ASAM NEWS

August / September 1998 Volume 13, Number 4

Newsletter of The American Society of Addiction Medicine

ASAM Member to Head Federal Treatment Agency

ASAM member H. Westley Clark, M.D., J.D., M.P.H., FASAM, has been named Director of the Center for Substance Abuse Treatment (CSAT), the lead federal agency for improving the quality and availability of addiction treatment services in the U.S. In announcing the appointment, Dr. Nelba Chavez, administrator of the Substance Abuse and Mental Health Services Administration, parent agency of CSAT, hailed Dr. Clark as "a well-known and highly respected leader in the substance abuse treatment field" and said the agency is "fortunate he is joining our management team."

A noted author and lecturer, Dr. Clark currently serves as Chief of the Associated Substance Abuse Programs and Medical Review Officer for the Department of Veterans Affairs Medical Center in San Francisco. He also is Associate Clinical Professor in the Department of Psychiatry at the University of California, San Francisco, and a Clinical Instructor at the University of California, Berkeley.

Dr. Clark has served ASAM in many capacities, most recently as a member of the Society's Board of Directors and as an editorial advisor for the second edition of ASAM's textbook, *Principles of Addiction Medicine*. He also is a consultant to The Robert Wood Johnson Foundation's Substance Abuse Policy Grant Program, and recently completed a three-year term on the National Advisory Council of the National Institute on Drug Abuse.

Dr. James F. Callahan, ASAM Executive Vice President, applauded the choice, saying, "ASAM is truly pleased that Dr. Clark will be the new CSAT Director. As a physician, he can bring increased attention to the medical aspects of the addictive disorders, thus enhancing CSAT's effectiveness in its mission of improving the availability, quality and effectiveness of the nation's addiction treatment system."

Dr. Clark is expected to take up his new duties in the fall.

H. Westley Clark, M.D., J.D., M.P.H., FASAM

ASAM TO ELECT NEW OFFICERS, DIRECTORS-AT-LARGE

David E. Smith, M.D., FASAM
Chair, Nominating and Awards Committee

ASAM members are about to choose the Society's next President-Elect, Secretary, Treasurer, and Directors-at-Large. Ballots will be mailed to ASAM members in good standing by **November 1, 1998**. Completed ballots are to be returned to ASAM's New York office by **December 1, 1998**. Winning candidates will be announced in the January-February 1999 issue of **ASAM News**.

Newly elected officers and directors will be installed at the Society's business meeting in April 1999 during ASAM's annual Medical-Scientific Conference. President-Elect Marc Galanter, M.D., will assume the ASAM Presidency at that time.

The election packages mailed to members will contain, in addition to the ballots themselves, biographical sketches and photos of all the candidates, with summaries of their campaign platforms.

Because the election ballots are secret and unidentifiable, there are few provisions for replacing ballots, since remailing would compromise secrecy. Ballots are remailed only to members whose first ballot is returned by the Post Office as undeliverable and for whom a better address is found. Also, given the errors that may occur in machine insertion of items into envelopes, election materials may be sent to members whose ballot packets do not contain all the necessary materials.

Profiles of the candidates, with their platform statements, begin on page 6 of this issue of **ASAM News**.

INSIDE

American Society of Addiction Medicine

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

ASAM News
is an official publication of the American Society of Addiction Medicine, and is published six times a year. Please direct all editorial and advertising inquiries to *ASAM News*, c/o the ASAM office.

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REPORT FROM THE EXECUTIVE VICE PRESIDENT

ASAM: USE CERTIFIED ADDICTION SPECIALISTS TO MANAGE OFFICE-BASED OPIOID THERAPY

Dr. James F. Callahan


Dr. Callahan

One of the most important ways in which ASAM represents its members' interests is in scientific and policy forums convened by government agencies. I recently had an opportunity to participate in just such a session, convened by the Office of Pharmacological and Alternative Therapies of the federal Center for Substance Abuse Treatment to consider regulatory changes that would allow management of opiate addicts in physicians' offices as well as in special federally-licensed clinics.

Some of the most important discussions in the session centered on the qualifications that should be required of physicians who would be allowed to perform such office-based management. I felt it important to get ASAM's position on paper, and so followed up the meeting with a letter to CSAT officials, in which I made the following points on your behalf:

"Enabling primary care physicians to provide office-based opioid therapy (OBOT) for stabilized addicts is in line with ASAM's interest in making increasingly available both new and existing pharmacotherapies for the addicted patient. This will make treatment more widely available for chemically dependent individuals, and will be an important step in making addictions treatment an integral part of the nation's health care delivery system.

"Because of the special needs of the chemically dependent individuals, the history of strict regulation of potentially addicting medications and the close surveillance of physicians prescribing such medications, and because of the special needs of the addicted patient, I ask you to consider seriously the following recommendations.

"OBOT is a major departure from the current system of administering opioid based therapies for addiction. As is necessary for any major endeavor, I suggest that your first step, prior to the development of guidelines for opioid-based office therapies, be to develop a strategic plan outlining the goals of the endeavor, the milestones toward those goals, the obstacles and facilitating factors, the major players (individuals and organizations), the timelines and costs, and the measures by which accomplishments, both process and outcome accomplishments, will be measured.

"It was not clear from our discussions at your office that such a plan has been developed. The discussions seemed to assume that OBOT would be launched, and that all that is needed are to develop the guidelines governing the selection of physicians, their credentialing, and the determinations of eligibility on the part of the patients.

"I suggest that the physicians you invite to participate in the OBOT initiative be physicians who are certified by one or more of the following groups: the American Society of Addiction Medicine (ASAM), the American Board of Psychiatry and Neurology (ABPN), or the specialty boards of the American Osteopathic Association (AOA). A high percentage of the physicians certified by ASAM are primary care doctors practicing in office-based settings. I suspect the same is true of those certified by the ABPN in Addiction Psychiatry and by the AOA boards.

"The engagement of physicians such as those I have suggested would provide greater assurance that the physicians are interested in the field of addiction medicine or addiction psychiatry; that they have achieved a level of knowledge (attested to by the certification) of addiction medicine or addiction psychiatry, and that they therefore have an understanding of addictive disorders and their treatment. My impression from the discussions at the meeting was that CSAT would consider inviting to participate in the initiative any physician who would express interest in the endeavor, as long as he/she were to qualify under the guidelines yet to be developed.

"To invite non-certified addiction specialists would, in my judgment, put both the

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patient and the physician, and the success of the initiative, at an unnecessary risk. Patients on opioid-based therapy for addictions often have comorbid problems with or dependence on alcohol or other addicting substances. Assessment of addicted patients and their treatment should, therefore, be done by a physician knowledgeable about addiction disorders and the chronic relapsing nature of addiction. Such physicians are not only knowledgeable, but dedicated to developing and maintaining the type of patient-physician relationship that successful treatment of addictive disorders requires.

"Selecting certified addiction specialists will also assure added protection for the physician. Addiction specialists are knowledgeable about drug scheduling and the special Drug Enforcement Administration (DEA) provisions governing dispensing of methadone and the ways in which these regulations are enforced. The incidents of encounters with the DEA which some of the members at the CSAT meeting related are a reminder that we need to set up as many safeguards for the physician and the patient as we can, in order to assure that the OBOT initiative is successful. There are many in our country who are opposed to methadone as a therapeutic modality, and who will be, therefore, opposed to its being dispensed as part of primary care medicine...

"Credentialing should include both certification by one of the groups I have indicated, and successful completion of a specific training program on issues pertinent to OBOT.

"ASAM currently has a model for such a credentialing process in the manner in which the Society certifies Medical Review Officers (MROs) by requiring passage of the ASAM Certification Examination, passage on that examination of the MRO subsection which is scored independently, and successful completion of a three-day course. Having met these requirements, the individual receives both a certificate in addiction medicine and a certificate as a Medical Review Officer.

"...CSAT staff are to be commended for this undertaking. My recommendations are offered as ways of helping to assure that the endeavor will be successful in every respect; most importantly, for the patient and the physician. The success of the OBOT initiative can open the door to future endeavors to mainstream pharmacologic therapies (both existing and yet to be developed). Failure of the initiative can further retard and set back the attempts to integrate the treatment of addictive disorders into our nation's health care and medical education and training systems."

SEPTEMBER IS ADDICTION RECOVERY MONTH

A month-long campaign on the theme "Addiction Treatment: Investing in Communities" will have a national kick-off at the beginning of September in Washington, DC. Throughout the month, cable television channels will air "community forums" to raise public awareness of addiction treatment.

Comprehensive activity kits for National Alcohol and Drug Addiction Recovery Month are available fom the Substance Abuse and Mental Health Services Administration (SAMHSA). The kits include materials to help treatment providers with outreach to local media, key constituency groups and special audiences, as well as a collection of informational resources. Kits can be ordered through the SAMHSA/CSAT Web site at www.samhsa.gov (from SAMHSA's home page, click on CSAT's icon), or phone CSAT at 301/443-5052.

NEW YORK MAYOR WANTS TO PHASE OUT METHADONE PROGRAMS

New York City Mayor Rudolph W. Giuliani stunned the addictions field by announcing that "within the next two, three or four years, we will phase out and do away with methadone maintenance programs in the City of New York." Mr. Giuliani criticized the programs for "substituting a dependency on heroin with a dependency on methadone." Describing drug addiction as the most serious obstacle to putting welfare recipients to work, the Mayor expressed his intention that addicts "learn to recover the hard way, without the help of medication."

Federal drug officials expressed astonishment at the Mayor's comments. "The Mayor of New York City said that?" one official asked *The Washington Post*. "Does he realize this is scientifically considered to be the best treatment for heroin?" Methadone treatment has been endorsed by the National Institutes of Health and by Gen. Barry R. McCaffrey of the Office of National Drug Control Policy, who called Giuliani's plan "at odds with the conclusions of the nation's scientific and medical community." McCaffrey added, "The problem isn't that there are too many methadone programs, it is that there are too few."

Closer to home, Don D. Des Jarlais, Ph.D., director of research for the Chemical Dependency Institute at New York's Beth Israel Medical Center and an expert on heroin addiction, remarked that "From a public health standpoint, that has to be one of the more ridiculous things for any public official to have said over the past 30 years. It implies that he was either misunderstood or misspoke, or he does not have much of an understanding of drug abuse treatment for heroin addiction."

Mr. Giuliani conceded that he could not unilaterally take action to eliminate methadone treatment, since federal and state programs provide about 92% of the financing for such programs in New York. Nonetheless, he said he would lobby to reduce the role of the programs in the city, which has the largest concentration of recovering heroin addicts in the U.S.

NCQA POSTPONES BEHAVIORAL HEALTH STANDARDS FOR MANAGED CARE PLANS

The National Committee for Quality Assurance (NCQA) has indefinitely postponed the application of quality standards for alcohol, drug and mental health services by general managed care plans, which had been set for 1999 implementation. This is in contrast to the specialized behavioral health managed care organizations, for which standards have been in place since 1997.

The differential treatment was immediately criticized by the behavioral health plans. "We are clearly at a disadvantage in the market," said E. Clarke Ross, departing executive director of the American Managed Behavioral Healthcare Association.

The decision to delay implementation also was opposed by 32 national organizations in the mental health and addictions fields, including ASAM. In a joint letter to NCQA president Margaret O'Kane, the organizations said that "mental health and substance abuse care require certain approaches and quality of care issues must be attended to in a different manner than for other health care. We are, quite frankly, appalled that NCQA would adopt a posture that certain types of plans—plans which dominate the marketplace—need not meet NCQA's minimal behavioral health care standards while specialized plans must continue to do so if they wish to be NCQA-accredited."

NCQA has not made an official response.

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ASAM ANNUAL REPORT

Dear Colleague:

This year you will receive ASAM's 1996 and 1997 Annual Reports. The 1997 Report will appear in the December issue of **ASAM News**, while the 1996 Annual Report follows.

The 1996 ASAM Annual Report reflects a strong overall financial position, despite an end-of-year negative balance. The Report reflects the following significant accomplishments by our colleagues in addiction medicine.

ASAM's 1996 Accomplishments

- ❑ Membership continued strong at 3,162.
- ❑ The number of Chartered State Chapters grew to 22, from 5 in 1989.
- ❑ 148 physicians were Certified and 134 were recertified in Addiction Medicine, bringing the total number certified to 2,939.
- ❑ ASAM published the second edition of its *Patient Placement Criteria* (*ASAM PPC-2*).
- ❑ The Society also published a practice guideline on "Detoxification: Principles and Protocols" in *Topics in Addiction Medicine*.
- ❑ ASAM continued publication of the *Journal of Addictive Diseases*, under the editorship of Barry Stimmel, M.D., FASAM.
- ❑ ASAM educated more than 2,100 physicians and other health professionals through its conferences and courses.
- ❑ Society leaders continued their dialogue with primary care boards in an effort to establish a Certificate of Special Qualifications (CSQ) in Addiction Medicine.
- ❑ ASAM elected leaders and staff represented members at policy meetings with federal, state and local governments, and in the forums of organized medicine, such as the American Medical Association, the American Osteopathic Association, the Joint Commission on Accreditation of Healthcare Organizations, and the National Committee on Quality Assurance.

The Society continued to commit its resources to fulfilling the ASAM mission of educating physicians and improving the quality of care for those suffering from addictive diseases. In 1996, ASAM expanded its Education, Credentialing, Standards and Economics of Care, Treatment and Clinical Issues, Membership, and Publications Programs. To do this, it successfully sought $238,000 in grants from foundations, government organizations and pharmaceutical firms. In addition, the Ruth Fox Endowment pledges from members increased to $1,161,366.

ASAM renewed its commitment to increasing access to care, improving the quality of care and establishing Addiction Medicine (ADM) as a recognized field of medical practice. The Society also continued to serve the needs of its members through the publication of practice guidelines and by representing addiction medicine in the medical community and elsewhere.

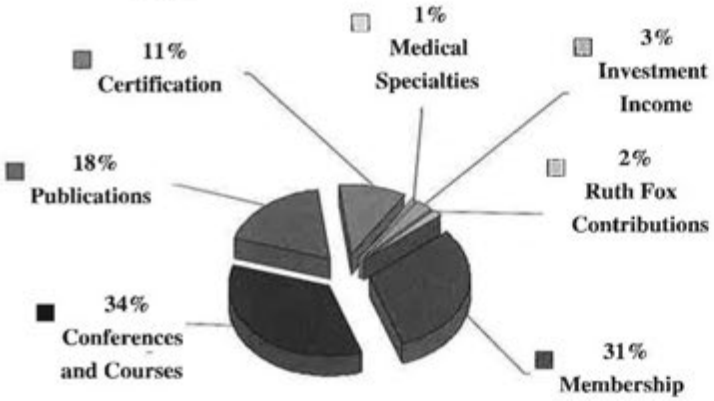
We want to assure you that the Officers and Board of Directors are truly dedicated to achieving the mission for which ASAM was founded.

Sincerely,

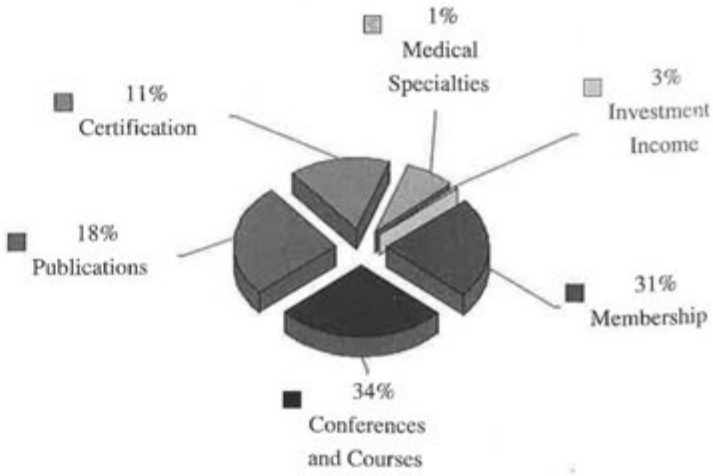
G. Douglas Talbott, M.D., FASAM
President

James W. Smith, M.D., FASAM
Treasurer

Support and Revenue



Expenses



The financial information presented herein is condensed from the audited financial statements of ASAM for the year ended December 31, 1996. ASAM will be pleased to provide, upon written request, copies of the complete financial statement from which this information was taken, together with all footnotes and the unqualified report of our independent auditors.

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Executive Vice President James F. Callahan, D.P.A.*

*Executive Committee

Addiction Medicine News – Continued from page 3

FEDERAL DATA SHOW RISE IN YOUTH DRUG USE

Drug use by young people is increasing, led by rising marijuana smoking by teens who regard it as a "soft drug," according to the annual National Household Survey on Drug Abuse, released by the Department of Health and Human Services in late August.

The survey projected the number of first-time users of marijuana as 2.5 million in 1996, up from 2.4 million in 1995. Marijuana is popular because many teens don't perceive it as dangerous, said Health and Human Services Secretary Donna Shalala, adding that "the perception of this country is that marijuana is safe, that it's a soft drug."

While the percentage of teens who used heroin held steady at 0.2%, the number of first-time heroin users was at an all-time high. Overall, 11.4% of survey respondents aged 12 to 17 reported some illicit drug use within the preceding month, compared with 9% in 1996. For adults, on the other hand, overall rates of illicit drug use remained fairly steady. About 14 million people, or 6.4% of the population age 12 and older, used illicit drugs in 1997. The rate for adults was roughly half that of the peak year of 1979.

The survey, an annual snapshot of illegal drug use, involved interviews with 24,500 people in their homes. It is sponsored by the National Institute on Drug Abuse.

NEW IN PRINT

CSAT PUBLISHES GUIDE TO CASE MANAGEMENT

To improve coordination of services available to persons receiving addiction treatment, the federal Center for Substance Abuse Treatment (CSAT) has issued a new best practices guideline, *Comprehensive Case Management for Substance Abuse Treatment.* The publication is number 27 in an ongoing series of Treatment Improvement Protocols (TIPs). This TIP provides models and practical information on how to coordinate addiction treatment with the additional services such patients may require. These additional services may include housing, medical care, job skills or treatment for mental disorders.

Nelba Chavez, Ph.D., Administrator of the Substance Abuse and Mental Health Services Administration, said, "Case management can improve treatment outcomes. With a single point of contact for multiple health and social service needs, the client can focus undivided attention on his or her recovery, rather than negotiating a maze of social services.

Guidelines presented in TIP 27 recommend that specific steps to be taken to: (1) provide patients with a single point of contact for multiple health and social services systems; (2) advocate for patients to assure that a complete range of services is provided by other social service delivery systems; and (3) promote patient-based systems that improve coordination of community resources.

The TIP series provides best practice guidelines for the treatment of substance abuse. TIPs are developed by a consensus panel of non-federal experts. For all TIPs, depending on the subject, the panel members come from a variety of backgrounds such as substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies and private practitioners. Harvey A. Siegal, Ph.D., Director of Substance Abuse Intervention Programs, School of Medicine, Wright State University, Dayton, Ohio, chaired the panel that developed TIP 27.

TIP 27 is available on the CSAT web page at www.samhsa.gov or can be ordered from the National Clearinghouse for Alcohol and Drug Information (NCADD) at 800/729-6686 or TDD (for hearing impaired) at 800/487-4889.

ASAM ELECTION OF OFFICERS

CANDIDATES FOR THE OFFICE OF PRESIDENT-ELECT

Andrea G. Barthwell, M.D., FASAM
Illinois

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? My greatest contributions to ASAM are in the areas of physician education, fundraising, member recruitment and advocacy for new physician roles in systems which treat addiction. I contribute to ASAM's visibility in a number of arenas, public and private, and ASAM's acceptance as an organization whose members are developing standards of practice for the treatment of addiction. I am a generalist in Addiction Medicine with training in many modalities and settings (i.e., medical mode—all levels of care, methadone maintenance, therapeutic community, sanctuary, social setting, detoxification, etc.). I have experience treating diverse populations (i.e., incarcerated, pregnant or parenting women, adolescents, ethnic minorities, etc.).

My contributions to ASAM are through committee work and promoting stronger links between the Board of Directors and ASAM's chapters and members. I am a member of the Task Force on Addiction Medicine, and I am concerned with funding mechanisms to assure continued treatment for people who are medically undeserved under the current fee-for-service system of care.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? The goals adopted by the Cross Cultural Clinical Concerns Committee, while I served as committee chair, generally describe interests for Addiction Medicine. They are to assure that physicians who treat individuals presenting with complications of addictive disease know how to recognize and refer. Those physicians who want to work with individuals with addictive disease in their practice, or addiction medicine settings, will be compensated for their work, and those who work in addiction medicine-specific settings understand cultural and ethnic differences in the acquisition and expression of these disorders.

James A. Halikas, M.D.
Florida

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I have been an active participant in ASAM for more than 20 years, as chairman of Medical Education, as co-chairman of the Fellowship Committee, as a member of the Executive Committee, and as an active presenter at our annual Medical-Scientific Conferences. In fact, if you've ever taken an ASAM course or gotten CME credits from ASAM, I probably helped organize or approved the course, and my signature is on your certificate. I've also contributed more than 100 articles to the Addiction Medicine professional literature, including the development of new cocaine pharmacotherapies.

I am particularly proud to have been the senior author of the original patient placement criteria in 1987, the "Cleveland Criteria," along with David Mee-Lee and Norman Hoffman, which became the ASAM Patient Placement Criteria, the national standard for our field. Yet, I believe that my most important contribution to ASAM and to the field of Addiction Medicine is still to come.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? The Presidency is a six-year arc which begins with being President-elect and ends with being immediate past president. My goals for the next six years will be to organize our membership, 3,000 expert Addiction Medicine Clinicians Scientists, into an effective voice for our specialty in order to improve reimbursement for our services and establish our position as a medical specialty. My agenda for that six year arc would be twofold:

Internally, I would try to guide ASAM committees and membership to define, clearly and specifically, the actions and activities of an Addiction Medicine Specialist. This definition of our clinical activities would be used with both managed care organization and with medical specialty organizations to demonstrate the uniqueness of the specialty of Addiction Medicine.

Externally, I would "spread the good news" that TREATMENT WORKS! And would try to steer ASAM into activities that demonstrate treatment response and effectiveness at every opportunity. For example, I would start a tradition of a "President's theme" for the annual meeting, and select, for my years, the theme of "TREATMENT WORKS!" In all conferences and CME activities that we are involved in, I would try to stimulate presentations on treatment and its effectiveness. NIDA and NIAAA would be encouraged to publicize treatment efficacy reports and develop public health proposals that stimulate public interest in the effectiveness of Addiction Medicine treatment. ASAM will work actively with the media in all parts of the country to assist our membership and inform the public of how very effective treatment actually is.

I have chosen to seek this responsibility at the same time that I am "hanging out a shingle" to practice Addiction Medicine and Psychiatry in Naples, Florida. I will, therefore, be immersed in the same clinical and fiscal issues of relevance to each of you, but am quite confident that together we will all succeed. Thank you for your consideration of my candidacy.

CANDIDATES FOR THE OFFICE OF PRESIDENT-ELECT

The ASAM Constitution & Bylaws state that "The President-Elect shall, in the absence or disability of the President, exercise the powers of the President. The President-Elect shall perform such other duties as may be assigned by the President or Executive Committee."

The Constitution & Bylaws also require that nominees for the office of President-Elect must be from or have served on the Board of Directors within the past four years. Officers, including the President-Elect, have a two-year term of office.

William B. Hawthorne, M.D.
Florida

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? ASAM has been an important part of my life since 1978. As Treasurer and Executive Committee Member for 10 years, I participated in the major changes and remarkable growth that brought our organization to the forefront of the field. My special responsibility was to work closely with the Executive Vice President and board members concerning administrative issues and the achievement of fiscal responsibility and security.

I chaired the Ruth Fox Memorial Endowment Fund during the time we raised its first million dollars. For six years, I served as ASAM's representative to the JCAHO and fashioned ASAM's relationship with the Journal of Addictive Diseases. The organization, the field, and the leadership of ASAM are well known and important to me.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? The next ASAM President-Elect will help shepherd our organization into the year 2000. I share the vision ASAM must grow in its service to our members and to the field. We cannot forget what brought us together in this effort. We remain committed to ASAM as a multidisciplinary clinical specialty organization. In pursuit of excellence, we must continue to increase the standards of practice in our field. We, not third parties, are the ones to set the standards for levels of care and clinical guidelines in the field.

I will continue to fight vigorously any discrimination against our members by managed care organizations. We need to increase training opportunities in addiction medicine and encourage fellowships and residency programs leading to board specialization. I would greatly appreciate your support.

James W. Smith, M.D., FASAM
Washington State

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I believe my greatest contribution to the field of Addiction Medicine is my many years of teaching the disease nature of addiction to medical students, nurses and counselors in training. As part of this activity, I was a member of the Curriculum Committee that put Addiction Medicine in all four years of the University of Washington School of Medicine. I carried these concepts to the general public as President of the Washington State Council on Alcoholism (an affiliate of NCADD). When I started this activity, the disease concept was a rather new and controversial idea.

I believe my greatest contributions to ASAM to date include years of work to insure financial stability of the organization as Chairman of the Finance Committee, Chairman of the Operating Fund Committee and now as Treasurer. In addition, I have actively participated in other policy-making committees (e.g., Certification, Public Policy, and Practice Guidelines).

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I believe that as President I will benefit ASAM by my familiarity with financial issues of the organization and will be an asset in keeping the organization viable. I also believe that my experience in the leadership of this and other membership organizations will be of value in achieving the goals of its members.

I believe that I will be of benefit to Addiction Medicine by assisting it to take its rightful place as a respected, influential medical specialty by strengthening ties with relevant governmental agencies and coalition-building with organizations with similar objectives.

The Nominating and Awards Committee is composed of the Immediate Past President; two committee chairs, who are elected by all committee chairpersons; two Regional Directors, who are elected by all Regional Directors; and two ASAM members, who are appointed by the President and approved by the Board of Directors.

ASAM's campaign guidelines prohibit the use of "restricted or unrestricted written or electronic communication" by candidates or their advocates.

ASAM ELECTION OF OFFICERS

CANDIDATES FOR THE OFFICE OF SECRETARY

The ASAM Constitution & Bylaws state that "The Secretary shall: (a) keep an accurate record of the proceedings of the meetings of the Society, the Board of Directors, and the Executive Committee; (b) preserve records, documents and correspondence; (c) cause notice to be given of elections and of meetings of the Society, Executive Committee, and Board of Directors; (d) advise the Board on parliamentary procedure in the conduct of its meetings, and (e) perform all other duties incident to the Office of the Secretary."

The Constitution & Bylaws also require that nominees for the office of Secretary must be from or have served on the Board of Directors within the past four years. Officers, including the Secretary, have a two-year term of office. A Secretary may succeed himself/herself once without hiatus, and may subsequently be reelected after a hiatus of two years.

Christine L. Kasser, M.D.
Tennessee

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? Practice Guidelines: Established committee and process for development of high quality addiction medicine guidelines, such as "Pharmacologic Management of Alcohol Withdrawal."
ASAM Board Membership: Served on the Board and helped to develop policies to strengthen the society.
Principles of Addiction Medicine: Participated in reorganizing and improving the second edition. Co-authored the "Topics" on detoxification protocols.
Patient Placement Criteria: Have participated in providing training on criteria implementation and new models of care.
ASAM Finance Committee: Recently accepted Chair of Finance Committee and began to reorganize the process of budget development and monitoring.
Tennessee Society of Addiction Medicine: Led the state chapter development.
Teaching: Have participated in multiple teaching opportunities. Currently provide an addiction medicine rotation and lectures for residents.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I have fairly extensive history with ASAM and therefore have some understanding about the structure and function of the organization. However, I bring new ideas to help the organization evolve to meet members' and patients' needs in the current health care environment.

Michael M. Miller, M.D., FASAM
Wisconsin

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I think these have been at ASAM's periphery, where it interfaces with those outside of ASAM: as Delegate to the AMA, where ASAM interacts with other medical specialty societies; as representative to the JCAHO; as member (and Chair Elect) of ASAM's Public Policy Committee, stating for others what physician leaders in addiction believe should occur; as representative of ASAM in the formal dialogue with AMBHA; as an "ambassador" for addiction (e.g., as Chair of my state medical society's Commission on Addictive Diseases). I have also worked within the core of ASAM, as a member of the Work Group for *PPC-2*, as a contributor to *Principles*, as the founder and past President of my state chapter, as the first Chair of ASAM's Managed Care Committee and QI Committee. I have been asked to take on leadership roles by ASAM (appointed to the Nominations and Awards Committee; a member of the Task Force that drafted the ASAM Core Benefit statement) and by other health care leaders (e.g., named chair of the JCAHO Hospital PTAC).

How do you feel your election would benefit ASAM and the field of Addiction Medicine? What should ASAM be doing? Focus on what we are: a medical specialty society. We are docs. Addicts are patients (not bums, criminals, sinners, or clients). Addiction is a medical condition. Addiction docs should write the diagnostic criteria, the admission/utilization criteria, the practice guidelines for addiction practice. Sure, there should be thousands more of us addiction docs, but we are the ones doing the clinical work, choosing this field, and should do the teaching, guide the research, shape the policy, develop the guidelines for addiction medicine. We are it; we've got to do the work.

What does a Secretary do? Write. My writing for ASAM has been extensive (policy statements, AMA resolutions, *Principles* chapters, reports for the Board and *ASAM News*. I hope this has advanced ASAM's cause.

As a hospital administrator, a practicing addictionist, a boarded Addiction Psychiatrist, a medical school clinical faculty member, a 12-year member of the impaired physicians' Managing Committee in Wisconsin, an ASAM Board member, a managed care consultant, and with a strong interest in public policy, I feel I have adequate grasp of the broad range of issues of medical finance, practice, process improvement, management, and policy to serve as Secretary and Executive Committee member for ASAM. I hope you concur.

CANDIDATES FOR THE OFFICE OF TREASURER

The ASAM Constitution & Bylaws state that "The Treasurer shall be the custodian of the Society's funds from whatever source those may derive. The Treasurer or individual designated by the Board of Directors shall deposit these funds in the Society's name in such depositories as the Finance Committee, following the guidelines of the Bylaws and the Board of Directors, shall recommend. The Treasurer shall dispense funds as authorized by the Board of Directors. The Treasurer shall report an accurate amount of all transactions at the Annual Meeting of the Society, and at all Board of Directors and Executive Committee meetings. The Treasurer shall be a member of the Finance Committee."

The Constitution & Bylaws also require that nominees for the office of Treasurer must be from or have served on the Board of Directors within the past four years or, in the case of a nominee from the general membership who has qualifications for the position, must have been active on the Finance Committee within the past four years. Officers, including the Treasurer, have a two-year term of office. A Treasurer may succeed himself/herself once without hiatus, and may subsequently be reelected after a hiatus of two years.

Elizabeth F. Howell, M.D.
Georgia

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I have contributed to ASAM in many ways, originally as President of the Georgia Chapter and later as member and Chair of several ASAM Committees, including the Finance and Examination Committees. I am currently the Chair of the ASAM Communications Section and the Publications Committee and have attended most of the ASAM Board meetings over the past several years.

Through 15 years of work in the private, public, and academic Addiction Medicine and substance abuse settings, I have had progressively responsible experience developing and administering programs and have developed a unique perspective on the field of Addiction Medicine and the larger issues facing us all.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? As Georgia's State Director for Substance Abuse, I administer or oversee $71 million in state and federal funds for substance abuse prevention and treatment services in the public sector, educate and advise state and federal decision-makers and advocacy groups, develop and review budgets for improvements to Georgia's public addiction treatment system, evaluate treatment programs, etc.

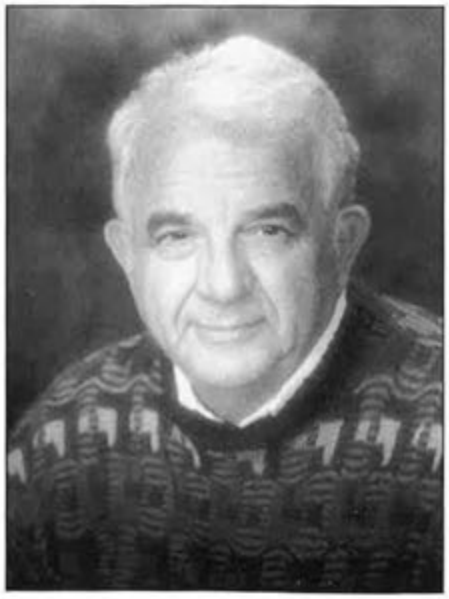
My professional leadership experience at the state government level, ability to design and implement strategies and administer a variety of resources, experience in integrating key national and program goals and priorities would benefit ASAM and the position of Treasurer. I look forward to the opportunity to further serve ASAM and the field of Addiction Medicine.

Richard E. Tremblay, M.D., FASAM
Washington State

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? My greatest contributions to ASAM and the field of Addiction Medicine are essentially three in number. First, in my 15 years as an ASAM member and attendee at every Medical-Scientific meeting, I have served or presently serve on numerous committees, including Membership, State Chapters, Methadone, Physician's Health, Constitution and Bylaws, and am the Chair of the Fellowship Subcommittee. I currently serve as Director representing Region VIII on the ASAM Board.

Second, I was the Founding President of the Washington State Society of Addiction Medicine. Last, I have worked in the field of Addiction Medicine for 16 years as addictionist and Medical Director of both private and public sector inpatient and outpatient treatment centers serving both adults and adolescents.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I would bring to the position of Treasurer my experience and determination to energetically and enthusiastically fulfill the duties of Treasurer in these highly challenging fiscal times in Addiction Medicine, to preserve the strength and vitality of ASAM as the paramount medical voice and organization of Addiction Medicine.



ASAM ELECTION OF OFFICERS

CANDIDATES FOR DIRECTOR-AT-LARGE

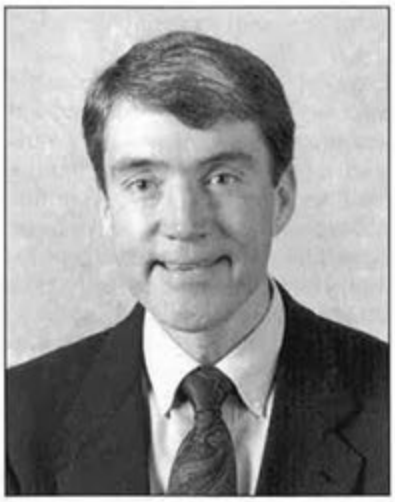
Daniel H. Angres, M.D.
Illinois

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I consider my greatest contribution to the American Society of Addiction Medicine to be my services as Chair of the Physicians Health Committee. During my active involvement with this committee for several years, I was happy to be involved in looking at various ways in which ASAM could contribute to supporting the recovering physician, particularly areas of discrimination or bias as a result of being chemically dependent. Inappropriate disciplinary action or non-inclusion in managed care panels are examples of the kinds of issues I was able to begin to address in my leadership in this committee.

Overall, I believe my greatest contribution to Addiction Medicine, in general, has been both my commitment to recovery in the health care professional, as well as my clinical and political work in bridging the areas of traditional psychiatry and Addiction Medicine. My ability to work with traditional psychiatry and engage and enlist that sector in the appropriate addictions has been an ongoing interest and, I hope, contribution of mine.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I believe that my election would benefit ASAM and the field of addiction medicine, particularly in regards to my focus on assisting the overall recovery and support of the addicted physician and health care professional. I also feel that my ability to bridge some existing gaps between traditional psychiatry and Addiction Medicine can benefit ASAM in terms of membership and a voice in the psychiatric community.

I believe I would also be able to continue to enhance the relationship with the American Medical Association and help the more complicated patient with psychiatric issues complicating one's chemical dependency.



Martin C. Doot, M.D., FASAM
Illinois

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I consider my greatest contributions to ASAM and the field of addiction medicine are the following: (1) Encouraging certification of all medical directors of Parkside addictions programs and enabling their participation in the ASAM national conferences by scheduling our medical directors' meetings prior to a national conference. (2) Establishing educational rotations for family practice and psychiatry residents at MacNeal Hospital and Lutheran General Hospital, training a series of family physicians and psychiatrists who later became leaders in the field of addiction medicine. (3) Helping to plan the original review courses in addiction medicine and later chairing the review course committee and coordinating courses for the Society. (4) Helping as associate editor of the first *Principles of Addiction Medicine*. (5) Implementing, with David Mee-Lee, the ASAM Patient Placement Criteria throughout the Parkside system; (6) Establishing a contract with the Illinois State Medical Society to administer the Illinois Society of Addiction Medicine. (7) Negotiating a contract with the state Department of Alcoholism and Substance Abuse to provide consulting services by physicians who are members of the board of ISAM. (8) Research contributions on the prevalence of alcoholism in a community hospital and screening for addiction in primary care.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I feel my election would benefit ASAM by bringing the perspective of an addiction medicine physician experienced with organized medicine, board activities, and clinical experience as well as educational and research interests.

Qualifications for Director-at-Large

The ASAM Constitution & Bylaws require that candidates for Director-at-Large must have been active members of ASAM for three years, must have demonstrated a commitment to ASAM's mission by having engaged in activities such as service on a committee, task force, or other significant state or national endeavor, and must be willing to attend two Board meetings a year for four years at his or her own expense. The Bylaws state that if a candidate is nominated to run for Officer, he or she also is eligible to run for Director-at-Large. If the nominee is elected Officer, the votes cast for that candidate as Director will not be counted. The nominee for Director-at-Large receiving the next highest number of votes will be elected. Voters thus may cast ballots for the same person for both director and officer positions.

CANDIDATES FOR DIRECTOR-AT-LARGE

David R. Gastfriend, M.D.
Massachusetts

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? My principles for work in addiction medicine are these: ASAM must be a vigorous advocate for both the art and science of addiction medicine. To do so, we must be willing to battle multiple stigmas of addictive disease: social, economic and political. Addiction medicine needs physicians from all specialties to contribute expertise.

There can be no balance of understanding within the field unless the voices of those who are themselves in recovery are represented as well as those in academia and research. In my own career, I have followed the path of taking what I have been taught by experience and subjecting those perceptions to the objectivity of research methods. At times, research methods have proven to be too coarse, failing to yield answers. But those answers remain badly needed.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? ASAM has great strength in being able to convene the leading researchers in the nation and to review whether their work is relevant and serves those who suffer from the illness and the stigma. I am committed to using this process to advance our mission among those who pay for, manage and legislate our work.

James A. Halikas, M.D.
Florida

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I have been an active participant in ASAM for more than 20 years, as chairman of Medical Education, as co-chairman of the Fellowship Committee, as a member of the Executive Committee, and as an active presenter at our annual Medical-Scientific Conferences. In fact, if you've ever taken an ASAM course or gotten CME credits from ASAM, I probably helped organize or approved the course, and my signature is on your certificate. I've also contributed more than 100 articles to the Addiction Medicine professional literature, including the development of new cocaine pharmacotherapies. I am particularly proud to have been the senior author of the original patient placement criteria in 1987, the "Cleveland Criteria," along with David Mee-Lee and Norman Hoffman, which became the ASAM Patient Placement Criteria, the national standard for our field. Yet, I believe that my most important contribution to ASAM and to the field of Addiction Medicine is still to come.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? My goals for the next six years will be to organize our membership, 3,000 expert Addiction Medicine clinicians and scientists, into an effective voice for our specialty in order to improve reimbursement for our services and establish our position as a medical specialty.

Thomas L. Haynes, M.D., FASAM
Michigan

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I have been a member of ASAM since 1983, and in that time have served on the Membership, Physician Health, and State Chapters Committees, as well as the Communications Task Force and Members Without a Residency Task Force. I have attended the last five ASAM Board meetings, including the last two as the Region VI Alternate Director, and have attended nearly every annual Medical-Scientific Meeting since 1986. In 1997, I was elected to the status of Fellow of ASAM, and I was certified by ASAM in 1986 and recertified in 1994.

I organized, and was the founding president of, the Michigan Society of Addiction Medicine. I also serve as the MD representative on the Michigan Health Professional Recovery Committee, and have been that Committee's chair since its inception in 1994. I have practiced full-time Addiction Medicine since 1985, and currently own and operate West Michigan Addiction Consultants, PC (WeMAC), which specializes in the treatment of addicted health professionals.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I believe that I can benefit ASAM by promoting the acceptance of primary treatment of addiction in mainstream medical practice, and doing whatever I can to bridge the gap that we currently have between the need for treatment of addiction and the lack of support for that treatment by government, industry, and third-party payers.

ASAM ELECTION OF OFFICERS

CANDIDATES FOR DIRECTOR-AT-LARGE

Elizabeth F. Howell, M.D.
Georgia

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My professional leadership experience at the state government level, ability to design and implement strategies and administer a variety of resources, experience in integrating key national and program goals and priorities would benefit ASAM and the position of Director-at-Large. I look forward to the opportunity to further serve ASAM and the field of Addiction Medicine.

Christine L. Kasser, M.D.
Tennessee

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine?
Practice Guidelines: Established committee and process for development of high quality addiction medicine guidelines, such as "Pharmacologic Management of Alcohol Withdrawal."
ASAM Board Membership: Served on the Board and helped to develop policies to strengthen the society.
Principles of Addiction Medicine: Participated in reorganizing and improving the second edition. Co-authored the "Topics" on detoxification protocols.
Patient Placement Criteria: Have participated in providing training on criteria implementation and new models of care.
ASAM Finance Committee: Recently accepted Chair of Finance Committee and began to reorganize the process of budget development and monitoring.
Tennessee Society of Addiction Medicine: Led the state chapter development.
Teaching: Have participated in multiple teaching opportunities. Currently provide an addiction medicine rotation and lectures for residents.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I have fairly extensive history with ASAM and therefore have some understanding about the structure and function of the organization. However, I bring new ideas to help the organization evolve to meet members' and patients' needs in the current health care environment.

David C. Lewis, M.D.
Rhode Island

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? My main interest has been to influence policy by designing clinical and research programs to improve the medical professions' response to people with addictions. Training has been a major facilitating mechanism for change.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? By representing ASAM on the ACP Council of Medical Societies, we now formally present our case to Internal Medicine. By working with ASAM for parity for substance abuse treatment, we further our contribution to the health care reform.

And recently, by working with medical leaders, who are not addiction medicine specialist, we join the mainstream of medicine, help our specialty and our patients, and further the goals of ASAM.

CANDIDATES FOR DIRECTOR-AT-LARGE

Peter A. Mansky, M.D.
New York

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? It is a privilege to be considered for Director-at-Large. My work in Addiction Medicine started in 1969 at the NIMH Addiction Research Center, Lexington, Kentucky, and has involved teaching, research and clinical activities. I serve as the Medical Director of The Committee for Physicians' Health in New York, which includes extensive outreach to other physicians and medical students; reviewing treatment; and advocating with regulatory agencies, managed care, and employers for physicians suffering from addictive illnesses.

My private practice in Addiction Medicine has continued to be active. In ASAM, I serve as the Alternate Region I Director, Vice President of the New York Chapter, on the Physicians' Health Committee (PHC) and as Liaison to the PHC from the Federation of State Physician Health Programs.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? My dedication is to further the treatment of those who are still out there suffering from addictive illnesses in this age of managed care and over regulation.

Gregory E. Skipper, M.D., FASAM
Oregon

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? My greatest contribution to ASAM and the field of Addiction Medicine has been to sit with one addicted patient at a time, to show compassion and understanding, and to share the "good news" that addiction is a disease and that there is hope. I have carried this same message of "addiction is a treatable disease" to other venues, including appearances on the Today Show, AM Northwest, the Oregon Medical Association, before the state legislature in Salem, Oregon, and others.

As an Assistant Professor of Medicine at Oregon Health Sciences University (OHSU), I have trained medical students and residents and developed curriculum guidelines in Addiction Medicine, and was instrumental in the development of the OHSU/Springbrook Northwest Addiction Medicine Fellowship Program in partnership with Springbrook Northwest and Oregon Health Sciences University. I have been on the Oregon Medical Association Physician's Committee, was a founding member of the Oregon Diversion Council, and was a founding member of the Oregon Society of Addiction Medicine.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I feel much desire to serve and contribute to ASAM. I will be active and provide creativity and action. I have lots of ideas and energy for this worthy cause. It is time for Addiction Medicine to gain the full stature of a specialty. I would like to see the establishment of associate and public membership under our organization.

We must maintain credibility by supporting our members and to acquire and utilize new knowledge regarding the neurobiology of addiction and other scientific approaches to understanding addiction. In this regard, I would like to see ASAM support the publication of an Audio Journal of Addiction Medicine to better keep members informed.

John Slade, M.D., FASAM
New Jersey

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? My greatest contributions have been related to nicotine.

Within the society, and largely through the Nicotine Dependence Committee, which I chair, I have sought to increase awareness and knowledge about nicotine and tobacco, giving clinicians tools to address problems related to tobacco in all clinical settings.

I have helped develop and give voice to ASAM's policies on tobacco and nicotine. In this connection, I have been privileged to represent ASAM before the Food and Drug Administration, the Federal Trade Commission, and other governmental bodies at the national and state levels.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I would work to continue the integration of nicotine concerns within Addition Medicine and to explore common policy areas between tobacco and other drug problems.

ASAM ELECTION OF OFFICERS

CANDIDATE FOR DIRECTOR-AT-LARGE

James W. Smith, M.D., FASAM
Washington State

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I believe my greatest contribution to the field of Addiction Medicine is my many years of teaching the disease nature of addiction to medical students, nurses and counselors in training. As part of this activity, I was a member of the Curriculum Committee that put Addiction Medicine in all four years of the University of Washington School of Medicine. I carried these concepts to the general public as President of the Washington State Council on Alcoholism (an affiliate of NCADD). When I started this activity, the disease concept was a rather new and controversial idea.

I believe my greatest contributions to ASAM to date include years of work to insure financial stability of the organization as Chairman of the Finance Committee, Chairman of the Operating Fund Committee and now as Treasurer. In addition, I have actively participated in other policy-making committees (e.g., Certification, Public Policy, and Practice Guidelines).

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I believe that as Director-at-Large I will benefit ASAM by my familiarity with financial issues of the organization and will be an asset in keeping the organization viable. I also believe that my experience in the leadership of this and other membership organizations will be of value in achieving the goals of its members.

I believe that I will be of benefit to Addiction Medicine by assisting it to take its rightful place as a respected, influential medical specialty by strengthening ties with relevant governmental agencies and coalition-building with organizations with similar objectives.

POLICY BRIEFS

ASAM MEMBERS TESTIFY IN FAVOR OF HAROLD HUGHES SUBSTANCE ABUSE TREATMENT PARITY ACT

Robert L. DuPont, M.D., FASAM
Donald Ian Macdonald, M.D., FASAM

(The following written testimony was provided to the Congress by Doctors DuPont and Macdonald.)

We have reviewed the Harold Hughes Substance Abuse Treatment Parity Act (H.R. 2409) and we are writing to convey our strong support for the bill. This legislation is an important step toward ensuring that working Americans and their families receive adequate treatment coverage.

As professionals involved in the alcoholism and drug addiction treatment field for many years, including serving as White House Drug Czars, we are familiar with the damage that the disease of addiction to alcohol and other drugs inflicts upon individuals, families, and countries. Many of these individuals who require addiction treatment are employed and have employer-provided insurance, yet their insurance does not sufficiently cover the treatment they could benefit from and that they should receive. This, unfortunately, is a common theme among employed Americans in need of addiction treatment. According to the Bureau of Labor Statistics, in 1995 roughly 80% of employees working for medium and large employers had health plans that covered a minimum level of detox for these diseases, but not for treatment. Fewer than 7% of the employer-provided health plans covered alcoholism and drug addiction treatment to the same extent as other medical conditions. At the same time, over 70% of drug users and 75% of alcoholics are employed.

The financial problems that arise from this problem of insufficient treatment coverage are serious. When working Americans run out of insurance coverage to pay for treatment for themselves or their children, they turn to their personal and retirement savings. When that runs out, they turn to the public system where costs are picked up by federal, state, county, or city treatment programs. Costs of alcoholism and drug addiction are also shifted back to the private health system which must deal with numerous alcohol- and drug-related accidents and addiction-related diseases such as cirrhosis, fetal alcohol syndrome, AIDS, stroke, hepatitis C, and cancer. Costs of untreated addiction may also be shifted to the criminal justice system which deals predominately with individuals with addiction disorders and substance abuse problems. The criminal justice system may eventually pick up the treatment costs for a few inmates who are offered access to alcoholism and drug addiction treatment.

In the U.S., under the current health care financing arrangements, the economic costs of addiction to alcohol and other drugs are estimated to be over $246 billion annually. When assessing the total economic toll that these chronic brain diseases exact in our country, it is ironic that private health insurance currently covers only 10% of the bill for alcoholism and 3% of the bill for drug addiction disorders. The American taxpayer, however, foots 39% and 46% of the bill respectively. Many of these undue costs could be avoided by providing an early investment in nondiscriminatory insurance coverage for alcoholism and drug addiction treatment. Parity is an effective way to resolve these issues.

It is worth noting that H.R. 2409 will not impose large additional costs upon employers. The most comprehensive parity study, *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance*

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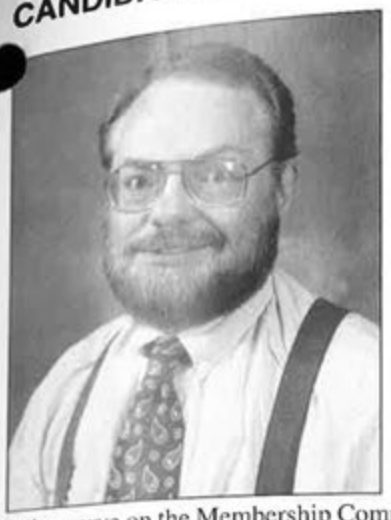
CANDIDATES FOR DIRECTOR-AT-LARGE REPRESENTING OSTEOPATHIC MEDICINE



Timothy L. Fischer, D.O.
South Carolina

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? I chair the State Chapters Committee of ASAM. Two goals that I have for the committee are:

1. To have all states a member of a State Chapter. As founder and first President of the South Carolina Society of Addiction Medicine, I have seen our membership grow by almost 100% in two years. Also, our society has been able to sponsor or co-sponsor conferences, has a seat on the Governor's Maternal, Infant and Child Health Council Substance Abuse Committee, an active role in State legislative issues and helped pass an Omnibus Highway Safety Act this year that had failed the last 10+ years, and are in the process of signing a contract with the Department of Alcohol and Other Drug Abuse Services (our state ATOD) agency to provide training and conferences for them in Addiction Medicine and to be their consultant. We are going to get paid for this as a chapter and individually. All of this because we are a State Chapter.
2. To strengthen current chapters so that they are organizationally strong and sustaining. Many chapters are only as good as the current president. When that one is no longer president, the chapter flounders. We need each chapter to be organizationally strong so as that these valleys can be eliminated.

I also serve on the Membership Committee, the Membership Campaign Task Force, the Strategic Planning Committee and the Practice Guidelines Committee. I am a member of the American Osteopathic Academy of Addiction Medicine and am active in the South Carolina Osteopathic Medical Association.

How do you feel your election would benefit ASAM and the field of Addiction Medicine? I feel that I would be able to help ASAM and Addiction Medicine in the areas of organization, public relations, public policy and politically.

William Vilensky, D.O., R.Ph., FAAFS, FASAM
New Jersey

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine? Certified on the first ASAM exam, I have maintained an active membership by attending annual conferences. I am a member of the Constitution and Bylaws, Public Policy and Forensic Addiction Medicine Committees. For the last two years, I have had the responsibility of co-directing the Ruth Fox Course.

As a founder, President and member of the Board of Directors of the American Osteopathic Academy of Addiction Medicine, a specialty affiliate of the AOA, I was appointed as the first *ex officio* member of the Board of ASAM linking our organizations. I am relinquishing that position to seek the newly designated voting seat for a D.O. Director-at-Large.

How do you feel your election would benefit ASAM and the field of Addiction Medicine I hope to increase D.O. membership in ASAM, work toward a Certificate of Added Qualification in Addiction Medicine as I accomplished at the A.O.A., promote addiction education in medical schools and provide education, experience and opportunities in Forensic Addiction Medicine.

EXPERTS FOCUS ON LEGAL ISSUES SURROUNDING SUBSTANCE USE IN PREGNANCY

Recent data from the National Institute on Drug Abuse (NIDA) suggest that more than one million children a year are exposed to alcohol and/or illicit substances during gestation. Although there is general consensus in the scientific literature that substance use during pregnancy can harm the developing fetus, the literature is inconclusive as to the precise mechanisms of action and the exact nature of the damage. The evidence is most definitive as to the harm caused by legal substances, particularly alcohol and cigarettes, and most controversial or contradictory regarding the effects of illicit substances. Other factors believed to contribute to prenatal compromise of the fetus include lack of prenatal care, poor nutrition, lack of social support, and maternal exposure to violence and stress—all of which frequently are present in the lives of women who abuse substances during pregnancy.

To address this problem, some states are considering criminalization or involuntary civil commitment of pregnant women who use substances that are potentially harmful to the fetus. While no state currently has laws on the books that criminalize such use, many legislatures have considered such language. Even in the absence of an express legislative prohibition, at least 200 women in more than 30 states have been arrested and criminally charged for their alleged drug use during pregnancy.

Policy Implications

These issues were explored at a recent forum convened by the Robert Wood Johnson Foundation and chaired by ASAM Board member H. Westley Clark, Jr., M.D., J.D.,

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AMA DELEGATION REPORT

THE FEDERATION OF MEDICINE

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

"The Federation of Medicine" is a term used to describe the cooperative efforts of medical organizations, which compose what often is referred to as "organized medicine." These components are state and county medical societies, medical specialty societies such as ASAM, and the AMA itself. A major AMA initiative called "The Study of the Federation" was undertaken in the mid-1990s; one result was the creation of a group of 27 physician leaders—the Federation Coordination Team, or FCT—tasked with carrying on the concept. The FCT gave an interesting update of its work at the AMA Annual Meeting in June.

The Study of the Federation was undertaken in recognition of the reality that medical organizations—especially the AMA and state medical societies—seem to have declining value in the view of physicians. Most physicians are more invested in their specialty society than in their county or state medical society.

Whereas the AMA stimulated the FCT initiative, and its Board named its 27 members, the AMA envisions a partnership effort that will be more than an AMA effort. The mission of the FCT is (1) to increase the value of membership in medical organizations (national, state, local, and specialty) for the individual dues-paying physician; (2) to decrease the resources required to operate medical organizations (so that the dues assessed by individual organizations could decline and aggregate membership expenses for a given physician could be reduced); (3) to increase efficiency for organized medicine as a whole (by decreasing duplication and enhancing synergy); and (4) to become a driver of change in how organized medicine is structured and functions.

Defining Collaborative Roles

The FCT was charged by the AMA Board with (1) clarifying the roles and responsibilities of various components of the Federation (who does what, who does it best, and when/where/how), and (2) establishing processes for pursuing collaboration among components of the Federation. Basically, the Federation exists only as a concept unless actual collaborative efforts occur. The FCT thus has been piloting such collaborative efforts, to demonstrate that collaboration is possible and that it generates efficiency and financial savings for societies and their members; and enhances value of membership in medical organizations.

The FCT has undertaken four demonstration projects for collaboration: (1) conflict resolution in managed care (so that efforts of separate organizations can be shared or pooled); (2) a conflict resolution module, outlining tools organizations provide their members on how to appeal disagreements between managed care organization and individual physicians; (3) a legislative initiatives module, outlining the legislative efforts of various state and national medical organizations; (4) a litigation resources module, outlining what types of advocacy litigation have been undertaken by various organizations, to guide organizations in whether and how they should pursue a litigation strategy in response to managed care problems faced by their members, and to assist their members' patients with education in health plan selection. The goal here is to prevent every organization going its own way in developing materials/processes to assist patients in evaluating/enrolling in various third-party-payer plans; and (5) an issues center (e.g., a repository of articles, lectures, and editorials written by members of various medical organizations on patient/physician advocacy issues).

The Virtual Federation

A particularly exciting aspect is the work product of the FCT called "The Virtual Federation." This is an Internet website (and Internet consultation service) developed by and for all component organizations of The Federation. The webpage (www.vfed.org) is to be a site that Federation leaders (officers and executives of state and county associations and specialty societies) can log onto via special passwords, so that they can communicate with each other and build a better sense of community among each other. Through peer forums (such as those involving specialty society presidents) and private chat rooms, leaders of medical organizations can learn from each other to solve problems and approach issues. They also will be able to post files (such as PowerPoint presentations they have given) for use by other Federation leaders from around the country. Beyond this, there is an initiative to coordinate the internet strategy of medical organizations such as ASAM: pool ideas and resources, establish links, build economies of scale for procuring technical support services for the organization's Web page. Thus, the Federation will be given a vehicle for real expression—it will move out of the "concept only" stage. The site went live June 15.

The Federation also plans to streamline membership enrollment processes for various medical organizations, partner in membership services, etc. There also is an Outcomes Measurement initiative, through which medical organizations would pool resources and ideas in developing clinical outcomes evaluation systems.

The work of the FCT promises to increase the return on investment to members, who will receive expanded, innovative services in exchange for their dues support of local, state and national medical organizations. It also provides organizations such as ASAM with tools for improved efficiency and decreased costs of operation through sharing ideas, resources, and technologies, as well as improving networking opportunities for ASAM leaders and administrative staff to reach colleagues in other medical specialty societies, and increasing the visibility of ASAM as a medical specialty society in the eyes of physicians who are members of other organizations.

New Information on ASAM's Web Site

William Hawthorne, M.D., ASAM Webmaster

A number of updates appear on ASAM's Web site this month:

- A new AMA draft of the HCFA Evaluation and Management Documentation Guidelines
- Action Alert: Save Lives, Not Tobacco
- *PPC-2* Training with ASAM and ETP
- Report on the 1998 annual meeting of AMA's House of Delegates
- Pain management in addiction medicine
- Programs for the 1998 ASAM Review Course in Chicago and the CSAM Review Course in Los Angeles
- The program of the MRO Course in Toronto.
- The program for ASAM's upcoming 11th National Conference on Nicotine Dependence in Marina Del Rey, CA.
- An updated copy of ASAM's Constitution & Bylaws.

The site can be accessed at **www.asam.org**.

CHAPTER UPDATES

California

Chapter President: Gail N. Shultz, M.D.
Regional Director: Gail N. Shultz, M.D.

Another in the series of CSAM Leadership Conferences was held in August: "How to Give Effective CME Presentations—Principles of Teaching and Learning." The five-hour workshop includes tips, techniques, and topics such as voice and gestures, the use of humor, cases and role plays, constructive ways to build in discussion time. (Previous workshops in the "Leadership..." series have included "How to Succeed with the Media" and "Hospital Medical Staff Committees on the Well-Being of Physicians.") Given twice—once in San Francisco and once in Los Angeles—the workshop was open to all interested physicians. Speakers for the 1998 Review Course in Los Angeles in October received personalized invitations and complimentary registrations.

At a regional meeting in San Diego in July, Doctors Robert MacFarlane and Edward Moore offered a CME program on opioids, opioid dependence and treatment approaches, including abstinence-based and agonist substitution therapies.

New York State

Chapter President: Merrill Herman, M.D.
Regional Director:
Peter Rostenberg, M.D., FASAM

The New York State Chapter will sponsor the opening reception for the 1999 ASAM Annual Medical-Scientific Conference, scheduled for April 29-May 2 at the Marriott Marquis Hotel in New York City.

North Carolina

Chapter President: Thomas E. Lauer, M.D.
Regional Director:
Paul H. Earley, M.D., FASAM

The North Carolina State Chapter will hold its annual business meeting Saturday, October 3, in Cary.

Chapter members also are developing a schedule of activities and issues for the chapter to undertake over the next several years, as well as planning election of officers.

Oklahoma

Chapter President: C.R. Roberts, M.D.
Regional Director: Ken Roy, M.D., FASAM

The Oklahoma State Chapter is setting an agenda for the next meeting, which is to be held in late October or early November 1998. Additional information is available from the State Chapter office. Minutes of the last meeting also are available.

South Carolina

Chapter President: John E. Emmel,II, M.D.
Regional Director:
Paul H. Earley, M.D., FASAM

The Board of Directors of the South Carolina State Chapter met August 31 at Orangeburg. SCSAM officers are planning a meeting with the State Alcohol and Drug Abuse Director to discuss SCSAM contracting to provide educational service to primary care physicians and treatment professionals.

The chapter also is working to develop a yearly statewide addiction conference.

IN APPRECIATION

Geraldine O. Delaney, pioneer leader in the addiction field, died in July. Mrs. Delaney was Executive Director of the Little Hill Foundation. With her late husband, Mrs. Delaney operated Alina Lodge, a rehabilitation program in Blairstown, NJ, and founded an organization that became the first New Jersey affiliate of the National Council on Alcoholism.

ASAM member Stanley Gitlow, M.D., recalls that "during the 1950s and 1960s, Mrs. Delaney published articles about women with alcoholism, lectured throughout the United States, all the while running her own facility with a firm hand (with good humor, she often signed letters with her initials, G.O.D.)." Dr. Gitlow adds that "when the rest of us ran up against a patient whose recovery was particularly nettlesome, we would send him/her to Gerry with a wish that the patient be kept as an inpatient until recovery seemed likely. She would use her best judgment, and a recovering patient often would return some three or six months later. Her dedication was a model for us all and her belief in the potential for recovery in every patient holds a lesson for many clinicians at the end of this century. All of us in this field owe her much and her passing is a great loss."

Also paying tribute was Dr. Joe Takamine, who said he was "privileged to know her for many years and experience her in a wide variety of situations. A list of her many and diverse activities and accomplishments would take pages. Let me give a brief synopsis of one evening which I am certain was replicated thousands of times across the country.... Mrs. D came one night to speak at Centinela Hospital in Los Angeles. As she walked back and forth, the air was punctuated by `go to meetings, get involved, make the coffee.' As she spoke, I looked about the room—outside of her voice, the silence was deafening, and on faces, both black and white, I could see tears trickling down cheeks—and for weeks after, there was still talk about her, in terms that were almost reverential." Dr. Takamine adds that "her integrity was seamless and evident in all she said and did. At times she appeared tough, at times abrasive, but beneath the exterior, her compassion and caring were limitless. Each and every patient was important to her and she challenged the very best in him/her.... The people she touched are too numerous to count, but speaking for myself, my life is markedly enriched by having known her."

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Associate Medical Director

Henry Ford Hospital Beahvioral Services Department is recruiting an Associate Medical Director for its Chemical Dependency Division. The hospital maintains a 40-bed residential program in West Bloomfield as well as a 500 adult and ambulatory care population at 4 different sites in the metropolitan Detroit area. The residential and ambulatory programs encompass the full continuum of chemical dependency treatment.

The candidate must be board certified or board eligible in Internal Medicine, Family Medicine or Emergency Medicine.

Candidates must be willing to become certified by the American Society of Addiction Medicine (ASAM) and/or to obtain a Certificate of Added Qualifications in Addiction Medicine.

Responsibilities would include detox and medical management of residential and ambulatory patients. The physician also would be involved in patient treatment planning, program development, and education of residents, PA's and medical students. The candidate may have the opportunity to spearhead the development of clinical research.

Candidates meeting these qualifications should send letters of interest and curriculum vitae to Michael F. Boyle III, D.O., Medical Director, Maplegrove Centers, Henry Ford Behavioral Services, 6773 W. Maple Road, West Bloomfield, Michigan 48322.

Henry Ford Medical Group is an equal opportunity employer.

ASAM Members Testify – Continued from page 14

Benefits, was conducted by Mathematica Policy Research, Inc. and was released in March of this year. Basing its cost projections upon an updated actuarial model, the study showed that the average premium increase due to full parity would be 0.2%. In addition, the parity Act is not an employer mandate for treatment coverage. Moreover, treatment gains through insurance parity is expected to REDUCE public and private costs associated with treating HIV/AIDS, tuberculosis, fetal alcohol syndrome, cirrhosis, and other diseases associated with alcoholism and drug abuse....

One concern regarding parity may be the effectiveness of treatment. Doubts surrounding addiction treatment's effectiveness are no longer reasonable. Alcoholism and drug addiction are, undeniably, treatable diseases. True, successful addiction recovery requires the client to be accountable and comply with a treatment plan. Relapse is sometimes a part of the recovery process. The same is true for the treatment of other chronic diseases like diabetes, asthma, and hypertension.

In fact, treatment of alcoholism and drug addiction compares favorably with that of other chronic recurring diseases. Fewer than 50% of sufferers from insulin-dependent diabetes are compliant with their medication regimen and only 30% are compliant with diet and foot care. At most, only 30% of people with medication-dependent hypertension or adult asthma are compliant with their treatment protocols. By comparison, alcoholism and drug addiction treatment patients have compliance rates of at least 40%—comparable to the chronic conditions listed above. Yet other chronic diseases are not faced with the costly problem of insufficient coverage.

Robert L. DuPont, M.D., FASAM, is President, Institute for Behavior and Health, Inc., Rockville, MD, and Clinical Professor of Psychiatry at the Georgetown University School of Medicine. Donald Ian Macdonald, M.D., FASAM, is Chairman and Chief Medical Officer of Employee Health Programs, Bethesda, MD.

THE ROBERT WOOD JOHNSON FOUNDATION ANNOUNCES POLICY RESEARCH FUNDING

The Robert Wood Johnson Foundation has announced a program of funding for substance abuse policy research. The program is intended to identify and assess policies that can reduce the harm caused by substance abuse; to analyze their feasibility, effectiveness, and likely consequences; and to help ensure that the understanding gained through these analyses will be used by decision makers in the public and private sectors. Experts in public health, law, political science, medicine, sociology, criminal justice, economics, and other behavioral and policy sciences are encouraged to conduct research in four areas: tobacco, alcohol, illegal drugs, and combinations of multiple substances.

In this fourth round of funding, approximately $6 million will be made available. Total project awards will be funded up to $350,000 and may extend up to three years. Letters of intent for projects requesting under $100,000 may be submitted at any time and will be reviewed as they are received. The deadline for receipt of letters of intent for projects requesting $100,000-$350,000 is December 16, 1998.

For an abstract or the full text of the Call for Proposals, visit The Robert Wood Johnson Foundation Web site, http://www.rwjf.org. Once at the site, click on "Applying for a Grant," then "List of Open Calls for Proposals."

Colorado

ADDICTION PSYCHIATRIST needed for state-of-the-art dual diagnosis 90-day program. Experienced, multi-disciplinary team. Immediate availability. Affiliation with University of Colorado Health Sciences Center. University faculty benefits. 40-hour work week; no call. Located in Pueblo, close to all recreational and cultural activities in Colorado.

Send CV to A.O. Singleton III, M.D., Chief of Medical Staff, Colorado Mental Health Institute, 1600 West 24th Street, Pueblo, Colorado 81003; phone 719/546-4637; fax 719/546-4484.

Substance Use in Pregnancy – Continued from page 15

M.P.H., FASAM. Panelists reported that, in the absence of directly applicable criminal statutes, prosecutors primarily have turned to laws that prohibit (1) child abuse, neglect, or endangerment, on the claim that a prenatal human is a child within the meaning of such laws, and (2) delivery and/or distribution of any controlled substance or a particular substance (such as cocaine or heroin) to a minor. For example, the State of South Carolina prosecuted two women for using crack cocaine while they were pregnant, based on a state law that makes it a crime to refuse or neglect to provide a child with proper care and attention, so that the child is endangered or is likely to be endangered. The South Carolina Supreme Court ruled that a viable fetus is a child under the law. In May 1998, the U.S. Supreme Court refused to rule on arguments by the two women that South Carolina should not be allowed to use its child-endangerment law to punish pregnant women.

Such punitive approaches were explicitly rejected by the RWJ panel members, including Mary Haack, Ph.D., R.N., of The George Washington University Center for Health Policy Research, Dr. Barry Lester of Brown University, attorney Lawrence Nelson, ethicist Mary Faith Marshall, Ph.D., of the Medical University of South Carolina, and Leslie Acoca of the National Council on Crime and Delinquency. In place of punishment, the panelists endorsed approaches that recognize the fact that addicted women can recover if they have reasonable access to treatment and related services.

Panelists pointed to many other legal issues raised by criminalizing women who use alcohol or drugs during pregnancy, including the legal status of the fetus, the state's interest in protecting the fetus, the woman's right to procreative freedom, unconstitutional sex discrimination, state policies on child custody and removal, etc. The panelists urged that these issues be resolved primarily by the state legislatures rather than by the judiciary.

For More Information

For additional information on the management of the addicted pregnant woman and drug-exposed neonate, see Section 16 of ASAM's ***Principles of Addiction Medicine, Second Edition***.

A SAMPLING OF SECAD/98 TOPICS

WHAT'S NEW IN ADDICTION
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RESIDENTIAL TREATMENT
NICOTINE
EATING DISORDERS
ALTERNATIVE THERAPIES
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ASAM CONFERENCE CALENDAR

1998

September 26–29
American Methadone Association Conference
New York, NY
(Jointly sponsored by ASAM)

September 28–30
ICAA 1998 Annual Research Conference
"Women and Adolescent Females in Community Corrections"
(ASAM is a Supporting Organization)

October 7–10
CSAM Review Course in Addiction Medicine
Los Angeles, CA
21 Category 1 CME credits

October 22–24
Review Course in Addiction Medicine
Chicago, IL
21 Category 1 CME credits

November 5–8
11th National Conference on Nicotine Dependence
Marina del Ray, CA
17.5 Category 1 CME credits

November 13–15
Medical Review Officer Training Course
Toronto, Ontario
19 Category 1 CME Credits

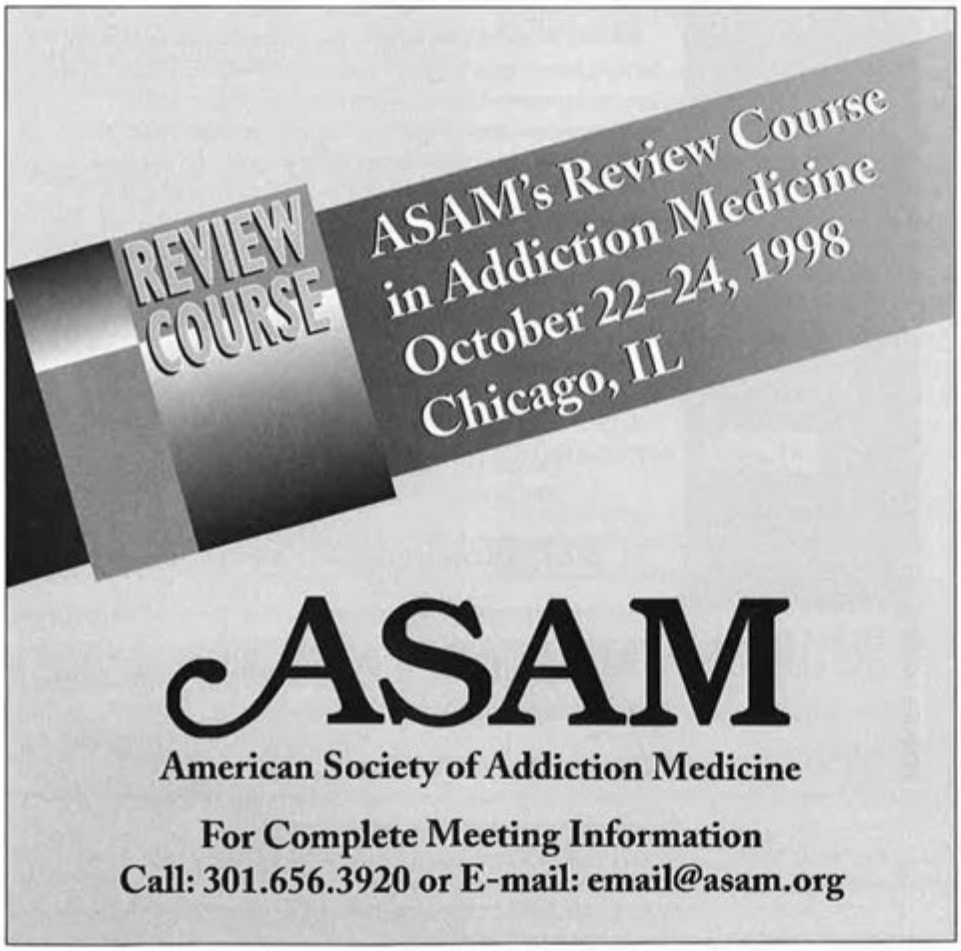
November 21
Certification/Recertification Examination
Atlanta, GA
LaGuardia, NY
Los Angeles, CA
5 Category 1 CME credits

1999

February 26–28
Medical Review Officer Training Course
Chicago, IL
19 Category 1 CME credits

April 29–May 2
30th Annual ASAM Medical-Scientific Conference
New York, NY

November 4–6
ASAM State of the Art Conference
Washington, DC
20 Category 1 CME credits



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