

# CSAM NEWS

Newsletter of the California Society of Addiction Medicine

Fall 1998

Vol. 25, No. 2

## I GREW UP IN THE

inner-city of Detroit. Neither one of my parents finished grade school. My father was a factory worker, my mother was a kitchen aid in the hospital. The family ethic was to go to school, and my three brothers and I all finished college.

Out of high school I got a job as a research technician working with Dr. Frances Noye, in respiratory physiology. We didn't have any money and I didn't have a scholarship, so I paid my way through college at Wayne State by monitoring respiration in people who were having surgery.



H. Westley Clark, MD

In addition to my classes and my job, I became active in extracurricular activities at Wayne State. I was invited onto the school newspaper — as a cartoonist — and I was elected to the Liberal Arts Student Faculty Board. My family had no relatives who were college graduates, or physicians, or scientists, or teachers, so these were my first exposures to that world. And, for me, it continued to be an incremental exposure to class-based differences.

At medical school at the University of Michigan, I was active in the Black Medical Student Association and then in the free clinic movement. **That's where I met David Smith.**

Working with the Student American Medical Association, it became clear to me that there were other forces in the universe that I needed to learn about. So, in my senior year I did a semester at the Institute of Public Policy Studies. **That's where the socioeconomic focus took hold.**

*Q. What drew you to psychiatry as your specialty?*

I chose psychiatry because it seemed to work well with my interest in health economics and the dynamics of the health care delivery system. Following my residency, I spent a year at the National Institute of Mental Health in the Division of Mental Health Services. **I saw how much regulatory activity was involved, so I decided to go on to law school!**

*Continued on page 14*

## THE NEW DIRECTOR TALKS ABOUT CSAT

*H. Westley Clark, MD, JD, MPH was named Director of the Center for Substance Abuse Treatment in October. A CSAM member since 1991, Doctor Clark graciously participated in a long interview for the newsletter shortly before he left for Washington. He described his background and the path he has followed to this place in his career, and he shared his viewpoints on some of the issues facing CSAT now as he assumes the leadership. This article is a transcript of the interview.*

CSAT is the only agency within the federal government devoted exclusively to substance abuse *treatment*. CSAT distributes the federal funds for treatment to all the States, through block grants. The money goes to the one department in each state government which is charged to allocate the funds according to that State's policies. In California, it is the Department of Alcohol and Drug Programs, headed by Elaine D. Bush.

CSAT brings treatment into the community. The other federal agencies -- NIDA, NIAAA and NIMH -- focus on the research. CSAT works closely with them to translate the science into effective treatments for substance abuse. For example, NIDA has come out with two manuals about cognitive behavioral treatment for cocaine abuse. If these manuals are not absorbed by those providing the treatment in the community, what good will they do?

CSAT is interested in the provision of the best care. CSAT must work closely with the states and the treatment providers to define standards of care so that we won't have two or three different tiers of care. We want one standard of care. If you get pneumonia, you get antibiotics to treat it; that is the standard of care whether the treatment is in the public or the private sector. I'm not naive; I understand that some people can get different care, but I hope it is just a better-looking facility as opposed to better medicine.

*Continued on page 2*

### *Inside:*

- **New Treatment Programs for Adolescents**
- **CSAM's 1998 Awards**
- **Profile of the Georgia State Chapter of ASAM**
- **Technical Assistance for Treating Nicotine Dependence in Chemical Dependency Treatment Programs**

The economic and political issues, such as limits on reimbursement and who can provide certain care, should fall into place when we focus on the standards of care.

CSAT should be in the fore dealing with the issues of parity in terms of substance abuse treatment because even though it looks like its a private sector issue, the fact of the matter is most public programs, medicare programs, medicaid programs are being administered in a context where parity issues will affect the kind of treatment which can be available.

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**CSAT is studying whether methadone maintenance can be offered to some patients from a physician's office. This is a key policy issue.**

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The people are watching us. Their sons and daughters are struggling with addiction and with recovery, and people want solutions. Making treatment available can make the difference. "Treatment works" is more than just a slogan.

The next steps are to bring a more sophisticated understanding of the legitimate spectrum of treatment approaches and the importance of matching the patient's individual needs to the treatment approach.

We should not have people singling out modes of treatment as being immoral...as we have seen with methadone. "It's immoral. You substituted one addiction for another." Well, if you have hypertension, you take antihypertensive medication for the long term. People with diabetes take insulin for the rest of their lives. A lot of analogous situations are well accepted; nobody seems to have problems with those concepts.

Decisions about treatment with methadone should be data driven, just as they are in other areas of medicine. Whether abstinence should be the treatment goal, and if so, for which patients, are matters to be studied. There are studies underway. We must wait for the data. Then we will have something with validity.

The whole question of methadone-to-abstinence is being studied. The data are coming. **The concerns of Mayor Guilliani of New York City are legitimate concerns but they're premature. He's acting without the data. We shouldn't repeat the error.** Guilliani proposed limiting all NYC-funded methadone maintenance programs to 180 days of treatment and moving all patients to abstinence in that time. As somebody who has worked in 28-day methadone detoxification programs, I can say from my own clinical experience that methadone abstinence is not achieved in

28 days. I have worked in 180-day abstinence based programs which don't work particularly well for everybody. So with this background I know that there are political issues, not driven by clinical sciences but by ideology. The real issue for CSAT is to identify the issues, supply the data, pool all the input and make the information and observations available to the policy makers in a way that is useful to them.

Here is another example. People are studying whether methadone maintenance can be offered to some patients from a physician's office. As you know I was a Senior Program Consultant for the Robert Wood Johnson Foundation, and one of our potential grantees proposed an experiment to look at the policy implications of office-based methadone maintenance. RWJ funded that, and some CSAT money is also supporting that study. This is a key policy issue. What does physician-prescribed opioid replacement treatment actually look like in practice? What are the downfalls; what are the issues to be addressed by regulation? We need to know the answers to those questions, so it is appropriate that first the studies are funded and completed before we formulate regulations. If that means holding up the regulations until the data come in, then we need to hold up the regulations until the data are available.

But that doesn't mean we need to stop the discussion.

My point is by having these dialogues with people and not acting impetuously or impulsively, we will be able to put together something with validity. We have no choice. **The problem of opioid dependence is too severe, it touches all of our lives.**

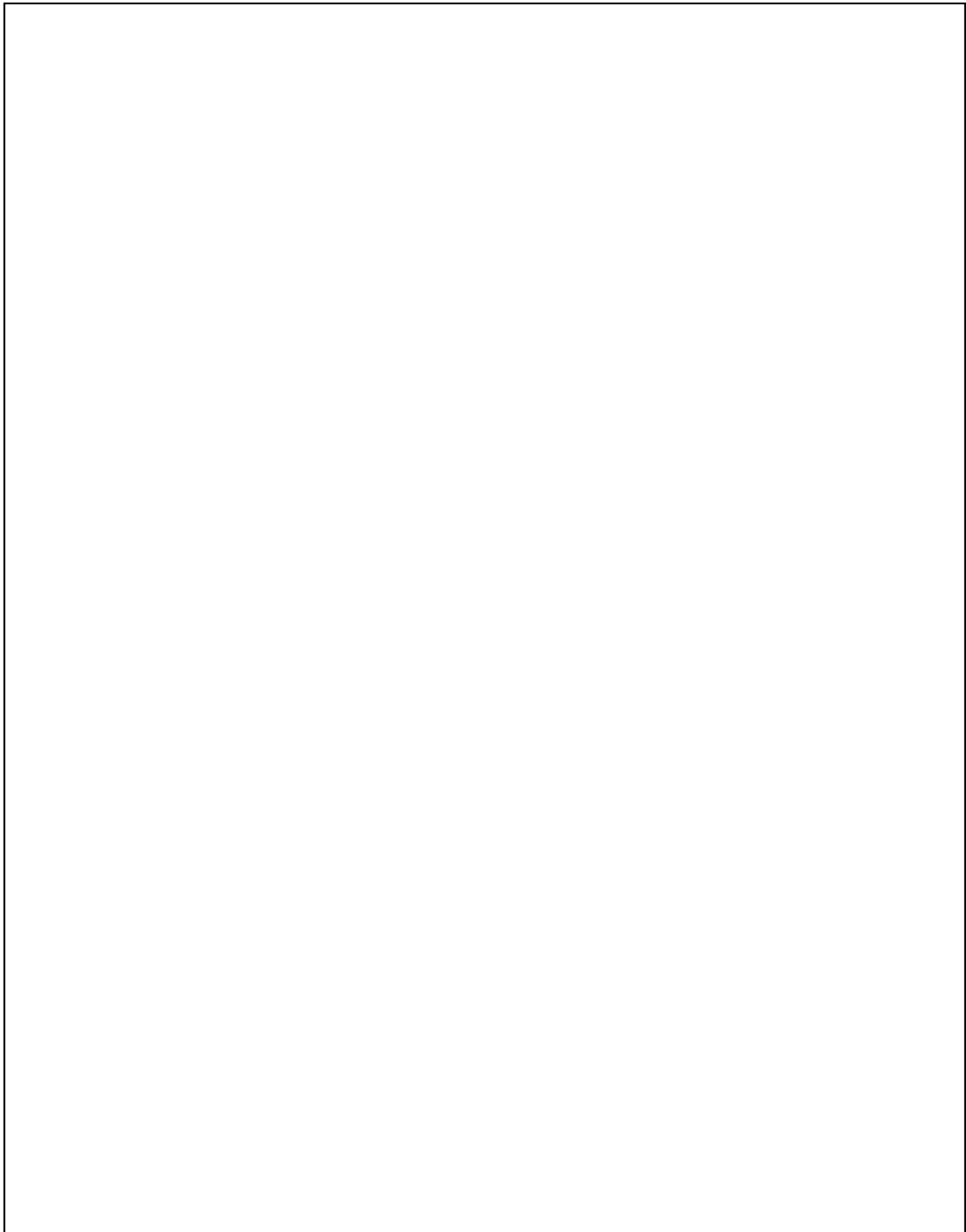
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**I want to preclude the creation of victims. I call it 'victim preclusion.'**

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When I talk about methadone, I don't talk about simply the opioid dependent person, I consider all the others that person comes in contact with. I'm concerned not just with the moral issues of that person's drug use; I'm concerned about the victims that that person might create if he or she is not on methadone. **That's a public health approach. I'm concerned about public health and public safety. As a physician I can say that because I've seen the consequences of dysfunctional behavior.**

My perspective: if I am a potential victim and the choice facing our society is to put this guy on methadone maintenance or take an increased risk that he's going to steal my wallet so he can buy some heroin, which would I prefer? Now I can't say there's a 100% chance he's going to victimize people, but if the policy-makers say "Well we're going to incarcerate him if he does bad things," my



response is yes, but in order for him to be incarcerated he's gotta do bad things. I don't want those bad things done on me". I want to preclude the creation of victims. I call it "victim preclusion."

*Q. Where do you stand in the spectrum of **harm reduction** philosophies and activities?*

Remember that CSAT focuses on treatment. In my mind, treatment approaches *are* harm reduction. I think of harm reduction in terms of treatment on demand and safety net issues. If one particular treatment modality doesn't work, what's our backup?

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**In my mind,  
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are harm reduction.**

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I think of harm reduction in terms of public safety as well as public health. Harm reduction can take the form of education about the spread of HIV disease and hepatitis, and TB, and venereal diseases. Harm reduction can be how you educate the public about prevention. The fact is the harm reduction paradigm is in the process of being informed by greater knowledge from research, especially about the pathophysiology of addiction.

Methadone maintenance is a harm reduction treatment.

There are other aspects of the harm reduction dialogue, like needle exchange, but I'm interested in the treatment aspect. That's my expertise. This administration's position on needle exchange appears to be mixed, and it is being addressed by others.

*Q. Do you think that, as the Director of CSAT, you will be able to maintain the larger public health, public safety viewpoint?*

I think the director of CSAT must have the larger view, but the director works within the administration and has to be in compliance with what the administration's positions. I serve at the pleasure of the Administrator of SAMHSA. If indeed, there is a disagreement and I can help the field shape the public perspective, then that's my job.

I've seen the failures of substance abuse treatment, and I've seen the successes. That puts me in an ideal position. What leadership entails is helping to synthesize what the treatment field is experiencing. Meld that with what the research field is developing, and negotiate changes in the provision of care so that care is enhanced.

CSAT should function as a leader. It should participate in resolution of conflicts. It should be the consensus builder. It should be attuned to both research and practice so that if one side is saying "It ain't going to work, it ain't going to work..." somebody is listening.

*Q. I'm developing the idea that you may be the C. Everett Koop of addiction treatment.*

Well, I do I think we need to deal foursquare with what's going on.

*Q. How do you assess the **leadership** qualifications you'll bring to CSAT?*

What I want to do is inspire people and that means providing leadership. If I can do that, it will be a victory for both CSAT and the community.

Remember that CSAT and all the government agencies are in a competitive participatory process, jockeying for funding and support. I have to help advocate for my agency so that we get adequate funds. That means my agency has to make sure it's always communicating information and working collectively, cooperatively with the other agencies – the White House Office of National Drug Control Policy (under General Barry McCaffrey), NIDA, HRSA, and others.

Leadership means bringing a little higher level of energy.

*Q. I understand CSAT is about to take over the federal regulation of methadone maintenance treatment programs.*

Yes. That is under study now. There is a large "field test" ready to begin in which 200 clinics in 14 states will be chosen to participate. This approach will replace federal regulation with an accreditation process similar to the way hospitals are accredited by JCAHO if they meet JCAHO standards. JCAHO inspectors -- peers -- determine if there is compliance.

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**We need to deal foursquare  
with what's going on.**

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Currently the FDA and the DEA maintain the oversight and control of methadone treatment programs through regulation and licensure. Programs must comply with detailed clinical regulations from both FDA and DEA, as well as state regulations, in order to maintain their licenses. State and federal inspectors are the ones who determine if there is compliance. So this will be a real change.

This is a good example of where the science and the data come into play. Now, the DEA's regulations are to prevent diversion of methadone to the street, but the literature doesn't support the observation that there is significant diversion of methadone. FDA regulations, among other things, proscribe enrolling people in methadone maintenance programs if they are not already dependent on opioids. We need to be able to assure the public that we won't be creating new opioid addicts. However, we must base our decisions on good data. We can't use extreme examples as a rationale for heavily regulating.

In the discussion about what should replace FDA and DEA regulation, we need both data and a balanced input. DEA should be at the table as well as the White House Office of National Drug Control Policy (ONDCP). The treatment community should be at the table.

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**I suggest that CSAM and ASAM members observe and share their clinical observations. The doc in the field has eyes and ears and can say what he or she is seeing. People who are well trained can identify the things that have significance.**

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**CSAT should be taking the minimalist approach – no excessive regulation.** We should always look at regulations from a libertarian or conservative point of view: no regulations are preferred when no regulations are needed. As a clinician and a provider of care, I am sensitive to this. I am also sensitive to the flip side and what happens when things go awry. People who have access to the cookie jar don't always leave all the cookies in the jar. Those are the balancing issues. I'm a moderate on most things, and I am a moderate on this issue. I've got experience as a clinician in the trenches, I've got experience as a teacher, I've got experience on community boards and in the community process. I've done research. I'm not the consummate researcher nor the consummate scholar, but I've got sustained exposure to all these aspects over a long period of time. I think that "vertical experience," from the ground up, is responsible for my moderate position. I think that is why I was selected for this position.

*Q: From your new position as CSAT Director, what do you see as the role of the individual CSAM/ASAM member?*

I'm still very much an ASAM member and still very much a CSAM member. ASAM and CSAM in the past 5 years have increased the focus on biological issues. I know that we've got a lot of people doing a lot of good work, both empirically and academically. I suggest that they observe and share their clinical observations. One way would be through discussion groups on the Internet. The doc in the field has eyes and ears and he or she can say what he or she is seeing. People who are well trained can identify the unique things that have significance. They can say, "This is an interesting case." The doc in the field who is on line can be informed and gets to contribute opinions.

I'd like to see ASAM inform members about the potential of interacting on line. Get them geared up. Most physicians have a computer now. It's a new technology that will enhance the ability of organizations to influence the public policy. ASAM and CSAM should continue to participate in the public discussion.

For example, as a clinician/scholar, I know from my own experience that hepatitis C is more prevalent and more infectious than HIV. Not only are we dealing with HIV and TB in the population of patients, we're also dealing with the hepatitises. **The medical component of addiction treatment needs to be buttressed. We need knowledgeable physicians working with counselors, psychologists and others who provide the psychosocial treatments.**

If you belong to ASAM and CSAM you should be knowledgeable about substance abuse.

The members bring unique intellectual and clinical experience to the whole discussion of substance abuse treatment. **The role of the physician cannot be understated. It is not an exclusive role, or the dominant role. I don't think that there is a dominant role.** I think multiple providers are necessary in the service delivery system, but we need to make sure that physicians are involved. All the new pharmacologic therapies on the radar screen make it doubly important. So it's critical that ASAM and CSAM continue to contribute the way they have. □

*YOU CAN WRITE FOR*

## **NIDA Manuals on Treatment of Cocaine Addiction**

NIDA published two therapy manuals on treatment of cocaine addiction. Manual 1 (127 pages) is based on the research of Kathleen Carroll, MD and Bruce Rounsaville, MD at Yale. The research drew extensively from the work of Alan Marlatt, PhD and others. It describes cognitive-behavioral coping skills treatment (CBT), which is a short-term, focused approach to helping cocaine-dependent individuals become abstinent from cocaine and other substances. Chapters include coping with craving, integrating CBT and medication, shoring up motivation and commitment, and reducing HIV risk.

Manual 2 (148 pages) describes research at the University of Vermont under the direction of Stephen Higgins, PhD. This treatment integrates a community reinforcement approach (CRA) with an incentive program that uses vouchers. Patients can earn points exchangeable for retail items by remaining in treatment and abstinent from cocaine. Chapters include drug avoidance skills, early counseling sessions, lifestyle change components, and relationship counseling.

The manuals are free and are available online at the NIDA web site: <http://www.nida.nih.gov/>. They can also be ordered from the National Clearinghouse for Alcohol and Drug Information (NCADI), Phone: 800-487-4889; Fax: 301-468-6433. Ask for NCADI # BKD254 (Manual 1) or # BKD255 (Manual 2). □

# What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are consensus statements from a group of experts gathered by CSAT under the leadership of a panel chairperson. CSAT first chooses the topic, then invites staff from the pertinent Federal agencies and national organizations to agree on the content of the TIP and the recommendations it will include. The draft they produce is sent widely for review and comment.

From CSAT's web page: "While each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey 'front-line' information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either panelists' clinical experience or the literature. If there is research to suggest a particular approach, citations are provided."

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**You can get TIPs via the Internet  
from the National Library of Medicine's  
home page: <http://text.nlm.nih.gov/>**

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TIPs are available by mail from NCADI or on line from CSAT's web page. "Today's technology permits access to the TIPs documents not only in print but online as well. The TIPs can be accessed via the Internet on the National Library of Medicine's home page. The move to electronic media also means that the TIPs can be updated more easily so they continue to provide the field with state-of-the-art information."

**Contact Information:** Anyone interested in becoming involved in the TIPs development process (as a field reviewer, panelist, or writer) should send email to [sclunies@samhsa.gov](mailto:sclunies@samhsa.gov).

**Ordering Information:** Up to five free hard copies of TIPs can be ordered from the National Clearinghouse of Drug and Alcohol Information (NCADI) by accessing its electronic catalog at <http://www.health.org/pubs/catalog/ordering.htm> or by calling 1-800-729-6686. Below is a list of each TIP and its NCADI order number.

**TIP 1 State Methadone Treatment Guidelines** 222 pages BKD98

**TIP 2 Pregnant, Substance-Using Women** 90 pages BKD107

**TIP 3 Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents** 270 pages BKD108

**TIP 4 Guidelines for the Treatment of Alcohol and Other Drug-Abusing Adolescents** 109 pages BKD109

**TIP 5 Improving Treatment for Drug-Exposed Infants**  
Guidelines for monitoring and evaluating programs that treat drug-exposed infants. 94 pages BKD110

**TIP 6 Screening for Infectious Diseases Among Substance Abusers.** 160 pages BKD131

**TIP 7 Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System** 129 pages BKD138

**TIP 8 Intensive Outpatient Treatment for Alcohol and Other Drug Abuse** -- documents the clinical viability and utility of intensive outpatient treatment; stresses the range of services. 104 pages BKD139

**TIP 9 Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse** 114 pages BKD134

**TIP 10 Assessment and Treatment of Cocaine-Abusing, Methadone-Maintained Patients.** 117 pages BKD157

**TIP 11 Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases** -- two screening instruments, one for substance abuse and one for infectious diseases; guidelines for their use. The instruments are designed for linking substance abuse treatment with treatment for HIV/AIDS, TB, and STDs. 74 pages BKD143

**TIP 12 Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System** 101 pages BKD144

**TIP 13 The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders** 74 pages BKD161

**TIP 14 Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment** 96 pages BKD162

**TIP 15 Treatment for HIV-Infected Alcohol and Other Drug Abusers** -- identifies a spectrum of core services and treatment approaches that should be available to all HIV-infected patients in treatment for substance abuse, regardless of the setting in which they receive care. 171 pages BKD163

**TIP 16 Alcohol and Other Drug Screening of Hospitalized Trauma Patients** -- recommends alcohol and blood screening (blood and urine) of injured patients age 14 and older at hospital admission. A comprehensive alcohol and drug use assessment is outlined, and some brief intervention techniques are described. 96 pages BKD164

**TIP 17 Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System** 116 pages BKD165

**TIP 18 The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers** 132 pages BKD173

**TIP 19 Detoxification From Alcohol and Other Drugs** 95 pages BKD172

**TIP 20 Matching Treatment to Patient Needs in Opioid Substitution Therapy** Opiate-addicted persons often need a broad range of services in addition to opioid substitution therapy. Research has shown that providing these services as part of the therapy program greatly increases retention in treatment and improves outcomes. The TIP outlines a comprehensive assessment process for identifying patient needs and describes core treatment elements to address those needs. 136 pages BKD168

**TIP 21 Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System.** This TIP introduces a new definition of diversion, concentrating on diverting youth already involved with the juvenile justice system. The TIP provides hands-on information about community collaboration to establish a diversion program for youth whose court involvement is associated with AOD abuse. 131 pages BKD169

**TIP 22 LAAM in the Treatment of Opiate Addiction** - levo-alpha-acetyl-methadol (LAAM), an opioid agonist medication approved by the Food and Drug Administration in 1993. This TIP describes the medication itself, its modes of action, possible side effects, and interactions with other medications. Separate chapters describe treatment planning, program administration, and regulatory and ethical issues. 66 pages BKD170

**TIP 23 Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing.** This TIP provides clinicians, administrators, and policymakers with the information they need to plan, implement, monitor, and evaluate treatment drug courts. The number of programs that integrate drug treatment into the pretrial processing of criminal cases has grown exponentially in the last several years: this TIP highlights the most successful of them and presents relevant information on financial, legal, and ethical issues. 65 pages BKD205

**TIP 24 A Guide to Substance Abuse Services for Primary Care Physicians** 168 pages BKD234

**TIP 25 Substance Abuse Treatment and Domestic Violence** Useful techniques for detecting and eliciting such information are supplied, along with ways to modify treatment to ensure victims' safety and to stop the cycle of violence in both parties' lives. 152 pages BKD239

**TIP 26 Substance Abuse Among Older Adults** -- people 60 and older. The TIP details how disorders typical in an aging person, such as dementia and delirium, can mask or mimic the effects of alcohol and prescription drug abuse. Elderly-specific screening and assessment instruments are included, along with adjustments to the DSM-IV criteria for substance abuse and dependence. 173 pages BKD250

**TIP 27 Comprehensive Case Management for Substance Abuse Treatment.** Research and clinical experience indicate that substance abusers have better treatment outcomes if their other problems are addressed concurrently. This TIP gives information on performing case management for multi-problem clients. It outlines all the leading case management models, explains how to establish linkages, and details how case management fits into a managed care environment. 121 pages BKD251

**TIP 28 Naltrexone and Alcoholism Treatment.** Naltrexone, a narcotic antagonist marketed under the name "ReVia," is the first new medication in 50 years approved for the treatment of alcohol dependence. This TIP aims to educate clinicians about the value and appropriate use of naltrexone, help break down resistance to supplementing standard treatment for alcoholics with pharmacotherapies, and enlarge understanding of basic neurological and preclinical research about the addictive process. 94 pages BKD268 □

## Office-based Methadone Maintenance

Two pilot projects are underway, one in New York and one in Connecticut, on physician office-based methadone maintenance. (See CSAM NEWS, Spring 1998) During the 1998 meeting of the American Methadone Treatment Association, the projects were reviewed in a workshop given by Edwin Salsitz, MD of Beth Israel Medical Center and Richard Schottenfeld, MD of Yale. In his introduction to the workshop, Doctor Schottenfeld described the expected effects. Making methadone maintenance available from physician's offices may:

- expand the availability of narcotic replacement therapy, and increase the number of patients who can be treated. Transferring stable patients who need only limited services to a medical office opens spaces for new patients to enroll in the narcotic treatment program where the full array of comprehensive services is available to them.
- increase access and convenience for patients. Primary care clinics and physicians' offices are more numerous and more widely dispersed than narcotic treatment programs. Patients admitted to an office-based program may get larger take-home supplies and thus may not be required to come to the program so frequently.
- improve the coordination of medical treatment with the treatment for narcotic addiction
- expand the reach of narcotic agonist therapy to some patients who have avoided methadone maintenance programs but who may be under the care of the physician for other medical disorders
- decrease the stigma associated with narcotic dependence and with methadone maintenance
- medicalize the treatment for narcotic addiction and integrate it into general medical care
- increase the likelihood that third party payments may cover agonist replacement treatment
- reduce the exposure of more stable patients to those newly in treatment and thus move the more stable patients further from the drug culture □

The California Society of  
Addiction Medicine  
presents its  
1998 Community Service Award  
to  
**Ruth King**  
in recognition of  
her tireless efforts to provide  
addiction treatment services for women,  
especially single women with children,  
and for the deaf.

Her leadership in the addiction community  
and as Executive Director of the  
CLARE Foundation in Santa Monica  
has brought advocacy and hope  
to many of those often neglected.

*Presented on October 8, 1998  
during CSAM's twenty-fifth annual meeting  
at the Biltmore Hotel, Los Angeles*



**Top:** Ruth King with the two presenters of the 1998 Community Service Award, Margaret Yates with Jokichi Takamine.

**Below:** ASAM President G. Douglas Talbott and CSAM President Gail N. Shultz with Ruth King.



**1998 Review Course Planners:** Gary Jaeger, Steven Eickelberg and John Chappel. Not in the photo: Mickey Ask and Nick Rosenlicht.

The California Society of Addiction Medicine  
presents its  
1998 Vernelle Fox Award  
to  
**Garrett O'Connor, MD**

for the lasting contributions he makes  
through his deeply held and forcefully articulated  
advocacy for humane and effective treatment  
for all alcoholics and addicts,

in recognition of his expertise  
in the treatment of highly specialized populations  
such as pilots and physicians,

in appreciation of the ways in which  
he has advanced awareness and understanding of  
the interrelationships and integration  
of addiction medicine, psychiatry,  
recovery and spiritual change,

in tribute to the creativity and unflinching honesty  
with which he teaches and enlightens.

He is a force in the California Society's history.

We can count on him to bring our attention to core issues  
and to be a voice for insight and integrity.

We know him to be a vital, provocative,  
maddening, entertaining, loving presence.

*Presented on October 9, 1998  
during CSAM's twenty-fifth annual meeting  
at the Biltmore Hotel, Los Angeles*



**After the Awards Dinner:** Bill Brostoff, Gail Jara, Gail Shultz, Barry Rosen, Garrett O'Connor, Ihor Galarnyk, Fionnula Flanagan, Peter Banyas, Turk O'Connor, Mary Cleary, Matthew O'Connor, Julie O'Connor, Steve Eickelberg

## Restrictions Eased on Prescribing for Pain for a Terminally Ill Patient

The California legislature passed two bills this September, and Governor Pete Wilson signed both of them, to ease restrictions on prescribing for terminally ill patients with pain. Copies are available from the CSAM office.

One, AB2305, provides that a physician will not be subject to discipline for excessive prescribing if he/she is in compliance with the California Intractable Pain Treatment Act.

The other provides that a prescription for a Schedule II drug for a patient who has a terminal illness does not require a triplicate prescription if the prescriber certifies, on the prescription, that the patient is terminally ill by writing the words "11159.2 exemption." (Section 11159.2 was added to the Health and Safety Code by passage of AB2693.)

For the purposes of this section, a "terminally ill" patient is one who has been determined to be suffering from an incurable and irreversible illness which will bring about the death of the patient within one year, if the illness takes its normal course.

## New Programs for Treatment for Adolescents

Passage of AB1784 requires California's Department of Alcohol and Drug Programs to work with counties and treatment providers to establish community-based residential and non-residential treatment programs for adolescents with funds which were included in the Budget Act of 1998. The Department must prepare criteria, again in cooperation with counties and treatment providers, for what the treatment program will be, the criteria for participation and for funding. A local match of at least ten percent is specified in the newly added Section 11759 of the Health and Safety Code.

## Connecticut Hospitals Must Screen Trauma Patients for Alcohol Abuse

Beginning October 1, 1998, outpatient surgical facilities, outpatient clinics or short term general hospitals in Connecticut are required to screen each trauma patient for alcohol and substance abuse and note the result in the patient's record. (Public Act No. 98-201.) Those who read the ASAM website ([www.asam.org](http://www.asam.org)) know that the passage of this bill was the culmination of several year's work and advocacy by ASAM member Peter Rostenberg

A copy of the full text of the Connecticut statute is available from the CSAM office.

## Parity for Substance Abuse Treatment

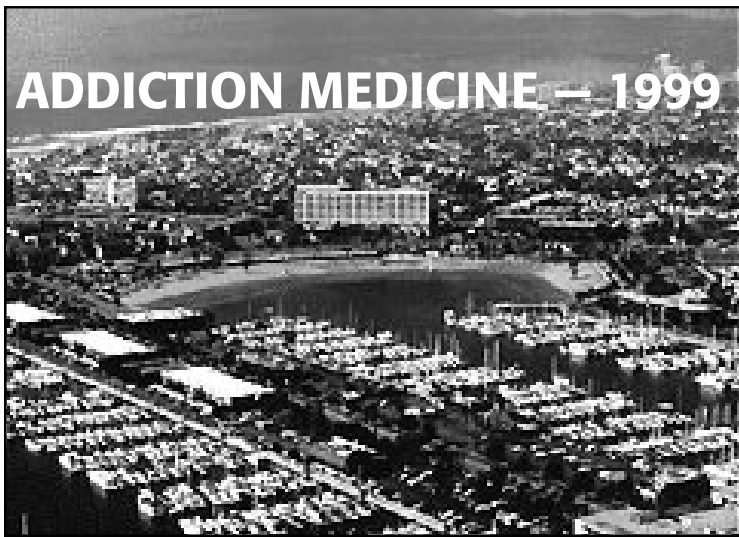
The House bill called the Drug Demand Reduction Act of 1998 (Ramstad, R-Minnesota) was supposed to include a provision for parity for substance abuse treatment, but that portion of the bill was amended out at the last minute. Stricken out was the requirement which would have prevented private insurance plans that offer substance abuse benefits from imposing spending caps, co-payments, or other restrictions different from those imposed for medical and surgical benefits, according to a report in by Todd Zwillich in *Clinical Psychiatry News*, October, 1998.

The whole bill failed passage in this session of the legislature and is expected to be introduced again next year.

The issue of parity for treatment of alcoholism and other drug dependence has received much attention and advocacy recently, especially from the Office of National Drug Control Policy headed by General Barry McCaffrey.

## STATE OF THE ART IN ADDICTION MEDICINE – 1999

OCTOBER 13-16  
MARINA BEACH MARRIOTT  
MARINA DEL REY



# The Georgia Chapter of ASAM

The Georgia Chapter of ASAM is a dynamic advocate for substance abuse treatment. GASAM gets some of the credit for changes to the state law giving Georgia's juvenile courts the authority to require teenagers convicted of DUI offenses to attend a substance abuse clinic or program. When a welfare reform package was in the state legislature, GASAM insisted that treatment for substance abuse be available to those being

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**What's behind this creative work?  
A dynamic team of ASAM members paired with a veteran lobbyist for health and education issues.**

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moved from welfare to work. Legislation introduced by a group of substance abuse advocacy groups, including GASAM, created a multi-agency group to report to the legislature on how Georgia's public funds are spent for prevention and treatment of substance abuse and how the dollars could be spent more effectively. Then they went to work to insure that the legislation required appointment of GASAM representatives. President John Lentor, MD, and Past President Elizabeth Howell, MD, were appointed to the Study Group. The Study Group issued its final report in January, 1998, with eight recommendations. A copy of the Final Report of the Georgia Senate and House Prevention and Treatment of Substance Abuse Committee is available from the CSAM office.

What's behind this creative work and these successes? A dynamic team of ASAM members paired with a veteran lobbyist for health and education issues, Lasa Joiner of JLH Consulting.

Joiner has been a professional lobbyist for 13 years with a client list which includes the Georgia Psychiatric Physicians Association (GPPA) and others from the non-profit world such as the public libraries and school libraries.

Elizabeth Howell, MD, a past president of GASAM and the founding chair of ASAM's Section on Communication and Technical Assistance, brought Joiner into the ASAM network in 1993. Howell is the chair of the Georgia Psychiatric Association's Legislative Committee and works with Joiner for both GPPA and GASAM.

Joiner provides the knowledgeable voice of GASAM in the capitol on legislation and regulation. She testifies before the legislature and is in regular contact with the state agencies. She herself is the Chair of the Georgia Board of Human Resources which oversees the State Divisions of Public Health; Mental Health, Mental Retardation and Substance Abuse; and Family and Children's Services. Her position alerts her to issues related to substance abuse as they emerge. She, in turn, alerts the physicians in GASAM to the opportunities to influence Georgia public policy and public programs for the benefit of substance abuse patients.

In 1985, she started her own firm, JLH Consulting, representing non-profit advocacy organizations and professional trade associations. Joiner and her staff provide administrative services for GASAM in addition to her work with the state legislature and state government. They maintain a membership database, publish a directory of GASAM members, and organize an annual dinner meeting for the 140 members of GASAM.

For GASAM, JLH Consulting helps plan speakers for GASAM's annual dinner meeting and has coordinated two Southeast Regional Addiction Conferences. Other than those activities, the focus of this State Chapter is on legislative/regulatory

activities and the State Capitol. Joiner said they testify on a variety of bills. When she sees the relationship a certain bill or proposed regulation could have to the availability of treatment, she will notify GASAM physicians. For example, when a bill proposed changes in the penalties imposed by drug courts, GASAM advocated for using the fines to pay for drug treatment. When the Department of Corrections sought to give priority admission to treatment programs to prisoners being released onto probation, GASAM promoted the need for treatment to be provided in prison, not after release -- which would further crowd already bulging community treatment programs.

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**GASAM always looks for opportunities to increase awareness and understanding among the legislators and the state government personnel.**

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Under Joiner's leadership, GASAM always looks for opportunities to increase awareness and understanding among the legislators and the state government personnel. "We need to find ways to reduce the stigma which people still associate with alcoholism and drug dependence," she said. When *Moyers on Addiction* was ready to be shown on Public Television early in 1998 and William Cope Moyers had been invited to appear in Atlanta, GASAM cosponsored a reception for the members of both houses of the state legislature to meet him and see an early screening of the 3-hour program. "Events and activities like that increase our personal understanding of the issues and can give the legislators an appreciation of what treatment means." □

## After I Retire

What am I going to do after I retire? After some in-depth thought it became obvious to me that what I really want to do is follow the principles of recovery that I have learned working with recovering persons and try to model myself after many of the recovering physicians that I have worked with in the Diversion Program. Then whatever I do in retirement will fall in place.

I have been so greatly impressed with the part of recovery which is beyond the physiological aspects of the human body. I have been constantly amazed at the radical change of perspective that takes place in recovery and how strong the adverse consequences have to be for many physicians before the physician can embrace the change. Intellect does not seem to be a factor.

We can call that change spiritual, turning it over, magic, growth or change of life style. No matter what we call it, it opens up a new way for the physicians to look at themselves and life in general. I hope to be able to carry that perspective of life with me in the coming years.

— Chet Pelton



## Program Manager for the Diversion Program

The Medical Board of California expects to announce the opening for a program manager sometime after the first of the year. The position will be open to those in state service who meet the criteria or qualifications.

### Confidential Assistance Line

The California Medical Associations's 24-hour phone service provides completely confidential assistance. Physicians volunteering their services will return your call within two hours.

**Northern California**  
**650/756-7787 (new area code)**

**Southern California**  
**213/383-2691**

These numbers may be used by anyone who is concerned about a physician or a physician's spouse who may have a problem.

## MBC Task Force on Diversion announces a meeting in January

The Medical Board of California appointed a 5-member Task Force to review the Diversion Program for Physicians last year after the Center for Public Interest Law criticized the program on several counts and after the Legislature's Sunset Review Committee, conducting a comprehensive review of all the activities of the Medical Board, questioned whether the Diversion Program should continue and if so whether it should be subcontracted out to be operated by a private agency (or "privatized"). (See *CSAM NEWS* Spring, 1998)

During its first meeting, Karen McElliott, Chair of the Task Force, said she wants the Task Force to undertake a deliberate and long-term evaluation of the Diversion Program — in particular, the evaluation of Diversion Group Facilitators, evaluation of Diversion participants before they graduate from the Program, monitoring the participants, evaluation of the caseload of the Program's Case Managers, review of the costs of the Program and the potential for cost savings, and an evaluation of privatizing some or all of the Program.

Other members of the Task Force are Robert del Junco, MD, Philip Pace, Kip S. Skidmore, and Alan E. Shumacher, MD. Mr. Skidmore said, during the June meeting, that he is less interested in the operational aspects of the Program and more interested in the monitoring and control of the participants, especially the ability of the MBC to assure the public that physicians in Diversion who should not be practicing medicine are, in fact, not practicing. Mr. Pace said his emphasis would be on assuring that there is good value for the money begin spent on the Diversion Program. (The current annual budget is approximately \$800,000.)

The Task Force announced its next meeting will be on Wednesday, January 20, 1999, in San Diego. All meetings are open to the public.

Representatives of the Liaison Committee to Diversion, CSAM and the California Medical Association will attend to advocate for continuing the Program under the Division of Medical Quality of the Medical Board. Gary S. Nye, MD will represent CMA. Garrett O'Connor, MD will represent CSAM. William S. Brostoff, MD will speak for the Liaison Committee.

The Liaison Committee to Diversion is make up of representatives of CMA, CSAM, and the Medical Board, along with the Chairperson of each of the five Diversion Evaluation Committees and a representatives of the Diversion Group Facilitators. Staff from the Diversion Program and from the three organizations participate in the meetings. The Liaison Committee, founded in 1982, is charged to serve as an information sharing and clarification body regarding Diversion Program policies and procedures, to serve as a forum for consideration of information from outside the Program and for discussion of long-term plans, and to develop and conduct quality assurance activities for the Diversion Program.

The recommendations made to the Diversion Program and to the Medical Board as part of the Liaison Committee's QA/QI function include:

- criteria for selection of members of Diversion Evaluation Committees (DECs)
- each physician applying to Diversion should have a comprehensive evaluation by a qualified physician
- the DEC should make a diagnostic formulation at the first meeting with the physician
- a description of the role and responsibilities of the DEC member who serves as a Case Consultant, including two measures to evaluate whether a Case Consultant is carrying out the intended functions
- if any DEC member attends fewer than 60% of the meetings of his/her DEC, the Program Manager should make a report to the Liaison Committee with an evaluation of the situation, so that a QA review can be done
- a list of elements which should be included in any report of a medical/psychiatric evaluation of a physician for Diversion
- the Diversion Case Manager (formerly called the compliance officer) should have a current clinical record for each physician in Diversion
- a description of the elements which should be in the record of each physician in Diversion
- the performance of Diversion Case Managers should be the subject of quality improvement activities. The role and functions of the Case Manager should be carried out for the joint purposes of a) protecting the public and b) keeping the physician in Diversion and progressing toward treatment goals.
- each Diversion Group Facilitator should have a qualified clinical supervisor who has knowledge and experience in clinical supervision and chemical dependence. In addition, the Diversion Program staff should have a licensed therapist who has oversight of the facilitators.
- the Diversion Group Facilitators should use a uniform format for a problem list which the DEC members can use when the DEC meets with a physician; list of elements which should be in the Group Facilitator's record; recommendation that the Group Facilitators keep the problem list current

The charge to provide quality assurance for the Diversion Program was added in 1993 when the Medical Board asked the Liaison Committee to assume the QA/QI function. That request was made after another, earlier Medical Board Task Force on Diversion highlighted several flaws and potential flaws in the Program. The 1993 Task Force was chaired by John Kassabian, MD, the then Chair of the Board's Division of Medical Quality.

*For information about the meeting of the MBC Task Force on Diversion, call the Medical Board Office, 916/263-2389.*

□

## TECHNICAL ASSISTANCE

### Treating Nicotine Dependence Simultaneously in Chemical Dependence Treatment Programs

With funds from Proposition 99, the tobacco tax initiative, Alameda County Tobacco Control Program supports a network for treatment providers to help those interested in addressing nicotine dependence in their alcohol and drug treatment programs. Directed by Catherine McDonald, MD, the network holds regular meetings and provides support, training, consultation, materials and resources to encourage and assist programs to implement "new model" protocols which integrate treatment for nicotine addiction with other substance abuse treatment. Training and consultation services are based on the manual *Drug-Free is Nicotine-Free* from the University of Medicine and Dentistry in New Jersey. Through a Project called "Addressing Tobacco in the Treatment and Prevention of Other Addictions" UMDNJ publishes the manual and a newsletter.

The manual is a step-by-step guide for developing tobacco-free policies, dealing with staff and client issues, and initiating assessment, diagnosis, education and treatment of nicotine dependence in the chemical dependency treatment setting. It includes model policies and model treatment protocols. It is available for \$50.00 plus 7.50 shipping and handling from Addressing Tobacco...Project, 78 New Street, 3rd Floor, New Brunswick, NJ 08901-1233 or call 732-846-4338. Make checks payable to UMDNJ-Addressing Tobacco.

Thunder Road Drug Treatment Center in Oakland provides the project offices. The Project Coordinator is Judy Gerard. For more information, call her at 510/653-5040, x323, voice mail #104.

**EDITORS**  
Donald R. Wesson, MD  
Gail Jara

**PRODUCTION**  
Michael Barack

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The California Society is a specialty society of physicians founded in 1973. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine.

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I had planned to go at night. I was already a physician, and I didn't see why should I drop everything to go to school again. I applied to all the law schools in the D.C. area which had a night school program, but at the same time I also acted on one fantasy — I applied to Harvard even though I wasn't prepared, economically, to go there. When I got accepted, I just closed up shop, sold my car and went off to live in the dorm for 3 years.

To support myself, I took a job as Medical Director of a methadone maintenance program in Massachusetts, so **I gained my first two years of substance abuse experience during law school.**

While I was at Harvard, I got a pitch from Senator Kennedy's staff to come check out the Hill. And I did. Just before I arrived, the power in the Senate had shifted in the election and the Democrats lost the majority. They became the minority party, which meant that in 1981 I was working with a staff that had only 6 months experience *not* being in charge. The majority party has lots of staff and lots of resources, but the minority party does not. On Kennedy's markedly reduced staff, I was a "two-fer." I was interested in public policy and I was a physician with some science background.

**Over the course of three years, I became reasonably proficient on Capitol Hill.** I won't claim that I was a superstar, but I did learn the process.

One of the things I brought was the ability to work with a broad spectrum of individuals. An ability to build consensus turns out to be more important when you don't have the power and weight of the majority. I learned to work with both the Democrats and the Republicans; I had no choice. I dealt with special issues like mentally retardation, Baby Doe questions, right to life, the right to die. On a number of delicate issues I think I redeemed myself.

*Q. Why did you leave Washington?*

After three years, I decided that it was time to move on. Because I had been out of medicine for six years, I needed a transition back into clinical work, and I decided I would do a fellowship. **I found an ad in the *New England Journal of Medicine* advertising a two-year fellowship in substance abuse at the San Francisco VA, and you know the rest.**

I came here in 1984 and met Peter Banys, Don Wesson, Don Tuscel, Sharon Hall, and many others. Wesson introduced all the Fellows to CSAM and to writing. I wrote two or three articles for the CSAM newsletter during my fellowship.

After the fellowship, I was asked to stay on. I ran an inpatient unit for three years. Then I was asked to develop an out-patient dual diagnosis program for post-traumatic stress disorder and substance abuse. Then we added HIV. I have been doing that for the past 8 years, as well as other, "extracurricular" activities. For example, I became active on the Board of Directors of **California Advocates for Pregnant Women**. In 1988-89 there was a move afoot to punish women substance users and there weren't many people who knew much about women substance users. **I came at it from the legal and ethical perspective and began to raise questions.**

When people were talking about the effects of cocaine on pregnancy, I asked, "What about the effects of cigarette

smoking...and how do we separate these things out, and how do we know what one is causing and the other isn't?"

I have this naive belief in good science. I recognize the limits of good science and I understand that science doesn't have all the answers. But, being African American, I suppose I'm always skeptical of situations where people rush to judgment. I identify with people who are being castigated in the absence of good science. The facts aren't there; the proof isn't there, yet these women were being sent to jail or metaphorically strung up. **The fact that bad science was being misrepresented as good science troubled me.**

**My involvement with workplace drug testing** began in a similar way when DOT began promulgating regulations around 1988. I found that things were being misrepresented. I found that some labs were claiming results that didn't happen; they were claiming things that weren't true. **My legal training prepared me to search out the facts.**

The labs then were saying you could not test positive for opioids from eating poppy seeds. I thought, "O.K. that's what the labs say; let me see what the literature says." I found a rich literature, even distinguishing the opioid residue in poppy seeds of various types. The lab people were saying you can't test positive for methamphetamine as a result of use of a Vicks inhaler. So I looked and I found a study languishing in the dust which had shown the opposite.

In workplace drug testing, the standard was that the worker would be protected against arbitrary decisions, but women and their kids had no such protection. They were being indicted on the basis of screening tests. In the work place, there was a two-tiered analysis (screening test confirmed by a second, more sophisticated lab test) plus a step in between in which someone was assigned to explore the possibility that maybe a mistake had been made. Somebody applying for a job got more protection than somebody who just gave birth to a baby. I said, "What's wrong with this picture?" **It seemed unfair.**

*Q. Does this move to Washington represent your decision that it's time to move on, or were you recruited?*

Winning appointment to federal positions is a competitive process. I had applied for this position in 1993, but it was David Mactus who was appointed Director of CSAT at that time, to succeed Beny Primm, MD. Much as I like San Francisco, I have always hoped to return to Washington, so I applied again, and this time I was selected.

San Francisco is the most beautiful city in the country as far as I am concerned. The people and the experiences have been equally wonderful. I got involved with CSAM and ASAM, both as a teacher and a participant in the activities. **In my mind, a lot of the things I've done have been because of ASAM and CSAM.** A lot of the inspiration is because of ASAM and CSAM. That's why I've liked the addiction field. I've been personally given a lot of opportunities. And I think I've benefitted tremendously from those opportunities. It's been people in the field that have given me those opportunities. □

## News About Members

**Don Wesson** left Merritt Peralta to establish a new organization with an office in Berkeley with a research staff of eight, conducting clinical trials of new medications for treatment of alcoholism and other drug abuse. Current studies include (1) a NIDA-sponsored controlled clinical trial of naltrexone in treatment of cocaine/alcohol dependence, (2) a controlled clinical trial of acamprosate in preventing relapse to alcohol dependence, and (3) a controlled clinical trial of a D1 antagonist for facilitating abstinence from cocaine. The last two are multi-center studies sponsored by pharmaceutical companies. The new organization, Friends Research Associates, is a division of Friends Research Institute of Baltimore.

**Al Rothman** is now the Medical Director of the Chemical Dependency Treatment Program at Merritt Peralta Institute.

**Nick Rosenlicht** has opened a private practice of psychiatry and psychopharmacology in Berkeley. He continues in his position at the San Francisco VA.

**Bill Brostoff** has closed his practice of internal medicine in Marin County and is now with the Chemical Dependency Treatment Service at Kaiser Vallejo.

**Max Schneider** is planning a fourth ASAM/People to People trip – this time to Portugal and Spain in the Fall of 1999. The previous trips have been to Russia, China and South Africa. More information is available from him at 3311 East Kirkwood Ave., Orange, CA 92869-5211 or e-mail Alexron@aol.com

**Doug Tucker** has returned to the San Francisco Bay Area after completing a Fellowship in Forensic Psychiatry at Rush Presbyterian St. Luke's Medical Center in Chicago. He is in private practice in Berkeley.

**David Smith** was honored by the Northern California Psychiatric Society with the Geri Taylor Memorial Award which recognizes a non-member who has made an exceptional contribution.

**Don Gragg** wrote to say, "my son Gary and I reached the summit of this 20,125 foot peak (Kanglachen) in the Indian Himalaya on August 3 after hiking about 80 miles over three passes of 16,000 feet and many lower ones. Arrived home on August 6, tired, jet-lagged and with Delhi Belly, but recovering nicely. Oh the joys of retirement!!"



## You Can Write For

**The Alcohol and Drug Wild Card: Substance Abuse and Psychiatric Problems in People with HIV** by Joan Ellen Zweben, PhD, published by the UCSF AIDS Health Project. 98 pages, indexed with references. From the introduction, "Substance use often functions as the "wild card" in AIDS care, influencing the diagnosis of HIV-related and psychiatric disorders as well as the efficacy of medical and therapeutic interventions. ... This monograph focuses on the reduction or elimination of substance use. It pays special attention to assessment and diagnosis because distinguishing among the three conditions is crucial to treating them." The section on Addiction Treatment includes foundations of addiction treatment, motivating clients toward abstinence, recovery: phases and approaches, severely mentally ill alcohol and drug users.

Copies are available from UCSF AIDS Health Project, Box 0884, San Francisco 94143. 415/502-4930. [www.ucsf-ahp.org](http://www.ucsf-ahp.org)

**Drug-Free is Nicotine-Free: A Manual for Chemical Dependency Treatment Programs**, a training manual for incorporating treatment for nicotine addiction in a chemical dependency setting. See page 13.

**NIDA therapy manuals on treatment of cocaine addiction.** See page 5.

## New Members

*As ASAM notifies us of new members, we ask each one for information to put in the newsletter.*

**Marina Khubesrian** is Medical Director of Glendale Adventist Alcohol and Drug Services and is Clinical Faculty with Glendale Adventist Family Practice Residency Training Program.

**Robert S. Martin** is Associate Clinical Professor of Psychiatry at the University of Southern California and Medical Director of the Addiction Medicine Program at Cedars Sinai Medical Center, Los Angeles.

## CONTINUING MEDICAL EDUCATION

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*ASAM MRO Course*

### **The Basics of Being a Medical Review Officer –**

Friday morning

### **The Latest on the Science, Rules and Art of Drug Testing and Assessment –**

Friday 1 pm to Sunday noon

February 26-28, 1999 in Chicago;

July 16-18, 1999 in Washington D.C.

**Credit:** Up to 19 hours of Category 1 credit

**For information:** ASAM, 4601 North Park Drive, Suite 101, Chevy Chase, MD 20815. Phone: 301/656-3920.

**MRO Certification:** The Medical Review Officer Certification Council (MROCC) will offer the Medical Review Officer Certification Exam immediately following each ASAM course. A separate application /eligibility form must be requested from the MROCC, 9950 West Lawrence Ave., Suite 106A, Schiller Park, IL 60176. 847/671-1829.

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*ASAM's 30th Annual Medical Scientific Conference*

### **American Society of Addiction Medicine**

April 29-May 2, 1999 / New York City Marriott Marquis

**Credit:** Up to 21 hours of Category 1 credit

**For information:** ASAM, 4601 North Park Drive, Suite 101, Chevy Chase, MD 20815. Phone 301/656-3920

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### **Critical Issues in Addiction**

May 21-23, 1999

UCSF Laurel Heights Conference Center, 3333 California Street, San Francisco

**Sponsored by** Haight Ashbury Free Clinics and the California Collaborative Center for Substance Abuse Policy Research

**Topics:** Day 1 - Basic Science, chaired by David Smith, MD and Ivan Diamond, MD. Day 2 - Prescription Drug Use and the Elderly, chaired by Donald Wesson, MD and Carroll Estes, PhD.

Day 3 - Treatment on Demand: A Policy Imperative, chaired by Joe Gudysh, PhD and Dorothy Rice.

Keynote speaker: Philip Lee, MD.

**Credit:** 18 hours of Category 1 credit.

**For information:** call 415/565-1904

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*22nd Annual Scientific Meeting*

### **Research Society on Alcoholism**

June 26 - July 1, 1999 / Fess Parker's Doubletree Resort, Santa Barbara, CA

**For information** call 512/454-0022. RSA Web Site: [www.rsa.am](http://www.rsa.am)

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