ASAMNEWS

NOVEMBER-DECEMBER 2000 VOLUME 15, NUMBER 6

NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

INSIDE

ASAM AT WORK FOR YOU:

ALSO SEE:

Buprenorphine Legislation Hailed as Treatment Breakthrough

Marc Galanter, M.D., FASAM

As I write this, the addiction field awaits final approval by the Food and Drug Administration of sublingual tablet forms of buprenorphine (Subutex®) and buprenorphine combined with naloxone (Suboxone®) for the treatment of opiate dependence.

The drugs represent important additions to the growing armamentarium of medications to treat addiction. Over the past five years, the National Institute on Drug Abuse (NIDA) has worked intensively with the developer, Reckitt & Colman Pharmaceuticals, Inc., to bring these products to market.

Pharmacologically, buprenorphine is related to morphine but is a partial agonist (that is, it possesses both agonist and antagonist properties). Clinical trials suggest that it offers a number of benefits in the treatment of opiate addiction:

First, buprenorphine (like most partial agonists) has a safety profile that is better than that of the full agonists such as heroin or morphine. Thus, buprenorphine is less likely to cause respiratory depression — the major toxic effect of opioid drugs — than is a full agonist such as morphine or heroin. NIDA projects that this will translate into a greatly reduced chance of accidental or intentional overdose.

Second, the withdrawal

▶ **BUPRENORPHINE LEGISLATION** *continued on page 8*

ASAM Policy on Buprenorphine

It is the policy of ASAM:

That physicians appropriately trained and qualified in the treatment of opiate withdrawal and opiate dependence should be permitted to prescribe buprenorphine in the normal course of medical practice and in accordance with appropriate medical practice guidelines, and

That federal controlled substances scheduling guidelines and other federal and state regulations should permit buprenorphine to be made available for physicians to prescribe to their patients in accordance with documented clinical indications.

(Excerpt from a public policy statement adopted by the ASAM Board of Directors, April 15, 1998)

ASAM Acts to Provide Training to MDs Who Would Use Buprenorphine

Andrea G. Barthwell, M.D., FASAM

Training and certification will be key requirements for the use of buprenorphine alone (Subutex®) and in combination with naloxone (Suboxone®) to treat opiate-addicted patients in office practice. ASAM is preparing to help physicians meet those requirements.

Under the Drug Addiction Treatment Act of 2000, qualified physicians can be approved to prescribe and dispense the drugs (as soon as they are approved by the FDA) in office practice. Qualified physicians are those who are certified by ASAM or one of the other organizations named in the law: physicians who are certified in addiction psychiatry by the American Board of Psychiatry and Neurology, or in addiction medicine by the American Osteopathic Association, or who have participated in a clinical trial of buprenorphine, or who are certified by state licensing agencies or have other training acceptable to the Department of Health and Human Services.

Physicians also may become qualified by completing an approved 8-hour training course. ASAM is working with officials of the Center for Substance Abuse

▶ **BUPRENORPHINE TRAINING** *continued on page 9*

ASAM Joins Coalition for Parity in Health Benefits

James F. Callahan, D.P.A.

ASAM has joined with Physician Leadership for National Drug Policy (led by ASAM member David C. Lewis, M.D.), Join Together and other leading national organizations and federal agencies (including the Center for Substance Abuse Treatment) to form a working group aimed at winning parity in health insurance benefits, so that addictive disorders are treated in the same way as other chronic diseases.

The group, called the "Coalition on Alcohol and Drug Addiction Treatment," is focused on achieving parity at the state level by working with the Coalition's chapter affiliates and other state constituents to educate legislators and other policymakers, and to form state-level action groups to promote parity.

At its most recent meeting, the Coalition selected six states as the focus of initial efforts toward parity: Arizona, California, Florida, Hawaii, New York and Wisconsin.

The next step is to develop an action plan that engages ASAM's members and the members of the Coalition's other partner organizations. Jeff Blodgett, who directs the Alliance Project, is developing an outline of an organizing process for review by ASAM Chapter Presidents and members.

To help us understand how things stand in your state, I have asked ASAM Chapter Presidents and members to respond to the following questions:

1. Are alcohol and drug addiction and treatment issues discussed much among legislators and other policymakers (including the medical societies in your state) now?
2. Do you think they have an understanding of how big the problem of addiction may be in your state?
3. Has there been much talk of parity among advocates or among your colleagues?
4. Which other groups, leaders and allies should be part of the conversation about mounting a parity legislative campaign?
5. What other legislative priorities around alcohol and drug treatment, prevention or related subjects do these groups have?
6. Can you think of some natural legislative allies who could help us push parity? Are they in positions of power?
7. Would you be willing to come to some kind of an initial organizing meeting in your state to talk about this? Would you be willing to help get some others there?

Any information you can provide will help to move this vital cause forward ■

Lawmakers Seek Support for Parity Legislation

In the Congress, Rep. Jim Ramstad (R-MN) and Sen. Paul Wellstone (D-MN) recently co-hosted hearings to heighten awareness of alcohol and drug addiction, which Rep. Ramstad has called "the Number 1 public health and safety issue in America."

The pair continue to work for greater visibility on the part of recovering persons and a shift in funding away from interdiction and toward demand reduction. In particular, Rep. Ramstad has criticized the $1.3 billion in drug aid the U.S. sent to Colombia, saying it could have funded treatment for 200,000 Americans. "The United States has misdirected its priorities," he said. "In 1972, when Richard Nixon began the war on drugs, 60% of federal funds went to treatment. That figure has fallen to 18%."

ASAM member H. Westley Clark, M.D., J.D., FASAM, Director of the federal Center for Substance Abuse Treatment, testified at the hearing that adding drug and alcohol treatment to the premiums of health care plans would raise premium costs by only 0.2%. ■

American Society of Addiction Medicine

4601 North Park Ave., Suite 101
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ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

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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).

Supreme Court to Hear Medical Marijuana Case

The U.S. Supreme Court has agreed to hear a Justice Department appeal of a ruling that would allow marijuana to be distributed for medical purposes.

The case pits the federal government against the Oakland (CA) Cannabis Buyers' Cooperative. That group has been in conflict with federal officials since 1996, when California voters approved a ballot referendum approving the distribution of marijuana to patients for medical purposes.

In 1998, Judge Charles Breyer of the U.S. District Court of San Francisco, CA, ruled in favor of the Justice Department and barred the Oakland club from openly distributing marijuana. However, a U.S. appellate court subsequently ruled that Breyer should amend the injunction to allow the club to provide marijuana to those who can prove that the drug is a "medical necessity." In July, Judge Breyer allowed the club to give marijuana to persons facing "imminent harm" from serious medical conditions and to those who did not respond to legal drugs for which marijuana is said to be an alternative.

The Justice Department appealed the appellate court decision to the U.S. Supreme Court, saying the case presented "an issue of exceptional and continuing importance." Federal officials claimed that the appeals court disregarded the provisions of federal law, which bans marijuana distribution outside strictly controlled circumstances, and thus undermined enforcement of federal drug laws.

The Supreme Court is scheduled to hear arguments in the case early in the new year. A decision could be made as early as June.

Source: Reuters News Service, November 27, 2000.

.08% Drinking and Driving Standard Adopted

President Clinton has signed into law a transportation bill that punishes states that fail to adopt a drinking and driving standard of 0.08% blood-alcohol content. It is expected that the .08 limit will save 500 lives a year, of the more than 15,000 Americans expected to be killed in alcohol-related crashes in the year 2000.

Under the new law, states that do not adopt the 0.08% standard will lose up to 8% of their annual federal highway aid. The penalties will be phased in gradually, starting at 2% in fiscal 2004, moving to 4%, 6% and 8% in successive years. A state could recover the lost funds if it complies with the national standard before September 30, 2007. After that date, the funds, which could amount to tens of millions of dollars, would be permanently lost.

Meanwhile, public support for stricter standards appears strong. A recent study by Mothers Against Drunk Driving (MADD) found that 72% of American drivers questioned favored lowering the legal blood-alcohol limit from 0.10 to 0.08 to keep impaired drivers off the roads. In addition, 65% of those surveyed thought a federal law requiring states to lower the limit was needed.

Source: American Medical News, November 13, 2000; Wall Street Journal, October 4, 2000; Associated Press, September 6, 2000.

ASAM Weighs in On Drug Testing of Pregnant Women

An ASAM policy statement has been cited in an *amicus* brief submitted to the U.S. Supreme Court, hearing a case to determine whether a hospital has the right to report pregnant women who test positive for illicit drugs. The case, *Crystal M. Ferguson, et al. v. The City of Charleston, SC, et al.*, arises from the Medical University of South Carolina's practice of working with local prosecutors to identify women who test positive for cocaine use. As a result of that testing, 10 women have been arrested either during pregnancy or immediately after giving birth.

The suit claims that the hospital's policy violates the women's constitutional protection against unreasonable searches. Attorney Robert Hood, who represents city and state officials in South Carolina, counters that the hospital's program meets the "special governmental needs" exception to the Fourth Amendment because of the health problems in offspring and resulting financial costs associated with maternal cocaine use.

The amicus brief cites ASAM's policy on "Chemically Dependent Women and Pregnancy," which says that "State and local governments should avoid any measures defining alcohol or other drug use during pregnancy as 'prenatal child abuse,' and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health services for these women." The statement also calls for "appropriate and accessible chemical dependency treatment services" for pregnant women and their offspring.

The plaintiffs argue that the drug testing policy actually drives women away from prenatal care and treatment programs. Before the case reached the Supreme Court, a federal appeals court ruled that drug testing was a necessary and effective step in helping mothers and their children. The appellate court found that the intrusion on the mothers' privacy was minimal. Moreover, the judges ruled that a urine sample is a normal part of a pregnant woman's medical examination, so any infringement on her rights was negligible.

Attorneys representing the plaintiffs argue that to conduct such a search without a warrant, the government must show that the search is not driven by the priorities of law enforcement. "The women entered the care of the hospital as free citizens," they wrote, adding that "They were assured by the hospital that their medical records would be treated as confidential. This deceptive scheme strikes at the core of the physician-patient bond, undermining [the women's] trust and confidence."

Source: Washington Post, September 22, 2000.

Lawsuits Seek to Block Funds for Faith-Based Treatment

A number of U.S. states are faced with lawsuits against allowing faith-based organizations to receive federal funding for providing services such as addiction treatment. A suit recently filed in Wisconsin, for example, is trying to block the use of state funds for Faith Works, a Milwaukee program that helps troubled fathers by providing treatment and job training.

Even as the U.S. Congress adopted charitable choice language that gives religious organizations a greater role in addiction treatment and other publicly funded services [*see* ***ASAM News****, July-August 2000*], opponents moved to the courts to challenge such funding, arguing that it blurs the line between church and state.

"It's absolutely incredible to believe you can have a religiously based program that isn't religious," said the Rev. Barry Lynn, executive director of Americans United for Separation of Church and State. The group is tracking the dozen or so lawsuits against state policies allowing religious organizations to provide social services.

But Rep. Mark Souder (R-IN) believes that religious groups have the community ties needed to provide effective services.

▶ **ADM NEWS** *continued on page 12*

FROM THE PRESIDENT'S DESK

ASAM Offers Members New Benefit

Marc Galanter, M.D., FASAM

I am pleased to report to you that ASAM has joined with Medem, the e-health network, to offer every ASAM member an exciting new practice opportunity.

Medem was established in October 1999 by the American Medical Association in partnership with the American Academy of Ophthalmology, the American Academy of Pediatrics, the American College of Allergy, Asthma and Immunology, the American College of Obstetricians and Gynecologists, the American Psychiatric Association, and the American Society of Plastic Surgeons. Its rapidly expanding network already consists of organizations whose membership includes more than two-thirds of American physicians.

ASAM is the 20th society to partner with Medem. We expect that a number of additional medical societies will join the Medem network over the next few months, in order to deliver both customizable physician Web sites and integrated secure e-mail to their members. The time is right; in fact, a recent Medem national survey of physicians found a doubling of the number of physicians who have developed Web sites for their practices, and a tripling of the number of physicians' offices that use e-mail to communicate with patients.

Our partnership with Medem offers ASAM members an important new avenue to educate patients and the public and to improve the treatment of individuals suffering from alcoholism or other addictions. As you well know, many of your patients search the Web for health information and then turn to you for clarification. To help you respond to this phenomenon, ASAM and Medem used Medem's *Your Practice Online*™ service to build a full-service practice Web site for you, complete with clinical information for your patients.

Medem™ Empowered by Leading Medical Societies

ASAM's goals in this venture are to help you:

- **Save Time**: Patients can go to your Web site for answers to common questions.
- **Save Money**: As an ASAM member, you have access to *Your Practice Online* with no start-up, hosting or maintenance fees.
- **Help Patients**: Through your custom Web site, you can provide your patients with comprehensive, credible information. Because the information comes from ASAM, you can rely on it to be accurate and up-to-date. Our partners at Medem will be sure it is presented in patient-friendly language. You will have the option of using all of the content material or selecting those portions that best fit your practice.

You will be notified by fax and e-mail when your Web site is available for your review. You'll also receive a brochure from Medem that explains the features of *Your Practice Online*. Please take a moment to review this brochure when it arrives, and also visit the Web site at ***www.yourpracticeonline.com***. (For more information about Medem, visit their Web site at ***www.medem.com***.)

Medem staff will conduct a workshop at the 2001 ASAM Med-Sci Conference to help members fully explore the potential of the e-health marketplace. One of the features of the workshop will be a "hands-on" discussion of how to add enhancements to your personal Web site.

For the sake of your practice and your patients, I strongly urge you to take full advantage of this exciting new benefit available to you as a member of ASAM. ■

DRUG TRENDS

New "Club Drug" Appears in U.S.

PMA, a new designer drug that is sometimes substituted for Ecstasy, is being blamed for a number of deaths among young clubgoers, media reports suggest. PMA (paramethoxyamphetamine) is similar to Ecstasy but gives users a less-intense high. Some illicit drug laboratories have formulated the cheaper PMA to resemble Ecstasy, right down to the pill size, color and logos.

As a result, when users take PMA and get a poor buzz, some are tempted to take more of the drug, thinking it's just weak Ecstasy. That can be fatal, because PMA's side-effects include hyperthermia. Ecstasy overdose deaths, on the other hand, are considered rare.

PMA is only now showing up on the U.S. rave scene. In one Chicago suburb, an 18-year-old girl died after taking what she thought was ecstasy, but in reality was PMA. The drug caused her temperature to soar to 108 degrees, causing her internal organs to shut down.

Resource Note: A recent publication on "club drugs" from the U.S. Drug Enforcement Administration is now available on ASAM's Web site.

"High-Energy" Malt Beverage Reaches Market

A malt beverage containing vitamins as well as alcohol was scheduled for a national roll-out in September, according to a California beverage maker. The Hard E Beverage Co. of Corona, CA, is marketing a malt beverage that is a mixture of beer, vodka, vitamins and ginseng. The manufacturer claims that the combination allows users to get a "buzz" without losing their energy.

Company officials are hoping the alcoholic drink will appeal to late-night partiers in their 20s and early 30s. "People are taking illegal drugs to dance all night. This is an alternative," said Mark Hall, senior vice president of marketing for Hard E Beverage.

Instead, "It might mislead people into thinking they actually could drink more without becoming impaired at the same rate as drinking anything else," said Mark Willenbring, M.D., Ph.D., associate professor of psychiatry at the University of Minnesota. Concerns also were expressed by Ken Winter, Ph.D., a University of Minnesota addiction researcher, who doesn't believe the drink could boost a person's energy while they get drunk. "I think it's a hard sell, from the science standpoint," he said.

The flavor and marketing of the product also are raising concerns. The Hard E beverage tastes like a sweet, carbonated lemon-lime soda, and is being marketed in a bright green bottle with a neon flame design. Hall said the design and taste are not efforts to attract underage drinkers or to make the beverage appear to be a health drink. "We're not trying to make a healthy drink," he said. "We're trying to make a drink that combines the effect of an energy drink with the effect of an alcoholic beverage."

Source: Associated Press, August 16, 2000. ■

MEMBERS SPEAK OUT

To the Recovery Community: Get Active!

David C. Lewis, M.D.

Are we ready for a million-person march of people in recovery? This was one of the ideas presented at a recent conference on "Mobilizing Recovery through Technology," co-sponsored by the National Council on Alcoholism and Drug Dependence (NCADD) and Join Together. The focus was on methods of communication and techniques for advocacy building. The enthusiasm of participants is well-illustrated by their suggestion of a million-person march of people in recovery. Enthusiasm or not, reality shows that this population, especially those in Twelve Step programs, prefer to remain silent — at least in terms of public policy. It need not be so.

The conference gave me the opportunity as a speaker to reflect on the overall role of people in recovery. In my opinion, people in recovery should form the heart and soul of a new rights movement, fighting unfair stigma against and punishment for the disease of alcoholism and drug addiction. Who else but people in recovery could form the basis of such an anti-discrimination movement?

There are two issues that discourage people from taking action: First is the issue of anonymity: How can our silent partners become a vocal force for change? The history of Alcoholics Anonymous is instructive. While AA is negative for individuals publicly disclosing their participation in the fellowship, it does not preclude them from advocating policy change and revealing that they are in recovery....

Second is the issue of tolerance of diversity: while people in recovery could be the heart and soul of a humane and effective alcohol and drug policy, they're not the only show in town. There are thousands of scientists and prevention and treatment specialists working in this field who are not in recovery. In fact, many of these scientists and specialists espouse treatment and preventive programs, which may even seem at odds with Twelve Step programs. Invigorated support for science and more tolerance of the many routes to recovery are required from the recovery community. When Bill Wilson wrote, "Let's be friendly with our friends," he was addressing this tolerance issue.

Consider the history of cancer treatment. There was a time when stigma prevailed and we avoided associating — and even talking — with people suffering from the disease. As effective medical treatments were developed, the stigma faded rapidly. Medicine was never the whole answer; however, as mutual and self-help support groups appeared in large numbers, cancer patients began to advocate for involvement in their own treatment and for less-toxic medications.

I view this evolution as progressing from medicalization to a combination of the medical and spiritual. I think it can be true for alcoholism and drug addiction as well. Here the progression starts with a large spiritual force in the Twelve Step programs, followed by medicalization and ending in much the same way — with a combination of the medical and spiritual.

Maybe we will have a million-person march after all.

Dr. Lewis is Editor of The Brown University Digest of Addiction Theory and Application and a member of ASAM's Board of Directors. This essay is reprinted with permission from The Brown University Digest of Addiction Theory and Application, November 2000, Vol. 19, No. 11. ■

FROM THE LITERATURE

Treat Addiction Like Diabetes, Other Chronic Diseases, Experts Advise

Addiction has much in common with other chronic illnesses such as diabetes, hypertension and asthma, and thus should be insured, treated and evaluated in a similar manner, according to a team of addiction field leaders.

Writing in the *Journal of the American Medical Association*, researchers Tom McLellan, Ph.D., David C. Lewis, M.D., Charles O'Brien, M.D., Ph.D., and Herbert V. Kleber, M.D., said that while many physicians believe there are no effective interventions for addiction, the research says otherwise. This is especially true when outcomes are compared with those for type 2 diabetes, hypertension and asthma — diseases that are "well studied and are widely believed to have effective treatments, although they are not yet curable." While 40% to 60% of drug-dependent individuals maintain sobriety a year after treatment, fewer than 30% of diabetics, asthmatics and persons with hypertension adhere to dietary or behavioral recommendations that would improve their health and prevent recurrence of their disorder.

The *JAMA* article also pointed out that addiction has a strong genetic component: for example, studies of twins show rates of genetic predisposition to drug addiction similar to those for the other diseases studied. Addiction, diabetes, hypertension and asthma also are alike in that personal responsibility often plays a strong role in development of the disease as well as success in treatment. For example, obesity, stress level and inactivity all are behavior-related risk factors for hypertension, the authors noted.

"These similarities in heritability, course and particularly response to treatment raise the question of why medical treatments are not seen as appropriate or effective when applied to alcohol and drug dependence," the authors concluded. Part of the problem, they said, is that addiction — a chronic disorder that causes long-term biological changes — often is treated as an acute condition, with detoxification and short-term counseling, rather than as a chronic medical problem that requires long-term follow-up. Also, few medical schools adequately train physicians about the nature of addictive illnesses.

But perhaps the biggest factor contributing to addiction treatment's image problem among physicians, they say, is simply that the outcome bar is set artificially high. "The usual outcome evaluated is whether the patient has been continuously abstinent after leaving treatment," the authors wrote. "Imagine the same strategy applied to the treatment of hypertension."

"It is interesting that relapse among patients with diabetes, hypertension and asthma following cessation of treatment has been considered evidence of the effectiveness of those treatments and the need to retain patients in medical monitoring," the authors said. "In contrast, relapse to drug or alcohol use following discharge has been considered evidence of treatment failure."

The *JAMA* article concludes with a call for physicians to "adapt the care and medical monitoring strategies currently used in the treatment of other chronic illnesses to the treatment of drug dependence."

Source: Journal of the American Medical Association, November 4, 2000. ■

CHAPTER UPDATES

California

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

Treatment Initiative Succeeds: CSAM President Peter Banys, M.D. has announced that the CSAM-supported state Proposition 36, The Substance Abuse and Crime Prevention Act of 2000, easily passed as a referendum in November balloting.

The California society took an aggressive "Yes" position on Proposition 36. The initiative mandated treatment rather than prison for simple possession of illicit drugs. CSAM wanted to send the message that "treatment works." CSAM President-elect and chair of the Public Policy Committee, Gary Jaeger, M.D., was featured on television commercials in support of the initiative, and CSAM President Peter Banys, M.D., was interviewed by CNN and other news networks. Member Jack McCarthy, M.D., appeared on a state-wide talk show and CSAM members across the state spoke at press conferences and other forums about the positive aspects of Proposition 36.

In supporting Proposition 36, CSAM joined a number of health and human service organizations, including the California Nurses Association, the state Association of Alcoholism and Drug Abuse Counselors, and the San Francisco Medical Society.

Public Policy Committee: CSAM's Committee on Public Policy worked hard this year to ensure the passage of SB 1807, recently signed by Governor Gray Davis. The new law authorizes the Department of Alcohol and Drug Programs (DADP) to establish an office-based opiate treatment program and allows persons participating in deferred entry of judgment programs or pre-guilty plea programs to participate in licensed methadone or LAAM programs.

Jack McCarthy, M.D., took the lead in working for this legislation on behalf of CSAM's Public Policy Committee and played a major role in getting this bill passed.

Workshops on Office Treatment of Opiate Dependence: CSAM is offering a series of workshops on the treatment of opiate dependence in office settings with buprenorphine. The workshops, to be offered in early 2001, are designed to fulfill the training requirements in the federal Drug Addiction Treatment Act of 2000, which requires that physicians who don't otherwise qualify must complete at least 8 hours of training provided by ASAM or other organizations.

CSAM Review Course: More than 300 participants attended CSAM's Review Course in Addiction Medicine, held October 11-14 in San Francisco. Also held were a gala honoring the society's founding executive director, Gail Jara. Masters of ceremonies for the evening were Garrett O'Connor, M.D., and Max A. Schneider, M.D., FASAM. During the festivities, Ms. Jara received many accolades, as participants testified to her many contributions to CSAM and the field of addiction medicine. Statements were read from ASAM President Marc Galanter, M.D., FASAM, ASAM Past-President G. Douglas Talbott, M.D., FASAM, and Janis Thibault, Manager of the California Diversion Program. A silent auction raised over $2,000 for CSAM and its Medical Education and Research Foundation.

New Workshop Series on Evaluation of Impaired Physicians: CSAM has launched a new series of workshops focusing on promoting best practices in evaluation, report writing, treatment, and monitoring of impaired physicians.

The first workshop in the series, "Best Practices: Evaluation of Impaired Physicians" was offered in September 2000 in both Los Angeles and San Francisco and featured Norman Reynolds, M.D. and Janis Thibault, M.F.T., who manages California's Diversion Program.

The second workshop in the series, on the evolving role of the Diversion Program, was offered as part of the CSAM Review Course in October.

The series continues in 2001 with additional workshops to be offered throughout the state. Workshop 3, "Best Practices: Rehabilitation of Impaired Physicians," featuring Garrett O'Connor, M.D., is to be offered early in 2001 at a location to be announced.

Florida

President: John C. Eustace, M.D.
Regional Director: Rick Beach, M.D.

2000 Educational Conference: The 14th Annual FSAM-ASAM Conference on Addictions is scheduled for February 9-11, 2001, at the Courtyard by Marriott, Lake Buena Vista/Orlando, FL.

FSAM and ASAM jointly sponsor this continuing education program. Other activities include FSAM's annual membership meeting and the chapter's business meeting.

Conference speakers include ASAM President-Elect Andrea G. Barthwell, M.D., FASAM, who will discuss opioid intoxication in hospitalized patients and women's addiction issues. Chapter President John Eustace, M.D., FASAM, and Region X Director Rick Beach, M.D., will share comments on the state of the art in addiction medicine.

A pre-conference workshop the evening of February 8th, to be sponsored by HealthCare Connections, will feature presentations on HIV/AIDS and domestic violence, as well as a pharmacology update.

The conference itself is organized as three half-day sessions, beginning each day at 8:00 a.m. and concluding at 1:00 p.m. This schedule leaves afternoons free for networking or enjoying the many attractions of Orlando.

The conference is approved for 15 hours of Category 1 continuing education credit (including 3 hours for the pre-conference workshop). Continuing education credits also will be available for nurses, social workers, counselors, and addiction therapists who attend the conference to network with peers and update their knowledge.

FSAM invites other groups to schedule break-out sessions in the afternoons during the conference. Interested parties should contact Robert Donofrio at the FSAM office by phoning 850/484-3560 or e-mailing ***fsam.asam@usa.net***.

North Carolina

President: Dewayne Book, M.D.
Regional Director: Paul H. Earley, M.D., FASAM

By-Laws Changes: In a mail ballot, members of the North Carolina Society of Addiction Medicine approved by-laws changes that involve reducing the size of the Board of Directors and adopting one-year terms of office for the President, President-Elect and Secretary-Treasurer.

Annual Meeting: At its annual meeting October 21, held in conjunction with the Addictions Conference of the North Carolina Physicians Health Program, the by-law changes were implemented with election of a new President, President-Elect and Secretary-Treasurer. Dewayne Book, M.D., was elected President, succeeding Philip L. Hillsman, M.D. Dr. Book can be reached at ***dewayneb@fellowshiphall.com***.

Chosen President-Elect is Thomas Brown, M.D., while the chapter's new Secretary-Treasurer is Warren Pendergast, M.D. They succeed outgoing Vice President Jerry Dirkers, M.D., and Secretary-Treasurer Wilmer Betts, M.D.

Members of the Society also heard reports from Sue Keith of the Alcohol/Drug Council of North Carolina and Flo Stein, Chief of the Substance Abuse Services for the state Department of Health and Human Services.

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

COMMITTEE REPORT

Pregnancy and Neonatal Addiction Committee

Kathleen B. Masis, M.D., Chair

I am writing this by way of introduction and query at the same time. I am a family physician, certified by ASAM in 1988, and have practiced in the Indian Health Service for 15 years.

I nominated myself for the chair of ASAM's Pregnancy and Neonatal Addiction Committee after a particularly powerful experience in reviewing the care given to adolescents in a juvenile detention center. Most of these adolescents had cognitive disabilities and known prenatal exposure to alcohol. There was no programming specific to their needs, and some were basically spending their adolescence in the custody of juvenile detention. In a way, I am looking to reduce my frustration with the lack of attention to these problems by taking on this chairmanship.

I have a personal and professional interest in fetal alcohol syndrome and the other disabilities common to people who have prenatal alcohol and other substance exposure. My experience has been both with pregnant women abusing alcohol and other drugs, and with children, adolescents and adults with prenatal brain damage.

I have been greatly disturbed by my own experiences in the past few years related to what seems to be to be a lower standard of care surrounding alcohol-related birth defects, whether it be in prevention (lack of screening, identification, and case management of women at risk), early identification (lack of training of family physicians and pediatricians), or case management (treatment planning for mental health or substance abuse treatment of affected individuals). There seem to be lower expectations for the success of prevention or treatment as compared to other birth defects.

Even the name "Pregnancy and Neonatal Addiction Committee" omits mention of the attention needed by the substance-abusing woman after delivery, and of the child after the neonatal period. Perhaps consideration should be given to the name of the committee as we attempt to revive it. A meeting is planned in April 2001 at the next ASAM Medical-Scientific Conference in Los Angeles. I hope you will be able to attend. During the coming year, we can work on an agenda for the meeting.

There are six committee members currently on the roster. I intend to phone each of you to introduce myself and ask you about your views and interests in these subjects. If you prefer to converse by e-mail, please send me a message and we can do that (***Kathleen.Masis@mail.ihs.gov***). If you know of other ASAM members who you think would be interested in this committee, please refer them to me. I look forward to working with you. ■

Is anyone interested in forming an interest group on Native American Issues in Addictions? If so, please call Kathy Masis, M.D., at 406/247-7124 or e-mail ***Kathleen.Masis@mail.ihs.gov***.

▶ **CHAPTER UPDATES** *continued*

Washington State

President: Bill Dickinson, D.O.
Regional Director:
Richard Tremblay, M.D., FASAM

Addiction Conference: The Washington Society of Addiction Medicine is collaborating with the Washington Department of Health and the Providence Everett Medical Center to sponsor the Third Annual Conference on Fundamentals of Addiction Medicine. Scheduled for March 2-3, 2001, at the Sheraton Hotel & Towers in Seattle, the conference is approved for 13.5 hours of Category 1 CME credit.

Chaired by WSAM President Bill Dickinson, D.O., the conference features presentations on alcohol and drug problems in adolescents and in pregnant and parenting women. There also is a focus on new pharmacotherapies and on controversies surrounding the abstinence/disease model and harm reduction approaches to addiction.

A WSAM luncheon meeting follows the conference at 1:00 p.m. on Saturday, March 3. For additional information, contact Jeri Sackett, CMP, by phone at 425/261-3690 or by e-mail at ***JSackett@Providence.org***. ■

Canadian Society of Addiction Medicine Certifies Members

Raju Hajela, C.D., M.D., M.P.H., CCFP, CASAM, FASAM, FCFP, Major (Retired)
President, Canadian Society of Addiction Medicine,
and Editor, Canadian Addiction Medicine Bulletin

For the first time, the Canadian Society of Addiction Medicine conferred the status of Certificant to 10 Canadian physicians in October. Certified were Dr. Nady el-Geubaly and Dr. Bill Campbell of Alberta and Dr. Raju Hajela, Dr. Peter Mezciems, Dr. Joe MacMillan, Dr. Michael Kaufmann, Dr. Mike Bloudoff, Dr. Jake Bobrowski, Dr. George McDermott and Dr. Rudy Regehr, all from Ontario.

All of these physicians are certified by the American Society of Addiction Medicine (ASAM), which they achieved after writing a specialty examination, prepared by the ASAM Examination Committee at the U.S. National Board of Medical Examiners (NBME) and administered by ASAM. They also passed an evaluation process established by the Canadian Society of Addiction Medicine, under the leadership of Dr. Raju Hajela, who continues as Chair of the Standards Committee.

Dr. Hajela expressed immense gratitude to the leadership and staff of ASAM for their assistance in the certification process. Collaboration with ASAM and NBME continues toward development of a Canadian certification examination by the year 2002.

The Canadian Society of Addiction Medicine was founded in 1989 as the Canadian Medical Society on Alcohol and Other Drugs. In 1996, the name was changed to emphasize the wider scope of the disease of addiction. Consensus was reached in 1999 to define addiction as a primary, chronic disease characterized by impaired control over the use of a substance and/or behavior.

It is estimated that alcohol, tobacco and other drug related problems cost the Canadian society $18.5 billion every year. Costs related to behavioral problems involving gambling, food, sex, compulsive use of the Internet, and the like are growing, but accurate estimates of the socioeconomic burden are hard to quantify.

Public and professional education for prevention and appropriate intervention is essential to decrease the morbidity and mortality burden to individuals; and emotional, financial and other social costs to family members and communities. The Canadian Society of Addiction Medicine continues to support education, research and public policy initiatives related to addiction. More information about the Society is available at ***www.csam.org***. ■

CSAT Issues Advisory on the Use of Buprenorphine

In response to confusion surrounding the status of buprenorphine (Subutex®) and buprenorphine with naloxone (Suboxone®) for the treatment of opiate addiction, the federal Center for Substance Abuse Treatment (CSAT), the Food and Drug Administration (FDA) and the Drug Enforcement Administration (FDA) recently issued a "Dear Colleague" letter that makes the following points:

- There has been considerable activity in Congress on the issue of new medications for the treatment of opiate addiction. Buprenorphine has been discussed often within the context of these activities. As a result, *some have mistakenly concluded that buprenorphine products are approved and available for use in the treatment of narcotic addiction.*
- There also has been rulemaking activity in this area. In May, the Department of Health and Human Services published a Notice of Intent to allow office-based treatment of opiate addiction using certain partial agonist medications. However, *no regulations have been issued yet to permit the use of partial opioid agonist medications.*
- For the last several years, buprenorphine, in liquid and solid oral dosage form, has been under investigation for use in the treatment of opiate addiction. Several multi-center clinical trials currently are under way. *Only practitioners participating in these IND-sanctioned trials are entitled to conduct this research under the federal Controlled Substances Act and the Food, Drug, and Cosmetic Act without separate DEA registration.*
- *It is important to emphasize that at present there are no buprenorphine products approved and available for the treatment of opiate addiction. Buprenex® (an injectible form of buprenorphine approved for the treatment of pain) is not approved for the treatment of opiate addiction.* Further, treatment standards have not yet been established by the Secretary of Health and Human Services to permit practitioners to be registered by DEA, as required under the federal Narcotic Addiction Treatment Act.

  Therefore, buprenorphine products may not be used in the treatment of opiate addiction at this time.

The letter is signed by CSAT Director H. Westley Clark, M.D., J.D., FASAM; Janet Woodcock, M.D., Director of the Center for Drug Evaluation and Research at the FDA; and John H. King, Deputy Assistant Administrator of the Office of Diversion Control, DEA.

Physicians who wish additional information about buprenorphine are directed by the letter to Robert Lubran, Acting Director, Office of Pharmacological and Alternative Therapies at CSAT (301/443-0744), or Robert Walsh, Associate Chief of the Regulatory Affairs Branch at NIDA (301/443-5280). The entire text of the legislation and excerpts from the *Federal Register* can be viewed on the SAMHSA Web site (***www.samhsa.gov***).

Source: Center for Substance Abuse Treatment, September 1, 2000.

▶ **BUPRENORPHINE LEGISLATION** *continued from page 1*

syndrome seen on discontinuation with buprenorphine is, at worst, mild to moderate and often can be managed without administration of narcotics.

Third, the addition of naloxone to the buprenorphine decreases the physiologic response when the drug is injected. This means that when addicts dissolve the tablets and inject them, they will experience either withdrawal or a diminished opioid effect. These properties render buprenorphine with naloxone undesirable for diversion to illicit use.

New Federal Legislation

A key development that should enhance the availability of the new medications is the recent enactment of the Drug Addiction Treatment Act (S.324), which was signed into law by President Clinton in October. The Act gives qualified physicians authority to prescribe or dispense buprenorphine (and possibly other anti-addiction medications) from their offices — a practice prohibited by existing federal regulations. It supersedes provisions of the Narcotic Addict Treatment Act of 1974, which required that physicians have special Drug Enforcement Agency registrations to use any narcotic medication for the treatment of addiction.

Enactment of the new law was spearheaded by Senators Carl Levin (D-MI), Orrin Hatch (R-UT) and House Commerce Committee Chairman Tom Bliley (R-VA). Sen. Levin successfully attached legislation to the SAMHSA reauthorization bill to establish a separate, simpler process for buprenorphine than the one that governs drugs like methadone and LAAM. The language of the Act allows qualified office-based physicians and group practices to treat up to 30 patients for opioid addiction at any given time (this number may be adjusted by the Secretary of Health and Human Services). It also requires that physicians who use the drug have the capacity to refer patients for counseling and other appropriate ancillary services.

The Drug Addiction Treatment Act preempts states from enacting regulations to restrict this expansion of opiate addiction treatment for three years. At the end of that time, states will be able to choose whether to continue allowing physicians to treat opiate addicts in office settings.

Expanding Treatment Capacity

The new law is expected to greatly expand the nation's opiate addiction treatment capacity. Numerous studies have shown that the current system of federally registered Narcotic Treatment Programs has not been able to keep pace with the spread of addiction. NIDA describes Narcotic Treatment Programs as "the most highly regulated form of medicine practiced in the U.S.," because they are subject to federal, state, and local regulation. Under this regulatory burden, expansion of the treatment system has been static for many years, resulting in the often-remarked "treatment gap." For example, there are only about 900 methadone treatment facilities in the U.S., and they have been losing funding in recent years.

Under the Drug Addiction Treatment Act, opiate addiction can be treated as a medical disorder and managed in physicians' offices like other chronic conditions. Treatment in office settings also allows improved coordination of drug treatment with behavioral health, primary medical care and supportive services.

Officials Urge Caution

Federal officials caution that buprenorphine — either alone or in combination with naloxone — is not yet legally available for the treatment of opiate addiction. While approval of the new indication is expected shortly, it has not yet been granted. At this time, only physicians who are participating in approved clinical trials may legally use the drugs for the treatment of opiate addiction (see the accompanying article).

At last report, the FDA was continuing to review the New Drug Application for buprenorphine to add treatment of opiate addiction to the list of approved indications for the drug. The Drug Enforcement Administration was preparing proposed regulations to allow office-based physicians to *prescribe* the drug, rather than being required to dispense it directly to patients. The Center for Substance Abuse Treatment (CSAT) was finalizing rules that elaborate on the physician training outlined in the federal law. CSAT also is funding the Federation of State Medical Boards to develop a model policy for state medical boards regarding the pharmacological treatment of opiate addiction in office practice.

It is only when these initiatives are completed that buprenorphine may be used lawfully in office practice to treat opiate addiction. Keep an eye on ***ASAM News*** and ASAM's Web site for updates as they occur! ■

▶ **BUPRENORPHINE TRAINING** *continued from page 1*

Treatment (CSAT) to design such a course. A CSAT official has underscored the importance of such training as follows: "A physician with little or no experience in treating opioid-dependent patients should learn as much as possible to do a good job." For an inexperience physician, the official continued, "eight hours of training is probably too little, while a fellowship is too much. Specialty groups should recommend an appropriate amount of training so that the practitioner avoids obvious malpractice mistakes."

The first ASAM-sponsored training is scheduled for April 22, 2001, in Los Angeles, in connection with ASAM's annual Medical-Scientific Conference. It has been organized and is to be co-chaired by Andrea Barthwell, M.D., FASAM, ASAM President-Elect; H. Westley Clark, M.D., J.D., FASAM, Director of the Center for Substance Abuse Treatment; Marc Galanter, M.D., FASAM, ASAM President; and Donald R. Wesson, M.D., Chair of ASAM's Medications Development Committee and a leading investigator in clinical trials of buprenorphine.

The training is divided into two parts: a Buprenorphine Symposium, to be offered Sunday morning, April 22, followed by a Buprenorphine Training Course on Sunday afternoon. (Attendance at the morning symposium is a prerequisite for participation in the afternoon course.)

Faculty for the training include Andrea G. Barthwell, M.D., FASAM, Warren K. Bickel, Ph.D., Walter Ling, M.D., Judith Martin, M.D., Laura McNicholas, M.D., Ph.D., Eric C. Strain, M.D., Frank Vocci, Ph.D., and Donald R. Wesson, M.D.

The schedule for the training is as follows:

Part I: Symposium 10: An Orientation to Buprenorphine

Sunday, April 22, 2001, 8:30 a.m. - 12:00 noon

Topics: Why buprenorphine? Why now? — A brief overview of the political and regulatory environment. The pharmacology of buprenorphine: what it is, how it works, and what makes it clinically different. Applied pharmacology: how buprenorphine is used and what makes it clinically challenging. Epidemiology and patient selection and evaluation: the "target population" and how to match the patient with available treatment services. Clinical management in office practice.

Part II: Medications Development Committee Training Course

(Open only to participants in the morning symposium)

Sunday, April 22, 1:00 p.m. - 7:00 p.m.

Topics: Configuring the office: recordkeeping, policies and procedures to comply with federal confidentiality requirements. Non-pharmacologic treatments. Patient selection. Pychiatric and medical comorbidities. Developing exclusion criteria, and the practice implications of inclusion/exclusion decisions. Protocols for use of buprenorphine.

The combined morning and afternoon sessions have been designated for 8 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association. Application also has been made to the American Osteopathic Association for continuing education credits for the buprenorphine training. Course certificates will be awarded only to those who attend both the morning symposium and afternoon training course.

Physicians who register for the full Medical-Scientific Conference will be able to attend the Sunday morning symposium and the afternoon training course at no additional fee. Those who wish to register only for the day Sunday will be charged the regular one-day registration fee.

All participants (both full conference registrants and Sunday-only registrants) must register for the course on the registration form. Medical-Scientific Conference registration brochures will be mailed to all ASAM members and will be available on ASAM's Web site (***www.asam.org***) in early February.

In addition, ASAM is working with other specialty societies to offer training sessions in 2001 on a monthly basis at locations around the U.S. Collaborating groups in addition to ASAM are the American Academy for Addiction Psychiatry, the American Osteopathic Academy of Addiction Medicine, the Association for Medical Education and Research in Substance Abuse, and the California Society of Addiction Medicine. The courses will cover the same content and will be taught by faculty drawn from the membership of all the groups. As arrangements are completed, additional information will be published in future issues of ***ASAM News*** and on ASAM's Web site (***www.asam.org***). ■

BUPRENORPHINE: Questions and Answers from NIDA

Question No. 1: Is buprenorphine (alone and in combination) a safe and effective treatment for drug addiction?
While the ultimate decision concerning safety and efficacy rests with the Food and Drug Administration (FDA), the National Institute on Drug Abuse (NIDA) has funded many studies that support the safety and efficacy of buprenorphine and the buprenorphine/naloxone combination for the treatment of opiate dependence. During the time NIDA has studied this medication, we have been impressed with its safety and efficacy as a treatment for opiate dependence.... The major studies of relevance have shown that buprenorphine is more effective than a low dose of methadone (Johnson et al., *Journal of the American Medical Association*, 1992), and that an orderly dose effect of buprenorphine on reduction of opiate use occurred (Ling et al., *Addiction*, 1998). Most recently, buprenorphine tablets (either buprenorphine alone or combined with naloxone) were shown in a large clinical trial to be superior to placebo treatment in reducing opiate use (Fudala et al., CPDD, 1998).

Question No. 2: Do current regulations properly set forth the rules for administration, delivery, and use of these drugs? .... The current regulations (*21 CFR 291*) for administration and delivery of narcotic medications in the treatment of narcotic dependent persons were written for the use of full agonist medications such as methadone... and do not take into account the unique pharmacological properties of [partial agonist medications such as buprenorphine]. Therefore, these regulations would need to be re-examined and substantially rewritten in order to recognize the unique possibilities posed by buprenorphine/naloxone....

First, buprenorphine's different pharmacology should be kept in mind when rules and regulations are promulgated.... It is our understanding that the Drug Enforcement Administration has recognized the difference between buprenorphine treatment products and those currently subject to *21 CFR 291*.

Second, there are many narcotic addicts who refuse treatment under the current system. In a recent NIDA-funded study (NIDA/VA1008), approximately 50% of the subjects had never been in treatment before. Of that group, fully half maintained that they did not want treatment in the current narcotic treatment program system. The opportunity to participate in a new treatment regimen (buprenorphine) was a motivating factor. Fear of stigmatization is a very real factor holding back narcotic dependent individuals from entering treatment.

Third, narcotic addiction is spreading from urban to suburban areas. The current treatment system, which tends to be concentrated in urban areas, is a poor fit for the suburban spread of narcotic addiction....

Question No. 3: Should more physicians be permitted to dispense these drugs under controlled circumstances?
....The safety and effectiveness profiles for buprenorphine and buprenorphine/naloxone suggest they could be dispensed under controlled circumstances that would be delineated in the product labeling and associated rules and regulations. As currently envisioned, buprenorphine and buprenorphine/naloxone would be Schedule V controlled substances. The treatment of patients by physicians in solo or group practice would allow office-based treatment to augment the current addiction treatment system, while placing an adequate level of control over the dispensing of these medications.

Source: National Institute on Drug Abuse, September 29, 1999.

States Expand Use of Behavioral Health Programs

Forty-two states used managed behavioral health programs in 1999, up from 14 states in 1996, according to data compiled by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

In addition to the three-fold increase in the use of managed care, the report by SAMHSA's Office of Managed Care — *State Profiles 1999: On Public Sector Managed Behavioral Health Care* — notes that states increasingly are contracting with managed care organizations to administer addiction treatment benefits. While state Medicaid agencies are the largest source of such contracts, they often are administered by Medicaid in collaboration with state alcohol and drug agencies.

According to the report, so-called "carved out" behavioral health programs (those that are contracted separately from other managed medical care) are more likely to cover such community-based services as residential, rehabilitation, support and consumer-run services. Plans that integrate behavioral health with other medical services are more likely to offer pharmacy benefits.

The full report is available on SAMHSA's Web site at ***www.samhsa.gov***.

Magellan Dominates Behavioral Health Market

Of an estimated 250 million Americans with health insurance, approximately 170 million (68%) were enrolled in some type of managed behavioral health care program in 2000, according to data published in the *Open Minds Yearbook of Managed Behavioral Health Market Share in the United States, 2000-2001*. This represents a 14% increase over 1999.

Data from the same source show that Magellan continues to dominate the behavioral health market, capturing 33.15% market share in 2000. The top three vendors (Magellan, ValueOptions and United Behavioral Health) collectively represent 50% of the market. About three-fourths of the market is controlled by the 10 largest companies (CIGNA, MHN, APS Healthcare, First Health Services of Tennessee, ComPsych Corp., FEI Behavioral Health, and PacifiCare Behavioral Health, in addition to the companies already cited). The Yearbook also includes information on internally managed behavioral health programs, such as those offered by HMOs.

Source: Open Minds Yearbook of Managed Behavioral Health Market Share in the United States, 2000-2001. For more information, contact Open Minds at 717/3334-1329 or e-mail ***openminds@openminds.com.***

Class action lawsuits have been filed in federal courts across the nation . . . The suits challenge whether HMOs refused to pay for treatments to which patients were entitled under the plans, whether they paid claims promptly and whether they gave physicians financial rewards if they did not order certain tests.

Managed Care Can Increase Access, Oregon Study Finds

A federally funded study of the Oregon Medicaid program concludes that participation by managed care plans in state Medicaid programs can increase access to addiction treatment. The study, which was jointly supported by the federal Center for Substance Abuse Treatment, the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, compared access to addiction treatment before and after managed care plans became responsible for administering addiction treatment benefits for Oregon Medicaid enrollees.

Investigators Dennis Deck, Ph.D., of RMC Research Corp. and Bentson McFarland, M.D., Ph.D., of the Oregon Health Sciences University, found that 7.7% of Medicaid enrollees were admitted to addiction treatment programs in 1997, compared with 5.5% in 1994. The researchers attributed the difference to the integrated design of the addiction treatment benefit.

The study results are reported in the October 25 issue of the *Journal of the American Medical Association*.

Source: Substance Abuse and Mental Health Services Administration, October 23, 2000.

HMO Lawsuits, Investigation Proceed

With dozens of lawsuits filed against managed care companies nationwide in the past year, the Florida attorney general is the latest to investigate whether HMOs in that state improperly denied care.

The investigation of Humana Inc. and Aetna, Inc. is being conducted by Attorney General Bob Butterworth under federal racketeering laws and is focusing on practices the two companies used in processing claims, according to Assistant Attorney General Keith P. Vanden Dooren. There is no set timetable for how long the investigation could take. "We're looking at the industry to see what is going on here," Vanden Dooren said. "Depending on what we find, it could be broadened out."

News of the Florida investigation, which began in October 1999, emerged recently as the Judicial Panel on Multidistrict Litigation ruled that about two dozen lawsuits filed against HMOs will have pretrial motions heard before the same U.S. district judge. In October, the Washington, DC-based panel assigned the managed care cases to U.S. District Judge Federico A. Moreno in Miami, who already had about a dozen HMO cases before his court. The panel's role is to decide whether similar cases should be combined.

Class action lawsuits have been filed in federal courts across the nation, some by the same attorneys who took the lead in suits against the tobacco and asbestos industries. The suits challenge whether companies refused to pay for treatments to which patients were entitled under the plans. They challenge everything from whether HMOs paid claims promptly to whether they gave physicians financial rewards if they did not order certain tests. Because the suits filed against HMOs are so similar, the judicial panel said it decided to put the lawsuits before the same federal judge to make evidence-gathering more efficient during the pretrial phase.

Lawsuits against managed care companies first were seen in the federal district court in Miami last year when two East Coast attorneys filed a suit there against Humana Inc. The lawsuit — the first of its kind in the nation — was filed on behalf of five Humana members and charges that the company misled patients about how it determined coverage. It also alleges that the company didn't disclose that coverage and treatment decisions were determined, in part, on cost-based criteria rather than medical necessity, as subscriber materials describe. Those actions violate federal racketeering laws and the 1974 Employee Retirement Income Security Act, the lawsuit says.

The attorneys who filed the initial suit against Humana also want to represent the

HMO's 6.2 million members as a class. After that suit was filed, others lodged later in various parts of the country were transferred to Miami. They made up the first wave of managed care cases assigned to Moreno.

The second wave of suits includes more than a dozen cases filed on behalf of health plan subscribers who claim the HMOs failed to disclose physicians' financial incentives, leading to fraud and racketeering. Other class action suits were filed on behalf of physicians who say that managed care uses faulty data to lower reimbursements to physicians.

The suits name most of the largest health insurers in the nation, including Aetna, Humana, Cigna HealthCare, UnitedHealthcare, Prudential HealthCare and PacifiCare Health Systems.

Source: American Medical News, November 13, 2000.

Commercial Guidelines Spark Controversy, Lawsuits

Milliman & Robertson, a company of actuaries and consultants with offices worldwide, is the leading commercial developer of guidelines for length of hospital stays and utilization of other health care services. Because of its influence, the Seattle-based firm now finds itself a target in the public backlash against managed care.

For example, two Texas physicians have sued the company and a colleague over a recent book of guidelines, which sets length-of-stay goals for children. The physicians, who are listed as contributing authors in the book, claim in their lawsuit that they did not participate in writing the guidelines. They also claim that children could die if the guidelines are followed. (A spokesman for Milliman & Robertson declined to comment specifically on the Texas lawsuit.)

Not in dispute is that Milliman & Robertson paid the University of Texas Medical Center's pediatrics department $100,000 to consult on the guidelines. Dr. Robert Yetman took the project's lead, earning $40,000 and spending more than a year on the project. He asked other pediatricians in the department, including Dr. Riley and Dr. Thomas Cleary, for comments on goals for certain illnesses. But Dr. Cleary, an infectious-disease specialist, said he looked at the guidelines only three times. He said he told Dr. Yetman the guidelines were unsafe and needed to be changed. He was even quoted in *The Wall Street Journal* as opposing the guidelines. "I told him they were dangerous, that children would die because of them," he said.

Dr. Riley, an endocrinologist, said he was asked to look at sections on childhood diabetes and endocrinological diseases. He made some suggestions, then left the University of Texas for a children's hospital in Corpus Christi. When the M&R Pediatric Health Status Improvement & Management guide was released in 1998, it listed the entire pediatrics staff at the medical school as contributing authors and thanked the school for its help.

Drs. Cleary and Riley sued Dr. Yetman and Milliman & Robertson for using their names without their permission. They were granted an injunction requiring the company to remove their names, but Dr. Cleary rejects that as a remedy, maintaining that the guidelines should be redone. "I'd like to pull them," he told the *Seattle Times*. "They represent a defective product, if you will, that represents a risk to the public." For example, the guidelines say an infant should stay only three days in the hospital for a serious bacterial infection, whereas the prevailing standard is up to three weeks, Dr. Cleary said. Similarly, the guidelines call for two days in the hospital for a bone infection, whereas the standard is up to six weeks, he added. Dr. Riley criticized the book's suggestion that a child suffering from a diabetic coma could be released after only one day in the hospital. "That is absolutely ludicrous," he said.

A trial is set for January 2001. If they are awarded money, the doctors say, they'll donate it to research or charity.

On its Web site and in its books, Milliman & Robertson says it bases its guidelines on reviewing the charts of more than 35,000 patients. The company stresses that its guidelines are for best-case scenarios, and are intended for individuals who are free of complications. Indeed, some physicians say that patients aren't usually pushed out of the hospital after a guideline is exceeded. Instead, the guidelines are more likely used behind the scenes, when an insurer is deciding how to pay the bills and what will be covered.

However, unrelated class-action lawsuits filed against health insurers in New York and Florida blame those insurers for relying too heavily on Milliman & Robertson guidelines. Critics call it "medicine by the numbers," citing goals such as only one day in the hospital following childbirth and an outpatient visit for a mastectomy. Milliman & Robertson once proposed that elderly patients with cataracts have surgery on only one eye because vision out of both eyes wasn't essential. After a public outcry, that suggestion was dropped.

Milliman & Robertson's Web site stresses that the guidelines shouldn't be substituted for sound medical judgment. "The guidelines are widely used in the health care industry. They are painstakingly assembled and checked," said Jim Loughman, a spokesman for a New York public relations firm that represents Milliman & Robertson.

Source: Seattle Times, March 14, 2000. ■

continued from page 3

"You cannot discriminate and use government programs for proselytizing," he said. "But if a group happens to have a religious component to their program not funded by the federal government, it does not mean that they have to drop everything else."

Source: Associated Press, November 3, 2000.

Ballot Campaigns Successful in Five States

In November balloting, voters in five states approved initiatives that reform state drug policies.

California voters approved Proposition 36, which allows first- and second-time drug users to be sent to community treatment programs instead of jail (see Chapter Update, this issue). The measure had the support of the California Society of Addiction Medicine and other medical groups.

In Colorado and Nevada, voters approved the use of marijuana for medical purposes, while voters in Oregon and Utah approved measures that would restrict government seizures of drug offenders' property.

"Politics is perception, and the perception up to this point is that voters want tougher and tougher drug policies," said Bill Zimmerman, executive director of the Campaign for New Drug Policies. "The votes we saw election night represent a sea change in that perception."

Source: Associated Press, November 13, 2000.

Trio of Funders Work to Change U.S. Drug Policy

Three wealthy businessmen are working to change U.S. drug policy by funding ballot initiatives on medical marijuana, incarceration of drug offenders and drug-related forfeitures. John Sperling, founder of the University of Phoenix, international financier George Soros, and Peter Lewis, head of Progressive Corp., the nation's largest auto insurer, are using their money, consultants and sophisticated polling to change U.S. drug policy.

Calling elected officials "cowards," Sperling said he felt it was time he used his wealth to confront the drug war, which he calls "social insanity." "We know the federal government is totally incapable of reform," Sperling told the *Washington Post*. "The politicians in Washington, they live in fear of the right-wing moralists. So we're going around them."

Opponents of such measures are concerned that the billionaires are buying public policy. "I think the initiative process is becoming dangerous," said Calvina Fay, executive director of the Drug Free America Foundation, which advocates a zero-tolerance approach to drugs. "The very wealthy who have the money to do it are buying public policy all over the country."

Ethan Nadelmann, director of the Lindesmith Center in New York, estimates that the three contributed $7 million during the 1997-1998 election cycle. They spent $1.2 million each on the California initiative alone.

"They have one thing in common," said Nadelmann, who brought the three men together. "They all hate the drug war and they all think it is a travesty, and despite what our opponents say, none of them support legalization. That's what they have in common, that and having a lot of money."

Source: Washington Post, October 23, 2000.

Court Rejects Bid to Overturn Tobacco Settlement

The U.S. Supreme Court has declined to hear a lawsuit by smokers who wanted the nationwide tobacco settlement agreement overturned. The tobacco settlement reached in 1998 between the tobacco industry and 46 states will award $206 billion to states. However, several lawsuits filed by smokers challenged the settlement on antitrust and constitutional grounds. To date, all have been rejected by lower courts.

The Supreme Court ruling was on an Oklahoma case filed by two smokers who claimed that the settlement eroded the "influence and power" of the legislative branch "by allowing select political activists to effectuate public policy through subterfuge litigation."

The justices made no comment when they declined to consider whether cigarette makers colluded to raise their prices to pay for the settlement in violation of federal antitrust laws.

Source: Dow Jones News Service, October 31, 2000.

McCain Wants Tobacco Funds Used for Anti-Smoking Programs

Sen. John McCain (R-AZ) called for more of the nationwide tobacco settlement funds to be used on anti-smoking programs, rather than to address budget deficits or pay attorney's fees. "I just think it's very harmful to the whole public perception of what was intended," said McCain, who chairs the Senate Commerce, Science and Transportation Committee. "Everyone understood that this money was not going to go for tax rebates."

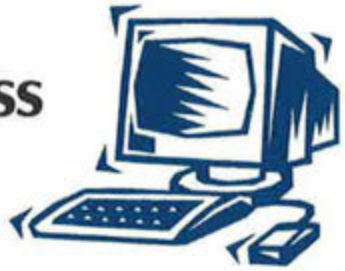
According to a joint report issued by the Campaign for Tobacco-Free Kids, the American Cancer Society, the American Heart Association and the American Lung Association, just five of the U.S. states have met the minimum spending levels for smoking prevention and cessation recommended by the U.S. Centers for Disease Control.

In a recent Senate committee hearing, Surgeon General David Satcher, M.D., told Senators that "We have the tools, the knowledge and the resources to cut smoking rates in half by the end of the decade. The question is, do we have the will?"

Under the master tobacco settlement agreement, states have the sole power to decide how to spend their portion of the settlement funds. Given the current spending patterns, McCain said people were justified in doubting the effectiveness of the tobacco settlement. "Their skepticism is warranted," he said. "I hope we are able to get a public outcry to force change."

Source: Winston-Salem Journal, October 6, 2000. ■

World Wide Web Offers Access to Tobacco Industry Secrets



Terry A. Rustin, M.D., FASAM

Tobacco control advocates maintain that the tobacco companies long have known about the addictive properties of nicotine and the health risks of tobacco, but have kept the information secret in order to keep profits high. The tobacco companies insist that they have done what all other consumer-product manufacturers do: research their markets and meet their customers' requests. This debate fueled the litigation by the attorneys general of Mississippi, Florida, Texas, and Minnesota, each of which reached a settlement with the major tobacco companies over the last five years; subsequently, the other 46 states reached a settlement with the tobacco companies as well.

One result of these settlements — which would not have occurred had the cases been decided by a jury verdict — was the release to the public of millions of previously secret internal company documents on many aspects of the tobacco manufacturing business. Thirty million documents were released in the Minnesota trial, and are still stored in dozens of file cabinets in a warehouse in Minneapolis. Less than one percent of these documents have been read and evaluated. Millions of other documents have been released by Phillip Morris, RJ Reynolds, British-American Tobacco, and the other companies; a substantial number of these documents have been scanned and made available on company Web sites.

Now, a programming expert has made it possible for everyone with Internet access to study these documents and decide for themselves what the tobacco companies knew and when they knew it. Tac Tacelosky, who wrote a ground-breaking foreign language translation program and built a company around it, says he "did pretty well" when he sold his company. "But I was sick of being around tobacco smoke," he says, and so he found a way to use his programming skills to advocate for tobacco control. Tacelosky wrote a sophisticated search program that seeks out documents from multiple sites and organizes them for easy study, and used his own money to install five computers running the software in his house.

Available at no charge to individuals, Tacelosky's Web site at ***www.tobaccodocuments.org*** makes finding tobacco industry documents easier than ever before. Unique among search engines, it can deal with misspellings and alternate spellings of names, and can organize hits in a variety of categories. After the user has selected a number of documents, the program can organize them in a "timeline" for better understanding, and can save the user's selections in a file. Users can share their timelines with others, and post messages about what they have discovered.

"I want everyone to be able to see for themselves," said Tacelosky, who spoke at the 11th World Conference on Tobacco OR Health in August 2000. "There's a lot of information out there that no one has seen yet."

Underscoring Tacelosky's assertion was Neil Francey, an attorney from Australia, also a speaker at the Chicago conference. He described how he learned about a secret 1977 meeting of executives from seven major international tobacco companies in England, at which they planned a strategy to diffuse the increasing concerns of consumers about the health dangers of smoking.

Francey told how a tobacco control advocate (who prefers to remain anonymous) found a document referring to a secret meeting on one of the industry Web sites in February 2000; he printed it out and sent a copy to Anne Landman, a respiratory therapist, and the Regional Program Coordinator for the American Lung Association in Grand Junction, Colorado. She hosts a listserv, a group of internet users with common interests who post messages and receive the messages of other members. Landman sent the document out to members of her listserv. Anne Jones, the head of Action on Smoking and Health in Australia, received the document and sent it to Francey.

Intrigued, Francey searched the industry Web sites for related documents. He found dozens of references to the secret meetings, known as "Operation Berkshire," which met originally at Shockerwick House near Bath, England, and later met in several sites in Europe. Francey contacted Simon Chapman, editor of the journal *Tobacco Control*, and the two co-authored a paper describing Operation Berkshire and the cooperative activities of the tobacco companies to improve their public image without actually improving their cigarettes. This paper has now been published in the prestigious *British Medical Journal* August 5, 2000.

"The tobacco industry has conspired to suppress information about the dangers of smoking for over 20 years," said Francey. "They colluded to engage in lies and deception, and we can now trace their campaigns of disinformation around the world."

Vocal critics like Landman and Francey are experts at using the Internet to support their positions. Now everyone with an interest in researching the tobacco industry documents can do so themselves, even if they have very little computer experience. "Find out what the tobacco companies have been doing," encourages Tacelosky. "Tobacco Documents Online makes it easy."

The tobacco companies maintained for years that nicotine was not addictive and that no link between smoking and human disease had been established. They now admit that nicotine is addictive and that cigarettes deliver nicotine, and they admit that some smokers may be harmed by smoking. However, tobacco industry spokespersons maintain that the activities of the tobacco companies have been similar to those of other consumer-product companies, and they have fought to keep their internal documents secret. The courts have decided against the tobacco companies, ruling that the documents may describe illegal activities, and therefore cannot be kept secret.

With millions of documents posted on the World Wide Web, and with a free and easy-to-use search engine available, Landman encourages ASAM members to browse through the documents. "These companies are guilty of crimes against humanity," she said. "People need to read these documents for themselves."

Dr. Rustin, an active member of ASAM, is a Houston physician specializing in the treatment of alcohol and drug dependence, including the treatment of nicotine dependence. ■

Weighing Alcohol's Benefits, Risks

How should physicians counsel patients and families who ask about the widely reported health benefits of alcohol? Alcohol abuse prevention advocates acknowledge that research proves moderate alcohol consumption can have positive health benefits for those who do not have addictive disorders. But they charge that the alcohol industry has overstated such health claims, and stress that any information on alcohol benefits should be offset with information on the negative consequences of alcohol consumption. The topic was a major subject of debate at the Global Alcohol Policy Advocacy Conference, held August 3-5 in Syracuse, NY.

Dr. Mary Jane Ashley, professor of public health sciences at the University of Toronto, told the conference that the "weight of evidence in favor of protection is now substantial," but stressed that alcohol's protective effects against coronary disease is related only to very modest levels of consumption — "as little as one drink every two days," she says. There are no additional benefits for higher levels of consumption, she added, and in fact, the risk of other problems — including cirrhosis, cancer, stroke, traumatic injury, and perinatal difficulties — have been proven to increase along with consumption.

Dr. Ashley pointed out that alcohol's protective affects have primarily been proven in certain subpopulations, especially for middle-aged men with a high risk of heart disease. Nevertheless, she and other advocates argue, the alcohol industry has been quick to seize upon the data and extrapolate the benefits to the population at large. The wine industry, for example, has been lobbying U.S. regulators and lawmakers to include information about the health benefits of wine on bottle labels.

"Our response should not be to reject the evidence, but rather to contest the exaggeration of it by the industry," said Dr. David Hawks, a researcher with the National Drug Research Institute at Curtin University of Technology in Perth, Australia. Dr. Hawks charged, for example, that in addition to erroneously generalizing alcohol's benefits to all heart disease, the industry also has failed to acknowledge that even small amounts of alcohol can increase the risk of diseases such as breast cancer.

George Hacker, Ph.D., director of the alcohol policies project at the Center for Science in the Public Interest, is even more blunt in his assessment of the industry's use of the "healthy alcohol" issue. "The Wine Institute basically argues that wine is the cure for everything," he said. The good news, he continued, is that new dietary guidelines issued by the U.S. government in 2000 not only point out the possible health benefits but also the risks of drinking. The guidelines also no longer use the general term "moderate" consumption, but specifically state that women should have no more than one drink daily, and men no more than two.

Indeed, while healthy-alcohol researchers always stress that moderation is the key to alcohol's positive effects, often little effort has been made to define what moderate drinking is. Dr. Ashley noted that Canada's Low-Risk Drinking Guidelines call for a maximum of two alcoholic drinks daily, up to a maximum of nine weekly for women and 14 weekly for men.

The Canadian guidelines stress that while drinking is an individual choice, it is a risky one; that the guidelines describe maximums, not targets for drinkers; that alternative means to drinking are available to reduce the risk of heart disease, such as diet and exercise; and that drinkers should contact a doctor if they are having a problem with alcohol consumption.

Unfortunately, a 1997 survey showed that many Canadians drink in excess of the recommended limits, says Ashley. The research found that 25% of men and 14% of women drank at unhealthy levels, while 58% of men and 66% of women stayed within the guidelines. The balance of those surveyed abstained from alcohol use.

Ironically, while the link between the reported health benefits of alcohol and consumption levels in developed countries is an issue of great concern to advocates, it's something of a non-starter in the developing world, according to Oye Gureje, a Nigerian alcohol researcher. That's because few people in poor countries are considering the possible health benefits of drinking when their more immediate concerns are as simple as finding clean water and adequate food and avoiding disease, he said.

Source: Join Together, November 11, 2000.

New Web Site Assesses Heart Risk

A new Web site provides individualized heart health risk assessments, including factors such as smoking, and provides tailored information about how to avoid heart attacks and strokes, according to an announcement from the Web site's sponsor, the American Heart Association (AHA). In addition to smoking history, individuals who use the site are asked for information about their physical activity, nutrition, smoking, blood pressure, cholesterol and medication compliance. Responses are confidential, although the AHA plans to store and use aggregated data. The Web site can be accessed at ***www.aha.org***.

Source: American Heart Association, October 24, 2000.

Smoking Increases Risk of Colon Cancer

A new link between smoking and colon cancer has been reported in the November issue of the *Journal of the National Cancer Institute*.

Researchers at the University of Utah who studied microsatellite instability (MSI), a genetic mutation found to be related to some cases of colon cancer, report that smoking may cause this genetic mutation. Their analysis found a clearer connection between smoking and colon cancer than previous studies. "Studies linking cigarette smoking to colon cancer have been inconsistent at best," noted Dr. Wade Samowitz, an associate professor of pathology with the university's School of Medicine. In the study conducted by Dr. Samowitz and colleagues, MSI mutation appeared to be the result of cigarette smoking in 21% of colon cancer cases. At one time, experts believed that heredity was the only reason that MSI would be present in such tumors. MSI subsequently has been discovered in sporadic, or non-inherited, colon cancer, meaning there must be other factors causing the mutation.

The risk of smokers getting colon cancer increases by twofold, the investigators found. Heavy smokers (those who smoke 20 or more cigarettes a day) have a greater chance of colon cancer. On the other hand, colon cancer patients who quit smoking 15 or more years before they were diagnosed had the same chance of having MSI in their tumors as did the general population.

Dr. Samowitz said earlier studies considered all colon cancer to be the same. This study discerned the different kinds of colon cancer at a genetic level. He estimated that the MSI mutation appears in 10% to 15% of non-inherited colon cancer cases.

For the study, researchers interviewed 1,510 patients who had been diagnosed with colon cancer between October 1991 and September 1994. Study subjects were between 30 and 79 years old when first diagnosed with colon cancer, and were of varied ethnic groups.

Source: Journal of the National Cancer Institute, November 2000.

Youth Show Signs of Addiction After Only a Few Cigarettes

A study at the University of Massachusetts has found that it takes just a few days of smoking for 12- and 13-year-olds to show signs of addiction. Writing in *Tobacco Control*, a journal of the British Medical Association, the investigators report symptoms including craving, escalating doses, withdrawal symptoms, and loss of control over the number of cigarettes smoked or the duration of smoking.

For years, experts have tried to determine how long people had to smoke before becoming addicted. "The best answer to date has been one to two years," said ASAM member Richard Hurt, M.D., director of the Nicotine Dependency Unit at the Mayo Clinic. "There's been a suspicion that many people become addicted very quickly, but this is really the first hard evidence we've had that this occurs."

Dr. Hurt said the study findings will help scientists better understand the biology of nicotine addiction.

Source: Tobacco Control, September 2000.

Women More Vulnerable to Smoking Risks

Women are more at risk than men for developing breathing problems and other harmful consequences of smoking, according to a study in the November issue of the *Journal of Epidemiology and Community Health*. "We don't know the exact cause of this. But it is probably because lungs of women are generally smaller than men's," noted investigator Arnulf Langhammer of the National Institute of Public Health in Norway. "If they smoke the same amount, women are exposed to higher concentrations of noxious gas."

In a study of 65,000 male and female smokers and nonsmokers, Dr. Langhammer and his colleagues determined that all smokers were twice as likely as nonsmokers to report respiratory symptoms like wheezing, breathlessness and coughing. "There was a strong association between tobacco smoking and respiratory symptoms. With increasing cigarette burden, women had a 50% higher risk of having respiratory problems and asthma," Dr. Langhammer explained.

The researchers also found that the prevalence of asthma increased in proportion to the number of cigarettes women smoked. No such increase was found in male smokers. "Higher prevalence of respiratory symptoms and current asthma in women compared with men with the same smoke burden or daily cigarette consumption indicate women are more susceptible to tobacco smoking than men," Dr. Langhammer and his colleagues concluded.

Source: Journal of Epidemiology and Community Health, November 2000. ■

NEW IN PRINT

Brief Interventions and Brief Therapies for Substance Abuse: Treatment Improvement Protocol (TIP) No. 34. *Center for Substance Abuse Treatment (copies available at no charge; order from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686).*

Because brief interventions and therapies are less costly than more intensive forms of treatment, yet have demonstrated effectiveness with appropriately selected patients, they are of increasing interest to payers, policymakers and clinicians as a way to fill the gap between primary prevention efforts and more intensive forms of treatment. This volume focuses on interventions designed to assist patients in achieving short-term goals such as entering treatment or modifying behavior. It reviews current scientifically validated information on the uses of brief interventions and other short forms of therapy.

Enhancing Motivation for Change in Substance Abuse Treatment: Treatment Improvement Protocol (TIP) No. 35. *Center for Substance Abuse Treatment (copies available at no charge; order from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686).*

With the health care system changing to a managed model of care, techniques to enhance patients' motivation to change assume increasing importance in the therapeutic armamentarium. This volume reviews the "stages of change" model developed by James Prochaska and Carlo DiClemente, as well as techniques for motivational interviewing, developed by William R. Miller and Stephen Rollnick as a means of helping patients — especially those who were coerced into treatment — to move beyond their initial feelings of anger and resentment.

Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues: Treatment Improvement Protocol (TIP) No. 36. *Center for Substance Abuse Treatment (copies available at no charge; order from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686).*

Designed to help treatment professionals work more effectively with adults who have a history of childhood abuse or neglect, this volume is particularly helpful in providing techniques to help patients understand and break the cycle of abuse. It provides clinical tools for assessing childhood traumas and understanding and treating the root causes of patients' current symptoms.

Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide. *Center for Substance Abuse Treatment (copies available at no charge; order from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686).*

This guide was created to give communities the tools they need to design comprehensive services for substance-abusing juvenile offenders. The guide outlines factors necessary to the development of effective programs for such juveniles, including: (1) focusing treatment on risk factors associated with antisocial behavior, such as antisocial attitudes and peers; (2) concentrating the most intensive services on those who are at risk of re-offending; and (3) offering comprehensive treatment that incorporates addiction treatment with medical and dental services, academic and vocational education, work skills training, and parenting education. ■

PEOPLE IN THE NEWS

Sheila B. Blume, M.D., CAC, FASAM, has received the New York State Governor's Lifetime Service Award for leadership in addiction medicine. The award was presented in a ceremony at the Sagamore in Bolton Landing, NY, on Lake George.

Dr. Blume's many contributions to the field of addiction medicine were recognized by ASAM with a 1998 award that cited her "thoughtful leadership" and "deep understanding of the art and science of addiction medicine."

Lawrence S. Brown Jr., M.D., M.P.H., FASAM, Director of ASAM's Region I, has been appointed to the Board of Directors of the United States Anti-Doping Agency (USADA). After October 2000, USADA a newly formed agency, independent from the United States Olympic Committee (USOC), assumed responsibilities previously held by the USOC.

USADA is charged with the responsibilities of testing Olympic caliber athletes, educating athletes and the public about banned substances and illegal drugs, conducting research pertaining to these and other potential agents, and adjudicating determinations of the use by athletes of these substances. Dr. Brown's appointment adds the perspective of addiction medicine and substance abuse to a Board consisting of members representing a wide range of expertise.

Michael M. Miller, M.D., FASAM, has been elected President of the Dane County (WI) Medical Society. Dr. Miller, who serves as ASAM's Secretary and chairs the Public Policy Committee, is Medical Director of Meriter Behavioral Services at Meriter Hospital, Madison, WI. He also has served as ASAM's Delegate to the House of Delegates of the American Medical Association, and is active in the Wisconsin State Medical Society.

Medicaid Rule Change Urged to Allow Funding of Residential Treatment

Addiction treatment advocates are pushing hard for a simple but important change in federal Medicaid regulations that would provide more funding for residential addiction treatment.

Groups ranging from the Community Anti-Drug Coalitions of America (CADCA) to the National Association of State Alcohol and Drug Abuse Directors (NASADAD) are urging Department of Health and Human Services Secretary Donna Shalala to lift the so-called "IMD exclusion" — a piece of Health Care Financing Administration (HCFA) regulatory language that effectively prohibits Medicaid funding of most residential treatment.

Medicaid rules established in 1965 prohibit payment for services delivered to individuals between the ages of 21 and 65 in an institution for mental disease (IMD), which the rules defined as a hospital, nursing facility or other institution with more than 16 beds. HCFA has interpreted this rule to include residential addiction treatment programs, while treatment advocates have called for the restriction to be lifted. "The unintended consequences of the IMD exclusion has been that substance abuse treatment that might be provided in less-costly community-based residential facilities is provided in a costly inpatient hospital setting," NASADAD pointed out in a recent letter to Secretary Shalala.

The subject of the IMD exclusion arose at a December 1999 meeting on drug abuse and criminal offenders, sponsored by the Office of National Drug Control Policy and attended by Secretary Shalala, ONDCP Director Barry McCaffrey and Attorney General Janet Reno. According to meeting attendee Deb Beck, President of the Drug and Alcohol Service Providers Organization of Pennsylvania, advocates told policymakers that changing the IMD rule would provide more treatment capacity for addicted criminal offenders.

Encouraged by a positive reception from federal officials, field groups began writing to Secretary Shalala to encourage her to amend the Medicaid rule. They argued that making the change not only would help break the cycle of addiction and crime, but also provide support to pregnant women and other Temporary Assistance to Needy Families (TANF) recipients, as well as Welfare to Work participants who need to be clean and sober in order to get jobs. "Families who receive TANF or who are in the child abuse/neglect system can either lose their income or custody of their children if they do not receive substance abuse treatment benefits," according to CADCA. "Long waiting lists face these families and other vulnerable populations, including youth. Lifting the IMD exclusion for substance abuse would help tremendously."

In response, Secretary Shalala appointed a work group to look at the problem. Composed of officials from the Substance Abuse and Mental Health Services Administration, HCFA, the Public Health Service, the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, the group has completed a report detailing the history of the IMD exclusion, the current addiction treatment system, the need for increased services and a list of policy options, all of which have been forwarded to the Secretary's office.

Addiction field leaders say that the cost benefits of changing the IMD rule in terms of increasing treatment recipients' employability, reducing their utilization of other health care services and reducing crime would far outweigh any additional treatment expenditures. Ms. Beck, for instance, notes that addiction treatment accounts for a far smaller percentage of behavioral health care costs than mental health, and that the welfare reform of the 1990s has meant a far smaller population of people eligible for Medicaid benefits.

However, with a behavioral health care system where the lines between addiction and mental health care have become increasingly blurry, federal officials reportedly are concerned that tinkering with the IMD language could cause a flood of claims for reimbursement for persons with co-occurring addiction and mental health problems. Policymakers also are wary of potential "cost-shifting" by states, which could take advantage of new IMD language to obtain Medicaid reimbursement for existing services without necessarily increasing capacity.

Advocates stress that Secretary Shalala has the power to amend the rule herself, since the inclusion of addiction treatment under the IMD exclusion is a matter of interpretation, and thus does not require legislation to amend. But the IMD regulations were written to prevent abuses of an institution-based mental health system that has changed radically over the past 35 years. If HHS determines that the rules need to be completely overhauled, then legislative action may indeed be necessary.

Source: Join Together, November 6, 2000. ■

Ruth Fox Memorial Endowment Fund

Dear Colleagues:

On behalf of ASAM and the Ruth Fox Memorial Endowment Fund Committee, we wish to thank you for your generosity and continued support, and extend to you and your family our warmest wishes for a wonderful holiday season and a happy and prosperous New Year.

New donors, additional pledges and contributions will be reported in the next issue of **ASAM News**.

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

AGENCY REPORTS

NIDA: Researchers Provide 'Heads Up' on Emerging Drug Trends

A network of researchers working in the nation's largest cities provide an early warning system for emerging drug trends and problems. Established in 1976, the Community Epidemiology Work Group (CEWG) includes hundreds of researchers in 21 cities who track local drug use trends through a variety of sources, from epidemiological data to anecdotal information.

CEWG members meet twice a year to share and discuss their findings, which are published as trend reports by the National Institute on Drug Abuse (NIDA). For example, a recent advance report from the group spotlighted a surprising uptick in cocaine use in 10 major U.S. cities; methamphetamine use — a hot topic in the press these days — actually was reported to be on the decline in cities like Los Angeles, San Diego, San Francisco, Denver and Phoenix.

Nicholas Kozel, M.S., assistant director of NIDA's Division of Epidemiology, Services, and Prevention Research and project officer for the CEWG, says that researchers in the network were the first to focus attention on the use of the "date rape" drug Rohypnol® in the early 1990s. Jim Hall, a CEWG researcher with the Miami Coalition who also is involved with a substance-abuse hotline, first heard of the drug when reports started coming in about construction workers working to repair damage from Hurricane Andrew using the sedative. And Jane C. Maxwell, Ph.D., a researcher at the Texas Commission on Alcohol and Drug Abuse, reported to CEWG that people were returning from Mexico with Rohypnol, then a legal drug. Testimony by these and other experts led Congress to add Rohypnol to the list of controlled substances and criminalize its possession and use, Kozel said.

CEWG members typically are NIDA grantees or state and local government employees whose job descriptions include analyzing community substance abuse data. They are not compensated by NIDA for their work, and usually do not conduct studies themselves. Rather, they rely on sources like the Drug Abuse Warning Network (DAWN) reports of hospital emergencies and their own network of contacts in the community to gain an understanding of local drug problems. "CEWG is a network of people who pull together secondary information that already exists in ongoing data systems," explains Kozel. "They go to the DAWN data, medical examiners' reports, treatment programs, and police departments — not just arrest data, but also assessments by officers.... Most [CEWG members] have been in place for a number of years, and have fairly polished and comprehensive linkages with their data sources."

Noting that qualitative data often lags behind drug use trends, the CEWG puts an emphasis on gathering anecdotal evidence about popular new drugs and the cultural and societal influences that drive and shape drug use. "A number of CEWG people are trained ethnographers; some have degrees in anthropology," notes Kozel. "Almost all of them consider themselves knowledgeable about the street, even the office-dwellers."

By analyzing multiple sources of information, CEWG members are sometimes able to show the unintended consequences of well-meaning policies. For example, Emory University researcher Claire Sterk, Ph.D., noticed a disparity between levels of female drug use reported by DAWN and Atlanta-area treatment programs and the numbers of women being arrested for drugs in the area. "Sterk conducted interviews and found that women were intentionally avoiding treatment programs and medical intervention because of concern that treatment was not attending to their needs [such as providing child-care services], and they were convinced that if they went in for medical treatment, they would be reported to police, especially if they had children," noted Kozel. That helped explain the low DAWN and treatment figures; Sterk also discovered that many of the women testing positive for drugs in law-enforcement reports were known sex workers who were easy targets for police, who tended to arrest them repeatedly — skewing the statistics again.

As Hall and Maxwell did with Rohypnol, Sterk is bringing her findings to policymakers in the hope that the CEWG information will help them shape better drug policies, both locally and nationally. With their extensive contacts and broad overview of community drug use and data sources, CEWG members also can be excellent resources for local anti-drug organizations serving any of the 21 current surveillance sites.

As federal grantmakers, including the Substance Abuse and Mental Health Services Administration (SAMHSA), increasingly require grantees to prove the effectiveness of their work, the CEWG is bound to become even more valuable to community leaders. Kozel notes that some in the epidemiology field feel that SAMHSA should take an active role in expanding the CEWG to additional communities and support the creation of statewide surveillance programs, such as those now in place in Texas and Louisiana. The ability of networks like the CEWG to give early warning of emerging public health programs should not be underestimated.

Information about the CEWG and its reports is available from NIDA's Division of Epidemiology, Services and Prevention Research, 6001 Executive Blvd., Room 5153 MSC 9589, Bethesda, MD 20892-9589, or by phone at 301/443-6543.

Source: National Institute on Drug Abuse. ■

MEMBERSHIP REPORT

Time is Running Out!

Richard E. Tremblay, M.D., FASAM
Chair, Membership Committee

Dear Colleague:

Here are some important facts for you to consider as you decide whether to renew your membership in ASAM:

- ASAM remains the only medical society for physicians in all specialties who are interested in addictive disorders.
- The fellowship among ASAM members is unparalleled. By continuing your membership in ASAM and your state chapter, you will meet other physicians who share your professional interests and expertise.
- ASAM will enrich your knowledge. The Society continues to produce outstanding educational materials and conferences. ASAM conferences are educational and fun, and next year the Annual Medical-Scientific Conference returns to Los Angeles! The ASAM textbook, *Principles of Addiction Medicine*, now in its second edition, is an essential addition to your professional library, containing clinically useful information found almost nowhere else. ASAM's newly revised and expanded *Patient Placement Criteria for the Treatment of Substance Use Disorders (ASAM PPC-2R)* will help you plan the treatment of even the most difficult dual disorder patients.
- The *Journal of Addictive Diseases* keeps you up to date on scholarly research on the addictions, while *ASAM News* delivers crisp summaries of key developments in research, drug trends and clinical practice, as well as reporting on agency actions and policy initiatives at the state and federal levels. All of these come to you, as a member, at discounted prices (*ASAM News* and the *Journal* are yours entirely free, as a benefit of membership in ASAM!) And don't forget to include the ASAM Web site **www.asam.org** among your "bookmarks" so that you can refer to it regularly for information useful to you and your patients.
- Through ASAM, you can be a force for change. If you believe that there should be parity in insurance coverage for addictive disorders, so that when there is an alcohol, nicotine or other substance use disorder diagnosis, neither you nor your patients face discrimination by insurers and managed care plans, then continuing your ASAM membership is particularly timely. There is no better vehicle in organized medicine for advocacy around the addiction parity issue than ASAM.

Don't lose these unparalleled benefits! Renew today by calling the national office at 301/656-3920, or by using the renewal notice you received in the mail.

For faster service, fax your credit card payment (MasterCard or Visa) to the ASAM office at 301/656-3815.

Thank you, on behalf of the Society and your patients! ■

FUNDING OPPORTUNITIES

Proposals Sought for Substance Abuse Policy Research

The Robert Wood Johnson Foundation is accepting proposals for research projects that will result in policy-relevant information on how to reduce the harm caused by the use of tobacco, alcohol and illicit drugs in the U.S. Grants will be awarded under the foundation's Substance Abuse Policy Research Program (SAPRP). The program is aimed at identifying and assessing policies that can reduce the harm caused by alcohol, tobacco and other drugs; analyzing the development, feasibility, effectiveness and likely consequences of such policies; and ensuring that information gained through these analyses would be used by decision-makers in the public and private sectors.

The grant program is open to experts in public health, law, political science, medicine, sociology, criminal justice, economics, and other behavioral and policy sciences.

The deadline for letters of intent is March 5, 2001. Applicants will be notified whether they have been selected to complete a full proposal. For information about the letters of intent format, contact Tracy Enright Patterson, Substance Abuse Policy Research Program, Department of Public Health Sciences, Wake Forest University School of Medicine, 2000 West First St., Piedmont Plaza II, Suite 101, Winston-Salem, NC 27104. Phone 336/716-5170 or e-mail ***tpatters@wfubmc.edu***.

Source: Robert Wood Johnson Foundation, November 14, 2000

Innovations in Government Grants

Applications are being accepted for the Innovations in American Government Program, which recognizes creative governmental initiatives that are effective in addressing vital public concerns, including alcohol and drug addiction and their public health consequences. The program, inaugurated in 1986, focuses on innovations at the federal, state, county, city, town, district, and tribal levels. Innovations grants are designed to support exemplary achievements in government problem-solving and to strengthen the voices of public-sector innovators.

The program is administered by the John F. Kennedy School of Government at Harvard University in partnership with the Council for Excellence in Government, with support from the Ford Foundation. In 2001, the Ford Foundation will award $100,000 to each Innovations winner and $20,000 to each finalist.

The deadline for paper applications is January 12, 2001, with a January 19 deadline for electronic applications. For information, contact the John F. Kennedy School of Government, Harvard University, 79 John F. Kennedy St., Cambridge, MA 02138.

Source: Ford Foundation, October 24, 2000.

On-Line Resource Provides Funding Data

A new on-line resource enables not-for-profit organizations to obtain summary data on private and community foundations and their funding patterns, according to an announcement from the Foundation Center.

The free service, established by the Foundation Center, is called *FC Stats*. It features more than 500 data tables and ranked lists representing the most frequently requested types of financial data on foundations and their grants.

Not-for-profit groups can use *FC Stats* to research foundation giving in various regions of the country and overseas. In addition, the service can help such groups identify key funders and grant recipients in specific subject areas and find out about the largest foundation grants ever reported.

Source: The Foundation Center, October 19, 2000. ■

ASAM CONFERENCE CALENDAR

ASAM

February 9-11, 2001
14th Annual Conference on Addictions
Florida Society of Addiction Medicine
(jointly sponsored by ASAM)
Orlando, FL
[For information phone 850/484-3560
or e-mail fsam.asam@usa.net]

February 27-March 4, 2001
Southern Coastal International Conference
Jekyll Island, GA
(jointly sponsored by ASAM)
37 Category 1 CME credits
[For information, phone 912/638-5530
or e-mail *hunterconf@aol.com*]

April 5, 2001
3rd Annual National Alcohol Screening Day
(ASAM is a cooperating organization)
[For information, phone 781/239-0071,
or fax 781/431-7447]

April 19, 2001
Ruth Fox Course for Physicians
Los Angeles, CA
8 Category 1 CME credits

April 19, 2001
Pain and Addiction: Common Threads
Los Angeles, CA
7.5 Category 1 CME credits

April 20-22, 2001
32nd Annual Medical-Scientific Conference
Los Angeles, CA
Up to 19 Category 1 CME credits

April 22, 2001
Buprenorphine Training Course
Los Angeles, CA
8 Category 1 CME credits

Southern Coastal International Conference

February 27 - March 4, 2001
Jekyll Island Club Hotel • Jekyll Island, GA

Medical professionals who complete this conference should be better prepared to:

- Correlate the principles of various treatment modalities.
- Identify and assist impaired professionals into treatment.
- Explain the need for and practice the application of ethics in counseling.
- Utilize the changes that have occurred in the last 50 years in developing treatment strategies for the 21st century.
- Describe the need for a strong spiritual foundation in all disciplines in order to receive optimal outcomes.

The registration fee of $435 includes all materials, Reception, breaks, lunches Wednesday through Saturday and dinners Wednesday through Friday. The conference is accredited for 37 hours of Category 1 CME credits.

For information or to register, contact the Southern Coastal International Conference
118 Winton Drive, Brunswick, GA 31525
Phone (912) 638-5530 • Fax (912) 638-5529
or E-mail hunterconf@aol.com

OTHER EVENTS OF NOTE

January 10-13, 2001
2nd Annual Juvenile and Family Court
Drug Training Conference
Miami, FL
[For information, phone 703/706-0576 x 40]

January 23, 2001
Food for Thought: Eating Disorders
and Substance Abuse
(Sponsored by the Center for Addiction
and Substance Abuse at Columbia University, NY)
New York, NY
[For information, phone 212/841-5215
or visit CASA's Web site at
www.casacolumbia.org]

February 22-25, 2001
Preventive Medicine 2001:
Science and Systems for Health
American College of Preventive Medicine
(ASAM is a supporting organization)
Miami, FL
[For information visit the web site at
www.PreventiveMedicine2001.org]

March 23-25, 2001
Society for Research on Nicotine and Tobacco
7th Annual Meeting
Seattle, WA
[For information phone 608/836-3787,
e-mail *srnt@tmahq.com* or visit *www.srnt.org*]

HIGHLIGHTS:

Plan to attend ASAM's Medical-Scientific Conference
APRIL 19-22, 2001 • LOS ANGELES, CALIFORNIA

April 19: Ruth Fox Course for Physicians
April 19: Pain and Addiction: Common Threads
April 20: ASAM Annual Business Meeting
April 20: Medical-Scientific Conference Opens
April 21: Annual Awards Luncheon
April 22: Buprenorphine Training Course

Watch your mail for the Registration Brochure!

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