ASAM NEWS

JANUARY-FEBRUARY 2000 VOLUME 15, NUMBER 1

NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

INSIDE

A Report from the ASAM Presidents...

Addiction Medicine — Where We've Been: Assessing 50 Years of Progress

G. Douglas Talbott, M.D., FASAM
ASAM Immediate Past President

In the 1950s and early 1960s, a handful of men and women held a shared belief that impelled them to action: Ruth Fox, Stan Gitlow, LeClair Bissell, Percy Ryberg, Marty Mann, Brinkley Smithers and others all held the conviction that alcoholism was a preventable and treatable disease.

Those were the days of "drunk tanks," when public inebriates were locked up in jail, when alcoholics were committed to mental asylums, and when hospital bylaws expressly forbade the admission of alcoholics. In those days, nearly everyone — physicians and laypersons alike — felt that alcoholism and other drug addictions were moral weaknesses. The federal and state governments had little, if any, interest. And there certainly was no concept of a special field called "addiction medicine."

Today, we have two institutes of the National Institutes of Health dedicated to research on the

TALBOTT *continued on page 12*

Addiction Medicine — Where We Are Now Confronting the Challenge of Changing Times

Marc Galanter, M.D., FASAM
ASAM President

ASAM's goal is to make treatment for addictive disorders a health benefit for all Americans who need this care. To this end we are putting forth a report on problems and solutions in the managed care arena, and working closely with government and insurers as well. Our stated policy is that "benefit plans for the treatment of addictive disorders, in both the public and private sectors, shall be comprehensive and should provide identical coverage and funding to those benefits covering physical illness, with the same provisions, lifetime benefits, and catastrophic coverage."

Our study of access to addiction treatment has identified striking and disturbing trends in the funding of addiction treatment benefits by employers, as well as in the design and utilization of addiction treatment benefits. As part of that study, we asked Hay Group

GALANTER *continued on page 14*

Addiction Medicine — Where We're Going Science and Society in the New Millennium

Andrea G. Barthwell, M.D., FASAM
ASAM President-Elect

That the treatment of addictive disorders will become a standard basic health benefit, and that physicians who specialize in addiction medicine will receive training and board certification in the treatment of these disorders, may seem to some to be a fading dream — an ideal that some early visionaries held when the health care system was stable, when monies for training were available, when treatment programs were being established rather than merged or closed, and when public and private funds for treatment was plentiful.

In our current era of managed care, when addiction too often is defined not as a disease but as a "behavioral disorder," ASAM's mission may sound naive and romantic. But rather than succumb to despair, let us review the giant strides we have made and are making.

BARTHWELL *continued on page 16*

NIDA Report Upholds ASAM's Treatment Principles

James F. Callahan, D.P.A.

Thirteen fundamental principles characterize effective addiction treatment, according to a new publication from the National Institute on Drug Abuse (NIDA). The principles affirm policies set forth in ASAM's educational programs, publications and public policy statements. As presented in the monograph, *Principles of Drug Addiction Treatment: A Research-Based Guide*, they are:

1. **No single treatment is appropriate for all individuals**. Matching treatment settings, interventions, and services to each patient's problems and needs is critical.
2. **Treatment needs to be readily available**. Treatment applicants can be lost if treatment is not immediately available or readily accessible.
3. **Effective treatment attends to multiple needs** of the individual, not just his or her substance use. Treatment also must address the patient's associated medical, psychological, social, vocational, and legal problems.
4. **Treatment needs to be flexible** and to provide ongoing assessment of patient needs, which may change during the course of treatment.
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness**. The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about three months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment**. In therapy, patients address motivation, build skills to resist drug substance use, replace their alcohol or drug use with constructive and rewarding activities, and improve their problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.
7. **Medications are an important element of treatment for many patients**, especially when combined with counseling and other behavioral therapies. Methadone and levo-alpha-acetylmethadol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol dependence. Nicotine patches or gum, or an oral medication such as bupropion can help persons addicted to nicotine.
8. **Patients with co-occurring mental health and substance-related disorders should have both disorders treated in an integrated way**. Because these disorders often occur in the same individual, patients presenting with one condition should be assessed and treated, as necessary, for the other.
9. **Medical detoxification is only the first stage of addiction treatment** and, by itself, does little to change long-term alcohol or drug use. Medical detoxification does, however, manage the acute physical symptoms of withdrawal and can be a precursor to effective treatment.
10. **Treatment does not need to be voluntary to be effective**. Sanctions or incentives in the family, workplace or criminal justice setting can significantly increase treatment entry, retention and success.
11. **Possible alcohol or drug use during treatment must be monitored continuously**. Monitoring a patient's drug and alcohol use during treatment (as through urine screens) can help the patient withstand urges to resume alcohol or drug use, and provide early evidence of relapse so that treatment can be adjusted accordingly.
12. **Treatment programs should assess patients for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases**, and offer counseling to help patients modify or change behaviors that place them at risk for infection, as well as help people who are already infected manage their illnesses.
13. **Recovery from addiction can be a long-term process**, which often requires multiple episodes of treatment. As with other chronic illnesses, relapse can occur during or after treatment episodes. Participation in self-help programs during and following treatment often helps to support recovery.

I commend the guide to you for use in advocating for your patients and your specialty of addiction medicine. Use it to educate managed care organizations, legislators and the public. You can obtain a copy of *Principles of Drug Addiction Treatment: A Research-Based Guide* (publication number BKD347) at no charge from the National Clearinghouse for Alcohol and Drug Information at 1-800/729-6686. The 47-page guide also can be downloaded from NIDA's website at ***www.drugabuse.gov***. ■

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

ATF Halts Approval of Wine Label Health Claims

Under pressure from Sen. Strom Thurmond (R-SC), the U.S. Bureau of Alcohol, Tobacco and Firearms (ATF) has halted further approvals of wine labels that claim health benefits for wine consumption. ATF officials already have approved 98 different wine labels that make such claims.

"The ill effects of alcohol are well documented," said Thurmond, whose daughter was killed by a drinking driver. "The government should not dilute the negative repercussions of alcohol consumption by allowing labels which may confuse the public."

The freeze on further approvals will remain in effect until the ATF conducts public hearings on the issue.

Source: Scripps News Service, December 13, 1999.

Surgeon General Asks Parity for Mental Health

U.S. Surgeon General David Satcher, M.D., has drawn praise from mental health advocates for a new report which, using data from the World Health Organization, shows that mental illnesses rank second only to cardiovascular disease in impact on health and productivity in established market economies like the U.S. The report also cites a variety of effective treatments available for mental disorders. "This report confirms that research about the complex workings of the brain has armed us with the knowledge needed to deliver effective treatment and better services for most mental disorders," said Donna Shalala, Secretary of Health and Human Services, on releasing the report.

While calling for parity in coverage of treatment of mental illnesses, however, the Surgeon General's report gives scant attention to addictive disorders, and then only where they co-occur with mental illness. Moreover, the National Institute of Mental Health, which worked with the Center for Mental Health Services of the Substance Abuse and Mental Health Administration to develop the report, was sharply criticized in a study released one week earlier by the National Alliance for the Mentally Ill, which charged that NIMH has failed to adequately fund research into major mental illnesses such as schizophrenia and manic-depressive disorder.

The 500-page report is available on the web at ***www.surgeongeneral.gov***. An executive summary can be obtained at no cost by calling 1-877/9MHEALTH.

Source: U.S. Department of Health and Human Services, January 4, 2000; Jenks Healthcare Business Report, December 24, 1999.

Supreme Court Hears Arguments In FDA Case

In December 1999 sessions during which attorneys presented oral arguments in a case challenging the Food and Drug Administration's authority to regulate cigarettes, several Supreme Court justices appeared skeptical of the government's arguments.

Solicitor General Seth Waxman asked the court to grant the FDA authority to regulate tobacco products because nicotine is a highly addictive substance, and new evidence shows that tobacco manufacturers manipulate nicotine content to keep smokers addicted. Justice Sandra Day O'Connor, noting that the 1938 Food, Drug and Cosmetics Act requires the FDA to regulate products that are safe and effective, asked Waxman, "Is it the position of the government that tobacco is safe and effective? If not so, it just doesn't fit." Others expressing doubts were Chief Justice William H. Rehnquist and Justices Antonin Scalia, David H. Souter and Anthony Kennedy.

Attorneys representing the tobacco industry argued that if the FDA is granted authority to regulate tobacco products, it would have to ban them outright because they are not safe. An outright ban would leave millions of smokers unable to legally satisfy their addiction, the attorneys argued, thus creating enormous economic and social policy problems. Industry attorneys also argued that Congress never explicitly authorized the FDA to regulate tobacco products.

A decision is expected in the spring.

Sources: Raleigh News & Observer, December 1, 1999; Washington Post, December 2, 1999.

Bias Against Recovering Addicts Persists

Although most Americans believe alcoholism is a disease, a new national survey has found that many people are biased against recovering alcoholics and addicts, according to the Hazelden Foundation. In a telephone survey of 1,500 adults across the U.S., 79% of respondents agreed that alcoholism is a disease. But when asked to choose between two equally qualified job candidates, one a recovering alcoholic and the other someone who never needed treatment, 47% said they would hire the applicant who never needed treatment. Only 14% said they would hire the recovering alcoholic, while 34% said they had no preference.

When the same question was presented for a recovering drug addict versus someone who never needed treatment, 60% said they would hire the person who never needed drug treatment, while 10% said they would hire the recovering drug addict and 26% percent expressed no preference.

"Obviously, more education needs to be done to help the public understand addiction and recovery," said Bob Ferguson, director of alumni relations for Hazelden. "It is unfair to discriminate against people who are recovering from this disease. Thousands of alcoholics and addicts go through treatment each year and return to healthy, productive lives....Recovering people don't need special privileges — they just need to be treated equally." On the positive side, 62% of respondents said insurance coverage for addiction treatment is just as important as coverage for diseases such as diabetes and heart disease.

Source: Hazelden Foundation press release, December 13, 1999. ■

AAFP: Medical Marijuana Evidence Lacking

The president-elect of the American Academy of Family Physicians says that "good, quality evidence that marijuana is superior to existing treatments" should be developed before physicians prescribe the drug. "If marijuana were really the wonder drug that some groups purport it to be, physicians would be in favor of prescribing it. But the fact is that the majority of patients respond very well to current, proven treatments," said Richard Roberts, M.D. of the State Medical Society of Wisconsin, who practices family medicine in Belleville, WI.

Dr. Roberts wrote in the *Milwaukee Journal-Sentinel's* on-line edition that, during his 16 years of practicing medicine, he had never found justification to recommend medical marijuana. "What would we have to lose by trying marijuana in those difficult to treat cases? What we lose — more specifically, what the patient may lose — is the chance to treat the problem with one of the medications that have survived rigorous, well-controlled studies. To do otherwise, is to risk making the problem worse by pursuing an unknown course that may cause severe side effects and even death," he pointed out. Subjecting patients to drugs that have not been proven scientifically "would be a violation of the physician's oath to do no harm," he added.

He concluded, "Science ultimately reveals secrets to conquering disease, even though the process may take longer than we would sometimes like."

Source: Milwaukee Journal-Sentinel on-line edition, January 5, 2000.

AMA: Policy on M.D. Reporting of Patients

Stuart Gitlow, M.D.
ASAM Delegate to the AMA

Twice each year, members of the American Medical Association's House of Delegates come together to deliberate a range of issues that directly affect physicians, their patients, and the general public. Our American Society of Addiction Medicine holds a voting seat within the House. At the AMA's December 1999 meeting in San Diego, ASAM was represented by Delegate Stuart Gitlow, M.D., Alternate Delegate Lloyd Gordon, M.D., and Executive Vice President James F. Callahan, D.P.A. The ASAM delegation

Delegate Stuart Gitlow, M.D.

actively participated in the activities of the House as well as in caucus activities for the Sections on Psychiatric and Preventive Medicine and in the work of the Section on Specialty Societies.

The following significant events took place at the meeting:

Reporting to State Agencies

By far the issue of most significance to ASAM members was the report of AMA's Council on Ethical & Judicial Affairs, advising that "In situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify the Department of Motor Vehicles."

This is the third time the Council has addressed this issue. Each time, the language of the report has been opposed by ASAM as an inappropriate invasion of patient confidentiality and an undue burden of potential liability for addiction medicine practitioners. (This is particularly important because Council opinions have the force of law in several states.) Given such an ethical guideline from the AMA, many physicians may feel compelled to report to the state motor vehicle agency the names of patients who have not yet entered recovery and who are continuing to drink and drive.

Despite opposing testimony from ASAM and several state and specialty societies, the House of Delegates adopted the Council's report. A summary of its implications for the practitioners of addiction medicine follows:

- Physicians should assess each patient's physical or mental impairments that might adversely affect his or her driving abilities. (Physicians who treat patients on a short-term basis may not be in a position to evaluate the extent or effect of an impairment.) Physicians should consider: (1) the physical or mental impairments that clearly relate to the patient's ability to drive and (2) the degree to which the patient's driving constitutes a clear risk to public safety.
- Before reporting to the state motor vehicle agency, the physician should discuss the risks of driving with the patient and his or her family, possibly suggesting further treatment, encouraging family intervention, and attempting to negotiate a workable plan.
- Physicians should use their best judgment in determining when to report impairments that could limit a patient's ability to drive safely. In situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving is ignored, it is desirable and ethical to notify the Department of Motor Vehicles.
- The physician's role is to report medical conditions that would impair safe driving, as dictated by his or her state's mandatory reporting laws and standards of medical practice. The actual determination of an individual's ability to drive safely falls entirely within the purview of the Department of Motor Vehicles.
- The physician's responsibility to report should be disclosed and explained to patients.
- Physicians should protect patient confidentiality by ensuring that only the required information is reported and that reasonable security measures are used in handling that information.
- Physicians should work with their state medical societies to create statutes that uphold the best interests of both patients and community, and that safeguard physicians from liability for good faith reporting.

Alternate Delegate Lloyd Gordon, M.D.

The Young Physicians Section brought forward a resolution recommending a study of diversion programs for impaired drivers. Although the Reference Committee recommended against such a study in its report to the House, ASAM and its allies prevailed and the House adopted the resolution, which calls on the AMA to: (1) study alternatives, including diversion programs, to immediate reporting of suspected impaired drivers to the DMV; (2) conduct a state-by-state survey of the

legal ramifications of reporting impaired drivers; and (3) develop model legislation to provide liability protection for the implementation of diversion programs.

Other Actions of the House

The AMA reaffirmed its support of an ASAM resolution calling for health plans to cover services for conditions that may result from patient behaviors. The resolution arose from ASAM members' reports that insurers are refusing to pay for services when an individual's behavior may (or may not) have led to the existence of a medical or surgical treatment episode.

An ASAM resolution promoting medical approaches to addiction treatment was amended to read as follows: "That our AMA continues to believe that the legalization of illegal drugs would be contrary to the best interests of the public health and that support for the positions of the Physician Leadership on National Drug Policy ought not be construed as support for such legalization."

ASAM helped to draft a series of AMA Council reports that were accepted and adopted by the House of Delegates. Among the recommendations in these reports are that "Primary care physicians should establish routine alcohol screening procedures for all patients, including children and adolescents" and "medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care."

In other action, ASAM testified in favor of a policy report on "designer drugs." Having adopted the report, the AMA is committed to oppose "the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and OTC drugs with the intent of circumventing laws prohibiting possession or use of such substances." The AMA also will pursue appropriate revisions of relevant federal laws and regulations as a means of interdicting the manufacture, distribution, or sale of such substances.

AMA staff have prepared a status report on the states' allocation of tobacco settlement funds for programs of tobacco use prevention and control. Board of Trustees Report 21 is available on-line to AMA members at ***www.ama-assn.org***.

ALLIED ORGANIZATIONS

AMA to Survey Member Societies

The AMA will survey other medical societies to determine which groups accept non-physicians as members. Staff will analyze the survey data to determine what influence such membership may have, if any, and will report back at the June 2000 meeting on the effects of non-physician membership in medical societies.

AMA staff also will review the availability of group insurance products that do not discriminate against members with mental illnesses. (Some of the current AMA-sponsored insurance plans discriminate against patients who are mentally ill).

Shortly before the AMA meeting, the National Labor Relations Board reversed an earlier decision and ruled that resident physicians are eligible as employees to organize bargaining units under the National Labor Relations Act. The AMA's new national labor organization, the Physicians for Responsible Negotiation (PRN), was established in November 1999. Extensive information is available from the AMA.

AOA: ASAM Represented at Annual Meeting

Board member William Vilensky, D.O., R.Ph., FASAM, and Past President David E. Smith, M.D., FASAM, represented ASAM at the 104th Annual Meeting of the American Osteopathic Association, where the American Osteopathic Academy of Addiction Medicine presented an educational program. ■

Dr. Vilensky (left) and Dr. Smith review the agenda for the American Osteopathic Academy of Addiction Medicine's meeting.

April 30 is Deadline to Register for Certification Exam

The deadline to register for ASAM's next Certification/Recertification Examination is April 30, 2000. The examinations, for physicians who wish to be certified/recertified in addiction medicine, 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. 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/Recertification or to request an application to sit for the exam, contact Christopher Weirs at the ASAM office by phone at 301/656-3920 or by e-mail at ***CWeir@asam.org***. ■

CHAPTER UPDATES

President Michel Sucher, M.D.

ARIZONA

Chapter President:
Michel Sucher, M.D.
Regional Director:
Richard E. Tremblay, M.D., FASAM

CME Program: President Mike Sucher, M.D., sends New Year's greetings from sunny Arizona. Dr. Sucher reports that the chapter is at work planning both a Board meeting and a statewide CME program on current issues in addiction medicine for Spring 2000. Dr. Sucher can be reached at ***Mike_Sucher@metro.com***.

CALIFORNIA

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

Region II Director Gail Shultz, M.D. and CSAM President Peter Banys, M.D., extend New Year's wishes to ASAM colleagues across the country. They report that CSAM continues to make important decisions about the chapter's future direction following the retirement of Executive Director Gail Jara. A gala honoring Ms. Jara's retirement is being planned for later this spring; details will be announced in **ASAM News**.

Transitions: Kerry Parker, CAE, of the management firm of Holland-Parlette will replace Gail as CSAM Executive Director.

New CSAM Executive Director Kerry Parker, CAE

Michael Barack, who has staffed the CSAM office for four years, has moved over to Holland-Parlette and will continue to work with CSAM, providing continuity during the transition. Gail also has agreed to continue work on some special projects on a consulting basis.

Review Course: The CSAM Review Course has been set for October 11-14, 2000, at the Miyako Hotel in San Francisco.

Contacts: CSAM's mailing address, effective January 1, is 74 New Montgomery Street, Suite 230, San Francisco, CA 94105. The new telephone number is 415/243-3322 and the fax is 415/243-3321. The Society's e-mail address remains ***csam@compuserve.com***.

FLORIDA

Chapter President: John Eustace, M.D.
Regional Director:
Richard A. Beach, M.D., FASAM

13th Annual Conference on Addictions: The FSAM Annual Conference on Addictions is set for February 4-6 in Orlando. Jointly sponsored by ASAM, 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.

FSAM has extended an open invitation to other State Chapters (and related organizations) to participate in the conference.

NEW JERSEY

Chapter President: Susan F. Neshin, M.D.
Regional Director:
R. Jeffrey Goldsmith, M.D.

Annual Meeting: President Susan Neshin, M.D., sends greetings for the New Year and the New Millennium to ASAM colleagues. Dr. Neshin reports that parity for addiction treatment will be a major topic of discussion at the chapter's annual meeting, to be held in March. Notices will be sent to all members, so watch your mail!

NEW YORK

Chapter President: Merrill Herman, M.D.
Regional Director: Lawrence S. Brown Jr., M.D., M.P.H., FASAM

Annual Meeting: President Merrill Herman, M.D., sends New Year's wishes to all, and reports that the New York Chapter is busy finalizing plans for its annual business/educational meeting, which is set for Thursday, March 23, at the Marriott Marquis Hotel in New York City. The invited speaker is John Slade, M.D., FASAM, Professor of Environmental and Community Medicine at the Robert Wood Johnson Medical School in New Jersey. Dr. Slade will address the group on "Managing Tobacco Dependence in Addiction Treatment Settings."

Conference speaker John Slade, M.D., FASAM

Dr. Herman invites all ASAM members in the TriState Area to attend the meeting.

SOUTH CAROLINA

Chapter President: Ron Paolini, D.O.
Regional Director:
Paul H. Earley, M.D., FASAM

New Officers: New officers of the South Carolina Society of Addiction Medicine, elected in December for the 2000-2001 term, are: Ron Paolini, D.O., President; Terry Clark, M.D., President-Elect; Bill Scott, M.D., Secretary; and Hugh Coleman, M.D., Treasurer. John Emmel II, M.D., assumes the office of Immediate Past President.

Physician Health Conference: SCSAM will host the International Conference on Physician Health, to be held at Seabrook Island, SC. Sponsored by the American Medical Association and the Canadian Medical Association, the conference is scheduled for March 29-April 2. Information on the conference is available from the AMA at 312/464-5073.

Conference chair Timothy Fischer, D.O., FASAM

Annual SCSAM Conference: Planning continues for the Second Annual Medical Aspects of Addiction Conference, to be held June 8-10 at Myrtle Beach, SC. A roster of outstanding speakers will address cutting-edge addiction issues, with a special focus on adolescents and the elderly.

SCSAM is seeking a grant from the federal Center for Substance Abuse Treatment to help underwrite conference costs, and is working closely with the state alcohol and drug agency in planning the event. Additional information on the conference is available from conference chair Tim Fischer, D.O., FASAM, at ***Timothy_Fischer@msn.com***.

REGION IV

Regional Director:
R. Jeffrey Goldsmith, M.D.
Alternate Director: Lee H. McCormick, M.D.

Chicago Meeting: Regional Director Jeff Goldsmith, M.D., reports that Region IV (Ohio, New Jersey and Pennsylvania) is

▶ **CHAPTER UPDATES** *continued on page 7*

CSAT Launches Internet Service to Locate Treatment Programs

Physicians and patients can identify addiction treatment facilities in any state, city or community anywhere in the U.S. easily and quickly through use of a new computer-driven service, according to an announcement by the federal Center for Substance Abuse Treatment (CSAT).

Availability of the Substance Abuse Treatment Facility Locator service was announced by Dr. Nelba Chavez, administrator of the Substance Abuse and Mental Health Services Administration — CSAT's parent agency — during a January 26 speech to the U.S. Conference of Mayors. Dr. Chavez said, "Just by typing in a zip code, the searcher can quickly retrieve detailed information on the location and services offered by nearby treatment facilities. This user-friendly and confidential locator service on the Internet will be especially helpful to health care providers, social workers, managed care organizations, consumers and anyone else who must quickly identify a specific type of treatment facility in a particular state, city or community."

The Locator pinpoints addiction treatment facilities located closest to a starting point provided by the user. It also allows users to tailor searches according to the type of service sought, offering broad categories such as "substance abuse treatment," "detoxification," or "methadone." The search can be further customized by type of payment accepted and special populations served (adolescents, pregnant women, and patients with co-occurring mental and substance use disorders, for example).

At the user's request, the Locator will continue searching for facilities in groups of five, up to a radius of 100 miles from the specified starting point. The Locator displays the name, address, telephone number and a brief list of the services available for each facility it identifies (see the accompanying example).

Other features of the Locator, according to CSAT, are (1) quick referencing of data on hotlines, crisis centers, and emergency services; (2) patient referral information on hospitals, health care providers, and social service agencies; and (3) the ability to determine in advance which treatment facilities accept various forms of public and private payment.

CSAT says that the facilities listed all are licensed, certified, or otherwise approved by their state alcohol and drug abuse agencies. Facility information (and inclusion in the Locator) are based on data submitted as part of CSAT's Uniform Facility Data Set; the data currently are published by CSAT in an annual print Directory of Drug Abuse and Alcoholism Treatment Programs.

Source: CSAT press release and SAMHSA website, January 26, 2000.

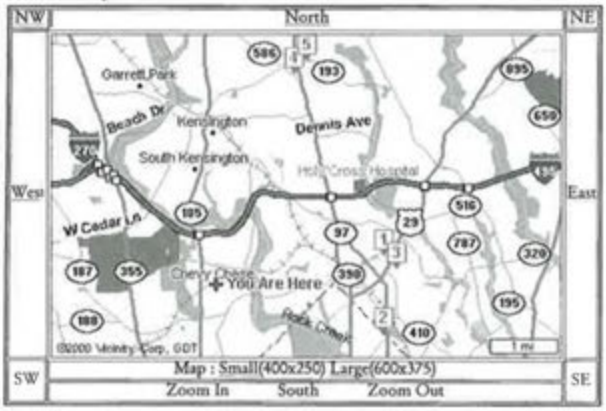
Example: Using the Substance Abuse Treatment Facility Locator, a search was launched for treatment programs nearest the ASAM office in Chevy Chase, MD. The user first called up the SAMHSA website at ***www.samhsa.gov***, then clicked on the home page selection, "Looking for help with alcohol, drug or mental health problem," and then on "Substance Abuse Treatment Facility Locator." The Locator asked for a city and state (a street address is optional). For the purpose of this example, the Locator was asked to find an intensive outpatient program that serves adolescents. No payment method was specified.

The Locator produced a list of 103 facilities within 100 miles of ASAM's address. The response screen is reproduced below:

Substance Abuse Treatment Facilities Near ...
4601 N Park Ave, Chevy Chase, MD 20815-4519

There are 103 facilities that meet your search specifications within 100 miles of your starting point.

The map below shows the location of five of these facilities, in order of distance from your starting point. The closer the facility, the lower the number on the white flag. For more information about each of these facilities, scroll down to the list below the map.



If you have any questions about the services, programs, or forms of payment accepted at any of these facilities, please contact the facility. Although the Substance Abuse Treatment Facility Locator is updated on a regular basis, it is possible that information may have changed since the last update.
Click on **Map It!** to view a detailed map for that facility.

Facility No.	Name	Address	Phone	Distance	Maps
1	Psychiatric Institute of Washington New Directions Recovery Center	4228 Wisconsin Avenue Washington, DC 20016	(202)965-8269	1.5 miles	Map It!
	Substance Abuse Services: Substance abuse treatment, Methadone/LAAM, Primary prevention, Detox **Type of Treatment:** Outpatient detox, Outpatient rehab, Intensive outpatient rehab, Hosp. inpatient detox **Special Programs:** Adolescents, Dually diagnosed, Persons with HIV/AIDS **Form of Payment Accepted:** Medicaid, Private hlth. ins.				
	Georgetown Medical *				

▶ CHAPTER UPDATES *continued from page 6*

planning a meeting during ASAM's annual Medical-Scientific Conference in Chicago (April 14-16). Check with the conference registration desk for an exact time and location.

INTERNATIONAL

Israel: Dr. Jorge Gleser reports that plans are well under way for the first Scientific Conference of the International Society of Addiction Medicine, scheduled for November 6-9, 2000, in Jerusalem. The conference, titled "Addictions 2000: Challenges and Opportunities for the New Millennium," will be hosted by the Israeli Department for the Treatment of Substance Abuse, which Dr. Gleser directs. Information is available from Dr. Gleser at ***dvdgleser@matat.health.gov.il***.

Pakistan: Ms. Sonia Sayed reports that the non-governmental organization PEACE (Project for Environmental Protection, Anti-Narcotics & Community Education) continues to offer comprehensive education and treatment services to the community, including medical detoxification and medication services provided without charge at Ahbab Hospital, Lahore. The organization is developing longer-term rehabilitation facilities at Fountain House, Farooqabad, in collaboration with The Richmond Fellowship International-Pakistan. ■

COMMITTEE REPORTS

ASAM Work Group on Screening for Alcohol Use Disorders

Jeanette Guillaume, M.A., Coordinator, Practice Guidelines Committee

The ASAM Work Group on Screening for Alcohol Use Disorders (one of four work groups of the Committee on Practice Guidelines) met in Boston in November 1999 to review the existing evidence and formulate recommendations on screening for alcohol abuse and dependence. The meeting culminated more than five years' work in reviewing the scientific literature and compiling a database of 500 relevant articles that met rigorous methodological criteria. It was on these data that the work group's recommendations were based.

After reviewing the sensitivity, specificity and patient and practitioner acceptability of screening instruments such as the CAGE questionnaire, the Michigan Alcohol Screening Test (MAST) and the Alcohol Use Disorders Test (AUDIT), the work group developed a set of draft recommendations that encourage screening at-risk and problem drinkers as well as those with overt signs of alcohol abuse and dependence.

Geoff Kane, M.D., and Terry Shaneyfelt, M.D., leaders of the screening work group, currently are preparing a manuscript that will be circulated to the work group and to the larger Guideline Committee for review and comment. The manuscript then will be distributed to a wider review group, including individuals and groups within and outside ASAM, and then finally will be submitted for publication in a peer-reviewed medical journal.

The Practice Guidelines committee anticipates that evidence-based guidelines like this one will make a contribution to improving the scientific basis for addiction medicine practice, resulting in more effective use of medical resources and better patient outcomes. ■

Med-Sci Fee Waived for Medical Students

The ASAM Board of Directors has voted to waive the registration fee for medical student members attending the Society's 2000 Medical-Scientific Conference, April 14-16 in Chicago. For more information, contact Caprice Falwell at the ASAM office of Conventions & Meetings, 301/656-3920.

PEOPLE IN THE NEWS

Louis E. Baxter, Sr., M.D., FASAM

Louis E. Baxter, Sr., M.D., FASAM, has been appointed to the National Advisory Council of the federal Center for Substance Abuse Treatment (CSAT), for a term that extends through 2003. The Council is charged with advising the CSAT Director and senior staff on current issues in addiction treatment and methods of improving services to the agency's multiple constituencies.

Dr. Baxter, who is Medical Director of the Physicians Health Program of the Medical Society of New Jersey, has been a member of ASAM since 1989 and was certified in addiction medicine in 1992. Among his many activities in ASAM, Dr. Baxter chairs the Cross-Cultural Clinical Concerns Committee and is a member of the Physician's Health, Membership, Forensic Medicine, and Ruth Fox Course committees. He also has chaired the Ambulatory Detoxification Committee of the Pennsylvania Department of Health and Human Services Bureau of Drug and Alcohol Programs. Dr. Baxter has held faculty positions at Temple University School of Medicine, Rutgers University School of Medicine, and Penn State University. He is a member of the Mercer County (NJ) Medical Society and the Medical Society of New Jersey, a Fellow of the Academy of Medicine of New Jersey, and an Associate of the American College of Legal Medicine.

A graduate of the University of Pennsylvania and Temple University School of Medicine, Dr. Baxter completed a residency in internal medicine at the Cooper Hospital University Medical Center, Camden, NJ, and trained in addiction medicine at the Portsmouth (VA) Psychiatric Hospital.

Will W. Ward, M.D.

The American Medical Association has bestowed its prestigious President's Citation for Service to the Public on the Jefferson County (KY) Medical Society for its work in establishing an outreach program called The Healing Place. ASAM member Will W. Ward, M.D., of Louisville, KY, who has been instrumental in developing the program, received the award at the December 1999 meeting of AMA's House of Delegates.

Dr. Ward and his colleagues created The Healing Place to provide shelter for homeless individuals and an innovative program of care and recovery for addicted, needy people in the Louisville area. Services offered include emergency shelter, a sobering-up center, a motivational track, a residential recovery program, and transitional housing. The program has expanded to three different facilities in the center city of Louisville. In the homeless shelter, The Healing Place serves over 26,000 free meals a month and provides 400 clean shelter beds. At the next level of care, 60 men and 30 women are enrolled in the site-based, residential, extended recovery program, participating in recovery dynamics classes, community meetings, Twelve-Step meetings, life skills workshops, health care and self-care training, and personal study. All medical services are provided free, either through on-site clinics operated by volunteer physicians or in volunteer physicians' offices, or through clinics staffed by physicians and medical students. Overall program support and oversight is provided by the Jefferson County Medical Society.

Donald R. Wesson, M.D.

Donald R. Wesson, M.D., FASAM, has joined DrugAbuse Sciences, Inc., a privately held specialty pharmaceutical company dedicated to addiction care, as Vice President, Clinical Development. Dr. Wesson originally joined the company as a member of its Scientific and Medical Advisory Board in 1998.

Dr. Wesson has been the Scientific Director of Friends Research Associates in Berkley, CA — a collaborative group of researchers dedicated to expanding the treatment options for addiction care. Previously Dr. Wesson was the medical director and scientific director for MPI Treatment Services, a chemical dependency treatment program at Summit Medical Center in Oakland, California. Dr Wesson started his medical career as Chief Psychiatrist at the renowned Haight-Ashbury Free Medical Clinic in San Francisco, followed by 13 years in private practice during which he conducted the first of many clinical trials of pharmacotherapies for addiction. ■

IN MEMORIAM

Maxwell N. Weisman, M.D.

ASAM founding member and Past President Maxwell N. Weisman, M.D., died January 2 at his home in Baltimore, MD. He was 87.

Dr. Weisman served ASAM as President from 1973 to 1975, and was the founder of the Ruth Fox Course for Physicians, which he chaired from 1980 to 1987. He also enjoyed a distinguished career as an educator, administrator, lecturer, world traveler, and author of *Relapse/Slips: Abstinent Alcoholics Who Return to Drinking*. "He was really a pioneer in the recognition of alcoholism as a medical disease," recalled ASAM Past President G. Douglas Talbott, M.D., FASAM. "Alcoholism was not known or considered a disease, and he was instrumental in helping to get that process started," Dr. Talbott added.

Dr. Weisman graduated magna cum laude from the City College of New York in 1930 and earned a master's degree in sociology at Columbia University in 1931. Throughout the 1930s, he taught biology at the City College of New York, where he earned his doctorate in 1936.

After several years at the University of Puerto Rico as a visiting professor of biology and acting director of veteran's education, Dr. Weisman traveled through Europe and enrolled in medical school at the University of Amsterdam, where he earned his medical degree in 1958. He then moved to Baltimore, where he took a psychiatric internship at the University Hospital and subsequently became associate chief resident at the hospital's Psychiatric Institute.

In 1962, Dr. Weisman was named director of community psychiatric services for the state Department of Mental Hygiene, later moving up to direct its Division of Alcoholism Control. He retired from that agency in 1980 and concentrated on treating patients in private practice, lecturing on alcoholism, and serving as a consultant to companies interested in establishing employee assistance programs. He traveled extensively and served as an advisor on the establishment of alcohol treatment programs to government agencies and non-governmental organizations in Russia and other Eastern European countries.

Dr. Weisman is survived by two nieces and two nephews. A memorial service was to be arranged by the National Council on Alcoholism and Other Drug Dependencies. ■

ASAM Board Honors Drs. Bromley, Weisman

ASAM's Board of Directors has voted that the Society's 2000 Medical-Scientific Conference will be dedicated to the memory of Jess W. Bromley, M.D., FASAM, and Maxwell N. Weisman, M.D., whom it cited as "pioneers in addiction medicine and in the establishment and growth of ASAM." In addition, the 2000 Ruth Fox Course for Physicians will be dedicated to the memory of Dr. Weisman, who helped establish the course and served as its chairman from 1980 to 1987.

Heated Heroin Damages Brain

Heating and then inhaling heroin, called "chasing the dragon," is popular because users believe it protects them against transmission of HIV and other diseases associated with injecting the drug. But Dr. Arnold Kriegstein and colleagues from Columbia University and other New-York based medical centers report that the practice puts heroin users at risk for untreatable brain damage, with death from progression of brain damage occurring in nearly 20% of cases.

According to researchers, regular inhalation of vapor produced by heating powdered heroin on aluminum foil could result in a rare brain disorder called progressive spongiform leukoencephalopathy. The brain damage is permanent, with more serious symptoms emerging as the person grows older.

"There is a certain heroin chic surrounding this mode of use that gives it an ominous appeal among the more affluent users," Kriegstein explained. "So our concern is that more patients may develop this illness, which is extremely grave and has no known treatment. Patients may improve gradually over months to years, but most patients do not return to normal."

Source: Neurology, November 1999.

Smoking Activates Cancer Gene In Women

A gene that increases lung cancer risk is more active in women than in men, and may explain why female smokers are more than twice as likely to develop lung cancer than men, according to researchers at the University of Pittsburgh.

According to the study, the gene, found on the X chromosome and linked to lung cell growth, is activated by cigarette smoke. Dr. Jill Siegfried, a University of Pittsburgh researcher and co-author of the study, said, "Men have to smoke for this gene to kick in. But women don't have to smoke at all for the gene to be active. This may be why nonsmoking women are more susceptible to lung cancer."

Source: Journal of the National Cancer Institute, January 5, 2000.

Marijuana Linked to Head and Neck Cancers

A new study has linked past marijuana smoking with an increased risk of cancers of the head and neck, according to researchers at the UCLA School of Public Health. They find that head and neck cancer, which often takes 30 to 40 years to develop, may be related to smoking marijuana.

In the first statistical study to look at the relationship between marijuana smoking and head and neck cancer, including cancers of the tongue, throat, mouth, and voicebox — investigators compared a group of 173 patients who had cancer of the head and neck with 176 blood donors without cancer. They asked the subjects questions concerning age, lifestyle, alcohol intake, cigarette smoking and marijuana use. Adjusting for the effects of alcohol and cigarette use, they found a relationship between the frequency of marijuana use and the disease. In other words, the number of marijuana cigarettes smoked and the number of years smoked had a direct relationship on the development of these cancers.

Overall, pot smokers were 2.6 times more at risk for head and neck cancer than those who never smoked marijuana.

Overall, pot smokers were 2.6 times more at risk for head and neck cancer than those who never smoked marijuana. "If they used more than one [marijuana cigarette] a day, the risk jumped to 4.9 times more than someone who never smoked," said lead author Zuo-Feng Zhang, M.D., Ph.D. Study subjects were tested for a genetic defect that predisposes to cancer. Those with the defect who smoked marijuana had a 77-fold higher risk of cancer than those without the defect.

The study also showed that smoking cigarettes increased a person's risk of head and neck cancer. Additionally, alcohol was found to be a risk factor, but it was not as strong as either the genetic risk or cigarette smoking.

Source: Cancer Epidemiology, Biomarkers & Prevention, December 1999.

Cocaine Triples Risk of Aneurysms

Cocaine use can lead to the development of aneurysms in heart arteries, researchers reported to the November 1999 Scientific Sessions of the American Heart Association. "After observing severe coronary artery aneurysms in a large number of young cocaine users, we wanted to determine if the drug was the cause of these aneurysms," said Aaron Satran, M.D., chief medical resident at Hennepin County Medical Center in Minneapolis, Minn. "Our findings strongly indicate that cocaine use is associated with an increased risk of aneurysms, and that the more cocaine consumed, the higher an individual's risk of developing an aneurysm."

The study was based on 112 individuals who used cocaine and had a history of chest pains and other cardiovascular health problems. Angiography revealed that 30% of the patients had aneurysms in a heart artery. Dr. Satran said the next step would be for researchers to identify the mechanisms involved in the association between cocaine use and the development of aneurysms.

Source: American Heart Association press release, November 9, 1999.

Alcohol Consumption Linked to Kidney Failure

More than one or two drinks a day could increase the risk of kidney failure, according to a study published in the *American Journal of Epidemiology*. Researchers Thomas V. Perneger, M.D., and colleagues at the Johns Hopkins University, Baltimore, MD, compared the drinking habits of 716 kidney-failure patients with 361 persons without kidney disease. They found the risk of kidney failure was four times greater in persons who consumed more than two alcoholic beverages per day.

Previous research has shown that alcohol increases the risk of kidney failure in persons with certain diseases. The current research is the first to link drinking with kidney disease in the general population.

Source: American Journal of Epidemiology, December 1999.

Skin Abscess Epidemic Reported Among Heroin Users

San Francisco is witnessing an epidemic of skin abscesses among heroin users, the *San Francisco Examiner* has reported.

Abscesses are a frequent side-effect of injection drug use, and health experts say they are seeing more of them. According to Joshua Bamberger, M.D., medical director for special projects at the Health Department, such abscesses now are the leading cause of admission to San Francisco General Hospital. In 1998, more than 1,000 persons were hospitalized to treat abscesses.

With most of San Francisco's estimated 17,000 injection-drug users lacking medical coverage, the epidemic is also taxing the

▶ **CLINCIAL NOTES** *continued on page 19*

Brazil: State Files Suit Against U.S. Tobacco Companies

The Brazilian state of Goas has filed suit against more than a dozen U.S. tobacco companies in Miami-Dade County Circuit Court. The action seeks to recover billions of dollars spent on treating sick smokers. The Brazilian state of Rio filed a similar suit in July 1999, which is now pending in a Texas court.

Source: Associated Press, October 18, 1999.

Canada: RJ Reynolds Affiliate Sued

The Canadian government has sued RJ Reynolds Tobacco Holdings Inc., the Canadian affiliate of the U.S. tobacco manufacturer, seeking $1 billion in damages for defrauding the government and undermining its tobacco control campaign.

In 1991, the Canadian government nearly doubled the cigarette excise tax as part of a campaign to reduce youth smoking. Soon after, the government case argues, RJ Reynolds stepped up efforts to ship black-market cigarettes into the country. As evidence of this activity, government lawyers cited data showing that whereas about 20% of cigarettes sold in Canada were bought on the black market in 1992, by 1994, that figure had increased to 40%.

"Today we are starting to prove in court that these companies named in the lawsuit have systematically and deliberately contravened not just the public health policies aimed at protecting Canadians and particularly youth from smoking, but the will of Parliament and the laws of this country and United States," said Allan Rock, Canada's minister of health.

Source: Washington Post, December 22, 1999; Bloomberg News, December 21, 1999.

Korea: First Anti-Smoking Class Action Filed

The first class action lawsuit was filed against Korea Tobacco and Ginseng Corporation in December by 31 Koreans requesting compensation for damages incurred from smoking. The plaintiffs claim the corporation knew specifically that cigarettes contained carcinogenic substances, and covered-up that fact. The plaintiff's attorney said that more victims will be added to the class action.

Source: Chosun Ilbo, December 12, 1999.

Sweden: Smoking Rates Decline, Meet WHO Targets

Less than one in five Swedish adults smoke tobacco daily, making Sweden the first and only nation to meet the World Health Organization's target for reducing smoking, according to a report published by the statistical research institute Veca.

Only 19.7% of Swedes between the ages of 16 and 84 smoked in 1998, compared to more than a third in 1980. However, the use of snuff has increased from 400 grams per person annually to 750 grams.

Source: Associated Press, September 17, 1999.

Turkmenistan: President Bans Public Smoking

Smoking will be banned in public places of Turkmenistan, President Saparmurad Niyazov announced at a government session on December 27. Niyazov, who wants to raise the life expectancy in his country, signed the decree "in the name of the health of the nation," the Interfax news agency reported. Violators will be fined the equivalent of a month's salary.

Source: Interfax News Agency, December 29, 1999. ■

ISAM and the Promise of Globalization

Nady el-Guebaly, M.D., ISAM President

As I write these lines, I am still inspired by the worldwide coverage of the millennial celebrations. Despite the hype, no major untoward event marred the joy with which we celebrated our expanded international ties and recognized the cultural bounty provided by each nation.

A sense of pride is derived from the fact that we at the International Society of Addiction Medicine (ISAM) are now able to identify and get to know physicians specializing in addiction in some 74 countries so far. The number of corresponding members today is 413, whereas 18 months ago we started with 25 names.

In its first year of operation, ISAM attracted more than 110 Founding Members, who opted to support its activities financially. The Society has three levels of dues, based on the World Bank's classification of national economies. The top level (currently $75 US per year) applies to members in the U.S. and Canada.

ISAM seems to attract established physicians, who are eager to inform and be informed by colleagues from around the world. This is happening through a network composed of a Board, eight committees, an electronic newsletter, a website and, increasingly, member-to-member communication. We have received several requests for referral of patients to recognized specialists in several countries, as well as requests for information about the effects of specific substances used by certain cultures.

We also are committed to organizing international meetings and a forum for scientific presentations, as well as more informal networking. May I seize the opportunity to invite all of you to our next annual meeting, "Addiction 2000," in Jerusalem, November 5-9, 2000?

Dr. Jorge Gleser and his organizing committee are designing a first-class scientific program. The main conference venue will be the Hotel Laromme, and a number of one- to three-day tours will be offered as options. We are assessing the feasibility of a meeting in Cairo, followed by a Nile cruise, immediately after the Jerusalem conference. The registration fee is $350 US for ISAM members and $450 US for non-members. Further information will be found on the ISAM website (***www3.sympatico.ca/pmdoc/ISAM***), as well as at the annual ASAM meeting in Chicago in April. See you there! ■

POLICY BRIEFS

Pain Relief Promotion Act: A Step Backward?

Howard A. Heit M.D., FACP, FASAM

ASAM members should know that the third meeting of the Liaison Committee on Pain (composed of representatives of ASAM, the American Pain Society, and the American Academy for Pain Management) took place in Atlanta, GA, in January 2000. One of the objectives of this committee is to promote humane and safe pain management, based on established scientific principles, to patients with or without the disease of addiction.

It is with this thought that the ASAM members of the Liaison Committee wish to alert all members of the Society to the provisions of the Pain Relief Promotion Act of 1999 (see the report, following). Comments on the act would be welcomed by the Liaison Committee and by ASAM's Pain Committee.

The Pain Relief Promotion Act of 1999: A Serious Threat to Palliative Care

In a commentary in the Journal of the American Medical Association, *authors David Orentlicher, M.D., J.D. and Arthur Caplan, Ph.D. discussed the implications of pending federal legislation on the use of controlled drugs to control pain. An abstract of their report follows:*

Recent educational efforts in the U.S. medical community have begun to address the critical issue of palliative care for terminally ill patients. However, a newly introduced bill in Congress, the Pain Relief Promotion Act of 1999 (PRPA), could dramatically hinder these efforts if enacted.

The act criminally punishes the use of controlled substances to cause or assist in causing a patient's death. The primary purposes of PRPA are to override the physician-assisted suicide law currently in effect in Oregon and prohibit other states from enacting similar laws. The act also includes valuable provisions for better research and education in palliative care, but the benefits of those provisions are outweighed by the punitive sections of the act.

Under PRPA, the quality of palliative care in the United States could be compromised when physicians, fearing criminal prosecution, err on the side of caution rather than risk their patients' deaths by using highly aggressive pain treatments. Furthermore, PRPA would put Drug Enforcement Administration officials, who have no medical expertise, in the position of regulating medical decisions. The act also would interfere with individual states' long-standing authority over medical practice. Finally, PRPA would discourage physicians from engaging in experimentation and innovation in palliative care, again out of concern for crossing the line between relief of suffering and physician-assisted suicide.

Other bills have been introduced that go much further than PRPA to encourage palliative care, without its problematic provisions. Regardless of the controversy surrounding physician-assisted suicide in the United States, the need for quality end-of-life care will be far better served if Congress enacts one of these bills rather than PRPA.

Orentlicher D & Caplan A (2000). The Pain Relief Promotion Act of 1999: A serious threat to palliative care. Journal of the American Medical Association 283(2):255-258. Reprinted by permission of the American Medical Association. ■

▶ **TALBOTT** *continued from page 1*

addictions: the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. We have a federal agency, the Center for Substance Abuse Treatment (headed by an ASAM member), whose sole mission is to improve access to and the effectiveness of addiction treatment.

And we have in ASAM a national organization of 3,200 physicians who practice addiction medicine, and who are dedicated to the belief that the treatment of addiction should be granted parity with the treatment of any other chronic relapsing disorder, that all physicians should receive education in addiction medicine, and that physicians who wish should be trained and board-certified in addiction medicine. We have a 1,300-page textbook, Principles of Addiction Medicine, that reflects the vast body of scientific knowledge in this field, and we have ASAM's Patient Placement Criteria, which have been adopted by 20 states and countless private providers.

The New Millennium invites us to consider how far we have come in establishing the field of addiction medicine, and how far we have yet to go.

Founding member Percy Ryberg, M.D.

Founding member Ruth Fox, M.D.

Founding member Stanley E. Gitlow, M.D.

The 1950s: Organizing the Movement

The New York Medical Society on Alcoholism held its first annual meeting in September 1954, with 14 physicians in attendance. The group was organized by Ruth Fox, M.D. (who was elected its first president), Stanley Gitlow, M.D., and Percy Ryberg, M.D. Dr. Fox had found that alcoholic patients in her practice did not respond to conventional psychoanalytic approaches, so she began to teach them about alcoholism as a disease, introduced them to Alcoholics Anonymous, prescribed Antabuse, and used group therapy and psychodrama as therapeutic modalities.

The 1960s: Becoming a National Presence

In 1967, the New York group — approaching 100 members — changed its name to the American Medical Society on Alcoholism (AMSA) and resolved to "henceforth be a national organization." This momentous change was reported in the Physicians' Alcohol Newsletter, published by the Society from 1965 to 1978 under the editorship of Frank Seixas, M.D. The group conducted its first national meeting in 1968 at the offices of the Medical Society of the District of Columbia.

The 1970s: Years of Growth

By 1970, AMSA's membership had reached 500. In California, Jess Bromley, M.D., and Gail Jara organized the California Society for the Treatment of Alcoholism and Other Drug Dependencies (now the California Society of Addiction Medicine) in 1973.

Under the leadership of Sen. Harold Hughes and field advocates, Congress created the National Institute on Alcohol Abuse

ASAM's first Executive Director, Emanuel M. Steindler

and Alcoholism (NIAAA) in 1971 and the National Institute on Drug Abuse (NIDA) in 1974, and approved the Career Teacher Program under the direction of Jim Callahan and Jeanne Trumble to encourage development of a cadre of medical school faculty knowledgeable about alcohol and drug addictions.

The 1980s: Unifying the Field

By the early 1980s, there were three distinct national efforts in addiction medicine: AMSA, which had grown out of the New York Society, the California Society, and the American Academy of Addictionology, organized in Atlanta, GA, by G. Douglas Talbott, M.D. to focus on impairment in physicians and other health professionals.

At the suggestion of Emanuel M. Steindler of the American Medical Association, leaders of the three groups agreed to meet to discuss a joint credentialing effort. Joan Kroc (wife of the owner of the McDonald's fast food chain) offered the use of the Kroc Ranch in Santa Barbara, CA (adjacent to President Reagan's Rancho del Cielo) as the site of the meetings, which were funded with the help of the AMA. Two "Unity Meetings" at the Kroc Ranch in 1983 brought together leaders of the New York, Georgia, and California organizations with representatives of NIAAA, NIDA, the American Psychiatric Association, and other interested groups. The meetings resulted in agreement that there ought to be a "national society of physicians" concerned with alcohol and drug addiction.

AMSA changed its name to the American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) as its membership reached 1,400. The organization acquired a full-time staff and two offices, as Mr. Steindler retired from the AMA and assumed the role of AMSAODD Executive Director in Chicago, while Claire Osman staffed an administrative office in New York. And the newsletter was reborn as ASAM News, under the editorship of Lucy Barry Robe.

Meanwhile, the California Society offered its first certification examination in 1983, followed by the new national society in 1986.

The addiction field took a major step toward unifying with organized medicine in 1988, when the American Medical Association voted to admit AMSAODD representatives to its House of Delegates. Jess Bromley, M.D., served as the society's first delegate to the AMA, with David E. Smith, M.D., as alternate delegate.

ASAM assumed its current identity in 1989, when AMSAODD members voted to change the group's name to the American Society of Addiction Medicine. Also in that year, Mr. Steindler retired as Executive Director and was replaced by Dr. James F. Callahan, who established ASAM's headquarters office in Washington, DC.

The 1990s: Striving Toward Excellence

In the 1990s, ASAM demonstrated its commitment to achieving excellence in clinical care and recognition of addiction medicine as a field of medical specialization in multiple ways. In 1992, the Society took part in the national health care reform agenda by creating a Task Force on Health Care Reform under the leadership of Sheila B. Blume, M.D. It also formed a coalition of national organizations and federal agencies to refine and promote the use of its Patient Placement Criteria. The American Council of Physicians admitted ASAM to its Council of Medical Societies, with David C. Lewis, M.D., as the Society's representative. In Washington, DC, more than 150 physicians attended ASAM's first Medical Review Officer training course, convened under the leadership of Donald Ian Macdonald, M.D.

By 1993, ASAM completed work on its "Core Benefit in Addiction Treatment," which it submitted to the White House for consideration by the President's Task Force on National Health Care Reform.

ASAM achieved another landmark in 1994 with publication of the first edition of its landmark textbook, *Principles of Addiction Medicine*, under the editorship of Norman Miller, M.D., and Martin Doot, M.D. A second edition of *Principles* was published in 1998 under the editorship of Allan W. Graham, M.D., and Terry K. Schultz, M.D. Supported by grants from the McGovern and Scaife Foundations, ASAM has sent copies of *Principles* to the chairpersons of medicine, family practice and psychiatry, and medical librarians in every medical school in the country.

The Society expanded its certification program in 1994 when it offered its first recertification examination, and inaugurated the Fellows program in 1996. To date, the program has recognized 90 Fellows who have made outstanding contributions to the Society and the field of addiction medicine.

Over the decade, ASAM expanded its Education, Credentialing, Standards and Economics of Care, Treatment and Clinical Issues, Membership and Publication programs, with the help of grants from public and private funders. Members have pledged $3 million to the Ruth Fox Memorial Endowment Fund.

2000: Into the Future

Entering the new millennium, ASAM has established itself as the preeminent organization for physicians specializing in addiction medicine. With 30 chartered State Chapters and 3,200 members, ASAM has become a national voice for the interests of addiction specialists and the patients in their care.

Through the beginning of the year 2000, ASAM has certified 3,126 physicians in addiction medicine, and recertified another 262. Moreover, the National Committee for Quality Assurance has recognized physicians certified by ASAM as providers in managed behavioral health care organizations.

▶ **TALBOTT** *continued on page 14*

PRESIDENTS

1954-1961: Ruth Fox, M.D.
1961-1962: Stanley E. Gitlow, M.D.
1963-1964: Luther A. Cloud, M.D.
1965-1966: Percy E. Ryberg, M.D.
1967-1968: Arnold S. Zentner, M.D.
1969-1970: Ruth Fox, M.D.
1971-1972: Stanley E. Gitlow, M.D.
1973-1974: Maxwell E. Weisman, M.D.
1975-1976: Charles S. Lieber, M.D.
1977-1978: Joseph Zuska, M.D.
1979-1980: Sheila B. Blume, M.D.
1981-1982: LeClair Bissell, M.D.
1983-1984: Irvin Blose, M.D.
1985-1986: Max A. Schneider, M.D.
1987-1988: Margaret Bean-Bayog, M.D.
1989-1990: Jasper Chen-See, M.D.
1991-1992: Anthony B. Radcliffe, M.D.
1993-1994: Anne Geller, M.D.
1995-1996: David E. Smith, M.D.
1997-1998: G. Douglas Talbott, M.D.
1999-2000: Marc Galanter, M.D.
2001-2002: Andrea G. Barthwell, M.D.

▶ **TALBOTT** *continued from page 13*

ASAM's current Executive Vice President/CEO James F. Callahan, D.P.A.

The U.S. Department of Defense has adopted ASAM's Patient Placement Criteria (Second Edition), as have the alcohol and drug treatment agencies in 20 states and a major national managed behavioral health firm. The Second Edition of ASAM's *Principles of Addiction Medicine* has been an outstanding success, and a third edition is planned for April 2002. ASAM's practice guidelines have been published in the Journal of the American Medical Association, and the ASAM website, under the direction of William Hawthorne, M.D., has won awards for its design and contents and attracted more than 50,000 visits. The Society also continues to publish its scholarly *Journal of Addictive Diseases* under the editorship of Barry Stimmel, M.D., FASAM.

Public policy remains a key ASAM activity, as ASAM continues to work with private-sector organizations such as the American Managed Behavioral Healthcare Association as well as federal agencies and members of Congress. In recent years, the ASAM Board has approved policy statements on the management of pain, the use of opioids, screening for addiction in primary care settings, and the relationship between self-help programs and formal addiction treatment. ASAM also played a major role in the legislative, regulatory and court battles against tobacco addiction. In 1999, ASAM persuaded the Internal Revenue Service to reverse a 20-year-old position by allowing smokers who participate in cessation programs to itemize the cost of their treatment as a medical expense.

ASAM's relationship with the American Medical Association continues to be productive, as our two representatives to the AMA House of Delegates have had input into all AMA reports and policy statements, including groundbreaking initiatives on alcohol, nicotine, and other addictive agents.

AMSA administrator Claire Osman, now ASAM's Director of Development

With guidance and support from ASAM, the International Society of Addiction Medicine formally came into being in 1999, at a meeting hosted by President and Mrs. Gerald Ford and keynoted by General Barry McCaffrey, Director of the Office of National Drug Control Policy. Delegates from over 25 countries elected former ASAM Board member Nady el-Guebaly, M.D. President of the new organization, and G. Douglas Talbott, M.D., FASAM, Vice President. The group is planning its first international scientific conference for Jerusalem in November 2000.

No doubt challenges lie ahead that will require our sustained commitment. But looking back at all that has been accomplished through the efforts of a group of visionary physicians, how can we in addiction medicine do other than to meet the future with a sense of optimism? ■

▶ **GALANTER** *continued from page 1*

to analyze trends in the proportion of employer health care dollars spent on addiction treatment benefits and to determine the value of addiction treatment benefits offered by medium and large U.S. employers.

The study found that the value of general health care benefits has decreased by 11.5% since 1988, while the value of addiction treatment benefits decreased by **74.5%**! As a proportion of the total value, addiction treatment benefits decreased from 0.7% in 1988 to 0.2% in 1998, a grave development indeed. In examining trends in the utilization of inpatient services for psychiatric and addiction diagnoses compared to all diagnoses, the Hay Group found that use of inpatient care has decreased across all categories of care. However, the decrease has been **most** dramatic for addiction treatment.

The results of the ASAM/Hay study were buttressed by research commissioned by the National Council for Community Behavioral Healthcare (NCCBH) and conducted by The Gallup Organization. This survey found that 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%).

How can a rational health care delivery system offer proper addiction treatment when the financial support for care has been cut by almost three-fourths? Working with leaders in ASAM and the larger addiction treatment field, we intend to raise this question to policymakers and purchasers of health care benefits.

> **"How can a rational health care delivery system offer proper addiction treatment when the financial support for care has been cut by almost three-fourths? Working with leaders in ASAM and the larger addiction treatment field, we intend to raise this question to policymakers and purchasers of health care benefits."**
>
> *– Marc Galanter, M.D., FASAM*

Managed Care as an Issue

The emergence of managed care has had an enormous impact on all areas of American medical treatment. ASAM's challenge is to address the effects of managed care on the addiction field in particular, and to make clear that it has been associated with a decline in the availability of rehabilitation services for the deeply compromised patients we treat. In fact, the problems associated with this decline have affected the extent and quality of employer-provided insurance coverage, access to and utilization of treatment services, benefits available under the Medicare and Medicaid programs, and the professional careers of addiction treatment professionals. In this regard, we are confronted with a number of very troubling facts:

- Alcohol and drug use disorders are among the most common health problems in the U.S., imposing a fiscal cost on society of $246 billion per year. Despite their enormous impact, these disorders are significantly undertreated. The ASAM/Hay study makes clear that the structures and practices of managed care may be significantly exacerbating this serious problem.
- The trend toward "carved out" benefits administered by for-profit "behavioral health" organizations is associated with reduced financial incentives for intensive, effective treatment. This effect is larger in the

for-profit model than in staff-model and not-for-profit managed care organizations.

- The shift toward managed care also has been associated with a dramatic reduction in the frequency and duration of inpatient hospital stays, even for patients who require this level of treatment intensity. This reduction has not been offset by a corresponding increase in the use of outpatient care. Moreover, initial positive cost containment results trumpeted by advocates of managed care often represented cost shifting rather than true cost savings.
- In a recent ASAM survey of addiction medicine specialists, a majority of respondents reported that managed care practices had exerted a negative effect on their ability to offer detoxification and rehabilitation services, often posing ethical dilemmas.

Confronting the Challenge

To address these issues, ASAM as an organization and each of us as individuals must respond constructively and forcefully. Here are some steps we can take in concert with other medical addiction treatment organizations. These steps reflect principles articulated by ASAM in its policy on a Core Benefit for Addiction Treatment:

1. We must insist that primary and specialty treatment for addictive disorders must be specifically included in any basic health benefit, not subsumed under some other category such as mental health. Further, addiction treatment must be accorded parity with medical care of other illnesses. Caps or limits on numbers of treatment visits, days or payments should be applied in the same manner as for any chronic disease. Where parity has been assured, increases in costs associated with addiction treatment have been modest. Moreover, dollars spent on addiction treatment are more than offset by significant savings in health and social costs.
2. We must work to assure that the selection of treatment modality and setting is consistent with empirically derived clinical practice guidelines (such as the ASAM *Patient Placement Criteria*) and implemented in accordance with the professional judgment of specially trained physicians and other addiction treatment staff. Health benefits also must cover the care of medical and psychiatric co-morbidities.
3. We must work to enact legislation to ensure that appropriate addiction treatment and rehabilitation are available, independent of any economic incentives or disincentives imposed by managed care organizations. Treatment should be financed from the same source as any other primary disease. Additional revenue could come from taxes on alcohol and tobacco products, but the budget for addiction treatment should not be contingent on sales of these products.
4. We must be able to hold insurers liable for any adverse results of the constraints they impose on access to needed services. This will require adoption of some version of the Patient Protection Act now pending in Congress, and continued enactment of other bills at the state level.

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 arena, even one person can make a difference. ■

MEMBERS SPEAK OUT

An Open Letter to Gov. Johnson on Drug Legalization

Steven Wright, M.D.

*Gary Johnson, Governor of New Mexico, recently announced that he favors legalizing use of drugs such as marijuana and heroin (see the November-December 1999 **ASAM News**). Here is one citizen's response to the Governor's stand:*

So you want to legalize drugs? Your proposal puts the fun back into the dysfunctional discourse on drug policy. Great entertainment, Governor, but please! Please help me understand.

Mary J. smokes pot — but only on personal time and only in the privacy of her own home. The marijuana she smokes "recreationally" one evening, however, impairs her driving to work the next day.

I also drive to work. Does Mary's right to toke and become dangerous supersede my right to get to work safely? Mary's "high" may last four hours, but her judgment and reaction time remain poor much longer, although she's not aware of it.

In one flight simulation study, impairment from pot was present 24 hours later in seven of nine trained pilots, but only one perceived the drug's effects. That's scary! The "Big Bong" theory has been confirmed: from a single hit, marijuana's effects are ever-expanding.

Let's clarify. Legalization means *elimination* of all legal consequences. No literature I know shows that legalization decreases crime overall. Allowing impaired individuals to threaten the safety of others: *that* is what we are really talking about when we consider legalizing mind-altering substances. And that's exactly why legalization is not okay.

Decriminalization, on the other hand, means *reducing* penalties. That's worth discussing. But, Governor, if you're really serious about this, convene an expert medical/public safety panel. Put an end to the showy and pedestrian debate in the public media. Let science right-size penalties to match the real danger drug use imposes on our community.

So what about this War on Drugs? I agree it hasn't worked. We've known that for quite some time. Thirty years ago, when untreated heroin addicts returned to the street from federal prison, almost all relapsed. Catch, jail, and release is unsafe for the environment and the addict. Untreated, most will continue to use drugs even though bad things happen.

This War on Drugs implies that "bad mistakes" are the cause of addiction. This war says that legal threats and consequences drive discipline, and discipline makes one clean and sober. This war kills many addicts who buy into the prescription to "be strong, not stupid." That cause, this solution turned out to be wrong — dead wrong....

This War has failed. Is that a good reason to throw in the towel? Pass out the joints and hand out the spoons?....No! It's

▶ **MEMBERS SPEAK OUT** *continued on page 19*

▶ **BARTHWELL** *continued from page 1*

Certification

ASAM certification is gaining acceptance as a credential. The National Committee for Quality Assurance (NCQA) and other accrediting organizations now recognize ASAM-certified physicians. And our CME programs offer members and other physicians high quality educational experiences in which the latest research findings and clinical practices are presented. However, this is not formal training.

We continue to make the case for granting privileges to ASAM-certified physicians. ASAM members Drs. Michael Miller, David Mee-Lee, Sheila Blume and Christine Kasser, working with representatives of the American Managed Behavioral Healthcare Association (AMBHA), have just drafted a joint ASAM-AMBHA policy statement on "Credentialing and Privileging." Once adopted, this paper can open doors for members to receive practice privileges with managed care organizations and other providers.

Specialty Status

While addiction medicine is a multidisciplinary specialty, which is now recognized by both the American Medical Association and the American Osteopathic Association, it is not yet recognized as such by the American Board of Medical Specialties. A major obstacle to recognizing addiction medicine as a specialty certified by ABMS member boards has been the lack of adequate formal training of at least one year in length associated with a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Full realization of ASAM's mission to have addiction medicine become an integral part of organized medicine, and to make treatment of addictive diseases a basic health benefit for all Americans can only be realized through the attainment of specialty status, that is, through board certification of addiction medicine by ABMS member boards. This will complement the board certification in addiction psychiatry which is now offered by the American Board of Psychiatry and Neurology and the CAQ in Osteopathic Addiction Medicine offered by the American Osteopathic Association.

Fellowship Training

Training is the necessary prerequisite to realization of ASAM's mission, and ASAM has fully committed itself to establishing accredited training, in order to fully meet this prerequisite.

In order to be accepted for consideration by the American Board of Medical Specialties (ABMS), ASAM must have fellowship programs in addiction medicine. Similarly, the primary care boards of medicine, pediatrics, family practice and others will not offer a subspecialty in addiction medicine until there is assurance that accredited training programs can be established.

Yet fellowship training remains a critical unmet need. To address this issue, ASAM is conducting a series of surveys of training opportunities, and is prepared to work unswervingly toward their establishment. Unless we do this, the Society will never achieve one of our primary goals: board recognition for addiction medicine.

Our colleagues in psychiatry are to be congratulated on the establishment of a subspecialty in addiction psychiatry. That achievement was the result of many years' intense work, culminating in the designation of 24 accredited training programs.

Parity

We have seen incremental gains on parity in recent years, but the big victories still lie ahead. In 1999, 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, 25 states have enacted some sort of parity legislation, but only six states — Vermont, Maryland, Minnesota, Georgia, Connecticut and Virginia — have language that specifically covers addiction treatment. On the plus side, some states' parity language also requires use of the ASAM Patient Placement Criteria to guide treatment decisions.

There are a number of things you can do to help us achieve full parity:

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%.

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.

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 to secure a brighter future for your community, for your patients, and for yourself. ■

"Our Society's mission...is to integrate the treatment of addictive disorders into the mainstream of health care, and to integrate the teaching of addiction medicine into all levels of medical education, including accredited training programs leading to board certification of the specialty of addiction medicine."

– Andrea G. Barthwell, M.D., FASAM

NEW IN PRINT

Treatment for Stimulant Use Disorders: Treatment Improvement Protocol (TIP) No. 33.

Center for Substance Abuse Treatment (copies available at no charge; order from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686).

Recent findings from federal and private studies have provided a better understanding of how and why methamphetamine, cocaine and other stimulants affect human behavior, and this state of the art knowledge is the basis for these new treatment guidelines for methamphetamine and cocaine addiction from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT).

The guidelines, developed by a panel of non-federal experts, provide treatment strategies that have been scientifically validated as effective in treating patients with stimulant use disorders. The guidelines are detailed in the publication, *Treatment for Stimulant Use Disorders*, which is number 33 in CSAT's Treatment Improvement Protocol (TIP) Series.

A Guide to Substance Abuse Services for Primary Care Clinicians: Treatment Improvement Protocol (TIP) No. 24.

Center for Substance Abuse Treatment (copies available at no charge; order from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686).

This set of three documents was designed by CSAT to educate primary care physicians and other health professionals about addiction treatment and to provide guidance on sound clinical and administrative practices.

Components of the set include:

- *A Guide to Substance Abuse Services for Primary Care Clinicians* (168 pages), a bound book version of TIP No. 24, which contains practical information on identifying alcohol and drug problems and initiating a discussion of the patient's substance use history and disorders, conducting brief interventions with patients in the early stages of alcohol and drug abuse, and referring more seriously alcohol- or drug-involved patients for appropriate assessment and treatment. The document includes recommendations about pharmacotherapy and legal issues surrounding privacy and confidentiality.
- *A Concise Reference Guide* (30 pages), which summarizes essential information on patient screening and assessment during the clinical interview.
- *Identifying Substance Abuse in the Primary Care Setting*, an eight-panel brochure, which provides a quick and easy-to-use tool for screening patients.

Health Effects of Exposure to Environmental Tobacco Smoke: The Report of the California Environmental Protection Agency.

Bethesda, MD: National Cancer Institute, November 1999.

This monograph compiles 18 studies to create a comprehensive assessment of the health risks of environmental tobacco smoke (ETS), including demonstrated links to lung cancer, heart disease, sudden infant death syndrome, and oropharyngeal cancer. The Centers for Disease Control and Prevention is making copies of the monograph available to state health departments. It also is available on-line at ***www.cdc.org/tobacco***.

A Guide for Providers of Mental Health and Addictive Disorder Services in Managed Care Contracting (Vol. 9 in the Managed Care Technical Assistance Series).

Produced for the Substance Abuse and Mental Health Services Administration, Rockville, MD, 1998 (DHHS Pub. No. 98-3242) (copies available at no charge; order from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686).

Drafted by a firm of health law experts, the guide provides legal guidance on contracts between providers of mental health and substance abuse services and managed care organizations. While it does not substitute for attorney review of a specific contract a provider may be asked to sign, the guide does lay out general principles for consideration, and is useful for educating board members, clinical and administrative staff members about issues that arise in contracting with managed care organizations.

Strategic Planning for Public and Nonprofit Organizations.

Jossey-Bass Inc., Publishers, 350 Sansome Street, San Francisco, CA 94104-98250; phone 1-800/9JOSSEY; fax 1-800/605-2665 (1998, $32.95).

This thoroughly revised and expanded second edition explains how leaders and managers of public and nonprofit organizations can use strategic planning to strengthen their organizations. It outlines the reasons public and nonprofit organizations should embrace strategic planning as a way of improving their performance and presents an effective planning process — Strategy Change Cycle — that has been successfully implemented by a large number of public and nonprofit organizations.

Ruth Fox, 1895-1989

Ruth Fox Memorial Endowment Fund

Dear Colleague:

We wish to extend to you and your family our warm wishes for a happy and prosperous New Year. It is with gratitude and pride we report that the Endowment reached the goal of $3 million before the new millennium. We want to thank you, our donors, for your commitment and continued support. We could not have done this without you.

Special thanks go to Elizabeth F. Howell, M.D., FASAM, long-time ASAM member and current Board member, for her very generous bequest, which put the Endowment over $3 million. This is in addition to her previous contributions. It gives us great pleasure to add her name to the Founders' Circle.

Retirement Fund Bequests: Bequests from retirement plan accounts are becoming a very attractive way to give money to non-profits because the tax advantages can be considerable. Although the contributions to, and assets in, many kinds of retirement plans are not taxed, withdrawals and distributions — whether to you or your heirs — are taxable. That means that any money in tax-deferred plans that is left to your heirs can be subject to both income and estate taxes. In some cases, these can erode up to 80% of the accounts' value. If, instead, the assets are passed to a charity, no taxes are levied and the full amount goes to the non-profit organization.

We ask you to consider a bequest from your retirement account to the Ruth Fox Memorial Endowment Fund to help secure ASAM's future. Please call to discuss this type of bequest. (Of course, final decisions should be discussed with your personal tax advisor.)

Reception: The annual Ruth Fox Memorial Endowment Fund reception is planned for Friday evening, April 14, 2000, in Chicago. Invitations will be sent to donors only.

For information about making a deferred gift, pledge, contribution, bequest, memorial tribute, or to discuss in confidence other types of gifts, please contact Claire Osman at 1-800/257-6776 or 212/206-6776.

Max A. Schneider, M.D., Chair, Endowment Fund
Jasper G. Chen See, M.D., Chair Emeritus, Endowment Fund
Andrea G. Barthwell, M.D., Chair, Resources & Development Committee
Claire Osman, Director of Development

As of January 25, 2000 — Total Pledges: $ 3,005,768

New Donors, Additional Pledges and Contributions

Founders' Circle ($25,000 — $49,999)
Elizabeth F. Howell, M.D., FASAM

President's Circle ($10,000 — $24,999)
LeClair Bissell, M.D.

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▶ MEMBERS SPEAK OUT

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not time to franchise addiction. The Japanese have a saying: fall down seven times, get up eight. The science of addiction medicine has now risen to the occasion. We can provide treatment that works as well as diabetes care.

We also can link effective medical treatment to criminal justice processes. Drug courts help make today sober for many citizens, one citation at a time, working well for both involuntary and voluntary clients, without legalization.

Laws are made to protect citizens from actual or potential violation of rights like safety. Medical care is for the treatment of addictive disease. People under the influence of intoxicants violate the rights of others, and that requires a legal response. They also deserve good treatment, and that requires a medical response.

Still want to legalize drugs? Picture this: *Crash!* That's the sound of metal on metal as Mary J. greets your car on the way to work. *Cash!* That's the sound of your insurance adjuster, who must balance the books on untreated addiction and its consequences in our communities.

Mess! That is your state on legalized drugs. Any questions? ■

Steven Wright, M.D., practices addiction medicine and family medicine in Santa Fe, NM.

▶ CLINICAL NOTES

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city's health care budget. Dr. Bamberger said that treating skin abscesses can require an eight-week stay in the hospital while patients receive aggressive antibiotic therapy to clear the bacterial infection from the bloodstream. He estimated the cost of such a hospital stay and treatment at $56,000 per patient.

To address the problem, the San Francisco Health Department has recommended that doctors and nurse practitioners staff needle exchange sites and other places where addicts congregate to treat soft tissue infections before they become worse.

Source: San Francisco Examiner, January 3, 2000. ■

NIDA Grants Available for Addiction, HIV/AIDS Research

The National Institute on Drug Abuse (NIDA) is making $1 million available in grants to study drug addiction and HIV/AIDS. Funds will be awarded to programs that currently receive federal research project grants from any agency. The grants are intended to encourage researchers to focus on the relationship between HIV/AIDS and drug use.

Deadline for grant applications is August 1. For information, contact the NIDA Center on AIDS & Other Medical Consequences of Drug Abuse by mail at 6001 Executive Blvd., Room 5198, MSC 9593, Bethesda, MD 20892-9593, by phone at 301/443-1801, or by e-mail at ***sg73f@nih.gov***.

Source: NIDA website, January 2000.

CSAT Treatment Grants Announced

Up to $30 million in grants are available from the federal Center for Substance Abuse Treatment (CSAT) to expand addiction treatment in local communities. The grants, part of CSAT's Targeted Treatment Capacity Expansion program, will provide funding to cities, towns, counties and Indian tribes with serious, emerging drug problems, or communities that propose innovative solutions to unmet needs. Award amounts range from $100,000 to $500,000.

"CSAT is interested in funding programs that provide a wide range of residential treatment services for women and children to provide a comprehensive continuum of care," said CSAT Director H. Westley Clark. "We will also give special funding consideration to applications from units of local government that propose to work with community-based indigenous racial and ethnic providers. Our experience indicates that an understanding of the client community increases access to treatment, retention in programs and positive treatment outcomes." Priority will be given to programs that identify clinical and service delivery approaches that are culturally responsive; address the clinical treatment needs of a specific population; propose approaches for outreach and retention of hard-to-reach populations; and utilize state-of-the-art treatment modalities.

Grant applications are available on-line at SAMHSA's website, or by calling 1-800/729-6686. Questions about program issues should be directed to Clifton Mitchell at

301/443-8804. Questions about grants management may be directed to Peggy Jones at 301/443-9666. Refer to announcement PA 00-001.

Source: SAMHSA press release, January 20, 2000.

SAMHSA Grants Support Conferences

Proposals are due May 10 and September 10, 2000, for conference support grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). Funds are available to support up to 75% of the total direct costs of conferences on addiction topics (to a maximum of $50,000). Such conferences must address coordinating, exchanging and disseminating knowledge to improve the provision of effective treatment, recovery, early intervention, and prevention services for individuals who suffer from, or are at risk of, problems related to mental illness and/or alcohol, tobacco or other drug abuse and addiction.

Public and private non-profit and for-profit organizations (but not individuals) are eligible to apply. To obtain a printed copy of the program announcement, contact the National Clearinghouse for Alcohol and Drug Information (NCADI) by phone at 1-800/729-6686; ask for announcement PA-99-050.

Source: SAMHSA web page, December 22, 1999.

Groups Collaborate to Fund Tobacco Research

Two federal research agencies and the Robert Wood Johnson Foundation (RWJF) are collaborating to fund a five-year project to study smoking, prevent tobacco use and deal with its consequences.

The National Institute on Drug Abuse (NIDA) and the National Cancer Institute (NCI) will spend $70 million over the next five years to create a network of Transdisciplinary Tobacco Use Research Centers at Brown University, Providence, RI; the University of California at Irvine; the University of Southern California, Los Angeles; Georgetown University, Washington, DC; the University of Minnesota, Minneapolis; the University of Wisconsin Medical School, and Yale University, New Haven, CT. The centers will focus on finding new ways to combat tobacco use and its consequences.

RWJF will contribute an additional $14 million to the initiative. The centers will focus on issues such as treatment of tobacco addiction, relapse, the behavioral elements of smoking initiation, and youth smoking prevention. "These centers promise to accelerate development of effective tobacco control interventions, speed the transfer of these applications to communities across the nation, and create a core of new tobacco control researchers," said NCI Director Richard Klausner, M.D.

Each research center will be organized around a special theme, with researchers studying a wide range of behavioral and cultural factors that contribute to tobacco use and looking for innovative treatments for tobacco addiction. In addition, the grants will be used to focus on certain areas, such as adolescent smoking, and to foster interdisciplinary collaboration among scientists.

Source: Press release, Robert Wood Johnson Foundation.

Foundation Shares Lessons in Grantmaking

The Robert Wood Johnson Foundation has released a 256-page report that contains lessons it has learned from its grantmaking experiences in the area of health care, including alcohol, tobacco and other drug addiction. The report, entitled "To Improve Health and Health Care 2000," is aimed at giving health care professionals, policymakers and the public an in-depth look at what programs a large national foundation funds, why it funds what it funds, and the lessons it has learned from its successes and failures.

"To Improve Health and Health Care 2000" is published in its entirety on the RWJF website and can be downloaded from ***www.rwjf.org***. Print copies can be purchased online from ***amazon.com*** or ordered from Jossey-Bass Publishers at ***www.josseybass.com***.

Source: Substance Abuse Funding News, December 13, 1999. ■

ASAM CONFERENCE CALENDAR

ASAM

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
ASAM 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 website at www.asam.org.]

Membership Renewals Due

Reminder!

It's time to renew your ASAM membership! Don't miss out on future issues of ***ASAM News*** and other benefits of membership.

If you have questions about your membership or renewal rates, contact Membership Manager Cheryl Kim at the ASAM office by phone at 301/656-3920 or by e-mail at ***CKim@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
National Institute on Drug Abuse
Bringing It All Together: A Research and Practice-Based Conference on Prevention, Treatment, and Care
Baltimore, MD
[For information: Keith Van Wagner at 301/443-6071]

May 8-10
South Carolina Society of Addiction Medicine
Second Annual Conference on Medical Aspects of Addiction
Myrtle Beach, SC
[For information: Timothy_Fischer@msn.com]

June 17-22
College on Problems of Drug Dependence
Caribe Hilton Hotel, Puerto Rico
[For information, fax Dr. Martin Adler at 215/707-1904]

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]

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