ASAM NEWS

American Society of Addiction Medicine

Vol. VII, No. 6 **November - December 1992** *Published Bimonthly*

ASAM's 24th Annual Medical-Scientific Conference
Los Angeles
April 29 - May 2,1993

Symposia, workshops, courses, Oral and poster sessions, Committee component sessions, Awards dinner, Ruth Fox Course for Physicians, National Forum on AIDS.

Details p. 7-10

Inside

Recertification Exam in 1994...... 3
New Board Election Process...... 3
1993 Annual Meeting Highlights... 7
Nicotine Dependence Conference. 4
Nicotine Patch Policy............ 6
BATF Allows Health Claim on Red Wine................. 12

ASAM is a specialty society of physicians who are concerned about alcoholism and other addictionsand who care for persons affected by these illnesses.

Break-Through for Patient Placement Criteria

Providers/Payers Agree to Use ASAM PPC in Montana

"The story in Montana of how one state and one payer agreed to use the *ASAM Patient Placement Criteria* gives us hope that we *can*, as we so strongly believe, protect access to quality CD care at reasonable cost," **David Mee-Lee**, MD, chair of ASAM Standards of Care Section, told *ASAM NEWS*.

Over 3,600 copies of the *ASAM PPC* are in circulation. EAPA (The Employee Assistance Professionals Association) and ACATA (The American College of Addiction Treatment Administrators) have endorsed the *PPC*. "Some payers, managed care organizations, and state agencies have said they would use the *Criteria* or a modification. Some providers are incorporating the *Criteria* into their program designs and documentation," said Dr. Mee-Lee. "But we hope that many more providers, payers, and managed care companies will decide that they should use the *ASAM Criteria*."

Are there any success stories in your area, such as this one from Montana, that you would like to share with *ASAM NEWS* readers? If so, write Dr. David Mee-Lee at Parkside, Little Harbor, MA 01945.

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Springboard Was CD Advisory Committee

by Rod Robinson, MA
Department Director CDU
Montana Deaconess Medical Center

Struggling with the dilemma of offering services in a managed care environment, chemical dependency providers more often than not find themselves on the short end of the stick. Montana has been no exception.

About 10 months ago, the Chemical Dependency Programs of Montana, Inc., began working on a compromise with Blue Cross and Blue Shield (BC/BS) of Montana and their managed care organization. The biggest concern was that BC/BS in Montana continued to use the HMS [Health Management Strategies International, Inc.] criteria, which CD providers believe to be restrictive and not relevant for chemical dependency patients. However, in all fairness, BC/BS needed better documentation from providers.

(cont. on p. 2)

ASAM PPC in Montana

(continued from p. 1)

In order to best serve group policy holders and individual subscribers who wanted to access CD treatment benefits, both providers and payers had to find a way to satisfy the access as well as the accountability issues.

BC/BS of Montana took the initiative and formed a Chemical Dependency Advisory Committee. This committee is comprised of CD practitioners, psychiatrists, private practitioners, the State Alcohol and Drug Abuse Division, concerned consumers, and themselves. Its first task: to examine the HMS and the ASAM criteria, and to recommend the most appropriate to BC/BS of Montana. After vigorous discussion in the first meeting, the Advisory Committee decided to pursue providing rationale for using the *ASAM Patient Placement Criteria* (PPC), which the group felt to be more relevant and less restrictive for CD patients than the HMS criteria.

BC/BS was initially skeptical. Their cost containment efforts had been successful to some degree; they did not want to reverse that momentum. Nor did they want to open the flood gates to inappropriate claims. In a series of meetings, the CD program providers focused on the reality that a few unethical providers had caused most of the problems for the many legitimate providers, due to lack of accountability from the perspective of documentation.

Therefore, providers strongly recommended adopting ASAM's PPC because they allow us to deliver a better quality of services to our patients, and in the process to be much more accountable. The Advisory Committee concurred, and effective Nov. 16, 1992, Blue Cross and Blue Shield of Montana has agreed to implement the *ASAM Patient Placement Criteria* into their review process.

Prior to putting the *PPC* in place, the committee decided that BC/BS nurse-reviewers and CD providers in Montana should receive appropriate training for their use. This will ensure that all parties are talking the same language.

David Mee-Lee, MD, a principal author of the *PPC*, conducted a training session "Proper Patient Placement of Chemical Dependency Patients" Nov. 12-13 in Helena, Montana. The seminar was sponsored by the State Alcohol and Drug Abuse Division, the Chemical Dependency Programs of Montana, Inc., Boyd Andrews Care Center, the Montana Deaconess Medical Center, and Blue Cross/Blue Shield of Montana. About 150 were expected to attend.

The Advisory Committee decided to keep itself intact as a forum to advise BC/BS as we proceed with this joint venture.

It will assist in forming a member provider network that will collectively provide treatment services to chemical dependents and their families. The network will allow for expanded benefits, a more consistent service delivery system and pattern of practice. The committee recognizes that clinical reviews should be conducted by specifically trained CD clinicians. Therefore, BC/BS of Montana has agreed to form a reviewer pool of CD clinicians from around the state, rather than use out of state reviewers. This reviewer pool will be used should any case be questioned by a Montana BC/BS nurse-reviewer as inappropriate for admission or continued stay for a requested level of service. After further review, this CD reviewer pool will offer recommendations regarding the appropriateness of the admission or continued stay for CD treatment.

Members of the Advisory Committee believe that this activity is important because NAATP, ASAM, and providers in the CD field have struggled for the last decade to get insurance companies, managed care firms, and the public to see that the real concern is not simply a matter of comparing inpatient and outpatient treatment costs. It is that services be provided at the appropriate level of care to patients, as needed, and at the most affordable cost. Committee members believe this move to focus on the continuum of care via the ASAM PPC *is* the future in delivering good quality individualized CD treatment.

It is heartening to note that insurance companies such as BC/BS of Montana are concerned with more than just containing costs, and that they can take a leading role in bringing all concerned parties together to work on the solution, instead of continuing to blame one another for the problem. The Montana situation is a good illustration of a successful, cooperative outcome.

In sum, the CD Advisory Committee accomplished the following in less than a year:

• Blue Cross/Blue Shield (BC/BS) of Montana has agreed to adopt the *ASAM Patient Placement Criteria.*

• BC/BS of Montana has agreed to form a pool of specifically trained CD clinicians to help determine appropriateness of admission and continued stays.

• BC/BS of Montana has agreed to consider combining the inpatient/outpatient benefits into a continuum of care benefit, and expand the benefit via a member provider network.

• by agreeing to form a member provider network that allows for a better continuity of care and broader base of clinical options to use, both parties have committed themselves to developing an improved system of accountability. All agree that this should result in better success outcome research data.

In a joint venture such as this one, there are no losers. Patients get better care and ease of access, providers stay in business to offer the services, and payers have a much better idea of what they are paying for and how well it is (or is not) working.

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SEC NEWS

NAADAC Citation

The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) honored ASAM last June with a resolution for its "pioneering work in the area of treatment placement, particularly the development of the *Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders*" Also honored was the National Association of Addiction Treatment Providers (NAATP) which collaborated with ASAM on the *PPC*.

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First Recertification Exam Scheduled for 1994

ASAM recertification will be required after 10 years in order for ASAM certification to remain current.

Although initial certification will not expire, it will not remain *current* after 10 years. Each ASAM membership directory will include the year of initial certification (e.g. "Certified by ASAM 1986") and the year of recertification, if there is one (e.g. "Recertified 1994").

Recertification will be by examination -- the same exam given to physicians who seek initial certification, with the same scoring policy.

The first recertification exam will be in 1994. ASAM does not restrict the number of times a physician may take the exam for ASAM certification or recertification.

Recertification Requirements

1. ASAM certification.

2. A valid license to practice medicine in the state, territory, commonwealth, or possession of the United States, or in a Province of Canada in which s/he practices: valid at the time of application and at the time of the examination.

3. Good standing in the medical community as evidenced by one letter of recommendation from the clinical director, chief of staff, or a society official who has known the applicant for two years and can attest to his/her current good standing.

1992 Exam

ASAM received 367 applications to take the 1992 certification exam. About 350 planned to take it on Dec. 5 at three sites: Atlanta, Chicago, Los Angeles. With 395 multiple choice items, this is the first exam prepared by ASAM in cooperation with the National Board of Medical Examiners (NBME). (In comparison, the 1990 exam had 300 multiple choice items; patient management problems are no longer on the exam).

Certificates for those who passed the 1992 exam will be awarded at a dinner on Saturday May 1, 1993, in a traditional ceremony during ASAM's annual meeting in Los Angeles.

The ASAM journal, *Journal of Addictive Diseases*, v. 12, no. 1 (publication late fall 1992) has a report by the Examination Committee about the first four ASAM exams (1986, 1987, 1988, and 1990). The article "includes an analysis and comparison of performance on the four exams, as well as a review of the development of the items," according to Exam Committee chair **Sidney H. Schnoll**, MD, PhD. Certification Section chair is **John B. Griffin**, MD. Credentialing Committee chair is **H. Blair Carlson**, MD; co-chair is **Paul Redmond**, MD.

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Newsletter Ads

Effective in 1993, *ASAM NEWS* will have a new advertising policy: payment in advance, rather than after publication. Advertisers will have the choice of paying by check or credit card (MasterCard or VISA).

This policy will begin with the January-February issue (Volume 8, #1).

Rates will stay the same.

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New Elections Procedure Two Candidates for Each Board Seat

Nominations Deadline Dec. 15

Elections for regional directors and officers on the ASAM Board of Directors will take place early in 1993. At its October meeting, the board approved new selection procedures, which are designed to make the process more democratic. "In this way, we hope to involve the membership more," said ASAM President **Anthony B. Radcliffe**, MD.

Regional Directors

ASAM is divided into nine geographical regions. Each region has one elected representative on the ASAM Board. As of April 1993, a regional director may succeed him/herself only once, but can be reelected after a four-year hiatus. (See ASAM Membership Directory, 1992 edition, p. vii, for a map of regions.)

Term: four years (1993-1997).

How nominated:

a) Two candidates for each regional director are nominated by regional nominating committees. Each committee is made up of state chapter presidents and state chairs from that region.

b) A candidate for regional director also can be nominated by petition of at least 25 active ASAM members who reside in that region.

c) If nominations do not yield two candidates for each regional directorship, the ASAM Nominating and Awards Committee will select one or more nominees.

Nominations deadline: At ASAM by Dec. 15, 1992.

How Elected: Mail vote by active members within each region. *Ballot deadline:* Mar. 15, 1993.

Officers

President, President-Elect, Secretary, Treasurer, Immediate Past President.

Term: two years (1993-1995).

A secretary or treasurer may succeed him/herself once without hiatus, and may be reelected after a two-year hiatus.

How nominated:

a) Two candidates for each officer (except president and immediate past president; and president-elect in 1993 only) will be nominated by the ASAM Nominating and Awards Committee.

b) A candidate for officer can be nominated by petition of at least 25 active ASAM members. Nominees must have served on the ASAM Board within the past four years. Exception: treasurer, who alternatively has special qualifications and has served on the Finance Committee within the past four years.

Nominations deadline: At ASAM by Dec. 15, 1992.

How Elected: Mail vote by active ASAM members. *Ballot deadline:* Mar. 15, 1993.

Directors-at-Large

There are 7 directors-at-large.

Term: four years (1991-1995, 1995-1999)

The next election for these board members: 1995, with similar election rules as regional directors.

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CONFERENCE DIGEST

Fifth Annual Nicotine Dependence Conference

ASAM's Fifth National Conference on Nicotine Dependence was held Sept. 17-19 in Seattle with 232 registrants and a faculty of 40 (20 physicians). **Les Berenson,** MD, was local coordinator. **Richard D. Hurt**, MD, of the Mayo Clinic was conference committee chair for the fifth time. ASAM Nicotine Dependence Committee Chair **John Slade,** MD, of the University of Medicine and Dentistry of New Jersey, will assume that post for next year's conference, at the Marriott Marquis Hotel in Atlanta, Sept. 9-12, 1993.

Plenary sessions included public health perspective of nicotine dependence; stages of readiness;the patch (see report and new ASAM Position Statement below); weight gain (not universal); relapse prevention; reimbursement for treatment; prevention in adolescents; smokeless tobacco; older adults; treatment in CD programs.

"Nicotine as a Potential Therapeutic Agent" which was the Second Nicotine Research Round Table, offered eight presentations. There were also workshops, many focussing on nicotine dependence treatment in CD programs.

New JCAHO Rule Begins Jan. 1

Five years ago, after ASAM's First National Conference in Nicotine Dependence, held in Minneapolis, *ASAM NEWS* posed the following question: "Why are most alcoholism treatment centers reluctant to go smoke-free?"

Among the typical excuses heard by this newsletter: "We can't afford to have that many empty beds ... the smokers on my staff might quit ... it's dangerous to take 'everything' away too soon from a recovering alcoholic/addict ... we can't risk relapse; a recovering person who craves a cigarette might pick up a drink or other drug instead ... our facility might try it after we see what happens at some of the smoke-free CDU's ... it's part of our long-term plan. We'll be smoke-free in about five years ... we do restrict smoking! There's none allowed during: group -- individual therapy -- lectures. They can't smoke in: bedrooms -- dining areas -- TV lounge areas -- some staff offices."

Any changes in five years?

"The Joint Commission on Accreditation of Hospital Organizations (JCAHO) has stated that as of January 1, 1993, there will be no smoking in treatment facilities, with certain exceptions," said **Max Schneider**, MD, recently in a related conversation. "The health care field is just beginning to deal with this problem now ... health care professionals must treat nicotine as another drug of addiction and not just tell people to quit smoking." Dr. Schneider told *The Counselor* magazine that 60% of chemical dependency counselors who are recovering are smokers.

Residential Treatment of Nicotine Dependence

Moderated by James Peters, MD, Dr.PH, three residential treatment programs for the treatment of nicotine dependence were described: the Mayo Clinic in Rochester, MN, by Kay Eberman, MS; Hazelden in Center City, MN, by Rick Dillner, LSW, and St. Helena's in Napa Valley, CA, by Dr. Peters, who was associated with it for four years. St. Helena's (a 7th Day Adventist hospital) has been in operation since 1969, the others for less than two years. Conference co-chair Richard Hurt, MD, is medical director of the Mayo Nicotine Dependence program.

Two programs (St. Helena's and Mayo) are seven days long; Hazelden's is five days. The number of participants is kept small: about ten per group. Cost to patients runs between $2,000 and $2,500. Reimbursement is notoriously difficult to get.

A typical patient profile at all three is someone who has tried many other ways to quit smoking: acupuncture, hypnosis, cold turkey, various community programs, even aversion therapy. The patient is severely dependent, physically and psychologically. At Hazelden, one-quarter tend to be recovered alcoholics.

Stop Rates

Hazelden: 45% had not smoked since leaving program; 39% did smoke but "not as much." Of these 51% of the men quit, vs. 39% of the women.

St. Helena's: 40% at one year.

Mayo: 29% at one year.

Nicotine Patch

Psychiatrist **John R. Hughes**, MD, of Burlington, VT, gave a presentation on transdermal nicotine replacement ("the patch"), and he also participated in two workshops on this subject.

"Nicotine replacement with brief physician advice has good compliance, is socially acceptable, produces steady nicotine blood levels, decreases craving, and shows less dependence potential than does nicotine gum," he said.

In Dr. Hughes' opinion, "the major indication for nicotine replacement is a serious prior attempt at cessation that failed in part due to withdrawal symptoms." But "patches do not work without very strong physician advice and commitment." He has found that withdrawal lasts an average three to four weeks, with symptoms being anger, anxiety, awakening at night, depression, difficulty concentrating, restlessness, impatience, hunger and weight gain.

Advantage over nicotine gum

- administration is better for the patient: once a day, instead of 10-14 times per day.
- more socially acceptable.
- more, and more constant, nicotine replacement. From gum it is erratic; the patient is constantly in and out of withdrawal. Blood level stays up, instead of rising and falling as with cigarettes or gum.
- physicians find the patch more 'high tech' therefore more acceptable.
- seems to have less dependence potential, although there are as yet no studies on this.

Side effects

- insomnia (difficulty falling asleep), abnormal dreams.
- mild, transient, itching and burning in about half the patients. Skin allergy in about 2% to 5%. Important to keep rotating patch site; "you can put the patch any place and it won't affect blood levels; but it must be flat as the patch doesn't bend very well."

Prescribing tips

• always encourage group behavioral therapy. However, unlike nicotine gum, nicotine patch is effective when given with brief physician advice and follow-up.

• remind patients to use educational materials that come with patches.

• Dr. Hughes prescribes it seven days at a time, as he believes that it doesn't make sense for a patient to pay $200 to $300 all at once. Most pharmacists will break up the packages. This also may motivate patients to come back to your office.

• physician or nurse should call patient two to three days after the quit date. Studies show that this followup can double quit rates.

• Dr. Hughes asks to see patients two weeks after quit date to make a decision about tapering. He believes it important to individualize treatment, as doses and durations are currently ballpark figures from the pharmaceutical companies. Nicotine is no different than any other psychoactive drug; a given dose will yield a ten-fold variation in blood levels between different people.

• group support and nicotine gum have a synergistic effect; it's probably the same with the patch, although there are no studies on this as yet.

• if patch/gum fail, and the patient wants to try the patch again, insist on group support this time.

• prescribe the patch only for people who have tried to quit smoking and failed.

• give Fagerstrom Dependence Scale; patient's score should be greater than 7 to warrant prescribing the patch at first.

Lowell C. Dale, MD, of the Nicotine Dependence Center at the Mayo Clinic, Rochester, MN, did a workshop with Dr. Hughes. He has given an estimated 800 prescriptions for the patch, which he believes should be used as an "adjunct only."

Smoking on the patch

"If people on the patch haven't quit smoking by four weeks, we find it's better to stop the patch and refocus the issues, examine their motivation, etc.," said Dr. Dale. "The patch is a drug and we don't know its long term consequences."

"To continue prescribing the patch under these circumstances, I like to measure a cotinine level," he said. [Cotinine is the principal metabolite of nicotine, excreted in the urine.] "This helps to determine the proper nicotine patch dose." Dr. Dale said that insurance companies will reimburse for this; and Dr. Hughes pointed out that a blood test is not necessary as saliva is accurate. He said that use of the patch plus smoking can result in higher nicotine levels than smoking alone. If a patient on the patch smokes more than five cigarettes a day, Dr. Hughes will decrease their dose or stop the patch. He really worries when a patient smokes above 10 to 12.

Dr. Dale believes that taking a cotinine level before patients go on the patch is a good idea, especially for the more difficult patients, and for those who have coronary artery disease.

Relapse prevention: gum plus patch

What about using nicotine gum as an adjunct to the patch? Dr. Hughes gives a gum prescription that can be filled if patients find they are having a bad time in specific situations. "If it's a daily problem, then I up the patch dosage. But if it's only once a week, or at an unpredictable time, and since a crucial situation may last only 15 minutes, I suggest chewing nicotine gum *before* getting into it." He recommends that these patients also use gum after going off the patch. They could keep gum at home, in their car, at their office; they may need it only eight or ten times in six months, but it's better to have it readily available.

Different Brands of Patch

Dr. Hughes says there is not much difference between brands despite the confusion emanating from the proliferation of ads. He recommends looking over the different brands, studying the support materials, checking the telephone backups for each, and then going with one brand.

Before Your Facility Goes Nicotine Free

Paul H. Earley, MD, of the Ridgeview Institute in Georgia, believes that the following questions and considerations should be resolved before a facility becomes nicotine-free.

Assess the nicotine status of key policy makers.

• Is the hospital for profit or not for profit?

• Is the administrator a nicotine addict?

• Is corporate management nicotine driven?

• Do hospital boards include nicotine addicts or tobacco executives?

• Is there a strong pro-nicotine lobby in the hospital?

• Do you have hidden allies in the management structure?

Decide depth of nicotine-free status of patients.

• Should patients be allowed to smoke at specified times or places? For example, not in individual sessions, but in group therapy? Not on the unit, but on smoking deck? Not in group therapy but in on-unit AA meetings? Not in on-unit AA meetings but at off-campus AA meetings?

Only at certain times?

• Should you stop patients from smoking cigarettes but allow other nicotine products? Chewing tobacco? Pipes? What about detoxification?

• Should you make the hospital no smoking, but allow smoking off grounds? Is the patient an inpatient? Or day patient? Or in an evening program?

• Can patients smoke at AA meetings? What if others at an AA meeting are smoking?

• Can you insist on patients being in complete nicotine-free recovery? What does that mean? Is one cigarette a relapse? Is it the equivalent of using cocaine, if that's the drug of choice? Is nicotine a gateway drug?

The cost of an illicit cigarette on your unit becomes a marker. As you become smoke-free, cost rises until, in an effective program, each cigarette can cost from one dollar to a dollar twenty-five.

• Should inpatient be smoke free, but allow outpatients or PHP patients to smoke? Can patients smoke at home? Can family members smoke?

What will you do with patients who smoke?

Because some will smoke. Reprimand? Punish? Counsel? Dismiss? What action for a first offense? A second? A third?

How deep should nicotine recovery go in the hospital staff?

• If therapists cannot smoke at the hospital, what about at home? Or out in public?

• Must all clinical staff be nicotine free? Does this include nurses, doctors, physical therapists, everyone?

• Can volunteer staff smoke? At the hospital? Or only outside the hospital? Or not smoke at all? Do you tell them they cannot be volunteers or active alumni any more if they still smoke? What about recovering alcoholics attending AA meetings on the unit? At the hospital?

• Can housekeeping, dietary , maintenance staff smoke? Experience shows that they can be a serious source of smuggling cigarettes to patients.

• Can administrative staff smoke?

• Can family members smoke while their loved ones are in treatment? Family smokers are the primary reason for relapse.

• Should you insist on no nicotine contraband on the unit?

What's the scope of the nicotine-free policy?

• How wide an area should be nicotine free?

• The individual

• The treatment unit

• Should all units in a hospital be nicotine free at once? (e.g. psych and CD, etc.) Will you have one nicotine-free unit and one not?

• Should the cafeteria, auditoriums, off-unit hallways, be nicotine free? Conference room? AA meetings? What about outdoors, on the facility's grounds?

• Should the nicotine free policy be part of your admissions packet? If not, when will patients be told? And where and when should outside smokers be warned of your nicotine policy?

Dr. Earley offered the following advice to *ASAM NEWS* readers: "Any facility going smoke free needs to consider many complex questions before you begin. Be prepared for resistance, be clear in your goals, and proceed with determination."

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ASAM's Public Policy Statement on Clinical Applications of the Nicotine Patch

Background

The transdermal nicotine patch is a useful adjunct to the treatment of nicotine addiction. Although effective in detoxification, and in relieving symptoms of nicotine withdrawal, the patch alone is not treatment for the addiction. The use of a nicotine patch while the patient continues to smoke can produce toxic effects from nicotine. As long as smoking continues, the patient is not making substantial progress toward abstinence.

Direct advertising of these patches to the public has led to unrealistic expectations of these devices in some quarters. It is critically important that these patches be prescribed only as part of a planned strategy to stop tobacco use.

Recommendations

ASAM recommends that the prescription of nicotine replacement for stopping smoking is adjunctive and appropriate only in the context of active management for nicotine dependence. Patients are treated for this condition in diverse clinical settings, and the severity and complexity of problems with nicotine with which patients present vary enormously. Therefore, a variety of interventions using nicotine replacement, including brief (five to ten minute) counseling by the physician combined with active followup, can be appropriate management in specific clinical situations.

Approved by the ASAM Board of Directors Oct. 3, 1992.

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*Names in **boldface** are first mentions of ASAM members.*

Florida Society of Addiction Medicine, a chapter of ASAM, presents

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This four-page section about the annual meeting can be removed from the newsletter and saved for reference. Registration packets will be sent to all ASAM members. Others may call headquarters, 202-244-8948.

L.A. 93

ASAM 24th Annual Medical-Scientific Conference

April 29 - May 2, 1993

Los Angeles, California

Westin Bonaventure Hotel

American Society of Addiction Medicine, 5225 Wisconsin Avenue NW, Suite 409, Washington, DC 20015
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Conference Highlights

ASAM 24th Annual Medical-Scientific Conference April 29 - May 2, 1993

Westin Bonaventure Hotel
Los Angeles, California

In addition to the symposia described in this newsletter, ASAM will offer courses and workshops developed by members and other addiction medicine professionals; component sessions in the evenings, based on activities and concerns of ASAM committees and sections; and papers of submitted abstracts in oral and poster sessions.

Program Committee chair: **Marc Galanter**, MD.

Major Events

Thursday April 29

Ruth Fox Course for Physicians (day-long)
National Forum on AIDS and Chemical Dependency (day-long)
Component Sessions

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Friday April 30

ASAM Annual Business Meeting/Luncheon
Distinguished Scientist Lecture
Guest lecturer: Floyd E. Bloom, MD, Chairman and Member, Dept. of Neuropharmacology, the Scripps Research Institute, La Jolla, CA
Psychosocial Treatments and Pharmacotherapeutic Interventions: NIDA (National Institute on Drug Abuse)
Needle Supply and Other Aspects of Harm Reduction in Drug Users
Recent Advances in Perinatal Addiction
Strengthening the Linkage Between Primary Care and Substance Abuse Treatment
Paper Sessions
Courses and Workshops
Component Sessions

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Saturday May 1

Poster Session of Accepted Abstracts
Bio-Behavioral Correlates of Relapse
Brief Interventions for Alcohol Use Problems
Prevention of Alcohol Problems: Evidence from Research Sponsored by the NIAAA (National Institute of Alcohol Abuse and Alcoholism)
Research on Motivation for Treatment
ASAM Awards Dinner
Certification Ceremony with awarding of certificates; also Annual Awards to Max A. Schneider, MD and Floyd E. Bloom, MD

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Sunday May 2

Benzodiazepine Dependence and Addiction: Relative Therapeutic Benefits and Adverse Consequences
Are They Addictions or Just Other Types of Problems?
Adolescents and Nicotine
Courses and Workshops

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(Note: these abstracts are published exactly as submitted-- Ed.)

Symposia

Psychosocial Treatments and Pharmacotherapeutic Interventions (No. 1)

Organizer: Dorynne J. Czechowicz, MD

This day long NIDA-supported symposium will address integrating psychosocial treatments and pharmacotherapies for the treatment of drug dependence. Research on psychotherapeutic and pharmacological advances will be presented and the clinical applications for service delivery will be discussed. With the emergence of new pharmacological treatments for drug abuse, approaches to effectively integrating these new medications into the various components of substance abuse treatment will be presented. Research on treatment approaches for women, adolescents, and other high risk patient populations will be included.

Needle Supply and Other Harm Reduction Strategies Regarding Drug Use (No. 2)

Organizer: John P. Morgan, MD

Harm reduction strategies have grown in practical and theoretical stature because of the spread of HIV in IV drug users (IVDU). The basic idea is easily expressed. Attempts to stop users from using are seldom successful, and perhaps never successful in the short run. Should we not support strategies that acknowledge drug use and provide services to users so that there is minimal harm? The supply of clean needles and syringes is a prime example and also recognizes that control of HI transmission in IVDU benefits the non-using society as well. Harm reduction ideas in the U.S. falter because of a continued commitment to abstinence as a absolute goal and the moral distaste for "controlled use." The supply of nicotine in various forms is a critical example of a harm reduction strategy which acknowledges continued use of the substance but in a safer format. Why are these ideas not applicable to other users and other drugs? Why is harm reduction not useful as a part of drug education? Is harm reduction a central tenant in drug policy reform?

Recent Advances in Perinatal Addiction (No. 3)

Organizer: Sidney H. Schnoll, MD, PhD

As we have become more aware of the problems of alcohol and other drug use during pregnancy, some previous concerns have been corroborated by the research findings, and others have not been confirmed. This symposium will present some of the more recent developments in perinatal addiction, with a focus on information that will be of significant clinical importance.

Strengthening the Linkage Between Primary Care and Substance Abuse Treatment (No. 4)

Organizers and co-chairs: James A. Halikas, MD, and Saul Levin, MD

This symposium will address the challenge of current medical problems faced by drip using patients, AIDS, Hepatitis B Virus, sexually transmitted diseases, tuberculosis, and cocaine-induced illnesses.

Bio-Behavioral Correlates of Relapse in the Addictions (No. 5)

Organizer: Alfonso Paredes, MD

The phenomenon of relapse has received considerable attention from the professional community. Most of the approaches to this phenomenon have been strongly influenced by pragmatic concerns. Lesser attention has been given to the neurobiology of this phenomenon, to its psychological and socioenvironmental correlates and their significance from the point of view of conceptual models of addiction. The mechanisms underlying relapse may be related to phasic changes in neurobiological function, changes in cognitive or emotional states or responses to socioenvironmental cues. Identification of the critical mechanisms responsible for this phenomenon may help to reliably identify the specific variable which will have to be manipulated in order to delay or avoid its occurrence. The empirical data leading to the elucidation of the mechanisms that provide a background to this phenomenon, the areas of research in need of attention, and their implications in the formulation of models of addiction will be covered in this symposium.

Brief Interventions for Alcohol Use Problems (No. 6)

Organizer: Allan Graham, MD

Brief interventions for hazardous alcohol use, including alcoholism, have proven effective in office settings, hospitals, and employee assistance programs. Yet, widespread neglect and ignorance in the health care field prevent the effective application of such screening and intervention techniques. Health care providers are generally unaware of the demonstrated utility of brief interventions for alcohol use problems.

This symposium will provide theoretical foundations and efficacy data about early identification and intervention strategies. Information concerning approaches to reduce hazardous, harmful, and dependence alcohol use will be presented by clinicians and research investigators. Symposium participants will leave with information useful for building concrete intervention strategies in their own clinical environments.

Prevention of Alcohol Problems: Evidence from Research Sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (No. 6A)

Organizers and co-chairs: Enoch Gordis, MD and Richard K. Fuller, MD

Prevention strategies require the physician to play many roles, which range from identifying high risk individuals to leadership within the community in approaching alcohol related problems. The physician is often called upon to translate scientific knowledge for the community to facilitate and implement prevention strategies. Although many approaches to prevention seem plausible, research knowledge to support these approaches is still limited. This symposium will expose the attendee to current developments arising from prevention research and enable the physician to be an effective community resource for alcohol (and other drug abuse) prevention. Speakers will review recent developments in biological markers that hold promise for identifying individuals at risk for developing alcoholism. Presentations will build on these markers of individual (host) susceptibility to describe the public health model of interaction between host, agent (alcohol), and environment. Illustrative examples of state-of-the-art community prevention programs and research-based policy decisions which result in considerable savings of lives will be presented.

Research on Motivation for Treatment (No. 7)

David A. Gorelick, MD, PhD

This symposium will discuss methods for evaluating drug addicts' motivation for treatment and the association between such motivation and treatment compliance and outcome. Topics will include self-reported motivation among cocaine and PCP abusers seeking treatment and the relationship between treatment motivation and drug use among stimulant-abusing schizophrenic patients.

Benzodiazepine Dependence and Addiction: Relative Therapeutic Benefits and Adverse Consequences (No. 8)

Norman S. Miller, MD

The distinction between pharmacological dependence and addiction is critical to make when evaluation the therapeutic benefits and liabilities from benzodiazepine use. The occurrence of pharmacological dependence to benzodiazepines has been documented in objective measurements in investigative trials from varied clinical settings. The prevalence rates for addiction to benzodiazepines according to DSM-IIIR criteria are much less well documented, and often must be inferred in studies. Studies show that pharmacological dependence occurs in virtually all users within weeks in low and therapeutic doses, and whose severity is dose related. The onset and severity are related to the pharmacokinetics of the benzodiazepines, earlier and more severe in short acting preparations. Self administration studies show that the addictive potential appears to be independent of pharmacokinetics of either short or long acting preparations. There are little data to determine the respective contributions of either pharmacological dependence or of addiction to morbidity and mortality from benzodiazepine use. Available data will be assess to demonstrate the importance of distinguishing between pharmacological dependence and addiction in clinical practice and research studies to determine the relative therapeutic and adverse consequences from benzodiazepine use in patients.

Are They Addictions or Just Other Types of Problems? (No.9)

Mark S. Gold, MD

Recent progress in basic science research has enabled clinicians to talk in terms of a unified neuroanatomical theory of addiction. This theory includes drugs of abuse, host or genetic factors and the projections from the ventral tegmental area to the nucleus accumbens and prerfontal cortex - most prominently the so-called "reward" neurotransmitter dopamine and its most famous modulator, the endorphins. The most recent data reporting that all illicit drugs of abuse share the ability to access the endogenous reward system and mimic natural rewards has had the unexpected effect of supporting suggestions of "addictive" behavioral patterns, fulfillment of survival drives and even gambling or the excitement of sporting events. These appear to be acutely reinforcing but may act like a drug in some people and stimulate its own repetition. Some behaviors like binge eating and purging or gambling can quickly develop an addiction-like life of their own and are repeated despite numerous and obvious consequences. Loss of control, denial, and re-

lapse all quite typical of addiction are found also in these "disorders." Furthermore, these illnesses appear to run in families where alcoholism and other addictions are found in disproportionate numbers. Finally, recent psychobiological theories have led to the use of traditional psychological therapies normally reserved for alcoholics and other addicts and even the use of psychopharmacological treatments previously reserved for opiate addicts (e.g. naltrexone). Can gambling, binging and purging, dieting, or sex become an addictive illness in the same way that alcohol is tried by over 90% of the population and alcoholism occurs in some, but not others or are they more logically part of another illness(es).

Adolescents and Nicotine (No. 10)

Peter D. Rogers, MD, MPH and
Marie E. Armentano, MD

The symposium will address the problem of the use of cigarettes and smokeless tobacco by our adolescent population. Tobacco advertising and ways to counteract it will be discussed, as well as epidemiology, prevention, and clinical treatment strategies.

◆

Medical-Scientific Conference Program Committee

Marc Galanter, MD, chair
Peter Banys, MD
Sheila B. Blume, MD
David J. Canavan, MD
Paul Cushman, Jr., MD
Dorynne J. Czechowicz, MD
Carlton K. Erickson, PhD
Daniel K. Flavin, MD
Richard K. Fuller, MD
Donald M. Gallant, MD
Anne Geller, MD
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Enoch Gordis, MD
David A. Gorelick, MD, PhD
Edward Gottheil, MD
James A. Halikas, MD
Lynn R. Hankes, MD
Charles S. Lieber, MD
Norman S.Miller, MD
Robert B. Millman, MD
John P. Morgan, MD
Alfonso Paredes, MD
Peter D. Rogers, MD, MPH
Charles C. Rohrs, MD
Sidney H. Schnoll, MD, PhD
Edward C. Senay, MD
John Slade, MD
Barry Stimmel, MD

"The committee spends all year between meetings preparing symposia and reviewing submissions for scientific papers, courses and workshops," Dr.Galanter told *ASAM NEWS*. "This carefully designed peer review process, which is conducted by phone and mail, begins at the preceding annual meeting."

◆

ASAM Certificate Ceremonies 1987, 1989

This year's ceremony will be a dinner Saturday evening, May 1, 1993, in Los Angeles.

(Above) Cleveland, April 25, 1987.
The first ceremony awarding certificates in person to some 200 of the first ASAM members to be certified.

(Below) Atlanta, April 29, 1989
Drs. Sheila B. Blume (on L) and Anthony B. Radcliffe (on R) bestow certificates in person to 125 of the 548 who passed the ASAM certification examination that year.

MRO

Current ASAM policy is that, for now, ASAM will consider a combination of ASAM certification and attendance at one of the ASAM-approved Medical Review Officer (MRO) training courses to be adequate training for the performance of MRO duties.

In 1992, ASAM sponsored MRO courses Feb. 14-16 and July 17-19 in Arlington, VA, and Oct. 16-18 in San Francisco. All attendees who have been certified by ASAM were sent the following letter from ASAM headquarters:

Dear Doctor [Name]:

ASAM maintains that physicians who serve as Medical Review Officers should be knowledgeable about alcoholism and other drug dependencies in addition to being informed about the duties and responsibilities of the MRO.

This letter affirms that you are certified by ASAM, through written examination, as knowledgeable in the diagnosis and treatment of alcoholism and other drug dependencies, and that you have completed a course given by ASAM for Medical Review Officers.

Sincerely,
/s/ Anthony B. Radcliffe, MD
President

ASAM will continue to offer MRO education courses, but not an MRO examination. However, the 1992 ASAM Certification Exam included several items testing the knowledge specifically required of an MRO. And the society will cooperate with the American College of Occupational & Environmental Medicine (ACOEM) which is offering a credentialing examination for MRO's, by making available experts in addiction medicine to assist in writing the questions for the ACOEM exam.

Further, ASAM will support the process begun at the June 1992 meeting of the AMA House of Delegates to develop consensus on the qualifications (knowledge, training and skills), credentialing, and the duties of the MRO. ASAM seeks dialogue aimed at developing consensus among the several different medical organizations whose members serve as MRO's or relate to drug testing in the workplace. [GBJ]

◆

New Chapter: Arizona

Arizona is ASAM's newest state chapter, bringing the total to 19. The others are Alabama, Arkansas, California, Florida, Georgia, Illinois, Iowa, Maryland, Missouri, Nevada, New York, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Utah, and Washington.

◆

Academy to ASAM

The name "The American Academy of Addiction Medicine," which was formerly owned by the Caduceus Foundation in Georgia, is now officially the property of the American Society of Addiction Medicine. **G. Douglas Talbott**, MD, who spearheaded the formation of the Academy in the early 1980s, arranged for the name to be acquired by ASAM. Any future use by ASAM of this name is subject to the board's determination and approval.

◆

Membership Brochure

ASAM has published a new membership brochure which describes the society in detail and includes a membership application. Copies are available at headquarters: 5225 Wisconsin Ave. NW, Suite 409, Washington, DC 20015. ☎ (202) 244-8948. FAX: 202-537-7252.

◆

Committee for Anesthesiology

ASAM now has a new committee, Anesthesiology, in the Specialty Section. Chair is **Seddon R. Savage**, MD, of Dartmouth-Hitchcock Medical Center in New Hampshire.

◆

New Name for Syllabus

The ASAM Review Course Syllabus, last published in 1990 and an integral part of the ASAM Review Courses, will have a new name: "Principles of Addiction Medicine: ASAM Review Course Syllabus." Publication is planned for spring 1994. Editor: **Norman S. Miller**, MD; Associate Editor: **Martin Doot**, MD; Managing Editor: Bonnie B. Wilford, MS.

◆

News About Members

George D. Comerci, MD, of Tucson, has been nominated to run for vice-president of the 45,000-member American Academy of Pediatrics. His specialities are pediatrics and adolescent medicine.

Jasper G. Chen See, MD, of Reading, PA, received the Marty Mann Founder's Award, given yearly by the National Council on Alcoholism and Other Drug Dependence to "individuals of national prominence in the field of alcoholism and other drug problems whose life work strongly reflects the energy, dedication and focus exemplified by NCADD's founder, Marty Mann." Dr. Chen See was president of ASAM from 1989-1991.

Richard Kunnes, MD, of New Jersey was recently appointed Vice-President, Mental Health, at Prudential's Group Insurance Dept. in Newark, NJ. He has overall responsibility for the company's mental health and substance abuse programs.

Joseph Pachman, MD, PhD, recently joined Liberation Programs in Fairfield County, CT, a methadone treatment outpatient and inpatient program.

Recovery Management Corp., of Coral Springs, FL, whose president is **Richard Tyson**, MD, bought a 60-bed Charter Hospital in Newport News, VA, last March for $3.1 million. Dr. Tyson told *Modern Healthcare* magazine (Oct. 12) that he does not plan to buy additional hospitals. He is a former president of the Florida chapter of ASAM.

The ASAM Board was delighted to welcome back **Margaret Bean-Bayog**, MD, during its October meeting in Arizona. She has been on a short leave of absence.

Steven Wolin, MD, of Washington, DC, was a guest speaker Sept. 15 for the *Treatment Works!* Month Congressional Briefing and Breakfast on Family Recovery.

◆

[ASAM Members: send the newsletter your news. We will print it as space permits. Send to Lucy B. Robe, 303-D Sea Oats Drive, Juno Beach, FL 33408]

◆

FROM THE EXECUTIVE VICE PRESIDENT

BATF Allows Health Claims on Red Wine

by James F. Callahan, DPA

For years, the Bureau of Alcohol, Tobacco and Firearms (BATF) was opposed to placing warning labels on containers of alcoholic beverages. Although many prominent ASAM physicians supported the labels, the opposition, led by the liquor industry and supported by the BATF, always managed to thwart them.

Until 1991, when warning labels were finally made mandatory by Congress.

Then, in late October of this year, the BATF decided to allow the Beringer Vineyards in California to make health claims about its red wine. This opens the door for all other wineries to gain similar permission for their products, which could severely damage the impact of the warning labels.

The Beringer Vineyard's health claims are in the form of an information piece, called a "neckhanger," which is attached to each red wine bottle. The piece contains quotes from a CBS "60 Minutes" segment of Nov. 17, 1991, on the "French Paradox" and on how alcohol and red wine in moderation can reduce the risk of heart disease. However, the "moderation" (about 1/2 bottle of wine per day mentioned by one physician on the program) would not be considered moderate drinking by most ASAM physicians.

Wine producers have used the "60 Minutes" piece to promote a popular belief that wine is some kind of a "health food," and, according to *The New York Times* (10/24/92), since the broadcast "red wine sales have soared, with shipments up 40%." These promotional endeavors may undermine many efforts by ASAM members and others to educate the public about negative health consequences of alcohol consumption, and may lead to increased rates of alcohol-related problems.

ASAM members may wish to make their views known to Secretaries Sullivan and Brady about this matter.

Dr. Louis Sullivan, Secretary
Department of Health & Human Services
Washington, DC 20201

Mr. Nicholas Brady, Secretary
Department of the Treasury
Washington, DC 20226

Dr. Callahan is Executive Vice President of ASAM.

◆

ASAM at the AMA

At the AMA House of Delegates meeting last June in Chicago, ASAM held its first-ever caucus of ASAM members. Those present were (L to R:)

E. M. Steindler, MS, former executive director of ASAM and long-time AMA staffer; ***Sam Cullison****, MD, of Washington state;* ***Jess Bromley****, MD, ASAM delegate to the AMA;* ***David E. Smith****, MD, ASAM alternate delegate to the AMA; James F. Callahan, DPA, ASAM executive vice president.*

BOOKSHELF

Substance Abuse Textbook Second Edition

Editors: **Joyce H. Lowinson**, MD, Petro Ruiz, MD, **Robert B. Millman**, MD, John G. Langrod, PhD.

"Substance Abuse, A Comprehensive Textbook, Second Edition," Williams and Wilkins, Baltimore, 1992.

"The first edition of this book, published in 1981, attempted reasonably successfully to describe a relatively new field," write the editors in their preface to this new, second edition. "During the past decade ... there has been a remarkable burgeoning of clinical basic research in substance abuse ... significant growth in .. prevention, treatment, and policy development ... the objective of [this] second edition is to provide a comprehensive and detailed description of current thinking and new developments in ... both basic science and clinical practice."

This 10-pound, 8-1/2' x 11", 1136-page book, is divided into 11 sections with 80 chapters. The index alone is 27 pages long!

The sections are: Background (3 chapters), Determinants of Substance Abuse (8 chapters), Substances of Abuse (17 chapters include cocaine and crack, nicotine, caffeine, eating disorders, anabolic steroids), Evaluation and Early Treatment (5 chapters), Treatment Approaches (15 chapters), Management of Associated Medical Conditions (5 chapters), HIV Infection and AIDS (4 chapters), Special Populations (11 chapters include women, CoAs, co-dependents, elderly, gay/lesbians, African, Hispanic and Native Americans, Asians, health professionals), Prevention and Education (3 chapters), Medical Education and Staff Training (4 chapters), Policy Issues (5 chapters, include insurance). Chapter lengths run from five to 20 encyclopedia-size pages.

Of the 125 contributors to this impressive work, 27 are currently ASAM members. Their names follow in **boldface**.

Donald R. Wesson, MD, **David E. Smith**, MD, PhD, and Richard B. Seymour, MA: "Sedative Hypnotics and Tricyclics."

J. Thomas Ungerleider, MD, and Robert Pechnick, PhD: "Hallucinogens."

John P. Morgan, MD: "Controlled Substance Analogues: Current Clinical and Social Issues."

Edward C. Senay, MD: "Diagnostic Interview and Mental Status Examination."

Anne Geller, MD: "Rehabilitation Programs and Halfway Houses."

Charles A. Dackis, MD, and **Mark S. Gold**, MD: "Psychiatric Hospitals ;for Treatment of Dual Diagnosis."

Edgar P. Nace, MD: "Alcoholics Anonymous."

Edward Kaufman, MD: "Family Therapy: A Treatment Approach with Substance Abusers."

Marc Galanter, MD: "Office Management of the Substance Abuser: The Use of Learning Theory and Social Network."

Joyce H. Lowinson, MD, Ira J. Marion, MA, HErman Joseph, MA, and **Vincent P. Dole**, MD: "Methadone Maintenance."

Jefferson J. Katims, MD, Lorenz K. Y. Ng, MD, and **Joyce Lowinson**, MD: Acupuncture and Transcutaneous Electrical Nerve Stimulation (ANS) in the Treatment of Addiction."

Beny J. Primm, MD: "Future Outlook: Treatment Improvement."

Ann Bordwine Beeder, MD and **Robert B. Millman**, MD: "Treatment of Patients with Psychopathology and Substance Abuse."

Peter A. Selwyn, MD, MPH, "Medical Aspects of Human Immunodeficiency Virus Infection and Its Treatment in Injecting Drug Users."

James L. Sorenson, PhD, and **Steven L. Batki**, MD: "Management of the Psychosocial Sequelae of HIV Infection Among Drug Abusers."

Sheila B. Blume, MD, CAC: "Alcohol and Other Drug Problems in Women."

Charles L. Whitfield, MD: "Co-Dependence Addictions and Related Disorders."

Linda Dusenbury, PhD, Elizabeth Khuri, MD, and **Robert B. Millman**, MD: "Adolescent Substance Abuse" A Sociodevelopmental Perspective."

Robert P. Cabaj, MD: "Substance Abuse in the Gay and Lesbian Community."

Lawrence S. Brown, Jr., MD and Arthur I. Alterman, PhD: "African Americans."

Joseph Westermeyer, MD "Cultural Perspectives: Native Americans, Asians and New Immigrants."

Lynn Hankes, MD and **LeClair Bissell**, MD: "Health Professionals."

John N. Chappel, MD: "Medical Education in Substance Abuse."

John N. Chappel, MD and **David C. Lewis, MD**: "Attitudes Toward the Treatment of Substance Abusers."

John P. Morgan, MD: "Prohibition Was and Is Bad for the Nation's Health."

(Names in boldface are ASAM members.)

*Ordering Information:*Phone Williams and Wilkins at 1-800-638-0672. Address: 428 East Preston St, Baltimore, MD 21202. Price is $129. Major credit cards accepted. *[LBR]*

◆

What You Can Do to Prevent Fetal Alcohol Syndrome A Professional's Guide, by Sheila B. Blume, MD

Johnson Institute, Minneapolis, 1992, 58 pages.

Dr. Blume, chair of ASAM's Public Policy Committee, former president and current board member, is one of the country's authorities on FAS. She has been interested in this alcohol-induced birth defect since the late 1970s, when she chaired the FAS Task Force of New York State. In this new booklet, she pulled together important facts, major research, and the educational and policy issues about FAS and FAE (fetal alcohol effects). The booklet is assembled in sections, with a very clear table of contents, two health questionnaires, and a well-selected four-page list of recommended reading.

Ordering information: Phone Johnson Institute at 1-800-231-5165. Address: 7205 Ohms Lane, Minneapolis, MN 55439-2159. Price is $6.95. Major credit cards accepted. *[LBR]*

◆

PHYSICIAN

VAMC, Martinsburg, WV, has opening for physician in Alcohol & Drug Treatment Unit. 319-bed acute medical, surgical and psychiatric with 50 beds dedicated to alcohol and drug treatment. Martinsburg is located approximately 70 miles from Washington, DC and Baltimore, MD. ASAM certified in addiction medicine preferred. EOE.

Contact Jeanie Henderson, AA/COS 304-263-0811, ext. 4015.

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Medical Director CD Center

Montana Deaconess Medical Center, the largest hospital in Montana, seeks medical director of chemical dependency center to oversee both medical and chemical-dependency facets for inpatient and outpatient programs, and to make recommendations to management for improvements in quality and efficiency. Must be licensed physician for state of MT; board certified or board eligible by American Society of Addiction Medicine, with at least 5 years experience in active practice of addiction medicine. Must be experienced in administration, supervision and education of health-care professionals and program development for chemical dep. programs.

Send cover letter and CV to: Pamela Worthington, Physician Liaison, Montana Deaconess Medical Center, 1101 26th Street South, Great Falls, MT, 59405. ☎ 1-800-548-9970 ☎ (406) 455-5540 Ext. 5587

Psychiatrist Coastal Maine

We are looking for a clinically experienced and well-trained psychiatrist to join the staff of our Addiction Resource Center in Bath, Maine. This position will be responsible for the development and support of programs in dual diagnosis, problem drinking, and hospital intervention. This is a half-time role that will also provide for the development of a much needed private practice in our area. Candidates should have experience or an active interest in addiction medicine. Bath is only a short commute to Portland, Maine, and is approximately two-and-a-half hours from Boston.

Please send your c.v. to:
George A. Hunter,
Mid-Coast Health Services,
58 Baribeau Drive, Brunswick,
Maine 04101.
For more information call:
(207) 720-0181, Ext. 352.

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Ruth Fox Memorial Endowment Fund

by Claire Osman
Director of Development

As we approach the end of 1992, we can look back over the past year with pride and say: "We did it!" We successfully completed the first phase of the Ruth Fox Memorial Endowment Campaign by reaching the $1 million goal in March 1992. Thanks to you, our members, and friends, for your pledges, contributions, bequests, etc. We now ask your help to reach the $10 million goal by the year 2000.

Just a reminder ... if you have not already participated in the Ruth Fox Memorial Endowment Fund, please do so now. There is still time to make your 1992 tax-deductible gift. Special thanks to Dr. Max Schneider for his very generous bequest to the Endowment Fund. He has now joined the Founders Circle.

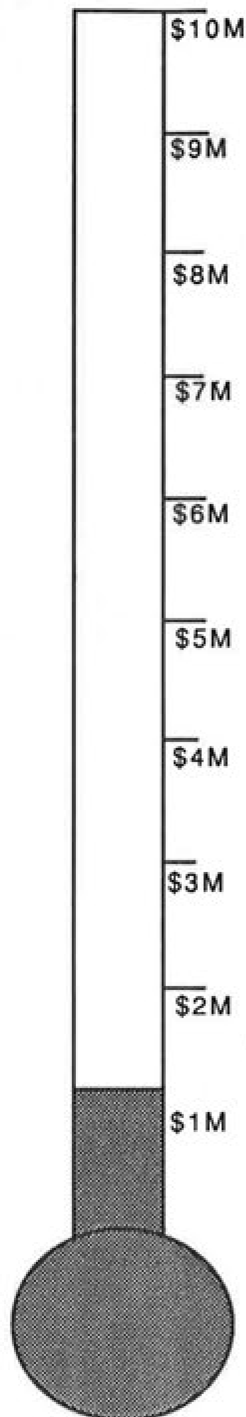
If you are interested in learning more about making a Planned Giving Gift, please feel free to call or write me in confidence/. Or send for your free brochure "**Better Estate Planning for Physicians**,"which is available from me, Ms. Claire Osman, Director of Development, ASAM, 12 W. 21st St, New York, NY 10010. Phone (212) 206-6770.

An Estate Planning Seminar is scheduled for members and spouses during ASAM's 1993 Annual Medical-Scientific Conference in Los Angeles (speaker to be announced). Again at the Annual Conference, we will hold the Ruth Fox Memorial Endowment Reception for donors, in appreciation of your generosity (by invitation only).

I want to personally express my appreciation for your generosity and kindness. I realize that it is not always convenient for you to speak to me during your busy schedules -- however, you did. I enjoy communicating with you -- not only the donors, but also those who are unable to pledge at this time. I look forward to continuing this endeavor.ASAM is a great source of pride to us all, and very special to me, as I have been a part of ASAM's growth since 1970. It is members like you that make working for ASAM a pleasure.

Our best wishes for a happy, healthy holiday season and a prosperous New Year.

Goal: $10,000,000



Pledged: $1,134,.819
(as of 10/31/92)

Recognition Roster by Giving Level Sept. 10 - Oct. 31, 1992

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ASAM Calendar

Information about ASAM conferences available at Washington headquarters: 5225 Wisconsin Avenue N.W., Suite 409, Washington, DC, 20015. ☎ (202) 244-8948 FAX: 202-537-7252

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- ❑ **ASAM Certification Examination:**
  Atlanta, Chicago, Los Angeles, Dec. 5, 1992
  (Deadline for applications to take exam was Jan. 15, 1992)

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- ❑ **Pacific Institute of Chemical Dependency:**
  Honolulu, HI, Jan. 11-12, 1993.
  Kenneth C. Hansen, Executive Director,
  1188 Bishop St, Ste 1701, Honolulu, Hawaii.
  ☎ (808) 526-2841

◆

- ❑ **Florida Chapter 6th Annual Conference on Addiction: Orlando, FL Jan. 14-17, 1993**
  Hotel Royal Plaza (Walt Disney World Village)
  Lucy B. Robe, FSAM, 303-D Sea Oats Dr.,
  Juno Beach, FL 33408
  ☎ (407) 627-6815

◆

- ❑ **ASAM Region III Annual Meeting:**
  Waterbury, CT, Jan. 23, 1993.
  Mark L. Kraus, MD, St. Mary's Hospital, Waterbury, CT.
  ☎ (203) 755-4577; FAX: 203-756-3628

◆

- ❑ **ASAM /GASAM Patient Placement Criteria Seminar: "Making It Work: Practical Strategies for Implementation & Reimbursement"**
  Atlanta, Feb. 19-21, 1993 *J. W. Marriott at Lenox*

◆

- ❑ **ASAM Board Meeting:**
  Los Angeles, April 28, 1993
  All members are welcome to attend.
- ❑ **Ruth Fox Course for Physicians:**
  Los Angeles, Apr. 29, 1993
- ❑ **National Forum on AIDS and Chemical Dependency:**
  Los Angeles, Apr. 29, 1993
- ❑ **ASAM 24th Annual Medical-Scientific Conference:**
  Los Angeles, Apr. 30-May 2.
  Westin Bonaventure Hotel

◆

- ❑ **Prevention 93: St. Louis, MO, Apr. 17-20, 1993.**
  Assoc. of Teachers of Preventive Medicine,
  American College of Preventive Medicine,
  1015 15th St NW, Ste 403, Washington, DC 20005.
  ☎ (202) 789-0006. FAX: 202-842-1980.

◆

- ❑ **ASAM 6th National Conference on Nicotine Dependence: Atlanta, Sept. 9-12, 1993.**
  Marriott Marquis Hotel

◆

Calendar includes only meetings that are sponsored or co-sponsored (CME credits) by ASAM; one time listing for co-sponsored conferences. For inclusion on this calendar, ***please send information directly to Lucy B. Robe, Editor, at least three months in advance.***

For information about conferring CME credits through ASAM, contact Claire Osman, ASAM, 12 West 21 St, New York, NY 10010.
☎ (212) 206-6770.

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