ASAM NEWS

AMA House of Delegates Report

July / August 1996 Volume 11, Number 3

Newsletter of The American Society of Addiction Medicine

New Federal Drug Czar Tells AMA: Addiction Treatment Is Key Weapon

Wayne Hearn

The nation's top drug policy official, addressing the American Medical Association's House of Delegates in June, called on America's physicians to help "establish the credibility" of treatment programs as a major weapon in the anti-drug campaign.

"You have to help me persuade legislators and the Congress that treatment programs can help and that education and prevention pays off," Gen. Barry R. McCaffrey, director of the Office of National Drug Control Policy, told the AMA delegates.

"We now know more about drug running in Bolivia than we do about the effectiveness of treatment programs and education," he said during a brief dialogue with Michael M. Miller, M.D., delegate from the American Society of Addiction Medicine, who told the general that many physicians suffer "therapeutic pessimism" in treating patients who abuse substances.

"Let's get the scientific data, subject to peer review, so we can argue [from] a set of facts and a set of hypotheses—that's what we lack right now," said McCaffrey, a Viet Nam veteran and an infantry commander during Operation Desert Storm. His nomination as the Clinton administration's chief drug policy strategist was confirmed in February.

At stake, he said, are millions of federal dollars that can easily be diverted from treatment programs unless lawmakers can be convinced that treatment is a cost-effective approach to the drug problem.

For example, he told delegates that the budget for the federal Substance Abuse and Mental Health Services Administration was slashed by 40% last year, and $540 million for the Safe and Drug-Free Schools program almost was lost.

He also urged physicians to participate in the approximately 3,000 community-based anti-drug alliances nationwide. "They would benefit not only from your knowledge, but from your leadership," he said. "You have to educate yourselves on drug addiction, pay attention to your patients and see the people who are suffering...and do something about it. Your judgement, example and influence are enormous."

McCaffrey said that the No. 1 goal of his $15.1 billion national drug control strategy, which was just unveiled in April, is "to motivate young people to reject the abuse of drugs, alcohol and tobacco.

"I don't need to tell this group that we have a national emergency in drug abuse among children," he said, citing data showing more youths are experimenting with tobacco, alcohol and drugs—from marijuana and inhalants to Rohypnol, the so-called "date rape drug"—at younger ages than ever before.

"Sixth grade is the onset of serious exposure to drugs in America," he said. "We understand that if you can get from age 10 to 20 without smoking cigarettes, abusing alcohol or using drugs, the chances of your having an addictive problem during your lifetime drops, statistically, to zero."

Gen. Barry R. McCaffrey

But while his plan stresses education and prevention to cut demand, McCaffrey said law enforcement efforts that are aimed at drug dealers, especially international distribution cartels, must continue.

"We'll never stop drugs from coming into America...but we can reduce the amount of drugs floating around this country, he said. "We are aware that if there are less drugs in America, fewer people try them and less

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INSIDE

ASAM
American Society
of
Addiction Medicine

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ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

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AMA REPORT

JESS BROMLEY, M.D., NAMED AMA DELEGATE-EMERITUS

Emanuel M. Steindler

Professor-emeritus, yes; president-emeritus, maybe; but *delegate*-emeritus?

When ASAM's Board of Directors bestowed that title in April on Jess W. Bromley, M.D., it probably marked the first time "delegate" had ever been appended this way, but the Board knew precisely what it was doing and whereof it spoke.

It was Dr. Bromley who set the wheels in motion nearly 15 years ago to link the fortunes and fate of what was soon to become ASAM with the American Medical Association.

In 1982, the House of Delegates adopted a resolution from its California delegation—a resolution that Dr. Bromley had instigated and nurtured through the California Medical Association. It called upon medical organizations in the addiction field to form a national society that would encompass alcohol and all other drugs of dependence. There followed two conferences at the Kroc Ranch and the birth of the specialty society that is ASAM today. As Dr. Bromley was fond of reminding his fellow delegates in the House, after ASAM was accorded a seat in 1988: "We are your offspring."

Largely through Dr. Bromley's efforts, not only was ASAM accepted into the House of Delegates, but addiction medicine was recognized by the AMA as a practice specialty. Dr. Bromley looked forward to each semi-annual meeting of the House as an opportunity to move the specialty closer to the middle of medicine's mainstream. At times he cajoled, often he politicked, but always he kept to the high road of enunciating to all who would listen—on the floor of the House, in reference committees, or in delegate caucuses and receptions—the nature and magnitude of addictive diseases and the role of physicians in coping with them.

The ASAM Board could look back on several influential policy actions taken by the AMA mainly as the result of Dr. Bromley's initiative and perseverance. For example, through Jess's leadership, drug dependence was recognized as a disease and its treatment as a legitimate part of medical practice. Physicians other than psychiatrists were recognized to be potentially qualified to practice addiction medicine. Substance abuse was called the nation's No. 1 public health problem. Alcohol and nicotine were identified as addictive "gateway" drugs. New methadone treatment guidelines and regulations were advocated, emphasizing performance-based standards. Licensing and accreditation bodies, as well as managed care entities, were urged not to exclude or discriminate against physicians with a history of substance abuse. Hospital medical staffs were called upon to screen for alcohol and other drug use in trauma patients. All physicians were advised to have no significant body content of alcohol before engaging in treatment.

Because of health problems, Dr. Bromley was unable to attend the last two meetings of the AMA House of Delegates. His presence was missed by colleagues. Said one: "With his staff-like cane and flowing beard, he reminded me of a prophet of yore, but the sermon he preached was as modern and relevant as any other issue being voiced in this House." Commented another: "You couldn't escape Jess. He'd buttonhole you and sit you down and make you listen. Yet what he said made a good deal of sense, and I'm grateful for having heard him."

Perhaps best expressing what still others were saying and feeling was this remark: "While he was a great spokesman for the drug docs, he also spoke as the conscience of the rest of us in medicine."

Jess Bromley: delegate-extraordinaire.

ADDICTION ISSUES IN SPOTLIGHT AT AMA ANNUAL MEETING

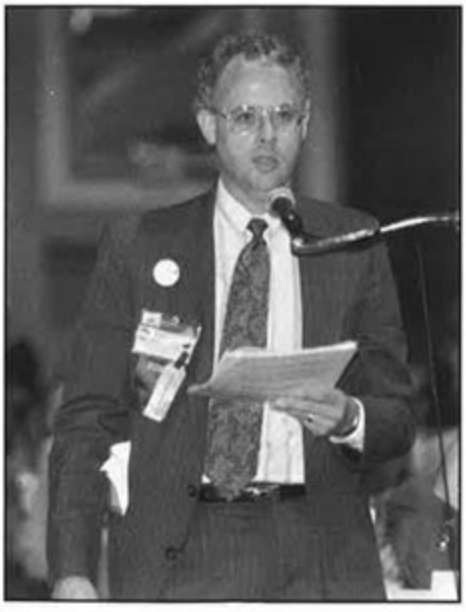
Emanuel M. Steindler

Addiction issues were front and center at the 1996 annual meeting of the American Medical Association's House of Delegates in Chicago in June. Delegates gave a standing ovation to Gen. Barry R. McCaffrey, director of the Office of National Drug Control Policy, after he delivered an upbeat opening-day address emphasizing the value and importance of treatment and underscoring his office's concern about alcohol and nicotine use, especially by young people.

In succeeding days, the House continued the AMA's relentless campaign against the tobacco industry by adopting a series of new anti-smoking resolutions and reports. It also approved several other items relating either directly or indirectly to addiction medicine.

Responding on the floor of the House to Gen. McCaffrey's address, ASAM delegate Michael M. Miller, M.D., commended the director for his call for greater physician involvement in prevention and treatment activities, and asked his help in achieving parity of coverage for addiction treatment by private health insurers and managed care organizations. Dr. Miller pointed out that the current disparity in coverage between addictive and other disorders is due in no small measure to the "therapeutic pessimism on the part of policymakers and leaders in both government and medicine."

On the tobacco front, the House endorsed a statement made in April by the AMA secretary-treasurer that all physicians, other health care professionals, and health care organizations should divest any tobacco holdings in their investment portfolios. In issuing the endorsement, the House specifically called upon life and health insurance companies and HMOs to make such divestitures.



Michael M. Miller, M.D.

In other tobacco-related action, the House asked the AMA to identify strategies to help psychiatric facilities become smoke-free; called on medical schools and their parent universities to decline research funding from the tobacco industry and urged "all scientific publications" to refuse to publish such funded research; committed the AMA to work with the Agency for Health Care Policy and Research in implementing practice guidelines on smoking cessation; pledged AMA assistance in meritorious class action lawsuits based on the addicting qualities of nicotine; and urged physicians to mark the covers of magazines in their waiting areas that contain tobacco advertising with a disclaimer saying they do not support the use of any tobacco product.

The House also took action on additional matters concerning the addiction field, with Dr. Miller and Stuart Gitlow, M.D., ASAM's representative in the AMA's Young Physicians Section, offering testimony on several items in reference committee hearings.

ASAM testified in favor of establishing a joint office between AMA and the Federation of State Physician Health Programs, and in support of a resolution asking the AMA to study the increasing number of diagnoses of Attention Deficit Hyperactivity Disorder, stressing ASAM's concern about the potential for diversion and abuse of psychostimulant drugs that are widely used to treat the disorder.

Neither of two resolutions submitted by ASAM for consideration by the House was adopted, however. One dealt with the disallowance of Social Security Disability benefits for persons with alcohol and other drug addiction. This restriction, contained in the federal budget act adopted in March, came to ASAM's attention after the regular deadline for submitting resolutions to the House of Delegates, and the AMA Rules Committee declined to accept it as a late resolution.

The other ASAM submission asked AMA to study the effects of a medical, as opposed to a criminal justice, approach to addiction. The reference committee noted that this issue already was under study by the AMA Council on Scientific Affairs and also would be addressed in a contemplated white paper by AMA staff in the newly created Office of Alcohol and Other Substances.

In other criminal justice matters, the House did adopt, with ASAM supportive testimony, a resolution asking the National Commission on Correctional Health Care to study all aspects of physical and mental health care in prisons, jails and detention facilities. The House also called on the Commission to collaborate with the AMA and designated specialty societies to study the feasibility of a program to help women prisoners bond with their newborn children. It was noted that of the women incarcerated in 1991, nearly two-thirds were for drug-related offenses.

The House accepted ASAM amendments to recommendations dealing with mental health "carve outs" in managed care contracts. The recommendations proposed that plans use physician-developed practice guidelines to identify the clinical circumstances under which referral to "psychiatrists or addiction medicine physicians" is indicated; that those who authorize patient access to behavioral health benefits be appropriately trained and supervised health professionals who have "relevant age-group specific psychiatric or addiction medicine training," and who will elicit only the patient information necessary to confirm the need for such care "in order to protect the patient's privacy and confidentiality of patient medical records."

Dr. Miller also pointed out to the reference committee that there are major operational problems with "behavioral managed care" firms in defining the parameters of "behavioral" conditions and in determining which financial risk pool—behavioral or otherwise—to assign carved-out services. He urged that firms adopt a disease management approach rather than imposing arbitrary coverage limits, caps or exclusions, and submitted a copy of ASAM's Core Benefit statement in support of his testimony.

A related resolution originally titled "Parity for Psychiatry in Medical Benefits Programs" was adopted with a new title suggested by Dr. Gitlow: "Parity for Mental Illness, Alcoholism and Related Disorders." The statement affirms AMA policy favoring such parity in health insurance plans.

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FROM THE PRESIDENT

Dear Colleague:

One of the major goals of the American Society of Addiction Medicine is to strengthen the scientific basis of the practice of addiction medicine by facilitating the transfer of research knowledge in the addictions to the clinician. By strengthening the scientific and clinical base of the practice of addiction medicine, we will not only improve care to our patients but gain credibility for our specialty as well as increase our ability to involve the primary care practitioner who sees the consequences of tobacco, alcohol and other drug addictions. One of the major ways of achieving this complex goal is to improve our collaborational relationships with other professional societies. Toward this end, ASAM has been very active since our Medical-Scientific Conference in Atlanta.

Our AMA delegation, led by Dr. Michael Miller, was very effective at the Chicago meeting. We not only served as a resource for a wide range of topics relating to addiction issues but we also gained valuable information as to how we can advance the specialty of addiction medicine as well as increase the primary care physician's involvement.

For so many years, the AMA delegation has been led by Jess Bromley, M.D., and the transition to new leadership upon Jess's retirement was very encouraging in terms of maintaining the effectiveness of the delegation and bringing in new faces to the movement. These new leaders are an excellent complement to old-timers like Manny Steindler and myself. I am hopeful that this will keep the addiction medicine movement fresh and vibrant.

I also met with the leadership of the Research Society on Alcoholism as they honored the 25th Anniversary of the National Institute on Alcohol Abuse and Alcoholism. It was encouraging to interact with RSA leaders and past ASAM award winners such as Drs. Charles Lieber and Harold Kalant, who emphasized their desire to expand their interaction with ASAM in order to better translate research findings into clinical practice. In the same vein, representing ASAM, I met with the leaders of the Committee on Problems of Drug Dependence, the American Academy of Addiction Psychiatry, and the Association for Medical Education and Research in Substance Abuse in San Juan, Puerto Rico. The outcome of this meeting was the development of an *ad hoc* consortium for substance abuse research, treatment and prevention, with the primary goal of transferring technology from "the bench to the trench."

In addition to emphasis on improving the scientific basis of the clinical practice of addiction medicine, advocacy to decrease regulatory barriers to treatment as well as to gain more support for treatment are high on our agenda. Despite the mounting economic and regulatory barriers to treatment, General Barry McCaffrey's presentation to the AMA House of Delegates called for increased physician involvement in the addiction area. He suggested that the environment is right not only for ASAM but for a consortium approach to focusing on expanding medicine's involvement. From a personal point of view, it was gratifying to me to see how broad based and effective the leadership of ASAM has been in interacting in these various forums. Dr. Jim Callahan's job of coordinating this interaction has been truly remarkable. His fine work and dedication to our mission makes our organization one of the best managed professional societies in the United States and I continue to be proud of my involvement with ASAM.

Peace and Health,

David E. Smith, M.D.

Addiction Issues – Continued from page 3

The House approved the Board of Trustees' plans to develop model state legislation on prescribing analgesics for patients with intractable pain, based on such laws already in place in California, Texas and other states. Although not incorporated into the succinct language of the Board's report, the following recommendations made by ASAM were received by the reference committee:

- State laws should provide disciplinary immunity for a physician who may find it clinically indicated to prescribe controlled substances to a recovering alcoholic or chemically dependent person for the treatment of chronic pain.

- Model legislation should encourage the use of second opinion consultations from addiction medicine physicians in cases where opiate use for management of intractable pain is anticipated for patients with addiction diagnoses.

- All patients expected to be placed on a regimen of chronic medication treatment with controlled drugs should be screened for addiction.

ASAM also testified in favor of these measures, which were adopted:

- A call for the AMA to conduct a public information campaign to highlight the successes of free clinics. (ASAM's delegate testified in reference committee and on the floor of the House regarding the coming 30th anniversary of the Haight Ashbury Free Clinics and how, through the leadership of David E. Smith, M.D., ASAM President, Haight Ashbury has become a model for free clinics in the management of withdrawal, intoxication and substance dependence.)

- A Council on Scientific Affairs report regarding fatigue, sleep disorders and motor vehicle crashes, with ASAM offering additional language—not incorporated in the recommendations eventually adopted—about the contribution of alcohol and other drugs to drowsiness and crashes, the impairment of driving by psychostimulants used to combat fatigue, and the need to increase public awareness of these issues.

- A report asking that federal block grants for essential public health programs and services be preserved. (ASAM recommended that alcohol and other substance abuse and addiction services be specified, but the wording was not accepted, for simplicity's sake, by the reference committee.)

- A report urging that decisions on discharging patients from treatment be based on clinical findings and not solely on financial criteria. (ASAM presented a copy of ASAM's *Patient Placement Criteria, Second Edition* (*ASAM PPC-2*) to the reference committee and arranged to give the Council on Scientific Affairs copies of both the *PPC-1* and *PPC-2*, as well as ASAM's evidence-based practice guideline on pharmacotherapy of alcohol withdrawal.)

- A report on family violence that acknowledges the important links between such violence and substance abuse.

- A resolution asking the AMA to help identify harmful practices in the sports training of children and adolescents, and to establish appropriate health standards for such training.

ASAM testified in favor of referral for further study of a resolution on the use of physical restraints in nursing homes, noting that the Joint Commission has been responsive to physician input regarding the revision of accreditation standards dealing with restraint and seclusion.

The ASAM delegation also voted in favor of a joint report of the Councils on Medical Education and Medical Service on the promotion of high-quality telemedicine services, and resolutions that were referred for further study on preparing a new Flexner Report on medical education in the United States, and proposing that the AMA undertake a greatly enhanced public education campaign on the benefits of animal research. These items, along with a resolution on the essential nature of clinical research (which was adopted), were forwarded to the ASAM Board for information.

ASAM's Representatives to the AMA

Michael M. Miller, M.D., is ASAM's delegate to the AMA House of Delegates, while David E. Smith, M.D., is the alternate delegate. Jess W. Bromley, M.D., who served as delegate from the time ASAM was admitted to the House in 1988 until last year, has been named delegate-emeritus.

Other ASAM representatives to the AMA are Stuart Gitlow, M.D., delegate to the Young Physicians Section, who was elected at the June meeting to the Section's Governing Council; Christina M. Delos Reyes, M.D., delegate, and Richard D. Paris, alternative delegate to the Resident Section; and Sarah Babai, delegate, and John Hergenrother, alternate delegate to the Medical Student Section.

Other ASAM members active at the AMA meeting included Lee McCormick, M.D., head of the Organized Medical Staff Section and a member of the Pennsylvania state delegation; Sam Cullison, M.D., delegate from Washington State; Silvana Menendez, M.D., delegate from Illinois; and Cesar Aristeiguieta, delegate from California to the Medical Student Section.

Make Treatment Key Weapon
–Continued from page 1

become addicted. So we have to do the foreign interdictions. We have to defend America's air, land and sea frontiers."

Asked his opinion of drug legalization, McCaffrey responded: "Some of them are unprintable. One of the things I am sure of is, we ain't legalizing drugs in America."

His adamant stand against legalization elicited sustained applause from the delegates—this three days after published news accounts about an early draft of an AMA Council on Scientific Affairs report said to recommend the decriminalization of marijuana and the easing of penalties on other drugs as part of a "harm-reduction" approach to the drug problem. AMA officials stressed that the draft, which was written by an outside author, was a work in progress and would undergo considerable revision before it is submitted for approval, possibly at the December AMA Interim Meeting.

In pledging AMA support for the government's anti-drug policy, House Speaker Richard F. Corlin, M.D., referred to McCaffrey's military success in Operation Desert Storm, where he led the successful "left hook" strike against the elite Iraqi Republican Guard. "We'd like to be your battalion to help deliver the right hook in this battle," Dr. Corlin said.

ICD AND DSM CRITERIA MOVE TOWARD AGREEMENT ON SUBSTANCE DEPENDENCE

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) recently published a comparison of the diagnostic criteria of the American Psychiatric Association and the World Health Organization, as shown below. APA criteria are drawn from that organization's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).* The WHO criteria are published as the *International Classification of Diseases, Tenth Revision (ICD-10).* (It should be noted that while the criteria refer to substance dependence, the NIAAA has adapted them to focus solely on alcohol dependence.)

NIAAA also compared the DSM-IV and ICD-10 diagnostic criteria for substance abuse or harmful use of substances. The criteria follow, as they have been adapted for alcohol:

	DSM-IV	ICD-10
SYMPTOMS	A maladaptive pattern of alcohol use, leading to impairment or distress as manifested by three or more of the following at any time during the same year:	Three or more of the following have been experienced at some time during the previous year:
TOLERANCE	Need for increased amounts of alcohol to achieve the desired effect, or diminished effect with use of the same amount;	Increased doses are required in order to achieve effects originally produced by lower doses;
WITHDRAWAL	Characteristic withdrawal syndrome for alcohol, or the taking of alcohol or related substances to relieve or avoid withdrawal symptoms;	Physiological withdrawal state when drinking ceases or decreases, as evidenced by alcohol withdrawal syndrome, or use of alcohol or related substance to relieve or avoid withdrawal symptoms;
IMPAIRED CONTROL	Persistent desire or one or more unsuccessful attempts to cut down or control drinking; Drinking in larger amounts or over a longer period than planned;	Difficulties in controlling drinking in terms of onset, termination, or levels of use;
NEGLECT OF ACTIVITIES	Important social, occupational, or recreational activities given up or reduced because of drinking;	Progressive neglect of alternative pleasures or interests to drink;
TIME SPENT DRINKING	A great deal of time spent in activities necessary to obtain alcohol, to drink, or to recover;	None
DRINKING DESPITE PROBLEMS	Continued drinking despite persistent physical or psychological problems likely to be caused by alcohol use.	Continued drinking despite clear evidence of harmful physical or psychological consequences;
COMPULSIVE USE	None	A strong desire to or sense of compulsion to drink.
DURATION	No duration criterion separately specified. However, three or more dependence criteria must be met within the same year and must occur repeatedly as specified by duration qualifiers linked to criteria (such as "often," "persistent," and "continued").	No duration criterion separately specified. However, three or more dependence criteria must be met during the previous year.
SUBTYPING DEPENDENCE	With physiological dependence: evidence of tolerance or withdrawal. Without physiological dependence: no evidence of tolerance or withdrawal.	None.

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DSM-IV: Alcohol Abuse

• A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within a year:
– recurring drinking resulting in a failure to fulfill major role obligations at work, school or home;
– recurrent drinking in situations in which it is physically hazardous;
– recurrent alcohol-related legal problems;
– continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

• The symptoms have never met the criteria for alcohol dependence.

ICD-10: Harmful Use of Alcohol

• A pattern of alcohol use that is causing damage to health. The damage may be physical or mental. The diagnosis requires that actual damage should have been caused to the mental or physical health of the users.

• No concurrent diagnosis of the alcohol dependence syndrome.

When the current versions of the DSM and ICD were being drafted, the sponsoring organizations tried to resolve some of the differences between them. While differences remain, a consensus seems to be forming, making it easier for clinicians and researchers to categorize patients.

In its most recent edition, ICD-10 has adopted the term "harmful use" in place of "abuse," so as to avoid underreporting of health problems caused by alcohol and other drugs. These health problems, both physical and psychological, can occur in the absence of dependence.

Meanwhile, DSM-IV notes that disorders other than dependence, such as anxiety or depression, may be linked to the use of alcohol or other drugs.

WisSAM

The Wisconsin Society of Addiction Medicine
Presents its 2nd Annual Education Conference
Saturday, October 12, 1996
Milwaukee Psychiatric Hospital
1220 Dewey Avenue, Wauwatosa, Wisconsin 53226

"Recognizing and Maintaining in Treatment the Newly Diagnosed Problem Drinker"

This one-day meeting covers mortality data on alcohol consumption (including counseling non-alcoholic patients on prudent use); tips for physicians who wish to improve their recognition and appropriate referral of problem drinkers; coping with resistance and denial; stages of change for the alcoholic in recovery; the relation between treatment and the criminal justice system; treatment in the managed-care era, and others. This conference will be of special interest to nurses, social workers, alcohol counselors and to physicians specializing in family practice, internal medicine or psychiatry.

Schedule – October 12

Registration ..... 7:45 – 8:30am
Welcoming Remarks ..... 8:30 – 8:45
Larry Heller, M.D., President, WisSAM
Barriers to Effective Recognition and Referral of Problem Drinking ..... 8:45 – 9:20
Christine Miller, M.D.
Stages of Change in the Problem Drinker ..... 9:20 – 9:55
Richard Brown, M.D.
BREAK ..... 9:55 – 10:15
Reframing Resistance to Treatment ..... 10:15 – 10:50
Harry Doweiko, Ph.D.
Managing Denial at the Initial Interviews ..... 10:50 – 11:25
David J. Langenfeld, CADCIII
Stump the Experts – Bring your questions on clinical cases. ..... 11:25 – 12:00
Lunch – WisSAM Business Meeting – Other Physicians Welcome
Medical Effects of Alcohol ..... 1:30 – 2:05pm
Dean Whiteway, M.D.
Is Coerced Treatment Effective? ..... 2:05 – 2:40
David J. Langenfeld, CADCIII
BREAK ..... 2:40 – 2:55
Antabuse—Pros, Cons and Appropriate Prescribing ..... 2:55 – 3:30
Dean Whiteway, M.D.
Changing With the Times—Alcohol Dependency in the Managed Care Era ..... 3:30 – 4:05
Michael Miller, M.D.
Questions & Answers from Afternoon Sessions ..... 4:05 – 4:30

For Information

To receive a course brochure and registration materials, please write or call:
Dr. Dean Whiteway
Gundersen-Lutheran Medical Center
1836 South Avenue
La Crosse, WI 54601
Phone toll-free 1 (800) 362-9567, extension 2175

MANAGEMENT OF COCAINE ABUSE AND DEPENDENCE

Jack H. Mendelson, M.D. and Nancy K. Mello, Ph.D., review the literature on management of cocaine abuse and dependence, as well as polydrug abuse involving cocaine, in the *New England Journal of Medicine* (1996;334:965-972). After describing diagnostic criteria for cocaine intoxication, abuse and withdrawal, the authors discuss the role of psychotherapy and behavioral therapies and evaluate the literature on various pharmacotherapies, involving antidepressants, drugs that affect dopaminergic function, opioid antagonists and mixed agonist-antagonists, carbamazepine, and new medications under development. They conclude that no drug therapy presently is uniquely effective in treating cocaine abuse and dependence, but that the treatment of such abuse or dependence continues to rely on a "triad of compassion, psychosocial enrichment, and safe and effective pharmacotherapy."

TOBACCO LEADING CAUSE OF MORTALITY FOLLOWING ADDICTION TREATMENT

Patients previously treated for alcoholism and/or other nonnicotine drug dependence had an increased cumulative mortality that was due more to tobacco-related than to alcohol-related causes, say the authors of a study in the *Journal of the American Medical Association* (1996;275:1097-1104). Dr. Richard Hurt and colleagues examined death certificates for 214 patients who had undergone inpatient addiction treatment at some point in their lives. They found that 50.9% of these patients had a tobacco-related and 34.1% had an alcohol-related underlying cause of death, and that the cumulative mortality rate exceeded that expected: at 20 years, the mortality rate was 48.1%, versus an expected 18.5%.

ALCOHOL AFFECTS LONGEVITY, STUDY FINDS

Not only can years of heavy drinking lead to heart disease, cirrhosis and other ailments, they can shear off as many as 20 years of life, according to a study in the journal *Alcoholism: Clinical and Experimental Research*. Scientists at Washington University (St. Louis) reported that in the population studied, nearly half of the women and 60% of the men who abused alcohol died within a 20-year follow-up period. Specifically, investigators followed 259 men and women—most of whom were in their 30s and 40s at the start of the study—who were hospitalized for treatment of alcoholism in the 1960s. They found that members of the group died at an average age of 56.

Elizabeth Smith, Ph.D., and colleagues expressed the hope that their work will help alcohol treatment programs target specific interventions to patients who are at greatest risk of premature death. For example, they found that risk of early death in women increased with binge drinking and decreased with a diagnosis of depression. From this, they hypothesize that the women in their study may have used alcohol to self-medicate for depression; once the depression was appropriately treated, the women stopped drinking.

NO LINK BETWEEN CHILDHOOD HYPERACTIVITY AND ALCOHOLISM

There has been much debate as to whether future risk of alcohol dependence is related to childhood symptoms of attention deficit/hyperactivity disorder (ADHD). Reviewing the research literature in the October 1995 *Drug Abuse & Alcoholism Newsletter* of the Vista Hill Foundation, editor Marc Schuckit, M.D. concludes that when specific diagnoses are considered, rather than mere symptoms of hyperactivity, there does not appear to be a close relationship between ADHD and alcohol dependence.

DIAGNOSING CO-MORBIDITY IN SUBSTANCE ABUSERS

Neither the computerized diagnostic interview schedules (C-DIS) nor the structured clinical interview for DSM-IIIR (SCID) should be administered only once to identify co-morbid disorders, according to a report by H. E. Ross and colleagues in the *American Journal of Drug and Alcohol Abuse* (1995;21:167-185). Researchers administered both instruments to 173 substance abusers who had been randomly assigned to one of two groups. Within two weeks, subjects in one group repeated the C-DIS, while those in the other group were re-interviewed by a clinician who was blind to the initial SCID. While reliability in diagnosing psychoactive substance abuse disorders was high for both, reliability in diagnosing coexisting mental disorders was uniformly poor.

TEEN DAUGHTERS OF MOTHERS WHO SMOKED DURING PREGNANCY MORE LIKELY TO SMOKE

Daughters of women who smoked during pregnancy are four times more likely to begin smoking during adolescence and to continue smoking than daughters of women who did not smoke while pregnant, reports a new study by Dr. Denise Kandel of Columbia University (*NIDA Notes*, Sept/Oct 1995;11-12). The study suggests that nicotine, which crosses the placental barrier, may affect the female fetus during an important period of development so as to predispose the brain to the addictive influence of nicotine more than a decade later. Prenatal exposure to smoking previously had been linked to impairments in memory, learning, cognition and perception in the growing child. "The clearest message from the study is that mothers should not smoke during pregnancy," concludes Dr. Kandel. "We need to let women know that if they use drugs during pregnancy, they may put their offspring at risk for future drug use."

According to NIDA's Monitoring the Future Study, the percent of adolescent girls who smoke cigarettes has increased in the past four years. Although smoking among adolescent girls has been linked to many different factors, Dr. Kandel's study is the first to document a possible link between prenatal exposure to nicotine and an adolescent girl's tendency to smoke cigarettes.

ALCOHOL ALERT

National Institute on Alcohol Abuse and Alcoholism No. 31 PH 362

Drinking and Driving

Driving involves multiple tasks, the demands of which can change continually. To drive safely, one must maintain alertness, make decisions based on ever-changing information present in the environment, and execute maneuvers based on these decisions. Drinking alcohol impairs a wide range of skills necessary for carrying out these tasks. This *Alcohol Alert* examines alcohol impairment of driving skills and describes some factors that increase motor vehicle crash risk.

Alcohol Alert, a publication of the National Institute on Alcohol Abuse and Alcoholism, provides timely information on alcohol research and treatment to health professionals and other interested people. This issue is the thirty-first in the series.

Some Factors That Influence Crash Risk

Blood alcohol concentration. The proportion of alcohol to blood in the body is expressed as the blood alcohol concentration (BAC). In the field of traffic safety, BAC is expressed as the percentage of alcohol in deciliters of blood—for example, 0.10 percent (i.e., 0.10 grams per deciliter). A 160-pound man will have a BAC of approximately 0.04 percent 1 hour after consuming two 12-ounce beers or two other standard drinks on an empty stomach (1).

All State laws stipulate driver BAC limits, which now vary by State. According to these laws, operating a vehicle while having a BAC over the given limit is illegal (2). The BAC limit for drivers age 21 and older in most States is 0.10 percent, although some States have reduced the limit to 0.08 percent.

Driving skills are impaired to varying degrees beginning at low BAC's.

The many skills involved in driving are not all impaired at the same BAC's (3). For example, a driver's ability to divide attention between two or more sources of visual information can be impaired by BAC's of 0.02 percent or lower (3–5). However, it is not until BAC's of 0.05 percent or more are reached that impairment occurs consistently in eye movements, glare resistance, visual perception, reaction time, certain types of steering tasks, information processing, and other aspects of psychomotor performance (3,4,6,7).

Research has documented that the risk of a motor vehicle crash increases as BAC increases (3,4,8) and that the more demanding the driving task, the greater the impairment caused by low doses of alcohol (3). Compared with drivers who have not consumed alcohol, the risk of a single-vehicle fatal crash for drivers with BAC's between 0.02 and 0.04 percent is estimated to be 1.4 times higher; for those with BAC's between 0.05 and 0.09 percent, 11.1 times higher; for drivers with BAC's between 0.10 and 0.14 percent, 48 times higher; and for those with BAC's at or above 0.15 percent, the risk is estimated to be 380 times higher (8).

Youth. Youthful age has been cited as one of the most important variables related to crash risk (9). Young drivers are inexperienced not only in driving but in drinking and in combining the two activities (9). In 1994, almost 7,800 persons ages 16 through 20 were drivers in fatal motor vehicle crashes (10). Twenty-three percent of these drivers, for whom drinking any quantity of alcohol is illegal, had BAC's of 0.01 percent or higher, compared with 26 percent of drivers age 21 and older (10).

According to Hingson and colleagues, each 0.02-percent increase in BAC above 0.00 percent places 16- to 20-year-old drivers at greater risk for a crash than older drivers (11). Roadside surveys indicate that young people are less likely than adults to

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drive after drinking; however, especially at low and moderate BAC's, their crash rates are substantially higher than those of other groups (9).

Driving inexperience and immaturity are considered to be the main causes of motor vehicle crashes among drivers ages 16 to 20, even when alcohol is not involved (9). In one study, Hingson and colleagues concluded that drivers in this age group have a greater risk than older drivers of being involved in a fatal crash even with a BAC of 0.00 percent (11). Young people's lack of driving experience renders them less likely than more experienced drivers to cope successfully with hazardous situations (9). This, combined with a penchant for risk-taking driving behavior such as speeding—along with a tendency both to underestimate the dangerous consequences of such behaviors and to overestimate their driving skill—contributes to the high crash rate among young drivers (12,13).

Young drivers are at greater risk for alcohol-related crashes than older drivers.

Gender. Twenty-nine percent of male drivers involved in fatal motor vehicle crashes had BAC's of 0.01 percent or greater, compared with 15 percent of female drivers (10). However, studies indicate that at BAC's ranging from 0.05 to 0.09 percent, crash risk may be greater for females than for males (8,14). Research shows that women metabolize alcohol differently from men, causing women to reach higher BAC's at the same doses (4,15). However, laboratory studies of alcohol impairment of driving skills among women are rare and the results are inconclusive (6).

Combining medications with alcohol and driving. Combining certain medications with alcohol increases crash risk. Sedatives and tranquilizers alone can impair driving skills (16) and can impair them even more when combined with alcohol (17–20). For example, low doses of flurazepam, a sedative-hypnotic prescribed for the treatment of insomnia, alone can impair a driver's ability to steer. The effect of this medication can be compounded with even a small dose of alcohol consumed the next morning (20). Driving skills can be impaired by other medications, such as codeine, as prescribed to treat moderately severe pain (20). When combined with alcohol, such medications' adverse effects on driving skills are exacerbated, as are the effects of some antidepressants, most antihistamines, certain cardiovascular medications, and some antipsychotic medications (20).

Alcohol tolerance. The repeated performance of a particular task in association with alcohol consumption can lead to the development of a form of adaptation referred to as "learned" or "behavioral" tolerance (21). Learned tolerance can reduce the alcohol-induced impairment that would ordinarily accompany the performance of that particular task (21). However, when conditions change or when something unexpected occurs, the tolerance acquired for that task can be negated (22).

These findings may be applicable to the performance of tasks involved in drinking and driving (21,23). A driver who has developed behavioral tolerance to driving a familiar car over a particular route under routine circumstances may drive without being involved in a crash, despite consumption of some alcohol (21,23). However, when encountering a novel environment—for example, a detour—or an unexpected situation, such as a bicycle darting in front of the car, this same driver would be at the same risk for a crash as a novice driver at the same BAC, due to lack of prior learning opportunities for these unexpected events.

Alcohol tolerance does not necessarily reduce a driver's risk for a crash.

Legal Sanctions for DUI Offenders

Legal sanctions, such as driver's license suspension and court-ordered alcoholism treatment, are designed to deter drinking and driving (24). Driver's license suspension and license revocation seem to be the most effective deterrents among the general driving population (24). However, a meta-analysis of deterrent strategies targeted to the drinking-and-driving population concluded that the most effective means for reducing rearrest for driving under the influence of alcohol (DUI) and crashes was a combination of license suspension and interventions such as education, psychotherapy/counseling, and some followup (25).

License suspension plus alcohol treatment are most likely to reduce rearrest for DUI.

Researchers contend that court-ordered treatment should be considered an adjunct, not an alternative, to license sanctions (24). According to Sadler and colleagues, a DUI conviction should serve to identify problem drinkers and guide or coerce them into

alcohol treatment (26). Alcohol treatment for DUI offenders can range from short-term educational sessions to therapy programs lasting at least 1 year (24).

Treatment of convicted drinking drivers normally emphasizes modifying drinking behavior (24). The type and duration of treatment depend on factors such as the severity of the person's drinking problem and DUI history (24,27). DUI offenders with less severe drinking problems benefit most from educational programs (24,27), although no known model is thought to be most effective (24) in reducing recidivism or alcohol-related crashes. For repeat offenders or those with more severe drinking problems, therapy that lasts for at least 12 months (24) and that includes intensive programs focused on the individual appears to be most effective (27).

Prevention

The National Highway Traffic Safety Administration (NHTSA) credits State laws raising the legal drinking age to 21 with preventing almost 1,000 traffic deaths annually (11). Legislation to reduce the BAC limit to 0.02 percent or lower, referred to as the "zero tolerance law" for young drivers, has been passed by 29 States and the District of Columbia to reduce alcohol-related fatalities further (10,11). The National Highway Systems Act provides incentives for all States to reduce their BAC limits for drivers under 21 to 0.02 percent beginning October 1, 1998.

Many States have lowered the BAC limit for young drivers.

One study (11) examined the effectiveness of lowering BAC limits for young people in States where such laws have been in force for at least 1 year. The researchers found that after the BAC limits were lowered to 0.00 or 0.02 percent, the proportion of nighttime fatal crashes involving single vehicles in this age group dropped 16 percent.

Drinking and Driving—A Commentary by NIAAA Director Enoch Gordis, M.D.

Progress has been made in reducing the consequences of drinking and driving; the percent of alcohol-related crash fatalities has declined from 43.6 percent of the total number of traffic crash fatalities in 1986 to 37.4 percent in 1992. Advances in technology (i.e., automobile engineering and road design), less public acceptance of drinking drivers, decreases in per capita consumption, and a growing willingness by the States to adopt public policies aimed at preventing alcohol-related injuries and deaths and enforce legal sanctions against drinking drivers may all be factors in this decline. Newer policies, such as the mandated "zero tolerance" for underage youth, have been shown to reduce crashes in this vulnerable age group. Additionally, increased attention to prevention programs that both impact on and affect adult behavior, such as server training, the designated driver concept, and intervention and education programs in secondary schools and colleges, have demonstrated some effectiveness in reducing alcohol-related driving fatalities.

While we have made progress, drinking and driving still claims about 15,000 lives annually. A variety of public policies, including law enforcement, prevention, and treatment efforts aimed at decreasing this unacceptably high rate, are being implemented by the States. Findings from research can provide information on which of these efforts, individually or in combination, are most effective in reducing drinking and driving. For example, although license revocation combined with treatment has been shown to be effective in preventing repeat drinking and driving offenses, we do not yet know specifically which types of treatment are the most effective with which types of offenders.

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ERRATUM: In *Alcohol Alert* No. 30, "Diagnostic Criteria for Alcohol Abuse and Dependence," the last sentence on page 2 should read as follows: "According to Babor, an important assumption in ICD–9 was that alcohol abuse in the absence of dependence 'merits a separate category by virtue of its detrimental effects on health'. . . ."

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FDA Approves Nicotine Nasal Spray

The Food and Drug Administration has approved a nicotine nasal spray to help nicotine addicts stop smoking. The spray comes in a pump bottle holding 100 mg. of nicotine that smokers can administer intranasally to ward off cigarette craving. Pharmacia & Upjohn, Inc., which created the spray, licensed it to McNeil Pharmaceuticals for sale under the name Nicotrol NS.

In three studies involving 369 spray users, 95 persons stopped smoking, but 43 percent of them relapsed. Other options for smokers trying to quit include prescription nicotine patches or, since May, nicotine gum avaible without a prescription. But the nasal spray, which requires a prescription, is much more powerful, reaching the bloodstream faster than the gum or patch. In fact, scientists have warned the FDA that the spray should be accompanied by a strong warning that it could be abused.

According to approved directions for use, smokers are to inhale one or two squirts of the spray each hour, but never more than five doses an hour. Each dose contains 1 mg. of nicotine. Patients are warned to be careful not to overdose—as little as 40 mg. of nicotine taken at once could be lethal to some persons. The spray is somewhat unpleasant to use, scientists say.

FDA has advised that the spray should be used for no more than three months—and never for more than six months—so that smokers don't find themselves as dependent on nicotine in spray form as they were on nicotine from cigarettes. No one who experiences nasal or sinus problems, allergies or asthma should use it, the FDA cautioned.

New Programs Address Youth Alcohol Abuse

The Robert Wood Johnson Foundation is making grants totalling $10.2 million over four years to establish 12 state and local coalitions to fight alcohol-related problems among youth. Additionally, the Foundation has allocated $8.6 million to a seven-year initiative to reduce binge drinking among college students.

The coalition program will emphasize changing environmental factors that contribute to underage drinking, including easy availability because of failure to enforce legal-age laws, beer and other alcohol promotions in youth-oriented publications and television and radio programs, and alcohol-industry sponsorship of sports events and concerts. Strategies to combat the problem include lowering blood-alcohol limits for young drivers, mandating server training, and eliminating billboards that promote alcohol. The RWJ grants are designed to build on these strategies and also foster youth leadership, aid in alcohol policy development and mount public awareness campaigns.

The grants targetted to reducing college and community binge drinking will encourage combined campus and community efforts. Eight high-risk campuses will serve as model sites for such partnerships, with college presidents taking active leadership of campus components and mayors leading community efforts. Each site will establish a task force to plan and implement changes in policies and practices, including offering substance-free dorms and campus events, reducing students' easy access to liquor in the community, supporting cooperation between campus and local police, and coordinating alcohol intervention and treatment. Also, a professional media campaign to deglamorize binge drinking will be developed and tested in the eight program sites.

Court Limits Drug Use Disclosures

A federal court has ruled that an employer's demand that employees disclose their use of prescription drugs violates the Americans with Disabilities Act (ADA). The case is noted as one of the first that addresses the issue of whether the ADA limits employers from gathering prescription drug information, a practice that is expanding as employers toughen their drug- and alcohol-testing policies. Previously, some employees have challenged similar workplace policies using privacy arguments, but the courts generally have not ruled in their favor.

A Colorado judge found that the Cheyenne Mountain Conference Resort in Colorado Springs couldn't require employees to tell supervisors what prescription medications they take as part of the resort's drug-testing program, concluding that such a disclosure violates the ADA. The ADA prohibits disability-related inquiries unless the question is "job-related and consistent with business necessity."

Heroin Abuse Increasing

Data collected for the National Institute on Drug Abuse show that heroin indicators are rising in most U.S. cities, with abusers in the West showing a preference for heroin from Mexico and a preferred intravenous route of administration. In the Eastern states, on the other hand, abusers show a preference for purer Columbia and Asian heroin, and snorting as the administration route. "Shabanging"—picking up cooked heroin with a syringe and squirting it up the nose—also has increased in popularity in some areas.

Other data reported by members of NIDA's Community Epidemiology Work Group suggest that marijuana use also is on the rise, with a dramatic increase in marijuana indicators in some cities. The western U.S. also is experiencing an increase in stimulant abuse, particularly involving methamphetamines. The use of Ice, a long-acting stimulant, is a major problem in Hawaii and the Pacific Islands. Diversion of Ritalin (methylphenidate) prescriptions also is increasing.

REMINDER OF 1996 MEMBERSHIP RENEWAL

If you haven't renewed your ASAM membership for 1996, please do so today. We want to continue your membership services without any interruption. Remember—committee members, committee chairs, and chapter leaders are required to renew their membership in order to maintain their posts throughout 1996. To renew, simply call Theresa McAuliffe at the ASAM Membership Department (301/656-3920, extension 108 or E-mail TMCAU@ASAM.ORG).

STATE CHAPTER UPDATE

California

The CSAM Committee on the Treatment of Opioid Dependence has been asked to define the role of the physician in a methadone maintenance treatment program so that the California Department of Alcohol and Drug Programs Licensing Branch can use the definition in its revision of California regulations governing the operations of narcotic treatment programs. Other clinical questions directed to the CSAM Committee concern discharge summaries and treatment of pregnant women.

In March, CSAM offered a one-day workshop for physicians who provide primary prenatal care as part of a two-year, state-funded project to educate physicians about the effects of prenatal use of alcohol and other drugs. Gail N. Shultz, M.D., chairs the project's steering committee, while ASAM Board member Andrea Barthwell, M.D., joined the workshop faculty.

Also, the CSAM Committee on Physician Impairment completed a year-long project to develop the quality assurance/quality improvement standards recently adopted and implemented by the Diversion Program. CSAM also worked with the California Medical Association to sponsor a bill, passed in the last session of the California legislature, which authorizes the state medical board to divert physicians into the program in lieu of disciplinary action for certain violations.

Hawaii

When Hawaii members were polled regarding the formation of an ASAM chapter in their state, they voted unanimously in favor of the chapter. The ASAM Board of Directors gave its final approval for formation of the Hawaii Society of Addiction Medicine (HISAM) in June. Interested members should contact member Gerald McKenna, M.D., or Regional Director Richard E. Tremblay, M.D.

Illinois

Chapter President Martin Doot, M.D., reports that the Illinois State Medical Society (ISMS) has been very helpful to ISAM by lending experienced staff to help the chapter organize its finances, staff Board meetings and publish chapter newsletters. ISMS also has solicited ISAM input on public policy questions related to addiction medicine, including state legislative initiatives to require screening of pregnant women for substance abuse problems and changes in regulations for methadone programs.

The Illinois Department of Alcohol and Substance Abuse also contracts with ISAM to assist the state in adopting patient placement criteria based on the *ASAM PPC* and *PPC-2.*

Maine

ASAM members from Maine met April 30 in Augusta to discuss local and national issues relating to ASAM and the practice of addiction medicine. The meeting was organized by George ("Joe") Dreher, M.D. of Portland and was very well attended. Regional Director Alan Wartenberg, M.D. updated Maine members on recent Board actions as well as activities during the Medical-Scientific Conference. Dr. Wartenberg also discussed newer treatments for opioid detoxification.

North Carolina

Over the past year, the North Carolina Society of Addiction Medicine (NCSAM) has sponsored three scientific CME seminars for its members. Recently G. Douglas Talbott, M.D. conducted a seminar on dependent family issues. Mark Gold, M.D. conducted a seminar on brain behavior; earlier, Marshall Levine, M.D., M.P.H. conducted a seminar on managed care, primary care, and addiction medicine.

The following new officers were elected at the recent NCSAM annual meeting: Thomas Lauer, M.D., President; Robert Gwyther, M.D., Vice President; George Hall, M.D., Secretary-Treasurer. The Governor's Institute on Alcohol and Substance Abuse, Inc. serves as the Secretariat for NCSAM. One of the chapter's goals for 1997 is to explore the role of the primary care system in addressing substance abuse and addiction problems. NCSAM hopes to pursue this goal by working with other organizations.

Oregon

Newly elected ORSAM officers are President, Douglas L. Bovee, M.D., F.A.C.P. (re-elected for another term); Vice President, Robert Senft, M.D.; and Secretary/Treasurer, James Thayer, M.D. Susan McCall, M.D. was elected to the ORSAM Board. ORSAM recognized the contributions of outgoing Board member Howard Newton, M.D., and outgoing Secretary/Treasurer Gary Jacobsen, M.D.

ORSAM is to co-sponsor a conference, "Addictive Disease Issues for the 21st Century: Diagnosis, Treatment and Healthcare Reform," with the Foundation for Medical Excellence in Seattle on October 4-5, 1996.

Rhode Island

On June 18th in Providence, ASAM members from Rhode Island conducted a joint meeting with the American Academy of Addiction Psychiatry. The dinner was organized by Robert Swift, M.D., Ph.D., and combined a business meeting with a presentation by David Gastfriend, M.D. on his research into implementation of the ASAM *Patient Placement Criteria.*

South Carolina

The South Carolina Society of Addiction Medicine (SCSAM), ASAM, and the Tri-County Commission on Alcohol and Drug Abuse (TCCADA) held a successful conference on the new ASAM *Patient Placement Criteria (PPC-2)* on July 29 and 30. Guest speaker for the conference, which was held at the Orangeburg-Calhoun (SC) Technical College, was David Mee-Lee, M.D., Chair of ASAM's Section on Standards and Economics of Care and Criteria Committee.

Wisconsin

WISAM is planning its Second Annual Educational Conference for Saturday, October 12, 1996, at Milwaukee. Targeted to primary care physicians and counselors, the conference themes will incorporate early intervention and recruiting and retaining clients in treatment. Please see the ad on page 7 of this issue of *ASAM News* or call Dean Whiteway, M.D., for information.

WISAM also is launching an ambitious chapter membership campaign. For more information on how to participate, contact Dean Whiteway, M.D.

REGIONAL NEWS

Region III (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Regional Director Alan Wartenberg, M.D. has announced that the next Region III meeting is tentatively scheduled for fall 1996 in Amherst, Massachusetts. Pyanamurtula Kishore, M.D., M.P.H. of Boston is in charge of meeting plans. Questions or suggestions should be sent to Dr. Kishore or Dr. Wartenberg.

Region VIII (Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming)

Regional Director Richard E. Tremblay, M.D. conducted a Region VIII meeting in

Continued next page

ASAM MEMBERS HONORED FOR ACHIEVEMENTS

At its 27th Annual Medical Scientific Conference in Atlanta, ASAM honored several individuals for their achievements in medical education and research in the addictions.

ASAM Annual Award

John B. Griffin, M.D., Professor of Psychiatry at the Emory University School of Medicine, received the ASAM Annual Award for "outstanding contributions to the growth and vitality of our Society, for thoughtful leadership in the field, and for deep understanding of the art and science of addiction medicine." Dr. Griffin has dedicated more than a quarter of a century to educating medical students and physicians about alcohol, nicotine and other drugs, their addicting properties and their health consequences. He has played a major role in developing, with the National Board of Medical Examiners, examinations for certifying physicians in addiction medicine, and for testing medical student knowledge of the addictions. He also is nationally known for his work in child psychiatry on issues of drugs and mental health in children, adolescents and parents. A graduate of Emory University and the Emory School of Medicine, Dr. Griffin is Board-certified in pediatrics, psychiatry and child psychiatry, as well as being certified by ASAM in addiction medicine.

Also honored was Jack E. Henningfield, Ph.D., for "expanding the frontiers of the field of addiction medicine and broadening our understanding of the addictive process through research and innovation." Dr. Henningfield is Chief of the Clinical Pharmacology Branch of the National Institute on Drug Abuse, Rockville, MD. Dr. Henningfield's basic research on nicotine and its addicting properties provided the scientific basis for President Clinton's and the Food and Drug Administration's recently proposed actions to regulate nicotine and advertising of cigarettes to children.

Smithers Distinguished Scientist Award

A conference highlight was the presentation of the R. Brinkley Smithers Distinguished Scientist Award to Charles S. Lieber, M.D. Dr. Lieber, an ASAM Past President, is Director of the Alcohol Research and Treatment Center and the GI/Liver Program, Bronx (NY) Veterans Administration Medical Center, and Professor of Medicine and Pathology at the Mount Sinai School of Medicine, New York. Dr. Lieber was honored for his "pioneering work on the metabolism and toxicity of alcohol, for mentoring a generation of research scientists, and for translating research into physicians' clinical practice." Dr. Lieber delivered the Distinguished Scientist lecture on Medical Disorders in Alcoholism: From Pathogenesis to Prevention and Treatment.

The Distinguished Scientist Award and Lecture are dedicated to the memory of R. Brinkley Smithers who, from the time he recovered from the disease of alcoholism in 1954, devoted his life and his considerable financial resources to the fight against alcoholism. A Nobel Prize nominee in 1989, Mr. Smithers' work was represented at the ASAM meeting by his widow, Adele C. Smithers, and his son Christopher.

Young Investigator Award

ASAM's Young Investigator Award went to Robert M. Anthenelli, M.D., Assistant Professor of Psychiatry, University of California Medical School at San Diego. Dr. Anthenelli was recognized for his groundbreaking research aimed at understanding the role of serotonin in the relationship between alcoholism and cigarette smoking, and the treatment implications of such a relationship.

Watch for your September *ASAM News* for a complete guide to the 1996 Election of Officers; you'll find complete profiles and platforms for all of the candidates!

Continued from the preceding page

April during the Annual Medical-Scientific Conference. Members from Region VIII discussed their hopes for the region, strategized for the future, and discussed major issues of concern. The next face-to-face meeting is scheduled for April 1997 in San Diego.

Region IX

(International Members)

Led by Regional Director Ray P. Baker, M.D., Region IX members met during the ASAM Med-Sci Conference in Atlanta to exchange chapter news and discuss ways in which ASAM can help international members achieve their goals for addiction medicine in their respective countries.

Bill Barakett, M.D., of Cowansville, Quebec, stressed the need for ASAM to attract primary care physicians by offering training and materials for screening, early identification and brief interventions for drug and alcohol problems.

Colin Brewer, M.D., of London, reported that British physicians tend to be dominated by a psychosocial approach to addiction. He suggested that an ASAM-sponsored satellite conference might help add the needed biomedical component.

Flavio Poldrugo, M.D., of Trieste, Italy, pointed to a potential for ASAM to assume a leadership role in unifying the many European approaches to addiction. He suggested that an international ASAM Medical-Scientific Conference in Italy or Greece might help to start this process.

Peter Mezciems, M.D., of Guelph, Ontario, and ADD-MED listowner on the Internet, described the list to which many members belong, and how it can be useful to international members as a source of information and collegial support. Peter's E-mail address is MEZCIEMS@WAT.HOOKUP.NET.

The group decided to schedule a half-day workshop, "Addiction Medicine Around the World," during the 1997 Med-Sci Conference in San Diego.

COMMITTEE REPORT

ASAM MEMBERS NEEDED TO WORK WITH AMA, FEDERAL ADVISORY COMMITTEES

A hot topic among physicians is the methodology (or absence thereof) by which the federal Health Care Financing Administration (HCFA) and other payers determine the amounts physicians will be paid for delivering medical services. A number of systems are currently in use:

• When Medicare reimburses physicians through a fee-for-service model, physicians are required to define the types of services through the use of specific codes. The compendium of these codes is called the *Handbook of Current Procedural Terminology (CPT)*. The American Medical Association has coordinated the development of the CPT system, and both Medicare and private insurance companies pay physicians based on CPT codes. CPT codes also are used by many HMOs and indemnity insurers as the basis of their reimbursement systems.

• In administering the Medicare program, HCFA uses a system of Diagnosis Related Groups (DRGs) to determine the payments to be made for various medical services. HCFA developed the DRGs, deciding the categories of diagnoses that fit within each DRG and the appropriate payments for inpatient treatment for each DRG.

• HCFA supported development of the Resource Based Relative Value Scale (RBRVS) to determine prospective payments to physicians for professional services. The RBRVS system proposes that physicians be paid for their Evaluation and Management of patients through E&M codes that use multipliers and complex formulas that derive partly from projections of overhead and other practice costs. The calculations are very complex, but the goal of the program is simple: HCFA looks to this prospective payment system to limit its financial liability for Medicare Part A (physician services) and Part B (hospital-based services) by shifting the risk from itself as purchaser of services to the providers of those services.

Physicians have an opportunity to influence the development and implementation of these systems by participating in various panels and committees that design, fine tune, and oversee their application of all these various naming, labeling, coding, and accounting systems. These panels may be neither glamorous or prominent, but they are critical to many "pocketbook issues" for ASAM physicians. Accordingly, the AMA frequently asks ASAM to nominate representatives to the various panels and committees. Doctors Herb Peyser and Christine Kasser have served in these capacities over the years, but they need the assistance of a pool of volunteers.

Accordingly, members who are interested in working with these panels and committees are asked to contact Dr. Kasser or Dr. Peyser. Specifically, those who are interested in the work of the CPT Advisory Committee are encouraged to call Dr. Kasser at (901) 524-5367. Those who would like to work with the RBRVS Update Committee should call Dr. Peyser at (212) 876-6778. Panel members pay their own expenses to attend the CPT or RBRVS Update Committee meetings; thus Dr. Peyser, who lives in New York, is particularly anxious to identify ASAM members who live in the Chicago area who could conveniently attend RBRVS Update Committee meetings. Volunteers need not be expert in accounting or finance, as the purpose of the committees is to provide advice based on experience in medical practice.

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STUDY URGES MORE RESEARCH ON WOMEN'S ADDICTION PROBLEMS

Women who abuse drugs and alcohol often escape notice and treatment because there is little or no understanding of women's motivations and recovery needs, according to a study released by the Center on Addiction and Substance Abuse at Columbia University, New York City. At the same time, women are closing the substance abuse gender gap by drinking and using drugs to nearly the same extent as men; for adolescents, the gap is gone.

The two-year study, supported by grants from the Bristol-Myers Foundation and the Pew Charitable Trust, involved analysis of more than 1,700 articles in the literature, surveys, government reports, and books and monographs.

"This report has long been needed to make the public aware of how much remains to be done in treating women for drug and alcohol abuse," said former First Lady Betty Ford, who added that only 14 percent of women who need treatment, get it. "This report...is a call to action."

"We've been doing research on substance abuse as though everybody was a man," said Joseph Califano, "but it's clear [women] need different treatment." Califano is the Center's president and a Secretary of Health, Education and Welfare under President Jimmy Carter. The differences between men and women with substance abuse problems should have been noticed earlier, considering the wide disparity described in the Center's study, Califano added. For example, 69 percent of women in alcohol treatment reported having been sexually abused as children, compared with 12 percent of men in treatment.

Depression is another common thread throughout substance abuse by women, according to the study. Female alcoholics are more likely to suffer depression that leads to addiction, while men's depression tends to follow the onset of alcoholic drinking. Both male and female alcoholics say they drink to escape life's pressures, but women more often report feeling powerless and inadequate prior to the onset of problem drinking, the report said.

Alcoholism symptoms also differ: alcoholism in men often is detected because of fighting, drinking and driving, financial problems and job impairment, the report said, whereas women more often experience internal struggles such as depression, anxiety and family conflicts.

The report found that 33 percent of female heroin addicts said men influenced their decision to use drugs, while just 2 percent of men said a woman influenced them.

According to the report, the percentage of drug addicts who are women doubled between 1960 and the late 1970s. Today, about 40 percent of crack addicts are women. The percentage of women who misuse prescription drugs, 3.7 percent, is about the same as the percentage of men who do so, 3.9 percent. About 22 percent of women smoke, compared with 28 percent of men.

The report found that girls and boys are about even in the number who smoke (about 12 percent), drink alcohol (about 18 percent), and use drugs (about 13 percent).

STATE SUBSTANCE ABUSE QUARTERLY

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) has announced plans to publish *State Substance Abuse Quarterly*. The publication focuses on the latest developments in treatment and prevention practice, funding opportunities, news of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the impact of managed care arrangements on the treatment system. Annual subscriptions are $80 for non-profit organizations, $100 for profit-making institutions (orders must be prepaid). To order, send a check payable to NASADAD to 444 N. Capitol St., N.W., Suite 642, Washington, D.C. 20001.

DETOXIFICATION FROM ALCOHOL AND OTHER DRUGS

Number 19 in the Treatment Improvement Protocol (TIP) Series from the federal Center for Substance Abuse Treatment, *Detoxification from Alcohol and Other Drugs* addresses a range of clinical, legal and financial issues relevant to detoxification services.

Directed to clinicians, program administrators and payers, the TIP series offers "best practices" developed by a CSAT-convened consensus panel (in this case, chaired by ASAM member Donald R. Wesson, M.D.) of non-federal clinical researchers, clinicians, program administrators, policy analysts and patient advocates. The panel's work is reviewed and critiqued through an extensive field review process.

Detoxification from Alcohol and Other Drugs specifically addresses selection of detoxification settings and patient-treatment matching, clinical protocols for detoxification from various drugs of abuse, detoxification of persons with psychiatric co-morbidities and other special populations, legal and ethical issues, and costs and current payment mechanisms. There is an extensive bibliography.

TIP publications may be ordered from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 800/729-6686 or 301/468-2600.

A SAMPLING OF SECAD/96 TOPICS

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The American Academy of Addiction Psychiatry

7th Annual Meeting and Symposium will be held December 6–7, 1996 and the Review Course will be December 8, 1996 at the Fairmont Hotel, in San Francisco. For a registration packet please call 913-341-6680.

Review Course Kits can be purchased through AAAP. The kits include tapes, syllabus and sample test questions. Call 913-341-6680 to order with Visa or MasterCard or send check for $180.00 + $6.00 shipping to AAAP, 8340 Mission Road, Suite B4, Prairie Village, KS 66206.

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1996

October 24-26
Review Course in Addiction Medicine
Chicago, IL
21 Category 1 CME credits

November 1-3
MROs:Medical Review Officer Training Course
Chicago, IL
19 Category 1 CME credits

November 3
MROCC Medical Review Officer Certification Examination
(Following ASAM's MRO Course)
Chicago, IL

November 14-17
9th National Conference on Nicotine Dependence
Washington, DC
15 Category 1 CME credits

December 7
Certification/Recertification Examination
Atlanta, GA
Los Angeles, CA,
and Newark, NJ
5 Category 1 CME credits

1997

March 20-23
Prevention '97
American College of Preventive Medicine
Atlanta, GA

April 17
Ruth Fox Course for Physicians
San Diego, CA
7 Category 1 CME credits

April 18-20
28th Annual Medical -Scientific Conference
San Diego, CA
22 Category 1 CME credits

October 23-25
State of the Art in Addiction Medicine Conference
Washington, DC
20 Category 1 CME credits

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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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