

# CSAM NEWS

Newsletter of the California Society of Addiction Medicine

Spring 1999

Vol. 25, No. 3

AB88

## Parity for Coverage of Major Mental Illnesses – But Not Chemical Dependence

A last-minute veto by Governor Pete Wilson last September killed a bill which had passed the Assembly and the Senate – it would have required parity of insurance coverage for treatment of 7 biologically-based severe mental illnesses and said they could be subject to no different restrictions than are placed on medical conditions. The bill contained no reference to treatment for substance abuse disorders. Addiction was not included.

The same bill is back as AB 88 with the hope that Democratic Governor Gray Davis will sign it. Once again, the current bill contains no reference to substance use disorders.

AB 88 is narrowly focused; it specifies 9 severe mental illnesses which should be covered:

- schizophrenia
- schizoaffective disorder
- bipolar disorder (manic-depressive illness)
- major depressive disorders
- panic disorder
- obsessive-compulsive disorder
- pervasive developmental disorder or autism
- anorexia nervosa
- bulimia nervosa

There is no language excluding addictive disorders; they simply are not included.

Sources close to the legislative process say they believe that an attempt to add treatment for chemical dependence would eliminate any chance the bill has for passage because opponents will argue that premium costs

*Continued on page 3*

### Inside:

- Human Ecological Disaster
- 1998 Certification/Recertification Results

## Janis Thibault Appointed Program Administrator for Diversion

Janis Thibault, MFCC, has been named Program Administrator for California's Diversion Program for Physicians, replacing Chet Pelton who retired last July. The position has been open since then, with John Lancara, Chief of Enforcement, filling in for some functions.



*Janis Thibault, MFCC*

Thibault has been a Case Manager with the Diversion Program since 1994. Before 1994, she was in private practice in Sacramento as a marriage and family counselor and worked in hospital-based chemical dependence and dual diagnosis treatment programs at Starting Point in Sacramento and CPC Sierra Vista. She has a Masters Degree in counseling from the University of San Francisco and a Bachelor of Science from UC Davis.



*From left: John Lancara, Janis Thibault, and William Brostoff, MD*

Commenting on her new role, she said, "I want to help others clearly understand what we do and how we do it. We have a rather sophisticated program here, and people should know how it

works." She said she wants to work cooperatively with the whole community of people who contribute to and support the Program and its goals.

The Program Administrator serves under the general direction of the Chief of Enforcement and is responsible for the overall functioning of the Diversion Program. She supervises Compliance Officers, the analytical staff who collect and analyze data, clerical employees. She indirectly supervises ten facilitators who conduct group meetings for physicians in Diversion, and indirectly supervises five Diversion Evaluation Committees, according to the State Personnel Board's duty statement.

She will be the primary spokesperson for the Diversion Program. To contact her call 916/263-2608. □

# Human Ecological Disaster

BY DAVID BREITHAUPT, MD

**D**ying, oil-soaked sandpipers on the beaches of Coos Bay are like the urban beggars and homeless camping out in San Francisco's United Nations Plaza. An oil spill is a scene of terrible loss and ugliness. So are the scenes that confront us in urban areas across America.

My contention is that 80% of beggars, homeless, prison inmates, and the residents of locked mental health facilities represent the end-stages of repeated "spills" -- they are ill with disabling mental illness and/or addiction and have received no treatment, inadequate treatment, effective treatment with poor compliance on their part, wrong venue for treatment (i.e. a prison instead of a hospital) and, most discouraging of all, a lack of support for treatment by medical and hospital professionals because "it does not work," or in the case of alcoholism/addiction "it is not a disease in the first place."

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**Human ecological disasters are the result of human negligence, discriminatory insurance practices of health delivery systems, public apathy and shareholder greed.**

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Any disabling illness impacts on education, work, relationships, and family structure. Behavioral illness plus a life in chaos equals disaster. Just as the oil-soaked sandpipers are a result of our total dependence on petroleum products, unreliable transport systems, storms, the fragility of the ecologic setting, vulnerability of the wildlife, and public and corporate apathy and greed, so are human ecological disasters the result of human negligence, discriminatory insurance practices of health delivery systems, public apathy and shareholder greed.

If I can persuade you to understand the issues and join in an effort to rescue us all from this disaster, we can band together to confront the public and corporate apathy, stupidity and greed that result in refusing or ineptly dealing with mental illness and addiction in their early, more treatable, phases. This is best done by assuring parity of money and resources for treatment of all disease and recognition of the ultimate cost to everyone of failing to treat illnesses that generate aberrant behaviors. Cancer of the prostate does not fill our prisons, alcoholism/addiction does.

People buy bad insurance. Employers buy bad insurance. Insurance companies sell bad policies and, in doing so, ignore actuarial reality. In 1989, one dollar spent on alcoholism treatment resulted in eleven dollars saved on alcohol related injury and illness (*Treatment Outcome Prospective Study* (TOPS) 1989). Only one HMO that I am aware of recognizes

this. Kaiser runs a comprehensive chemical dependency program. It is the right (ethical) thing to do, as well as being cost effective.

Only five states (Arizona, Minnesota, Maryland, North Carolina, and Vermont) have even a partial parity requirement -- Vermont having the most comprehensive program with the fewest restrictions. In these states costs have risen for subscribers by 3% (\$3.10 per person per month). Savings in alcohol related illness and injury are not yet clear, but even if nil, parity is the right way.

The private insurance sector's fair share of the costs should be doubled. The employed addict or mental patient is the one on whom we should be lavishing the available, good treatments -- repeatedly if necessary. Employed persons generally have some social and family structure that can aid rehabilitation. Without treatment, their brains and lives become chaotic. Then their care becomes the government's responsibility. Is that what Aetna, Prudential, Blue Shield and the others are counting on?

In 1996, government (federal, state, Medicare and MediCal and local programs) paid for 60% of the costs of treatment of mental illness and alcohol and drug abuse in the U.S. (*National Expenditures for Mental Health, Alcohol and Other Drug Treatment*, 1996, MEDSTAT Group). Private insurance covered 30% and cash payments equaled 10%. The government programs addressed acute care (detox and so-called 72-hour holds) and warehousing of the critically and chronically ill. Little is available for patients when they are in the fragile and vulnerable stabilization and recovery phases of addiction and mental illness treatment. Relapses, revolving door admissions and discharges, are the rule.

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**Breaking down denial takes time and skill. Mental illness and addiction can not be dealt with by volunteer bird washers and an occasional dedicated veterinarian.**

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It is not my purpose here to describe good comprehensive treatment but it exists, and it works. We all know many highly effective, productive human beings who are successfully dealing with their addictive illnesses.

A simple circumstance explains the majority of re-admits for mental illnesses: patients can not get their medicines, or, more likely, stop taking them because they are feeling better, or they are having adverse symptoms which they

blame on the drugs. The irony in 1999 is that we have never before had so many effective drugs for the treatment of schizophrenia, obsessive-compulsive disorder, bi-polar disease and depression. Talk therapies, monitoring, safe-living are even more important today in conjunction with psycho-chemo therapies. The very nature of both mental illness and addiction is that patients are in high denial. They do not think that they are ill. They will not stay with treatment disciplines. They act like the oil drenched otters who are terrified of the first aid givers but after being cleaned up and nursed back to survival status promptly return to their damaged habitat. Breaking down denial takes time and skill. Mental illness and addiction can not be dealt with by volunteer bird washers and an occasional dedicated veterinarian. These illnesses require many professionals and suitable venues over the lifetime of the affected human being. Their loved ones need the instruction to understand the illness and signs of relapse and to realize they are relatively powerless at controlling the disease.

Groups who should support parity of treatment and why:

1. Addicts, the mentally ill and their families -- duh!
2. Health insurance industry -- it will save them money
3. Gun Lobby -- consistent with their view that it is damaged brains that shoot people (bullets do the damage in my opinion)
4. Feminists -- 80% of all domestic abuse and violence is committed by alcoholic males
5. Law enforcement professionals -- 60% of felons in California prisons are addicts: think family court, think traffic court, think

juvenile court; reflect on the fact that court-mandated therapy depends on economic feasibility and thus is discriminatory

6. Doctors and other health care professionals -- treating alcohol-induced traumatic injury, cirrhosis, or other alcohol-induced illness without referral for alcohol treatment is bad medicine, it is unethical, it is a polluting practice.

7. Taxpayers -- the more recovering patients there are, the more taxpayers there are, not to mention inventors, innovators, poets, playwrights, etc. etc.

When was the last time that environmentally oriented citizens (GREENIES), gun lobby, feminists, the insurance industry, law enforcement, alcoholics, the mentally ill and their loved ones, county and state government, and hundreds of mayors like Willie and Jerry, all had one reason to rally around a common cause?

If interested, call or write your representative. The debate is going on now in Sacramento. For more information call Join Together (National Policy Panel on Treatment and Recovery) 617/437-1500, [www.jointogether.org](http://www.jointogether.org). Or David Breithaupt, MD, at 418/272-3308, e-mail: [dlbmlb@earthlink.net](mailto:dlbmlb@earthlink.net) □

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*David Breithaupt recently retired from the private practice of internal medicine in San Jose. He was Medical Director of the O'Connor Alcohol and Drug Treatment Center for 15 years. He is a past chairman of the California Medical Association Committee on the Well-being of Physicians and a current member of the Santa Clara Medical Society Committee.*

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### PARITY -- continued from page 1

would increase so much that it would make the cost prohibitive. Actuarial data are scarce. CSAM and ASAM are collecting data which can illustrate the financial impact on premiums and on utilization of services. One study actuarial study was conducted by Coopers & Lybrand for the Vermont Association for Mental Health, the Vermont Psychological Association and the American Psychological Association in 1997. The actuarial modeling results for mental health and substance abuse combined showed increase in premium ranging from 0.9% for 'partial parity' to 3.4% for 'comprehensive parity' in a managed care environment. The increase in fee-for-service plans ranged from 1.3% to 4.9%. A recently released Coopers and Lybrand study from Massachusetts shows similar numbers.

CSAM has asked the author of AB 88, Assemblywoman Helen Thomson, to add language to her bill which takes note of co-existing substance use disorders and recognizes that other states have adopted legislation for parity for treatment of mental illness as well as substance use disorders and have experienced minimal additional costs if medically necessary services are well managed. Ms. Thomson's legislative consultant, Nancy Chavez, has received the CSAM recommended language and has said that she will discuss it with the Assemblywoman.

### **SB 468**

A very similar bill by Senator Richard Polanco, SB 468, calls for coverage for diagnosis and medically necessary treatment of mental illness as generally applied to other medical conditions -- with one difference: it includes *all* DSM IV diagnoses but it explicitly excludes chemical dependence. SB 468 defines mental illness as "the mental disorders defined in DSM IV *except those codes defining substance abuse disorders ...*" (Emphasis added) □

An ASAM position statement was adopted in October of 1997:

*Benefit plans for the treatment of addictive disorders, in both the public and private sectors, shall be comprehensive; i.e., they shall cover the entire continuum of clinically effective and appropriate services provided by competent licensed professionals, and should provide identical coverage and funding to those benefits covering physical illness, with the same provisions, lifetime benefits, and catastrophic coverage.*

## Letter to the Editors

The Fall, 1998 (Vol.25, No.2) *CSAM News* featuring an interview with Wes Clark, new director of CSAT was outstanding. Wes is a leader in addiction medicine who has many contributions to our field. I have known and respected him for many years, but the interview provided fascinating new information about his developmental years and his future policy initiative.

We will miss Wes in San Francisco, and I have fond memories of his going away party at Joan Zweben's home, but wish him well in his important new mission.

David E. Smith, MD



**Going away party for Westley Clark:** (from left) David Mee-Lee, David Smith, Westley Clark, Ray Deutsch, Gail Jara, Don Wesson

### CALIFORNIA PHYSICIANS

## Newly Certified/Recertified by ASAM

*The following California physicians passed the ASAM Certification or Recertification Exam in 1998:*

David L. Albin, MD, *La Habra Heights*  
Diana S. Amodia, MD, *San Francisco*  
Carl Leroy Bauer, MD, *St. Helena*  
Marshall D. Bedder, MD, *Palm Springs*  
Michael Fawzy Bishara, MD, *Riverside*  
Robert Paul Cabaj, MD, *San Francisco*  
Charles Peter Connor, MD, *San Francisco*  
Craig Earl Duncan, MD, *Ventura*  
Parviz D. Fahimian, MD, *Los Angeles*  
Craig Fischer, MD, *Walnut Creek*  
David Austin Gilder, MD, *Encinitas*  
Lee M. Goldman, MD, *Carmel*  
David Gudeman, MD, *Ventura*  
Neil B. Haas, MD, *Los Angeles*  
Daniel Joseph Headrick, MD, *Newport Beach*  
Bruce S. Heischober, MD, *Redlands*  
David C. Ianacone, MD, *Fontana*  
Alison L. Jacobi, MD, *Lafayette*  
Marina Khubesrian, MD, *Glendale*

Jean Anne Marsters, MD, *San Francisco*  
Robert Melikian, MD, *Lakewood*  
Hyman J. Milstein, MD, *Los Angeles*  
Arvin L. Mirow, MD, *Encinitas*  
Timothy John O'Connell, MD, *Pasadena*  
Samuel Park, MD, *Beverly Hills*  
David R. Pating, MD, *San Francisco*  
Sina Radparvar, MD, *Long Beach*  
Kenneth A. Saffier, MD, *El Sobrante*  
Douglas E. Severance, MD, *San Ramon*  
Michael W.T. Shwayder, MD, *Marina del Rey*  
Suma Singh, MD, *San Jose*  
Clifford John Straehley III, MD, *Fair Oaks*  
Travis Svensson, MD, *San Francisco*  
Ernest J. Vasti, MD, *Stockton*  
Jaap Kaur Waraich, MD, *Fremont*  
Peter Washburn, MD, *Oakland*  
Christy S. Waters, MD, *Sacramento*  
John H. Wieland, MD, *Glendale*  
Donna D. Yi, MD, *Los Angeles*  
Rony Zodkevitch, MD, *Los Angeles*

# Buprenorphine May Become Available for Office Practice

A bill currently in the US Congress would allow certain physicians to treat opiate-dependent patients in office practice using buprenorphine. S. 324, introduced by Orin Hatch, is an amendment to the Controlled Substances Act (21 U.S.C. 823). While the bill does not specifically mention buprenorphine, it makes provisions for physicians to dispense *narcotic* drugs in Schedule IV and V that have been approved by FDA for use in maintenance or detoxification treatment. It would establish a 3-year period during which the Secretary of Health and Human Services would give waivers to physicians to use buprenorphine for up to 20 patients at a time. The physician would have to certify that he/she has, by training or experience, the ability to treat and manage opiate-dependent patients and that he/she has the capacity to refer the patients for appropriate counseling and other appropriate ancillary services.

Because there will be a requirement to certify training, experience and the ability to manage opiate-dependent patients, CSAM and ASAM are considering a pilot project to offer a program of continuing medical education about the practical aspects of using buprenorphine and to design a certification mechanism. One full-day workshop on buprenorphine will be given on Wednesday, October 6, 1999 as a pre-conference activity before the State of the Art course in Los Angeles. For more information, contact the CSAM office.

Buprenorphine in an injectable form, Buprenex, is already available in the US for treatment of moderate to severe pain. It is classified under federal law as a Schedule V

narcotic (21CFR section 1308.15. Copies of the United States Code are available at <http://uscode.house.gov/>). NIDA is developing sublingual tablets to be used for treatment of opiate addiction: Subutex, which is buprenorphine alone, and Suboxone, a combination of buprenorphine with naloxone. Because buprenorphine has some abuse potential, the Suboxone combination will probably be the form used in treatment of addiction. Although a determination of the Federal Schedule for Subutex and Soboxone has not yet been made, Schedule IV or V narcotic is considered likely.

As plans are made to increase its clinical availability, several safeguards are in place. S. 324 includes the ability for the Federal government to terminate the waiver authority with 60 days notice. A State may enact a law prohibiting the practice in that state. As for the drug itself, the combination buprenorphine with naloxone will discourage intravenous use. Furthermore, the pharmacological action of buprenorphine provides its own safety protections against fatal overdose. At low dosages, the effects are predominately those of an opiate agonist. As the dose is increased, opiate antagonist effects become increasingly dominant. Consequently, it is less likely than methadone, LAAM or heroin to produce life-threatening respiratory depression if taken in extra-therapeutic amounts.

A review of the current legal status of prescribing buprenorphine appeared in *CSAM NEWS* in 1993. Although six years old, it is still accurate. (*CSAM NEWS*, Vol. 20, No. 2)

— Donald R. Wesson, MD

## San Francisco Community Mental Health Center Substance Abuse Specialist Physician

Westside Community Mental Health Center, a community-based, nonprofit, organization is seeking a FT/PT Substance Abuse Specialist Physician to work in our general outpatient substance abuse clinic and methadone clinic. Background and work experience with adolescents and dually diagnosed adults highly desirable. Flexible hours available; full time preferred. Minimum requirements: candidates must be Board Eligible with proven substance abuse training and/or experience.

Please send CV and proof of licensure to WCMHC, Human Resources Department 1153 Oak Street, San Francisco, CA 94117 or fax in confidence to 415/552-3917. EOE/People of Color encouraged to apply.

## San Jose Job Opportunity PSYCHIATRIST

Santa Clara County, Department of Alcohol and Drug Services, is looking for a California licensed Psychiatrist with clinical and administrative skills to work with the department for 25-30 hours per week.

- Experience in chemical dependency treatment
- Knowledgeable in the area of dual diagnosis
- Willingness to prescribe psychiatric medications for clients in alcohol/drug treatment
- Flexibility to travel between two sites in Santa Clara Co.
- 25-30 hours at \$80/hour
- Provide case consultation for individual clients and their counselors
- Help facilitate linking clients with physicians in community for continued care
- Experience working with multi-disciplinary team
- Bilingual/bicultural encouraged

### PLEASE CALL MELISSA DOTY FOR MORE INFORMATION AT 408/299-6141

or submit a letter of interest and resume to Dr. Cheryl Berman, SCC/DADS/QI-CM Branch 976 Lenzen Ave, 3rd Floor, San Jose, CA 95126-2737

## News About Members

**Mace Beckson** has opened a private practice of forensic psychiatry and psychopharmacology in Santa Monica. He is certified in forensic psychiatry by the American Board of Psychiatry and Neurology.

**Steven Ey** is now Medical Director of the Genesis Program at South Coast Medical Center in Laguna Beach. He continues his private practice of family medicine in Laguna Beach.

**Amy Khan** begins a 2-year training program with the Centers for Disease Control and Prevention's Epidemic Intelligence Service in Atlanta in July. She has taken a leave of absence from her position as Medical Director of Chemical Dependency Services at Kaiser, Vallejo.

**William Brostoff** will serve as Acting Medical Director.

**Glen Taylor** is now the Chair of the Diversion Evaluation Committee (Northern II).

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## New Members

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

**Denise C. Bridgeford** is completing her Psychiatry Residency at King Drew Medical Center in Los Angeles.

**Miron J. Hom** is an outpatient psychiatrist at San Marino Psychiatric Associates. He is also an inpatient psychiatrist and chemical dependency detoxification physician at Columbia Las Encinas Hospital in Pasadena.

**Jay Michael Otero** is Acting Medical Director of the Psychiatry Service at the Loma Linda VA Medical Center.

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## CSAM on ASAM Website

ASAM's excellent website, [www.asam.org](http://www.asam.org), has a section devoted to state chapters. News and information from CSAM, updated regularly, appears there. The full text of two CSAM documents, *CSAM Position Paper on the Medical Use of Marijuana*, and *CSAM White Paper: Medical Use of Marijuana* appears there. The site also has information on CSAM Regional Meetings, California legislation, and the October conference, State of the Art 1999: Evidence-based Addiction Medicine. □

## You Can Write For

### Fighting For Parity in an Age of Incremental Health Care Reform by the Vermont Association for Mental Health

This new publication recounts the story of Vermont's successful campaign for mental health and substance abuse parity. It highlights key variables in the legislative process and provides first hand accounts and perspectives. It is a handbook on how to influence public policy.

Available for \$12 from VAMH -- Parity, PO Box 165, Montpelier, VT 05610, 802/223-6263. Make checks payable to VAMH -- Parity.

### Marijuana and Medicine: Assessing the Science

Report from the National Academy of Sciences, Institute of Medicine, John A. Benson, Jr. and Stanley J. Watson, Jr. Principal Investigators. The medical use of marijuana is surrounded by a cloud of social, political, and religious controversy, which obscures the facts that should be considered in the debate. This book summarizes what we know about marijuana from evidence-based medicine -- the harm it may do and the relief it may bring to patients. *Marijuana and Medicine* addresses the science base and therapeutic effects of marijuana for medical conditions such as glaucoma and multiple sclerosis. It covers marijuana's mechanism of action, acute and chronic effects on health and behavior, potential adverse effects, efficacy of different delivery systems, analysis of the data around marijuana as a gateway drug and the prospects for developing cannabinoid drugs. The book evaluates how well marijuana meets the accepted standards for medicine and considers the conclusions of other blue ribbon panels.

The full 200 page report is available for purchase for \$34.36 from the National Academy Press web page: [www.nas.edu](http://www.nas.edu). It is also available for reading on-line. An executive summary can be downloaded from the same web page and is also available from the CSAM office.

### Research Projects in California

California law requires specific review and approval, by the Research Advisory Panel of California for any research project using a controlled substance. The annual report to the Legislature describes all projects currently underway, giving brief summary reports of the projects, as well as those completed or discontinued.

Among those completed are several studies of SCH39166 in the treatment of cocaine dependence; study of isradipine v. placebo in opioid-cocaine dependence; a study of the synaptic actions of cannabinoids on hippocampal brain slices.

Ongoing studies include the short-term effects of cannabinoids in HIV patients (Donald Abrams, MD); cigarette smoking and response to methamphetamine (Neal Benowitz, MD); quantification of human opioid responsivity (Peggy A. Compton, RN); cocaine and ethanol pharmacokinetic interactions (John Mendelson, MD); methadone fate in the pregnant subject fetus and newborn (Marvin A. Peters, PhD); fluoxetine treatment of crack cocaine abuse and of methamphetamine abuse (Steven Batki, MD); office-based buprenorphine treatment for opiate addiction (Walter Ling, MD); effects of continuing cocaine exposure on tolerance and craving (John Mendelson, MD); rapid opiate detoxification and naltrexone induction with buprenorphine (Donald Wesson, MD).

Copies of the 64-page report are available on request from the Executive Secretary of the Panel, Robert R. Quandt, Jr., PharmD, Research Advisory Panel of California, 455 Golden Gate Avenue, San Francisco, 94102.

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### College on Problems of Drug Dependence

June 12-17, 1999

Acapulco Princess Hotel, Acapulco, Mexico

**Fees:** \$345 for CPDD members, \$395 for non-members, \$215 for pre-doctoral students

**For information** contact SailairTravel 800/759-5800

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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 1pm to Sunday noon

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

November 12-14, 1999 in Lake Buena Vista, FL

### Forensic Issues in Addiction Medicine

Thursday, July 15, 1999 in Washington D.C.

**Credit:** Up to 19 hours of Category 1 credit for MRO Course; 7 hours of Category 1 credit for Forensic Issues Course

**Fees:** Full Course \$575 ASAM members, \$650 non-members; Course One (The Basics...) \$75 members, \$100 non-members; Course Two (The Latest on the Science, Rules and Art...) \$500 members, \$550 non-members. Forensic Issues, \$225

**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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#### 50th Annual Meeting

### International Doctors in Alcoholics Anonymous

August 4-8, 1999

The Camelback Resort Inn, Scottsdale, Arizona

**Credit:** 12 hours of Category 1 Credit for the scientific portions of the meeting

**Fees:** \$300 IDAA member; \$200 spouse/significant other; \$175 resident/student; \$60 Alateen

**For information** contact George A. Streza, MD, registrar 6040 N. 41st Street Paradise Valley, Arizona 85253; phone 602/808-0631; fax 602/808-0631; gstreza@home.com

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#### CSAM's State of the Art 1999:

### Evidence-based Addiction Medicine

October 6-9, 1999

Marina Beach Marriott, Marina del Rey

**Topics** include: New Treatment Medications including Acamprostate and Buprenorphine, Buprenorphine in Office-Based Treatment, NIDA's Clinical Trials Network, Compulsive Disorders, Update on Smoking Cessation / Pharmacologic Treatments, Alternative Therapies, Assessing the Risks/Benefits of Alcohol Use

**Credit:** 26 hours Category 1 Credit for Thursday-Saturday; an additional 6 hours are available for the pre-conference workshops on Wednesday.

**For more information:** California Society of Addiction Medicine, 3803 Broadway, Oakland, CA 94611. Phone: 510/428-9091. E-mail: csam@compuserve.com

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### 12th National Conference on Nicotine Dependence

October 14-17, 1999

Cleveland, Ohio

**Sponsored** by American Society of Addiction Medicine

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

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#### American Society of Addiction Medicine

### State of the Art in Addiction Medicine

November 4-6, 1999

Marriott at Metro Center, Washington, DC

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

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#### AMERSA National Conference

November 4-6, 1999

Old Towne, Alexandria, Virginia

**Sponsored** by Association for Medical Education and Research in Substance Abuse

**For information** contact AMERSA, Brown University Center for Alcohol and Addiction Studies, Box G Providence, RI 02912, 401/863-2960

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#### 10th Annual Meeting and Symposium

### American Academy of Addiction Psychiatry

December 2-5, 1999

Nassau, Bahamas

**For information** contact AAAP, 7301 Mission Road, Suite 252, Prairie Village, KS 66208; 913/262-6161; 913/262-4311 (fax) addicpsych@aol.com

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#### American Methadone Treatment Association

April 9-12, 2000

San Francisco

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#### EDITORS

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Gail Jara

#### PRODUCTION

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NEWS is published three times a year by the California Society of Addiction Medicine, a nonprofit professional organization in the state of California with offices at 3803 Broadway, Oakland, CA 94611; (510) 428-9091. FAX: (510) 653-7052; E-mail: csam@compuserve.com

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.

#### EXECUTIVE COUNCIL

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Lori D. Karan, MD  
Walter Ling, MD  
David E. Smith, MD  
Margaret Yates, MD

## CONTINUING MEDICAL EDUCATION

### 11th Annual Western States Regional Conference on Physicians' Well-Being

Wednesday, May 19, 1999

Parkview Community Hospital, Founders Circle, 3885 Jackson Street, Riverside, CA

**Sponsored by:** Riverside/San Bernardino County Medical Associations Joint Physicians' Well-being Committee

**Credit:** Up to 6 hours of Category 1 credit

**Fees:** \$450 for hospital teams of 4, \$150 for individuals, \$25 for interns, residents, and students

**For information:** Jeanne Vale, Physicians' Well-being Committee, 909/686-3342.

### 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 Gurdish, PhD and Dorothy Rice. Keynote speaker: Philip Lee, MD.

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

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

### 22nd Annual Scientific Meeting

#### Research Society on Alcoholism

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

**Credit:** 23.5 hours of Category 1 Credit

**Fees:** \$300 RSA Members; \$400 non-members; special rates for post-doctoral and graduate students

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

*Continued on page 7*

### State of the Art 1999: Evidence-based Addiction Medicine

October 6-9, 1999

Marina Beach Marriott, Marina del Rey

- New Treatment Medications including Acamprosate and Buprenorphine
- Buprenorphine in Office-Based Treatment
- NIDA's Clinical Trials Network
- Compulsive Disorders
- Update on Smoking Cessation / Pharmacologic Treatments
- Alternative Therapies
- Assessing the Risks/Benefits of Alcohol Use

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