NewStart™

MERIT-ER®

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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.

NEWSTART COUNSELING STRATEGIES EXPANDING

Jennifer Schoff

Competency in alcohol and drug counseling requires that we learn new skills and refresh existing skills for treatment of substance use disorders. That is why NewStart staff is currently focusing staff development efforts on Cognitive Behavioral Therapy (CBT), specifically Cognitive Behavioral Therapy of Substance Abuse (Beck, et al, 1993). In these weeks of training, the staff is reviewing each chapter, discussing techniques, and how CBT is helpful in therapeutic settings. Although NewStart's alcohol and drug counselors have been using the CBT techniques, it has been a learning experience to discuss specific techniques as a group. This has given the counselors the opportunity to hone their skills for more effective practice and share skills/ideas with their colleagues.

What is CBT? The underlying theme to CBT is that our feeling and thoughts relate to our actions. The focus is then changing our thoughts in order to have more control over actions. The goal is to slow down our reactions so that we make healthier decisions, like not using alcohol or drugs. Our core beliefs lead to emotions, which lead to addictive beliefs, which lead to addictive behaviors. With CBT, we are able to change our core beliefs, which lead to different emotions, leading healthy decisions, like not using substances.

CBT is one more tool in the tool belt of our counselors. CBT is used in conjunction with other treatment techniques, such as 12-Step facilitation. Using the techniques in CBT, we are teaching our clients more ways to remain abstinent, become more productive citizens and improve relationships.

FIFTH ANNUAL RECOVERY RALLY

September is National Recovery Month, when thousands of Americans and their families and communities celebrate recovery from alcohol and other drug abuse. In Wisconsin, we are celebrating with a Recovery Rally at the State Capitol in Madison, Saturday, September 17, 11:00 a.m. to 2:00 p.m.

This is Wisconsin's Fifth Annual Recovery Rally which emphasizes how the communities can heal through celebration of recovery from substance abuse—"Healing the Wisconsin Community: Celebrating Recovery from Alcohol and Other Drug Abuse."

Organized by the Wisconsin Association on Alcohol and Other Drug Abuse and the Alliance for Recovery Advocates, the 2005 Recovery Rally includes music and dance from some of Wisconsin's diverse communities. The Rally presents special performances by the Madison Community Gospel Choir, Wolf River Singers, United Refugee Services of Wisconsin Sunshine Dancers, Jazz Works, Tiawanaku Bolivian Dance Group, and the Kalaanjali School of Dance and Music with Bharatanatyam Classical Indian dance. Speakers at the Rally include Racine County Executive and WAAODA Board Member William McReynolds, Dane County Executive Kathleen Falk, Centro Hispano Executive Director and WAAODA Board Member Peter MuËoz, Mark Sanders of the Great Lakes Addiction Technology Transfer Center, and others.

The goal of our Recovery Rally is to increase awareness throughout the state of the terrible, tragic toll of substance abuse on Wisconsin communities, families, and productive citizens. Wisconsin still leads the nation in the per capita consumption alcohol beverages and women drinking while pregnant, and ranks high in other indicators of substance abuse. Alcohol and other drug abuse has a staggering economic impact on Wisconsin, too—almost $5 billion per year.

But the Recovery Rally celebrates hope and resolve: Recovery happens every day!

In conjunction with the 2005 Recovery Rally, we are sponsoring a 5K (3-mile) walk, starting at the Camp Randall Stadium at 8:30 a.m. and arriving at the West Wing of the State Capitol in time for the Rally. The theme of the 2005 Recovery Rally Walk is, "You don't have to run, you can walk for recovery!" WAAODA President Steve Tate will lead the Walk for Recovery to the State Capitol.

More than 570 people from 34 Wisconsin cities and three other states attended the 2004 Rally. Rally organizers WAAODA and AFRA reported that at least 24 for-profit businesses provided sponsorships and donations in support of recovery from substance abuse.

The 2005 Recovery Rally will attract hundreds to enjoy the music and dance and celebrate recovery from alcohol and other drug abuse. Participation of those who are in recovery and their family members and friends will offer proof that recovery works and that recovery happens every day.

For more information, please contact:

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NEWSTART TO PARTICIPATE IN NATIONAL STUDY SPONSORED BY TEXAS CHRISTIAN UNIVERSITY

The study sponsored by TCU focuses on developing an assessment and information system for drug abuse treatment providers that will monitor organizational attributes and program resources, and link these factors to client performance and program changes over time. It uses a program change model as a conceptual framework for getting the system incorporated into practice. The sample consists of 100 outpatient drug-free community-based treatment providers. Our primary goal is to develop reliable instruments that can measure and provide feedback on program resources and organizational dynamics (along with aggregated client data) for the purpose of clinical management in real world community settings where the majority of substance abuse treatment occurs. The specific aims of this proposed project are to – (1) develop a set of field instruments and procedures (i.e., the Organizational and Resource Assessments, ORA) that treatment programs are willing to implement and use; (2) demonstrate the feasibility and utility of these assessments in a sample of 100 outpatient drug free treatment providers from two regions in the U.S.; (3) monitor organizational changes over time and relate them to client-level indicators of program effectiveness; (4) plan and evaluate a training protocol for program directors on how to use ORA information systems for improving program management and functioning; and (5) study the process of program change and the long-range implementation of this new technology.

The TCU study hopes to examine a number of different hypotheses. They are:

a. better program functioning will be associated with a higher level of services, better training resources, lower staff turnover, accreditations, and a stable organizational climate.

b. better program functioning will be associated with higher staff levels, lower staff/client ratios, higher education and certification levels among staff, and higher levels of revenues.

c. better program functioning will be associated with staff who are growth-oriented and have high levels of influence, efficacy, and adaptability, and an organizational climate that has a clear mission, strong communication, high staff cohesion, and are change-oriented.

d. better program functioning will be associated with adoption of new technologies, especially those involving evidence-based clinical strategies and counseling approaches.

The first subject pool consists of treatment program staff and the second is the

client pool. The staff pool will include program directors, financial officers, and clinical staff (counselors). The first subject pool will be asked to complete a survey. This survey will measure organizational structure, capacity, program outcomes, revenues, costs, staff background, motivation, attitudes.

TCU hypothesizes that there is a connection between the organization of the treatment center and the effectiveness in treatment. NewStart is excited to be apart of this nationwide study and looks forward to examining the results.

LIMITATIONS ON BUPRENORPHINE LIGHTENED

Since the federal Center for Substance Abuse Treatment and the DEA implemented office-based treatment of opioid addiction with buprenorphine in 2003 (in response to Congress' Drug Addiction Treatment Act of 2002, DATA), medical group practices have been limited to admitting a census 30 patients at a given time for buprenorphine treatment. This meant that solo practices could treat 30 patients; a two-person group like the NewStart physicians could treat 30 patients; or a 1000-physician group like the Mayo Clinic could treat 30 patients. This didn't seem logical or fair to many persons in the addiction treatment field, but it was the law, and we've followed it.

NewStart has been treating selected patients using Suboxone brand of buprenorphine since the spring of 2003; over 60 patients have been started on Suboxone for detoxification or maintenance treatment. Twenty-nine patients are currently in ongoing outpatient treatment.

But August 3, President Bush signed legislation that had worked its way through Congress, to take away the 30-patients-per-group-practice ceiling. Now, each 'qualified physician' can treat up to 30 patients with this treatment method. So NewStart's two physicians will gradually raise our census of Suboxone patients to 60. Patients are still selected carefully and must agree to detailed treatment contracts. Drs. Miller and Powell are pleased to be able to offer this treatment when it is indicated, and are delighted that restrictions on total patient census are not as burdensome as they have been for the last two years.

Guest Article:

"Light" at the End of the Addiction Tunnel for Quad/Graphics Employees and Family Members

Bill Arnold, CADC III, CCS II, ICADC

Most people in Wisconsin obtain health insurance through their employer. But even insured persons are often 'under-insured' or even uninsured for addiction services. One Wisconsin employer handles the health care needs of its employees differently: it doesn't buy insurance, but has developed its own health care delivery system, hiring primary care physicians, nurses, and behavioral health professionals to work in company-owned facilities, supplementing company-operated clinics with local providers as necessary. NewStart is pleased that Quad/Graphics accepted our invitation to 'share their story' in our Newsletter.

Quad/Graphics is the largest privately held printing company in the western hemisphere, with 12,000 employees and annual sales of over two billion dollars. Its headquarters are in Sussex, Wisconsin.

In 1990 Quad/Graphics initiated the first of three benchmark experiments, the opening of the first onsite medical clinic in a Quad/Graphics production plant. The clinics are managed and run by Quad/Graphics employees and perform services ranging from routine prenatal exams to minor surgical procedures. Ultimately, two more medical clinics opened in other plants in Wisconsin and one in our Saratoga Springs, New York plant. Including employees and dependents, health care services are offered for over 21,000 'covered lives'.

It was in 1991 that we pioneered our onsite alcohol and drug treatment program. Consistent with the mission of the medical clinics—to promote comprehensive wellness—establishing the recovery program was a natural next step for our company. By bringing AODA treatment in-house, we would know exactly what kind of services our employees were getting. Quad/Graphics AODA Counseling Services is a Wisconsin State Certified all inclusive outpatient AODA treatment program. The program was, and continues to be, far more successful than we ever envisioned. The quality of our services has also been recognized by others: Quad/Med LLC AODA Counseling Services was presented with The Meta House Substance Abuse Awareness Award for Corporate Leadership in 1999.

Our goal is to make addiction recovery as easy to access as possible. An employee calls me directly to schedule an intake session. There is NO CHARGE for any individual or group counseling and NO LIMIT on the number of sessions.

Our third experiment was the most challenging. I was meeting with one of the Vice Presidents shortly after starting up the Alcohol and Drug Treatment Program. He asked me if I ever thought it would be a good idea to have volunteers who had gone through the Quad/Graphics Recovery Program wear a patch on their uniform as contact people in the workforce for other employees who wanted to get into recovery. (All employees wear uniforms at Quad/Graphics, including the CEO and President). I initially rejected the idea because we are very conscientious about the importance of confidentiality particularly because our services are onsite. After many days of review, I asked some of the clients whom I had worked with previously at Quad/Graphics if they would be interested in a volunteer program of wearing a patch on their uniform, signifying the "unspoken advocates of recovery" for employees, so there could be an avenue to get quick and comprehensive treatment.

As it turns out, the group decided that a patch of a lighthouse—signifying hope and direction—would be appropriate for their volunteer services. Currently there are over 140 employees who have signed on to the volunteer program, and we are represented in all of our major printing plants in the country. Any Quad/Graphics employee in stable recovery, no matter where they went to treatment, can apply to be a "lighthouse" volunteer; and when approached by another employee, the conversation is bound by confidentiality—even I don't know about it if the employee decides not to access services at that time.

Our goal at Quad/Graphics is "to get substance abuse and recovery out of the closet", out of darkness and into light. Our employees know that is okay and desirable to get the help you need to overcome substance use issues and still work at Quad/Graphics.

Bill Arnold, CADC III, CCS II, ICADC, is the Director, Manager, and Founder of The Quad/Med LLC Substance Abuse Counseling Services, and founder of the Friends Of Recovery "Lighthouse Patch" Volunteer Program at Quad/Graphics.

Marijuana: Health Benefits?

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

Third in a three-part series on marijuana. Dr. Miller addressed Marijuana's health effects in the Fall 2004 NewStart Newsletter.

"*Drugs Kill.*" It's a phrase we've heard many times. Alcohol and other "rewarding" drugs certainly have the potential to produce health problems, even death, due to effects of intoxication, overdose or chronic use. Marijuana is not a lethal drug, however, and marijuana addiction—while it can lead to significant impairments in functioning—does not result in mortality like many other "drugs of abuse."

"*Drugs Heal.*" That's a sign that could hang outside of pharmacies. Many kinds of medications act on the body to change functioning or to abort or reverse the course of illness. Significant debate in popular, even political circles—not just in scientific and medical circles—centers on whether, and to what extent, marijuana or active ingredients in the marijuana plant (or chemicals synthesized in a lab that are similar to the chemicals in marijuana) have effects that are beneficial to human health.

Marijuana's effects are well known: relaxation, euphoria, blood pressure and pulse changes, changes in blood vessels and appetite, changes in perception (especially time perception), etc. However, some effects of marijuana may prove to be so beneficial that chemicals from marijuana may be useful as medications some day. In fact, there are already some benefits so well established that the active ingredient in cannabis (the marijuana plant), delta-9-THC, is available in an oral capsule form, called dronabinol (the trade name is Marinol).

Many health claims have been made about marijuana or chemicals similar to THC called cannabinoids. But scientific research has confirmed safety and efficacy only to the extent that the Federal Food and Drug Administration has approved Marinol for two indications. One, to treat nausea in cancer chemotherapy patients who have not responded to other medications used to control nausea and vomiting. And two, to stimulate appetite in patients who have

been wasting away from AIDS, to help them regain weight. There are many other indications for which delta-9-THC has been alleged to be beneficial—to treat spasticity in patients with multiple sclerosis, to lower intraocular pressure in patients with glaucoma, etc. However, the FDA has not found convincing evidence from research studies to grant the manufacturer of Marinol the authority to state that these conditions are an approved indication for this medication. In England, there is no pharmaceutical THC available, but drug companies are licensed to market nabilone, a synthetic cannabinoid.

What has been discovered the last 25 years is that the reason delta-9-THC has an effect on the brain is that there are brain cell receptors that respond to THC. Thus, when THC comes into contact with these specialized regions on nerve cell membranes, the cell changes its functioning, resulting in changes in emotional, motor, perceptual, cognitive or overall behavioral functioning. There are three well-known cannabinoid receptors: CB1, CB2, and CB3. What is also known is that there are naturally occurring chemicals in the human body that attach to these cannabinoid receptors. Anandamide is the name of one of the endogenous chemicals, made by the human body, that acts on cannabinoid receptors.

What is the role of endogenous cannabinoids? The best available knowledge is that they affect inflammation and the ability of other naturally occurring chemicals, called prostaglandins, to produce an anti-inflammatory response in general. CB1 receptors are located in regions of the brain that control mood, motor control, memory formation, regulation of food intake and central control of cardiovascular and reproductive functioning. CB1 receptors are also present in areas that control processing of pain information. CB2 receptors seem concentrated in areas that influence the immune response, and in reproductive glands. Another identified receptor is the CB3 receptor. It is thought that pharmaceutical companies have, in their development "pipelines," synthetic products that serve as both agonists and antagonists to CB1, CB2 and CB3 receptors. Current research will determine what happens when you agonize (turn on) or antagonize (turn off) one or a combination of these CB receptors.

So there are legitimate medical questions about the use of cannabinoids as analgesics, as they have the ability to directly affect the body's ability to produce and interpret information about pain. It is also known that cannabinoids can potentate the pain relieving actions of opioid analgesics.

Here is what research has shown so far. Five milligrams of medicinal THC is equivalent to 30 milligrams of codeine as a pain reliever. Ten milligrams of medicinal THC is equivalent to 60 milligrams of codeine. Twenty milligrams of medicinal THC has the potency of 120 milligrams of codeine. However, even when given in this oral, medicinal form, patients experience side effects to the higher doses of pharmaceu-

tical THC, including sedation, confusion, dizziness, uncoordination, slurred speech, disorientation, disconnected thoughts, impaired memory, blurred vision and dry mouth. The 20-milligram dose of oral THC is tolerated by few patients in clinical trials. The 10-milligram dose is somewhat better tolerated, but has clearly more adverse effects than when people take a 60-milligram dose of codeine. The five-milligram dose of THC is well tolerated, and does not change consciousness or behavior in ways patients find uncomfortable. Note, however, that five milligrams of THC has a pain-killing potency equal to only 30 milligrams of codeine. Most patients with significant pain conditions certainly need a higher dose of opiate analgesic than that.

There are several groups of patients for whom it was hoped that cannabinoids might prove to be effective analgesics: individuals with neuropathic pain (peripheral nerves themselves are injured), patients with cancer pain and patients with pain from AIDS. The problem is that it has not been shown that pharmaceutical cannabinoid has the power to block pain in these patients effectively without producing undesirable side effects.

The medical question is, are there conditions for which pharmaceutical cannabinoids will be beneficial? Researchers are looking into alternative delivery systems for cannabinoids—such as nasal sprays and inhalers—which might offer better ways to deliver the drug to the bloodstream and the brain. Still, there's the question of side effects.

The political question, however, is whether smoked marijuana has medicinal benefits to the extent it should be approved as a medicine, thus made legal for "patients." The political debate, well publicized in the media, is whether medical marijuana should be legalized in various states. What has happened is that when the question is put to referendums, citizens almost always vote in significant majorities in favor of "legalizing medical marijuana."

The reason people vote this way is fairly obvious. The question is posed as, "if something isn't really harmful (the assumption is that marijuana is a benign agent), and there are patients who are really suffering (such as AIDS patients), would you want to make it okay for them to smoke this benign product and get benefits, rather than being thrown in jail?" Of course, the compassionate side of voters says "yes" to such issues.

Physician organizations don't agree, because they look to the medical evidence. The American Medical Association and the American Society of Addiction Medicine positions on this question are explicit. These organizations support that well-supervised biomedical research—clinical trials—be conducted to answer questions about the benefit/risk ratio of using smoked marijuana to treat various medical conditions.

To date, no published study shows that smoked marijuana provides clear-cut benefits for any of the conditions for which Marinol is currently approved.

Of course, in calculating a benefit/risk ratio, one has to factor in the negative health effects of delivering marijuana to the body via smoking. On one hand, delivering a predictable dose via the smoked route is challenging. On the other hand, smoke itself contains harmful chemicals, including carbon monoxide and carcinogens. Use of smoked marijuana has limitations that include acute adverse effects (bothersome dry mouth, blurry vision, palpitations and anxiety or other psychiatric phenomenon) and the potential chronic effects of smoking. Finally, research is pretty clear now that the amount of analgesic effect one can get from smoked marijuana does not exceed the analgesic potency of 30 milligrams of codeine. So there is not much true benefit to be derived, despite the acute and potential chronic adverse effects.

This sort of medical information rarely enters the public ("media") or political debate. In Wisconsin, the chairman of the Assembly Health Committee has introduced a medical marijuana bill. This bill, like most around the country, is well intended. The problem is that there is no medical evidence to show that smoked marijuana has benefits to a sufficient degree to warrant its use given its side effects and the potential for harmful outcomes from long-term use—not the least of which is the fact that probably 10 percent of marijuana users do develop addiction with long-term use.

The question of whether drugs should be legalized in America is a complex one. Compared to other countries, the United States has stringent laws and harsh penalties with respect to euphoria-producing chemicals. In some countries, such as Mexico, opioid analgesics are available over the counter, without a prescription.

"Medical marijuana" proponents are leading the debate about whether using and possessing marijuana should be decriminalized. Some proponents of "medical marijuana," such as National Organization for the Reform of Marijuana Laws (NORML) clearly believe that this is a health issue, but many "medical marijuana" proponents have broader political agendas, and are using efforts to decriminalize marijuana for "medical use" as a subterfuge—a way to get the public gradually comfortable with the idea of overall decriminalization. Legalization arguments should be analyzed on their own merits—but current biomedical evidence does not support the "medical argument" as a compelling one for legislative action to decriminalize marijuana.

CLINICAL TIPS REGARDING USE OF URINE DRUG TESTS

In the last issue of the *NewStart Newsletter*, we introduced the newly formatted urine drug test panels, and urine drug test report slips, that had been constructed for clinical settings by Meriter's General Medical Laboratories (GML). In this issue, we provide some helpful tips on how best to interpret urine drug tests in clinical practice.

- Many people have questions about testing for THC, the active ingredient in marijuana. Over-the-counter 'kits' will have adequate specificity for THC, but the detection thresholds may be rather high, and only qualitative 'answers' can be gleaned from these inexpensive testing methods. GML reports a 'positive' result in a clinical test for a THC level of 20 or greater. But a specific advantage of panels ordered through GML (or, a single-drug test request for THC) is that GML quantifies THC and also quantifies the creatinine level in the urine, then calculates a THC/creatinine ratio. It is this ratio that can be trended over time to see if a patient's THC levels are rising or falling. Normal dilutional effects (diet, illness) can affect the urine, as can conscious attempts by the patient to overhydrate themselves. Use of these THC/creatinine ratios has proven very helpful in NewStart when reviewing sequential test results.
- Some benzodiazepines are hard to detect using even GC/MS methodologies. If a doctor is concerned about unauthorized use of a sedative/hypnotic, and the patient needs treatment with a benzodiazepine for a medical/psychiatric condition, one strategy is to prescribe clonazepam or lorazepam, for many urine drug tests will read 'negative'; then if the urine drug test returns 'positive', it is a fair assumption that the person has used a compound not authorized for their use. If clonazepam and/or lorazepam testing is required call the laboratory or order a panel that includes them.
- One needs to be quite careful in interpreting results of urine drug tests for opioid analgesics. Most drug tests comply with the federal Department of Transportation requirement to test for 'opiates', not 'opioids'. 'Opiates' refers to the natural products derived from the opium poppy: codeine (which is a pro-drug, exerting its effects after its metabolism into morphine), morphine, and heroin, which is diacetylmorphine. So a patient could be prescribed, or could be illicitly taking/snorting/shooting, a synthetic or semi-synthetic 'opioid' such as meperidine (Demerol), oxycodone (Percocet), hydrocodone (Vicodin), hydromorphone (Dilaudid), or methadone (Dolophine), and the drug test report would give the result "Negative". This reality can be turned into an advantage by a physician: if a doctor is concerned about unauthorized use of a narcotic analgesic, and the patient needs treatment with such a pain-killer, one strategy is to prescribe one of these agents *other than* codeine or morphine; then if the urine drug test returns 'positive', it is a fair assumption that the person has used codeine, morphine or heroin, which are not metabolic breakdown products of the synthetic opioids.
- Based on the above discussion, it's important to not come to a hasty conclusion that a patient is non-compliant with (or diverting) the opioid one has prescribe for pain relief, just because the drug test result is 'negative'; make sure that the compound you're trying to detect is part of the contents of the drug test panel you ordered. The new GML panels make it far easier for the physician to order the test that will give the information he/she is looking for.
- A side comment: codeine does require metabolism by the cytochrome p450 isoenzyme 2D6 in the liver, for it to be converted into the active analgesic morphine. About 10 percent of the population lacks this metabolic enzyme. So a patient prescribed higher and higher doses of codeine who says 'Doctor, this isn't working', may be right!
- Note that codeine and heroin (diacetylmorphine) are both metabolized to morphine; but it doesn't go in the other direction. So a patient authorized to take codeine will have codeine and morphine reported 'positive' on comprehensive drug test panels that use GC/MS methods, and a patient using heroin will have morphine reported 'positive' (6-mono-acetyl-morphine is the first break-down product of heroin, and detecting it in the urine is confirmatory for heroin use, but it lingers in the body only a few hours, so usually is not detected). But a patient using heroin or MS Contin who has a urine positive for codeine, has obtained that codeine from another source!
- Yes, poppy seed muffins can produce urine drug tests positive for 'opiates'. One way to rule-out a false-positive is that, when poppy seeds have caused the positive test, the ratio of morphine to codeine is greater than 5:1. (To get this kind of quantitative and specific information, more expensive and time-consuming GC/MS confirmatory testing is required. Call the laboratory if the quantitation is necessary.
- Another thing to watch for: some hydrocodone (the active ingredient in Vicodin) is metabolized into hydromorophone (the active ingredient in Dilaudid). So a urine 'positive' for hydromorphone might be explained by the fact that the patient has taken hydrocodone.
- Methadone is included in several of the new GML panels; but if one is using a different lab, and one is interested in authorized or unauthorized use of this compound, one has to be sure that the drug test ordered has methadone in its contents.
- Physicians Plus and other Wisconsin health insurers are required to consider lab tests, including urine drug tests, to be 'medical care', and thus the costs of testing *do not* count against the limited insurance benefits for inpatient/outpatient mental health or addiction care. So any primary care physician or behavioral healthcare provider can order a urine drug test, and it won't come out of the 'behavioral health' benefits. But this is *not the case for all payors*, e.g., ERISA-exempt plans, so you may need to check with the patient's carrier, especially for the more expensive tests.

There are many options for using urine to detect recent drug use. It is important to remember **that confirmation of the fact there has been recent substance use by no means confirms that a patient has addiction or another substance use disorder.**

NEWSTART RETREAT

Michael Gerst, MSW, CADC III, CAPSW

NewStart staff participated in a retreat on June 8th, 2005. NewStart is a multi-leveled AODA/mental health treatment facility that draws on the talents of many disciplines to complete its work. A retreat gives NewStart the time to stop evaluate and find more effective and patient orientated methods of operations.

This year the retreat had two aims: one to evaluate progress on action plans of 2005 and to plan for new action plans for 2006.

Newstart decided on three action plans for 2005. They were

- improve customer service,
- improve handoffs between levels of care, and
- improve communications between Utilization Review and therapists.

Reviewing the action plans for 2005 substantial improvements were made in:

- NewStart has improved customer services, as evidenced by improvement in customer services scores. In general NewStart scores extremely well with customer satisfaction, however one score was bothersome. After reflecting on our practice we made some adjustments. As a result the patient satisfaction score went from 47 percent satisfaction to 94 percent satisfaction.
- Improving communications between Utilization Review and therapists as evidenced by substantial decrease in the number of unauthorized charges.
- NewStart improved handoffs between levels of care by creating check lists for RN and therapists to follow.

Looking to the future the action plans for 2006 include:

Patient Satisfaction

- Patient Satisfaction Questionnaires will include items regarding satisfaction with program elements such as small group experience, individual sessions, family programming, and patient education content (lectures, videos); make changes in programming based on survey results.

Clinical Outcomes

- Reduce variation in clinical approach
- Standardize patient education content across services
- Better cataloging of Patient Education materials
- Resource Book of group activities that clinicians could draw from
- Review curriculum of IOP: patient activities
- Twelve Step Facilitation and standardizing expectations

NewStart will continue to hold retreats on a yearly basis to review our programming and examine our practice guidelines. NewStart recognizes the need to reflect on our practice so that we will provide the best possible treatment for our patients.

STAFF PROFILE: SUE KLEIN-KENNEDY, MS, CADCIII

Sue started working for Meriter Hospital as a recreational therapist on a part-time basis until she graduated from College. Sue worked for Tellurian for approximately 3 years until she came to APEC (Alcohol Prevention and Education of Madison General Hospital) in 1977. Sue then worked for the APEC/NewStart Satellite clinic in Mount Horeb for 20 years doing general outpatient alcohol and drug treatment until she moved to the Gammon Lane clinic in 2002.

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

A. "I was a recreational therapist at Madison General Hospital and they kept bugging me to be a counselor—I did the rec. therapy consultations. Originally, I didn't want to be a counselor anymore because I like rec. therapy so much. Actually, I really wanted to coach women's college sports. It wasn't planned at all and I haven't gotten out yet. I like helping people and seeing them change and I like the people I work with. I love the flexibility that I am given in my job at NewStart."

Q. What is the therapist role in all addiction therapy?

A. "To help them discover who they are and what is stopping them from becoming happy with who they are. To help them develop the healthy skills to find who they are. To role model healthy, assertive communication, caring and support, and teach them how to trust themselves. Also learn how to have fun again."

Q. What style of therapy do you use?

A. "I use an eclectic mix of therapy techniques—CBT (Cognitive Behavioral Therapy), EMDR (Eye Movement Desensitization and Reprogramming)... a little but of everything. I think that I am fairly unrigid and go a long way with people. I like to have people to pick their goals and have a say in their treatment."

Q. How did you get into this work?

A. "I took job at Tellurian and learned about alcohol and drug treatment. I then took a job at APEC/NewStart again and the rest is history."

Q. What keeps you going in the business?

A. "Seeing people change...becoming happy and healthy people."

Sue is an integral member of the NewStart team. She is involved in assessments for potential patients, individual therapy, couples therapy, and several continuing care groups, including two women's only continuing care groups.

NewStart Medical Director Michael M. Miller, M.D., FASAM, is presented the Wisconsin Association on Alcohol and Other Drug Abuse's 2005 Professional of the Year Award by Lawrence S. Brown, Jr., MD, MPH, FASAM, Medical Director of Addiction Research and Treatment Corporation of Brooklyn, NY. at the 39th Annual WAAODA Conference on May 10th. Dr. Brown is Immediate Past President of the American Society of Addiction Medicine. Dr. Miller is President-Elect of ASAM.

COERCED TREATMENT

The only requirement for membership in AA is 'a desire to stop drinking.' A substance user's internal motivation to change their behavior is an important variable in treatment outcome. Reliable methods exist to assess a person's motivational level (such as the University of Rhode Island Change Assessment), and clinical methods have been developed to enhance a person's motivation and move them along the continuum of motivation to change as described by Prochaska and diClemente (the authors of the URICA). MET, or Motivation Enhancement Treatment, was one of the three approaches used in the famous NIAAA study Project MATCH. Researchers from Texas Christian University have shown that while 'intra-treatment factors' are very important in eventual outcome (what happens to patients during treatment), 'pre-treatment factors' are also important, and proactive efforts to motivate them to enter treatment, as well as to engage them so they don't depart early from treatment, are critical as well.

So what about the corollary to this: if a person 'isn't ready', doesn't have the internal motivation, isn't contemplating quitting use, is treatment worthwhile? The answer, from the literature, is a clear-cut 'Yes'.

Much is known about so-called 'coerced treatment.' 'Coersion' can take many forms. At the extreme, there is the civil commitment process, in which a court determines that an individual's right to refuse treatment is overridden by the duty of the state to assure safety (for the person or for third parties who may incur injury if the individual were not treated). Next, there are the court orders that make the completion of treatment a condition for a reduction in criminal penalties, e.g., in convictions for intoxicated driving.

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Persons may receive an order from a court that if they do not complete chemical dependency treatment, they will not be allowed to have visitation rights with their children (in a divorce case) or custodial rights (in a child protection case). Completion of treatment may be a condition of retaining a professional license (MD, RN, etc) or of retaining a job. Athletes who have positive urine drug test results may be required to complete treatment as a condition of further participation in their sport; students who are found in possession of illegal substances on the school grounds may be required to complete treatment as a condition of further matriculation. And the external pressure or external motivation to enter treatment may be in the form of a non-legally-binding contingency ("I won't stay in a relationship with you if you don't go through treatment").

Many people believe that if treatment is forced on the individual, then benefits will not accrue or persist after the person leaves the treatment environment. Many health insurers will not pay claims for treatment costs if the treatment was 'ordered' by a 'third party', such as an employer or the courts. The assumption in such cases is, 'why waste the investment?' There are also ethical considerations in mandating treatment (these are summarized in 1998 by the renowned Edinburgh psychiatrist Jonathan Chick).

The facts about 'coerced treatment' are as follows. Individuals treated via the civil commitment process have equal outcomes to those who enter treatment voluntarily.

Individuals required to enter treatment as a condition of having their driving privileges reinstated, do just as well as those who enter treatment without such an external 'nudge.'

Moreover, when persons enter treatment voluntarily, they have better outcomes when contingencies are applied through the treatment planning process. For example, if a contingency is, "if you stop coming to treatment, I'll contact your spouse/employer/probation officer/licensing board", patients are more likely to complete treatment and have a successful outcome after treatment.

Scientific literature confirming this extends over four decades. Gallant et al.(1968) found that parolees required to attend outpatient treatment had better clinic attendance and lower rates of criminal offenses than voluntary patients in the same clinic. As far back as 1976, it was reported that retention in outpatient treatment in Boston was far greater for persons mandated to treatment after a drunken driving than for voluntary clinic patients. Marc Galanter's group in New York City (1990) published similar results: treatment retention (not dropping out) was identical in voluntary outpatients and those coerced by a public assistance agency. Vogler et al. reported (1976) no differences in one-year outcome for patients in a 17-week treatment program between legal system referrals and self-referrals. Paul Moberg of the UW-Madison (1982) studied inpatients referred by their employers and found that the involvement of the employer in the referral had a positive influence on outcome at 9 months, and that coercion by the employer had no detrimental effect. Hoffmann et al. (1987) found that outcomes were no different between inpatients forced into treatment in the wake of a drunk driving conviction and voluntary inpatients. Persons committed or coerced to enter a VA inpatient service had comparable outcomes to voluntary admits, and trends suggested better outcomes for the former group (Watson et al., 1988). A more recent study of residential patients in Switzerland (2001) found that while the civil commitment patients had greater severity-of-illness at admission based on bio-psycho-social complications of their use, at follow-up (averaging 500 days after treatment entry) the health-related quality of life scores on a standardized questionnaire were better for the committed-and-treated group than for other cohorts of alcoholics post-treatment. Moreover, viewing their treatment retrospectively, a majority of those who had undergone civil commitment believed it had been justified and that the treatment had been useful. These authors described civil commitment of these alcohol patients as having been a 'life-saving' intervention.

One hypothesis to explain why 'coerced' patients do as well as 'non-coerced' patients is the notion that no treatment for addiction is 100% voluntary. Persons with addiction are universally ambivalent about their illness: there are aspects of their substance use that they view as positive, and other aspects they recognize as negative. Through the natural processes of defense mechanisms and cognitive reframing (combined with possible constitutional differences in the way their frontal lobes make judgments to ascribe 'value' to the rewards and punishments that come from substance use), substance addicts under-value the negative aspects of use and over-value the positive aspects of use. They may want to cease (possibly to make others around them happier) but they still want to be able to use (though maybe in a less out-of-control manner). Their ambivalence about whether or not to cease use, and whether or not to enter treatment, gets resolved on the side of entering treatment, largely due to external pressures they perceive in their lives. These pressures may be more subtle (a gradual withdrawal of affection from a life partner) or may be more overt (a summons from a deputy). But everyone who enters treatment for addiction has experienced some sort of 'nudge.' The most recent study in the literature on this topic (2004) assessed motivational level in patients coerced by the legal system compared to non-coerced outpatients, and discovered that it was the coerced cohort that—after addiction severity and prior treatment were controlled for—had higher readiness for change at treatment entry. Maybe they perceived that they had more to lose by not changing their behavior patterns. One trend that emerged from many of these studies is that outcome doesn't depend as much on the degree of coercion at treatment entry as it depends on the amount of support one has after treatment.

Wisconsin Statutes do provide for the involuntary treatment of persons with alcoholism. If an individual has a pattern of heavy drinking and a pattern of life impairments due to drinking, and it can be demonstrated that it would be dangerous or life-threatening to the patient, or to others, for them to continue drinking, and if they have refused voluntary treatment, then a petition can be signed by three adults and submitted to the probate court in the county of the individual's residence. This is rarely necessary, but our experience is comparable to that reported in the literature. Persons with severe medical problems due to their drinking, and inadequate social supports for sobriety, can be committed by the courts, and can have good outcomes after involuntary treatment.

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NEWSTART PHYSICIANS RECEIVE ASAM CERTIFICATION

The American Society of Addiction Medicine recently announced that NewStart Physicians Ian Powell, M.D., and Randy Brown, M.D., passed the ASAM Certification Examination in December 2004. ASAM certification is considered 'the gold standard' of physician expertise in the diagnosis and treatment of substance related disorders, and is required by several states as a requirement for being a medical director of a treatment program. It is recognized by many managed care firms, the federal TriCare program, and many states (including Wisconsin) as an indicator of physician quality. Over 3500 physicians have become ASAM-certified since the inception of the certification program in 1986. NewStart Medical Director Michael Miller, M.D., certified in 1986 and recertified in 1994, also passed his ASAM Recertification exam in 2004, as well as his recertification exam in Addiction Psychiatry.

NewStart Medical Director Michael M. Miller, M.D., FASAM, FAPA, ASAM President-Elect, is presented his Recertification Certificate by Elizabeth F. Howell, M.D., FASAM, ASAM President.

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