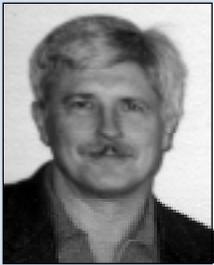


## New Era Begins Under Proposition 36

By Peter Banyas, M.D., CSAM President



**AS PRESIDENT** of the California Society of Addiction Medicine (CSAM) and a full-time clinician, researcher, and educator in addiction treatment, I've taken

an active role in promoting the passage of Proposition 36 and now, its implementation. As I complete my term as President of CSAM, I am pleased by what has been accomplished in just two years.

Proposition 36 passed with 61% of the vote last November. Arizona's Initiative 200 passed in 1996. Similar initiatives are slated to be on the November 2002 ballot in Michigan, Ohio, and Florida. Coalitions in all three states, including many of the same people who saw this through in California, are now preparing these initiatives.

The paradigm shift that began in Arizona in 1996, continued in California in 1998, and is spreading across the nation is a shift from incarceration to "Medicalization." It is not a shift to legalization. In fact, CSAM publicly opposes legalization.

Both before and after the passage of Prop 36, we have had some good experiences with California Drug Courts. However, prior to Proposition 36 they handled only about 3% of the eligible population. And, we believe that modern treatment offers a much wider array of interventions (medications, counseling, residential care, and other ancillary services) than is possible through a court and probation system.

*Continued on page seven*

**T**wo key questions need to be asked about "parity" for treatment of substance-related disorders. First: Does it work? Second: Does it make business sense from an insurance company's point of view?

Based on research and personal experience, my answer to both those questions is a clear "yes."

For additional proof, just ask health officials in Baltimore and San Francisco, where, according to new data from the Drug Abuse Warning Network (DAWN), drug-related emergency room visits dropped sharply from 1999 to 2000. In Baltimore, cocaine-related emergency visits declined nearly 29 percent. Heroin-related visits fell 23 percent. In San Francisco, drug-related emergency visits were down 12 percent during the same period.

In an interview with the *Baltimore Sun*, Peter Beilenson, M.D., the city's health commissioner, attributed the reduction in drug-related ER visits to a substantial boost in funding for drug abuse treatment. He added that it was "not coincidental" that Baltimore and San Francisco were the only cities in the DAWN study to demonstrate such declines, because both cities have stepped up their efforts to provide "treatment on demand" for people who need it.

**Treating Addiction Like Other Illnesses**  
"Treatment on demand" is an appropriate description of how the HMO where I work approaches chemical dependence treatment. As chief of addiction

medicine for Kaiser Foundation Hospital in Harbor City, CA, I am able to provide extensive services "on demand."

Treatment for alcoholism in federal employees began 30 years ago. Since then, we have progressed to the inclusion of treatment for chemical dependence as a "basic benefit" – the same as for other chronic medical illnesses.

At our hospital, a treatment team develops a plan for each patient to guide his or her care. No additional review or authorization is required. A wide spectrum of services is available, including:

- Emergency care, 23-hour hold, and hospital care for detoxification or stabilization, which are all offered without yearly or lifetime limits
- Outpatient care, including specialized programs for dual-diagnosis, day treatment and outpatient programs
- Case management for all patients with complex needs
- Residential treatment (up to 60 covered days per calendar year)

### Lower Costs, Better Outcomes

Data from a study at Kaiser's Sacramento Chemical Dependence Treatment Program, funded by NIAAA and NIDA, address the issues of cost and effectiveness for substance abuse treatment. In the *Journal of Studies on Alcohol* (62:89-97, 2001), S. Parthasarathy and colleagues reported on the first 18 months post-treatment follow-up of 1,011 adult patients treated in an outpatient chemical dependency recovery program. Costs for

*Continued on page three*

### HEALTH PLAN PERSPECTIVE

## Parity for Addiction Treatment is Good Care and Good Business Practice

By Gary A. Jaeger, M.D.,  
Chief of Addiction Medicine,  
Kaiser Foundation Hospital,  
Harbor City, CA

# A Neurophysiological Theory For Alcohol-Induced Amnesia (Blackouts)

By Timmen Cermack, M.D.

Every practitioner of addiction medicine has heard multiple stories of alcohol induced memory loss and generally uses a history of blackouts as one measure of the severity of addiction. Unlike many of the symptoms of alcoholism, the public is often familiar with blackouts. Ray Milland, in *The Lost Weekend*, portrayed an extended blackout that many, but not all, alcoholics can relate to.

We all probably have our favorite amusing anecdote about patients experiencing a blackout. Many have heard of the surgeon who was irate upon arriving at the hospital one morning to find that someone had performed an appendectomy on his patient, only to discover that it was he himself who had written the post-op note. Careful checking with the operating room nurses confirmed not only that he had done the surgery himself, but also that no one had observed anything out of the usual in his demeanor. Apparently people do not have to be grossly intoxicated to be in a blackout, nor do they necessarily lose their intellectual or motor skills.

I was intrigued to hear the story of a woman on a Hawaiian vacation who was having a few cocktails before leaving her hotel room for a dinner show. The next thing she remembers is "waking up" on stage with a magician, apparently having volunteered to be part of his show. This seems to indicate that the termination of a blackout (and very possibly the onset as well) can happen abruptly. People do not slide into, and out of, blackouts. Amnesic episodes appear to begin and end with a dynamic that closely resembles the onset, and offset, of sleep. As I will argue in a moment, there is good reason to view blackouts as essentially an electrophysiological phenomena.

Two additional facts are generally accepted regarding blackouts. First, the memory disturbance closely resembles that found in Korsakoff's. When presented with new material, both the Korsakoff's patient and the alcoholic in a blackout retain immediate and remote memory, but are unable to move scratchpad information into long term storage. Over the course of approximately three minutes, whatever material was briefly retained is lost. It is not as though the camera of memory has no film, but rather that the image recorded is very temporary, rather like a photograph that fades not over years, but over a couple minutes.

Second, there clearly appears to be a genetic

component contributing to blackouts. While some people drink very heavily for their entire lives and never experience a blackout, others develop amnesia at their first moderate exposure to alcohol. Anecdotally, I have frequently asked alcoholics to divide into two groups – those who had a blackout in the first year of their serious drinking, and those without a blackout during this first year. I next ask each group how many have an alcoholic parent. Close to 90% of those with early blackouts are family history positive for alcoholism, while the figure has been no more than 50% for those without a blackout in the first year of drinking.

The legitimate concerns of ethics committees have undoubtedly made the investigation of blackouts extremely difficult, given the intrusiveness of some of our technology and the inadvisability of providing alcoholics enough alcohol to produce amnesic episodes. However, there is some interesting data collected by Richard Thompson in the 1970's (Thompson, et al, 1980) that does not appear to have been integrated into our understanding of alcohol induced amnesia yet. His work entailed placing single cell electrodes in the hippocampus of rabbits that were undergoing a classical conditioning paradigm. A tone preceded a puff of air to the cornea. A transducer measured movement of the nictitating membrane to protect the eye.

Thompson recorded histograms of increased hippocampal unit activity that represented neuronal evidence of learning that preceded somatic evidence. Only after the hippocampus had developed a template for action, and then began moving that template forward in time, did the nictitating membrane begin to anticipate the puff of air that followed the tone. Learning was first evidenced by creation of a neuronal template in the hippocampus, then by pairing that template with the tone, and finally by closing

the nictitating membrane sooner.

Furthermore, Thompson noted that some rabbits learned much faster than others. What differentiated the fast learners from the slow was the percentage of time their hippocampus exhibited a background theta rhythm. The more theta rhythm, the more efficiently the hippocampus performed in the classical conditioning paradigm. There is a positive linear relationship between percentage of hippocampal theta and the speed of learning. Apparently theta rhythm activates, or organizes, the hippocampus in a manner necessary for the hippocampus to function properly.

What makes this data relevant to understanding blackouts is that hippocampal theta rhythm is driven by afferent pathways originating in the medial septal area. The more these nuclei are destroyed, the less hippocampal theta exists. This phenomenon brings to mind the finding that the most common lesions in Korsakoff's patients, who are lost in the functional equivalent of a permanent blackout, are found in midline nuclear structures,

*Continued on page three*

**While some people drink very heavily for their entire lives and never experience a blackout, others develop amnesia at their first moderate exposure to alcohol.**

Continued from page two

most often including the mammillary bodies. Korsakoffs results from the destruction of these midline nuclei. Recent work has demonstrated that one of the early low-dose effects of ethanol in an interruption of the normal physiological regulation of the hippocampus by the medial septal area. Ethanol enhances GABAergic transmission in the MSA, thereby reducing the regularity and vigor with which rhythmic bursting of neurons in this area drive the hippocampal theta rhythm. (Givens, Williams, Gill, 2000)

I am advancing the following hypothesis: First, transient alcohol induced amnesic episodes are physiological equivalents of the anatomically based permanent Korsakoff deficits. This places blackouts on a continuum with Korsakoffs, functional precursors to later anatomic destruction. Second, electrophysiological measurements of hippocampal theta might serve as a marker for when an individual is experiencing a blackout. Should this prove correct, it might have forensic significance as well.

Discovering the substrate underlying blackouts will probably not lead to new treatment modalities in the foreseeable future. However, it will further our understanding of the biological effects of alcohol; and every step forward in our understanding solidifies the disease concept of addiction. In addition, there is simply the intellectual satisfaction that would stem from better understanding the mechanisms producing such a ubiquitous phenomenon as the alcohol-induced amnesic episode – the common blackout.

## Parity for Addiction Treatment is Good Care & Good Business Practice

Continued from page one

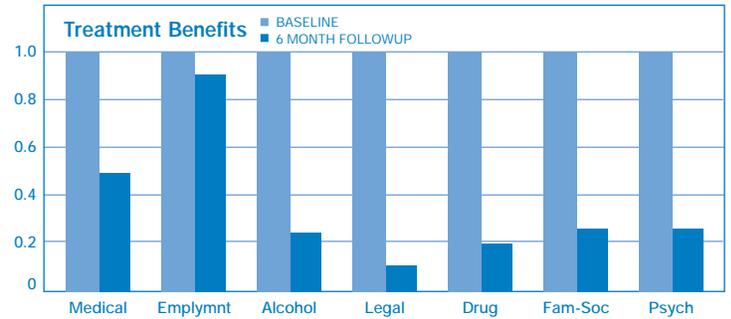
hospital inpatient care, emergency room care, and outpatient medical care were measured for 18 months prior to treatment and compared with costs in the 18 months after treatment. Costs for these same services were also determined for 4,925 matched controls.

Medical care costs for the control group remained unchanged from the first to the second 18-month period. For the treated group, costs decreased by \$31 per month after treatment – a savings of \$558 per patient over the post-treatment period. The total cost of treatment was \$663 per patient for an eight-week period. During the treatment and post-treatment periods, the “net cost” (including the offset for reduced medical costs) was \$105 per treated patient. When the net treatment cost is spread across the insured population of 3 million individuals, the result is a net cost of \$2.52 per insured individual per year.

This population will be studied again at five and seven years to determine whether this trend continues.

Improvement across a range of outcomes was measured at six months post-treatment with the Addiction Severity Index (ASI). Although employment-related problems showed only slight improvement, all remaining ASI scales demonstrated improvement ranging from 55 percent to 90 percent.

**Addiction Severity Index at Intake and After Six Months of Treatment (n=1,205)**



Clearly, there are both cost and outcome benefits from treatment for chemical dependence. Within our managed care system, we take a population-based approach to care. By treating chemical dependence treatment as a basic medical benefit, we eliminate the need for the additional expense of “managed care review.” Even more important, patients and their treatment team providers can negotiate and implement appropriate care plans without submitting to unnecessary review.

This produces a “win-win” situation for everyone. Patients are pleased they can receive necessary care “on demand.” Providers are pleased that their professional judgments are respected and put into action. Employers are pleased that their employees get the complete care they need in a timely manner. Primary care and emergency physicians are pleased to have readily available help with difficult cases they cannot manage alone. And the insurance provider is pleased to be able to provide a service that produces purchaser and customer satisfaction at a very reasonable cost.

So, to go back to our original questions: Does parity for chemical dependence treatment work? Yes. Does it make sense for insurers? Most definitely.

– By Gary A. Jaeger, M.D., Chief of Addiction Medicine, Kaiser Foundation Hospital, Harbor City, CA. You can reach Gary at 310-816-5380 or via [gary.a.jaeger@kp.org](mailto:gary.a.jaeger@kp.org).

**FOR MORE INFORMATION ON PARITY**, visit the CSAM website to download these PDF documents viewable using Adobe Acrobat:

“The Costs of Covering Mental Health and Substance Abuse Care at the Same Level as Medical Care in Private Insurance Plans,” a Rand Health study by Roland Sturm, July, 2001.  
<http://www.csam-asam.org/randreportparity.pdf>

“The Impact of Substance Abuse on State Budgets,” by the National Center on Addiction and Substance Abuse, January, 2001.  
<http://www.csam-asam.org/shovelingup.pdf>

“Substance Abuse: The Nation’s #1 Health Problem,” a report from RWJ Foundation, February 2001.  
<http://www.csam-asam.org/rwjf.pdf>

# Forensic Addiction Consultation Regarding Corporations and Businesses

By Raymond Deutsch, M.D. and Douglas Tucker, M.D.

**Editor's Introduction:** *Addiction and intoxication in the workplace are unfortunately common, with current alcohol and/or drug abuse in at least one out of every 10 U.S. workers. This has led to a variety of problems, from absenteeism, workers compensation claims, and generally decreased productivity, to serious accidents and workplace violence (1). I have asked Raymond Deutsch, M.D., an internist and forensic addictionist, to co-author the following article, which explores some of the issues that arise for addiction medicine specialists when they consult in litigation against corporate employers. Of note, the ASAM Medical Review Officer (MRO) Training Course mentioned in this article takes place three times per year, and will next take place from Nov. 30 through Dec. 2, 2001 in Washington D.C. – Douglas Tucker, M.D.*

One of the most interesting but technical and challenging areas in forensic addiction medicine involves rendering expert opinions when the defendant is a business or corporation. These cases often involve such issues as compliance with Department of Transportation regulations, continuation or discontinuation of employment for an individual where there is knowledge of continued drinking or drug use, and failure to require adequate treatment and monitoring after alcohol and drug-related accidents (2). Participation in such cases usually requires familiarity with the legal and regulatory environment surrounding corporate substance abuse prevention and treatment programs. This information goes beyond what is traditionally taught in addiction medicine training, such as standard patient evaluation and assessment, detoxification protocols, patient placement criteria, and work and social (including family) consequences of drug and alcohol use. Although basic concepts including the disease model, compulsive drug use, knowledge of symptoms of toxicity and consequences of drug and alcohol use, etc. are still useful and important in most instances, additional expertise is necessary to address problems which commonly arise in corporate litigation.

When businesses and corporations are faced with litigation involving employee drug and alcohol use, the relevant evidence is generally voluminous. The expert is often presented with thousands of pages of manuals, technical documents, drug compliance statistics, depositions, and records of prior treatments, as well as records of previous litigation or trials. When dealing with this amount of information, the organizational challenges are significant. Many of the documents may be irrelevant, and others many duplicate information present in other documents.

Frequently there is not enough time to review most of the material more than one time. Being able to remember and retrieve important documents and information at deposition or trial can be one of the major factors determining the effectiveness of the expert. The ability to use ancillary support including computers, secretarial support, specialized dictating equipment and filing systems are additional factors determining the effectiveness of the expert.

Current law holds both the individual and the employer responsible for damages, and these cases thus frequently go through both criminal and civil litigation phases. The first phase generally involves the employee as an individual, while the second phase involves the business or corporation. The forensic expert may be called upon at either or both phases. The employee as an individual may have broken specific laws (such as driving under the influence), and be responsible for the specific injuries. Therefore, the individual may be subject to both criminal and civil liability. To the extent that the individual is incapable of paying the monetary award, the corporation or business becomes liable for damages. This liability may potentially involve both compensatory and punitive damages. Particularly when litigation is directed at a business or corporation, concepts of liability for punitive damages may involve many millions of dollars. The client is no longer an individual, although an individual under the influence of drugs or alcohol may have initially been responsible for the injuries. If the forensic addiction specialist is called upon during this second stage involving the corporation or business, the issues frequently revolve around compliance with specific federal regulations.

Performance as a legal consultant or expert witness in corporate cases involving substance abuse thus requires a level of skill and experience beyond basic competence in clinical addiction medicine. This is one of the reasons that a forensic addiction medicine track has been incorporated into the Medical Review Officer certification course given by the American Society of Addiction Medicine. Attendees at this course have an opportunity to listen to experts who have been involved in such cases, and to benefit from their expertise. A history of corporate litigation is included in the Medical Review Officer course, and specific cases are presented and discussed during the forensic components of the course. One example is the New York subway accident of 1991, which resulted in the addition of alcohol testing to the Department of Transportation regulations in 1996. Large corporations dramatically updated and changed the way they viewed the importance of compliance with federal regulations following the \$5 billion judgment against the Exxon Corporation in 1994, after the captain of the Exxon Valdez ran it onto a reef while intoxicated with alcohol. Following is a case example involving corporate liability which illustrates some of the principles involved in these cases.

## Case Example:

An out-of-state trucking firm employed Mr. B. as a truck

*Continued on page five*

*Continued from page four*

driver. One morning, shortly after pulling his 18-wheel truck onto a freeway, he had a severe coughing fit and passed out. His truck crossed all three lanes on his side of the freeway, jumped the oleander bushes in the median, and landed on top of an oncoming car in the opposite lane, instantly killing two teenage girls. His blood alcohol was 0.17% when tested by the highway patrol two hours after the accident. The final judgment resulted in a \$28 million award for the parents of the girls who were killed.

Mr. B. was arrested for felony drunk driving, and given a jury trial for this crime. Previous to this accident he had had a perfect driving record. No one who he worked with had apparently ever witnessed him to be intoxicated at work in the past, and no witnesses at the scene saw evidence of intoxication. He had had several prior episodes of coughing to the point that he passed out, and on one occasion had visited a physician for this problem. Mr. B. was nonetheless convicted and sentenced to six years in prison. The conviction relied heavily upon his blood alcohol level, but it can be seen that this is not simply a case of uncomplicated alcohol intoxication. The expert for the defense at this criminal phase presented a plausible explanation for the accident, i.e. cough syncope, but the jury evidently felt otherwise.

The more difficult and technical civil litigation followed the criminal phase. Discovery revealed that Mr. B. had been treated for alcoholism prior to his employment at the defendant company. No one at this company ever asked if there had been any prior history of alcohol problems. Testimony revealed that Mr. B. had a pattern of daily drinking after work, but would not drink on the job or in the presence of anyone connected with his job. The jury had a difficult time believing that after eight years of daily drinking while employed at this company, no one had detected any problems. Additional history indicated that although Mr. B. did not drink prior to or while driving his truck for his employer, he would drive drunk after work. Frequently when he would reach a stopover at the end of his workday, he would take his truck to be cleaned prior to reloading it. He would buy a half gallon bottle of Southern Comfort and consume this during the cleaning process. He would then drive his truck a short distance to a local motel, where he would spend the remainder of his day off. On this occasion, however, he never arrived at the motel.

At first glance it appeared that the defense for the company was straightforward. During the job application process, it was established that there is no legal requirement for a company to ascertain whether a prospective employee has had prior drug or alcohol treatment. Testimony from company personnel verified that no one was aware of any alcohol problems during Mr. B.'s period of employment. Problems for the defense became apparent, however, following an in-depth review of compliance requirements with the federal regulations of the Department of Transportation during the period of time that Mr. B. was employed by the defendant company. Unfortunately for the company, the mandatory standards for alcohol testing had changed during this period. Although

companies were initially required to alcohol-test 50% of employees in safety sensitive positions, this requirement changed to 25% several years into Mr. B.'s employment. The defendant company had in fact met the requirement for testing a minimum of 25% of its employees, but they had never tested Mr. B. during his eight years of employment following the initial pre-employment examination. It was possible he would not have been called to give a specimen, but the jury was skeptical that the reason for this was not solely statistical, but was because he was out of state most of the time, which would have made testing much more difficult.

Also, they had changed the companies they contracted with for drug and alcohol testing several times, and the results of much of the testing could not be found. Depositions of the supervisors and owners of the company revealed that many of them were not even aware of their own policies and procedures, and had no idea whether or not they were in compliance. It was also brought out at trial that in order to meet the minimum requirement for drug and alcohol testing, a large percentage of the tests should have been conducted on the supervisors and owners themselves. Out-of-state truck drivers represented a very small percentage of the safety sensitive employees who were tested, and even those test results were not available in any company records, and were accessed only with difficulty by the expert for the drug testing company. It was also brought out that very few of the smaller companies throughout the state of California were compliant with federal guidelines, although this did not seem to affect the final outcome.

Thus, what initially appeared to be an uncomplicated defense turned into a case requiring knowledge and interpretation of evolving workplace testing standards and regulations. The jury ultimately awarded damages of \$28 million in this highly publicized case, which sent a strong message to other businesses falling under the Department of Transportation regulations that rigorous compliance is necessary to avoid similar consequences.

## Conclusions

The traditional skills and knowledge of clinical addiction medicine are relevant to corporate liability involving employee substance abuse, but more is required of forensic addiction specialists in this area. Familiarity with evolving regulatory requirements and workplace substance abuse testing standards is critical. Perhaps equally important is the ability to organize voluminous material, pay attention to details, and remain unflappable under hostile cross-examination.

## REFERENCES

1. Everett WD, Linder N, Drug Testing in the Workplace: What Primary Care Physicians Need to Know, *Postgraduate Medicine*, vol. 91, No. 4, March 1992.
2. Smith DE, Glatt W, Tucker DE, Deutsch R, Seymour RB, Drug Testing in the Workplace: Integrating Medical Review Officer (MRO) Duties into Occupational Medicine Practice, in J. Zweben (ed.), *Addictions in the Workplace*, volume 17, no. 1, January-March 2002 (in press).

## NEW MEMBERS

# CSAM Members Vote in New Executive Council

All voting members of CSAM were mailed ballots to vote for the CSAM Executive Council. The results of the election are being announced on October 18<sup>th</sup> at CSAM's Annual Business Meeting. The Annual Business Meeting (12 noon) will be held at the Marriott Marina Del Rey during the CSAM State of the Art Conference. Members were asked to cast their votes for two contested directors-at-large positions. Director-at-large nominees securing the highest number of votes will be announced at the Annual Meeting. The results of the election will be announced in the next issue of CSAM News. The newly elected Executive Council takes office January, 2002.

- President
- Immediate Past President
- President-Elect
- Treasurer
- Executive Director (ex-officio)
- Medical Education Research Foundation Representative
- American Society of Addiction Medicine Region Director Rep.

**Gary Jaeger, MD**  
**Peter Banys, MD**  
**Don Kurth, MD**  
**Lyman Boynton, MD**  
**Kerry Parker, CAE**

**Steve Eickelberg, MD**

**Lori Karan, MD**

*Committee Chairs appointed by the President to serve on the Council\*:*

- Education Committee
- Opioid Dependence Committee
- Physician Well-Being Committee
- Publications/ Communications Committee

**David Pating, MD**  
**Judith Martin, MD**  
**Bill Brostoff, MD**  
**Don Wesson, MD**

*\* Committee chairs are appointed by the President and there are four positions on the Executive Council for Committee Chairs. CSAM has other Committee Chairs not serving on the Executive Council.*

- Directors-at-Large –  
Two Contested positions.  
The Candidates are:

**Steve Ey, MD**  
**James Gagne, MD**  
**Dan Glatt, MD**  
**Steve Hansen, MD**  
**Jean Marsters, MD**  
**Norm Reynolds, MD**  
**Barry Solof, MD**

Leslie H. Alhadeff, MD — *Palm Desert*  
Everett Allen, MD — *Crescent City*  
Marilyn Ancel, MD — *Oakland*  
Thomas Andrews, MD — *Redding*  
Aziz Awad, DO — *Anaheim*  
Jeanne Axler, MD — *Santa Monica*  
John G. Bors, MD — *San Francisco*  
Randy Brown, MD — *Modesto*  
Debra Bunger, MD — *Fremont*  
Alvaro Camacho, MD — *La Jolla*  
Orlando Carraya, MD — *Santa Monica*  
Frank DelReal, MD — *Fresno*  
Michael V. Elam, MD — *Newport Beach*  
Margaret Elfering, MD — *Santa Maria*  
Michael Fong, MD — *Redwood City*  
Leandro Gatus, MD — *Los Angeles*  
Otashe Nyoku Golden, MD — *Sacramento*  
David Granovetter, MD — *San Jose*  
Alan Jacobs, MD, PhD — *So. San Francisco*  
Rebecca Fran Keilman, MD — *Davis*  
James Lewis, MD — *Sunnyvale*  
Romana Markvista, MD — *Los Angeles*  
Michael McGrail, MD — *Beverly Hills*  
Jeffrey Metzner, MD — *Los Angeles*  
Alison Moore, MD, MPH — *Los Angeles*  
Jorge Naranjo, MD — *Chula Vista*  
Kristen Colleen Ochoa — *Alhambra*  
J. Neil Ortega, MD — *Redondo Beach*  
Viswanatham Piratla, MD — *Palmdale*  
Nicole Pol'Quin, MD — *Los Angeles*  
Stephen Ripple, DO — *Paso Tobles*  
Trisha Roth, MD — *Beverly Hills*  
Ronald Schilling, MD — *Newport Beach*  
Mark Singleton, MD — *San Jose*  
Stephen Douglas Smith, MD — *Los Angeles*  
Bruce Spring, MD — *Pasadena*  
Aung Thu, MD — *Hemet*  
Wendy Warwar, MD — *Ventura*  
Jeffery Wilkins, MD — *Los Angeles*  
William A. Woods, MD — *Indian Wells*  
Caroll Yap, MD — *Newport Beach*

## A Model for Predicting Alcohol Withdrawal Delirium

Tom Palmstierna, M.D., Ph.D. (Karolinska Institute)  
*Psychiatric Services, Vol 52, No 6, pp. 820-823, June 2001*

**OUT OF A TOTAL** of 334 alcohol-dependent patients, 6.9% developed withdrawal delirium tremens (DT) despite administration of benzodiazepines (BZ). Five predictive factors were identified in a multiple regression model (1) Current infectious disease, (2) Tachycardia >120 on admission, (3) Withdrawal symptoms despite presenting blood alcohol concentration > 1 gram/liter of body fluid, (4) History of prior grand mal seizures, (5) History of prior delirium. Interestingly, risk factors enshrined in medical lore, such as extreme drinking, long periods of continuous drinking, and benzodiazepine abuse, were found to be of no significance.

## Symptom-Triggered Therapy for Alcohol Withdrawal Syndrome in Medical Inpatients

Thomas M. Jaeger, Robert H. Lohr, and V. Shane Pankratz  
*Mayo Clin Proc 2001;76:695-701, July 2001*

**IN THIS RETROSPECTIVE** cohort study of medical inpatients (216 admissions), symptom-triggered treatment of alcohol withdrawal syndrome did not result in shorter duration of treatment or lower total dose of benzodiazepine used but was associated with a decreased occurrence of delirium tremens, the most severe complication of alcohol withdrawal syndrome.

Symptom-triggered benzodiazepine (BZ) management of withdrawal ("front-loading") is generally done in conjunction with the CIWA-Ar alcohol withdrawal scale. Using this scale, Sullivan et al. (1991) reported less BZ use in a general hospital setting, but were unable to find any difference in withdrawal complications. Now, this study suggests that there is a difference, that CIWA-guided benzodiazepine dosing will reduce the risk of Delirium Tremens, particularly in a patient population without prior history of DT's.

– Both summaries by Peter Banys, M.D., CSAM President

## New Era Begins Under Proposition 36

*Continued from page one*

To our surprise, Proposition 36 was opposed by most politicians, most law enforcement leaders, and even by some addiction medicine practitioners. In this instance the people were plainly out ahead of the politicians and the vested agencies.

If you would like more details on Proposition 36, go to the CSAM website ([www.csam-asam.org](http://www.csam-asam.org)). There you will find several PowerPoint slide presentations about Proposition 36 and the CSAM White Paper on Implementation of Proposition 36.

Working with state agencies and with public interest groups to pass and implement Proposition 36 strengthened CSAM's reputation among California's policy leaders and helped build important alliances – including a critical one with the Prop 36's sponsors – that are instrumental to our efforts to pass substance abuse insurance parity legislation (an issue arguably more important and more universal than treatment for convicted individuals). SB 599 (Chesbro), the parity bill, is nearing passage in the second legislative house, and we are in negotiation with the Governor's office over amendments that might ensure his signature if and when the bill reaches his desk.

Our involvement with Prop 36 has also engaged CSAM physicians and improved its relationship with the Department of Alcohol and Drug Programs, with University of California researchers, the judicial system, the administration and key state legislators and has provided benefits to the organization and the entire treatment community that dramatically exceed any expectations we held when we voted to support it.

I am proud to have served as CSAM's President during this politically active time and look forward to continued involvement representing CSAM as part of the advisory team working with the CA Department of Alcohol and Drug Programs in the years ahead. I encourage you as a CSAM member to take advantage of the benefits I've enjoyed being part of this exciting effort – get involved – we all benefit from our collective voice and experience.

### CSAM news

CSAM NEWS is published quarterly by the California Society of Addiction Medicine, a nonprofit professional organization in the state of California with offices at: 74 New Montgomery Street, Suite 230, San Francisco, CA 94105; Phone: 415/243-3322; Fax: 415/243-3321; E-mail: [csam@compuserve.com](mailto:csam@compuserve.com). The California Society is a specialty society of physicians founded in 1973. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine.

#### EDITORS

Donald R. Wesson, MD  
 Kerry Parker, CAE

#### PRODUCTION

Michael Barack

#### ASSOCIATE EDITORS

Monika Koch, MD  
 Douglas Tucker, MD  
 Peter Washburn, MD

#### EXECUTIVE COUNCIL

Peter Banys, MD, President  
 Lyman Boynton, MD  
 William Brostoff, MD  
 Steven Eickelberg, MD  
 John Harsany, Jr., MD  
 Gary Jaeger, MD

Lori Karan, MD  
 Walter Ling, MD  
 David Pating, MD  
 Gail Shultz, MD  
 David Smith, MD  
 Donald Wesson, MD

## CONTINUING MEDICAL EDUCATION

**October 17-20, 2001**

### **CSAM State of the Art Conference**

(Including One-Day Workshops: Spirituality: Applications in Addiction Medicine, Intro. To Addiction Medicine for the Primary Care Physician, Buprenorphine Training)  
Marina Beach Marriott, Marina del Rey, CA  
Up to 27 Category 1 CME Credits  
[www.csam-asam.org](http://www.csam-asam.org)

**October 25-27, 2001**

### **Summit for Clinical Excellence: Innovations in Addiction Treatment and Behavioral Health Care**

Ben Franklin Institute  
Marriott's Mountain Shadows Resort, Scottsdale, AZ  
Up to 34 Category 1 CME Credits  
[www.bfisummit.com](http://www.bfisummit.com)

**November 1-3, 2001**

### **Conference on the State of the Art in Addiction Medicine**

American Society of Addiction Medicine  
Washington, DC  
19 Category 1 CME Credits  
[www.asam.org](http://www.asam.org)

**November 28, 2001**

### **2<sup>nd</sup> International Conference for Alcohol & Drug Professionals**

The Southeastern Conference on Alcohol and Drug Addiction  
[www.naatp-secad.com](http://www.naatp-secad.com)

**November 29, 2001**

### **Forensic Issues in Addiction Medicine**

American Society of Addiction Medicine  
Washington, DC  
8 Category 1 CME Credits  
[www.asam.org](http://www.asam.org)

**November 30-December 2, 2001**

### **Medical Review Officer (MRO) Training Course**

American Society of Addiction Medicine  
Washington, DC  
20 Category 1 CME Credits  
[www.asam.org](http://www.asam.org)

**December 13-16, 2001**

### **12<sup>th</sup> Annual Meeting & Symposium**

American Academy of Addiction Psychiatry  
Amelia Island, FL  
[www.aaap.org](http://www.aaap.org)

**February 7, 2002**

### **National Center on Addiction and Substance Abuse (CASA) Conference on Substance Abuse and Sexual Behavior**

New York, NY  
For information e-mail: [swinkell@casacolumbia.org](mailto:swinkell@casacolumbia.org)

**April 25, 2002**

### **Pain & Addiction: Common Threads III**

American Society of Addiction Medicine  
Atlanta, GA  
7.5 Category 1 CME Credits  
[www.asam.org](http://www.asam.org)

**April 25, 2002**

### **Ruth Fox Course for Physicians**

American Society of Addiction Medicine  
Atlanta, GA  
8 Category 1 CME Credits  
[www.asam.org](http://www.asam.org)

**April 26-28, 2002**

### **33<sup>rd</sup> Annual Medical-Scientific Conference**

American Society of Addiction Medicine  
Atlanta, GA  
Up to 19 Category 1 CME Credits  
[www.asam.org](http://www.asam.org)

**October 9-12, 2002**

### **CSAM Review Course**

Newport Beach Marriott, Newport Beach, CA  
Up to 28 Category 1 CME Credits  
[www.csam-asam.org](http://www.csam-asam.org)



California Society of Addiction Medicine  
74 New Montgomery Street, Suite 230  
San Francisco, CA 94105

Nonprofit Org.  
US Postage  
PAID  
San Francisco, CA  
Permit No. 1026