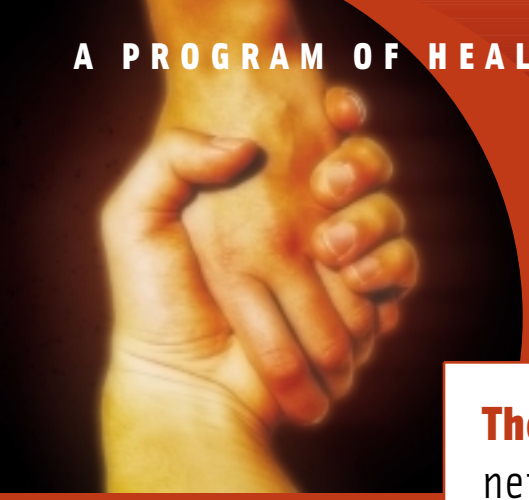

NewStart™

MERITER

VOLUME XXV WINTER 2005

The Mission of NewStart is to provide a comprehensive network of treatment, education, and referral services for persons with alcohol or other substance use disorders, and others affected by the patient's substance use.

DIRECTORY OF SERVICES

Addiction Medicine Consultation and Evaluation Services (AMCES)

202 S. Park Street
Madison, Wisconsin 53715
(Ph) 608-267-6291
(Fax) 608-267-6687

- Addiction Medicine Consultation and Evaluation
- Information and Referral
- Chemical Dependency Assessment
- Emergency Services
- Medical Inpatient Detoxification
- Nursing Evaluation
- Referral Services

Outpatient Services and Adolescent Program

1015 Gammon Lane
Madison, Wisconsin 53719
(Ph) 608-271-4144
(Fax) 608-271-3457

- Assessment and Referral Service
- Adolescent Intensive Outpatient Program
- Adult Intensive Outpatient Program
- Adult Day Treatment
- Individual, Group, and Family Counseling for Chemical Dependency and for Family Members
- Chemical Awareness Programs

Inpatient Services

Unit 1 East
202 S. Park Street
Madison, Wisconsin 53715
(Ph) 608-267-5330
(Fax) 608-267-5334

- Adult Inpatient Rehabilitation Services

IN THIS ISSUE...

NEWSTART'S SCOPE OF TREATMENT

NewStart is the sole remaining hospital-based treatment program for alcohol and drug use disorders in South-Central Wisconsin. NewStart continues to offer a full continuum of services including outpatient, intensive outpatient, and full-day treatment; detoxification; and inpatient rehabilitation services. NewStart remains one of the few local providers which accepts fee-for-service Medical Assistance patients. NewStart counseling staff are all certified to provide addiction treatment services through the Wisconsin Certification Board, and all are Masters-prepared. In our current two-physician model of care, 24-hour coverage is available for emergency room and hospital consults and inpatient coverage while allowing for consistent availability of physician services in our outpatient clinic every week.

WADTPA INFORMS LEGISLATORS

The Wisconsin Alcohol and Drug Treatment Providers Association, the trade association of inpatient, residential, and outpatient treatment centers to which Meriter/NewStart belongs, has been more focused in its legislative advocacy activities of late. WADTPA sponsored a legislative breakfast on May 11, 2004 in Madison inviting members of the State Assembly and Senate as well as staff members from legislative offices. The President of WADTPA, Dennis Reichelt, Director of the chemical dependency program at All Saints in Racine, prepared remarks for legislators and aides at this breakfast. He has allowed NewStart to reprint his remarks as a Guest Article for our Newsletter.

WADTPA is holding another legislative breakfast May 10, 2005, as part of its 39th Annual Conference. Addiction professionals are invited to contact WAAODA about attending this breakfast, bringing their own Wisconsin legislator as their guest.

Every two years, newly elected members of the Legislature come to Madison to represent their districts, and they must address a myriad of public policy issues. Health care issues are certainly important, given the proportion of the state budget that is devoted to the Medical Assistance Program and BadgerCare, the Wisconsin High Risk Insurance Plan, and the health benefit packages made available to all state employees. In an attempt to provide accurate basic information to legislators about the topic of addiction, to help them understand how citizens in all communities

(Continued on page 2)

WADTPA Informs Legislators

(Continued from page 1)

and from all socioeconomic and racial/ethnic groups are affected, how treatment works, and how costly it is to the state Medicaid program to not treat addiction effectively, WADTPA has worked with Sen. Jon Erpenbach to invite the National Conference of State Legislatures to provide a briefing on addiction, treatment, and recovery in early 2005 for incoming elected representatives and their staff members.

DR. MILLER TO BE ASAM PRESIDENT

The American Society of Addiction Medicine announced the results of its recent elections for Officers and Board Members. NewStart Medical Director Michael M. Miller, M.D., FASAM, FAPA, has been elected President-Elect for 2005-07, and will serve as national president of ASAM from April 2007 through April 2009.

ASAM is an association of physicians dedicated to improving the treatment of alcoholism and other addictions, educating physicians and medical students, promoting research and prevention, and enlightening and informing the medical community and the public about these issues. It has over 3000 active members, 34 chapters, and is the largest medical specialty society focusing on addictions. Its major activities include publication of its textbook, Principles of Addiction Medicine, and its Patient Placement Criteria for the Treatment of Substance-Related Disorders, as well as its certification program for physicians.

Dr. Miller is a Fellow of both the American Society of Addiction Medicine and the American Psychiatric Association. He is an Associate Clinical Professor of the UW Medical School and was the founding President of the Wisconsin Society of Addiction Medicine. He has previously served ASAM as Chair of its Reimbursement, Managed Care, and Quality Improvement Committees; on the Steering Committee of its Task Force on Health Care Reform (which developed the ASAM Core Benefit document in 1994); as its Representative to the JCAHO Hospital Accreditation Program PTAC (to which he was elected Chair in 1998); as ASAM's Delegate to AMA House of Delegates (1996-99); as the Chair of ASAM's Public Policy Committee (1999-2004); and as Secretary of ASAM's Board of Directors (1999-2003). Dr. Miller also has been a chapter author for Principles of Addiction Medicine, served on the Working Group which developed the second edition of the ASAM Patient Placement Criteria (PPC-2), and was Deputy Chair of ASAM's Strategic Planning Task Force (2000-02). He is also active in the Wisconsin Medical Society, where he has served as Chair of its Commission on Addictive Diseases (1996-99); on the Managing Committee of its Statewide Physician Health Program (1985-97); and as Alternate Delegate to AMA House of Delegates (2000 to the present).

MERITER WELCOMES NEW ADOLESCENT COUNSELOR

Bobbi Jo (B.J.) Nichols joins Meriter's Child and Adolescent Psychiatric Hospital as an adolescent counselor. She is a 2001 social work graduate from UW-Eau Claire. She did her undergraduate field placement with an Eau Claire County agency called the MARTY Project and ran an after-school program for kids who were at risk for becoming involved in the juvenile justice system. Upon graduation, she moved to south-central Wisconsin and became employed for the Iowa County Department of Social Services as a juvenile intake/on-going delinquency social worker. She worked for Iowa County for 2-1/2 years before making the decision to return to school for her Master's Degree in Social Work. She is currently attending UW-Madison and is on track to graduate with her Master's Degree in May 2005.

URINE DRUG TESTING

Urine drug testing is commonplace in modern America. However, urine drug testing is more complicated than most clinicians appreciate. Most drug test panels are constructed to meet the needs of occupational medicine rather than general healthcare. After a yearlong effort of physicians from several clinical departments and Meriter's General Medical Laboratories (GML), GML now offers new urine drug test panels that meet clinicians' needs. These panels will detect additional drugs and at lower concentrations than previous offerings.

Three critical issues in urine drug testing are the **content** of the panel (what substances are assayed for in a test panel); the **reason** for the testing (e.g., diagnostic versus employment related) and the **cost** of various test methods and panels.

Most physicians refer to urine drug panels as "toxicology screens". This is a misnomer; "toxicology" testing screens urine or serum for poisons in cases of overdose (suicide attempt, unexplained coma, etc). When physicians look for evidence of recent use of what could be called "euphoriants," they are asking for "urine drug panels." Ethanol and nicotine metabolites can be tested for, as well as illicit drugs and prescription drugs that patients may be using in an unauthorized manner.

There are several general classes of urine drug panels:

- **Employment drug panels.** These are done pre-employment; for cause, (e.g., for a workplace injury or absenteeism); or on a random ongoing basis. Often the **contents** of the panel are the five compounds mandated by federal law for Commercial License drivers (interstate truck drivers, bus drivers, railroad workers, etc.). These drug panels detect only marijuana, some opiates, amphetamines, cocaine, and PCP. Detection thresholds are federally mandated to high levels that may fail to detect drug presence. Their cost is usually low.
- **Rehab drug panels.** These are provided for addiction rehabilitation programs such as NewStart, Gateway, etc. Detection thresholds are low for compounds that are assayed. However, lorazepam, clonazepam, and sometimes even oxycodone, hydrocodone, hydromorphone and meperidine have *not* been included in these panels in the past.
- **Specialized drug panels.** For several years, Meriter's General Medical Laboratories (GML) has offered a "Health Care Opiates" urine drug test panel. The contents of this included pharmaceuticals that health care professionals may have access to through their work, but that are not commonly available to "street drug users". This panel is done for health care professionals whose state license status

(Continued on page 3)

Urine Drug Testing

(Continued from page 2)

is being monitored. It is also done at Meriter and other area hospitals when a health care staff member is required to undergo 'for cause' testing (e.g., suspicion of use/intoxication on the job). **Contents** include oxycodone, hydrocodone and hydromorphone. However, meperidine (Demerol) and fentanyl are *not* detected even by the "Health Care Opiates" panel. At NewStart's request, GML developed a new, very comprehensive urine drug panel for a wide range of classes of euphoriants—but the cost was considerable.

Throughout 2004 physicians from several clinical departments met with GML representatives to construct new urine drug test panels to best meet clinicians' needs. GML now offers these new panels. The new panels should be more useful to emergency room physicians, pain clinics, general medical practitioners in clinic and inpatient settings, psychiatrists, addictionologists, and chemical dependency treatment centers.

For other clinical users of urine drug testing, panels with different tiers of contents and costs will be available. GML also revised its report format for health care customers. The reports will state what substances are tested for, and also what substances are not tested for in the given panel. It took the hard work of dozens people to bring this all about, including EPIC and medical records system programmers, billing staffs at GML and Meriter, health unit coordinators on the nursing units and their trainers, and many others. Special thanks go to Javier Velasco, Director of Toxicology for GML.

Recently a reliable lower cost oxycodone test became available. GML constructed our new panels so that even the 'Basic' versions of the panels *will* now test for oxycodone. Previously this required expensive GC/MS methodology.

This and other information on urine drug testing are available to Meriter physicians and staff by accessing CORA and clicking Urine Drug Testing under the heading "Clinical Reference Material."

STAFF PROFILE: PHIL CARAVELLO, MS, CADC-III

Phil started work at APEC (Alcohol Prevention and Education Center of Madison General Hospital) in August of 1981. He worked as an outpatient counselor at the East Washington clinic. The clinic was located next to the Red Wing shoe store on East Washington Avenue. In 1984 the clinic moved to Monroe Street. Phil moved to NewStart on Gammon Lane in 1989 when the clinic opened.

Q. How and why did you get into this work?

A. "To help people get insights into their human condition. People need to ask themselves 'what is this all about and why am I doing what I do?" Phil continues, "This work is about spirituality and the meaning of life. People strive for significance in their lives. Those who find themselves struggling with alcohol and drugs are finding that the drugs that were so useful in the past and worked so well for them are now complicating their life."

Q. What is the role of the therapist in all this?

A. "To help people to find the significance they seek. Therapists teach different ways to enhance life other than using alcohol and drugs. The therapist's job is to help people see the cost of continued use and to seek the enhancement of their social, communicative and spiritual sides in other ways than drugs/alcohol."

Q. What style of therapy do you use?

A. "What ever works with the client." Phil goes on to explain the importance of meeting the client where they are at and adjusting to the client's needs. He uses CBT (Cognitive Behavioral Therapy) to a great extent. He is trained in EMDR (Eye Movement Desensitization and Reprogramming)—a technique specific for post traumatic stress disorder—and employs it when needed with his clients.

Q. How did you get into this work?

A. "By accident. I was a psychiatric medic in the Army and I just continued with the job after I left the Service."

Q. What keeps you going in the business?

A. "It is a fascinating job. I am grateful for the ability to continue to search for more effective ways to do therapy and live my own life."

Phil is an important member of the NewStart team. He is involved in individual therapy and the Chemical Awareness Program, and he facilitates two continuing care groups.

Marijuana: Effects of Use

Michael M. Miller, M.D., Meriter Hospital NewStart Medical Director

The last issue of the NewStart Newsletter included an article on marijuana and how some people develop addiction when they use it regularly. In this issue, we will explore the short-term and long-term effects of marijuana use, including marijuana smoking.

Effects of Use

The human body contains receptors for the active chemical in marijuana. Yes, human beings have evolved with natural receptors on the membranes of certain cells that react if chemicals called **cannabinoids**, including 5-delta-tetrahydrocannabinol (THC), come into contact with them. Once a receptor has interacted with its activating chemical, the cell begins to undergo changes. These include the way it lets ions such as sodium or calcium enter or leave the cell, or changes in the way it makes proteins that code for the manufacture of chemicals by the cell (such as hormones or neurotransmitters).

Many subtypes of **cannabinoid-like receptors** have been identified by neurochemists, and so-called endogenous cannabinoids – chemicals naturally manufactured in the body which act on cannabinoid receptors – have been identified as well. Many cannabinoid receptors are found in the parts of the brain that influence pleasure, memory, thought, concentration, sensory and time perception, and coordinated movement. Within a few minutes after marijuana smoke is inhaled:

- THC moves from the lungs into the bloodstream and to the brain, where it interacts with centers that regulate vital signs.
- The heart begins beating more rapidly, the airways of the lungs relax and become enlarged, and blood vessels in the eyes expand, making the eyes look 'blood-shot' or red. Heart rate can increase by 25-50 percent, or even double.
- If the person has used another drug that increases heart rate (such as *Ecstasy*, speed, or cocaine), pulse increases can be even more dramatic.

Because of marijuana's actions on the brain, users may experience:

- Pleasant sensations as well as colors and sounds of high intensity, and time appears to pass very slowly. The euphoric 'high' is the reason people choose to smoke pot or hashish.

- A sensation of dry mouth and sudden thirst.
- Hunger.
- Measurable interference with short-term memory in novice as well as regular users. THC interacts with receptors in the hippocampus, the area of the brain responsible for memory formation. Recalling what you have learned isn't possible when memories aren't stored well in the first place. In fact, researchers have found that the ability to perform tasks requiring short-term memory is reduced in laboratory rats treated with THC at the same degree as it is in rats who have had the nerve cells in their hippocampus destroyed.
- Loss of the ability to focus or shift attention.

Information on the National Institute on Drug Abuse website (www.nida.nih.gov) describes how:

"Marijuana's adverse impact on memory and learning can last for days or weeks after the acute effects of the drug wear off. For example, a study of 129 college students found that among heavy users of marijuana, those who smoked the drug at least 27 of the preceding 30 days, critical skills related to attention, memory, and learning were significantly impaired, even after they had not used the drug for at least 24 hours. The heavy marijuana users in the study had more trouble sustaining and shifting their attention and in registering, organizing, and using information than did the study participants who had used marijuana no more than 3 of the previous 30 days. As a result, someone who smokes marijuana once daily may be functioning at a reduced intellectual level all of the time."

It is well-known that THC alters time perception: things seem to be moving slower when one is 'high' on marijuana. What is less well known is that the chemical acts on cannabinoid receptors in the cerebellum and basal ganglia of the brain, regions that control coordination, movement, posture and balance.

THC also affects perception, including the ability to track moving objects crossing one's visual field (for example, a car entering an intersection and moving from right to left). Driving ability is certainly impaired by the combination of effects on the nervous system (time perception, spatial perception, visual tracking, reaction time, coordination, rapidly shifting the focus of one's attention, the ability to accurately estimate changes in velocity of other vehicles). This is a consistent finding in research studies on immediate effects of THC on complex motor and mental tasks; the results are more predictable than accidental: in 5 to 10 percent of fatal car crashes, the deceased tests positive for THC. And as highlighted by NIDA, studies by the National Highway Traffic Safety Administration show that the effects of even low doses of marijuana, especially when combined with alcohol, impair driving, with impairments far greater from the combination than from either drug alone.

When used in a positive social context (e.g., around friends, especially those who are experienced marijuana users), the emotional effects of THC are usually pleasurable. But THC can also produce

anxiety, a sense of distrust, and even full-blown panic attacks.

Other emotional effects can include a sense of depersonalization or de-realization, in which the person feels dissociated from the physical and interpersonal environment. Thus, the person may have a feeling of, "I'm not really myself," or experience other unpleasant perceptions. High-dose use can result in perceptual distortions including auditory and visual hallucinations, even hallucinated odors.

When these experiences come together, especially in a social context that feels unsafe (the user doesn't grasp what's happening, there are no friends or experienced users around to explain what's happening or to provide reassurance, the effects are unexpected because the drug exposure took place unwittingly, such as through brownies, etc.), the result can be a 'bad trip' as severe as one resulting from LSD or 'magic mushroom' intoxication.

Occasionally, an individual who is predisposed to a psychotic mental illness, such as schizophrenia or psychotic bipolar disorder, will experience psychosis for the first time when high on marijuana. The diagnosis of the mental illness can be delayed if the person is a regular pot smoker: the symptoms can be mistakenly attributed to drug use rather than to a new-onset serious mental illness.

One of the most predictable effects of marijuana is its effect on THC receptors in the nucleus accumbens, resulting in the overall phenomenon of 'reward.' All potentially addictive drugs act directly or indirectly on this compact brain region, often called 'the reward center.' Because of their actions on this brain area, the few drugs that are self-rewarding – cocaine, nicotine, alcohol, heroin, THC – are self-administered by lab animals that have been exposed to them regularly. Humans and lesser creatures certainly find these drugs not only pleasurable but 'rewarding.' When addiction develops, the drugs are used in preference to other behaviors that might be pursued.

The development of addiction in humans is a complex process involving social/cultural variables as well as genetic variables. The drug alone doesn't produce addiction. Instead, addiction happens due to interactions among the drug's chemical effects, the genetic make-up of the user, and the stresses, supports, and interpersonal context in which the drug use occurs. Again, the vast majority of drug users can use their drug to produce the desired effects – on mood, on appetite, on perceptions.

But certain users do not have this luxury. When they use drugs, including marijuana for some individuals, they develop problems in their performance of life tasks, problems with relationships, and even difficulty shaping their drug use to retain the pleasure they desire and avoid the problems they know they can experience from their use. Yes, for some persons, even teenagers, true addiction to THC can occur.

Effects of Chronic Use

What about other problems from long-term marijuana use? Without question, smoking marijuana irritates the airways and delivers carbon monoxide and cancer-causing 'tars' to the lungs – in amounts over

50 percent higher than in tobacco smoking. Typically pot smoking involves deeper 'drags' and holding in the hot, poisonous smoke longer and deeper in the lungs. As NIDA points out, in one study of 450 individuals, it was found that "people who smoke marijuana frequently, but do not smoke tobacco, have more health problems and miss more days of work than nonsmokers do. Many of the extra sick days used by the marijuana smokers in the study were for respiratory illnesses."

Not only are there more cases of acute bronchitis and asthma in pot smokers; there are also longer-term effects that include chronic bronchitis and emphysema. And, marijuana use is linked to lung cancer and other cancers. One study showed that regular marijuana smoking doubles or triples the risk of head and neck cancers: to the vocal cords, trachea, lymph nodes in the neck and even mouth cancer.

Cancer of the respiratory tract and lungs may also be promoted by marijuana smoke. A study comparing 173 cancer patients and 176 healthy individuals produced strong evidence that smoking marijuana increases the likelihood of developing cancer of the head or neck, and that the more marijuana smoked, the greater the risk. A statistical analysis of the data suggested that marijuana smoking doubled or even tripled the risk of these cancers.

Marijuana has the potential to promote cancer of the lungs and other parts of the respiratory tract because it contains irritants and carcinogens. Compared to tobacco smoke, marijuana smoke contains 50 to 70 percent more carcinogenic hydrocarbons. It also produces high levels of an enzyme that converts certain hydrocarbons into their carcinogenic form. For more details, one can access the Research Report on Marijuana by the National Institute on Drug Abuse: www.drugabuse.gov/ResearchReports/Marijuana/Marijuana2.html#scope.

This report contains one more interesting fact: the Drug Abuse Warning Network (DAWN), a system for monitoring the health impact of drugs, estimated that, in 2001, marijuana was a contributing factor in more than 110,000 hospital emergency department visits in the United States. This total includes people who decided on their own that they needed emergency care as well as those who were conveyed by police or EMTs, where it was determined that marijuana use wasn't just an incidental finding, but significantly contributed to the person's need for emergency services.

Additionally, the number one reason youths seek addiction treatment from specialty treatment centers like NewStart has been (for over 20 years) – and still is – a cannabis use disorder.

In the next issue of the NewStart Newsletter, we will explore the potential health benefits of marijuana use.

Guest Article:

Remarks at WADTPA Legislative Breakfast

Dennis Reichelt, Program Director, Center for Addiction Recovery, All Saints Healthcare, Racine, Wisconsin

WADTPA is a trade association of state-certified organizations that provide alcohol and drug treatment services in the public and private sector. Our membership represents over half of the treatment providers in Wisconsin who provide services to individuals and families struggling with issues related to substance dependency and abuse. I would like to thank all of our legislators, who took time out of their busy schedules, to join us this morning. We really appreciate your being here.

Scope of the Problem

Alcohol and drug abuse is a serious public health problem. Addiction to alcohol and drugs is the number one cause of preventable illness and death in America. Nationally, it is estimated that 20 percent of the population is affected by substance dependency and 10-13 percent are actually dependent. Alcohol and drug abuse is the fourth leading cause of death in Wisconsin behind heart disease, cancer and stroke. It is the fourth leading cause of hospitalization behind mental illness, heart disease and cancer. Each year in Wisconsin there are nearly 2,200 deaths, 2,400 substantiated cases of child abuse, 8,500 traffic accidents resulting in nearly 7,000 injuries and 90,000 arrests all attributable to substance abuse. The economic costs of substance abuse in this state total over $4.6 billion dollars per year.

Impact on Business is Significant

Approximately 90 percent of alcohol abusers and 75 percent of drug abusers are employed. Alcohol and drug abuse among employees, on and off the job, can have a significant impact in the workplace: reduced productivity, increased healthcare costs, increased absenteeism and tardiness, on-the-job injuries resulting in Workers' Compensation claims. We could spend an entire day discussing the impact in the workplace. However, the bottom line is that alcohol and drug problems cost U.S. employers about $300 billion dollars every year.

How many of these people receive treatment for their problems?

In Wisconsin, according to the Bureau of Mental Health & Substance Abuse Services, only 21 percent of people in need of treatment actually receive services. Annually, that amounts to over 350,000 adults and 40,000 adolescents who need treatment.

These are issues of concern to members of WADTPA. WADTPA recognizes that at the federal, state and local levels, vast financial and institutional resources are made available to treat our sick and – when necessary – to support their recovery from chronic, recurring diseases. Indeed, we take great pride in our country's and our state's health care organizations and the talented caregivers who staff them. But with one exception – millions of people with the disease that manifests itself in dependence on alcohol and other drugs are left to search for care. They must do this in private and public systems that too seldom connect to the health care and supporting systems that research tells us can reduce their symptoms and return them to their families, jobs and communities. Science has shown us that drug abuse is a preventable behavior and drug addiction a treatable disease: alcohol and drug use is a voluntary behavior, but addiction is not; addiction is a compulsive, uncontrollable drug-seeking and drug use act.

The switch from drug use to addiction is the result of a fundamental and long-lasting alteration of pathways in the brain. If it was as easy as "just say no" there would be no need for treatment and we wouldn't be here today to explore how we can help these individuals, their families and their communities recover from this illness. It's ironic that at a time when science is helping us understand the value and efficacy of treating alcohol and drug addiction, it is as difficult as ever to obtain appropriate treatment. We are in the midst of an urgent, national public health crisis, yet our public policy has failed to respond effectively. Instead, public policy treats substance abuse primarily as a crime. It locks up addicts and tries to block the flow of drugs across our borders. It sees those dependent on, or who abuse, alcohol and drugs as lacking willpower and personal responsibility. No matter what we may think about people who are dependent on, or who abuse alcohol or drugs, we are wrong to push them aside. Substance abuse hurts everyone, if not directly, then indirectly through higher crime, unnecessary health care expenses, added law enforcement costs, lost workplace productivity and personal and family hardship. The emotional and psychological costs are immeasurable.

In Wisconsin, only 21 percent of people in need of treatment actually receive services. Annually, that amounts to over 350,000 adults and 40,000 adolescents who need treatment.

Recovery from substance dependence challenges us, individually and as a society – it challenges addicted people, family, friends, employers, caregivers and public officials.

It's time for substance abuse treatment to be pulled into the mainstream of health care. For this to happen, it is essential that we all recognize addiction as a chronic, primary, relapsing disease, and treat it as any other such condition, be it hypertension, diabetes, asthma or arthritis. Likewise, health care purchasers, in particular employers and governments, must demand

(Continued on page 7)

WADTPA Legislative Breakfast

(Continued from page 6)

that full coverage of treatment be included as a basic element of any health benefit.

Conclusion

The solution to our nation's drug and alcohol problem is for public policy leaders to recognize alcoholism and addiction for what they are – chronic diseases, with biopsychosocial causes and manifestations, whose prevalence has created a public health crisis. What we've been doing to address addiction in terms of treatment has been successful, at least for those who are able to receive services – recovery is happening every day. Recovery rates for addiction are as good, or better, than recovery rates for other chronic illnesses like diabetes, hypertension and asthma. But what about that 79 percent of people in Wisconsin who need help but never receive services? We have to stop focusing just on the problem, and start to focus on the solution. We need to respond by making treatment broadly available to all who suffer from these diseases. Such policies would have immediate and far-reaching effects, not only in reducing substance abuse and improving health, but also in making our communities safer, lowering our taxes, improving workplace productivity and reducing healthcare costs. Addiction to alcohol and other drugs affects us all – some more personally than others. What will finally make a difference is our knowledge of addiction and recovery, our willingness to lend our voices to eliminating the stigma that still exists, improving public understanding of these issues and encouraging support for treatment and recovery. Anything that we can do to help people struggling with this devastating illness find their way into recovery is a step in the right direction – we're not just helping them, we're helping ourselves and our communities. Addiction is a bad disease that happens to good people. Together we can make a difference. SB 71 is a good example – we are grateful for its passage but it has to be just the start. I hope that today is the start of an ongoing dialogue that will enable us to work together to find better ways to help those in need.

MOTIVATIONAL AND COGNITIVE BEHAVIORAL TREATMENT

Addiction treatment has changed. In the late 70s and early 80s addiction treatment focused on the Minnesota model of treatment, which was a standard 28-30 day inpatient treatment. NewStart participated in this model for a number of years and had a very successful residential treatment facility ("the Ranch"). However, treatment here at NewStart changed for a variety of reasons. If we fast forward to 2005 NewStart looks different. There is no residential facility. We have a hospital-based short stay inpatient facility. The short stay unit is the focus of this article. After meeting with NewStart inpatient counselor Jennifer Schoff and discussing with other members of the team, we have focused on using motivational interviewing and CBT with our inpatients.

Ms. Schoff has been putting the program together. It focuses on the pre-contemplative and contemplative stages of change. Accordingly she has been using the counseling/therapy techniques of reframing, affirming, and double-sided reflection, all with the emphasis on personal choice. She has been working on getting clients to identify potential change strategies for the most appropriate behaviors they need to change at this time in their life. Many of NewStart's inpatient clients have been through treatment multiple times and have had a positive reaction to it. They know that they have problems with drugs and alcohol. Convincing them that they have a problem is not the issue. The issue becomes a sense that their life can be better. One of the biggest obstacles to long-term sobriety with this particular population is the lack of hope. Therefore, the main issue of the short stay has become motivation and correcting errors in thinking to enhance and foster a sense of hope and possibilities. Increasing the patient's perception that there is hope for change becomes the most important part of treatment.

Hope can be defined as the ability to believe, even without obvious evidence to sustain the belief. Some of the techniques NewStart's inpatient staff uses to foster hope include: expressing empathy through reflective listening; developing discrepancy between clients' goals and values and their current behavior; and above all avoiding argument and direct confrontation. Ms. Schoff and her colleagues, Peter Laubach and at times Bonnie Allen, work on increasing self esteem and addressing those "self esteem busters" that make it difficult to find hope.

Motivational and CBT therapy do not in any way discount 12-step facilitation. Clients are still encouraged to attend 12-step meetings in the evenings and at those meetings to obtain a temporary sponsor. NewStart still sees addiction as a disease that needs to be treated with abstinence. However, newer approaches allow NewStart's therapists to work with clients in achieving motivation to change and helping them to create an environment where sobriety is possible.

IN MEMORIAM–JANELL DOERING, RN

Janell Doering, an AMCES nurse for Meriter's NewStart Program for the last two years, passed away on Saturday, January 15, 2005, at home with her loving husband and brother at her side. Diagnosed with ovarian cancer four years ago, Janell courageously and quietly struggled for life. She had chemotherapy and surgery and blood transfusions; she went to Texas to participate in a research study. Janell went to healers, prayed to access the spiritual power in the universe, and she asked her coworkers to pray for her.

Janell graduated from the Deaconess Hospital Nursing School in Milwaukee in 1979 and was a caring and dedicated nurse in many areas at Meriter for 25 plus years. She worked in obstetrics and child/adolescent psychiatry, endoscopy, eating disorders, ENT, recovery room, and lastly in addictions.

Janell loved to garden, and she shared her vegetables. She loved to cook and bake, and she shared her cookies and candies. She loved to travel, and she visited in America, Europe, and Asia. She loved her friends, and she shared herself and her time with them. We will miss her impish grin, her ability to focus to accomplish work, her kindness. We extend our heartfelt sympathy to her husband Kendall Koeppler and all her surviving family and friends and coworkers. She touched many lives and we at NewStart will miss her.

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CHANGES COMING FOR NEWSTART NEWSLETTER

The NewStart Program has produced a Newsletter for over 20 years. The format, target audience, and content have changed with the times. We used to maintain a huge mailing list of all patients who had 'graduated' from one of our services in the past 12 months and we mailed our Newsletter to each of them! In more recent years, we determined that the most important target audience was professionals who refer patients to us. The educational content has been geared to the 'referrant' population, and we hope you've enjoyed the articles! There may have been a time that we produced the Newsletter bimonthly; it was quarterly for a while. Now it's three times a year.

What we have in mind is that we will shift the Newsletter to a semi-annual publication and include more information for patients to use: educational material about addiction but also about addiction services and self-help resources available through NewStart and through the community.

We'd love to know if you think this is the right direction for us, and even how much you find the Newsletter of value: do you read it, do your patients read it, does your staff read it? Do you want copies for your waiting room? Would that be useful?

Please contact NewStart Manager Michael Gerst at 608 271 6996 or mgerst@meriter.com with your 'reader feedback' on these questions—or any other feedback you have for us.

NewStart™