

The University of Utah School on Alcoholism and Other Drug Dependencies, 53rd Annual Session - June 20-25, 2004.

OVERVIEW: OVERALL OBJECTIVES, TARGETED AUDIENCE AND 53rd SESSION CURRICULUM DESIGN

The University of Utah School on Alcoholism and Other Drug* Dependencies offers on an annual basis a one-week course to update the current knowledge in the field and stimulate awareness and prevention of health and social problems that result from these afflictions.

This course traditionally targets a wide audience that comprises not only specialists in the field of addiction and treatment centers personnel, but also representatives of various health care professions including dentists, medical personnel, nurses, pharmacists, physicians, public health administrators and their respective educators, as well as representatives of the judicial system including county commissioners, judges, lawyers, peace officers. In addition, the course is made available for credit to college and graduate students desiring special instruction in the field, as well as to families affected by this disease. The program of this course is therefore designed to fulfill the needs of all in attendance by means of the following curriculum design that consists of:

General Sessions, open to the entire student body and focusing on general issues and current trends in the field of substance abuse addiction education, prevention and treatment (see below).

Group Sessions, providing a specific background to benefit various disciplines and groups as follows: American Indians; Criminal and Juvenile Justice; Dental; Drugs: Treatment and Rehabilitation; Education and Youth Counseling; Employee Assistance and Human Resource; Nursing; Pharmacy; Physician; Professional Treatment; Relapse Prevention Counseling; Residential Treatment; Substance Abuse Overview and Current Issues; Vocational Rehabilitation; Women's Issues.

Some of these group sessions address combined audiences, e.g. Dental-Physicians Sections, Dental-Nursing-Physician Sections, etc. (see below).

Additionally, optional **Extracurricular Activities** are offered to the general audience. They consisted for this 53rd session of: 1/ a video festival, consisting of the presentation of newly released educational material, 2/ a luncheon with dental, nursing and physician sections combined, 3/ an on-campus picnic offered to the program participants of all sections combined, and 4/ the opportunity to attend a meeting of Alcoholics Anonymous (A.A.) open to all sections as well.

Lastly, it is worth noting that a large number of those attending the course as well as a significant portion of the lecturers and staff were themselves in a recovery program of some sort [Alcoholics Anonymous (A.A.), Narcotics Anonymous (N.A.), Adult Children of Alcoholics (ACoA), Alanon, etc.].

* *Alcoholism and Other Drug* referred to as *AOD* in the remainder of this report.

SPECIFIC OBJECTIVES AND COURSE CONTENT REVIEW

GENERAL SESSIONS

These sessions were **planned** broadly for the entire student body comprised by specialists in the field of addiction, health care professions, judicial system professions, as well as students (credit and non-credit attendance), families of affected individuals and all desiring special instruction in the field of AOD dependencies.

The **objectives** outlined in the session program consisted of:

1. Revealing latest trends and significant advancements in the field of addiction to benefit professional and lay personnel.
2. Keeping pace with the increased awareness of health and social problems of AOD dependencies.
3. Exposure to latest methods and techniques for working effectively in the respective disciplines.

Review of Lectures:

In "A Tapestry of Connections", **Charlotte Kasl** presented both her clinical observations and a theoretical model, thereby stressing the importance of a number of connection points she thinks are key elements to the individual in recovery:

1/ "*Know the committee of who you are*"; allows control of impulses, to walk away from dangerous situations versus surviving on a substance. Learning to relax with the help of the "committee", finding a way to wake up to those parts in us.

2/ "*Turn on fascination and curiosity*"; both are great healers that should replace shame and guilt. Let oneself know feelings and learn how to feel more relaxed as a result. Turn on the brain and switch to action instead of freezing, conducive of depression and despair.

3/ "*Longing for bigger self*"; feel "high" on oneself, feeling expansive, feeling Zen, different from being just some one individual "out there". The real purpose of life is... to be alive!

4/ "*Show-up*"; Letting oneself go and connect with the ambient energy: the energy feels right. And you don't need to know why!

5/ "*Beware*", "*Pay attention*"; a person is a vibration of energy. Feel the resonance: our own body is our own musical instrument. There is a the difference between:

Self-awareness "Why did I do That?"	Self-absorption Feeling bad about what one did
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6/ "*Disconnection point*", you are not your mind, your thought. Remove the resulting core of false beliefs. Relax inside and open to the universe: it is basis for experiencing joy.

Note: This presentation was very conceptual and therefore difficult for the author of this report to summarize while making full sense of the content in the present text.

Cardwell Nuckol addressed "Early Life Trauma Issues in early Recovery".

Maltreatment of infants is a documented risk factor for disorders such as: 1/ violent behavior, 2/ criminal activity, 3/ teenage pregnancy, 4/ becoming a perpetrator of abuse, 5/ becoming a victim of more trauma, 6/ psychiatric disorders, 7/ substance abuse.

The resulting *psychiatric disorders* are multiple and consist of: a/ ADD and ADHD⁺, b/ oppositional defiant disorder, c/ clinical depression, d/ bi-polar disorders, e/ phobias, f/ obsessive-compulsive disorders, g/ generalized anxiety disorders, h/ borderline personality disorders, i/ antisocial personality disorders, k/ eating disorders, l/ substance-related disorders, m/ somatoform disorders, n/ panic disorders.

* This keynote speaker was the recipient of the Ewart A. Swinyard Award.

+ ADD: Attention Deficit Disorders; ADHD: Attention Deficit Hyperactivity Disorders.

Among subjects/clients in the substratum of *substance-related disorders* studied/treated: 1/ opiates appear to be the most desirable drug, because they mimic a dissociative state and compensate for lower levels of endogenous opioids, although, 2/ Etoh and tranquilizers, 3/ cocaine and metamphetamine, were frequently found to be used; and in addition, 4/ nicotine and/or 5/ cannabis dependence was (were) also prevalent. The two basic psychophysiological responses were reviewed:

“hyperarousal”	→	“fight or flight”	older children	males (mostly)	hyper-vigilant	tachy-cardia	norepinephrine
“numb”	→	“freeze” or dissociate	young children	females (mostly)	disen-gage	brady-cardia	endogenous opioids

A mechanism for psychophysiological alteration through neurotransmitters was presented:

repeated hyperarousal	→	altered noradrenergic systems
repeated dissociation	→	altered opioid and dopaminergic systems

By means of these biochemical mechanisms *early life trauma* can lead to:
 1/ a relationship to depression –which is the most common outcome along with PTSD*,
 2/ physiological changes –increase in cortisol & norepinephrine, decrease in endorphins-
 3/ physical symptoms-GI upset, headaches, insomnia- and somatic symptoms –vaginal and rectal pain and infection, nausea in relation to the anticipation of sex, fibromyalgia, chronic fatigue, chronic back and neck pain-
 4/ effects on development, in particular –aspects of development: cognition, attention, Self-esteem, attachment, fears, social interaction, impulse control; implementation of self-defense: self-hypnosis, compartmentalized memories, dissociation, amnesia and fugue, splitting, need to control, projection; correlated with age: from cognitive impairment and severe stress reaction; to aggression, impulsivity, destructive acts and fearfulness; to anxiety, depression, obsessive thought, and phobia/counter phobia; interpretation: trauma experienced or interpreted, perception often accurate, invent explanations –e.g. “Life means suffering”, “People who love you hurt you”, “Hit me for my own good”-
 5/ impacts on the brain –same brain areas as in PTSD (amygdalia, hippocampus, anterior cingulate and prefrontal cortex), areas appear smaller in size and less developed-
 6/ a fear response –sensory stimuli trigger a/ thalamus, b/ high road (cortex), c/ low road (amygdalia is involved in its various susceptible areas)-
 7/ complex PTSD –repeated inescapable early life trauma, multigenerational trauma, may have genetic basis, involves changes in physiology, self identity and dissociation-
 8/ suicidal/parasuicidal behaviors –in which case elaborate assessment is needed, patient and clinician responsibilities become complex -.

Treatment considerations were then reviewed, including:

1/ a/ stabilization (threefold: physiological, psychological, social) –closed contract advised, psychotropic medications, decrease social alienation, behavioral and cognitive-behavioral therapies-, b/ trust –validate feelings, enter the map of the world, rapport-, and c/ safety –above all else make sure that no harm is done to client-
 2/ working with “hyperarousal” and “numbing” –client seeks comfort from therapist, uses Etoh, drugs, food, sexual behavior for relief, medication, help patient make contact between internal state and external reality, “mindfulness” and tolerance of feelings-
 3/ psychotherapeutic options –behavioral exposure therapy with imaginal exposure and in vivo exposure, eye movement desensitization reprocessing (EMDR) in which trauma is visualized and negative thoughts are replaced by positive ones-
 4/ trauma treatment in early recovery from addictive disorders –preliminary studies show success in treating PTSD in early recovery, PTSD and related symptoms (depression, insomnia); however, early life trauma clients often struggle in self help group-.

* PTSD: Post Traumatic Stress Disorders.

DENTAL SESSIONS

These sessions were **planned** specifically for the dental profession at large, including: dentists, hygienists, dental office team members, dental societies well-being committee members, state diversion program members, licensure board members, dental school educators and students*, as well as spouses, and other members of the dental family.

The **objectives** were clearly defined in the session program and consisted of:

1. Articulating the pathophysiology of addictive illness in general and in relation to specific drugs of abuse.
2. Discussing the key components of treatment for addictive illness and develop outreach skills for affected colleagues.
3. Exploring the impact of addictive illness and recovery in women.
4. Integrating knowledge of the disease process, pharmacology and treatment recommendations into dental treatment plans.
5. Knowing the components of a recovery program and how to develop and relapse intervention plan.
6. Providing an opportunity for personal renewal and professional networking.
7. Promoting substance abuse education in dental schools and developing implementation strategies.

Review of Lectures, Sessions and Workshops:

In “Pathophysiology of Addiction” **a replacement speaker* for Darryl Inaba** discussed both current knowledge and theory pertaining to the pathophysiological changes occurring in the brain during the addictive process. Currently, many theories with different degrees of relevance exist. While the ultimate goal of *using* (drugs) consists of achieving a state of altered consciousness, some individuals develop *addiction* while others manage not to. Two corollaries to the addictive process are *tolerance*, i.e. increased amounts of the substance are needed to produce the same effect, and *withdrawal* i.e. using becomes necessary to avoid the substance’s side effects. It is currently thought that *cravings* result from both an endogenous process and environmental exposure.

A current theory of *addiction* sets forth the possibly irreversible alteration of the brain chemistry that occurs at a specific point in the developmental curve of addiction (c.f. //) –possibly coinciding to the expression “crossing the invisible line” coined in A.A. jargon:-

Abstinence/ Experimentation // Abuse/ Addiction

The respective role and relative importance of three determinants of the addictive disease -1/ heredity, 2/ environment, and 3/ drugs/behavior- were emphasized in this theory, along with its concomitant treatment implications.

Maximum Susceptibility	Addiction
Type of Drugs/ Type of Behavior	Change of life style → Treatment
Environment	Stress added → Alteration
Genetic Inheritability	Even if non-existent at onset of addictive process, can reach susceptibility with habitual use. Then, changes become permanent, i.e. relapsing alcoholic “right where he/she left off”

* Two dental students only attended the June 2004 Dental Session. They were the two dental students from Boston, MA, benefiting every year from a scholarship offered by the Massachusetts Dental Society Well-Being Committee. Both women -one first-year Harvard student and one second-year Tufts student- are expected to re-group with their respective classes to share experience and knowledge gained during the session to promote the awareness of the student body to the problems resulting from AOD dependency.

+ Replacement speaker name not noted. Sorry ☹!

Addiction can be described as the virtual theater of the battle between reptilian brain and cortex, when the reptilian brain becomes dominant. The “turn off” switch -for “enough” dopamine and endorphin levels- does not function anymore: therefore satiation is absent. Notes of interest to the dental profession: once the brain chemistry is altered for one particular drug, other drugs may be substituted. The clinical implication is the potential for *cross-addiction* while for instance prescribing opioids to an alcoholic patient in recovery.

Linda Keating presented an overview of the AOD treatment processes in “Getting Better: Fundamentals of Treatment”. The *acute phase treatment* can be very disconcerting to the patient with feelings of uncertainty and fear. Different levels of care, including in- and out-patient, residential and length of treatment exist. A thorough initial assessment is carried out, including: 1/ DSM-IV treatment criteria, 2/ physical, 3/ psychological and psychiatric, 4/ emotional, 5/ social, including work, 6/ spiritual, 7/ *readiness for change*. The latter assessment is very critical in the determination of AOD treatment outcome. The stages of change are: 1/ precontemplation (“I don’t have a problem”, reluctance, rebellion, resignation and rationalization), 2/ contemplation (“I might have a problem”, not quite ready to changing it), 3/ preparation for action (“what would I need to do, what does it cost to change?”), 4/ action (change in behavior followed by self-efficacy, realization that “I can do it”), 5/ maintenance, relapse and recycling (requires a strong commitment, long term daily-ness and repetition of that “which works”). Additional goals pursued in the *maintenance phase* of the treatment consist of: 1/ physical stabilization, 2/ accurate personal assessment of problem, 3/ skills in managing negative emotions, 4/ learning the “culture of recovery”, 5/ developing strategies to manage urges and cravings, 6/ addressing underlying issues, 7/ formulating a specific maintenance plan. In summary, treatment is both an *art* –involving experience, intuition, empathy, collective wisdom, anecdote-, and a *science* –neuroscience support experience, many styles of treatment work, the key factor in success resides in relationships, more = better outcome-. Addiction is a *chronic* illness that needs an *ongoing* (not acute phase only!) treatment. The recovery rates for addiction are higher than for any other chronic illness. Notes of interest to the dental profession: Professionals have very high recovery rates.

Patrick Sammon presented a timely topic: “Marijuana Update: Harder than Thought!” Marijuana is the most widely abused and readily available illicit drug in the United States with 83 million lifetime users, 12 million current users and average age of first use declining. 1/ Information is readily available over the Internet (e.g. Vault of Erowid) that promotes the production, use, sale and therefore the “drug culture”, 2/ compounded is a current debate on the legalization of marijuana for medical use—glaucoma control, forestall AIDS-wasting syndrome, ease nausea while undergoing chemotherapy, relieve pain in MS-, 3/ in contrast, the Institute of Medicine Report downplays the effectiveness of marijuana, stressing the high doses needed for effectiveness and the many negative side effects —“There is little future in the use of smoked marijuana as a medication”; “The future lies in cannaboid-type drugs more certain composition, characterization, and delivery system”-. Therefore, marijuana use is at the center of highly charged emotional and political issues. Also worth noting is the current availability of higher potency forms with stronger effects. The major chemical of marijuana -among 450 to 500- is Delta-9-Tetrahydrocannabinol. Major *health and impairment consequences* of marijuana use include: 1/ effects on the nervous system –delayed reaction times, increased risk for accidents-, 2/ short term memory loss, 3/ decreased pulmonary function and all effects of smoking, 4/ negative effects on the cardiovascular system –among many, 5 X increased risk for MI-, 5/ may be immunosuppressant, 6/ negative effects on the reproductive system at high doses –decreased testosterone levels, sperm count and motility, disruption menstrual cycles, lower birth weight-, 7/ social behavior -resulting from the abuse of a psychoactive drug-. *Physical dependence* consists of developing: 1/ tolerance to many of its side effects and 2/ withdrawal symptoms that include restlessness, irritability, agitation, insomnia, nausea, cramping. *Psychological dependence* is characterized by the increase in dopamine levels

in the reward system (laboratory animal brains), hence long term use can lead to addiction –use despite adverse consequences, compulsive drug seeking behavior-.

Note: A key element in prevention of marijuana use appears to be parental involvement.

Mary Martin made a thorough review of the “Dental Management of the Active and Recovering Patient” including history taking, examination and treatment considerations. Two main characteristics of the *active alcoholic patients* are: 1/ failure to keep scheduled appointments and 2/ elaborate explanations as to why their mouth has been neglected.

A/ The importance of a very thorough, empathetic and non-judgemental *health history interview* was stressed. Specific questions should be geared towards family history of alcoholism, quantity/frequency of use, screening with MAST questions and/or CAGE test may also be helpful in the diagnosis when the answers of the *active patient* proved evasive. [If *in recovery*, familiarity of the dental provider with the 12-step program and knowledge of sobriety date (for future reinforcement), as well as bi-laterally agreeable meeting with the sponsor may be assets in building a trusting patient/doctor relationship].

B/ Extra-oral examination may further reveal (*active alcoholic*): 1/ alcohol smell on breath, 2/ tremors of hands, 3/ excessive perspiration, 4/ bloated appearance, edema, and puffy facial features, baggy eyes, 5/ erythematous facial skin and telangiectiasis, 6/ general signs of malnutrition including weight loss and skin disorders, 7/ lymphadenopathy (a thorough palpation of head & neck is imperative because of the increased risk for cancer).

Peri/Intra-oral examination may bring the following observations (*active alcoholic*): 1/ oral signs of malnutrition such as dry lips and angular cheilitis, 2/ yellow/brown pigmentation of the hard palate, 3/ glistening red buccal mucosa, 4/ coated or beefy red tongue, 5/ evidence of oral hygiene neglect with gingivitis, periodontitis, numerous untreated carious lesions (high sugar content of Etoh), composite resin restoration with decreased longevity.

C/ Treatment considerations in the case of the *active alcoholic*, include: 1/ one to one and half hours long appointments (maximum) in the morning, with time preferably selected by patient, 2/ avoid medications/rinses containing Etoh (Chlorhexidine 17%; Listerine 26.9%; Scope 18.5%), 3/ surgical considerations: increased bleeding time, 20% to 50% longer wound healing time, 4/ increased a/ amount of local anesthesia and b/ time to be effective, 5/ consideration for decreased liver function: review all medications interacting with Etoh, advise to refrain from drinking prior to taking antibiotics and two hours following ingestion, 6/ consideration for pain management*: a/ avoid opioids (cross-addiction: dental provider contributing to relapse) and pre-treatment tranquilizer (consider Inderal 10-40mg 1hr prior), b/ caution with aspirin and Ibuprofen (gastritis) as well as Acetaminophen (liver damage, c/ consider Vioox: 50mg q 24hrs for *acute pain*, 25mg q 24 hrs for *chronic pain* and/or Ibuprofen 800mg tid (start day before surgery or at end of surgical appointment), d/ avoid nitrous oxide and conscious sedation, e/ considering long lasting local anesthesia (Marcaine) & re-injecting in the afternoon following the procedure, 7/ other considerations: patient seeking narcotics, -a/ potential for Rx altering (spell numbers), b/ eliminate easy accessibility of drugs, Rx pads, syringes, c/ post-appointment inventory of supplies-.

D/ Medico-legal Consideration for treating *any chemically dependent patient* include: 1/ possible drug interactions with Etoh, 2/ increased CNS sedation or depression, 3/ antibiotics pre-medication, 4/ contribution to relapse through prescription (opioids), 5/ contribution to systemic disease (liver, lungs, stomach).

John Chappel presentation “Interviewing and the Addiction Medical History” targeted primarily a physicians’ audience. Whereas patients & families cite MDs as the “most appropriate” source of advice with respect to AOD issues, they also report MDs to be the “least” helpful in addressing these issues (Graham, et al: ADM, ASAM, p325, 2003). Therefore, the importance of mastering basic clinical skills -despite increasingly reduced visit time- was emphasized throughout all steps involved in the work up, from screening and assessment, to negotiating a treatment plan and monitoring treatment and recovery.

* For further information, refer to review of lecture on “Pain Management of the addicted Patient” by Penelope Ziegler.

Simple “bed-side” manners such as, for instance, establishing rapport and trust during the initial physical examination were stressed: the health provider must be empathetic and non-threatening and questions need be non-judgemental. “Red flags” are: 1/ absenteeism, 2/ history of frequent trauma, 3/ depression, anxiety and sleep disorders, 4/ labile hypertension, 5/ GI symptoms, 6/ sexual dysfunction.

Laboratory tests for AOD assessment were extensively reviewed.

Presenting a positive screen diagnosis to the patient –and avoiding pitfalls such as threats, guilt, shame, hedging-was reviewed extensively. Assessing *readiness to change* received a special emphasis because of its value in the prognosis of AOD dependencies treatment. The various stages are: pre-contemplation, contemplation, preparation for action, action, maintenance and relapse. Lastly, the importance of positive reinforcement during the follow-up monitoring phase was stressed.

Notes of interest to the dental profession: in screening for AOD abuse, a highly sensitive self-report questionnaire such as the CAGE is useful*. Also, low risk drinking is quantified in 1/ men: not over two drinks/day, not over four on any single occasion (at less than one drink/hour), 2/ women: not over one drink/day, not over three on any single occasion.

Positive screening = one positive on CAGE + drinking > low risk + using any illicit drugs and two useful additional questions -have you ever had a drinking problem? Have you had a drink in the last 24 hrs? Yes to both = 92% sensitive for alcohol problem-.

Claude Grant, Jr., and Stephen Sheppard reviewed the rationale, indications and validity of “Group Therapy Techniques”. This form of therapy is efficient in the treatment AOD dependencies (currently the dominant method of therapy, indeed preferred by experts in the field to individual therapy), in conjunction to the participation to 12-step recovery programs, behavioral modification therapy, and family resources.

The characteristics of this technique follow: *group therapy*: 1/ is economical, practical and efficient, 2/ teaches interdependence and not dependence on a therapist, 3/ decreases anxiety, tension and depression, 4/ fosters hope and self-acceptance among participants. Universality, catharsis, altruism, social skills, cohesiveness, and interpersonal learning ability are among the key elements that the participants must become familiar with, in order to make progress in their recovery.

The role of the psychologist/psychiatrist conducting group sessions consists of: 1/ providing information and structure to reduce anxiety and promoting therapy, 2/ setting limits within which the group will work, 3/ clarifying expectations, compared with other groups, 4/ keeping the group on target, 5/ dealing with slips and relapses, 6/ managing intoxication.

The potential problems inherent to this technique are: 1/ one person monopolizing the discussion, 2/ in contrast, silent participants, 3/ chronic interrupters, 4/ private conversations, 5/ interpersonal conflicts, 6/ extended arguments, and 7/ digressions.

Claude Grant, Jr., and Stephen Sheppard proceeded from theory to practice in two sessions that followed entitled respectively “Group Therapy Demonstration” and “Debriefing Session Following Group Therapy”. A *group therapy session* was conducted among 16 in-patients of the Alcohol and Drug Abuse Clinic of University of Utah School of Medicine, Salt Lake City, UT. *Debriefing of the session* by the two psychologists and the participating clients was demonstrated (all proceedings to be kept confidential).

Despite the “displacement” from their usual therapeutic environment, the participating clients appeared to be at ease (almost at once) in their new setting, and the “take home” message of the session that resulted from the debriefing session seemed both agreeable to them and applicable when transposed to real life situations.

* Also, AUDIT, MAST.

Harold Crossley* presentation "What's New on Street Drugs?" consisted of a thorough review of the street drugs currently used, including: heroin, marijuana, amphetamines (dextroamphetamine = "Black Beauties"; metamphetamine = "Speed"), psilocybin ("Shrooms"), GHB (Georgia Home Boy), dextromethorphan ("Robo Tripping"), MDMA ("Ecstasy"), super K, steroids and cocaine. General information about the drugs, pharmacological effects, paraphernalia, excretion and detection were presented. Current regional distribution of use was also mentioned: prevalence of metamphetamine on the West coast, while only 3% on the East coast; prevalence of heroin and crack cocaine on the East coast; Ecstasy, marijuana and inhalants have an equal distribution of use throughout the United States. Concern and alertness of the DEA is directed towards newer "club drugs" such as "Foxy" and "Mystic". Notes of interest to the dental profession: The current prevalence of drugs of choice among dentists (in decreasing order) is: 1/ alcohol, 2/ hydrocodone, 3/ benzodiazepams, 4/ street drugs, and 5/ nitrous oxide. Lastly, the presenter correlated: 1/ the high incidence of Class V carious lesions (affecting both buccal and lingual surfaces) in heroin addicts *to* their high sugar content diet, 2/ the crown preparation-like erosions frequently seen on the lingual surfaces of maxillary anterior teeth in metamphetamine abusers *to* the highly acidic carbonated drinks they drink copiously in order to dissipate the significant heat this substance generates in the oral cavity.

Whereas alcoholism affects 10% of the general population of the United States -at any given point in life-, at least 25% of the population is indeed affected indirectly as a result. **Mary Martin** presentation entitled "Movin' On, Finally: Growing Up in An Alcoholic Family" used the traditional ACoA (and by extension Alanon) format to support her own story. Family traits, perception of affected family members, resiliency of children of alcoholics, and common protective factors of resilient children were highlighted in this moving presentation. Erikson's theories of development, Ackerman's typologies of adults under stress, ACoAs and the work place, as well as transitions needed for recovery were also reviewed.

Penelope Ziegler addressed the issues of "Pain Management of the Addicted Patient". The pain perception specific to the addicted patient, and the potential for cross-addiction, i.e. individuals in recovery at risk of relapsing when administered medication for pain control, were reviewed. A multidisciplinary medical team approach was emphasized. Guidelines for the management of *acute pain addicted patient* were discussed. Mild to moderate pain is best addressed with non-opioid drugs and intensified recovery support. Special caution must be exercised in the management of severe pain because the increased tolerance of such patient translates into the need for an increased dosage, which is in sharp contrast with the current common belief among health care professionals. Hence the following recommended protocol for opioids drugs: 1/ high dosage (cautious half dosage to "protect" the addicted patient is a fallacy because the receptors have been already exposed to the drug), 2/ fixed dosage, no PRN, 3/ involvement of a third person dispensing the drug, 4/ switch to non-opioid drugs promptly, 5/ increased recovery support. Because of the uncertain outcome, safe and progressive discontinuation of drugs upon which the patient has become dependent must be carried out (detoxification). The presentation was geared equally towards the management of the *chronic pain addicted patient*. Sample protocols for pharmacologic interventions and pain management agreements were discussed in the event opioid drugs have to be prescribed, while for instance the addicted patient is enrolled in a professional diversion program contract. Specific non-opioid medications consist of: 1/ steroidal and non-steroidal anti-inflammatory drugs, 2/ anti-convulsants (Depacote, Topamex), 3/ tricyclics and other anti-depressants, 4/ tryptans, 5/ topicals. Complementary/alternative approaches to allotherapy were also reviewed, including:

* This speaker was the recipient of the Clyde and Mary Gooderham Award.

1/ acupuncture, acupressure and electrical stimulation of acupuncture points, 2/ chiropractic adjustment and manipulation, 3/ massage therapy, 4/ psycho-physiological stimulation, 5/ stimulation (TENS), and 6/ physical and exercise therapies.

Additional notes of interest to the dental profession: the management of post-operative pain in the addicted patient is best handled with the administration of 800mg of Ibuprofen immediately at the end of the procedure. Also, injectable Toradol is recommended for the treatment of acute dental pain.

George Obermeier presentation “Humor and Laughter: A Prescription for Well Being” was implemented strategically in the middle of the session and contributed in placing all material taught into a “healthy” perspective. A number of “recipes” for well being aimed at decreasing anxiety, tension and potential burnout and depression were outlined.

Great disparity exists at present among dental schools drug education that includes strategic implementation of such curriculum with respect to both academic calendar and course topic contingencies, actual amount of time allocated, review of professionals’ risk factors and predisposition, ethical and legal consequences of using, etc.

Mary Martin, Patrick Sammon and James Reilly co-facilitated a panel discussion that reviewed design and implementation of such curriculum in “Dental Schools” and involved a roster of selected participants.

This sub-group of participants was comprised of several current/former dental and hygiene schools faculty members, the two dental school students mentioned previously and the author of this report who represented the ADEA.

Topics for discussion and data gathering during this workshop were:

1/ What is done now? 2/ What is working? Not working? Why? 3/ What is the best teaching model? 4/ What are our observations? 5/ What actions might be taken?

a/ Careful review of the various schools competency statements was suggested to be helpful in identifying the area of the curriculum where to best implement drug education. Moreover, this pro-active approach may also prove to have an excellent “leverage” effect in establishing rapport with presently reluctant or resisting administrations; b/ testing of the course material was thought to be the best resource to ensure attendance of the student body to such lectures and in turn, retention of the material presented; c/ development of a working connection with the American Dental School Association (ASDA) was also suggested to have an instrumental potential for curriculum implementation; d/ the workshop ended on an optimistic note as far as future communication with the various schools administrations is concerned, as the existence of federal funding made available to keep campuses Etoh-free could be used for “leverage”.

In summary, a working process was initiated and the various participants will communicate on both individual and collective basis prior to a future session. The long-term goal of the workshop was that guidelines for implementation of uniformed a drug education curriculum for dental schools are presented next year at the University of Utah 54th session.

Linda Keating was the facilitator of a panel discussion pertaining to “State Help Programs”, where the respective representatives of various states presented mission, objective and structure of their currently implemented impaired professionals’ assistance programs. Kentucky, Massachusetts, Missouri, Nevada and North Carolina appear to have different approaches because of different relationships between Licensure Boards and State Dental Societies, existence of legislative mandate for Diversion Programs*, and disparity in *service providers* –e.g. Physicians/Professionals Health Programs–member

* “Diversion Program”: mechanism whereby the state licensing authority may “divert” a licensee from sanction pending completion/compliance with recommendation of designated treatment professionals.

Federation of State Physician Health Programs (FSPHP)-, Dental Societies Well-Being Committees, traditional Employee Assistance Program (EAP) company, outside agency⁺-. A survey reporting structures of impaired professionals assistance programs nationwide is published and updated on an annual basis in the ADA Well-Being Program website:

<http://www.ada.org/prof/resources/topics/wellbeing.asp>

In order to benefit states currently implementing/modifying such programs, an attempt was made to define general guidelines as to how to design and implement state help programs effectively. Parameters such as state laws, program by-laws, record keeping, financial structure, outcome assessment, participants' satisfaction, etc., were reviewed.

In "Relapse: Investigation and Intervention"^{**} **Roland Williams** covered the rationale and chronological steps involved while a committee of colleagues "confront" an impaired professional experiencing a relapse. The rationale is that, as colleagues, "if we are not part of the solution, we are part of the problem". Over the last ten years, Licensing Boards have become increasingly tougher in their punitive actions: clear and convincing evidence is standard of proof for cases alleging substandard care. Hence the importance of a thorough *investigation* by this committee that will: a/ accept and protect sources –colleagues, staff, patients, others-, b/ meet and open a confidential case file –no dates nor behavior reported yet- to be best kept in one committee member's home safe place, c/ collect data –face to face, i.e. avoid telephone, emphasize confidentiality and educate potential source-, d/ obtain confidentiality agreement and then only information may be documented with dates, times, places and behaviors, e/ meet and discuss data and reach decision regarding need for intervention.

A similarly rigid protocol applies to the *intervention*: a/ assign intervention leader and another committee member and decide on whether to include any colleague/family member, b/ the intervention per se is planned including location –private place preferably-, time of the day –early if possible to avoid intoxication-, material to be presented –express care/concern and educate about role and function of committee-, ground rules –listen without interruption, no physical violence-, c/ outcome elements –insist on evaluation by experienced independent professionals, and health care professionals treatment programs; if colleague refuses, pass him/her to the Licensure Boards Diversion Program-

Nonmaleficence –"do no harm"- is the mantra of all health professions. Evidently, a health care professional failing health or wellness -due to conditions either chronic/degenerative, or the result of substance abuse/mental illness- may put patients at risk. **Linda Keating** presented an overview of all aspects involved in "Professional Accountability in Peer Intervention". One of the key issues is that, whereas concerns expressed in terms of "impairment" and "discipline" may help patient protection, they do not help the health care professional in benefiting from treatment. Specifically, 1/ The American Medical Association (AMA) defines impairment as "any physical, mental or behavioral disorder that interferes with the ability to engage safely in professional activities"; in turn, 2/ colleagues of the

⁺ "Outside Agencies" that provide services to dentists include physicians health programs, multi-disciplinary professional health programs and employee assistance services.

^{*} An intervention is a group process during which the reality of an individual's alcohol or other drug (AOD) use is presented to that person by a group of other individuals, e.g., family, friends, colleagues, etc.. Each member of the group should be a significant person in the patient's life, and should be prepared to relate several experiences in which the person's drinking or drug use adversely affected him or her. The weight of all this objective evidence, presented in an structured manner by friends and family members, usually overcomes the "denial" of the identified patient (IP) so they can be motivated to enter a treatment program. This approach is characterized by statements that affirm: (1) positive regard, love, affection for the individual, (2) statements that specify negative consequences of the IP's AOD use in a descriptive and non-judgmental manner and (3) statements that affirm the need for the IP to seek treatment. When necessary (4) the behavior changes, i.e., consequences, the participants will make if the IP does not seek treatment are presented. [Definition courtesy of: *The Dublin Group: Behavioral Health Consultants Inc.*]

impaired health care professional have both the moral obligation and the ethical responsibility to take action to avoid harm to patients, which in extreme cases results in reporting the impaired practitioner to the licensing authorities. However, throughout for instance Physicians/Professionals Health Programs, Dental Societies Well-Being Committees, etc., mechanisms exist that: a/ facilitate colleagues' efforts to intervene, b/ therefore helping the impaired professional avoid such pitfalls, c/ prompting him/her to seek treatment and d/ embrace the long-term recovery process to return to wellness. Unlike a "12-step call" that is anonymous, based on Step 12 of the A.A. program of recovery and is the result of personal and family concerns, *peer intervention* is confidential and peer led; professional and public accountability are involved and the outcome is specific including *both* public protection and return of the practitioner to wellness. "Practicing is a privilege and not a right" is a frequently coined adage that further stresses the need for ethics and professional self-regulation as well as personal and professional accountability.

Alan Blanton, John Chappel, James Tracy and Curtis Vixie further added to the topic of intervention by a committee of colleagues in the following two sessions summarized herein: "Intervention and Assessment of the Impaired Professional" and "Secondary Intervention and Treatment".

Health care professionals are at an increased risk for divorce, depression, alcoholism, drug addiction and suicide. When compared to the general population, this sub-stratum has:

- the following *characteristics*:

more likely to become chemically dependent	six times as likely to become addicted to prescription drugs	24 times as likely to become addicted to I.V. drugs	85% self medicate	feel that they know too much to ever become chemically dependent.
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- with (currently) the following *drugs of choice*:

Etoh: 60%	Opiates: 44%	Tranquillizers: 23%	Cocaine: 18%	More than one*: 46%
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* Etoh and Opiates most common.

Early detection is often difficult due to a/ denial on the part of the family, peers, friends, and even patients, b/ lack of education concerning addiction as a primary, psychosocial and biogenetic disease, c/ lack of understanding of professional help available to health care professionals and high successful outcome rates. Early detection is very important: a/ in order to avoid any action which results in public record and National Data Bank, b/ voluntary Diversion participation is confidential, c/ hospital-based Well-Being program participation is confidential and d/ being removed from an insurance panel is far more common than the loss of license as a result of formal discipline. Unfortunately a "conspiracy of silence" does exist and as a result health care professionals: a/ resist acknowledging what we are seeing, b/ are reluctant to "accuse" a colleague without "proof", c/ don't want to cause more problems for our colleagues, or d/ simply don't want to be involved.

Health care professionals protect their job and professional status at all cost and it is not unusual that their entire life is in a state of total chaos before there is evidence at work that a problem exists: verbal IQ vs. performance IQ.

- A few facts attempting to elucidate why health care professionals *can't ask for help* and *self-treat* instead:

1/ Professional development: work all hours; must have all answers; taught to use intellect to solve problems; know how to get good grades and look good in the face of a crisis; avoid showing weakness or personal feelings.

2/ Impaired health care professional: massive denial and higher shame; care “givers” not “takers”; perceive they are the only ones who can do their job; community holds them in high regard; often have good skills to cover up behaviors.

3/ Health care professionals as patients: seek general medical check-ups and consultation visits less often than controls and tend to wait longer before seeking help for serious symptoms; difficulty accepting patient role; potential or real loss of status and authority associated with becoming a patient; and the myth that having knowledge protects from illness.

- A few facts pertaining to *treatment* of health care professionals and its *outcome*:

1/ Professional oriented treatment: higher success rate when treated within their peer group; health care professionals with self image organized around identification with their profession do better when treated together –helps reduce shame and break denial.

2/ Professional Treatment Programs: design needs to address issues of massive malignant denial and professional status; ability to provide extended treatment (90 + days); staff experienced in setting firm limits and boundaries; capable of addressing continuing care needs following discharge: licensure, hospital privileges, DEA privileges.

3/ Outcomes: adequate initial treatment combined with long-term professional monitoring have the highest success rates (> 90%); by the end of a long-term monitoring program, benefits of a recovery program become self-sustaining.

The purpose of an evaluation consists of: a/ making a diagnosis, if warranted, and to recommend a valid treatment plan, b/ conveying this information to the patient and the referent and assist the patient in his/her decision making process regarding what action to take (secondary intervention), c/ providing reports regarding the evaluation to appropriate agencies.

Several types of evaluation exist including multidisciplinary team or single evaluator, professional oriented or not, treatment center based or not. A multidisciplinary assessment is definitely indicated when: a/ unclear diagnostic picture, confusing constellation of behavioral observations, b/ the professional in question has clear-cut addictive disorders with massive denial and resistance, c/ suspicion of complex psychiatric picture, with or without substance use disorder, d/ disruptive behavior, boundary violations. The elements of a multidisciplinary assessment follow: a/ chemical dependency assessment, b/ psychiatric assessment, c/ internal medicine assessment, d/ complete laboratory studies including appropriate urine toxicology, e/ psychological testing, f/ family assessment, g/ other assessments as indicated -pain, sexual compulsivity/addiction, eating disorders, cognitive impairment/brain injury, compulsive gambling-. The elements of a chemical dependency assessment are: a/ performed by ASAM^{*}-certified addictionist, b/ includes interview with a physician and extensive data gathering –persons observing day to day function, friends/family members, partners/colleagues-, c/ persons expressing concern, d/ persons involved in investigations –Well-Being Committee representative, Licensure Board investigator-.

In order to avoid the pitfalls of a conflict of interest, a second opinion is recommended, and the patient sent elsewhere for treatment. Lastly, the purpose of a secondary intervention are: a/ to assist the health care professional/patient to understand his/her options and their consequences, b/ to encourage the patient to accept the diagnosis and treatment recommendation.

Prochaska and DiClemente’s stages of change “wheel” was used to explain what really influences changes and what strategies apply: 1/ precontemplation –rapport and active listening, demonstrate empathy and build trust-, 2/ contemplation –ambivalence, but favors resisting change; raise doubt, practice reflective listening, framing is key-, 3/ preparation –increasing readiness; active helping, clarify goals provide options, offer advice, explore treatment expectancies and lower barriers to treatment entry-, 4/ action –change underway; engage in treatment, acknowledge difficulties, support realistic views of change, identify high-risk situations, testing and pleasure therapy-, 5/ maintenance –relapse prevention; maintain contact, plan for relapse, testing, new socialization,

* ASAM: American Society of Addiction Medicine.

pleasure therapy, return to full functioning-, 6-A/ *stable change* or 6-B/ *relapse* –do not panic!/rapid re-entry to change; higher level of care, when safe, re-introduce client to same treatment environment to ensure vicarious learning with other clients, encourage change through strong therapeutic alliance-

The goals of a professional intervention follow: a/ goal is for assessment, not treatment, b/ give assistance to professionals affected by AODs, including spouses, staff, c/ protect their career, d/ gain control of potentially unsafe situation, e/ protect the public.

A successful intervention needs to be caring, not punitive: “ We are concerned and we are going to ask you to do something about it”. Trust needs to be built with elements of a therapeutic relationship: empathy, genuineness and unconditional positive regard. Framing is the key to success. Lastly, an intervention can be very time intensive and is always beneficial to the committee members in maintaining their own sobriety, when they are themselves in recovery. Each committee develops his own style within these guidelines.

The last session of the course consisted of an attempt to explain “Spirituality and its Impact on the 12-Steps Process” by **Father Bernard Flynn**.

Attendance to a support group practicing the twelve steps is not the only way to recovery from addiction under any of its presentations, but “it certainly seems to beat anything else that appears to be available”. Whereas one may be able to live without a given chemical by substituting it –i.e. other chemical, or some distraction-, real recovery from the disease of addiction can only be achieved through a *spiritual awakening*.

Therefore, the two elements to elucidate are: 1/ *spirituality*, and 2/ *spiritual awakening*.

1/ The key point –in what seems most often to be a process- is the relationship that an addicted individual develops with his/her *Higher Power*. Belief in a Higher Power is an unmerited gift that can be best explained as the ability to break through the delusion that the alcoholic/addict lives in. It is not the product of any form of intelligence nor reasoning. Hence, *spirituality* can be defined as a relationship established between oneself and a Higher Power that is both personal and unique.

2/ The question “How does one have a *spiritual awakening*?” finds an answer on page 60 of the Big Book*: “Having had a spiritual awakening **as the result** of these steps...”

The most effective method to bring about a spiritual awakening, namely establishing a relationship with a Higher Power –in the experience of millions of recovering alcoholics and addicts- consists of “working” the twelve steps of Alcoholics Anonymous. This in turn leads to the “promises” being fulfilled as mentioned on pages 83-4 of the Big Book.

The twelve steps of the A.A. program of recovery along with their respective significance were outlined in the remainder of the presentation.

* “Alcoholics Anonymous” is the basic reference textbook of the Fellowship of the same name and has been referred to as the “Big Book” ever since its second edition in 1955.

PROGRAM OUTLINE

Day	Session	Topic	Lecturer(s) and/or Facilitator(s)
06/21	General	Introductions and Welcome	<i>Claude Grant, Jr., Ph.D.</i>
06/21	General	A Tapestry of Connections	<i>Charlotte Kasl, PhD.</i>
06/21	General	Early Life Trauma Issues in Early Recovery	<i>Cardwell Nuckol, Ph.D.</i>
06/21	Dental	Pathophysiology of Addiction	<i>Darryl Inaba, Pharm. D.*</i>
06/21	Dental	Getting Better: Fundamentals of Treatment	<i>Linda Keating, M.S., R.N., CSADC</i>
06/21	General	Video Festival	
06/22	Dental	Marijuana Update: Harder than Thought!	<i>Patrick Sammon, Ph.D.</i>
06/22	Dental	Dental Management of the Active and Recovering Patient	<i>Mary Martin, D.D.S., M.S.</i>
06/22	Dental Nursing Physician	Luncheon	
06/22	Dental	Interviewing and the Addiction Medical History	<i>John Chappel, M.D.</i>
06/22	Dental Track I	Group Therapy: Techniques	<i>John Chappel, M.D.; Claude Grant, Jr., Ph.D.</i>
06/22	(combined with Physician Section)	Group Therapy: Demonstration	<i>Claude Grant, Jr., Ph.D.; Stephen Sheppard, Ph.D.</i>
		Debriefing Session Following Group Therapy	<i>Claude Grant, Jr., Ph.D.; Stephen Sheppard, Ph.D.</i>
06/22	General	School Picnic	
06/23	Dental	What's New on Street Drugs	<i>Harold Crossley, Ph.D., D.D.S.</i>
06/23	Dental	Movin' On, Finally: Growing Up in An Alcoholic Family	<i>Mary Martin, D.D.S., M.Ed.</i>
06/23	General	Burn-Out	<i>James Comstock, M.Ed., CEAP, CAS</i>
06/23	Dental	Pain Management of the Addicted Patient	<i>Penelope Ziegler, M.D.</i>
06/23	Dental	Humor and Laughter: A Prescription for Well Being	<i>George Obermeier, M.S.</i>
06/23	General	Alcoholics Anonymous Meeting	
06/24	Dental	Dental Schools: Designing and Implementing a Drug Educational Curriculum	<i>Mary Martin, D.D.S.; Patrick Sammon, Ph.D.; James Reilly, D.M.D.</i>
06/24	Dental	State Help Programs: Panel Discussion: How to develop and Implement an Effective State Help Program	<i>Linda Keating, M.S., R.N., CSADC; Ira Davis, M.Ed., LPC, LCS, NCACD; Thomas Derosier, D.M.D.; Brian Fingerson, R.Ph.; Margaret Graves, LCSW, CCAS; Gerald Jackson, D.M.D.</i>
06/24	Dental	Relapse: How to Recognize and Develop An Intervention Plan	<i>Roland Williams, M.A., NCACII, CADC</i>
06/24	Dental	Professional Accountability in Peer Intervention	<i>Linda Keating, M.S., R.N., CSADC</i>

06/24	Dental	The Impaired Professional: What it Was Like, What Happened and What it is Like Now	<i>Anonymous Speaker</i>
06/24	Dental	Intervention and Assessment of the Impaired Professional	<i>John Chappel, M.D.; James Tracy, D.D.S.; Curtis Vixie, D.D.S.; Alan Blanton, D.D.S.</i>
06/24	Dental	Secondary Intervention and Treatment	<i>John Chappel, M.D.; James Tracy, D.D.S.; Curtis Vixie, D.D.S.; Alan Blanton, D.D.S.</i>
06/25	Dental	Spirituality and its Impact on the 12-Steps Process	<i>Father Bernard Flynn, M.S., M.Div.</i>
06/25	Dental	What the Week Has Meant and Certificates	<i>Mary Martin, D.D.S., M.Ed.; Patrick Sammon, Ph.D</i>
06/25	General	Closing Session	<i>Claude Grant, Jr., Ph.D.</i>

* Replacement speaker name not noted. Sorry ☹!

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* Lecturers and staff mentioned herein are those of sessions attended only (General and Dental Sections).

+ Replacement speaker name for the dental section lecture on the "Pathophysiology of Addiction" not noted. Sorry ☹!

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