ASAM NEWS

Special Med-Sci Issue

April / May / June 1996 Volume 11, Number 2

Newsletter of The American Society of Addiction Medicine

Addiction is No. 1 U.S. Health Problem, Sen. McGovern tells ASAM Conference

Senator George McGovern

Retired Senator and former Presidential candidate George McGovern addressed the Awards Luncheon at ASAM's 1996 Medical-Scientific Conference in Atlanta. Sen. McGovern began by describing how his commitment to ending the war in Vietnam led him to seek the Presidency in 1972. He then told the group...

"There's a wall in Washington—the Vietnam memorial—a black granite wall that stretches for several hundred feet with the names of 58,000 young men and women who died in Vietnam. But if we had a wall with the names of all of the young people who die every year from alcoholism, it would be a much longer wall and just as sad and just as costly, in terms of its impact on the country.

"I've come to the conclusion—perhaps belatedly—that if you think of all of the ramifications of alcoholism, this terrible disease is the Number One problem that faces this country, not only in terms of health, but in so many other areas. We know that it kills over a hundred thousand Americans every year, that it fills up our hospital beds, and that it is a chief ingredient in crime in the United States. Addiction is a major cause of auto accidents, of family breakups, of spousal and child abuse, lost productivity, and unemployment.

"I've made my income since I left the Senate lecturing around the country. This experience of being out on college campuses day after day—more than 1,000 different campuses since leaving the Senate some 15 years ago—has been a great experience. But there's one problem, and that is that too many college students drink too much. There are too many weekend beer busts where the six-pack is starting to be replaced by the case, and where 19-year-olds down a pint or a fifth of vodka. They're young enough and optimistic enough that they don't worry about it. But then the drinking continues and increases, and they start missing work, and marital troubles develop, and they wreck their cars and lose their jobs, and they get arrested, and all kinds of bad things happen. Everybody in this room recognizes that pattern.

"I had known for years as a member of the United States Senate and as a reasonably well-informed person, of the statistics on alcoholism and drugs and what they do. And I'd read these accounts and researches, including some written by members of ASAM. But just before midnight of 1994, about Christmastime, there was a ringing of the doorbell at our home in Washington. My wife and I had come from dinner at a favorite restaurant, and she had gone upstairs to bed to read a novel. I was sitting in the living room looking at a magazine when I was startled by the ringing of the doorbell. We expected all four of our daughters and their families to come home for Christmas, and I thought possibly one of them might have arrived a few days ahead of schedule.

"But as I walked toward the front door, I could see through the glass a policeman and what appeared to be a clergyman standing there. I had a sinking feeling, as you can imagine. There was a kind of seriousness about their demeanor that worried me. They told me they were sorry to come so late. Then the police officer said, 'Senator, we have some very bad news. Your daughter, Theresa Jane McGovern, was found dead...' He said it appeared that she had fallen into the snow while heavily intoxicated and that, from preliminary indications, she had frozen to death.

"I can tell you that at that moment, mathematical formulations and statistics on ad-

Continued on page 8

[See also the Alcohol Alert on College Student Drinking, on page 9.]

INSIDE

- EVP's Report: The future of addiction medicine / *page 2*
- Med-Sci Report: Distinguished Scientist Award / *page 3*
- From the President: ASAM Fellows / *page 4*
- Med-Sci Report: Ruth Fox Course / *page 5*
- Focus On... Patient Placement Criteria / *page 7*
- Alcohol Alert: College Student Drinking / *page 9*
- ASAM Election News / *page 13*
- Committee Reports / *page 14*
- ASAM Member News / *page 15*
- State Chapter News / *page 16*
- Ruth Fox Fund / *page 18*
- Career Opportunities / *page 19*
- Conference Calendar / *page 20*

ASAM

American Society *of* Addiction Medicine

4601 North Park Ave., Upper Arcade, Suite 101
Chevy Chase, MD 20815

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

ASAM News is an official publication of the American Society of Addiction Medicine, and is published six times a year. Please direct all editorial and advertising inquiries to *ASAM News*, c/o the ASAM office.

Officers

President
David E. Smith, M.D.

President-Elect
G. Douglas Talbott, M.D.

Immediate Past President
Anne Geller, M.D.

Secretary
Marc Galanter, M.D.

Treasurer
James W. Smith, M.D.

Chair, Publications Committee
Elizabeth F. Howell, M.D.

Newsletter Review Board
LeClair Bissell, M.D.
Sheila B. Blume, M.D.
Max Schneider, M.D.
Marvin Seppala, M.D.

Executive Vice President/CEO
James F. Callahan, D.P.A.

Managing Editor
(Interim) Bonnie B. Wilford

Subscriptions
Free to ASAM members;
$25 a year (6 issues) to non-members.
Order from the ASAM office at (301) 656-3920, or
Fax (301) 656-3815.
E-Mail: asamoffice@aol.com
http://members.aol.com/asamoffice

EXECUTIVE VICE PRESIDENT'S REPORT

ADDRESS TO MED-SCI AWARDS LUNCHEON: INTERNATIONAL AND STATE CHAPTER ACTION

Each year we honor our colleagues by giving them awards that express our thanks for their lifelong dedication and achievements in addiction medicine. And as we thank them, we know that the truest honor we can bestow on them is to assure them that we will continue in solidarity with them, with our patients and with our colleagues, to pursue ASAM's vision that one day every addicted person may have the *right* to live drug-free, and that every husband, wife, significant other or child whose life is lived in the terror of an addicted family may have the right to be free of that terror.

But doesn't every American have the Constitutional right to be drug-free? Would that that were true for the addicted and their families. They do not have the right; on the contrary, they are enslaved. They are enslaved, first, by the compulsion that drives them to consume the drug and, ultimately, to consume themselves and their loved ones in the process. Dante, in the *Inferno* of his *Divine Comedy*, characterizes the essence of what addiction is when he describes Hell as that place where one yearns for what one fears, "*la tema si volve in disio*": The addict yearns for what consumes him.

However, unlike the *damned*, our patients desire, just as you and I desire, to be healthy, joyful human beings. They want to be free of their compulsion. And we know that our patients *can* be, because we collectively have helped save thousands from addiction. Thousands of our patients, and several of you in this room, have been successfully treated and, in their recovery, in your recovery, are living evidence that treatment can work. But many thousands more are denied the *right* to a drug-free life that is a result of treatment and the recovery process.

Our health care system denies them the *right* to treatment. Further, it denies you and your colleagues the *right* to practice addiction medicine. And our medical education and training systems deny you and your colleagues, and the young men and women in medical schools the *right* to learn the science and the art of addiction medicine.

As we meet in Atlanta, state legislatures and health care corporations throughout the country are writing legislation or setting policies that define addiction as a nonmedical problem by describing it as a "behavioral health problem," that exclude addiction treatment from general medical care (the so-called "carve-out" benefit), that place limits on the extent of the addictions treatment benefit, and that deny addiction medicine physicians the right to be credentialed to practice addiction medicine. And our undergraduate and graduate medical education systems continue to give only token time to education in addiction medicine. Then there are the corporate policies and health systems, and the medical education policies and systems that deny the addicted the *right* to appropriate treatment, and that deny you and your colleagues the *right* to be educated and to practice addiction medicine.

The denial of these rights presents addiction medicine with the greatest challenge it has faced in its forty years of existence. ASAM is responding to that challenge by mounting a three-part national-state campaign that I urge you to take part in. First, the ASAM Board has established a Task Force on Addiction Medicine in the 21st Century. The Task Force will review all of ASAM's policies and program activities and present to the Board a strategic plan for assuring: (1) that every addicted person and his or her family will have the right to the treatment he or she needs, (2) that all of our nation's health care institutions will provide complete addictions treatment, (3) that every physician will be educated to recognize and treat or refer the addicted patient, (4) that every ASAM certified physician will be recognized as qualified and eligible to treat, and (5) that addiction medicine will become a board-certified medical specialty.

Second, the Board has launched an International Membership Campaign to increase the size of our organization, and thereby increase ASAM's influence in setting policies on treatment, education, training and practice.

Continued on next page

CHARLES LIEBER, M.D. RECEIVES ASAM DISTINGUISHED SCIENTIST AWARD

Terry Rustin, M.D.

ASAM presented the 1996 Distinguished Scientist Award to Charles Lieber, Professor of Medicine and Pathology at Mount Sinai School of Medicine, at the Annual Medical-Scientific Conference in Atlanta. The author of more than 800 journal articles and nine books, Dr. Lieber has been a leading researcher, teacher, and clinician for more than thirty years in medicine, gastroenterology, and addiction medicine.

In his Distinguished Scientist Lecture, Dr. Lieber reviewed the effects of alcohol on the human organism, with special reference to how our understanding of alcohol and alcoholism has grown over the years. Dr. Lieber quoted from the 1958 edition of Harrison's *Textbook of Medicine*, which categorically states that alcohol is not a hepatotoxin and that the liver disease seen in alcoholics is secondary to nutritional depletion. This erroneous belief was shattered by Dr. Lieber's work with primates, proving that alcohol has specific and direct toxic effects on the liver and other organs. In fact, seventy-five percent of alcohol-related medical deaths are due to liver damage. Chedid reported in 1991 that the 48 month survival in patients with fatty liver was 70 percent, in those with alcoholic hepatitis it was 58 percent, in those with cirrhosis it was 49 percent, and in those with both cirrhosis and inflammatory changes it was 35 percent.

Dr. Lieber also reviewed his data regarding alcohol metabolism in the stomach wall. This finding first became widely known when Dr. Lieber reported that alcohol blood levels are lower when alcohol is given orally than intravenously. The enzymes responsible for this metabolism, variants of alcohol dehydrogenase, have been identified; the gene coding for the unique stomach variant, ADH7, has now been cloned. This enzyme facilitates the metabolism of alcohol after absorption and before it reaches the liver, serving as a protective barrier against intoxication and the toxic effects of alcohol. This protective barrier breaks down in alcoholics; biopsies of their stomachs reveal a significant decrease in this enzyme. Women have lower levels of the enzyme than do men. This results in women achieving relatively higher blood levels of alcohol after drinking than do men, corrected for body weight. Alcohol use further lowers the enzyme levels in women, resulting in a near-total loss of the gastric protective barrier in alcoholic women. Dr. Lieber estimated that, on average, it requires sixty grams of alcohol a day to produce liver toxicity in men, but only twenty grams a day in women.

Recent data also show that some commonly-used medications block the gastric ADH, including histamine blockers (such as cimetidine) and aspirin, resulting in higher blood alcohol levels in those who take these medicines and then drink alcohol.

Dr. Lieber went on to describe some of the cellular mechanisms believed to be responsible for the hepatotoxicity of alcohol. Alcohol induces P450 IIE1, a P450 enzyme subtype; alcoholics have shown up to a five-fold increase in the activity of this enzyme over non-drinkers. This subtype has "a unique capacity to activate xenobiotic agents," according to Dr. Lieber, causing a wide range of chemicals to develop an increased toxicity. Included in this group are industrial solvents, inhalation anesthetics, acetaminophen, vitamin A, and certain carcinogens. The extreme toxicity of smoking in alcoholics may be due to this effect as well; Dr. Lieber showed data that compared the rates of carcinoma of the esophagus in smokers and drinkers. Heavy smoking increased the incidence of esophageal carcinoma five-fold; heavy drinking increased it eight-fold; and heavy smoking with heavy drinking increased it forty-four fold.

Finally, Dr. Lieber discussed some recent data and ongoing research projects on prevention of hepatocellular damage using phosphatidylcholine (PPC), a soybean extract that binds free radicals, protecting cellular membranes from injury. This agent has shown promise in reversing the hepatic fibrosis induced by acetaldehyde.

Dr. Lieber concluded with a warning to addiction medicine specialists: With the advent of over-the-counter H2 blockers, we may see the results of higher blood alcohol levels due to blockade of gastric alcohol metabolism, including more highway deaths and greater hepatotoxicity.

Continued from preceding page

Finally, with the State Chapter presidents and our Regional Directors, we are hard at work to develop a fully functioning state chapter in each state by the year 2000.

This is a defining moment for addiction medicine. The actions we take or decide not to take will determine the shape of addiction treatment and addiction medicine for the remainder of our lifetime. The actions we take or decide not to take will have lifesaving or life-threatening consequences for our patients, and for our patients' children and their grandchildren. We are here today to honor our colleagues. Let us truly honor them by rededicating ourselves to achieving the realization of ASAM's vision that:

- ❑ One day treatment of addictive diseases will be given parity with treatment of all the other diseases;
- ❑ One day the science and the healing art of addiction medicine will be taught throughout all medical education;
- ❑ One day all physicians who wish, and who are educated and trained to do so, may *have the right* to practice addiction medicine.

PRESIDENT CLINTON IS PRESENTED MIKE SYNAR AWARD

President Clinton, in a White House ceremony honoring the President as the first recipient of the Mike Synar Award, called on all Americans "to protect our children from what is rapidly becoming the single greatest threat to their health, cigarette smoking and tobacco addiction." The approximately 80 individuals taking part in the event included young students, corporate executives, sports figures and representatives of public health and other organizations in the tobacco prevention and treatment field.

Dr. James Callahan, who represented ASAM at the event, said that the President thanked those present and all whom they represented for their work in the field, and urged them to continue their efforts "to guarantee (young people)...the health necessary to pursue their dreams." Among those whom the President thanked by name was George Comerci, M.D., ASAM member and past President of the American Academy of Pediatrics. Mr. Mike Synar, who recently died of brain cancer, was a Congressman (D-Okla.) who was a vehement advocate of smoking prevention, and of tobacco and nicotine regulation by the FDA.

FROM THE PRESIDENT

Dear Colleague:

As further evidence of the growth of our organization, I am pleased to report to you that ASAM is now accepting applications for Fellow membership within the Society. Individuals who are eligible for fellow status are those who:

- Have been a member of ASAM for at least five consecutive years.
- Are ASAM-certified.
- Demonstrate active membership in ASAM in one or more of the following ways: (a) service on the ASAM Board of Directors; (b) service as an ASAM committee chair or ASAM committee member; (c) service as an ASAM delegate or alternate to the AMA; or (d) service as an officer of a state society or chapter of ASAM.
- Have made and continue to make significant contributions in at least three of the following areas:

1. Participation in other medical and professional organizations. This might involve active participation as an officer, committee member, or representative in medical societies or organizations such as the AMA, AOA, ASIM, APA, RSA, etc., or state and local medical societies.
2. Participation in non-compensated activities of social significance such as: (a) volunteer at community health agencies; (b) serve on a volunteer Board of Directors for a health care agency; or (c) volunteer work with the JCAHO, County AIDS Task Force, schools, Planned Parenthood, the Boy Scouts, etc.
3. Clinical contributions such as developing a model for addictions treatment or significantly advancing the knowledge base of addictionists (not necessarily published work).
4. Administrative contributions such as: (a) faculty appointment(s) to medical school staff in administrative position(s) for substance abuse treatment programs for 3 or more years; (b) Board of Trustees appointment(s) to Boards of substance abuse treatment programs for 3 or more years; or (c) federal or state appointments to positions of administrative authority in federal or state alcoholism and/or drug abuse departments for 3 or more years.

5. Teaching contributions such as: (a) appointment to a medical school faculty(ies) in substance abuse teaching for 5 or more years; (b) volunteer teaching of alcoholism and drug abuse information to patients in publicly funded treatment or education programs for 5 or more years; or (c) presentations of formal lectures in the substance abuse field to physicians and/or health care providers in the addiction field, on a consistent basis over five or more years.
6. Published writings in peer reviewed journals and/or books or chapters of books written for the education of professionals (special emphasis in evaluating the application will be placed on addiction-related topics and on clinical or basic research).

Members whose records indicate that they may qualify for Fellow status have been sent a letter and an application form. (If you did not receive such a letter but believe that you qualify, based on the criteria, please contact John Keister at the ASAM Office for an application.) Return your completed application and the $250 application fee (U.S. funds only) to the ASAM office by June 30, 1996.

This is an exciting development for ASAM and a professionally rewarding step for practitioners of addiction medicine. I look forward to many of you joining the first Fellows class!

David E. Smith, M.D.
President

ASAM MOURNS PASSING OF *ASAM NEWS* EDITOR LUCY BARRY ROBE

Lucy Barry Robe, founding editor of *ASAM News* and addiction field leader for more than 20 years, succumbed to complications of emphysema on May 11 at Jupiter, Florida.

Memorial services for Mrs. Robe, who also served as staff for the Florida Society of Addiction Medicine until 1994, were held Thursday, May 16 at the Bethesda-by-the-Sea Church in Palm Beach. Mrs. Robe is survived by her husband, Robert, a daughter, Parrish, and legions of friends and admirers in the field of addiction medicine.

Until health problems forced her to resign in October 1995, Mrs. Robe edited and published the ASAM newsletter for ten years. She liked to recall that the first issue consisted of only four pages, and that under her stewardship, the newsletter grew to 16 pages. She also noted with pride that in her tenure as editor, the newsletter never missed a deadline. In recognition of her years of dedicated service, the ASAM Board voted her a special service award, announced at the 1996 Medical-Scientific Conference.

Summarizing Mrs. Robe's service to ASAM, Dr. Stanley Gitlow noted that "No single person knew our membership as well nor cared as much about them as did Lucy Robe. They will miss her. She has been a striking example of how a person could turn adversity and illness into a life characterized by honesty, integrity and courage. I will miss her. Ultimately, she was fortunate enough to experience fully her own love for those about her, especially Robert and Parrish. They will miss her. She touched us all and we will all be richer for having known her. She deserves her rest—but we will all miss her."

RUTH FOX COURSE COVERS THE ADDICTION MEDICINE SPECTRUM

Terry Rustin, M.D.

The 1996 Ruth Fox Course upheld the tradition of offering challenging and stimulating programs, begun 17 years ago when Max Weisman, M.D., initiated the Course at ASAM annual meetings in honor of Ruth Fox, M.D., one of the pioneers in addiction medicine. This year's program, directed by Alan Wartenberg, M.D., with the assistance of Charles Whitfield, M.D., and Lynn Hankes, M.D., included nine presentations covering the spectrum of addiction medicine. Among these were talks on withdrawal scales by Michael Mayo-Smith, M.D., M.P.H.; addiction among Hispanics by Rudy Arredondo, Ed.D.; addiction as a spiritual disease by George Nash, M.D.; a presentation on SMART recovery by Joseph Gerstein, M.D., and Barbara Gerstein, R.N.; and a review of the past year's literature in the field by David Gastfriend, M.D.

Use of Assessment Instruments in Withdrawal

The signs and symptoms associated with discontinuation of alcohol use were described by Hippocrates, and addiction medicine specialists continue to search for better ways to manage alcohol withdrawal. Dr. Michael Mayo-Smith, Manchester (New Hampshire) VA Medical Center, first described the "standard approach" in which benzodiazepines (principally chlordiazepoxide) are administered in decreasing doses on a schedule lasting three to six days. He then described the "symptom triggered approach" in which medication (again, usually chlordiazepoxide) is administered based on an objective measurement of specific symptoms associated with withdrawal.

The symptom triggered approach was pioneered by Sellers with the Total Severity Assessment in 1973; the revised CIWA scale, designed by Sullivan in 1989, represents the most frequently used instrument today. Dr. Mayo-Smith described how the use of this scale decreases the length of stay in detoxification and reduces the quantity of benzodiazepines needed for detoxification, without increasing the incidence of seizures or other complications.

Rehabilitative Treatment in Hispanics with Chemical Dependency

Rudy Arredondo, Ed.D., Texas Tech University School of Medicine (Lubbock, Texas), described strategies by which addiction treatment physicians can be more effective in the treatment of patients of Hispanic origin. Barriers to success include lack of knowledge about Hispanic culture, not having Spanish speaking staff, and making assumptions about the degree of acculturation of specific patients. Physicians will be more successful, stated Dr. Arredondo, by accepting the use of folk medicine by patients and their families, providing options for Hispanic patients to attend Spanish or English language 12-Step meetings, the cautious use of probing questions in the initial interview, and bringing the extended family into the treatment process.

"Anybody can work with the Hispanic population," said Dr. Arredondo. "But they need to take into consideration the differences between different cultural groups, and some identify more with the dominant culture more than others."

Alcoholism: The Spiritual Quest

"I was a chemical gourmet," said George Nash, M.D., medical director at Cottonwood de Tucson treatment center in Tucson, Arizona. Dr. Nash used his personal story to describe the concept of addiction as a spiritual quest best understood through the study of transpersonal psychology. He referred to the work of philosophers and spiritual leaders from Buddha to Bill W. to illustrate his primary points: that the desire to alter consciousness to achieve a greater knowing is universal, that peak emotional experiences obtained through spiritual discipline is the historic route to doing so, and that chemicals represent an inadequate substitute.

Dr. Nash went on to support the concept of accepting that we are all powerless over our lives and those of others, and that freedom to grow emotionally and spiritually depends on accepting this concept. "Power is a fantasy, an illusion," he said, "and the need for power and control makes you sick."

SMART Recovery

In direct contrast to Dr. Nash's description of acceptance of powerlessness as the route to recovery, Dr. Joseph Gerstein presented a paper on SMART Recovery (Self-Management and Recovery Training), a method which teaches that alcoholics always have control over their drinking choices and that treatment involves strengthening this ability. SMART Recovery, the successor to Rational Recovery, uses rational methods to help addicts learn where they have made self-defeating choices so they can make better choices and stay sober. This method utilizes other cognitive-behavioral strategies, including self-talk, personification of the urge to use/drink, writing lists of advantages and disadvantages of using/drinking, and identifying cues to use/drink.

Most of the Ruth Fox attendees interviewed by ASAM News agreed that the cognitive-behavioral methods of Ellis and the interviewing techniques of Miller and Rollnick described by Dr. Gerstein are cornerstones of effective treatment, but many objected to his ready dismissal of the spiritual aspects of recovery described previously by Dr. Nash. Several also hoped that future forums could work towards an integration of these ideas.

Review of Recent Literature

A highlight of this year's Ruth Fox Course was the review of recent literature in the addiction medicine field, presented by Dr. David Gastfriend, Chief of Addiction Services at the Massachusetts General Hospital. Dr. Gastfriend discussed addiction research extending from the molecular level to the tissue level to the level of therapeutic interventions. This review includes a few of the more important papers he reviewed.

A new genetic line of mice has been developed by Giros et al (1996) in which the gene that codes for the dopamine transporter has been altered, leading to ineffective dopamine reuptake from the synaptic space. This results in the persistence of dopamine in the synapse up to one hundred times as long as in the normal condition. This situation would correspond to the "dopamine depletion hypothesis" of cocaine dependence. These mice—normal in every other respect—show marked spontaneous hyperactivity, impaired maternal behavior (dams regularly abandon their pups), and insensitivity to amphetamine and cocaine. These studies offer the first opportunity to develop an animal model for stimulant dependence.

Dr. Gastfriend did not have encouraging information for those in the audience who had hoped to hear about pharmacological agents

continued on page 17

MATCHING PATIENTS TO TREATMENT

Michael Miller, M.D.

In a symposium chaired by David Gastfriend, M.D., Stephen Higgins, Ph.D., of the University of Vermont reported on recent NIDA funded research on the use of financial incentives in the management of opiate and cocaine dependence. If patients are given financial rewards for producing clean urines when urine monitoring is added to methadone maintenance treatment or drug-free addiction counseling, treatment outcomes are vastly increased. This has important public health implications. The question is, do patients differ regarding who is more likely to respond to such incentives; and how can such incentives be introduced into the private sector?

James Prochaska, Ph.D. discussed his "Stages of Change" models for human behavior, and how they apply to patients' willingness (or lack thereof) to change behaviors regarding substance use, diet, and exercise; and physicians' willingness (or lack thereof) to change their behavior with regard to how much they incorporate prevention interventions in their primary healthcare activities with their patients.

Dr. Prochaska pointed out that we have many problems in addiction treatment. There is a problem of patient recruitment—only a tiny percentage of patients with addictions get professional help. Primary care physicians generally don't attempt to intervene with addiction, and even if they recognize a problem, their success at getting patients to go to specialty treatment facilities or providers is very low. Next is the problem with patient retention—both professional services and self-help services for addiction have dropout rates of 50% or greater. As a result of these phenomena, there is the problem of therapeutic pessimism and high frustration on the part of treatment providers with what they perceive as a low level of patient progress. Finally, if one looks at addiction in population-based models, the extent to which we improve the functional level of population is much lower than what would ideally be. He points out that whereas 85% of persons have been exposed to public education about the dangers of cigarette smoking, only 15% of them have had any professional contact about it, such as their doctor talking with them about their nicotine usage; and only 5% have availed themselves of a specific intervention, such as an educationally-based smoking cessation program. So from a public health standpoint, we are only scratching the surface.

Dr. Prochaska believes that too much focus is placed on what he calls "action interventions"—those interventions that require patients to really work hard to bring about change. He believes that more attention should be placed on interventions to help people at earlier points in the change continuum—when they are simply contemplating change, or even when they are precontemplative with respect to behavior change. He thus points out that there are many extremely helpful things that professionals can do that do not have to wait for the patient to be ready for the action stage; he went so far as to state that the problem is not that patients are simply resistant or in denial, but that treaters have been resistant—and in denial—about what they might be able to do to help patients who aren't yet ready for the action stage. Dr. Prochaska concluded by pointing out that dropout rates are much lower when patients are matched for the proper intervention based on their motivational stage.

A presentation by Tom McClellan, Ph.D. of the University of Pennsylvania, discussed matching patients to treatment based on dimensions of illness as identified by the Addiction Severity Index (ASI).

The McClellan group has also developed an instrument called the Treatment Services Review (TSR), which does telephonic or face-to-face interviews of patients and asks them whether or not they've received a particular type of treatment in the proceeding interval—for instance, were they given medications for a physical problem, were they given counseling for an emotional problem, were they helped with job-related problems or family-related problems, etc. In a survey of four different treatment programs, two inpatient and two outpatient, it was found that the services people receive in those programs does vary. The amount of alcohol and drug related treatment is much higher in the inpatient programs than in the outpatient programs. But the amount of service for psychiatric problems, family problems, job problems, or medical problems doesn't vary in a clear way between inpatient and outpatient programs. There is much variability between one service and another.

The conclusions that are building from the work that McClellen, et al., are doing, is that dropout rates are lower, and treatment outcome success is greater, when patients actually receive treatment interventions in specific modalities to address the scatter of types of clinical problems that have been identified in those patients through the ASI. Dr. McClellan's conclusion is that it doesn't matter as much where a patient goes for treatment, as it matters what kinds of treatment services are offered them once they get there, and whether those services match with the patient's identifiable clinical needs.

The symposium concluded with Dr. Gastfriend presenting materials on a study that attempted to validate the *ASAM Patient Placement Criteria (PPC)* as a tool for matching patients to treatment settings. Different treatment services in the Boston site of the Target Cities program were studied. Patients were recommended to either Level II or Level III treatment by the *ASAM PPC*.

Some patients actually received Level II treatment and some Level III—but the treatment people received wasn't always what was recommended. What this research shows is that there is large variability amongst different Level II treatment programs, based on the number of hours of individual therapy per patient, the number of hours of group therapy per patient, the diversity of available services, the patient census and the critical mass available for group therapy process, and the capacity of the program to specialize in different types of services for different special populations. The conclusion was that it is possible that the ASAM Criteria distinguish amongst Level I, Level II and Level III services in so global a manner that they are not sufficiently descriptive; but note that *ASAM PPC-2* has now been published, which does differentiate between at least two different intensities of Level II care.

The study was not only intended to look at patient matching with *ASAM PPC*, but also to examine how valid are the patient placement decisions that derive from the *ASAM PPC*. Dr. Gastfriend's group tried to determine if assessment instruments that have already been developed, validated and utilized in the field, can be used to collect information required for the 260+ decision points that come when the *ASAM PPC* are applied to a clinical situation. It was determined that 27% of the decision points in a patient placement decision (per *ASAM PPC*) can be decided by asking items found in the ASI; 40% of the decision points can be decided by answering items found in the RAATE (instrument developed by David Mee-Lee, M.D., et al.); and 7% of the decision points can be decided by items found in the CIWA and CINA detox rating scales. Only 36% of the 260+ decision points cannot be decided by items found in these instruments; these all relate to items in the assessment of the patient's physical status; and the Gastfriend group developed questionnaire items that could address these decision points.

SECOND EDITION OF ASAM PATIENT PLACEMENT CRITERIA ARRIVES

David Mee-Lee, M.D.

When the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* was released in March, 1991, little did we know what impact it would have on the addiction treatment field. Since then, more and more states are expecting their funded programs to use the ASAM Criteria as is, or their modified version. While not universally accepted by providers, payers and managed care organizations, the ASAM Criteria has defined the dialogue about placement criteria and the continuum of addiction care.

The process for the publication of the *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, (ASAM PPC-2)*, really began in November of 1991. Annual invitational roundtables of all stakeholders kept us in touch with providers, payers, regulators, researchers and professional organizations. The investment in these forums for feedback has returned broad benefits in identifying areas for improvement in implementation, the scope of criteria and research.

Development Process

Key features of the development process of the *ASAM PPC-2* included the following:

- Response to questionnaires, roundtable discussions, Coalition for National Clinical Criteria meetings and general feedback from the field since 1991 resulted in identification of a variety of gaps and areas for improvement;
- Subcommittees of the Coalition, including ASAM committee members, prepared drafts of revised sections or new additions which were distributed for field review;
- Reviewers were invited to participate in the field review from a wide variety of organizations and field interests, including providers, payers, professional organizations, managed care organizations, industry and state and federal agencies;
- Revisions to the drafts were made by a small working group based on widespread field and ASAM member leadership review;
- Approval by the Executive Committee of the Board of Directors of ASAM.

From "Supplement" to New Edition

What started as a supplement to the ASAM Criteria changed into a whole new second edition as improvements were made to its user-friendliness. *ASAM PPC-2* has been totally reformatted to allow easier comparison of levels of service. However, not all sections were revised. What was revised and what was added was shaped by feedback from the field on perceived inadequacies and gaps. A loose leaf format is being used to allow the opportunity to revise or update sections of the criteria more efficiently and expeditiously, since the process is an evolutionary one.

What Changed and What Didn't?

In the adult criteria, Levels I and IV were not revised except for minor modifications made to update DSM-IV diagnostic terminology. For Level II, new criteria were developed to separate Intensive Outpatient (designated Level II.1) from Partial Hospitalization (Level II.5). In Level III, three levels of care were added to the original Medically-Monitored Intensive Inpatient, now designated Level III.7. But, like Levels I and IV, only minor modifications updating DSM-IV terminology were made to Level III.7.

The new Level III additions were in response to public sector concerns for criteria for halfway houses and extended residential and therapeutic communities. Hence the development of Clinically-Managed, Low Intensity Residential Treatment (designated Level III.1); Clinically-Managed Medium Intensity Residential (III.3); and Clinically-Managed Medium/High Intensity Residential (III.5).

Other new additions are: Early Intervention Services (Level 0.5) for individuals who do not meet criteria for a substance use disorder, but who are at high risk for alcohol or other drug problems (e.g., DUI clients, school based early intervention); Opioid Maintenance Therapy (OMT) to address methadone and LAAM; and five levels of detoxification services criteria to match varying severities of withdrawal management needs in assessing Dimension 1, Acute Intoxication and/or Withdrawal Potential.

In the adolescent criteria, criteria for Early Intervention Services were added, but no specific revision of the adolescent criteria was done. This was not because such a revision would not be useful, but that it was not an expressed priority from the field. The adolescent criteria, however, were reformatted with minor modifications, as with the unrevised sections of the adult criteria.

Other New Features

There are a number of other new developments in *ASAM PPC-2* as well as plans to publish the *ASAM PPC-2* on disk. But you'll just want to get your own copy to be fully informed!

ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (Second Edition)

Please send me ______ copies of *ASAM PPC-2* at ____________ **($85 for ASAM members · $100 for nonmembers)** per copy!

(Canadian orders, please add 10 percent for shipping and handling; International orders, add 25 percent.)

Name ______________________

Address *(No post office box addresses, please)*

____

____

____

Method of payment: ❑ Check ❑ Visa ❑ Mastercard

Credit Card # ______________ Exp ______

Signature ______________________

Return order form with payment to:

ASAM PPC-2 • P.O. Box 80139 • Baltimore, MD 21280-0139

Phone: 301/656-3920 · Fax: 301/656-3815

E-Mail: asamoffice@aol.com

McGovern – Continued from page 1

diction take on an entirely different dimension. You never can read again about 100,000 people dying from alcoholism and think that it's just another statistic. Three hundred people die like that every day in the United States. Most of them are not from prominent families. They often go unnoticed. Many have been out of touch with their own families for many years. There might be a little item in the paper, an unidentified body that's been found in a park or in an alley or on the street or in a cheap rooming house. For the most part, these deaths go virtually unnoticed. The difference with Terri was that she was from a prominent family. She had campaigned for me across this country in 1972. Even then, it appears in retrospect, she had the beginnings of alcoholism. However, she campaigned with such enthusiasm, and she was a person so filled with life and such a witty, funny, delightful young woman, that most people never suspected that she had any kind of a problem at that stage of her life.

"Later Terri was in and out of some of the best treatment centers in the country for years—once achieving sobriety for eight years, during which time she fell in love and had two wonderful little girls—but always the relapse would follow, sometimes on the way home from a treatment center. She was in and out of one detox center 68 times in the last four years of her life. And even while that was going on, she went through several other treatment programs. I don't think the relapses resulted from any lack of effort on her part. It was not lack of will power: she was one of the strongest-willed persons I've ever known. It was not lack of intelligence: she was one of the brightest, one of the most creative young people I've known. It was not a moral or ethical breakdown. She was a person who for years conducted a spiritual quest to try to be a better person.

"It was a disease, alcoholism, that she was powerless to contain, even with expert professional help. I'm not going to argue today that she did everything she should have done to deal with this disease. I'm not going to say that our family did everything that we should have done. You all know about denial. There were times when she'd go through a kind of reasoning where she'd say, 'After all the price I've paid for alcoholism, I know better than to let this get me down again. But today, I just have to have one drink to get out of this misery.' She suffered from clinical depression, as well as alcoholism. One thing that was more painful to her than intoxication was sobriety.

"On the day she died, Terri had gone into the Crystal Corner Bar in Madison, Wisconsin, a favorite of the neighborhood, about 5:00 p.m. on December 12. She had just left the Tularian Center after six or seven days of detoxing at 9:00 that morning. With her hopes high, she had rented a small apartment just a block from where her two little girls lived with their father, alcoholism having broken up that family a couple of years earlier. And she got through until 5:00 in the evening, when she decided to visit the old friendly Crystal Corner Bar. Three-and-a-half hours later, with seven inches of snow on the ground and the temperature way below freezing, the bartender refused to serve her any more, and she stumbled out into the dark and got about 50 yards. Then she wandered into a little driveway behind a print shop, and either collapsed or lay down and went to sleep. The next day, about noontime, the owner of that print shop looked out the back door and thought he saw a 13- or 14-year-old child lying in the snow. Of course, it was Terri.

"The press picked up the story in a matter of minutes, as soon as Terri was identified. The phone began to ring about 5:00 in the morning after Terri's body was discovered, and just a few hours after I learned about it. Even if I had wanted to, I could not have avoided public comment on her death. But I made a judgment within a few minutes of that very first telephone call that we were going to try to regain something from this tragedy by being as honest and as candid as we could about this illness and what it did to my daughter and to my family. Since then, I have done articles for major newspapers, I have done interviews on television, I've written a book about my daughter. It's simply called *Terri: My Daughter's Life and Death Struggle with Alcoholism*.

"There are questions I can't answer. To what extent is alcoholism a genetic problem? There must be some reason why so many McGoverns, both in Ireland and on this side of the pond, were alcoholics. I don't think it's simply because of environment. The environment is drastically different in various aspects of the McGovern clan I've known. But a fairly generous percentage of them suffer from alcoholism and from relapses, and they're stubborn cases in many instances. We need to know more about this, and I'm delighted that NIH and others are working hard on the problem.

"Let me tell you a couple of things I *have* learned. First, I've come to understand how precious life is. That may seem like a very trite observation, but one thing Terri's death has done is to increase my awareness and my love of my other daughters, my son, my wife, my friends, every human being. They're all precious people, and they all live a very fragile existence.

"Second, I have learned that people who are afflicted with alcoholism are sick. Some of Terri's friends used to say to me, 'There were two Terris: the sober Terri and the drinking Terri. I loved Terri when she was sober; I couldn't stand her when she was drunk.' Well, that's understandable. Alcoholic behavior is not always pleasant to family members and friends. But the truth is, there was always only one Terri, the one who was very sick with an illness that she struggled to hide, that she struggled to deny, that she struggled to recover from.

"It disturbs me when I read what some of my colleagues in the Congress have said about this problem. One or two of them have told me directly that, while they have sympathy for the problem our family has faced, they believe that people are responsible for their own lives. They have said that alcoholics have to have the character and the the will to deal with the problem of drinking; that we can't allocate public funds for a problem like alcoholism. If there is any one thing that I would say to my former colleagues in Congress or to the national press corps or the citizens in general, it is that we need to learn to hate alcoholism but love the alcoholic. My Methodist preacher father used to say, 'Hate the sin, but love the sinner.' That's a pretty good formulation for dealing with alcoholics. Hate the alcoholism, but love its victim. I think if we do that, it helps to restrain some of the anger and resentment and frustration.

"I'm very grateful for the work that the members of ASAM do in trying to find even better answers to the problem of alcoholism. The more I've studied it, the more I've become aware of how much there is left to learn. I used to think I knew quite a bit. But the more I read the literature and talk to people who are much better informed and more professionally competent than I, the more I realize how desperately we need more research to answer some of the unanswered questions.

"I hope all of the medical schools will give more attention to addiction and addictive diseases. I hope doctors will come to know more about it. And I hope that in some small way, I can play a part in working to come to grips with what I regard as Health Problem Number One."

ALCOHOL ALERT

National Institute on Alcohol Abuse and Alcoholism No. 29 PH 357

College Students and Drinking

An overwhelming majority of college students (88 percent), including those under the legal drinking age, have used alcohol (1). In 1994, 67.5 percent of college students had used alcohol within the past 30 days, a rate that has been in an overall decline since 1980 (1). By comparison, 61.7 percent of young people not in college reported monthly alcohol use in 1994 (1). This *Alcohol Alert* reviews drinking—especially binge drinking and its consequences—among college students and compares it to that of noncollege peers. It also considers some colleges' attempts to prevent and treat abusive drinking on campus.

Alcohol Alert, a publication of the National Institute on Alcohol Abuse and Alcoholism, provides timely information on alcohol research and treatment to health professionals and other interested people. This issue is the twenty-ninth in the series.

Binge Drinking

Most research on drinking among college students focuses on the widespread pattern of binge drinking. Many researchers define binge drinking for men and women as drinking five or more drinks at one sitting (1–3). In 1994, by this definition, 40 percent of college students reported binge drinking at least once within 2 weeks of being surveyed (1). Thirty-one percent of college women binge drank compared with 52 percent of college men (1). However, a strong argument has been made that a more equivalent bingeing criterion for women is four drinks per occasion (3,4) and that the five-drink level may underestimate binge drinking among women (4). Developmentally, the ages 18 through 21 is the period of heaviest alcohol consumption for most drinkers in the United States (5). However, within this heavy-drinking age group, binge drinking is more prevalent among college students than nonstudents (1).

Binge drinking is widespread on college campuses.

Message From Secretary of Health and Human Services Donna E. Shalala

Even as college students discover the intricacies of quantum physics and American history, many do not grasp an enormous health problem on our college campuses—alcohol abuse. As a former university chancellor, I know that the culture of drinking on many campuses puts these students at risk for many serious problems, ranging from car crashes to date rape. Heavy drinking over a long period of time can lead to health problems, such as cirrhosis and various types of cancer.

Prevention, early detection, and timely intervention are vital if we are to reduce the number of alcohol-related problems on college campuses today. For example, NIAAA research shows that college students who receive a single individual counseling session often will significantly reduce their drinking.

A growing number of colleges and universities are addressing campus drinking problems by providing prevention education; expanding counseling services; and offering more alternatives, such as alcohol-free parties. It is encouraging to see these activities gaining in force across the country.

At the same time, all of us must encourage college students—our national future—to take personal responsibility for making healthy choices with the only lives they will ever have. Getting drunk doesn't need to be a rite of passage, and hangovers aren't a prerequisite for graduation.

A Commentary by NIAAA Director Enoch Gordis, M.D. 3

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service • National Institutes of Health

Binge drinking prevalence varies among campuses, ranging from almost 0 to nearly 70 percent of the students (3). Rates vary depending on the type of college and its geographical location as well as on the ethnic and gender-based makeup of the student body (2,3).

In one multicampus survey, white students reported the highest percentage of binge drinking in a 2-week period (43.8 percent), followed by Native American (40.6 percent), Hispanic (31.3 percent), Asian (22.7 percent), and black (22.5 percent) students (2). This pattern of drinking differences among ethnic groups is also seen in high school students (6).

Students' drinking patterns vary with their ages and their years in college (7). One survey reported that more students under age 21 binge drink and have alcohol-related problems than those over 21 (2). However, Wechsler and colleagues found that age differences in drinking rates apply only to older students (i.e., above age 23), who drink less than traditional-age students (i.e., ages 17 to 23) (3). Any variation by age group in students' drinking rates does not differ noticeably from variation between the same age groups in the noncollege population (8).

Students who binge drink are more likely to damage property, have trouble with authorities, miss classes, have hangovers, and experience injuries than those who do not (3,9). Alcohol-related problems of this nature increased between the early and late 1980's (10,11). Interestingly, frequent binge drinkers and those who report experiencing specific alcohol-related problems do not perceive themselves as problem drinkers (3).

Binge drinking is related to sexual aggression and assault.

Among men, research indicates that greater alcohol use is related to greater sexual aggression (12). Sixty-seven percent of the male sexual aggressors at one university, as well as about 50 percent of female victims, had been drinking at the time of the sexual assault or other incident of victimization (13). Binge drinkers appear to engage in more unplanned sexual activity and to abandon safe sex techniques more often than students who do not binge drink (3).

Students living on campuses with higher proportions of binge drinkers experience more incidents of assault and unwanted sexual advances as a result of their peers' drinking than do students residing on campuses with lower proportions of binge drinkers (3,14). The former also more often report having their studies disturbed or having to take care of a drunken student (3,14). Students who consume alcohol but do not binge drink seem to have a lower frequency of drinking and getting drunk than do binge drinkers (3). The former also experience fewer of the alcohol-related problems cited above than their binge drinking peers (3).

Drinking and driving has been reported by more than 60 percent of college men and almost 50 percent of college women who binge drink at least three times in a 2-week period (3). By comparison, drinking and driving has been reported by 20 percent of college men and 13 percent of college women who do not binge drink (3). College students reported a decrease in drinking and driving incidents between 1982 and 1991 (9).

Factors Associated With Heavy Drinking

Heavy drinking is associated with psychological problems, expectancies, and perceptions of peers' drinking.

Heavy drinking or alcohol-related problems during college may be associated with personality characteristics, such as being impulsive (15); psychological problems, such as depression or anxiety (15–17); or early deviant behavior (18). As in the general population (19), a positive family history of alcohol abuse appears to be a risk factor for problem drinking in college students (17,20,21), although not all studies report this relationship (22,23).

Several studies indicate that students generally perceive their peers' drinking levels to be higher than their own (24–26) and higher than they actually are (24). Some studies further indicate that exaggerated perceptions of others' drinking are associated with greater individual consumption (24,26,27) but not with more alcohol problems (25,27).

Research indicates that students' expectancies that alcohol will loosen inhibitions or promote relaxation appear to be correlated with increased drinking (28). Such expectancies also predict changes in drinking by college students and other youth (28).

Binge drinking during high school, especially among men, is strongly predictive of binge drinking in college (20,29,30). Research has shown that expectancies develop well before students enter college, even before they have begun to drink (28,31). Furthermore, students' perceptions of the drinking behaviors of which their peers approve may exist before they enter college (32).

Students relate drinking to social acceptance.

Irrespective of the alcohol-related problems that college students experience, their degree of social acceptance may be tied to drinking behavior. In one report, for example, students who binge drink fewer than three times per week have reported more intimacy in their relationships than those who do not binge drink and those who binge drink more frequently (33).

Fraternity and sorority members drink more and drink more frequently than their peers (7,20,30) and accept as normal high levels of alcohol consumption and associated problems (32). Fraternity-sponsored parties also may foster heavy drinking (34). Studies have found that students who consider parties or athletics important and those who drink to get drunk appear most likely to binge drink or to drink heavily (9,30).

Drinking in groups and serving oneself may promote higher levels of alcohol consumption. In one study, college students at bars drank more beer when in groups and when ordering pitchers than when alone and when ordering glasses or bottles (35). In another study, beer drinkers assigned to serve themselves at a fraternity party drank more than those assigned to receive beer from a bartender (34). In simulated natural settings (i.e., a simulated tavern), the amount of alcohol consumed by college students was influenced by the social behavior and drinking of those around them (7).

Interventions

Few campus intervention programs have been evaluated.

Alcohol abuse prevention and treatment programs exist on many campuses, but few have been evaluated. Interventions include education programs and efforts to change drinking behavior.

Some campuses sponsor alcohol awareness events and classroom lectures and disseminate information about alcohol use. Although such education programs raise students' awareness of issues surrounding alcohol use (36), these programs appear to have minimal effect on drinking and on the rates of alcohol problems (37).

Behavioral interventions have been more successful than education. The Alcohol Skills Training Program focuses on giving students the cognitive behavioral skills they need to monitor and moderate their own drinking. Heavy-drinking students who completed the course reported significantly less drinking 1 year later, compared with similar students who took an alcohol education course. More recently, a single individual motivational session providing feedback on drinking practices for heavy-drinking freshmen has proven effective in reducing alcohol-related problems over the first 2 years of college (7,38).

Interventions that challenge erroneous alcohol expectancies can reduce drinking (7,28,38,39). Students are encouraged to examine their own beliefs about the likely effects of alcohol. Their expectancies may be "challenged" by administering nonalcoholic placebo "drinks" or by presenting contradicting factual information.

Other interventions target specific aspects of drinking behavior or environments. Students served low-alcohol beverages at one fraternity party had lower blood alcohol concentrations (BAC's) upon leaving the party than students served standard alcoholic beverages at another party (40). However, students given a choice of beverages preferred standard beer to low-alcohol beer, suggesting that this intervention may be unrealistic (41). Simple sobriety tests designed to demonstrate unfitness for driving also have been tested (42). However, the higher the students' BAC's, the less impact test performance had on their decision to drive (42).

College Students and Drinking—A Commentary by NIAAA Director Enoch Gordis, M.D.

It is clear that an overwhelming number of college students, many of whom are below the minimum drinking age, use alcohol and that the pattern of binge drinking is widespread among our college campuses. Binge drinking is of particular concern, not only because of its risks to the drinker but because of the problems it causes for those around the drinker. Research on the extent of the problem is detailed and persuasive. Unfortunately, comparatively little evidence exists about which interventions would be successful if applied widely and at an acceptable cost. Not only must future research inform us on effective interventions, but other questions must be answered that involve both science and social policy. For example, proscribing alcohol on campus may drive students onto the highway with risk of crashes. Risk of this complication might differ between urban and rural schools. Restrictions on advertising are not only of unknown impact but raise issues of rights of expression because many students are 21 or older. Even when these questions are answered, within any campus administration, faculty and alumni may differ on the degree to which schools are obligated to act as surrogate parents and on which measures are acceptable. We have much to learn.

References

(1) **Johnston, L.D.**; O'Malley, P.M.; & Bachman, J.G. *National Survey Results on Drug Use from the Monitoring the Future Study, 1975–1994: College Students and Young Adults.* Rockville, MD: National Institute on Drug Abuse, in press. (2) **Presley, C.A.**; Meilman, P.W.; & Lyerla, R. *Alcohol and Drugs on American College Campuses: Use, Consequences, and Perceptions of the Campus Environment. Vol. II: 1990–92.* Carbondale, IL: Southern Illinois University at Carbondale, 1995. (3) **Wechsler, H.**; Davenport, A.; Dowdall, G.; Moeykens, B.; & Castillo, S. Health and behavioral consequences of binge drinking in college: A national survey of students at 140 campuses. *Journal of the American Medical Association* 272(21):1672–1677, 1994. (4) **Wechsler, H.**; Dowdall, G.W.; Davenport, A.; & Rimm, E.B. A gender-specific measure of binge drinking among college students. *American Journal of Public Health* 85(7):982–985, 1995. (5) **Chen, K.**, & Kandel, D.B. The natural history of drug use from adolescence to the mid-thirties in a general population sample. *American Journal of Public Health* 85(1):41–47, 1995. (6) **Bachman, J.G.**; Wallace, J.M., Jr.; O'Malley, P.M.; Johnston, L.D.; Kurth, C.L.; & Neighbors, H.W. Racial/ethnic differences in smoking, drinking, and illicit drug use among American high school seniors, 1976–89. *American Journal of Public Health* 81(3):372–377, 1991. (7) **Marlatt, G.A.**; Baer, J.S.; & Larimer, M. Preventing alcohol abuse in college students: A harm-reduction approach. In: Boyd, G.M.; Howard, J.; & Zucker, R.A., eds. *Alcohol Problems Among Adolescents: Current Directions in Prevention Research.* Hillsdale, NJ: Lawrence Erlbaum Associates, 1995. pp. 147–172. (8) **Crowley, J.E.** Educational status and drinking patterns: How representative are college students? *Journal of Studies on Alcohol* 52(1):10–16, 1991. (9) **Wechsler, H.**, & Isaac, N. 'Binge' drinkers at Massachusetts colleges: Prevalence, drinking style, time trends, and associated problems. *Journal of the American Medical Association* 267(21):2929–2931, 1992. (10) **Hanson, D.J.**, & Engs, R.C. College students' drinking problems: A national study, 1982–1991. *Psychological Reports* 71(1):39–42, 1992. (11) **Engs, R.C.**, & Hanson, D.J. Boozing and brawling on campus: A national study of violent problems associated with drinking over the past decade. *Journal of Criminal Justice* 22(2):171–180, 1994. (12) **Koss, M.P.**, & Gaines, J.A. The prediction of sexual aggression by alcohol use, athletic participation, and fraternity affiliation. *Journal of Interpersonal Violence* 8(1):94–108, 1993. (13) **Frintner, M.P.**, & Rubinson, L. Acquaintance rape: The influence of alcohol, fraternity membership, and sports team membership. *Journal of Sex Education and Therapy* 19(4):272–284, 1993. (14) **Wechsler, H.**; Moeykens, B.; Davenport, A.; Castillo, S.; & Hansen, J. The adverse impact of heavy episodic drinkers on other college students. *Journal of Studies on Alcohol*, in press. (15) **Camatta, C.D.**, & Nagoshi, C.T. Stress, depression, irrational beliefs, and alcohol use and problems in a college student sample. *Alcoholism: Clinical and Experimental Research* 19(1):142–146, 1995. (16) **Deykin, E.Y.**; Levy, J.C.; & Wells, V. Adolescent depression, alcohol and drug abuse. *American Journal of Public Health* 77(2):178–182, 1987. (17) **Kushner, M.G.**, & Sher, K.J. Comorbidity of alcohol and anxiety disorders among college students: Effects of gender and family history of alcoholism. *Addictive Behaviors* 18(5):543–552, 1993. (18) **MacDonald, R.**; Fleming, M.F.; & Barry, K.L. Risk factors associated with alcohol abuse in college students. *American Journal of Drug and Alcohol Abuse* 17(4):439–449, 1991. (19) **Harford, T.C.**; Haack, M.R.; & Spiegler, D.L. Epidemiologic Bulletin No. 18: Positive family history for alcoholism. *Alcohol Health & Research World* 12(2):138–143, 1987/88. (20) **Baer, J.S.**; Kivlahan, D.R.; & Marlatt, G.A. High-risk drinking across the transition from high school to college. *Alcoholism: Clinical and Experimental Research* 19(1):54–61, 1995. (21) **Perkins, H.W.**, & Berkowitz, A.D. Collegiate COAs and alcohol abuse: Problem drinking in relation to assessments of parent and grandparent alcoholism. *Journal of Counseling & Development* 69(3):237–240, 1991. (22) **Engs, R.C.** Family background of alcohol abuse and its relationship to alcohol consumption among college students: An unexpected finding. *Journal of Studies on Alcohol* 51(6):542–547, 1990. (23) **Havey, J.M.**, & Dodd, D.K. Variables associated with alcohol abuse among self-identified collegiate COAs and their peers. *Addictive Behaviors* 18(5):567–575, 1993. (24) **Baer, J.S.**; Stacy, A.; & Larimer, M. Biases in the perception of drinking norms among college students. *Journal of Studies on Alcohol* 52(6):580–586, 1991. (25) **Baer, J.S.**, & Carney, M.M. Biases in the perceptions of the consequences of alcohol use among college students. *Journal of Studies on Alcohol* 54(1):54–60, 1993. (26) **Prentice, D.A.**, & Miller, D.T. Pluralistic ignorance and alcohol use on campus: Some consequences of misperceiving the social norm. *Journal of Personality and Social Psychology* 64(2):243–256, 1993. (27) **Wood, M.D.**; Nagoshi, C.T.; & Dennis, D.A. Alcohol norms and expectations as predictors of alcohol use and problems in a college student sample. *American Journal of Drug and Alcohol Abuse* 18(4):461–476, 1992. (28) **Smith, G.T.**, & Goldman, M.S. Alcohol expectancy theory and the identification of high-risk adolescents. *Journal of Research on Adolescence* 4(2):229–247, 1994. (29) **Wechsler, H.**; Isaac, N.E.; Grodstein, F.; & Sellers, D.E. Continuation and initiation of alcohol use from the first to the second year of college. *Journal of Studies on Alcohol* 55(1):41–45, 1994. (30) **Wechsler, H.**; Dowdall, G.W.; Davenport, A.; & Castillo, S. Correlates of college student binge drinking. *American Journal of Public Health* 85(7):921–926, 1995. (31) **Johnson, H.L.**, & Johnson, P.B. Children's alcohol-related cognitions: Positive versus negative alcohol effects. *Journal of Alcohol and Drug Education* 40(2):1–12, 1995. (32) **Baer, J.S.** Effects of college residence on perceived norms for alcohol consumption: An examination of the first year in college. *Psychology of Addictive Behaviors* 8(1):43–50, 1994. (33) **Nezlek, J.B.**; Pilkington, C.J.; & Bilbro, K.G. Moderation in excess: Binge drinking and social interaction among college students. *Journal of Studies on Alcohol* 55(3):342–351, 1994. (34) **Geller, E.S.**, & Kalsher, M.J. Environmental determinants of party drinking: Bartenders versus self-service. *Environment and Behavior* 22(1):74–90, 1990. (35) **Geller, E.S.**; Russ, N.W.; & Altomari, M.G. Naturalistic observations of beer drinking among college students. *Journal of Applied Behavior Analysis* 19(4):391–396, 1986. (36) **Flynn, C.A.**, & Brown, W.E. The effect of a mandatory alcohol education program on college student problem drinkers. *Journal of Alcohol and Drug Education* 37(1):15–24, 1991. (37) **Gonzalez, G.M.** Five-year changes in alcohol knowledge, consumption and problems among students exposed to a campus-wide alcohol awareness program and a rise in the legal drinking age. *Journal of Alcohol and Drug Education* 37(1):81–91, 1991. (38) **Kivlahan, D.R.**; Marlatt, G.A.; Fromme, K.; Coppel, D.B.; & Williams, E. Secondary prevention with college drinkers: Evaluation of an Alcohol Skills Training Program. *Journal of Consulting and Clinical Psychology* 58(6):805–810, 1990. (39) **Darkes, J.**, & Goldman, M.S. Expectancy challenge and drinking reduction: Experimental evidence for a mediational process. *Journal of Consulting and Clinical Psychology* 61(2):344–353, 1993. (40) **Geller, E.S.**; Kalsher, M.J.; & Clarke, S.W. Beer versus mixed-drink consumption at fraternity parties: A time and place for low-alcohol alternatives. *Journal of Studies on Alcohol* 52(3):197–204, 1991. (41) **Russ, N.W.**, & Geller, E.S. Exploring low alcohol beer consumption among college students: Implications for drunk driving. *Journal of Alcohol and Drug Education* 33(2):1–5, 1988. (42) **Russ, N.W.**, & Geller, E.S. Using sobriety tests to increase awareness of alcohol impairment. *Health Education Research* 1(4):255–261, 1986.

All material contained in the *Alcohol Alert* is in the public domain and may be used or reproduced without permission from NIAAA. Citation of the source is appreciated.

Copies of the *Alcohol Alert* are available free of charge from the Scientific Communications Branch, Office of Scientific Affairs, NIAAA, Willco Building, Suite 409, 6000 Executive Boulevard, Bethesda, MD 20892–7003. Telephone: 301–443–3860.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service
National Institutes of Health
Bethesda, MD 20892–7003

Official Business
Penalty for Private Use $300

BULK RATE
POSTAGE AND FEES PAID
DHHS/NIH
PERMIT NO. G–763

NOMINATING COMMITTEE ANNOUNCES CANDIDATES FOR ASAM OFFICE

Anne Geller, M.D.

A slate of candidates for the 1997 election of officers has been approved by ASAM's Nominating and Awards Committee, and approved by the Board of Directors. In April 1997, terms of office will expire for all officers and regional directors. (The Secretary, Treasurer and all Regional Directors are eligible to stand for re-election.) The Nominating and Awards Committee is composed of the Immediate Past President; two Committee Chairs, who are elected by all Committee Chairpersons; two Regional Directors, who are elected by all Regional Directors; and two ASAM members, who are appointed by the President and approved by the Board of Directors.

Officers, 1997-1999

In accordance with the ASAM By-laws, two candidates are nominated for the offices of President-Elect, Secretary, and Treasurer. The By-laws require that candidates be from, or have served on, the Board of Directors within the past four years (except for the Treasurer, who may be from the general membership, have qualifications for the position, and have served on the Finance Committee within the past four years). The nominees are:

President-Elect
Marc Galanter, M.D., New York
William B. Hawthorne, M.D., Florida

Secretary
Andrea G. Barthwell, M.D., Illinois
H. Westley Clark, M.D., J.D., California

Treasurer
James W. Smith, M.D., Washington *(incumbent)*
Alfonso D. Holliday, M.D., Indiana

Regional Directors, 1997-2001

Nominations for Regional Directors and Alternate Directors were made by Regional Nominating Committees. As specified in the By-laws, the Regional Director in each region shall be the person receiving the highest number of votes, while the Regional Alternate Director shall be the person receiving the second highest number of votes. Each Region submitted the names of at least two candidates for this position, which were approved by the Board of Directors.

Candidates for Regional Director must have been active members of ASAM for three years, must have demonstrated a commitment to ASAM's Mission by having engaged in activities such as service on a Committee, Task Force, or other significant national or state endeavor, and must be willing to attend two Board meetings a year for four years at his or her own expense. The nominees are:

Region I, New York
Lawrence S. Brown, Jr., M.D., M.P.H., Brooklyn, NY *(incumbent)*
Andrei C. Jaeger, M.D., Rego Park, NY
Peter A. Mansky, M.D., Albany, NY

Region II, California
P. Joseph Frawley, M.D., Santa Barbara, CA *(incumbent)*
Gail N. Schultz, M.D., Rancho Mirage, CA

Region III, CT, ME, MA, NH, RI, VT
Mark L. Kraus, M.D., Connecticut
John D. Melbourne, M.D., Connecticut
Peter Rostenberg, M.D., Connecticut
Alan A. Wartenberg, M.D., Rhode Island *(incumbent)*

Region IV, NJ, OH, PA
R. Jeffrey Goldsmith, M.D., Ohio *(incumbent)*
Lee H. McCormick, M.D., Pennsylvania

*Region V, DE, DC, GA, MD, NC, SC, VA, WV**
Paul H. Earley, M.D., Georgia
Morris Z. Effron, M.D., Maryland

Region VI, IL, IN, KY, MI, MN, ND, SD, TN, WI
Thomas L. Haynes, M.D., Michigan
Norman S. Miller, M.D., Illinois

Region VII, AR, IA, KS, LA, MO, NE, OK, TX
Ted E. Ashcraft, M.D., Arkansas
Ken Roy, M.D., Louisiana

Region VIII, AK, AZ, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY
Douglas L. Bovee, M.D., Oregon
Gregory E. Skipper, M.D., Oregon
Richard E. Tremblay, M.D., Washington *(incumbent)*

Region IX, Canada & International
Saul Alvarado, M.D., Panama
Edgardo Della Sera, M.D., Panama

Region X, AL, FL, MS, PR, VI (new region)
Richard A. Beach, M.D., Florida *(incumbent)*
Lloyd J. Gordon, III, M.D., Mississippi

* Because the membership in Region V exceeded 600, the Membership and State Chapters Committees recommended the creation of a new region (Region X), and states were divided between the two regions as indicated above. This action was approved by the Board of Directors.

Petitions

Nominations for Officers may be made upon petition by at least 25 active members of the Society. Nominations for Regional Director may be made by at least 25 active members of the Society who reside within the Region. All nominees by petition must meet the criteria stated above. Before submitting such petitions, ASAM encourages members to review a potential candidate's qualifications and willingness to serve. **Nominating petitions must be received at the ASAM office by August 15, 1996.**

Elections

Ballots will be mailed to all active, voting members on November 1, 1996. **The deadline for return of voted ballots is December 1, 1996.** Results will be announced in the January-February 1997 issue of *ASAM News*. G. Douglas Talbott, M.D., will become President, and other new Officers and Regional Directors will take office in April 1997 at the Society's annual Medical-Scientific Conference in San Diego.

More information about the candidates will appear in a future issue of *ASAM News*.

ASAM HIV/AIDS COMMITTEE PRESENTS TWO-PART COURSE

Penelope P. Ziegler, M.D.

ASAM's Committee on HIV / AIDS organized a two-part course for addictionists which was presented at the Annual Medical/Scientific Conference in Atlanta, GA. Part One, directed by Marc Gourevitch, M.D. and Penelope Ziegler, M.D., featured a comprehensive review of complementary or alternative therapies currently in use by patients with HIV / AIDS presented by Rick Elion, M.D., Assistant Clinical Professor of Medicine at The George Washington University School of Medicine; and an overview of adolescents and HIV / AIDS, presented by Elizabeth Khouri, M.D., Associate Professor of Clinical Public Health and Pediatrics, Cornell University Medical Center.

Dr. Elion explored nutritional therapies including the use of antioxidants, other vitamins, and herbal and animal extracts for "immune boosting." He reviewed the role of Chinese medicine, acupuncture, and homeopathic therapies. In addition, he focused on spiritual approaches including twelve-step programs, meditation, hypnosis, hands-on healing, energy work and prayer. He stressed the importance of the physician knowing about complementary/alternative treatments, since patients are using them extensively with or without the physician's knowledge and participation. Most patients do not tell their doctors about these therapies unless asked, and some can interact adversely with some antivirals.

Dr. Khouri spoke about her own experiences in a methadone treatment program for teens in New York City, and also reviewed data about the spread of the virus in the adolescent population and its relation to drug use, abuse and dependency. She discussed education and prevention strategies for youth, addressing reproductive decision-making, safer sex counseling and HIV testing, including special features of pre- and post-test counseling for adolescents. Harm reduction strategies, including needle-exchange programs and condom distribution were presented, and sparked a lively exchange with course attendees.

The third section of the course was a panel discussion led by Drs. Gourevitch and Ziegler, which focused on two case studies, one involving management of chronic pain in an addicted patient with AIDS, and the other the management of generalized anxiety disorder in an addicted patient who has just learned that he or she is HIV seropositive. Active participation by those attending the course provided a fertile field for examining these difficult treatment issues.

Part Two of the course was directed by Charles Morgan, M.D. and Melissa Warner, M.D. It featured an update on the medical aspects of HIV / AIDS, presented by Larry Siegel, M.D., and an experimental training seminar on sexual history taking, safer sex counseling and the relationship of sexuality to addictive diseases and to the spread of the virus, led by Melvin Pohl, M.D. and LeClair Bissell, M.D.

Dr. Siegel opened his remarks by describing the newest understanding of the HIV life cycle and how this has both led to and demanded the development of more sophisticated laboratory testing which can measure viral load. Studies have shown that there is no "latency" period during the course of HIV infection. Virus remains at very high levels throughout, and viral burden slowly outstrips CD4 replacement over time, leading to the failure of the immune system. Combinations of drugs are more effective than single drugs in reducing the viral burden, particularly combinations which disrupt different stages of the viral life cycle. This allows reconstitution of the immune system, at least temporarily. Theoretically, these combination therapies would be even more effective if started before the immune system was already severely compromised. Long-term maintenance of stable or improved immune function is the goal, and studies are showing exciting results.

Dr. Pohl explored in depth the taking of a sexual history, with the focus on communicating with patients in understandable and direct language, and setting a tone which promotes trust and self-disclosure. He assisted course participants in exploring how one's own internal attitudes and nonverbal communications affect the patient's willingness to take the risk of talking openly with his/her physician about sexual behavior, concerns, etc.

Dr. Bissell discussed safer sex techniques, primarily the use of barrier methods to prevent infection, and working effectively with patients or clients to teach self-protective strategies. Injection drug use, needle sharing, and their relationship to sexual behavior were reviewed. An active discussion of harm reduction involving course participants explored needle exchange programs, condom distribution and other controversial approaches.

CREDENTIALS AND MANAGED CARE

The following letter is in response to the article by Dr. Michael Miller in the November-December ASAM News *on ASAM's new Managed Care Task Force.*

It has been reported that many ASAM-certified physicians are not being accepted by managed care providers: "Instead, many seek non-physician providers of mental health and addiction services to provide the bulk of patient care, supervised by physicians who are board certified in psychiatry (even without the CAQ in addiction psychiatry)."

I believe the operative issue is that the managed care provider is seeking the least expensive, least costly, and not necessarily the best trained physician to provide services. To wit, Dr. Miller's article states that many managed care provider panels seek non-physician providers to provide mental health and addiction services.

I believe the [managed care organizations] are using the ruse of lack of credentials to exclude as many physicians as possible, thus allowing them to use lesser qualified and less expensive providers of mental health and addiction services. Also, the operative component is that the physicians who are selected are supposed to "supervise" care but not necessarily to *give* direct patient care or patient contact. Here again, my belief is that the managed care panels are attempting to seek the least costly care for their "customers."

Bernard Sobel, D.O., F.A.P.A., F.A.C.N.,
ASAM Certified

WHO WILL WRITE THE GUIDELINES FOR ADDICTION TREATMENT?

It was not long ago that this question had a simple and direct answer. You and I did at our respective treatment programs. Yes, we usually involved a multidisciplinary team in the process–but it was *us*. It also seemed rather reasonable that those of us who were responsible for delivering the treatment would make the decisions according to our judgment as to what would be most effective in achieving beneficial results in each individual patient.

continued next page

ASAM LAUNCHES MEMBERSHIP CAMPAIGN

ASAM's 1996-1997 International Membership Campaign, chaired by Paul H. Earley, M.D., has announced a new incentive plan for ASAM members who recruit new members.

As announced by Dr. Earley and Team Captains Gary Olbrich, M.D., P. Joseph Frawley, M.D., and William B. Hawthorne, M.D., the incentives are as follows:

If you recruit:	**Your award is:**
1-2 new members	ASAM pin and an announcement in *ASAM News*
3-5 new members	ASAM "mouse pad" and an announcement *ASAM News*
6-9 new members	ASAM clock, free one-year membership, and an announcement in *ASAM News*
10 new members	"TOP RECRUITERS": one-year free membership ($200 value), one free Med-Sci registration ($450 value), ASAM T-shirt, VIP seating at the Annual Meeting, and an announcement in *ASAM News* and the Med-Sci program.

Top recruiters for the year will receive an award and will be listed in the ASAM Hall of Fame.

In addition, chapters will receive a $10 dues rebate for each new full physician member recruited. Special awards will go to the chapters enrolling the **greatest percentage** and the **largest number** of new members in 1996.

For more information on the International Membership Campaign, contact Theresa McAuliffe, at the ASAM Membership Department (301/656-3920, extension 108).

EMERITUS MEMBERSHIP STATUS APPROVED

The ASAM Board and Membership Committee have approved establishment of a category of Emeritus Membership for members who meet the following criteria:

- 65 years old or older, or
- 15 years membership in ASAM, or
- Bestowed by the ASAM Board of Directors on those members who have made, according to the Board, a significant contribution to ASAM or to the field of Addiction Medicine.

Applications will be available in January 1997, and members who may be eligible will receive applications in late November 1996. Direct questions to Theresa McAuliffe in the ASAM Membership Department.

REMINDER OF 1996 MEMBERSHIP RENEWAL

If you haven't renewed your ASAM membership for 1996, please do so today. We want to continue your membership services without any interruption. Remember—committee members, committee chairs, and chapter leaders are required to renew their membership in order to maintain their posts throughout 1996. To renew, simply call Theresa McAuliffe at the ASAM Membership Department (301/656-3920, extension 108).

IN MEMORIAM

Richard P. Gardine, D.O., ASAM member from Springfield, Missouri, died April 7th. Dr. Gardine was a member of the ASAM Public Policy Committee. An educational fund has been established on behalf of Dr. Gardine's three children (ages 24, 18 and 13), whose mother died six years ago.

Dykes Cordell, M.D., died at his home in Nashville, Tennessee, on February 23rd after a long illness.

Continued from the preceding page

Today the answer to that question is no longer clear and simple. As we all know, managed care companies are increasingly moving into this area of decision making with some appalling results. One national company which is actively marketing guidelines has listed the following as part of their criteria for "...medical conditions which **might** require inpatient detoxification":

- Ventricular fibrillation *(if you die first they might let you in)*
- Sustained ventricular tachycardia
- Frequent nonsustained ventricular tachycardia
- Atrial tachycardia causing hemodynamic impairment
- Hypotension causing inability to stand despite fluid rehydration in an outpatient setting.

This partial list of proposed criteria that "might" qualify a patient for inpatient detoxification would be slightly humorous if it were not for the fact that some organizations seriously intend to use them. In these cases the physician, presumably, is expected to place a call to the precertification organization and negotiate the pros and cons of inpatient detoxification with the screener (rather than make a red light and siren run to the hospital with the patient who is fibrillating).

The point of all of this is that if we do not develop and successfully promote our own guidelines for detoxification and other elements of treatment, others will be only too happy to do so. Fortunately, the second edition of ASAM's *Patient Placement Criteria for the Treatment of Substance-Related Disorders 2 (ASAM PPC-2)* is now available. The *ASAM PPC-2* contains criteria for admission to various levels of detoxification services, from ambulatory to medically-managed intensive inpatient. This will, before long, be followed by publication of practice guidelines on the appropriate intensity of services for management of alcohol withdrawal by the ASAM Committee on Practice Guidelines. Both of these works are literature based rather than financially based. I believe that they are much more likely to result in survival of the detoxification experience and entry of the patient into an appropriate level of ongoing care.

I believe that we must all diligently promote these ASAM criteria and guidelines so that they quickly become the standard for the field. If we don't call the shots, the accountants will!

James W. Smith, M.D.

CHAPTER NEWS

California

The CSAM Committee on Physician Impairment recently completed a year-long project to develop the quality assurance and quality improvement standards recently adopted by the state's Diversion Program. Also, CSAM–working with the California Medical Association–sponsored a bill adopted in the last session of the state legislature that authorizes the state medical board to divert physicians into the program in lieu of disciplinary action for certain violations.

Working with the medical association, CSAM sponsors and hosts three meetings each year of the Liaison Committee, which is tasked with receiving information and developing recommendations concerning the policies and procedures of the 13-year-old Diversion Program for Physicians, which is sponsored by the state medical board.

Georgia

At the 8th Annual GASAM Winter Meeting, state chapter election results were reported. Michael Fishman, M.D. has been elected Secretary/Treasurer, and both Guy Sommers, M.D. and Melody Stancil, M.D. have been elected Directors-at-Large. The Georgia Chapter is planning the 5th Annual Southeastern Regional Addiction Conference for October 1996. The conference is co-sponsored by several ASAM state chapters.

Hawaii

During its April meeting, the ASAM Board of Directors voted to approve Hawaii's petition to begin forming a state chapter. In fact, Hawaii members have been extremely active during the last ten years. In 1986, Terry Schultz, M.D. helped to organize the first meetings. William Haning, M.D. organized the meetings from 1989 until 1995. During the Annual Pacific Institute of Chemical Dependency Scientific Conference in January, officers and directors were elected: Gerald McKenna, M.D. was elected President and Director; Stephen Denzer, M.D. was elected President-Elect, Treasurer, and Director; William Haning, M.D. was elected Secretary and Director; Gabrielle Batzer, M.D. was elected Director; Royal Randolph, Jr., M.D. was elected Director.

The Hawaii group invites all ASAM members to attend the next Annual Pacific Institute of Chemical Dependence Scientific Conference in January 1997. The meeting will be held at the East-West Center on the Manoa (Honolulu) campus of the University of Hawaii.

Illinois

ISAM is working with the University of Illinois-Chicago School of Public Health to develop a Substance Abuse Subcommittee of the Chicago Area Primary Care Consortium to bring together representatives of the many medical schools in the Chicago area, as well as the Chicago Department of Health and Illinois Department of Alcoholism and Substance Abuse (DASA).

ISAM also continues to work with DASA towards the goal of implementing the new *ASAM PPC-2* in DASA licensed and funded programs.

The Illinois State Medical Society is seeking input from ISAM members on state legislation which affects the care of addicted patients. Comments should be directed to Martin Doot, M.D.

Michigan

At MISAM's January meeting, Keith Bruhnsen from the University of Michigan gave a presentation on "Drinkwise," a program designed to teach people with drinking problems to drink responsibly. During the business meeting, the group discussed its goal of gaining recognition by the Michigan State Medical Society. The Legislative Committee has begun to develop its goals. Comments should be directed to Berny Goldman, M.D.

Plans also are underway for the MISAM Annual Medical-Scientific Conference. Members who wish to participate in the planning process should contact Steve Bendix, M.D.

Montana

Members interested in forming a Montana chapter are invited to contact their Regional Director, Richard E. Tremblay, M.D., so that a meeting time may be established and elections conducted.

New York

NYSAM held a business meeting on Sunday, April 21st in Atlanta during ASAM's Medical-Scientific Conference. The meeting was conducted by Chapter President Merrill Scot Herman, M.D., and Regional Director Lawrence Brown, M.D., M.P.H., Ph.D. was in attendance. A detailed report of the meeting was mailed to New York Chapter members.

North Carolina

The North Carolina Chapter held a joint business meeting with the South Carolina and Virginia Chapters during ASAM's Medical-Scientific Conference.

Ohio

Robert Liebelt, M.D. has been elected Chapter Vice President. Chris Adelman, M.D. is the new Treasurer, and Marc Whitsett, M.D. is the new Secretary. Members elected to the Executive Committee are Stan Sateren, M.D., Edna Jones, M.D., Cybil White, M.D., and Ronald Fleming, M.D.

The Ohio Chapter will hold a general membership meeting in conjunction with the Physician's Track of the Ohio State University's Summer Institute of Addiction Studies, at the Fawcett Center of OSU. Scheduled for July 31, the day-long program will focus on addiction and mental health and will feature an address by ASAM President David E. Smith, M.D. For more information, contact Dr. Stan Sateren at (614) 868-6710.

Pennsylvania

PASAM held a business meeting during ASAM's Medical-Scientific Conference.

South Carolina

SCSAM received its official ASAM Charter during the ASAM Awards Luncheon in Atlanta. President Timothy Fischer, D.O. received the charter on behalf of the chapter. SCSAM held a joint business meeting with the North Carolina Chapter and the Virginia Chapter during Med-Sci; the next regular chapter meeting is July 28-30 in Charleston.

Texas

Anand Mehendale, M.D., of Hunt, TX, was elected chapter President during the March Business Meeting. The Texans also met during ASAM's Medical-Scientific Conference in Atlanta.

Virginia

VASAM received its official ASAM Charter during the ASAM Awards Luncheon in Atlanta. Chapter President William McConahey, III., M.D. received the charter on behalf of the newly formed chapter.

Washington

Steven M. Juergens, M.D. of Seattle was recently elected WASAM President. In September 1995, WASAM sponsored a CME course entitled "Addictions 101" at the Washington State Medical Society's Annual Meeting. The course was very well attended and will be repeated in September 1996.

Wisconsin

Larry L. Heller, M.D. recently assumed the office of Chapter President. WISAM held a

business meeting in Atlanta during ASAM's Annual Medical-Scientific Conference to review the status of their chapter's membership, as well as ASAM's new membership incentives for recruiting new members.

Chapter President Larry L. Heller, M.D. issued a "Call for Action" to urge WISAM members to recruit new members and take advantage of ASAM's incentive plan. During their meeting, WISAM members also reviewed the new ASAM document entitled "Addiction Medicine in the 21st Century." Michael M. Miller, M.D. is one of the authors of the document. Every member of WISAM is strongly encouraged to learn about the document and become a part of the process. Interested members should contact Larry L. Heller, M.D.

Chapter News? Contact Theresa McAuliffe at the ASAM office.

INTERNATIONAL NEWS

Panama

Saul Alvarado, M.D., Panama Chapter President, attended the ASAM Board Meeting in Atlanta, Georgia and gave a presentation on the Chapter's history and goals. Dr. Alvarado also participated in the Region IX Meeting on Sunday, April 21st. The meeting was conducted by Ray P. Baker, M.D., Region IX Director from British Columbia.

Portugal

Joaquim Carrilho, M.D., an ASAM member from Portugal, attended the ASAM Board Meeting in Atlanta and gave a presentation on his organization's history, as well as a description of recent meetings and upcoming goals. Dr. Carrilho also participated in the Region IX (International) Meeting.

Ruth Fox Course – continued from page 5

for the treatment of cocaine dependence. "Agents showing promise in uncontrolled studies are not being confirmed as being beneficial in controlled studies," he cautioned, citing the failure of dopamine agonists (bromocriptine and amantadine), dopamine antagonists (antipsychotics), antidepressants (desipramine, fluoxetine), or opioid agonists or antagonists (buprenorphine, naltrexone) to show consistently positive findings. Carbamazepine has yielded somewhat better results, he said, and may be helpful in some patients, and disulfiram may also be beneficial (but only when alcohol is a trigger for cocaine use).

Dr. Gastfriend had better news in the area of alcoholism treatment. Volpicelli, who authored one of the original papers on naltrexone in alcoholism treatment, reported in 1995 that naltrexone treatment reduces drinking days and relapses by about 50% in alcoholics. Further investigation has confirmed the impression of many: Alcoholics who drink while on naltrexone have a reduced sense of euphoria than when not taking it, especially while on the ascending limb of the BAC curve. Thus, Volpicelli concluded, alcohol is less reinforcing, and they drink less.

A new approach to opioid detoxification was recently reported by O'Conner, and reviewed by Dr. Gastfriend. In this report, 125 addicts were offered a standard clonidine taper or a rapid detoxification using clonidine, oxazepam and naltrexone. The rapid detox group were given naltrexone 12.5 mg on the first day, 25 mg on the second day, and 50 mg on the third day, along with prn medications. This group had "lots of symptoms," but when allowed to choose which method they preferred, more than half chose the clonidine/naltrexone combination because the length of treatment was shorter. Results showed that the treatment completion rate was higher in the naltrexone group, and that the overall number of prn medications were the same in both groups. Hypotension was not a problem, although some patients in the naltrexone group had transient delirium.

Hoffman reported in 1995 on an investigation of psychosocial treatment for cocaine dependence that applied investigative methods usually used only in pharmacotherapy research. This group sought to develop a "dose-response" relationship between intensity of psychosocial therapies and the clinical response. They placed 184 crack cocaine addicts into treatment that included group sessions two or five times each week, did or did not include a weekly individual session, and did or did not include a weekly family session. They measured weekly cocaine use at one year, and found improvement in all groups, but no significant difference between groups. The best predictors of success were the total number of days that patients remained in treatment and the total number of sessions they attended—but was unrelated to the type of sessions they attended.

Next Year in San Diego

Next year's Ruth Fox Course will take place on April 17, 1997, in San Diego, California, preceding the 1997 Annual Meeting. Dr. Weisman will be looking for us there.

EDUCATION AND TRAINING

NYU WEB SITE

Address:
http://www.med.nyu.edu.substanceabuse

A new web site has been organized by the Center for Medical Fellowships in Alcoholism and Drug Abuse at New York University, in cooperation with the American Academy of Addiction Psychiatrists, the Association for Medical Education and Research in Substance Abuse, and the American Society of Addiction Medicine.

This web site is designed to serve as a forum for issues related to medical education and research in substance abuse for academics and trainees based in medical schools and teaching hospitals. The web site carries extensive information on 47 medical fellowship programs across the United States in the addiction field. It is also available for posting of information regarding activities of faculty and trainees. The site is available through the World Wide Web, and includes hypertext links to related agencies and organizations such as NIH, NIDA, and NIAAA, as well as to other substance abuse related sites on the Web.

In addition, it includes a newsgroup, which allows for interchange on specific topics in substance abuse. For example, communications can be established around techniques of addiction training, applications of new medications, or on a particular problem in clinical research. Parties associated with national fellowship training programs and other specialists in addiction may participate in these exchanges. This represents an entirely new opportunity for developing academic and clinical options without the need for costly meetings or teleconferencing.

Suggestions for additional features and links to other sites should be sent to:
Marc Galanter, M.D., Dept. of Psychiatry
New York University Medical Center
550 First Avenue
New York, NY 10016
E-mail: marcgalanter@nyu.edu
Fax: 212-263-8285.

ASAM WEB SITE

Members who wish to receive an E-mail alert whenever the ASAM web page is updated with new information should send their E-mail addresses to:
William Hawthorne, M.D., at
BenBill@aol.com.

RUTH FOX MEMORIAL ENDOWMENT FUND

Dear Colleague:

The Ruth Fox Memorial Endowment Fund has received pledges from one-third of the ASAM membership. ASAM is grateful to those who have given and pledged. Are you amongst them? We are nearing our $2 million dollar goal for this year, and your pledge/donation can put us over.

This fund is to help stabilize ASAM's financial future and help the Society obtain its goals. Please help us in this endeavor by making a pledge, contribution, or deferred gift (bequest, insurance, trust fund, etc.)—giving for the first time if you haven't already, or by increasing your current support.

Dr. David Smith, President of ASAM, together with Dr. G. Douglas Talbott, President-Elect, and Dr. William Hawthorne, former Chair of the Ruth Fox Memorial Endowment Fund, presented medallions to recent major donors at the Endowment Reception in Atlanta. This year's medallions went to: *Colleagues' Circle* – George W. Nash, M.D., Richard Tyson, M.D.; *Founders' Circle* – R. Jeffrey Goldsmith, M.D.; *President's Circle* – Ted E. Ashcraft, M.D., Dr. and Mrs. James F. Callahan, Thomas E. Lauer, M.D., Gail N. Shultz, M.D.; *Leadership Circle* – H. Westley Clark, M.D., J.D., MPH, Andrew DiBartolomeo, M.D., Michael L. Fox, D.O., Karl V. Gallegos, M.D., Charles F. Gehrke, M.D., James F. Graham, Jr., M.D., William L. Jackson, M.D., Wilton N. Jones, M.D., Christine L. Kasser, M.D., Robert V. Kiel, D.O., LaMonte P. Koop, M.D., Michael S. Levy, D.O., Earl A. Loomis, Jr., M.D., George W. Lutz, M.D., Norman S. Miller, M.D., Barry M. Rosen, M.D., Stephen B. Shapiro, M.D., Lisa Sparks, M.D., Trusandra E. Taylor, M.D.

A popular session at this year's Medical-Scientific Conference in Atlanta was a program presented by Paul E. Dow, J.D. on "Estate Planning for Physicians and How to Protect Your Pension Plan." Some 37 ASAM members received valuable information, helpful in arranging their finances as well as current tax laws. If you would like to receive any of the brochures distributed at the meeting, *i.e.* "Giving through Retirement Plans," "Taking Stock and Giving It," or "Your Guide to Effective Giving in 1996," call or write Ms. Claire Osman, and she will be glad to send these to you. If you would like to speak to Mr. Paul Dow (in confidence), there is no fee. His telephone number is (610) 821-0150.

To obtain more information on how you can help support the Endowment Fund, or make or upgrade a pledge/contribution or bequest, please contact Ms. Claire Osman, ASAM, 12 West 21st Street, New York, New York 10010. Telephone: (212) 206-6776. Fax: (212) 627-9540. A payment schedule can be arranged over a five-year period (longer if necessary). All contributions to ASAM are completely tax-deductible since the Society is a 501(c)(3) organization.

We are very grateful to all our donors for their generous and continued support. If you are not a donor, please join your colleagues, and help us reach our goal of $2 million by the end of this year. The Endowment Fund is an investment in your future and the future of Addiction Medicine. Let us hear from you now!

Max A. Schneider, M.D.
Chair, Endowment Fund

Jasper G. Chen See, M.D.
Chair Emeritus, Endowment Fund

Claire Osman, Director of Development

Ruth Fox
(1895-1989)

Total Pledges: $1,730,756
Goal: $10,000,000

New Donors, Additional Pledges and Contributions
February 1, 1996 – May 1, 1996

President's Circle ($10,000 – $24,999)
Ted E. Ashcraft, M.D.
Thomas E. Lauer, M.D.

Leadership Circle ($5,000 – $9,999)
Terry L. Alley, M.D.
Karl V. Gallegos, M.D.
James F. Graham, M.D.

Donor's Circle (up to $2,999)
Saul Alvarado, M.D.
James A. Arnold, M.D.
Akin O. Ayeni, M.D.
Michael C. Bower, M.D.
Mark G. Fuller, M.D.
Lance L. Gooberman, M.D.
Lucy Jane King, M.D.
Willy Mautner, M.D.
Michael David McGee, M.D.
Mel Pohl, M.D.
Colin Kerry Quinn, M.D.
Peter G. Ronan, M.D.
Jennifer P. Schneider, M.D.
David James Silas, Jr., M.D.
Gary L. Simpson, M.D., Ph.D.
Robert D. Sparks, M.D.
Richard A. Weiss, D.O.

Advertise in ASAM News!

Published six times a year for 3,500 physicians specializing in addiction medicine.
For rates and deadlines, call the ASAM office:
Larry Hoffer •ASAM Publications Manager • 301/656-3920 • E-mail: LHOFF@ASAM.ORG

MEDICAL REVIEW OFFICER

MRO

Three 1996 Training Courses for Medical Review Officers (MRO)

March 1-3 Washington, DC

July 12-14 Denver, CO

November 1-3 Chicago, IL

Attendance qualifies for 19 hours of category 1 of CME credit. Contact ASAM for complete details

ASAM

American Society of Addiction Medicine
4601 North Park Ave., Arcade Suite 101 Chevy Chase, MD 20815
301/656-3920 Fax: 301/656-3815 EMail: ASAMOFFICE@aol.com

Florida Society of Addiction Medicine and
American Society of Addiction Medicine
present

Fun in the Sun with FSAM!

10th Annual Conference on Addictions

January 17–19, 1997

Walt Disney World Village

Grosvenor Resort
(Group Rate $89 per room)

Orlando, Florida

As in the past, CMEs for Physicians;
CEUs for Psychologists, Nurses, Counselors and Addiction Professionals.
Topics—practical aspects of addiction medicine

Low conference fees $235—ASAM physicians
$135—Non-physicians

For more information:

Robert Donofrio, FSAM, 890 Lexington Road
Pensacola, FL 32514
904-484-3560 Fax 904-857-1301

WYOMING PHYSICIAN WELLNESS PROGRAM

Seeks ASAM Certified Physician as Medical Director, a 1/4 Time Position. Salary Negotiable to $25,000. No Benefits.

This newly formed corporation replaces the volunteer work of the Wyoming State Medical Society Committee on Physician Wellness. The directors represent equally the Wyoming Board of Medicine and the Wyoming State Medical Society.

Position requires a Wyoming license, ASAM certification, experience in the recovery of health professionals, and travel in state.

Submit resume to:
Carol Shotwell
PO Box 6164
Cheyenne, Wyoming 82003.

Deadline: July 15, 1996.

Director of Medical Services

A dedicated & committed professional needed for an exciting opportunity in health care. Candidate must be a Board Certified Family Practitioner or Internist, three years experience in substance abuse or ambulatory care, NYS licensed, supervisory experience. Responsible for directing a medical staff servicing substance abusers. Negotiable salary & benefits. Call **Recruiter, (718) 260-2920 or fax resume (718) 260-8276. EOE.**

ALAN R. ORENBERG
PROFESSIONAL RECRUITER

Specialty:
Placements in
Treating
Addictive Diseases

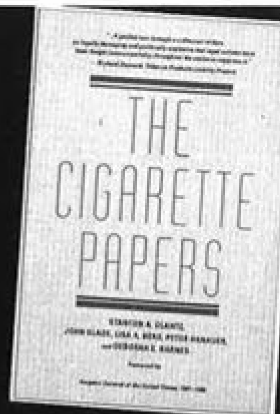
117 Pine Ridge Trail
Madison, WI 53717

(608) 833-3905

"The most revealing look we have at the cynicism and 'profit at any price' mindset of the tobacco industry.

. . . Extraordinary ."

—Joseph A. Califano, Jr., President, Center on Addiction and Substance Abuse, Columbia University, and former Secretary of Health, Education, and Welfare



THE CIGARETTE PAPERS

STANTON A. GLANTZ, JOHN SLADE, LISA A. BERO, PETER HANAUER, & DEBORAH E. BARNES
Foreword by C. Everett Koop

$29.95 cloth at bookstores or order 1-800-822-6657
UNIVERSITY OF CALIFORNIA PRESS

ASAM CONFERENCE CALENDAR

1996

July 12-14
MROs: Medical Review Officer Training Course
Denver, CO
19 Category 1 CME credits

July 14
MROCC Medical Review Officer Certification Examination
(Following ASAM's MRO Course)
Denver, CO

October 24-26
Review Course in Addiction Medicine
Chicago, IL
21 Category 1 CME credits

November 1-3
MROs:Medical Review Officer Training Course
Chicago, IL
19 Category 1 CME credits

November 3
MROCC Medical Review Officer Certification Examination
(Following ASAM's MRO Course)
Chicago, IL

1996

November 14-17
9th National Conference on Nicotine Dependence
Washington, DC
15 Category 1 CME credits

December 7
Certification/Recertification Examination
Atlanta, GA
Los Angeles, CA,
and Newark, NJ
5 Category 1 CME credits

1997

April 17
Ruth Fox Course for Physicians
San Diego, CA
7 Category 1 CME credits

April 19-21
28th Annual Medical -Scientific Conference
San Diego, CA
22 Category 1 CME credits

October 23-25
State of the Art in Addiction Medicine Conference
Washington, DC
20 Category 1 CME credits

ASAM Staff Now Online

In addition to accessing ASAM's web page, members can reach any ASAM staff member via E-mail, at the following addresses:

James F. Callahan, D.P.A.
Exec. Vice President/CEO
JCALL@ASAM.ORG

Cassandra Cuffee
Office Manager
CCUFF@ASAM.ORG

Catherine Davidge
Membership Assistant
CDAVI@ASAM.ORG

Mark Douglas, C.P.A.
Director of Finance
MDOUG@ASAM.ORG

Linda Fernandez
Asst. Director of Meetings & Conferences
LFERN@ASAM.ORG

Joanne Gartenmann
Exec. Assistant to the Exec. Vice President
JGART@ASAM.ORG

Larry Hoffer
Publications Marketing and Fulfillment Manager
LHOFF@ASAM.ORG

John Keister
Credentialing Project Manager
JKEIS@ASAM.ORG

Theresa McAuliffe
Director of Membership
TMCAU@ASAM.ORG

Sandy Schmedtje Metcalfe
Director of Meetings and Conferences
SMETC@ASAM.ORG

For additional information, call the ASAM Meetings Department at (301) 656-3920.

ASAM NEWS
4601 N. PARK AVE, UPPER ARCADE, SUITE 101
CHEVY CHASE, MD 20815

Address Correction Requested

BULK RATE
U.S. POSTAGE PAID
MERRIFIELD, VA
PERMIT NO. 328