

Helping Patients with Substance Abuse Problems

A HEALTH PROFESSIONAL'S GUIDE



“He came to see me about his recurring back trouble and his blood pressure, which was going up. I recalled he had problems with his ex-wife, his kids, his job. I remembered I asked him on a previous visit if he had a drinking problem. ‘So, Jim, are you drinking a lot?’ He flashed a look at me that told me in an instant I had hit the right question.

Developed to accompany

MOYERS ON ADDICTION

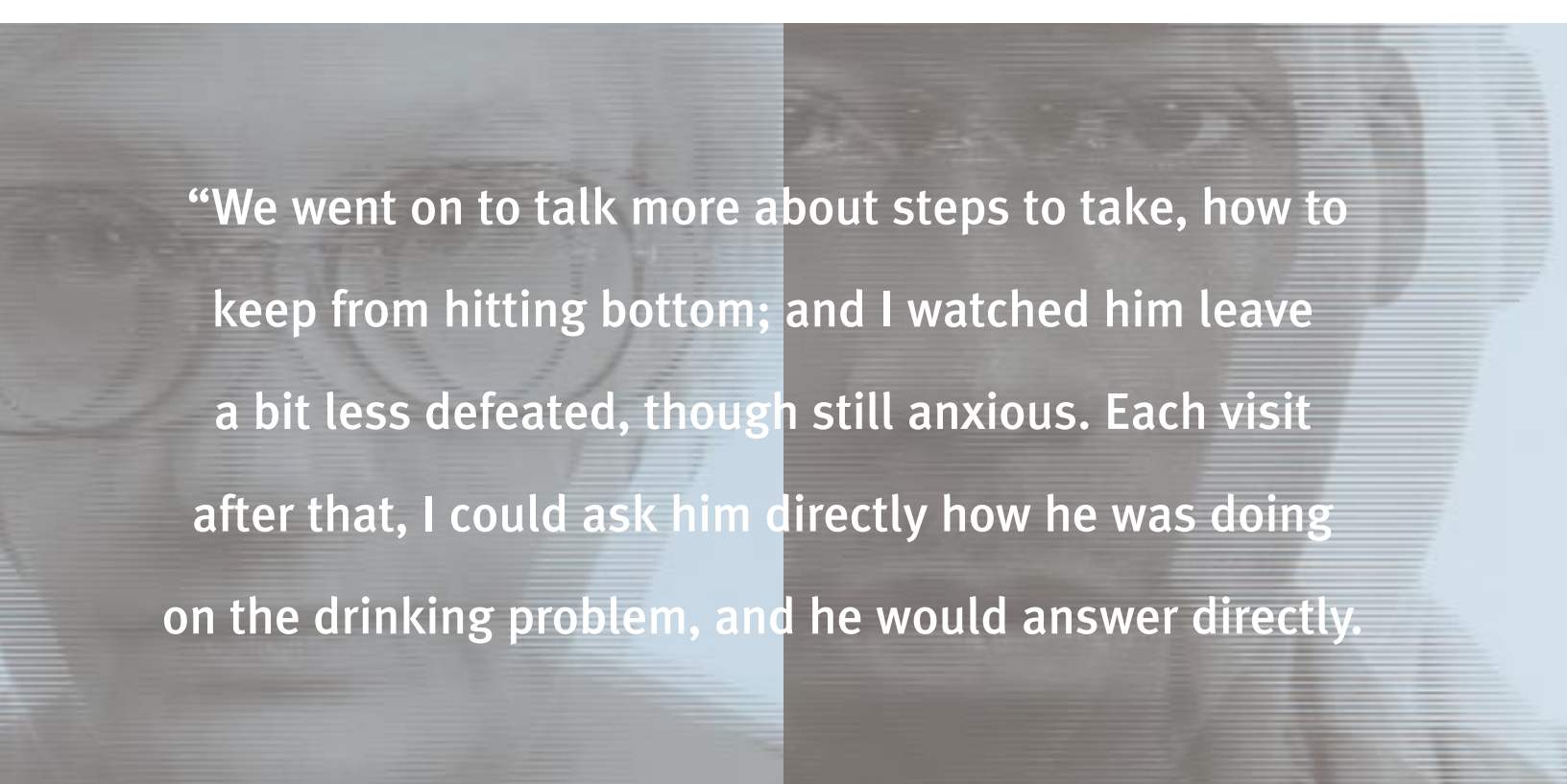


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“We went on to talk more about steps to take, how to keep from hitting bottom; and I watched him leave a bit less defeated, though still anxious. Each visit after that, I could ask him directly how he was doing on the drinking problem, and he would answer directly.

INTRODUCTION

*by Steven E. Hyman, M.D.
Director, National Institute
of Mental Health*

Addiction to tobacco and alcohol is the greatest cause of preventable sickness and death worldwide. Abuse of other drugs spreads AIDS and hepatitis through contaminated needles when injected intravenously and causes many additional health complications. Without appropriate diagnosis and treatment, addictions create suffering, disability, death, and immense costs to society.

The proper diagnosis and treatment of addictions, therefore, is an area where health professionals can be of inestimable value to their patients. Unfortunately, it’s also an area that has been greatly neglected in medical education and practice.

Addiction and the brain: Why the addicted person can’t “just say no”

Science is making inroads into understanding the fundamental processes of addiction. By showing that addiction is a brain disease produced by drugs in a vulnerable brain, these findings can help overcome the stigmatization and frustration that often interfere with a successful clinical approach to the addicted person.

At the core of any definition of addiction is compulsive substance use despite negative consequences. Why is it that many addicted individuals cannot stop their use of alcohol, tobacco, or other drugs after suffering some serious consequence—an automobile accident, a bout of acute alcoholic

He had gotten to AA and a counselor. What felt best about that incident and my ongoing care for him was he trusted me enough to be honest about something that was obviously a source of much embarrassment to him. I felt like his ally instead of his adversary.”

*John J. Frey III, M.D., a family doctor
in Madison, Wisconsin*

hepatitis, or a heart attack? Because the drugs themselves cause long-lived alterations in the biochemical and functional properties of neurons in the brain. Drugs of abuse alter nerve pathways intimately involved in setting behavioral priorities and regulating emotions, thus impairing the insight and volitional control of the addicted person. At the same time, the drugs facilitate the formation of deeply etched emotional memories that predispose to drug craving, and hence to relapse.

People who experiment with drugs or use them socially neither plan nor expect to become addicted. What happens in the transition from experimentation or social use to dependence? There is good evidence that use of a substance at adequate dose with adequate frequency and chronicity changes brain functioning. Many of these changes represent adaptations to excessive bombardment by the drug of key brain structures, especially the mesolimbic reward pathway. It is these drug-induced changes in brain function that produce addiction in vulnerable individuals.

Risk factors for becoming addicted are as yet poorly understood, but seem to be related to the interaction of genes and environment, which probably influence both the likelihood of an individual experimenting with drugs and the risk of developing dependence if experimentation occurs. Other risk factors include such things as psychiatric illness, chronic pain, and the intrinsic addictiveness of the drug used.

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What we can do to help

However, addiction is treatable. Abstinence and recovery, or at least a reduction in use or improvement in health, are frequent outcomes of caring intervention by health care providers. We can make a potentially life-saving difference to our addicted patients.

Barriers to treatment include problems that health professionals may have in dealing with addicted patients or in framing the issue as a medical problem that falls within their purview. Many health professionals still see addiction as nothing more than willful misbehavior, deserving neither sympathy nor society's resources. Since they see addiction not as a disease but as a moral issue, or since they are not aware of the causes that underlie the frustrating phenomenon of post-treatment relapse, they tend to be too pessimistic about treatment's effectiveness and their own ability to make a difference by intervening. The problem is compounded when addicted people are seen as hard to treat—they sometimes reject help, and are sometimes dishonest about their use—baffling professionals who want to be helpful, but who are unaware of the nature of addiction or effective methods of intervention.

However, once we have understood addiction as a treatable disease, our responsibilities to our patients become clear. We do not blame them for the disease any more than we blame patients with coronary artery disease. Instead we diagnose them and then recommend behavioral change and formal treatment if necessary and ask them to take responsibility for complying with our recommendations. We understand addiction as a chronic illness and accept the possibility of relapse as an element of treatment, providing support, encouragement, and consistent advice during the process of helping an addicted patient to change.

***Steven E. Hyman, M.D., Director,
National Institute of Mental Health***

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Educational Resources Center
Ruth Ann Burns, Director

PUBLISHER

Robert A. Miller

SUPERVISING EDITOR

Sue Young Wilson

DESIGN

Lou Lomurno

WRITERS

Maia Szalavitz
Joseph R. Volpicelli, M.D., Ph.D.

RESEARCH

Ben Alsup
Christina L. Draper

PHOTOGRAPHY

Kate Kunz
Joe Sinnott

PHOTO RESEARCH

Christina L. Draper

COPY EDITOR

Shannon Rothenberger

ADVISORS

Anne Geller, M.D., Chief of the Smithers
Alcoholism Treatment and Training Center

Joan K. Hollendonner, Communications
Officer, The Robert Wood Johnson
Foundation

Christine Rodemich, R.N., M.S., F.N.P.,
C.S., Associate Professor,
Nursing Department,
Glendale Community College

Lois Widly, R.N., B.S.H.S., C.A.R.N.
President of the National Nurse Society
on Addictions

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and education organizations.

what is substance dependence?

The core definition of addiction, technically known as substance dependence, is compulsive use of a psychoactive substance despite adverse consequences (see the fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual). Evidence of compulsion appears in decreased ability to control drinking or other drug use, particularly once an episode of use has begun. The obsession with obtaining and using the substance may cause the addicted person to ignore important social and personal responsibilities. Recent research has determined that these symptoms of addiction may be related to long-lasting neurochemical changes in the brain.

Addiction to a wide range of substances can occur. Nicotine, alcohol, and other legal and illegal drugs can be addictive. The latter two categories include marijuana, tranquilizers and sedatives such as the benzodiazepines, opiates such as heroin, and stimulants such as cocaine and amphetamines.

A feature of addiction that is often present is physical adaptation to the drug, as shown by drug tolerance and withdrawal. However, one can be "physically dependent" on a drug without being addicted, and addicted without being physically dependent. Pain patients, for example, frequently become tolerant to opiates; however, in a landmark study of 10,000 burn victims, fewer than 1 percent of those without a previous history of addiction had the obsession with the drug, the uncontrolled use, and the inability to stop that characterizes addictive disorders. Conversely, cocaine addicts often show no physical signs of withdrawal, but are obsessed with the drug, are unable to quit, and show psychosocial harm.

Addiction is considered to be a chronic disorder with a high probability of relapse. Most patients will relapse at least once after initial treatment. However, the majority will show substantial improvement in most life areas after completing care. Clinical studies find that about half of those treated for substance dependence will sustain significant improvement for one to three years (the duration of the studies).

Substance dependence thus has much in common with other chronic illnesses, with similar rates of improvement and periods of relapse. For example, people with diabetes or hypertension will have periods in which their glucose levels or blood pressure is not well controlled. As with most chronic medical disorders, recovery from addiction is a long-term commitment, and a good treatment outcome often requires major lifestyle changes.



diagnosing substance abuse and dependence



There is no typical substance-dependent patient. People from all walks of life are vulnerable. It is therefore advisable to include questions about drinking, smoking, and other drug use when taking every patient's medical history. If these questions are seen as part of the normal medical history, they are far less likely to arouse resistance.

Because these disorders are highly stigmatized, it is important to be nonjudgmental and to assure confidentiality when making a diagnosis. Many addicts believe that revealing the extent of their substance use might lead to the loss of their jobs or their children, and so are understandably reluctant to discuss it. But research has found that addicted people are often quite willing to discuss their substance use when they believe that they will not be judged or "badgered" about it, and when they believe that there are acceptable, healthy alternatives.

CAGE Alcohol Problems Screening Test

The following is the most widely used screening test for alcohol problems. It can easily be adapted for other substances. Any positive response is a potential indicator of a problem, and two or more positive responses does indicate a problem.

- C** Have you ever felt the need to **C**ut down on your drinking [or other drug use]?
- A** Have you ever felt **A**nnoyed by someone criticizing your drinking [or other drug use]?
- G** Have you ever felt bad or **G**uilty about your drinking [or other drug use]?
- E** Have you ever had a drink [or other drug] first thing in the morning to steady your nerves and get rid of a hangover [or other withdrawal symptoms]? (**E**ye-opener)

If the CAGE questionnaire indicates a problem, you will want to do a more complete assessment. Here are some other red flags to look for:

- 1) Repeated accidents. About half of all serious accidents are alcohol and/or other drug-related.
- 2) Elevated liver enzymes (e.g., elevated GGT).
- 3) HIV or viral hepatitis. One third of all AIDS cases are related to IV drug use.

In order to diagnose dependence, physicians should consult the DSM-IV for the complete diagnostic criteria. R.N.s may make a nursing diagnosis by utilizing North American Nursing Diagnosis Association taxonomy.

The following are some risk factors for substance abuse and addiction:

- 1) Family history of substance abuse or psychiatric disorders, such as depression. Children of alcoholics have a three to four times greater risk of developing alcoholism than children of nonalcoholics. Addicts and alcoholics frequently have first-degree family members with other psychiatric disorders.
- 2) Mental illnesses. About 50 percent of people with severe mental illness (e.g., schizophrenia, bipolar disorder, major depression) have substance abuse disorders, and the same percentage of addicts and alcoholics suffer a comorbid psychiatric disorder.
- 3) Exposure to traumatic life events, particularly early childhood trauma, and severe life stress.

People who abuse substances without meeting the criteria for dependence may also suffer negative consequences, and their problems should be addressed. They may be responsive to minimally invasive interventions, such as simple suggestions to stop or cut down (see section on “Brief Interventions” below).

intervention

Once you have diagnosed a substance problem, approach the patient about it in a matter-of-fact way. Ask whether they believe their drinking, smoking, or other drug use is a problem, and discuss the possible negative health effects of continued heavy use. Patients are often most open to change when they have just experienced drug-related health problems. An attitude of optimism and compassion is likely to be most effective in helping the patient.

If patients deny problems or insist that they don't need formal help, you may try simply recommending that they try cutting down or stopping use on their own for the next month. If they discover that they cannot control their use for even a month, they may then be more open to seeking help.

treatment

BRIEF INTERVENTIONS

Remarkably, simply doing the above assessment, discussing the consequences of continued heavy use, and recommending cutting down or stopping can have a major impact on heavy drinkers, smokers, and illicit drug users.

The technique is called a “brief intervention,” and studies of physicians who spent 15 minutes discussing patients' drinking in this manner had significant positive outcomes. One study found that nearly twice as many problem drinkers who received a brief intervention had significantly reduced heavy drinking a year later compared to controls.

Patients respect health professionals, and many are motivated to change if advice to cut down or stop is offered.

OTHER TREATMENT

For patients who are not able to control their drinking or other drug use after a brief intervention, the health care provider has several other options for treatment.

Substance dependence is biopsychosocial in etiology, and its causes and consequences are seen not just in the brain and body, but in a person's psychological state and social interactions. Because of this, recovery requires work in many areas and is different for individual patients. A depressed businessman, for example, may need different treatment than

Needle Exchanges

For intravenous drug users who are unwilling to give up injection, these programs can be crucial. They have been found to cut rates of AIDS and other blood-borne illnesses and frequently prepare addicts for abstinence-based or methadone treatment by showing them that help is available and that change is possible.

“One day I encountered a young woman in my practice who was slowly dying of alcoholism. She was depressed and suicidal, and she drank a lot—up to 12 beers a day. I advised her to cut down to two drinks per day and come back in a week. When she returned a week later, she had quit drinking entirely and remained sober the entire time she was in my practice. Her sleeping problems and depression resolved within three months. Similar experiences occurred with other patients.”

Michael Fleming, M.D., M.P.H.,
family doctor and addiction
specialist in Madison, WI

Smoking Cessation

Cigarette smoking kills more people than AIDS, suicide, car accidents, murder, and illegal drugs combined. Yet only 12 percent of all smokers who visit their doctors report being urged to quit.

Research finds that a three-minute conversation with a health professional about the advantages of stopping smoking can double the number of patients who quit successfully. U.S. Department of Health and Human Services recommendations for physicians are to ask every patient at every visit about smoking. Keep smoking status on patients' charts. Urge all smokers to quit, and discuss the positive health benefits of quitting and the use of nicotine replacement therapy like gum or the patch. Screen for depression—research finds that nearly half of smokers today are depressed, and may need antidepressant medication in order to quit. Strive to be positive with relapsers—research finds that the more times people try to quit any addiction, the greater their odds of success.

a chronically unemployed woman. A patient without skills or education, or with an untreated comorbid disorder, may be unable to avoid relapse unless those specific needs are addressed. Sensitivity to individual issues like culture, gender, social status, and past trauma issues is particularly important in treating biopsychosocial disorders.

You may be most effective if you offer options and suggestions but, if the patient is resistant, leave the choice up to him or her. Research finds that those given choices do better in treatment.

Complete abstinence is the preferred goal for substance-dependent patients. For those who categorically refuse to consider quitting, moderation approaches can help. Failed attempts at moderation often convince otherwise reluctant patients that abstinence is necessary, while successful moderation also improves lives.

The following is a list of treatment options for substance dependence. They are presented for informational purposes only and are not endorsements of particular treatments. Psychosocial treatments are presented in ascending order of intensity.

Medications (partial list):

- **Detoxification Medications:** The abrupt discontinuation of alcohol, other sedatives, and opioids after chronic use can lead to a withdrawal syndrome that requires medication, such as benzodiazepines for alcohol withdrawal. A general practitioner in an ambulatory setting can often safely administer these medications without the need for a referral to a specialized program and/or inpatient care. Sometimes, hospital treatment is needed.
- **Naltrexone:** This relatively new medication shows promise in reducing alcohol cravings and periods of excessive drinking. Naltrexone can block the “high” from alcohol and may reduce the chance of one drink leading to an alcoholic binge. One study found that those who take naltrexone regularly have a relapse rate three times lower than those on placebo. Also, of those who took one drink while taking naltrexone, fewer than half had a binge, compared to nearly all of those who “slipped” while on placebo. This drug can also be used for opiate dependence. However, it cannot be started until the patient has been completely detoxified (otherwise it exacerbates withdrawal). An antidepressant may also be needed, as anhedonia is sometimes a side effect for these patients.
- **Outpatient Methadone Maintenance:** This replacement therapy is the most successful treatment for opiate addiction in terms of reduced drug use and improvement in psychosocial functioning. Patients best suited to methadone are heroin addicts who have failed abstinence treatment. Only special clinics may prescribe methadone.

Physicians wishing to prescribe any medication for substance dependence should also offer behavioral support to enhance compliance. Without medication compliance, relapse rates return to that for placebo.

Self- and Mutual-Help Groups:

- **Alcoholics Anonymous and Other 12-Step Groups:** AA is the “grandfather” of the 12-Step movement and may be useful for anyone who wants support with abstinence. It has a nonsectarian spiritual focus and requires nothing of its members but “a desire to stop drinking.” Other 12-Step programs include Narcotics Anonymous, Cocaine Anonymous, Smokers Anonymous, Pills Anonymous, and Marijuana Addicts Anonymous. Local groups can be found in telephone directories.
- **Rational Recovery:** An abstinence-based self-help group without the spiritual components of AA. The national office is at P.O. Box 800, Lotus, CA 95651; (916) 621-4374.

- **Secular Organizations for Sobriety:** Another nonspiritual recovery program. SOS National Clearinghouse, The Center for Inquiry-West, 5521 Grosvenor Blvd., Los Angeles, CA 90066; (310) 821-8430.
- **Women for Sobriety:** A non-12-Step-based recovery program for women. P.O. Box 618, Quakertown, PA 18951; (800) 333-1606.
- **Religious Groups:** Many religious organizations offer recovery support within their spiritual traditions. Some examples are the Salvation Army, the Nation of Islam, and JACS (Jewish Alcoholics and Addicts). Many local churches have their own programs.
- **Moderation Management:** Started in 1995 by Audrey Kishline, this is a program for problem drinkers who are trying to control their drinking. It is not intended for heavily dependent patients or those who have already achieved abstinence. Moderation Management Network, Inc., P.O. Box 27558, Golden Valley, MN 55427; (612) 512-1484. Those interested may also get support from Kishline's book, *Moderate Drinking* (New York: Random House, 1994).

Psychosocial Treatment:

- **Outpatient Counseling:** There is wide variability in the type (and the quality) of outpatient counseling available for substance dependence. Best for highly motivated clients who do not need more intensive support. Often also used as aftercare following more intensive treatment.
- **Intensive Outpatient "Minnesota Model" Programs:** Based on the idea that addiction is a disease, and that total, lifelong abstinence and attendance at 12-Step groups is the best route to recovery. They often include family therapy, group therapy, and relapse prevention classes. At least four hours of treatment are provided daily. Programs typically run for several months, though there are shorter versions. They work best for patients who are not averse to abstinence, and who have a good employment history and family support.
- **Recovery Homes:** Residences for recovering people, with a counseling staff available. Recommended for those who need to leave their environment in order to avoid relapses. There are also programs called Oxford Houses, which are groups of recovering people in 12-Step programs living together without professional support.
- **Inpatient Minnesota Model Treatment:** Similar to the outpatient programs, except the patient sleeps at the center, and daily treatment runs longer. Managed care has cut typical length of stay from 28 days to 7 to 10 (and may be unwilling to pay unless the patient has not been helped by less intensive treatment or has serious concomitant psychiatric or medical conditions).
- **Therapeutic Communities:** Inpatient programs aimed at illicit drug addicts, with the idea that their problem is primarily rebellion and anti-social behavior. They tend to run for 18 months, though cost cutting has created six-month versions. Best suited to adults with few life skills.



relapse and aftercare

About the Authors

JOSEPH R. VOLPICELLI, M.D., Ph.D., is the program director of the University of Pennsylvania Health System Treatment Research Center and senior scientist at the Penn/VA Center for Research on Addictive Disorders. He is an associate professor of psychiatry and psychology at the University of Pennsylvania.

MAIA SZALAVITZ is a journalist who writes frequently about addiction and other health and science topics. She was the researcher and an associate producer for *Moyers on Addiction: Close to Home*.

Because relapse is a common phenomenon with substance dependence disorders, it is important for patients to plan for long-term support and continuing care after initial treatment. If you have a patient returning from inpatient treatment, or whom you have helped detoxify, it is important to be sure that this need has been met. This can be accomplished through use of medications that can reduce the chance of relapse as well as referral to self-help groups and psychosocial aftercare programs.

Continue to monitor for psychiatric disorders, particularly anxiety or depression, which may have been masked by the substance abuse and which may need treatment if the patient is to avoid relapse. For those with complicated comorbidities, a psychiatric consultation is often advisable.

Relapse need not be seen as a sign of treatment failure. Because addiction is partially a learned behavior, it may take some time before new ways of coping are acquired. Research shows that the more times a patient tries quitting, the more likely he is to finally succeed. Relapse may necessitate additional formal treatment.

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resources

ADDICTION MEDICINE TRAINING FOR HEALTH PROFESSIONALS

The following are examples of programs that offer training to health care professionals to help them better recognize and treat patients with substance abuse problems. (You can learn about other educational programs from the resources listed on the back cover.)

Hazelden New York’s Physicians in Residence Program each year offers more than 50 physicians from nine New York-area teaching hospitals a week-long course on recognizing and dealing with addiction. In addition to learning about the etiology, pathology, and treatment of the disease of addiction, doctors are paired with an addict “buddy” in a residential treatment program and share chores, meals, and stories with people in recovery. Participants report that they have come away with an increased awareness of their ability to significantly impact the health of the chemically dependent patient.

For more information, contact:

Jan Meredith, Project Coordinator
233 East Seventeenth Street
New York, NY 10003
(212) 420-9522

The National Nurse Society on Addictions (NNSA)

is a professional specialty organization for nurses that is committed to the prevention, intervention, and treatment of addictive disorders, including alcohol and other drug dependency, nicotine dependency, eating disorders, dual and multiple diagnosis, and process addictions such as gambling. To this end, NNSA offers the following opportunities for professional development:

- An annual educational conference featuring educational sessions for nurses with varying levels of expertise in addictions nursing
- Information on the Certified Addictions Registered Nurse (CARN) program
- Prevention workshops offered with the assistance of the U.S. Center for Substance Abuse Prevention (CSAP) that provide training in the prevention of and early intervention in addictions

NNSA is also a resource for published works aimed at advancing addictions nursing practice.

For more information, contact:

National Nurse Society on Addictions
4101 Lake Boone Trail, Suite 291
Raleigh, NC 27607
(919) 783-5871

The American Society of Addiction Medicine (ASAM) is an association of some 3,000 physicians dedicated to improving the treatment of alcoholism and other addictions by educating physicians, medical students, and the general public, and promoting addiction research and prevention.

ASAM offers certification to physicians for expertise in the diagnosis and treatment of alcoholism and other drug dependencies. Its educational programs include the annual one-day Ruth Fox Course, which covers new directions and concepts in clinical practice in addiction medicine and in selected areas of research and practical application. Topics covered by last year’s course included Spirituality and Recovery, Adolescent Substance Abuse, Hot Topics in Opioid Detoxification/Maintenance Treatments, and Treatment of Pain and Addiction.

ASAM also conducts continuing education courses on such topics as AIDS and Addictions, in which participants learn up-to-date strategies for intervention and treatment of HIV infection and AIDS.

For more information, contact:

American Society of Addiction Medicine
4601 North Park Avenue #101, Arcade Level
Chevy Chase, MD 20815
(301) 656-3920



Additional Suggested Reading

Lowinson, J., et al. *Substance Abuse: A Comprehensive Textbook, Third Edition*. Baltimore: Williams & Wilkinson, 1997.

Marlatt, G., and Gordon, J. *Relapse Prevention*. New York: Guilford Press, 1985.

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Volpicelli, J., et al. *Techniques to Enhance Behavioral Compliance: The BRENDA Manual*. 1998. (To request a copy, send e-mail to volpicelli_j@trc.research.upenn.edu)

Winger, G., et al. *A Handbook on Drugs and Alcohol Abuse: The Biomedical Aspects*. New York: Oxford University Press, 1992.

Other Organizations to Contact for Information

National Institute on Alcohol Abuse and Alcoholism

Office of Scientific Affairs
Wilco Building
6000 Executive Boulevard, Ste. 409
Bethesda, MD 20892
(301) 443-3860

National Institute on Drug Abuse

5600 Fishers Lane
Rockville, MD 20857
(301) 443-6245
<http://www.nida.nih.gov>
(800) 662-HELP

National Council on Alcoholism and Drug Dependence, Inc.

12 West 21st Street
New York, NY 10010
(212) 206-6770
(800) NCA-CALL

The University of Pennsylvania's Center for the Study of Addictive Disorders

<http://www.med.upenn.edu/recovery>

Visit the CLOSE TO HOME Web Site

For more information on addiction and recovery, visit the CLOSE TO HOME Web site at www.pbs.org/closetohome or www.wnet.org/closetohome. CLOSE TO HOME ONLINE will feature a Web soap comic book for teens plus an informational piece with:

- Animated illustrations of the brain and the mechanism of drugs in the body
- Real-life stories of people who talk about their struggles with the disease of addiction and their lives in recovery
- Editorials debating controversial policy issues
- Up-to-date articles with information about the latest advances in the science of understanding and treating addiction
- An extensive, user-friendly resources section, and
- A bulletin board



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New York, NY 10019