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.

Gamma-hydroxybutyrate

by Gantt P. Galloway, PharmD, S. L. Frederick, PhD, Marco Gonzales, PharmD, S. Alex Stalcup, MD, Frank E. Staggers, Jr., MD, David E. Smith, MD

Note from the Editors: *According to an article in the public press, the San Francisco Bay Area Regional Poison Control Center has reported up to 40 cases of overdose with gamma-hydroxybutyrate in one year. The following article gives a helpful overview of this emerging drug of abuse.*

Gamma-hydroxbutyrate (GHB) is a putative neurotransmitter, structurally related to gamma-aminobutyric acid (GABA) and glutamic acid, which has been the subject of investigation since 1960. GHB was first studied for its ability to induce short-term coma and possible surgical anesthesia. Subsequently, it was discovered that GHB could produce absence seizures, and it was used in animal studies to evaluate the effects of medications on absence seizures. Recently, GHB has been studied for its sleep-inducing properties, the treatment of narcolepsy, and the treatment of alcohol and opiate dependence. At the same time, GHB has been under investigation as a potential neurotransmitter. In the past several years, GHB has had a popularity on the illicit drug market in the US. Many cases of adverse reactions have been reported, but little attention has been paid to physical dependence and persistent use despite adverse consequences of GHB. Experience with several patients indicates that GHB can produce physical dependence and a withdrawal syndrome.

Potential therapeutic indications

GHB was first synthesized in 1960 as an orally bioavailable GABA analog that would cross the blood-brain barrier. Because of its ability to induce both sleep and reversible coma, GHB was investigated for its potential as a surgical anesthetic. However, it was found to have little analgesic effect, and onset of coma was often associated with seizure activity including tonic-clonic jerking movements of the limbs or face.[12] GHB alters sleep cycles, increasing slow wave sleep at the expense of sleep stages 1 and 2.[15] This observation led to several small trials that have demonstrated the efficacy of GHB for the treatment of narcolepsy.[16-19]

GHB suppresses alcohol withdrawal tremors and seizures in rats.[20] Gallimberti and colleagues have followed up on this observation with a series of clinical trials that suggest GHB may have utility in the treatment of alcohol dependence. In a placebo-controlled trial in 23 subjects in alcohol withdrawal, GHB, 50 mg/kg, markedly suppressed withdrawal for the seven hour observation period and was well tolerated.[21] The long-term efficacy of GHB in alcohol dependence was tested in a three month randomized trial. Subjects were administered placebo or GHB, 50 mg/kg/day, in three divided doses. Subjects were told at study intake that they should abstain from drinking, but further psychosocial intervention was not noted. Of the 82 subjects who entered the

study, results were reported for the 71 who completed it. Subjects in the GHB group had three times as many abstinent days and half as many drinks per day during the study period. No data were presented on outcomes after GHB was discontinued.[22]

Though in limited use in Europe as a surgical anesthetic, GHB is not approved in the US.

Gallimberti, et al., also evaluated the utility of GHB in suppressing the signs and symptoms of opiate withdrawal. GHB, 25 mg/kg, or placebo was administered in double blind fashion to 22 heroin dependent subjects and 19 methadone dependent subjects. Withdrawal signs and symptoms were markedly suppressed for the three hour period of observation and the GHB was well tolerated. Subjects in the GHB group were given additional open-label doses every 2-6 hours for the following eight days, which continued to suppress withdrawal.[23] Two other methadone-maintained patients were detoxified with GHB, 50/ mg/kg every 4-6 hours and 30 mg/kg every 4 hours, respectively. GHB treatment was suspended after 9 and 8 days respectively, and both subjects were given naloxone 0.4 mg IV; no withdrawal symptoms were noted.[24] Hajra, et al., in a double blind trial, failed to find any difference between GHB 0 mg/kg, 15 mg/kg, and 30 mg/kg in suppressing naloxone-precipitated withdrawal in an unspecified number of levorphanol dependent subjects.[25] While reports of the utility of GHB in the treatment of addictions are intriguing, confirmation by a second group of investigators is needed.

Current Use

Though in limited use in Europe as a surgical anesthetic, GHB is not approved in the US. It was, however, marketed as a health food product in the US in 1990 for its hypnotic effects and also to promote weight loss and muscular development. The latter claim presumably stems from the fact that GHB acutely facilitates slow-wave sleep, during which growth hormone release takes place. Luby, Jones & Zalewski have reported that several gymnasiums surveyed in South Carolina were selling GHB for this purpose, though the actual efficacy of GHB in promoting muscle development is not documented.[26] In addition to the above effects of GHB, subjective reports suggest that a significant proportion of users also experience euphoria, and some users take more than the recommended dose (approximately 2.5 g or 36 mg/kg for a 70 kg person) to enhance this effect.[13, 26] GHB is sold as 'GHB,' 'liquid ecstasy,' and occasionally as 'GBH' or 'grievous bodily harm.' GHB has gained limited popularity in the UK, where it has been sold at raves — all night dance parties — as 'liquid ecstasy.'[27] The illicit use reported has been only ingestion by the oral route.

Adverse Effects

The dose response curve for GHB is steep. Exceeding the recommended or intoxicating dose can result in severe adverse effects. Effects of GHB in humans include somnolence leading to arousable sleep at 40-50 mg/kg and, at 60-70 mg/kg, coma for 1-2 hours (generally without depression of the reticular activating system). The LD_{50} has been estimated at 5 to 15 times that inducing coma.[12] GHB and alcohol have synergistic hypnotic effects.[28]

Introduction of GHB into the United States over-the-counter market in the spring of 1990 was rapidly followed by reports of adverse effects at doses from 1 tsp. (approximately 2.5 g) to 4 Tbs. (approximately 30 g).[13, 29, 30] Widespread reports of poisonings led to a US Food and Drug Administration ban on distribution for human use outside of approved clinical trials in November of 1990. Consistent with known psychopharmacology, adverse effects reported include dizziness, nausea, vomiting, weakness, tonic-clonic seizure-like activity, loss of peripheral vision, confusion, agitation, hallucinations, bradycardia, decreased respiratory effort, unconsciousness, and coma.[13, 26, 30] These effects can appear within 15 minutes of oral ingestion of the drug, and acute symptoms appear to remit after 7 hours, though some people have reported lingering dizziness for up to 2 weeks.[13, 30] Respiratory arrest occurred in one healthy 24 year old male who reportedly ingested 'several' beers and a 'small' amount of GHB; he was intubated and mechanically ventilated, and he recovered without sequelae.[31]

Given the evidence that GHB produces relaxation and euphoria, it is clearly important to understand the abuse potential of this drug.

Neuropharmacology

Roth & Giarman showed that GHB is a naturally occurring substance in mammalian brain and proposed its role as a neurotransmitter.[1] The structural similarity of GHB to GABA and the demonstration of pathways that can convert GHB to GABA led to speculation that GHB might be a GABA agonist. However, GHB does not appear to exert direct actions on the $GABA_A$ receptor and, while GHB has partial agonist activity at $GABA_B$ receptors, this effect has been demonstrated only at supra-physiologic concentrations[2-4].

GHB and alcohol have synergistic hypnotic effects.

Several lines of evidence support the hypothesis that GHB is a neurotransmitter. Specific high-affinity binding sites for GHB have been found in rat brain.[5] GHB has a specific enzyme for its biosynthesis and a high affinity uptake system.[6, 7] Moreover, it is located primarily in the synaptosomal compartment and is released from brain tissue by membrane depolarizing concentrations of potassium in a calcium dependent process.[8] High affinity binding sites appear to be in

close proximity with dopaminergic structures.[9] GHB administration transiently suppresses dopamine release, followed by a marked increase in dopamine release, particularly along the neurons of the nigrostriatal pathway.[10] This increase in dopamine release is accompanied by increased release of endogenous opioids.[11] The physiologic function is not well understood.

Tolerance and physical dependence can develop.

GHB is rapidly absorbed, with peak plasma concentrations occurring 20-60 minutes after oral administration. At a dose of 12.5 mg/kg, clearance is 14.0 ml $min^{-1}kg^{-1}$, and half life is 20 min. GHB is almost completely oxidized to carbon dioxide.[12] Only 2%-5% eliminated in the urine.[13] Pharmacokinetics of GHB in alcoholics are not significantly different than those in non-alcoholics.[14]

Discussion

GHB is a putative neurotransmitter that has a number of potential clinical roles, including treatment of alcohol and opiate dependence, and a recent history of abuse. GHB is used for its euphorigenic, anabolic, and sedative properties. GHB can cause a variety of adverse effects, including potentially fatal respiratory depression, seizure activity, vomiting, and discoordination. Combining GHB with alcohol, methamphetamine, or MDMA may increase the incidence of adverse effects. Our clinical experience indicates that tolerance and physical dependence can develop, as evidenced by a withdrawal syndrome that may include insomnia, muscular cramping, tremor, and anxiety.[32,33] This withdrawal syndrome has been seen only after people have used high doses. Physical dependence on GHB may contribute to the continued use among those individuals who continue to use it despite adverse consequences. Evaluation of the effects of discontinuation of GHB at the end of clinical trials is essential, particularly in light of the suggestion that GHB be used as a maintenance medication in the treatment of alcoholism, analogous to use of methadone in opiate dependence.[22] Prudent management of GHB dependence would appear to include observation, reassurance of the absence of dangerous withdrawal symptoms, and drug abuse counseling. The role of sedative-hypnotic drugs in relieving symptoms of GHB withdrawal is unclear; their use should be limited to patients in whom withdrawal is severe or presents a significant risk for relapse.

As with any illicitly manufactured drug, purity and dose of GHB are uncertain, increasing the likelihood of adverse reactions. GHB may be misrepresented as a safe, natural, and nonaddictive hypnotic or anabolic. Patients in recovery are often troubled by insomnia and are generally advised to exercise; this may make them vulnerable to the claims made for GHB. The euphoric and physical dependence-inducing properties of GHB may lead to widespread and prolonged use. Several points will be important to emphasize in educational campaigns to reduce harm from GHB's use. Psychostimulants, such as methamphetamine, may increase the risk of seizures from GHB; concurrent use with alcohol may increase the risk of vomiting and respiratory depression; the therapeutic index of this compound is low; accurate dosage estimates are difficult with illicit supplies, particularly when sold in solution; and physical dependence is a possibility.

Widespread reports of poisonings led to an FDA ban on distribution for human use outside of approved clinical trials.

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HEDIS

Measuring the Performance of Managed Care Plans

The National Committee for Quality Assurance (NCQA), a not-for-profit organization based in Washington, DC, formed to evaluate and report on the quality of managed care plans, is the accrediting entity for managed health plans.

In addition to the accreditation program, NCQA collects and provides standardized data from more than 330 health plans across the US. NCQA publishes the data — called the Health Plan Employer Data and Information Set (HEDIS) — in a form that allows you to compare the data from one managed health plan with the data from another. Purchasers ask for HEDIS rates when evaluating which health plan to select. HEDIS is a list (or data set) of data elements standardized so that each plan collects the same data in the same way. The version now in use is 2.5. A revision, 3.0, is currently circulating for public comment. In HEDIS 3.0, sixty-one elements fall into eight general areas:

1) **effectiveness of care**: Is care achieving expected gains in health?

   There are 16 measures in this area including the following:
   - screening for breast cancer
   - low birth weight babies
   - prenatal care in first trimester
   - advising smokers to quit
   - treating children's ear infections
   - beta blocker treatment after a heart attack

2) **accessibility/availability of care**: Is care available without inappropriate barriers and delay?

   There are 14 measures in this area including the following:
   - appointment access
   - telephone access
   - availability of OB and prenatal care providers
   - initiation of prenatal care
   - low birth weight deliveries at facilities for high-risk deliveries and neonates
   - availability of mental health/chemical dependency providers

3) **satisfaction with the experience of care**

   There are two measures in this area:
   - the annual member health care survey
   - survey descriptive information

4) **cost of care**

   There are two measures in this area:
   - high-occurrence/high-cost DRGs
   - rate trends

5) **stability of the health plan**: Will there be a change that could disrupt care?

The four measures of stability include the following:
- physician turnover
- disenrollment

6) **informed health care choices**: Is the health plan helping members to be active and informed partners in health care decisions?

There are two measures in this area:
- language translation services
- new member orientation/education

7) **use of services**: Is there evidence of too much or too little care?

The 18 measures in this area include the following:
- chemical dependency utilization — percentage of members receiving inpatient, day/night care and ambulatory services
- chemical dependency utilization — inpatient discharges and average length of stay
- readmission for chemical dependency
- frequency of ongoing prenatal care
- mental health utilization

8) **plan descriptive information**: How is the plan organized? What type of doctors participate, and how many?

There are 18 measures in this area:
- board certification/residency completion
- arrangements with public health, educational and social service entities

HEDIS 3.0 was developed under the direction of a 24-member Committee on Performance Measurement which includes medical providers, managed health plan providers, public health officials, representatives of organized labor, consumer organizations such as AARP, as well as health policy consultants.

David Mee-Lee, MD, and James Callahan, DPA, ASAM's Chief Executive Officer, serve as members of NCQA's Managed Behavioral Health Care Task Force. Michael Miller, MD, serves on another NCQA task force which is working on the standards for accrediting health care programs. Through their efforts, ASAM was instrumental in expanding "psychiatrist" to "and/or physician certified in Addiction Medicine." The American Society of Addiction Medicine emphasized the need to measure continuity of care and to recognize levels of service besides inpatient for treatment of chemical dependence.

ASAM policy states that it is a fundamental responsibility of the *health care organization* to screen for alcohol use disorders as a routine element of all patient care and that screening for alcohol use disorders should be a standard for accrediting health care organizations. That position is reflected, not in the 61 measures in this draft version of 3.0, but in an additional list of 30 items called the "testing set" which NCQA will refine over the next 12-24 months for future use. The testing set includes these measures:
- chemical dependence screening
- smokers who quit
- substance abuse counseling for adolescents
- continuity of care -- substance abuse
- treatment failure -- substance abuse
- use of behavioral health services

ASAM policy states that screening for alcohol use disorders should be a standard for accrediting health care organizations.

The period allotted for public comment on draft 3.0 of the Health Plan Employer Data and Information Set ended on September 3, 1996. Copies of the 414-page document were circulated for comment from NCQA Publications Division, 1-800-839-6487.

Universal Application Form for Credentialing Physicians

Six health care organizations have joined together to endorse one standardized form which health plans, IPAs, medical groups or medical staffs can use for credentialing and recredentialing. The six organizations are:

California Association of HMOs
California Healthcare Association
California Medical Association
IPA Association of California
Medical Quality Commission
Unified Medical Group Association

A commonly seen question asking whether an applicant has a history of chemical dependence is now considered to be a violation of the protections established by the Americans with Disabilities Act (ADA), according to Kimberly Davenport, Legal Counsel for the California Medical Association. An ADA-appropriate question is, "Are you able to perform all the services required... with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?"

Questions asking about actions against your license or DEA registration do not conflict with the ADA protections. The new form asks if your license or DEA registration has ever been denied, limited, suspended, revoked, not renewed or subject to probationary conditions. It asks if you have been fined or received a letter of reprimand — or if such action is pending.

A copy of the standardized application is available from the CSAM office.

Drug Abuse No Longer Disabling

An Editorial by John McCarthy, MD

On March 29, 1996 President Clinton and Congress eliminated drug dependence and alcoholism as disabilities under Supplemental Security Income (SSI). Despite all their rhetoric about how disabling drug use is, they have apparently changed their minds. As of January 1, 1997, drug addiction will not be disabling any more.

Over the years, SSI has enabled thousands of addicts to pay for methadone maintenance and other forms of drug treatment.

SSI now provides small cash benefits and eligibility for Medi-Cal to recipients. Over the years these cash benefits from SSI have enabled thousands of addicts to pay for methadone maintenance and other forms of drug treatment. Now, with benefits to be terminated, over 4,500 Sacramento addicts and thousands more throughout the state and country will lose their access to treatment. Many will also become homeless.

Cost-saving is the publicly stated rationale for this political decision. Yet the effect will be increased costs in healthcare and, of course, in the criminal justice system. Numerous studies have documented the cost-effectiveness of providing drug treatment to reduce infectious diseases, crime, and the real disabilities associated with drug addiction. The comprehensive 1994 California Drug and Alcohol Treatment Assessment (CALDATA) study showed, for example, that methadone treatment saved $12 for every dollar spent by the state. Yet this political decision will put thousands of injection drug users back on the streets with no provision for continued access to treatment. They will become the responsibility of the county. The response of some California counties to the loss of this federal support has been to introduce in the California legislature, a bill (SB 1465 — Johannessen) to eliminate a county's legal responsibilities for any medical or economic aid to those denied federal or state benefits! This is an attempt to make a whole group of people invisible until they surface in our prisons, hospitals, and homeless shelters.

This spring, some patients started receiving letters announcing the impending termination of their benefits. In the first week I had three suicidal patients in my office who had been doing well and were in recovery. Two of the three had relapsed. What the letters meant to them was an inevitable return to addiction. Suicide seemed a better option.

Treatment is our most powerful tool for reducing demand for drugs. Driving addicts out of treatment will increase demand and enrich drug-dealing networks. Meanwhile, the Clinton administration is calling for more narcotics police to deal with amphetamines, i.e. more millions spent on supply reduction. Supply reduction has been shown to be the least cost-effective drug control strategy. But this is an election year. Time to look 'tough on drugs.' For three years the administration has obstructed projects to make clean needles available to reduce the epidemic of infectious diseases among drug users. It has ignored racist incarceration policies that are ravaging black communities. And it has ignored the soaring criminal justice costs of the drug war that are diverting resources from schools and social services in communities across the country. Governor Pete Wilson has pursued the same policy in California. The political goal has little to do with reducing drug use or the spread of HIV and hepatitis C. Drug policy in the U.S. seems little more than a vehicle for campaign propaganda.

A cynical drug war is increasing societal harm. This cries out for an independent commission on drug policy that places societal needs for effective policies above the needs of election campaigns.

Both parties continue a cynical drug war that is increasing societal harms. They pretend that we are saving money by ending public support for addiction treatment, but they fail to mention the far greater costs of enforcement, imprisonment and infectious diseases. This kind of hypocrisy cries out for an independent commission on drug policy that places societal needs for effective policies above the needs of election campaigns. We simply must have more integrity in our drug policy.

Doctor McCarthy is the Executive and Medical Director of Bi-Valley Medical Clinic in Sacramento which includes narcotic treatment programs in Sacramento and Carmichael.

YOU CAN WRITE FOR

Research Advisory Panel Report

The Twenty-sixth Annual Report of the Research Advisory Panel covers activities in 1995. The Research Advisory Panel must approve research projects in California which involve any controlled substance (California's Health and Safety Code, Section 11213). The Panel's annual report to the legislature describes the research under way in the state. Examples include:

- a controlled trial comparing buprenorphine and methadone maintenance in opioid dependence, conducted by Walter Ling, Donald Wesson and colleagues at the Los Angeles Addiction Treatment Research Center
- an intensive outpatient approach for cocaine abuse treatment, conducted by Richard Rawson, PhD at Matrix Center in Los Angeles
- a study to assess the safety and efficacy of selegiline in cocaine-dependent outpatients, a National Institute on Drug Abuse (NIDA) multi-center study in which Steven Batki and San Francisco General Hospital participated
- a NIDA-sponsored multi-center study of tuberculosis chemoprophylaxis in injection drug users, conducted at San Francisco General Hospital by Steven Batki and colleagues
- a study of the effects of amphetamine on Rorschach measures in normal subjects, conducted by David Braff and William Perry at UCSD
- a study of the effects of varying delta-9-THC concentrations on deposition of tar in the lung and the bioavailability of delta-9-THC, conducted by Donald Taskin at UCLA.

Copies of the 42-page report are available on request from the Executive Secretary of the Panel, David W. Schieser, PhD, 50 Fremont Street, Suite 300, San Francisco, CA 94105-2239.

CSAT TIPs

Titles in the Treatment and Improvement Protocol Series published by the Center for Substance Abuse Treatment now include:

- Detoxification from Alcohol and Other Drugs (TIP 19)
- LAAM in the Treatment of Opiate Addiction (TIP 22)
- Matching Treatment to Patient Needs In Opioid Substitution Therapy (TIP 20)
- Tuberculosis: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers (TIP 18)
- Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases (TIP 11)
- The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders (TIP 13)

TIPs are free. Order from the National Clearinghouse for Alcohol and Drug Information (NCADI) 1-800-729-6686.

CSAM Activities

Methadone Regulation Review

A newly formed Committee of CSAM is reviewing the California regulations which govern the licensure and operation of narcotic treatment programs. At the request of a Work Group on Regulation Review convened by the California Department of Alcohol and Drug Programs (ADP), CSAM is providing comments and suggested changes to reflect good clinical practices.

The CSAM Committee on Treatment of Opioid Dependence is chaired by Walter Ling, MD, the Chief of Substance Abuse Programs at UCLA and the Executive Medical Director of Matrix Center in Los Angeles. Three members of the CSAM Committee serve on the State's ADP Work Group.

The first task assigned to CSAM by the ADP Work Group was to define the role of the physician in narcotic treatment programs. The Committee approached the question by first describing the basic elements of narcotic treatment programs. The preamble to their statement says:

> Opiate substitution therapy is a medical treatment for narcotic addiction which takes advantage of a pharmacologic strategy within a comprehensive treatment setting. The physician has the ultimate responsibility for the treatment.
>
> The main goals of treatment are to maximize the health and well-being of the patients, minimize the adverse health and social consequences of their disease, and protect public health and safety, particularly by containment of infectious disease.

Members of the CSAM Committee are Walter Ling, MD, Chair; John J. McCarthy, MD; Judith Martin, MD; Laurene Spencer, MD; Deborah K. Stephenson, MD; Forest Tennant, MD; and Donald R. Wesson, MD. Karen Sees, DO, and Ernie Vasti, MD, are consultants.

Earlier this year levo-alpha-acetylmethadol (LAAM) was approved for use in California narcotic treatment programs (*CSAM News*, Vol. 22, No. 2, Summer 1995).

Medical Management of Opioid Dependence

A day-long conference, "Medical Management of Opioid Dependence: The Research, the Regulations, the Clinical Dilemmas" will be offered as an alternate session of the 1996 Review Course on Saturday, November 9. The faculty will include Jerome Jaffe, MD, the Director of the Office of Scientific Analysis for the Center for Substance Abuse Treatment (CSAT).

President's Column

William S. Brostoff, MD
President, CSAM

Election of New Officers

The Executive Council has prepared a slate of nominees for the offices of President-elect and Treasurer and four Members-at-large.

- **Gail N. Shultz, MD**, Medical Director of the Betty Ford Center is the nominee for President-elect.
- **Lyman H. Boynton, MD**, Chief of Addiction Medicine and Medical Director of the Chemical Dependency Recovery Program of Kaiser, San Francisco is the nominee for Treasurer.

There are four nominees for the two-year terms as Member-at-large on the Executive Council:

- **Peter Banys, MD,** is Interim Chief of Psychiatry at the Veteran Affairs Medical Center in San Francisco and also has a private practice in Psychiatry.
- **Gary A. Jaeger, MD,** is Chief of Addiction Medicine at the Kaiser Chemical Dependency Recovery Program in Carson.
- **Michael S. Parr, MD,** has a private practice in Obstetrics and Gynecology and is Medical Director of the Sutter Outpatient Drug and Alcohol Program in Sacramento.
- **Margaret B. Yates, MD,** has a private practice in Psychiatry and Addiction Medicine and is an Assistant Clinical Professor of Psychiatry at UCLA.

Additional nominees will be requested from the floor during the business meeting on November 9.

Specialty Distribution of CSAM Members

A review of the numbers of members in each of the major specialties reveals no major differences from previous years, except for a small and gradual increase in the proportional representation of psychiatrists (26% in 1993, 30% in 1995, 32% in 1996). Internists composed 26% of the membership in 1993, 24% in 1995 and 26% in 1996. Those who report their specialty as Addiction Medicine dropped sharply from 16% in 1993 to 9% in 1995. For 1996, those who report their primary specialty as Addiction Medicine are 10% of the CSAM membership.

Addictionist or Addiction Medicine Specialist

The number of times I have heard the term "addictionist" used to indicate a nonphysician health care provider has made me favor the phrase "Addiction Medicine specialist" to identify the physicians.

1996 Specialty Distribution of CSAM Members
and the percentage which is ASAM certified

Specialty	Number/percentage of total membership of CSAM	ASAM Certification
Psychiatry	144 members (32%)	40% of the psychiatrists are ASAM certified
Internal Medicine	114 members (26%)	43% of the internists
Family Practice	65 members (15%)	52% of the family physicians
Addiction Medicine	43 members (10%)	84% of the addiction medicine specialists
Other	81 members (18%)	30% of the other specialists
TOTAL MEMBERS	447 members	45% of all CSAM members are ASAM certified

NEWS ABOUT MEMBERS

Laurene Spencer is now Medical Director at the Geary Clinic of BAART — Bay Area Addiction Research and Treatment -- in San Francisco. She and her family have returned to California after three years in Wisconsin. She is serving on the CSAM Committee on Treatment of Opioid Dependence.

Mickey Ask has been appointed to the Diversion Evaluation Committee for the Board of Registered Nurses.

Steven Ey has completed the fellowship in Addiction Medicine/Preventive Medicine at UC Irvine and Kaiser Fontana.

Max Schneider is now serving as the Deputy Chair of NCADD — the National Council on Alcoholism and Other Drug Dependence.

Merritt Smith was appointed director of CME at West Oakland Health Council, Inc.

Joseph Galletta was the featured speaker at a meeting of the California Medical Association Alliance. The meeting was titled "Searching Out Solutions for Stress."

Frank Staggers is a senior member of the hypertension research team whose work produced landmark findings on the effect of a stress reduction technique, deep relaxation, on lowering blood pressure. The findings were published in *Hypertension*, the Journal of the American Heart Association, and featured on CNN. The study was sponsored by the Retirement Research Foundation in Chicago and funded by the National Institutes of Health.

Bill Shaw is Chairman of ASAM's Task Force on members who have not completed residency, a new task force working with the ASAM Committee on Membership and its Subcommittee on ASAM Fellow Status.

Barbara Burdan is retiring as a Medical Consultant for Disability Evaluation for the State of California and thinking of moving to Las Vegas to play golf.

Diane Hambrick has moved to Angwin, near Saint Helena, and is doing some phone consultation work regarding pre-employment drug tests.

Susan McCall left California where she was Medical Director of the Department of Alcohol and Drug Services at Santa Clara Valley Health and Hospital System and is now the Director of the Oregon Health Professionals Program.

Daniel Headrick is now the full-time Medical Director of the Chemical Dependency Unit at Hoag Memorial Hospital in Newport Beach.

Marilyn Sponza has been made a Fellow of the American Psychiatric Association.

Joseph Chudy will be the physician in charge of Kaiser's new satellite primary care office in Oakhurst, 20 miles south of Yosemite.

Kathleen Unger and **Robert Cabaj** have been elected to offices in the Northern California Psychiatric Association: Doctor Unger is the representative of NCPS to the American Psychiatric Association Assembly, and Doctor Cabaj is an NCPS Councilor at Large.

Margaret Gregory and **Tony Radcliffe** published the results of a treatment outcome study of 1,986 patients consecutively entering treatment at the Chemical Dependency Recovery Program (CDRP) of Southern California Kaiser.

23rd Annual Business Meeting of the Members

Saturday, November 9, 12:30 pm
Biltmore Hotel, Los Angeles
During the 1996 Review Course in Addiction Medicine, November 6-9

- Reports on each CSAM committee and activity
- Election of officers and Executive Council members
- Opportunity for comment from members

This is an open meeting; all are welcome. We encourage dialogue with the members regarding acitivities for the coming year. You do not need to purchase lunch in order to attend the meeting. Lunch is $25 per person.

California's Diversion Program for Physicians

About 250 Physicians are in the Diversion Program

The Medical Board of California's Diversion Program is in its 16th year of service to the physicians of California. Since it began, 794 physicians have completed the program. Two hundred five are currently enrolled. An additional 50 have asked to participate and are waiting to complete the intake process.

Should there be more?

Some observers believe that the Program should be used by more physicians — that in a state with 60,000 practicing physicians there should be more than 255 in the program.

Most agree in theory that more physicians could and should use the Diversion Program, and many people have ideas about what keeps the numbers low. It has been a subject of discussion for both the Liaison Committee to Diversion and the Medical Board.

The enclosed questionnaire is intended to gather comments on this subject from the readers of *CSAM NEWS*. It is a open-ended questionnaire designed to gather ideas, not a survey designed to measure any factor.

Responses will go directly to the CSAM Committee on Physician Impairment and will be given serious consideration. From there, a report may be forwarded to the Liaison Committee to Diversion by CSAM representatives William Brostoff, Michael Parr and John Lanier. Other members of the CSAM Committee are Joseph Galletta, Glenhall Taylor, Lyman Boynton, Barrett Levine. Consultants are Gary Nye, John Milner, Garrett O'Connor, Norman Reynolds, Max Schneider, Peter Washburn.

Diversion Evaluation Committees

Northern I
Sharon Bjornson, MFCC (V. Chair)
William Brostoff, MD
Michael Parr, MD (Chair)
Michael Stulberg, MD
Maureen Whitmore, MFCC

Northern II
Lyman Boynton, MD
Amy Khan, MD (V. Chair)
Robert Matano, PhD
Duane Menefee, MD (Chair)
Jeff Roth, MA

Southern I
Anne LaBorde, PhD
Barrett Levine, MD (V. Chair)
Linda Oliver, LCSW
Norman Reynolds, MD (Chair)
Philip Spiegel, MD

Southern II
Judge William Beard
H. Westley Clark, MD
N. J. Marciano, MD
Marilyn Sponza, MFCC (V. Chair)
Robert Tartar, MD (Chair)

Southern III
(no chair is designated for Southern III)
Sara Granger, MFCC
James Johnson, MD (V. Chair)
Gail Shultz, MD
Richard Wachsman, MD
Naomi Siegal, MFCC

A Letter to the President

Dear Bill,

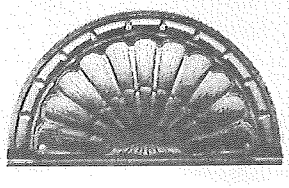
I just received the announcement of the Review Course sponsored by the California and American Society of Addiction Medicine. I am again discouraged by the absence of any discussion of adolescent substance abuse or dependence. There never seems to be enough interest in adolescent problems to have any time given to that topic, unless a specific separate program is done.

It is my feeling that Addiction Medicine Specialists are considered to be the authorities in the field and are looked upon as referrals for problems with adolescents as well as adults. Yet there is virtually no information in the Review Course that deals with the specific problems of adolescent substance abuse. I hope you would agree with me that the evaluation, treatment, and, particularly, the prevention of adolescent chemical dependency differs from that of adults. Are we not interested in this subject? It is my observation that adolescents are being handled by nonmedical professionals or by psychiatrists who have little or no experience with adolescents who are not seriously mentally ill.

It would seem to me that there are a number of subjects related to adolescent substance abuse that would be appropriate for inclusion in an addiction medicine program. There is a session on women and addiction and also a presentation on perinatal problems. Where are the adolescents and young adults?

I'm sure the California Society is tired of hearing from me about the lack of interest in adolescent substance abuse, but I had to share my feelings after seeing the program.

Sincerely,
Arthur Bolter, MD



California Society 23rd Annual Meeting

1996 Review Course in Addiction Medicine
November 6-9, 1996, Biltmore Hotel, Los Angeles

Reception — Thursday evening, November 7
Presentation of the Community Service Award to
Stanton Glanz, PhD

Awards Dinner — Friday evening, November 8
Presentation of the Vernelle Fox Award to
James West, MD

CONTINUING MEDICAL EDUCATION

ASAM Review Course in Chicago

Review Course in Addiction Medicine

October 24-26, 1996
Hyatt Regency O'Hare, Chicago
Sponsored by the American Society of Addiction Medicine
Speakers include John Allen, PhD; Daniel Angres, MD; Raymond Anton, MD; Milton Burglass, MD; John Chappel, MD; H. Westley Clark, MD; Rosa Crum, MD; Steven Eickelberg, MD; Anne Geller, MD; Mark Gold, MD; Allan Graham, MD; Harry Haverkos, MD; Roger Meyer, MD; Norman Miller, MD; Seddon Savage, MD; Terry Schultz, MD; David Smith, MD
Fees: $350 for three days for members and for non-physicians; $425 for nonmember physicians; $250 for residents; $50 for medical students. $150 for one-day registration.
Credit: 21 hours of Category 1 credit
For information, contact ASAM, 4601 North Park Avenue, Chevy Chase, MD 20815; (301) 656-3920

The day before the Los Angeles Review Course

Serving Two Masters: Ethical Dilemmas Facing Addiction Medicine Physicians — a Daylong Consultation

Wednesday, November 6, 1996
Biltmore Hotel, Downtown Los Angeles
Sponsored by the California Society of Addiction Medicine
Speakers include George Lundberg, MD; Peter Banys, MD; Barry Rosen, MD; John McKinnon, MD; Garrett O'Connor, MD; A. Thomas McLellan, PhD
Fee: $120
Credit: 7 hours Category 1 credit
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611. (510) 428-9091.

CSAM/ASAM Review Course in Los Angeles

Addiction Medicine 1996 Review Course

November 6-9, 1996
Biltmore Hotel, Downtown Los Angeles
Speakers include David Mee-Lee, MD; Billy Martin, PhD; Jerome Jaffe, MD; A. Thomas McLellan, PhD; Joan Ellen Zweben, PhD; Richard Sandor, MD; John Slade, MD; Carol Archie, MD; John Chappel, MD; Steven Batki, MD; Walter Ling, MD; Richard Rawson, PhD; David Smith, MD
Credit: 21 hours of Category 1 Credit
Fees: $350 for three days for members and for nonphysicians; $425 for nonmember physicians; $200 for residents; $50 for medical schools. Different fees for one-day registrations are listed on the registration form.
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611. (510) 428-9091.

7th Annual Meeting and Review Course in Addiction Psychiatry

December 6-8, 1996
Fairmont Hotel, atop Nob Hill, San Francisco
Sponsored by American Academy of Addiction Psychiatry
Speakers include Neil Benowitz, MD; J. Raymond DePaulo, Jr., MD; Roger Weiss, MD; Kevin Olden, MD; Charles Daley, MD; Robert Gish, MD; Sheila Blume, MD; Jerome Jaffe, MD; Richard Rosenthal, MD
Credit: Up to 22.5 hours of Category 1 credit
Fees: For the annual meeting program on December 6 and 7, $375 for members, $500 for nonmembers before October 4. After October 4, $425 for members and $550 for nonmembers.
For the Review Course on December 8, $275 for members, $425 for nonmembers before October 4; $305 or $475 after October 4.
For information, contact American Academy of Addiction Psychiatry, 8340 Mission Road, Suite B4, Prairie Village, KS 66206. (913) 341-6680.