comments from the members before the Executive Council acts to accept them as members. If you have comments to bring to the attention of the Executive Council, please contact Richard Sandor, MD, at (310) 392-4644, or write to him in care of the California Society office.

Ansar M. Haroun, MD, is Supervising Forensic Psychiatrist at the San Diego Superior Court and a staff psychiatrist with the California Department of Corrections. He graduated from King Edward Medical College in Pakistan, and completed a residency in psychiatry at Yale University in 1984. He was a public health fellow at Yale University, and a fellow in pediatric psychiatry at Columbia University from 1985-87. Doctor Haroun is Assistant Clinical Professor of Psychiatry and Pediatrics at UCSD.

Michael Parr, MD, is an obstetrician/gynecologist in private practice in Sacramento, Medical Director of the Sutter Outpatient Drug and Alcohol Program, and Medical Director of Options for Recovery, a perinatal drug and alcohol program. Doctor Parr graduated from the University of Michigan Medical School in 1965, and completed a residency at UC-Davis in 1971.

Jeffrey Shelby, MD, is an internist in private practice in Fresno. He graduated from Bowman Gray Medical School in 1983, and completed a residency at Pinedale Clinic in Fresno in 1988.

William Weathers, MD, is a psychiatrist at the Parole Division of the California Department of Corrections, and at Tehama Recovery Center in Redding. He completed a residency in 1970 at Patton State Hospital.

Unified ASAM/CSAM Membership Means Changes in the Application Process

Beginning January 1, 1995, applications for membership in CSAM will be considered as applications for membership in ASAM, and *vice versa*. CSAM will adopt ASAM's criteria for membership and ASAM's application review process. For more information and for membership applications, contact the CSAM office. □

NEWS ABOUT MEMBERS

Westley Clark and **Tony Radcliffe** were elected to the ASAM Board for four-year terms as Directors-at-Large. Their terms begin at the April, 1995 meeting of the Board in Chicago, in conjunction with the annual Medical-Scientific Conference.

Joe Takamine is now at the Chemical Dependence Unit at CompCare's Starting Point in Costa Mesa, where **Ted Williams** is Director of the hospital.

Ken Saffier was named Director of Ambulatory Care for Contra Costa County.

Dan Glatt is in a medicine residency at the Naval Medical Center in San Diego.

Bill Shaw has retired from the Navy and will spend six weeks on the ski slopes of the Western US before deciding on his next position.

John Lanier has an appointment as Assistant Clinical Professor of Health and Education in the School of Public Health, and Assistant Clinical Professor of Public Health and Preventive Medicine in the School of Medicine, Loma Linda University.

Peter Washburn has left Merritt Peralta Institute Chemical Dependence Recovery Hospital in Oakland and is now at the Chemical Dependence Recovery Program at Kaiser, San Francisco, where **Lyman Boynton** is Medical Director.

Donald Wesson is now serving as the Medical Director of Merritt Peralta Institute Chemical Dependence Recovery Hospital. He has moved his office from Beverly Hills to Oakland, but he continues as the Associate Director of Research for the LA Addiction Treatment Research Center. □

In Memorium

Harvey Lerner, MD, died of a heart attack in July of this year. He had been a member of CSAM since 1981. At the time of his death, he was serving as Chief of the Department of Addiction Medicine at Kaiser, Granada Hills.

Substance Use and Fetal Mortality

The results of a two-year review of fetal/infant mortality in Alameda and Contra Costa Counties were released in November. Among the findings:

- substance use was considered a contributing factor to fetal and infant death in 10% of the cases
- 22% of the cases were known to have involved use of three or more substances—alcohol, tobacco or illicit drugs—during pregnancy

Among the recommendations is that "all providers should adopt a common system and protocol for identifying women and infants for substance abuse screening in perinatal care and at delivery." Mentioned as valuable, with or without urine tests for drug use, was the screening instrument called the "4 Ps"—similar to the CAGE, but developed specifically for pregnant women. With an addition made by the Born Free Project in Contra Costa County, where Hope Ewing is Medical Director, a fifth question is added about peers. (See Tables) The CSAM-sponsored physician education project on perinatal addiction recommends that all providers of primary care for pregnant and parenting women use the 5Ps routinely, with every patient, and advise and refer women as indicated.

The study was funded by the American College of Obstetrics and Gynecology as part of its National Fetal/Infant Mortality Review Program, and by California's State Department of Health Services, Maternal and Child Health Branch. It was conducted by the Perinatal Network with an inter-agency work group. Participating hospitals included Alta Bates in Berkeley, Brookside Hospital in Richmond, Alameda County Medical Center/Highland General Hospital in Oakland, Kaiser Permanente Hospital in Oakland, Summit Medical Center, and Children's Hospital Medical Center in Oakland.

Copies of the 47-page report are available from the Perinatal Network of Alameda/Contra Costa, 6536 Telegraph Avenue, Suite C201, Oakland, CA 94609. For information, contact Sean Casey, Program Coordinator, 510/652-5188. □

Table I: 5 Ps. Born Free Project Chemical Dependence Screen for Prenatal Care Services

Parent	Alcoholic or addict?	Alcoholic ___ Addict ___ Neither ___
Partner	Does your partner have a problem?	Alcohol ___ Drugs ___ None ___
Peers	Do your friends use drugs and alcohol?	Alcohol ___ Drugs ___ Neither ___
Past	Did you have a problem with or consequences of use?	With Alcohol ___ With Drugs ___ Neither ___
Pregnancy	Have you used since you knew you were pregnant?	Alcohol ___ Drugs ___ Neither ___
Score of 2 positive answers should trigger additional questions such as the CAGE or T-ACE.		

Table II: T-ACE

2 points	T	How many drinks does it take to make you feel high (TOLERANCE)?
1 point	A	Have people ANNOYED you by criticizing your drinking?
1 point	C	Have you felt you ought to CUT DOWN on your drinking?
1 point	E	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (EYEOPENER)?
Score of 2 positive answers is considered positive for risk drinking in pregnancy.		

Table III: CAGE

C:	Have you ever tried to Cut down on your drinking? (drug use)
A:	Have you ever felt Annoyed when someone mentioned...
G:	Have you ever felt Guilty after...
E:	Have you ever used alcohol (drugs) as an Eyeopener in the morning?

Treatment Shown To Be Cost Effective

For every dollar spent on treatment, society saves seven dollars, according to findings reported by California's State Department of Alcohol and Drug Programs in August from a study commissioned in 1992 by Andrew M. Mecca, DrPH, Director of that Department. The three major findings were these:

- for every $1 spent on treatment, society saves $7
- criminal activities declined significantly
- significant improvements in health and corresponding reductions in hospitalizations were found during and after treatment

The types of programs that produced the greatest absolute benefit were also the most expensive.

The study, conducted by the National Opinion Research Center, looked at four types of treatment programs: residential programs in general, social model recovery houses (a type of residential program, but considered separately in this study), outpatient treatment programs which do not provide daily methadone, and methadone treatment programs (both maintenance and detoxification programs). From 97 possible treatment programs in 16 counties, 82 unique programs were chosen.

Participants were selected at random from the total of 3,000 who were discharged or currently in treatment between October, 1991 and September 30, 1992. The number successfully contacted and interviewed over a nine-month period was 1826. The participant interview questionnaire took approximately one hour and fifteen minutes to administer. The interviews occurred an average of 15 months after treatment, with the longest interval being 24 months. (The sample also included persons who were in continuing methadone maintenance treatment.)

The drug of choice, or "main drug," is the drug(s) reported as the reason for seeking treatment. They were alcohol, heroin, the hydrochloride salt of cocaine, crack cocaine (crystalline or "free-base" cocaine), and methamphetamine. The most prevalent drugs of choice which led the CALDATA population to seek treatment were heroin (45%) and alcohol (31%). A measured outcome of treatment was reduction of use. When the study focused on the main drug of choice results showed reductions of use by 40%. The criterion was whether the drug was used five times or more during the period measured.

Another measure was general health and use of health care services. The conclusion reached was that increases in health and reductions in health care utilization were significant and were not restricted to any modality of treatment, the length of treatment, or any demographic variable. The same improvement of health and reduced utilization of services appeared throughout.

According to the report's summary, "The results will fill many of the gaps in the research literature — such as the detailed coverage of social model programs and the side-by-side comparison of cost and effectiveness of treatment for alcohol, cocaine, and heroin abuse."

"Regardless of the modality of care, treatment-related economic savings outweighed costs by at least 4 to 1 (for inpatient settings) and appeared to be greater than 10 to 1 for outpatient and discharged methadone participants. For residential and social model care, benefits during treatment barely covered the costs of providing care — however, benefits following treatment were substantial. The types of programs that produced the greatest absolute benefit were also the most expensive. The least expensive treatments yielded the lowest absolute benefits."

The 90-page report is titled *Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA)*. Copies are available from the California Department of Alcohol and Drug Programs Resource Center, 1700 K Street, Sacramento, CA 95814; 800/879-2772. □

The Medical Board of California's Diversion Program

In response to a decreasing number of participants in the Diversion Program, the number of Diversion Evaluation Committees (DECs) was reduced from six to five. At the end of June, 1994, there were 218 active participants plus 24 candidates waiting to be seen by a DEC or awaiting the return of their signed treatment agreement.

The Sixth DEC, which was created to oversee cases in which a mental health problem or psychiatric diagnosis brought the physician into Diversion, was dissolved and its members were reassigned to Southern California I. They have retained the specialized mental health focus and will be convened to evaluate certain physicians as appropriate, to be determined by the Diversion Program Manager, Chet Pelton.

Currently the rosters of the five Diversion Evaluation Committees are as follows:

Northern California I
William Brostoff, MD, Chair
Sharon Bjornsen, MFCC
Michael Parr, MD
Marsha Young, PhD
one vacancy for a physician

Northern California II
Robert Matano, PhD, Chair
Lyman Boynton, MD
A. Duane Menefee, MD
Jeff Roth, MA
one vacancy for a physician

Southern California I/Mental Health Combined
Norman Reynolds, MD, Chair
Barrett Levine, MD, Co-Chair
Cassandra de la Coeur, PhD
Margaret Gregory, MD
Linda Oliver

Southern California II
H. Westley Clark, MD, JD, MPH, Chair
Robert Tarter, MD, Vice-Chair
Judge W. William Beard
N.J. Marciano, MD
Marilyn Sponza, MFCC

Southern California III
Donald Dougherty, MD, Chair
Keven Bellows
James Johnson, MD
Gail Shultz, MD
one vacancy for a non-physician

Medical Students in Diversion

In July, action of the Medical Board authorized the Diversion Program to accept medical students into Diversion. Until that time, they had been ineligible. Medical students are now eligible if the student is enrolled in a California medical school; if the medical school is aware that the student is in Diversion and agrees to assist in the monitoring; and if the medical student signs an agreement to enter Diversion. This change in policy and practice came as a result of recommendations and follow-up by DEC member Robert Tarter, MD, from Redlands.

Legislation to Authorize Diversion from Discipline

The policy of the Diversion Program since mid-1992, following the decision of the California Supreme Court in Kees v. MBC (June, 1992), has been that a physician cannot enter Diversion with a formal, signed agreement if a complaint of any sort (including an 805 report) has been received about him/her by the Enforcement Department of the Medical Board. If there is a complaint, Enforcement reserves the right to investigate it and file an accusation.

Efforts have begun to seek legislation to authorize a change in this situation. Discussions are scheduled with representatives of the California Medical Association, the California Society of Addiction Medicine, the Medical Board's Enforcement Department, the Attorney General's office to see if these different groups — and different points of view — can reach agreement on how to change the law. □

Numbers of Physicians in Diversion: 1991-1994

	July 1991	March 1992	Aug 1992	July 1993	Dec 1993	June 1994
Current active participants	246	248	256	213	231	218
Awaiting review by a DEC, or awaiting a signed treatment agreement after acceptance by a DEC	30	40	29	39	25	24
Cumulative total of successful completions since January 1, 1980	319	350	365	429	439	468
Cumulative total of other terminations since January 1, 1980	157	168	172	191	200	210

Comments Requested

Nominations for Award Recipients

Each year the California Society recognizes accomplishments which further the fundamental goals of the Society and the profession. This description of the Society's two awards comes from the Executive Council.

For the Vernelle Fox Award

The mission of the California Society is to foster and encourage the improvement of the quality of health care services for chemically dependent patients and to increase communication and research among health professionals providing care for alcoholic and drug dependent patients.

Nominations are requested for future recipients of the Society's two annual awards.

The California Society wishes to recognize physicians who have made noteworthy and lasting contributions in line with the mission of the Society: contributions which improve the quality of health care services, increase communication and education among providers of care and add to the research on which the understanding of the field is based and on which the health care services are built.

Because the Society has designated Vernelle Fox, MD, as the model against which future recipients will be measured, the criteria for selection will reflect the contributions and qualities for which she was honored at the Society's Tenth Annual Meeting: an inquiring mind (contributions to the understanding of the field), courage (resolution, tenacity), and enthusiasm (energy for the positive).

Previous recipients have been George Lundberg, J. Thomas Ungerleider, Enoch Gordis, Peter Banys, Gill Ayotte, Josette Mondanaro, Jess Bromley, Max Schneider, David Smith, Joseph Zuska, and Mary Pendry.

For the Community Service Award

Alcohol and other drug use, abuse and addiction are public health problems. The California Society wishes to recognize persons who have made a positive impact on the public health of our communities in California.

The Community Service Award is given in recognition of activities which have made a significant positive impact on the public health and have beneficially influenced the quality of life for the citizens of a California community.

There is no requirement that the recipient be a public servant or working in the public sector, but the Executive Council gives greater weight to those who are.

There is no requirement that the recipient be from the local community where the Society's annual meeting is being held and the award given, but the Executive Council gives greater weight to those who are.

Previous recipients have included Darryl Inaba, Assemblyman Lloyd Connolly, Tom and Katherine Pike, Betty Ford, Stephanie Brown, and Joan Kroc.

Members are invited to send comments to the Society's office to the attention of the Executive Council. □

State-of-the Art in Addiction Medicine — 1995

November 2-4, 1995
Ritz-Carlton Hotel, Marina del Rey, CA

Planning Committee
Timmen Cermak, MD, Chair
William S. Brostoff, MD — Joel Nathan, MD
Nicola Longmuir, MD — Nicholas Rosenlicht, MD

CONTINUING MEDICAL EDUCATION

Western Region Conference - State Physician Health Programs

February 16-19, 1995
Gleneden Beach, OR
Sponsored by the Oregon Health Professionals Program
For information, contact Oregon HPP, 6950 SW Hampton, Suite 220, Tigard, OR 97223-8331.

ASAM's 26th Annual Medical-Scientific Conference

April 27-30, 1995
Marriott Hotel, Downtown Chicago
Sponsored by the American Society of Addiction Medicine
Symposia topics include New Approaches to Drug Abuse Treatment (NIDA); Disassociation of Withdrawal and Addiction, Marc Gold; Impact of Drinking Restrictions, John Morgan; Perinatal Addiction—Where Are We Now?, Sidney H. Schnoll; A Quarter Century of Alcohol Research—Milestones and Challenges, Enoch Gordis; Treatment of Pain in Individuals with Addictive Disorders, Seddon Savage; Intensive Outpatient Treatment, Ed Gottheil; Emerging Ambulatory Therapies, Alfonso Paredes; Substance Abuse and Domestic Violence, James Halikas; Integration of Pharmacotherapy and Non-Pharmacotherapy, Norman Miller
DIstinguished Scientist Lecture: Harold Kalant, MD, PhD, Professor Emeritus, Department of Pharmacology, University of Toronto. "Experimental Studies on Tolerance: What Can They Teach Us About Alcoholism in Humans?"
For information, contact ASAM, 4601 North Park Avenue, Suite 101, Chevy Chase, MD 20815. 800/844-8948.

AIDS and Drug Abuse

June 9-10, 1995
Princess Hotel, Scottsdale, AZ
Sponsored by National Institute on Drug Abuse (NIDA) and National Institutes of Health (NIH), in conjunction with CPDD
Speakers and topics: investigators from biomedical and behavioral sciences review research on AIDS and drug abuse
Fee: $60
For information about program activities, contact Harry Haverkos, MD, at NIDA, 301/443-6697; for information about registration, contact Jacqueline Downing at NIDA, 301/443-1056.

57th Annual Meeting

College on Problems of Drug Dependence (CPDD)

June 10-15, 1995
Princess Hotel, Scottsdale, AZ
Topics include molecular mechanisms of the brain reward system; neuroendocrine function and the relationship to addictions; drug testing in the workplace; cannabinoids: receptors, endogenous ligands and a newly synthesized antagonist; functional evidence for effects of drugs of abuse on infection and immune responses; basic neurobiology of abused drugs
Fees: $335 before 4-14-95, then $385
For information about the program, contact Martin Adler, PhD, Department of Pharmacology, Temple University, 3420 N. Broad Street, Philadelphia, PA 19140. About registrations, contact SAILAIR Travel, 800/759-5800.