

## History of Addiction Treatment in North America

And the History of Addiction Medicine

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### ASAM Disclosure of Relevant Financial Relationships ASAM Review Course 2014

Name	Commercial Interests	Relevant Financial Relationships: What Was Received	Relevant Financial Relationships: For What Role
Michael M. Miller, MD	Rogers Memorial Hospital	Salary	Primary professional position
	Alkermes	Honorarium	Speakers Bureau training
	Braeburn Pharmaceuticals, Inc.	Consulting Fee	Advisory Board Member
	Orexo	Honorarium	Speakers Bureau training
	Curry Rockefeller Group	Consulting Fee	Advice re: educational materials to patients
	BioDelivery Sciences	Honorarium	Speakers Bureau training
	Leavitt Partners	Honorarium	Advice re: population health & prevention approaches to substance use and addiction



## Addiction Treatment in the U.S.

- “The Minnesota Model”
- Hazelden Foundation
- Willmar State Hospital
- Miller MM. “Treatment of Addiction: A Clinical Overview.” In Principles of Addiction Medicine, First Edition, 1994 (ASAM)
- Miller MM. “Traditional Approaches to the Treatment of Addiction.” In Principles..., Second Edition, 1998.
- *Addiction Treatment in the U.S. is often caricatured as nothing other than that*



## One Reference Everyone Cites

“Slaying the Dragon”

The History of Addiction Treatment and Recovery in America

William L. White

Bloomington, IL: Chestnut Health Systems. 1998



## Outline

1. How do we conceptualize what we’re treating?
2. Early treatment approaches in America
3. AA (but it is *not* treatment)
4. Hazelden and the Minnesota Model
5. Treatment Programs – East Coast, SE, Midwest
6. Treatment Programs – West Coast, et al.
7. General Musings about Addiction Treatment –so, what is Addiction Treatment anyway?



## Outline

8. History of Addiction Treatment Research
9. History of Addiction Policy and Advocacy
10. History of Addiction Medicine
11. Broadening the Base of Treatment
12. Pharmacotherapy
13. Treatment Criteria
14. Chronic Disease Management
15. Contemporary Addiction Treatment
16. Living History as it Happens



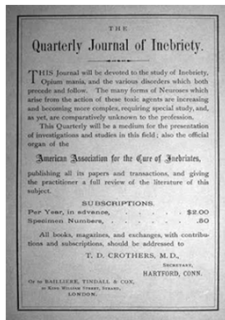
## Addiction

### How the Condition is Conceptualized

- The signatory of the U.S. Declaration of Independence, Dr. Benjamin Rush, had described the “alcoholic disease syndrome” in 1779 (Li, Hewitt, Grant, 2007).
- The two terms most frequently used to refer to alcoholism at the end of the nineteenth century were *dipsomania* and *inebriety* (White, 2004), with both referring to the behaviors of excessive drinking and intoxication.



## The Journal of Inebriety



Weiner, B., & White, W. The Journal of Inebriety (1876–1914): history, topical analysis, and photographic images. *Addiction*, 102 (1): 15-23, 2007.



## Addiction: How the Condition is Conceptualized

- Alcoholism is one thing
- Drug Addiction is another



## Addiction How the Condition is Conceptualized

- The term “addiction to alcohol” appears to have first been used in the German medical literature in 1901 (Bonhoeffer, 1901; Blakemore, Jennett, 2001), but it became established enough that the National Conference on Nomenclature of Disease, the 1933 American process that had inspired the International Classification of Disease (the latest edition, from 1992, is ICD-9), had a diagnostic code for “alcohol addiction (code 000-332)” (Keller, 1976).
- Jellinek himself (Jellinek, 1942) referred to “alcohol addiction” (Robinson, 1972) for almost two decades prior to the publication of his best known work, *The Disease Concept of Alcoholism* (Jellinek, 1960). He also described phases of alcohol addiction in an attempt to capture the heterogeneity in manifestations of the disease (Jellinek, 1952).



## The Broader Context

- The American Medical Society on Alcoholism and Other Drug Dependencies
- Alcohol vs. Drugs
- Alcoholics Anonymous
- Narcotics Anonymous
- Alcohol, Nicotine, and Other Drugs



## WHO Expert Committee on Mental Health, Alcoholism Subcommittee (1<sup>st</sup> Report, 1950)

“Alcoholism: any form of drinking which in its extent goes beyond the traditional and customary ‘dietary’ use, or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behavior...”

WHO Technical Report Series No. 42,  
December 1950, pg 5



## WHO Expert Committee on Mental Health, Alcoholism Subcommittee (2<sup>nd</sup> Report, 1952)

“The subcommittee has distinguished two categories of alcoholics, ‘alcohol addicts’ and ‘habitual symptomatic excessive drinkers’. For brevity’s sake the latter will be referred to as non-addictive alcoholics. In both groups, the excessive drinking is symptomatic of underlying psychological or social pathology...”

WHO Technical Report Series No. 48, August 1952, pp. 26-27



## WHO Expert Committee on Mental Health, Alcoholism Subcommittee (2<sup>nd</sup> Report, 1952)

“The subcommittee would now consider it more appropriate to use the preceding definition to define the term ‘excessive drinking’ and would add to it the following definition of alcoholism:”

WHO Technical Report Series No. 48, August 1952, pg 16



## WHO Expert Committee on Mental Health, Alcoholism Subcommittee (2<sup>nd</sup> Report, 1952)

“...but in one group after several years of excessive drinking ‘loss of control’ over the alcohol intake occurs, while in the other group this phenomenon never develops. The group with ‘loss of control’ is designated as ‘alcohol addicts’.”

WHO Technical Report Series No. 48,  
August 1952, pp 26-27



## WHO Expert Committee on Drugs Liable to Produce Addiction

“Drug addiction is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its character-istics include:

- (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means



### WHO Expert Committee on Drugs Liable to Produce Addiction

“(2) a tendency to increase the dose;  
(3) a psychic (psychological) and sometimes a  
physical dependence on the effects of the  
drug.”

WHO Technical Report Series No. 21, 1950



### WHO Expert Committee on Mental Health, Alcoholism Subcommittee (1st Report, 1950)

“...the Subcommittee recommends that  
consideration should be given to the  
setting-up of a subcommittee on Alcohol  
of the Expert Committee on Drugs Liable  
to Produce Addiction.”

WHO Technical Report Series No. 42, December 1950, pg 6



### The Definition of Alcoholism

(NCADD / ASAM – 1990, JAMA 1992: Morse et al.)

Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.



### What is Addiction?

American Society of Addiction Medicine • April 2011

#### Definition of Addiction:

“Addiction is a *primary, chronic disease of brain reward, motivation, memory and related circuitry*. Dysfunction in these circuits leads to characteristic *biological, psychological, social and spiritual manifestations*. This is reflected in an individual *pathologically pursuing reward and/or relief* by substance use and other behaviors.”



### Definition of Addiction

American Society of Addiction Medicine • April 2011

“Addiction is characterized by *inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response*. Like other chronic diseases, addiction often involves cycles of *relapse and remission*. Without treatment or engagement in recovery activities, addiction is *progressive* and can result in disability or premature death.”



### Models for Understanding Addiction Joseph Westermeyer, MD, PhD, MPH

Moral Model, Criminal Model, Epidemic Model, Illness Model, Personality Disorder Model, Learning Model, Self-treatment Model, Genetic Model, et al.

#### The Illness Model:

“This model evolved over two centuries ago when addicted persons were unable to cease addictive use of psychoactive substances on their own.”

Westermeyer J. “Chapter 1: Historical Understandings of Addiction.” In: Principles of Addiction (Peter M. Miller, ed.). Elsevier (2013), page 4.



## Models for Understanding Addiction

Joseph Westermeyer, MD, PhD, MPH

"First, the addicted person must view him- or her-self as a blighted or diseased person in need of outside help. This step, involving illness behavior, occurs after a period of misery and dysfunction. Second, those around the person must be willing to deed the person a period of relief from ordinary social expectations and responsibilities, in order to permit treatment and recovery. This involved social assignment of a temporary sick role. Third, a culturally approved or licensed health care worker must ordain that disease exists and treatment is warranted."

Westermeyer J. "Chapter 1: Historical Understandings of Addiction." In: Principles of Addiction (Peter M. Miller, ed.). Elsevier (2013), page 4.



## Responses to Addiction

- The Washingtonians – 1840-1845
  - The Washingtonian Total Abstinence Society
  - "The Washingtonian program of recovery consisted of (1) public confession, (2) public commitment, (3) visits from older members, (4) economic assistance, (5) continued participation in experience sharing, (6) acts of service toward other alcoholics, and (7) sober entertainment."

White, 1998, page 10.



## Antediluvian Addiction Care (before the Minnesota Model)

- The Moral Movement and Dorothea Dix

From Wikipedia: **Moral treatment** was an approach to mental disorder based on humane psychosocial care or moral discipline that emerged in the 18th century and came to the fore for much of the 19th century, deriving partly from psychiatry or psychology and partly from religious or moral concerns. The movement is particularly associated with reform and development of the asylum system in Western Europe at that time. It fell into decline as a distinct method by the 20th century, however, due to overcrowding and misuse of asylums and the predominance of biomedical methods.



## The Earliest Institutions

"During the second half of the 19<sup>th</sup> century, there was a rapid growth in the number of institutions specializing in the treatment of inebriety. When a professional association of inebriate home and inebriate asylum managers – the American Association for the Cure of Inebriates – was launched in 1870, only six institutions were in operation. By 1878, 32 institutions were represented in the association, and by 1902 there were more than 100 facilities in the U.S. that specialized in the treatment of alcoholism and other addictions.

White, W. (1998). "Chapter 4. The Rise and Fall of Inebriate Homes and Asylums." *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.



## Inebriety

"If one central idea was shared across the spectrum of early treatment programs, it was the concept of 'inebriety.' 'Inebriety' encompassed a wide spectrum of disorders that resulted from acute or chronic consumptions of psychoactive drugs. 'Inebriety' was the term that captured the morbid craving, the compulsive drug-seeking, and the untoward physical, psychological and social consequences of drug use."

White, W. (1998). "Chapter 5. Inebriate Homes and Asylums: Treatment Philosophies, Methods and Outcomes." *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.



## Treatment Philosophies

- Inebriety was broken down into its numerous forms through elaborate classification systems that included "alcohol inebriety," "opium inebriety," "cocaine inebriety," "tobaccoism," "chloroform inebriety...."

White, W. (1998). "Chapter 5. Inebriate Homes and Asylums: Treatment Philosophies, Methods and Outcomes." *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.



## Pre-Asylum Days: Care of the Addicted

“Before the development of institutions specializing in the treatment of addiction, alcoholics and addicts landed in all manner of institutions – the almshouse, the charitable lodging home, the jail, the workhouse, and the newly created asylum. None of these institutions desired the inebriate’s presence, and none were equipped to treat addiction.”

White, W. (1998). “Chapter 4. The Rise and Fall of Inebriate Homes and Asylums.” *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.



## A Variety of Modalities

- Hydrotherapies
- Drug Therapies
  - The Keeley Institutes, Dr. Leslie Keeley: the Double Chloride of Gold
  - Morphine for Alcoholism
  - Tonics and Elixirs of the Patent Drug Era
- Convulsive Therapies – 1930’s
- Psychosurgery – 1940’s



## Reforms in 1906

### Flexner Report Pure Food and Drug Act

“...The Pure Food and Drug Act contained some of the earliest federal provisions affecting narcotics; if any over-the-counter remedy in interstate commerce contained an opiate, cannabis, cocaine, or chloral hydrate, the label was required to state its contents and percentage. The effect of this simple measure apparently was to reduce the amount of such drugs in popular remedies and also to hurt their sales, although other proprietaries flourished.”

Musto DF. Chapter 1: Historical Perspectives. In: Lowinson, J., editor (2005). *Substance Abuse: A Comprehensive Textbook (Fourth Edition)*. Philadelphia: Lippincott Williams & Wilkins, page 4.



## Models for Understanding Addiction Joseph Westermeyer, MD, PhD, MPH

“During the early 1900’s, diagnostic classifications included alcoholism and drug addictions as personality or character disorder. These disorders were viewed as a form of antisocial personality, since the individual broke social mores, acted primarily in their own apparent self-interest, and often transgressed the rights of others while intoxicated or drug seeking. According to this view, addiction evolved in irresponsible or self-centered people who ignored the effects of their choices and behaviors on others. The 2<sup>nd</sup> Edition of the DSM of the APA typified this perspective.”

Westermeyer J. “Chapter 1: Historical Understandings of Addiction.” In: *Principles of Addiction* (Peter M. Miller, ed.). Elsevier (2013), page 5.



## Models for Understanding Addiction Joseph Westermeyer, MD, PhD, MPH

“During this period personality and character disorder were seen as untreatable. Thus, this model justified the noninvolvement of many clinicians in the care of these patients. Abandoned by the medical profession, alcoholics in the United States supported one another’s recovery in the brotherhood of Alcoholics Anonymous.”

Westermeyer J. “Chapter 1: Historical Understandings of Addiction.” In: *Principles of Addiction* (Peter M. Miller, ed.). Elsevier (2013), page 5.



## A bit of history...

- From “Alcoholics Anonymous”, the “Big Book” of A.A.



[http://www.aa.org/pages/en\\_US/what-is-aa](http://www.aa.org/pages/en_US/what-is-aa)

- Alcoholics Anonymous is an international fellowship of men and women who have had a drinking problem.
- It is nonprofessional, self-supporting, multiracial, apolitical, and available almost everywhere.
- There are no age or education requirements. Membership is open to anyone who wants to do something about his or her drinking problem.



## Taking a step back Origins and Notables

- Oxford Groups (a spiritual movement in the 1920's in Pennsylvania—Frank Buchman)
- “The Central Idea of the Oxford Group was that the problems of the world could be healed through a movement of personal spiritual change.” (White, 1998, page 128)
- William Silkworth, MD—in 1930 became physician in charge at the **Charles B. Towns Hospital for the Treatment of Drug and Alcohol Addiction** in New York City (founded in 1901)



## Taking a step back Origins and Notables

- Charles B. Towns: “Towns’ writings on addiction described and brought to popular understanding the most essential elements of physical addiction: (1) increased tissue tolerance, (2) an identifiable withdrawal syndrome following cessation of drug use, and (3) craving and compulsive drug-seeking behavior.”
- Bill Wilson was admitted on December 1934.

White, W. (1998).] “Chapter 10. Physical Methods of Treatment and Containment.” *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.



## Taking a step back Origins and Notables

- **William Silkworth, MD.**
- “He described alcoholism as an *allergy of the body and an obsession of the mind.*”
- “Silkworth’s suggestion of a constitutional vulnerability which prompted alcoholics to drink—out of necessity rather than choice—became the cornerstone of the modern disease concept of alcoholism.”

White, W. (1998).] “Chapter 15. The Birth of Alcoholics Anonymous: A Brief History.” *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.



## Taking a step back Origins and Notables

- Akron, Ohio
- **St. Thomas Hospital**  
“Managed Care and its Impact on Addiction Treatment”  
8<sup>th</sup> Annual St. Thomas Hospital Conference on Addictions: Issues In Addiction Treatment In A Changing Healthcare Environment  
Summa Health System, Akron, Ohio, October 9, 1996
- **Sister Ignatia**
- **Dr. Bob Smith**
- **Bill Wilson** was on a business trip to Akron, got drunk, and was looking for an Oxford Group member to call; he was connected with Dr. Bob and they met in a woman’s home on May 12, 1935. [ Note: They did not meet at the hospital; Dr. Bob was never Bill W’s doctor. ]



[http://www.aa.org/pages/en\\_US/what-is-aa](http://www.aa.org/pages/en_US/what-is-aa)

- Since the book *Alcoholics Anonymous* first appeared in 1939, this basic text has helped millions of men and women recover from alcoholism.



## Foreword to First Edition

- PRECISELY HOW WE HAVE RECOVERED
- Better understand the alcoholic
  - The alcoholic is a very sick person
- Anonymity
- Non alliance



## Foreword to the Second Edition

- By 1955
  - 6000 groups, 150,000 members
- The two elements of recovery
  - Carry the message – alcoholic to alcoholic
  - Spiritual principles
- A brief history of the early days



## Foreword to the Third Edition

- By 1976 over 1,000,000 members and 28,000 groups
- “...At its core it remains simple and personal. ...One alcoholic talks to another alcoholic sharing experience strength and hope.”



**As in other health conditions, self-management, with mutual support, is very important in recovery from addiction.**

Peer support such as that found in various “self-help” activities is beneficial in optimizing health status and functional outcomes in recovery. ‡



Public Policy Statement on  
the Relationship Between Treatment and Self Help:

A Joint Statement of the  
American Society of Addiction Medicine, Inc.,  
the American Academy of Addiction Psychiatry,  
and the American Psychiatric Association

<http://www.asam.org/1TREATMENT%20AND%20SELF-HELP%20-%20JOINT%2012-971.pdf>



**Public Policy Statement (1997) on the Relationship between Treatment and Self Help: a Joint Statement of the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, and the American Psychiatric Association**

ASAM, AAAP and APA recommend that:

1. Patients in need of treatment for alcohol or other drug-related disorders should be treated by qualified professionals in a manner consonant with professionally accepted practice guidelines and patient placement criteria;
2. Self help groups should be recognized as valuable community resources for many patients in addiction treatment and their families. Addiction treatment professionals and programs should develop cooperative relationships with self help groups;
3. Insurers, managed care organizations and others should be aware of the difference between self help fellowships and treatment;
4. Self help should not be substituted for professional treatment, but should be considered a complement to treatment directed by professionals. Professional treatment should not be denied to patients or families in need of care.



**Recovery from addiction is best achieved through a combination of self-management, mutual support, and professional care provided by trained and certified professionals.**



## Addiction Treatment The Minnesota Model

- Build upon the principles of Alcoholics Anonymous
- Utilizing the multi-professional team as is used in inpatient psychiatric treatment
- The mentally ill stayed for a lifetime
- Treatment for the alcoholic: some could leave in a year
- Duration: 6 months, 3 months, 2 months....



## Willmar

Treatment of the Chronically Mentally Ill

- Psychiatrists (MD/DO)
- General Medical Physicians
- Psychologists
- Nurses
- Social Workers
- Occupational Therapists
- Recreation Therapists
- Art and Music Therapy
- Nutrition: Registered Dieticians



## Daniel J. Anderson, Ph.D.

- Master of Arts in clinical psychology, Loyola University in Chicago, 1956
- Ph.D. in clinical psychology, University of Ottawa, 1966.
- Clinical psychologist at Willmar State Hospital from 1952 to 1961.
- Consultant and lecturer, Hazelden, 1957-61.
- He joined Hazelden full time in 1961 and was executive vice president and director there until 1971.
- President of Hazelden, 1971 until 1986.



## Daniel J. Anderson, Ph.D.

- As a psychologist at Willmar State Hospital in the 1950s, Anderson and Nelson Bradley, superintendent of the hospital, were dedicated to finding an effective way to address "inebriates," a group that was considered "at the bottom of the patient pecking order" at that time, Anderson said in a 1998 interview.
- "Everyone looked down on them, including the community, hospital staff, and even our mentally ill patients. The inebriates had a lower status than the schizophrenics and the manic depressives, or even the kleptomaniacs or pedophiles."



## Hazelden

- Bio-Psycho-Social-Spiritual Illness
- Bio-Psycho-Social-Spiritual Treatment
- Multidisciplinary Team
- Principles of AA
- Family Recovery
  
- Group Therapy is Primary
- Individual Therapy is Supplement
- Multiple Family Groups > Individual Family Tx



## From www.Hazelden.org

### Hazelden history

- **1947**  
The idea for Hazelden is born when Austin Ripley, a recovering alcoholic, sets out to create a rehabilitation center for alcoholic priests. Lynn Carroll, a lawyer and recovering alcoholic, and Robert McGarvey, owner of McGarvey Coffee, support Ripley's pursuit but favor a center that would serve "all professionals." Ripley's insistence on a priests-only facility removes him from the venture.
- **1948**  
Carroll initiates a meeting that paves the way for Hazelden. Joining Carroll and McGarvey, are Richard Coyle Lilly, a St. Paul banker, and other businessmen. On December 29, 1948, the Coyle Foundation authorizes purchase of the Power family farm in Center City, Minn., known as Hazelden Farms.



## From www.Hazelden.org

- **1949**  
Hazelden incorporates and admits its first patient: "the new hospital corporation is to operate the premises as a sanatorium for curable alcoholics of the professional class." Lawrence Butler is Hazelden's first patient.
- **1951**  
Emmett, Patrick and Lawrence Butler assume contract for deed of the financially troubled Hazelden.
- **1952**  
Patrick Butler is named president of Hazelden. The Butlers provide financial stability for Hazelden.
- **1953**  
Fellowship Club, a halfway house for men, opens in St. Paul.
- **1954**  
Pat Butler acquires rights to *Twenty-Four Hours a Day*, a meditation book for alcoholics, launching the beginning of Hazelden's publishing efforts.



- ANDERSON, D.J.; MCGOVERN, J.P.; AND DUPONT, R.L. The origins of the Minnesota Model of addiction treatment: A first person account. *Journal of Addictive Diseases* 18:107-114, 1999.



## The other "pillar" in Minnesota

- St. Mary's Hospital, Minneapolis
- In-patient Hospital-based program started in 1968.
- Dr. George Mann, Medical Director, worked with Sr. Mary Madonna, president of St. Mary's Hospital, to open the program over the objections of Board members who didn't want "alcoholics" in the hospital.
- 4 weeks: third week was "family week" where family came and participated in a group, joined by the person "in treatment," for 5 straight days. So for Week 3, the person joined multiple family group therapy with others who were in Week 3.



## The Diaspora from Hazelden

- To Lutheran General Hospital, Park Ridge, IL
  - To Madison General Hospital (now: Meriter)
  - To Proctor Hospital, Peoria, IL (Illinois Institute for Addiction Recovery, 1979)
  - To hospitals too numerous to count
  - To the Betty Ford Center (1982)
- ...and now: the Hazelden Betty Ford Foundation



## American Treatment Programs East Coast

- Beech Hill Farm/Beech Hill Hospital (Dublin, NH)—John Supple (1948-2001)
- Chit Chat Farms (Reading, PA)—now Caron (1959)
- Roosevelt Hospital: the Smithers Center (NYC)
- 1973 East Side; 1995 West Side
- Serenity Hill (New Canaan, CT)—James O'Neill (1974), the first detox/rehab in CT, JCAHO; sold to Parkside 1982; now Mountainside
- Seminole Point (Sunapee, NH)—James O'Neill (1982-97)
- Arms Acres (1982)/Conifer Park (1983) —New York



## American Treatment Programs East Coast

- Boston State Hospital (closed 1979)—early provider of methadone services
- Edgehill Newport (Newport, RI) – treated Kitty Dukakis; closed.
- McLean Hospital/Harvard (Belmont, MA)
- Father Martin’s Ashley (Havre de Grace, MD) – 1983
- Hanley Center (West Palm Beach, FL) – 1986
- Talbott, Ridgeway, MARR, and Willingway (Ga)
- Thanks to Michael Walsh, NAATP, for reminiscences



## Parkside Health Services (part of Lutheran General Hospital, Park Ridge, IL—now Advocate Health)

- Flagship: Parkside (Lutheran General Hospital)
- Martin Doot, MD
- Over 100 locations, including the U.K.
- Treatment Criteria: David Mee-Lee, MD, Marblehead, MA
- Outcome Studies: Bill Filstead, PhD (in sociology and program evaluation) – later at the AMA



## The US Navy

- Long considered the premier armed service for the treatment of addiction in active duty servicemen/women.
- In 1982, it was the Navy that filmed Father Martin’s “Chalk Talk” for use in its treatment programs.



## Long Beach Naval Station

- 70 acres at the north end of El Dorado Park in the City of Long Beach was sold to the U.S. Navy for \$1 in 1965 to build a new naval hospital. It became known for its alcoholism treatment program which launched in 1967 and became known as the hub of the military’s dependency program.<sup>13</sup> Perhaps its most famous patient was Betty Ford, who was admitted for drug and alcohol dependence in 1978. This hospital closed in 1994 along with the closing of the Long Beach Naval Shipyard and Naval Station and disbanding of the Long Beach Naval Fleet.



## L.A. Times, November 2, 1997, DOUGLAS P. SHUIT, STAFF WRITER

- Back in 1965, newly recovering alcoholic and retired Navy Cmdr. Dick Jewell wanted to know why the Navy wasn’t doing more about alcoholism. He took his questions to Dr. Joseph J. Zuska, then the senior medical officer at the Long Beach Naval Station on Terminal Island.
- Treatment in Long Beach revolved around inpatient medical care, daily group therapy, psychological counseling, lectures and movies on alcoholism and—as a consequence of that first meeting between Jewell and Zuska—daily attendance at Alcoholics Anonymous meetings.
- “I made people go to a meeting every night,” said Dr. Joseph A. Pursch, who succeeded Zuska as the program’s director in 1973. “We had a meeting every Thursday night in the hospital. We had men and women from the outside come in.” On other nights, Pursch said, Navy vans took patients to AA meetings in Long Beach, Signal Hill and other cities.



## West Coast Programs

- Schick Shadel (1935)
- Max Schneider MD at Orange County (1964)
- Lyman Boynton MD at Kaiser—San Francisco
- Ron Mineo MD at Scripps Memorial—La Jolla
- Betty Ford (1982)
- Sierra Tucson (1983)
- Cottonwood de Tucson (1987)
- CRC Health (1995)—145 locations. 30,000 lives per day under treatment (some MH)



## Betty Ford Center

- At Eisenhower Medical Center, Rancho Mirage, CA
- The Center was co-founded by U.S. First Lady Betty Ford, Ambassador Leonard Firestone, and Dr. James West in 1982. West also served as the Betty Ford Center's first medical director, from 1982 until 1989. The administrator was an Illinois native, recommended by Hazelden from among its best administrative staff: John Schwarzlose (Proctor Hospital, Peoria; staff/administrators were trained by Hazelden).
- On February 10, 2014, Betty Ford Center merged with Hazelden Foundation to create the Hazelden Betty Ford Foundation. On June 12, 2014, Jim Steinhagen was named Vice President and Administrator in charge of the Betty Ford Center, and Steve Eickelberg, M.D., was appointed Medical Director of the Center.



## West Coast – “Different Strokes”

- Narcotics Anonymous (1953) – Los Angeles
- Synanon (1958) – Santa Monica
- Esalen Institute (1962) – Big Sur
- Haight Ashbury Free Clinic, Inc. – HAFCI – 1967 – David Smith, MD
- Therapeutic Communities (not just West Coast)
- Later: Celebrity Rehab and Spas



## TC's

- Therapeutic Communities (TCs) are structured, psychologically informed environments – they are places where the social relationships, structure of the day and different activities together are all deliberately designed to help people's health and well-being. ([www.therapeuticcommunities.org](http://www.therapeuticcommunities.org))
- DayTop Village (1964) – TC but also outpatient
- Phoenix House (1972) – > 120 programs in eleven states
- United Kingdom



## <http://schickshadel.com/about/history/>

Schick Shadel Hospital's founder, Charles A. Shadel, was a pioneer in the field of treating alcoholism. He developed the counter conditioning treatment program for substance abuse, and, in 1935, opened up a colonial mansion with the comforts of home for those who were then considered society's outcasts – alcoholics. *Mr. Shadel believed that the only thing wrong with alcoholics was alcohol.*

His philosophy was that the body, not the mind, was dysfunctional. He viewed alcoholism as a drug addiction and, together with Dr. Walter Voegtlin, a Seattle gastroenterologist, developed and tested a safe and effective formula to create a chemical aversion to alcohol.



## <http://schickshadel.com/about/history/>

The work of Shadel Hospital in Seattle continued quietly and effectively until 1964, when then-chairman and CEO of the Schick Safety Razor Company, Patrick J. Frawley, Jr., checked into the facility.

After the first day of the program, Frawley reported that he felt immediate relief from the compulsion to drink and, months later, was astonished to find that he still didn't crave any of his favorite drinks.



## <http://schickshadel.com/about/history/>

- Schick Safety Razor Company formed Schick Laboratories, Inc. with Frawley as chairman in 1965 and purchased the Shadel Hospital, investing \$6 million in researching habit formation.
- The research, under the direction of Schick Shadel Hospital's Chief of Staff, James W. Smith, M.D., resulted in a program for nicotine addiction. Programs for cocaine, marijuana, and methamphetamines, prescription opioids and heroin were later developed by the Schick Shadel clinicians.
- *Today, Schick Shadel Hospital continues to treat patients using the evidence-based counter-conditioning techniques pioneered by Mr. Shadel.*



## Other large systems

- Charter
- HCA
- CRC Health
- Of course, Hazelden-Betty Ford and Caron
- Kaiser: Permanente Medical Group
- But none larger than the VA



## “Professional Addiction Treatment” didn’t begin as professional treatment

- Early treatment was started by and delivered by recovering alcoholics without any formal clinical training. These folks filled a void created by the abdication of the professional community to treat alcoholics.
- Almost all treatment staff were recovering alcoholics in AA and their treatment was “sharing their strength, hope and experience.” The major and non-negotiable requirement for counselor positions was two years of sobriety.  
– Jerry Shulman, M.A. (ASAM Award 2012)



## Musings of Shulman and Miller

- Early treatment, which was based on an abstinence-based, Twelve Step, “disease concept” model, was not what would be considered treatment by today’s standards. There was no individualized assessment, no treatment planning and “treatment” was one size fits all. Group therapy was 10 patients sitting in a circle discussing a chapter in the book “Alcoholics Anonymous.” But strangely, many of these early patients recovered and some went on to become alcoholism counselors. One explanation is that the patient group was very homogeneous with little co-occurring psychiatric problems.
- All alcoholics, almost all men, mostly middle-aged and employed, and psychiatric conditions and medications were not allowed.



## One Level of Care: Inpatient

- No IOP until 1970’s and 1980’s
- No “continuing care” – discharge planning from “rehab” was to “attend AA” rather than to see a professional
- “Aftercare” was a no-charge service.
- All services were self-pay.



## Third Party Payment (Shulman)

- In 1975, Blue Cross America, the trade organization for individual Blue Cross Plans, recommended that the individual plans develop an insurance benefit for alcoholism. Capitol Blue Cross (Southeast PA) sent a research analyst to live at Chit Chat Farms for a week to make recommendations for a plan. They were one of the first Blue Cross Plans to provide a benefit which was 30 days of inpatient treatment (no outpatient) and covered alcoholism but not drug addiction. The plan mirrored the provision of treatment at that time.



## Third Party Payment (Shulman)

- In Minnesota, the Blue Cross plan, collaborating with Hazelden, established a benefit which the Minnesota legislature mandated for all private insurance plans.
- With the advent of the impact of managed care in the late 1970s and the unwillingness of payers to reimburse for 28 day, fixed length of stay treatment, many inpatient programs which were unable to adapt, closed. Others developed more creative solutions including some which moved from a 28 day to a 21 day fixed length of stay but kept the overall charge for four weeks.



## Recollections of Tony Radcliffe, MD ASAM President (1991-93)

- General Medical Addictologist at Kaiser Permanente-Southern California
- The addiction benefit in the 1970s under Kaiser-SoCal was for alcohol addiction only, and only for members of the Federal Employees Health Benefit Program
- The comprehensive benefit for chemical dependency care in Kaiser was written as part of the basic medical benefit, not the psychiatric benefit (psychiatric benefits were supplemental benefits until the mid-1990s)
- Determination of whether to offer services to Kaiser Health Plan enrollees under this new benefit was based upon medical necessity, not the experience of previous episodes of detox care, etc.
- The establishment of medically-monitored detox within Kaiser-SoCal was made possible via a grant from the Kaiser Foundation
- The California legislation which enabled the establishment of the freestanding Betty Ford Clinic was used to enable Kaiser to establish a medically-managed inpatient service, under the Department of Medicine, in 1980-82



## A Response to Insurance's "Intrusion"

- The Northern Ohio Chemical Dependency Treatment Directors Association (NOCDDTA) create The Cleveland Criteria (Hoffmann, Halikas & Mee-Lee, 1987)
- The NAATP Criteria (the National Association of Addiction Treatment Providers) are developed by Richard Weedman, 1988
- The ASAM-NAATP Criteria (1989-90; Mee-Lee)
- The ASAM Criteria (1991; 1996; 2001)



## What are we trying to accomplish through "Professional Treatment?"

### ASAM Public Policy Statement on Treatment for Alcohol and Other Drug Addiction

- **Addiction Treatment** is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from alcoholism or from another drug addiction, and which is designed to enable the affected individual to achieve and maintain sobriety, physical, spiritual and mental health, and a maximum functional ability.
- **Addiction Treatment** services are professional healthcare services, offered to a person diagnosed with addiction, or to that person's family, by an addiction professional. Addiction professionals providing addiction treatment services are licensed or certified to practice in their local jurisdiction and may be nationally certified by a professional certification body for their professional discipline.

Adopted by ASAM Board of Directors May 1980; revised September 1986, October 1997, July 2001, October 2009, and January 2010.



## Targeted Therapeutic Changes in Addiction Treatment

### BEHAVIORAL CHANGES

- Eliminate alcohol and other drug use behaviors
- Eliminate other problematic behaviors
- Expand repertoire of healthy behaviors
- Develop alternative behaviors
- Identify triggers for using behaviors/relapses

### BIOLOGICAL CHANGES

- Resolve acute alcohol and other drug withdrawal symptoms
- Physically stabilize the organism
- Develop sense of personal responsibility for wellness
- Initiate health promotion activities (e.g., diet, exercise, safe sex, sober sex)
- Address cravings through medical interventions (treatment medications)



## Targeted Therapeutic Changes in Addiction Treatment

### Targeted Therapeutic Changes in Addiction Treatment

- Increase awareness of illness
- Increase awareness of negative consequences of use
- Increase awareness of addictive disease *in self*
- Decrease denial

### AFFECTIVE CHANGES

- Increase emotional awareness of negative consequences of use
- Increase ability to tolerate feelings without defenses
- Manage anxiety and depression
- Manage shame and guilt



## Targeted Therapeutic Changes in Addiction Treatment

### SOCIAL CHANGES

- Increase personal responsibility in all areas of life
- Increase reliability and trustworthiness
- Become resocialized: reestablished sober social network
- Increase social coping skills: with spouse/partner, with colleagues, with neighbors, with strangers

### SPIRITUAL CHANGES

- Increase self-love/esteem; decrease self-loathing
- Reestablish personal values
- Enhance connectedness
- Increase appreciation of transcendence

Taken from: Miller, Michael M. Principles of Addiction Medicine, 1994; published by American Society of Addiction Medicine, Chevy Chase, MD

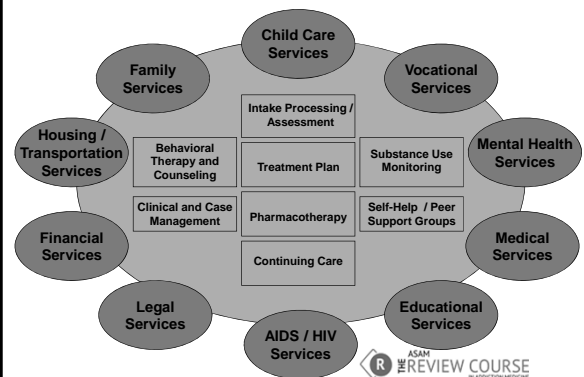


## Treatment of Addiction

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Individual or GROUP Counseling
- Family or Multifamily Group Therapy
- Pharmacotherapy
- Chronic Disease Management
- Comprehensive Case Management
- Consultation-Liaison Services



## Components of Comprehensive 'Drug Abuse' Treatment



## Treatment of Non-Substance Addiction

- "Pathological Gambling"
- South Oaks Hospital – now North Shore-L.I. Jewish
- In January 1882, The Long Island Home Hotel for Nervous Invalids opened
- Amityville, New York
- Sheila Blume, MD
- S.O.G.S.
- But also: Proctor Hospital / I.I.A.R. (1993) and Paradigm Magazine (1995)



## South Oaks Hospital

- In 1970, South Oaks established Hope House, a specialized inpatient unit for young men and women who were addicted to drugs.
- In 1971, recognizing the special needs of adolescents with emotional problems, the hospital opened an Adolescent Pavilion for young people between the ages of 13 and 20.
- In 1972, South Oaks set up a Training Program for Alcoholism Counseling. The training program, one of only a few in the country, graduated many trained counselors.



## South Oaks Hospital

- In June 1980, South Oaks established Sage House, a rehabilitative program for young men aged 13 to 20 who had a history of abusing more than one drug, in combination with alcohol.
- In 1981, South Oaks conducted an extensive study and three-part program on compulsive gambling. With the advent of this program, South Oaks became one of the first hospitals in the country to offer services for compulsive gamblers and their families. A key feature of this program was South Oaks Gambling Screening (SOGS), a valuable tool for the detection of compulsive gambling problems.



## History of Addiction Research (arguably, clinical research preceded basic research)

- The Addiction Research Center, Lexington, KY—founded as the "Narcotic Farm" in 1935
- Re-dedicated in 1948 as part of USPHS, jointly administered by the federal Bureau of Prisons; there was also a prison hospital that did addiction research in Ft. Worth, TX (founded 1938)
- Mandatory minimum sentences for drug crimes; inmates "rewarded" with cocaine or opiates for participation in clinical trials
- Became part of NIDA in 1974 when that agency was established as part of the Alcoholism, Drug Abuse and Mental Health Administration (ADAMHA), the precursor to SAMHSA
- Relocated to Baltimore in 1979



## NIDA

- Created in 1974 two years after the Drug Abuse Warning Network (DAWN) and National Household Survey on Drug Abuse (now the National Survey on Drug Use and Health) were initiated
- Predecessor had been the NIMH's Division of Narcotic Addiction and Drug Abuse
- ONDCP was created in 1998
- NIDA became part of NIH in 1992



In 1999, NIDA launched the National Drug Abuse Clinical Trials Network (CTN) to rapidly and efficiently test the effectiveness of behavioral and pharmacological treatments in real-life settings; and NIDA released its pamphlet *Principles of Drug Addiction Treatment: A Research-Based Guide*.



NIDA

[www.drugabuse.gov](http://www.drugabuse.gov)



## Addiction Research

- Basic Science Research
- Clinical Research
- Epidemiological Research
- Research into Medical Complications (liver disease, HIV, FAS/FAE, cancer)
- Health Services Research
  - Brandeis, Penn, Brown, BU, Dartmouth, UCLA, et al.
  - <http://ahsr2013.com/>



## Sen. Harold Hughes

- Governor of Iowa (R) 1963-69
- U.S. Senator from Iowa (D) 1969-75
- Member of AA: 1955 onward
- Wikipedia: As a U.S. Senator, Hughes persuaded the Chairman of the Senate's Labor and Public Welfare Committee to establish a Special Sub-committee on Alcoholism and Narcotics, chaired by Hughes himself. This subcommittee, which gave unprecedented attention to the subject, held public hearings on July 23–25, 1969. A number of people in recovery testified, including Academy Award-winning actress Mercedes McCambridge, National Council on Alcoholism founder Marty Mann, and AA co-founder [Bill W.](#) The hearings were considered a threat to anonymity and sobriety.
- Hughes also talked about the need for treatment of drug addiction. He stated that "treatment is virtually nonexistent because addiction is not recognized as an illness."



## The Creation of NIAAA

- The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 –also known as the Hughes Act– is signed into law by President Richard M. Nixon on December 31, 1970. This legislation authorized a comprehensive Federal program to address prevention and treatment of alcohol abuse and alcoholism.
- The National Institute on Alcohol Abuse and Alcoholism (NIAAA) was first established as a component of the National Institute of Mental Health (NIMH). It then became a separate institute alongside NIMH and NIDA under ADAMHA, the Alcohol, Drug Abuse, and Mental Health Administration.
- Since 1974, the NIAAA has been an independent Institute of the National Institutes of Health.



## NIAAA Milestones

- 1971—First Special Report to the U.S. Congress on Alcohol and Health issued.
- 1981—U.S. Surgeon General's Advisory on Alcohol and Pregnancy published.
- 1988—Federal minimum legal drinking age law instituted.
- 1989—Collaborative Studies on Genetics of Alcoholism (COGA) initiated.
- 1991—National Longitudinal Alcohol Epidemiologic Survey (NLAES) launched.
- 1999—First National Alcohol Screening Day.
- 2001—National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) launched.
- 2005—NIAAA releases *Helping Patients Who Drink Too Much: A Clinician's Guide*.
- 2007—NIAAA releases *The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking*.
- 2007—NIAAA shares an Emmy award with HBO, NIDA, and the Robert Wood Johnson Foundation for *The Addiction Project*.

[ Note: At the behest of ASAM President Mike Miller, MD, ASAM establishes its Media Award, given annually; the first recipient, in 2008, was producer John Hoffman for his HBO series "ADDICTION"; the latest awardee, in 2014, was producer Greg Williams, for his documentary *Anonymous People* ]



## Addiction Treatment is Politicized in the US—so Policy Matters

- Harrison Act of 1914—made it a crime for any physician to treat a person with opioid addiction or opioid withdrawal with an opioid: the criminalization of medical practice of the non-person: the addict, the pariah
- Not until methadone was approved in 1972-- and only for use in highly regulated clinics—was there an exception
- The Drug Addiction Treatment Act of 2000—known as DATA 2000—offers the only other exception to the Harrison Act, permitting the use of Schedule III buprenorphine by "waivered physicians"



## National Drug Control Policy

- In 1968, under President Johnson, the Bureau of Narcotics in the Department of the Treasury, which had jurisdiction over marijuana and heroin, was merged with the Bureau of Drug Abuse Control in the Department of Health, Education and Welfare (DHEW), which had jurisdiction over sedatives, stimulants, and hallucinogens, to create the Bureau of Narcotics and Dangerous Drugs (BNDD), the precursor of the DEA. It was placed under the Department of Justice.



## Comprehensive Drug Abuse Prevention and Control Act (1970)

- Title II of the Act was the Controlled Substances Act (CSA) which established the five Schedules of Controlled Substances and required manufacturers to maintain security over the supply chain.
- The Drug Enforcement Administration (DEA) was created by President Richard Nixon through an Executive Order in July 1973 in order to establish a single unified command to combat "an all-out global war on the drug menace." At its outset, DEA had 1,470 Special Agents and a budget of less than \$75 million. Today, the DEA has nearly 5,000 Special Agents and a budget of \$2.02 billion. ([www.dea.gov](http://www.dea.gov)).



## Methadone

- Developed in 1937 in Germany by scientists working for the forerunner of Hoechst Pharmaceuticals, who were looking for a synthetic opioid to solve Germany's opium shortage problem: Dolophine®.
- Methadone was introduced into the United States in 1947 by Lilly Pharmaceuticals as an analgesic.
- Studied by Dole, Nyswander and Kreek at Rockefeller University, New York.
- Levomethadone is a full  $\mu$ -opioid agonist.
- Dextromethadone does not affect opioid receptor but binds to the glutamatergic NMDA (N-methyl-D-aspartate) receptor as an antagonist.
- The FDA approved methadone as a Schedule II drug for the treatment of opioid addiction in 1972.



## Wikipedia on Methadone

- "To date, methadone maintenance therapy has been the most systematically studied and most successful, and most politically polarizing, of any pharmacotherapy for the treatment of drug addiction patients."
- In 2006, the U.S. Food and Drug Administration issued a caution about methadone, titled "Methadone Use for Pain Control May Result in Death."
- Now: 16,000 opioid overdose deaths per year, 1/3 are due to methadone.



## The Role of the AMA

1956 – appropriate for members of hospital medical staffs to admit alcoholics to general hospitals

### H-30.999 Admission of Alcoholics to General Hospitals

The AMA encourages insurance companies and prepayment plans to remove unrealistic limitations on the extent of coverage afforded for the treatment of alcoholism, recognizing that alcoholism is a chronic illness and that multiple hospital admissions under medical supervision may be essential to arresting the progress of the disease. (CMS Rep. G, I-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

### H-95.983 Drug Dependencies as Diseases

The AMA (1) endorses the proposition that drug dependencies, including alcoholism, are diseases and that their treatment is a legitimate part of medical practice, and (2) encourages physicians, other health professionals, medical and other health related organizations, and government and other policymakers to become more well informed about drug dependencies, and to base their policies and activities on the recognition that drug dependencies are, in fact, diseases. (Res. 113, A-87; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: Sunset Report, I-97 Reaffirmed: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)

### H-95.976 Drug Abuse in the United States - the Next Generation

... (6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence as indicated by the Surgeon General's report, are diseases... (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09)



## The Role of the AMA

### H-30.995 Alcoholism as a Disability

(1) The AMA believes it is important for professionals and laymen alike to recognize that alcoholism is in and of itself a disabling and handicapping condition. (CSA Rep. H, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

### H-30.997 Dual Disease Classification of Alcoholism

The AMA reaffirms its policy endorsing the dual classification of alcoholism under both the psychiatric and medical sections of the International Classification of Diseases. (Res. 22, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

### H-30.998 Recommendations for AMA Involvement in Alcoholism Activities

To further emphasize the seriousness of alcoholism and the importance of the physician's role in prevention and treatment of this disease, our AMA: encourages relevant medical specialty societies to inform their membership about opportunities for treatment and early intervention, especially among women alcoholics and children of alcoholics; reaffirms that effective and comprehensive treatment for alcoholic persons requires the involvement of a physician; and urges that quality of treatment not be sacrificed to cost considerations. (CSA Rep. E, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)



## The Role of the AMA

### H-295.972 Education Regarding Prescribing Controlled Substances

The AMA (1) encourages physicians, hospital medical staff organizations, resident physicians, and medical students to participate in education programs to ensure proper prescribing and dispensing of controlled substances; and (2) encourages regulatory agencies, state medical societies, and state medical boards to recognize the value of participation in such educational programs as an alternative to imposing disciplinary sanctions on well-intentioned physicians. (Sub. Res. 76, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

### H-95.951 Role of Self-Help in Addiction Treatment

The AMA: (1) recognizes that (a) patients in need of treatment for alcohol or other drug-related disorders should be treated for these medical conditions by qualified professionals in a manner consonant with accepted practice guidelines and patient placement criteria; and (b) self-help groups are valuable resources for many patients and their families and should be utilized by physicians as adjuncts to a treatment plan; and (2) urges managed care organizations and insurers to consider self-help as a complement to, not a substitute for, treatment directed by professionals, and to refrain from using their patients' involvement in self-help activities as a basis for denying authorization for payment for professional treatment of patients and their families who need such care. (Res. 713, A-98; Reaffirmed: CSAPH Rep. 2, A-08)



## Advocacy for Alcoholism

The National Council on Alcoholism (NCA), now NCADD

- NCADD is the leading advocacy organization in the world addressing alcoholism and drug dependence. Since 1944, NCADD has raised public awareness about addiction throughout the United States and increasingly across the global community. NCADD's founder, Marty Mann, believed alcoholism was a disease, that it could be treated and it should be treated like a public health problem. Marty advocated this belief strongly to the medical and scientific community.

**The foundation of NCADD was built on three simple ideas:**

- Alcoholism is a disease and the alcoholic is a sick person;
- The alcoholic can be helped and is worth helping;
- This is a public health problem and therefore a public responsibility.



<http://ncadd.org/index.php/about-ncadd/testimonials-from-the-media>

**“Our Founder.”**

Marty Mann was an alcoholic. Plain and simple. She admitted it and once sober she dedicated the rest of her life to help others who suffered from the same crippling, often fatal, disease. Educating an ignorant public drove her every day to eradicate the stigma of addiction.



<http://ncadd.org/index.php/about-ncadd/testimonials-from-the-media>

- Marty came from privilege, born in 1905 into a wealthy Chicago family and attended the best private schools. Married at 22, divorced at 23, Marty was a drunk at 24, around the same time her father lost his fortune.
- Attractive, intelligent, engaging with a sharp wit and a flair for parties, things came easy for Marty and drinking was increasingly part of the picture.
- Despite her strong will power, she could not stop drinking. Then, in 1934, Marty fell from a small balcony during a party. She never knew if she fell or jumped. A fractured leg, a broken jaw and traction for six months did not stop her from continuing to drink. Out of money, jobs gained and lost, Marty wound up in a secluded corner of Hyde Park in London, sipping booze from a bottle. She was close to hitting her bottom.



## Advocacy

- Faces and Voices of Recovery (FAVOR)
- National Alliance of Advocates for Buprenorphine Treatment (NAABT)
- National Alliance for Medication Assisted Recovery ([www.methadone.org](http://www.methadone.org)) – formerly National Alliance of Methadone Advocates
- <http://www.dpt.samhsa.gov/patients/support.aspx> (Division of Pharmacologic Therapies)



## History—Professional Societies

- ASAM – founded 1954
- Name becomes ASAM – 1989

# ASAM



## Non-Physician and Multi-Disciplinary Professional Associations

- Association for Medical Education and Research in Substance Abuse (AMERSA) -- 1976



## Physician Specialty Associations

- American Osteopathic Academy of Addiction Medicine -- 1976
- American Academy of Addiction Psychiatry-- 1987



## Researchers' Societies

### AMERSA

Research Society on Alcoholism (RSA) –37<sup>th</sup> annual meeting in 2014:  
[www.rsoa.org](http://www.rsoa.org)

College on Problems on Drug Dependence (CPDD) -- until 1991,  
"Committee on...."

- Founded 1929 as part of National Academy of Sciences, National Research Council
- Independent membership organization since 1976
- <http://www.cpdd.vcu.edu/Pages/AboutUs/AboutCollege.html>



## ASAM/CSAM: The Early Years

- **1951:** New York City Medical Committee on Alcoholism established. (Under NCA; Marty Mann, Ruth Fox collaboration).
- **1954:** New York City Medical Society on Alcoholism's (NYCMSA) first scientific meeting, September 16, 1954 at New York Academy of Medicine.
- **1967 (September):** The New York City Medical Society on Alcoholism becomes the American Medical Society on Alcoholism (AMSA)—it served as the Medical-Scientific Committee of NCA, with offices housed at NCA in NYC.
- **1972:** California Society for the Treatment of Alcoholism and Other Drug Dependencies incorporated (CSTOADD)—offices housed at CMA headquarters.



## www.asam.org

### The Founders

Ruth Fox, MD  
Founding President  
President 1954-1961, 1969-1971

Stanley E. Gitlow, MD  
President 1961-1963, 1971-1973

Luther A. Cloud, MD  
President 1963-1965

Percy E. Ryberg, MD  
President 1965-1967

### The Early Presidents

Sheila B. Blume, MD  
President 1979-1981

Max A. Schneider, MD  
President 1985-1987

Jasper G. Chen See, MD  
President 1989-1991

David E. Smith, MD, FASAM  
President 1995-1997

G. Douglas Talbot, MD, FASAM  
President 1997-1999



## Medical Societies Contribute to Progress Toward Recognition

**1954:** The goals of the NYCMSA were to gain recognition of alcoholism as a treatable disease and to persuade hospitals to admit patients with a diagnosis of alcoholism, which at that time many refused to do so; Ruth Fox did not admit her alcohol withdrawal patients to a hospital due to this stigma/discrimination

**1956:** the AMA stated that it was appropriate to treat alcoholics in hospitals.

**1971:** The National Institutes of Health created the Career Teacher Program in the addictions, supported by faculty development grants to 63 medical schools (Jean Trumble and Jim Callahan were co-chairs of the CTP)



## Medical Societies Contribute to Progress Toward Recognition

**1972:** The California Society for the Treatment of Alcoholism and Other Drug Dependencies (CSTAODD) was incorporated (with support from the California Medical Association), to focus on medical education and certifying physician competency in the addictions

**1975:** The American Academy of Addictionology was organized by G. Douglas Talbot, M.D., and other leaders in Georgia and in the Southeastern U.S. to certify physicians in Chemical Dependency



## Progress Toward Medical Specialty Recognition

**1976:** Development of curriculum guides for medical schools was supported by the National Institute on Drug Abuse (NIDA). The Association for Medical Education in Substance Abuse (AMERSA) was founded (Ed Senay said there were 78 physician specialists at the founding).

**1977:** AMSA began to publish *Alcoholism: Clinical & Experimental Research* (the "Blue Journal") in partnership with the National Council on Alcoholism (NCA) and the Research Society on Alcoholism (RSA). *A:CER* was AMSA's official journal for almost 15 years and remains RSA's official journal.



## Progress Toward Medical Specialty Recognition

**1982:** The California Society for the Treatment of Alcohol and Other Drug Dependencies (CSTAODD) launched a certification program, spurred in part by state legislation requiring that physicians who direct addiction treatment programs must be able to demonstrate expertise in that subject.

**1982:** The American Medical Association endorsed the concept that a single organization should provide an umbrella for the multiple existing societies (in California, New York, and Georgia) to become a single national medical specialty society for Addiction Medicine.



## The Unity Meetings Kroc Ranch

- AMSA, CSTOADD, AAA come together
- AMSA focused on alcoholism and was headquartered in the Northeast; but Chicago had a major contingent (Ed Senay, MD)
  - The Illinois Drug Abuse Program (IDAP) had been founded when Jerome Jaffe, MD, moved from the Lexington Hospital to the University of Chicago under Daniel X. Friedman, MD; Ed Senay joined Jerry Jaffe in 1969 and methadone came to Chicago)



## Progress Toward Medical Specialty Recognition

**1983:** At the first Kroc Ranch unity meeting, addiction field leaders agreed that a single national medical specialty society should represent the field.

**1985:** At a second Kroc Ranch meeting (convened by the AMA), the conferees accepted AMSA's offer "to be the national society of physicians concerned with problems of psychoactive drug use."



## The Unity Meetings at the Kroc Ranch: AMSA-CSTAODD-AAA

- CSTAODD included alcohol and drug treatment experts (including methadone and "drug-free outpatient") but also included nicotine/tobacco experts
- The American Academy of Addictionology, founded by Doug Talbott, MD, included primarily recovering physicians who had been treated by Dr. Talbott and who practiced in facilities throughout the Southeastern U.S.



## Doug Talbott

- G. Douglas Talbott, MD, is a graduate of Yale University and received his medical degree from the Columbia University College of Physicians and Surgeons. Dr. Talbott began his career as a cardiologist.
- Dr. Talbott founded and became Director of the Cox Heart Institute, a nationally recognized cardiac research institute, and also worked with the National Aeronautics and Space Administration (NASA) to select suitable crew for the Mercury, Apollo and Gemini Space Programs.



## Doug Talbott

- Founded Talbott Recovery Campus—the leading treatment program and model for physicians with addiction
- Pioneer, with Roger Goetz, MD, of Florida, of Physician Health Programs – now there is a Federation of State Physician Health Programs, FSPHP
- Founded the American Academy of Addictionology at the second meeting of the AMA's Physician Health Committee
- Served as President of the American Society of Addiction Medicine (ASAM) and Vice President and USA Representative of the International Society of Addiction Medicine (ISAM).
- His nephew is Nelson Strobridge "Strobe" Talbott III.
- With the facilitation of his nephew, Doug travelled often to the USSR and helped promote A.A. in Russia



[http://en.wikipedia.org/wiki/Strobe\\_Talbott](http://en.wikipedia.org/wiki/Strobe_Talbott)

### Nelson Strobridge "Strobe" Talbott III

Through the 1980s he was *Time* magazine's principal correspondent on Soviet-American relations, and his work for the magazine was cited in the three Overseas Press Club Awards won by *Time* in the 1980s. Talbott also wrote several books on disarmament. He is currently the president of the Brookings Institution in Washington, D.C., and a member of the Council on Foreign Relations.

He is a former Deputy Secretary of State and after the Soviet breakup served as Ambassador-at-Large and Special Adviser to the Secretary of State Warren Christopher on the new independent states of the former USSR.



## The Evolution of Recognition of ADM

**1988 (A-88):** ASAM is approved and accepted into membership by the House of Delegates of the American Medical Association (AMA) as a national medical specialty society; the AMA Resolution to achieve this milestone was authored by the California Medical Association (CMA) at the behest of the San Francisco (County) Medical Society

NOTE: New York was the "founder" of the unified national Society, but California was the inspiration for "the big tent"—Jess Bromley of the East Bay became ASAM's first Delegate to the AMA in 1988 and David Smith of San Francisco became ASAM's first Alternate Delegate (Jess was succeeded by Mike Miller of Wisconsin in 1995).

**1990 (A-90):** The AMA House of Delegates acts to assign addiction medicine a code as a self-designated practice specialty in the AMA Physician Masterfile by approving a resolution inspired by ASAM and introduced by the California Medical Association. The code (ADM) is officially approved by the AMA Board of Trustees in July.



## The Legacy of the Unity Meetings AMSAODD becomes ASAM

- The merger of AMSA and the California Society and the American Academy of Addictionology became AMSAODD: the American Medical Society on Alcoholism and Other Drug Dependencies
- AMSAODD changed its name to ASAM in 1988, named an Executive Director (Manny Steindler; part-time, in Chicago), took over the certification process from California Society, and partnered with NAATP in the development of Placement Criteria.
- Jim Callahan, DPA, became the first full-time Exec Dir (then EVP/CEO) and moved the offices to Washington, DC area
- ASAM offered National Conferences on Nicotine Dependence (1988, 1990) and on Patient Placement Criteria (1991, 1992, 1993)



## Milestones in ASAM's Adolescence

**1990:** ASAM Board approves the *ASAM Guidelines for Fellowship Training Programs in Addiction Medicine* (amended 1992), developed by the ASAM Fellowship Committee.

**1991:** ASAM President Jasper Chen See, M.D., established the Ruth Fox Memorial Endowment Fund to support ASAM's mission and goals. The *Journal of Addictive Diseases*, edited by academic internist Barry Stimmel, M.D., FASAM, of Mt. Sinai (NY) became ASAM's official journal, replacing *AZCR*. ASAM published the first edition of its Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders (PPC), which quickly became the standard for the field.

**1993:** The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) awarded Addiction Medicine a representative on its Hospital Accreditation Program (HAP) Professional and Technical Advisory Committee (PTAC)—joint seat of NAATP, NAADAC and ASAM (Mee Lee 93-94; Miller 95-98)

**1994:** ASAM is awarded its own seat on the JCAHO's Accreditation Program for Behavioral Health Care PTAC.

**1994:** *Principles of Addiction Medicine* published by ASAM



## Physician Certification

- **1983-1984:** The California Society (CSTAODD) develops a Certification Examination
- The California Society contracts with the NBME to assure the quality of the exam
- **The California Society donates the exam to AMSAODD**
- **1985-1986:** AMSAODD/ASAM offers the exam, then does so every other year through 2008
- **1994:** *For Board Certified Psychiatrists only* the American Board of Psychiatry and Neurology (ABPN) begins offering a certification examination leading to an ABMS-recognized credential (ADP)
- **1997:** The National Committee for Quality Assurance (NCQA) adopted a requirement that NCQA-accredited managed behavioral health care organizations must have standards for credentialing "psychiatrists and/or physicians certified in Addiction Medicine."
- **2009:** **ASAM donates the exam to ABAM**
- **2010, 2012, 2014:** **ABAM offers the exam**



## The History of Addiction Medicine

- David Smith on the Evolution of Addiction Medicine as a Medical Specialty

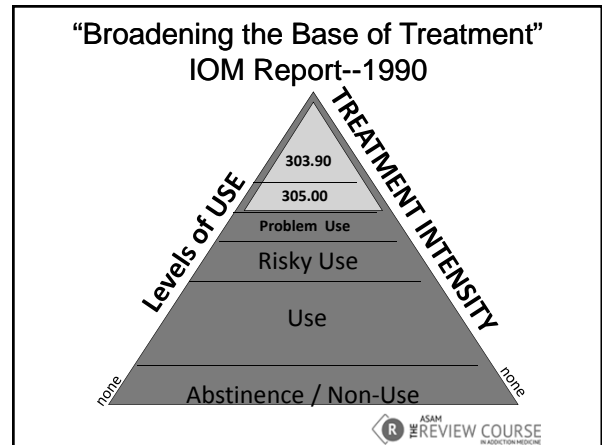
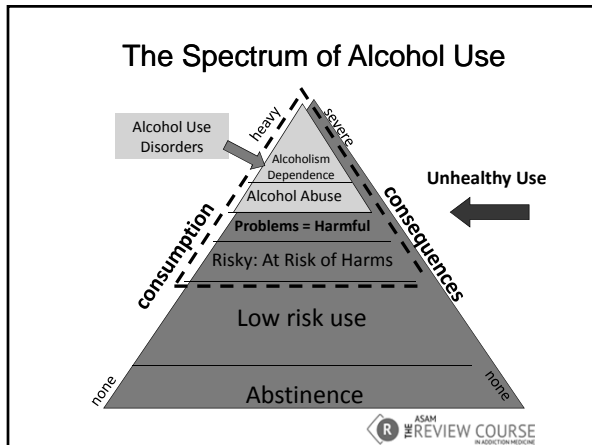
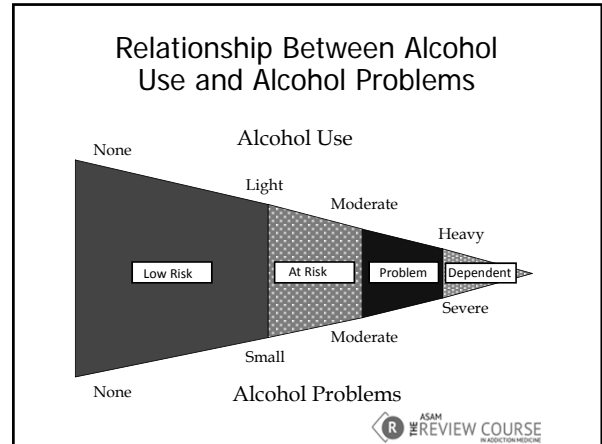
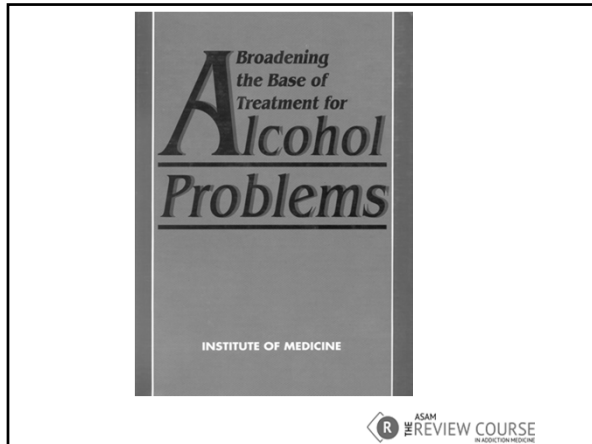
- <http://virtualmentor.ama-assn.org/2011/12/mhst1-1112.html>



## Addiction Psychiatry

- As of October 1991, the American Board of Psychiatry and Neurology (ABPN) and the American Board of Medical Specialties (ABMS), with support of the American Psychiatric Association, established a "Committee on Certification of Added Qualifications in Addiction Psychiatry." This was a way to identify the most educated and experienced psychiatrists in the profession; however, it was not until 1993 when "Addiction Psychiatry" was granted sub-specialization status by the ABMS.
- Diplomates admitted in 1994 via the first ADP (Addiction Psychiatry) exam—initially called CAQ rather than 'Subspecialty Certification'
- Years later, in 1997, the committee's board of trustees along with the ABMS renamed the committee "Committee on Certification in the Subspecialty of Addiction Psychiatry." The committee became more geared toward developing the subspecialty of addiction psychiatry.
- As of 1997, there were only 13 addiction psychiatry programs that the Accreditation Council for Graduate Medical Education (ACGME) recognized. Currently the ACGME recognizes 45 different residency programs in the United States.





- ### Broadening the Base
- Pay attention to more than “addiction”
  - There is a role for the primary care physician in the evaluation and management of alcohol problems
  - Early identification leads to early intervention
  - Results are better with intervention is early in the course of the condition: don’t just treat end-stage problems

- ### Substance Related Health Conditions
- **Substance Intoxication**
  - **Substance Withdrawal**
  - **Substance Use Disorders**
    - Substance Abuse
    - Substance Dependence
  - **Substance Induced Disorders**
    - Psychiatric Complications/Co-morbidities
    - General Medical Complications/Conditions

## Physicians Should attend to Sub-Syndromal Substance Use

### Unhealthy Alcohol Use =

- ❖ Addiction (Alcohol Dependence--DSM-IV; Alcohol Use Disorder, Moderate or Severe—DSM-5: 303.9)
- ❖ Harmful Use (includes Addiction plus the former Alcohol Abuse from DSM-IV, i.e., Alcohol Use Disorder, Mild, from DSM-5: 305.0; but also Problem Use; problems/harms already present)
- ❖ Hazardous Use (Risky Use/At-Risk Use); no harms yet, but risk for development of harm



## ASAM Definitions (from DDTAG)

- **Unhealthy use** of alcohol and other drug (substance) is **any** use that increases the risk or likelihood for health consequences (hazardous use), or has already led to health consequences (harmful use).
- **Hazardous use (alternatively, At-Risk use)** : Use that increases the risk for health consequences.
- HEAVY DRINKING vs. ADDICTIVE DRINKING



## History has brought us to this point in time

- What is “Addiction Treatment” circa 2014?
  - Modalities
  - Goals: targeted outcomes of treatment



## What are we trying to accomplish through “Professional Treatment?”

### ASAM Public Policy statement on Treatment for Alcohol and Other Drug Addiction

- **Addiction Treatment** is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from alcoholism or from another drug addiction, and which is designed to enable the affected individual to achieve and maintain sobriety, physical, spiritual and mental health, and a maximum functional ability.
- **Addiction Treatment** services are professional healthcare services, offered to a person diagnosed with addiction, or to that person’s family, by an addiction professional. Addiction professionals providing addiction treatment services are licensed or certified to practice in their local jurisdiction and may be nationally certified by a professional certification body for their professional discipline.

Adopted by ASAM Board of Directors May 1980; revised September 1986, October 1997, July 2001, October 2009, and January 2010.



## Non-Pharmacological Tx

- Addiction Counseling (supportive / RET / confrontational)
- Cognitive Behavioral Therapy (CBT)
- Coping Skills Training
- Recreational Therapy
- Psychoanalytically-oriented Psychotherapy
- Motivational Enhancement Therapy (MET)
- Community Reinforcement Approach (CRAFT)
- Twelve-Step Facilitation (TSF)
- Network Therapy
- Behavioral Therapy
- Aversion Therapy



NIDA

[www.drugabuse.gov](http://www.drugabuse.gov)



## NIDA Principles of Drug Addiction Treatment (1999, rev 2009)

1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased.
2. **No single treatment is appropriate for everyone.**

NIH Publication No. 09-4180



- In some cases of addiction, medication management can improve treatment outcomes.
- In most cases of addiction, the integration of psychosocial rehabilitation and ongoing care with evidence-based pharmacological therapy provides the best results.
- Chronic disease management is important for minimization of episodes of relapse and their impact.
- Treatment of addiction saves lives



## Using DRUGS to treat Drug Addiction



## Addiction

- Nicotine—*pharmacotherapy is available*
- Opioids—*pharmacotherapy is available*
- Alcohol—*pharmacotherapy is available*
- Sedatives
- Stimulants
- Cannabinoids
- Hallucinogens
- Inhalants
- Gambling



## Overview of Pharmacotherapies for Addiction

- Antabuse—for alcohol addiction
- Naltrexone, acamprosate, topiramate, et al.—for alcohol addiction
- Naltrexone—for opioid addiction
- Opioid Agonist Therapies—MMT
- O.B.O.T.—buprenorphine
- N.R.T., bupropion, varenicline—for nicotine addiction



## The NIAAA Clinician's Guide



## DSM has no descriptions of “sub-syndromal use” that is harmful or risky

- Substance Use Disorder—severe
- Substance Use Disorder—moderate
- Substance Use Disorder—mild
  
- But what about harmful use that doesn’t meet 2 or more criteria—and thus is not a ‘disorder’?
- And what about risky use that hasn’t led to harm but carries probability of doing so?
- SBIRT -- Level 0.5 care in *The ASAM Criteria*



## Unhealthy Alcohol Use

- ❖ Addiction (Alcohol Dependence--DSM-IV; Alcohol Use Disorder, Moderate or Severe—DSM-5: 303.9)
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- HEAVY DRINKING vs. ADDICTIVE DRINKING



## *The ASAM Criteria and ASAM Criteria Software*



## The ASAM Criteria

- Intensity of Service should derive from Severity of Illness
- Treatment should follow multidimensional Assessment
- Diagnosis—Treatment Plan—Determination of Level of Care



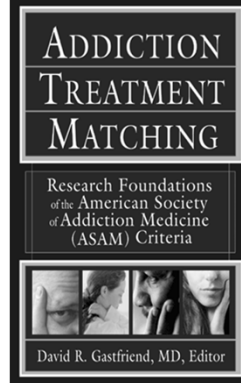
## Assessment Dimensions

- Intoxication/Withdrawal Potential
- Biomedical Conditions/Complications
- Emotional/Behavioral/Cognitive Conditions
- Treatment Acceptance/Readiness/Motivation
- Relapse/Continued Use Potential
- Recovery Environment



## Levels of Care

- 0.5 Screening/Brief Intervention/Education
- 1.0 General Outpatient
- 2.0 Intensive Outpatient/Partial Hospital
- 3.0 Medically Monitored/Residential
  - halfway houses, extended care, TC's
- 4.0 Medically Managed/Inpatient



[www.haworthpress.com](http://www.haworthpress.com)



## The Role of the Physician in the Care of Addiction and Other Substance Related Disorders



## Addiction Specialist Physician

**Addiction specialist physicians include** addiction medicine physicians and addiction psychiatrists who hold either a board certification in addiction medicine from the American Board of Addiction Medicine (ABAM), a subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology (ABPN), a subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA), or certification in addiction medicine from the American Society of Addition Medicine (ASAM).



## The Role of the Physician

- We made a good faith effort to differentiate the role of the physician in the Criteria themselves, under the Staffing section describing each Level of Care (and sub-level)
- We tried to understand:
  - Where is a physician needed—vs. a PA or APNP?
  - Where is an addiction medicine physician needed—vs. a non-specialist physician?
  - Where is an addiction psychiatrist needed?



## Treating All Patients Like We Treat Doctors who have Addiction

- Contingencies
- Structure and Accountability
- Chronic Disease Management
- Monitoring
  - Treatment monitoring
  - Laboratory monitoring
  - Workplace monitoring
- Adequate Dose and Duration: 2-5 years



## Treatment of Addiction

- **What are the treatment goals for a chronic disease?**
- Decrease frequency of relapses
- Decrease severity of relapses
- Increase duration of remission
- Optimize level of function during remissions



## Examples of C.D.M.

- A-I-R.com (A/R)
- Caron's Recovery Care Services
  - Program specialists get to know patients while in treatment, and right before discharge, the Recovery Care Services Specialist meets with the patient to enroll in the program. Monthly phone calls to patients allow Caron RCS Specialists to track many aspects of a patient's ongoing recovery and provide problem solving, coaching, and intervention-based approaches, as appropriate.



## Examples of C.D.M.

Hazelden's MORE program:

MORE – 18 months of effective, personalized recovery support. MORE connects you with the tools, support, and fellowship you need to build your new life in recovery. Think of MORE as a personal guide for your recovery journey.

**Recovery tools:** worksheets, journaling, fact sheets, articles, videos

**MORE supports you with**

- Guidance from your recovery coach, a licensed addiction counselor, both electronically and by phone
- Encouragement to set and reach personal commitments each week
- Spiritual insights and inspiration through an online Serenity Room

**MORE connects you with**

- Online, real-time discussion boards with Hazelden alumni



## Examples of C.D.M.

### Alcohol Research & Health, Volume 33, Number 4 (2009) **Treating Alcoholism As a Chronic Disease: Approaches to Long-Term Continuing Care**

- James R. McKay, Ph.D., and Susanne Hiller-Sturmhöfel, Ph.D.
- JAMES R. MCKAY, PH.D., is a professor in the Department of Psychiatry, University of Pennsylvania, and director of the Philadelphia VAMC Center of Excellence in Substance Abuse Treatment and Education, both in Philadelphia, Pennsylvania.
- SUSANNEHILLER-STURMHÖFEL, PH.D., is senior science editor with Alcohol Research & Health (NIAAA)



## Addiction Treatment

- Offered by addiction specialists:
  - A continuum of care, as described in The ASAM Criteria
  - Level I, II, III, IV
  - Many patients receive IOP as “primary treatment”
- Offered by addiction specialist physicians
  - A combination of psychosocial services, in a continuum based on medical necessity, with evidence-based pharmacotherapy



## Addiction Treatment

- Offered by researchers:
  - Virtually never anything beyond ASAM Level I
  - Various pharmacotherapies (clinical trials)
  - Various individual therapies
  - Infrequently group or family therapy
  - Often 12 sessions or less



## Addiction Treatment

- Offered by mental health therapists:
  - Mental health therapy
  - Usually individual therapy
  - CBT, MET, coping skills training
  - Occasionally TSF; more often just referral to AA



## Addiction Treatment

- Offered by primary care physicians:
  - Treatment of medical (or psychiatric) complications of addiction
  - General support
  - Maybe medication management
  - If sophisticated: SBIRT using MET
  - At times, referral (outside) to an addiction counselor
  - At times, referral to AA
  - At times, referral to 'specialty addiction care'



## Addiction Treatment

- As approved by “managed care”
  - “fewer visits” is better
  - “stabilization/crisis management” then “go to AA” or “fend for yourself”
  - Anything but “chronic disease management”
  - Transitioning to....
    - Generate results (reduce readmissions)
    - Truly manage health status/population outcomes
    - Increase utilization of ADM services to decrease utilization of med/surg services



## Living History—As It Happens!

### Current trends

- Pharmacotherapy
- Reactions to “Pharmacotherapy Only”
  - LMD (“Like Minded Docs”)
  - <http://www.likemindeddocs.com/about-us.html>
  - <http://www.behavioral.net/article/naatp-minded-docs-tout-disease-modifying-impact-12-step-addiction-treatment>
  - C.O.R.E.



## Living History—As It Happens!

### Current trends

- Improving Treatment via Improving Education
  - The ABAM Foundation: subspecialty GME
  - C.O.P.E.—imbedding improved education in all undergraduate and graduate medical education



## Living History—As It Happens!

### Current trends

- Attention to the “Heavy Drinker”
- Saving Costs by Reducing Medical Complications of Heavy Drinking
- Treatment = Prevention
- Saving Lives by Reducing Medical Complication of Drug Use (IVDU)
- “Harm Reduction”



## Living History—As It Happens!

### Current trends

- “Medicalization” – have PHYSICIANS involved
  - CASA Report
  - Do what doctors do: diagnose, medicate, consult
- Integration of Addiction Care and Primary Care
  - Integration
  - “Reverse Integration”
- Help Doctors to become Part of the Solution, not Part of the Problem
  - Improved prescribing practices for opioids
  - SBIRT by physicians – primary care, med/surg specialties, psychiatrists



## Living History—As It Happens!

### Current trends

- True Integration
  - Not just “addiction care” and “medical care”
  - Addiction Care and Mental Health Care
  - Not just alcoholism care and drug addiction care but also nicotine/tobacco addiction care
  - Not just “medical care” by physicians, but “health care” and “health promotion” by health care teams (physicians integrated into physician-led teams)



**Treat  
Addiction  
Save  
Lives**



© ASAM



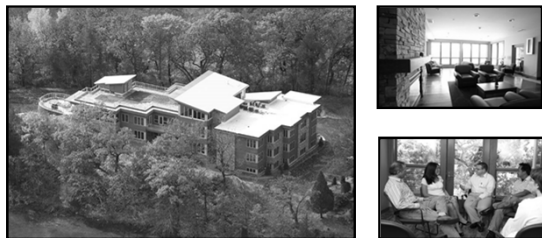
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rogershospital.org



## The Herrington Recovery Center



## Thank you!



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