CSAM

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of Addiction Medicine

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Kicking Nicotine: Helping Patients Quit Smoking

An Outpatient Office-Based Approach

by Steve Heilig, MPH

INSIDE

NEWSLETTER 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; 415-428-9091.

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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.

Helping patients to quit smoking is far easier said than done. On top of the stubbornness of the addiction itself, time and cost constraints have hindered the adoption of ideal approaches in the medical office. How can physicians most efficiently and effectively accomplish this often time-consuming and frustrating goal? A number of models have been put forward to help physicians who wish to improve their ability to guide their patients to what has been called the single most effective step a patient can take towards good health.

Jess Bromley, MD, thinks the approach taken in his office practice may provide some answers. Bromley has adapted the model now being publicized as part of the National Cancer Institute and the California Medical Association's "Tobacco-Free California" project. It is an effort predicated on increasing evidence that despite constraints on their time, physicians can influence patients' nicotine use. The NCI/CMA guidelines incorporate intensive anti-smoking counseling and treatment into the regular office visit setting, with adjunctive support both in and out of the office. The guidelines call for the following steps:

(1) Select a person in the office who will coordinate the smoking cessation activities;

(2) Create a smoke-free office;

(3) Identify all patients who use tobacco;

(4) Develop smoking cessation plans;

(5) Provide follow-up support.

After some initial experimentation, Bromley implemented a comprehensive office-based anti-smoking effort in a manner he has found to be both practical and acceptable to staff and patients. Most importantly, early results seem to indicate it may be a more effective approach to the desired outcome than any other system Bromley has used.

...intensive anti-smoking counseling and treatment in the regular office visit setting...

"What we're doing is basically the NCI program with more 'oomph' in it—meaning more time spent with patients when they need it," says Bromley. In addition to assessing all his current patients for nicotine use, Bromley has advertised his "Start Fresh" program in local publications and with brochures to attract new patients who would come to him for the smoking cessation program. He has also been receiving referrals from other providers. However the patients get into the program, the course of treatment is fairly standardized.

■ **"Start Fresh" Program**

At the initial visit for nicotine cessation, Bromley takes a brief medical history and makes an assessment of smoking history and motivations for quitting. Patients then choose one of two treatment options—a "fast track" or a more traditional (and slower) behavioral modification track. Bromley clearly favors the former. "When they're ready to try quitting, you have to grab onto that, with no delays or excuses on either side," he maintains. "We have to have them make a commitment to quit in that first session, but if they can't accept abstinence that quickly, we try to have a quit date agreed upon at the first meeting."

The initial commitment to quit is, of course, only the start. "The key is to use good support systems," says Bromley, and he or staff members personally provide much of that continuing assistance in the office.

Patients in Bromley's program begin with weekly medical visits, which then taper down to bi-weekly and then monthly as appropriate. Most patients require pharmacological adjuncts: approximately two thirds of Bromley's patients wear clonidine patches, a treatment method which has been shown in a number of studies to decrease nicotine craving. Bromley favors a relatively low dose patch, "because I think it's as much a placebo effect as anything else." He uses Catapres TTS-1 or -2 mg. patches, depending on the patient's body weight. Exclusion criteria for clonidine include hypotension, hypersensitivity to the drug or tape, pregnancy, lactation, current heavy alcohol consumption, significant liver disease, and recent myocardial infarction among others. Side effects such as postural hypotension, dizziness, dry mouth, and lethargy have been noted. When Bromley sees such problems, he reduces the dose or discontinues the drug. These considerations highlight the need for a good medical history and careful monitoring of response to treatment.

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■ **Proper use of nicotine gum**

Bromley regards the proper use of nicotine gum as an extremely important component of treatment. The gum is offered to almost all patients who wish to quit—provided there are no contraindications (most commonly, ulcer disease, oral inflammations, or pregnancy and lactation). "The big thing is to teach them how to use the gum correctly," he notes,

echoing the remarks of Karen Sees, DO, at the November CSAM Annual Meeting in San Francisco. "Nicotine gum does have good effects—it decreases craving, anxiety and irritability," said Sees. "But the biggest problem is that physicians prescribe it without telling patients how to use it correctly. You need to go over it in detail, including the mechanics of how to actually chew it. [See Table 1.] Patients may get local effects such as nausea before the systemic benefits, so they will think it doesn't work. Plus they often don't use enough; a one-pack-a-day smoker needs 12-15 pieces per day to start. After a time, as the psychological dependence on smoking is broken, patients can decrease their use of the gum by 1-2 pieces per week—over a period of three to six-months."

"if we ignore nicotine dependence, we're just giving our patients piecemeal services, singling out one form of addiction and ignoring others."

Bromley also uses the anxiolytic buspirone (BuSpar) for patients who show high levels of anxiety in the first month or two of abstinence —about a third of those he sees. "I find that this drug has a slow onset and offset, with no rebound or reported addictive properties," he notes.

In addition to their medical office visits, all patients in Bromley's nicotine cessation program are encouraged to read the articles he gives them, to join Nicotine Anonymous, and to come to his office each week for an evening support group. These sessions are led by Karen Damron, MPA, a health educator who is herself a recovering smoker. An average of seven or eight patients attend each week.

■ Weekly meetings

"The meetings provide a place where patients can talk about the experience of trying to stop smoking and to find ways to deal with the symptoms of withdrawal," says Damron. "We talk about both the alternatives to smoking and the negative aspects of smoking. A number of our patients have been medically compromised by smoking and will share their progress since stopping—such as being able to walk up the stairs to get to the meeting!"

Damron feels the group process fills a definite need: "It's not enough to just tell patients 'Don't smoke.' Having a support group is very important and greatly increases the likelihood of success. I think it's very important for all physicians to begin to address smoking in their practices; they may not need a program like ours, but they should have someone in their office who can support people who are trying to quit, or they should refer patients to a program like Dr. Bromley's."

"We know that we have to treat this like any other addictive disease—to stay with the patients and support them through any slips which may occur," states Bromley. "And slips do occur for some patients, but you stay with them and keep up the effort. This is something every addictionist should be doing," according to Bromley. The recognition and treatment of nicotine dependence is a central part of the specialty focus on addictions; "if we ignore it, we're just giving our patients piecemeal services, singling out one form of addiction and ignoring others."

Any qualified and interested physician could duplicate this program with a minimum of disruption and cost.

■ Results

So how is it all working? Bromley cautions that it is too early to make any statements about long term outcome, but initial results are promising, especially in light of the high initial failure rate encountered in nicotine cessation programs.

"Since last January, we've had about 45 patients enter the program," he says. Bromley also notes that his office has begun to receive referrals from satisfied patients and other physicians who have heard about the program.

Bromley is confident that any qualified and interested physician could duplicate his program with a minimum of disruption and cost. "The initial workup session is billed like any other first visit (new office service, brief [90000] or limited [90010]) and the subsequent ones are billed as regular office visits [90050]. The support groups meet in my office every Tuesday evening for one hour. I pay for the group leader's time without billing the patients, although perhaps I could and probably should," he notes. "Thus far, I am extremely pleased with the program," Bromley concludes. "I think it shows that it can be done expeditiously and well in the doctor's office."

ACKNOWLEDGMENT

The California Society gratefully acknowledges a contribution received in December 1990 from the Upjohn Company in support of the Society's educational programs.

■ Resources/References

California Medical Association/Tobacco-Free California. Target Intervention: How to Help Your Patients Stop Smoking. A comprehensive manual of techniques and resources, available from Tobacco-Free California, (415) 882-5124 or (213) 483-1581, x378.

Kottke, TE, et al. Attributes of successful smoking cessation interventions in medical practice. *JAMA* 1988; 259, 2882-2889.

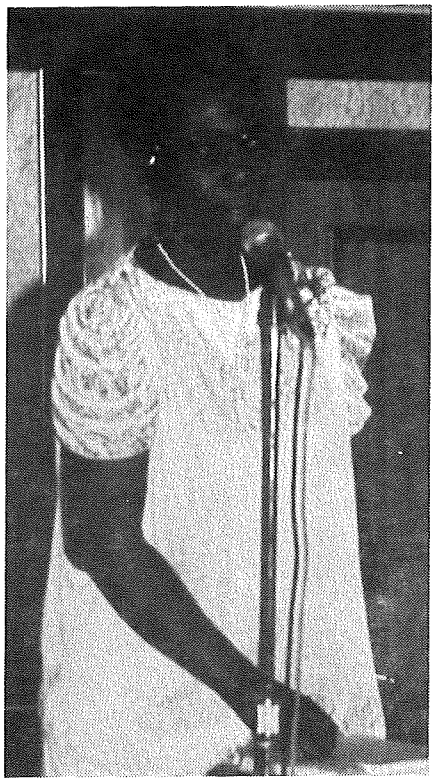
Sees, KL. Cigarette smoking, nicotine dependence, and treatment. Addiction Medicine (Special Issue), *The Western Journal of Medicine,* May 1990; 152, 578-584. □

Table 1: Instructions for nicotine gum use
From Sees (The Western Journal of Medicine 1990; 152: 581).

It is not to be chewed like regular chewing gum; it should be chewed slowly and intermittently.
It takes approximately 15 chews to release the nicotine from the polacrilex; at that time a tingling sensation will be felt in the mouth.
When the tingling sensation starts, the gum should be parked between the cheek and teeth or gums.
When the tingling is almost gone, chewing should begin again.
One piece of nicotine gum should be chewed for no longer than 20 to 30 minutes, and after that time period it should be discarded for another piece.
Do not swallow immediately; 70% of the nicotine in swallowed saliva is inactivated by first-pass metabolism in the liver, and patients get minimal effect from the gum if most or all of the nicotine is swallowed; the nicotine must be absorbed in the mouth to be effective. Also, swallowing the nicotine increases the amount of nausea and potential vomiting.
Nicotine gum should be used in sufficient quantities—usually 10 to 15 pieces per day for the average smoker, but as many as 30 may be used.
It should be used steadily day to day, not 2 pieces today, 20 tomorrow, and 7 the next day.
It should be used for the relief of discomfort as well as for urges to smoke.
Avoid drinking liquids when chewing or when about to chew the gum because most liquids change the pH in the mouth, which will decrease nicotine absorption.

California Society Annual Community Service Award

California Society of Addiction Medicine with great pleasure presents its community service award to C.W. Roddy for her steadfast determination to keep her home and neighborhood free from the violence and destruction brought about by drug abuse. By insisting on her right to live in peace and safety, Mrs. Roddy has given us an extraordinary example of individual courage.



William Brostoff, MD, presented the award to Mrs. Roddy, with this introduction.

Within the past year Mrs. Roddy, who is a resident of East Palo Alto, began to attract national attention because of her outspoken, unique and courageous stand against drug dealers. She was reporting identified dealers to police and insisting that she be allowed to live in peace and safety. When the drug dealers retaliated, Mrs. Roddy and her house were attacked by bullets and bombs. Her inspirational actions resulted in mobilization of her community and had some significant consequences.

Mrs. Roddy inspires us because she embodies the hope that a single individual can truly matter. She continues undaunted by threat of death or worse. In a time when William Bennett has resigned from his office as the US "Drug Czar" because of fears for his personal safety, Mrs. Roddy has chosen to stand firm in her home and in her neighborhood and her community.

To me, Mrs. Roddy also embodies the best qualities of our own field and of 12-Step recovery. Just as we in addiction medicine have at times lacked the full support of our colleagues in medicine, Mrs. Roddy has not always had the full support of her community. Nevertheless, she has put into direct personal action the principle of tough love. She has been living in a courageous, determined, and inspirational manner, the principles of the serenity prayer: "God grant me the serenity to accept the things that I cannot change, courage to change the things I can, and the wisdom to know the difference." Tonight we recognize and applaud her contributions.

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The Vernelle Fox Award

Kevin Olden, MD, presented the Award to Doctor Banys with this introduction.

Our model for this award is Vernelle Fox, MD. When she started her work in this field of medicine, it truly was a barren arena. She had to have tremendous courage and dedication to go forward. Things have gotten better because of her efforts and the efforts of others, but the challenge continues.

Tonight the Vernelle Fox Award goes to someone who has shown the same courage and dedication. Peter Banys took a new and struggling fellowship that was striving to be accepted in the university and that was under the threat of being closed by the VA, and, over the last decade, he built it into the finest, the largest, most productive chemical dependency fellowship in the United States. It is a model to people from all over the country who call and visit in order to learn how to train young physicians in the care of chemically dependent patients.

The obstacles have been immense, and the fact that the fellowship continues in excellence is a tribute to Peter's leadership, strength, wisdom and ability to deal with a complex bureaucracy in a very hostile environment.

Several of the Fellows are here to add their perspective.

California Society of Addiction Medicine presents the Vernelle Fox Award to Peter Banys, MD, in recognition of his outstanding contribution to addiction medicine in the area of physician education. His untiring efforts have developed the largest and most effective addiction medicine fellowship in the United States, and have led to the education of a large number of young physician specialists who have emerged as future leaders of our field. This award salutes Doctor Banys' unwavering dedication to intellectual honesty and scientific medicine and his passion for quality training for physicians in addiction medicine.

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Joel Nathan: I came to the fellowship as a primary care internist for the Department of Public Health in San Francisco. I came from a 12-Step background which was full of dogma, as I am told. Peter has taught me how to assess dogma with scientific questioning, and I value that tremendously. But what I really hold dear are those times in his office, talking with him over a cup of tea, when he was there to console, energize, and recharge us.

Westley Clark: When I came to the fellowship in 1984 from Washington, DC, where I had been a lawyer on the City Committee of Labor and Human Resources, I hoped that the fellowship would get me back into the practice of medicine and immersed in substance abuse theory. It did that.

Peter Banys expanded the VA's contributions to substance abuse, both in clinical practice and in theoretical orientation, helping us think through the role of physicians, and the role of substance abuse treatment in the larger society. Peter also brought to the VA a stellar cast of lecturers and a grand rounds that I've yet to see rivaled in the country. Recently, Peter has secured a number of grants from the VA to treat under-served populations, as well as expand research opportunities. In that sense, he's made a revolutionary contribution to the field of addiction medicine. Personally, I thank him for his mentorship and his guidance and his inspiration.

Robert Daigle: When I came to this fellowship in 1987, I had been in practice for a few years and had been relying on clinical experience. It was at Peter's conferences with their emphasis on the scientific literature that I learned more than I ever did anyplace else in medicine.

Peter Washburn: I think my years were the best two years of the fellowship, because there was a very rich stew of people there, from Don Wesson to Joan Zweben. But there were things unique to Peter, and not just that rich stew. His grand rounds gave the Fellows the chance to rub elbows with and learn from people like Marc Schuckit and Mary Pendery. That was unforgettable.

He encouraged me to go to a Tavastock conference. At the time, I wasn't sure what I experienced during that three-day conference, but over the years and with some discussions about boundaries, institutions and the role of physicians, I realize that it made me see things differently.

Karen Sees: When I came to the fellowship my career goal as an internist was to work on an in-patient unit that treated mentally unstable patients. I was somewhat interested in teaching but intimidated by the process and I suffered from severe stage fright. I had no interest in writing or publishing, had no interest at all in doing research, and lastly had no plans to stay in California on a long-term basis. All of this changed because of Peter and the fellowship. Although I'm still interested in treating medically unstable patients, my primary focus now is on substance abuse research, concentrating on nicotine dependence and methadone. Directly because of Peter and his encouragement, I am teaching a course at UC Berkeley, now for the fifth time. I've published several articles, and I'm still in California a year and a half later. Probably the only thing I don't thank him for is the Tavastock experience. □

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Peter Banys Accepts the Vernelle Fox Award

I'm really very deeply honored and touched by this award.

This morning, as my six-year-old son Alex and I were driving to school, he said, "You're getting an award tonight, huh? Sort of a prize?" "Yes." "Is that anything like the award that I got last year?" (He had received an award for being well behaved on the kindergarten bus.) At first I said, "No, no, no; it's nothing at all like that." And then I thought, well, you know, it really is the same thing.

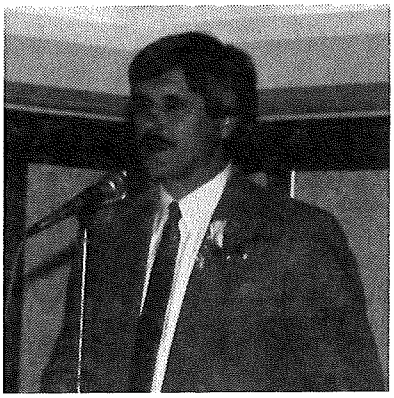
When I first came around in 1980, I got on a bus whose route had already been established by some of the physicians in this room, and, since then, I have been modestly well behaved, sitting in the back, throwing only a few spitballs from time to time. I am gratified that my peers believe that I have made a contribution.

For a couple of years after my psychiatry residency, my wife and I had travelled to the wildest places on earth. We'd lived in villages in New Guinea, Indonesia, India and Nepal. When I came back to the United States, I wanted to be in a teaching setting, and I began to look for a position. I had no intention of working in substance abuse. I was going to be a psychoanalyst. The San Francisco VA had this very bad job in the alcohol clinic, but it was a teaching institution and the job was more appealing than another bad job at San Francisco General Hospital, so I made the following deal: I said that I would run the alcohol clinic at the VA on a temporary basis—this was ten years ago—until a really good job came along, such as working with chronic schizophrenics. But I discovered that I enjoyed working with alcoholics; I enjoyed the field and I thought that there were some contributions to be made.

■ Those who influenced me

People started to say things about me, like, "Peter used to be smart; wonder what happened to him?" There's a certain kind of brush you get tarred with when you get interested in this field, but that did not stop me. I was interested and I didn't find it beneath me. As I reflect on why that was, I focus on four people. The first is my father, who died recently. He was a GP, the kind of GP who took care of everybody from his office in our home in a small Illinois town. He treated whoever came along and I learned a lot from that. He treated plenty of alcoholics and I think he treated them well. I'm not sure he knew a great deal about substance abuse, but he worked at treating patients. I took from my father the view that a patient was a patient.

...we need to do physicianly things and not simply repeat what other people do better...



Many years later, in London, I had the opportunity to work with Norman Zimberg from Harvard, who also died this year. At that time he was in London on sabbatical. He helped me do a little piece of trivial research on marijuana. I had this elaborate theory about how marijuana smokers were wildly different than everybody else, and under his supervision, I spent a year discovering that they were just like everybody else. I remember his expectation that we must think carefully about what we were doing and know our own untestable assumptions.

In medical school at Case Western Reserve in Cleveland, there were two men who influenced me. One was Maurice Victor who has made major contributions to neurology. His point of view was that the alcoholics who were his patients were very interesting, very worth

treating, and he would not tolerate anyone in his program being disdainful of them. The other person was George Gabuzda who had done metabolic research on hepatic disease in alcoholics. He was a fine teacher who took time to interact with medical students. Both of these men were at a county hospital where doctors rolled up their sleeves and got the job done. Both of them communicated a scholarly mind set and a hands-on approach.

We need to try to find our rightful place in existing specialties and the rightful place for our patients in the changing health care system.

So without realizing it too much at the time, I was influenced by the example of people who were interested in the troubles that came their way, and who thought of alcoholics and addicts as being worthy of respectful treatment.

■ The SFVA Fellows

I'm very proud of the fellows that we've graduated, about 15 so far. They make me look good, but I can't take credit for them. My job was to sift through the applications and try to find the people with heart and brains, compassion and empathy. From that point on, I see myself as a caretaker, maintaining the environment in which they can learn from the people and the experiences to which they are exposed during the fellowship. And, I hope and trust that they are being influenced by example the same way that I was.

The point of view that I've tried to push in the SFVA fellowship is that we need to be physicians; we need to do physicianly things and not simply repeat what other people do better, such as many of the things done in AA and elsewhere. We have to keep our eye on the ball—on the new developments that are proving themselves—and keep treating our patients well and respectfully.

There are a number of substance abuse fellowships around; some of them are more meaningful training than others. There's a trend emerging now in the VA system that I don't agree with, which is to turn the VA fellowships into research tracks, very much like NIH research tracks. I think that is a terrible mistake, because we don't need to discover one more blocker drug. We have some very potent drugs that do very interesting biochemical things, but they don't cure addiction as a process. We need clinicians with compassion, empathy, brains, and heart, and if we just send everybody off to the research lab, we're not going to get that. I see a distressing trend to think that the answer is always in the lab, and I don't think it is. I think research is useful and very necessary, but I don't think that is all there is to say about the treatment of addiction.

■ What does the future hold?

The treatment field as a whole, I think, has done itself some damage with an overemphasis on inpatient treatment and has been forced by third parties to back away from that. I think the question is, what are we left with if we can't do inpatient treatment for addiction? What does the future hold? I think it's a certain kind of retrenchment and becoming a little bit more modest about what we can accomplish. I think we need to integrate what we know about addiction with the rest of medicine, try to find our rightful place in existing specialties and the rightful place for our patients in the changing health care system. □

1991 State of the Art Conference and California Society Annual Meeting

Planners have been named for the next annual meeting to be held in conjunction with the State of the Art Conference.

Margaret Gregory, Nicola Longmuir, Richard Sandor, and Karen Sees will serve on the planning committee chaired by Peter Banys. □

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NEWS ABOUT MEMBERS

Hope Ewing is Director of the Born Free project at Merrithew Memorial Hospital in Martinez. The project, which provides recovery-oriented treatment services to women in prenatal clinics and in labor and delivery rooms, received the Third Annual County Hospital Innovator's Award from the California Association of Public Hospitals.

John Lanier is now full time on staff at the Chemical Dependence Recovery Service at Kaiser Permanente Medical Center, Fontana. □

APPLICANTS FOR MEMBERSHIP

As part of the California Society's application process, the names of applicants are published in the newsletter twice and sufficient time is allowed for comments from the members before the Executive Council acts on the applications. The first time the name appears, a biographical sketch prepared from information on the application form is included.

If you have comments to bring to the attention of the Executive Council, please contact P. Joseph Frawley, MD, at (805) 687-2411, or write to him in care of the California Society office.

David C. Dougherty, MD, is the medical director at Alta Vista Chemical Dependency Program at Kern View Hospital in Bakersfield. He was certified by the American Board of Internal Medicine in 1987. After attending the University of Southern California from 1977-1981, he completed a residency at Kern Medical Center in 1987. He is Assistant Clinical Professor of Medicine at UCLA.

Catherine A. McDonald, MD, MPH, is a medical consultant for Alameda County Juvenile Hall and for Thunder Road Drug Treatment Program in Oakland. She received her medical degree from Tufts Medical School in 1972, and completed post-graduate work in pediatrics at St. Louis Children's Hospital and Oakland Children's Hospital. She also has a master's degree in public health from the University of California, Berkeley.

William L. McDonald, MD, is the medical director of the Chemical Dependency Service at El Camino Hospital in Mountain View. After graduating from UCSF medical school he completed a residency in general surgery in 1958 and in family practice in 1960. He was certified by ASAM in 1988.

Charles D. Moore, MD, is an internist at Kaiser Permanente's Alcohol and Drug Program in Sacramento. He attended the University of Texas-Southwestern from 1978-1983, and completed his residency in 1986 at Parkland Veteran's Hospital in Dallas.

Other candidates for membership are:
Clarence Harper, MD, Larkspur
Samuel Mayeda, MD, Irvine
John Nork, MD, Diamond Bar □

Treatment Outcome Studies

Proposed recommendations for measurement of outcome in research on treatment efficacy have been completed and are being sent to the Society's 3-member "Devil's Advocate Committee" to receive a thorough critical review and assessment before they are presented to the Executive Council for adoption. Members are Donald Wesson, MD, John Chappel, MD, and Rudolf Moos, PhD.

The proposed recommendations appeared in the Winter, 1989 issue of the Newsletter when they were distributed for comment. Over 70 responses were received and comments were incorporated. A copy of the current draft is available from the California Society.

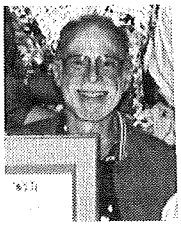
CSAM's Collaborative Study of Addiction Treatment Outcome

The first phase of this project is to describe the scientific, clinical and policy needs of the patients, the clinicians, the program administrators, and the payers, and to identify what information and research methods might be used to answer the needs of each.

The project's thesis is that a comprehensive database of patient information could be identified which would function like the patient databases developed for other chronic diseases. The American Rheumatism Association Medical Information System— ARAMIS—is an example.

This CSAM project is designed to help the clinician in treatment planning, to improve the chances of appropriate matching of patient to treatment options and to improve the cost effectiveness of treatment.

The Steering Committee: P. Joseph Frawley, MD, Chair, Anthony B. Radcliffe, MD, Donald R. Wesson, MD, Thomas Babor, PhD, Brian S. Gould, MD, and Daniel A. Bloch, PhD. □



IN MEMORIUM

Sandy Reder died in December after a long illness. When he retired as Chairman of the Department of Chemical Dependence for CIGNA Healthplan of California, he received CIGNA's Annual Community Service Award. In September, the Executive Council voted to honor the outstanding contributions he made to the California Society on the Committee on Education and the Executive Council.

A Memorial Fund is being established through the Psychiatrists' Education and Research Foundation (PER Foundation), which is associated with the Southern California Psychiatric Society. Sandy Weimer, MD, a colleague and personal friend of Sandy Reder's who is spearheading the new fund, said that donations will be kept in a capital account and interest used to support an annual Sandy Reder Lecture at UCLA. The project is to be conducted through the PER Foundation, but under the direction of a separate Board. "The project Board will be made up of people committed to the field of addiction, who knew Sandy Reder and who can select speakers to bring the same kind of creative and passionate voice that Sandy contributed to our field."

Weimer said that contributions will be matched by CIGNA Healthplan. Donations can be made by check to "PER Foundation Sandy Reder Fund," mailed to him at 801 N. Brand Boulevard, #1150, Glendale, CA 91203. The PER Foundation is a non-profit corporation founded in 1990; the Tax ID Number is 95-4288042.

The Executive Council of the California Society of Addiction Medicine confers this special award on

Sanford Reder, MD

in recognition of the significance of his contributions to the programs and policies of the California Society,

~ especially his commitment to furthering the integration of addiction medicine and psychiatry, saying that addictionists must know psychiatry and psychiatrists must know addiction,

~ his persistence and candor in keeping the hard questions before us, insisting on an unbiased approach, not accepting rationales based on belief systems, pushing for changes in attitude and practice where they are warranted, and

~ his advocacy for the academic and the scientific which has made a lasting contribution to the quality of all the Society's activities.

Presented the 21st day of September, 1990
in Los Angeles, California

CONTINUING MEDICAL EDUCATION

Broadening the Base of Treatment for Alcohol and Other Drug Problems
Bahia Resort Hotel, Mission Bay, San Diego
February 1-2, 1991, 8:30 am - 4:15 pm
Sponsored by University of California, San Diego
Speakers include David Lewis, MD; Thomas Babor, PhD; Richard Fuller, MD; Frederick Glaser, MD; Saul Levin, MD; G. Alan Marlatt, PhD; Marc Schuckit, MD; Harvey Skinner, PhD
Credit: 12 hours
Fees: $150
For information, contact University of California, San Diego, UCSD Extension 0176, 9500 Gilman Drive, La Jolla, CA 92093-0176. (619) 534-3400; FAX (619) 534-8527.

Psychotherapeutic Intervention in Chemical Dependency. New Techniques for New Challenges
Morrissey Auditorium, 2200 Hayes Street, St. Mary's Hospital, San Francisco
Saturday, February 9, 1991, 9:00 am - 1:15 pm
Sponsored by the Northern California Psychiatric Society and California Society of Addiction Medicine
Speakers include Kevin Olden, MD; Sam Naifeh, MD; Garrett O'Connor, MD; Peter Banys, MD; Timmen Cermak, MD; Robert Matano, PhD
Credit: 3 hours
Fees: $45, NCPS and CSAM members; $25, trainees (members or non-members); $60, non-members
For information, contact NCPS, 1631 Ocean Avenue, San Francisco, CA 94112. (415) 334-2418.

11th Annual Betty Ford Center Conference
Annenberg Center, Rancho Mirage
February 18-20, 1991
For information, call (800) 621-7322 from California; (800) 321-3690 from outside California.

ASAM's 5th National Forum on AIDS and Chemical Dependency
Stanford Court Hotel, San Francisco
February 21-24, 1991
Sponsored by American Society of Addiction Medicine; co-sponsored by NIDA and NIAAA
Credit: 12 hours; 4 additional hours for Thursday workshop
The workshop on Thursday, Feb. 21 from 12:00 -4:00 pm, "*Antiviral Therapy in the Seropositive Chemically Dependent Patient*," has no fee.
Fees: $275, ASAM members; $295, non-members; $200, program directors, nurses, PhDs; $150, counselors; $50, students/trainees; $125, residents/fellows
For information, contact ASAM's conference coordinator, Meeting and Travel Services, P.O. Box 81691, Atlanta, GA 30366. (404) 458-3382.

Conference on the Patient Placement Criteria from ASAM and NAATP
Atlanta
March 14-15, 1991
Sponsored by ASAM and National Association of Addiction Treatment Providers
Topics include interpretation of the criteria and practical hands-on practice with how they are to be applied
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