ASAMNEWS

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NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

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Dr. Lawrence Brown Is ASAM President-Elect

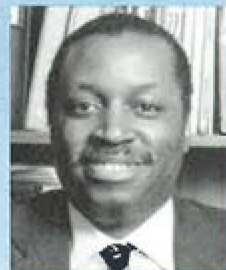
G. Douglas Talbott, M.D., FASAM
Chair, Nominating and Awards Committee

Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, has been voted ASAM President-Elect in recently completed balloting. Joining Dr. Brown as new officers of the Society are Michael M. Miller, M.D., FASAM, who has been re-elected Secretary, and Elizabeth F. Howell, M.D., re-elected Treasurer. Elected Directors are Louis E. Baxter, Sr., M.D., FASAM; Paul H. Earley, M.D., FASAM; Lloyd J. Gordon III, M.D., FASAM; Thomas L. Haynes, M.D., FASAM; Lori D. Karan, M.D., FACP, FASAM; Peter A. Mansky, M.D.; Peter E. Mezciems, M.D., FASAM; Ronald F. Pike, M.D., FASAM; A. Kennison Roy, M.D., FASAM; Berton E. Toews, M.D., FASAM.

Newly elected officers will serve two-year terms, while Directors serve four-year terms. They will be installed during the Business Meeting at ASAM's 31st Annual Medical-Scientific Conference, April 19-22, 2001, in Los Angeles. President-Elect Andrea G. Barthwell, M.D., FASAM, will assume the ASAM Presidency at that time, as current President Marc Galanter, M.D., FASAM, assumes the duties of Immediate Past President.

A Senior Vice President of Addiction Research and Treatment Corp. in Brooklyn, NY, Dr. Brown also holds faculty appointments as Clinical Associate Professor of Public Health at Cornell University and as Visiting Physician at Rockefeller University. Trained in internal medicine and endocrinology, he also is engaged in clinical and epidemiological research related to understanding and treating substance abuse and its complications, and has published more than 100 papers and reports on the subject.

▶ **ASAM PRESIDENT-ELECT** *continued on page 4*



"I believe I can utilize my past experience in substance abuse-related research, clinical care and public policy to continue the work of past Presidents and carry the baton of ASAM into the future through improvements in the care that our patients deserve and in the professional experience of our hard-working clinicians."

Lawrence S. Brown, Jr., M.D., M.P.H., FASAM

New Federal Rule Requires Oversight, Accreditation of Methadone Clinics

A federal rule announced January 17 by Joseph H. Autry III, M.D., acting administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), is designed to improve the oversight of addiction treatment programs that use methadone and other medications to treat opiate dependence. The rule creates a new accreditation program managed by the Center for Substance Abuse Treatment (CSAT). This accreditation program replaces a 30-year-old inspection program conducted by the Food and Drug Administration (FDA).

Joseph H. Autry III, M.D.

Under the rule, clinics that treat addiction with methadone, levo-alpha-acetyl-methadol (LAAM) or other medications would be accredited by non-federal agencies in accordance with standards established by CSAT. The standards emphasize improving the quality of care through individualized treatment planning, increased medical supervision, and assessment of patient outcomes. Acknowledging that the change mirrors recommendations made by organizations such as ASAM, the

▶ **NEW FEDERAL RULES** *continued on page 4*

Be Strategic in Advocating for Parity

James F. Callahan, D.P.A.

The arrival of a new administration in Washington — as well as in many governors' mansions and state legislatures — has advocates thinking about how they can effectively work for parity in a changed political environment.

Fortunately, there are some strategies for crafting and delivering our message to lawmakers and the public that are effective regardless of whether Democrats or Republicans are in charge. Jeff Blodgett of the Alliance Project, in which ASAM is an active partner, offers the following advice:

Define the Message

The first thing any organization that intends to lobby for increased funding, legislation or other policy changes needs to do is determine the core message it wants to deliver to its audience, says Mr. Blodgett. Advocates need to boil their message down to a word, phrase or sentence that captures the essence of what we want to convey.

Of course, that message won't just come out of thin air; it must be salient, relevant both to the mission and the prevailing social and political environment, and believable. Moreover, Mr. Blodgett says, a good message must be well-tested, such as through internal feedback, focus groups or polling. Through a series of focus groups, for example, the Alliance Project has learned that the public responds well to messages that emphasize the cost-effectiveness of treatment and the medical basis of addictive disorders.

Be Strategic

The message also must be strategic. Backed by data, for example, a message like "Treatment is Effective," can support the goal of winning increased funding for services, while the "Recovery Happens" message reinforces efforts to fight stigma against persons with addictive disorders.

Stay Relevant

Messages need to be tailored differently for different audiences. What we say to opinion and community leaders may be different than what we would say to elected officials — and usually will be framed differently than what we say to persons in recovery or others who are more familiar with their issues. Messages must be audience-specific even when the ultimate goal in addressing each is the same.

Keep It Simple

Above all, the message must be simple. "I can't emphasize that enough," says Mr. Blodgett. "In politics, simple is the overarching tactic — sometimes to the point of the absurd."

Be Persistent

Finally, our message must be delivered frequently, and with great discipline. Members must speak with one voice on key issues, and leaders must be certain to stay "on message" whenever possible.

The Alliance Project has prepared the following information for use in letters and other efforts to advocate for parity. As I have written before, it is only with the active involvement of all ASAM members that we can achieve this vital goal. ■

What is Alcohol and Drug Addiction Parity? It Brings Fairness and Equity to Insurance Coverage for Alcohol and Drug Addiction. Addiction parity means making insurance coverage for alcohol and drug addiction treatment equal with coverage for other chronic disorders. It is a key reform that allows alcohol and drug addiction to be treated as the disease it is.

Currently, millions of people in the United States find that their health plans place strict limits on both in-patient and outpatient coverage for addiction treatment services. Yet, alcohol and drug addiction remains an enormous public health problem. Nearly half of all Americans report knowing someone with an addiction problem. As many as 20 million Americans each year experience alcohol or drug addiction.

Addiction Parity: It Makes Treatment More Accessible and Affordable. The millions of people in recovery from addiction are living proof that treatment works. Yet less than half the people who need treatment can get it, and only 20% of adolescents can obtain treatment. Addiction parity will allow more people to get treatment when they need it.

Addiction Parity: It's Cost Effective. Untreated alcohol and drug addiction costs taxpayers and businesses $276 billion dollars per year in lost earnings, new prisons and accidents, and unnecessary health care. On the other hand, economic data show that every dollar spent on alcohol and drug treatment saves seven dollars in medical and other social costs. Adding full and equal coverage for alcohol and drug addiction increases premiums by only 0.2%, or about $1 per month for most families. It would allow many more people to access treatment, reducing costs to taxpayers and businesses.

A RAND study found that addiction treatment services could be made available to employees for $5.11 per year, or 43 cents a month. Chevron Corp. reports that it saves $10 for every dollar spent on coverage for addiction services.

Addiction Parity: It Makes Sense!

American Society of Addiction Medicine

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

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

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

Tobacco Whistleblower Testifies on Censored Documents

Jeffrey Wigand, whose 1995 testimony about perjury and other wrongdoing was key in litigation against cigarette manufacturers, told a New York court in December that tobacco firms altered and destroyed documents that confirmed the risks of smoking. Wigand added that while he was head of research at Brown & Williamson Tobacco Corp. in the early 1990s, company lawyers censored any internal document that confirmed that cigarettes cause cancer.

Wigand's testimony came in a multi-billion-dollar jury trial in Brooklyn, NY. The civil case was brought by a trust for sick asbestos workers and their heirs against Brown & Williamson, R.J. Reynolds, Philip Morris and other major tobacco firms. The lawsuit claims that the tobacco industry took part in a conspiracy to hide and distort findings that asbestos workers who smoked were five times more likely to get lung disease than the average smoker.

According to Wigand, Brown & Williamson researchers agreed that there was a "lethal synergy" between tobacco and asbestos, but the company ordered them not to go public with the findings. "When you were at Brown & Williamson, where you permitted to publicly say that smoking caused lung cancer?" asked plaintiff attorney Edward Westbrook. "No," Wigand replied.

Brown & Williamson attorney David Bernick accused Wigand of tailoring his testimony "to create a stir about misconduct at Brown & Williamson."

Source: Associated Press, December 13, 2000.

Beer Companies Back New College Alcohol Programs

A number of U.S. colleges and universities are changing their approach to on-campus drinking, and beer companies are playing a key role in funding such efforts, the *Wall Street Journal* reports. Rather than taking a hard line on abstinence from alcohol, colleges are experimenting with campaigns that stress moderation. Funding for the new alcohol programs is coming from beer makers, including Anheuser-Busch, the nation's largest brewer.

The new concept, called "social-norms marketing," includes the placement of upbeat ads about student drinking behavior in campus newspapers. In addition, messages of moderation are displayed on posters, T-shirts, coffee mugs and screen savers.

To date, Anheuser-Busch has committed nearly $400,000 to the University of Virginia and six other schools for social-norms campaigns. The company also is talking with other schools about sponsoring ads urging moderation. Other brewers funding similar efforts are the Miller Brewing Co., which has given $25,000 to Georgetown University to develop a social-norms program, and the Adolph Coors Co., which contributed $8,000 to the University of Wyoming to help pay for placards advertising that 'A' students average no more than three drinks when they party, while 'C' students consume as many as five.

School officials must decide, however, whether their partners in addressing campus alcohol abuse should be the companies that make and market the beer and liquor young people use to get drunk. "One always becomes a little concerned if there seems to be strings attached, but there were none," said James Turner, director of the Student Health Department at the University of Virginia. "I likened it to General Motors asking a university to help them come up with new air-bag or seat-belt technology. Of course we'd say yes."

But Richard Keeling, editor of the *Journal of American College Health* and a former student health director at both the University of Virginia and the University of Wisconsin, thinks the schools should refuse the financial support from beer makers. He said that social-norms marketing attacks the wrong end of the problem, and he called industry support for it "amazing, but very predictable." "I don't think the industry is prepared to reduce consumption, which is what is necessary," Keeling added.

Source: Wall Street Journal, November 2, 2000.

'Frontline' Says U.S. Drug War Failed

"Drug Wars," a four-hour Frontline report airing on the Public Broadcast Service, features interviews with high-level government officials, drug traffickers, drug agents and drug lords, including men who once headed Colombia's notorious Medellin cartel. The report gives an inside look at the business of producing and trafficking illicit drugs, including footage of the ambush of Mexican federal drug police by a unit of the Mexican army protecting drug smugglers.

The examination begins with the first days of Richard Nixon's presidency. "I think people will be surprised that Nixon turns out to be the most effective in terms of getting control of a particular drug, in this case heroin," said reporter and co-producer Lowell Bergman. Bergman insists that "Drug Wars" does not draw its own conclusions, but reflects the view echoed by every drug enforcement official reporters interviewed: demand reduction works better than supply reduction.

The report also explores the consequences of the drug war, such as increases in the U.S. prison population. The film points out that the U.S. fights the drug war with a bureaucracy that, by next year, will total 51 government agencies spending some $20 billion a year.

Source: October 6, 2000.

Coalition Pushes to End Smoking in Pregnancy

A consortium of government agencies and medical organizations is launching a new campaign advocating additional physician involvement in helping pregnant patients who smoke to quit. The goal is to reduce the number of low-birth-weight babies and increase the overall health of infants in accordance with the Public Health Service's Healthy People 2010 initiative, which aims to reduce smoking during pregnancy to 2%. The current rate is about 13%.

The consortium is working to increase the number of physicians and other health care professionals who give smoking cessation counseling and treatment in a five- to 15-minute initial intervention with follow-up care. Current practice and recommendations include asking pregnant patients if they smoke and advocating that they stop. But many physicians never tell their patients how or monitor their progress. "Doctors are crucial," said Doris Barnette, principal adviser to the administrator of the Health Resources and Services Administration. "We have an evidence-based intervention that has a good chance of helping women to quit, and it's doable." Her office will direct the campaign to the public "safety net" clinics that see many poor women.

The campaign is backed by the American Association of Health Plans, the American College of Obstetricians and Gynecologists, the Association of Maternal and Child Health Programs, the Centers for Disease Control and Prevention, and many other agencies.

Source: American Medical News, January 15, 2001. ■

FROM THE PRESIDENT'S DESK

WANTED: Accounts of Treatment Discrimination

Marc Galanter, M.D., FASAM

I have written and spoken to you many times of my concern that changes in the health care system are preventing many individuals from receiving the health care and addiction treatment they need and deserve.

Now the Join Together project at the Boston University School of Public Health has set up a program to collect reports about barriers to receiving high quality treatment for addictive disorders.

Join Together wants to hear the stories of individuals who have experienced discrimination, delays, financial obstacles or other barriers to seeking treatment for themselves or someone close to them. Examples might include:

- A student who lost federal financial aid as a result of a conviction for a drug-related offense.
- An individual whose entry into treatment was delayed by the reluctance of a primary care "gatekeeper" to make a required referral.
- A worker who lost her job, and thus her health benefits, as a result of identifying her need for treatment.
- An individual who could not afford treatment because his health insurer refused to pay for such care.
- An insurer that routinely refuses to cover the types of treatment or length of care recommended by an addiction specialist.
- A physician who does not know how to help a patient find treatment.

Selected anecdotes, which will carry no identifying information, will be published on the Demand Treatment! Web site to document barriers to high-quality treatment. Demand Treatment! is Join Together's new initiative to increase the number of persons who receive high-quality treatment for their alcohol and drug disorders.

"We know that people are often discriminated against when they suffer from drug or alcohol disease," writes David Rosenbloom, Director of Join Together. "By publicizing their personal stories, and the experiences of those who have tried to assist them, these unfair episodes will no longer be seen as isolated exceptions, but as a national pattern of shameful neglect."

I urge you to send reports that meet these criteria to ***speakout@jointogether.org***, or send them to Join Together/ Demand Treatment, 441 Stuart St., 7th floor, Boston, MA 02116, or fax 617/437-9394. Building this database will provide all of us with a valuable resource in the struggle for better access to care. ■

New Feature: Addiction Medicine Essentials

With this issue of ASAM News, we inaugurate a new feature, "Addiction Medicine Essentials," designed to bring our readers important reference tools in a simple-to-save, easy-to-use form.

Inserted in the envelope with this issue, you will find a card containing the Clinical Institute Withdrawal Assessment — Alcohol, Revised (CIWA-Ar), one of the best known and most extensively studied scales for monitoring alcohol withdrawal. This scale has well-documented reliability, reproducibility and validity, is easy to use and has been shown to be useful in a variety of clinical settings, including detoxification units.

Peter Banys, M.D., FASAM, President of the California Society of Addiction Medicine, was instrumental in the development of "Addiction Medicine Essentials." The inserts will be offered in collaboration with CSAM.

▶ **ASAM PRESIDENT-ELECT** *continued from page 1*

He currently serves ASAM as Director of Region I and as a member of the editorial board of the *Journal of Addictive Diseases*. Dr. Brown also is a member of the Society's Strategic Plan Task Force and the Continuing Medical Education, AIDS, and Opioid Substitution committees. He was certified in Addiction Medicine in 1987 and became an ASAM Fellow in 1992. Other professional appointments include service on the National Advisory Council of the National Institute on Drug Abuse and the National Institute on Allergy and Infectious Diseases, advisory committees to the Food and Drug Administration and the National Academy of Sciences, and a recent appointment to the U.S. Anti-Doping Agency of the International Olympics Committee. ■

▶ **NEW FEDERAL RULES** *continued from page 1*

> **"By moving methadone treatment closer to the heart of the nation's health care system, we help people open the door to treatment....And with that transfer...clinical decisionmaking will be where it belongs — in the hands of treating professionals working with opiate-addicted patients."**
>
> *SAMHSA Acting Administrator Joseph H. Autry III, M.D.*

National Institutes of Health, Dr. Autry said that the new rule marks "an important turning point in how SAMHSA and the substance abuse treatment community do business. It took time; it took research; it took negotiation. Above all, it took the knowledge that today's best practices in treating opiate addiction have a solid research base, thanks to NIDA and its grantees. And it took the recognition that methadone and LAAM are medications just as beneficial as medicines used to treat other chronic illnesses, from hypertension to asthma and from clinical depression to diabetes."

ONDCP Acting Director Edward H. Jurith said the new rule represents "a fundamental shift in the way we approach drug abuse treatment in our nation" and that it will "substantially and fundamentally reform the federal government's role in assuring that methadone treatment programs are both effective and accountable for results. Doctors and other health care professionals will assure the appropriate dosage based on the best medical care for patients...." ONDCP estimates that there are 980,000 heroin addicts in the U.S. Roughly 20% currently receive methadone or LAAM as part of an addiction treatment program. There are approximately 1,000 methadone treatment programs in the U.S.

The final rule reflects consideration of approximately 200 comments submitted in response to the proposed rule, which was published in July 1999. It is to go into effect March 19, 2001. At that time, existing FDA regulations will be rescinded. The rule includes a transition plan that allows existing treatment programs approximately two years to achieve accreditation under the new system.

CSAT Director H. Westley Clark, M.D., J.D., FASAM, predicted that most methadone clinics would meet the new accreditation standards. "We want to promote state of the art treatment services," said Dr. Clark. "The accreditation system will set a higher standard of care for those receiving methadone treatment."

Source: Press briefing, December 18, 2001. ■

New Secretary, Treasurer, Board Members Elected

The following officers and Board members have been elected to terms beginning in April 2001. The Secretary and Treasurer are elected to two-year terms, while Board members serve four-year terms.

Secretary

Michael M. Miller, M.D., FASAM (incumbent)
Madison, Wisconsin

"This is a critical time for our field. Continuing in national office will provide a bit of extra visibility as I throw my energies into the parity fight on the state and national level. It's so ironic that so many patients need our services, that the role of the physician in helping people with addiction is clearer than ever before; that the biomedical science is on our side and now the economic analyses are on our side — so, more than ever, we need docs who are interested in this field and an organization that can provide cohesion and leadership for physicians who choose to focus on the care of patients with substance-related problems."

Treasurer

Elizabeth F. Howell, M.D., FASAM (incumbent)
Atlanta, Georgia

"During my tenure as Georgia's State Director for Substance Abuse, I administered or oversaw $71 million in state and federal funds for substance abuse prevention and treatment services in the public sector, educated and advised state and federal decision-makers and advocacy groups, developed and reviewed budgets for improvements to Georgia's public addiction treatment system, evaluated treatment programs, etc. My professional leadership experience at the state government level, ability to design and implement strategies and administer a variety of resources, experience in integrating key national and program goals and priorities would benefit ASAM and the position of Treasurer."

Region I (New York)

Peter A. Mansky, M.D.
Albany, NY

"My dedication is to further the treatment of those who are still out there suffering from addictive illnesses in this age of managed care and over-regulation. The skills and knowledge I have from my work in addiction medicine will allow me to serve in helping to develop standards for teaching, certification, research and treatment of addictive illnesses within ASAM."

Region II (California)

Lori D. Karan, M.D., FACP, FASAM
San Francisco, CA

"I am...concerned about the emerging gap between the traditional clinical practice of addiction medicine and the rapid progress being made in neuroscience, molecular signaling, genetics, and diagnostic imaging. Physicians of the future will need improved methods for inquiry and for the critical analysis of research results, rather than relying on their past memorization of factual data. The upcoming challenges will be exciting, provoke ethical controversy, and challenge our field. I am dedicated to helping navigate our future path, and to keeping addiction medicine practitioners cognizant of this forefront."

Director of Region III
(CT, ME, MA, NH, RI, VT)

Ronald F. Pike, M.D., FASAM
Worcester, Massachusetts

"My goal...is to bring to the ASAM Board a physician with many years of experience in the private sector. We have made the changes required to treat patients in a transitional managed care environment and have succeeded in treating patients with high quality. The Medical Model survives and flourishes, with our patients having the greatest benefit in all phases of treatment. I want the Board of Directors of ASAM to continue to perpetuate this model, along with the physicians who will continue to lead the treatment of the addicted in this country."

Director of Region IV
(NJ, OH, PA)

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

"I have always sought to promote and advance the field of addiction medicine and ASAM....There is a tremendous need to continue the work that has been done by my predecessors in ASAM regarding the research, the education and the dissemination of information. I believe that as the Regional Director, I can accomplish much in this regard because I am dedicated and I believe in the message and the mission. I believe that my drive and dedication to completion of tasks would benefit ASAM and the field of addiction medicine at large."

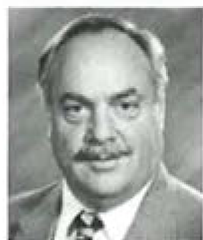
Director of Region V
(DC, DE, GA, MD, NC, SC, VA, WV)

Paul H. Earley, M.D., FASAM (incumbent)
Smyrna, Georgia

"Many members of ASAM are active at the state and local level, but feel less involved at the national level. To continue to grow, we must have a unified national focus with local action. I believe that the Chapters Committee is at the center of this action....ASAM has provided my own career with focus and I believe the Regional Directorship gives me the opportunity to give back to ASAM some of what I have received."

▶ **NEW BOARD MEMBERS** *continued on page 6*

NEW BOARD MEMBERS
continued from page 5



Director of Region VI (IL, IN, KY, MI, MN, ND, SD, TN, WI)

Thomas L. Haynes, M.D., FASAM
Grand Rapids, Michigan

"I believe that I can benefit ASAM by promoting the acceptance of the primary treatment of addiction in mainstream medical practice, and by doing whatever I can to bridge the gap that we currently have between the need for treatment of addiction and the lack of support for that treatment by government, industry, and third-party payers....As a business owner and practicing addiction medicine specialist, I understand the pressures faced by those of us outside of academia and government."

ADDICTION RESEARCH AND TREATMENT CORPORATION

Medical Director, ARTC:

A dedicated and committed professional needed for an exciting opportunity in health care. ARTC is a not-for-profit organization serving substance abusers in the New York Metropolitan area. Candidate must be a Board-certified family practitioner or internist with five years' experience in substance abuse treatment, ambulatory care, and administrative supervision in a health care setting. Responsible for directing a medical staff.

Competitive salary and benefits.

Call recruiter at 718/260-2997 *or fax resume to* 718/522-2916. *EOE*

Director of Region VII (AR, IA, KS, LA, MO, NE, OK, TX)

A. Kennison Roy, M.D., FASAM (incumbent)
Metairie, Louisiana

"Following attention to my own recovery in 1982, I developed an interest in addiction medicine and, over time, became a full-time worker in the field of addictive diseases....In December of 1994, I completed a residency program in Psychiatry at Tulane University School of Medicine. I am part of the faculty of a new fellowship program in addiction medicine at Tulane....I will bring my prior leadership experience, my interest in the welfare of addicted people, and my interest in training physicians in addiction medicine to the leadership of our society."

Director of Region VIII (AK, AZ, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY)

Berton E. Toews, M.D., FASAM
Casper, Wyoming

"Much of the energy and momentum in ASAM has been based in the densely populated East and West Coasts. By contrast, Region VIII is immense and extremely diverse; it contains some of the country's most sparsely populated areas....where we face challenges different from those of urban areas. For example, the methamphetamine phenomenon, which has been a significant problem in Wyoming and much of the west for 20 years, is just recently moving into more populous regions. With this problem and others, those of us in the West can provide an 'early warning,' through ASAM, to the rest of the country."

Director of Region IX (Canada and International)

Peter E. Mezciems, M.D., FASAM (incumbent)
Ontario, Canada

"With the support of ASAM, I have been involved in the creation of the International Society of Addiction Medicine, both as a founding Board member and as creator of the ISAM web site and Listserv mailing list....I continue to run the ***add_med*** Internet addiction mailing list, now with about 300 members from some 20 countries. This resource allows medical professionals to network and exchange addiction-related information worldwide with colleagues. My international involvement will allow me to continue to support and work for ASAM worldwide, and to bring a wide field of international experience to the ASAM Board."

Director of Region X (AL, FL, MS, PR, VI)

Lloyd J. Gordon III, M.D., FASAM (incumbent)
Brandon, Mississippi

"I am a clinician. I was blessed with the ability to connect with patients and mirror back to them the faulty logic and self-destructiveness of their thinking. When I contribute to the patient gaining some insight, becoming a more spiritual person, making behavior changes in their lives and becoming healthy and productive, that is the greatest contribution I am capable of making."

Membership Renewals Due

Don't lose your complimentary subscriptions to ***ASAM News*** and the ***Journal of Addictive Diseases***, and your other valuable benefits as a member of ASAM! Renew today by calling the national office at 301/656-3920, or by using the renewal notice you received in the mail.
For faster service, fax your credit card payment (MasterCard or Visa) to the ASAM office at 301/656-3815.

Smoking-Related Cancer Main Cause of Epidemic

Smoking-related cancers have skewed cancer death rates and created the misperception of a cancer epidemic, according to a study by two researchers at the University of Alabama at Birmingham. Once researchers removed lung cancer death rates from aggregate national data, they found that the overall cancer death rate declined 25%.

The study, which was underwritten by a smokeless tobacco company, further showed that when death rates from all smoking-related cancers are excluded, the overall cancer rate declined by 31% between 1950 and 1998.

"The focus on all-cancer mortality led to the widespread perception of a cancer epidemic caused by environmental pollution," the authors said. "There is no denying environmental problems, but the present data show that they produced no striking increase in cancer mortality. In reality, the so-called cancer epidemic consisted of one disease, cancer of the lung, and was due to one lifestyle factor, cigarette smoking."

Source: Journal of Clinical Oncology, January 1, 2001.

Many Americans Abstain from Alcohol Use

A new poll confirmed previous reports that about one-third of Americans do not drink alcoholic beverages. According to a survey of 1,035 adults conducted by the polling research organization Zogby America, 22% of respondents said they drink alcohol twice a month, 21% said they drink twice a week, and 17% said they drink twice a year.

The poll found that just 7% of those surveyed drink every day, while 34% said they never drink. The survey further found that respondents 18 to 29 years old had the lowest percentage of everyday drinkers, at 4%, followed by 30- to 49-year-olds. Eleven percent of those in the 50- to 64-year-old age group drink every day.

A higher percentage of men (8%) were daily drinkers, compared to 6% of women. Respondents who had less than a high school education were both the largest cadre of daily drinkers (15%) and the largest percentage of people who never drink (58%).

Source: Reuters News Service, October 20, 2001.

Survey: Youths Using Less Cocaine and Heroin, More Ecstasy

The newly released 2000 Monitoring the Future Survey shows a continuing downward trend in overall illicit drug use among youth, but reveals a significant increase in ecstasy use. The study also found significant declines in tobacco use at all grade levels, but alcohol use — already at high levels — remained essentially unchanged.

The survey of 45,000 students in grades 8, 10 and 12 found that heroin use declined 21% among 8th graders and cocaine use dropped 19% among 12th graders. In addition, use of LSD is down among 10th and 12th graders, while use of hallucinogens declined in all three grade levels.

However, the study found a significant increase in use of Ecstasy among all three grade levels. According to the report, between 1999 and 2000, Ecstasy use among 8th graders increased 82%, with a 44% increase among 10th graders and a 46 percent increase among 12th graders.

"The MTF Study also showed a huge increase in the use of MDMA or Ecstasy expanding beyond prior use solely at all-night rave clubs among all three grades," said Gen. Barry McCaffrey, former Director of the Office of National Drug Control Policy. "Kids think Ecstasy is safe, but they are actually harming themselves in a major way. They are destroying their memories, their hearts, their kidneys, and their nervous system, while risking immediate strokes and heart attacks. Risking permanent brain damage is not worth dancing the night away."

Source: ONDCP, December 14, 2000.

Kids think Ecstasy is safe, but they are actually harming themselves in a major way. They are destroying their memories, their hearts, their kidneys, and their nervous system, while risking immediate strokes and heart attacks.

WARNING to ASAM Members!

A number of ASAM members and staff have received e-mails and/or faxed messages from various parties in Nigeria, outlining a scheme to retrieve funds from a bank — usually by fraudulently impersonating an heir — and promising great financial rewards to a collaborator.

Recipients' names appear to have been obtained from the ASAM Membership Directory. Your Society recently refused an order for 70 copies of the Membership Directory to be shipped to Nigeria.

ASAM has forwarded these messages to the Nigerian desk of the U.S. Secret Service, which is investigating. In addition, the e-mail service providers involved (Yahoo and Hotmail) have been given copies of the e-mails and informed that the account holders are violating the terms of service.

If you receive such a message, please forward it (showing the entire original e-mail heading) to Joanne Gartenmann at **JGart@asam.org** or fax it to **301/656-3815**.

CHAPTER UPDATE

Florida

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

Educational Conference: All ASAM members are invited to attend the 14th Annual FSAM-ASAM Conference on Addictions, scheduled for February 9-11, 2001, at the Courtyard by Marriott, Lake Buena Vista/Orlando, FL, in connection with FSAM's annual membership meeting and the chapter's business meeting.

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

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

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

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

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

Washington State

President: Daniel E. Wolf, D.O.
Regional Director: Richard Tremblay, M.D., FASAM

Addiction Conference: Plans are moving ahead for the Annual Conference on Fundamentals of Addiction Medicine, which is scheduled for March 2-3, 2001, at the Sheraton Hotel & Towers in Seattle. Sponsored by WSAM in partnership with the Washington Department of Health and the Providence Everett Medical Center, the conference is approved for 13.5 hours of Category 1 CME credit.

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

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

AGENCY REPORTS

DOD: Benefit Parity for TRICARE

The Department of Defense has enhanced access to mental health and addiction treatment in the military's TRICARE Health System. The Department's initiative to eliminate patient co-pays for active duty TRICARE Prime family members who seek care from civilian network sources affords these beneficiaries care at no cost. The expanded access includes care for mental health and addictive disorders.

Edward H. Jurith, Acting Director of the Office of National Drug Control Policy, hailed the change as evidence that "The Federal government is taking an historic leadership role." He noted that, coupled with the Office of Personnel Management's commitment to provide parity for approximately 9 million federal workers, the TRICARE initiative means that nearly 12 million more people will have enhanced access to this care. Jurith said, "Parity will improve public understanding of addiction, increase access to care, bring drug treatment into the mainstream of health care, and reduce suffering for millions of Americans."

ONDCP: Jurith Named Acting Director

Edward H. Jurith has been named Acting Director of the federal Office of National Drug Control Policy (ONDCP), succeeding Gen. Barry McCaffrey, who resigned effective January 6. Mr. Jurith has been at ONDCP as Chief Counsel, after working for years on Capitol Hill.

Department Budgets Include Addiction Funds

The recently passed fiscal 2001 budgets for the U.S. Commerce, Justice and State Departments include approximately $269 million in funds for addiction prevention and treatment.

The Justice Department's anti-drug budget includes $63 million for residential substance abuse treatment for state prisoners; $50 million for drug courts; $48.5 million for the COPS meth/drug hotspots program; and $10 million for the Safe Start program.

In addition, $5 million is earmarked for demonstration grants on alcohol and crime in Native American reservations; $2 million for the Drug Abuse Resistance Education (DARE) program; $1.4 million for a rural alcohol program in Alaska; and $1 million for Drug Free America.

Source: Substance Abuse Funding News, December 28, 2000.

CSAP: New Director to Localize Funding

Localizing funding as much as possible is the goal of Dr. Ruth Sanchez-Way, the newly appointed director of the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA). Dr. Sanchez-Way said she plans to increase state and community funding and tailor federal support to meet drug crises in specific regions and ethnic groups.

CSAP's State Incentive Grants program would be used to expand and localize the agency's efforts. Under the grant program, prevention services providers can apply for funding for research-based programs. CSAP plans to fund nine to 13 states, plus the District of Columbia, in fiscal year 2001. Its goal is ultimately to fund all 50 states.

In addition, CSAP will direct funds to fight the use of club drugs by teens. The funding will enable providers to target 18- to 24-year-olds. (The National Household Survey found that this age group has the greatest growth in drug use.)

Source: Substance Abuse Funding News, December 26, 2000. ■

READER EXCHANGE

Scam Alert from the DEA

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

From the U.S. Drug Enforcement Administration, Office of Diversion Control: The Medical Society of New Jersey recently learned that con artists have targeted physicians with a phony questionnaire asking for vital, confidential information, including the physician's DEA number, Social Security number, and credit card data.

The New Jersey State Attorney General is investigating a mailing sent to physicians on what appears to be the letterhead of the state's Division of Consumer Affairs. The letter says the department is seeking to update physician profiles "in our system." It further asserts that physicians who comply by providing the requested information will be able to order controlled drugs over the phone or via the Internet.

Not only could the solicited personal information render the physician vulnerable to financial fraud, but improper use of the confidential professional information (such as the DEA number) could facilitate illegal drug trafficking. In fact, the fraudulent questionnaire asks the physician to provide two signature samples, "as you sign on your prescription pad."

Do not respond to such a questionnaire! This is not a legitimate mailing from the New Jersey Division of Consumer Affairs. Contact the Division of Consumer Affairs at 1-800/242-5846 or the New Jersey Board of Medical Examiners at 609/826-7100 if you have any questions or doubts about the authenticity of any document received from a state agency.

If you have recently completed and returned such a questionnaire, immediately contact the Consumer Affairs Enforcement Bureau during regular business hours at 973/504-6300.

If you reside outside New Jersey but have received a similar inquiry, please contact your state medical board and/or division of consumer affairs. Remember, always safeguard your personal and professional information. And always verify the authenticity and necessity of unusual requests for information.

The Medical Society of New Jersey is assisting the Division of Consumer Affairs in alerting physicians about this scam and will continue to provide updates to the medical community. Feel free to check the Society's Web site at ***www.msnj.org*** for additional postings.■

STATE OF GEORGIA

The Division of Mental Health, Mental Retardation, and Substance Abuse (MHMRSA) is seeking a Substance Abuse Program Chief to serve as the Single State Authority in overseeing the federal SA Prevention and Treatment Block Grant. Performs in a leadership capacity managing the statewide planning and development of adolescent and adult substance abuse treatment programs and policies; coordinates the activities and functions of adolescent and adult substance abuse treatment programs; establishes regional and facility planning parameters for substance abuse treatment programs and manages the review process; supports special projects and needs of the regional boards; and provides consultation, technical assistance and training.

Minimum training and experience qualifications are a Master's degree in psychology, social work, counseling, public administration, or a related field, with five (5) years of experience in substance abuse and at least three (3) years of experience in developing statewide or regional systems (may include statewide task force or work groups) and a reputation as a statewide leader in substance abuse. Preferred qualifications are a doctoral degree in the above-listed fields, or a medical degree with board certification and three (3) years of experience in substance abuse, with at least one (1) year in developing statewide or regional systems of substance abuse services/support, and a reputation as a national leader in substance abuse.

Salary range for individuals who meet minimal qualifications is $3,940.50 to $6,883.49 monthly. The salary for a medical doctor is based on Georgia's physician pay scale. For more details, visit our Web site at ***http://www.thejobsite.org.*** Submit two State of Georgia Applications and/or two comprehensive resumes to Darlene Meador, Ph.D., MHMRSA, Program & Policy, 2 Peachtree St., Suite 23-410, Atlanta, GA 30303-3142.

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PEOPLE IN THE NEWS

Frederick N. Karaffa, M.D., has been named Physician of the Year by his colleagues at Licking Memorial Health Systems. Dr. Karaffa is medical director of Shepherd Hill, Licking Memorial Hospital's alcohol and drug treatment center in Newark, OH.

Dr. Karaffa received his medical degree from the Ohio State University and trained in addiction medicine at Shepherd Hill, completing a one-year fellowship in 1989. He was certified by ASAM in 1990.

After joining the medical staff of Licking Memorial Hospital in 1996, Dr. Karaffa served as chair of the Pharmacy and Therapeutics Committee, the Medical Ethics Committee and the Staff Effectiveness Committee. He currently is vice-chair of the hospital's Department of Behavioral Health.

An avid violinist, Dr. Karaffa was for 20 years concertmaster of the Licking County Symphony Orchestra and continues to perform with the Central Ohio Symphony Orchestra and the Capital/Bexley Symphony. He also is a licensed pilot.

Lewis E. Gallant, Ph.D. has been named Executive Director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), succeeding Jack Gustafson, who is relocating to Florida.

Dr. Gallant has been Director of the Office of Substance Abuse Services in the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. Before joining the state agency, he spent 20 years in active military service as a human services manager and administrator in the U.S. Army Medical Department. Dr. Gallant also has served NASADAD in the elected posts of Vice President and President.

Gen. Barry McCaffrey, Director of the federal Office of National Drug Control Policy (ONDCP), resigned that post January 6. A retired Army general who served on the front lines in Operation Desert Storm as well as the nation's war on drugs in Central America, Gen. McCaffrey said he is leaving the post to pursue academic interests. He may return to teaching at West Point, where he was an associate professor in the mid-1970s.

In a statement, Gen. McCaffrey praised President Clinton for his commitment to fighting drugs, and said he was "enormously proud" of the progress made during his tenure, particularly in reducing adolescent drug use and drug-related crime.

Gen. McCaffrey was outspoken in his support of methadone maintenance programs, but often criticized other harm reduction efforts and fiercely opposed the medical marijuana movement. As drug czar, he won bipartisan praise for his hard-charging style and for improving the efficiency and scope of ONDCP's work. He won many fans in the treatment and prevention communities for his stated support for demand reduction programs. Critics, however, pointed out that although both demand reduction and supply reduction spending increased during Gen. McCaffrey's tenure, the overall national drug control strategy remained heavily skewed toward overseas interdiction and law enforcement programs. ■

CLINICAL NOTES

FDA Approves Test for Alcoholism Risk

The U.S. Food and Drug Administration (FDA) has approved a test designed to identify individuals who are at risk of alcohol-related disease. The carbohydrate-deficient transferrin (CDT) test, manufactured by the Anglo-Scandinavian diagnostics company Axis-Shield, is expected to be marketed in the U.S. early this year by a California firm, BioRad.

"The beauty of this marker is that it detects whether you are drinking more alcohol than your body can take," said Svein Lien, chief executive officer of Axis-Shield. According to Lien, heavy drinking elevates levels of CDT, which are maintained for several weeks even when people stop drinking.

The CDT test could be used to monitor the health of patients in alcohol treatment programs. In addition, Lien said the test could be used to check the alcohol intake of airline pilots and passengers. Test kits are expected to cost $4.30 to $5.70 each.

Source: Press release, December 5, 2000.

Alcohol Increases Liver Damage in Hepatitis C Patients

Individuals with hepatitis C who drink heavily may quadruple their already high risk of developing cirrhosis of the liver, according to researchers from the National Heart, Lung and Blood Institute Study Group. An estimated 4 million persons in the U.S. and 150 million worldwide have hepatitis C. About 20% of those infected with HCV will develop severe and potentially fatal liver damage, or cirrhosis, which in turn increases the risk of liver cancer.

The scientists found that patients with the hepatitis C virus (HCV) who said they were heavy alcohol users had 31 times the odds of developing cirrhosis than did HCV-infected people who were not heavy drinkers. "These results stress the need to counsel patients with HCV about their drinking habits," the researchers said in their report.

Source: Annals of Internal Medicine, January 16, 2001.

Youth Alcohol Abuse Predicts Later Problems

Adolescents who abuse alcohol often have worse drinking and mental health problems as they mature, compared with young people who do not drink, researchers claim.

In a study led by Dr. Paul Rohde of the Oregon Research Institute, Eugene, researchers followed 940 high school students up to age 24. They found that individuals who were diagnosed with alcohol problems in their early teens were at increased risk for drinking problems, other substance abuse, depression and personality disorders as they got older.

"Clearly, for many adolescents, alcohol use disorders and problematic alcohol consumption are not benign conditions that self-resolve," the researchers wrote in their report.

Source: Journal of the American Academy of Child and Adolescent Psychiatry, January 2001.

Women More Likely to Quit Treatment

Working women who are single and have lower incomes are more likely to drop out of addiction treatment programs than men, according to a study by California's Kaiser Permanente HMO.

Investigators followed 317 women and 599 men being treated in private, abstinence-based treatment programs for a one-year period. They found that, all other things being equal, women who are unemployed, married, or from moderate- to high-income families are more likely to remain in treatment, according to lead author Jennifer Mertens, of Kaiser Permanente's Division of Research. "Men's completion of treatment in those programs is related to being older, being pressured by an employer to enter treatment, and having a goal to abstain from drinking and [illicit] drug use," she added.

The study further found that women with higher levels of psychiatric symptoms and African-American women are at higher risk of dropping out than other women.

Source: Alcoholism: Clinical & Experimental Research, October 2000.

Chronic Alcohol Abuse Profoundly Affects Brain

Chronic alcohol abuse disrupts the brain's molecular programming, say researchers at the University of Texas at Austin. Through use of gene-array technology, the researchers determined that alcohol abuse can change the programming of important areas of the human brain on a molecular level. "A critical question in addiction is how the reprogramming of the brain leads to long-lasting, severe, life-threatening dependence. This study provides insight regarding the molecular neurocircuitry of the frontal cortex that is altered in alcoholism," said Dr. R. Adron Harris, director of the university's Waggoner Center for Alcohol and Addiction Research and lead author of the report.

In particular, the Texas researchers studied the superior frontal cortex of the brain, the area used for judgment and decisionmaking. According to Dr. Harris, "These are tasks that are corrupted in addiction. Just as a computer virus can change the programming of specific functions, our data show that chronic alcohol abuse can change the molecular programming and circuitry of the frontal cortex."

Source: Alcoholism: Clinical & Experimental Research, December 2000.

Early Stress Linked to Cocaine Use

Trauma and stress in early life increase the potential for cocaine addiction in adulthood, according to researchers at Yale University. "Using well-established animal models, we've found strong evidence that early-life stress enhances vulnerability to drug addiction," said Therese A. Kosten, assistant professor of psychiatry at the Yale School of Medicine. "This study demonstrates the need to target drug abuse prevention strategies to children with early-life traumas."

Yale researchers tested 14 adult rats, eight of which had experienced the stress of isolation from their mother, siblings and nest three months earlier. Compared to six rats that had not experienced this stress, isolated rats learned to press a lever to receive a cocaine infusion in two-thirds the number of days and at half the dose needed for the non-isolated rats. Because there was no difference between the two groups of rats in the number of days it took to learn to press a lever to receive food pellets, researchers concluded that the isolation effect was specific to cocaine.

"Previous studies show that most drug addicts have had early-life trauma," said Kosten, principal investigator on the study. "Given that 1.8 million Americans are currently using cocaine, this information will be valuable in directing future research toward potential interventions for children with early stress experiences in order to reduce the risk of developing drug addiction in adults."

Source: Brain Research, November 2000.

Genes Affect Risk for Tobacco Use

Genes play a key role in determining an individual's vulnerability to regular tobacco use, according to a twin study supported by the National Institute on Drug Abuse (NIDA).

For women, researchers speculate that the genetic element of vulnerability to smoking has increased in importance as society's once-strong taboos against tobacco use by women have diminished. The study found that women born prior to 1925 had lower rates of tobacco use, mainly because of environmental factors. Among women born since 1940, the inheritability of tobacco use was found to be 63% — the same as in men.

For men, the patterns of tobacco use suggest genetic and environmental factors account, respectively, for 61% and 20% of the differences in individuals in their risk for becoming regular users of tobacco.

The study was conducted by Dr. Kenneth S. Kendler of the Medical College of Virginia and researchers at the Karolinska Institute in Stockholm, Sweden.

Source: Archives of General Psychiatry, September 2000.

Heroin Addiction's Genetic Component

Some heroin users may have a genetic variation that hinders them from quitting and may need alternative treatments. Dr. Ernest Noble, a psychiatrist at Neuropsychiatric Institute and Hospital at the University of California Los Angeles, and colleagues drew this conclusion after following 95 heroin patients who entered a methadone treatment program. Of these patients, 54 successfully completed treatment, 22 dropped out and 19 did poorly.

The researchers discovered that the heroin addicts who failed the program were four times more likely to have a gene called DRD2. Of the patients studied, 22% of those who dropped out of the program and 42% of those who had a poor outcome had the genetic variation, compared to 9% of the patients who successfully completed treatment. (Previous studies have linked DRD2 with other addictions, such as alcoholism, smoking and overeating.)

"Heroin users who have this genetic variation may suffer from a more virulent form of the addiction that is less amenable to the standard course of treatment," said Noble. "I don't think these patients can get off drugs. If they don't use heroin, they'll use other things."

Source: Neuropsychiatric Genetics, September 2000.

Children Emulate Addicted Parents

Previous studies have shown that alcoholism and drug dependency tends to run in families, but researchers at Massachusetts General Hospital in Boston wanted to know whether increased risk is a result of inherited factors or exposure to addictive behavior. Their study found that children of addicted parents are more likely to mimic their parents' behaviors. "Environmental exposure to substance abuse shapes the directions of addiction in children, especially those that are genetically vulnerable," said Dr. Joseph Biederman, who led the team of researchers.

The researchers analyzed the alcohol and other drug use patterns of 260 families. "If a parent abuses drugs or alcohol, the risk to children increases selectively," said Dr. Biederman. He explained that children of cocaine abusers tend to abuse cocaine rather than other drugs or alcohol, for example.

Dr. Biederman said the study findings should prompt pediatricians and other physicians to pay more attention to adult addictive disorders and prompt efforts to reduce use among their children.

Source: Pediatrics, October 2000. ■

Maine College Town

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Most States Fall Short on Tobacco Settlement Spending

A majority of states are failing to use their share of the 1998 multistate tobacco settlement to adequately fund tobacco prevention programs, according to a report by a coalition of public health organizations. The report says that only 17 states have committed substantial funds for tobacco prevention and cessation programs. Of these, only six states — Arizona, Indiana, Maine, Massachusetts, Minnesota and Mississippi — are funding tobacco prevention programs at minimum levels recommended by the Centers for Disease Control and Prevention for effective, comprehensive programs.

The report was sponsored by the Campaign for Tobacco-Free Kids, the American Heart Association, the American Cancer Society, and the American Lung Association.

Check Your State's Use of Tobacco Funds

The Campaign for Tobacco-Free Kids offers information on its Web site that reports what each state has received in tobacco settlement funds and how those funds have been allocated. To learn how your state is spending its tobacco funds, and how it compares with other states and with the CDC guidelines, visit ***www.tobaccofreekids.org***.

AZ: Counties a Model for Shift to Treatment

Two counties in Arizona are showing promising results from programs designed to treat addicts rather than imprison them. Arizona began making the shift from jail to treatment in 1992, expanding it in 1996. According to a study for the Arizona Supreme Court, 77% of 2,622 offenders tested drug-free at the end of their outpatient treatment programs. As a result, the state saved $2.5 million in prison costs.

Maricopa County provides treatment to addicts who have committed felonies. Officials there plan to expand the program to include drug addicts who are not yet in jail. The expansion also will include a family case-management program, through which judges would give tickets and other incentives to families who take their children to museums, zoos, historical societies and other educational sites.

Similar success is being reported in Pima County, where 60% of the addicts in the system have graduated from the drug court program, with no re-arrests for drug use. According to Judge Leslie Miller, who presides over Pima County's drug court system, the key is a team approach. With such a focus, the judge, county attorney and treatment case managers all make decisions about drug users in the system. In addition, they provide clients with tools necessary for their treatment, including counseling to learn new types of behavior to battle addiction, coping mechanisms, and guidance for ending old habits of lying and psychological manipulation of addiction counselors. Judge Miller said the intervention program saves the county about $600,000 in court costs. The savings help underwrite the cost of the treatment programs.

Because of the effectiveness of the Arizona programs, officials are providing technical assistance to California as that state prepares to implement its ballot-approved treatment program.

Source: Substance Abuse Funding News, November 28, 2000.

CA: Initiative Could Overwhelm Treatment Programs

California officials say that transferring drug arrestees from jail to treatment programs under the voter-approved Proposition 36 could overwhelm the state's already strained addiction-treatment programs.

As a result of Proposition 36, tens of thousands of drug offenders in the criminal-justice system could be transferred into treatment programs. California's drug treatment programs currently serve 70,000 people a year, but 5,000 are waiting for admission to programs in any given month. When Proposition 36 goes into effect July 1, it is expected to generate an additional 36,000 new treatment clients a year.

Prior to the measure's implementation, officials said the state needs to resolve several issues, including what exactly needs to be done and what funding is available. Proposition 36 authorized only $60 million for treatment for the remainder of the 2000-2001 fiscal year. State officials say that an additional $330 million annually would be required to serve the new treatment clients.

"We've got people looking at it now," said state Senate President Pro Tem John Burton (D-San Francisco). "There will be a need for additional funding in order to implement Proposition 36. And there is going to have to be some legislation passed to clean it up so that it can go into effect. We are going to try to put together a task force to sit down and take a look at it and figure out exactly what needs to be done."

An analysis of California's drug treatment programs conducted last year found that the existing network of service providers in the state is already overwhelmed. Members of the executive committee of the Community Alcohol and Drug Program Administrators Association of California are meeting to formulate a strategy for putting Proposition 36's provisions in place. "There is a lot of concern about how to make this work," said Bill Demers, the association's president. "We are going to make it work. But it is going to be a challenge."

Source: San Francisco Chronicle, November 13, 2000.

DC: Expansion Ends Detox Waiting Lists

Since the District of Columbia added beds and contracted with a private agency to handle overflow cases, residents who seek detoxification have been admitted without a waiting period. In previous years, uninsured residents seeking detox were placed on a waiting list for admittance to city facilities.

"We are very pleased," said Susan Shaffer, director of the D.C. Pretrial Services Agency, which refers many criminal defendants to detox. "We used to direct people to go there at 5:30 in the morning to get priority in getting in. Now we can send clients over at any time of day, and we get them in."

Although there is improved access to detox, experts are concerned that the District's funding will not be sufficient to provide full treatment to the city's estimated 60,000 residents with addiction problems. Health Department Director Ivan C.A. Walks acknowledged that uncertainty about funding makes it more difficult to expand treatment.

Source: Washington Post, January 15, 2001.

AROUND THE STATES

IN: Court Limits School Drug Testing

The Indiana Court of Appeals unanimously ruled against random school drug testing, stating that testing should only be done if there is suspicion of drug use. According to the Indiana appellate judges, students can't be forced to submit to drug tests in exchange for driving privileges, playing sports or taking part in after-school activities. Such testing, the judges ruled, violated the Indiana Constitution's protection against unreasonable searches.

The ruling overturns the drug-testing policy of schools near Kokomo. "This is a very damaging decision at a time when we're charging school officials with greater responsibility for the health and safety of our children," said Frank Bush, executive director of the Indiana School Boards Association. About 26% of Indiana school districts have some form of random drug-testing program in place.

Source: Indianapolis Star, August 22, 2000.

MA: No Health Benefits in Non-Burning Cigarette

A Massachusetts Department of Public Health study found no health benefits to the new non-burning cigarette developed by R.J. Reynolds Tobacco Company. State laboratory tests found that the non-burning Eclipse cigarette had 734% more acetaldehyde and 475% more acrolein — two cancer-causing agents — than R.J. Reynolds' own low-tar Now King Size Hard Pack ultralights.

The tobacco maker claims that the Eclipse cigarette is "the next best choice" to quitting, and is up to 87% less carcinogenic than ultralights. "This is truly astonishing," said Dr. Howard Koh, commissioner of the Department of Public Health. "There is no such thing as a safe cigarette. It is an oxymoron. These health claims by R.J. Reynolds are blatantly false."

R.J. Reynolds disputed the state's findings, calling the tests invalid because they involved "a limited set of data." The company said it conducted a broader testing to support its claim that Eclipse poses fewer health risks than other cigarettes.

Koh plans to ask the state attorney general to investigate whether R.J. Reynolds is violating the 1998 nationwide tobacco settlement agreement, which prohibits cigarette makers from misrepresenting the health consequences of their product.

Source: Boston Globe, October 4, 2000.

ME: Team Effort Increases Treatment Funding

Addiction treatment advocates, working together with the media and state officials, have been able to nearly double funding for addiction treatment services. The push for funding began in 1997, when the state's largest newspaper published a week-long series entitled "The Deadliest Drug: Maine's Addiction to Alcohol." Two years earlier, the state had cut its treatment and prevention funding by $2 million. The series caught the attention of political leaders, with the governor and legislature establishing a commission to examine the impact of substance abuse in Maine. At the same time, the state's leading anti-drug groups sponsored study circles, which were attended by Maine residents of all ages and backgrounds.

As a result of the cooperative efforts, Maine's Governor Angus King recently signed a budget that increased the state's treatment and prevention spending by 90%, to $5.75 million a year. The funding will continue for the next 25 years, as the state agreed to earmark $5.75 million each year for substance abuse from Maine's share of the tobacco settlement. "As long as Maine gets tobacco settlement money, there will be this money for substance abuse," said state Rep. Michael Brennan, who also is a drug treatment therapist. "This is the first time since 1986 that any new money has been allocated for substance abuse."

The key to the funding, observers noted, was the coordination and lobbying roles of the state's anti-drug professionals. The state's professional treatment organization, the Maine Association of Substance Abuse Programs, and the professional prevention group, the Maine Association of Prevention Programs, organized their coordinators by county. Among their successful lobbying efforts were finding people who succeeded in treatment and were willing to tell their stories to lawmakers; providing a comparison of addiction treatment to the treatment of other diseases, using a cost-analysis perspective; tying drug and alcohol addiction to nicotine in order to justify spending tobacco settlement funds; and a willingness to negotiate with lawmakers on their funding needs.

Source: Substance Abuse Funding News, August 10, 2000.

Maine increased the state's treatment and prevention spending by 90%...

UT: Tobacco Settlement Funds Addiction Center

A portion of Utah's first $4 million from the nationwide tobacco settlement is helping to support a new addiction research center in the state. The center, which will investigate the relationship between addiction and genetics, will be located at the University of Utah. $1 million in tobacco settlement funds will help underwrite the center. John Mauger, dean of the school's College of Pharmacy, will oversee the new addiction research center. He said the funding is a suitable use of settlement monies because many smokers also abuse other substances.

The University of Utah also will receive $1 million for the construction of a $20 million research facility for genetic research. The remaining $2 million will go to the Huntsman Cancer Research Institute.

Source: Salt Lake Tribune, November 16, 2000.

WI: State Launches Campaign Against Tobacco Use

The state of Wisconsin is going all-out in its grassroots fight against tobacco use, spending $7 million on a statewide education campaign. The state Tobacco Control Board approved an $18.3 million plan aimed at fighting the effects of smoking. Included in the funding package are $6.5 million for an anti-tobacco media campaign and $7 million for fighting tobacco use at the grassroots level.

The grassroots campaign includes grants to local groups that work towards ending smoking in their communities. "Our plan is comprehensive. Our plan is locally driven," said Chairwoman Earnestine Willis, M.D., associate professor at the Medical College of Wisconsin. "We must work to prevent 8,000 tobacco-related deaths each year."

The plan would establish a network of community coalitions that would emphasize the dangers of tobacco use. The Tobacco Control Board also set aside $4.8 million for other anti-tobacco efforts, such as programs to help smokers quit, a youth-led campaign, programs for minorities, and the creation of an information clearinghouse.

The board was established in mid-2000 to oversee the spending of $23.5 million over two years for anti-smoking programs. The money came from the nationwide tobacco settlement.

Source: Milwaukee Journal Sentinel, September 27, 2000.

Indian Path Pavilion

Mountain States Health Alliance
Medical Director, Addiction Service

Indian Path Pavilion, a 52-bed JCAHO licensed psychiatric hospital in Kingsport, Tennessee, has an immediate opening for a psychiatrist to serve as Medical Director for an inpatient and outpatient addiction treatment service. Certification as an addictionologist is desirable but not required. Current daily inpatient census averages 12 patients, with no cap. Call requirements include Monday through Thursday and every seventh or eighth weekend. The position provides a stipend, along with negotiable relocation expenses. Office space for private practice is available. Affiliation with the ETSU, Quillen College of Medicine, Department of Psychiatry, is an additional option.

Kingsport and the surrounding region has been described as a place of beauty blessed with rich traditions and opportunity. Termed "America's Original Model City," Kingsport boasts a rich heritage, magnificent scenery, numerous cultural and civic events, strong community spirit, and excellent schools.

For more information, contact
Bill Fuqua, Director of Behavioral Services, Indian Path Pavilion, 2300 Pavilion Dr., Kingsport, TN 37660. Phone 423/857-5001.
E-mail ***FuquaBF@msha.com.***

CARON FOUNDATION

Excellence In Addiction Treatment

Medical Director Opportunity

Caron Foundation is consistently ranked among the country's top resources in the treatment of addiction. The program is differentiated by the unparalleled medical presence of two full-time employed physicians as well as by the range of programs offered, the acuity of the patient population, and the progressive nature of the treatment protocols. Caron is located in southeastern Pennsylvania.

Caron has retained Diversified Search to recruit an ASAM-certified **internist or family practitioner** to serve as full-time Medical Director and to provide compassionate, cutting-edge care for Caron's adult and adolescent population.

Please fax or e-mail CVs to Cynthia Barth; fax 215/568-8399 or e-mail *cynthia.barth@divsearch.com.*

Ruth Fox Memorial Endowment Fund

Dear Colleagues:

We are very grateful to you, our members and friends, for your generous support, which helped the Endowment reach its $3 million goal. We are now working toward the $4 million goal, and hope that you will continue to help us in this endeavor. Please let us know if you have named the Endowment in your will so that we can acknowledge your generosity now. All contributions are completely tax deductible because ASAM is a 501(c)(3) organization.

We especially wish to thank long-time member Michael I. Michalek, M.D., for his very generous pledge. This is in addition to his previous contributions. It gives us great pleasure to add his name to the Founders' Circle.

At this year's Medical-Scientific Conference in Los Angeles, we are presenting a workshop on "Wealth Management" by Michael H. Graham, CIMA, Vice President of Merrill Lynch. The workshop, chaired by Max Schneider, M.D., FASAM, is scheduled for Thursday, April 19, 2001, at 7:30 p.m. Learn how you can be more successful in managing your resources for your retirement, for your heirs, and for the charitable causes you support. Please check this event on the conference registration form, and plan to attend.

Also during the Medical-Scientific Conference, the Ruth Fox Endowment Donor Reception honors your generosity. We are extremely grateful for the continuing support of Dr. and Mrs. Joseph E. Dorsey, who are underwriting the 2001 reception (which is by invitation only).

For information about providing a life insurance policy or making a deferred gift, pledge, contribution, bequest, tribute, or to discuss in confidence other types of gifts, please contact Ms. Claire Osman at 1-800/257-6776 or 718/275-7766. Of course, final decisions should be discussed with your personal tax advisor.

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

As of January 15, 2001 — Total Pledges: $ 3,137,893

New Donors, Additional Pledges and Contributions

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Richard D. Hurt, M.D., FASAM, knows first-hand how hard it is to stop smoking. When he says that asking patients to give up cigarettes is like asking them to give up a friend, he speaks as an expert in nicotine addiction and as a former smoker.

How, then, does he persuade patients to give up cigarettes for good? Despite lingering misconceptions, few people wake up one morning, toss their cigarettes in the trash, and never look back. "That's a rare occurrence," says Dr. Hurt. "I hear people say 'my Uncle Charlie smoked two packs a day for 50 years, and one day he was driving his pick-up down the road and decided to throw his cigarettes out'. Everyone has a story like that, so they question the need for treatment. What they don't know is that Uncle Charlie is a different human being who did not have the severe degree of dependence of the people that we see."

Dr. Hurt is head of the Nicotine Dependence Center at the Mayo Clinic in Rochester, MN. The Center offers a comprehensive approach that includes individual counseling, group therapy, weekly support groups, and residential treatment. Begun in 1988 as one of the first programs in the U.S. to focus exclusively on the treatment of nicotine dependence, the Center incorporates four components: addiction treatment, pharmacologic and behavioral therapies, and relapse prevention.

Dr. Hurt came to the Mayo community in 1973 as a resident and a smoker. Although he trained as an internist and is today a professor of medicine, Dr. Hurt did several rotations during his residency at Mayo's inpatient treatment program for alcoholism. In 1975, the desire to stop smoking led him to the Mayo Smoker's Clinic, then an outpatient community-based program, where he first was a patient and then a group leader. "I went back as counselor for the groups, but it was more for my own recovery, and it worked both ways" says Dr. Hurt, who eventually took over as the clinic's medical director.

During those years, Dr. Hurt fielded calls from physicians looking for treatment options for hospitalized patients who continued to smoke despite having limb-threatening vascular problems. "Physicians were calling and asking what we had to offer them, and the answer was 'not much'." In 1986, Dr. Hurt and his colleagues developed a proposal for a comprehensive

MY PRACTICE

Smoking Cessation is Focus of Dr. Hurt's Work at Mayo Clinic

*[With this issue, **ASAM News** inaugurates a new feature that focuses on the many ways ASAM members contribute to the field of addiction medicine. Suggestions for subjects of future profiles should be sent to the Editor.]*

Jeanne Erdmann

clinic modeled after counselor-based chemical dependency and addiction treatment programs. "Early on, we began to incorporate the concept of addictive disorders into the community-based outpatient group program," Dr. Hurt adds. "The first Surgeon General's report on addiction was not published until 1988. By then, we were 10 years ahead of everybody else."

Today, Mayo's Nicotine Dependence Center treats 2,400 patients annually. About half the patients come from Minnesota, while 80% are from within 500 miles of Rochester. The average age of patients, who are evenly divided between men and women, is the forties. Most are referred by physicians within the Mayo system. Many have a tobacco-related illness and most have tried to quit smoking in the past. About nine patients per month are admitted to the residential program, which involves an eight-day stay in a hospital unit.

At the Center, counselors provide services under the supervision of physicians. Dr. Hurt says that the program is strong because all counselors are trained at the Master's degree level and are fully versed in treating addictions. The Center also has a strong research program. The clinical and research teams meet regularly, which keeps the counselors up to date on cutting-edge behavioral and pharmacologic therapies.

"Our counselors are active in education and practice; some do research, and all are fully versed in what goes on in the research area. We have lots of cross-pollination and fertilization, which keeps the staff energized. We rarely lose a counselor. They have fun doing this because the variety of treatments offered keeps the staff energized. We told the first three counselors 'when you get bored with all of this, let us know'. We've had no one complain about boredom. This is an exciting place."

The Nicotine Dependence Center has impressive data to demonstrate its success. After tracking the smoking status of all patients who completed the program over an entire year, staff found that the former patients were eight times more likely to successfully maintain their abstinence from cigarettes than were those who tried to stop on their own.

While he hopes and believes that the future will bring more programs like the Mayo Nicotine Dependence Center, Dr. Hurt says that lack of reimbursement by health plans continues to be a major obstacle. However, he points to guidelines recently released by the U.S. Public Health Service as a positive step, because they underscore the need for treatment and call on insurers to reimburse for such care. Thus, they may allow additional smokers to receive professional treatment. "It's happening, but it's slow," Dr. Hurt adds.

Summarizing his experience, Dr. Hurt says, "We think of stopping smoking as a process, of stages a person goes through. One of the goals of a health care provider is to move patients to a higher stage of readiness to change. We have good outcome data that treatment programs do work and are cost effective. There is a dose response: the more intensive the treatments, the better the outcome." ■

***Jeanne Erdmann** is a St. Louis-based medical writer who also writes for the St. Louis Post Dispatch and CBS Health Watch.*

ASAM CONFERENCE CALENDAR

ASAM

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

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

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

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

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

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

OTHER EVENTS OF NOTE

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

March 9-11, 2001
Conference 2001, Recovery in Practice
Columbia Medical Professional Group
Research Triangle Park, NC
(jointly sponsored by ASAM)
3 Category 1 CME credits
[For information, phone 919/489-8053]

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

April 26-27
Neurobiology of Drug and Alcohol Abuse
(symposium co-sponsored by NIAAA and the University of California, San Francisco)
San Francisco, CA
[For information, contact *sitasav@itsa.ucsf.edu* or phone 510/985-3100]

Buprenorphine Training Offered

Training and certification will be key requirements for the use of buprenorphine alone (Subutex®) and in combination with naloxone (Suboxone®) to treat opiate-addicted patients when those drugs are approved for use in office practice. Qualified physicians are those who are certified by ASAM or one of the other organizations named in the law.

Physicians also may become qualified by completing an approved 8-hour training course. ASAM is working with officials of the Center for Substance Abuse Treatment (CSAT) to design such a course, which will be offered for the first time on April 22, 2001, in Los Angeles, during ASAM's annual Medical-Scientific Conference.

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

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

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

ASAM MED-SCI CONFERENCE

Plan to attend ASAM's Medical-Scientific Conference

APRIL 19-22, 2001
LOS ANGELES, CA

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

Watch your mail for the Registration Brochure!

ASAM STAFF

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

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

Ann Boonn
Database Manager
ABOON@ASAM.ORG

Nancy Brighindi
Director of Membership & Chapter Development
NBRIG@ASAM.ORG

Caprice Falwell
Meetings Assistant
CFALW@ASAM.ORG

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

Cheryl Kim
Membership Manager
CKIM@ASAM.ORG

Katherine May
Director of Meetings & Conferences
KMAY@ASAM.ORG

Peter Miller
Office of Finance
PMILL@ASAM.ORG

Claire Osman
Director of Development
Phone: 1-800/257-6776
Fax: 718/275-7666
ASAMCLAIRE@AOL.COM

Christopher Weirs
Credentialing Project Manager
CWEIR@ASAM.ORG

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