ASAMNEWS

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NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

INSIDE

ASAM At Work for You...

David Mee-Lee, M.D.

Behavioral Health Firm Adopts ASAM Patient Placement Criteria

Managed behavioral health company ValueOptions has become the first national managed care firm to adopt ASAM's nationally recognized *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2)* as its corporate standard for treating persons with addictive disorders. The ASAM Criteria are the most widely used and comprehensive national guidelines for placement of patients with alcohol and other drug problems.

ValueOptions is one of the nation's largest managed behavioral health firms, serving over 22 million persons through contracts with commercial, publicly funded, and federal clients. The company operates administrative and full-risk behavioral management services for employers, unions, health plans, and government, including behavioral health, employee assistance programs and workplace services.

"The *PPC-2* is a strong complement to our clinical values," said ValueOptions' Chief Medical Officer, Ian Shaffer, M.D. "We recognize that it is a necessary component in determining effective treatment planning for people with substance abuse problems and their providers."

"We are very encouraged that ValueOptions has decided to use the Criteria; it's a real vote of confidence," said James F. Callahan, D.P.A., ASAM Executive Vice President and CEO. Dr. Callahan said that ASAM's ultimate goal is national acceptance of the Criteria so that ASAM can collect standardized utilization data from providers and develop industry benchmarks and outcome measures.

▶ **PLACEMENT CRITERIA** *continued on page 26*

ASAM Criteria to Undergo Trial in Israel

David R. Gastfriend, M.D.

ASAM's *Patient Placement Criteria (PPC)* have moved onto the international stage with the agreement of the government of Israel to fund a study of the criteria in treatment programs in three cities. To support the project, Israel has committed facilities, staff and a budget of U.S. $125,000. Three government agencies have agreed to collaborate in sponsoring the research: the Ministry of Health, the Ministry of Labor and Social Affairs and the Anti-Drug Authority. Moreover, the plan has been approved by the Anti-Drug Authority's General Director, Retired General Shlomo Gal.

Proposed by David R. Gastfriend, M.D., who chairs ASAM's Treatment Outcome Research Committee, the study marks the first international application of the ASAM Criteria. It is a major replication and extension of an ongoing study of the validity of the ASAM Criteria that is led by Dr. Gastfriend and funded by the National Institute on Drug Abuse (NIDA). A subsequent naturalistic project, also funded by NIDA and led by Dr. Steven Magura, is under way in New York.

David R. Gastfriend, M.D.

The Israeli project offers an opportunity to test the ASAM Criteria in multiple languages (Hebrew, Russian, and Arabic) and cultures (Israeli native, Israeli emigre, Palestinian Arab), and could pave the way for subsequent trials by the World Health Organization. The project also will test the criteria in a single-payer model through the Israeli national health system.

The project has an interesting sociopolitical dimension, as well, in that a group of treatment program directors and researchers in the Palestinian Territories is interested in participating. ■

A YEAR OF PROGRESS ON PARITY

James F. Callahan, D.P.A.

A year ago, I reported to you that enactment of parity legislation in the states and at the national level would be ASAM's most important immediate goal. Parity is simply defined as providing the same insurance benefits (e.g., cost sharing, service limits, and spending limits) for the treatment of *all* medical disorders, without imposing different requirements for alcohol, tobacco and other drug disorders.

Now that a year has passed, I want to give you a report on the considerable progress we have made, and share my sense of the challenges ahead.

Progress in 1999

At the federal level, results are mixed. Despite the efforts of Rep. Jim Ramstad (R-MN), Sen. Paul Wellstone (D-MN), ASAM and other health organizations, the Congress failed to act on parity legislation. Rep. Ramstad, who has worked tirelessly on this issue, even appeared before the House Government Reform Committee's panel on criminal justice, drug policy and human resources to tell his colleagues, "If it weren't for treatment, I would be dead." His efforts, and ours, will continue when the Congress reconvenes.

On the other hand, the executive branch made real progress, as President Clinton directed the federal Office of Personnel Management to achieve parity for mental health and substance abuse coverage in the Federal Employees Health Benefits Program (FEHBP) by 2001. "The goal is to make plan coverage for mental health and substance abuse care identical to traditional medical care with regard to deductibles, coinsurance, copayments, and day and visit limitations," the President said. Because of its size and the large number of participating health plans, the FEHBP is in a unique position to serve as a model for other employers and for the insurance industry.

At the state level, the picture is somewhat brighter. Through the third quarter 1999, six states—Vermont, Maryland, Minnesota, Georgia, Connecticut and Virginia—have language that specifically covers substance abuse. In some states, parity language also requires use of the ASAM *Patient Placement Criteria* to guide treatment decisions.

In addition, Indiana legislators adopted a measure requiring parity in coverage for state employees (joining North Carolina and Texas), and legislators in Delaware, Hawaii, North Carolina and North Dakota adopted resolutions to study parity. (For a review of 1999 activity in all the states, see the accompanying Table.) Developments of particular relevance to addiction medicine include:

California. Signed into law in September 1999, California's parity bill requires health plans to cover diagnosis and medically necessary treatment of serious mental illness in adults and serious emotional disturbances in children, but does not require parity for substance abuse.

Connecticut. Parity language adopted in 1999 broadens a measure enacted by Connecticut in 1997 in two ways: (1) it extends the parity mandate to individual as well as group coverage, and (2) it expands the mandate to include substance abuse as defined by the *DSM-IV*. (The 1997 measure did not specifically cover substance abuse, instead limiting parity to "a mental or nervous condition caused by a biological disorder of the brain".)

1999 also is the first full year of implementation for a Connecticut law requiring that all hospital and clinic emergency departments adopt and use protocols for screening patients for alcohol and drug problems, and further requiring that physicians and other health professionals receive formal training in "alcohol and substance abuse prevention, screening, assessment and referral" as a condition of graduation. Peter O. Rostenberg, M.D., FASAM and other ASAM members were instrumental in the adoption of this groundbreaking legislation (see the accompanying story).

Virginia. Virginia's 1999 parity legislation requires coverage for all "biologically based mental illnesses," including substance abuse. However, the legislation exempts companies with 25 or fewer employees from the parity mandate. Virginia's chapter of the National

▶ **A YEAR OF PROGRESS** *continued on page 17*

American Society of Addiction Medicine

4601 North Park Ave., Suite 101
Chevy Chase, MD 20815

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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Web Site
For members visiting ASAM's web site (*www.asam.org*), entrance to the on-line Membership Directory requires the Username "asam" and the password "asam" (in lower case letters).

Insurer Sued for Denying Drug Treatment Benefits

Aetna/U.S. Healthcare is being sued for denying drug treatment benefits to a man who subsequently died of an overdose.

Robert Payton, 42, a New York attorney who was addicted to illicit drugs and alcohol, sought inpatient drug rehabilitation. The treatment was recommended by his physician, but Payton's insurance company, Aetna/U.S. Healthcare, refused to pay for the service. Aetna paid for Payton's drug detoxification, but said rehabilitation was not covered by his policy.

The state attorney general's health care bureau investigated the case and found in favor of Payton and wrote to Aetna saying his policy "plainly covers inpatient substance abuse rehabilitation." Following the attorney general's ruling, Aetna/U.S. Healthcare decided to grant Payton coverage for the treatment. The decision was made seven months after his first request, and the same day Payton was found dead of a drug overdose.

Payton's mother, Delores, is suing Aetna/U.S. Healthcare and two of its medical directors for $800 million. Her suit claims that the company violated state law and its own policies by denying the benefits sought by her son. In addition, the lawsuit charges the plan's medical staff with malpractice and accuses the company of being grossly negligent and acting with "willful disregard" of Payton's life.

Aetna/U.S. Healthcare has asked New York Supreme Court Judge Herman Cahn to dismiss most of the charges. According to a company spokesperson, "We don't believe those claims are recognized by the state of New York."

Source: The Village Voice, September 23, 1999.

Supreme Court Allows Drug Testing of Teaching Applicants

The U.S. Supreme Court has ruled that school officials can require drug testing of applicants for teaching jobs. In ruling on a suit against the Knox County, TN, Board of Education, the court allowed a drug testing program established by the board in 1994, under which teachers, principals, assistant principals, teacher aides, school secretaries and bus drivers applying for a job in the school district must undergo urinalysis drug testing.

In making its decision, the court turned away without comment an argument by the Knox County Education Association that the drug tests are unconstitutional if officials do not suspect the tested individual of using drugs. The Education Association is made up of teachers, principals and other professional school employees.

Source: Associated Press, October 5, 1999.

Medical Marijuana Initiatives Pass in DC, Maine

Voters in Maine and the District of Columbia have passed initiatives authorizing medical use of marijuana. In November balloting, 61% of Maine voters approved such a referendum. Under the initiative, marijuana could be possessed and used for certain medical conditions when doctors advise patients that the drug might benefit them. Among the list of qualifying medical conditions are loss of appetite from AIDS or cancer treatments, glaucoma, and seizures or muscle spasms from chronic diseases.

The Maine Medical Association's House of Delegates had opposed the referendum, citing lack of evidence of marijuana's safety in therapeutic use.

Meanwhile, ballots cast in a November 1998 referendum in the District of Columbia finally were counted, showing that 60% of District voters approved the measure. The initiative would allow for the possession, use, cultivation and distribution of marijuana if recommended by a physician for a serious illness.

A series of measures enacted by the U.S. Congress prevented city officials from counting the votes until a federal judge intervened, allowing release of the results.

Despite the outcome, Republican members of Congress vowed that the initiative will not become law. They have said that the measure is too broadly drafted and would hinder enforcement of any anti-marijuana laws in the city.

Sources: Washington Post, September 21, 1999; Associated Press, November 3, 1999.

NM Governor Supports Legalizing Marijuana, Heroin

The governor of New Mexico has said he supports the legalization of such drugs as marijuana and heroin. "I think legalization is a viable alternative to what we are now doing," said Gov. Gary Johnson (R). He said he believes that the nation's war on drugs has failed to stop the flow or use of drugs and costs too much money that could be used for other purposes, such as reducing violent crime.

While pledging his support for drug legalization as national policy, Gov. Johnson said he would not propose legislation to make heroin and marijuana legal in New Mexico.

Source: Associated Press, September 30, 1999.

NYC to Search Welfare Records for Drug Abusers

A New York City plan to examine welfare recipients' medical records for evidence of drug use so that addicts can be placed in treatment has stirred considerable opposition.

Under the plan, the city's Human Resources Administration would search its Medicaid payment records to determine if welfare applicants had sought drug or alcohol treatment in the past. Applicants whose names appear in the records could be required to undergo treatment in order to receive or keep their welfare benefits.

Paul N. Samuels, director of the Legal Action Center, a nonprofit advocacy group, said the planned search is an invasion of privacy. "Violating confidentiality is an ambush that will drive many people away from treatment," he said. In an editorial, the *New York Times* commented, "This abuse of confidential records is precisely what worries privacy groups about the creation of large government databases."

▶ **ADDICTION** *continued on page 16*

New Research Points to Decrease in Funding for Addiction Treatment

Marc Galanter, M.D., FASAM

Even as demand for mental health and addiction treatment services has increased, funding has decreased, according to a survey commissioned by the National Council for Community Behavioral Healthcare (NCCBH). The survey findings underscore the results of a study conducted for ASAM by the Hay organization, which I reported to you in the May-June **ASAM News**.

Conducted by The Gallup Organization, the NCCBH survey consisted of questions about community-based treatment organizations' budgets, services, and needs. Over the past two years, the study found significant increases in the demand for services for children and adolescents (up 91%), children in the juvenile justice system (up 79%), school-based care (up 91%), and children with severe emotional disturbances (up 86%).

Among the adult population, respondents reported that the need for services substantially increased among abuse victims (up 51%), adults with severe persistent mental illness (73%), adults with co-occurring mental illness and substance abuse disorders (up 80%), addictive disorders (68%), and drug users (65%).

In addition, the survey found that as a result of managed care practices, the number of denials for care per facility increased four-fold during the five-year period 1994-1999. Financial concerns were the main factor in clinical decision-making, respondents said.

In releasing the survey, NCCBH President Charles G. Ray commented that "the implementation of managed behavioral healthcare has created additional administrative and operational costs for organizations providing such care....Behavioral healthcare organizations are under pressure to help those most in need, even as their abilities to do so are threatened by undependable funding sources; a changing technological world; and shifts in local, state and national support." He added, "What won't go away is the need for these services."

I couldn't agree more.

Source: National Council for Community Behavioral Healthcare. ■

Treatment is Cost-Effective

While treatment costs are influenced by a number of factors, 1999 data from the federal Center for Substance Abuse Treatment show that treatment is uniformly cost-effective. For example, CSAT estimates the following costs of treatment in a variety of modalities:

Outpatient Treatment
120 days @ $15 per day
= $1,800.

Corrections-Based Treatment
75 days @ $24 per day
= $1,800.

Pharmacologic Treatment
300 days @ $13 per day
= $3,900.

Short-Term Residential Treatment
30 days @ $130 per day
= $3,900.

Long-Term Residential Treatment
140 days @ $49 per day
= $6,860.

AMA: Liquor Labels Should be Easier to Read

A petition by the American Medical Association (AMA), acting in concert with substance abuse and religious groups, asks the federal government to make warning labels on beer, wine and other liquor easier to find and to read.

The petition by the AMA claims that the U.S. Treasury's Bureau of Alcohol, Tobacco and Firearms (BATF) has been lax in enforcing how the health warnings should appear. "The government has been asleep at the wheel in terms of assuring that the labels meet Congressional intent and even meet the requirements of their own regulations," said George Hacker, director of the alcohol policies project for the Center for Science in the Public Interest.

The health warning reads that "women should not drink alcoholic beverages during pregnancy because of the risk of birth defects" and that drinking impairs the "ability to drive a car or operate machinery." The petition noted that the labels appear in a multitude of different ways and positions, depending on the product. It asks that the BATF require consistent labeling and placement, similar to the rectangular warning labels on cigarette packs.

A spokesman said the beer industry sees no need for change. "As a practical matter, the public is well-informed right now," said Jeff Becker, president of the Beer Institute, the industry's research and lobbying arm. "We shouldn't go down a road where changing a label is going to create this additional awareness that frankly is at saturation point right now."

While alcohol-related driving deaths have decreased steadily over the past two decades, a 1997 study by the U.S. Centers for Disease Control and Prevention found that drinking by pregnant women is increasing.

Source: Associated Press, November 17, 1999.

Catherine DeAngelis, M.D., M.P.H. Named JAMA Editor

The American Medical Association announced in October that Catherine D. DeAngelis, M.D., M.P.H. will become editor-in-chief of the *Journal of the American Medical Association*. The first woman to edit the journal in its 116-year history, Dr. DeAngelis most recently served as vice dean for academic affairs and faculty of the Johns Hopkins University School of Medicine. She replaces George Lundberg, M.D., whose firing in January provoked a controversy over *JAMA*'s editorial independence. Since Dr. Lundberg's departure, AMA has created a journal oversight committee to serve as a buffer between the editor-in-chief and the association's management.

Dr. DeAngelis has been editor of the *Archives of Pediatrics and Adolescent Medicine*, also published by the AMA, and a member of *JAMA*'s editorial board since 1993. Responding to questions about her goals for the journal, she said that she would like more focus on women's and children's health, as well as on concerns about substance abuse.

Dr. Lundberg had praise for the AMA's choice of his successor: "Cathy DeAngelis is well-known for her moral strength and willingness to do the right thing no matter what. I believe she is up to the task of preserving the editorial independence of the AMA journals." ■

APA: Fight for Patient's Rights Bill Continues

The American Psychiatric Association has joined the AMA and other health care groups in fighting for passage of HR-2723, the Bipartisan Consensus Managed Care Improvement Act. Sponsored by a bipartisan group of House members led by Reps. Charlie Norwood (R-GA) and John Dingell (D-MI), the act would make it easier for patients to go to an emergency room or see a specialist. It will also give them a right to take complaints to independent panels.

The managed care industry spent millions of dollars to defeat the measure. The final vote, 275 to 151, was a major rebuff to the House Republican leadership, who strongly urged members to vote against the bill.

Norwood acknowledged the effect of health groups on the bill's passage. "The key to passing a bill like this was the face-to-face influence individuals wielded," said Rep. Norwood. "Contacting your Members of Congress at home, in Washington, in letters, in newspapers, made my job easier." Terms of the final legislation will be determined by House and Senate negotiators.

Source: American Psychiatric Association On-Line News, October 20, 1999.

NMA: New President to Focus on Substance Abuse, HIV/AIDS

Walter W. Shervington, M.D., new President of the National Medical Association, has announced that his agenda for the organization will focus on access to care, substance abuse treatment, therapy for inmates, and adolescent violence. Dr. Shervington is chief executive of the New Orleans Adolescent Hospital, a psychiatric facility for children and adolescents.

Dr. Shervington also said he will focus on HIV/AIDS in the African-American community. "Mental health and HIV/AIDS are critical health issues for African Americans. Eliminating disparities through advocacy and education are major initiatives for the NMA," the new president declared.

Source: Press release, National Medical Association. ■

PEOPLE IN THE NEWS

NCADD Award to Dr. Blume

Honoring Dr. Sheila Blume (center) for her exemplary work in the addictions field are NCADD President Stacia Murphy and NCADD Board chair Max Schneider, M.D., FASAM.

The National Council on Alcoholism and Drug Dependence, Inc. (NCADD) has honored retired ASAM Board member Sheila B. Blume, M.D, FASAM, with its Marty Mann Founders Award, citing Dr. Blume's "three decades of exemplary work in the field of alcoholism and other drug addictions." The award was established to honor individuals of national prominence in the field of alcoholism and other drug problems whose life work strongly reflects the energy, dedication and focus exemplified by NCADD's founder, Mrs. Marty Mann.

"Dr. Blume has devoted her career to persuading the public, policymakers and the medical establishment that alcohol is a women's issue," said NCADD President Stacia Murphy. "While greater numbers of men may become alcoholic, Dr. Blume has demonstrated in countless articles and lectures that drinking poses unique problems for women, particularly in the areas of stigma, sexuality and treatment."

Dr. Blume, a clinical professor of psychiatry at the State University of New York at Stony Brook, recently retired as medical director of the alcoholism, chemical dependency and compulsive gambling programs at South Oaks Hospital on Long Island, a position she held since 1984. She directed the New York State Division of Alcoholism and Alcohol Abuse from 1979 to 1983, and has served ASAM in multiple capacities, most recently as a member of the Board of Directors and chair of the Public Policy Committee. ■

IN MEMORIAM

Jess W. Bromley, M.D., FASAM

Addiction field pioneer Jess W. Bromley, M.D., FASAM, died September 17 at his daughter's home in Chicago.

A tireless advocate of addiction medicine, Dr. Bromley served with distinction as ASAM's first representative to the American Medical Association's House of Delegates. He retired from that post in 1995. During his tenure as delegate, Dr. Bromley was prominently involved in formulating major AMA policy initiatives, such as the identification of substance abuse as the nation's leading public health problem, the characterization of alcohol and nicotine as addictive gateway drugs, and the recognition that drug dependence in all of its forms is a disease. He was honored by the AMA on three separate occasions for his efforts in recruiting new AMA members.

Dr. Bromley also was actively involved in the California Medical Association, chairing its committee on alcoholism and other drug dependencies from 1984 to 1986, and with the Alameda-Contra Costa County Medical Association, heading its committee on addictions from 1991 to 1994.

He was the founder and a president of the California Society of Addiction Medicine, and was instrumental in unifying addiction medicine practitioners throughout the country under a single medical specialty society: the American Society of Addiction Medicine (ASAM), which he served as a Board member and officer.

In recognition of his many achievements, the ASAM Board elected Dr. Bromley an Emeritus Member of the Society in April 1997. ASAM has submitted a resolution marking Dr. Bromley's passing for the AMA's Interim Meeting in December.

Former ASAM Executive Director Emanuel M. Steindler offered the following appreciation of Dr. Bromley's character and accomplishments:

"Jess Bromley, to me, was the consummate prophet. Not in the narrow sense of predicting things to come, although he would do just that on a number of occasions. He was, in the more profound meaning of the term, a man who had vision and could articulate his dreams and aspirations in such a way as to move people to action.

"His persona and demeanor were almost Biblical. I see him on the floor of the AMA House of Delegates in 1988 just before the vote on whether to admit ASAM to membership. Standing there with white beard and staff-like cane, he cuts an imposing figure. 'We are your child,' he intones, reminding delegates that at another of their meetings several years earlier, they had adopted a resolution from the California Medical Association calling for a national medical specialty society that could encompass alcoholism and all other drug addictions—ASAM, in other words. That was Bromley in public.

"I see him on the eve of that earlier meeting, too. He is huddled with Stan Gitlow and Doug Talbott to craft language for this very resolution to make it acceptable to the principal organizations in addiction medicine as well as to CMA. That was Bromley working successfully behind the scenes, as he often did.

"Jess was a missionary. His goal was to take addiction into the mainstream of medicine. Achieving AMA membership for ASAM was the first milestone. Persuading the AMA to recognize addiction medicine as a practice specialty was another. Regrettably, the final milestone—acceptance as a specialty or sub-specialty by the American Board of Medical Specialties—is yet to be reached. In the end, like Moses, Jess Bromley did not live to see the promised land. It now remains for his colleagues in the field to accomplish his mission and complete the journey."

Dr. Bromley is survived by his wife, Jane, who has asked that memorial donations be directed to ASAM, to be used to advance the specialty of addiction medicine.

IN MEMORIAM

Donald Goodwin, M.D.

Prominent addiction researcher Donald W. Goodwin, M.D., died at his Kansas City home in early August. He was 67 years old.

A recipient of the ASAM Annual Award in 1985, Dr. Goodwin was remembered by ASAM Board member James Halikas, M.D., as "the finest alcoholism clinical researcher of his generation."

Dr. Halikas added, "I had the privilege of working closely with Don Goodwin during some of his most exciting work. In those days, he was amazing to watch. Research ideas came off him like sparks. Some were charming but impractical, like his idea to study drunken goldfish by pouring alcohol into their waters (all promptly died). Others were seminal, like his systematic study of flagyl as an alcohol aversive drug (he showed that it wasn't). Thirty years later, Dr. Goodwin's article is still the first one cited by persistent investigators still trying—and failing—to prove that flagyl works.

"Dr. Goodwin made three discoveries that changed our field forever. Thirty-five years ago, he documented the basic characteristics of alcohol-induced blackouts by clinically reproducing them in a systematic study. I had the privilege of assisting in that study, which demonstrated that the alcoholic blackout involved failure of anterograde memory, while preserving retrograde memory, and was triggered by the rapidity or rate of rise in the blood alcohol level. Dr. Goodwin's report stands 35 years later as the definitive clinical study of blackouts.

"Dr. Goodwin also documented, for the first time, the clinical phenomenon of state-dependent learning. In so doing, he demonstrated scientifically what our patients have always known: what you learn drunk, you remember better drunk.

"But his major contribution was to open the field of genetics in alcoholism and psychiatry. His Danish Adoption Study, published more than 25 years ago, definitively demonstrated the heritability of alcoholism. (It was said that his grant application was so well and clearly written that it received the highest score in the history of NIAAA.)

"What results that study produced! His proof that alcoholism is genetically transmitted revolutionized our field and the field of psychiatry. It firmly established that this apparently behavioral disorder was, at its core, a biologic disorder—a disorder of the brain. From this discovery emerged our understanding of the genetic component of virtually all psychiatric disorders, scientific interest in molecular genetics, and the Decade of the Brain.

"Few of us will do as much to move the world forward as Donald Goodwin. Few of us have his vitality and Renaissance talents. All of us are diminished by his passing."

Michael Ford

Alcohol policy expert Michael Ford died September 23 at the age of 49 while en route from Washington, D.C. to his home in California.

Mr. Ford was a founder and first Executive Director of the National Association of Addiction Treatment Providers (NAATP). Before that he served as Director of Public Policy with the National Council on Alcoholism. For the past five years, he was Executive Director of the National Nutritional Foods Association.

George Dimas, President of the Utah Alcoholism Foundation, praised Mr. Ford's work in raising policymakers' understanding of alcoholism, and said that his legacy is an example that "with hard work, public policy change is possible."

ASAM Executive Vice President James F. Callahan, D.P.A., described Mr. Ford as a man of vision, recalling that it was Mr. Ford who initiated meetings between ASAM and NAATP that led to development of what subsequently became the ASAM *Patient Placement Criteria*. ■

Deadline to Register for ASAM Certification Exam Nears

The next deadline to register for ASAM's Certification/Recertification Examination for physicians who wish to be certified/recertified in addiction medicine is January 30, 2000. The examinations are set for Saturday, November 18, 2000, at three sites: Chicago, IL; Newark, NJ; and Los Angeles, CA.

Physicians who wish to sit for the examination must complete and submit an application. Applications are sent automatically to all ASAM members. Completed applications will be accepted on the following schedule:

- Standard Registration through Sunday, January 30, 2000
- Late Registration through Sunday, April 30, 2000.

All applications will be reviewed and candidates notified by mail as to whether they qualify to sit for the examination.

Physicians who pass the examination become ASAM Certified/Recertified in Addiction Medicine. Since the exams first were offered in 1986, 3,126 physicians—including many of the nation's top addiction treatment professionals—have been certified.

For more information on ASAM Certification and the examination, contact Christopher Weirs at the ASAM office, 301/656-3920.

READER EXCHANGE

Subjects Needed for Study of Genetic Factors in Alcoholism

Note: The Reader Exchange asks ASAM members and other readers to share their knowledge and experience to advance the field of addiction medicine. Readers are encouraged to use this column to respond to questions posed by others, as well as to report unusual phenomena, share diagnostic or treatment insights, and identify potential trends. Correspondence should be addressed to the ***Editor, ASAM News****, by fax at* ***703/536-6186****, or by e-mail at* ***BBWilford@aol.com****.)*

Request: Dr. Kirk Wilhelmsen and colleagues at the University of California, San Francisco, are seeking subjects for a research study of genetic factors in alcoholism. Investigators are seeking large families in which more than one member has had a problem with alcohol. At a minimum, each family would be represented by one alcoholic (active or recovering) family member and one sibling or both parents.

The study involves an interview, blood draw, and personality tests, requiring about four hours to complete. Work can be done by phone and mail, so subjects anywhere in the U.S. are eligible. Subjects are paid $30 to $50 for their time, and are covered by a federal Certificate of Confidentiality. The study has enrolled 500 subjects to date, and seeks an additional 500 participants.

Information is available from Jodi Cornell, UCSF Family Study, by phone at 888/805-8273, or through the UCSF web site at ***http://egcrc.ucsf.edu/alcoholgene***. All information is kept strictly confidential. ■

CHAPTER UPDATES

California

Chapter President: Peter Banys, M.D.

Regional Director: Gail N. Shultz, M.D., FASAM

Gail Jara

Transitions: CSAM founding Executive Director Gail Jara has announced plans to retire at the end of 1999. Following Ms. Jara's retirement, the chapter's Executive Council has decided to move the CSAM offices into the hands of an association management group in San Francisco.

CSAM also is reorganizing its governance structure and adding several new committees. A Committee on Public Policy, to be chaired by Gary Jaeger, M.D., is to review legislation and guide the activities that give the Society a voice in California issues. A Committee on Publications, to be chaired by Donald Wesson, M.D., will direct the newsletter and explore other vehicles for communicating CSAM positions and information. Continuing their work will be the CSAM Committees on Education (chaired by David Pating, M.D.), Fund-Raising (Steven Eickelberg, M.D.), Treatment of Opioid Dependence (Walter Ling, M.D.), and the Task Force on Medical Marijuana (Timmen Cermak, M.D.). CSAM leadership will continue with the Liaison Committee to the Diversion Program for Physicians, chaired by William Brostoff, M.D.

Chapter President Peter Banys, M.D. encourages CSAM members to stay in touch with the chapter leadership as these changes unfold. CSAM's e-mail address is ***csam@compuserve.com***.

Connecticut

Chapter President: Mark L. Kraus, M.D., FASAM

Regional Director: Peter Rostenberg, M.D., FASAM

1999 Accomplishments: Leading the list of 1999 achievements is the chapter's incorporation as the Connecticut Society of Addiction Medicine. Chapter officers are Mark L. Kraus, M.D., FASAM, President; Michael Feinberg, M.D., Vice President; and Kenneth I. Freedman, M.D., Secretary.

In the policy arena, President Mark Kraus, M.D., FASAM, worked on behalf of the chapter in advocating for state adoption of full parity for substance abuse treatment. This legislation was passed in 1999 and will become effective January 1, 2000.

Thanks to the efforts of Region III Director Peter Rostenberg, M.D., FASAM, the state adopted legislation requiring substance abuse screening of all emergency room patients.

Upcoming Activities: Chapter activities now under development include a web page and a speaker's bureau.

Florida

Chapter President: John Eustace, M.D.

Regional Director: Richard A. Beach, M.D., FASAM

13th Annual Conference on Addictions. Planning continues for the FSAM/ASAM 13th Annual jointly sponsored Conference on Addictions, scheduled for February 4-6, 2000, in Orlando. The conference will be held at the Sheraton Safari Hotel, which is less than a mile from the Walt Disney World Resort. Many participants bring their families to enjoy the sunny hospitality of Orlando in the middle of winter.

As in the past, the conference is organized into three morning sessions, with afternoons free to enjoy Orlando. It is designed as a multidisciplinary continuing education activity for physicians, psychologists, physician assistants, nurse practitioners, addiction counselors, social workers, mental health counselors, nurses, and others interested in practical aspects of addiction medicine. The event is approved for 13 Category 1 CME credits for physicians and 1.3 CEUs or 13 contact hours of continuing education credits for most other disciplines.

Program chair Kevin O'Brien, M.D., FASAM, reports that featured speakers will include Douglas Eaton, M.D., Rick Beach, M.D., FASAM, Marcia Flugsrud-Breckenridge, M.D., Ph.D., Michael Sheehan, M.D., and Raymond Pomm, M.D. Topics include: "The Biopsychosocial-Chemical Evaluation of Addictions," "Parameters of Self-Harm, Physical and/or Sexual Abuse in Treating Adolescent Addicts," "Post-Traumatic Stress Disorder," "Nicotine Addiction and Treatment," "Sexual Misconduct," "Parallels Between Psychiatric and Substance Abuse Symptoms," "Methamphetamine Use/Abuse Issues in the USA," "Neurobiology of Addictions," "HIV/AIDs Co-morbidity Issues in Addictions," and "Future Trends in Addiction Treatment."

FSAM has extended an open invitation to other State Chapters (and related organizations) to participate in the conference. Groups as small as 10 persons can schedule a special breakout session as part of the conference, taking advantage of the favorable conference rates. With the 2000 conference, FSAM will continue to offer high quality educational opportunities at the lowest possible cost. The FSAM conference rate for hotel rooms is $109 per night, while the conference registration fee is $250 for physicians and $150 for non-physicians.

To learn more about the conference, visit the "State Chapter" section on the main ASAM Website, or contact Robert Donofrio, FSAM Office, 890 Lexington Road, Pensacola, FL 32514. FSAM's e-mail address is ***fsam.asam@usa.net*** or fax 850/857-1301, or phone 850/484-3560.

Illinois

Chapter President:
Norman S. Miller, M.D. FASAM
Regional Director:
Norman S. Miller, M.D., FASAM

Annual Meeting: ISAM held its annual meeting and Medical-Scientific Workshop in Chicago in October. The chapter is collaborating with Region VI on a Membership Survey.

Task Force: Dr. Norman Miller will head an ASAM Task Force to survey the goals of the Regional Directors.

Ohio

Chapter President:
Gregory B. Collins, M.D.
Regional Director:
R. Jeffrey Goldsmith, M.D.

Book Award: The Ohio Society of Addiction Medicine has awarded a copy of ASAM's *Principles of Addiction Medicine, Second Edition*, to Rebecca Zarko, M.D., a recent graduate of the North East Ohio Universities College of Medicine, in recognition of her special interest in addictions. Dr. Zarko chairs the ASAM Members-in-Training Committee.

OSAM has received a private grant to make similar awards of the ASAM textbook to a student or to the school library at each of Ohio's seven colleges of medicine and osteopathic medicine.

Chapters interested in initiating a similar program should contact OSAM President Gregory B. Collins, M.D., for information.

Dr. Toews is Elected Region VIII Alternate Director

Berton Toews, M.D., FASAM, of Casper, WY, has been elected Alternate Regional Director for Region VIII. Dr. Toews will complete the unexpired term (1999-2001) previously held by Gregory Skipper, M.D., FASAM, whose relocation outside the region created the vacancy on the Board.

Oregon

Chapter President:
Douglas L. Bovee, M.D., FASAM
Regional Director:
Richard E. Tremblay, M.D., FASAM

Board Election: ORSAM held a special election in November to replace outgoing Board member Lee McCullough, M.D. Dr. McCullough's interest and involvement will be missed.

Dinner Meeting: At the September quarterly dinner meeting, Barbara Cimaglio, Director of the Oregon Office of Alcohol and Drug Abuse Programs, addressed the chapter on "Future Directions of Opioid Maintenance Therapies." This meeting continued the good working relationship between ORSAM and Ms. Cimaglio's office.

Washington State

Chapter President: Claire Trescott, M.D.
Regional Director:
Richard E. Tremblay, M.D., FASAM

Fundamentals Conference: The Washington chapter has scheduled a conference on "Fundamentals of Addiction Medicine" for March 3-4, 2000, at the Sheraton Hotel & Towers in Seattle. Topics to be addressed include "Medical Use of Marijuana," "Opioid Agonist Treatment," "Treating Anxiety Disorders While Avoiding Addiction," and "The Interplay of Domestic Violence and Substance Abuse."

For more information on the conference, contact Priscilla Van Horne at the Washington Society of Addiction Medicine office by phone at 425/822-5329 or by fax at 425/889-8104.

Conference Postponed: The Region VIII meeting being considered for Hawaii in Winter 2000 has been postponed. More information will follow as plans are reformulated. ■

PAHO: Health Ministers Meet on Tobacco Control

Smoking has become the leading preventable cause of death in the Americas, but some countries with economic interests in tobacco are preventing aggressive measures to reduce smoking, Dr. George A.O. Alleyne, director-general of the Pan American Health Organization, told a conference of health ministers in San Juan, Puerto Rico.

His report said that smoking is encouraged through the low prices of cigarettes in Latin America and a lack of education about the dangers of smoking.

World Health Organization director-general Dr. Gro Harlem Brundtland said the only way to prevent a global epidemic of tobacco-related diseases is the Framework Convention on Tobacco Control, an international treaty that would set international tobacco control standards.

Thirty health ministers and health officials from every country in the Western Hemisphere agreed to support the Framework Convention.

Source: Associated Press, September 28, 1999.

UN: Discussions of Tobacco Treaty Begin

Health officials from more than 100 nations met in October to begin work on the first international treaty to curb tobacco use and promotion. Initial discussions focused on a global tobacco advertising ban, an increase in taxes on tobacco products and the right to a smoke-free environment. Although delegates at the World Health Organization (WHO)-sponsored meeting reached consensus on several components of the treaty, many obstacles lay ahead.

Two of the world's largest tobacco-producing countries, the United States and Japan, agreed to support only general guidelines instead of specific, enforceable provisions. Citing Constitutional protections of free speech, the U.S. delegates said they would not support a ban on tobacco advertising. In addition, many delegates from the world's NGO community said they fear that as negotiations start, the tobacco industry will insert itself into the process.

The meeting produced a list of 13 provisions to be included in the treaty, covering such issues as tobacco taxes, labeling and subsidies. Delegates will meet again in March 2000 to narrow the list. WHO chief Gro Harlem Brundtland said he hopes that a legally binding treaty can be in place by 2003.

Sources: New York Times (on-line), October 30, 1999; Associated Press, October 29, 1999; Reuters News Service, October 25, 1999.

WHO: Global Counter-Advertising Campaign Launched

The World Health Organization (WHO) is set to launch a global counter-advertising campaign, using ads created for California's aggressive anti-smoking program. The WHO has copied the ads in six languages, for use in 191 countries.

Epidemiologist Derek Yach, head of the WHO's Tobacco Free Initiative, said the ads will be tailored to different nation's cultural sensitivities.

Drawing on a $1.5 million grant by the United Nations Foundation, a charity established with a $1 billion pledge from CNN founder Ted Turner, WHO also plans to promote international regulation of the tobacco industry and to press for excise taxes on cigarettes in countries around the world.

"The consequence of the enormous gains [of anti-smoking efforts] in the United States is that tobacco companies have to make up for lost revenues domestically by looking to international markets," epidemiologist Yach said.

Source: Washington Post, November 4, 1999.

Australia: Spending on Marijuana As Much as For Beer

A new report shows that Australians spend as much money for illegal marijuana as they do for beer, long known as their favorite drink. Moreover, the report by researchers at the University of Western Australia's Economic Research Centre found that Australians buy twice as much marijuana as they do wine.

"Expenditures on marijuana in 1995 were a little over $3.25 billion," said researchers Ken Clements and Mert Daryal in a report entitled "The Economics of Marijuana Consumption."

The researchers noted that the marijuana expenditures were equivalent to one percent of Australia's 1995 gross domestic product, much higher than previously estimated. "Alcohol and marijuana seem to be substitutes, with cross-price elasticities," said Clements and Daryal. "In most cases, liberalized marijuana legislation lowers drinking. Spirits consumption falls the most, then wine and then beer." The researchers estimated that marijuana is used by one-third of Australia's entire adult population.

Source: Reuters News Service, September 30, 1999.

China: Smokers Unaware Of Risks

Only 40% of Chinese smokers and nonsmokers surveyed were aware that smoking could lead to lung cancer, and just four percent knew that smoking increased the risk for heart disease, according to a study by Chinese and U.S. researchers.

The survey found that 34% of respondents said they smoked at least one cigarette every day—an increase of three percent since 1984. Men were much more likely to smoke than women, with 63% reporting that they smoked at least once a day, compared to 3.8% of women. In addition, smokers were taking up the habit three years earlier on average than in 1984.

Source: Journal of the American Medical Association, October 6, 1999.

Japan: Officials Unveil Campaign To Reduce Smoking

Japan's Council on Public Health has proposed a campaign to reduce the country's tobacco consumption by 50% over the next 10 years. The program, "Healthy Japan 21," was presented to

Japan's Health and Welfare Ministry advisory board in August.

The Council is setting numerical targets for reducing the number of Japanese who smoke. According to a 1998 survey, 55% of adult men and 13% of adult women in Japan smoke.

Japan Tobacco, the country's only cigarette maker and the world's third-largest cigarette manufacturer, opposed the proposal, saying it would hurt the tobacco business.

Source: The Wall Street Journal, August 13, 1999.

UK: Initiative to Reduce Drug-Related Crime

British Prime Minister Tony Blair has announced a new initiative aimed at cutting rates of drug-related crime in half by 2008. The program includes mandatory drug testing of all criminal suspects at the time of arrest and random drug testing of persons who are on probation or serving community sentences. "There will be a crime and justice bill and drugs will be its main focus," Blair said. "We will be looking at some of the key issues that all governments have ducked for far too long."

According to Home Secretary Jack Straw, government statistics indicated that there were an estimated 200,000 drug users in England and Wales and that 60,000 were arrested each year. He added that the government wants to reduce drug-related crime 25% by 2005 and 50% by 2008.

The plan is being opposed by civil liberties groups, who call it wrong in principle and a possible breach of the European Convention on Human Rights. "The link between drugs and crime needs to be closely examined, but eroding rights won't end crime," said John Wadham, director of Liberty, Britain's leading human-rights group.

Source: Christian Science Monitor, September 29, 1999. ■

ISAM to Meet in Jerusalem

ASAM will co-sponsor the International Society of Addiction Medicine's international scientific congress in Jerusalem, set for November 5-9, 2000. ASAM President Marc Galanter, M.D., has accepted ISAM's invitation to address the meeting.

The preliminary agenda calls for the ISAM Board to meet on Sunday, November 5; the Society's annual meeting to be held on Monday, November 6; and the ISAM Scientific Congress to open on Tuesday, November 7.

Additional information is available from Dr. Jorge Gleser, who chairs the ISAM program committee, at Department of the Treatment of Substance Abuse, Ministry of Health, 20 King David Street, POB 1176, Jerusalem, Israel 91010.

Staff Coordinator Joins Practice Guidelines Committee

Michael Mayo-Smith, M.D., Chair
Practice Guidelines Committee

Jeanette Guillaume, M.A.

An exciting development has recently occurred for the ASAM Clinical Practice Guideline Committee, with the hiring of a part-time staff coordinator. The Guideline Committee has led ASAM's effort to develop high quality, evidence-based clinical practice guidelines in the area of addiction medicine. However, the committee has found that developing such guidelines is a time-intensive project, in need of strong staff support. In the past, that support was provided by Gail Jara of the California Society of Addiction Medicine, who has announced her plans to retire at the end of 1999.

With the support of ASAM Executive Vice President Jim Callahan, a part-time coordinator has been hired to provide administrative and research support to the committee in the future. Jeanette Guillaume, M.A., the new coordinator of the guidelines program, holds a Master's degree in psychology and is completing work on a Ph.D. in the same field. She has an extensive background in counseling, formal training in research methodology and experience in managing databases. She has worked individually with patients who have addictive disorders in clinical settings and also participated in research in this area.

Ms. Guillaume will be based at the Research Service Office of the Manchester (NH) VA Medical Center, working with the Chair of the Practice Guidelines Committee. Drawing on her clinical and research background, she will work with the committee chair, the work group chairs and committee members to: (1) coordinate the in-depth literature searches required as the initial step of guideline preparation, (2) review and abstract selected articles from the peer-reviewed literature, (3) maintain databases of identified articles, (4) draft recommendations and prepare manuscripts, and (5) circulate and review draft guidelines both within and outside ASAM. Last but not least, Ms. Guillaume will assist the committee chair with efforts to raise additional funds for the guideline program through the preparation of proposals to foundations, government agencies and private-sector organizations.

The Practice Guidelines Committee chair and members wish to acknowledge Gail Jara's outstanding contributions to the committee's work, and are pleased to note that Ms. Jara has agreed to continue to participate as a member of the committee. ■

Have you observed an association between interferon treatments for Hepatitis C and relapse in opioid dependent patients?

Please forward your observations or experiences to the ASAM Pharmacological and Therapeutic Issues Committee
c/o Dr. Arnold J. Hill, Chairman
Fax 508/481-4727

Join the Members-in-Training Committee

Rebecca M. Zarko, M.D., Chair
Members-in-Training Committee

The Members-in-Training Committee is dedicated to improving the training of medical students and residents in addiction medicine. Committee members also work to improve the visibility and membership of ASAM, as well as to improve programs for "impaired" students and residents.

Becoming a member of this committee affords an opportunity to be closely involved in the planning process of many exciting projects geared toward promoting ASAM. It is a committee open to new ideas and strategies. In addition, we are fortunate to have outstanding support from ASAM headquarters staff.

If you have the desire to be involved in a committee where your imput is truly appreciated and you feel strongly about the importance of addiction medicine, this is the committee for you. As a member, you will see your ideas grow into successfully completed projects. If you are a resident or a medical student interested in being a Members-in-Training Committee Member, please contact ***BeckyzMD99@aol.com***. ■

NIDA: Grants Fund Clinical Trials Network Across U.S.

A clinical trials network to improve drug addiction treatment in community settings will be established through grants totaling $55 million from the National Institute on Drug Abuse (NIDA). The grants, awarded for five years, are aimed at implementing science-based pharmacological and behavioral treatments.

Six universities awarded grants in the initial round of funding will serve as the foundation of the National Drug Abuse Clinical Trials Network (CTN). They are Yale University, New Haven, CT; the University of Pennsylvania, Philadelphia; Johns Hopkins University, Baltimore, MD; Medical College of Virginia, Richmond; the University of California at Los Angeles; and the Oregon Health Sciences University, Portland.

The network will expand as NIDA awards additional annual grants. When complete, the network will link 20 to 30 regional research centers. At the local level, each network site will be linked with up to 15 community-based treatment programs.

"The clinical trials network will help us change the face of drug abuse treatment by enabling us to take what we learn in the lab and rapidly put it into practice across the country," said Dr. Alan I. Leshner, NIDA Director.

Source: Press release, National Institute on Drug Abuse, September 28, 1999.

USPHS: Surgeon General Endorses Needle Exchanges

Surgeon General David Satcher, M.D., director of the U.S. Public Health Service (USPHS) has announced that he supports needle-exchange programs as a means of significantly reducing the spread of the HIV virus. "You do not deserve a death sentence because you're addicted," Satcher said. He made his remarks during the U.S. Conference on AIDS in Denver, CO.

Source: Rocky Mountain (CO) News, November 6, 1999.

FTC: Tests Show Increase in Cigarette Nicotine Content

The nicotine content of the average cigarette rose slightly between 1995 and 1997, according to annual tests sponsored by the Federal Trade Commission. The average cigarette delivered 0.89 milligrams of nicotine in 1997, up from 0.87 milligrams in 1995 and 0.88 milligrams in 1996. The average tar content was unchanged at 12 milligrams per cigarette.

The FTC warned that the results may be misleading because a smoker can compensate for reduced tar and nicotine content by taking longer and more frequent puffs. "The commission is concerned that smokers may incorrectly believe....[that] they will get three times as much tar from a 15 mg tar cigarette as from a 5 mg tar cigarette," the FTC report said. "It is possible for smokers to get as much tar and nicotine from relatively low-rated cigarettes as from higher-rated ones."

Source: Bloomberg News Service, September 28, 1999.

DOEd: New Rules Link Aid, Drug Offenses

Under new regulations from the U.S. Department of Education (DOEd), students convicted of drug offenses will lose their eligibility for federal college tuition aid programs. "We are very concerned about students being truthful about all aspects of the financial aid application," said D. Jean Veta, the DOEd's deputy general counsel. "There is no database of drug convictions that we can check. On the other hand, if we find out a student has lied, we not only require repayment of any aid received, but the student would be at risk for prosecution for lying to the federal government."

The rule, which took effect July 1, is based on a higher education law enacted by the Congress in 1998, which requires students to report their drug convictions, including the sale of drugs, on federal financial aid forms, such as Pell Grants and student loans.

Under the rule, a student with a first-time drug possession conviction is ineligible for aid for one year, while those convicted of possessing drugs for a second time would lose aid for two years, and those with a third conviction, forever. A conviction for selling drugs would block aid for two years, while a student convicted a second time of drug sales would lose aid forever. (The rule does not apply to juvenile records or proceedings.)

The rule does allow students to regain or keep financial aid eligibility by completing drug rehabilitation or receiving reversed or set-aside convictions. "We certainly hope that any student otherwise affected by this provision will enter an appropriate rehabilitation program," Veta said. "We continue to believe that getting an education may be the best way to get people off drugs."

Source: Associated Press, October 23, 1999. ■

Addiction Medicine and the Decade of the Brain

ASAM's 1999 Conference on State of the Art in Addiction Medicine attracted 270 physicians to Washington, D.C. in November to hear leading researchers discuss their cutting-edge work. Conference chairs Terry K. Schultz, M.D., FASAM, and David Gastfriend, M.D., M.P.H., assembled an outstanding program on basic and applied research and clinical practice issues, with the collaboration of the directors and staff of the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, which co-sponsored the event.

In his conference overview, Dr. Schultz discussed the relationship of addictions to basic research undertaken as part of the NIH-funded "Decade of the Brain":

The designation of the 1990s as the "Decade of the Brain" was designed to foster public awareness and to create a climate in which neuroscience could flourish. This has happened to an outstanding degree both in the U.S. and worldwide. The National Institutes of Health are the greatest source of research funding, with a 1999 budget for brain disorders exceeding $3 billion. A recent report estimated that more than 35,000 neuroscience papers were published each year between 1991 and 1994; in most basic disciplines, the number was increasing at a rate of 10% per year.

Terry K. Schultz, M.D., FASAM

The surge in neuroscience research has been driven by two major factors. First, there is a growing awareness of the social and economic burden imposed by brain disease and an expectation that, as the population ages, this will worsen. (For example, estimates of the annual cost of brain disease to the U.S. economy exceed $400 billion, and this is expected to rise sharply beginning in 2011, when the first members of the "baby boom" generation reach retirement age). The second factor, set against these grim statistics, is the increasing optimism of the research community that brain disease has become a tractable problem.

An April symposium at the National Academy of Sciences celebrated "the extraordinary results neuroscience has delivered" during the "Decade of the Brain" and reviewed prospects for the 21st century. Participants compiled a list of the six most significant neuroscience advances of clinical relevance in the past decade:

1. The cloning of genes that underlie several major brain disorders.
2. The identification of mechanisms underlying neural plasticity.
3. Advances in understanding the neuropharmacology of addiction.
4. Developments of new techniques for functional brain imaging.
5. Advances in understanding neurogenesis and neuronal death.
6. The identification of molecules and mechanisms that underlie normal brain development.

Over the past 10 years, neuroscientists have gained fresh understanding of the brain's pathways, largely through new imaging techniques, and have discovered chemical ways to influence those pathways, based on fundamental methods of drug discovery. However, the obstacles to development of new clinical treatments based on this research are enormous, and not just for technological reasons. The cost of developing a modern drug can run to hundreds of millions of dollars, which all but precludes the "trial-and-error" approach that characterized the development of earlier therapies. Moreover, the pharmaceutical industry will have no incentive to develop new drugs unless societies find ways to pay for them, and the health care reforms now under discussion have brought new uncertainties to what is already a high-risk enterprise. Finally, drug development is a slow process; it now takes an average of 15 years to bring a new drug to market. As a result, there will be a substantial lag before advances in basic neuroscience have a significant impact on the social and economic costs of brain disease.

...neuroscientists have gained fresh understanding of the brain's pathways, largely through new imaging techniques...

Without immediate "pay-offs" in sight, the continuation of these impressive neuroscience and treatment developments will require the confidence of policymakers and the public in the research community. Such confidence must be bolstered by an understanding of the process through which basic science leads to new clinical treatments if we are to reap the full benefits of the Decade of the Brain.

Enzyme Linked to Alcohol Craving

An enzyme known as PKCe may be linked to sensitivity to alcohol, which could have implications for interventions aimed at reducing craving, according to research by Dr. Clyde Hodge and colleagues at the University of California at San Francisco.

Studies show that mice which lack the enzyme are 75% less likely to consume alcohol than those with the PKCe enzyme. Researchers postulate that the absence of PKCe enhances the effect of alcohol on a molecular receptor in the brain known as GABA-A. This receptor is primarily involved in transmission of feelings of gratification, relaxation and sedation.

Alcohol and other drugs increase these signals by acting chemically on neurotransmitters in the brain. Researchers found that mice lacking PKCe reacted twice as strongly to alcohol as those with the enzyme, which in turn reduced their craving for the drug. "These mice support the concept emerging in alcohol research that increased sensitivity to alcohol intoxication lessens the likelihood that a person will become an alcoholic," said Dr. Hodge.

Source: Nature Neuroscience, November 1999.

Protein Molecule Causes Alcohol-Induced Liver Damage

Researchers have found that a pro-inflammatory protein plays a significant role in the development of early liver damage associated with alcohol consumption.

Researchers from the University of North Carolina at Chapel Hill found that mice with the pro-inflammatory protein TNF-alpha that were fed alcohol continuously over four weeks had liver damage nearly seven times as severe as mice without the protein.

"This major increase in our understanding of the mechanisms of liver injury brings us one step closer to therapies for alcoholic liver disease," said Enoch Gordis, M.D., Director of the National Institute of Alcohol Abuse and Alcoholism.

Source: Gastroenterology, October 1999.

Brain Chemicals Involved in Cocaine Addiction

New research indicates that two chemicals in the brain play a significant role in cocaine addiction. One of the brain chemicals involved appears to be a gene that codes for the production of a protein called delta-FosB. Repeated cocaine use seems to stimulate production of this protein in the nucleus accumbens, an area of the brain that regulates pleasure.

Researchers at Yale University, Harvard Medical School and Northwestern University further studied the role of the protein by developing mice with an extra delta-FosB gene which, when activated, would produce large quantities of the chemical in the nucleus accumbens. The study showed that the mice became more sensitive to the pleasurable effects of cocaine. It also indicated that a second brain chemical called glutamate plays a major role in the cocaine addiction process. The researchers found that the delta-FosB gene increased the production of one glutamate receptor called FluR2. This increase occurred in the nucleus accumbens.

Scientists said the next step in the research will be to determine how these changes in brain chemicals lead to the abnormal brain responses to cocaine that bring on addiction. "It seems that prolonged drug use eventually causes a 'switch' to be thrown in the brain, symbolizing the onset of addiction," said Dr. Alan I. Leshner, Director of the National Institute on Drug Abuse, which funded the study. "With this new research, we are beginning to understand exactly what that switch is and how it works, and this should help us develop medications to turn the switch off."

Source: Nature, September 16, 1999; press release, National Institute on Drug Abuse. ■

ASAM to Co-Sponsor National Alcohol Screening Day 2000

The American Society of Addiction Medicine will sponsor and participate in *National Alcohol Screening Day (NASD)* in the Year 2000. The second annual NASD, to be held April 6, is the product of a unique partnership between the National Mental Illness Screening Project (NMISP), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Center for Substance Abuse Treatment (CSAT).

A one-day public outreach event, NASD is designed to identify persons with potential alcohol problems and guide them into treatment. In addition to reaching out to members of the public, a special college component targets students who are risky drinkers, with a focus on binge drinkers.

In 1999, NASD attracted more than 50,000 participants. More than 27,000 persons were screened at 1,700 sites nationwide, located at hospitals, treatment centers, colleges, and various public locations. As a result, NASD sponsors received wide exposure and played a significant role in helping to educate thousands of attendees and their families.

Building on the 1999 experience, and with the addition of a new outreach component involving primary care providers and intensified efforts to reach friends and family members of persons with alcohol problems, NASD 2000 is expected to help approximately 60,000 individuals at 1,800 community-based screening sites and 500 colleges.

Health care facilities, colleges and private practitioners are encouraged to register for NASD 2000. Sites that register to participate in National Alcohol Screening Day 2000 will receive:

- A procedure guide that describes how to implement and promote the program in a variety of settings.
- A publicity packet of sample media releases, ad slicks and promotion tips.
- A kit of education and screening materials containing:

The AUDIT (Alcohol Use Disorders Identification Test), a standardized, self-reported screening instrument with scoring instructions and referral guidelines.

An Alcohol Risk Assessment questionnaire to guide individuals who would like to help a friend or family member with a potential alcohol problem.

Videotape, educational presentation with slides, promotional posters and flyers, and referral resources.

Organizations that would like to participate in NASD 2000 should contact NMISP/NASD at One Washington Street, Wellesley Hills, MA 02481, or phone 781/239-0071. The registration deadline is February 1. ■

DRUG TRENDS

Abuse of Codeine Cough Syrup a Growing Problem

Doctors and pharmacists should be aware of scams to obtain codeine cough syrup, say officials at the Texas Commission on Alcohol and Drug Abuse.

"This is a drug of abuse," says TCADA's Dr. Jane Maxwell, a leading researcher of drug trends. "Hospitals, doctors and pharmacies need to realize that some drug users have figured out ways to manipulate the system to get codeine syrup."

The Commission recently released a study that examines the illegal use of codeine cough syrup and the ways users obtain the drug. Users with insurance or Medicaid have learned which symptoms to describe to get a prescription for cough syrup, according to the study, which was conducted for the commission by Dr. William N. Elwood, adjunct professor at the University of Texas School of Public Health in Houston.

"Sometimes they won't give me the codeine syrup," said one user interviewed for the study. "When that happens, I'll go back to the doctor and say it hasn't worked and I need something stronger. And then I get it. If that doesn't work, though, I'll just go to the emergency room around shift change."

Other users buy cough syrup that has been stolen or smuggled into the U.S. from Mexico. The price of an eight-ounce bottle of codeine syrup averages $200 on the streets in Houston, says Jerry Ellis, diversion program manager in the U.S. Drug Enforcement Administration's Houston office. "It's certainly still running rampant in the Houston area," Ellis says of the illegal use of codeine cough syrup. "We also have received anecdotal information that it's spreading to San Antonio and Austin."

Some users buy unfilled prescriptions obtained by patients with insurance. "They're coming up with more scams all the time to get this," Ellis says. While the abuse of over-the-counter cough syrups is widespread in the United States, the abuse of prescription cough syrup appears to be limited to Texas, Dr. Elwood said. "This is a problem that really seems to have originated in Houston and is spreading to other cities in Texas," he said. There were 14 deaths in Texas in 1998 that involved the main ingredients in cough syrups, including codeine.

"Codeine cough syrup, and even over-the-counter cough syrups, can be dangerous, especially when mixed with other drugs," Dr. Maxwell says. "This is a serious problem, and we want the public—particularly medical professionals—to be aware of this growing problem."

Source: Texas Commission on Alcohol and Drug Abuse, October 14, 1999 (for more information, contact the commission at 512/349-6600). ■

▶ **ADDICTION** *continued from page 3*

City officials said the record checks are needed because the city's current drug screening system is finding unrealistically low rates of drug use. The record search will use computerized Medicaid insurance bills submitted for applicants who have voluntarily sought substance abuse treatment. "These are our own records," said Jason A. Turner, commissioner of the city's Human Resources Administration. "We are not interfering with the doctor-patient relationship. We're helping poor people."

A date for when the record search will begin has not been determined.

In a related development, City Comptroller Alan G. Hevesi released a report saying that the city has failed to adequately ensure that drug offenders complete their treatment. According to the report, criminals released on probation after agreeing to enroll in drug treatment programs commonly broke their promise without receiving any punishment. Moreover, the report found that one-third of criminals with documented drug abuse problems were released instead of jailed but never offered drug treatment programs. The study said the Probation Department, and to some extent the court system, were to blame for the lack of follow-through of drug offenders.

The study was based on two years of tracking 147 men between the ages of 19 and 29 who were identified at the time of their convictions in 1994 as serious cocaine users. According to the findings, a third of the men did not receive drug treatment recommendations from probation officials and judges, even though they were classified as having a drug problem. Of the 100 men who received drug treatment instead of prison, 75% did not complete their treatment, including 25 men who were ordered to drug treatment by the court as a requirement of their probation sentence.

"These numbers are unacceptable," the report said, "especially given the demonstrated success of drug treatment in lowering recidivism rates of probationers having a drug problem."

Sources: Associated Press, September 27, 1999; New York Times, *September 28 and 30, 1999.* ■

▶ A YEAR OF PROGRESS *continued from page 3*

Alliance for the Mentally Ill worked closely with allies in the addiction field and insisted that the legislation must include parity for both mental health and substance abuse. Advocates argued not only that including addiction in parity legislation was the right thing to do, but also pointed out that failure to include it would make it possible for insurers to limit or deny coverage to dually diagnosed individuals simply by designating substance abuse as their primary illness.

Hawaii. Adopted in 1999, the Hawaii law mandates full parity for mental health services, but allows limits on substance abuse benefits. It narrowly defines "mental illness" as schizophrenia, schizoaffective disorder and bipolar disorder. The law does not include substance abuse within the definition. Instead, it addresses the coverage of substance abuse services by allowing health plans to limit substance abuse treatment to not less than two treatment episodes per lifetime.

New Jersey. Although New Jersey's parity law, enacted in 1999, does not require coverage of addictive disorders, ASAM member Peter Blumenthal, M.D., has been instrumental in organizing a coalition to promote adoption of a full Drug Abuse and Alcoholism Treatment Parity Bill in the state. Dr. Blumenthal is working to enlist the help of the Medical Society of New Jersey in the effort.

Louisiana. Louisiana's limited 1999 parity law requires plans to *provide* mental health coverage for serious mental illness, but only requires that plans *offer* benefits for other mental disorders. For both categories of disorder, the law provides less than full parity by allowing plans to be in compliance if they limit benefits to 45 inpatient days or 52 outpatient visits per year.

Missouri. Legislation enacted in 1999 updates and expands a 1997 parity measure. The 1999 law specifically defines alcohol and drug abuse (as described in the *ICD-10*) as covered conditions. It requires insurers to cover up to 26 outpatient visits, 21 inpatient days, and six days of detoxification per year, and prohibits establishment of any rate, term, or condition that places a greater financial burden on an insured, except that alcohol and other drug abuse benefits must allow at least 30 inpatient days and 20 outpatient visits per year. The law also allows insurers to impose a lifetime limit on benefits for alcohol and drug treatment that is no less than four times the annual limit.

Washington State. Washington State has not yet enacted parity legislation. However, ASAM member James W. Smith, M.D., FASAM, worked with the state's Insurance Commissioner to achieve a permanent rule change in 1999 that: (1) defines chemical dependency as a chronic illness, (2) defines "medical necessity" in the treatment of chemical dependency as that which conforms to the ASAM *Patient Placement Criteria*, and (3) specifies standards for the coverage of addictive disorders that must be met by any insurance contract offered in the State of Washington. For example, the regulation prohibits any special waiting

▶ A YEAR OF PROGRESS *continued on page 18*

▶ **A YEAR OF PROGRESS** *continued from page 17*

periods, as well as preexisting condition exclusions for addiction coverage that are different from those for any other chronic medical condition; it prevents insurers from denying benefits for treatment services solely because the course of treatment was not completed; and it forbids contract language that includes "definitions, predetermination procedures or other prior approval requirements, or other provisions, requirements or procedures, which restrict access to treatment, continuity of care or payment of claims."

James W. Smith, M.D., FASAM

Dr. Smith's success demonstrates that there are multiple ways to achieve parity, and that working with Insurance Commissioners and other state officials to achieve regulatory change can be a viable alternative to the legislative process.

The Road Ahead

To assure passage of effective parity legislation in your state, I urge you to work with your state and local medical societies to promote parity, and to work with your state legislature and local governments to provide for parity in the prevention and treatment of addictive disorders. In this area, even one person can make a difference. In Virginia, for example, prospects for inclusion of substance abuse in a parity bill appeared dim until a physician from the Medical College of Virginia presented evidence of the biological basis of addiction to a legislative committee considering the bill. Following the presentation, an amendment that would have removed substance abuse from the bill's language was resoundingly defeated.

There are a number of things you can do:

First, ask your state legislators to adopt parity legislation. Provide them with factual information. For example, opponents of parity argue that such a policy is too expensive. To the contrary: the facts show that parity is **not** costly; it is **cost-effective**. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has estimated that full parity for substance abuse and mental health services would increase family insurance premiums by an average of 3.6% (see the accompanying Figure). SAMHSA further estimates that plans with tightly managed care would experience a premium increase of only 0.6% for full parity for mental health and substance abuse services.

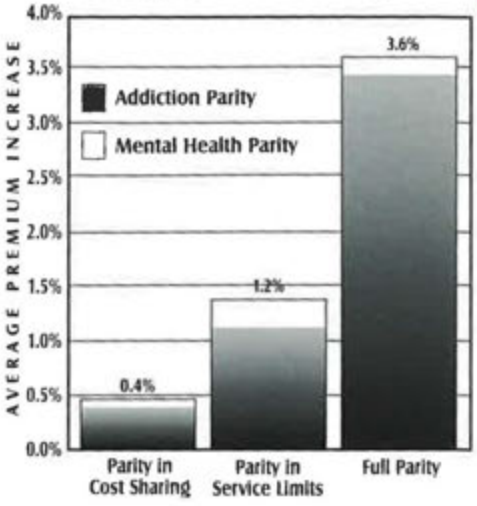
Legislators also frequently ask, "How do you determine that someone needs treatment?" The answer is, "By using the ASAM *Patient Placement Criteria (ASAM PPC-2)*." The ASAM Criteria provide guidelines on how to determine the need for care and the intensity of services each patient requires. The Criteria thus assure that decisions regarding the need for treatment are both clinically proper and cost effective.

Second, if your legislature is considering parity legislation, urge that the bill **specifically** include parity for addiction treatment, rather than being limited to treatment for mental illness. It is not sufficient for a state bill to require compliance with the federal Health Insurance Portability and Accountability Act of 1996, as that act **does not** cover addiction treatment.

Ideally, state legislation should include the broad definition of parity contained in ASAM's policy statement, to the effect that "benefit plans for the treatment of addictive disorders, in both the public and private sectors, shall be comprehensive; i.e., they shall cover the entire continuum of clinically effective and appropriate services provided by competent licensed professionals, and should provide identical coverage and funding to those benefits covering physical illness, with the same provisions, lifetime benefits, and catastrophic coverage." The AMA, with support from the American Society of Addiction Medicine passed a resolution in 1996 (reaffirmed in 1997) that "the AMA supports parity of coverage for mental illness, alcoholism and substance abuse."

Your state will enact legislation requiring equal benefits for treatment only if you take the time to educate your legislators and give them the accurate information they need to draft parity legislation. Please do this for your community, for your patients, and for yourself. ■

Figure: Average Premium Increases for Addiction and Mental Health Parity, by Extent of Parity*



* Estimated premium increases were averaged across fee-for-service plans, preferred provider organizations, point-of-service plans, and health maintenance organizations. The estimated premium increases for individual plans varies according to the extent to which the plans used managed care.

Sources: Substance Abuse and Mental Health Services Administration (September 1999). The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits.

WHERE DOES YOUR STATE STAND ON PARITY?

To date, 26 states have enacted some sort of parity legislation. Of the 26 (described below), six states—Vermont, Maryland, Minnesota, Georgia, Connecticut and Virginia—have included language that specifically covers substance abuse. In addition, 13 states (Arizona, Delaware, Florida, Indiana, Kansas, Louisiana, Montana, North Carolina, New Mexico, Nevada, South Carolina, Tennessee, and West Virginia) have enacted limited parity under the federal HIPAA compliance law; three states (Indiana, North Carolina, and Texas) require parity in state employees' health coverage; and eight states (Alaska, Delaware, Hawaii, Louisiana, North Carolina, North Dakota, Oklahoma and Virginia) have passed resolutions to study the feasibility of parity.

While most state laws adopted to date cover only mental health services, the success of advocates in expanding existing laws in Connecticut and Missouri to cover substance abuse suggests that even limited parity legislation, once adopted, can be improved in subsequent legislative sessions. A persuasive argument for such expansion might employ data from states that mandate coverage of both mental health and substance abuse services, demonstrating that adding a substance abuse benefit is associated with a very small premium increase (see the accompanying figure).

As used here, "full parity" describes laws requiring that a mental health/substance abuse benefit be offered under the same terms and conditions imposed on benefits for any other medical condition. "Limited parity" is used to describe laws that allow differences in the terms and limitations of the mental health or substance abuse benefit.

Status of State Legislation as of December 1999

Arkansas (*full parity; enacted 1997*). Requires full parity for mental health services, but allows insurers to opt out of covering substance abuse services. Exempts companies with 50 or fewer employees.

California (*full parity; enacted 1999; effective 2000*). Requires insurers to cover diagnosis and medically necessary treatment of serious mental illness in adults and serious emotional disturbances in children, but does not require coverage of substance abuse services. No exemptions.

Colorado (*full parity; enacted 1997; expanded 1999*). Requires insurers to cover mental health services, but does not provide parity for substance abuse services. No exemptions.

Connecticut (*full parity; enacted 1997; expanded 1999*). Language adopted in 1999 broadens a 1997 law by: (1) extending the parity mandate to individual as well as group coverage, and (2) specifically including benefits for substance abuse services, as defined by the *DSM-IV*. No exemptions.

Delaware (*full parity; enacted 1998*). Requirements mirror the terms of the 1996 Federal Mental Health Parity Act. Does not address coverage of substance abuse services. No exemptions.

Georgia (*limited parity; enacted 1998*). Requires that insurers *offer* coverage of mental health and substance abuse services, but does not require that such coverage be provided. Caps the benefit for mental health and substance abuse services at 30 days per year of inpatient treatment or 48 visits per year of outpatient treatment, retaining the disparity with all other medical disorders. No exemptions.

Hawaii (*full parity; enacted 1999*). Requires full parity for mental health services, but allows limits on substance abuse benefits to not less than two treatment episodes per lifetime. Exempts companies with 25 or fewer employees.

Indiana (*full parity; enacted 1999*). Does not require coverage of either mental health or substance abuse services, but imposes certain requirements on insurers that do offer mental health coverage. Exempts companies with 50 or fewer employees.

Louisiana (*limited parity; enacted 1999*). Requires the insurers *provide* mental health coverage for serious mental illness, but only that they *offer* benefits for "other mental disorders," presumably including substance abuse. Allows insurers to limit benefits to 45 inpatient days or 52 outpatient visits per year. No exemptions.

Maine (*full parity; enacted 1995*). Requires that insurers provide mental health coverage in group policies, and that they offer it in individual policies. Does not require coverage of substance abuse services. Exempts companies with 20 or fewer employees.

Maryland (*full parity; enacted 1994*). Requires that insurers cover both mental health and substance abuse services under the same terms and limitations as other physical illnesses. Prohibits discrimination in health care coverage against any person with a drug or alcohol abuse disorder. No exemptions.

Minnesota (*full parity; enacted 1995*). Requires that HMO plans cover "mental health and chemical dependency" services, but only that this coverage be *offered* in individual and group policies. Contains a general requirement that the resulting terms and limitations may not place a greater financial burden on the insured and are not more restrictive than requirements and limitations for other medical services. No exemptions.

Missouri (*limited parity; enacted 1997; expanded 1999*). The 1999 law expands a 1997 parity act by imposing requirements on those insurers that offer mental health and substance abuse benefits. Requires such insurers to cover up to 26 outpatient visits, 21 inpatient days, and six days of detoxification services per year, under the same terms and conditions imposed for other medical problems. However, the benefit for substance abuse services is required to cover at least 30 inpatient days and 20 outpatient visits per year, and may include a lifetime limit that is four times the annual limit. No exemptions.

Montana (*full parity; enacted 1999*). Requires that insurers cover mental health services. Does not address coverage of substance abuse services. No exemptions.

Nebraska (*full parity; enacted 1999*). Imposes requirements on insurers that offer mental health benefits. Does not address substance abuse benefits. Exempts companies with 15 or fewer employees.

New Hampshire (*full parity; enacted 1994*). Requires that insurers provide mental health coverage, but does not require coverage of substance abuse services. No exemptions.

New Jersey (*full parity; enacted 1999*). Requires that insurers cover mental health services. Does not require coverage of substance abuse services. No exemptions.

Nevada (*limited parity; enacted 1999*). Requires that insurers provide mental health coverage, but does not require coverage of substance abuse services. No exemptions.

Oklahoma (*full parity; enacted 1999*). Requires coverage of mental health services, but not substance abuse services. Exempts companies with 50 or fewer employees.

Pennsylvania (*limited parity; enacted 1998*). Requires that insurers *offer* coverage of mental health benefits. Does not address coverage of substance abuse benefits. Exempts companies with 50 or fewer employees.

Rhode Island (*full parity; enacted 1994*). Requires that insurers cover mental health services. Does not require coverage of substance abuse services. No exemptions.

South Dakota (*full parity; enacted 1998*). Requires that insurers cover mental health benefits. Does not address coverage of substance abuse benefits. No exemptions.

Tennessee (*limited parity; enacted 1998*). Requires that insurers cover mental health benefits. Does not address coverage of substance abuse benefits. Exempts companies with 2 to 25 employees.

Texas (*limited parity; enacted 1997*). Requires that insurers cover mental health benefits. Does not address coverage of substance abuse benefits. Exempts companies with 50 or fewer employees.

Vermont (*full parity; enacted 1997; effective 1998*). Requires coverage of both mental health and substance abuse services. Does not exempt small employers.

Virginia (*full parity; enacted 1999*). Requires coverage of all "biologically based mental illnesses," including substance abuse. Exempts companies with 25 or fewer employees.

Information on the status of parity legislation was provided by Pamela Greenberg, M.P.P., Executive Director, American Managed Behavioral Healthcare Association (AMBHA), Washington, D.C. Legislative analyses were prepared by Darcy E. Gruttadaro, J.D., of AMBHA.

ASAM MEMBER SPURS CONNECTICUT LEGISLATION

Peter O. Rostenberg, M.D., FASAM

ASAM member Peter O. Rostenberg, M.D.,FASAM played a key role in enactment of a law requiring that all hospitals and clinics adopt protocols for screening patients for alcohol and drug problems, and further requiring that physicians and other health professionals receive formal training in "alcohol and substance abuse prevention, screening, assessment and referral" as a condition of graduation.

Dr. Rostenberg reports that this accomplishment is the result of what he characterizes as a "change in policymaking culture" in the state capital. Dr. Rostenberg says that "all three branches of government are beginning to show genuine interest in reducing the human and economic costs of substance abuse. Legislators talk about possibilities among themselves and with others. Proposed bills stream to various legislative committees. Laws are being passed. We are beginning to fracture the useless dichotomy between drug policy and alcohol policy."

Using the new ER screening law as an example of this change in the policymaking process, Dr. Rostenberg points to the law's requirement that all clinical entities that treat injured patients develop protocols to screen for alcohol- and drug-related problems, that the protocols be approved by the state Department of Health, and that the entities provide the state with proof that the protocols actually are used. He recalls that these provisions initially were written to cover only patients hospitalized with alcohol-related injuries. However, the bill's sponsor promised to find the funding to support extension of the provision to emergency departments, demonstrating—as Dr. Rostenberg points out—"how determined Connecticut legislators are to facilitate the screening process"!

He also notes that, in addition to requiring that state schools graduating physicians and eight other categories of health care professionals implement a plan for substance abuse education that has been approved by the state Board of Higher Education, the law requires practicing professionals in those nine categories to take continuing education courses in the subject.

Summing up this successful effort, Dr. Rostenberg—who serves on the ASAM Board of Directors representing Region III—notes with pride that "Connecticut ASAM members played an important role at each step of this process. The work of the task force and its offspring, the Alcohol and Drug Policy Council, was responsible for the incredible change in attitudes that we now see." He adds that "more new laws and policy changes leading to improved care and greater efficiencies are expected."

The text of the Connecticut law follows:

An Act Concerning Substance Abuse Emergency Room Screening and Training and Education for Health Professionals (Public Act No. 98-201)

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Each institution of higher learning licensed or accredited under section 10a-34 of the general statutes to offer a degree qualifying a person for licensure in medicine, advanced practice nursing, psychology, clinical social work, professional counseling, alcohol and drug counseling or marital and family therapy or as a registered nurse or a physician assistant shall present to the Board of Governors of Higher Education, on or before December 1, 1998, an implementation plan for creating courses of instruction on alcohol and substance abuse prevention, screening, assessment and referral and requiring each student to take such a course as a condition of receiving a degree. Not later than January 1, 1999, the Board of Governors shall submit a report on the implementation plans to the joint standing committees of the General Assembly having cognizance of matters relating to education and matters relating to public health, in accordance with section 11-4a of the general statutes.

Sec. 2. *(NEW)* (a) Each hospital licensed by the Department of Public Health as a short-term general hospital, outpatient surgical facility or outpatient clinic shall include in the record of each trauma patient a notation indicating the extent and outcome of screening for alcohol and substance abuse. For purposes of this section, "trauma patient" means a patient of sufficient age to be at risk of alcohol and substance abuse with a traumatic injury, as defined in the most recent edition of the International Classification of Disease, who is admitted to the hospital, is transferred to or from an acute care setting, dies or requires emergent trauma team activation.

(b) Each such hospital shall establish protocols for screening patients for alcohol and substance abuse and shall annually submit to the Departments of Public Health and Mental Health and Addiction Services a copy of such protocols and a report on their implementation.

Sec. 3. *(NEW)* The Department of Mental Health and Addiction Services, after consultation with the Department of Public Health, shall assist each hospital required to conduct alcohol and substance abuse screening pursuant to section 2 of this act with the development and implementation of alcohol and substance abuse screening protocols.

Sec. 4. The Department of Mental Health and Addiction Services, after consultation with the Department of Public Health and health care providers, shall develop model continuing education standards for alcohol and substance abuse screening, assessment and referral for health care providers licensed in medicine, advanced practice nursing, psychology, clinical social work, professional counseling, alcohol and drug counseling or marital and family therapy or as a registered nurse or a physician assistant. Not later than January 1, 1999, the department shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health, in accordance with section 11-4a of the general statutes.

Sec. 5. This act shall take effect from its passage, except that sections 2 and 3 shall take effect October 1, 1998.

RESOURCES

Fighting for Parity in an Age of Incremental Health Care Reform: A Battle Against Discrimination in the Health Care Industry *by Ken Libertoff, Ph.D., National Mental Health Association, January 1999, 90 pages (copies can be purchased from the National Mental Health Association, 1021 Prince St., Alexandria, VA 22314-2971; phone 703/684-7722; e-mail* ***mking@nmha.org***). This volume chronicles the successful effort to enact parity legislation in Vermont. *Fighting for Parity* is potentially useful to every ASAM chapter and member, as it suggests basic steps to take in forming broad coalitions, preparing to introduce parity legislation, and working with legislators to build their understanding, support and sponsorship of parity bills.

The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits *(DHHS Pub. No. SMA 98-3205), Substance Abuse and Mental Health Services Administration, September 1999 (copies available at no charge; order from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686)*. This analysis from the Substance Abuse and Mental Health Services Administration provides estimates of the cost of parity at various benefit levels, and examines the experiences of specific states that have adopted parity legislation.

Milliman & Robertson's Premium Estimates for Substance Abuse Parity Provisions for Commercial Health Insurance Products. ASAM was a co-sponsor of this important report by Milliman & Robertson, which provides actuarial and management consulting services to a majority of commercial managed care organizations. ***www.health.org/pubs/insur/***.

The Economics of Drug Treatment: A Bibliography *by William S. Cartwright, Ph.D. National Institute on Drug Abuse.* This 38-page bibliography, prepared by a health economist, is a valuable resource for demonstrating the cost-effectiveness of addiction treatment. (Can be downloaded from the NIDA web site at ***www.nida.nih.gov***; click on "Health Services Research".)

Cocaine Affects Men's, Women's Brains Differently

Long-term frontal lobe effects from cocaine appear to differ in men and women. In previous studies, cocaine use has been associated with cardiac infarcts, cerebral infarcts, depression and neuropsychological abnormalities, as well as neurochemical abnormalities that indicate brain injury. Such studies have shown that female cocaine users have fewer abnormalities in the frontal lobe than do male cocaine users. Also, female cocaine users have better treatment outcomes than do male cocaine users.

Dr. Linda Chang and fellow researchers from the departments of neurology and radiology at the UCLA School of Medicine and the department of psychiatry and human behavior at the King-Drew Medical Center in Los Angeles set out to investigate persistent neurochemical changes in the frontal lobes of abstinent crack cocaine-dependent men and women. They used a localized proton magnetic resonance spectroscopy ('H-MRS) to detect any difference in subtle biochemical markers of brain injury in the frontal gray and white matter of the brain.

All subjects showed normal results on neurological examinations, negative HIV test, and negative urine tests. Drug use history showed that 62% used marijuana intermittently and 74% used nicotine, while 72% used caffeine regularly. Those using alcohol and/or opiates were excluded from the study. A sample of 58 normal, non drug-using controls (50% female, average age = 30.5 years) served as a comparison group.

Several of the cocaine users showed minor abnormalities such as small basal ganglia infarcts and small discrete periventricular white matter lesions. There were no differences in MRI abnormalities between men and women.

The women used more cocaine than the men and for a longer period of time. The 1H-MRS studies permitted study of a previously inaccessible area of the brain, an area where cocaine is theorized to exert major effects and injury. Compared to normal controls, the frontal brains of abstinent cocaine-dependent subjects showed evidence of neuronal damage and subsequent reactive protective and restorative proliferation of the supporting glial cells. These findings were no different in men and women cocaine users in gray-matter regions. However, in white-matter regions, men showed evidence of greater neuronal loss and women showed a greater response by the glial cells.

These findings are similar to previous studies that found cocaine-dependent women to have fewer perfusion abnormalities in the frontal lobe than the cocaine-dependent men. According to the authors, "The etiology of this gender effect of cocaine is unknown; conditions associated with female gender (e.g., hormonal differences) may have a protective effect for cerebral insult due to cocaine." These long-lasting brain effects may be related to findings that women who are cocaine-dependent have better treatment outcomes than men.

Source: American Journal of Psychiatry, September 1999. (Reprint requests to Dr. Linda Chang, Department of Neurology, 1000 West Carson St., B-4, Harbor-UCLA Medical Center, Torrance, CA 90509.)

Early Tobacco Use Predicts Later Drug, Alcohol Problems

Individuals who begin smoking before age 13 are significantly more likely than nonsmokers and those who begin smoking later to have drug and alcohol problems, according to a recent study. Researchers Eleanor Z. Hanna and Bridget F. Grant also found that younger smokers are more likely to have a lifetime diagnosis of major depression.

Hanna and Grant reached these conclusions based on data gathered from the 1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES). The survey included 42,862 respondents ages 18 or older. Diagnoses of depression and drug use disorders were made based on questions from the Alcohol Use Disorders and Associated Disabilities Interview Schedule (AUDIS). The survey also asked respondents about the onset, duration and volume of daily smoking and about any family history of alcoholism. Investigators found that 15% of the sample were lifetime drug users, 6% met criteria for either lifetime abuse or dependence, and 10% met criteria for a lifetime diagnosis of major depressive disorder.

Men, non-Blacks, younger people, married people, those of a lower socioeconomic status, and those with less than a high school education were most likely to begin smoking before age 13. Early smokers also were more likely to have a family history of alcoholism. Smokers who began early were more likely to be current smokers and were significantly younger at age of onset of depressive symptoms. They were significantly more likely to have a lifetime diagnosis of any depressive disorder, including major depressive disorder.

Early-onset smoking was associated with a higher likelihood of meeting *DSM-IV* criteria for drug dependence and abuse than later smokers or nonsmokers. They were likely to begin using drugs at a younger age and to be lifetime drug users.

Based on these data, the authors concluded that early smoking is predictive of drug use, depressive disorders and alcohol use disorders and that all three are more likely to cluster in a single family. The association of these behaviors lends support to the hypothesis that a common factor may underlie all the disorders.

Source: Alcoholism: Clinical and Experimental Research, September 1999. (Reprint requests to Eleanor Z. Hanna, Ph.D., National Institute on Alcohol Abuse and Alcoholism/DBE, Willco 514, 6000 Executive Blvd., MSC7003, Bethesda, MD 20892.) ■

Tobacco Settlement Funds to be Released to States

The national tobacco settlement, first announced in November 1998, reached final approval status on November 12, 1999. A judge's ruling in Virginia cleared the way for release of funds to the 46 states involved in the historic agreement, as well as the District of Columbia, American Samoa, Northern Mariana Islands, Guam, the U.S. Virgin Islands and Puerto Rico. States that have not reached formal approval of the Master Settlement Agreement include Alabama, Arizona, Arkansas, Missouri, New Jersey, and Tennessee. (Minnesota, Florida, Texas, and Mississippi are not included in the master agreement because they reached separate settlement agreements with the tobacco companies.)

Final approval of the settlement was achieved seven months earlier than stipulated in the Master Settlement Agreement, which provided that the settlement would become final when either 80% of the states representing 80% of the tobacco payments exhausted their individual appeals processes, or on June 30, 2000, whichever came first.

With final approval, the payments will move from interest-bearing escrow accounts to state treasuries. Funds will be sent only to those states and other political entities that have reached "state specific finality," in which all legal challenges to the agreement between the state and the tobacco companies have been cleared.

Eligible states were to receive their first payment by early December, followed by payments in January and April of 2000. Tobacco payments will continue in perpetuity and are expected to total about $206 billion nationwide over the next 25 years.

Other Settlement Terms

Also under the settlement:

- More than 14,000 tobacco billboard advertisements have been torn down or replaced with anti-smoking messages.
- Outdoor advertising is banned on all public transit systems and in public arenas, stadiums, shopping malls, and video arcades.
- Joe Camel, the infamous icon of tobacco marketing to children, has been retired, along with all other cartoon characters used to advertise tobacco products.
- Tobacco merchandise popular with young people—such as hats, shirts, backpacks, and trinkets—was banned as of July 1, 1999.
- Two of three industry trade groups that helped hide the truth about the effects of tobacco use on public health have been dissolved. The final trade group is to be dissolved 45 days after final approval of the tobacco settlement.
- A web site, ***www.tobaccoresolution.com***, containing all formerly secret tobacco industry documents uncovered in state lawsuits, is now available for public viewing on the Internet.
- Tobacco sponsorships have been severely restricted, including a total ban on events that have significant proportions of young people in attendance.
- Free samples of tobacco products, which were widely available as handouts or through the mail one year ago, are now permitted only in all-adult facilities.
- Payments for tobacco product placement in movies, videos, and other media are banned.
- Lobbying against a variety of tobacco control laws and ordinances is banned. Consent decrees, bolstered by a $54 million industry-financed national enforcement fund, have been filed in every state.
- The American Legacy Foundation, which will oversee a sustained $1.45 billion nationwide public education campaign, was created in March 1999 and has established a web site at ***www.americanlegacy.org***.

Spending the Windfall

The next step in the process is in the hands of state lawmakers, who will decide how the funds are to be spent. The National Conference of State Legislatures (NCSL) reports that state legislators are seeking public input and weighing competing demands to choose how best to spend the tobacco funds. Even so, a number of health groups have charged that many states see the money as a budget windfall, rather than a tool to reduce smoking.

According to an analysis of state budgets and tobacco bills by NCSL, the Campaign for Tobacco Free Kids, and the Center for Social Gerontology, only three cents of every dollar going into the states this year will go to reduce smoking. "The states have used pitifully little of the money for the purposes the lawsuits were originally brought for," says Clifford Douglas, an attorney and tobacco control advocate.

Only 15 of the 46 states that are part of the settlement have allocated settlement funds to tobacco control programs, according to legislation tracked by the three groups. Of the allocations to date, more than 30% is earmarked for health care services, about 23% is set aside for education, 11% goes to tobacco control and smoking cessation programs, 10% is spent on non-health related children's services, and 9% provides for services to the elderly. The remaining funds (about 17%), have been set aside for various general fund needs and budget reserve accounts.

Some states are establishing endowments, trust funds, foundations and separate general fund accounts. Kansas, Louisiana and Minnesota established endowments—which continue to grow while only the interest is spent—to provide new initiatives with funding in perpetuity. North Carolina created a nonprofit corporation that will oversee spending half the settlement money each year to assist tobacco-dependent and economically affected communities. New Hampshire, New Jersey, Maine, Montana and Wyoming have chosen to establish separate accounts within their budgets and appropriated tobacco funds for health care, tobacco cessation and education purposes.

Arkansas, Illinois, Iowa, Missouri, New Mexico, Ohio and Pennsylvania have created task forces or commissions to seek public input. Kansas' Children's Cabinet will advise the governor and legislature on spending from the Kansas Youth Endowment Fund. Louisiana's governor is required to establish a separate tobacco fund section in his annual budget proposal to the legislature. Commission members and a Board of Trustees with considerable health experience will make decisions on allocating the funds to health and tobacco control in North Carolina and Virginia.

In some states, observers report that competition for settlement funds threatens to divide health groups that usually are allies. "It's brother against brother and sister against sister. It's going to be a real battle," said one Maryland legislator.

Sources: Washington Post, November 27, 1999; Richmond (VA) Times-Dispatch, November 19, 1999; Press release, National Conference of State Legislatures, November 16, 1999; Press release, National Association of Attorneys General, November 12, 1999; Bloomberg News Service, November 12, 1999.

Justice Dept. Files Suit Against Tobacco Industry

The U.S. Department of Justice has filed a multi-billion dollar civil lawsuit against the tobacco industry in an effort to recoup federal funds spent on health care for smoking-related illnesses. The lawsuit also will seek to force the industry to finance smoking education and cessation programs. In filing the civil suit, the Justice Department announced that there are no "pending criminal division investigations" of the tobacco industry, signaling the end of the long-standing criminal investigation.

The federal government spends approximately $20 billion a year to treat smoking-related diseases, and statutes of limitations will permit the government to go back three years to recover costs under the Medical Care Recovery Act and six years under the Medicare law governing health payments for the elderly.

The suit also includes a civil RICO (Racketeer Influenced, Corrupt Organizations Act) charge, which has no statute of limitations, and will allow the government to seek a portion of any "ill-gotten" tobacco industry profits since 1954, when tobacco executives met in New York to discuss a public relations campaign countering scientific evidence about the dangers of smoking.

The 131-page complaint charges the five largest cigarette companies and their public relations and research associations with engaging in a 45-year conspiracy to mislead, defraud and conceal from the American public and the federal government the deadly and addictive effects of smoking.

The case has been assigned to U.S. District Court Judge Gladys Kessler, who was appointed to the federal bench by President Clinton in 1994 and has a reputation for encouraging out-of-court settlements. Judge Kessler has vowed to keep the lawsuit moving along, but warned that it won't go to trial until January 2003. "It is a long way down the road," Kessler said. "If it is going to trial, that is the time frame I am hoping to meet." There is a good possibility, she added, that the case would be resolved before it reaches trial, either by a dismissal or by a settlement.

The tobacco industry is in a position to wait until the next presidential administration, hoping that the president will be less committed to the case. Government lawyers argue that the suit will be far enough along by then that dropping the suit would be difficult.

Judge Kessler gave the industry until December 27 to file motions to dismiss the case. The Justice Department has until February 25, 2000, to respond, and arguments on the motions will be held on April 24.

Source: Wall Street Journal, November 22, 1999; Reuters News Service, November 19, 1999; USA Today, September 23, 1999.

CDC Reports Little Progress in Reducing U.S. Smoking

Smoking rates in the U.S. have remained virtually unchanged in the last decade, according to a recent report from the Centers for Disease Control and Prevention (CDC).

Some 48 million Americans, or 24.7% of the adult population, smoked in 1997. This rate was unchanged from 1995. According to the survey, 27.6% of men and 22.1% of women smoked in 1997, with the highest smoking rates among 18 to 44 year olds.

CDC officials say the smoking rate among 18 to 24 year olds, which rose from 24.8% in 1995 to 28.7% in 1997, probably is the result of growing levels of teen smoking. "For the first time that we've been collecting data, there are as many young adult smokers, 18 to 24, as there are middle-age smokers," said Michael Eriksen, director of the CDC's Office on Smoking and Health.

The survey also found 26.7% of blacks, 25.3% of whites and 20.4% of Hispanics smoked regularly in 1997. Adults who lived below the poverty line were more likely to smoke than those who lived above the poverty line, and high school dropouts were three times more likely to smoke than college graduates.

About 44.3 million adults described themselves as smokers who had quit. As a result, the CDC expects to fall short of its goal to reduce smoking to 15% of the adult population by 2000.

Eriksen commented, "During the 1990s, we've made virtually no progress whatsoever. The fact that we can't get rates below 25% really speaks to the addictive power of nicotine."

Source: Morbidity and Mortality Weekly Report, November 5, 1999.

HHS, States Not Enforcing Synar Amendment

The U.S. Department of Health and Human Services and many state governments have failed to enforce the 1992 Synar Amendment, which was designed to prevent the sale of tobacco

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▶ **TOBACCO NEWS** *continued from page 23*

products to minors, says a study by the Substance Abuse Policy Research Program at Wake Forest University's School of Medicine.

Under the Synar amendment, a state's performance in reducing underage tobacco purchases is linked to continued federal funding for substance abuse treatment and prevention. While there are laws prohibiting the sale of tobacco to minors in every state, the study, published in the *Archives of Pediatric and Adolescent Medicine*, found that most states and U.S. territories have neglected to properly investigate whether or not the laws are enforced. Very few states have implemented effective enforcement programs, and national surveys confirm that there has been no measurable reduction in the availability of tobacco to youth, explained the study's author, Dr. Joseph DiFranza, a professor at the University of Massachusetts Medical School.

Meanwhile, the *Providence (RI) Journal* has reported that eight states could lose millions in federal drug treatment grants for poor compliance with the Synar amendment. According to the *Journal*, a total of $37 million in federal money could be lost by eight states because they failed to meet the requirements of the Synar amendment, which requires states to meet targets for limiting minors' access to tobacco.

Sources: Archives of Pediatric and Adolescent Medicine, October 13, 1999; Providence (RI) Journal, September 22, 1999. ■

RESOURCES

State Facts on Tobacco and Cancer. Data from all 50 states on tobacco use among high school students, adults, lung cancer mortality and medical costs related to smoking can be accessed at ***www.health.org/pubs/qdocs/tobacco/state***, or by contacting the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345 or by phone 1-800/729-6686.

State Tobacco Control: 1999 Highlights. This report from the Centers for Disease Control and Prevention provides state-based data for all 50 states and the District of Columbia concerning tobacco use, the impact of tobacco control measures, costs, laws, et al. Order by phone at 1-888/CDC-FAXX, or visit the CDC's web site at ***www.cdc.gov/tobacco***.

Best Practices for Comprehensive Tobacco Control Programs. Designed to help states plan and carry out effective tobacco control programs, this report from the Centers for Disease Control and Prevention can be ordered by phone at 1-888/CDC-FAXX, or by visiting the CDC's web site at ***www.cdc.gov/tobacco***.

NIDA Research Report: Nicotine Addiction. This compilation of scientific information from the National Institute on Drug Abuse discusses nicotine addiction and its harmful effects. The report is available on NIDA's website at ***www.nida.nih.gov/ResearchReports/Nicotine/Nicotine***, or from the National Clearinghouse on Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345.

TREATMENT NEWS

Alcohol Use May Cause Cocaine Relapse

Patients treated for cocaine dependence who drink during aftercare are highly likely to relapse, especially if they are currently alcohol dependent, according to a study published in the *Journal of Studies on Alcohol*.

Investigators James R. McKay and colleagues at the University of Pennsylvania studied the effect of alcohol consumption on cocaine relapse in a sample of cocaine-dependent patients who had just completed a four-week intensive outpatient rehabilitation program. Subjects were enrolled in aftercare at the time of the study.

Subjects were diagnosed at entry into aftercare using the Structured Clinical Interview for DSM-III-R (SCID). Three possible alcohol diagnoses were derived: none, past diagnosis only, and current diagnosis. Subjects were followed up at three and six months using the timeline follow-back technique and the Cocaine Relapse Interview (CRI). Subjects also were required to provide two urine samples each week.

One or more days of cocaine use were reported by 34.7% of subjects in months one to three and by 45.6% of subjects in months four to six. Average days of cocaine use in months one to six was 4.71%. Alcohol use was reported by 34.4% of subjects in months one to three and 38.6% in months four to six. Researchers found that of the three alcohol diagnoses—current dependence—compared to the other two, was associated with greater cocaine use during aftercare. These patients also had a higher percentage of days drinking during follow-up (11% compared to 4% to 5% for the other two categories of alcohol diagnosis).

Drinking frequency in months one to six was found to predict cocaine relapse in the next month. In addition, subjects who relapsed reported that they were more likely to consume alcohol in the week prior to the day of their episodes than patients who had "near misses."

Investigators concluded that drinking during treatment and aftercare was "consistently associated with worse cocaine use outcomes." Current alcohol use was more important than past history of alcohol use in predicting cocaine relapse.

Source: Journal of Studies on Alcohol, October 1999. (Reprint requests to Dr. McKay, Treatment Research Center, Dept. of Psychiatry, University of Pennsylvania, School of Medicine, 3900 Chestnut St., Philadelphia, PA 19104.)

Effectiveness of Twelve Step Programs Studied

A recent study confirms that weekly participation in Twelve Step programs, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), helps persons in recovery to maintain their abstinence for up to two years after completing addiction treatment.

In an article published in the *American Journal of Drug and Alcohol Abuse*, investigator Robert Fiorentine, Ph.D., reported the results of a series of interviews conducted with alcohol and drug treatment clients.

A sample of clients who received treatment at 26 Los Angeles area treatment programs completed the UCLA Client Needs-Services-Outcomes Questionnaire while in treatment, at a six-month follow-up, and at a 24-month follow-up. The investigator examined the resulting data to learn whether there was an association between AA attendance and abstinence from alcohol and other drug use.

Results indicated that Twelve Step attendance was associated with reduced drug and alcohol use. Analyses also indicated that subjects who persisted in attending Twelve Step programs over time were significantly less likely to have used drugs or alcohol than were subjects who dropped out.

Fiorentine found that subjects who attended Twelve Step programs were not more motivated to stop alcohol and drug use than subjects who did not, nor was participation in treatment aftercare the cause of Twelve Step participants' higher levels of abstinence. Thus, it did not appear that AA involvement was simply a proxy for a more motivated subject.

The investigator postulated that weekly or more frequent attendance at Twelve Step programs may be effective in maintaining long-term drug and alcohol abstinence. He recommended that treatment providers encourage and assist their clients in Twelve Step participation.

Source: American Journal of Drug and Alcohol Abuse, September 1999. (Reprint requests to Dr. Robert Fiorentine, UCLA Drug Abuse Research Center, 1640 South Sepulveda Blvd, Suite 200, Los Angeles, CA 90025.)

Naltrexone Reduces Craving in Heavy Drinkers

Naltrexone, an opiate antagonist used to treat alcohol dependence, works both by reducing the urge to consume alcohol and by making drinking less pleasurable, according to an article published in the journal *Alcoholism: Clinical and Experimental Research*.

Dr. Dena Davidson and colleagues compared the effects of naltrexone versus placebo on drinking in a social bar setting in a sample of heavy beer drinkers. Subjects were randomly assigned to receive either 50 mg/day of naltrexone or an identical amount of placebo. After seven days of treatment, subjects' alcohol consumption was tested. Subjects were gathered in a local bar or restaurant and their drinking was videotaped to determine how much they drank, how long to their first sip of beer, and how long it took them to finish a beer.

After a seven- to 14-day washout period, subjects switched medication groups and were again observed in the bar setting. Subjects also completed a number of subjective measures asking about their urges to drink, positive and negative affect while drinking, mood, and side effects of the medication. Subjects could consume up to five beers, at which point they were "cut off" from further alcohol consumption.

Investigators found that there were significant differences in consumption, mood and drinking behavior between naltrexone and placebo groups. Naltrexone group members consumed fewer beers (3.4 versus 3.9) and took longer to finish the beers they drank than placebo subjects. They reported lowered urge to drink, found drinking less stimulating and reported fewer positive affects while drinking. They also experienced negative side effects of naltrexone while drinking, including nausea and headaches. All findings reached statistical significance.

The authors concluded that naltrexone's effect on drinking is mediated by several different components, including blocking cravings for alcohol, reducing positive effects of drinking and increasing negative side effects of drinking.

Source: Alcoholism: Clinical and Experimental Research, October 1999. (Reprint requests to Dena Davidson, Ph.D., Institute of Psychiatry Research, 791 Union Dr., Indianapolis, IN 46202.) ■

FUNDING NEWS

January 31 is Deadline for Smoking Cessation Grants

Letters of intent must be submitted by January 31, 2000, for research on new smoking cessation interventions to help women quit smoking before, during and after pregnancy. The Robert Wood Johnson Foundation will fund up to $11.5 million in grants in Phase II of its Smoke-Free Families initiative.

The Foundation reports that public and private organizations are eligible to apply. Public-private partnerships—involving community-based clinics, health plans, and university-based researchers, for example—are encouraged. Potential sites of the research might be prenatal clinics, private physician offices, hospital clinics, group practices, health plans, health departments, home visiting programs, family resource centers, and other health care or research settings.

An abstract and the full text of the Call for Proposals is available at the Foundation's web site, ***www.rwjf.org***. Once at the site, click on "Applying for a Grant," then "List of Open Calls for Proposals."

Source: Press release, The Robert Wood Johnson Foundation, October 24, 1999. ■

Ruth Fox, 1895-1989

Ruth Fox Memorial Endowment Fund

Dear Colleague:

As another year draws to a close and a new century is upon us, we wish to thank those whose generosity and continued support have helped to secure the future of the Society and addiction medicine. Your additional contributions and pledges to the Endowment Fund bring us closer to our goal of $3 million by the Year 2000. Only $37,000 is needed to reach the goal. There still is time to make your tax-deductible contribution to the Endowment.

We wish to extend to you and your family our warm wishes for a wonderful holiday season and a happy and prosperous New Year.

For information about making a pledge, contribution, bequest, memorial tribute, or to discuss in confidence other types of gifts, please contact Claire Osman at 1-800/257-6776.

Max A. Schneider, M.D., FASAM, Chair, Endowment Fund
Jasper G. Chen See, M.D., Chair Emeritus, Endowment Fund
Claire Osman, Director of Development

As of October 25, 1999 — Total Pledges: $2,963,000

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Annually Semi-Annually Quarterly Monthly *(circle one)*.

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Contributions to the Endowment Fund are tax deductible to the full extent of the tax laws.

Please make check payable to the **Ruth Fox Memorial Endowment Fund**

▶ **PLACEMENT CRITERIA**
continued from page 1

"The *PPC-2* is a strong complement to our clinical values....We recognize that it is a necessary component in determining effective treatment planning for people with substance abuse problems and their providers."

Ian Shaffer, M.D.,
ValueOptions
Chief Medical Officer

ASAM published the *PPC-2* in cooperation with the Coalition for National Clinical Criteria, a group of approximately 50 representatives of treatment providers, managed care professionals, federal and state health and addictions agencies, and the major professional and trade associations of counselors, state alcohol and drug agency directors, physicians and other treatment professionals.

To support use of the criteria, ValueOptions has provided comprehensive ASAM *PPC-2* training for all of its clinical staff. Led by *PPC-2* developers Dr. David Mee-Lee and Gerald Shulman, M.A., the training consists of a combination of didactic lectures, clinical case exercises, and case consultation.

"As Chair of the ASAM Criteria Committee and the Coalition for National Clinical Criteria, I find it very gratifying that a major managed behavioral health care organization like ValueOptions has chosen to use the ASAM PPC as its chemical dependency utilization management criteria," commented Dr. Mee-Lee. "This places ValueOptions in an increasing pool of organizations and government agencies that have adopted the ASAM PPC." ■

INDEX TO ASAM NEWS VOLUME 14

The following index lists subjects covered in **ASAM News** in 1999 by issue and page number. Issue dates and corresponding numbers are: January-February (**Number 1**), March-April (**2**), May-June (**3**), July-August (**4**), September-October (**5**), November-December (**6**). Thus, an article cited as **1:3** appeared in the January-February 1999 issue on page 3.

ASAM CONFERENCE CALENDAR

2000

March 3-5
Medical Review Officer Training Course
Marina del Rey, California
19 Category 1 CME credits

April 13
Ruth Fox Course for Physicians
Chicago, IL
7 Category 1 CME credits

April 13
Pain and Addiction: Common Threads
Chicago, IL
7 Category 1 CME credits

April 14-16
ASAM's 31st Annual Medical-Scientific Conference "Addiction Medicine Enters the New Millennium"
Chicago, IL
21 Category 1 CME credits

July 28-30
Medical Review Officer Training Course
Chicago, IL
19 Category 1 CME credits

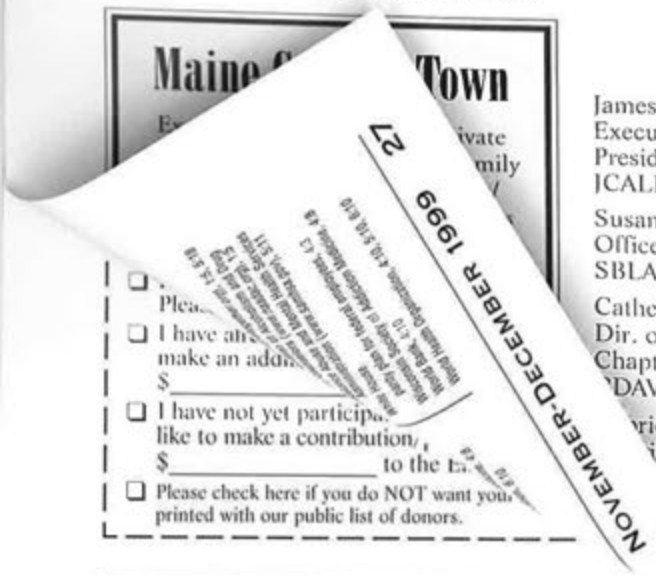
October 26-28
Review Course in Addiction Medicine
Chicago, IL
21 Category 1 CME credits

November 18
ASAM Certification Examination in Addiction Medicine
Los Angeles, CA
Chicago, IL
Newark, NJ
5 Category 1 CME credits

November 30
Forensic Issues in Addiction Medicine
Washington, DC
7 Category 1 CME credits

December 1-3
Medical Review Officer Training Course
Washington, DC
19 Category 1 CME credits

[For information on ASAM Conferences, call the ASAM Conference staff at 301/656-3920 or visit the ASAM web site at www.asam.org.]



OTHER EVENTS OF NOTE

January 22-23
American Academy of Addiction Psychiatry Review Course on Addiction Psychiatry
Albuquerque, NM
[For information: 913/262-6161]

January 29
Gender Differences in Addiction and Recovery
Smithsonian Institution
Washington, DC
[For information: 202/357-3030]
(Co-sponsored by the National Institute on Drug Abuse and the Society for Women's Health Research)

February 4-6
Florida Society of Addiction Medicine
13th Annual Meeting
Orlando, FL
[For information: 850/484-3560 or e-mail fsam.asam@usa.net]

February 13-14
National Council on Alcoholism and Other Drug Dependencies
Substance Abuse Symposium for Medical Professionals
Montgomery, AL
[For information: 334/262-1629]
(ASAM is a cooperating organization)

February 29-March 4
Southern Coastal International Conference
Jekyll Island, GA
37 Category I CME credits
[For information: 912/638-5530]

March 3-4
Washington Society of Addiction Medicine
Fundamentals of Addiction Medicine
Seattle, WA
[For information: 425/261-3690 or e-mail JSackett@Providence.org]

March 29-April 2
2000 International Conference on Physician Health:
Recapturing the Soul of Medicine
Seabrook Island, SC
(Co-sponsored by the American Medical Association and the Canadian Medical Association]
[For information: 312/464-5073]

April 9-12
American Methadone Treatment Association Conference 2000
San Francisco, CA
[For information: 856/423-7222, ext. 350]
(Jointly sponsored by ASAM)

May 7-10
Drug Use/HIV/Hepatitis:
Bringing It All Together—
A Research and Practice-Based Conference on Prevention, Treatment, Care
Baltimore, MD
[For information: 877/565-3693]
(Co-sponsored by the Center for Substance Abuse Treatment, the National Institute on Drug Abuse, and the Centers for Disease Control and Prevention)

September 22-24
Addictions 2000:
Prevention of Substance Use Problems:
Directions for the Next Millenium
Cape Cod, MA
[For information: www.elsevier.com/locate/addictions2000]

ASAM STAFF

[Except where noted below, ASAM staff can be reached by phone at 301/656-3920, or by fax at 301/656-3815]

James F. Callahan, D.P.A.
Executive Vice President/CEO
JCALL@ASAM.ORG

Susan Blaz
Office Manager
SBLAZ@ASAM.ORG

Catherine Davidge
Dir. of Membership & Chapter Relations
CDAVI@ASAM.ORG

Janice Falwell
Meetings Assistant
JFAL@ASAM.ORG

Joanne Gartenmann
Exec. Assistant to the EVP
JGART@ASAM.ORG

Sandy Schmedtje Metcalfe
Director of Meetings & Conferences
SMETC@ASAM.ORG

Peter Miller
Office of Finance
PMILL@ASAM.ORG

Claire Osman
Director of Development
Phone: 212/206-6776
Fax: 212/627-9540
ASAMCLAIRE@AOL.COM

Christopher Weirs
Credentialing Project Manager
CWEIR@ASAM.ORG

Bonnie B. Wilford
Editor, ***ASAM News***
Phone: 703/538-2285
Fax: 703/536-6186
BBWILFORD@AOL.COM