ASAM NEWS

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NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

INSIDE

ASAM AT WORK FOR YOU:

ALSO SEE:

ASAM at Work for You...

The Impact of Managed Care on Addiction Treatment

Marc Galanter, M.D., FASAM, President

The rise of managed care and other changes in health insurance have had a major effect on all areas of the health care system. The impact of these changes on the addiction treatment system has been largely negative, and needs to be addressed. I want to take this opportunity to review the key issues and suggest some steps we can take to reverse the trend.

The untoward consequences of managed care are evident in the declining rates of insurance coverage, access to treatment, utilization of services, and implementation of research advances. For example, a

Dr. Galanter presides at a session during ASAM's annual Medical-Scientific Conference

▶ **GALANTER** *continued on page 10*

ASAM and AMBHA Agree on Credentialing and Privileging Guideline

Michael M. Miller, M.D., FASAM, Secretary

Following significant negotiations by a team of physicians and other addiction experts, theAmerican Society of Addiction Medicine (ASAM) and the American Managed Behavioral Health Care Association (AMBHA) have agreed on a "Guideline for Credentialing and Privileging of Clinical Professionals for Care of Substance-Related Disorders." The Guideline was adopted by AMBHA's Executive Committee in October 1999 and by ASAM's Board of Directors on February 14, 2000.

Participants in the negotiations on behalf of ASAM were Sheila B. Blume, M.D., FASAM; James F. Callahan, D.P.A.; Christine Kasser, M.D.; David Mee-Lee, M.D.; and Michael M. Miller, M.D., FASAM. Representatives of AMBHA were Barry Blackwell, M.D.; Jonathan D. Book, M.D.; William Eckbert, M.D.; Barry M. Gershuny, M.D.; Pamela Greenberg, M.P.P.; Chris Kvasnica, MSW, CICSW; David K. Nace, M.D.; Rick Rawson, Ph.D.; Ethan S. Rofman, M.D.; and Ian A. Shaffer, M.D.

The Guideline delineates certain clinical activities (such as screening) as appropriate for a full range of generalists and specialists, but specifies that other activities (such as medication management) should be performed only by specially credentialed professionals. Such discriminations become particularly important in the creation of managed care panels. When physicians with addiction expertise try to join the panels established by managed care organizations and behavioral health "carve out" groups, there often is no mechanism to allow their participation because the panels frequently are set up for psychiatric providers only. Without the kinds of information provided in the new Guideline, the credentialing departments don't know how to evaluate non-psychiatrists' training.

Accreditation specialists have praised the Guideline as helping the addiction field keep up with a recent trend toward specialty organizations standardizing the credentialing and privileging of practitioners. G. Louis Ruppersberger, an accreditation consultant, told the newsletter *Behavioral Health Accreditation & Accountability Alert*, "Concern has been growing in recent years regarding the competence of a variety of practitioners in this field, including psychiatrists, primary care physicians, psychologists, nurses and counselors." ■

The full text of the Credentialing and Privileging Guideline is enclosed with this issue of ASAM News.

REPORT FROM THE EXECUTIVE VICE PRESIDENT

Primary Care Physicians Need Our Help in Diagnosing Addiction

James F. Callahan, D.P.A.

A newly released study by the National Center on Addiction and Substance Abuse (CASA) at Columbia University has found that 94% of primary care physicians missed or misdiagnosed signs of alcohol abuse in their patients, while 41% of pediatricians failed to diagnose illegal drug abuse among teens.

In the course of the study, investigators found that physicians presented with early symptoms of alcohol abuse in an adult patient often failed to detect the disorder. Moreover, the physicians interviewed indicated that they lack confidence in the effectiveness of addiction treatment treatment.

The study report, called "Missed Opportunity: The CASA National Survey of Primary Care Physicians and Patients," offers several recommendations, including:

- Medicare, Medicaid, private insurers and managed care should expand coverage for addiction treatment services and pay physicians to talk to patients about alcohol and drug abuse.
- Primary care physicians need to screen their patients for signs of alcohol or drug abuse and be responsive to clusters of symptoms that may signal such problems.
- Primary care physicians should be held liable for negligence if they fail to diagnose substance abuse and addiction.

The report can be downloaded from CASA's web site (*www.casacolumbia.org*) or can be ordered for $22 from CASA at 152 West 57th St., New York, NY 10019-5510.

The CASA study reminds us that we have not yet reached our goal of universal acceptance of addiction as a medical disorder. But you can help to overcome this problem by using every available opportunity to provide general information and expert consultation to your colleagues in primary care practice.

Enclosed with this issue of ASAM News is a pocket-sized card that summarizes current expert advice on "Screening and Brief Interventions for Alcoholism." Pass the card along to a colleague, or use the information it contains as part of your own educational efforts.

To assist you in this undertaking, you will find enclosed with this issue of **ASAM News** a pocket-sized card that summarizes current expert advice on "Screening and Brief Interventions for Alcoholism." Pass the card along to a colleague, or use the information it contains as part of your own educational efforts. I am pleased that ASAM can offer these cards at no cost to you, courtesy of an unrestricted educational grant from DuPont Pharma. Each and every one of us in ASAM has a role to play in advancing understanding of the disease of addiction, not only among policymakers and the public, but among our professional colleagues as well. Thank you for all you have done in the past, and will do in the future. ■

CHAPTER NEWS

Robert Donofrio of the **Florida Society of Addiction Medicine** writes: "We in the Florida chapter have discovered an easy and convenient service offered by American Express. They provide us with a free e-mail service (we do not need to have an American Express account to use the service). The great advantage to this service is the address you can design for your state chapter. We chose *fsam.asam@usa.net* for our e-mail address. Other state chapters could design their e-mail address to be "ourstate.asam@usa.net," and it would be an easy and prestigious address." For more information, contact Robert Donofrio, Florida Society of Addiction Medicine, by phone at 850/484-3560 or by e-mail at *fsam.asam@usa.net*. ■

American Society of Addiction Medicine

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

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Supreme Court Rejects FDA Regulation of Tobacco

The U.S. Supreme Court, rejecting the Clinton administration's unprecedented effort to control how cigarettes are sold and marketed, has ruled that the Food and Drug Administration (FDA) does not have unilateral authority to regulate tobacco as an addictive drug. The 5-4 decision applied to the Clinton administration's main anti-smoking initiative in 1996, which flowed from the agency's determination that nicotine is a drug and that cigarettes and smokeless tobacco are "drug-delivery devices" and thus subject to FDA regulation.

The court said that Congress, through existing laws, had effectively prevented such regulation. "Congress, for better or for worse, has created a distinct regulatory scheme for tobacco products, squarely rejected proposals to give the FDA jurisdiction over tobacco, and repeatedly acted to preclude any agency from exercising significant policymaking authority in the area," Justice O'Connor said in her opionion for the majority. O'Connor was joined by Chief Justice William H. Rehnquist and Justices Antonin Scalia, Anthony M. Kennedy and Clarence Thomas.

In his dissent, Justice Stephen G. Breyer referred to the "perverse result" of the majority's views. He said the court should have interpreted the relevant statutes "in light of Congress' overall desire to protect health" and deferred to the FDA's interpretation of its governing statute. "Far more than most, this particular drug and device risks the life-threatening harms that administrative regulation seeks to rectify," he added. Signing on to his opinion were Justices John Paul Stevens, David H. Souter and Ruth Bader Ginsburg.

The FDA's anti-smoking initiative would have required retailers to check the identification of cigarette and smokeless-tobacco buyers under age 27 and prohibited cigarette vending machines except in bars and other adults-only places. But the rules were more important as the first test of FDA authority to control the powerful tobacco industry.

Reacting to the court's decision, advocates called on the Congress to pass legislation giving the agency such power. "Now the finger is pointed appropriately at the Congress and we ought to get moving," said Sen. Frank Lautenberg (D-NJ). Sen. Edward Kennedy (D-MA) urged Congress to act as soon as possible. "The FDA clearly has the expertise to implement a fair plan to reduce youth smoking and help addicted smokers to quit," he said.

It is uncertain whether the Republican-controlled House of Representatives and Senate will address FDA legislation before the November 2000 elections. Comprehensive tobacco legislation collapsed in Congress in 1998, and further efforts were effectively on hold while the court case was pending. Former FDA commissioner David A. Kessler, who had signed the proposed rules at issue in the case, said that "Congress has a moral responsibility to act." President Clinton also called on lawmakers "to protect our children," noting that more than 400,000 Americans die of tobacco-related diseases each year and that an estimated 80% of them began smoking as children.

Sources: Associated Press, March 21, 2000; Reuters News Service, March 22, 2000; Washington Post, March 22, 2000.

News Analysis

In analyzing the Supreme Court's decision in the FDA case, John Slade, M.D., FASAM, Chair of the ASAM Committee on Nicotine Dependence, said that the court's ruling leaves "Congress as the tobacco industry's regulatory agency." Dr. Slade said that "New legislation is now needed to fashion a more conventional approach to tobacco product regulation. The issue will be before the next Congress in 2001, so the outcome of this Fall's election will determine whether big tobacco or public health gets the more favorable bill through on Capitol Hill. Whoever is in the White House will also help shape this legislation, and it will be the next President's FDA that begins its implementation.

Dr. Slade warned that, "Not content to wait for these events to unfold, R.J. Reynolds has launched a marketing blitz for its pseudo-cigarette, Eclipse, in Dallas and on the web (*www.eclipse.rjrt.com*). Claiming that Eclipse may lower the risk of cancer and of chronic pulmonary disease in smokers, RJR has set up an elaborate set of rationalizations to justify making these health claims without bothering to obtain independent review. Instead, it is relying on its own panel of paid consultants. Reynolds has positioned Eclipse as being in the grand tradition of filtered and low-tar cigarettes, products that have made the tobacco problem worse in recent decades. This self-regulatory approach is disquieting both because of the tobacco industry's long past history of bad faith and intellectual dishonesty and because, until the re-launch of Eclipse on April 20th, RJR had appeared to be eager to cooperate with the development of an orderly regulatory process.

He noted that "Eclipse delivers more carbon monoxide than any cigarette on the market, and the amounts of carcinogens it delivers to consumers is similar to those from at least one brand of conventional cigarette already on the market. Any possible reduction in cancer risk in the distant future has to be weighed against the immediate cardiovascular benefits of simply quitting smoking."

Dr. Slade concluded that "The next months and years promise more interesting developments on the tobacco product regulation front. Stay tuned." ■

▶ **ADM NEWS** *continued on page 4*

▶ **ADM NEWS** *continued from page 3*

High Court to Rule on Legality of Testing Pregnant Women for Drugs

The U.S. Supreme Court will decide whether testing pregnant women for drug use is a violation of the U.S. Constitution. The issue centers around a South Carolina public hospital's drug testing policy, which is designed to detect pregnant women who use crack cocaine. In a ruling expected some time in 2001, the court will decide whether the policy violates Fourth Amendment rights against unreasonable searches.

"On one level, the question before the court is whether pregnant women have lesser constitutional rights than other Americans," said Simon Heller of the Center for Reproductive Law and Policy, one of the lawyers representing 10 women who tested positive. Heller said some of the women who tested positive were arrested "right out of their hospital beds, still bleeding from having given birth." The women were arrested under the state's child endangerment law, which targets women who use illegal drugs while pregnant.

"South Carolina's policy of protecting unborn children from their mother's cocaine abuse will continue even at public hospitals," said South Carolina Attorney General Charlie Condon. "Search warrants can be used as well as consents to search." However, the Medical University of South Carolina discontinued such testing after a 1993 lawsuit.

Condon said the case before the Supreme Court will not hinder the state's efforts. "There is no constitutional right for a pregnant mother to use drugs. The unborn child has a constitutional right to protection from its mother's drug abuse," he said. But Lynn Paltrow of the Women's Law Center called the policy "bad medicine" because it discourages women from seeking prenatal care.

Source: Associated Press, February 28, 2000.

Secondhand Smoke, Alcohol Added to Cancer List

Secondhand tobacco smoke and alcohol have been added to the official list of substances that cause cancer. The bi-annual report issued by the National Institute for Environmental Health Sciences (NIEHS) listed 218 substances known or suspected to cause cancer in humans. The recent report included 14 substances that had either been upgraded to the "known" category or added to the list.

Second-hand smoke topped the upgraded list, based on research showing that second-hand smoke could cause lung cancer, as well as studies demonstrating that nonsmoking wives and coworkers of smokers have higher rates of lung cancer. According to the report, "Environmental tobacco smoke, generated from sidestream and exhaled mainstream smoke of cigarettes, pipes, and cigars, is listed as a 'known human carcinogen'."

The report also added alcoholic beverages as known causes of human cancer, as well as smokeless tobacco, including chewing tobacco and snuff.

Source: Reuters News Service, May 15, 2000.

READER EXCHANGE

Cases Sought by NIDA

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

Alan I. Leshner, Ph.D., Director of the National Institute on Drug Abuse, writes: "Considerable research data are available on the initiation of drug involvement, on the factors that predispose individuals to or protect them from these early stages of drug abuse, and on some of the factors that contribute to the likelihood of escalation. There also is a growing body of evidence characterizing both the behavioral and biological correlates of addiction. However, one of the most critical, yet least understood, phenomena in drug abuse is the transition process from heavy use to actual addiction. NIDA is interested in increasing the understanding of this transition and how to prevent or reverse it.

"As part of this effort, the Institute is interested in collecting case studies or other descriptive accounts of the experiences described by patients and/or observed by clinicians related to the transition from drug use to addiction. NIDA would appreciate receiving case studies that could be used as a basis for further developing the direction of our research program in this area. If you have access to any case studies that you would be willing to share with us, please send them to Dr. Steve Gust in my office, who is coordinating this activity on behalf of NIDA. His address is 6001 Executive Blvd., Room 5274, MSC 9581, Bethesda, MD 20892-9581.

Thank you in advance for your consideration of this request. If you have additional questions, please contact Dr. Gust at 301/443-6480."

SAMHSA to Develop Regs on Buprenorphine

In a notice in the *Federal Register*, the federal Center for Substance Abuse Treatment announced its intention to develop regulations that will allow physicians to provide partial agonist treatment medications such as buprenorphine (when approved by the FDA) in office-based settings to patients addicted to heroin — a practice prohibited under existing federal regulations.

Recognizing that partial or mixed agonist medications are different than full agonist medications (such as methadone or LAAM) and have different risks associated with their use, CSAT announced that the government is considering tailoring federal opioid treatment standards to the "specific characteristics of these future medications." The notice of intent indicates that the proposed rule will include standards for the quantities of medication that may be prescribed, dispensed or administered to patients for unsupervised use. Without the ability to prescribe, physicians would need to store and dispense medications directly to patients. This would be expensive and impractical and not likely to be embraced by office-based physicians.

CSAT Director and ASAM member H. Westley Clark, M.D., FASAM, noted that "the proposed rule will include standards for determining the training and experience necessary to safely treat opiate addicts with these new medications in an office-based setting. These standards could include limits on the number of patients any one physician may treat and requirements for medical and psychosocial services follow-up, such as substance abuse counseling."

Source: Federal Register, May 4, 2000.

Senate: Tobacco Settlement to Pay for Health Services

A U.S. Senate committee has cut funding for state health and human services, arguing that U.S. states received enough money from the tobacco lawsuit settlements to pay for them.

The Senate Appropriations Committee passed a $342 billion plan for health, education, labor and social programs. But the Senate bill would cut $1.1 billion from the Clinton administration's request for $1.7 billion in block grants to states for services such as foster child care, meals for shut-ins and other services for the elderly and disabled.

Committee chair Sen. Arlen Specter (R-PA) commented that the states could make up for the cut in services through funds from the tobacco lawsuit settlements. President Clinton has threatened to veto the bill unless the cuts are restored.

Source: Reuters News Service, May 11, 2000.

Rep. Ramstad: "Fight Drug Problems with Treatment"

Congressman Jim Ramstad (R-MN), a recovering alcoholic, says the U.S. needs to address the war on drugs with treatment, not eradication efforts.

"We're about to spend almost $2 billion to escalate the war on drugs in Colombia, while here in the United States 26 million addicts and alcoholics go untreated," said Ramstad, who is a member of the House Ways and Means Committee and co-chair of the House Law Enforcement Caucus.

"Let's face it, our supply-side efforts have been a colossal failure. Congress and the president need to wake up and face reality," Ramstad said. He added that the $400 million the administration has requested to supply helicopters to the government of Colombia could provide treatment for 200,000 American addicts. "When will Congress and the President wake up to the basic fact that our nation's supply-side strategy does not attack the underlying problem of addiction that causes people to crave and demand drugs?" he asked.

Source: Minneapolis Star Tribune, March 27, 2000.

Bill Creates New Treatment Funding Program

Federal legislation proposed by Sens. John D. Rockefeller (D-WV) and Olympia Snowe (R-ME) would create a new funding avenue for treatment of alcoholism and drug addiction for families in the child welfare system. The bill would require $1.9 billion in federal funds over five years, with $200 million scheduled for fiscal 2001.

In addition, the measure would require cooperation between child welfare and addiction treatment agencies and providers. Specifically, the bill would require addiction treatment and child welfare agencies to apply for funding jointly. Such applications would have to outline joint administration of the program by both agencies, including goals to be achieved, elimination of barriers to treatment, cross training of staff, and evaluation strategies.

Source: Alcoholism & Drug Abuse Weekly, March 27, 2000.

U.S. Criticized for Underfunding Anti-Alcohol Programs

The U.S. lacks a comprehensive federal strategy to reduce the problem of alcohol abuse, says a report by the nonprofit organization Drug Strategies. In its yearly report, "Keeping Score," Drug Strategies points out that alcohol abuse costs the United States an estimated $167 billion each year, yet the amount of federal funding for anti-drinking programs is less than $1 billion, compared to more than $18 billion for anti-drug programs.

The report's authors speculate that the illicit drug problem receives higher funding priority because "voters have demanded action to stop illicit drug problems, but have not expressed similar concerns about alcohol."

Drug Strategies did use the report to laud several federal agencies for key anti-alcohol initiatives, including the Transportation Department's $57 million state incentive grants program for lowering the blood-alcohol limit to .08 percent and the Education Department's grants for reducing college drinking.

Copies of the report can be obtained from Drug Strategies by faxing requests to 202/414-6199.

Source: Substance Abuse Funding News, April 26, 2000.

Study Shows Effectiveness of Methadone Maintenance

A new study shows that long-term methadone maintenance therapy (MMT) combined with psychosocial counseling is much more effective than the temporary use of methadone to detoxify or reduce drug craving among heroin addicts.

The study, by a research team at the University of California, San Francisco and the San Francisco Veteran Affairs Medical Center, was based on interviews with 179 heroin- or cocaine-dependent volunteers. The study team included ASAM members H. Westley Clark, M.D., FASAM, and Peter Banys, M.D.

Volunteers were placed into two groups — a methadone maintenance treatment group and a methadone detoxification group. The MMT group was eligible for 14 months of methadone maintenance, followed by a two-month detoxification. Participants in the group were required to attend substance abuse group therapy for one hour per week for the first six months of maintenance, and one hour per month of individual therapy.

Patients in the detoxification group received methadone only for the first 180 days of their treatment. During their first six months of treatment, the detoxification group was required to attend two hours per week of substance abuse group therapy; one hour per week of cocaine group therapy (if they had tested positive for cocaine when admitted to the study), a series of 14 one-hour, weekly substance abuse education classes, and four weekly individual therapy sessions. This group also received six months of aftercare services that included weekly individual and group psychotherapy and liaison services with the criminal justice system, medical clinics, and social service agencies, but no additional methadone after the first 180 days of their treatment.

"The goal of this study was to determine whether short-term methadone-assisted detoxification, when enriched with intensive psychosocial services and aftercare, could provide an effective alternative to MMT," said Dr. Sharon Hall, study director. "Our results show that no matter how ideologically attractive the notion of a time-limited methadone treatment for heroin abusers, longer-term methadone maintenance treatment is far more effective."

ASAM Executive Vice President James F. Callahan, D.P.A., added that "Some day, all the evidence we've gathered on the effectiveness of MMT will hit home with legislators who want to discontinue it as an addiction treatment modality, or severely limit its use."

Source: Journal of the American Medical Association, March 8, 2000; NIDA press release, March 7, 2000.

Researchers: High-Dose Methadone Improves Outcomes

In a separate NIDA-supported study, Dr. Eric Strain and colleagues at The Johns Hopkins University have demonstrated that high-dose (80 to 100 mg per day) methadone treatment is more effective in reducing heroin use than treatment with a moderate dose (40 to 50 mg per day). Investigators measured the effectiveness of treatment through analysis of twice-weekly observed urine testing, weekly patient reports of heroin use, and the length of time patients remained in treatment. The study has important implications for treatment programs that administer fixed doses of methadone, rather than adjusting dosages to the needs of individual patients.

Source: NIDA Notes, December 1999. ■

Acamprosate Shows Promise in Treating Alcoholics

In the first American trial of acamprosate — a drug designed to help alcoholics avoid drinking — the drug showed promising results. Researchers at the University of Miami School of Medicine reported to the annual meeting of the American Psychiatric Association that the drug worked more effectively for people who wanted to stop drinking entirely as opposed to those who just want to cut down.

"It's not magic," said researcher Barbara Mason. "It's not something a spouse can put in the coffee of the alcoholic in the morning and the problem will go away. It has to go hand-in-hand with having abstinence as your treatment goal."

The six-month study involved 601 alcoholics treated at 21 medical centers. The patients were randomly assigned to take either acamprosate tablets or a placebo twice a day, starting two to 10 days after their last bout of excessive drinking. Study participants also received psychological treatment, education about the effects of alcohol, strategies to help them reduce and quit drinking, and exercises to identify what prompted them to drink.

Dr. Mason noted that 241 of the participants had a goal of complete abstinence. Of that number, those on the placebo stayed away from alcohol 58% of the days they were studied, while those taking 2 grams a day of acamprosate didn't drink on 70% of the days they were studied.

"It's another way to treat alcoholism," said Raye Litten, Ph.D., a program officer for medications development at the National Institute on Alcohol Abuse and Alcoholism. "The more weapons you have to treat, the better off you'll be, because what works for one person may not work for another." Acamprosate, which is manufactured by Lipha S.A. of Lyon, France, is already on the market in Europe, South America and Asia.

Source: Associated Press, May 16, 2000.

A New Strategy to Help Smokers Quit

Researchers at the University of Toronto have developed a strategy that could help wean smokers from cigarettes. The process targets the enzyme that metabolizes nicotine to its inactive byproduct, cotinine, and activates carcinogens in tobacco smoke. "This principle is quite different than anything currently in use," said Edward M. Sellers, M.D., lead investigator of the study. Sellers explained that by inhibiting the action of the enzyme, more nicotine remains in the bloodstream, and the pleasure that the smoker gets from a cigarette lasts longer. Smokers thus light up less frequently. In addition, blocking the enzyme prevents activation of carcinogenic substances in tobacco smoke.

"Smoking is a regulated behavior," Sellers said. "People will not let their nicotine levels go beyond a certain amount. If they go up momentarily, smokers will take fewer or smaller puffs. That can be the first step to quitting."

Source: Presentation to the annual meeting of the American Society for Clinical Pharmacology and Therapeutics, March 17, 2000. ■

SAMHSA: Block Grant Requirements Eliminated

The recently enacted reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA) eliminates an existing requirement that states must spend at least 35% of their allotment on drug-related activities and at least 35% on alcohol-related activities. In addition, states no longer will be required to maintain a $100,000 revolving fund to support recovery homes for individuals with substance abuse problems. It also allows states to use the substance abuse block grant funds for screening and testing for HIV, hepatitis C, and mental illness.

In exchange for the new flexibility, the measure holds states more accountable for how they use federal funds than in the past. Under the measure, the substance abuse block grant is reauthorized as a "performance partnership block grant" which requires that each state work with SAMHSA to develop goals and performance objectives to improve substance abuse services.

Source: Alcoholism & Drug Abuse Weekly, December 13, 1999.

ONDCP: Anti-Drug Budget for 2001 Released

President Clinton's drug control budget for fiscal year 2001 provides only a slight increase for substance abuse prevention and treatment. In recent years, the Clinton administration has heavily promoted its budget increases in treatment and prevention, even as the ratio of supply reduction to demand reduction spending has remained static at about 2:1. This year, however, ONDCP's marquee initiative is an overseas interdiction program dubbed Plan Colombia, which directs $1.3 billion in "emergency" appropriations to help the Colombian government combat cocaine cultivation and fight the drug gangs and Marxist guerrillas who protect the crops in the Andean jungle.

The proposed drug budget also includes a $10 million increase for the National Youth Anti-Drug Media Campaign, which targets youth, their parents and other influential adults on the consequences of illicit drug use. Total program funding would be increased to $50 million annually.

However, funds for the Center for Substance Abuse Prevention (CSAP) would be cut by $5 million, in addition to the $16 million in CSAP budget cuts in the Year 2000 budget.

The budget proposal includes a small increase in the substance abuse block grant and the Center for Substance Abuse Treatment (CSAT) budget. The Block Grant — the primary funding vehicle for drug treatment and prevention services delivered through the states — would receive a modest $31 million increase under the Clinton administration's proposed drug budget.

The Targeted Capacity Expansion Program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) would receive a boost of $53.8 million. The funding would enable SAMHSA to expand the availability of drug treatment in areas of existing or emerging treatment need and provide additional states with State Incentive Grants.

Another $37.2 million is included in the 2001 budget for treatment and prevention research conducted by the National Institutes on Health, primarily the National Institute on Drug Abuse.

Source: ONDCP press release, April 12, 2000: Alcoholism & Drug Abuse Weekly, Feb. 14, 2000.

DOJ: Collaboration Needed on Methamphetamine Problem

A new report from the Methamphetamine Interagency Task Force recommends collaboration among public health, education, law enforcement and public safety agencies to address the growing methamphetamine problem in the U.S. The report was released at last week's 68th Winter Meeting of the U.S. Conference of Mayors by U.S. Attorney General Janet Reno and Barry McCaffrey, director of the Office of National Drug Control Policy (ONDCP), co-chairs of the task force.

"The findings of the Methamphetamine Interagency Task Force will enable us to take the next step toward ridding our communities of the public safety and health problems caused by methamphetamine," said Reno. "By combining prevention and treatment with education and enforcement, we can enable those who are abusing methamphetamine to break the cycle of drugs and crime and become productive citizens."

The task force was authorized with the Comprehensive Methamphetamine Control Act of 1996. Copies of the task force report are available from the National Criminal Justice Reference Service at 1-800/851-3420 (refer to document NCJ 180155).

Source: DOJ press release, February 1, 2000.

FDA: Tobacco Sales Data Posted on the Web

The Food and Drug Administration (FDA) has posted on its website (*www.fda.gov*) the results of nationwide spot-checks to determine retailers' compliance with laws prohibiting tobacco sales to minors. In addition to national and state-specific compliance rates, the site can be searched by zip code to identify local retailers that sold tobacco products to minors. Data on the website were compiled from more than 140,000 compliance checks FDA staff have conducted since 1997.

FDA sources said that, nationally, young people were able to buy cigarettes on 25% of attempts. However, rates for specific states ranged from a high of 53% in Georgia to a low of 9% in Maine. "The disparity in the results is the clearest evidence ever that serious efforts to reduce illegal sales of tobacco to kids work," said Matthew Myers, president of the Campaign for Tobacco Free Kids. "It demonstrates that states that try can cut down on illegal sales."

Source: Wall Street Journal Interactive Edition, January 24, 2000.

NIAAA: Dr. Kunos Named Scientific Director

George Kunos, M.D., Ph.D., has been named Scientific Director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Dr. Kunos joined NIAAA's intramural program in 1987 as Chief of the Laboratory of Physiologic and Pharmacologic Studies, then became Head of the Section on Pharmacology. He left that position to assume his present post as chair of the Department of Pharmacology and Toxicology at the Medical College of Virginia.

At MCV, Dr. Kunos' laboratory provided the first evidence that the effects of alcohol on the neural circuits that control blood pressure and heart rate are mediated by GABA receptors in the brainstem, and that endogenous cannabinoid receptors play an important role in cardiovascular regulation. Dr. Kunos has published more than 105 journal articles and trained 24 postdoctoral fellows and nine graduate students. He assumes his new post at NIAAA in May 2000. ■

2000 MEDICAL-SCIENTIFIC CONFERENCE

ASAM Convenes 31st Annual Medical-Scientific Conference in Chicago

Participants Sid Schnoll, M.D., Ph.D., FASAM, and Richard K. Fuller, M.D., relax during a break in the 20th Annual Ruth Fox Course for Physicians. Course directors Anne Geller, M.D., FASAM and Anthony H. Dekker, D.O., FASAM, assembled an outstanding faculty to provide up-to-date information about current trends in addiction medicine.

More than a thousand physicians and other health care professionals gathered in Chicago for ASAM's 31st Annual Medical-Scientific Conference, April 14-16. During the conference, Enoch Gordis, M.D., Director of the National Institute on Alcohol Abuse and Alcoholism, presided over a day-long symposium on "Alcohol-Induced Organ Toxicity: Implications for Treatment of Alcoholism."

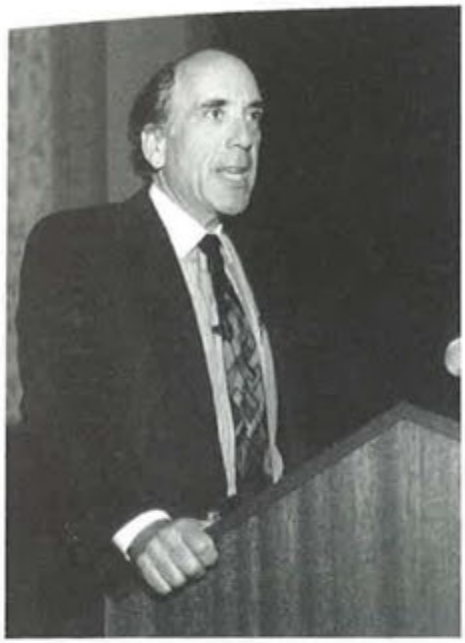
Mel Pohl, M.D., FASAM, and Larry Siegel, M.D., organized a clinical update on AIDS issues. Here Dr. Pohl (left) congratulates faculty members Barbara Chaffee, M.D., and David Ostrow, M.D., at the conclusion of the course.

ASAM ASAM Executive Vice President/CEO James F. Callahan, D.P.A. (right) greets Robert E. Larsen, M.D., Hazelden's Coordinator of Health Care Professional Services, during a visit to the exhibit hall.

An overflow crowd packed a special ASAM Forum on "Pain and Addiction: Common Threads." Program chairs Howard A. Heit, M.D., FACP, FASAM and Seddon R. Savage, M.D., FASAM, and their planning committee designed the Forum to equip addiction medicine practitioners to act as consultants in the treatment of pain, to review the basic science and clinical practice of pain management in addicted patients, and to explore evolving insights into common features of pain and addiction.

ASAM Awards Honor Leadership in the Society and the Addictions Field

The ASAM Awards Luncheon featured presentation of the John P. McGovern Award on Addiction and Society to former First Lady Betty Ford, Founder and Director of the Betty Ford Center at Rancho Mirage, CA. Mrs. Ford accepted via video. The McGovern Award was established in 1997 to honor individuals whose contributions to public policy, treatment, research or prevention "have increased our understanding of the relationship of addiction and society."



A highlight of the opening ceremony was the R. Brinkley Smithers Distinguished Scientist Lecture, delivered this year by Marc A. Schuckit, M.D., Director of the Alcohol Research Center at the VA San Diego Healthcare System and Professor of Psychiatry at the University of California, San Diego, School of Medicine.

ASAM's Web Master, William B. Hawthorne, M.D., received an Annual Award "for outstanding contributions to the growth and vitality of our Society, for thoughtful leadership in the field, and for deep understanding of the art and science of addiction medicine."

David I. Canavan, M.D. (left) was presented a Special Award by President Marc Galanter, M.D., in recognition of Dr. Canavan's contributions to the health and effectiveness of all physicians.

A special ASAM Award was presented to Mrs. Adele C. Smithers-Fornaci, President of the Christopher D. Smithers Foundation, "in recognition of her personal endeavors and for continuing the vision of her late husband, R. Brinkley Smithers, who dedicated his life and considerable financial resources to creating a better public understanding of alcoholism as a treatable disease...." Shown here congratulating Mrs. Smithers-Fornaci are Mr. Fornaci (left) and ASAM Executive Vice President James F. Callahan, D.P.A.

Medical-Scientific Program chair Edward Gottheil, M.D., FASAM, presented ASAM's Young Investigator Award for the year 2000 to Estee Sharon, Psy.D., for the best abstract submitted for presentation at the conference.

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

recent evaluation of health insurance coverage available to employees in a representative sample of 1,017 American companies found that the value of benefits for addiction treatment declined by 74.5% from 1988 through 1998, compared with declines of 11.5% in the value of general medical coverage and 52.3% in benefits for mental health care exclusive of addiction[1]. This trend is corroborated by data from the U.S. Department of Labor, Bureau of Labor Statistics, which has reported increasing restrictions on health insurance benefits for addiction treatment[2]. Similarly, the trend toward for-profit and "carved out" managed health care arrangements is associated with incentives for less investment in addiction treatment[3,4].

As a result, the options for providing addiction treatment have narrowed, as the shift toward managed care has come to be associated with marked reductions in the frequency and duration of inpatient hospitalization, despite the demonstrable need for such care on the part of many patients. This decrease has not been offset by a corresponding increase in the utilization of outpatient treatment[4].

The impact of these developments is apparent in a 1998 survey of physicians specializing in addiction medicine, a majority of whom indicated that managed care has had a negative impact on both inpatient detoxification and rehabilitation, and on inpatient and outpatient rehabilitation[5]. Moreover, physicians are constrained by federal ERISA legislation, which stipulates that liability for poor outcomes of treatment decisions resides with providers, rather than payers (see the related story, following)[6], even though physicians' clinical decision-making authority increasingly is usurped by representatives of the insurance industry.

These developments stand in contrast to the results of a recent exhaustive evaluation[7], which showed that coverage for substance use disorders would add little cost to overall health expenditures. It is puzzling also because a decade's worth of research into treatment techniques has yielded improved psychosocial and pharmacologic approaches and better accuracy in patient-treatment matching, resulting in real advances in patient outcomes. Reported decreases in the availability of treatment thus deprive patients of the benefits of treatments that are proved to be effective, thereby effectively compromising the very research-based approaches that could make managed care more efficient and cost-effective[8].

To address these issues, ASAM as an organization and each of us as individuals must respond constructively and forcefully. Here are some recommendations, which we seek to have endorsed by other addiction treatment organizations:

Economic Policy

1. Parity should be established for addiction treatment relative to other medical disorders. However, it should not be secured at the expense of access to treatment or at a prohibitively low reimbursement rate.
2. Since higher quality treatment is made available by removing arbitrary ceilings on reimbursement, and studies show that costs would not increase appreciably if this were done, major constraints on expenditures should be eliminated.
3. Physicians should not be forced out of the treatment field by an inadequate reimbursement structure or by unwarranted exclusion from provider panels.

Clinical Practice

4. Treatment should be guided by criteria for patient care that are empirically derived by physicians and other clinical researchers, such as the ASAM Patient Placement Criteria and practice guidelines.
5. Treatment should include support for patients' entry into care. Motivational difficulties and denial are part of the addictive disorder and must be addressed through support for initiation of treatment.

Managed Care

6. Insurers and managed care organizations should be liable for the results of any constraints they impose on treatment. This will require modification of federal ERISA statutes.
7. It should be possible to appeal a denial or reduction of treatment. Such appeals should be decided expeditiously by appropriately trained and experienced clinicians who act independently of the managed care organization or other third-party payer. This is a key feature of many of the Patient Protection Acts introduced in the Congress and the state legislatures, and deserves our support.

▶ **GALANTER** *continued on page 11*

Illinois Court Allows Patient to Sue Managed Care Plan

In a landmark ruling expected to alter the way managed care plans do business, the Illinois Supreme Court has ruled that HMOs and other managed care organizations can be held liable for negligence involving a patient's medical care. In the past, managed care organizations have enjoyed presumed legal protection against malpractice suits.

"This ruling means patients can now proceed directly against the HMO for the HMO's carelessness or negligence for causing an injury," said A. Denison Weaver, a Chicago attorney who successfully brought the action against Chicago HMO, a Medicaid managed care plan now operated by United HealthCare of Illinois Inc. "HMOs can't hide behind the skirts of the doctor," he said.

In overturning an appellate court ruling that had sided with Chicago HMO, Supreme Court Justice Michael Bilandic wrote that the plaintiff's claim that Chicago HMO was negligent in not providing adequate physician services "falls within the purview of institutional negligence." The Supreme Court's action carries no verdict of innocence or guilt; those issues are to be decided at separate legal proceedings in Cook County Circuit Court.

The Illinois ruling has an immediate impact on 2.4 million residents of the state who are enrolled in "insured" HMOs, but it is not likely to directly affect hundreds of thousands of residents in self-insured plans, which are exempted from such litigation by federal ERISA statutes.

Pending in Congress is a measure that would create uniform regulations on managed health care that could affect self-insured health plans. In California, Gov. Gray Davis last year signed a health reform package into law that allows patients to sue MCOs for malpractice — a right enjoyed by patients in Texas and a few other states. And another case that originated in Illinois is pending before the U.S. Supreme Court on issues that could affect managed care practices.

Source: Chicago Tribune, May 19, 2000. ■

▶ GALANTER continued from page 10

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[7] Sturm R, Zhang W & Schoenbaum M (1999). How expensive are unlimited substance abuse benefits under managed care? *Journal of Behavioral Health Services Research* 26:203-210.

[8] U.S. Department of Health and Human Services (1998). *The Economic Costs of Alcohol and Drug Abuse in the United States, 1992*. Washington, DC: U.S. Government Printing Office.

Study Shows Lower Copayments Encourage Addiction Treatment

A new study shows that more people addicted to alcohol or other drugs would undergo effective addiction treatment if copayments under their managed care plans were reduced. The study was conducted at the RAND Corporation by Dr. Bradley Stein, assistant professor of psychiatry at the University of Southern California, and RAND researchers.

"Our study showed that 79% of detoxification patients in managed care received formal substance abuse treatment follow-up, but their participation in these follow-up treatment programs depended on the amount of their copayments," Stein said.

The study was based on an analysis of seven years of data for more than 1,000 patients from 14 employer groups whose benefits are managed by United Behavioral Health Inc., the third-largest managed behavioral healthcare company in the United States.

The research team found that having no copayment increased treatment participation by 24%, while a $10 copayment increased participation by 5%. On the other hand, if the copayment was $30, there was a 43% decrease in the number of patients participating in follow-up treatment. Copayments of $20 resulted in a 19% decrease in participation.

Source: Psychiatric Services, February 2000. ■

MRO UPDATE

DOT Urged to Emulate FAA's Drug Program

The U.S. Department of Transportation should adopt the Federal Aviation Administration's (FAA) drug protocols as a model in establishing a medical certification program for bus and truck drivers, according to James Hall, chair of the National Transportation Safety Board (NTSB). Mr. Hall testified on the issue during hearings into a crash that killed 22 bus passengers in May 1999.

> ...physicians who certify pilots as alcohol- and drug-free must have passed a special training course. This is not currently the case for those who examine bus and truck drivers.

Under the FAA's pilot medical certification program, physicians who certify pilots as alcohol- and drug-free must have passed a special training course. This is not currently the case for those who examine bus and truck drivers.

In addition, all pilot examination results, including those for alcohol and drug screens, must be forwarded to the FAA for possible review. Pilots who test positive for alcohol or other drugs are grounded while they undergo treatment.

Congress passed laws in 1999 that would require employers of bus and truck drivers to report positive drug tests to state officials and to check drivers' drug-test histories. But transportation experts say that many physicians who perform examinations of bus drivers and truckers never receive training on the assessment of commercial drivers.

Source: Associated Press, January 20, 2000.

MRO Training and Certification Exams Offered

ASAM training courses for Medical Review Officers are to be offered July 28-30, 2000, in Chicago, IL, and December 1-3, 2000, in Washington, DC. Each of the courses is approved for 19 Category 1 CME credits. Information on these courses is available from the ASAM Conference staff at 301/656-3920, or consult the ASAM web site (*wsw.asam.org*).

Following each of the ASAM MRO training courses, the Medical Review Officer Certification Council (MROCC) will conduct a certification examination. Information and registration for the examination are available from MROCC by phone at 847/671-1829 or by fax at 847/671-1931. An application for the exam can be downloaded from the MROCC web site (*www.mrocc.com*). The deadline for registering generally is 30 days prior to an examination.

DOL Information Database

The U.S. Department of Labor's Substance Abuse Information Database (SAID), a web-based tool, contains information ranging from workplace alcohol and drug programs and policies to materials for educating employers and employees and conducting drug testing, as well as references on pertinent laws and regulations. Access the database at *http://www.dol.gov:8001/said.nsf/*.

Source: U.S. Department of Labor web site.

Employer's Guide Addresses Workplace Issues

The U.S. Department of Labor has published *An Employer's Guide to Dealing with Substance Abuse*, which explains the requirements of the Drug Free Workplace Act of 1998, describes steps to build drug-free workplace programs, and provides links to additional resources. The guide is available on the DOL web site (*www.dol.gov*). ■

Computer Training for MDs

According to a recent report in *American Medical News*, many physicians are going back to class to brush up their computer skills. As an example, *AMNews* cited the case of Nancy Barr, M.D., an associate professor of pathology at the University of Southern California School of Medicine who felt she wasn't keeping up with advances in her field and wasn't using her computer and the Internet as efficiently as she could. So Dr. Barr signed up for a three-day basic computer training class for physicians at the University of California, San Diego, last year. She had such a good experience that she registered for a more advanced course this summer at UCSD.

"The course was well organized and very useful to me because I'm in academic medicine and I need to stay current with recent advances in pathology," Dr. Barr said. "I write a lot of papers and chapters and I need to search, retrieve and get the right information [online] as efficiently as possible."

As the Internet and other technologies increasingly affect how physicians practice medicine, *AMNews* reports that a number of universities have implemented or are on the verge of offering web-based distance learning courses and certificates in medical informatics for physicians who want to learn about technology but not invest the years and thousands of dollars on a degree in medical informatics, the study of the use of computers in medicine.

Mastering the Basics

University of California, San Diego: Basic computer training for physicians is available at the University of California, San Diego (*http://cme.ucsd.edu/brochures_frame.htm*), where the three-day "beginner course" draws physicians from throughout the U.S. The monthly course has been so successful that UCSD's CME department this year added two-day advanced training courses focusing on mastering e-mail, Internet searches, word processing, spread sheets and Microsoft PowerPoint. Physicians receive 14 to 20 hours of CME credits for the courses, which cost $575 each.

Stanford University: Stanford offers an on-line introductory course in medical informatics for $1,000. The on-line course (*www.smi.stanford.edu/shortcourse.html*), which is available throughout the year, lasts 12 weeks.

A week-long version of the course, offered twice a year at Stanford's Palo Alto (CA) campus, costs $1,500 or $1,850, depending on whether a computer laboratory fee is included. Physicians can receive 25 hours and 34.25 hours of CME credits, respectively, for the on-line and on-campus courses.

University of Michigan: The University and the Association of Medical Directors of Information Systems, or AMDIS (*www.amdis.org*) are planning a web-based distance learning certificate program for medical informatics. To be available in late 2000, the course will cost about $1,000. Physicians will receive continuing medical education credits.

Oregon Health Sciences University: Portland-based OHSU plans to launch a one-year, on-line distance learning certificate program in medical informatics in the fall semester 2000 (*www.ohsu.edu/bicc-informatics/distance/*). To earn the certificate, physicians will complete eight courses costing about $1,500 each, said William Hersh, M.D., associate professor and chief of OHSU's Division of Medical Informatics and Outcomes Research.

OHSU also offers a more basic course about computers and the Internet that costs $395. The two-day CME course is available only on-campus, but the university hopes to have an on-line version ready by the end of the year, Dr. Hersh said.

Physicians also can contact community colleges and local universities for basic computer literacy classes. Many local high schools also offer basic computer training classes in adult-education programs.

Advanced Courses

Experts advise that physicians who seek advanced technical knowledge are better served by enrolling at one of several universities around the country that offer a master's of science or Ph.D. in medical or health informatics. Tuition for a master's program costs up to $12,500 a year. Many universities, however, offer postdoctorate fellowships, funded by the National Library of Medicine (NLM; *http://www.nlm.nih.gov/*), which offer a stipend and free tuition.

In addition to funding fellowships, the Library offers a weeklong introductory medical informatics course for physicians and other medical professionals twice a year at Woods Hole, MA. NLM pays for tuition, room and board, and travel expenses. However, physicians must apply and be accepted into the program (*http://courses.mbl.edu/Medical_Informatics/*), which targets medical professionals as potential "agents of change" in their communities and health care organizations.

While the cost of obtaining a master's degree is substantial, physicians who hold both a medical informatics degree and clinical experience are much in demand. For example, pharmaceutical companies in recent years have hired five physicians who completed Columbia University's program at annual salaries of $300,000, said Stephen Johnson, Ph.D., associate professor of medical informatics at Columbia (*http://www.cpmc.columbia.edu/*) in New York. The Columbia master's program costs $25,000 regardless of whether a physician completes the coursework over one year or two years, Dr. Johnson said.

Source: T Chin, American Medical News, May 22/29, 2000.

IN MEMORIAM

Gerald L. Summer, M.D., FASAM, who headed the Physicians' Recovery Network of Alabama, died peacefully February 10 at his Montgomery home after a two-year battle with pancreatic cancer.

As a past President of the Federation of State Physician Health Programs, Dr. Summer is widely credited with advancing that organization "from adolescence to adulthood." Current Federation President Lynn Hankes, M.D., FASAM, recalled that Dr. Summer "played an integral role in helping the Federation of State Medical Boards to develop definitive guidelines for physician impairment."

Dr. Summer was ASAM-certified in Addiction Medicine in 1986, as well as Board-certified in Internal Medicine. Donations in his memory may be made to the Pancreatic Cancer Network, PO Box 4809, Palos Verdes, CA.

Sherrod V. Anderson, M.D., M.P.H., died October 23, 1999, at Washington, DC.

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. ■

Ruth Fox, 1895-1989

Ruth Fox Memorial Endowment Fund

Dear Colleague:

During the annual Ruth Fox Memorial Endowment Fund reception, held as part of ASAM's Medical-Scientific Conference in Chicago, the generosity of the funds' many donors was celebrated.

Singled out for special recognition with a Gold Medallion was Elizabeth F. Howell, M.D., FASAM, while a Silver medallion went to Michael S. Levy, D.O. Bronze Medallions were awarded to Howard A. Heit, M.D., FASAM, Clyde E. Elliott, M.D., Harley J. Harber, M.D., P.A., FASAM, John P. McGovern, M.D., FASAM, and Richard J. Ready, M.D.

The reception was underwritten by a generous gift from Joseph E. Dorsey, M.D., FASAM, and Mrs. Dorsey. Their current gift is in addition to many previous gifts to the endowment fund by Dr. and Mrs. Dorsey, for which they have been named members of the fund's Distinguished Fellows' Circle.

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

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

Medical-Scientific Program Coordinator Louisa Macpherson shares a rare moment "off-duty" at the reception with husband Ian.

ASAM President Marc Galanter, M.D., FASAM, congratulates honoree Elizabeth F. Howell, M.D., FASAM.

Director of Development Claire Osman chats with Percy E. Ryberg, M.D., who chairs ASAM's History Committee.

Dr. Galanter and President-Elect Andrea Barthwell, M.D., FASAM, welcome honoree Howard Heit, M.D., FASAM.

Ruth Fox Fund Chair Max A. Schneider, M.D., welcomes Fund supporter H. Westley Clark, M.D., J.D., FASAM.

FUNDING OPPORTUNITIIES

RWJ Program Seeks Applicants

The Robert Wood Johnson Foundation is accepting applications for its Local Initiative Funding Partners Program (LIFPP) 2001. The program is designed to create partnerships between the foundation and local grantmakers in support of innovative, community-based projects that focus on underserved and at-risk populations.

More than $48 million in grants have been awarded through the initiative since it began in 1987. In 2001, up to $7 million will be awarded. Grants for 36 to 48 months range from $50,000 to $500,000. The grants must be matched fully by local sources.

To be eligible for funding, projects must provide community-based services that are new and innovative for the community. Local grantmakers may be corporate or private foundations, local charitable organizations, religious groups, special fundraising entities or individual benefactors.

Deadline for submission of a concept paper and preliminary budget is August 1, 2000. Projects selected for second stage applications must submit full proposals by December 5.

For details, contact Pauline M. Seitz, Director, or Orrin T. Hardgrove, Deputy Director, Local Initiative Funding Partners Program, c/o Health Research and Educational Trust of New Jersey, 760 Alexander Rd., PO Box 1, Princeton, NJ 08543-0001; phone 609/275-4128, or e-mail *thardgro@njha.org*.

Source: Robert Wood Johnson Foundation press release, March 13, 2000.

Grants Fund Programs on Co-Occurring Mental, Addictive Disorders

Up to $1.2 million in grants are available for programs directed at youth and adults with co-occurring substance use and mental disorders. Specifically, the funding will support a national center for designing and implementing effective addiction and mental health services for youths and adults involved in the criminal justice system.

Applicants must propose a strategy to provide technical assistance at the community and national levels to enhance the ability of treatment professionals to affect the behaviors of the targeted population.

"It is very common to see emotionally disturbed youth turning to drugs and getting into trouble with the justice system," said SAMHSA Administrator Nelba Chavez. "The center must bring together substance abuse and mental health providers, corrections officials and the community to create appropriate treatment approaches that can integrate mental health and substance abuse services at key points in the criminal justice system, from entry into the justice system, to jails, prisons, probation and parole."

The deadline for applications is July 21. Applications are available by calling 1-800/729-6686 and referring to GFA Number TI 00-007. Questions on program issues should be directed to Bruce Fry, project officer, at 301/443- 0128. Grants management questions should be directed to Christine Chen at 301/443-8926.

Source: SAMHSA press release, May 16, 2000.

Publication Lists Grant Opportunities

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a publication, called *Snapshot*, to provide information about its grant programs to service providers, state and local organizations, educators, consumers, and family organizations.

The guide's first issue offers a preliminary view of funding opportunities in addiction treatment and prevention, as well as mental health services, for fiscal year 2000. It also provides an overview of how the grant process works, eligibility criteria, contact information, and how to develop and submit applications.

The free guide is available by sending an e-mail request, including mailing address, to *snapshot@samhsa.gov*. For additional information, call SAMHSA's Division of Extramural Activities, Policy and Review, at 301/443-4266 or fax 301/443-1587.

Source: Alcoholism & Drug Abuse Weekly, March 6, 2000.

PHYSICIAN HEALTH

Early Detection and Treatment Enhances Physician Health

Lynn R. Hankes, M.D., FASAM

Attendees at a conference co-sponsored by ASAM heard researchers report that early detection and treatment can prevent impaired doctors from harming others or themselves. The study authors, presenting their work at the International Conference on Physician Health, reviewed 10 years' research data on physician mental disorders.

"The old adage 'physician heal thyself' is just about impossible for somebody with a drug and alcohol problem. That's where some help is needed," said George D. Miller, MD, medical director of the Medical Association of Georgia's Physicians Well Being Program.

Although the age-old problem of delayed intervention persists, some physician health programs are finding ways to minimize this barrier. Key to this process is developing trusting relationships with hospitals, large clinical practices, managed care plans and the doctors themselves.

Physicians now surpass commercial airline pilots as being in the profession that has the most successful outcomes from intervention programs.

"Physicians are more prone to get involved, with less resistance than before," said Lynn R. Hankes, M.D., FASAM, President of the Federation of State Physician Health Programs. "It's become almost unusual where we have to threaten an 'either/or' — either come into our program or I'm picking up the phone to call the [medical] board."

Such intervention programs have developed an impressive track record: physicians now surpass commercial airline pilots as being in the profession that has the most successful outcomes from intervention programs. "It's primarily because we have in place programs to provide early identification, intervention and treatment, followed by a critical element, which is monitoring these physicians for an extended period of time," Dr. Hankes said.

Source: Foubister B, Professional Issues, American Medical News, April 3, 2000.

ASAM CONFERENCE CALENDAR

ASAM

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

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

November 3-5
Adolescent Substance Abuse —
A Course for Health Care Practitioners
Washington, DC
(co-sponsored by the American Academy of Pediatrics, the Society for Adolescent Medicine, the Academy of Child and Adolescent Psychiatry, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism)

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

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

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

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

STATE OF GEORGIA

The Division of Mental Health, Mental Retardation and Substance Abuse (MHMRSA) is seeking a Substance Abuse Program Chief to serve as the Single State Authority in overseeing the federal SA Prevention and Treatment Block Grant and to manage statewide planning of SA treatment programs and policies. Minimum qualifications are a Master's degree in a related field with extensive SA experience. Preferred qualifications are a doctoral degree in a related field, or a medical degree with board certification and an additional Certificate of Added Qualifications in Addiction Psychiatry or ASAM Certification, three years of SA experience with at least one year in developing statewide or regional systems, and a reputation as a national leader in SA.

Salary range is dependent on qualifications, with the salary for a medical doctor based on Georgia's physician pay scale.

For more details, visit our web site at *http://www.thejobsite.org*. Submit two State of Georgia applications and/or two comprehensive resumes to Darlene Meador, Ph.D., MHMRSA, 2 Peachtree St., Suite 23-410, Atlanta, GA 30303-3142 by July 11, 2000.

OTHER EVENTS OF NOTE

May 7-10
National Institute on Drug Abuse
Bringing It All Together: A Research and Practice-Based Conference on Prevention, Treatment, and Care
Baltimore, MD
[For information: Keith Van Wagner at 301/443-6071]

June 9-10
Medical Aspects of Addiction — Adolescents and Older Adults: Conference of the South Carolina Society of Addiction Medicine
Myrtle Beach, SC
[For information: e-mail *Mmiller@daodas.state.sc.us*]

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

August 6-11
11th World Conference on Tobacco OR Health — Promoting a Future Without Tobacco
Chicago, IL
[For information phone 312/464-9059 or visit *www.wctoh.org*]

September 9-13
National Commission on Correctional Health Care
St. Louis, MO
[For information phone 773/880-1460 or e-mail *ncchc@ncchc.org*]

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

October 11-14
CSAM Review Course in Addiction Medicine
San Francisco, CA
[For information: phone 415/243-3322]

October 13
Pain, Opioids and Addiction
Birmingham, AL
(sponsored by the Pain and Rehabilitation Institute)
[For information phone 205/591-7246]

November 6-9
Addictions 2000: Conference of the International Society of Addiction Medicine
Jerusalem, Israel
[For information: e-mail *dvdgleser@matat.health.gov.il*]

Highlights:

Addictions 2000 Conference

July 1, 2000, is the deadline for submission of abstracts for the Scientific Conference of the International Society of Addiction Medicine, set for November 7-9 in Jerusalem. Dr. Jorge Gleser and the local organizing committee report that the conference program will be available on the ISAM web site (*www.sympatico.ca/pmdoc/ISAM*) in July. For more information, contact Dr. Gleser at 20 King David St., Jerusalem, Israel 91010, or e-mail *jorge.gleser@moh.health.gov.il*.

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