NewStart™

MERITER

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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) 608-267-5339
(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 BENEFITS FROM MERITER FOUNDATION

Meriter foundation continues to be a source of innovation and support for NewStart. The foundation has funded three important projects in the past year. One project included updating the adolescent treatment milieu. That is a fancy word for making the adolescent room look like a room adolescents' can enjoy. Through the generosity of the Meriter Foundation a Foosball Table was purchased, the adolescent room was decorated and other necessary treatment activity supplies were purchased.

The second project was continued education for all therapists; the entire NewStart staff was able to attend the WAAODA conference which included various topics to help improve patient care and clinical expertise. New research and clinically proven seminars were made available to all the staff.

The third project allowed the NewStart AMCES providers to attend the National nursing Conference. As NewStart, continues to provide quality and up to date services the financial support of the Meriter Foundation is greatly appreciated by all levels of service at NewStart.

NEWSTART ADOLESCENT STAFF GAINS A NEW THERAPIST

The NewStart Adolescent Program continues to provide the unique Intensive Adolescent Outpatient Program that supports abstinence from all mood altering substances. Now the Adolescent services also has the benefit of the expertise of Hannah Flanagan. This energetic woman also works at the Meriter Adolescent Inpatient Psychiatric Program. Ms. Flanagan was born and raised in LaCrosse has traveled to UW Eau Claire to attain her BA in Psychology, to Flagstaff Arizona, to Portland Oregon for four years and then returned to Madison attaining her Masters Degree at Edgewood College in Marriage and Family Therapy. We are hoping she has returned to Madison for a long time. Ms. Flanagan not only brings great clinical expertise to NewStart, she also brings a playfulness and creativity that is appreciated by the staff, the adolescents and their parents.

NEWSTART STAFF GAINS NEW SUPPORT PERSON

Brenda Bellisle has joined the NewStart Support Team. You may recognize her because she has been with Meriter for 17 years. She started in the brand new Children's Center. The Children's Center was fortunate enough to have Ms. Bellisle for 11 years until she "spread her wings" and transferred to Guest Services for 3 enjoyable years. She had a brief stint in Complementary Medicine until that clinic closed. She then worked in the Gift Shop at Meriter. NewStart was fortunate enough to gain Ms. Bellisle's expertise in June of 2006. If you have ever worked with or seen Ms. Bellisle at Meriter, you will know that NewStart is benefiting from her presence. She has caught on quickly to the NewStart system. The NewStart staff and clients are enjoying her smile and if you call NewStart, you may have Ms. Bellisle answer your call in a very pleasant, helpful manner.

Brenda Bellisle

NEWSTART ADDICTION MEDICINE CONSULTATION AND EVALUATION SERVICE NEWS

NewStart's Addiction Medicine Consultation and Evaluation Service nurse, Kathryn Curio, RN, MSN, has attained certification by examination in addictions nursing. This level of expertise is designated with the credential of CARN-AP (Certified Addictions Registered Nurse – Advanced Practice). The Addictions Nursing Certification Board administered the first certification examination in addictions for Registered Nurses (CARN) in 1989, leading to the first examination for CARN – AP in 2000. To date, more than 2600 nurses have taken the CARN and over 50 nurses with master's degrees have taken the CARN- AP. We acknowledge and congratulate Kathryn on her commitment to excellence as a CARN – AP.

Two of our certified addiction nurses have advanced in the Meriter Clinical Recognition Program to achieve Clinical Nurse II status. Ann Frank, RN, CARN and Jan Snortum, RN, CARN completed the requirements set forth by the Central Review Committee at t Meriter Hospital. The Meriter Clinical Recognition Program was established to recognize and reward professional nursing staff members who have demonstrated exceptional clinical competency, professional behavior and knowledge.

Ann Frank joined the NewStart Addiction Medicine Consultation and Evaluation Service (AMCES) at Meriter – Park in 1998 and has been certified in addictions nursing since 1999. Jan Snortum transferred to AMCES in 2001 and obtained her certified addictions registered nurse (CARN) designation in 2003.

We congratulate them on this new achievement and recognize the important role that they play in meeting the needs of patients and families dealing with alcohol and substance use disorders. We are pleased to have them as part of our treatment team.

RESOURCES AVAILABLE ON THE INTERNET

There are so many resources available on the internet these days. We would like to suggest a few sites that you may find helpful. These sites also have links you may find helpful:

http://www.meriter.com/mhs/hospital/newstart.htm

At this site you can read the newsletter on line, look up support group information, find out more about NewStart services and read more articles.

http://www.theantidrug.com

At this site you will find information primarily for parents who are concerned about their children's use of chemicals: news, drug information, is your teen using?, and other resources.

http://www.nida.nih.gov

At this site you will find drug information and facts that are kept up to date especially for parents.

http://www.drugs.com/pill_identification.html

At this site you will be able to access a Pill Identification Wizard to help you identify pills or capsules that you may have found.

http://www.drugfree.org/

At this site you will be able to find information for parents and for teens. This is the Partnership for a Drug Free site.

COMPASSION, PALLIATIVE CARE AND NEWSTART

Addiction permeates the American culture. It is responsible for much suffering in the lives of many people. How should we respond to such pain, suffering and loss? This article will discuss one alternative for responding: compassion. It will define com-

passion, compare the response of palliative care to AODA treatment, and finally will describe what NewStart is doing to respond to this disease.

Compassion

Looking at two important religious traditions gives insight into the meaning of compassion.

Buddhism prescribes compassion as a response to anger. When we feel compassion for a person it is difficult if not impossible to feel anger at the same time. Compassion is gown through meditation. If a person meditates on the suffering of all living beings there is a greater capacity to respond to people without anger. So the first response our society needs to the problem of addiction is compassion. The first step in this response is to meditate.

Christianity prescribes self examination to avoid judging your brother. "How do you expect to take that out of your brother's eye with a plank in your own." Look within yourself at your own suffering so that you can respond appropriately to others.

Palliative Care

Goal of palliative care is to relieve suffering. Palliative care does not seek so much to cure a disease but to control symptoms. Palliative care seeks to provide for a full and comfortable life until death. This is precisely what AODA treatment providers hope to provide for their patients/clients/consumers. Addiction is a condition that is potentially fatal, primary, and progressive. There is no ultimate cure, nor a magical treatment. The only treatment is to control the symptoms so that the person has the potential for a joyful, productive, and happy life.

NewStart

NewStart seeks to be of service to those who suffer from addiction, both the user and the family of the user. We provide care at any level the patient/client/consumer needs. We are the last provider in southern Wisconsin to provide the full continuum of care for those who suffer because of addiction.

ONE FOR THE ROAD

By Gabe Curio

First Place Winner
2006 Ruth Cooley Poetry Prize, Shimer College
The Academy of American Poets
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Now I drink the rest of a beer and dream
Are my two hands steady at the wheel now
And the whir of the tires inside my head
They scream at me obscene lies and slander

Are my two hands steady at the wheel now
I hear the voices of children long dead
They scream at me obscene lies and slander
I see that I am moving no longer

I hear the voices of children long dead
I stopped short at eternity, but why
I see that I am moving no longer
I start to breathe, taking in hope and life

I stopped short at eternity, but why
The car came to a halt and we are safe
I start to breathe, taking in hope and life
Now I drink the rest of a beer and dream

SEPTEMBER IS NATIONAL RECOVERY MONTH:

State Rallies for Substance Abuse Prevention, Treatment, and Recovery

MADISON (August 10, 2006) — Governor Jim Doyle recently proclaimed September as alcohol and other drug abuse Recovery Month in Wisconsin. The Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA) is celebrating recovery from alcohol and other drug abuse with special events throughout the month. They would like to invite you to attend their Recovery Month celebrations, which follow the theme "Healing the Wisconsin Community: Celebrating Alcohol and Other Drug Abuse Recovery".

For Wisconsin's Recovery Month, they are planning four big events:

• **Saturday, September 9th** — First Annual Candlelight Vigil for Recovery, Lakeview Park, Middleton, which honors families, friends, and co-workers who have supported those in recovery. Governor Doyle has been invited to be our keynote speaker.

• **Saturday, September 16th** — Second Annual Walk for Alcohol and Other Drug Abuse Recovery, where "You don't have to run, you can walk for Recovery!" in Madison, with the finish line at the West Wing of the State Capitol, with music, food, and fun. Scheduled keynote speakers include Attorney General Peggy Lautenschlager and Dane County Executive Kathleen Falk.

• **Saturday, September 23rd** — Sixth Annual Rally for Alcohol and Other Drug Abuse Recovery, on the theme "Healing the Wisconsin Community: Celebrating Alcohol and Other Drug Abuse Recovery" at Frame Park in Waukesha, with music, food, and more fun. Confirmed keynote speakers include Lieutenant Governor Barbara Lawton, Attorney General Peggy Lautenschlager, and Dane County Executive Kathleen Falk.

• **Saturday, September 30th** — Annual Recovery Celebration in Rhinelander, with food, music, and fun for the whole family.

Hope you can attend. If you have any questions please contact the Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA), Inc., office located at 6601 Grand Teton Plaza, Suite A, Madison, WI 53719, tel. 608.829.1032 or 1.800.787.9979, fax 608.829.3473, waaoda@tds.net, www.waaoda.org

Adolescent Substance Use & Addiction: Trends

Michael M. Miller, M.D., and Lauren Bern, M.D.

Second in a series on adolescent substance use and addiction.

Any discussion of adolescent substance use must begin with tobacco, alcohol and marijuana.

Tobacco is clearly the "gateway drug"—along with inhalants, tobacco products are the substances used earliest in the lives of most persons who use substances or who eventually develop an addiction in adulthood.

Alcohol causes the most health problems during adolescence, due to accidents, violence, unintended/unwanted sexual behavior, STDs, teen pregnancy, drownings and suicides.

Cannabis abuse or dependence is the substance-use disorder that brings more teens into professional treatment for substance abuse or dependence.

The newest developments in adolescent substance use have to do with "club drugs," prescription drug misuse and use of herbal products.

Club Drugs

The National Institute on Drug Abuse (NIDA) Web site (www.nida.nih.gov) is a tremendous resource for descriptions of "club drugs." Club drugs is a term that includes any of a number of pharmaceutical drug classes, and refers to the setting where it is used and the user group demographics.

Ecstacy is a methylated amphetamine (MDMA); methylation of amphetamines retains their stimulant properties, their potential for development of tolerance to stimulant effects, the withdrawal ("crash") that can come with abrupt discontinuation after daily use and the "positive" result for stimulants on many urine drug test procedures. Methylation also enhances the hallucinogenic properties of the molecule. Methamphetamine itself is considered a club drug in some areas.

Dextromethorphan, or DM, is an important and somewhat newer, club drug. While chemically an isomer of an opioid analgesic, and while safe and effective as a cough suppressant when taken in recommended doses, DM is known to psychopharmacologists as an antagonist of the NMDA-subtype of the glutamate receptor. Glutamate is the number-one excitatory neurotransmitter in the brain. The best-known NMDA antagonist is phencyclidine (PCP), whose behavioral effects were all-too-well-known to ER and public safety personnel in the last third of the 20th century.

"Word on the street" is that PCP can be dangerous, but that ketamine ("Special K" in the club drug circuit) is safe—even though its actions on NMDA receptors and its behavioral effects (and neurotoxicities) are virtually identical, and only somewhat milder, than those of PCP. Dextromethorphan, when ingested in the doses desired by substance users (two or three eight-ounce bottles of DM-containing cough syrup such as Vicks Formula 44D or Robitussin DM; or a dozen or more capsules of Coricidin Cough and Cold—called "Triple Cs" in club-drug circuits), has the same psychotomimetic and neurobehavioral effects as PCP. Clinical toxicologists know that dextromethorphan creates a "positive" screening test result for PCP; an initial "positive" should be confirmed by GC/MS to see if it was truly PCP, or was ketamine or DM.

Prescription Drug Misuse

Kids have found that over-the-counter preparations can be intensely euphorigenic—and are inexpensive, readily available and often ignored by adults as being "dangerous street drugs," which they can be. Kids have also found their parents' medicine cabinets and purses to be sources of intensely euphorigenic substances, primarily opioid analgesics. Prescription drug misuse can even result in opioid, sedative (often benzodiazepine) or even stimulant addiction.

In the last edition of Drugs of Abuse Digest, we pointed out the leadership role the Partnership for a Drug Free America (www.drugfree.org) had in bringing this topic to the public's attention—describing the current cohort of teens (those younger than Gen X and Gen Y) as "Generation Rx."

The newest developments in adolescent substance use have to do with "club drugs," prescription drug misuse and use of herbal products.

Adults are prescribed opioids for chronic pain conditions in increasing amounts, since various health organizations have brought to physicians' attention the extent of under-treatment of pain in America. The increasingly appreciated fact that the vast majority of patients who are prescribed opioid for chronic pain do not develop opioid addiction had reduced physicians'

hesitance to prescribe these products for patients. However, parents do not usually protect access to their prescription drug supplies, and kids have proven to be quite resourceful in using parental supplies as free sources of powerfully psychogenic agents.

Red as a beet, Dry as a bone, Hot as a hare, Mad as a hatter." Youth have for decades seemed to enjoy the "altered state" they could subjectively recognize as being a bit confused, "loopy" or even perceptually-altered, from anticholinergic effects of a variety of pharmaceuticals.

Industrious kids surf the Net and go to botanical Web sites to purchase seeds or plants that they grow themselves—perfectly legally—to produce herbal products that they can use or sell which have atropinic properties that will make kids hallucinate.

Herbal Product Use

Just as available to kids, and affordable for many of them, are herbal products with psychogenic properties. Most of these are undetected by any urine drug test. The "high" people receive from these plant derivatives is rather crude: it is the "different" feeling of anticholinergic excess.

Acetylcholine is a common neurotransmitter in the autonomic nervous system; systemic inhibition of acetylcholine results in increased pulse and temperature, dryness of mucous membranes and slowing of smooth muscle contraction that impedes urination and defecation. The individual can experience tiredness and/or a clouding of consciousness, so that mental sharpness is affected. Effects on the eye and brain include blurry vision, dilated pupils that are slow to constrict, confusion, hallucinations, even delirium. These have been called "atropinic effects" because they are the effects of the archetypal acetylcholine inhibitor, atropine.

Many readers are "old enough" (like the authors!) to recall an era in which tricyclic antidepressants were the major therapeutic agents for depression, anxiety and even enuresis; and clinicians from the pre-SSRI era were quite familiar with what to watch for in cases of overdose or simply toxic side effects from tricyclics: the extreme picture of being "Blind as a bat,

Nowadays, not just psychiatric medications or over-the-counter cold remedies can produce atropinic states. Products such as jimson weed produce mental/emotional effects in just the same way. The Internet is the source of many of these products. Industrious kids surf the Net and go to botanical Web sites to purchase seeds or plants that they grow themselves—perfectly legally—to produce herbal products that they can use or sell which have atropinic properties that will make kids hallucinate. The detection is clinical—observation of the atropinic state, marked conspicuously by pupillary or vital signs changes along with confusion/disorientation—or by botanical inspection, rather than via laboratory toxicology.

We should accept as a truism that some segment of our youth will pursue altered mental states, and that the "drug du jour" changes from decade to decade. The club drug phenomenon itself—in which kids ingest or inhale things they perceive to be fun, new and safe—shows that kids may use compounds from a previous generation, but with a new name, a new route of administration or simply a new social context of use, and define it as novel or "anti-establishment." Some of these will indeed be new, but at times, only superficially so.

Recall that humans take street drugs only because they work. As Alan Leschner, Ph.D., former director of NIDA said, "People use drugs because they affect people's brains!" They work on neurotransmitter systems—serotonin, norepinephrine, dopamine, glutamate, acetylcholine, nitric oxide, peptides and others—and that's the only way their effects can be mediated in the nervous system. The number of molecules that affect neurotransmitter systems is fairly small, though neuropharmacologists are developing new ones all the time—with toxicologists determining their "chemical fingerprint" in step behind them or along with their colleagues in unauthorized labs next door.

The current group of adolescents has proven that it does not take a financial fortune to find psychoactive substances. The fact that such substances are not on the street corner, but in the medicine cabinet, or the seed catalog or—ubiquitously—on the internet, also proves that they're not that difficult or risky to find.

Drug Testing of Students: Varying Perspectives

Michael M. Miller, M.D., and Lauren Bern, M.D.

Third in a series on adolescent substance use and addiction

Drug testing is now commonplace in America, and raises issues that are complex and, in many instances, remain unresolved. Even though the U.S. Supreme Court has ruled that mandatory drug-testing programs in workplaces and schools are not unconstitutional, it is worthwhile to explore some assumptions behind, and controversies embedded in, the process of testing people for drug use.

Employers are the major purchasers of drug testing services. They often view drug testing as risk management or personnel management, or even as an occupational health and safety activity. Health-care professionals, on the other hand, usually view the analysis of urine or other body fluids (saliva) or tissues (hair) as a clinical activity. Clinicians consider these studies as they do any lab test: What does the information from a test result mean? How valid is the test? How reliable and how sensitive is it? What will I do differently once I have the results?

As covered in the first two articles in this series, adolescent drug use tends to change over time. Nationally, hallucinogen use—including PCP, ketamine, Ecstasy and LSD—is dropping. Marijuana use is decreasing, especially in younger cohorts (middle schoolers). Base rates of cocaine and heroin use remain low, but unauthorized use of prescription painkillers and sedatives is rising epidemically. Nasal use of heroin is rising among youth who erroneously perceive heroin to be a "club drug" and "safe" as long as it is not injected. Another rising problem is the use of psychoactive herbal products, which are not detectable by routine drug testing methods, sometimes not even by exotic laboratory analyses.

Let's look at some of the issues:

Q. What can be found by drug testing?

A. More affordable test panels or kits look for certain substances, but not necessarily those that youth use frequently. The agents tested for in most panels may be those of interest to the Department of Transportation, or they were of interest when Congress passed laws regarding drug testing of truck drivers and train engineers. The "target substances" in school-based drug tests often do not reflect what kids are likely to use, or the substances most likely to impair kids' functioning in school.

The "target substances" in school-based drug tests often do not reflect what kids are likely to use, or the substances most likely to impair kids' functioning in school.

Testing can detect alcohol, but breath testing is as reliable, easier and cheaper to do than urine testing. Kids' use of alcohol is usually not on school grounds or just before specimen collection, anyway, and recent use is easily detectable by functional impairment (speech, gait, behavior). Marijuana can be detected, but a single test only means that a person has used marijuana at some point in time; since heavy marijuana use can produce positive test results weeks later, someone could have stopped using and still test "positive." Methamphetamine can be detected, but in screening tests (usually less costly panels or kits used by schools), typical "cold remedies" can create a positive result just as true "meth" use does. Many, if not most, pharmaceutical opioids and benzodiazepines are not detected by simpler testing methods, so teens can use these substances and the test will be "negative," a false negative.

Q. What does a "positive" drug test result mean?

A. "true positive" urine drug test result means that the person providing the sample has used a chemical in an amount detectable by the threshold of the test, within the time frame derived from the half-life of the drug in the person's system. If they produce a sample too soon after use, before the product has a chance to be filtered by the kidneys and deposited in the bladder (i.e., if the person has emptied their bladder before drug-containing urine got there), the test would come back "negative."

A positive test only indicates the presence of the substance at a detectable level. It does not mean a person has addiction nor can it indicate if the substance was impairing (in motor function or other behavior) to the individual.

Q. What does a "negative" drug test result mean?

A. A "true negative" result may mean that the person has not used a drug, or it may occur because the drug in question is not included in the test kit or panel. If the use was of low enough volume or remote enough in time to not be detectable by the test, the result will be negative. A "false negative" result can come from adulteration or artificial dilution of the sample.

Q. What is done with test results—positive or negative?

A. In America, at this point in our history, we usually use drug test results in a punitive way. Employers may use a "positive" test as the basis to terminate or refuse employment, or to justify some other sanction. Similarly, "positive" urine drug test results of students are often the basis for suspension or expulsion from classes, or denying participation in extracurricular activities. Some data is available from adult populations that workplace drug testing has been associated with decreased levels of drug use: adults not wanting to face the consequences of testing "positive" have eliminated regular use or use altogether. The "deterrent" argument may apply to students as well: simply knowing that they may be tested may well lead larger numbers of kids to be "total abstainers."

Given recent evidence on the harm caused to developing brains by substance use (especially alcohol), having more kids be non-users is a good thing. However, many teenage citizens "at risk" of addiction have dropped out and are no longer students, or may be on the student population's social fringe and not involved in sports or clubs where mandatory testing is in place. So the kids who are most likely to have positive urine drug test results are not the most likely "target population" for prevention or deterrence of substance use.

From a clinician's viewpoint, testing should be used to identify disease states or risk factors for development of disease, and to assist with treatment planning or early intervention to prevent development or progression of disease. Thus, a "positive" test ideally would serve the person tested, through referral to a professional for diagnostic evaluation or definitive treatment of a substance use disorder. But our nation has tremendous ambivalence about addiction, often not wanting to consider it a health problem, and not making appropriate distinctions between "use" (often of a product that is illegal to use or possess) and a health condition (such as addiction).

Given recent evidence on the harm caused to developing brains by substance use (especially alcohol), having more kids be non-users is a good thing.

Given the nation's mixed feelings and mixed messages about addiction, it probably is worth considering the potentially harmful effects of labeling a person a "substance user." There are laws that prevent a person with a drug possession offense on their record from ever getting a student loan, housing assistance or employment training, even if the offense was associated with a youthful indiscretion. Hence, prudence and caution probably deserve a high place at the table as institutions such as school boards decide on whether to enact student drug testing programs, and what such programs will entail.

In any consideration of drug testing, it would be foolhardy to pretend that illicit drug use is at the crux of our society's substance use problems. By far, the most commonly used intoxicant in our society—at any age—is alcohol. Yet most school districts fail to acknowledge or address this when they discuss "drug testing" and "drug problems" in our schools. Furthermore, nicotine is the substance that is most clearly the "gateway" to using other substances. In light of this, financing programs to test and identify youthful users (most of whom are at the "experimenting" stage of illicit drug use)—rather than supporting students and families in remediating alcohol and tobacco use and funding recovery programs for any and all who have a diagnosed substance use disorder—may represent misallocation of precious fiscal resources.

Co-authors:
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Lauren Bern, M.D., is a Fellow in Psychiatry at UW. She is board-certified in Internal Medicine and board eligible in General Psychiatry and Child-Adolescent Psychiatry.

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