CSAM NEWS

Newsletter of the California Society of Addiction Medicine Fall 2000 Vol. 27, No. 2

Treat Opioid Dependence In the Office

California Society of Addiction Medicine is offering a series of workshops beginning in early 2001 on the treatment of opioid dependence in office settings using Buprenorphine. This is intended to meet the requirement in the newly passed federal legislation (the Drug Addiction Treatment Act of 2000) that requires physicians who don't otherwise qualify to have completed not less than eight hours of training provided by ASAM (or other designated organizations). Watch your mail for a flyer describing these workshops scheduled to take place in San Diego, San Francisco, Los Angeles, Inland Empire, and Sacramento in 2001.

INSIDE:

DRUG TREATMENT INITIATIVE PASSES

Why CSAM Backed Proposition 36

CSAM took an aggressive "YES" position on Proposition 36 in the November election – the ballot initiative mandating treatment rather than prison for simple possession of illicit drugs. CSAM wanted to send the message that "treatment works." CSAM's President-elect and chair of CSAM's Public Policy Committee Dr. Gary Jaeger was featured on TV and radio commercials and Dr. Peter Banys, CSAM's President, was interviewed by CNN and other news networks. Dr. Jack McCarthy appeared on a state-wide talk show and CSAM members across the state spoke at press conferences about the Proposition.

Unfortunately, our position on Proposition 36 put us head to head with the Drug Courts who came out against Proposition 36. This was unfortunate, because CSAM believes that Drug Courts work and have been demonstrably effective; however, in California they manage only 3-5% of eligible arrestees. The system isn't working for the majority of arrestees and until a statewide Drug Court system is in place, Proposition 36 presented the best option for ensuring that 1st and 2nd time drug offenders get treatment options, instead of jail.

Imprisonment is a blunt instrument. In the U.S., 7% of adults in the 1999 national household survey and 26% of high school seniors have used an illicit drug in the prior 30 days. The rate of incarceration in California leads the nation and is now over twice the national average. In California, we have incarcerated 45,455 individuals for drug offenses. Until the early 1990's, the majority of drug arrests were for sale or manufacture. In 1999, 52.9% of new drug imprisonments were for possession.

Incarceration, costing $25,900/yr., is only slightly cheaper than a year at Stanford University. By contrast, drug abuse treatment is a bargain: long-term residential ($6,800), methadone maintenance ($3,900), intensive outpatient ($2,500), and regular outpatient ($1,800). The CalData study found public services cost savings of $7 for every dollar spent on treatment.

We regret the decision to prohibit these funds from going to urine testing. We understand that this was to prevent agencies from equating testing with treatment, which has been done elsewhere. Please note, however, that courts may order the probationer to pay for testing (as has been done in Arizona), and, state and local agencies may internally move other treatment funds for this use.

Arizona passed a similar initiative in 1997, and the State of New York Chief Justice has issued an executive order that will increasingly send arrestees to treatment instead of prison. An essential ingredient in the California initiative is that the University of California is mandated to evaluate the outcomes of this initiative, thus providing a feedback loop. This proposition will help us to develop evidence-based, rather than ideology-based treatment for addicted Californians on probation for simple drug possession.

CSAM intends to play a role in monitoring the implementation of the initiative, which provides $120 million in funding to counties to provide drug treatment. Please tell us your views; e-mail CSAM at csam@hp-assoc.com.

Primary Care Physicians Failing to Recognize Substance Abuse

A survey by the National Center on Addiction and Substance Abuse at Columbia University, New York, has found that 94% of primary care physicians may be missing or misdiagnosing alcohol-abusing patients.

Researchers presented a test case to a national representative sample of doctors. The case scenario stated, "A 38-year-old married patient has recurrent abdominal pain, intermittently elevated blood pressure, gastritis, and irritability, and wakes up frequently at night." Only 6% of physicians mentioned alcohol misuse as a possible diagnosis.

Richard Corlin, a California gastroenterologist, said that while the symptoms "are vague and common [and] can be related to a whole variety of conditions, they clearly indicate alcohol abuse, and doctors need to be made more aware of this possibility."

In the same survey, 41% of pediatricians failed to suggest drug misuse when presented with a classic description of a teenaged patient who is misusing drugs.

The survey of 648 primary care physicians, the most comprehensive so far, involved physicians in family medicine, general practice, internal medicine, obstetrics and gynecology, and pediatrics.

Only 19.9% of physicians felt that they were "very prepared" to deal with alcoholism, while only 16.9% felt very prepared to manage illegal drug use. In sharp contrast, 82.8% felt very prepared to identify hypertension, 82.3% to identify diabetes, and 44.1% to identify depression.

Although most physicians felt that medical treatment was effective for hypertension and diabetes, only 3.6% thought that it was effective for alcohol dependence and 2.1% for substance misuse.

The study also surveyed 510 patients being treated for substance misuse. Most (53.7%) said that their primary care physician did nothing about their addiction, 43% said that the physician never diagnosed it, and 10.7% said that the physician knew about it but did nothing.

Most physicians (57.7%) said that they do not discuss substance abuse with their patients because they believe their patients lie about it, and nearly 85% of patients agreed that they lie. More than a third (35.1%) of physicians cited time constraints as a reason for failure to discuss the issue, and 10.6% were concerned that they would not be reimbursed for the time necessary to screen and treat a substance-abusing patient. Less than a third of primary care physicians (32.1%) carefully screened for substance abuse.

Addiction Education — A Call to Arms!

BY DAVID PATING, MD, CHAIR, CSAM COMMITTEE ON EDUCATION

At their last meeting, the members of the CSAM Committee on Education noted that addiction medicine continues evolving at a blistered pace. This year, office-based opiate treatment, including buprenorphine, as well as new mental health parity legislation will take center stage. The need for timely and relevant addiction education is more important than ever.

Taking the lead, several CSAM committees are now planning comprehensive updates on: 1) substance abuse parity and the role of addictionists in legislation; 2) office-based opiate treatment; and 3) treatment of the impaired physician. Look for these events within the year.

Call to Arms! ...You Can Help

The CSAM Committee on Education now actively seeks members to participate on educational planning groups for the following topics:

- Primary Care Treatment of Addiction
- Harm Reduction/Treating Difficult Patients
- Addiction Medicine for Physicians-in-Training
- Office-Based Research
- Special Populations: Women, Adolescents, Elderly and Minorities
- Trends in Drug Use: Club Drugs, Heroin, Amphetamine
- Integrating Components of Addiction Treatment
- Wellness & Self-Help Recovery

The committee is also looking for members interested in coordinating regional CME lecture-dinners or half-day seminars. These events are great ways to meet colleagues while hearing the latest trends in addiction medicine. Our CSAM Executive Director, Kerry Parker, can help you focus your topic and identify speakers. She will also discuss how you can find accessible sites and sponsorship. Please call CSAM today at 415/243-3322 to make it happen!

THANK YOU!

CSAM gratefully acknowledges the financial support of the following to our 2000 educational activities:

- Abbott Laboratories
- Betty Ford Center
- Bristol Myers Squibb
- Eli Lilly
- GlaxoWellcome, Inc.
- Mallinckrodt
- Purdue Pharma
- Roxane Laboratories
- Schering Corporation
- Solvay Pharmaceuticals
- Tenet Healthcare Foundation
- Wyeth Ayerst Laboratories

Psychotherapy and the Treatment of Alcohol Dependence

BY DONALD R. WESSON, MD

Psychotherapy is used here to refer to verbal interactions between a therapist and a patient intended to alter the patient's emotions, maladaptive beliefs or behavior. Psychotherapy, particularly of the psychoanalytic variety, has a tarnished reputation as a treatment for alcohol dependence. Psychoanalysts and psychodynamically oriented psychotherapists theorized that alcoholism was a symptom of an underlying conflict and that gaining insight into the origin and nature of the conflict would provide a "cure" of the alcohol dependence. Treatment of alcohol dependent patients using this paradigm was rarely effective in producing alcohol abstinence, and many patients remained in psychotherapy for years while the severity of their alcoholism progressed.

Other treatments for alcohol dependence, evolving primary from a twelve-step recovery model, held that, regardless of the initial cause, alcohol dependence eventually developed a life of its own and must be treated as a primary disorder. In the 1980's, private inpatient treatment of alcoholism greatly expanded and was driven primarily by the tenants of twelve-step recovery, in what became widely known as the Minnesota or Hazelden treatment model (Stinchfield & Owen 1998). Inpatient alcohol treatment programs offered initial detoxification followed by drug abuse counseling, most often provided by a counselor who was also recovering from alcohol or some other drug dependence disorder. The Hazelden Model explicitly evoked the disease model of addiction, although there was little emphasis on medical treatment beyond detoxification and medical management of co-existing medical conditions, such as hypertension or diabetes. The approach emphasized direct confrontation of the alcoholics' beliefs and thinking that enabled them to drink while denying the adverse effects that their drinking was having on their health, family, and sometime work performance. Patients were usually required to attend Alcoholics Anonymous meetings during their inpatient stay, and daily attendance was mandated or strongly encouraged during aftercare. The mantra of 90 meetings in 90 days was standard. Family involvement was often included as part of the treatment. Professional psychotherapy, particularly of the insight-oriented or psychoanalytic variety, was discouraged during early recovery, as was medication treatment of insomnia, depression, or anxiety. Inpatient treatment of alcohol dependence has been greatly curtailed by managed care and the evolution of effective outpatient treatment strategies with demonstrated effectiveness. Pharmacotherapy — particularly with antidepressants and mood stabilizers and medications to deter alcohol use, such as naltrexone or disulfiram — has become more accepted.

Psychotherapeutic approaches that evolved during the 1980's were a pragmatic blend of principles from social leaning theory and behavioral psychology. Relapse prevention, popularized by a book, *Relapse Prevention, Maintenance Strategies in the Treatment of Addictive Behaviors* (Marlatt & Gordon 1985), is a systematic application of cognitive-behavior techniques including self-monitoring to identify early drug cravings, identifying situations that are high-risk for use, and developing strategies for coping with or avoiding high-risk situations.

A set of psychotherapy techniques that has evolved from motivational interviewing (Miller & Rollnick 1992) have been codified into a brief intervention called Motivational Enhancement Therapy (Miller 1994). Motivational Enhancement centers on engaging the patient's ambivalence about treatment and stopping drug use. This is a brief therapy, usually consisting of an initial assessment followed by two to four individual treatment sessions. Motivational interviewing principles are used to strengthen motivation and build a plan for change. More recent evolutions include what is popularly known as the MATRIX model (Obert, Rawson & Miotto 1997). None of

Continued on page four

TABLE 1. TYPES OF PSYCHOTHERAPY

MODALITY	KEY ELEMENTS	REFERENCES
Cognitive-behavioral therapy	Provides information and skill training.	(Rohsenow et al. 1991)
Contingency contracting	Reward or punishment based on alcohol use behavior	(Caddy & Block 1983)
Coping skill	Identifying skill deficiencies and providing remedial skill training, e.g., assertiveness training	(Monti & O'Leary 1999)
Family	Involvement of family members who may sabotage treatment effectiveness	(Kosten et al. 1986)
Modified psychodynamic	Emphasis on resolving current conflicts.	(Fox 1965)
Motivational enhancement	Non confrontational. Provide information, encourages patient to make decisions about behavior based on new information	(Project Match Treatment Group 1998)
Network therapy	Engages the patient in a support network composed of family members and peers	(Galanter 1993)
Psychodrama	Role playing	(Loughlin 1992)
Relapse prevention	Information, identification of high-risk situations, anticipatory guidance	(Marlatt & Gordon 1985)
Supportive	Encouragement and support for patients own strategies for remaining alcohol abstinent, advice given if requested	(O'Malley 1995; O'Malley et al. 1992)

Continued from page three

these therapies emphasizes direct confrontation and the psychotherapeutic models are acceptable to some patients who are distanced by the religious underpinnings of Alcoholics Anonymous.

In alcoholism treatment, the boundary between drug abuse counseling and psychotherapy is often fuzzy. The distinction is usually based more on training and degrees than what occurs during treatment sessions. Many drug abuse counselors, particularly those who are themselves recovering from alcohol or another drug dependency disorder, draw heavily on their own experience with addiction and recovery. Their formal training about alcohol or drug dependency treatment may vary widely. They refer to themselves as "counselors" and to the people they treat as "clients." Licensed psychotherapists, such as psychiatrists and psychologists, refer to their work as "psychotherapy" and the people they work with as "patients." Because of the blending between psychotherapy and counseling, non-pharmacotherapy techniques are often called "psychosocial treatments." Peer led, self-help recovery groups, such as alcoholics anonymous, are generally not called "treatment."

In common usage, psychotherapy is sometimes narrowly defined as something provided by a professional licensed to provide such services, or more broadly defined as verbal interaction between a therapist or counselor and a client or patient that is designed to change behavior and feeling (Zimberg 1999). With a broad definition, the distinction between a drug abuse counselor and a psychotherapist largely disappears.

Table 1 (found on page three) lists of some of the more common forms of psychotherapy that have been applied in treatment of alcohol dependence. The modalities are adaptations of techniques that have been developed for treatment of other psychological disorders. There is considerable overlap in techniques, particularly between cognitive-behavior, skill training and relapse prevention.

In general, many patients who engage in any type of psychosocial treatment show improvement in their drinking behavior, and demonstration of differences between treatment modalities in controlled clinical trials has been difficult. The largest study has been a study sponsored by the National Institute on Alcohol and Alcohol Abuse called Project Match, an acronym for Matching Alcoholism Treatment to Client Heterogeneity (1993). Data from Project Match showed similar treatment outcome with cognitive behavior and coping skills therapy, motivational enhancement therapy, and twelve-step facilitation (1997).

Combined Psychotherapy and Pharmacotherapy

Psychosocial treatment is increasingly combined with pharmacotherapy. Pharmacotherapy may be directed at relapse prevention (e.g., disulfiram, naltrexone, or in Europe, acamprosate), or treatment of the underlying psychiatric condition (e.g., antidepressants, lithium, or valproate).

Pharmacotherapy may enhance psychosocial treatment. For example, a recent article reporting the results of oral naltrexone in combination with cognitive behavior therapy found that 62 percent of the naltrexone treated patients did not relapse into heavy drinking compared to 40 percent of the patients treated with placebo (Anton et al. 1999). The initial studies supporting the efficacy of naltrexone in treatment of alcohol dependence were in combination psychotherapies (O'Malley et al. 1992; Volpicelli et al. 1992).

A recent review of pharmacological treatment of alcohol dependence in the Journal of the American Medical Association concluded "We herald the advances in the pharmacotherapy of alcohol dependence as valued developments, but we note that treatment of patients with alcoholism should continue to incorporate a biopsychosocial perspective in an effort to change a life from a pattern of addiction to a pattern of sobriety and improved physical, mental, and social health" (Garbutt et al. 1999).

Conclusion

A variety of psychotherapeutic approaches have demonstrated efficacy in treatment of alcohol dependence. For personal reasons, some patients will find one approach more acceptable or effective than another. For many patients, the combination of psychotherapy and pharmacotherapy improves the chances of successful outcome.

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Doctor Wesson is Chair of the Medications Development Committee, American Society of Addiction Medicine and Vice President, Clinical Development, DrugAbuse Sciences, Inc.

CSAM Honors Gail Jara for Nearly 30 Years of Service to CSAM

On October 13, CSAM honored its founding executive director, Gail Jara with a Gala tribute. Gail Shultz, MD chaired the Gala Planning Committee and hosted the evening along with Masters of Ceremonies Garrett O'Connor, MD and Max Schneider, MD. Gail received many accolades, as participants lined up to testify about her many contributions to CSAM and the field of addiction medicine. Statements were read from ASAM President Marc Galanter, Douglas Talbott, MD and Janis Thibault, MFT, Manager of the Diversion Program. A surprise guest, "Lt. Columbo" uncovered many funny stories and anecdotes. Gail received a standing ovation and a teddy bear embroidered with "CSAM Loves Gail." A silent auction raised over $2,000 for CSAM and the Medical Education and Research Foundation.

Gail B. Jara

Whose leadership as the founding Executive Director enabled the California Society of Addiction Medicine to thrive and to become the premier society for physicians who treat patients with alcoholism and other drug dependencies. Thank you for your caring, expertise, inspiration and dedication from 1973 to 1999. Presented on October 13, 2000 in San Francisco We will miss you!

From left: Max Schneider, Gail Jara, Garrett O'Connor, William Brostoff, Peter Banys, Gail Shultz, David Smith

Gail Jara with "Lt. Columbo"

First Annual Jess W. Bromley Memorial Lecture

On October 12, David Smith, MD introduced CSAM's first annual founder's lecture honoring Jess Bromley, MD for his leadership and clinical skill in the field of Addiction Medicine. H. Westley Clark, MD, JD, MPH, Director of the Center for Substance Abuse Treatment delivered the lecture. Dr. Clark was also presented with the Vernelle Fox award. Following is the text of Dr. Smith's remarks.

Fine memorials outlining Jess' many contributions have been published in *CSAM News* by Art Bolter and in the ASAM newsletter by Manny Steidler. I hope everyone in the field of ADM reads them – particularly the younger members who did not know Jess – so they can understand the roots of our ADM movement and its goal of mobilizing medicine to respond to the needs of suffering addicts and alcoholics.

I first talked to Jess two years after I started the Haight Ashbury Free Clinic in 1967. He called me and began to tell me, with his booming voice, that two doctors had just been arrested in Southern California for detoxifying addicts on an outpatient basis using the controlled drug Valium.

Don Wesson and I had just developed a phenobarbital technique for detoxifying addicts who readily adapted to an outpatient setting, and we were using it at the Haight Ashbury Free Clinic. Jess stressed that doctors treating addicts were in legal jeopardy. In the 1920's, when the physician's movement to treat addicts in New York and Los Angeles first appeared, they were arrested and, as a result, the first incarnation of addiction medicine died in part because the AMA refused to back them.

Jess explained his vision of a field of addiction medicine closely aligned with organized medicine and then introduced me to his colleague, Gail Jara, who worked with the CMA.

Jess W. Bromley, MD and David E. Smith, MD at the AMA House of Delegates meeting in June 1989 following recognition of addiction medicine as a specialty within the AMA with its own code: ADM.

It was their vision and leadership that fueled the founding of CSAM and the beginnings of the modern addiction medicine movement.

Certainly there were individual doctors such as Max Schneider in California and Sheila Blume and Stan Gitlow in New York who treated individual addicts and alcoholics, and there was the beginning of the methadone maintenance movement in New York but there was no field of addiction medicine. The AMA had accepted alcoholism as a disease and there was an American Society on Alcoholism. However, a clear separation between legal drugs and illegal drugs prevented a unified national medical movement.

Having met Doug Talbott in Georgia and worked with Doug on the AMA impaired physician movement, Jess, Gail and I traveled to Georgia to form an alliance between CSAM and Doug's developing American Academy of Addictionology. A unity meeting was called at the Kroc ranch in 1981. The meeting was sometimes stormy and in fact the APA psychiatric representative walked out, but Jess' vision held true and a national addiction medicine movement was formed. With Manny's guidance, ASAM, the organization for this national addiction medicine movement, gained a seat in the AMA house of delegates, introduced the motion that all addictions (not just alcoholism) were diseases, and gained acceptance of ADM as a recognized AMA specialty with its own code: ADM.

Some of my fondest memories of the time were sitting with Jess and Manny, planning strategy and testimony. Many of these meeting were to implement ASAM Public Policy, including ASAM's Tobacco initiative. The ASAM Nicotine Dependence Committee, originally formed by Manny Steindler (and now headed by John Slade) had, in conjunction with Stanton Glantz of UCSF, uncovered and were preparing to publish "The Tobacco Papers" demonstrating the dishonest behavior of the tobacco industry. Tobacco industry lobbyists were in the back rooms of the AMA meetings trying to defeat our motion that nicotine is addicting. Jess Bromley stood up in the House of Delegates and challenged this lobbying process. Jess said that "back room lobbying" lost its power in the light of day. The motion passed the AMA. ASAM and The Cigarette Papers became significant factors in the subsequent punitive damage liability suits against the tobacco industry.

Addiction medicine is the study and treatment of addictive disease focusing on all addictions including tobacco, alcohol, and illicit drugs. ADM has become an international movement and has impacted millions of people worldwide. Jess' vision and power of persuasion was a driving force behind this international movement and I am privileged to have known and worked with him for four decades.

After his retirement from active clinical practice we worked together as ASAM MROs with some of his fine staff most notably Adelle Ferguson. Adelle and I called him shortly before his death. Unfortunately Jess was beset with health, family and financial problems at the time but we chose not to discuss the present but rather to discuss all ADM had accomplished the last four decades. Such remembrances gave him great happiness in his final days and he asked us to convey this sense of joy and satisfaction to all of his friends and colleagues in the ADM movement and to encourage a new generation to carry on our vision so that medicine can do more to help the still suffering addicts and alcoholics. I am honored to carry his final message to you.

Vernelle Fox Award

The California Society of Addiction Medicine
presents the
Vernelle Fox Award
to
H. Westley Clark, MD, JD, MPH

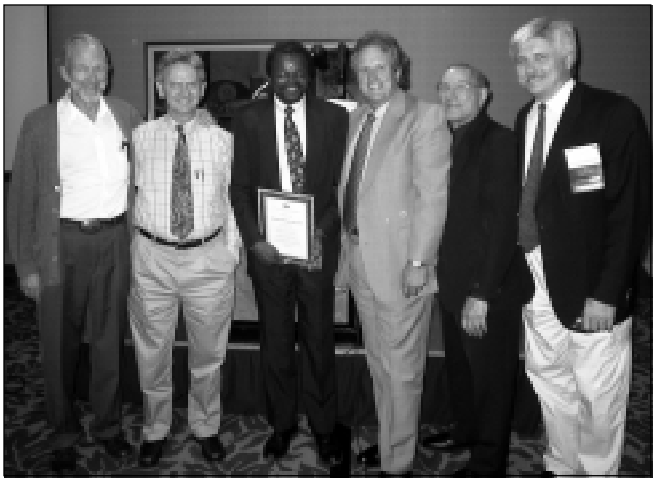
We honor him tonight
because he represents excellence
in
Addiction Medicine, Education, and Public Service.

Dr. Clark is first and foremost a clinician,
willing and able to work with complex patients.
He keeps the needs of patients in his mind,
and in ours.

Long active in public policy discourse,
he has taken an advocacy stance
for educating physicians
and for bringing research findings
to direct patient care.

As Director of the Center for Substance Abuse
Treatment, Dr. Clark has stimulated the development
of national policies directly beneficial to communities,
to young people, and to all of us.

Presented this 12th day of October, 2000
in San Francisco



H. Westley Clark, MD, JD, MPH (third from left) recipient of the Vernelle Fox Award in 2000 along with previous recipients (from left) John Chappel, MD (1997); Garrett O'Connor, MD (1998), David Smith, MD (1986); Max Schneider, MD (1987); Peter Banys, MD (1990).

New Members

CSAM welcomes the following new members:

Everett D. Allen, MD, Crescent City, *Internal Medicine*
Bruce Barker, MD, San Francisco
David B. Baron, MD, Malibu, *Family Practice*
Hector D. Barreto, MD, Colton, *Internal Medicine*
Bharat Bhushan, MD, Redwood City, *Psychiatry*
Thomas J. Brady, MD, San Francisco, *Psychiatry*
Donald Breneman, MD, Los Angeles
William Brose, MD, Palo Alto, *Preventive Medicine*
Richard Buscho, MD, Fortuna, *Internal Medicine*
Ann Carroll, MD, Freedom, *Internal Medicine*
M. Bruce Carter, MD, Salinas, *Internal Medicine*
Jeremy L. D'Morias, MD, Fresno, *Internal Medicine*
Dyan Dreisbach, MD, San Francisco, *Family Practice*
Laurie Endo, MD, Long Beach, *OB/GYN*
Gerald W. Frank, MD, Piedmont, *Internal Medicine*
Jason Giles, MD, Sacramento, *Anesthesia*
Debra Harris, MD, San Francisco, *Psychiatry*
James Rodney Jones, MD, San Francisco, *Psychiatry*
Jeffrey King, Laguna Niguel, *Medical Student*
Dennis A. Lange, MD, San Francisco, *Psychiatry*
Elizabeth LeBourhis, MD, Fresno, *Developmental Disability*
Michael H. Lowenstein, MD, Huntington Beach, *Family Practice*
Michael MacLean, MD, Visalia, *Internal Medicine*
Martha Madrid, MD, Diamond Bar, *Anesthesiology*
Shaikh B. Matin, MD, Fresno, *Internal Medicine*
Cesar A. Maurtua, MD, Sacramento, *Anesthesiology*
John J. McCue, MD, San Jose, *Internal Medicine*
Leland S. Rickman, MD, *San Diego*
John Roberts, MD, Red Bluff, *OB/GYN*
Donald W. Robinson, MD, Tulare, *Internal Medicne*
David I. Rohrdanz, MD, Sacramento, *Family Practice*
Christian B. Rutland, MD, Pasadena, *Psychiatry*
Jose R. Sanchez, MD, Sacramento, *Internal Medicine*
William M. Serbin, MD, Martinez, *Psychiatry*
Steve Shifflett, MD, St. Helena, *Emergency Medicine*
Suma Singh, MD, San Jose, *Addiction Medicine*
Paul Thomas Slominsky, MD, Pinole, *Anesthesia*
Charles L. Springfield, MD, Redding, *Emergency Medicine*
Steven S. Stepto, MD, Oakland, *Family Practice*
Michael D. Thompson, MD, Lemoore, *Family Practice*
Bradley Donald Tourtlotte, MD, Riverbank, *General Practice*
Michael Trindle, MD, San Mateo, *Family Practice*
Laura G. Valdovinos, MD, Merced, *Psychiatry*
Creed Wood, MD, Petaluma, *Orthopedic Surgery*

NEW WORKSHOP SERIES CONTINUES

Best Practices: Evaluation of Impaired Physicians

CSAM has launched a new series of workshops focusing on impaired physicians. The aim of these workshops is to promote best practices in evaluation, report writing, treatment, and monitoring of impaired physicians. In addition the series aims to raise the level of professionalism and sophistication of the systems and organizations that serve impaired physicians. The increasing sophistication of diversion programs and the pressures for greater accountability by medical boards has created a need for this series.

The first workshop in the series, Best Practices: Evaluation of Impaired Physicians was held in September in both Los Angeles and San Francisco and featured Norman Reynolds, MD and Janis Thibault, MFT, the Manager of the Medical Board of California's Diversion Program. The second workshop in the series on the evolving role of the diversion program was offered at the CSAM Review Course in October.

This series continues in 2001 with additional workshops being offered throughout the state. Workshop #3, *Best Practices: Rehabilitation of Impaired Physicians*, to be offered early in 2001, will be presented by Garrett O'Connor, MD. Each workshop qualifies for up to 4 CME hours. Visit www.csam-asam.org to download registration information and watch your mail for a registration flyer.

Is Disability Insurance Going the Way of Managed Care?

BY GARY NYE, MD

Your disability insurance policy may not be what you think it is. The Physician Well-Being Committee for the California Society of Addiction Medicine has noted doctors are being pressured to settle by insurance carriers for much less than their policies are worth. This is particularly true for physicians disabled by an addiction.

The insurance carriers may allege the illness is not a disability, deny benefits, and intimidate the physician into settling, knowing that the physician is vulnerable and not able to wage a long legal battle.

The committee would appreciate any information about such cases that CSAM members may be aware of. Information on which carriers are involved, policy provisions, rationale for denial, names of expert reviewers used by the companies to justify denials, and outcomes of such deliberations or denials would be particularly of interest. Please call the CSAM office at 415-243-3322.

New Web Site of Interest

AlcoholMD.com is a new web site that brings multimedia information, services and forums on alcohol and health to the general public, recovering alcoholics and clinicians. "AlcoholMD.com will be extremely helpful for anyone interested in, suffering from or treating alcohol abuse. Alcohol-dependent patients need access to an array of medical and psychological services to help them recover. AlcoholMD.com provides that access," said David Smith, MD AlcoholMD's editor-in-chief.

The site offers health care professionals an extensive list of benefits including an on-line version of the Journal of Psychoactive Drugs, The International Addictions Infoline, and links to over 100 other medical journals; specialized forums; interviews with physicians and patients; information on treatments; assessment tools for evaluation of a patient's drinking, multimedia presentations; academic courses and "Alcopedia" a unique alcohol specific medical encyclopedia. The site also features a clinical trials locator service, a grant locator service and conference calendars. Once a month AlcoholMD.com will host an on line interactive multimedia conference by an opinion leader.

The site also features resources for the general public, patients and their families. AlcoholMD.com is a service of DrugAbuse Sciences in collaboration with the Haight Ashbury Free Clinics and Haight Ashbury Publications.

CSAM PUBLIC POLICY COMMITTEE

SB1807 Passes!

CSAM's newly formed Committee on Public Policy worked hard this year to ensure the passage of SB1807 which was recently signed by Governor Davis authorizing the Department of Alcohol and Drug Programs (DADP) to establish an office-based opiate treatment program (OBOT) and authorized a person participating in a deferred entry of judgment program or pre-guilty plea program to also participate in a licensed methodone or LAAM program. Senator John Vasconcellos carried this bill and Dr. Sam Armstad spoke vigorously for it on the floor of the Senate. Dr. Jack McCarthy took the lead on this Bill for CSAM's Public Policy Committee and played a major role in getting this bill passed. This state legislation complements the recently signed federal legislation allowing office-based treatment for opiate dependence.

BEST PRACTICES: EVALUATION OF IMPAIRED PHYSICIANS

Checklist on Who Should be Referred for Evaluation

Examples of behaviors warranting referral (modified and adapted from the Diversion Program by Norman Reynolds, MD and presented at the workshop Best Practices: Evaluation of Impaired Physicians)

Suggestive of Axis I Psychiatric Clinical Disorder:

- ❑ Disturbances of affect (flat, depressed, withdrawn, loud; labile or fixed)
- ❑ Manic behaviors
- ❑ Psychotic behaviors (severe mental disorder characterized by impairment in reality testing as reflected in thought content and thought processes)
- ❑ Somatic symptoms that are psychological, not physical, in origin
- ❑ Unkempt appearance, poor hygiene

Suggestive of Substance-related Disorder:

- ❑ Appearing at work under the influence
- ❑ Driving under the influence, DUI citations
- ❑ Deficient patient care (forgetting, poor judgment, impaired physical performance impaired interpersonal skills)
- ❑ Self-prescribing
- ❑ Writing false prescriptions for personal use
- ❑ Falsifying patient records to support personal use
- ❑ Using medications intended for others, samples, house supply, O.R. medications

Suggestive of Cognitive/Organic Impairment:

- ❑ Confusion and Disorientation
- ❑ Decreased concentration and attention
- ❑ Forgetfulness/short-term memory problems
- ❑ Poor judgment
- ❑ Problems with sequencing and organization
- ❑ Problems with new learning
- ❑ Confabulation
- ❑ Errors in work

Suggestive of Disruptive Behavior:

The behaviors can be directed at, or exhibited in, the presence of patients, their families, or coworkers.

- ❑ Loud, angry, foul language
- ❑ Rude, demeaning attitude tone
- ❑ Physically threatening or abusing others
- ❑ Racial discrimination or harassment
- ❑ Gender discrimination or harassment, non-sexual

Suggestive of Poor Boundaries:

- ❑ Sexual discrimination or harassment
- ❑ Sexual relationships with patients
- ❑ Frotterism
- ❑ Using the patient relationship for betterment of oneself, e.g., acting on stock tips offered by the patient

Tobacco-Free Treatment in the New Millennium

CATHY MCDONALD, MD, MPH
PROJECT DIRECTOR, ALAMEDA COUNTY ATOD NETWORK

Is it appropriate for a person to enter substance abuse treatment as a non-smoker and leave dependent on tobacco when tobacco related diseases are the leading cause of death among treated substance abusers and those in recovery who are tobacco-free tend to stay clean and sober longer? This article discusses the rationale for tobacco-free policies in substance abuse treatment programs, strategies to make this paradigm shift and resources to help clinicians and programs that want to rise to the challenge.

Rationale

Tobacco is documented to be as addictive as heroin and as difficult to quit. Because 25% of the general population smokes cigarettes and the rate of smoking among substance abusers is more than three times this (80-90%), substance abusers account for a disproportionate number of tobacco-related deaths. A Mayo Clinic study of death certificates among people treated for substance abuse, revealed that 51% died of tobacco-related diseases (Hurt, 1996). During substance abuse treatment smoking is often accepted as a way to handle the stress of withdrawal and recovery. According to a recent NIDA study (Heishman, 2000) substance abusers who smoked had cue induced cravings for opiates and cocaine when tobacco cravings were triggered. Frosch's (2000) NIDA study shows that those in methadone treatment who are not using tobacco tend to relapse less to heroin and cocaine than those who continue to smoke, paralleling previous studies by Stuyt (1998) and Toneatto (1995) in recovering alcoholics. NIDA director Dr. Alan Leshner stated that the Frosch and Heishman studies "suggest that smoking cessation programs should be offered as part of other drug treatment programs."

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The June, 2000 Public Health Service Clinical Practice Guidelines for Treating Tobacco Use and Dependence states that "tobacco dependence is a chronic condition that warrants repeated treatments until long term abstinence is achieved" and "that effective treatments for tobacco dependence exist and should be offered to all tobacco users." The recommended treatments raise the one year abstinence rate for tobacco treatment from 5% for self quitting to 25-30% when appropriate pharmacotherapy and counseling (practical counseling, social support as part of treatment and/or outside of treatment) are provided. These treatments have been shown to result in similar rates of 1 year abstinence even in recovering substance abusers (Hurt , 1995, Martin, 1997) and clients with a history of major depression (Hall, 1994). Further the guidelines recommend that health care systems must institutionalize consistent identification, documentation and treatment of every tobacco user at every visit. The drug treatment setting is an optimal site to operationalize this recommendation by integrating tobacco treatment into existing treatment programs.

Drug treatment programs have traditionally excluded nicotine addiction from their protocols, believing that those addicted to alcohol and drugs shouldn't give up everything at once focusing on drug addictions that have had more immediate and dangerous or criminal consequences for clients. Since there is growing evidence that tobacco dependence treatment can facilitate alcohol and other drug recovery, and the drug treatment setting may be the ONLY time a recovering substance abuser could have the necessary support and clinical supervision to quit smoking we must rise to the challenge of providing tobacco treatment on par with other substance abuse treatment.

Strategies

Many programs begin to treat nicotine dependence without comprehensive tobacco-free policies only to discover the greatest obstacle to addressing tobacco in treatment programs is staff who smoke. While these staff role-model clean and sober lifestyles, their dependence on nicotine sends a mixed message to clients, and places these staff members in an impossible "double bind" when asked to treat clients for tobacco dependence. It is difficult to provide a tobacco-free environment and nicotine treatment when staff smell like tobacco smoke and carry packs of cigarettes. We are fortunate that pioneers, John Slade, MD and Abby Hoffman of New Jersey's Addressing Tobacco project have developed a twelve step system to guide treatment programs in a gradual transformation to a tobacco-free program (see sidebar). These steps begin by acknowledging the challenge of treating tobacco dependence in the substance abuse treatment community and establishing a leadership group to set up a timetable for phasing in comprehensive policies that address staff training, support for tobacco dependent staff, and the gradual evolution to a tobacco-free facility, grounds, staff and clients. This approach in collaboration with New Jersey's Division of Addiction Services has been so successful over the last 8 years that the New Jersey Department of Health and Senior Services recently adopted new licensure standards for residential drug treatment and extended care facilities which addresses tobacco on par with alcohol and other drugs.

Resources

Programs in Northern California are beginning to follow suit. From my experience over the last decade both at Thunder Road Adolescent Treatment Program, a tobacco-free program, and as Project Director of the Alameda County Alcohol, Tobacco and Other Drug Treatment Provider Network, (ATOD Network) there has been a growing interest and willingness among adult and adolescent treatment providers to treat clients for nicotine dependence. The ATOD Network has trained 400 clinicians, from 75 facilities, in the Bay area who are stepping up their efforts to address tobacco. Just one committed clinician can make all the difference in moving an agency toward developing tobacco-free policies and treating clients for nicotine addiction. Help is available both through Addressing Tobacco in New Jersey (732-846-4338) and by contacting the Alameda County ATOD Network which offers:

- 4 hour training in nicotine dependence treatment for clinical staff
- regular Roundtable Discussions
- a quarterly newsletter
- a brochure for clients

The Network can be reached by calling 510-653-5040. Ask for Judy Gerard, Project Coordinator.

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Hoffman & Slade, Following the Pioneers: Addressing Tobacco in Chemical Dependency Treatment. *Journal of Substance Abuse Treatment* 10, 153-160

The 12 Steps to Becoming A Tobacco-Free Agency

from ***Addressing Tobacco*** in New Brunswick, NJ

1. Acknowledge the profound challenges tobacco creates for the addictions treatment community.
2. Establish a leadership group or committee and secure the commitment of your organization.
3. Develop a tobacco-free policy for your agency.
4. Establish a policy implementation time-line with clear, measurable goals and objectives.
5. Conduct staff training.
6. Provide recovery assistance for nicotine dependent staff.
7. Assess and diagnose nicotine dependence in your patients/clients and use this in treatment planning.
8. Incorporate tobacco/nicotine into your patient education curriculum.
9. Establish on-going communication with AA/NA, professional colleagues and referral agents about these changes at your agency.
10. Require that no staff be identifiable as a tobacco user.
11. Establish your facility and grounds as tobacco-free.
12. Implement nicotine dependence treatment throughout your program.

NEW COLUMN ON FORENSICS AND ADDICTION MEDICINE

Violence and Stimulant Abuse

BY DOUGLAS TUCKER, MD

[This issue of CSAM News inaugurates a new column, which will focus on the forensic aspects of addiction medicine. This is an area of great significance for our field, but one which is often given insufficient attention. For this reason, I have asked Douglas Tucker, MD to edit this column. He is a clinical and forensic psychiatrist who has specialized expertise and experience in addiction-related issues. He is board-certified in general, addiction, and forensic psychiatry, as well as ASAM-certified in addiction medicine and MROCC-certified as a Medical Review Officer. I believe his particular background and perspective will lead to a stimulating and informative new feature for this newsletter. — Donald Wesson, MD, Editor]

I have been honored to be named editor of this new Forensic Column, which will examine and discuss issues at the interface of addiction medicine and the legal system. This is a wide-ranging and often intensely controversial border area, which involves many important legal and social policy concerns. I invite individuals with expertise in specific forensic addiction issues to contribute articles related to their experience, which could involve a broad range of topics in both the criminal and civil sectors. The following list of potential topics is by no means complete. Relevant criminal issues could include criminal responsibility and "diminished capacity" defenses, mitigation evidence in capital cases, interpretation of blood/urine drug levels as forensic evidence, drug-assisted assault and robbery (including "date rape"), the "drug court" phenomenon, and treatment of addictions in the correctional setting. Civil law issues could include liability for manufacturers of addictive substances (e.g., alcohol and tobacco companies), fetal vs. maternal rights for the addicted mother, and parental rights for addicted parents. One area of civil law that is of particular interest for addiction medicine specialists involves malpractice and the standard of care in addictions, including pain management of addicted individuals with narcotic medications, the medical marijuana controversy, appropriate vs. inappropriate use of dependency-producing agents, and managed-care issues. Another area with implications for civil litigation involves addictions in the workplace, including workplace drug testing, fitness for duty issues, impaired professionals, addiction-related disability, and medical review officer (MRO) and employee assistance program (EAP) policies regarding screening, assessment, and treatment for addicted employees. Other important issues involving substance abuse law and policy include appropriate legal sanctions for possession and use of currently illegal substances (e.g., pros and cons of legalization, decriminalization, and the status quo), ethical aspects of addiction medicine, confidentiality issues, needle exchange and other harm reduction approaches, and appropriate vs. inappropriate legal oversight of addiction medicine practice (e.g., office based opioid treatment, triplicate prescription forms, etc.). This is just a sampling of the kind of topics that this column might address. I welcome suggestions regarding other topics of particular interest and relevance for our field.

I will inaugurate this column with a brief review of the legal issues that arise in cases of stimulant-related aggression and violence, which is a topic of considerable current importance to the criminal justice system. I have chosen this class of drugs to review because of its timeliness in the context of the current upsurge in methamphetamine abuse in California and nationwide, as well as the frequent liability of drugs in this class to produce aggressive and violent behavior. Below is the presentation of a recent case of methamphetamine-induced psychosis and homicide, which was selected to illustrate the types of questions and problems that arise in this area.

Case Review

M.S. is a 21 year old single Caucasian man with no prior legal or criminal history, or any history of violence or antisocial behavior, who was arrested immediately after having killed his father, his mother, and his maternal grandmother. At the time of the incident, he was living in his parents' home in an upper middle-class neighborhood, and working as a laborer for his father's construction business. He had only slept for two or three hours the night before these murders because he had stayed awake snorting methamphetamine ("crank") and masturbating with pornographic magazines.

When he awoke that morning he continued to snort crank. In the early afternoon Mr. S. took his father's handgun from the drawer in his father's office, brought it back to his room, and loaded it. He then walked to his father's bedroom, where he shot his father in the neck at close range while his father was talking on the telephone. He denied that he was angry at his father, and stated that he felt like he was "in a movie," and that the situation was "pre-programmed" and did not seem real. He felt frightened when he heard the shot and saw his father's blood flowing, and he then ran out into the kitchen, where he shot his mother. He then pushed his grandmother onto the ground and dragged her down the hallway by her ankles to his bedroom. He then "went off" and started choking her, struck her in the head with a chair and with the gun butt a number of times, stabbed her several times in the throat with a knife, strangled her with a cord, and finally shot her in the head. He subsequently shot his father twice more because he "did not want him to suffer." He heard sirens and police outside the house, so he loaded two of his father's rifles and switched between different defensive positions in the house. Later in the afternoon he lit a smoke grenade because he thought the police and SWAT team were coming to get him, and were gassing him in the house. The house became filled with smoke from the grenade, and he jumped into a shower with his clothes on while carrying the rifles in order to rinse off the gas he thought he had been exposed to. He then shot out the bathroom windows to get air in the room. He thought he heard people drilling through the walls to get him, so he put a handgun where he thought they were drilling and shot into the wall. He heard a television news

anchorman talking to him through a bullhorn, and he screamed for the police not to shoot. No one else was actually present at his house, however, until his brother arrived home later in the evening and notified the police, who arrived immediately and instructed Mr. S. to come out of the house unarmed . He cooperated and was arrested without incident. Blood drawn from Mr. S. that evening was qualitatively positive for THC, and indicated a methamphetamine level of 224 ng/ml.

Mr. S. denied having any reason for killing his parents or grandmother, and denied any prior homicidal plans or intent towards them. He did understand that he was killing them at the time, and described feeling rage towards them, but he denied having any particular reason for this anger. He expected to be confronted by the police, but believed that he would be released from custody once he had explained what he had done. He recognized that killing his family members was wrong, but felt "driven to act" and unable to control his actions. He interpreted this as evil spirits taking control of his actions when drugs weaken his defenses. He generally had a very strong drive to look at pornography and masturbate when using methamphetamine, and on the day of these events had put his grandmother's face on the picture of a pornographic magazine model "out of curiosity." He denied a sexual motive, however, and denied having any pre-or postmortem sexual relations with any of the three relatives who were killed. He has had sexual relations on only a few occasions, and had never been involved in a significant relationship with a woman.

Mr. S. began smoking marijuana at age 14, with daily use from age 18 to "decrease anxiety, improve sleep, and help with work focus." He reported feeling continuously depressed after graduating from high school at age 18, but has no history of psychiatric or substance abuse treatment of any kind. He began snorting methamphetamine at age 19, about two years before this incident, and had escalated to snorting several lines of methamphetamine per day by about nine months before the incident. He was also smoking approximately one pipe bowl of marijuana seven or eight times per day, to help relax him from the methamphetamine stimulation. Since increasing his methamphetamine consumption, he felt "more demonized," and tried to communicate with spirits in order to "pump himself up" and to be "more of a warrior." He began to develop interests in the occult, including witchcraft and spells, and began to believe that people were watching him around the house, and that the government was trying to monitor him because he had discovered secrets about flying saucers and superconducting magnets. He suspected that the CIA was masquerading as aliens in latex masks and suits and abducting people. He reported that his parents had noticed a change in his behavior several months before the incident, in that he had become more depressed and less responsive than usual, with more absenteeism from work. They were apparently unaware of his drug use, however. They suggested that he see a psychiatrist, but he avoided this, knowing that his problem was primarily related to drug abuse.

There was no significant history of medical or surgical illness, and Mr. S. was not taking any medications at the time of the killings. Family history was positive for alcoholism in both grandfathers and a maternal cousin, chronic psychosis in a maternal aunt and uncle, and "sexual addiction" in his father.

On mental status examination several months after the incident, Mr. S. presented as a young man with adequate social skills, who attempted to be cooperative and cordial. His mood was moderately anxious and depressed, with mildly decreased level of psychomotor activity. He described some visual hallucinations of "people in the trees," and paranoid thoughts regarding his safety in jail, as well as intermittent suicidal thoughts. There was no evidence of thought disorganization or homicidal ideation, however, nor any evidence of cognitive impairment.

Discussion

What would be the role of the forensic addiction medicine specialist in this case? Such a specialist would most likely be called in to evaluate the defendant by either a prosecution or defense attorney. Of course, whichever side initiates the forensic consultation request is hoping that the evaluation will yield evidence helpful to their side.

However, even neutral or unhelpful information can be an important contribution, as it allows the attorney to more realistically appraise the strengths and weaknesses of his or her case. In situations where the attorney does not feel that the evidence gained by the evaluation will be of direct use to their side of the case, they may not ask for a written report or expert testimony. More often, however, even when the results of the evaluation are not directly helpful, they will decide to go ahead with a report and/or testimony in order to educate the finder of fact (judge and/or jury) about the addiction-related issues involved in the case. Forensic questions that are commonly asked in a case such as this include: What is this man's diagnosis? What are the effects of methamphetamine on mood, sexuality, behavior, and thought process? Can it lead to aggression or violence? What is the effect of simultaneous intoxication with multiple drugs, such as methamphetamine and marijuana? What is amphetamine psychosis, and how does it differ from ordinary intoxication? How should the toxicology results be interpreted? Were these killings caused by Mr. S.'s substance abuse? Is he eligible for a mental state defense of insanity or diminished capacity? An important question of more interest to clinical addictionists is whether or not these murders could have been prevented.

The issue of diagnosis carries important legal implications. Mr. S. was clearly dependent on marijuana and intranasal methamphetamine, with abundant evidence of reduced control over his use of these substances, and continued use despite negative consequences. The issue of personal responsibility vs. complete loss of control in continuing substance abuse often arises in addiction-related criminal proceedings. In this context it is useful to explain how control over drug use lies on a continuum from complete control to complete loss of control, with most individuals lying somewhere in the gray middle area of "diminished control." Another important diagnostic issue in this case involves distinguishing between a potential underlying, primary psychotic disorder such as schizophrenia or schizoaffective disorder, as opposed to a substance-induced psychotic

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disorder. In this case, abuse of potentially psychotogenic substances clearly predated the onset of psychotic symptoms, and intensification of methamphetamine use could be correlated temporally with the onset of psychotic symptoms. The persistence of psychotic symptoms for at least several months beyond the last use of methamphetamine or marijuana, however, and the positive family history of psychotic disorder are evidence of a possible underlying primary psychotic disorder. In general, judges and juries are more sympathetic to defendants who suffer from a primary mental illness which is clearly "not of their own doing." They tend to view addictions as blameworthy, and addicted individuals as responsible for whatever physical, psychological, or social consequences are engendered. Thus, defense attorneys will hope that a primary psychotic disorder is present, while prosecutors know that they are more likely to get a conviction if the psychiatric disturbance is found to be substance-induced. In actuality, of course, there are underlying genetic diatheses for both psychotic and addictive disorders which are beyond the individual' s control. Thus, even if this is truly a case of methamphetamine psychosis, it is possible that Mr. S. would not have become psychotic without his genetic loading for psychotic illness.

Most of the published human case reports and series suggest that stimulant-induced violence is characterized by being apparently unmotivated, irrational and bizarre.

Most of the published human case reports and series suggest that stimulant-induced violence is characterized by being apparently unmotivated, irrational and bizarre [1, 2]. It is generally associated with very high doses and the presence of paranoid psychosis [3]. In addition, there is evidence that these drugs can lead to heightened sexual arousal and sexual aggression [4]. Stimulant-related violence is not only directed towards others, but may also involve self-mutilation or suicide [5, 6]. Other stimulant-induced effects that may lead directly to violence include panic, emotional lability, lowered impulse control [7], and impaired judgment with risk-taking [8, 9].

The proper interpretation of body fluid toxicology results often emerges in drug-related cases where such evidence is available. There is no one-to-one correlation between drug level and mental state or psychiatric symptoms, particularly because different degrees of genetic vulnerability, tolerance, sensitization, and psychological experience with the drug will be present among different people. However, therapeutic levels for medically-prescribed methamphetamine are usually less than 50 ng/ml, while intoxication, psychosis, and violence usually occur in the range of about 150-1000 ng/ml, with increased incidence of such effects at higher levels. The official lethal level is often cited as 1000 ng/ml, although levels as high as 9500 ng/ml have been nonlethal.

Although the finder of fact will try to determine to what degree a homicide was "caused by" the defendant' s substance abuse, in actuality the forensic addiction expert will never be asked this question on the witness stand. Any statement by the expert witness which addressed such a crucial element of innocence or guilt would be seen as invading the province of the judge or jury. However, many questions might be asked which bear indirectly on this central concern. For example, the degree to which methamphetamine intoxication or psychosis prevented Mr. S. from killing in a willful, deliberate, or premeditated manner would be relevant to a finding of guilt or innocence of first degree murder. Likewise, if the defendant was so psychotic that he was incapable of knowing or understanding the nature and quality of his act and of distinguishing right from wrong at the time of the commission of the offense, then he would be eligible for the defense of insanity. California no longer allows the defense of diminished capacity to form specific intent, although testimony which shows that the defendant did not actually form specific intent remains admissible. Finally, testimony may be given in the penalty phase of capital cases which describes the nature and effects of substance dependence, thus leading to potential mitigation at sentencing.

The post-hoc question of whether or not a given mass murder could have been prevented has gained national importance with the increasingly common media reporting of such killings, often in the context of mental illness and/or substance abuse. Although his parents were aware of his increasingly erratic moods and behavior, and had recommended that he seek psychiatric attention, Mr. S. was not willing to follow through with this because he did not want his substance abuse to be discovered. Were there warning signs that might have indicated to his parents (or himself) that he was close to violence? There was no apparent prior history of antisocial behavior, aggression, or violence. In the absence of overt indications of rage or impending violence, could or should his parents have done anything further? If they had pressed more insistently for psychiatric evaluation, would this have led to discovery of his substance abuse, appropriate treatment, and avoidance of such a tragic outcome? Or would it simply have precipitated violence more rapidly? It is significant that firearms were kept in the house, and as is usually the case ended up being used against the occupants themselves. It seems unlikely that this triple homicide would have occurred if no gun had been available. Overall, however, the realities of this case seem to suggest that these murders would have been very difficult to prevent. The usual agents of detection and prevention (significant other, family, friends, teachers, employers and colleagues, medical caregivers, law enforcement) were either not present in this individual's life, or were unaware of the true dimensions of the problem.

Forensic cases involving violence or homicide associated with stimulant abuse are unfortunately quite common, and there is increasing pressure on caregivers to anticipate and prevent these tragedies. Hopefully, this case report and brief overview of the clinical and forensic issues involved in such cases will stimulate more interest and awareness of this problem by members of our specialty.

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