



HARRY DIORIO/MCT

New medications and connected services, including job training and low-cost housing, made the difference for Joseph Bryant during his seventh attempt at kicking his addictions. "People look at it as a business," he says of the recovery process.

Getting it straight

By WILLIAM CELIS
Public Access Journalism

Seven. That's how many attempts it took Joseph Bryant to kick lifetime addictions that began with alcohol when he was just 10, followed by heavy marijuana use in his teens, and topped by a \$700-a-day heroin habit in his 20s.

After he served prison sentences for car theft and drug peddling, and as he took up residence in abandoned houses at the age of 27, he realized he had to change his life, or he would find himself, as he put it, "in jail for the rest of my life or dying on the streets of Baltimore."

Bryant's seventh — and last — try to overcome his addictions in 2004 couldn't have been better timed.

Even as he bounced in and out of a string of ineffective treatment centers, innovative research and changing attitudes about drug addiction, treatment and recovery were starting to take hold.

New and effective medications now suppress drug cravings. Hospitals and treatment centers are making stronger efforts to prevent people with addictions from falling through the cracks as they are passed between institutions. And physicians, hospitals and private clinics have learned that treatment means not only medical attention but setting the stage for a successful reentry into a challenging life without drugs and alcohol, with social services, housing and job training.

The strongest treatment programs have always offered a smorgasbord of services under one roof or connected critical lifelines for their clients, but the push now across the country is fueled by groundbreaking brain research in the late 1990s that indicates that addiction isn't driven by weak character, loose morals or lax discipline.

Addiction treatment begins to catch up with groundbreaking brain and genetic research



TOBY JORRIN/MCT

Air Force veteran Carlos Canales, 48, said patients were "warehoused" during his first hospital stay in the mid-1990s.

While downing those first few drinks or pills may be a choice, 20 studies conducted over as many years indicate that, from there, genetics may take over for up to half of addicted Americans. In 1987, Brookhaven National Laboratory became the first research institution to use imaging to study brain changes in the aging, obese or addicted. Led by Nora Volkow, now the director of the National Institute on Drug Abuse, researchers at the Upton, N.Y., lab documented alterations in the brain linked to drug abuse, alcoholism or other impulse behaviors that suggested a genetic predisposition to addiction.

Subsequent research, increasingly sophisticated, has made even stronger connections.

The discovery has led to a growing sense that a connect-the-dots approach is needed at every turn to help people like Bryant, who has clearly benefited from his first comprehensive treatment plan — he's been clean since that summer two years ago.

"It's a good time to be addicted," said Thomas McLellan, the founder and executive director of the Treatment Research Institute in Philadelphia, a research think tank that attempts to influence clinical practice and public policy through scientific and real-world studies. "The treatment is beginning to catch up with research. This will save a ton of money and, more importantly, lives."

At the same time, the medical, addiction and treatment communities are paying attention to what's called "the continuum of care," a buzz phrase meaning addiction treatment and recovery — as well as the training of health-care professionals — that promises seamless experiences for patients who work with a variety of specialists on the way to their new lives.

Still, McLellan and others see an area of medicine that still languishes. The ties between

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'When I'm released, I'll change people, places and things'

By WILLIAM CELIS
Public Access Journalism

(EDITOR'S NOTE: The subject of this story was referred to the reporter by *Faces & Voices of Recovery*, a national grassroots organization based in Washington, D.C., which works to broaden understanding of addiction. The subject, who lives in Richmond, Va., was willing to talk about his experiences in addiction treatment, saying he considers it a "public service" to others struggling with addictions, but requested that his last name not be used, citing the stigma of substance abuse.)

"A haze," is how Pierre describes his first few days of treatment for his addictions to Valium and alcohol.

"I can't remember the first 48



hours," he says of his 30-day stay at the McShin Foundation in Richmond, Va., last fall. "A lot of people slept through three straight days. When you're on drugs, you don't sleep. Now that you're not on drugs anymore, you need to sleep."

At 46, Pierre is a successful businessman working for a national retail company. His addiction to the prescription drug Valium, used to control his cerebral palsy, was exacerbated by his long-standing and increasingly heavy dependence on alcohol.

He also didn't realize until he was an adult that his father, who died

when Pierre was 15, was a heavy drinker. "If I had known that, I would have been more careful," says Pierre, aware that medical research has linked addiction to genetics.

Spring is here, and he's been out of treatment about a dozen weeks now — "110 days," in the world of day-by-day recovery. But his month at the center, a critical time during which he addressed his addictions, his health and his ghosts, is still fresh on his mind.

"My mindset was, 'I am a hopeless addict. What's wrong with me?' You feel like you're pretty much of an outcast. Addiction is a disease. Not drinking — it can be averted. It's the easiest cure in the world. But total abstinence is the only way because I've never met alcohol I didn't like, and it's tough to go to a party and you can't drink. Alcohol is a social lubri-

cant. In the society I'm in, it's readily accepted."

The social drinking started long ago; he began in prep school in order to "fit in."

"My story goes back many years. I was a heavy drinker since high school. ... I also went to one of the nation's biggest party schools, the University of Virginia. It's probably not a good place to go if you're an alcoholic." The stress and pressure of work, and his chasing success, all contributed to even more alcohol, he says.

By the summer of 2005, his heavy drinking, combined with the sedating effect of Valium, produced results that alarmed his family.

"It got to the point late last summer that I had difficulty walking. I was walking around in a fog. I was out of it," he remembers. "I was a top

performer at my company, and I was slipping. My brother and sister were very concerned. They knew something was wrong. We met for lunch and they suggested a treatment center, and then they went with me to the treatment center. I guess you could call it tough love. I didn't appreciate it then, but I appreciate it now."

He also appreciated his siblings' help with treatment costs. They covered a substantial piece of the \$20,000 it cost for his monthlong treatment; his employer covered just two days. But Pierre's company also put him on disability, a move that allowed him to continue receiving his salary.

Intervention by and support from family, friends and employers is key, say physicians and researchers. But

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Choosing a quality treatment program

Public Access Journalism

Finding an effective addiction treatment center or program can be a confusing and frustrating process, but if you're armed with the right questions, it doesn't have to be. Here's some help; more can be found at http://www.drugfree.org/Intervention/Treatment/13_Questions_to_Ask:

■ What type of accreditation or licensing does the program have?

Failure to obtain accreditation may mean nothing, but it could indicate fringe status or, in the worst case, a quasi-cult or an abusive form of "care." Look for accreditation from national programs — such as the Joint Commission on Accreditation of Health Organizations, the Rehabilitation Accreditation Commission, the National Committee for Quality Assurance and the All-States — that look for effective elements of treatment. Accreditors also require a well-documented patient complaint process. Remember that "state licensing" is not the same as accreditation, since states vary widely in their requirements.

■ Have there been studies to measure the effectiveness of the program's treatment methods?

Treatment effectiveness is a new field of study, so it is too early to expect all providers to have done the full research necessary to credibly evaluate their methods. Still, it's not too early for them to be planning these studies. Keep in mind that the most objective evaluations usually come from outside agencies rather than "in-house" evaluators.

■ What medications does the program support or prescribe to treat other medical problems?

Many medical symptoms may be complications of addiction, and clear up after a period of sobriety, but that's not always the case. Clinical depression or anxiety can undermine chances for recovery. The best programs evaluate patients shortly after admission and offer appropriate care, including medication. Methadone, naltrexone and disulfiram (antabuse) can be effective in helping some addicts. Staff should discuss them with patients.

■ What sort of "aftercare" does the program offer?

Short-term treatment by itself is not enough to sustain recovery in most patients. Aftercare is crucial, preferably at least a year of weekly or biweekly outpatient counseling, plus participation in 12-Step programs such as Alcoholics Anonymous or other addiction self-help groups, like Smart Recovery or Women for Sobriety. A good treatment program will actively help the patient integrate into a self-help group, although patients sometimes have to shop around to find a comfortable fit.

■ What does the program do about relapse?

Unfortunately, relapse is a common occurrence in substance abuse treatment, just as it is in treatment for other chronic illnesses. A good program includes prevention classes that teach patients to recognize and avoid or deal with situations and emotional states that could trigger relapse. It should also have a plan for the patients reentering treatment or support groups to prevent a one-time lapse from becoming a full-blown return to active addiction. Relapse, though demoralizing, can be an important learning experience — with the necessary coping skills.

OTHER KEY CONSIDERATIONS:

■ Does the program accept your insurance? If not, will they work with you on a payment plan or find other means of support?

■ Is the facility clean, organized and well run? What is the ratio of clinical staff to patients?

■ What is the average length of treatment?

■ What is the treatment philosophy?

■ Are services or referrals offered to family members to ensure they understand addiction and the recovery process?

■ What happens in a typical day or session?

■ Does the program encompass the full range of needs, including help in finding a job and child care; dealing with legal problems; parenting?

SOURCES: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, U.S. SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION'S CENTER FOR SUBSTANCE ABUSE; PUBLIC AFFAIRS TELEVISION, INC.'S "MOVERS ON ADDICTION: CLOSE TO HOME"; [HTTP://WWW.DRUGFREE.ORG/INTERVENTION/TREATMENT/13_QUESTIONS_TO_ASK.](http://www.drugfree.org/Intervention/Treatment/13_Questions_to_Ask)

Change: Recovering addict vows to transform his life

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the hard work was done by Pierre himself.

"A lot of people think the treatment center is an institution," Pierre says. "I don't. It's not like going to the Plaza, but I couldn't have done this without the center."

Dozens of meetings — both in group therapy, individual therapy, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) — helped him identify difficult personal issues.

"I had some relationship problems," he says of his breakup with a woman in Texas. "I hadn't completely gotten over the death of my

father. I'm a very driven personality; I work hard and am very successful."

Few people, he says, could have matched his talent for balancing work and drugs. "Other people taking Valium and alcohol couldn't have done it. But I couldn't wait to get home to start all over again."

Eventually, even he had to admit that he had lost control.

"With addiction, you are killing yourself on the installment plan. ... There are a lot of pressures in this life. A lot of people use alcohol and drugs to alleviate stress, but when you sober up, all of the problems are a thousand times worse. You don't solve the problem. You

“A lot of people think the treatment center is an institution. I don't.”

— Pierre, recovering addict

just numb yourself."

Identifying what's behind addiction is crucial, he learned during treatment with staff and psychologists, but so is moving forward with a different mindset.

"(The counselors) are very concerned that you will go back to your old behaviors," he says, and he's got some ideas on how to avoid that when he moves out of the recovery house he's been living in since leaving treatment.

"When I am released, I will change people, places and things. I plan on getting a roommate, especially someone in recovery, and plan on moving into another apartment in the same complex. You have to radically alter your lifestyle."

He knows he will always be in recovery, so support groups are a part of his future.

"You need to sometimes take it a little slower," he says of the lessons he's learned during NA meetings. "No one can do it all in one day."

Another part of the credo: "Take it easy. I have taken it to heart. I'm not working as hard as I used to."

Realistic recovery: How to survive the first year

By JODI MAILANDER-FARRELL
Public Access Journalism

Once you've emerged from any alcohol or drug treatment program, the real work begins: staying clean and sober. People in recovery and those who support them all agree that the first year is the most difficult, a bewildering time when relapse is most likely to occur. Here are some tips for beginners or those trying again:

■ **BLOOD SUGAR:** Hypoglycemia is common among active alcoholics, but instead of burning sugar, they're burning alcohol. For people in recovery, the body's craving for sugar often gets mixed up with a craving for alcohol — that's why there's always lots of candy around Alcoholics Anonymous (AA) and other self-help meetings. Find a substitute for alcohol to deal with the biological cravings caused by fluctuating blood sugar; consider a hypoglycemic diet, with six meals a day to avoid wide swings.

■ **EMOTIONAL REMINDER:** One stress management acronym widely used in the recovery community is H-A-L-T, which is a reminder to avoid becoming hungry, angry, lonely or tired.

■ **AVOID TRIGGERS:** Stay away from people, places and things that are going to remind you of drinking or using drugs.

■ **SUPPLEMENTS:** In addition to eating healthy, consider taking B complex vitamins. Thiamine, in particular, helps prevent delirium and tremors in alcoholics. Also L glutamine, an amino acid available in health food stores, has a unique function in the brain and is said to offer a natural way to help the body fight off cravings.

■ **AVOID NEW ADDICTIONS:** If your recovery isn't going well, chances are you may have additional addictions. It's very common for recovering addicts to simply switch addictions.

■ **SEEK SUPPORT:** Regularly attend a supportive group, such as AA, Narcotics Anonymous

■ PLAN AHEAD:

Make a list of dangerous situations and how to deal with them. Let's say you're invited to a wedding. Be prepared to leave early or make sure in advance that a nonalcoholic beverage will be at the table if you're going to be called upon to make a toast.

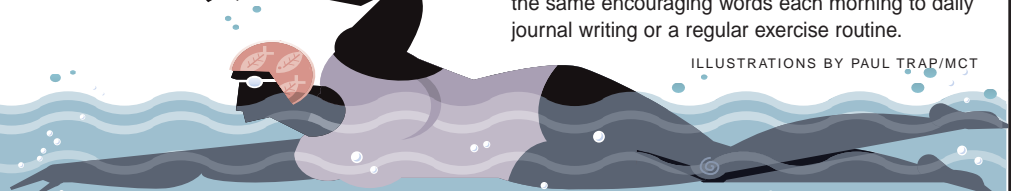


(NA) or one of the alternatives to 12-Step programs, to help deal with depression, which is common among alcoholics, particularly women. Meeting with others in recovery can help you understand the scope of the disease and prevent you from becoming bitter or angry.

■ **CHOOSE YOUR FRIENDS:** Keep in contact with people who are in good recovery.

■ **EXERCISE:** Develop a regular exercise routine, even if it's only walking on a daily basis. During a good workout, the brain releases endorphins that create a "natural high," one that is certainly less potent than what you're used to, but still a mood elevator.

A good workout, such as swimming, releases endorphins which can elevate moods.



ILLUSTRATIONS BY PAUL TRAP/MCT

SOURCES: "STAYING SOBER: TIPS FOR WORKING A TWELVE STEP PROGRAM OF RECOVERY," BY MEREDITH GOULD (HAZELDEN, \$15.95); DR. NICHOLAS A. PACE, A LIFE MEMBER OF THE NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE BOARD OF DIRECTORS; ADDICTIONZ IN CANADA; ALCOHOLICS ANONYMOUS.

Challenge No. 1: Fighting addiction Challenge No. 2: Paying for it

By WILLIAM CELIS
Public Access Journalism

Every month, the staff at Caron Treatment Facilities in Wernersville, Pa., field calls from nearly 2,500 people looking for help to pay for treatment to kick their addictions.

The call volume points out one of the larger dilemmas of addiction treatment. You've made the life-saving decision to go for help; now how do you pay for it?


With 30 days of treatment running anywhere from \$14,000 to \$30,000, the cost can seem insurmountable for someone already in a shaky position to deal with high finance, red tape and insurance companies.

"You're not out of luck, but you face a lot of challenges getting help," said Dr. Eric Goplerud, the director of Ensuring Solutions to Alcohol Problems, which reviews state insurance policies for the Department of Health Policy at George Washington University in Washington, D.C.

If you live in Connecticut, Delaware, Indiana, Kentucky, Minnesota, New Jersey, Vermont or Virginia, you're fortunate. Laws there require that insurers treat alcoholism as a chronic disease, offering coverage equal to that for diabetes or cancer.

But there are nearly as many states where you're virtually unprotected. In Arizona, Idaho, Iowa, Oklahoma and Wyoming, insurers aren't required to pay for treatment and recovery programs. There is little uniformity in the rest of the nation, but coverage is minimal.

For starters, co-payments for addiction treatment are severely curtailed. Under the strictest of policies, you're expected to pick up as many additional doctors' visits as necessary, and if you need the extended treatment recommended for a good chance at recovery, most carriers will pay for no more than a month at the top end. If you need help for the mental or

 MORE INFO

■ For more information, resources and interactive forums on substance abuse issues, visit www.silenttreatment.info.

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emotional health issues often paired with addiction, your co-payments go even higher.

Uneducated views about the causes of substance abuse actually have resulted in steady erosion in coverage, Goplerud said. Insurance companies today pay roughly 25 percent of all claims related to alcohol and drug addiction treatment and recovery expenses, down from a third as recently as 1991. The balance is largely absorbed by public sources, like Medicaid, and the affluent, who can dip into their own pockets for customized treatment.

That leaves most low- and middle-income Americans struggling to pay for treatment, or going without.

Treatment and recovery providers are stepping into the void, offering help in determining how much coverage you're entitled to and where to find it. Some centers even provide financial assistance.

Caron Treatment Facilities, a nonprofit treatment and recovery provider, offers what it calls "scholarships" to help offset its fees, ranging from \$23,000 for adults and \$25,000 for clients 19 and under. The expense covers a 31-day treatment program and outpatient services. Riggs says 35 percent of Caron's clients currently receive some financial aid. Caron has covered up to half of a client's bill with money generated by fundraising events that include dinners and contributions from alumni — and even employees.

The application process is a lot like seeking a credit card. Caron reviews an applicant's income, debt and credit rating, since the balance of the bill will fall to the client.

In the workplace, corporate benefits officials still balk at paying for substance abuse-related expenses. Stubborn attitudes contribute to the discriminatory policies.

Last fall, Goplerud conducted four focus groups with corporate executives and benefits managers about the coverage offered for substance abuse treatment in company-sponsored health plans. While most of the participants said they were aware of the research linking biological factors to addiction, "You don't have to scratch too far below the surface for them to say they aren't sure they want to pay for 'bad behavior,'" Goplerud said.

A handful of companies have come up with enlightened benefits, policies and practices. Quad Graphics, a large, private commercial printing company in suburban Milwaukee that prints Newsweek magazine, offers employees with addictions 24-hour access to health care professionals.

Antiquated laws also play a role in limited financial support and access to treatment. Thirty-two states still enforce statutes — the Uniform Accident and Sickness Policy Provision Laws — enacted in 1947 that allow insurance companies to refuse payment to hospital emergency rooms if an alcohol- or drug-related trauma brought you there. To get around the payment issue, doctors may not report the substance abuse, so those who need treatment don't get it.

Goplerud, whose center tracks, among other trends, the financial impact of alcohol addiction, calls these "bad laws." Four states and a number of leading medical and physician-led organizations agree; they've called for their repeals.

Progress: Innovative treatments incorporate latest medical research

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doctors, hospitals and treatment centers are still disconnected in many communities. Tired stigmas and misconceptions about addiction hinder vital partnerships between institutions, and make it harder for patients to talk to their doctors about their problem.

Health-care providers also make it exceedingly difficult for people with addictions to get help; insurers severely limit coverage, leading to what amounts to a class divide in treatment. Affluent Americans can dip into their own pockets or tap into company benefits for services that can easily exceed \$20,000 for treatment and ongoing recovery, while middle-class and poor Americans struggle to find financial help, or go without.

Addiction also gets relatively low priority in the medical community, starting with training. Though efforts to improve medical school curriculum are growing, a new generation of doctors still doesn't get enough exposure to diagnosing and treating addiction. Dr. Jennifer Smith, a physician at John Stroger Hospital of Cook County in Chicago and a professor at Rush Medical College, remembers receiving two hours of instruction in addiction during her four years of medical training in the early 1980s. The scenario has only slightly improved, she says.

"We're not at a tipping point yet," Smith said. "But we're getting there."

That's important, because physicians, researchers say, are key in making the link between addiction and chronic disease, a connection that historically hasn't been strong. While treatment and recovery centers, pharmaceutical companies, scientists and researchers all liken addiction to heart disease, cancer and diabetes, medical doctors aren't applying the latest data to their patients.

"As a country, we took alcoholism out of the medical milieu," Smith said. "For many years, addiction didn't belong to doctors. This is changing with time."

If addicts today stand a much stronger chance of getting and staying sober and clean, science is largely the reason. While environment and stress play a role, the studies indicate strong genetic and biological links passed through addicted parents make offspring more susceptible to addiction.

If your parents or siblings are hooked on alcohol or drugs, these studies concluded, you have a 50 percent chance of addiction; some studies put the likelihood of addiction as high as 70 percent. What's more, once addicted, the part of the brain linked to the pleasure-reward system heightens cravings for the drug, so trying to stop addiction without treatment is near impossible.

Armed with the science, pharmaceutical companies have responded with three different drugs to combat the cerebral cravings: buprenorphine, acamprostate and naltrexone. The drugs, available only this decade under a variety of commercial brands, are designed to curb or even eliminate cravings and minimize the side effects of withdrawal for both alcohol and specific drugs, like opiates, marijuana and cocaine.

The drugs alone don't ensure successful recovery; they need to be part of a larger strategy, doctors say. But the new medications, taken over a period of days, months or years, have offered new hope.

For Bryant, one new medication provided the antidote to a string of failed recovery efforts, when, he says, previous treatment centers "didn't pay attention to details. There was no one on one to help you find out why you were on drugs. Therapy was not available."

The new medicines weren't available to him, either, so he tried slowly weaning himself off drugs. During one such attempt while he was in prison, the pain of withdrawal was so great that he ran head-first into the brick wall of his cell to knock himself unconscious.

On his last try, Bryant turned to an uncle in New York who enrolled him in a Phoenix House treatment facility in Brooklyn, N.Y. What Bryant found there is everything researchers and social scientists recommend in a drug rehabilitation and recovery program — beginning with buprenorphine.

The small orange pill, quickly dissolved under his tongue, eliminated Bryant's cravings. The intense physical pain common to withdrawal was so minimal that Bryant found he could sleep through the night. "I could eat," he said. "The hot and cold sweats, the chills — the drug minimized all of that."

Within his first week of treatment, Bryant was off buprenorphine and



TOBY JORRIN/MCT

Now 10 years in recovery, Carlos Canales says he "wandered around in a self-medicated state for 22 years." He credits the "caliber of care and the caliber of understanding" he received at the Audie Murphy Hospital in San Antonio.

transferred from his detoxification room to a bed under the same roof, a logistical godsend at a critical time in treatment. Following his previous detox experiences, he had been sent to recovery centers often miles away; sometimes they had available beds, but more often Bryant had to wait two or three days. The interruption proved costly. That's when Bryant invariably found himself back on drugs.

On the one occasion that he could immediately move from detox to a bed, he was told after 28 days that he was being discharged because another client needed the bed — and because his funds had run out. "Whether you are ready or not, you have to go. That's one of the messed-up things about recovery. People look at it as a business."

And treatment and recovery is a lucrative business. In 2001, the last year for which statistics are available, \$18 billion was spent on substance abuse treatment, up from \$11 billion in 1991, according to a study by the federal Substance Abuse & Mental Health Services Administration. In that same 10-year period, public sources like Medicaid shouldered the brunt of payment.

Bryant, for example, had to use Medicaid to pay for his treatment and recovery at Phoenix House, the nation's largest nonprofit addiction treatment and recovery organization, which charges \$19,000 a year. Drug-free for 18 months and in the last stages of his recovery program, Bryant still lives there, leasing a room for \$15 a week until he saves enough money from his job as a carpenter to find his own place. Housing assistance is key in its recovery program, Phoenix House officials say, because the low-cost shelter allows people in recovery a solid shot at long-term stability as they piece together their lives.

After spending much of his life living on the edge, Bryant approaches his life these days with simplicity — and sobriety. "I take my life one day at a time," he says.

New attitudes about taking responsibility, more support from psychologists and psychiatrists, assistance from job counselors and vocational training programs have ushered in a fresh mindset in the last decade at places like the Audie Murphy Hospital, part of the sprawling South Texas Veterans Health Care System in San Antonio.

"Before, we treated anyone for any reason," said Dr. Ursula Sanderson, chief of the residential rehabilitation program. Maybe their habit had become too expensive. Or they were homeless with an addiction. Whatever the reason, Sanderson said, veterans with addictions showed up routinely at the clinic, appearing so often that the staff considered them "family" and welcomed them warmly.

"We would admit anyone as long as we had a bed," Sanderson said. "We had a large revolving door."

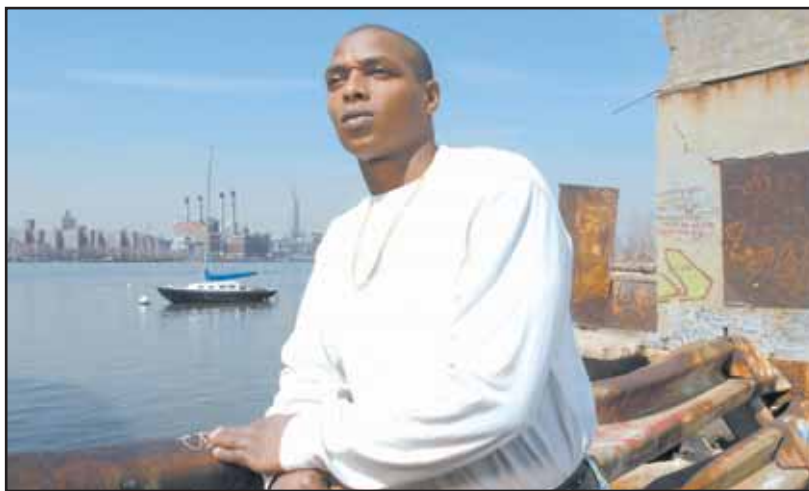
Gone are the days when people with addictions could simply walk into the clinic and check themselves in. Non-emergency room visitors are screened for possible substance abuse, and if there is no immediate health risk, addicted veterans are referred to a psychiatric unit or the health center's detoxification unit.

The promise of addiction treatment drugs

Four "miracle" drugs — so called by health-care professionals because of their effectiveness in treating alcohol or other drug addictions — are now available through prescription under a variety of trade names. Despite long-term controversy over "replacing one drug with another," studies have shown each is successful in helping combat addictions. Success rates vary significantly based on dosage and access to support services.

| DRUG | DESCRIPTION | HOW IT WORKS | WHAT IT DOES | SIDE EFFECTS |
|----------------------|--|---|--|--|
| Methadone | The granddaddy of maintenance medications: First developed as a synthetic drug in Germany during World War II, it's been used for more than 40 years in the United States. | A pain reliever, methadone actually blocks the euphoric effects of heroin. | Taken orally once a day at decreasing doses, methadone suppresses the effects of narcotic withdrawal for 24 to 36 hours. | Nausea, constipation, confusion, excess sweating, and flushing. |
| Acamprostate | The first medication dedicated exclusively to alcohol addiction approved by the Food and Drug Administration (FDA) in more than a decade (2004). | Alters the way the brain works by calming down neurotransmitters, chemicals that become unbalanced during repeated alcohol abuse. | Has been successful in clinical trials in easing sickness and cravings during sobriety. | Headaches, diarrhea, flatulence, nausea. |
| Buprenorphine | First introduced in the 1980s, a new form received FDA approval in 2002 for use in addiction treatment. | Alters the way brain cells work by binding to the areas that dictate cravings. | Helps in detoxification from heroin, opium, morphine and other opiates by relieving painful withdrawal symptoms. Has fewer side effects and requires lower doses than methadone. | Nausea or vomiting, mood swings, muscle aches and cramps, sweating. |
| Naltrexone | Received FDA approval for drug treatment from 1998 to 2003; recently approved for treatment of alcoholism. Vivitrol, an injectable version of the drug, was approved for use in April. | Competes with opioids — a class of drugs that includes morphine, heroin and codeine — for opioid receptors in the brain. | Blocks the effects of narcotics and decreases alcohol craving, but does not treat the addiction itself. | Upset stomach, anxiety, muscle or joint pain, confusion, drowsiness, vomiting. |

SOURCES: U.S. FOOD AND DRUG ADMINISTRATION, THE WHITE HOUSE OFFICE OF NATIONAL DRUG CONTROL POLICY (<http://www.whitehousedrugpolicy.gov>), THE AMERICAN ACADEMY OF FAMILY PHYSICIANS (www.aafp.org). ADDITIONAL INFORMATION AVAILABLE AT THE FDA'S WEB SITE: <http://www.fda.gov>



HARRY DIORIO/MCT

The Phoenix House treatment facility in Brooklyn, N.Y., saved Joseph Bryant from "dying on the streets of Baltimore."

During the typical monthlong stay, days are structured, crammed with meetings with doctors, psychologists or psychiatrists, nurses and job counselors and, when the time is right, job training and job placement. The revamped treatment and recovery program is more collaborative, more comprehensive.

"For one, the veteran was not participating," said Sanderson of the old days. Now, she said, after developing a written statement of his life, he meets with a psychiatrist, a nurse, a psychologist, a social worker, a recreational therapist and even a chaplain, all in the same room, to design a lifestyle plan that will take him through recovery and reintroduction

to society. "We establish pretty clearly where they are going to go," Sanderson said, "and how they are to support themselves."

Carlos Canales, 48, in recovery for a decade, has benefited from the hospital's heightened sophistication. During his first stay in the mid-1990s, he remembers a strong sense that people were simply "warehoused." Today, Canales said, "the caliber of care and the caliber of understanding of what it takes to care for people in this situation is greater."

The Air Force veteran and former teacher credits the services with helping him redirect a life that was waylaid for more than two decades by addictions of every sort.

He first began drinking beer at his San Antonio high school to "fit in" and to overcome his low self-esteem. By the time he graduated in 1976, he was drinking heavily. He joined the Air Force and added recreational drugs. Every chance he had, he either drank or did drugs — sometimes both.

"I wandered around in a self-medicated state for 22 years," he said. "I did coke, heroin, pot, alcohol, whatever was accessible."

In his late 30s, he knew was in trouble. He checked himself in to the veterans' hospital, where he detoxed and began using the hospital's growing array of services. Key to his recovery was the support from the Veterans' Administration — "Otherwise," Canales said, "I would have ended up in a state hospital or prison."

He still attends weekly support meetings at the hospital and the staff greets him by his first name, even though he hasn't seen anyone there medically for four or five years.

"That's pretty outstanding," he says, of the staff's attention to details. "I'm in good shape now, thanks to the hospital."

The years of abuse and failed treatment took their toll, however. Canales has terminal liver disease.

William Celis teaches journalism at the University of Southern California's Annenberg School for Communication. He is a former reporter for *The New York Times* and *The Wall Street Journal*.