CSAM NEWS

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INSIDE

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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.

An Outcome Study: A Comparison of Patients Treated and Those Not Treated by the US Navy

Commander S. W. Shaw (MC) USNR

The Navy Alcoholism Treatment Program functions under the direction of Operation of the Navy Instruction (OPNAVINS) 5350.4B. This instruction delineates how members of the Navy are to be identified (diagnosed) as alcohol or other drug abusers or alcohol or other drug dependent. It outlines in specific detail what education and/or rehabilitation procedures are to be followed based on the severity of the illness as evidenced by adverse life events.

The Navy has established 92 Counseling and Assistance Centers both ashore and afloat, staffed with alcoholism counselors who are trained at the Navy Drug and Alcohol Counselor School, an intensive ten-week training program of the Navy Alcohol Rehabilitation Center (ARC) at Mirimar Naval Air Station, San Diego.

Active-duty Navy personnel who are thought to have a possible problem are referred by their commands to a Counseling and Assistance Center (CAAC) for a screening evaluation for abuse and/or psychological dependence. Such screenings are carried out according to Navy guidelines and local protocols developed by the individual CAACs.

A semi-controlled outcome study

Screenings are reported to the Navy Alcohol and Drug Management Information Tracking System (ADMITS) office for recording and tabulation. Summary reports are prepared annually and made available to all components of the Navy Alcoholism Treatment Programs. Review of the 1985 and 1986 reports shows the following: of the active-duty personnel found psychologically dependent on alcohol, some are referred for treatment and some are not. The reasons why some members are referred for inpatient treatment by their commands and others are not is unclear at this time, but is deserving of future study. This fact does, however, offer a unique opportunity for a semi-controlled outcome study of members who did receive residential treatment.

A Comparison of Patients *(continued)*

Of those referred for treatment some are recommended for inpatient Level III treatment at a Navy Alcohol Rehabilitation Department (ARD) or Navy Alcohol Rehabilitation Center (ARC). The objective of treatment is retention on active duty for men and women in good standing and of value to the service. One measure of the effectiveness of treatment in reaching that objective is whether members (a) have been separated from the service and are *not* eligible for reenlistment, or (b) are remaining on active duty after their initial CAAC screening and/or ARD/ARC treatment or are discharged from the Navy, but *are* eligible for reenlistment.

Methods

A retrospective review of CAAC records of active-duty members who had been screened, found psychologically dependent on alcohol and recommended for inpatient Level III treatment was conducted at the Naval Air Station in Alameda for the years 1985 and 1986. Two hundred subjects were identified and described by all the demographic data available from the screening records. Verification of collected data was completed by a second investigation and confirmed by correlation with the ADMITS office. This process resulted in dropping 59 subjects from the original 200, resulting in a study group of 141 active-duty members. These subjects were divided into two groups: Group A—those subjects who have completed a Level III Treatment program; and Group B—those who have not.

Using the Navy Locator and the reenlistment coding list, each subject was identified as either currently on active duty or separated from the Navy. For those members separated from active duty, their Reenlistment Code was obtained from the Naval Recruiting Command. This code identifies whether or not the individual was deemed eligible for reenlistment at the time of release from active duty.

A program was developed to generate matched pairs of individuals, one treated and one not treated in each pair. Due to the limited number of subjects, pairs could be generated for only 107 Navy males. Women and other than Navy active-duty subjects were dropped from the final pair matching.

Findings

The study looked at these variables: age, married or single, family history positive or negative, score less than 10 or greater than 10 on the Michigan Alcoholism Screening Test (MAST). It is apparent that the significant variable as regards to retention in the service for alcohol dependent active duty members is Level III Treatment. Of the 36 subjects receiving treatment (Group A), 86% were on active-duty two or more years after Level III Treatment, as compared to 44% of the non-treated (Group B) group ($p=0.001$). In Group A, 100% of the subjects were either on active duty or eligible for reenlistment two years after Level III Treatment, as compared to 69% in Group B ($p=0.001$). In Group A none of the discharged members was considered not eligible for reenlistment, whereas in Group B, 30% were considered not appropriate for further military service ($p=0.001$).

Although the numbers in the present study are small, the opportunity exists to expand the study to a much larger group. Using Navy-wide ADMITS and recruiting services data, a similar study can and should be conducted to further validate the value of Level III Treatment. Such a study can be set up on a continuing basis and provide a reasonably reliable measure for treatment outcome as program changes are tried in attempts to arrive at the most cost-effective way of providing medical management for active-duty members suffering from the disease of alcoholism. □

Spencer W. (Bill) Shaw is the Senior Medical Officer at the Naval Branch Clinic at Mare Island. From 1985 to 1992, he was Head of the Alcohol Rehabilitation Department at the US Navy Hospital in Oakland. He served on the CSAM Treatment Outcome Committee from 1987 to 1991.

Department Status for Addiction Medicine

Southern California Permanente Medical Group Board of Directors voted Department status to the Chemical Dependency Recovery Programs (CDRPs) in all the areas of Southern California. Anthony Radcliffe is the Coordinating Chief of the new Department as well as Chief of the CDRP at Kaiser Fontana. Margaret Gregory has recently been made chief at Bellflower. James Johnson is chief at Sunset. Harvey Lerner is chief at Granada Hills. Richard Merrick is chief at Harbor City. James Korb is chief at Kaiser West Los Angeles. □

CSAM HELPS LINK RESEARCH TO PRACTICE

P. Joseph Frawley, MD

The Collaborative Study of Addiction Treatment Outcome, a project of CSAM, will consider moving along three different fronts as a result of a meeting of providers, managed care organizations, database directors and top officials of government research agencies held in Los Angeles on July 17 and 18, 1992.

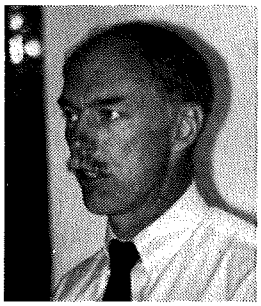
CSAM brought together 30 leaders from among those who use the data (managed care firms, payers, providers) and those who collect and analyze the data (researchers) and those who pay for the research. The focus was on patient treatment matching and whether observational databases can help answer the questions which face the clinicians.

The purpose of the meeting was to explore together how to measure more accurately and make better decisions about which patients should be directed which way. Databases have been used effectively for these purposes for other chronic diseases such as arthritis and coronary artery disease. It is essential that we develop tools of similar quality and clinical utility for chemical dependence. To this end, we have proposed that a collaborative effort be developed to give users access to several cooperating databases. We believe this can give us much more meaningful information for patient-matching.

Instead of asking does treatment work,
we should ask
which kinds of individuals,
with what kinds of alcohol problems,
are likely to respond to
what kinds of treatments
by achieving what kinds of goals
when delivered by
which kinds of practitioners
for what cost?

To learn more about the databases available for this kind of colloboration, we invited the directors of seven projects to join the discussion with us.

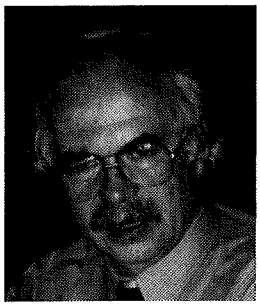
CATOR (Comprehensive Assessment Treatment Outcome Research)/New Standards, Inc., is an independent patient registry that provides treatment evaluation and outcome information to contracting treatment programs. CATOR provides standardized data collection forms, questionnaires and interview schedules; conducts post-treatment telephone interviews with patients who consent to follow-up at 6, 12, 18, and 24 month intervals after treatment; analyzes program level and aggregate data; and reports program level and aggregate information to individual programs. Norman Hoffmann, PhD, the Executive Director of CATOR, has been studying the effects of treatment and the factors which are related to recovery for the last decade.



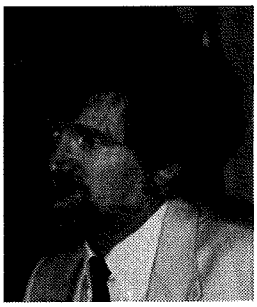
A. Thomas McLellan, PhD, at the University of Pennsylvania, has recently established a treatment follow-up registry that is pooling data from inpatient chemical dependency treatment programs using the Addiction Severity Index. Approximately 28 programs are contributing to the database, which also includes the Treatment Services Review, a systematic interview that describes the treatment that patients receive during their inpatient program. At this meeting, McLellan described a comparison of four treatment programs: two inpatient and two outpatient. Preliminary indications are that a differential efficacy can be identified.

The database maintained by Parkside was represented by David Mee-Lee, MD. The director, William Filstead, PhD, could not attend. Doctor Mee-Lee, Associate Director of Parkside Medical Services Corporation in Marblehead, MA, is also Chair of ASAM's Standards and Economics of Care Committee.

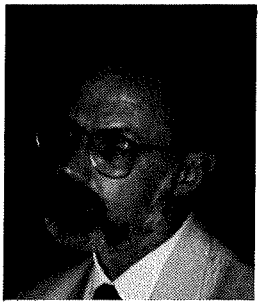
CSAM Links Research to Practice *(continued)*



The State of Michigan Office of Substance Abuse Services funded a study of treatment effectiveness of the state-supported treatment. Bertram Stoffelmeyr, PhD, at Michigan State University collected data between 1984 and 1991 and is beginning to report observations now. Unfortunately, he lost the state funding for the analysis which was originally planned.



Thomas Babor, PhD, illustrated the capabilities of an observational database as he showed his studies of a program for early identification, referral and treatment of adolescents – the Regional Youth Substance Abuse Project – an assessment and case management service that collects systematic diagnostic information from adolescent substance users, with a six-hour battery. This multisite study also collects data about the cost of treatment.



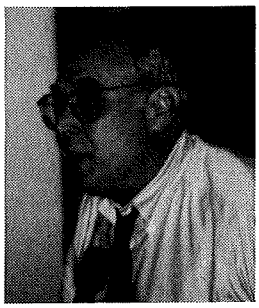
DATOS – the Drug Abuse Treatment Outcome Study – was described by its director, Robert Hubbard, PhD. This is a federally funded comprehensive multisite prospective study of drug abuse treatment effectiveness including an assessment of cost-effectiveness. Four treatment settings will be evaluated: long-term therapeutic community, methadone maintenance, outpatient drug free, and short-term residential (Minnesota Model-type programs).

G. Richard Smith, MD, the Director of the Centers for Mental Health Care Research at the University of Arkansas, described the Outcomes Management System for alcohol and drug abuse. A data collection instrument is now available in the public domain. In addition to clinician ratings of alcohol dependence, patient characteristics, co-occurring psychiatric conditions and treatment received, the instrument includes an extensive patient questionnaire that obtains the same kind of data from the patient's perspective.

NIAAA, NIDA, OTI

The national research agenda was described by officials from the research agencies. James Kaple, PhD, from the National Institute on Drug Abuse, reviewed the Drug Services Research Survey (DSRS) and the Services Research Outcome Survey (SROS). A national outcome study was done by mail and telephone of a sample of over 2,000 clients who left treatment in the last 12 months. Treatment programs/facilities (1183 or 82% of those eligible) were also described.

Margaret Mattson, PhD, from the National Institute on Alcohol Abuse and Alcoholism, discussed Project MATCH, the first national multisite trial of matching where patients will be randomly assigned to one of three alcoholism treatment approaches: Twelve-Step, cognitive behavioral therapy, or brief motivational enhancement therapy.



Herman Diesenhaus, PhD, from the Office for Treatment Improvement, described the National Treatment Improvement Evaluation Studies (NTIES) and its "crosswalk approach" to existing studies which collect data on patient characteristics and status, organizational and program characteristics, services provided, expenditures and funding sources. NTIES addresses the similarities and differences.

Discussion

Participants listened to the needs of each constituency represented and tried to integrate the viewpoints of providers of care, payers, managed care companies, researchers, and Federal agencies who conduct and fund research. All agreed that what is needed is "a knowledge base that provides information useful for answering

policy questions about effectiveness and efficiency," in the words of Tom Babor.

The physicians from both providers and managed care corporations would like to see all providers using the same core set of data elements. This would facilitate communication and would let us make patient placement decisions based on research data which use similar baseline assessments.

Everyone agreed that the information collected must be clinically relevant and efficient to gather and report.

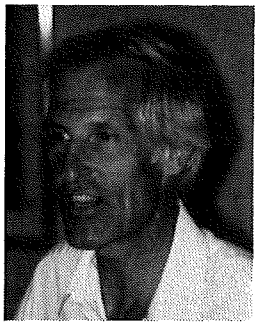
...what is needed is a knowledge base that provides information useful for answering policy questions about effectiveness and efficiency.

Mechanisms for collecting and reporting should be incorporated into the routine evaluation of patients. Jim Kaple said, "We need to build the capability at the point of delivery to capture high quality data. You can't capture the data at the state level or the federal level unless it is being generated at the local level. And if it isn't useful at the local level, you won't get very good data no matter what you do."

Self report by the patients was seen as appropriate for some data collection. As much as possible of the rest should be gathered by trained non-clinicians. The most experienced clinicians should be responsible for the most complex parts of the assessment and for making the recommendations regarding patient treatment matching.

Next Steps

The most challenging idea to come out of the workshop is for a clinical database of high quality which can work in tandem with randomized controlled trials. Such databases have been developed in other areas of medicine. Examples include the Duke University Coronary Artery Surgery Study and the American Rheumatism Association Medical Information System (ARAMIS) at Stanford. We have selected ARAMIS as the model most closely related to our field and situation, and we have included Daniel Bloch, PhD, the biostatistician with ARAMIS, on our Steering Committee. His vision for what is possible and his experience with managing a database on a daily basis have guided us for the last two years.



Another recommendation is for secondary analysis. There are several databases at present monitoring chemical dependencies, but their efforts have not been coordinated or integrated nor has there been funding for doing secondary analysis of the data that they collect. The Steering Committee is considering a specific proposal for secondary analysis of as many of the databases as possible. The first task for such a collaborative effort might be to query the existing databases to see if patients matched to treatment according to the ASAM Patient Placement Criteria are more successful in treatment (have better outcomes) than those who would be

(Continued on p. 8)

Workshop Materials Available

The 500-page syllabus prepared for the workshop is available from the California Society office. It contains detailed information provided by each presenter and the paper, "The Use of Databases to Study Addiction Treatment Outcome," by Thomas Babor, PhD, and P. Joseph Frawley, MD, an overview discussion, problem statement and recommendations from the Collaborative Study. [A charge of $30 is made to cover copying and postage.] Copies of the paper (30 pages) only are available for $6.50 to cover copying and postage.

The presentations and discussions of the workshop were audiotaped and are available for $55 from InfoMedix, 12800 Garden Grove, Garden Grove, CA 92643; (714) 530-3454.

Recommended Variables

As part of the Collaborative Study of Addiction Treatment Outcome, CSAM has recommended **assessment** variables (Table 1) which will be able to provide prognostic information about problem severity and treatment needs, as well as baseline information with which to compare follow-up data.

Recommended variables to **describe treatment** (Table 2) should help us measure and quantify. We need to identify the therapeutic events, assess the quality of treatment relationships, assess the relationships of the treatment provided to the patient's problem severity, and identify continuing care elements.

Recommendations for Design of Treatment Efficacy Research with an Emphasis on Outcome Measures were agreed upon through a national consensus process conducted by CSAM from 1989 to 1991. (See NEWS, Spring 1991, Vol. 18, No. 1.) **Outcome** variables (Table 3) are also part of the recommendations of this project. We want to monitor measures of environmental support and stressors which influence relapse so that opportunities for treatment intervention can be identified following treatment or during the period of being at highest risk for relapse.

— *PJF*

Table 1. Recommended Variables for Comprehensive Assessment of Client Drinking Career, Natural History, and Related Problems

Variables reflecting lifetime involvement with alcohol and drugs and global problem severity (e.g., ASI alcohol/drug severity ratings, total MAST and DAST score); developmental, etiological and drug use career variables

*Number/type of previous treatments for drug/alcohol abuse (including DUI programs, 12 Step meetings, individual/group counselling, residential programs, etc.)

*Parental alcoholism, drug dependence, psychiatric disorders and criminality

*Childhood disorders, especially HK/MBD, ADD, ASP

*Age sequence of significant life events in drug and alcohol misuse career (e.g., age of first use, first problems, first dependence, first treatment, etc.)

Physical/sexual abuse; parents separated, divorced, intact up through age 18; felt loved by parent(s) who raised child

Lifetime history of psychopathology, with relative ages of onset of depression, ASP, drug dependence, alcohol dependence, etc.

Personality functioning variables, especially emotional stability, sociopathy, anxiety level

Variables related to the severity of presenting symptoms and the nature and patterning of drug use

*Drug use pattern, including recent and past quantity, frequency and variability of using psychoactive drugs, alcohol and tobacco

*Route of drug administration

*Biological test results (e.g., liver function tests, blood alcohol level, urine screening)

*Recent withdrawal symptoms: affective, physiological state on admission

*Use patterns and consequences

*Social support for sobriety/use in living and social environment

*Problems related to drug/alcohol use (social, economic, legal, etc.)

Severity of dependence (recent episode, most severe episode for each drug of abuse) including tolerance, withdrawal, craving, compulsive drug-taking behaviors in relation to common drugs,* alcohol,* and tobacco*

Ratings of withdrawal severity at admission to treatment

History of withdrawal

Medication use during withdrawal

Drinking/using contexts, situations, social supports, expectancies, reasons for use, reasons for nonuse, alternative reinforcements

Drinking/using expectancies, reasons for use/non-use, alternative reinforcements

Physical health-severity ratings of major ICD-9 diagnosis (e.g., mild, moderate, severe, life-threatening)

Biological tests on admission (toxicity, drugs, liver function, BAC)

*Minimal or core criteria

Table 1 *(continued)*

*Personal, background and demographic variables

- Marital status
- Age
- Education/Intelligence level
- Socioeconomic status of family
- Occupational prestige of most typical employment
- Month/years of unemployment
- Highest and most recent annual net income (adjusted)
- Marital status including number of marriages, divorces and sexual partners
- Number of different jobs
- Arrest record
- History of trauma
- Method of payment for care

Variables related to current cognitive and psychosocial functioning

- *Current psychiatric diagnosis and
- * psychiatric severity
- Personality disorder
- Recent life events and distress level associated with them
- Coping skills (general and substance-related)
- Psychotropic medication
- Job functioning

Variables describing client's motivation and readiness for treatment

- Spiritual/religious resources
- Primary motivation for treatment
- Type and degree of perceived coercion
- Denial of dependence/problem or need for treatment
- Patient choice in selection of treatment
- History of treatment completion/compliance
- Patient and significant other participation in treatment

*Minimal or core criteria

Table 2. Recommended Variables for Assessment of Treatment (the Process and Quality of the Treatment)

Goals and Objectives of Treatment

- Philosophy of the treatment program
- Theoretical or conceptual rationale guiding treatment
- Short and long term goals of treatment

Structure of the Treatment Program

- Location
- Setting characteristics
- Level of care (outpatient low intensity, outpatient high intensity, in-patient medical monitoring, inpatient medical management, residential)
- Staffing and therapist characteristics and training
- Program atmosphere
- Number of beds/treatment slots

Process of the Treatment Program

- Services (detoxification, rehabilitation, maintenance, residential)
- Types of care/treatment
- Units of care
- Length of stay
- Specialty focus (e.g. youth, women)
- Assessment procedures
- Individualization - matching
- Integrity of treatment
- Continuing care recommendations

Finances/Marketing

- Program ownership
- Program funding
- Cost of services and program of care
- Referral sources
- Occupancy rate/waiting lists

Table 3. Recommended Variables for Assessment of Outcome

SHORT-TERM GAINS

Major Domains

- Intoxication/Withdrawal
- Denial Resistance
- Physical/Medical
- Relapse Potential
- Behavioral/Emotional
- Recovery Environment

Specific Items

- Information gain
- Attitude change
- Psychological adjustment
- Physical health
- Social rehabilitation
- Vocational rehabilitation
- Alcohol/Drug Expectancy Change
- Physiological responses to drug/stimuli
- Sober coping responses
- Discharge status

LONG-TERM GAINS

Substance Use/Treatment/Retreatment

- Total Abstinence since start of treatment
- Months Abstinent prior to follow-up
- Days Abstinent/using during follow-up
- Intensity of drinking/using
- Dependence severity (alcohol/other drug)
- Alcohol and other drug problems
- Readmission for use or threatened reuse

Physical Health/Subjective Sense of Well Being

- Mortality
- Hospitalizations since start of treatment
- Appropriate biochemical markers
- Standardized psychological test/scales
- Health care utilization
- Psychiatric status/Personality adjustment
- Stressors and Ability to cope with them

Role in Society

- Employment Function
- Legal Problems
- Relationship with family/significant others
- Social functioning

CSAM Links Research to Practice *(continued from p. 5)*

considered mismatched according to the criteria. The results would contribute to the validation testing of ASAM's criteria and may lead to upgrading and improving those criteria and possibly identifying other core variables which would better predict patient outcome and treatment needs.

Another recommendation is to get the voice of the clinician heard at the policy-making level. Each Federal agency is working on a piece of the treatment outcome question, but who is linking it to today's treatment questions? Providers should have a voice in the process which sets the Federal policies and priorities. What would be most useful for the clinician to know? There is a need for more user focus to go into the process of selecting the important questions and facilitating the link between research and treatment. A professional organization such as ASAM should be involved in helping to set the clinical research agenda. The Project Steering Committee for the Collaborative Study of Addiction Treatment Outcome and the Executive Council of CSAM will consider these and other recommendations from the workshop.

Those who serve on the Steering Committee are P. Joseph Frawley, MD, Chair; Thomas Babor, PhD; Daniel Bloch, PhD; John Chappel, MD; Brian Gould, MD; and Donald Gragg, MD. □

President's Column

A Tale of Two Screening Tests

Drug testing for airline employees has been conducted since 1990. The number of "positive tests" has been quite low. The costs to the airlines as well as the emotional costs to employees have not been as low, however. In an article in *Aviation Week & Space Technology*, Deborah McElroy, Vice President of the Regional Airlines Association, was quoted as saying, "For the first year alone, testing costs, not including training and record keeping, were about half a million dollars." In the same article, the Air Transportation Association, which represents all airlines, estimated that urine testing for the airline industry cost $9 million in the first six months of testing. This testing program, which has been opposed by the Air-Line Pilots Association (ALPA), has been supported by the Airline Passengers Association, whose spokesperson, Suzanne Lubin, has said that random testing is "necessary."

A major stimulus to the program was the January 19, 1988 crash of a Trans Colorado Airlines commuter plane in Durango, Colorado, which killed seven passengers and two crew members. The captain of the crashed airplane was found on autopsy to have metabolites of cocaine in his blood. A vigorous debate ensued between the National Transportation Safety Board (NTSB) and ALPA. The NTSB stated that "degradation of the captain's performance resulting from his use of cocaine" contributed to the accident. ALPA maintained that the effects of cocaine use could have had no direct effect on the cause of the crash because the First Officer, not the Captain, was flying the airplane at the time of the crash.

The Air-Line Pilots Association vigorously opposed the FAA conclusions, stating, "The First Officer didn't take drugs and was not impaired." To help keep perspective, it should be noted that this was the first airline accident before *or since* where drugs were involved. It is clear that the decision to institute testing was not based on the same cost-benefit or cost-yield analysis used to determine whether other screening tests will be employed.

As physician scientists, we should formulate a position in an objective and consistent manner. What is the yield of drug testing of airline employees? According to the *Aviation Week* article, the positivity rate is 0.042%. In 1990, there were 230,621 tests administered, of which 966 were positive. (What is more interesting is that most of these positives did not come from random testing of employees, but rather from pre-employment screening.) As physicians we should ask: is it cost-effective to spend $9 million over six months on a test that yields less than a .05% positivity?

We as physicians should be cautious that we do not tacitly support conclusions which are not scientifically supportable.

Comparisons to other screening tests might prove helpful. For screening for colon cancer, the American Cancer Society recommends that after age 50 flexible sigmoidoscopy be performed two years in a row and thereafter every three to five years – a regimen which yields a positivity rate of 10%. However, flexible sigmoidoscopy, which costs up to $200, will pick up only 65% of colon cancers. The remainder occur in the colon proximal to where the sigmoidoscope can see. Since this disease is so lethal, would it not be more appropriate for the public health to recommend complete colonoscopy, which costs up to $2000, to reduce the mortality and morbidity rate? The answer is, as with every other medically accepted screening test, that the rates of detection must be balanced against the invasiveness and cost of the screening procedure.

We as physicians cannot scientifically support testing where the costs outweigh the benefits by such a large margin. The cost to the airlines, particularly small regional airlines, is considerable. The ALPA official quoted in *Aviation Week* was right: there are no data to show what role (if any) the cocaine metabolites played in the Trans Colorado Airline crash, and the accident should not be used to support the FAA rule. We as physicians should be cautious that we do not tacitly support conclusions which are not scientifically supportable.

There is clearly a role for urine testing. There is clearly a key role for the Medical Review Officer (MRO), particularly one trained in addiction medicine. The challenge we face is to define those roles by using scientific principles which have worked so well for us in other areas of medicine. If we allow urine testing policies and practices to be determined not by public health principles but by bureaucrats, politicians, and entrepreneurs – as we allowed treatment decisions to be made by others in the 1980s – the urine testing programs and the role of an MRO in 10 years will be discredited by the same flaws that have devastated the chemical dependency treatment industry. This is clearly a moment of great importance. The choice is ours. □

Kevin W. Olden, MD

1. Critics fault scope of drug, alcohol tests. **Aviation Week & Space Technology**, June 8, 1992, p. 55.

2. Colorectal Cancer. **Gastroenterology Clinics of North America**, 17:4, December 1988.

APPLICANTS FOR MEMBERSHIP

The names of applicants are published and sufficient time is allowed for comments from the members before the Executive Council acts to accept them as members. If you have comments to bring to the attention of the Executive Council, please contact Kevin Olden, MD, at (415) 668-1001, or write to him in care of the California Society office.

Stephanie Amritt, MD, an internist, is the Administrator at Redgate Memorial Hospital in Long Beach. She graduated from Rutgers Medical School in 1977 and did two years' residency in internal medicine at Martin Luther King, Jr. General Hospital in 1980.

Peter Barglow, MD, is Chief of Substance Abuse Treatment Programs at the Martinez VA, and Chief of Substance Abuse Training at the University of California, Davis. He graduated from Northwestern University in 1956 and completed a residency in psychiatry at Michael Reese Hospital in Chicago. He is a Visiting Professor of Psychiatry at UC Davis, where he will be associated with the NIDA-NIAAA funded study of LAAM.

Patrick J. Fitzsimmons, MD, is a board-certified psychiatrist in private practice in Los Gatos and a psychiatric consultant to the Good Samaritan Recovery Center in San Jose. After graduating from Northwestern in 1981, he completed a residency in psychiatry at Northwestern Memorial Hospital in 1984.

Amy J. Khan, MD, a board-certified internist, is Medical Director of the Alcohol and Drug Abuse Program at Kaiser in Santa Rosa. She graduated from Wayne State University in Detroit in 1986, and completed a residency in internal medicine in 1989 at Kaiser Foundation Hospital in Santa Clara. Doctor Khan is Chair of the Professional Staff Well-Being Committee at Kaiser Santa Rosa.

David Malish, MD, is Medical Director at Good Samaritan Recovery Center in San Jose and is in private practice in allergy/immunology. He is board-certified in both Internal Medicine and Allergy and Immunology. Doctor Malish graduated from Hahnemann University and completed a residency in internal medicine in 1976. He was a fellow in allergy/immunology at Kaiser Foundation Hospital in 1978.

J. Thomas Payte, MD, is Medical Director of Drug Dependence Associates in San Antonio, Texas, a private practice limited to addiction medicine, which includes a methadone treatment program for over 300 patients. He graduated from the University of Oklahoma in 1957. He began to work with heroin addicts in 1963. In 1972 he stopped general practice to devote full time to treatment of addictive disorders. He is the Chairman of the ASAM Methadone Committee and a lecturer to national audiences on methadone maintenance treatment.

Nicholas Z. Rosenlicht, MD, a board-certified psychiatrist, is Director of Mental Health Services at the VA Northern California System of Clinics and Director of Outpatient Services at the Department of Psychiatry, University of California at Davis. Doctor Rosenlicht graduated from Case Western Reserve in 1984 and completed a residency in psychiatry at UCLA NPI, and Brentwood and Westwood VA in 1988. He has been Assistant Professor at UC Davis since 1989.

Andreas Subadya, MD, board-certified in internal medicine, is Director of Medical Services at Ingleside Hospital in Rosemead and is a partner with Hanson Medical Group in San Gabriel. Doctor Subadya graduated from UC Davis in 1987 and completed a residency in internal medicine at Huntington Memorial Hospital in Pasadena in 1990.

Other applicants include:
Howard Kornfeld, MD, Kentfield
Jack Lynch, MD, Mission Hills
John McCarthy, MD, Sacramento □

NEWS ABOUT MEMBERS

Robert Bloomfield is medical consultant to a new outpatient chemical dependency treatment program at Torrance Memorial Medical Center. □

CSAM COMMITTEES

Committee on the Scope of the Field of Addiction Medicine

Chairman Tim Cermak has nominated Maureen Strohm, Daniel Ahearn, Steven Eickelberg, Nicholas Rosenlicht, and Margaret Yates for appointment to the committee. He said they will begin deliberations by phone and mail in September.

Committee on the Chemically Dependent Physician

Chairman Gary Levine is coordinating a consensus process to help identify an effectively functioning hospital medical staff committee on physician health and well-being. A list of possible outcomes was drafted and reviewed by 12 physicians experienced in the work of these committees. The list was ranked according to the degree of relevance each had to effectiveness of the committee. Now several hospitals will be surveyed via interviews with members of the medical staff and administration. The reviewers have been asked to submit names of hospitals which they think should be studied.

CSAM members who would like to participate in the committee or review the list of outcomes should contact Gary Levine or the California Society office.

Call for Papers

AHA Psychiatric and Substance Abuse Services

The American Hospital Association Section for Psychiatric and Substance Abuse Services invites proposals for presentations at its annual conference, "The Leadership Edge: Management of Psychiatric and Substance Abuse Services," June 17-19, 1993, in Boston. Mental health professionals of all disciplines from hospital-based programs attend.

Proposals are requested for presentations which address such topics as cost-effective service delivery methods, state-of-the-art technology, quality assurance issues, treatment of special populations, and strategic planning. The deadline for submitting proposals is October 1, 1992. For further information and a presentation application form, please call Rebecca Chickey, (312) 280-6650. □

1992 Review Course and Workshops

Spirituality and Its Place in the Practice of Addiction Medicine

Physician Health and Physician Impairment

What is Different About Outpatient?

Management of Psychopathology

Awards Dinner
Annual Business Meeting

Ramada Renaissance Hotel, Long Beach, California

November 5-7, 1992

CONTINUING MEDICAL EDUCATION

ASAM 5th National Conference on Nicotine Dependence

Seattle Sheraton, Seattle
September 17-19
Speakers include Neal Benowitz, MD; Paul Earley, MD; Karl Fagerstrom, PhD; Max Schneider, MD
Fees: ASAM members, $265; non-members, $315; non-physician, $210; resident/intern, $150; medical student, $50
Credit: 13 hours
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.

ASAM MRO Courses
San Francisco Marriott, San Francisco
October 16-18

The Basics of Being an MRO

Friday morning, October 16
Fees: ASAM members, $100; non-members, $125
Credit: 4 hours
Speakers are Donald Ian MacDonald, MD; M.P. George, MS

The Latest on the Science, Rules & Art of Medical Review

Friday afternoon to Sunday, October 16-18
Fees: ASAM members, $350; non-members, $375
Credit: 14.5 hours
Speakers include Donald Ian MacDonald, MD; Robert Willette, PhD; J. Michael Walsh, PhD; David E. Smith, MD; H. Westley Clark, MD, JD, MPH; Robert Dupont, MD
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.

ASAM Review Courses in Addiction Medicine

O'Hare Marriott, Chicago, October 8-10
Marriott Marquis, Atlanta, October 22-24
Fees: ASAM members, $350; non-members, $400; residents/fellows, $275; medical students, $50
Credit: 19.5 hours
Speakers include Milton Burglass, MD; Timmen Cermak, MD; H. Westley Clark, MD, JD, MPH; Loretta Finnegan, MD; David Mee-Lee, MD; Al J. Mooney, MD; Terry Rustin, MD; Stephan Sorrell, MD
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.

Psychopharmacology 1992: Clinical and Research Update

Sponsored by West Coast College of Biological Psychiatry
Hilton Hotel, San Francisco
October 16-17
Fees: Full course, $395; one day, $200
Credit:14 hours
Speakers include Michael Gitlin, MD; Michael Irwin, MD; Stephen Marder, MD; Peter Roy-Byrne, MD; Karen Sees, DO; Alan Schatzberg, MD
For information, write to Conference Registration, P.O. Box 27127, San Francisco, CA 94127; 800/432-5585.

5th National Conference on Professional Well-Being

Sponsored by the Society for Professional Well-Being
Hyatt at Fisherman's Wharf, San Francisco
October 22-25
Fees: Members, $395; non-members, $450; guests/spouses, $395; students/residents, $150; one-day, $125
For information, contact John Pfifferling, PhD, Center for Professional Well-Being, 21 West Colony Place, Durham, NC 27705; 919/419-0011.
