ASAM NEWS

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NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

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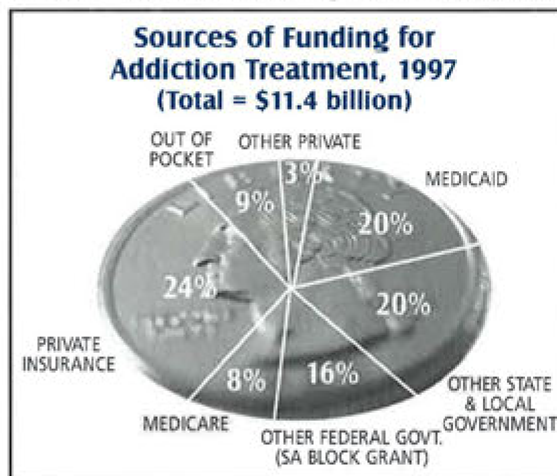
Private Sector Funding for Treatment Declines; Experts Point to Need for Parity

New federal data show that overall spending on addiction treatment is shrinking as a percentage of total national health care expenditures, and that the private sector's contribution to treatment funding has dropped markedly over the past decade. This underscores the need for parity in coverage of addiction treatment, according to the Administrator of the federal Substance Abuse and Mental Health Services Administration (SAMHSA). In releasing the data, Dr. Nelba Chavez said that about 28% of American adults experience a mental health or substance abuse problem in the course of any given year. So that Americans can get the treatment services they need, she said, "we must continue to fight the stigma and work for insurance parity."



CSAT Director H. Westley Clark, M.D., FASAM, comments on the study findings.

ASAM member H. Westley Clark, M.D., J.D., M.P.H., FASAM, who directs the federal Center for Substance Abuse Treatment (CSAT), which co-sponsored the research, added that "It is time to treat substance abuse like any other illness....It is my hope that this data will begin to change the public perception that substance abuse treatment is too costly. In reality, *not* treating patients for alcohol or drug

▶ **PRIVATE SECTOR FUNDING** *continued on page 15*

States Report Some Progress on Parity

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

As the new CSAT report on treatment funding makes clear, the issue of parity for addiction treatment gains urgency with each passing day. Parity is simply defined as providing insurance coverage under the same terms and conditions (e.g., cost sharing, service limits, and spending limits) for the treatment of *all* medical disorders, without imposing different requirements for addictive (or mental health) disorders.

Earlier this year, I reported to you that enactment of state and federal legislation guaranteeing parity in benefits for addiction treatment would be ASAM's most important immediate goal. Now that most of the state legislative sessions have adjourned for the summer, I want to give you a "report card" on our progress to date. You will note that this report includes several bills introduced but not yet passed, because even these "failures" help us to identify our allies and opponents so that we can be more effective in the next effort. Also, a significant number of the bills have been carried over to the next legislative session, which presents another opportunity for enactment of parity legislation.

Full Parity Acts

Five states — Connecticut, Maryland, Minnesota, Vermont and Virginia — have enacted laws that guarantee full parity for addiction treatment.

Connecticut. A law adopted in 1999 broadens a measure enacted by Connecticut in 1997 in two

▶ **PARITY** *continued on page 15*

POLICY ALERT

Federal Bills Would Override Counselor Education Requirements

Education requirements for alcohol and drug counselors would be undermined by legislation passed by the House and pending in the Senate, according to the National Association of Alcoholism and Drug Abuse Counselors. NAADAC is coordinating action by a number of addiction field organizations, including ASAM, to modify the legislation.

The language on training and certification is part of a House bill that passed in late July by a vote of 397 to 27. In the Senate, the objectionable language has been made part of the New Markets/Community Renewal Act (S.2779), a bipartisan measure that would expand the role of religious organizations in providing federally funded community services. In addition to providing tax breaks and savings incentives to poor neighborhoods, the bill would allow faith-based organizations to run federally funded addiction treatment programs.

Like its House counterpart, S.2779 would require the states to accept religious education as equivalent to the professional preparation currently required of alcohol and drug counselors (e.g., a theology degree without any counselor training would be accepted as comparable to a degree in social work). NAADAC reports that the bills' language is wide-ranging and could be applied to other professions, including mental health and social workers and day care providers.

NAADAC cautions that quick action is needed to amend the Senate bill, which is sponsored by four Republicans and three Democrats and has bipartisan support. Because the White House already has announced its support for the measure, there is little doubt that, if passed, President Clinton would sign the bill into law.

What You Can Do

Phone your Senators (the Capitol switchboard number is 202/224-3121). Tell them that you want the waiver of educational requirements for faith-based addiction treatment providers deleted from the New Markets/Community Renewal Act (S.2779).

Also, contact Bill McColl at the National Association of Alcoholism and Drug Abuse Counselors (***bmccoll@naadac.org***) or 1-800/548-0497 to let him know that you made the calls so that he can report the number of opposing messages to the bill's sponsors.

Sources: Associated Press, June 23, 2000; National Association of Alcoholism and Drug Abuse Counselors, July 20 and 25, 2000.

S.2779: Talking Points

- The training provisions of the New Markets/Community Renewal Act (S.2779) represent a setback in the long effort to develop and credential professional staff to deliver addiction treatment services.
- As drafted, the bill would override state laws and undermine the states' traditional role in licensing, certifying and regulating the health professions.
- Language in the bill incorrectly states that addiction treatment counseling is *not* a professional field and that formal education for counselors is detrimental to the practice of effective counseling. *In fact, addiction is a disease, and its treatment requires the services of appropriately trained and credentialed professionals.*
- Specifically, the bill would require states to "give credit for religious education and training equivalent to credit given for secular course work in drug treatment...."
- To demonstrate how dangerous the bill's provisions could be, simply substitute the name of a comparable health profession: e.g., "give credit for religious education and training equivalent to credit given for secular course work in ***laboratory technology***...."

House Democrats Ready to Introduce SAMHSA Bill

Democrat members of the U.S. House of Representatives said they were ready to introduce a reauthorization bill for the Substance Abuse and Mental Health Services Administration (SAMHSA). The House bill, which is 75 days behind schedule, is expected to be modeled on legislation passed by the U.S. Senate last fall. The Senate bill proposed $60 million in new at-risk youth substance abuse treatment and prevention grants. The measure also calls for a revamping of SAMHSA's grantmaking rules.

The House bill could go further, with the inclusion of an additional $25 million to fund community grants for alcohol prevention among teens.

Source: Substance Abuse Funding News, June 13, 2000

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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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Miami Jury Awards $145 Billion in Tobacco Case

In the largest product liability award in U.S. history, a Miami jury has assessed five U.S. tobacco makers $145 billion in punitive damages on behalf of Florida smokers harmed by cigarettes. The jury said Philip Morris Cos. should pay $74 billion in punitive damages; R.J. Reynolds Tobacco, $36.3 billion; Brown & Williamson Tobacco, $17.6 billion; Lorillard, $16.3 billion; and Liggett Group, $790 million. The jury deliberated roughly five hours before handing down the verdict, which was less than plaintiff's attorney Stanley Rosenblatt had said was "appropriate." Rosenblatt had argued that the five companies could afford to pay as much as $198 billion.

In July 1999, the same jury held the tobacco companies liable for the deaths and serious illnesses of hundreds of thousands of Florida smokers, and in April 2000 it awarded $12.7 billion in compensatory damages.

Legal experts disagreed on the industry's prospects on appeal, pointing out that Florida appeals courts already have passed up several opportunities to halt the trial. Attorneys for the tobacco companies said, however, that under the state's unique rules, no final judgment can be entered or monies paid until a jury assigns actual damages for every member of the class, which could take several years.

Buprenorphine Measure Clears House

By a vote of 412 to 1, the House of Representatives has approved legislation that would make it easier for office-based physicians to use buprenorphine and other federally controlled substances to treat patients addicted to heroin and other opiates. The Drug Addiction Treatment Act would allow physicians who are registered with the federal Drug Enforcement Administration (DEA) and qualified to treat opiate-dependent patients to obtain a three-year waiver from separate requirements imposed by the DEA to dispense schedule IV or V drugs for detoxification treatment and maintenance. The bill also would waive state and local requirements.

The bill is intended to make it easier for physicians to dispense buprenorphine, which the Food and Drug Administration (FDA) is expected to approve as a Schedule V controlled substance. Numerous studies have shown that buprenorphine is effective in treating heroin and other opiate addiction, particularly when combined with naloxone.

Bill sponsor Thomas Bliley (R-VA) has argued that making buprenorphine available through physicians' offices could make it easier for addicts to obtain treatment if they live in areas without methadone programs or if they do not qualify for such treatment. Democratic members of the House Commerce Committee, which Bliley chairs, opposed the measure in committee vote, arguing that it is premature to provide waivers for a drug not yet approved. They also argued that the drug's likely price (estimated at $10 per day, compared with $1 per day for methadone) could put it out of the reach of many addicts. Nevertheless, a substantial number of Democrats joined House Republicans in voting for the bill when it was called for a floor vote July 21. The measure still needs Senate approval to become law.

Source: Reuters Health News Service, July 21, 2000.

.08% BAC Bill Goes to Conference Committee

The Department of Transportation appropriations bill that passed the Senate in June with a federal .08 blood-alcohol concentration (BAC) provision is now headed to a House-Senate conference committee. Under the Senate bill, states that refuse to adopt the .08% standard would lose their share of highway trust fund money. "This is a reasonable, common sense standard that could save an estimated 500 lives a year, while still permitting adults to drink responsibly and moderately," President Clinton said in applauding the actions of the Senate committee.

Two years ago, the Senate failed in a bid to establish .08% as the national standard for legal drunkenness. The same could happen again, since the national standard language is not included in the transportation spending bill passed last month by the U.S. House of Representatives. Instead, the House version (H.R.4475) authorizes, in addition to the alcohol-impaired driving incentive grant program, $5 million in grants over six years for states that have enacted and are enforcing .08 BAC laws.

Researchers have estimated that if all states lowered their BAC limits to .08, alcohol-related highway deaths would decrease by 500 to 600 per year *(Hingson et al. Lowering state legal blood alcohol limits to 0.08%: The effect on fatal motor vehicle crashes. American Journal of Public Health, September 1996)*. BACs of .10 and above were involved in an estimated 2,570,000 crashes that killed 13,466 and injured 762,000 people in 1996. BACs between .08 and .09 were involved in an estimated 40,000 crashes that killed 1,067 and injured 34,000 people in the same year.

Sources: Center for Science in the Public Interest Legislative Alert, July 5, 2000; Associated Press, June 14, 2000.

States Avoid Losing Substance Abuse Block Grants

Seven U.S. states and the District of Columbia have reached an agreement with the federal government that will let them avoid the loss of 40% of their Substance Abuse Prevention and Treatment Block Grants. Delaware, Iowa, Minnesota, Missouri, Oregon, Rhode Island and Wyoming were slated to lose their funding because they did not meet the 1999 goals of the Synar Amendment, the federal law aimed at reducing teen smoking. But Nelba Chavez, Ph.D., Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), said the penalties had been suspended because the states and the District of Columbia agreed to commit a total of $7.6 million to antismoking enforcement programs.

The agreement also calls on the states to spend more money on regulating and licensing tobacco vendors, educating members of the retail tobacco industry, conducting routine compliance inspections and targeted visits to past violators, and providing youth education on retail age restrictions.

Source: Substance Abuse Funding News, May 12, 2000.

Supreme Court Rejects Drug Test Appeal

The U.S. Supreme Court has upheld a lower court ruling that drug testing of elected officials violates the constitutional privacy protection against unreasonable searches and seizures. Without comment or dissent, the Court rejected an appeal by Louisiana Gov. Mike Foster. In doing so, the court let stand a ruling that struck down as unconstitutional a Louisiana law requiring random drug tests of elected officials.

Under the law, 10% of state and local officials would be randomly tested each year. Results of the first drug test would be kept confidential, but if a second test showed signs of drugs, the identity of the official would be made public. Officials who refused the drug test would face fines of $10,000 and censure.

Both a federal judge and a U.S. appeals court struck down the law, saying that state officials had failed to show a special need for the drug tests.

Source: Reuters News Service, June 30, 2000.

ASAM Board Adopts Policy Statement on Opioid Detoxification

Marc Galanter, M.D., FASAM, ASAM President

I am pleased to report to you that the ASAM Board of Directors has voted to adopt a new ASAM Public Policy Statement on "Opioid Antagonist Agent Detoxification Under Sedation or Anesthesia (OADUSA)." Dr. Michael Miller, chair, and the members of the ASAM Public Policy Committee are to be congratulated for their work in drafting the statement, the text of which follows:

Background

Opioid addiction has been a significant health problem for individuals and a significant public health problem for the United States throughout the twentieth century. The unauthorized use of opioid analgesics continues to be a factor in significant health care problems as well as legal and societal problems in North America and elsewhere. The prevalence of opioid addiction in American adults is around 2%. There has been an increasing prevalence of heroin use in the U.S. in the late 1990s within multiple socioeconomic groups, such that treatment admissions for opiate dependence have come to exceed those for cocaine dependence. When opioids are used intravenously, special public health problems can occur, including transmission of hepatitis B and hepatitis C viruses (HBV and HCV) and the human immunodeficiency virus (HIV). Illicit heroin use, procurement, and distribution is associated with violence and criminal activity which affects the social fabric of neighborhoods and can affect the individual health and well-being of drug users and non-users alike.

Opioid addiction is a complex disease involving physiological, psychological, genetic, behavioral and environmental factors. It shares features of other drug dependencies but often requires unique treatment strategies. No single treatment approach is effective in all cases. Both abstinence-based treatment and opioid agonist maintenance treatment are effective, safe and accepted modalities. *(See the ASAM Public Policy Statements on Methadone and Buprenorphine).*

Where abstinence is the ultimate goal, the establishment of abstinence generally requires detoxification services to manage the withdrawal symptoms that result from discontinuation of drug use. The withdrawal syndrome from opioids — including those that have been therapeutically administered in an opioid maintenance treatment program — can be protracted and intensely symptomatic, even if it ultimately carries virtually no risk of mortality. There is no single "right way" to detoxify all opioid addicted patients. More traditional methods include tapering with methadone, or discontinuing opioids and administering oral clonidine to ameliorate symptoms of withdrawal. Buprenorphine is a newer agent that can be appropriate to use in a detoxification regimen. Even when pharmacologic agents are utilized in the management of opioid withdrawal, there is often a significant amount of patient discomfort. Patients who are unwilling to tolerate this discomfort often terminate the detoxification process and return to opioid use (especially illicit use).

Thus, a risk factor in any attempt at opioid detoxification is relapse to active opioid addiction. Other opioid addicted patients — both those engaged in active illicit drug use and those stabilized in an opioid agonist maintenance program-will not even attempt detoxification, even if it is therapeutically appropriate, because of their fears of the discomforts of the withdrawal process. Whereas the mortality from traditional detoxification itself is essentially nil, the mortality rate for persons who relapse due to failed detoxification attempts is significant, due to the mortality inherent in active opiate addiction.

With this in mind, clinicians have developed various accelerated methods of opioid detoxification which rapidly induce withdrawal through the monitored therapeutic administration of opioid antagonist agents, while at the same time blocking patients' subjective discomfort by inducing various degrees of sedation through the use of sedative hypnotic agents or general anesthetics. Currently used antagonists include naltrexone, naloxone, and nalmephine. Currently used sedatives during this process include orally administered benzodiazepines and barbiturates, and intravenously administered benzodiazepines, barbiturates, propofol or other general anesthetics, as well as various standard anesthetic inhalant agents. The degree of sedation induced is generally a matter of patient choice after consultation with the treatment team; the agents employed are selected by the medical treatment team. Factors considered include the training and experience of the treating addiction medicine physician, the agents and medical settings available to the treatment team, the targeted duration of the withdrawal experience, and the financial costs of treatment alternatives. A major benefit of opioid detoxification using antagonist agents along with either heavy oral sedation or general anesthesia is its shorter duration of acute withdrawal symptoms. The prospect of a withdrawal process with minimal experiences of subjective distress, can assist in securing patient acceptance of the treatment plan when the treatment team determines that detoxification is indicated.

The risk-benefit analysis for various methods of opioid detoxification includes the potential morbidity and mortality from anesthetic agents and from the loss of protective reflexes due to heavy oral sedation. The use of appropriately trained staff, and the availability of proper equipment to treat any medical emergency that may arise, can minimize these risks.

The pharmacologic effect of the use of antagonist agents is that a state of abstinence can be quickly induced. However, one of the dangers of the procedure is that patients coming out of anesthesia or conscious sedation often continue to experience psychological needs or cravings, leading to preoccupation with obtaining and using opioid drugs. Thus, substantial psychosocial support is generally required to help the patient overcome this craving and to sustain abstinence.

Medical monitoring and management may also be required because of agitation during the period immediately following detoxification. Therefore, it is useful for the treatment team that has performed the detoxification procedure to provide initial medical monitoring. In addiction, detoxification characteristically alters opioid receptor sensitivity, so that patients lose the high degree of tolerance to the drug that existed before detoxification. The resumption of opioid use at the same high doses that were used before detoxification can lead to overdose and death.

▶ **GALANTER** *continued on page 12*

AMA REPORT

AMA House Acts on Parity, Tobacco Resolutions

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

The House of Delegates of the American Medical Association opened its annual meeting June 11th, following days of Section and Council meetings, caucuses, and extended telephone conferences. The House is newly enlarged, with increased representation from specialty societies. Lloyd Gordon III, M.D., FASAM (ASAM's Alternate Delegate), ASAM EVP James F. Callahan, D.P.A., and former ASAM Executive Director Manny Steindler joined me in the ASAM delegation, as did Christina Delos-Reyes, M.D., who represents ASAM to the Resident and Students Section of the House. Michael Miller, M.D., FASAM, former ASAM delegate to the House and now an Alternate Delegate representing the Wisconsin Medical Society, met with us throughout the session as well.

During the meeting, ASAM participated actively in matters before the Section Councils on Psychiatry and Preventive Medicine, the caucus of medical specialty societies, and several state delegations and regional caucuses.

ASAM Resolutions

ASAM brought forward two resolutions for consideration by the House. The first addressed the fact that AMA has policy endorsing parity of coverage for addictive disorders, but does not reflect that policy in its Standard Benefit Package. ASAM's resolution called for that package to be amended to clarify that physician services for the evaluation, management, and prevention of substance-related disorders should be covered at the same level as benefits provided for general medical conditions.

As a matter of policy, AMA requires that any amendments to its Standard Benefits Package must be referred to the Council on Medical Services. After hearing reference committee testimony, the House agreed to refer ASAM's resolution to the Board, which will refer it to the Council on Medical Services for consideration.

In a second resolution, ASAM asked that the AMA urge physicians to question each new patient regarding past or present use of tobacco products. The resolution also asked that physicians hold regular discussions with each patient regarding tobacco use.

AMA staff determined that this resolution reaffirmed current AMA policy and thus was not eligible for consideration by the House. In fact, we learned that current AMA policy calls on physicians to routinely inquire about their patients' use of tobacco products and to provide assistance with quitting. Although this policy is not entirely consistent with ASAM's proposed resolution, we concluded that it is substantially similar and the determination thus was reasonable.

Medicare Reimbursement

ASAM supported the New England delegation's resolution regarding Medicare payment for psychiatric diagnoses. The resolution asked AMA to strongly oppose the discriminatory Medicare 50% co-payment for psychiatric treatments (as compared to a Medicare co-payment of 20% for other medical conditions) and supported adoption of a 20% co-payment for the diagnosis and treatment of all disorders listed in the *ICD-9* Mental Disorders Section 290-319. The resolution, which was adopted, also asked the AMA to communicate this opposition to the Congress and the Health Care Finance Administration.

The American Association of Public Health Physicians introduced a resolution urging the AMA to publicize the amount of money members of Congress receive in contributions from the tobacco industry. This resolution did not receive significant support in the House. However, in the course of the debate, we learned that the web site ***www.ash.org*** contains links to data about political contributions from tobacco companies to national and state legislators and candidates, as well as those legislators' voting records on tobacco-related matters.

Other Actions

Other resolutions adopted by the House call for:

- Ensuring that syringes and needles used outside health care settings are disposed of properly;
- Studying and taking appropriate action to end federal funding of tribal smokeshops; and
- Reviewing options for preserving the integrity of state tobacco settlement funds.

The House also asked the AMA to urge each state to adequately fund the enforcement of state laws prohibiting tobacco sales to minors.

Finally, the AMA will strongly support the ability of physicians to prescribe syringes to injecting drug users as a means of reducing the risk of HIV infection from reused syringes. AMA policy will link this right with the physician's obligation to refer such patients to treatment services for their addiction.

E-Mail Guidelines

The House also adopted guidelines for the use of e-mail in patient records. The guidelines clearly state that e-mail between physicians and patients may be included in patients' medical records at the discretion of the physician and with the knowledge of the patient. Alternatively, e-mail contacts between physicians and patients may be summarized in the chart in the same way a telephone call or verbal communication would be. Physicians were cautioned, however, to take steps to assure that sensitive information about patients contained in e-mail messages is not automatically appended to the medical record. The complete e-mail guidelines are available on the AMA's web site at ***www.ama-assn.org***. ■

WAKE FOREST UNIVERSITY SCHOOL OF MEDICINE

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Send CV to: Burton V. Reifler, M.D., M.P.H., Chair, Department of Psychiatry, WFU School of Medicine, Medical Center Blvd., Winston-Salem, NC 27157-1087. Fax 336/716-6830. E-mail: *breifler@wfubmc.edu*. AA/EOE

CSAT, NIDA Warn About Hepatitis C

The confluence of HIV/AIDS, drug abuse and hepatitis C is becoming a public health nightmare, warn experts at the federal Center for Substance Abuse Treatment (CSAT) and the National Institute on Drug Abuse (NIDA). To counteract this public health emergency, both agencies have issued special publications to provide information to the public and health professionals. NIDA Director Alan I. Leshner, Ph.D., warned that "hepatitis C is the most common blood-borne infection in the United States, and young adults who inject drugs have the highest rate of new infections." He added that "for this reason, it's very important to get the word out to health care professionals and the public about how to prevent this infection, which is estimated to affect 80% of the nation's drug injecting population."

A copy of the NIDA "Community Drug Alert Bulletin on Hepatitis C" is enclosed with this issue of *ASAM News.*

ER Visits Offer Opportunity to Motivate Patients

Because of the strong links between alcohol use and personal injury, the hospital emergency room is one of the most likely venues for dealing first-hand with problem drinkers. Edward Bernstein, M.D., a professor in the Department of Emergency Medicine at the Boston University School of Medicine, saw the need for proactive medical assessment of patients' alcohol use, and developed a grant proposal. His effort was successful: in 1994, the Boston Medical Center received a three-year federal grant to launch Project ASSERT (Alcohol and Substance Abuse Service and Education for Provider Referral to Treatment) to give emergency department staff better strategies for assessing and referring patients with substance abuse problems to treatment.

The tool for determining patients' possible needs for treatment is an overall health-needs assessment contained on a plastic card. Dr. Bernstein says that the assessment is used "to create rapport with the patient" and to "raise the subject with permission of the patients to explore pros and cons of their alcohol and drug use." Patients' statements are presented back to them with the aid of a visual tool, a scale, demonstrating that perhaps the disadvantages of alcohol and drug use might be outweighing their benefits. Once people agree that they're ready to do something about it," Dr. Bernstein said. "The next step is to ask: What are your options? What would you like to try?...The negotiation interview is one method of engaging people where they're at. What we say is, 'We give people a voice, we give them a choice.'...It's a medical interview method of improving the encounter between the doctor and the patient."

The program includes an additional component that Dr. Bernstein maintains is essential for community success: the participation of emergency room "health promotion advocates," who are drawn from the community and trained at the Boston University School of Public Health. The HPAs, as they are known, are chosen to reflect the ethnic makeup of the community. In the often chaotic environment of the emergency room, the HPAs are essential Project ASSERT interview and referral personnel. According to Dr. Bernstein, the project has proven its worth. Follow-up research on patients who received treatment showed that their recovery rates improved as a result of the Project ASSERT referrals, he says.

Source: Join Together newsletter, Winter 2000.

Breast Cancer Linked to Second-Hand Smoke

A Health Canada study reports that second-hand smoke may increase the risk of breast cancer. The study, "Passive and Active Smoking and Breast Cancer Risk in Canada, 1994-97," provides evidence that the risk of breast cancer is greater among women who have been exposed regularly and for long periods of time to second-hand smoke, even though they personally never smoked. The longer the exposure, the higher the risk.

After comparing 1,420 women diagnosed with breast cancer to a similar number of women without cancer, the study found that long-term exposure to second-hand smoke was associated with more than a 100% increase in premenopausal breast cancer risk, and a 30% increase in postmenopausal breast cancer risk. In women who also personally smoked, premenopausal breast cancer risk was 90% higher and postmenopausal risk was 60% higher. Detailed data were collected from each of the women on standard breast cancer risk factors, as well as a lifetime residential and occupational history of exposure to second-hand smoke.

Until recently, breast cancer generally has not been associated with women's smoking. However, six previously published studies of second-hand smoke and breast cancer each have suggested increased risk associated with second-hand smoke and with active smoking. The Canadian study — the largest published to date — extends that evidence. While a study of this nature cannot confirm a causal relationship of second-hand smoke to breast cancer, it can serve to identify important associations.

Source: Cancer Causes and Control, March 2000.

Blood Infections More Frequent in Smokers

A new study shows that smokers are four times more likely to develop life-threatening blood infections or meningitis than are non-smokers. The study compared 228 patients with invasive pneumococcal disease to 301 people without the disease. It found that smokers were 4.1 times more likely than nonsmokers to develop the infections. Non-smokers who were frequently exposed to cigarette smoke were 2.5 times more likely to develop infections than were persons who were not exposed to cigarette smoke.

The study by researchers at the Centers for Disease Control and Prevention (CDC) further found that the more cigarettes an individual smokes, the higher the risk of an infection from a type of bacteria that usually causes pneumonia. "We're used to thinking of smoking as causing terrible results long in the future. But smokers in this study had a much higher risk of this immediate infection," said Dr. Anne Schuchat of the CDC.

Investigators believe that the risk for infection is higher among smokers because cigarette smoke makes it harder for the lungs to expel foreign material, and easier for bacteria to stick.

Source: New England Journal of Medicine, March 9, 2000.

Low-Level Ecstasy Use Can Affect Brain

Even low-level use of Ecstasy may be harmful to the brain, according to scientists at the University of Aachen in Germany. Their research has shown that those who used Ecstasy with marijuana performed worse on intelligence tests than those who smoked marijuana alone or used no drugs at all.

Previous studies have shown that Ecstasy can impair brain function and cause a long-term decrease in a brain chemical involved with thought and memory. The latest research on a group of Ecstasy users, which evaluated a broader range of cognitive functions,

found that users performed worse in complex tests related to attention, memory, learning and general intelligence than did individuals who did not use the drug.

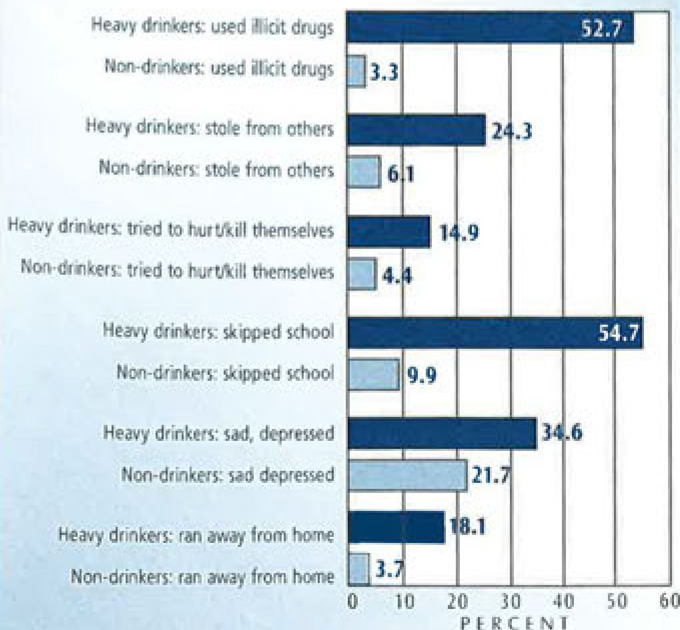
Moreover, investigators found that performance deteriorated as consumption increased. "These were not heavy Ecstasy users. On average, they took four tablets a month — that's one every weekend," said Dr. Euphrosyne Gouzoulis-Mayfrank, the neurologist who led the study. Alan Leshner, Ph.D., Director of the National Institute on Drug Abuse, added that "If your brain is getting zinged, then you ought to have some kind of deficit in cognitive ability, and here it is. There is this misconception that [Ecstasy] is a benign, fun drug, and it's not."

Source: Journal of Neurology, Neurosurgery and Psychiatry, May 2000.

Adolescents' Behavioral Problems Related to Alcohol Use

Adolescents who use alcohol are more likely to have behavioral problems than their peers, according to a study for the Substance Abuse and Mental Health Services Administration (SAMHSA). Based on findings from a sample of 18,000 adolescents who participated in SAMHSA's 1994, 1995 and 1996 National Household Surveys on Drug Abuse, the study found that 12- to 17-years-olds who use alcohol are more likely to report behavioral problems than are non-drinkers. Federal data show that there are 10.4 million underage drinkers in the United States, a rate that has not changed significantly since 1994.

Titled "Patterns of Alcohol Use Among Adolescents and Associations with Emotional and Behavioral Problems," the study further found that adolescents who drink are more likely to use illicit drugs than are non-drinkers. Moreover, adolescents in the study who were heavy drinkers were 16 times more likely to have used an illicit drug in the preceding month, while light drinkers were eight times more likely to use illicit drugs.



The report also found that adolescents who were heavy drinkers were four times more likely to commit theft outside the home than non-drinking adolescents. Heavy drinking teens also were three times more likely to try to deliberately hurt or kill themselves or get into a physical fight and were five times more likely to drive under the influence of alcohol.

Source: SAMHSA press release, March 6, 2000.

Marijuana Increases Heart Attack Risk

Smoking marijuana increases the risk of heart attack in middle-aged men and women, according to data presented at a conference of the American Heart Association. Investigators questioned 3,882 heart attack victims — men and women — at 62 locations across the country about their habits and found that 124 were marijuana users. While pot was uncommon among the elderly heart patients, 13% of those under age 50 said they smoke it.

Among those questioned, 37 suffered heart attacks within a day of using marijuana, including nine within an hour afterward. Based on these data, the researchers calculated that an individual's risk of a heart attack is five times higher during the hour after using marijuana. After an hour, the risk falls to twice normal. It soon returns to the usual level. Marijuana typically makes the heart speed up by about 40 beats a minute, although whether this is how it contributes to heart attacks is unclear.

Whether a fivefold increase is a worry depends on whether an individual has other risk factors, such as high blood pressure or diabetes. The increased risk is probably insignificant for a 20-year-old, whose chance of a heart attack under any circumstances is vanishingly small. However, "with baby boomers aging, more people in 40s and 50s are smoking marijuana than in prior generations," Dr. Mittleman said. "The risk of coronary artery disease increases with age. Whether this will emerge as a public health problem remains to be seen."

Source: Associated Press, March 1, 2000.

Cocaine + Alcohol Affect Mental Ability

Cocaine and alcohol in combination cause more damage to mental ability than either drug alone, according to Dr. Jean Lud Cadet of the National Institute on Drug Abuse (NIDA) Intramural Research Program in Baltimore, MD, and Dr. Karen Bolla of John Hopkins Medical Institutions.

Drs. Cadet and Bolla studied the interactive effects of cocaine and alcohol in 56 adult cocaine abusers. About half the study participants also consumed at least 10 alcoholic drinks per week. During the study, participants were given a series of tests to measure general intelligence, verbal memory and learning, and attention, planning, and mental flexibility. They found that cocaine and alcohol use in combination led to more impulsive decision-making and poorer performance on tests of learning and memory. The negative effects continued for at least a month after use of the substances stopped.

"This study reveals important basic information about the way these substances interact," said NIDA Director Dr. Alan I. Leshner. "It also has significant implications for drug abuse treatment, which involves learning and remembering concepts that help recovering drug abusers to change behaviors and avoid situations where they might use drugs."

Source: Neurology, June 27, 2000.

Practice Guidelines Committee Focuses on Pharmacotherapy of Alcohol Dependence

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

The ASAM Work Group on Pharmacologic Management of Alcohol Dependence (one of four work groups of the Committee on Practice Guidelines) recently met in Baltimore to review the existing evidence and formulate recommendations on the pharmacologic management of alcohol dependence. Pharmacologic agents of interest include disulfiram, the opiate antagonists naltrexone and nalmefene, the SSRIs (including citalopram), metronidiazole, lithium, hallucinogens, bromocriptine and acamprosate, a promising new agent currently in use in Europe.

Over the past several years, the work group has reviewed the scientific literature on the efficacy of pharmacotherapies in the treatment of alcohol dependence, and has summarized the evidence and formulated preliminary recommendations. The group has made extensive use of an evidence-based report funded by the federal Agency for Healthcare Research and Quality (AHRQ, formerly AHCPR), which was developed with input from ASAM.

Such evidence summaries and recommendations formed the basis of discussions at the April meeting, during which work group members evaluated the evidence — giving preference to randomized controlled clinical trials — and assigned "grades." In making recommendations, members of the work group were attentive to factors such as treatment setting, contraindications, long-term safety, co-morbidities, patient selection and drug interactions. Work group members also grappled with issues such as whether standards of care should dictate "consideration of" or a "recommendation for" use of pharmacotherapies, and the appropriate context for such therapies.

Richard Saitz, M.D., M.P.H., of the Boston University School of Medicine, chairs the Work Group on Pharmacologic Management of Alcohol Dependence. Other members are Ray Anton, M.D., Richard K. Fuller, M.D., James Garbutt, M.D., David Gorelick, M.D., Ph.D., Robert Gwyther, M.D., M.B.A., Mark Kraus, M.D., Michael Mayo-Smith, M.D., M.P.H., Hugh Myrick, M.D., Stephanie O'Malley, Ph.D. and Suzanne West, Ph.D. Dr. Saitz is preparing a draft manuscript that will be circulated to the work group and to the larger Guideline Committee for review and comment. The manuscript then will be distributed to individuals and groups within and outside ASAM for wider review and comment, and finally will be submitted for publication in a peer-reviewed medical journal.

ASAM anticipates that evidence-based guidelines like the one on pharmacologic management of alcoholism will make a contribution to improving the scientific basis for medical practice, leading to more effective use of medical resources and better patient outcomes.

Family Practice Committee Maps Strategies for Outreach

Norman Wetterau, M.D., Chair, Family Practice Committee

During the last two ASAM national conferences, family physicians met under the auspices of the Family Practice Committee to discuss issues of mutual interest. Several participants have signed on as official members of the Family Practice Committee, which corresponds by e-mail and telephone, and meets once a year during the annual Medical-Scientific Conference.

In these meetings, we identified several issues that require the attention of all family physicians in ASAM. Please accept the following report as a combination of minutes of our meetings and a statement of needs identified and plans for the future.

CASA Report

A report from the Center for Addiction and Substance Abuse (CASA) at Columbia University, entitled "Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse," was reviewed. [Note: see the Report from the Executive Vice President, May-June **ASAM News**.] You can find this report on the CASA web site (***www.casacolumbia.org***).

The survey, which has been widely reported in the lay media, tells us what we in ASAM already know: that primary care physicians have little interest in diagnosing substance abuse in their patients. Although the report itself was not issued until after the April meeting, it touched on problems we had been discussing. In fact, it gives us independent documentation of the problem, and we need to respond. I hope to meet with members of CASA, as well as with Dr. Bruce Bagley, President of the American Academy of Family Physicians (AAFP). We hope that AAFP and ASAM can work together to try to change things.

AAFP Scientific Assembly

At the April meeting, committee members recommended that ASAM sponsor an exhibit booth at the AAFP's 2001 Annual Scientific Assembly, October 3-7 in Atlanta. Such a booth would provide information about ASAM and handouts that family physicians could use to order publications from ASAM, as well as from the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

ASAM Accepting Applications for 2000 Fellows Program

All ASAM members who are certified and who have been members of the Society for at least five years are eligible to apply for admission to the select group who have earned the prestigious designation, "Fellow of the American Society of Addiction Medicine" (FASAM). Application materials are to be mailed to eligible members in early August.

Kevin O'Brien, M.D., FASAM, chair of the Fellows Subcomittee, advises those who receive the applications to carefully review the requirements to become a Fellow and to follow the described policies and procedures in completing the application. Completed applications must be postmarked by October 28, 2000.

Those whose applications are accepted will be notified in January 2001 and recognized at an Awards ceremony during ASAM's 2001 Medical-Scientific Conference.

If you have questions about the Fellows program or wish more information, contact Cheryl Kim at the ASAM office by phone at 301/656-3920 or by e-mail at ***ckim@asam.org***.

We will need ASAM members to staff this booth, hand out information, and talk with interested physicians about ASAM and about dealing with substance abuse problems in their practices. If you are willing to help, with the idea that you could attend some sessions and spend only part of your time at the booth, please let me know.

The committee also discussed the fact that no presentations or workshops on alcohol or drug problems have been scheduled during the AAFP's 2000 Scientific Assembly in Dallas. The program shows 10 sessions on dermatology, 11 on nutrition and weight control, 11 on ENT problems, 8 on alternative therapies, and 24 on cardiology, but none on substance abuse. In the section on community health promotion and disease prevention, of 21 sessions, one deals with tobacco, but none address drugs or alcohol.

Before raising this issue with the AAFP program committee, we need to know if there are family physicians in ASAM who would be able and willing to do a program at the assembly in 2001. Applications for next year will need to be submitted late this fall.

Please consider coming to the AAFP meeting in 2001 and being involved in a presentation and/or helping to man our information table. And let me know if you are available, so that we can plan.

Local Meetings

Several committee members shared positive experiences in making presentations at state AAFP meetings and hospital staff meetings. After our Thursday meeting at Med-Sci, I addressed the ASAM Chapter presidents and encouraged them to work with their state AAFP chapters, pediatric and internal medicine groups about collaborating on programs. At the recommendation of our Family Practice Committee, I encouraged the state ASAM Chapter presidents to work with these groups on reimbursement issues.

Reimbursement

Reimbursement of family physicians for time spent during office visits on alcohol, drug and tobacco problems has become a major issue. During our annual meeting, several committee members reported that they had checked with their local health plans. Although many physicians believed that they would not be paid for such services, the data presented at our meeting showed that most are paid. Such payments generally covered an office visit when the primary diagnosis was tobacco, alcohol or marijuana abuse.

The Family Practice Committee is encouraging state ASAM Chapters to conduct more formal studies with their state AAFP chapters, and then to let the state AAFP Chapter provide the results to their memberships. We believe this is the way to go since the issues differ across states and insurance companies.

Please write or e-mail if you are interested in any of the activities discussed here (please include your name and contact information): Norman Wetterau, M.D., 6 Clinton Street, Dansville, NY 14437 (or e-mail ***normwetterau@aol.com***). We would appreciate your ideas and involvement!

PEOPLE IN THE NEWS

Louis E. Baxter, Sr., M.D., FASAM, has been appointed to the National Advisory Council of the federal Center for Substance Abuse Treatment (CSAT). The role of the Advisory Council is to serve as a bridge between development of national substance abuse treatment policy and the needs of consumers and professionals in communities across the nation, according to CSAT Director H. Westley Clark, M.D., J.D., M.P.H., FASAM, who adds that the Council members' "expertise and advice serve as a compass to guide partnerships and areas ripe for new development, and as a voice for national, state and local interests in the Nation's capital." (ASAM President-Elect Andrea G. Barthwell, M.D., FASAM, also is a member of the Council.)

Dr. Baxter directs the physician health and effectiveness program of the Medical Society of New Jersey, and is a member of the Impairment Review Committee of the New Jersey Board of Medical Examiners. A Fellow of ASAM, Dr. Baxter chairs the Society's Cross-Cultural Clinical Concerns Committee.

Larry Siegel, M.D., has been named Senior Deputy Director for Substance Abuse Services of the Department of Health of the District of Columbia, and Administrator of the District's Addiction Prevention & Recovery Administration (APRA). In this post, Dr. Siegel is responsible for establishing an effective infrastructure for delivering prevention, treatment and rehabilitation services to persons suffering from alcoholism, drug abuse and other substance abuse-related illnesses.

A co-founder of the Delphos Alcohol and Drug Treatment Center in Key West, FL, Dr. Siegel also founded and directed ImmuneCare of Key West, a model comprehensive outpatient center for HIV-infected persons. Most recently, he served as Medical Director of the Whitman-Walker Clinic in Washington, D.C. Within ASAM, he is an active member of the HIV/AIDS Committee (which he founded and chaired from 1985 to 1990) and a member of the editorial board of the *Journal of Addictive Diseases*. Dr. Siegel also is a past President of the Florida Society of Addiction Medicine. ■

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HIV 2000: A Status Report

Larry Siegel, M.D.

*On the occasion of the biennial International Conference on AIDS, held July 10-14 in Durban, South Africa, **ASAM News** asked Dr. Larry Siegel for an update on the epidemic. Dr. Siegel is Senior Deputy Director for Substance Abuse Services of the Department of Health of the District of Columbia, and Administrator of the District's Addiction Prevention & Recovery Administration (APRA). He is a founding member and past chair of ASAM's Committee on AIDS. This report is adapted from remarks Dr. Siegel delivered at ASAM's 2000 Medical-Scientific Conference.*

"It's the virus, stupid!" Until recently, it seemed obvious that that's all there was. In the early 1980s, when a damaged immune system was recognized as a correlate of what is now known as AIDS in homosexual men and intravenous drug users, it was not yet appreciated that a retrovirus was the cause. After HIV was identified, arguments arose (and still persist) regarding the role of other agents as cofactors in the disease. Some even doubted that HIV was anything more than a confounding fellow traveler. It now appears that the state of the immune system is equally important, along with certain genetic predispositions.

The current treatment era began with an appreciation that antiretroviral therapy with AZT (a transcriptase inhibiting nucleoside analogue) led to definite benefits in some persons with AIDS. Later, congeners of that analogue became available. Of these, AZT, ddI, ddC, D4T, 3TC and Abacavir are now approved, and more are on the way. In addition, we now have five approved protease inhibitors and three NNRTIs, with more coming soon. Gene therapeutics, immunomodulators, attachment blockers and other techniques are just over the horizon.

As we have gained a better understanding of the prevalence of HIV in infected persons, it has become apparent that the virus may be found in large amounts that are not readily discernible with standard blood tests. With improved techniques for measuring the amount of HIV, it now appears that massive and nearly complete turnover and replacement of both virus and CD4 cells occurs every few days throughout the course of the HIV infection, with viral burden slowly overwhelming CD4 replacement over time.

Moreover, as our ability to measure viral burden, or "load" (similar to "tumor load" in cancer patients) has improved, it has become increasingly clear that combinations of drugs must be used to reduce that burden, rather than relying on single agents. (Drugs that interrupt the HIV life cycle at various stages, such as reverse transcriptase and protease inhibitors, are particularly effective.) As the viral burden is reduced, reconstitution of the immune system occurs — at least partially and transiently. Combinations of antiretroviral drugs can prolong viral load reduction and extend the duration of immune reconstitution. Maintenance of these effects is the goal of combination therapy. New techniques of immune system modulation (e.g., infusion of cytokines such as IL2, or therapeutic immunization), administered concurrently with combinations of antiretroviral agents that minimize viral burden, thus offer hope of further prolonging patient survival. Intense research and clinical consultation are ongoing to determine when to initiate therapy and whether the immune system can be "tweaked" by "strategic interruption" of drugs to contain the infection.

Despite these advances, the HIV crisis continues. Worldwide, there are about 30 million HIV infected persons, most in countries for which antiretroviral therapy is a fiscal impossibility. To date, more than 16 million persons have died with AIDS. Antiretrovirals have given the U.S. and other developed nations a "breathing spell," so that — for the first time in years — the newspapers do not contain daily obituaries of young people killed by AIDS.

But there are shadows over the good news, because:

- The drugs do not work for everyone, may not work forever, are difficult to use, cost a lot and have side effects that may well be cumulative and therefore limiting.
- The possibility of multi-drug resistant virus is real and worrisome, and costly new tests to measure it are now part of clinical practice.
- Development of preventive and therapeutic vaccines is a high priority, but an effective vaccine remains elusive.

Of the 40,000 new infections in the U.S. each year, almost 70% are found in injection drug users, their sex partners and children. Many "recreational" drug users are at high risk for HIV infections, or already are infected. Harm reduction strategies are critical, as is outreach to disenfranchised and disaffected persons. Even in the U.S., inability to access the health care system remains a major barrier to containing the HIV epidemic.

While the horizon does not offer a readily discernible "magic bullet," there are weapons that, in combination, can keep the enemies — HIV, immune system destruction, and death — at bay. Keep hope alive!

HIV Infections Among At-Risk Populations in America's 96 Largest Cities

Risk Group	Estimated Number in Risk Group	Estimated Percent HIV Positive	Estimated New Infections Each Year
Injecting drug users	1.5 million	14.0%	1.5 per 100
Men who have sex with men	1.7 million	18.3%	0.7 per 100
At-risk heterosexuals*	2.1 million	2.3%	0.5 per 100

* Men and women who are at risk because they have sex with injecting drug users and/or bisexual or gay men. *Source: NIDA Infofax #13558: Drug Abuse and AIDS (www.nida.nih.gov/Infofax/DrugAbuse.html).*

Recommended reading:

Drug Abuse and AIDS. ***NIDA Infofax #13558*** *(www.nida.nih.gov/Infofax/DrugAbuse.html).*

HIV-Recreational drug interactions. ***HIV Plus*** *58 (September 1998).*

Sherer R. Adherence and antiretroviral therapy in injection drug users (editorial). ***JAMA*** *280(6):567-568 (August 12, 1998).*

Chair Peter D. Rogers, M.D., M.P.H., FAAP, FASAM

Adolescent Substance Abuse Course for Health Care Practitioners

Current research underscores the startling degree to which adolescents are at risk for early and persistent problems with alcohol, tobacco and other drugs. In fact, there are currently 10.4 million underage drinkers in the United States, a rate that has not changed significantly since 1994. Moreover, there is a perverse synergy to substance use in adolescents, in that adolescents who use alcohol, tobacco or other drugs are demonstrably more likely to have problems in other domains.

For example, federal data show that adolescents who consume alcohol are more likely also to use illicit drugs than are non-drinkers. Teens who are defined as "heavy drinkers" are 16 times more likely to have used an illicit drug in the preceding month, compared to non-drinkers. Such heavy drinkers were four times more likely to commit theft outside the home than non-drinking adolescents, and three times more likely to try to deliberately hurt or kill themselves. Heavy drinkers also are five times more likely to drive under the influence of alcohol and four times more likely to drive while under the influence of drugs. Even so-called "light drinkers" are eight times more likely to use illicit drugs than are teens who abstain.

Young people 12 to 17 years old who use alcohol, tobacco or other drugs are more likely to have behavioral problems (particularly aggressive, delinquent and criminal behaviors) than their non-using peers. Indeed, underage alcohol, tobacco and drug use "is dangerous, illegal, and must not be tolerated," according to Nelba Chavez, Ph.D., Director of the federal Substance Abuse and Mental Health Services Administration, who adds that the effects of such use "extend far beyond 'drinking and driving'. [It] also can be a warning sign or a cry for help that something is seriously wrong in a child's life." Dr. Chavez and adolescent experts recommend that physicians, counselors, and other caregivers "reach children early enough so they can intervene before troubling behaviors lead to serious emotional disturbances, illicit drug use, school failure, family discord, violence, or even suicide."

But how is such identification accomplished? And once an adolescent is identified as involved in, or at risk for, substance use, what interventions are most likely to be effective? How can the results of current research be employed in day-to-day practice?

These questions and others will be addressed in an important event, "Adolescent Substance Abuse: A Course for Practitioners," to be held October 26-28, 2000, at the Omni Shoreham Hotel in Washington, D.C.

Mark Your Calendar!
Act now to join an outstanding group of experts at "Adolescent Substance Abuse: A Course for Practitioners," November 3-5, 2000, Washington, D.C.

Sponsored by the American Society of Addiction Medicine in cooperation with the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, the course will attract leading experts from across the country to address practical concerns of practicing physicians and other health care practitioners.

The goal of the course is to present the most up-to-date information on identification of and intervention with adolescents who are involved in (or at risk for) use of alcohol, tobacco and other drugs. Geared to the needs of adolescent medicine specialists and other pediatricians, addiction medicine specialists and primary care physicians, psychologists and other counselors, the course will focus on translating clinical and behavioral research into useful, usable knowledge and techniques that can be adopted in everyday practice. Through a highly interactive mix of plenary sessions, workshops, symposia and hosted lunches, participants will have an opportunity to interact with experts and contribute their own experiences to a rich dialogue about how best to care for adolescents today.

Course registration includes two special evening symposia on cutting-edge clinical and policy concerns:

- *Pediatric/Adolescent Medicine Roundtable: Skill-Building in Assessing Adolescents for Substance Abuse in the Office Setting*: A hands-on discussion of clinical skills, chaired by pediatricians and addiction experts Peter D. Rogers, M.D., M.P.H., FASAM, and Richard Heyman, M.D., FACP.
- *The Crisis in Funding for Adolescent Substance Abuse Treatment*: A practical review of policy and strategy, chaired by ASAM President-Elect and nationally recognized policy expert Andrea G. Barthwell, M.D., FASAM.

For more information or to register, contact the ASAM Conference staff by phone at 301/656-3920, or visit the ASAM web site at ***www.asam.org***.

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▶ **GALANTER** *continued from page 4*

It is the position of ASAM that:

1. Treatment of addiction is a complex process that involves management of substance use, relapse potential, denial, treatment acceptance, treatment engagement, treatment retention and, when necessary, the treatment of withdrawal symptoms.
2. Any method of opioid detoxification is only a first step, and is not in itself an effective treatment of opioid addiction. ASAM does not support the initiation of opioid detoxification interventions when these are not a part of a continuum of services that promote ongoing recovery from addiction.
3. Opioid detoxification using antagonist agents along with either oral or intravenous sedation or general anesthesia may be referred to as 'Opioid Antagonist Agent Detoxification Under Sedation or Anesthesia', or OADUSA.
4. OADUSA can be an appropriate withdrawal management intervention for selected patients, provided that such services are performed by adequately trained staff with access to appropriate emergency medical equipment.
5. All candidates for OADUSA should be informed about the known benefits, risks, and financial costs of the proposed procedure in comparison with the known benefits, risks, and financial costs of other treatment options available in the community. Women of childbearing age should have pregnancy tests completed prior to the initiation of OADUSA. For patients receiving opioid agonist maintenance therapy, risk of relapse to addiction with the discontinuation of maintenance treatment should also be discussed.
6. The patient's written informed consent should be obtained prior to any planned course of OADUSA.
7. Patients treated with OADUSA, especially when it employs general anesthesia, require a sufficient period of medical monitoring of their clinical status by the medical detoxification treatment team immediately subsequent to the procedure, in order to address clinical issues of craving, acute relapse risk, and accompanying agitation.
8. Although there is medical literature describing various techniques of OADUSA, more research is needed to better define its role in opioid detoxification. Further studies of outcome are needed, including both the safety and efficacy of OADUSA as compared to other opioid detoxification modalities, as well as any differential effects on the long-term rehabilitation of opioid addicts.
9. It is recognized that the methods of opioid detoxification available in a given community will evolve over time with the advancement of biomedical knowledge and treatment research, and that efficacy, safety, and cost profiles will continue to change along with the science and practice of addiction medicine.

Adopted by the ASAM Board of Directors, April 2000. ■

CHAPTER UPDATES

Arizona

President: Michel Sucher, M.D., FASAM

Regional Director: Berton Toews, M.D., FASAM

Correction: The correct e-mail address for Arizona chapter President Mike Sucher, M.D., FASAM, is ***Mike_Sucher@metro.com***.

California

President: Peter Banys, M.D.

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

Parity Legislation: Led by Gary Jaeger, M.D., and the Society's public policy committee, CSAM members spent a great deal of time over the past year working for adoption of parity legislation by the state's General Assembly. However, in the final hour, the bill was amended beyond the point of usefulness. Specifically, S.1764 was amended to remove the parity provision and instead to require an analysis of the cost of parity in treating addictive disorders. This amended study version was passed by the Senate on May 31, 2000. As amended, the bill requires that a legislative analyst shall review existing data and research relating to the cost effectiveness of parity for addiction treatment in health care service plans and disability insurance policies. The findings of this review are to be reported back to the Assembly.

The legislative analyst also is charged with reviewing existing research and surveying a sample of health care service plans in order to report to the Assembly the range and utilization of substance abuse treatment services covered by those plans, and the impact of those services on the cost of health care benefits to employers and employees.

The legislative analyst also is to review existing information on private resources available statewide that provide alcohol and drug treatment services, and is to survey and report back to the Assembly on organizations statewide that provide alcohol and drug treatment, including community-based and faith-based organizations, and the number of clients served by those organizations.

Although the bill did not pass in this session, it accomplished quite a bit by way of educating all who were involved, and can pave the way for a successful future effort. The full text of the amended bill is available at ***www.leginfo.ca.gov/pub/bill/sen/sb_1751-1800/sb_1764_bill_20000526_amended_sen.html***. For more information, contact Kerry Parker, CAE, CSAM Executive Director, at 74 New Montgomery St., Suite 230, San Francisco, CA 94105; phone 415/243-3322, fax 415/243-3321; or visit the CSAM web site at ***www.csam-asam.org***.

Review Course: CSAM will sponsor a Review Course in Addiction Medicine on October 11-14, 2000, at the Miyako Hotel, San Francisco. For more information, contact Kerry Parker, CAE, CSAM Executive Director, at 74 New Montgomery St., Suite 230, San Francisco, CA 94105; phone 415/243-3322, fax 415/243-3321; or visit the CSAM web site at ***www.csam-asam.org***.

Florida

President: John C. Eustace, M.D.

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

Electronic Outreach: An abridged version of FSAM's semiannual newsletter is posted on the ASAM web site (***www.asam.org***) at the "State Chapters" Hot Button. Robert Donofrio, FSAM staff director, reports that this is an excellent opportunity for the Florida Chapter to reach out to prospective members. He adds that "Having a copy of the newsletter on the Internet has generated contacts with individuals from all over the world, who request information on a wide range of topics, from the names of Florida physicians to whom they may refer a patient to information about our annual conferences."

To request a copy of the FSAM newsletter, contact Mr. Donofrio by phone at 850/484-3560 or by e-mail at ***fsam.asam@usa.net***.

2000 Educational Conference: FSAM and ASAM jointly sponsor a continuing education program in concert with the Florida chapter's annual business meeting. The 2000 FSAM-ASAM Conference on Addictions was held in February

in Orlando, FL. Continuing education credits were provided to physicians, nurses, social workers, counselors, and addiction therapists who attended the conference to network with peers and update their knowledge.

Rick Beach, M.D., FASAM

Rick Beach, M.D., FASAM, began the conference with a "Bio-Psycho-Social-Chemical Examination of Addiction." Dr. Beach was followed by Marcia Flugsrud-Breckenridge, M.D., Ph.D., who discussed "Parallels Between Psychiatric and Substance Abuse Symptoms — Practical Experiences in the Current Methamphetamine State in the USA." In a second presentation, Dr. Flugsrud-Breckenridge addressed "Adolescent Addict Victims in Treatment: Treatment Parameters of Sexual Abuse and Self-Harm."

FSAM President John Eustace, M.D., discussed how addiction medicine works within the Florida State Medical Association, while Penelope P. Ziegler, M.D., FASAM, of the ASAM Committee on Treatment and Clinical Issues, provided an update on HIV/AIDS.

Douglas Eaton, M.D., a fellow in Clinical Research at the University of Florida College of Medicine, presented on "Tobacco Addiction" and "Post-Traumatic Stress Disorder." Dr. Michael Sheehan provided an "Update on Neurobiology of Addiction," while Dr. Ray Pomm concluded the conference with a presentation on "Psycho-sexual Disorders and Sexual Misconduct" in impaired physicians and other practitioners.

Other activities at the conference included FSAM's annual membership meeting and the FSAM officers' business meetings. Participants received 13 hours of continuing education for attending the conference.

2001 Conference: Mark your calendar now for the 14th Annual FSAM-ASAM Conference on Addictions, scheduled for February 9-11, 2001, at the Courtyard by Marriott, Lake Buena Vista/Orlando, FL.

Chapter Conference Calls

Nancy Brighindi, ASAM Director of Membership & Chapter Relations, reports that a series of conference calls in June successfully advanced the chapters' efforts to take concerted action toward parity in addiction treatment coverage and involvement with state medical societies and state governments.

Participants in ASAM's March 2000 Medical Review Officer Training Course at Marina del Rey, CA, included (from left): Milton Earl Burglass, M.D., FASAM; David E. Smith, M.D., FASAM; Raymond M. Deutsch, M.D.; Barbara Johnson, J.D.; Robert DuPont, M.D., FASAM; H. Blair Carlson, M.D., M.P.H., FASAM; and Robert Willette, Ph.D. Future MRO Training Courses are scheduled for July 28-30, 2000, in Chicago, IL, and December 1-3, 2000, in Washington, DC.

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USPHS Issues Guidelines for Smoking Cessation

New guidelines for smoking cessation, sponsored by a consortium of seven federal agencies, endorse a range of therapies, including drugs, nicotine gum, patches, inhalers and counseling. The guidelines also call on insurance companies to cover pharmacotherapies for use in smoking cessation. "A Clinical Practice Guideline for Treating Tobacco Use and Dependence: A U.S. Public Health Service Report" was prepared by an independent panel of 18 scientists, clinicians, consumers, and methodologists selected by the federal Agency for Healthcare Research and Quality. The panel reviewed approximately 6,000 English-language, peer-reviewed articles and abstracts, published between 1975 and 1999, and conducted 50 meta-analyses.

Major conclusions and recommendations in the guidelines include: (1) Tobacco dependence is a chronic condition that warrants repeated treatment until long-term or permanent abstinence is achieved. (2) Effective treatments for tobacco dependence exist and all tobacco users should be offered those treatments. (3) Clinicians and health care delivery systems must institutionalize the consistent identification, documentation, and treatment of every tobacco user at every visit. (4) Brief tobacco dependence treatment is effective, and every tobacco user should be offered at least brief treatment. (5) There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. (6) Three types of counseling were found to be especially effective: practical counseling, social support as part of treatment, and social support arranged outside of treatment. (7) Five first-line pharmacotherapies for tobacco dependence — sustained-release bupropion hydrochloride, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch — are effective, and at least one of these medications should be prescribed in the absence of contraindications. (8) Tobacco dependence treatments are cost-effective relative to other medical and disease prevention interventions; as such, all health insurance plans should cover the counseling and pharmacotherapeutic treatments identified as effective in the guidelines.

Source: Journal of the American Medical Association, June 28, 2000.

Anti-Addiction Drugs Poised for Approval

With scientists ready to launch naltrexone and other anti-addiction medications, analysts say the new drugs represent a significant advancement. Much of the drug development has been funded by the National Institute on Drug Abuse (NIDA), which has provided $4.5 million for such research since 1996. "Just as medications have been developed for other chronic diseases, such as hypertension, diabetes, and cancer, drug addiction is a disease that also merits medication for its treatment," NIDA wrote in its five-year strategic plan.

One new drug, to be marketed as Suboxone®, is a combination of buprenorphine and naloxone in a once-a-day pill. Suboxone could be approved by the Food and Drug Administration (FDA) as early as September. "This is cutting-edge because it's different from methadone," said Dr. Charles O'Brien, chief of psychiatry at the Philadelphia VA Medical Center. "You almost can't overdose on heroin when you're on buprenorphine. It's really been a huge success. People can function totally normally and be very alert if it's properly dosed."

The FDA also is reviewing several other anti-addiction medications, and researchers currently are testing an anti-cocaine vaccine, as well as vaccines for nicotine, PCP and methamphetamine. The vaccines are designed to attack pleasure-inducing chemicals that the brain craves.

Dr. Frank Vocci, director of NIDA's Treatment Research and Development Branch, noted that when combined with therapy and psychiatric drugs, anti-addiction medications could be a powerful weapon against addiction. "If a patient is in an emergency room with high methamphetamine levels and experiencing a cardiovascular crisis, antibodies would bind the drug up and cause the individual to excrete it," Dr. Vocci said.

Sources: NIDA Notes, NIDA press releases.

Disulfiram + Buprenorphine for Cocaine/Heroin Addicts

It is estimated that more than half of persons addicted to opiates such as heroin also are addicted to cocaine. A study in the Spring 2000 issue of *Biological Psychiatry* reports that combining buprenorphine, an alternative to methadone for treating opiate addiction, with disulfiram (Antabuse®) was more effective than buprenorphine alone in reducing cocaine use in persons with this dual addiction. (Buprenorphine has reached the final stages of the Food and Drug Administration's new drug approval process.)

Previous research has shown that either buprenorphine or methadone alone is effective in reducing opiate use, but neither is effective in reducing concurrent cocaine use by opiate-dependent individuals. The study, funded by NIDA and conducted by Dr. Tony P. George and his colleagues at the Yale University School of Medicine, found that the participants who received a combination of disulfiram and buprenorphine abstained from cocaine use for longer periods of time than those who received only buprenorphine. These same participants also achieved three weeks of continuous cocaine abstinence sooner than those who received buprenorphine alone. No significant differences were found in the total weeks of opiate abstinence between the disulfiram/buprenorphine and the buprenorphine-only group.

According to Dr. George, this research reinforces previous studies that suggest administering disulfiram prior to cocaine inhalation may block the pleasurable and rewarding effects caused by an excessive release of dopamine in the brain after cocaine use. Instead of experiencing euphoria and other feelings of well being associated with cocaine use, an individual who has taken disulfiram before using cocaine will experience adverse reactions such as anxiety, dysphoria or paranoia.

Source: Biological Psychiatry, Spring 2000.

Relapse Linked to Memory

Certain kinds of memory may be a primary cause of relapse among persons recovering from alcohol, tobacco and other drug addiction, according to researchers at the University of Wisconsin Medical School. Dr. Anne Kelley and colleagues found that the brain recognizes familiar reminders, such as smells or sights associated with the addiction. "We found that there are very long-term changes in the brain that far outlast the effect of the drug itself," said Dr. Kelley. "In a way, the drug kind of hijacks the part of the brain involved in rational decision-making and makes it hard to overcome the craving that results."

Dr. Kelley added that the study's results could prove beneficial for development of anti-addiction medications. "If we can treat the emotional craving..., we can better treat the addiction," she explained. "So the more we understand what's happening in the systems which cause cravings, the better drugs that can be developed to treat the craving state."

Source: Synapse, August 2000. ■

▶ **PARITY** *continued from page 1*

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

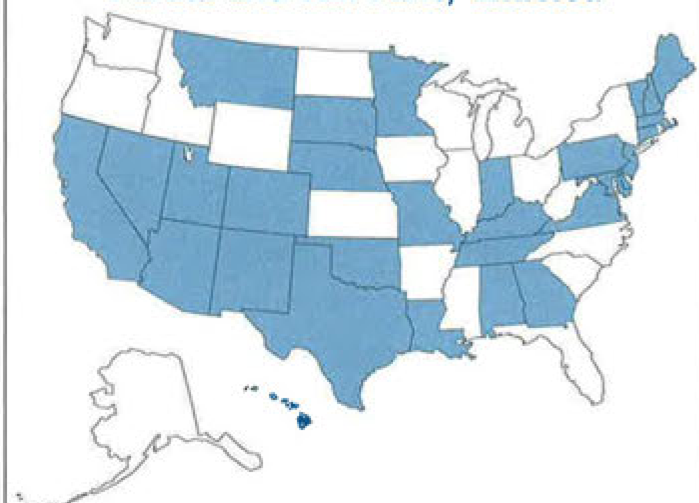
Maryland. Adopted in 1994, Maryland's law requires that insurers provide benefits for the diagnosis and treatment of alcohol or drug use disorders and mental illnesses under the same terms and conditions that apply to the diagnosis and treatment of other physical illnesses. The law prohibits discrimination in health care coverage against any person with a drug or alcohol abuse disorder. It also prohibits insurers from imposing separate lifetime maximums, deductibles, coinsurance amounts, or out-of-pocket limits on addictive and mental health disorders.

Minnesota. The 1995 Minnesota parity law covers "mental health and chemical dependency" services, but allows health plans to define those terms in benefit design. It contains a general requirement that the resulting cost-sharing requirements and benefit or service limitations for inpatient and outpatient services do not place a greater financial burden on the insured and are not more restrictive than requirements and limitations for other medical services.

Vermont. Enacted in 1997, Vermont's law is considered the most comprehensive in the nation. Vermont advocates even rebuffed an effort to exempt small employers from parity requirements. However, the Vermont law has two shortcomings that should be corrected in drafting future parity measures: first, it defines alcohol or substance abuse as a "mental health condition." ASAM policy makes clear that "alcohol, nicotine and other drug dependencies are primary diseases...and should not be subsumed under...mental health." Second, the law does not expressly cite physicians as eligible service providers. ASAM endorses specific inclusion of physicians as eligible providers in parity legislation.

H.628, passed in May 2000, expands on the 1997 parity law by creating an annual "report card" to analyze the performance of the state's largest health care plans in delivering substance abuse and mental health benefits, and mandating creation of a task force to develop performance quality measures.

Partial and Full Parity Enacted



Full parity enacted: CT, MD, MN, VT, VA
Partial parity enacted: GA, HI, KY, LA, MA, MI, NJ
Parity bills pending: AK, HI, IA, MO, NY, OH, SC, WV

Virginia. Virginia's parity legislation requires coverage for all "biologically based mental illnesses," including substance abuse. However, the legislation exempts companies with 25 or fewer employees from the parity mandate. Virginia's chapter of the National Alliance for the Mentally Ill worked closely with allies in the addiction field and insisted that the legislation must include parity for both mental health and substance abuse. Advocates pointed out that failure to include addictive disorders it would make it possible for insurers

▶ **PARITY** *continued on page 16*

▶ **PRIVATE SECTOR FUNDING** *continued from page 1*

abuse is the costly alternative — in lives destroyed, promise unfulfilled and the quality of life we experience in all our communities diminished."

Dr. Clark explained that "Others of our studies have shown that treatment for substance abuse is effective and cost-effective. Today, we have the third part of the puzzle — real data on what is actually being spent on substance abuse treatment, and what the trends are. Unfortunately, he said, "it turns out that what we are spending on substance abuse treatment is not much, and trending downward." Pointing out that less than $12 billion was spent on addiction treatment in 1998, even though federal data show that more than 3 million people who needed treatment in that year did not get it, he said the new study shows that private health insurance "is not filling the void." In fact, the study found that state and local governments are paying for almost two-thirds of addiction treatment, with the remaining third paid for by a combination of private insurers, philanthropy and patients and their families. He added that private funding for addiction treatment did not even keep pace with inflation, and actually fell about 0.2% per year over the study period.

The study, "National Expenditures for Mental Health and Substance Abuse Treatment, 1987-1997," was conducted by the Medstat Group, under the direction of Mady Chalk, Ph.D., Director of the CSAT Office of Managed Care, and Jeffrey Buck, Ph.D., Director of the Office of Managed Care at the Center for Mental Health Services. Key findings include:

- Addiction and mental health services represented 7.8% of U.S. health care expenditures in 1997, down from 8.8% in 1987. Real spending by private insurers for addiction treatment services fell by 0.6% annually in that 10-year period.
- Spending on addiction and mental health treatment grew more slowly than spending for all health care. Inflation-adjusted, mental health and addiction treatment services grew by 3.7% annually between 1987 and 1997, while all health care spending grew an average of 5% each year.
- The study documented a growing trend toward outpatient treatment. Hospital expenditures as a proportion of all addiction and mental health treatment spending declined by more than 10% between 1987 and 1997.

The study report is available on-line at ***www.samhsa.gov*** or can be ordered from the National Clearinghouse for Alcohol and Drug Information at 1-800/487-4889. A special report by the study authors appears in the July-August issue of the peer-reviewed journal, *Health Affairs*. ▪

Achieving Parity: What You and Your Chapter Can Do

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

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

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

Ideally, state legislation should include the broad definition of parity contained in ASAM's policy statement, which says that "benefit plans for the treatment of addictive disorders, in both the public and private sectors, shall be comprehensive; i.e., they shall cover the entire continuum of clinically effective and appropriate services provided by competent licensed professionals, and should provide identical coverage and funding to those benefits covering physical illness, with the same provisions, lifetime benefits, and catastrophic coverage."

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

▶ **PARITY** *continued from page 15*

to limit or deny coverage to dually diagnosed individuals simply by designating substance abuse as their primary illness.

Partial Parity Acts

Seven states — Georgia, Hawaii, Kentucky, Louisiana, Massachusetts, Missouri and New Jersey — have adopted laws that guarantee some benefits for addiction treatment, albeit with limits not imposed on coverage of other medical disorders. These laws are a significant first step toward subsequent enactment of full parity.

Georgia. Georgia's 1998 statute, which applies to both individual and group plans, specifically includes substance abuse. Small employers *are not* exempted. However, the statute only mandates that insurers *offer* such coverage, rather than requiring that they *provide* it. It also caps the required benefit at 30 days per year of inpatient treatment or 48 visits per year of outpatient treatment, retaining the disparity between mental and addictive disorders and all other medical disorders.

Hawaii. Adopted in 1999, the Hawaii law mandates full parity for mental health services but allows health plans to limit substance abuse treatment to not less than two treatment episodes per lifetime.

Kentucky. Signed into law by the Governor in April 2000, H.268 requires that coverage issued after the act's effective date include mental and addictive disorders, as defined in the *DSM-IV* or the *ICD-9*. However, the law exempts groups of less than 50, individual coverage, and employer-organized associations. It also allows plans that currently exclude mental and addictive disorders to continue to do so after the effective date.

Louisiana. Louisiana's limited 1999 parity law requires plans to *provide* mental health coverage for serious mental illness, but only requires that plans *offer* benefits for addiction treatment and some mental disorders. For example, the law allows plans to limit benefits to 45 inpatient days or 52 outpatient visits per year.

Massachusetts. S.2036, signed into law May 2, 2000, includes in its many requirements a definition of certain detoxification and addiction treatment services that must be covered, albeit with limits different from those for other medical disorders. The act also contains a time-limited exemption of small group and individual plans.

Missouri. Legislation enacted in 1999 updates a 1997 parity measure. The 1999 law specifically defines alcohol and drug abuse (as described in the *ICD-9*) as covered conditions. It requires insurers to cover up to 26 outpatient visits, 21 inpatient days, and six days of detoxification per year, and prohibits establishment of any rate, term, or condition that places a greater financial burden on an insured, except that alcohol and other drug abuse benefits must allow at least 30 inpatient days and 20 outpatient visits per year. The law also allows insurers to impose a lifetime limit on benefits for alcohol and drug treatment that is no less than four times the annual limit.

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

Parity Bills Introduced

Alaska. H.149 would require that firms providing group coverage for five or more employees must provide coverage for addictive disorders and mental illness. It would prohibit different deductibles, coinsurance or co-payments, claims payment methods, precertification requirements, or coverage limits for addictive and mental disorders. *(Pending in House Committee on Labor and Commerce.)*

Florida. S.1658 would require full parity for mental illness in plans offered by group health insurers, HMOs and out-of-state groups. Also would require that when a diagnosis of serious mental illness is accompanied by an addictive disorder, benefits must cover treatment of the addictive disorder. *(Withdrawn from further consideration.)*

Hawaii. S.2891, H.2550 and H.320 would amend the 1999 act to require that the covered benefit for addictive disorders be not less than 30 days of inpatient services

each year and not less than 12 outpatient visits per year. It also would prohibit higher co-payments and deductibles for coverage of addictive disorders. *(H.320 carried over to the next session of the legislature.)*

Iowa. H.241 and S.83 would provide full parity for addictive disorders and mental illnesses, as defined in the *ICD-9*. The House version also would require a study of the impact of parity on employers, insurers and patients. *(H.241 and S.83 carried over to the next session of the legislature.)*

Maine. H.1062 and S.346 both would require insurers to provide coverage for addiction treatment on a par with that for other medical conditions. *(Majority Committees in both House and Senate recommended that the bills Ought Not to Pass.)*

Missouri. H.2115 would amend current law to require that insurers' cost-sharing requirements for coverage of inpatient and outpatient treatment of mental or addictive disorders may not be different from those for other illnesses. However, the bill would not require insurers to cover mental or addictive disorders. *(Pending in the House Committee on Critical Issues.)*

New York. A.286 would require that the cost-sharing requirements imposed by health plans for coverage of mental or addictive disorders may not be different from those for other illnesses. However, the bill would not require insurers to cover mental or addictive disorders. *(Pending in the Senate Committee on Alcoholism and Drug Abuse.)*

Ohio. H.53 would require that health insurance policies provide full parity in their benefits for the diagnosis and treatment of mental and addictive disorders, if a licensed provider has clinically diagnosed the condition and the prescribed treatment is not experimental or investigational. *(Carried over to the next session of the legislature.)*

South Carolina. H.3351, H.3417, S.2779 and S.382 all would require that health insurance policies provide at least one choice for treatment of mental and addictive disorders that is offered under rates, terms and conditions that place no greater financial burden on the insured than for access to treatment of other physical conditions. *(All bills carried over to the next session of the legislature.)*

West Virginia. H.2986 would amend current law by requiring health insurers to provide coverage for mental and addictive disorders under the same terms and conditions as for all other illnesses. *(Pending in House Committee on Banking and Insurance.)*

Wisconsin. A.793 would amend current law by deleting the minimum mandated benefits for treatment of addictive and mental disorders, and replacing that language with a requirement of coverage that is the same as for all other medical disorders. *(Failed to pass, pursuant to a Joint Senate resolution.)*

Other Approaches

Some states have approached parity from other perspectives. For example, legislators in **Indiana**, **North Carolina** and **Texas** have adopted measures requiring parity in coverage for state employees, while legislators in **Delaware**, **Hawaii**, **North Carolina** and **North Dakota** have adopted resolutions to study parity.

California. Passed in June 2000, this law was amended at the last minute to require a legislative analysis of parity for addictive and mental disorders, rather than actually mandating parity (see Chapter Updates, this issue).

Washington State. The Washington State legislature has not yet enacted parity legislation. However, ASAM member James W. Smith, M.D., FASAM, worked with the state's Insurance Commissioner to achieve a permanent rule change in 1999 that: (1) defines chemical dependency as a chronic illness, (2) defines "medical necessity" in the treatment of chemical dependency as that which conforms to the ASAM *Patient Placement Criteria*, and (3) specifies standards for the coverage of addictive disorders that must be met by any insurance contract offered in the State of Washington. Dr. Smith's success demonstrates that there are multiple ways to achieve parity, and that working with Insurance Commissioners and other state officials to achieve regulatory change can be a viable alternative to the legislative process. ■

Tools for Working with Legislators

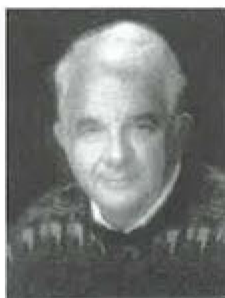
Campaign for Treatment: Educating Our Legislators. *Join Together (Boston University School of Public Health).* This Action Kit helps community leaders bring about policy changes to insure quality addiction treatment, including treatment parity. Available as a PDF document at ***www.jointogether.org/sa/files/pdf/Campaign_Treatment.pdf***, or in a print version from Join Together, 441 Stuart St., Boston, MA 02116; phone 617/437-1500; fax 617/437-9394.

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

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

Milliman & Robertson's Premium Estimates for Substance Abuse Parity Provisions for Commercial Health Insurance Products. ASAM was a co-sponsor of this important report by Milliman & Robertson, which provides actuarial and management consulting services to a majority of commercial managed care organizations. The report estimates that "full and complete substance abuse parity provision would increase 'composite' per capita health insurance premiums...by 0.5%, or less than $1 per member per month." The entire report can be viewed at ***www.health.org/pubs/insur/***.

ASAM Welcomes New Members



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

The Society welcomes the following physicians, who became members in recent months. Individually and collectively, their diverse backgrounds, clinical and research interests promise to bring increased breadth and depth to ASAM.

Bikash Agarwal, M.D., an internist, is on the staff of St. Anthony Memorial Hospital, Michigan City, IN.

Mohamed A. Al-Garhy, M.D., a psychiatrist, practices in Dammam, Saudi Arabia.

Ammar Alrefai, M.D., a psychiatrist, practices in Muscle Shoals, AL.

Bassam A. Amawi, M.D., M.P.H., a resident, lives in Daytona Beach, FL.

John M. Bentz, M.D., an obstetrician and gynecologist, practices in Fort Wayne, IN.

Bharat Bhushan, M.D., a psychiatrist, practices in Redwood City, CA.

Barry I. Blum, M.D., practices internal medicine at the Huntington Medical Foundation and Huntington Memorial Hospital, and treats chemical dependency at Las Encinas Hospital, Pasadena, CA.

William Bobo, M.D., a resident in psychiatry, lives in Washington, DC.

Harold T. Bolnick, M.D., is an anesthesiologist in Longview, TX.

Beth K. Boyarsky, M.D., is a resident in psychiatry (with special interests in research and addiction psychiatry) at the Albert Einstein College of Medicine, Bronx, NY.

Robert James Brauer, D.O., is a resident in psychiatry in Cleveland Heights, OH.

Terry Lynn Bucan, D.O., practices emergency medicine in Marinette, WI.

Edgar H. Clark, M.D., a family physician, practices in Paradise, CA.

Richard M. Cohen, M.D., a pediatrician, practices in Brandon, FL.

Yolanda L. Dagnino, M.D., is Medical Director of C.U.R.A., Inc., in Cedar Grove, NJ.

John Dewar, M.D., is Medical Director of the Substance Abuse Unit, Canton-Potsdam Hospital, Potsdam, NY. Dr. Dewar also is Clinical Assistant Professor of Family Practice at the State University of New York Upstate Medical University, Syracuse, NY.

Jeremy L. D'Morias, M.D., an internist, lives in Fresno, CA.

Lisa Doupe, M.D., D.I.H., D.O.H.S., practices in Toronto, Ontario, Canada.

Shadi Duchesne, M.D., is Medical Director of White Deer Run, Inc., an addiction treatment program in Allenwood, PA.

Emmanuel O. Emenike, M.D., a resident in pediatrics, lives in Derby, CT.

Nestor Fernandez, M.D., an internist, practices in Margate, FL.

William R. Ford, M.D., is a psychiatrist in private practice in Tulsa, OK.

Carol V. Garner, M.D., an internist, is on the staff of the Faulkner Hospital, West Roxbury, MA.

Veena Garyali, M.D., is Executive Director of the Kirby Forensic Psychiatry Center, Wards Island, NY.

Stephen Gilman, M.D., is a resident in psychiatry in New York City.

Pamela J. Goebel, M.D., practices in Calgary, Alberta, Canada.

Cristina Goldizen, M.D., a psychiatrist, practices in Owensboro, KY.

Jennifer E. Graham, a medical student, lives in Titusville, PA.

J. Carol Grigg, M.D., FACEP, FAAFP, is Contract Manager of the Emergency Departments at Memorial Hospitals in Ormand Beach, Bunnell and Peninsula, FL. Dr. Grigg also is a certified Medical Review Officer in Palm Coast, FL.

Hiroaki Harai, M.D., a psychiatrist, is affiliated with Koushi-Machi in Kumamoto, Japan.

Carlos A. Hernandez-Avila, M.D., is Assistant Professor of Psychiatry at the University of Connecticut School of Medicine, Farmington, CT.

David Hersh, M.D., is Director of the Division of Substance Abuse and Addiction Medicine, Department of Psychiatry, University of California at San Francisco/San Francisco General Hospital.

Kevin P. Hill is a medical student in Philadelphia, PA.

Gray Hilsman, M.D., a psychiatrist, practices in Jackson, MS.

Susan C. Holman, M.D., an internist, practices at the Sisters of Mercy Urgent Care Center-South, Asheville, NC.

Steven C. Ingalsbe, M.D., a family practitioner, is with the Crossroads Medical Associates in El Paso, IL.

Craig T. Jaffe is a medical student at the University of Washington Medical School, Seattle.

Carmen L. Johnson, M.D., is a primary care physician with the Sidney Health Center, Sidney, MT.

Michelle E. Johnson, M.D., a psychiatrist, practices in Asheville, NC.

H. Frederick Koch, M.D., a pediatrician, practices in Alliance, NE.

Saba Lahood, MB.Ch.B., practices addiction medicine at the Queen Mary Hospital, Hammer Springs, New Zealand.

Michelle A. Lally, M.D., is on staff at The Miriam Hospital, Providence, RI.

Notify ASAM Now to be Listed in New On-Line Membership Directory

ASAM now offers its members the opportunity to be listed in a new electronic membership directory, which will be available both to professional colleagues and to the general public around the world. The directory will be reached through ASAM's web site (***www.asam.org***).

Each entry will list a member's name, degree(s), primary and secondary areas of specialization, telephone and fax numbers, e-mail and web addresses, and dates of ASAM certification or recertification, as they appear in ASAM's records.

To be listed in the directory and/or to verify your information, simply contact Ann Boonn at the ASAM office by phone at 301/656-3920 or by e-mail at ***aboon@asam.org***.

Keith Lipsitz, M.D., a board-certified anesthesiologist, practices addiction medicine and is Director of the Connecticut Nutmeg Intensive Rehabilitation Center, Weston, CT.

C. Frederick Lord, M.D., practices in Windsor, VT.

Shaohua Lu, M.D., is an emergency psychiatrist with the Vancouver General Hosital. Dr. Lu also practices onco-psychiatry at the British Columbia Cancer Agency and is a Clinical Instructor in Psychiatry at the University of British Columbia, Canada.

Stephen Douglas Lykins, M.D., practices addiction medicine in Olympia, WA.

Donna MacKuse, D.O., is Director of Psychiatric Services for Family Addictions Treatment Services, Summers Point, NJ.

William B. Mahoney, M.D., is a Staff Psychiatrist with the VA West Side Medical Center, Chicago, IL.

E. Jean Mander, M.D., an emergency medicine specialist, practices in Auckland, New Zealand.

David T. Manganaro, M.D., an internist, practices in Staten Island, NY.

Susan McNamara, M.D., a resident in psychiatry, lives in Middlefield, CT.

Kenneth J. Miller, M.D., a psychiatrist, practices in Gahanna, OH.

Fran L. Moore, M.D., an adult and child psychiatrist, is Medical Director of Cottonwood de Tucson, Tucson, AZ.

Rodney Moret, M.D., a general practitioner, is on the staff of the Michigan Counseling Service, Madison Heights, MI.

Judith Morishima-Nelson, M.D., is a psychiatrist in acute care in Seattle, WA.

Robert Mullan, M.D., practices family medicine in Kentville, Nova Scotia, Canada.

Aaron M. Murowitz, D.O., a family practitioner, is with the Midtown Medical Center, Atlanta, GA.

David K. Nace, M.D., is President of United Behavioral Health, Philadelphia, PA.

Dennis A. O'Brien, M.D., a psychiatrist, practices in Smyrna, GA.

Chandrakant A. Patel, M.D., is an internist with Spectrum Health Care, Jersey City, NJ.

Jan M. Pederson, M.D., is a psychiatrist on the faculty of the University of Nevada School of Medicine, Sparks, NV.

Thomas J. Prendergast, D.O., practices emergency medicine in Turlock, CA.

Ellen W. Price, D.O., practices in Grand Junction, CO.

James V. Richardson, M.D., of Montgomery, AL, is retired from the practice of medicine.

William E. Rizzo, M.D., practices in Rochester, MI.

David Sabo, M.D., practices in Ft. Mitchell, KY.

Mario Sanchez-Martinez, M.D., is a Resident Fellow in Psychiatry at the Mt. Sinai Center, Miami, FL.

Mohammed S. Seedat, M.D., is a Clinical Assistant Professor of Medicine at the State University of New York at Syracuse, NY.

Michael Shallman, M.D., is a Clinical Professor of Medicine at the University of California at Los Angeles and Teaching Head of Gastroenterology at St. Mary Medical Center, Long Beach, CA.

Kay Shiu, M.D., a family medicine specialist, is affiliated with the Centre for Addiction and Mental Health, Toronto, Ontario, Canada.

C. J. Shukla, M.D., is a resident in psychiatry in Lexington, KY.

Paul T. Sicola, D.O., an emergency medicine specialist, practices in Miami Beach, FL.

Kirby D. Slifer, D.O., an internist, practices in Crown Point, IN.

Jose M. Soto, M.D., practices psychiatry at the Bronx Hospital, West New York, NJ.

Carol Z. Stearns, M.D., practices in Pittsburgh, PA.

James J. Stockard, M.D., Ph.D., is a staff psychiatrist and works with the Professionals in Crisis Program at the Menninger Clinic, Topeka, KS.

Raymond L. Struck, M.D., is a resident in addiction medicine specialist at the University of Minnesota/VA Medical Center, Minneapolis, MN.

C. Lee Sturgeon, Jr., M.D., practices addiction medicine with the Sequoia Alcohol & Drug Center, Redwood City, CA.

Eva Styrsky, M.D., FRCP(C), is a staff psychiatrist with St. Michael's Hospital, Mississauga, Ontario, Canada.

Michael G. Sumner, M.D., a neuropsychiatrist, practices in Hamilton, Ontario, Canada.

Stephen M. Taylor, M.D., M.P.H., a psychiatrist, practices in Madison, AL.

Robert P. Turner, M.D., is with the Division of Pediatric Neurology at the University of South Carolina Medical Center, Summerville, SC.

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Frank David Wright, M.D., is a family physician with the Laredo Medical Group, Laredo, TX.

Sajjad Abid Zaidi, M.D., is a child psychiatrist affiliated with the Pediatric Unit of the Monmouth Medical Center, Freehold, NJ. ■

Members Cite Reasons for Joining ASAM

Becoming certified in addiction medicine and networking with other addiction specialists are the reasons for joining ASAM cited most often in a recent member survey.

Asked why they chose to renew their memberships, 38% of respondents said they wished to continue receiving **ASAM News**. Other frequently cited reasons for renewing include networking opportunities (58%), to promote education and research in addiction medicine (41%), and to work for parity for addiction treatment (27%).

The survey was mailed in March 2000 to a random sample of 283 members, 93 of whom responded. Respondents ranged in age from under 30 to over 70, with the largest number (75) in the 41 to 60 age range. Fifty-one of the 93 respondents have been ASAM members for 10 or more years.

Survey responses were analyzed by Norman S. Miller, M.D., FASAM, of Michigan State University. Dr. Miller is Regional Director of ASAM Region IV. A detailed report of the survey results will appear in a future issue of **ASAM News**.

ASAM CONFERENCE CALENDAR

ASAM

September 28-October 1
Carolina Conference on Addiction 2000
(jointly sponsored by ASAM)
Charlotte, NC
32 Category 1 CME credits
[For information phone 912/638-5530 or e-mail *huntercon@aol.com*]

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.]

September is "Recovery Month"

September 2000 will be observed as "National Alcohol and Drug Addiction Recovery Month" to promote the importance and effectiveness of addiction treatment. The theme of the 2000 celebration is "Recovering Our Future — One Youth at at Time." A kit containing promotional event ideas, a sample press release, a sample media advisory, a sample "op ed" article, a script for a radio public service announcement, sample proclamations, special letterhead and other useful materials has been developed by the Center for Substance Abuse Treatment (CSAT) to help local leaders promote Recovery Month. Order your kit, free of charge, from the National Clearinghouse for Alcohol and Drug Information (NCADI) at ***www.health.org/recovery00/kit/index.cfm***. ASAM is a supporting organization of National Alcohol and Drug Addiction Recovery Month.

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*]

OTHER EVENTS OF NOTE

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 2-4
24th Annual Conference
Association for Medical Education and Research in Substance Abuse
Alexandria, VA
[For information phone 401/785-8263]

November 6-9
Addictions 2000: Conference of the International Society of Addiction Medicine
Jerusalem, Israel
[For information visit the web site *www.sympatico.ca/pmdoc/ISAM*]

Highlights:

ASAM Review Course 2000

The ASAM Review Course in Addiction Medicine will be held October 26-28, 2000, at The Westin O'Hare Hotel, Rosemont, IL (at Chicago's O'Hare Airport). To receive the special conference rate of $137 single or double, phone 847/698-6000 and tell the reservation agent that you are attending the ASAM 2000 Review Course. Reservations must be made by Friday, September 29, 2000, to guarantee the conference rate.

Course participants will receive a Study Guide that contains outlines of the speakers' talks, copies of their slides and related readings, as well as sample questions from past Certification/Recertification Exams and information on the topics covered and the distribution of questions on past examinations. The Study Guide will be mailed September 1, 2000, to all persons who have registered for the Review Course by that date. Late registrants will be sent the Study Guide as their registrations are received.

To register or for information, call the ASAM Department of Conferences and Meetings at 301/656-3920, or consult the ASAM web site at ***www.asam.org***.

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