ASAM Cautions White House Against Over-Hasty Approval of Tobacco Settlement

G. Douglas Talbott, M.D.

On behalf of the officers and members of the Society, I have sent the following letter to President Clinton, commenting on the proposed tobacco settlement:

Dear President Clinton:

Tobacco is both the leading cause of preventable death and the leading cause of addiction in the United States today. Working out a solution to this problem is too important for it to be done in haste, and it seems folly to do it before all the facts are known.

The manufacturers of tobacco products have never been accountable for the harm their products cause. The main objective of any legislation in this area must be, finally, to hold the industry accountable. This is the most certain way to reduce the terrible toll of illness and death from these products. Unfortunately, the Proposed Resolution negotiated by some of the states' Attorneys General with the larger manufacturers falls far short of this goal.

While the American Society of Addiction Medicine is open to the possibility that new federal legislation might make the industry accountable, the Society is profoundly disturbed by the seeming haste with which things are moving forward on this matter.

The proposed Resolution has been found seriously wanting by every medical and public health group of which the Society is aware. Rumors abound of negotiations which are leading to changes in the terms, but there has yet been no public examination of these new terms.

The tobacco industry must become accountable. Legislation to resolve the tobacco issues now on the public agenda should be considered with great deliberation. Hasty action will lead to needless illness and death. Artificial early deadlines to complete action on this matter only work to the advantage of the tobacco product manufacturers. They are not in the public interest.

(Copies of this letter also were delivered to Vice President Gore, ONDCP Director Gen. Barry McCaffrey, members of Congress, and John Slade, M.D., FASAM, Chair of the ASAM Nicotine Dependence Committee.)

"The Society is especially concerned that some of the short term gains...are being oversold to members of Congress and the public as being of greater public health importance than they actually are."
JAMA PUBLISHES ASAM PRACTICE GUIDELINE ON MANAGEMENT OF ALCOHOL WITHDRAWAL

Michael Mayo-Smith, M.D.

Significant advances in the management of alcohol withdrawal and treatment of alcohol dependence were signaled with publication in the Journal of the American Medical Association of a clinical practice guideline developed by ASAM on the "Pharmacologic Management of Alcohol Withdrawal: A Meta-analysis and Evidence-Based Practice Guideline" (JAMA 1997;278(2):144-151). The ASAM Guideline was developed by a group of physicians including specialists in addiction medicine, primary care physicians and researchers in alcohol withdrawal drawn from institutions around the country including Harvard, Yale, and Johns Hopkins Medical Schools. The evidence-based process used in developing the Guideline incorporated the latest recommendations on clinical practice guidelines from such organizations as the Institute of Medicine, the Agency for Health Care Policy and Research, and the American Medical Association.

The review demonstrated that a certain class of medications, the benzodiazepines, have been proven to both lessen the severity of alcohol withdrawal and prevent major complications including seizures and delirium tremens. In addition, it was found that individualizing therapy using objective withdrawal severity scores greatly reduced the amount of medication needed, and the duration of treatment, without lessening safety. Surveys have shown that this approach is largely underutilized in the field.

The Guideline, derived from a careful analysis of published scientific studies, is strongly evidence-based. All scientific studies published in the medical literature regarding pharmacologic management of alcohol withdrawal were identified and carefully reviewed. While previous individual studies have suggested that benzodiazepines lessened the severity of alcohol withdrawal and prevent major complications, the opportunity to pull together a large number of studies from the literature and combine their results, allowed this finding to stand out in a striking way. The review also found that, although dozens of other medications have been used to treat alcohol withdrawal, none have been proven to be as effective as the benzodiazepines.

This Guideline is one of several evidence-based guidelines being developed by ASAM's Committee on Practice Guidelines to strengthen the scientific foundation of addiction treatment and improve the care of patients with these disorders throughout the country.

VOTE 425 ON THE AMA SPECIALTY SOCIETY BALLOT

Michael M. Miller, M.D., ASAM Delegate to the AMA

The American Medical Association is again asking AMA member physicians to indicate the medical specialty society they want to represent them in the AMA House of Delegates.

Ballots must be received by December 31, 1997. Voting can be done in several ways:

- Faxing a ballot reply card that was attached to the October 13 issue of AMNews;
- Calling a toll-free phone number: 888/200-5309; or
- E-mailing the choice to ballot@ama-assn.org.

However you cast your ballot, remember to "Vote 425" for ASAM as your representative medical specialty society!
MILITARY MANAGED CARE WILL USE ASAM “GOLD STANDARD”

If the various elements of the military health care system could be viewed as soldiers marching in unison, then substance abuse treatment has traditionally been the recruit having trouble keeping up with the group. But as managed care gradually envelops the military, addiction treatment is expected to evolve into a multidisciplinary system of care steeped in the field’s most widely accepted guidelines.

Substance abuse has been off to the side in the military health care system,” Roger Hartman, health policy analyst in the Department of Defense’s Office of the Assistant Secretary for Health Affairs, told ADAW. “Our programs of treatment have been very service-specific; that is, the Army, Navy and Air Force all have done their own thing. The other feature was a “one-size-fits-all” approach to treatment, Hartman continued. “There was four-week residential treatment if that was indicated, and there was a comparable stay for outpatient. Those were about the only two choices.”

But a policy memorandum issued earlier this year indicates that the old system is changing in a big way. As the military’s medical program for active-duty members, retirees and qualified family members becomes a managed care system known as TRICARE, substance abuse treatment will grow to resemble the continuum of care outlined in ASAM’s Patient Placement Criteria, which come closest to being the nation’s clinical standards for addiction treatment.

“We pretty much recognized that ASAM is the gold standard in the industry right now,” Hartman said.

Under TRICARE, the continental United States has been divided into 12 regions for health care services; in each region, one branch of the military or one facility has the lead role in overseeing care. Seven regions have managed care contracts already in place, with the remainder expected to have contracts by the end of this year or early 1998, Hartman said.

Hartman described the evolving substance abuse treatment system as offering “a full range of services provided by requisite professionals,” including certified substance abuse counselors, mental health professionals and primary care physicians. With ASAM’s patient placement criteria as a guide, the Department of Defense will be seeking to place clients in the least restrictive setting appropriate to their case, with civilian providers playing a prominent role.

Hartman, who worked in the Navy’s drug and alcohol program for 10 years, says TRICARE’s regional approach will result in a much more efficient system of substance abuse treatment services. In the past, active-duty members who were diagnosed as having addiction problems often had to be sent halfway across the country for the appropriate residential treatment, he said.

Under TRICARE, line personnel still will have some involvement, but all treatment and aftercare services will be overseen by medical personnel, Hartman said.

MONEY FOR TREATMENT II: CLASS ACTION SUITS — A ROLE FOR YOU?

Marc Galanter, M.D., FASAM

How many times have you been on the phone with a representative of managed care and been told that your treatment plan is not accepted? How can we in addiction medicine address this un“manage”-able problem?

Fortunately, the time is ripe for us to take steps to limit the way managed care companies can compromise our patients’ care. The public and their representatives in government are beginning to understand why doctors should not be blocked from making their own medical judgments. In fact, requirements are being imposed on managed care plans to provide a fairer system of appeals for emergency care and for inadequate care, as when needed hospitalization is denied. Recent investigations of managed care plans’ operations suggest that numerous such abuses have occurred.

In “Money for Treatment I” (May-June ASAM News), we considered the many roles ASAM has played as an organization to assure proper coverage for addiction treatment. In this column, we will consider one way that individual physicians can confront corporate wrongdoers: namely, the class action lawsuit. In the addiction field, the effectiveness of this approach has been amply evidenced by tobacco. Individuals compromised by billion-dollar purveyors of cigarettes have gotten their day in court when represented as a group.

Here are some particulars about one relevant set of lawsuits, and information on how you can contact the attorneys who are undertaking this initiative if you have relevant information.

Up to 23 class action lawsuits are being considered against Blue Cross plans that “carve out” substance abuse and mental health from their managed care operations and then use Green Spring Health Services, Inc., to review the appropriateness of proposed treatment. The underlying allegation is that patients are being denied needed care because the criteria used by Green Spring to evaluate an inpatient stay are more restrictive than those spelled out in the description of benefits patients received from Blue Cross. The suits would allege that Green Spring deliberately uses its criteria for medical necessity, and that these criteria are more restrictive and impose more preconditions than those described in the publicly available benefit documents. Not only will the lawsuits seek to enforce the criteria described by Blue Cross, they will attempt to correct the harm from this practice by having all prior denials reviewed using the Blue Cross criteria.

ASAM’s Executive Committee has decided to provide you with the following information so that, as an independent practitioner, you can decide whether you wish to bring any cases to the attention of the law firm handling the class action suits, although ASAM as an organization is not taking a formal position on the suits at this time.

Members of ASAM have been invited by the law firm pressing the suits to provide clinical examples of the practices being alleged. The attorneys have asked for case histories of patients who could bring suit in order for the class actions to succeed. They will represent patients who: (1) are covered under a health insurance plan issued or administered by a Blue Cross plan, and (2) have been denied coverage for substance abuse treatment at any time due to a determination by Green Spring that the treatment was not medically necessary.

If you have such a patient in your practice, you can prepare a case summary with blinded patient identity, giving particulars of (1) the patient’s characteristics and diagnosis, (2) the indications for care, and (3) the denial of care, so that its suitability can be reviewed. Patient identification might later be undertaken, with the patient’s consent, if the case is added to the suit.

You should send this material directly to Edward Carnot at the law firm of Carnot, Zapor & Klassen, P.C., Suite 290, 1370 Piccard Drive, Rockville, MD 20850-4304; or phone 301/258-1994 or fax 301/948-2155.

FROM THE PRESIDENT-ELECT

IN MEMORIAM

Long-time ASAM member Julian F. Keith, M.D., died July 18, 1997, after a long illness. During his illness, Dr. Keith continued his leadership activities in the field of addiction medicine, which he served most recently as Director of Alcohol and Other Drug Services in the North Carolina Department of Human Resources.

Dr. Keith is survived by his wife, Sue Ann Keith, and by his five sons and one daughter. The family has requested that memorials be directed to the Hazelden Foundation (Center City, MN 55012-0176); the Julian F. Keith Family Medicine Visiting Professorship at the Bowman Gray School of Medicine (Winston-Salem, NC 27157); the Julian F. Keith Prevention Advocacy Center (c/o Sue Gray, UNC Campus, Box 7470, Chapel Hill, NC 27599); or the Hospice of Wake County (4513 Creedmoor Road, Raleigh, NC 27612).

PSYCHIATRISTS

Lutheran Medical Center is a community based teaching hospital distinguished by a strong academic affiliation with the SUNY Health Science Center in Brooklyn. Currently, we have positions available for full time Inpatient Psychiatrists and for Evening/Weekend psychiatric coverage in our newly created Department of Behavioral Health. NYS license and geriatric or addiction experience required. Second language skills in Spanish, Russian, Arabic, or Chinese preferred.

Please fax (718)630-8593, or forward CV to: David Bries, MD, Director of Behavioral Health, Lutheran Medical Center, 150 55th Street, Brooklyn, NY 11220. EOE M/F/D/V

Lutheran Medical Center
A Higher Standard of Caring
THOUGHTS ON SPIRITUALITY AND HIV INFECTION

Charles W. Morgan, M.D.

Each of the Medical-Scientific Conferences of the American Society of Addiction Medicine has highlighted the tremendous advances in our knowledge of the basic science of addiction. Similarly, treatment options for and knowledge of the disease process in patients infected with HIV have advanced significantly. Triple therapy has resulted in plummeting viral loads, which have remained low or nil over time. Understandably, we are delighted with our increased scientific knowledge and its clinical applications.

However, we also must remember the importance of spiritual recovery and treatment for our patients who are infected with HIV. As addictionists, we know that it is necessary to address the needs of the body, the mind and the spirit. This is equally true of persons who have HIV infection. Our expertise in treating the patient’s physical problems must be complemented by attending to their emotional and spiritual needs. Many of us have heard statements such as, “If I were infected with HIV, I don’t know if I would get sober either.” Such hopeless, negative attitudes are communicated to patients in subtle ways by treatment providers. We may have heard fellow professionals say these things, or even said or thought them ourselves. At the same time, we are convinced that there are only the best reasons to become sober, regardless of—perhaps even because of—whatever other conditions our patients may have.

Certainly with triple drug therapy, long-term survival seems increasingly within reach for many patients. Regardless of life expectancy, quality of life is supremely important. Even if total life expectancy is short, we can assure our patients of increased survival rates if risky behaviors are reduced, if self-care is increased, and if the likelihood of contracting other related or unrelated illnesses and injuries is decreased. When these conditions are met, length and quality of life improve.

One of the main gifts we have to offer our patients is hope, either for longer term survival or for enhanced quality of life. We can offer this to our patients who are HIV-positive whether or not they have associated problems with addiction.

In addition, there is a growing body of evidence that shows a direct correlation of improved immune function with enhanced emotional health. Helping others (e.g., volunteer work or 12th Step work in a recovery program) boosts immunity. Intercessory prayer has been shown to enhance survival in acute exacerbation of chronic illness. Therefore, attention to the spiritual needs of patients with HIV infection is certainly indicated.

We must also address the spiritual needs of family members and friends of HIV-positive patients. The patient’s lover, spouse, parents, children and friends can provide tremendous support to the patient and each other which can enhance not only the quality of life of the HIV-positive patient, but also the long term survival. Providing encouragement for involvement in support groups is of paramount importance.

For our addicted patients, the ongoing support of 12 Step programs for HIV-positive patients and their loved ones is of inestimable importance in maintaining sobriety and building emotional support networks. Various 12 Step groups around the country have developed in which it is now common to speak of one’s HIV infection and the emotional, physical and spiritual aspects of dealing with the infection. 12 Step meetings for Gay and Lesbian people have led the way for this openness. The twelve steps themselves provide effective ways for dealing with the emotional aspects of one’s own HIV infection or the infection of a loved one, as well as clinical improvement in the disease process.

The spiritual aspect of making panels for the AIDS Quilt, as well as providing support for memorialization in various organizations, is extremely helpful. Decisions will be made during the course of HIV infection, including decisions about various arrangements such as Living Wills and powers of attorney, as well as who will give the care and what kind of care will be given.

Caring for HIV-positive patients and their loved ones in a non-judgmental way is one of the truly important ways that we can be helpful to our patients. We can naturally bring this skill with us as a result of our experience in treating addicted patients. Our caring, compassionate, loving approach can intensify the spiritual well-being of our patients.

As addiction professionals, we are uniquely and especially situated to help our patients harness powerful tools to deal with a remarkable problem. We need to recognize this fact, use it to our patients’ advantage in dealing with a complex problem, and encourage our staffs and colleagues to do the same.

Dr. Morgan welcomes replies to his comments, which may be addressed to him at West Jersey Health System, 1000 Atlantic Ave., Camden, NJ 08104. Members are encouraged to contribute articles to ASAM News, which should be sent to the ASAM office c/o the Editor.
ACROSS COMMUNITIES: A Guide for Local Community Epidemiology

Alcohol and the Cardiovascular System, NIH Publication No. 96-3817.

Edited by Nicholas J. Kozel and Dr. Zili Bassin, Shaw Inc., 5530 Wisconsin Ave., Suite 1600, Chevy Chase, MD 20815; Fax 301/654-2210; or order through the CEWG Home Page at www.NIDA.NIH.GOV or www.CDMGROUP.COM/CEWG.

NEW IN PRINT

ALCOHOL AND THE CARDIOVASCULAR SYSTEM

Number 31 in the Research Monograph series from the National Institute on Alcohol Abuse and Alcoholism, Alcohol and the Cardiovascular System, presents the results of state-of-the-art research on the consequences of both moderate and immoderate consumption on the heart, blood and blood vessels. The book is divided into major sections on Epidemiological Studies, Clinical Studies, Biochemical and Molecular Studies (Alcohol and the Heart, Alcohol Interactions with Cardiovascular Risk Factors, Alcohol and Blood Vessels), and Alcohol Interactions with Medications. Edited by Sam Zakhari, Ph.D. and Montaz Wassef, Ph.D., the 712-page book is available without charge from NIAAA. Research Monograph No. 31-Alcohol and the Cardiovascular System, NIH Publication No. 96-4133. Order from the NIAAA, Scientific Communications Branch, Office of Scientific Affairs, 6000 Executive Blvd., Suite 409, Bethesda, MD 20892-7003.

ASSESSING DRUG ABUSE WITHIN AND ACROSS COMMUNITIES

Edited by Nicholas J. Kozel and Dr. Zili Sloboda of NIDA's Division of Epidemiology and Prevention Research, this guide was developed as a resource for state, county, city and local organizations that are interested in developing the capacity to identify and monitor drug abuse patterns and trends. Based on the Community Epidemiology Work Group (CEWG) model, the methods described in the guide can be used to collect and analyze data to assist in formulating public health policy, drug abuse prevention and treatment resource management, needs assessments and research plans, and public education campaigns. 100+ pages; single copies are available without charge from NIDA. Assessing Drug Abuse Within and Across Communities: A Guide for Local Community Epidemiology Work Groups. May 1997. Order from George Beschner, Project Director, The CDM Group, Inc., 5530 Wisconsin Ave., Suite 1600, Chevy Chase, MD 20815; Fax 301/654-2210; or order from gbeschner@cdmgroup.com.

WOMEN AND ALCOHOL: ISSUES FOR PREVENTION RESEARCH

NIAAA's Research Monograph No. 32 presents current research in the area of alcohol use among women, and provides recommendations for future studies that could better serve this population. Topics include alcohol use across the life span, alcohol use in the workplace, alcohol-related birth defects, drinking and driving, parenting interventions for preventing alcohol and drug use among children, and the influence of genetics, sexuality and violent victimization on women's alcohol use. 361 pages; single copies are available without charge. Research Monograph No. 32-Women and Alcohol: Issues for Prevention Research, NIH Publication No. 96-3817. Order from the NIAAA, Scientific Communications Branch, Office of Scientific Affairs, 6000 Executive Blvd., Suite 409, Bethesda, MD 20892-7003.

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

The Advance Report is a synthesis of findings presented at the 42nd meeting of the Community Epidemiology Work Group (CEWG) and the 3rd meeting of the International Epidemiology Work Group (IEWG) on Drug Abuse, held in Washington, DC, in June 1997. The CEWG is a network of epidemiologists and researchers in the U.S., sponsored by the National Institute on Drug Abuse, that meets twice a year to review current and emerging substance abuse problems. At the most recent meeting, members reported that use of cocaine hydrochloride and crack, while still at high levels, decreased in 17 of the 21 CEWG areas. Heroin use, on the other hand, increased in 17 areas. Methamphetamine patterns were variable. Indicators of marijuana use show a continuation of the dramatic increases reported over the past several years. The 25-page report is available at no charge from NIDA. Advance Report: Epidemiologic Trends in Drug Abuse—Report of the Community Epidemiology Work Group, June 1997, NIH Publication No. 97-4206. Order from Ms. Marcia Meth, Johnson, Bastin, Shaw Inc., 8630 Fenton St., Suite 1200, Silver Spring, MD 20910; Fax 301/587-4352; or order through the CEWG Home Page at www.NIADA.NIH.GOV or www.CDMGROUP.COM/CEWG.

Certification Reminder!
The standard deadline for the ASAM Certification Application is January 30, 1998. Late registration, at an extra fee, will be available through April 30, 1998. This will allow attendees at the ASAM Annual Medical-Scientific Conference to apply to sit for the examination. The next Certification/Recertification Examination for physicians in addiction medicine is to be offered Saturday, November 21, 1998, at three sites: Atlanta, GA; Newark, NJ; and Los Angeles, CA.

Physicians who wish to sit for the examination must complete and submit an application. All applications will be reviewed and candidates notified by mail as to whether they qualify to sit for the examination. Physicians who pass the examination become ASAM Certified/Recertified in Addiction Medicine. Since the examinations first were offered in 1986, 2,939 physicians have passed the examination, including many of the nation's top addiction treatment professionals.

ASAM certification is recognized by the National Committee for Quality Assurance (NCQA), which in its 1997 standards for credentialing and recredentialing requires that behavioral health care organizations accredited by NCQA have credentialing procedures that assure that "psychiatrists and/or physicians who are certified in addiction medicine" are available to care for patients.

Fellows Reminder!
Applications for fellow status (FASAM) will be accepted through December 31, 1997. ASAM inaugurated the Fellow program in 1996 to recognize substantial and lasting contributions to the Society and the field of addiction medicine. Candidates must meet certain criteria to qualify for Fellow status: they must have been an ASAM members for at least five consecutive years; (2) they must be ASAM-certified; (3) they must have taken a leadership role in ASAM through committee service, or have been an officer of a state chapter; and they must have made and continue to make significant contributions to the additions field. To date, a total of 108 member physicians have been elected Fellows of the American Society of Addiction Medicine.
Pharmacological Management of Alcohol Withdrawal

A Meta-analysis and Evidence-Based Practice Guideline

Michael F. Mayo-Smith, MD, MPH; for the American Society of Addiction Medicine Working Group on Pharmacological Management of Alcohol Withdrawal

Objective.—To provide an evidence-based practice guideline on the pharmacological management of alcohol withdrawal.

Data Sources.—English-language articles published before July 1, 1995, identified through MEDLINE search on "substance withdrawal—ethyl alcohol" and review of references from identified articles.

Study Selection.—Articles with original data on human subjects.

Data Abstraction.—Structured review to determine study design, sample size, interventions used, and outcomes of withdrawal severity, delirium, seizures, completion of withdrawal, entry into rehabilitation, adverse effects, and costs. Data from prospective controlled trials with methodologically sound end points corresponding to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, were abstracted by 2 independent reviewers and underwent meta-analysis.

Data Synthesis.—Benzodiazepines reduce withdrawal severity, reduce incidence of delirium (-4.9 cases per 100 patients; 95% confidence interval, -9.0 to -0.7; P = .04), and reduce seizures (-7.7 seizures per 100 patients; 95% confidence interval, -12.0 to -3.5; P = .003). Individualizing therapy with withdrawal scales results in administration of significantly less medication and shorter treatment (P < .001). β-Blockers, clonidine, and carbamazepine ameliorate withdrawal severity, but evidence is inadequate to determine their effect on delirium and seizures. Phenothiazines ameliorate withdrawal but are less effective than benzodiazepines in reducing delirium (P = .002) or seizures (P < .001).

Conclusions.—Benzodiazepines are suitable agents for alcohol withdrawal, with choice among different agents guided by duration of action, rapidity of onset, and cost. Dosage should be individualized, based on withdrawal severity measured by withdrawal scales, comorbid illness, and history of withdrawal seizures. β-Blockers, clonidine, carbamazepine, and neuroleptics may be used as adjunctive therapy but are not recommended as monotherapy.

From the American Society of Addiction Medicine

A complete list of the members of the Working Group on Pharmacological Management of Alcohol Withdrawal appears at the end of this article.

Physicians in all areas of medicine therefore frequently encounter the problem of managing withdrawal, particularly as medical encounters, such as hospital admission or pregnancy, are often a precipitating event for cessation of alcohol.

In recent decades there has been extensive research on pharmacological interventions aimed at ameliorating withdrawal. However, these studies are widely dispersed in the medical literature, generally involved few subjects, and are often of uncertain methodological quality. Uncertainty continues to exist about the role of pharmacotherapy and its effectiveness in reducing the rate of major complications, such as seizures or delirium. Significant variation in physician management of withdrawal has been documented, even among specialists in the field, with a wide range in choice of medication, approaches to medication delivery, and method of patient monitoring. Recommendations from authoritative sources, such as medical and surgical textbooks, vary even more widely, with recommendations for agents that have never been tested in clinical trials or for approaches that have been shown to result in administration of unnecessary medication. Given the frequency with which this condition is encountered by physicians, the wide variety of settings in which it occurs, and the variation in the way it is managed, we believed an evidence-based guideline would have widespread utility.

The purpose of this review and guideline, therefore, is to aid physicians in providing the appropriate pharmacological management of alcohol withdrawal. This guideline does not address treatment of the patient who is examined after having an alcohol withdrawal seizure or who has already developed alcohol withdrawal delirium (delirium tremens), or the optimal setting for withdrawal management (inpatient or outpatient). These are important issues and will be addressed in separate guidelines. The role of phenytoin in alcohol withdrawal is the topic of a guideline already published.

METHODS

Selection of the Topic

Pharmacological management of alcohol withdrawal was a topic identified for guideline development by the Practice Guideline Committee of the American Society of Addiction Medicine. A work group was appointed that included individuals with training in internal medicine, family practice, psychiatry, and pharmacology and individuals involved in primary care medicine, addiction medicine, and research on alcohol withdrawal.

Outcomes

Outcomes studied were (1) severity of alcohol withdrawal syndrome, corre-
responding to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, definition,19 (2) alcohol withdrawal delirium, corresponding to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, definition,19,20 (3) withdrawal seizures, (4) completion of withdrawal, (5) entry into rehabilitation, (6) adverse effects, and (7) cost. Acquisition costs were determined by averaging wholesale prices listed in the Red Book.11

Options
Pharmacological management was defined as the use of any pharmacological agent to affect one or more of the outcomes listed above. Different strategies for administering medication were reviewed when data were available.

Review of the Evidence
The English-language medical literature was reviewed by searching MEDLINE with the key words “substance withdrawal syndrome, alcohol withdrawal” from MEDLINE’s initial entries in 1966 through June 1995. References from selected articles and reviews were also examined. Articles were considered only if they involved human subjects and included clinical data. Articles that met these criteria underwent structured review. Prospective controlled trials with methodologically sound end points and documented reporting of the end point in question underwent further review, with 2 reviewers independently extracting data from each article. Differences reported in individual studies were analyzed by means of the Fisher exact test and 95% confidence intervals for the relative risk calculated by means of Taylor series.12 When appropriate, meta-analysis was performed by means of a random effects model,13-15 with risk differences used as the measure of effect. All tests were 2 tailed, and differences were considered statistically significant when \( P \leq .05 \).

Recommendations
Recommendations based on the evidence were drafted and graded according to a published system (Table 1).16 In several areas it was recognized that a single recommendation could not be formulated to guide the treatment of all patients, but that the decisions should be guided by a series of clinical considerations. In such areas the level of evidence supporting these considerations was identified. In formulating recommendations, greatest value was placed on patient safety, followed by facilitation of treatment of alcohol dependence, patient comfort, and then cost.

Guideline Review
The draft guideline was sent for review to first authors of articles from the past 10 years that met inclusion criteria and to representatives of 68 medical organizations, The American Society of Addiction Medicine board of directors approved the final version in June 1995, with review and revision scheduled for June 2001, unless new information requires revision before then.

RESULTS
Original data were found in 134 articles,17-108 which included 65 prospective controlled trials and involved 42 different medications. In the following sections, data on different agents are reviewed.

Benzodiazepines and Other Sedative-Hypnotic Agents
Six prospective trials involving 5 different agents all demonstrated that benzodiazepines are more effective than placebo in reducing the signs and symptoms of alcohol withdrawal.109-115 Summary and meta-analysis of prospective, placebo-controlled trials (Table 2) also demonstrated a highly significant reduction of seizures (risk reduction of 7.7 seizures per 100 patients treated; \( P < .003 \)) as well as delirium (risk reduction of 4.9 cases of delirium per 100 patients treated; \( P = .04 \)).

Trials comparing different benzodiazepines demonstrated that all appear similarly efficacious in reducing signs and symptoms of withdrawal.13-14 However, there is some evidence that longer-acting agents may be more effective in preventing seizures.13-14 A summary of prospective controlled trials (Table 3) also demonstrates a trend in this direction. There are few data on the comparative efficacy in reducing delirium. Pharmacological data and clinical experience13-14 suggest that longer-acting agents can pose a risk of excess sedation in selected groups, in

Table 1.—Method of Grading Levels of Evidence and Recommendations

<table>
<thead>
<tr>
<th>Levels of evidence</th>
<th>Description</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I studies</td>
<td>Randomized trials with low false-positive and low false-negative errors</td>
<td>Grade A</td>
</tr>
<tr>
<td>Level II studies</td>
<td>Randomized trials with high false-positive and/or high false-negative errors</td>
<td>Grade B</td>
</tr>
<tr>
<td>Level III studies</td>
<td>Nonrandomized, concurrent cohort comparisons</td>
<td>Grade B</td>
</tr>
<tr>
<td>Level IV studies</td>
<td>Nonrandomized historical cohort comparisons</td>
<td>Grade C</td>
</tr>
<tr>
<td>Level V studies</td>
<td>Case series without controls</td>
<td>Grade C</td>
</tr>
</tbody>
</table>

*Data from Cook et al.*14

Table 2.—Prospective, Placebo-Controlled Trials Examining the Effectiveness of Benzodiazepines in Reducing the Incidence of Delirium or Seizures

<table>
<thead>
<tr>
<th>Source, y</th>
<th>Intervention</th>
<th>No. of Patients with Delirium/No. of Patients in Group</th>
<th>No. of Patients with Seizures/No. of Patients in Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosenfeld and Bizzoco, 1961</td>
<td>Chlordiazepoxide</td>
<td>2/30</td>
<td>-</td>
</tr>
<tr>
<td>Senery and Kalant, 1965</td>
<td>Chlordiazepoxide</td>
<td>0/24</td>
<td>0/24</td>
</tr>
<tr>
<td>Kaim et al., 1969</td>
<td>Chlordiazepoxide</td>
<td>3/100</td>
<td>-</td>
</tr>
<tr>
<td>Zine et al., 1960</td>
<td>Chlordiazepoxide</td>
<td>3/15</td>
<td>-</td>
</tr>
<tr>
<td>Sellers et al., 1983</td>
<td>Diazepam</td>
<td>0/5</td>
<td>-</td>
</tr>
<tr>
<td>Naranjo et al., 1983</td>
<td>Lorazepam</td>
<td>0/5</td>
<td>-</td>
</tr>
</tbody>
</table>

Risk differences with benzo[diazepine]:

- 9.9 cases of delirium/100 patients
- 95% CI, -1.2 to -3.5

\( P < .001 \)

\( *RR \) indicates relative risk; CI, confidence interval; and ellipses, data not reported.

"Pharmacological Management of Alcohol Withdrawal—Mayo-Smith et al"
In most studies, medications were given in fixed amounts at scheduled times, eg, chlordiazepoxide, 50 mg every 6 hours for 5 days. However, it has been shown that many patients can go through withdrawal with only minor symptoms despite receiving little or no medication. An alternative to giving medication on a fixed schedule, known as symptom-triggered therapy, has been developed. In this approach, the treatment is monitored by means of a structured assessment scale and given medication only when symptoms cross a threshold of severity. Two prospective, randomized controlled trials have demonstrated this approach to be as effective as fixed-dose therapy, but it results in the administration of significantly less medication and a significantly shorter duration of treatment. In the larger of these studies, the median amount of chlordiazepoxide given to the symptom-triggered group was 100 mg, compared with 425 mg in the fixed-dose group, and the median duration of treatment was only 9 hours compared with 68 hours. Withdrawal seizures usually occur early in the course of withdrawal. Because a history of withdrawal seizures is a strong risk factor for seizures during a withdrawal episode, some practitioners administer medication on a fixed-dose schedule to patients with a history of withdrawal seizures. Seizures were not observed in series of patients treated with symptom-triggered therapy, however, so it is possible that provision of symptom-triggered therapy alone may be adequate to prevent seizures.

**β-Adrenergic Antagonists**

There is some evidence that β-adrenergic antagonists reduce manifestations of withdrawal.

**Pharmacological Management of Alcohol Withdrawal—Mayo-Smith et al**

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withdrawal. Furthermore, delirium is a known side effect of β-blockers, particularly those with good central nervous system penetration, such as propranolol, in at least 1 study, the incidence of delirium was increased with propranolol, but studies of adequate size have not been done to accurately assess the effect of β-blockers on this outcome. The selective reduction in certain manifestations of withdrawal may mask the development of other significant withdrawal symptoms and make it difficult to use withdrawal scales to guide therapy. In 1 case report, the diagnosis of withdrawal delirium was significantly delayed in a patient who presented with marked confusion because the patient had earlier been placed on a regimen of propranolol and thus demonstrated none of the autonomic hyperactivity classically associated with alcohol withdrawal delirium.

Clonidine

Well-designed studies have consistently demonstrated the effectiveness of centrally acting α-adrenergic agonists, such as clonidine, in ameliorating symptoms in patients with mild to moderate withdrawal. As with β-blockers, studies of adequate size have not been reported to indicate what effect these agents have on the rate of delirium or seizures.

Carbamazepine

Carbamazepine has been widely used in Europe for alcohol withdrawal. Methodologically sound studies have shown it to be superior to placebo and equal in efficacy to barbiturates and oxazepam for patients with mild to moderate withdrawal. Data comparing its efficacy in preventing seizures or delirium are limited. Carbamazepine was documented to be without significant hematological or hepatic toxic effects when used in 7-day protocols for alcohol withdrawal, and was associated with less psychiatric distress and a faster return to work.

Carbamazepine has well-documented anticonvulsant activity and has been shown to prevent alcohol withdrawal seizures in animal studies. It does not potentiate the central nervous system and respiratory depression caused by alcohol, does not inhibit learning (an important side effect of larger doses of benzodiazepines), and has no abuse potential. It has also been proposed that it may retard a kindling-like phenomenon in which repeated episodes of alcohol withdrawal may be associated with increasing severity of withdrawal.

Neuroleptic Agents

Neuroleptic agents, including the phenothiazines and the butyrophenone haloperidol, demonstrate some effectiveness in reducing signs and symptoms of withdrawal, but phenothiazines are less effective than benzodiazepines in preventing delirium (risk difference, 6.6 cases per 100 patients treated; *P = .002*) (Table 4). These agents increase the incidence of seizures compared with placebo and are much less effective than benzodiazepines in preventing seizures (risk difference, 12.4 seizures per 100 patients treated; *P < .001*) (Table 4). There are differences in the epileptogenic potential among the neuroleptic agents, and the agents used in these studies, chlorpromazine and promazine, are among those with the greatest effect on seizure threshold. Neuroleptic agents are widely used to calm agitated patients, and uncontrolled clinical experience indicates that they are useful for this purpose in the setting of alcohol withdrawal as well.

Magnesium

It has long been recognized that magnesium levels are frequently low during alcohol withdrawal. A double-blind, placebo-controlled randomized trial studying intramuscular administration of magnesium as a supplement to benzodiazepines showed no significant difference in severity of withdrawal symptoms, even after adjustment for magnesium levels. There were also no differences in the incidence of seizures and delirium, although the power to detect these outcomes was limited. Thus, while supplementation with magnesium is without substantial risk, no evidence indicates that such supplementation reduces withdrawal severity or the frequency of delirium or seizures.

Ethyl Alcohol

By definition, intake of alcohol alleviates the initial symptoms of alcohol withdrawal. Alcohol has long been used for this purpose, both by those with alcohol dependence and by some practitioners. Case series describing alcohol given orally or by intravenous drip for the prevention or treatment of withdrawal symptoms have been published. These reports suggest that alcohol is effective in reducing withdrawal symptoms, but the risks and benefits of its use are not well understood.
ports have been small and uncontrolled and did not use objective or quantitative assessment of withdrawal severity. There are no controlled trials evaluating its safety or relative efficacy, compared with either placebo or benzodiazepines. Intravenous alcohol infusions require close monitoring because of the toxicity of the highest doses, involve expense in preparation and administration, and pose risks of tissue damage at the infusion site. As a pharmacological agent, ethyl alcohol has numerous adverse effects, including its well-known hepatic, gastrointestinal, hematomal, and neurological toxic effects, as well as its effects on mental status and judgment.

Thiamine

In a large trial, thiamine did not reduce delirium or seizures. However, individuals with alcohol dependence are frequently thiamine deficient, with a high risk for Wernicke disease and Wernicke-Korsakoff syndrome, sequelae that can be prevented by administration of thiamine.

Other Agents

Results of trials involving other agents show that some ameliorate withdrawal, but no evidence has been published to indicate that any are effective in reducing delirium or seizures.*

Special Populations

No studies were identified on managing withdrawal in adolescents. While the signs and symptoms of withdrawal may differ in older individuals compared with younger individuals, no studies of different treatment approaches in these
deries were identified. Similarly, no studies on managing withdrawal in pregnant women were identified. Ethyl alcohol is a well-known teratogen, to be avoided in pregnant women. Retrospective studies have indicated a risk of congenital malformation with both benzodiazepines and barbiturates. Wernicke-Korsakoff syndrome may be caused by a lack of thiamine, and administration of thiamine at or above levels recommended for Wernicke disease and alcohol withdrawal is indicated. Ethyl alcohol increases the risk of thiamine deficiency because it induces hepatic, gastrointestinal, hematological, and neurological toxic effects, as well as its effects on mental status and judgment.

Choice of Pharmacological Agent

Because of their documented efficacy, benzodiazepines are recommended as suitable agents for alcohol withdrawal (grade A recommendation). All benzodiazepines appear equally efficacious in reducing signs and symptoms of withdrawal, and the choice among them can be guided by the following clinical considerations: (1) Long-acting agents may be more effective in preventing withdrawal seizures (level II evidence). (2) Long-acting agents contribute to a smoother withdrawal with fewer rebound symptoms (level I evidence). (3) Short-acting agents may have a lower risk of oversedation (level III evidence). (4) Certain benzodiazepines have a higher efficacy for abuse (level I evidence). (5) Cost of these agents varies considerably.

Benzodiazepines are recommended over most nonbenzodiazepine sedative-hypnotics because they have better documented efficacy, a greater margin of safety, and lower abuse potential. However, phenobarbital appears to be a clinically acceptable alternative, although the margin of safety for this agent may be lower than for benzodiazepines when high doses are needed (grade C recommendation).

Determination of Dose

Withdrawal severity varies greatly, and the amount of medication needed to control symptoms can also vary significantly. Alcohol withdrawal cannot be adequately treated by providing only a fixed standardized dose for all patients. Treatment should allow for a degree of individualization so patients can receive large amounts of medication rapidly if needed (grade A recommendation).

In substance abuse treatment programs, the use of structured assessment scales, such as the CIWA-Ar, for initial assessment and subsequent monitoring is recommended, as this allows objective titration of doses to individual need and reduces administration of unnecessary medication (grade A recommendation). In patients with acute comorbid medical or psychiatric illness, or concurrent withdrawal from other drugs, these scales should be used with caution because they relate signs and symptoms that may be caused by the other condition and not by the alcohol withdrawal.

Determination of the dosage of medication administered should be based on the following clinical considerations.

1. For those with mild symptoms (for example, CIWA-Ar scores <8), a reasonable clinical option is supportive nonpharmacological therapy and continued monitoring (level I evidence). Those with moderate symptoms (eg, CIWA-Ar scores of 8–15) benefit symptomatically from medication that will also reduce the risk of major complications. Those with severe symptoms (for example, CIWA-Ar scores ≥15) have a significant risk of major complications if untreated (level I evidence). It is recommended that such patients receive benzodiazepines in the amounts necessary to control symptoms, as well as continued close monitoring until symptoms are controlled.

2. For patients with a history of withdrawal seizures, it is reasonable to provide 1.0 of the recommended medications at the time of presentation, regardless of the severity of withdrawal symptoms (level III evidence). Monitoring the patient and providing symptom-triggered therapy without fixed scheduled therapy is also a reasonable option.

3. For patients who have notable co-morbid medical illness, medications should be considered even if withdrawal is mild to moderate. In addition, caution should be exercised in treating patients who are using sedative-hypnotic medications, as they may be at higher risk for major complications and may exhibit tolerance to benzodiazepines requiring adjustment of dosage (level III evidence). The use of structured assessment scales and symptom-triggered therapy is possible in other settings, such as psychiatric inpatient, and general medical/surgical wards, but requires training of staff. Where such training has not taken place, the use of fixed schedu-
ule therapy, with the provision of additional medicine when symptoms are not controlled with scheduled doses, is an acceptable alternative. While this may result in the provision of unnecessary medicine, it provides a margin of safety.

Examples of specific treatment regimens that meet these recommendations are provided in Table 5.

Other Agents

β-Blockers, clonidine, and carprofenazone are not recommended as monotherapy (grade B recommendation). While they reduce selected signs and symptoms of withdrawal, they have not been shown to reduce delirium or seizures. They may be considered for use in conjunction with benzodiazepines in patients with certain coexisting conditions, such as coronary artery disease for β-blockers, opiate withdrawal for clonidine, and benzodiazepine withdrawal for carbamazepine.

It is recommended that neuroleptic agents not be used as monotherapy because they do not reduce delirium and may increase seizures (grade A recommendation). Neuroleptics may be considered for use in conjunction with benzodiazepines for marked agitation or hallucinations.

Routine parenteral administration of magnesium is not recommended because existing controlled data do not demonstrate improvement in alcohol withdrawal severity, delirium, or seizures (grade B recommendation).

Ethyl alcohol is not recommended because of the lack of controlled studies as well as its known adverse effects as a pharmacological agent (grade C recommendation).

It is recommended that thiamine be administered to all patients with alcohol dependence at initial examination (grade C recommendation).

Special Populations

There is no evidence that the recommendations should change for adolescent or geriatric populations. As noted, shorter-acting benzodiazepines may have a lower risk of oversedation, which may be of particular relevance in the elderly (grade C recommendation). Ethyl alcohol should not be used in pregnant women because of its teratogenic effects (grade C recommendation). In addition, because both benzodiazepines and barbiturates have been associated with adverse effects on the fetus, the amount of these medications administered should be limited to that necessary to prevent the major complications of withdrawal (grade C recommendation).

Members of the Working Group on Pharmacological Management of Alcohol Withdrawal: Michael F. Mayo-Smith, MD, MPH (chairman), Ambulatory Care Service, Veterans Affairs Medical Center, Manchester, NH, and Harvard Medical School, Boston, Mass; Paul Cashman, Jr, MD, New York, NY; Arnold J. Hill, MD, Marlborough Hospital, Marlborough, Mass, and Department of Psychiatry, University of Massachusetts Medical School, Worcester; Gail Jara, California Society of Addiction Medicine, Oakmont, Christine Kassier, MD, Addiction Services, University Behavioral Health Care, Department of Medicine and Psychiatry, University of Tennessee College of Medicine, Memphis; Mark Knuss, MD, Departments of Medicine and Psychiatry, Waterbury Hospital, Waterbury, Conn, and Department of Medicine, Yale University School of Medicine, New Haven, Conn; Daniel Nauts, MD, Chemical Dependency Center, Benson Hospital Center, Great Falls, Mont; Richard Suitz, MD, MPH, Section of General Internal Medicine, Boston Medical Center, Boston University School of Medicine; James W. Smith, MD, Chemical Dependency Program, Shady Hospital, Seattle; Wash; John T. Sullivan, MD, Department of Clinical Pharmacology, Bayer Corporation, West Haven, Conn; and Nima Tuchscherer, MD, Department of Psychiatry, Downstate Medical Center, State University of New York, Brooklyn.

References


ASAM'S WEBSITE COMES OF AGE: LOGS 10,000 VISITS

William Hawthorne, M.D., ASAM Webmaster

If you have not visited ASAM's website at http://www.asam.org, you are not getting the full advantage of your membership. ASAM's Website keeps you current on activities between meetings and brings you an on-line version of ASAM News a few weeks before the "snail mail" version arrives. Not only does the site contain ASAM's current activities, but it has its history: it truly is a resource to amplify your membership.

The site contains the ASAM News archives, with issues going back several years. All of ASAM's public policy statements are available for downloading, as are abstracts from recent issues of the Journal of Addictive Diseases. A conference calendar gives you the opportunity to check upcoming events, with hyperlinks to full programs as they become available. The recently added ASAM Membership Directory updates the hard copy, which is two years old and not scheduled for revision until later this year.

The site also contains lists of ASAM staff (with E-mail addresses and areas of responsibility), Committee chairs, Board members, and state chapter dues. It's all there—only a few clicks away!

Special sections on important topics, including a Nicotine Channel, State Chapter Channel, Physician's Health Channel and, soon, an MRO Channel. A Conference Channel provides links to the cities (and hotels) where ASAM conferences are held, so that members can easily find the information needed to make their travel plans, down to plotting out local sightseeing and ground transportation.

Late-breaking addiction medicine news is posted to a bulletin board, and there are links to many Websites of interest to ASAM members. Current applications for Certification and Fellow status can be downloaded and completed directly from the site.

The California and Florida chapters have accepted ASAM's offer to share their Websites with ours. The site is responsible for 25 new ASAM members, who first learned of the organization while surfing the net. These are physicians, like ourselves, looking for a connection with other addiction medicine practitioners. ASAM also has sold publications and conference registrations to people new to the addiction field who found the organization on the World Wide Web.

For all of these reasons, you should take full advantage of what our Website brings to your membership and visit us soon at http://www.asam.org!

Colorado - The Colorado Permanente Medical Group (Kaiser Permanente) is seeking a full-time physician to serve in our chemical dependency programs beginning July 1998. Candidates must be board certified in either internal medicine or family practice and be certified in addiction medicine. They should enjoy participating as active members of treatment teams and appreciate sharing treatment decisions with care providers from multiple disciplines.

Clinical responsibilities include inpatient and outpatient detoxification for alcohol and other drugs of dependence; inpatient consultations for dependency and withdrawal problems; outpatient pharmacotherapy for addictive diseases; consultations for prescription drug dependency and for chronic pain syndromes; and a supportive, educational role with primary care providers, assisting the development of system-wide identification and intervention programs for alcohol and drug use problems.

Kaiser Permanente of Colorado serves 330,000 members, using 450 staff physicians in 18 facilities in the greater Denver metropolitan area. We are proud of the excellent care we deliver and of the high level of satisfaction our members report. We actively support clinical research and outcome evaluation programs to maintain our preeminent position both locally and nationally. Colorado's environmental and recreational opportunities match the exceptional quality of our health care organization.

Contact: Physician Recruitment
Colorado Permanente Medical Group
10350 East Dakota Avenue
Denver, CO 80231-1314
303/344-7302
EOE,M/F,V/H
For one part of the conference, the planners have designed something new: a series of very brief presentations called “Epitomes of Progress.” Each speaker will review one area of patient care where emerging information is leading clinicians to consider new approaches. In just 12 minutes, the speaker will first describe the traditional thinking, then summarize the newly available data and its clinical relevance. Each segment will close with the speaker’s recommendation as to whether it is time to change the practice or await further data. For each topic, the course syllabus will contain one review article and an annotated bibliography. Ten different topics will be reviewed in the series, including rapid opioid detoxification, aggressive pharmacologic treatment of alcohol withdrawal, and kindling.

Florida
Chapter President: Richard Keesal, M.D.
Regional Director: Rick Beach, M.D.
FASAM’s 11th Annual Conference is scheduled for January 23-25, 1998, in Orlando. Agenda and registration information is available from Robert Donofrio at the FSAM office, 904/484-3560.

Georgia
Chapter President: John D. Lenton, M.D.
Regional Director: Rick Beach, M.D.
Chapter President John Lenton, M.D., has been appointed to the Governor’s Joint Study Committee on the Prevention and Treatment of Substance Abuse. The language of the Senate resolution creating the study committee specifically called for representation from the Georgia ASAM chapter.

Illinois
Chapter President: Martin Doot, M.D.
Regional Director: Andrea Barthwell, M.D.
ISAM will sponsor a pre-conference workshop in connection with its annual meeting (scheduled for November 21-22) in Chicago. At the annual meeting, the chapter will present its lifetime achievement award to Dr. James Leonard.

ISAM also is planning a program for primary carephysicians for its Midwest Clinical Conference, scheduled for February 20-22, 1998.

Michigan
Chapter President: Thomas Haynes, M.D.
Regional Director: Norman Miller, M.D.
Chapter members are planning an educational conference for the Detroit area in late March or early April 1998. The chapter also has elected a new slate of officers, who are: President, Thomas Kane, D.O.; President-Elect, Stephen Bendix, M.D.; Immediate Past President, Thomas Haynes, M.D.; Secretary, Martin Gleespen, M.D.; and Treasurer, Herbert Malinoff, M.D.

New York
Chapter President: Merrill Herman, M.D.
Regional Director:

Lawrence Brown, Jr., M.D.
With the assistance of Herbert Peyser, M.D., New York State trustee for the American Psychiatric Association, Dr. Merrill Herman has met with the Executive Committee of the American Psychiatric Association for the purpose of forging a link between the New York Society of Addiction Medicine and the APA in the furtherance of mutual goals related to legislation, managed care, and educational initiatives.

Oregon
Chapter President: Douglas L. Bouvee, M.D.
Regional Director:

Richard E. Tremblay, M.D.
ORSAM had an excellent quarterly meeting in September in Tualatin, with Greg Clark, Ph.D., giving a stimulating talk on the early treatment of depression in patients who present for treatment of alcoholism. Upcoming activities for the chapter include December elections for two Board positions currently held by Douglas Bouvee, M.D. and Robert Sealf, M.D.

South Carolina
Chapter President: Timothy L. Fischer, D.O.
Regional Director: Richard Beach, M.D.
South Carolina has scheduled a chapter meeting for December 6, 1997, in conjunction with a conference the chapter is co-hosting with the University of South Carolina School of Medicine. Speakers will include ASAM President G. Douglas Talbott, M.D., and Dr. Velasquez of the University of Texas. Additional information is available from Dr. Fischer at 800/536-4900, ext. 130.

Virginia
Chapter President:

William McConahey, M.D.
Regional Director: Paul Earley, M.D.
The Virginia chapter’s 1998 annual meeting has been set for April 30-May 2, 1998, at the Fort Magruder Inn and Conference Center in Williamsburg. Concurrent with the annual meeting, the chapter and the Farley Institute will co-sponsor a conference on “A New Approach for Impaired Healthcare Providers: The Virginia Intervention Program.” Conference speakers are to include the intervention program’s administrator and medical director. Inquiries about the conference may be directed to Ernie Leclerc at the Farley Institute (800/950-6688). Contact person at the Virginia chapter is Dorothy G. Tompkins, M.D., who can be reached at 804/243-4646.

Region VIII
Region VIII will hold its first annual meeting February 11-13, 1998, at Honolulu, Hawaii. For program information, contact Dr. Gerald McKenna at 808/246-0663. For hotel reservations, call 800/645-5687.

INTERNATIONAL
Iceland
Contact Person: Person G. Bjornsson, SAA
Regional Director: Peter Mezciens, M.D.
Iceland hosted the SAA 20th Anniversary Conference on Alcohol and Substance Abuse, October 16-18, 1997. ASAM representatives participating in the conference were Drs. Sheilie B. Blume, David E. Smith, and Norman S. Miller. For information on the Iceland chapter activities, contact Person G. Bjornsson, SAA, at one of the following: telephone (+354) 567-6333; fax (+354) 567-6615; Website: http://www.this.is/saa; or E-mail: saa@this.is.

Panama
Contact Person: Saul Alvarado, M.D.
Regional Director: Peter Mezciens, M.D.
ASAM Past President David E. Smith, M.D., brought greetings from the Society to the 9th Annual Chemical Dependency Conference of the Panamanian Society of Addiction Medicine, held in August 1997. Pictured in the photo are (left to right): Panamanian Society members Carlos Smith, M.D., Carlos Del Rey, M.D., Dr. Smith, and Saul Alvarado, M.D.
“Among the World’s Leading Conferences on Alcohol and Drug Addiction.”

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WEB SITES OFFER RESOURCES ON MANAGEMENT OF PAIN
Seddon Savage, M.D., Chair Committee on Pain

Through a recently established ASAM Website link, ASAM members and others can easily access extensive resources on pain and pain management. After signing on to the ASAM website at http://www.asam.org, a virtual world of pain management resources can be accessed by opening “Web Site Links of Interest,” then “Treatment and Recovery Resources,” then “Worldwide Congress on Pain.” Or, to enter directly, sign on to www.pain.com. The Worldwide Congress on Pain is in part commercially funded, carries significant advertising and is most directly focused on anesthesia management. However, the site also provides a valuable entry point into the broader world of pain management.

From the Worldwide Congress on Pain, physicians can link to most pain organizations (the American Pain Society, the American Academy of Pain Medicine, and the International Association for the Study of Pain all sponsor useful sites), obtain lists of pain clinics and pain treatment providers in many locations, obtain lists of pain publications, and discuss pain issues with other physicians through chat rooms and forums. Extensive resources on pain can be found at www.pain.com

The ASAM Committee on Pain and Addictive Disease currently is working with Webmaster Bill Hawthorne, M.D., to set up reciprocal direct links from the ASAM Website to the American Pain Society and the American Academy of Pain Medicine.

As with most Internet sites, finding resources that are consistently useful may require some exploration. The library at the Worldwide Congress on Pain seems limited in some areas and at least some of its articles are condensations that differ significantly from the originally published versions. Similarly, the list of pain meetings is incomplete. However, more complete lists of meetings and educational opportunities can be identified by exploring the resource links. Addictionists who want information on pain should be able to find whatever they need by using this point of entry.
Dear Colleagues:

As we approach the last few months of the year, it is time for you to review your financial affairs while there still is time to take steps to maximize tax savings and other benefits before the year's end.

You will soon be receiving the Ruth Fox Memorial Endowment Fund year-end letter and brochure, *Giving at Year-End 1997*. This brochure offers a number of ideas you might want to consider when planning your charitable gifts for 1997. We hope that you will remember the Endowment Fund in your plans.

Special thanks to The Yasuda Bank and Trust Company (USA), New York City. They have made another contribution to the Endowment Fund, bringing their total contributions over the years to $10,000. We are very grateful to the bank's officers for their ongoing support.

For contributions, pledges, or information about making a planned gift (bequests, insurance, stock, pensions), contact Ms. Claire Osman at 800/257-6776.

Max A. Schneider, M.D., FASAM
Chair, Endowment Fund

Jasper G. Chen See, M.D.
Chair Emeritus, Endowment Fund

Claire Osman
Director of Development

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Aaron Handler
Mr. & Mrs. Richard North
Mr. & Mrs. Andrew Sheren
In Memory of Lonnie Smith,
Father of Ed Smith
Michael E. Bohan, M.D.

UC San Francisco Faculty Position
Medical Director of Outpatient Substance Abuse Services

The Department of Psychiatry at the University of California, San Francisco (UCSF) seeks a Medical Director of the Outpatient Substance Abuse Services (OSAS), at San Francisco General Hospital (SFGH), a major teaching hospital of UCSF. This clinician-teacher position is in the Clinical series at the Clinical Instructor, Assistant or Associate Clinical Professor level, and is available on July 1, 1998.

The ideal candidate will be a Board-certified or -eligible psychiatrist with a commitment to an academic career as a clinician-teacher, and a demonstrated interest and cultural competence in working with underserved, culturally diverse populations in a public setting. Candidates who have completed a fellowship in Substance Abuse or Addiction Psychiatry are preferred. Possession of a Certificate of Added Qualifications in Addiction Psychiatry or American Society of Addiction Medicine certification is highly desirable. California licensure is essential. Demonstrated leadership, administrative, and supervisory experience, and experience in working with patients with HIV or other medical or psychiatric problems which complicate substance abuse, is required.

Duties involve direct patient care, clinical supervision, and organization of outpatient medical services for patients with substance abuse. The position requires strong organizational and writing abilities, and interpersonal skills. Research interest is highly desirable.

Applications must be received by January 20, 1998. Please send letter of interest, curriculum vitae, and three current letters of reference to Mark Leary, MD, Search Commitment Chair, c/o Susan Brekhus, Department of Psychiatry-7M36, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110. UCSF is an Equal Opportunity/Affirmative Action Employer. Women and minorities are strongly encouraged to apply.
Position: Physician, Clinical Director–Institution
Location: Orofino, in scenic North Central Idaho

Idaho Department of Health and Welfare, State Hospital North, is recruiting a Clinical Director for its 60-bed Adult Psychiatric Hospital with Drug Dependency/Dual Diagnosis Program components. The Hospital will hire a Board Certified psychiatrist who is seeking an opportunity for a progressive and innovative practice in the treatment of patients who are severely mentally ill and drug dependent. A physician with expertise in addictions treatment is desired.

State Hospital North is one of two state hospitals in Idaho, and an important link in the State and Regional Mental Health network. The Hospital values participative and collaborative management, and team approach to treatment.

The Hospital is located on a beautiful campus in a modern facility only two years old. Orofino is an attractive rural community located on the Clearwater River at the base of the Selway-Bitterroot Wilderness Area. Professionals enjoy a quality lifestyle and outdoor recreational activities.

The compensation package includes competitive salary, relocation assistance, and excellent State benefits. For more information, contact Debbie Manfull, Assistant Administrator, State Hospital North, 310 Hospital Drive, Orofino, ID 83544. Phone 208/476-4511.

UCSF Faculty Position
Attending Psychiatrist,
Outpatient Substance Abuse Services

The Department of Psychiatry at the University of California, San Francisco (UCSF), is searching for an Attending Psychiatrist for the Outpatient Substance Abuse Service (OSAS) at San Francisco General Hospital (SFGH), a major teaching hospital of UCSF. This clinician-teacher position is in the Clinical series at the Clinical Instructor or Assistant Clinical Professor level, and will be available July 1, 1998. The ideal candidate will be a Board-certified/Board-eligible psychiatrist with a commitment to an academic career as a clinician-teacher, and demonstrated interest, commitment, and cultural competence in working with underserved and culturally diverse populations. California licensure is essential. Required: an interest in substance abuse, dual diagnosis of psychiatric disorders and substance abuse, and medical/psychiatric issues including HIV/AIDS; the ability to work effectively with cocaine- and heroin-dependent patients in outpatient substance abuse treatment; strong organizational and writing abilities, and interpersonal skills. Research interest is highly desirable.

Applications must be received by January 20, 1998. Please send letter of interest, curriculum vitae, and names, addresses, and telephone numbers of three references to Mark Leary, MD, Search Committee Chair, c/o Susan Brekhus, Department of Psychiatry–7M36, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110. UCSF is an Equal Opportunity/Affirmative Action Employer. Women and minorities are strongly encouraged to apply.
ASAM STAFF NOW ONLINE

In addition to accessing ASAM's web page, members can reach any ASAM staff member via E-Mail, at the following addresses:

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BONUS!

Readers of ASAM News will find a bonus enclosed with this issue: a handy reference card on "Screening and Brief Interventions for Alcoholism."

Developed by ASAM (with the support of an unrestricted educational grant from DuPont Pharma), the card summarizes the best current advice on patient screening and follow-up techniques, including the CAGE.

Readers are encouraged to share the cards with medical students and colleagues in primary care. For information on obtaining additional cards, contact the ASAM office.