ASAM NEWS

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Newsletter of The American Society of Addiction Medicine

States, Treatment Programs Brace for Impact of Aid Cutoff to Alcoholics, Drug Addicts

The impact of recent federal legislation promises to make 1997 a year of severely straitened finances for alcoholics and drug addicts who have been receiving federal cash welfare and health insurance benefits, as well as for the alcohol and drug treatment programs that serve them.

As of January 1, the Social Security Administration had sent letters to more than 200,000 recipients of federal Social Security Insurance (SSI) who have been claiming benefits based on substance abuse disability. Of those, about 120,000 already had filed appeals, saying they still qualify for the aid because of other impairments. Although 40,000 of the appeals have been granted, the 80,000 recipients who did not appeal were cut off on January 1. Those with pending appeals who lose their cases also will be cut off.

Cutting off SSI benefits to alcoholics and drug addicts will save the federal government an estimated $300 million in 1997 and as much as $500 million when projected through the year 2000, a spokesman for the Social Security Administration said. However, Joseph A. Califano, Jr., chairman of the Center on Addiction and Substance Abuse at Columbia University, said the savings represent a false economy. "If we were intelligently using the reduction in benefits to get more of these people into treatment, it would make sense as public policy. But to simply cut them off is insane. It's going to increase homelessness, increase the incivility of our urban life and just savage these people," said Califano, who was Secretary of Health, Education and Welfare under President Jimmy Carter.

Previous SSI reforms had required that alcoholics and drug addicts not directly receive assistance checks, which could nonetheless be made out to treatment programs or other representatives of the beneficiaries. Also, they could not receive benefits if treatment was available and they refused it. The Social Security Administration had a large number of contracts with organizations that referred addicts to treatment programs and monitored their progress. Those contracts, which cost the federal government $100 million a year, are being terminated.

"It may save the government some money in the short run," Califano said, but in the long run it's going to cost the state and local governments even more."

The largest number of alcoholics and addicts receiving SSI benefits have been concentrated in three states: California, with 44,000; Illinois, with 24,000; and Michigan, with 15,000. California welfare officials said the cutoff could cost the state's 58 county governments $45 million in additional general relief payments alone when alcoholics and addicts whose Medicare eligibility is linked to their SSI coverage lose their health benefits and turn to county hospitals for care.

Gramm Amendment

In a second blow to funding, Section 115 of the federal Welfare Reform Act (Public Law 104-193; known as the Gramm Amendment) permanently denies cash welfare and food stamps to anyone who receives a felony conviction for drug use, possession or distribution after August 22, 1996. There are no automatic exemptions for anyone, including pregnant women or individuals who are participating in drug treatment. Moreover, the ban is permanent, regardless of successful participation in drug treatment or abstinence from drug use.

Under the terms of the act, applicants for cash welfare or food stamps will be required to disclose their own or a household member's drug-related convictions in writing. A family's benefits will be reduced by the amount that would have been provided for the individual with the drug conviction.

Many treatment programs depend on public benefits (including welfare and food stamps) to cover the cost of treatment. Those benefits constitute a substantial portion of

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INSIDE

ELECTION OF OFFICERS

Due to the absence of election guidelines in the first round of balloting, the Executive Committee of the ASAM Board of Directors has determined that the Society shall conduct a new round of voting for election of officers. New ballots, dated December 15, 1996, have been mailed to all members who are eligible to vote, with a request that members complete and return the new ballots by January 31. (Only new ballots are to be counted in tabulating the vote.)

Officers to be elected are the President-Elect, Secretary, Treasurer, and Regional Directors. Results will be published in the March/April *ASAM News*.

ASAM
American Society
of
Addiction Medicine

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

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EXECUTIVE VICE PRESIDENT'S REPORT

TRAINING FOR THE SPECIALTY OF ADDICTION MEDICINE

Dr. James F. Callahan

ASAM has taken a major step toward establishing addiction medicine as a specialty certified by member boards of the American Board of Medical Specialties (ABMS). The Society has resolved to establish training programs and seek the American Medical Association's support for this action, thus removing one of the last remaining obstacles to specialty status (that is, through board certification of addiction medicine by ABMS member boards).

While addiction medicine is a multidisciplinary specialty, and is recognized as such by the AMA and the American Osteopathic Association, it is not yet recognized as a specialty by the American Board of Medical Specialties. A major obstacle to recognizing addiction medicine as a specialty certified by ABMS member boards has been the lack of adequate formal training of at least one year in length associated with a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). Acknowledging this, the ASAM Board of Directors, at its October 1996 meeting, resolved to make the development of fellowship training a high priority, near-term goal, and further resolved that a plan, including allocation of needed resources, should be prepared for further consideration by the Board of Directors.

The plan will be developed by the "Work Group on Certification and Specialty Status: Accredited Fellowships," chaired by Sidney Schnoll, M.D., Ph.D. The Work Group is a component of the ASAM Task Force on Addiction Medicine in the 21st Century, which is chaired by Sheila B. Blume, M.D.. Three essential elements of the plan will be to identify training sites, to seek financial resources to help fund the training, and actually to promote training in the specialty residency programs.

While Dr. Schnoll and his Work Group have yet to consider the specifics of how each of these three elements will be addressed and achieved, some preliminary work has begun. ASAM President-Elect G. Douglas Talbott, M.D., has agreed to take the lead in identifying financial resources and in opening a dialogue with potential training sites. David C. Lewis, M.D. (Chair of the ASAM Internal Medicine Specialty Committee) paved the way when he convened and chaired a 1994 meeting attended by residency review committee directors, the presidents of ABMS member specialty boards, and representatives of the AOA, the AMA and other organizations. The goal of the conference, supported by the Josiah Macy, Jr. Foundation, was as Dr. Lewis clearly stated, "that all certifying boards in the primary care specialties of Family Practice, Internal Medicine, Obstetrics/Gynecology, and Pediatrics, and our colleagues in Osteopathy will require training of every resident in the basics…so that every physician trained in those specialties can recognize, intervene and appropriately refer."

The third area of endeavor is for ASAM to seek support from the AMA and the primary care national medical specialty societies for training in addiction medicine in the various specialties. To gain specialty society support for and involvement in establishment of training, ASAM will introduce a resolution at the June 1997 AMA House of Delegates meeting on "Training as Prerequisite to Recognition of Sub-specialization in Addiction Medicine" (text follows).

To gain support for passage of the resolution, the chairs of ASAM's medical specialty committees will write to the President, AMA Delegate and AMA Alternate Delegate of each of the concerned specialty organizations, asking that the national medical specialty society cosponsor or speak in favor of the resolution. The ASAM committee chairs are: Andrew DiBartolomeo, M.D. (Emergency Medicine), Michael Fleming, M.D. (Family Medicine), David C. Lewis, M.D. (Internal Medicine), Larry Patton, M.D. (Pediatrics), and Paul Brattain, M.D. (Preventive Medicine). In addition, ASAM members who are specialists in Aerospace Medicine (Paul Brattain, M.D.), General Preventive Medicine (Linda Ferry, M.D.), and Occupational and Environmental Medicine (Robert Hunter, M.D.) have agreed to write to the presidents and delegates of their respective specialty societies.

ASAM State Chapter Presidents in eight states will seek similar cosponsorship or endorsement from their state medical societies. They are William Brostoff, M.D. (Cali-

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fornia), Marilyn C. Moss, M.D. (Florida), John D. Lenton, M.D. (Georgia), Martin C. Doot, M.D. (Illinois), Merrill Scot Herman, M.D. (Illinois), Lee McCormick, M.D. (Pennsylvania), Steven Juergens, M.D. (Washington State), and Larry L. Heller, M.D. (Wisconsin).

ASAM members who also are members of state delegations to the AMA will be asked to urge their delegations to support the resolution. At least three ASAM members are state delegates: Samuel W. Collison, M.D. (Washington State), Silvana Menendez, M.D. (Illinois), and Lee H. McCormick, M.D. (Pennsylvania). If other ASAM members are delegates or alternate delegates of state delegations, please ask your state delegations to cosponsor or endorse the ASAM resolutions and call to tell me who you are, so that you can join the ASAM caucus.

The ASAM Delegate and Alternate Delegate to the AMA House (Michael M. Miller, M.D. and David E. Smith, M.D.) will work to gain support from not only their state delegations, but from as many specialty society and state delegations as possible. The San Francisco Medical Society will submit a resolution identical to ASAM's to the California Medical Association. The resolution will be sponsored by Dr. Smith. Jess W. Bromley, M.D. (ASAM AMA Delegate-Emeritus) will also call or write to those whom he feels will support the resolution.

Finally, Stuart Gitlow, M.D. (member of the AMA Young Physicians Section Governing Council), Christina Delos Reyes, M.D. (ASAM Resident Physician Section Delegation), and Sarah Babai and John Hergenrother (ASAM AMA Medical Student Section Delegate and Alternate) will be asked to carry the resolutions to their respective AMA bodies for passage and referral to the AMA House of Delegates.

Full realization of ASAM's mission to have addiction medicine become an integral part of organized medicine, and to make treatment of addictive diseases a basic health benefit for all Americans, can only be realized through the attainment of specialty status. This will complement the board certification in addiction psychiatry which is now offered by the American Board of Psychiatry and Neurology and the CAQ in Osteopathic Addiction Medicine offered cojointly by several American Osteopathic Association specialty groups. Training is the necessary prerequisite to realization of ASAM's mission, and ASAM has fully committed itself to establishing accredited training, in order to fully meet this prerequisite.

ASAM BOARD HONORS FORMER EDITOR

In recognition of her valuable contribution as Editor of the ASAM News, 1985-1995, the Board of Directors of ASAM has designated the late Lucy Barry Robe as Founding Editor, and directed that she shall be so listed, with the dates she served as Editor, in all future issues of the newsletter. The resolution adds that "The Board of Directors and members of the Society are forever grateful to Lucy for her years of creativity and devotion to advancing the field of Addiction Medicine."

Training as a Prerequisite to Recognition of Sub-Specialization in Addiction Medicine

(A Resolution to the American Medical Association House of Delegates)

Whereas, the AMA stated that substance abuse is the nation's Number 1 public health problem, affecting an estimated 20% of Americans with consequences affecting a wide range of medical conditions; and

Whereas, the AMA previously acknowledged the extent and diversity of physician involvement in addiction treatment by adding "ADM" to its list of self-designated specialty codes; and

Whereas, the American Board of Psychiatry and Neurology has established a certificate of added qualifications (CAQ) in addiction psychiatry; and

Whereas, the AMA affirmed in December 1993 that "many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse..." and resolved to "direct its representatives to appropriate Residency Review Committees to ask the committees...to consider requiring instruction in the recognition and management of substance abuse. . ." beyond what is already given; and

Whereas, physicians other than psychiatrists who are involved in the prevention, diagnosis and treatment of addictive disorders and their widespread complications are not now able to obtain board certification as addiction medicine specialists; and

Whereas, CAQs give assurance to colleagues and patients that a physician has attained the necessary knowledge to address special aspects of a given area of practice; and

Whereas, training is a prerequisite to a CAQ; therefore, be it

RESOLVED, That the American Medical Association request national medical specialty societies of Emergency Medicine, Family Practice, Internal Medicine, Pediatrics, Preventive Medicine and others to determine the desirability and feasibility of having training available which would lead to the development of CSQs or CAQs in addiction medicine; and be it further

RESOLVED, That the AMA Board of Trustees be asked to report on the response to its request at the 1997 Interim Meeting of the AMA House of Delegates.

Fiscal Note: No significant fiscal impact.

FROM THE PRESIDENT

Dear Colleague:

Voters in California and Arizona passed referenda in November that allow the use of marijuana and other illicit drugs for certain medical purposes. Specifically, Proposition 215 in California allows physicians to recommend the medical use of marijuana and provides physicians with a legal defense if charges are brought. Doctors can order marijuana for patients either verbally or in writing. The ballot initiative also encourages the state and federal governments to develop a plan to distribute marijuana to patients who have medical problems that may be helped by marijuana.

The Arizona initiative, Proposition 200, is more far-reaching in that it allows doctors to prescribe marijuana, heroin, hallucinogens and other drugs for even minor health complaints. In light of these developments, the ASAM Executive Committee asked that the members be informed about ASAM's Public Policy Statement on Marijuana.

The policy statement, which appears on page 5, stresses the need to provide education, beginning in the earliest stage of elementary school and continuing through university level, using "scientifically accurate information on the dangers and harmful effects of marijuana, and on the disease of marijuana dependence," the need to educate health professionals, and the need to offer treatment rather than punishment to marijuana-dependent individuals. The policy also states that any approved medical use of marijuana should only be done "under the direct supervision of a physician licensed to prescribe it." (It should be noted that the federal Controlled Substances Act specifically prohibits the prescribing of Schedule I drugs—including marijuana—except under approved research protocols.)

Indeed, in issuing its response to the California and Arizona legislation, the Office of National Drug Control Policy (ONDCP, The White House) reminds us that the production, sale and distribution of marijuana for medical use is not approved by DEA and violates the Controlled Substances Act and the Federal Food, Drug and Cosmetic Act. In fact, Gen. Barry McCaffrey, who heads the Office of National Drug Control Policy, has warned that the federal government could revoke the licenses of physicians who prescribe marijuana and other illegal drugs, on the grounds that the federal narcotics laws overrides state laws.

In its communiqué, ONDCP notes that "The Federal Government is not opposed to the medical use of any drug, if it passes scientific scrutiny. There is no convincing scientific evidence that smoked marijuana is superior to currently available therapies for glaucoma, weight loss and wasting associated with AIDS, nausea and vomiting associated with cancer chemotherapy, and muscle spasticity associated with multiple sclerosis or intractable pain."

The communiqué went on to say the U.S. Department of Health and Human Services (National Institutes of Health and the Food & Drug Administration) will "examine all medical and scientific evidence relevant to the perceived medical usefulness of marijuana; identify gaps in knowledge and research regarding the health effects of marijuana; determine whether further research or scientific evaluation could answer these questions, and determine how that research could be designed and conducted to yield scientifically useful results."

The Federal Government also has issued Policy Guidance for MROs, reaffirming that under federal Drug-Free Workplace Program rules, "Medical Review Officers (MROs) shall not accept a prescription, or the verbal or written recommendation of a physician for a Schedule I substance as a legitimate medical explanation for the presence of a Schedule I drug or metabolite in a Federal employee/applicant specimen."

To further the prospects of rigorous scientific research into the medical value of smoked marijuana, I have co-authored for the San Francisco Medical Society a resolution to be brought to the California Medical Association, which resolves that the CMA "urges that carefully designed controlled clinical trials of the effectiveness of marijuana for medical indications be allowed to proceed, and urges the American Medical Association to assist in making such studies possible."

The California and Arizona laws have reopened public debate over the role of marijuana in our society and of its potential medical usefulness. As the debate proceeds, ASAM members can confidently be guided by the Society's Public Policy Statement for a balanced approach that is concerned with educating children, youth, and health professionals as to the dangers of illicit use, as well as with the need for treatment of marijuana dependence and research into marijuana as an adjunct to medical care.

Peace and Health,

David E. Smith, M.D., President

IN MEMORIAM

Harold Hughes, retired U.S. Senator from Iowa, died in November 1996 at his home in Arizona. A long-time leader in the addictions field, Sen. Hughes worked tirelessly for recognition of addictions as medical disorders. He sponsored and worked for enactment of legislation that created the federal Alcohol, Drug Abuse and Mental Health Administration (now the Substance Abuse and Mental Health Services Administration). In retirement, he founded and served as CEO of SOAR—the Society of Americans for Recovery—to promote consumer education and advocacy for better services for addicted and recovering persons. ASAM EVP Dr. James F. Callahan praised Sen. Hughes as "a giant in every sense of the word," adding that "It was his good fortune to not only have the gift of thinking of achieving great things, but of actually doing great things. All of us who work in the field of alcoholism and drug dependencies, and everyone who has or continues to suffer from these diseases, owes him a very great debt of gratitude."

Charles G. Smith, 75, who was an active member of ASAM, died November 21, 1996, at Arlington, VA. Dr. Smith, an internist, helped open Arlington (VA) Hospital's alcoholism unit in 1974 and served as its medical director for 18 years. During that time, he supervised the treatment of about 8,000 patients, with a recovery rate estimated at 87 percent. For his work at the hospital, he was awarded the Arlington Medical Society's 1975 Willburn Award, and was named Man of the Year by the Ethos Foundation, an organization concerned with the treatment of alcohol and drug problems.

ASAM PUBLIC POLICY STATEMENT ON MARIJUANA

(Adopted April 1987)

Marijuana is a mood-altering drug capable of producing dependency. Its chief active ingredient is delta-9-Tetrahydrocannabinol. Significant increases in potency of marijuana have been noted in street samples of this drug purchased in the 1980s compared to similar samples purchased 10 years earlier.

Marijuana has been shown to have adverse effects on various organ systems, on perception, behavior and functioning, and on fetal development. Because of the widespread use of this drug, its effects on mind and body, and the increasing potency of available supplies, ASAM strongly recommends:

1. Education about drugs, beginning in the earliest grades of elementary school and continuing through university level. Drug education should contain scientifically accurate information on the dangers and harmful effects of marijuana, and on the disease of marijuana dependence.

2. Health and human service professionals should be educated about marijuana and marijuana dependence as a required part of their curriculum.

3. Persons suffering from alcoholism and other drug dependencies should be educated about the need for abstinence from marijuana and its role in precipitating relapse, even if their original drug of choice is other than marijuana.

4. Marijuana dependent persons, like other drug dependent people, should be offered treatment rather than punishment for their illness. Treatment of marijuana dependence should be part of the plan for rehabilitation of any person convicted of a drug-related offense, including driving under the influence of alcohol and/or drugs, who is found to be marijuana dependent.

5. Any approved medical use of marijuana or delta-9-tetrahydrocannabinol for the treatment of glaucoma or the emesis associated with chemotherapy should be carefully controlled and the drug administered only under the direct supervision of a physician licensed to prescribe it.

(Adopted April 1987)

BRAIN IMAGES OF ADDICTION IN ACTION SHOW ITS NEURAL BASIS

Daniel Goleman

Some neuroscientists are experiencing what amounts to a natural high. For the first time, they have captured images of the brains of addicts in the throes of craving for a drug, revealing the neural basis for addiction.

The finding caps a decade or more of intensive brain research seeking the grail of substance abuse, the neurological circuitry that compels addicts to pursue the next fix. And the discovery confirms a number of emerging scientific hunches about the neurology of addiction.

For instance, no matter what the addictive substance is—amphetamines, heroin, alcohol or nicotine—all seem to activate a single circuit for pleasure deep in the most ancient part of the brain. This circuit, for the neurotransmitter dopamine, is the site of the high that addictive drugs bring. And fine-grained studies of brain cells reveal that repeatedly dosing the brain with addictive drugs is akin to a chemical assault that alters the very structure of the neurons in the circuitry for pleasure. These changes starve brain cells of dopamine, triggering a craving for the addictive drugs that will once again swamp the brain with it.

A drumbeat of findings from dozens of scientific laboratories, several within the last few months and as yet not published, herald these conclusions, which "offer an extraordinary insight into the brain basis of drug addiction," said Dr. Alan I. Leshner, director of the National Institute on Drug Abuse. He added, "There have been a tremendous number of major advances in the last year."

The identity of this brain circuit for addiction is a scientific flashback of sorts, if not a hallucinatory dejá vu: the same brain area was the focus of intense study as long ago as the 1950s, when psychologists routinely implanted electrodes into rats' brains in the region they then called the brain's "reward center." After the rats were trained to push a lever to stimulate this center, they would do nothing else, even forsaking food and water to dose themselves with dollops of rodent bliss—an animal model of addiction. But the specific neural circuitry involved was, at the time, a scientific mystery.

Today that mystery seems to have been solved by using positron emission tomography scans of the brains of patients being treated for cocaine addiction. Reports from three different laboratories using PET scans show that when addicts feel a craving for a drug, there is a high level of activation in a strip of areas ranging from the amygdala and the anterior cingulate to the tip of both temporal lobes.

This mesolimbic dopamine system, as it is called, shows heightened metabolic activity "when people are in a profound state of craving for cocaine, primed to seek it out and take it," said Dr. Anna Rose Childress, a neuroscientist at the University of Pennsylvania who did one of the PET studies. The work has been reported at scientific meetings, but has not yet been published. The same system seems to be ordinarily in play to provide a sense of pleasure in whatever people find rewarding, like sex or chocolate or a job well done. Dopamine may also be part of a reward system in creatures as different from humans as bees, other researchers have shown.

In Dr. Childress's study, PET scans were done on patients under treatment for cocaine addiction while the patients were being exposed to cues that had made them crave cocaine in the past — like seeing a videotape of people taking cocaine or handling crack pipes or other drug paraphernalia. Drug treatment programs routinely caution patients to avoid such Pavlovian cues, which addicts have learned to associate with the drug high itself, because the cues have long been known to trigger the craving for the drug.

The PET scans showed activation in the mesolimbic dopamine system as the addicts described feeling intense cravings for cocaine. The mesolimbic dopamine system connects structures high in the brain, especially the orbitofrontal cortex, in the prefrontal area behind the forehead, with the amygdala in the brain's center, and with the nucleus accumbens, a structure that in animal research has proved to be a major site of activity in addiction, although in humans it is about the size of a squished pea, too small to register in PET images. The ultimate source of the dopamine system is the same brain region where psychologists stuck electrodes decades earlier to make rats endlessly stimulate themselves for pleasure, a location called the ventral tegmental area.

These brain areas have emerged in the last several years as hot spots in research on every addictive substance studied, and some that create dependency, if not strict addiction. Last month, for instance, Italian researchers reported in the journal *Nature* that the mesolimbic dopamine system was active in nicotine addiction, adding tobacco to a roster that includes heroin, morphine, cocaine, amphetamines, marijuana and alcohol.

In addiction studies with lab animals, a main site of activity is the outer layer of the nucleus accumbens. In humans, a nearby interconnected structure, the amygdala, "is more important in craving," said Dr. George F. Koob, a neuroscientist at the Scripps Institute in San Diego. "If people have a lesion in a section of the amygdala, they no longer link pleasure to its causes—they wouldn't experience a favorite food as enjoyable," he said.

What ties years of brain research on addiction together in a "final bow," Dr. Koob said, is the new finding by Dr. Childress and others that "what lights up during craving is the temporal lobe, particularly the amygdala, where all these pathways converge." Dr. Koob reviewed earlier findings on the dopamine system in the May issue of the journal *Neuron*.

The various brain pathways he is referring to all have a particular kind of cell that has the D2 dopamine receptor, which is distinct from other dopamine receptors, like those involved in Parkinson's disease. PET images of cocaine patients taken over several weeks after they stop using the drug show a drop in those neuronal activity levels that is consistent with a lessened ability to receive dopamine. Although the degree of this reduction lessens over time, it is evident "even a year and a half after withdrawal," said Dr. Nora Volkow, director of the Division of Nuclear Medicine at Brookhaven National Laboratory on Long Island. She has also done some of the other recent PET studies.

This pattern of reduced brain activity directly reflects the course of the craving. "The highest risk of relapse for cocaine addicts is during the third and fourth week after they've stopped taking the drug," said Dr. Joseph C. Wu, a psychiatrist at the University of California at Irvine who has made PET images of cocaine addicts that verify the other reports. "You see the lowest levels of activity in the mesolimbic dopamine system during that time." This work has also been reported at meetings, but is still unpublished.

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Addiction appears to steal the normal sense of pleasure

The brains of addicts are almost back to normal after a year without the drug, though not completely, he said. "If you can stay abstinent for about a year," Dr. Wu said, "you've weathered the periods of greatest vulnerability." Scientists are still debating whether the dopamine cells ever fully return to normal.

The gross patterns of brain activity detected in PET scans represent changes at the microscopic level that are so dramatic that they are akin to the kinds of changes that result from a brain injury, in the view of Dr. Eric J. Nestler, a neuroscientist at the Laboratory of Molecular Psychiatry at Yale University School of Medicine. In an anatomical study of dopamine cells in rats who had become addicted to morphine, Dr. Nestler's team found that the neurons with D2 dopamine receptors had become 25 percent smaller and had lost much of their ability to receive dollops of dopamine from nearby neurons. Their report will be published later this year in The Proceedings of the National Academy of Sciences.

The afflicted neurons also underwent a drastic change in their internal dynamics, altering the workings of the so-called second messengers, proteins like cyclic AMP. After a molecule like dopamine latches on to a receptor on the cell surface, the second messenger acts within the cell to coordinate its response, like the release of neurotransmitters to signal other neurons.

"When you take a drug like cocaine, it floods the neurons with levels of dopamine never seen in nature," Dr. Nestler said. "The addictive drugs have an impact on the dopamine circuitry like a sledgehammer, storming through this pathway with an intensity that never occurs ordinarily. Taking drugs over and over perturbs these systems, and they try to adapt by making the dopamine less effective."

Once the cells adapt this defensive maneuver and become less responsive, the cells are left bereft of normal levels of the neurotransmitter if a person stops taking a substance that floods the mesolimbic systems with dopamine. These changes seem to be the neural engine driving the craving for more of any drug.

"You find the same changes not just with cocaine," Dr. Volkow said, "but also with other addictions, such as to heroin and to alcohol," although each drug affects the dopamine system through distinctive neural routes.

The shift to addiction seems to occur as dopamine deprivation produces chronic unpleasant feelings, depression and a loss of motivation, which leads to the need to take the drug to feel better. "Once these cellular changes occur," Dr. Nestler said, "addicts will take a drug just to feel right, not for a high."

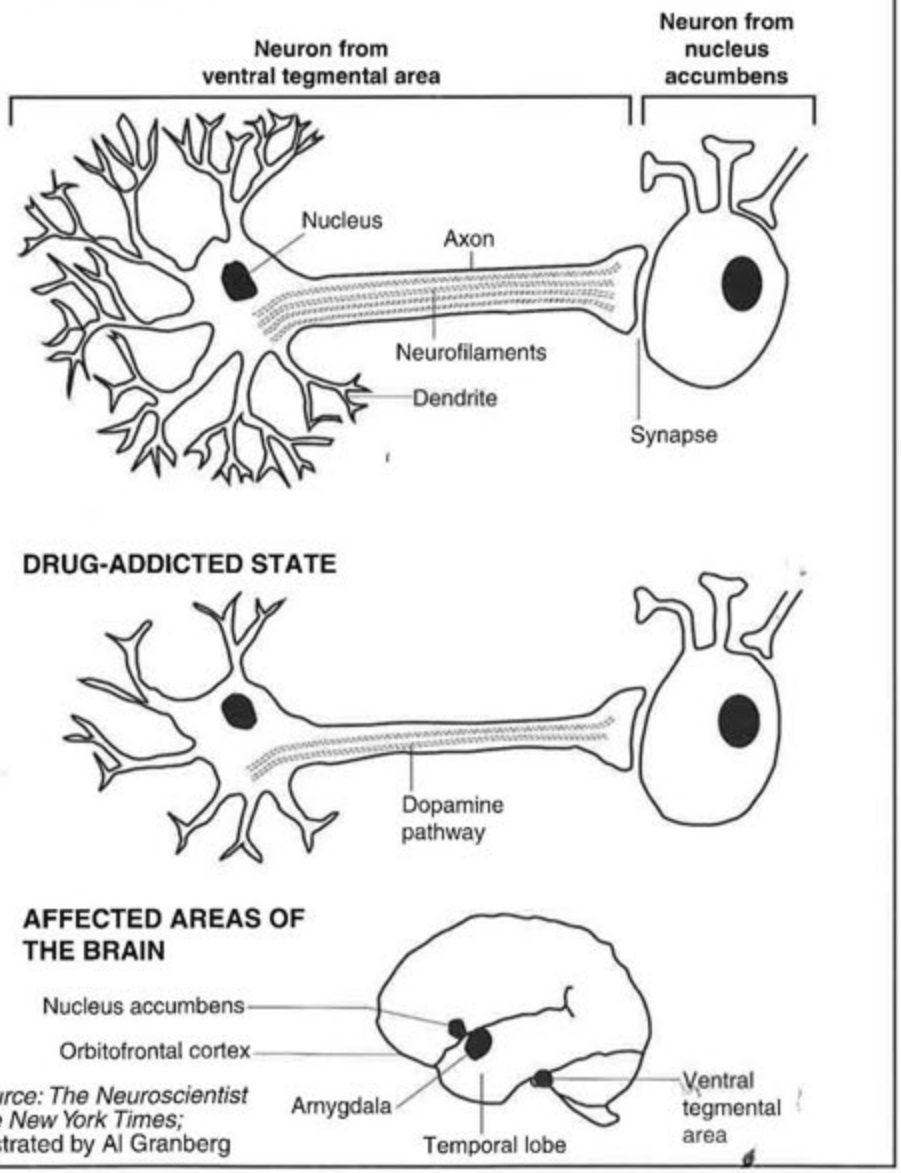
What does all this portend for the treatment of drug addiction? "The research suggests a common biological essence to all addictions," Dr. Leshner, of the National Institute on Drug Abuse, said, "though I don't think we'll ever have a single magic bullet. We might instead one day have neurochemical cocktails that are specific to each addictive drug that would break the cycle of craving."

In the meantime, Dr. Leshner sees a continued role for behavioral treatments of addiction. Approaches that count on people's ability to resist craving, like that of Alcoholics Anonymous, are still the most successful many studies have found. "If addiction means the brain has changed, then the task is to change the brain back to normal," Dr. Leshner said. "But that doesn't mean treatments have to be biological. Behavioral treatments can change the brain, too."

As seen in **The New York Times**.

Altered Pathway in 'Pleasure Center'

A primitive pathway in the brain, called the mesolimbic dopamine system, shows heightened metabolic activity when people crave cocaine. The structure of the neurons along the pathway are altered. Repeated drug doses overload normal neurotransmitter systems, and cells compensate by making dopamine less effective and becoming smaller. When doses stop, craving ensues.



Source: The Neuroscientist The New York Times;
Illustrated by Al Granberg

POLICY ALERT

Aid Cutoff – Continued from page 1

funding for residential programs, which need them to pay for the recipients' room and board. The ban will leave significant gaps in the budgets of those treatment programs—particularly those that serve pregnant women and women with young children—and thus lead to denial of care to individuals who want and need treatment; it may even force some programs to close. It also will impede the efforts of "drug courts" and other initiatives to divert drug offenders from the criminal justice system into treatment.

The Legal Action Center, a Washington, D.C.-based advocacy group, argues that the ban hurts children because a mother's cash assistance or food stamps go toward caring for the entire family, not just the individual who qualifies for federal assistance. In some cases, the loss of benefits may result in children being placed in the child welfare or foster care systems, at great financial cost to the state and equally great emotional cost to the children.

States Can Modify or Opt Out

The federal law allows states to adopt statutes opting out of Section 115 entirely. The Legal Action Center argues that opting out will help ensure the continued availability of treatment and prevent an increase in crime that may result from the loss of access to drug treatment and other essential social services.

Alternatively, states can adopt statutory language modifying the provisions of Section 115. For example, states could lift the lifetime ban on benefits for individuals who:

❑ Since their conviction, are in treatment for or recovery from alcohol or drug problems, have worked or gone to school, or otherwise have demonstrated their rehabilitation;

❑ Are pregnant or have young children, are adolescents, are HIV-positive, or otherwise are particularly vulnerable;

❑ Have not been convicted of another drug-related felony in a specified time period (such as one to three years).

Individuals who would like to receive more information on state options are urged to contact Gwen Rubinstein at the Legal Action Center, 236 Massachusetts Ave., N.E., Suite 505, Washington, D.C. 20002, or to call 202/544-5478, fax 202/544-5712, or E-Mail 76726.2112@compuserve.com.

COMMITTEE REPORT

ASAM Sections, Committees and Task Forces

Members who would like to join an ASAM committee or task force should contact the chairperson directly, or send a letter of interest to the ASAM office.

TREATMENT & CLINICAL ISSUES SECTION
Andrea G. Barthwell, M.D.

Adolescents
Marie Armentano, M.D.

AIDS
Melvin Pohl, M.D.

Criminal Justice
H. Blair Carlson, M.D.

Cross-Cultural Clinical Concerns
Lawrence Brown, Jr., M.D.

Dual Diagnosis
Norman S. Miller, M.D.

Family & Generational Issues
(Open)

Forensic Science
(ad hoc)
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Elizabeth Khuri, M.D.

Nicotine Dependence
John Slade, M.D.

Pain and Addictive Disease
Seddon Savage, M.D.

Pharmacological Issues
(VACANT)

Pregnancy & Neonatal Addiction
(VACANT)

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Trauma
Peter Rostenberg, M.D.
Carl Soderstrom, M.D.

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ALCOHOL ALERT

National Institute on Alcohol Abuse and Alcoholism No. 33 PH 366

Neuroscience Research and Medications Development

Research suggests that the processes leading to the development of alcoholism reside largely in the brain. This has led to the concept of developing medications that act on specific brain chemicals to interfere with these processes. In 1995, the U.S. Food and Drug Administration approved the use of one such medication—naltrexone, under the brand name ReVia™—to help prevent relapse in recovering alcoholics. By combining results of clinical and neuroscience research, this advance signals a new era in alcoholism treatment. This *Alcohol Alert* shows how brain chemistry research may lead to further breakthroughs in the medical treatment of alcoholism and its effects.

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 thirty-third in the series.

Phenomena of Addiction

Reinforcement. It may seem self-evident that a person will repeat an action that brings pleasure, or reward. The process by which such an action becomes repetitive is called positive reinforcement. Normally, this process functions to sustain motivation for behaviors essential to the individual or species, such as eating, drinking, or reproductive behavior (1,2). Evidence suggests that alcohol and other drugs of abuse (AOD's) are chemical surrogates of such natural reinforcers (3). AOD's that cause a rewarding mental state (e.g., euphoria) function as positive reinforcers upon initial exposure (3). These drugs may be more powerfully and persistently rewarding than the natural reinforcers to which the human brain is accustomed (4). Thus, continued exposure to AOD's can initiate increased drug-seeking behavior and set the stage for addiction. Although the remainder of this discussion concentrates on alcoholism, the principles described are generally valid for other addictions as well.

Alcohol is a surrogate of natural reinforcers such as food.

After alcohol-seeking behavior has been established, the brain undergoes certain adaptive changes to continue functioning despite the presence of alcohol. As a consequence of this adaptation, however, certain abnormalities occur in the brain when alcohol is removed. Thus, periods of abstinence are marked by feelings of discomfort and craving, motivating continued alcohol consumption. This kind of motivation—based not on reward but on avoidance of painful stimuli—is called negative reinforcement. Both positive and negative reinforcement are involved in the maintenance of alcoholism (5,6).

Dependence. Physical dependence in alcoholism is the need for continued alcohol consumption to avoid a withdrawal syndrome that generally occurs from 6 to 48 hours after the last drink. Withdrawal symptoms include anxiety, agitation, tremor, elevated blood pressure, and, in severe cases, seizures. The withdrawal syndrome is distinct from the ongoing process of negative reinforcement described above, although both phenomena result from adaptation of the nervous system (7,8).

Alcohol and the Brain

All brain functions, including addiction, involve communication among nerve cells (neurons) in the brain. Each of the brain's neurons connects with hundreds or thousands of adjacent neurons. The points of connection between neurons are generally separated by microscopic gaps called synapses. Messages are carried across synapses by chemicals called neurotransmitters. Although there are approximately 100 different neurotransmitters, each neuron releases only one or a few different types. After its release, a neurotransmitter crosses the synapse and activates a receptor protein in the outer membrane of the "receiving" neuron.

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Each receptor type responds preferentially to one type of neurotransmitter. However, most neurotransmitters can activate different subtypes of the same receptor, producing different responses in different brain cells or in different parts of the brain (9). Determining the specific neurotransmitters and receptor subtypes that may be involved in the development and effects of alcoholism is the first step in developing medications to treat alcoholism (10,11).

Receptor activation causes a change in the receiving neuron. This change may consist of a transient increase or decrease in the neuron's responsiveness to further messages (12). Alternatively, some receptors promote long-term changes that support functions such as growth; learning; or adaptation to changes in the neuron's environment, such as the presence of alcohol. The process of converting messages from other neurons into changes within the receiving neuron is called signal transduction (9). Alcohol may produce some of its effects by interfering with signal transduction (13,14).

Brain cells adapt to the presence of alcohol, promoting continued consumption.

Pharmacological treatment for alcoholism has focused on the processes described above. Other elements of message processing, described below, may provide additional targets for medications development.

The brain's long-lasting adaptations to alcohol may result in part from changes in gene function (15). Genes direct the synthesis of proteins, such as receptors. By influencing gene function, alcohol may alter the structure and function of specific receptors that have roles in intoxication, reinforcement, and physical dependence (16–19). Alcohol's effects on genes may also alter proteins involved in signal transduction (14). Additional research is needed in this area before practical benefits, in the form of medications, can be realized.

Groups of neurons with similar functions extend from one brain region to another, forming neural circuits. Circuits interact with one another to integrate the functions of the brain. One important part of a circuit that has been studied for its role in reward is the nucleus accumbens, located near the front of the brain (3,20). Other circuits are involved in various aspects of alcoholism. For example, circuits involved in physical withdrawal have long been targets of medications development.

Medications Development

Any alteration in the function of message reception or transduction systems may have significant effects on the progression of alcoholism after drinking has started. An understanding of how specific changes in the function of these systems affect susceptibility to alcohol provides a starting point for medications development (21–23). Medications can theoretically be developed to block receptors or enhance their function; to increase or decrease the synthesis, release, or synaptic concentration of neurotransmitters; or to modulate signal transduction.

Medications development for alcoholism focuses mainly on two goals: treatment of withdrawal and the maintenance of abstinence (relapse prevention). Many withdrawal symptoms appear to result in part from overactivity of the sympathetic ("fight or flight") nervous system (24), which normally functions to prepare the body for stressful situations. The preferred medications for withdrawal are benzodiazepines, such as Valium®, which "brake" the racing sympathetic nervous system while helping prevent seizures (25,26).

Medications can be developed to block the adaptive . . .

Medications to interrupt the process of reinforcement are being investigated. The key neurotransmitters involved in reinforcement include the endogenous opioids and dopamine. The endogenous opioids are a group of brain chemicals similar in action to morphine. They appear to amplify the pleasurable effects of rewarding activities (27,28) and have been shown to help maintain drinking behavior (29,30). Naltrexone helps prevent relapse and reduce craving by blocking certain opioid receptors, presumably reducing the pleasurable effect of alcohol (31–33).

. . . and reinforcing properties of alcohol.

Dopamine is involved in aspects of motivation and has been implicated in addiction to several drugs (34). Alcohol has been shown to increase levels of dopamine in the nucleus accumbens (35), although dopamine's precise role in the development of alcoholism remains unclear (34,36). Bromocriptine, a medication that activates dopamine receptors, has been thought to reduce craving in alcoholics; however, it has not been found to maintain abstinence (37).

A significant impetus to medications development has been the recognition that alcoholism and some psychiatric disorders appear to involve some of the same neurotransmitter systems (38). This presumed similarity in neural mechanisms may also be related to the substantial co-occurrence of AOD and psychiatric disorders in the same patients (39–41). For both of these reasons, researchers have investigated current and experimental psychiatric medications to treat alcoholism occurring either alone or in the presence of psychiatric symptoms. An example

is buspirone, an antianxiety medication that activates certain serotonin receptors. Serotonin, a neurotransmitter that helps regulate many mental and bodily functions, helps modulate reinforcement (42,43). Extensive research has demonstrated a limited effect of buspirone on alcohol craving and consumption among anxious alcoholics (44,45). Similarly, the antidepressants imipramine (46) and desipramine (47) were found to decrease alcohol consumption among alcoholics whose co-occurring depression improved in response to the medication.

The antidepressants that have stimulated the most alcohol-related research activity include fluoxetine (Prozac®) and related medications that increase serotonin concentrations in synapses (48,49). Clinical trials of these medications to date have not shown effectiveness in treating alcoholism (23).

Some psychiatric medications may alleviate co-occurring alcoholism.

In summary, medications that treat psychiatric disorders may in some cases be effective in treating co-occurring alcoholism as well. Further research is needed to determine whether such medications can improve treatment outcome in the absence of co-occurring psychopathology.

Neuroscience Research and Medications Development—A Commentary by NIAAA Director Enoch Gordis, M.D.

Developing effective pharmacotherapies for alcoholism treatment is a top priority of alcohol research. Doing so depends on neuroscientists' continued elucidation of how alcohol acts on the brain to produce the fundamental phenomena of alcoholism—tolerance, withdrawal, impaired control over drinking, and craving—and how these phenomena can be interrupted or controlled. It also depends on clinical researchers' testing the efficacy of medications through carefully controlled clinical trials. The development of naltrexone in the United States and acamprosate in Europe is based on just such an important convergence of neurosciences and clinical research.

At the present time, clinical research indicates that the best treatment results are achieved with a combination of pharmacotherapy and skilled counseling. Research is underway to determine how alcoholism treatment medications work (the mechanism of action), the potential therapeutic value of using pharmacotherapy over a longer period of time, and which subsets of patients are most likely to benefit from new pharmacological treatments. The prospects for improved alcoholism treatment have never been better.

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SWEEPING CHANGES SEEN IN NEW MEDICARE RBRVS FEE SCHEDULE, CODES

The 1997 RBRVS Medicare Fee Schedule, released in late November, contain changes in psychiatric coding for Medicare billing that were characterized as "sweeping changes" by Jay Cutler of the American Psychiatric Association. The new schedule also adopts new relative work value units as part of the five-year work value review effort. In what Mr. Cutler characterized as a "good news/bad news story," several psychiatric services receive work value increases in 1997 and thus increases in reimbursement. On the other hand, HCFA has unilaterally decided to move in the direction of so-called "pure psychotherapy" (i.e., psychotherapy with and without a medical or "evaluation and management" component).

Effective January 1, 1997, HCFA no longer recognizes the AMA CPT codes for psychotherapy services--CPT Codes 90842 (75-80 minutes individual psychotherapy), 90843 (20-30 minutes individual psychotherapy), 90844 (45-50 minutes individual psychotherapy), and 90855 (interactive individual psychotherapy)—for Medicare payment. (The AMA codes will, however, continue to be used by virtually all other third-party payers.) HCFA has replaced the CPT codes with new HPC codes designated G0071 through G0082 for office or outpatient settings, and G0083 through G0094 for inpatient or partial hospital settings.

The new codes effectively "unbundle" psychotherapy and medical evaluation and management; there will be a "psychotherapy-only" code and a "psychotherapy furnished with medical evaluation and managed services" code. (The medical evaluation and services component is viewed by HCFA as "medical management of patients, medical diagnostic evaluation, drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations, review of activity therapy reports, the supervision of nursing and ancillary personnel, the programming of all hospital resources for diagnosis and treatment, and activity in leadership or direction of a treatment team.")

The new coding system eliminates the term "medical" from "medical psychotherapy" and will not include the CPT descriptor phrase "by a physician," so that the "psychotherapy only" can be used by physicians, psychologists, and social workers. The new codes distinguish between (and pay at different rates based on site of service for) office-based psychotherapy and psychotherapy based in an inpatient or other facility setting. There are 12 new office-based psychotherapy codes and 12 new hospital-based psychotherapy codes, as follows:

Codes for Office-Based or Other Outpatient Psychotherapy	Codes for Inpatient or Partial Hospital or Residential Care Facility
Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy	***Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy***
G0071: 20 to 30 minutes individual outpatient therapy.	G0083: 20 to 30 minutes individual inpatient therapy.
G0072: 20 to 30 minutes individual outpatient therapy, with medical evaluation and management services.	G0084: 20 to 30 minutes individual inpatient therapy, with medical evaluation and management services.
G0073: 45 to 50 minutes individual outpatient therapy.	G0085: 45 to 50 minutes individual inpatient therapy.
G0074: 45 to 50 minutes individual outpatient therapy, with medical evaluation and management services.	G0086: 45 to 50 minutes individual inpatient therapy, with medical evaluation and management services.
G0075: 75 to 80 minutes individual outpatient therapy.	G0087: 75 to 80 minutes individual inpatient therapy.
G0076: 75 to 80 minutes individual outpatient therapy, with medical evaluation and management services.	G0088: 75 to 80 minutes individual inpatient therapy, with medical evaluation and management services.
Interactive Psychotherapy	***Interactive Psychotherapy***
G0077: 20 to 30 minutes individual outpatient therapy.	G0089: 20 to 30 minutes individual inpatient therapy.
G0078: 20 to 30 minutes individual outpatient therapy, with medical evaluation and management services.	G0090: 20 to 30 minutes individual inpatient therapy, with medical evaluation and management services.
G0079: 45 to 50 minutes individual outpatient therapy.	G0091: 45 to 50 minutes individual inpatient therapy.
G0080: 45 to 50 minutes individual outpatient therapy, with medical evaluation and management services.	G0092: 45 to 50 minutes individual inpatient therapy, with medical evaluation and management services.
G0081: 75 to 80 minutes individual outpatient therapy.	G0093: 75 to 80 minutes individual inpatient therapy.
G0082: 75 to 80 minutes individual outpatient therapy, with medical evaluation and management services.	G0094: 75 to 80 minutes individual inpatient therapy, with medical evaluation and management services.

ASAM MEMBERSHIP CAMPAIGN RECRUITS 475 NEW MEMBERS

ASAM's 1996-1997 International Membership Campaign, chaired by Paul H. Earley, M.D., assisted by Team Captains Gary Olbrich, M.D., P. Joseph Frawley, M.D., and William B. Hawthorne, M.D., has welcomed the following new members to ASAM in 1996.

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CHAPTER NEWS

Arkansas

President James Tutton, M.D., reports that ASAM President David E. Smith, M.D., gave a great presentation to a chapter meeting in Little Rock in October 1996. The turnout for the meeting was excellent and all participants were enthusiastic. In fact, the chapter hopes to recruit some new members as a result of the meeting. Also in October, the chapter sponsored anti-tobacco advertisements in local papers as part of a local campaign for tobacco-free youth.

The Chapter is offering informal help and consultation to a fledgling state organization of nurses in recovery.

California

A CSAM Leadership Conference for hospital medical staff Committees on the Well-Being of Physicians is scheduled for March 15th in San Francisco. The program will be devoted to the impact of the recent California Supreme Court decision holding that records of medical staff peer review activities are not protected from discovery by the California Medical Board or other state agencies. The ruling in the case (Arnett v. Dal Cielo) upheld the state's complaint against Alameda Hospital, which had refused to release peer review records concerning a staff anesthesiologist who had a history of addiction treatment. For more information on the program, contact Gail Jara at 510/428-9091.

CSAM President William Brostoff, M.D., reports that in the society's recent election of officers, held in conjunction with the 1996 CSAM Review Course in Los Angeles, Gail N. Shultz, M.D. was voted President-Elect and Lyman Boynton, M.D., was elected Treasurer. Dr. Shultz is Medical Director of the Betty Ford Center at Rancho Mirage; Dr. Boynton is Chief of Addiction Medicine at the Chemical Dependence Recovery Program at the San Francisco Kaiser Permanente Medical Center. Four new members were elected to the CSAM governing body: Peter Banys, M.D., who is Chief of Addiction Medicine at the San Francisco Veterans Affairs Medical Center; Gary Jaeger, M.D., who is Chief of Addiction Medicine at the Chemical Dependency Recovery Program at Kaiser Permanente in Carson Michael Parr, M.D., who is in private practice in Sacramento; and Margaret Yates, M.D., who is in private practice in Los Angeles.

Illinois

Chapter President Martin Doot, M.D., reports that the Illinois Department of Alcohol and Substance Abuse (IDASA) will renew its contract with the Illinois Society of Addiction Medicine (ISAM) for ISAM to provide consulting services to the department in fiscal year 1997.

Three sites have been selected for ISAM/IAFP training of family physicians in the third quarter 1997. Information regarding this meeting will be reported in future issues of *ASAM News*.

ISAM will sponsor training sessions at the Local Counselors Certification Association annual meeting in April 1997. The chapter sponsored a training session for 120 counselors in October 1996.

Kentucky

ASAM members in the state of Kentucky are working toward formation of a Kentucky Chapter of ASAM. Meetings will be held during ASAM's 1997 Annual Medical-Scientific Conference in San Diego and during the Kentucky Medical Association's Annual Meeting in September. Interested parties are invited to contact Robert J. Middleton, M.D., by phone at 502/454-8700 or by fax at 502/454-8702.

New Jersey

Chapter President George Mellendick, M.D., reports that the New Jersey Chapter held a general business meeting on Wednesday, January 29 at 3:00 p.m. at the office of Dr. John Verdon, 535 Sycamore Ave., Shrewsbury, NJ. The meeting agenda included plans for election of officers and other Chapter activities. For more information, members are invited to contact Dr. John Verdon by phone at 908/842-9468 or by fax at 908/842-0666.

North Carolina

At the February annual meeting of the North Carolina Governor's Institute on Alcohol and Substance Abuse, NCSAM will cosponsor (with the South Carolina and Virginia Chapters) a dinner seminar by Ray Anton, M.D. on "Psychopharmacology Treatment."

An October meeting that was jointly sponsored by the North Carolina chapter and the North Carolina Physicians Health Program featured a lecture on the state of addiction medicine by Al Mooney, M.D., formerly with Willingway Hospital in Georgia and now in private practice in Raleigh, NC.

Ohio

The Ohio State University Medical Center and Mount Carmel Health System presented

MEMBERS IN SERVICE TO ASAM

❑ Michael Miller, M.D. and David Gastfriend, M.D. have been reappointed as Representative and Alternate Representative to the Joint Commission on Accreditation of Healthcare Organizations expert advisory committee. Drs. Miller and Gastfriend will serve as joint representatives of ASAM, the National Association of Addiction Treatment Programs, and the National Association of Alcohol and Drug Abuse Counselors.

❑ Donald Ian Macdonald, M.D., has accepted President David E. Smith's invitation to serve as the ASAM member of the Board of Directors of the Medical Review Officer Certifying Council. Dr. Macdonald chairs ASAM's MRO Committee.

❑ In response to a request from Gen. Barry McCaffrey, Director of the Office of National Drug Control Policy, the ASAM Board of Directors has nominated the following members for service on an ONDCP medical advisory committee: Sheila B. Blume, M.D., Andrea Barthwell, M.D., Robert DuPont, M.D., Donald Ian Macdonald, M.D., Anthony B. Radcliffe, M.D., Terry C. Schultz, M.D., David E. Smith, M.D., and G. Douglas Talbott, M.D.

❑ Anne Geller, M.D. and Dr. James F. Callahan met with the Preventive Medicine Residency Directors to discuss the ASAM Board's resolution to establish Addiction Medicine Fellowships, and ASAM's interest in collaborating with Preventive Medicine and other specialty residency directors to accomplish this.

❑ David E. Smith, M.D. and Dr. James F. Callahan attended the American Academy of Addiction Psychiatry annual conference in San Francisco and met with President Edgar Nace, M.D., and other representatives of AAAP to discuss the development of fellowships and parity for treatment of addictive diseases.

❑ EVP Dr. James F. Callahan represented ASAM at the Johnson Institute's National Leadership Forum, where leaders of 30 organizations discussed how to collaborate in informing policymakers and the public about the prevention and treatment of addictive diseases.

their Fourth Annual Update on Chemical Dependency at Mount Carmel East Hospital. The annual program, which benefits the National Council on Alcoholism and Drug Dependence of Ohio, featured ASAM members and representatives of the National Institute on Alcohol Abuse and Alcoholism and the National Council on Alcohol and Drug Dependency.

Oregon

Addiction medicine won a big electoral victory in Oregon on November 5. Measure 44, An Act to Support the Oregon Health Plan (also know as the Tobacco Tax Initiative) passed by a margin of 56% to 44%. The measure will increase taxes on cigarettes by 30 cents, raising the total Oregon tax to 68 cents per pack. Additional revenues are earmarked for the Oregon Health Plan and tobacco use prevention programs. Despite the tobacco industry's campaign to defeat the measure—one of the most expensive ever seen in Oregon—a major grassroots campaign prevailed.

Many health care organizations and societies working together helped convince the electorate of the great value of raising tobacco taxes. ORSAM President Douglas Bovee, M.D., helped instigate a major letter writing campaign by members of the county medical society to their patients.

South Carolina

Chapter President Timothy Fischer, D.O., reports that SCSAM co-sponsored a successful conference with the South Carolina College of Medicine's Department of Drug and Alcohol Studies. The program, entitled "Protecting Your Clinical Practice: Pain Management and the Interface with Addiction," was held in December 1996. Featured speakers included G. Douglas Talbott, M.D., William Green III, M.D., and J. David Haddox, D.D.S., M.D. Moderators were Pete Johnson, Ph.D., Martin Zwerling, M.D., F.A.C.S., and Timothy Fischer, D.O.

The Chapter held a business meeting in January for all SCSAM members. The chapter also has a Website up and running to provide news and updates on chapter activities, and provides news via E-Mail at SCSAM@Columb.mindspring.com. Members are asked to provide their E-Mail addresses so that they can be reached quickly with news and other important chapter information.

SCSAM also is exploring the possibility of sponsoring television advertisements regarding alcohol and violence, and has joined the Smoke-Free Coalition in South Carolina. Interested members are invited to call Tim Fischer, D.O. at 803/536-4900, ext. 120.

Region III

Regional Director Alan Wartenberg, M.D., reports that the 1996 Region III Conference, held in November, was a success. The theme was "Addiction Medicine: The 21st Century." The meeting included updates on chemical dependency treatment as well as state, regional and national ASAM news. Dr. Wartenberg also reports that Region III has exceeded its 1996 projections for membership growth.

Region IV

Regional Director R. Jeffrey Goldsmith, M.D., reports that the first Region IV meeting was held in Philadelphia in November 1996. Members should contact Dr. Goldsmith at 513/475-6384 or Ralph Stolz, D.O., at 215/967-3115 for more information regarding the outcome of the meeting.

Region IX

Regional Director Ray Baker, M.D. reports that October 4–5 marked the second annual Regional Cascadia Conference hosted by The Foundation for Medical Excellence in Seattle. John Ulwelling skillfully organized and chaired this successful meeting, featuring speakers such as Garrett O'Connor, M.D., Lynn Hankes, M.D., Tom Payte, M.D., and G. Douglas Talbott, M.D. John Ulwelling reports that evaluations for this conference were as high as any he has seen in over 10 years of hosting top quality CME events, so don't miss it in Vancouver in 1997!

On October 18–20, the Canadian Medical Society on Alcohol and Other Drugs (CMSAOD) held its annual general meeting and medical-scientific conference at the Prince Hotel in North Toronto. (CMSAOD has been renamed C*SAM, The Canadian Society of Addiction Medicine, with * representing a maple leaf.) ASAM President David E. Smith, M.D. addressed participants on the important ways the Canadian and U.S. national organizations can work together. (In fact, the ASAM Board of Directors is considering a request to create a new region to represent international members, with Region IX designated as Canada.)

Participants in the C*SAM conference heard about an exciting new initiative of the five Ontario Medical Schools on addiction medicine and medical student wellness Curricula, entitled Project CREATE. The University of British Columbia's AMIR program also was featured. This marks a very important point in medical education in addiction medicine in Canada. All Canadian members are invited to attend the 1997 medical-scientific conference in Halifax, Nova Scotia.

International

Dr. Flavio Poldrugo, President, has announced that the Italian Society of Addiction Medicine will sponsor its first International Conference in October 1997.

RUTH FOX FUND: YEAR-END REVIEW

Dear Colleague:

WE DID IT!

The Ruth Fox Memorial Endowment Fund's 1996 goal of $2 million has been reached! We thank ASAM's many members and friends who gave so generously to this endeavor.

Dr. Anthony Radcliffe, an ASAM Board member and Past President, has confirmed that he is making a deferred gift that puts the Endowment over the $2 million mark. This will be acknowledged at the Ruth Fox Memorial Endowment Reception.

Special thanks go to Janet K. Johnson, M.D., of Cordova, Tennessee, who is naming the Endowment Fund as owner/beneficiary of a $50,000 insurance policy. Thanks also go to Ted E. Ashcraft, M.D., of Russellville, Arkansas, for naming the Endowment Fund as owner/beneficiary of a $25,000 insurance policy. These gifts are in addition to Drs. Johnson's and Ashcraft's previous generous contributions. We are very grateful to them for their commitment and their continued support.

The Yasuda Bank and Trust Company (USA), New York City, has made another contribution to the Endowment, bringing its total contributions over the years to $8,750. We are very grateful to the bank's officers for their ongoing support, which is helping to secure the Society's future and the future of Addiction Medicine.

The Ruth Fox Memorial Endowment Fund Reception (by invitation only) is scheduled for Friday, April 18, 1997, at the Annual Medical-Scientific Conference in San Diego. All donors will receive an invitation.

If you have not already contributed/pledged to the Endowment Fund, it is not too late to have your name added to the donor list and receive an invitation.

Pledges can be paid over five years and all contributions to the Endowment are 100% tax-deductible. Medallions will be presented at the Reception to donors who contribute/pledge $5,000 or more. (Recipients of major donor medallions are asked to wear them during the Annual Meeting.)

Please contact Claire Osman if you would like to discuss other ways to support the Endowment Fund, i.e., bequests, insurance, stock. She will be pleased to discuss any of these planned gifts with you (in confidence). She can be reached at 1/800 257-6776.

Remember the special program to be presented by Paul E. Dow, J.D. on "Protecting Pension Plan Assets & Distribution Strategies," on Thursday, April 17, 1997, from 7:00 to 8:30 p.m., during the Society's 28th Annual Medical-Scientific Conference in San Diego. Last year's program was very successful, and participants received valuable information. If you plan to attend, please check this session on the conference program/registration form when you return it. Everyone is invited.

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

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

Claire Osman, Director of Development

Total Pledges: over $2 million
1996 Goal: $2 million

New Donors, Additional Pledges and Contributions

October 16, 1996 – December 27, 1996

Benefactors' Circle ($50,000-$99,999)
Janet K. Johnson, M.D.

Founders' Circle ($25,000-$49,999)
Ted E. Ashcraft, M.D.
R. Jeffrey Goldsmith, M.D.

Leadership Circle ($5,000-$9,999)
Arnold J. Hill, M.D.

Donors' Circle (up to $2,999)
Parveen Azam, M.D.
LeClair Bissell, M.D.
David A. Gilder, M.D.
Enoch Gordis, M.D.
Edward Gottheil, M.D.
Allan W. Graham, M.D.
John S. Howie, M.D.
Theodore M. Hunter, M.D.
John A. Kotyo, M.D.
I. Martin Krauss, D.O.
Michael R. Liepman, M.D.
Mr. Harry Lucas, Jr.
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Rodolfo M. Medina, M.D.
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John W. Sherman, M.D.
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Michel A. Sucher, M.D.
Nina Thiessen, M.D.
Melissa Lee Warner, M.D.
Robert L. Wick, Jr., M.D.
Leah E. Williams, M.D.

In Honor of Thomas E. Lauer, M.D.
from Mr. Barry Schultheiss

EARLE M. MARSH, M.D. IS ASAM'S FIRST EMERITUS MEMBER

Earle M. Marsh, M.D., of Walnut Creek, California, has been named the Society's first Emeritus Member. One of the early pioneers in the field of addiction medicine, Dr. Marsh has been an ASAM member for more than 17 years.

Pennsylvania General and Addictions Psychiatry

Hospital-based position combining inpatient and outpatient psychiatry with responsibility for taking the lead in the development of a program track for dual-diagnosed patients. Includes active involvement in clinical research and teaching, with eligibility for faculty appointment at Penn State/Hershey Medical Center.

Seeking BC/BE psychiatrist with added qualifications and/or experience in addiction medicine. Join eight other general psychiatrists and three child and adolescent psychiatrists at Lehigh Valley Hospital in Allentown, a safe, attractive city with good schools, nine colleges, many cultural and recreational activities.

Send CV to:

Michael Kaufmann, M.D.
c/o Lehigh Valley Hospital
Physician Recruiting Dept.
1243 S. Cedar Crest Blvd.
Suite 3335-B, Allentown, PA 18103

Fax 610/402-3089.

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Treating
Addictive Diseases

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Madison, WI 53717

608/833-3905

Maine

Group practice consisting of three physicians is looking for a family practice physician who also specializes in addiction medicine to join their group.

The practice is located in the city of Waterville, Maine, which has a beautiful small town, safe environment. First year income is guaranteed.

Contact Louisa Barnhart, M.D., for details at 207/872-6869.

"Carefrontation" Intervention Program

National Counseling Intervention Services, Inc., is the largest crisis intervention organization in the United States. Our "Carefrontation Intervention Program," developed by James Fearing, Ph.D., CCDP, has been successful in 90% of our cases in *helping people get help*.

We work with individuals, families, corporations, professional sports organizations, or anyone who is suffering from substance abuse, gambling addiction, eating disorders, codependency, work addiction, sexual compulsivity, or depression.

Our experienced staff is highly trained and has facilitated over 1200 interventions throughout 10 countries worldwide. We work closely with the top clinics and hospitals throughout the country in referring our patients and their families to the appropriate health care provider. Our program is designed to be "user friendly and accessible" to the referring health care professional.

We respect existing therapeutic relationships. We go to great lengths to keep these relationships intact for future work. Our referrals come from a wide range of sources, including MDs, EAPs, PhDs and chemical dependency treatment centers, hospitals, etc.

Contact us for intervention information, published intervention research and articles published by Dr. James Fearing, President/CEO, NCIS.

Phone 612/512-0000
Fax 612/512-0099
or visit our Website at
WWW.NATIONALCOUNSELING.COM
"Intervention Hotline"
800/279-3321
Offices located in Minneapolis
& Southern California.
"We help people get help"

ADDICTIONIST

The Mid-Atlantic Permanente Medical Group, P.C., a physician owned and managed medical group, is growing and expanding our facilities in Virginia, Maryland, and Washington, D.C. We are seeking an ASAM certified Addictionist for our practice who can provide excellent service in our modern, state-of-the-art offices. Excellent salary and benefit package including vacation and sick time, health/life benefits, occurrence malpractice coverage, retirement plan, relocation allowance, shareholder opportunity, and much more. Reasonable call schedule allows for predictable time off. Nationally recognized for quality care, Kaiser Permanente presents an ideal opportunity to practice medicine. To learn more, send/fax CV to Dorothy Houlihan, Physician Recruitment, MAPMG, 2101 E. Jefferson Street, Box 6649, Rockville, Maryland 20849. 1-800-227-6472. Fax 301-816-7472. EOE

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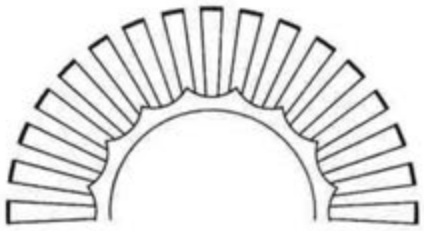

Come Practice Psychiatry in the Beautiful Southwest

Remuda Treatment Center is a progressive facility located on a guest ranch setting 50 miles northwest of Phoenix. Remuda individualizes TX for eating disordered females meeting medical, nutritional & psychological needs blended with a Biblical perspective. We are seeking a BC/BE psychiatrist interested in eating disorder treatment. We offer a charming resort town atmosphere, excellent salary and very predictable schedule. E.O.E.

Call or FAX your CV to
Linda Hughes
Remuda Ranch Center
1 E. Apache St. Wickenburg, AZ 85390
(520) 684-4244
FAX (520) 684-4247

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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

ASAM CONFERENCE CALENDAR

1997

January 30
ASAM Conference on
Forensic Issues in Addiction Medicine
Washington, DC

January 31-February 2
ASAM MRO Course
Washington, DC

February 26-27
North Carolina, South Carolina and
Virginia Chapter Meeting
Greensboro, NC

March 7-8
North Carolina Chapter of IDAA Conference
Raleigh, NC

March 20
New York Chapter Meeting
New York, NY

March 20-23
Prevention '97 (cosponsored by ASAM)
Atlanta, GA

April 13-16
Annual Meeting,
American Methadone Treatment Association
(Jointly sponsored by ASAM)
Chicago, IL

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

April 17
ASAM Computer and Online Course
San Diego, CA

April 17
ASAM HIV/AIDS Course
San Diego, CA

1997

April 18-20
ASAM 28th Medical-Scientific Conference
San Diego, CA
22 Category 1 CME credits

July 18-20
ASAM MRO Conference
Dallas, TX

August 6-10
IDAA Medical-Scientific Conference
(Jointly sponsored by ASAM)
Minneapolis, MN

September 7-20
South Africa People-to-People Conference
(jointly sponsored by ASAM)

October 16-19
ASAM 10th Annual Conference on
Nicotine Dependence
Minneapolis, MN

October 23-25
State of the Art in Addiction Medicine
Washington, D.C.
20 Category 1 CME credits

October
Adolescent Substance Abuse and
Addiction Conference
14 Category 1 CME credits

October
Fifth Annual Southeast Regional
Addiction Conference
Atlanta, GA

November 14-16
ASAM MRO Conference
Seattle, WA

November
CSAM Review Course
(site and dates to be announced)

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:

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***For additional information**, call the ASAM Meetings Department at 301/656-3920.*

ASAM IS NOW ACCEPTING NOMINATIONS FOR EMERITUS MEMBERSHIP

ASAM members may now nominate their fellow members for Emeritus membership. Emeritus members will receive complimentary membership, as well as a complimentary subscription to the *ASAM News* and the society's *Journal of Addictive Disease*.

Emeritus status is bestowed by the ASAM Board of Directors, which will review all nominations. To qualify, members must be: (1) ASAM member for at least 15 years; AND (2) at least 65 years old; AND (3) retiring or retired from the practice of addiction medicine. (However, in special cases, the Board reserves the right to bestow Emeritus membership independent of any of the criteria listed.)

Nomination forms are available through the ASAM Membership Department at 301/656-3920.