ASAM NEWS

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NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

INSIDE

ASAM AT WORK FOR YOU:

ALSO SEE:

32nd ASAM Medical-Scientific Conference Set for Los Angeles

More than a thousand physicians and other health care professionals will gather in Los Angeles for ASAM's 32nd Annual Medical-Scientific Conference, April 19-22. The conference — which welcomes ASAM members as well as non-member physicians, nurses, psychologists, counselors, students and residents — is preceded by two special events: the Ruth Fox Course for Physicians and an ASAM Forum on Pain and Addiction, both scheduled for Thursday, April 19th. It concludes on Sunday, April 22, with a groundbreaking training course designed to qualify ASAM members and other physicians to prescribe an exciting new anti-addiction medication.

The annual Business Meeting and Breakfast will be gaveled to order by President Marc Galanter, M.D., FASAM, at 7:00 a.m. Friday, April 20. The official opening of the Medical-Scientific Conference immediately follows the business meeting. A highlight of the opening ceremony is the R. Brinkley Smithers Distinguished Scientist Lecture, to be delivered this year by Charles P. O'Brien, M.D., Ph.D., Professor and Vice Chair, Department of Psychiatry, the University of Pennsylvania, and Chief of Psychiatry at the Veterans Administration Medical Center, Philadelphia. Dr. O'Brien's lecture topic is "Science-Based Treatment of Addictions."

The Smithers Lecture initiates a three-day program rich in scientific and clinical presentations. Program chair Edward Gottheil, M.D., Ph.D., and his committee have planned a range of symposia, courses, workshops, invited papers and poster sessions. Major events include a special day-long symposium on "Neurobehavioral Aspects of Adolescence: Factors Contributing to Developing Alcoholism," organized by Enoch Gordis, M.D., Sam Zakhari, Ph.D., Walter Hunt, Ph.D., and Richard K. Fuller, M.D., and sponsored by the National Institute on Alcohol Abuse and Alcoholism, as well as a day-long research review sponored by the National Institute on Drug Abuse.

New this year is a Friday symposium on "Medical Education in Addiction Medicine," organized by Norman S. Miller, M.D., FASAM, and co-sponsored by ASAM and the Association for Medical Education and Research in Substance Abuse.

Details of Med-Sci sessions and activities are found throughout this issue of **ASAM News**. ■

National Treatment Plan Calls for System-Wide Improvements

A new consensus report with recommendations for improving the way in which alcohol and drug treatment services are delivered and paid for has been released by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA). Based on a series of public hearings across the country, "Changing the Conversation: Improving Substance Abuse Treatment," is the first product of CSAT's National Treatment Plan Initiative, in which ASAM has an active role.

In releasing the report, ASAM member and CSAT Director H. Westley Clark, M.D., J.D., M.P.H., FASAM, said that "CSAT sees this as the beginning of the end of a fragmented system of substance abuse treatment. We will work with the treatment field to apply the guidelines contained in the plan to the organization, delivery and financing of high-quality treatment services for children, adolescents, and adults with substance abuse problems."

The report outlines five major principles that compose the cornerstone of the National Treatment Plan. The first of these is that for resources to be used effectively, there must be an *investment for results*. The report recommends development of a standard

▶ **TREATMENT PLAN** *continued on page 18*

Making a Difference

James F. Callahan, D.P.A.

The story I want to share with you this month is important for three reasons. On one level, it represents an important victory for addiction providers and their patients, as an unjust rule has been rescinded. On another level, it is an inspiring example of how the efforts of one person can make a difference to our practice and our patients. And on a third level, it highlights a way for all of us to make a difference.

Larry Gentilello, M.D., is a physician with an interest in the addictions. More specifically, Dr. Gentilello has become deeply involved in a struggle whose outcome will determine whether thousands of patients receive the care they so clearly need.

The problem Dr. Gentilello identified is rooted in a 50-year-old model law drafted by the National Association of Insurance Commissioners (NAIC). This "Alcohol and Drug Exclusion Provision of the Uniform Individual Accident and Sickness Policy Provision Model Act" permits insurance carriers to deny claims for the care of injuries sustained by an insured who was intoxicated or under the influence of drugs at the time of injury. The language of the model law allows insurers to deny reimbursement for care of injuries sustained in motor vehicle crashes and all sorts of traumatic injuries that are linked to alcohol or drug use.

Dr. Gentilello saw an opportunity in June 2000, when a task force of NAIC convened a public hearing to consider eliminating the exclusion and invited interested parties to testify. At the hearing, proponents of eliminating the exclusion testified to its chilling effect on physician treatment decisions, particularly in emergency room settings.

A representative of the Health Insurance Association of America (HIAA) urged the task force to leave the model unchanged. She argued that there is no evidence that alcohol or drug interventions are effective and that, even if they are, a physician who believes that such screening or intervention is warranted in a given case is obligated to provide it regardless of whether third party reimbursement is available.

The task force asked NAIC staff to survey the states to determine how many permitted insurers to incorporate this exclusion. They discovered that at least 38 states do permit the exclusion.

After weighing the evidence, the task force unanimously voted to draft a repeal of the model act, to be referred to the full NAIC at its spring meeting.

Dr. Gentilello next focused his efforts on the National Conference of Insurance Legislators (NCOIL), urging that organization to support state adoption legislation forbidding insurers to deny claims for medical and hospital expenses on the grounds that a patient had a positive blood alcohol concentration.

ASAM vigorously supported the change, both in written communications and through the presence of Dr. Peter Rostenberg, who testified on behalf of ASAM at a March 2 meeting. As a result, NCOIL adopted the ban on denials of coverage, over the vocal opposition of the insurance lobby.

Next Steps

Two things will happen next. First, NCOIL has informed the NAIC of its vote to amend the model act and recommended that NAIC take the same step. Second, and more important, NCOIL staff are preparing a packet of information for the states to explain why the model act should be repealed. This informational packet is to be distributed to Insurance Commissioner in states that have adopted the model act, as well as state legislators who deal with insurance issues in those states, or who sit on the state's insurance committee.

This is where ASAM members can help. We need to develop and maintain a grassroots effort in each of those states, so that after NCOIL sends out its information packets, interested individuals and organizations contact their state Insurance Commissioners and legislators to urge them to take action in accord with the NCOIL position.

Also, the battle is only partially won until the NAIC adopts language similar to NCOIL's. Therefore, letters to the NAIC urging a positive vote on the change are important.

As Dr. Gentilello says, "If we accomplish that, then we will have educated and convinced every state Insurance Commissioner in states that have this legislation, as well as key legislators, of the need to remove it, and will have given them the legislative framework to do so. It will be up to stakeholders in each state to put lobbying pressure on those individuals to see that action is taken."

Dr. Gentilello and Dr. Rostenberg have done their part. Now it is up to the rest of us to make a difference. Please send letters expressing support for this long-overdue change to: National Association of Insurance Commissioners, 444 North Capitol St., N.W., Washington, DC 20001 (attn: Julie H. Matthews). Send a copy of your message to Larry Gentilello, M.D., Associate Professor of Surgery, Harborview Medical Center, University of Washington School of Medicine, by fax at 206/731-3656 or by e-mail at ***larrygen@u.washington.edu.*** ■

American Society of Addiction Medicine

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

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Proposed FY 2002 Budget Expands Treatment Funding

In a preview of its Fiscal 2002 spending proposals, the Bush administration has released a budget summary that calls for an additional $111 million for addiction treatment and an increase in spending for the prevention-oriented Drug-Free Communities Support Program. The budget summary, entitled "A Blueprint for New Beginnings," estimates the cost of drug abuse to society at $100 million annually, adding that "this figure does not capture the human costs associated with drug abuse—wasted opportunities, families torn apart, and lives lost."

Overall, the Bush administration's first anti-drug budget includes a significant increase—$111 million—in federal spending to "increase access to substance abuse treatment and help to close the treatment gap, the difference between the number of individuals who would benefit from treatment and the number who receive it; and targeting treatment to adolescents." Of the proposed funds, $60 million would be added to the Substance Abuse Block Grant, $40 million would be delivered through Targeted Capacity Expansion Grants, and $11 million would be added to the Residential Substance Abuse Treatment program.

The President's budget describes the need for accountability among recipients of treatment funding: "While the administration proposes a variety of treatment initiatives, there are two main concerns: the approaches must be evidence-based, and there must be real accountability for recipients."

In the research arena, President Bush used his recent address to Congress to announce his support for a plan to double the research budget of the National Institutes of Health (NIH) by 2003. This could mean substantial funding increases for the National Institute on Drug Abuse and the National Institute on Alcoholism and Alcohol Abuse, which are NIH agencies.

The budget also proposes adding $10 million to the $40 million Drug-Free Communities Support Program, which has been a major force in developing community anti-drug coalitions.

The President's anti-drug budget is largely in line with a $2.767 billion proposal he outlined last October while campaigning for president. Full, agency-by-agency budget figures are to be released April 3.

Source: Join Together, Boston University School of Public Health, March 2, 2001.

Transplant Policies Put Recovery At Risk

Methadone maintenance patients who are awaiting liver transplantation are being asked to give up their methadone therapy as a condition of receiving a transplant, according to a report in the Journal of the American Medical Association (JAMA). The report's authors found that 87 of the 97 liver transplantation programs in the United Network of Organ Sharing program require patients to stop using methadone. "This may indicate a clinical confusion between heroin dependence as a problem and opiate replacement therapy as a medically supervised treatment," said the report. "Opiate replacement therapies are successful and well-documented long-term treatment interventions for opioid addiction."

The researchers speculated that the no-methadone requirement could cause addicts to relapse to heroin use, noting that research studies have found that discontinuing methadone "may result in relapse to illicit opiate use in as many as 82% of stably maintained patients."

Source: Journal of the American Medical Association, March 1, 2001.

Alcohol and Other Drugs Cost States $81 Billion

States pay as much to address the negative effects of illicit drug, alcohol and cigarette use as they do for higher education, according to a study by the Center on Addiction and Substance Abuse (CASA) at Columbia University. According to the three-year, state-by-state study, "Shoveling Up: The Impact of Substance Abuse on State Budgets," the 50 states and the District of Columbia collectively spent $81.3 billion on alcohol and other drug problems in 1998, or about 13% of their budgets. By comparison, the states spent on average 13.1% of their budgets on higher education in that year, 11.3 on Medicaid and 8.3% on transportation.

The report estimates that New York State spent the most, using 18% of its budget for alcohol- and drug-related problems, while South Carolina spent the least, at under 7%. "Substance abuse and addiction is the elephant in the living room of state government, creating havoc with service systems, causing illness, injury and death and consuming increasing amounts of state resources," said Joseph A. Califano Jr., President of CASA. Califano noted that just 4 percent of the amount spent, or $3 billion, went to prevention and treatment programs. The remainder of the funds went to law enforcement, welfare, health care and education.

"Governors who want to curb child abuse, teen pregnancy and domestic violence and further reduce welfare rolls must face up to this reality: unless they prevent and treat alcohol and drug abuse and addiction, their other well-intentioned efforts are doomed," Califano said.

Source: Press release, Center on Alcohol and Other Drug Abuse, January 30, 2001.

Anti-Smoking Efforts Are Reducing Cancer Rates

Lung and bronchial cancer rates declined by 14% in California between 1988 and 1997, compared with only a 2.7% decline in other parts of the country, according to a report from the Centers for Disease Control and Prevention (CDC). State officials attribute the decline to higher cigarette taxes and other anti-smoking efforts.

The drop in lung cancer rates occurred after California voters approved a 1988 initiative that added a 25-cent tax on cigarettes. Funds raised from the increased tax supported smoking prevention education, health care for the poor and research into smoking-related illnesses.

The CDC report noted that the proportion of California adults who smoke dropped from 22.8% in 1988 to 18% in 1999. Moreover, per capita cigarette consumption declined by more than 50% during the same period. The report also found that the decline in lung and bronchial cancer among California men was 1.5 times greater than that among men living elsewhere in the country. Among women, the cancer rate dropped 4.8% in California, while increasing by 13.2% elsewhere.

"There's really no question that the drop in lung cancer rates in California, relative to the rest of the country, is due to the public attention that's been paid to tobacco reduction in California," said Dr. David Fleming, the CDC's deputy director for science and public health. "This is a strong message that says investing in tobacco prevention works." The CDC estimates that cigarette smoking causes 87% of lung cancers, the most common cause of cancer deaths in the U.S.

Source: Reuters News Service, November 30, 2000.

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Passing the Torch

Marc Galanter, M.D., FASAM

The role of President in an organization such as ASAM has obvious parallels to a member of a relay team. The team achieves its goals only when each individual gives his or her total commitment to achievement of their common goal. Within ASAM, the President functions as part of such a team with the President-Elect, the Immediate Past President and the Executive Vice President. Together, they strive to provide continuity of leadership and sustained effort toward achievement of the organization's goals.

Now it is time for me to pass the torch to my good friend and team member Andrea Barthwell, M.D., FASAM, who will be ASAM's next President. As I do so, I want to report to you on developments during my tenure, so that you can take the measure of our team's progress.

ASAM's Role and Mission

ASAM has established itself as the preeminent organization representing physicians who specialize in or have a professional interest in addiction medicine. With 31 chartered Chapters and 3,068 members, ASAM has become a national voice for the interests of addiction specialists and the patients in their care. Building membership remains a high priority if ASAM is to retain its stature as the premier medical specialty organization in addiction medicine.

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

ASAM's influence is felt internationally as well. With guidance and support from ASAM, the International Society of Addiction Medicine formally came into being in 1999, at a meeting hosted by President and Mrs. Gerald Ford and keynoted by General Barry McCaffrey, Director of the Office of National Drug Control Policy. Delegates from over 25 countries elected Nady el-Guebaly, M.D. President of the new organization, and G. Douglas Talbott, M.D., FASAM, Vice President. I am pleased to serve on its Board of Directors. ISAM is planning its second international scientific conference for Trieste later this year.

Collaborations in Science

I am particularly proud of the fact that ASAM's collaborative initiatives with NIAAA and NIDA have increased in scope and intensity during my tenure. The presence of NIAAA Directors Enoch Gordis, M.D. and NIDA Director Alan Leshner, Ph.D., at our Medical-Scientific conference certainly symbolizes this collaborative relationship in a powerful way, but our work together also flourishes in many other venues. During my term, I have been honored to serve on NIAAA's National Advisory Council.

Similarly, I am pleased to report that ASAM has a strong relationship with the federal Center for Substance Abuse Treatment, which has found a vigorous voice for the needs of patients and caregivers in its Director, H. Westley Clark, M.D., J.D., M.P.H., FASAM, who also is an ASAM member and former member of the ASAM Board of Directors.

Public Policy

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

Certification

ASAM has certified 3,386 physicians in addiction medicine and recertified another 2,333. Moreover, the National Committee for Quality Assurance has recognized physicians certified by ASAM as providers in managed behavioral health care organizations. ASAM certification is gaining acceptance as a credential. The National Committee for Quality Assurance (NCQA) and other accrediting organizations now recognize ASAM-certified physicians. And our CME programs offer members and other physicians high quality educational experiences in which the latest research findings and clinical practices are presented.

We continue to make the case for granting privileges to ASAM-certified physicians. ASAM members Drs. Michael Miller, David Mee-Lee, Sheila Blume and Christine Kasser, working with representatives of the American Managed Behavioral Healthcare Association (AMBHA), drafted a joint ASAM-AMBHA policy statement on "Credentialing and Privileging." Adopted in January 2001, this paper can open doors for members to receive practice privileges with managed care organizations and other providers.

Specialty Status

Addiction medicine is a multidisciplinary specialty, which is now recognized by both the American Medical Association and the American Osteopathic Association. Further recognition of our physicians awaits the establishment of adequate formal training of at least one year in length associated with a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). For non-psychiatrists, this would complement the board certification in addiction psychiatry which is now offered by the American Board of Psychiatry and Neurology and the CAQ in Osteopathic Addiction Medicine offered by the American Osteopathic Academy of Addiction Medicine.

Fellowship Training

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

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

Our colleagues in psychiatry are to be congratulated on the establishment of a subspecialty in addiction psychiatry. That achievement was the result of many years' intense work, culminating in the designation of 50 accredited training programs.

Access to Treatment

One of ASAM's goals is to make treatment for addictive disorders a health benefit for all Americans who need this care. To this end, we put forth a report on problems and solutions in the managed care arena, which identified striking and disturbing trends in the funding of addiction treatment benefits by employers, as well as in the design and utilization of addiction treatment benefits. As part of that study, we asked the Hay Group to analyze trends in the proportion of employer health care dollars spent on addiction treatment benefits and to determine the value of addiction treatment benefits offered by medium and large U.S. employers.

The study found that the value of general health care benefits has decreased by 11.5% since 1988, while the value of addiction treatment benefits decreased by 74.5%! The results of the ASAM/Hay study were buttressed by research commissioned by the National Council for Community Behavioral Healthcare (NCCBH) and conducted by The Gallup Organization. This survey found that among the adult population, respondents reported that the need for services substantially increased among abuse victims (up 51%), adults with severe persistent mental illness (73%), adults with co-occurring mental illness and substance abuse disorders (up 80%), addictive disorders (68%), and drug users (65%).

How can a rational health care delivery system offer proper addiction treatment when the financial support for care has been cut by almost 75%? Working with leaders in ASAM and the larger addiction treatment field, ASAM will continue to raise this question to policymakers and purchasers of health care benefits.

Parity

We have seen incremental gains on parity in recent years, but the big victories still lie ahead. In 1999, President Clinton directed the federal Office of Personnel Management to achieve parity for mental health and substance abuse coverage in the Federal Employees Health Benefits Program (FEHBP) by 2001. "The goal is to make plan coverage for mental health and substance abuse care identical to traditional medical care with regard to deductibles, coinsurance, copayments, and day and visit limitations," the President said. Because of its size and the large number of participating health plans, the FEHBP is in a unique position to serve as a model for other employers and for the insurance industry.

At the state level, 25 states have enacted some sort of parity legislation, but only six states — Vermont, Maryland, Minnesota, Georgia, Connecticut and Virginia — have language that specifically covers addiction treatment. On the plus side, some states' parity language also requires use of the ASAM *Patient Placement Criteria* to guide treatment decisions.

Looking Back, Looking Forward

I leave the Presidency with deep gratitude for the help and support of our Immediate Past President, G. Douglas Talbott, M.D., FASAM. I look forward to the tenure of our next President, Dr. Andrea Barthwell, as well as that of our new President-Elect, Dr. Larry Brown.

As I pass the torch to the next members of the team, I also convey my good wishes and a continuing commitment to the achievement of ASAM's mission. No doubt challenges lie ahead. But looking back at all that we have accomplished, how can we do other than meet the future with a sense of optimism for the future of ASAM, of our members, and of the field of addiction medicine? ■

To Marc Galanter, M.D., FASAM, President, on behalf of the Members of ASAM

Dear Doctor Galanter:

The January-February issue of **ASAM News** described the new government rule that is changing how addiction medicine specialists such as you will be able to treat patients addicted to opioids. The restrictive regulation-based system of the past is being replaced by an accreditation-based model, similar to that for other health facilities and programs — a long-standing recommendation of the Institute of Medicine. The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Substance Abuse Treatment (CSAT) are proud to have played a leading role in moving methadone and LAAM treatment closer to the heart of the nation's health care system.

In doing so, we are helping people open the door to treatment. At the same time, addiction medicine specialists will have new opportunities to rely on state-of-the-art scientific and clinical knowledge to treat their patients with methadone or LAAM. With that opportunity, however, comes responsibility. Under the accreditation system, it is your responsibility to create inividualized treatment plans, to increase your level of patient supervision, and to monitor patient outcomes.

You know better than anyone that the ability to individualize treatment can make the difference in patient compliance and successful outcomes. Clinical decisionmaking will be where it belongs — in the hands of treating professionals working with opiate-addicted patients. After all, methadone alone is not the answer. It is just one part of a many-faceted, personalized treatment approach that embraces psychosocial and supportive community-based services as well as medication. CSAT and SAMHSA are relying on you to step up to the challenge and advance the quality of care available to those addicted to opioids. You are the key to the success of this new approach to treatment. We remain ready to help you in any way we can.

Sincerely,

Joseph H. Autry III, M.D.
Acting Administrator
Sustance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., FASAM
Director
Center for Substance Abuse Treatment

Why Should We Treat Addicts Anyway? The Solution We Refuse to Use

Alan I. Leshner, Ph.D.
Director, National Institute on Drug Abuse

Imagine a debilitating disease for which there are effective treatments. Imagine that this treatable disease costs society $110 billion a year. Can you imagine not using these treatments? It seems unfathomable, but that often is the case with the treatment of drug addiction.

Addicts are often denied treatment that would not only improve their lives, but would improve our own lives as well by cutting crime, reducing disease, and improving the productivity of employees and the economy.

People are polarized on the issue of treatment: they are either strong advocates for treating addiction or they hate the idea. People debate with passion whether treatment works or not, which approaches are best, and whether treatments like methadone simply substitute one addiction for another.

Research Shows Effectiveness of Drug Addiction Treatment

From my observation post, the core of the issue cannot simply be whether drug treatments are effective or not, since there already are abundant scientific data showing that they are. In fact, research shows that drug treatments are as, or more, effective than treatments for other chronic often relapsing disorders, such as forms of heart disease, diabetes, and some mental disorders.

The central issue for many people is whether addicts should be treated at all. I frequently hear people say: Do they really deserve to be treated? Didn't they just do it to themselves? Why should we coddle people who cause so much social disruption? Shouldn't they be punished, rather than treated? Even many people who recognize addiction as a disease, still get hung up on whether or not it is a "no-fault" illness.

Do they really deserve to be treated? Didn't they just do it to themselves? Why should we coddle people who cause so much social disruption? Shouldn't they be punished, rather than treated?

Treatment Reduces Drug Use, Increases Productivity

Science has brought us to a point where we should no longer be focusing the drug treatment question simply on these kinds of unanswerable moral dilemmas. From a practical perspective, benefits to society must be included in the decision equations. The very same body of scientific data that demonstrates the effectiveness of treatment in reducing an individual's drug use, also shows the enormous benefits that drug treatment can have for the patient's family and the community at large.

A variety of studies from the National Institutes of Health, Columbia University, the University of Pennsylvania, and other prestigious institutions have all shown that drug treatment reduces drug use by 50% to 60% and arrests for violent and non-violent criminal acts by 40% or more. Drug abuse treatment reduces the risk of HIV infection, and interventions to prevent HIV are much less costly than treating the person with AIDS. Treatment tied to vocational services improves the prospects for employment, with 40% to 60% more individuals employed.

The case is just as dramatic for prison and jail inmates, 60% to 80% of whom have serious substance abuse problems. Scientific studies show that appropriately treating addicts in prison reduces their later drug use by 50% to 70% and their later criminality and resulting arrests by 50% to 60%. These data make the case against warehousing addicts in prison without attending to their addictions. If they are not treated, most will be back and may continue to pose a threat to our communities.

Successful drug treatment takes a person who is now seen as only a drain on a community's resources and returns the individual to productive membership in society. Best estimates are that for every $1 spent on drug treatment there is a $4 to $7 return in cost savings to society. This means that dwelling on moralistic questions, such as who deserves what kind of help, blocks both the individual and society from receiving the economic and societal benefits that can be achieved from treating addicts.

Addicts Need Treatment

It is true that the individual initially makes the voluntary decision to use drugs. But once addicted, it is no longer a simple matter of choice. Prolonged drug use changes the brain in long lasting and fundamental ways that result in truly compulsive, often uncontrollable, drug craving, seeking and use, which is the essence of addiction. It becomes a more powerful motivator for that person than virtually any other. Once addicted, it is almost impossible for most people to stop using drugs without treatment.

It is clearly in everyone's interest to rise above our moral outrage that addiction results from a voluntary behavior and get addicted people into drug treatment. If we are ever going to significantly reduce the tremendous price drug addiction exacts from every aspect of our society, drug treatment for all who need it must be a core element of our society's strategies.

Source: Web site, National Institute on Drug Abuse (www.nida.nih.gov), February 16, 2001.

The OxyContin Dilemma

Michael D. McNeer, M.D.

Be thou a spirit of health or a goblin damn'd.
Bring with thee airs from heaven or blasts from hell.
Be thy intents wicked or charitable,
Thou com'st in such a questionable shape.

Hamlet, I, iv

To chronic and terminal pain sufferers, relief. To conscientious physicians, an effective alternative for the treatment of pain. To the manufacturer, a marketing success. To pharmacists, fear. To the drug abuser and addict, an instant opioid rush and euphoria—or death; to their families, grief. To drug diverters and pill-mill doctors, massive health-care fraud and ill-gotten gains. To some treatment centers, an epidemic. To law enforcement, the latest in a long series of drug problems. To the media, a breaking story.

OxyContin is all these things.

Since its introduction by Purdue Pharma in 1996, OxyContin™ (oxycodone in a controlled-release form) has found wide acceptance for the management of pain. Now available in 10mg, 20mg, 40mg, 80mg and 160mg strengths, the product contains no aspirin or acetaminophen.

Unhappily, OxyContin also has found favor with addicts, who crush the tablets for snorting or dissolve them for intravenous injection, either of which delivers an immediate high dose of oxycodone. As a reflection of its current popularity, sixty 40mg tablets of OxyContin, which retail for about $300, can bring $2400 on the black market.

The 40mg tablet is the most commonly diverted, with addicts entering treatment typically reporting doses of 200 to 300mg a day (although intravenous doses of more than 900mg a day have been reported).

A Media Sensation

Current headlines about extensive OxyContin diversion and abuse are based on cases reported in a series of geographic "hot spots," including southwestern Virginia, eastern Kentucky, West Virginia, Cincinnati and rural areas of Ohio, and areas of Maine and Alabama. Since the story first broke in the national media in January, OxyContin has been the subject of major network news programs and feature articles in *Time* ("The Potent Perils of a Miracle Drug," Jan. 8) and *U.S. News and World Report* ("The 'poor man's heroin,' An Ohio surgeon helps feed a growing addiction to OxyContin," Feb. 12).

Media interest in OxyContin abuse has been stoked by dramatic law enforcement operations ("OxyFest 2001" in eastern Kentucky made national news when it led to the arrests of 207 persons in one day in February) and stories of drug-related deaths (59 reported in Kentucky in 2000 and the first two months of 2001).

Southwestern Virginia and eastern Kentucky appear to have particularly severe problems with OxyContin abuse and diversion. In southwestern Virginia, Tazewell County (population 45,000) Commonwealth's Attorney Dennis Lee told an interviewer that his office brought about 150 felony charges related to OxyContin between August 1999 and August 2000 and that about half of all felony charges in the preceding 18 months were OxyContin-related. Offenses included 12 to 15 armed robberies in a three-county area, and two dozen break-ins of pharmacies in Tazewell County alone.

As a result, some area pharmacies have posted window signs announcing that they no longer stock OxyContin — a real setback to local patients who use the drug for its intended purpose.

Purdue Pharma's Senior Medical Director, J. David Haddox, D.D.S., M.D., said, "As a physician, I am outraged that people are abusing this valuable medicine and thereby making it more difficult for legitimate patients to obtain it. Purdue Pharma strongly supports the efforts of law enforcement and has been cooperating with them to curb drug abuse." A statement on Purdue Pharma's Web site (***http://www.pharma.com/news/statement. htm***) describes the company's efforts to cooperate with law enforcement and to educate health care professionals and pharmacists to prevent diversion.

Treatment Impact

A methadone treatment program in Grayson County, VA (about 100 miles east of Tazewell County) reports that 284 of its 291 patients are addicted to prescription opioids, and that OxyContin is almost exclusively their drug of choice.

Adequate treatment for those addicted to OxyContin, like those addicted to alcohol and other drugs, has become more difficult to obtain because of progressive decreases in insurance coverage and insufficient availability. The two major options are traditional detoxification and rehabilitation, or methadone maintenance treatment when indicated. Due to the severity of withdrawal symptoms associated with potent opioids, detoxification with methadone, where appropriately licensed, could well result in higher treatment retention than the more common clonidine detoxification.

A Longstanding Problem

OxyContin represents only the most publicized and visible component of widespread abuse and diversion of controlled prescription drugs (initially publicized by the American Medical Association in the early 1980s).

We who specialize in addiction medicine need to continue to support the appropriate use of opioids in pain management, while educating unwary physicians about trends, the ubiquity of addiction and common scams. The modern dealer/addict — wireless phone in one hand and PDR in the other — is sophisticated at downloading symptoms and diseases and armed with an arsenal of excuses for losing prescriptions and pills. He or she needs to be identified, confronted and offered a helping hand in dealing with the addictive disease.

We also must encourage increased cooperation among all those involved in prescription drug diversion and abuse — physicians, pharmacists, regulatory boards and law enforcement. Doctors who use their medical licenses merely to deal drugs should be punished to the fullest extent of the law. Public education, particularly for young people, must include information that the abuse and misuse of prescription drugs can be equally as hazardous, addictive and potentially fatal as abuse of illicit drugs. Perhaps most important, we need to continue to work for addiction treatment parity and closing the treatment gap. ■

ASAM member ***Michael D. McNeer, M.D.,*** *is an associate clinical professor of psychiatry and behavioral medicine at Marshall University School of Medicine, Huntington, WV, and a clinical assistant professor of behavioral medicine and psychiatry at West Virginia University School of Medicine, Morgantown, WV. His major interests are addiction and prescription drug abuse.*

Volunteers Needed for Study of Alcoholism

Researchers from the University of California, San Francisco (UCSF) are seeking volunteers nationwide for a new study of family traits associated with alcoholism. The UCSF Family Alcoholism Study will investigate links among behavior, personality characteristics and biological factors associated with alcoholism.

The research is part of ongoing work by the UCSF team on the genetic basis of alcoholism. Study results are expected to contribute to future advances in understanding causes of the condition and in developing new treatments. Originally launched in 1996, the project planned to enroll volunteers only from the San Francisco Bay Area, but phone interviews with participants proved so successful that the study has been expanded nationwide. "We realized that we don't have to be restricted by geography, which means a wider research base, a larger number of participants, and more comprehensive data," said study coordinator Cassi Vieten, PhD, a researcher with the UCSF Gallo Clinic and Research Center.

Researchers are looking for volunteers who are heavy alcohol users or recovering alcoholics and who also have a family member who will take part in the study. All participants must be 18 years of age or older and free from addiction to other drugs, except nicotine. Study volunteers must take part in a telephone interview about use of alcohol and other drugs, complete a pencil-and-paper personality questionnaire, and provide a blood sample for genetic analysis. The study covers expenses for drawing blood at a local laboratory or physician's office near the volunteer's home and for sending the sample to the UCSF team via a courier service. All information will be kept confidential, and each person who completes the study will be reimbursed $30 to $50.

The research team hopes to enroll 2,000 study participants over the next two to three years. Interested persons should contact the UCSF Family Alcoholism Study at 1-888/805-8273. Additional information is available at the study's Web site, ***www.familystudies.org***. The study is supported by funds from the State of California.

Source: Press release, University of California, San Francisco, February 1, 2001.

Genetic "Fingerprint" for Addiction Found

Researchers at the Yerkes Primate Research Center have discovered the first molecular profile for human drug addiction, which could result in new treatments for addiction, they said. Dr. Scott Hemby and colleagues

RESEARCH UPDATES

at the Yerkes Center have identified more than 400 human genes that are affected by long-term cocaine abuse. They were able to develop a fingerprint for drug addiction by applying DNA microarray technology, the most powerful method for gene expression profiling.

The study analyzed brain tissue from 10 human subjects who had overdosed on cocaine and an equal number of control subjects. Among the 9,000 genes examined per subject, more than 400 had become disregulated — either turned on or off — as the result of long-term cocaine use.

"For the first time, we have looked at a portion of the human genome and determined the effects of a drug like cocaine," said Dr. Richard Hemby, director of the Emory DNA Microarray Facility and an assistant professor of pharmacology in the Emory University School of Medicine. "It's going to take a long time to work this out, but we're setting up a framework that we can take into studies of opiate and alcohol addiction and other human diseases that will ultimately lead to the development of new treatments." He added that as scientists gain further understanding about the biology of cocaine addiction, they may be able to develop medications that effectively treat addiction without serious side effects. These medications would target specific aspects of the biochemical pathways that promote craving for cocaine.

Source: Annual Meeting of the Society for Neuroscience, November 28, 2000.

Marijuana Withdrawal Symptoms Identified

In the first out-of-laboratory study on marijuana, researchers at McLean Hospital (Belmont, MA) have identified clinical symptoms associated with marijuana withdrawal, including increased irritability, anxiety and physical tension and declines in appetite and mood.

The four-week study followed chronic marijuana users who abstained from using the drug during the study period. "Symptoms of withdrawal first appeared in chronic users within 24 hours," said Harrison Pope, chief of McLean's Biological Psychiatry Laboratory and co-author of the study. "They were most pronounced for the first 10 days of the study, but increases in irritability and physical tension were observed in chronic users for all 28 days of abstinence."

"There is disagreement in the scientific community about whether withdrawal causes significant symptoms," said Elena M. Kouri, associate director of the hospital's Behavioral Psychopharmacology Research Laboratory and lead author of the study. "This study," she added, "shows that using marijuana for a long time has consequences."

Source: Psychopharmacology, November 2000.

Likelihood of Multidrug Dependence Measured

Researchers from the University of Vermont compared the use of three licit psychoactive and addictive substances—alcohol, caffeine and nicotine—among a general population sample of Vermont residents ages 18 and older. John R. Hughes, M.D., and colleagues used the World Health Organization's Composite International Diagnostic Interview—Substance Abuse Module (CIDI-SAM) to interview 196 Vermont adults regarding their use of the three substances. The CIDI-SAM yields DSM-IV substance dependence criteria for nicotine and alcohol dependence. Caffeine dependence was measured using the same DSM-IV criteria tested in the CIDI-SAM.

The investigators found that a significant number of the subjects used the three substances: 20% met criteria for lifetime dependence on alcohol, while 34% met criteria for lifetime dependence on nicotine and 25% met criteria for lifetime dependence on caffeine. While the prevalence of alcohol dependence appeared to be greater in subjects with a history of nicotine or caffeine dependence, this result was not statistically significant. Likewise, lifetime nicotine dependence appeared higher in those dependent on caffeine and alcohol, but these results also were not statistically significant. Lifetime caffeine dependence was higher in those who were dependent on the other two substances; again, the results were not statistically significant.

The authors noted that the study had several limitations. First, sample size was small, and yielded an even smaller pool of people who had a history of dependence on each substance. In addition, the investigators used a general population sample. Dependence is likely to be more severe among persons seeking treatment, and these persons may experience more comorbidity. Finally, the study looked only at licit drugs. Dependence associations may be more common among illicit drug users.

Source: Brown University Digest of Addiction Theory and Application, December 2000. Reprint requests to HR Hughes, Dept. of Psychiatry, University of Vermont, 38 Fletcher Place, Burlington, VT 05401. ■

The moment of truth for the commited quitter.

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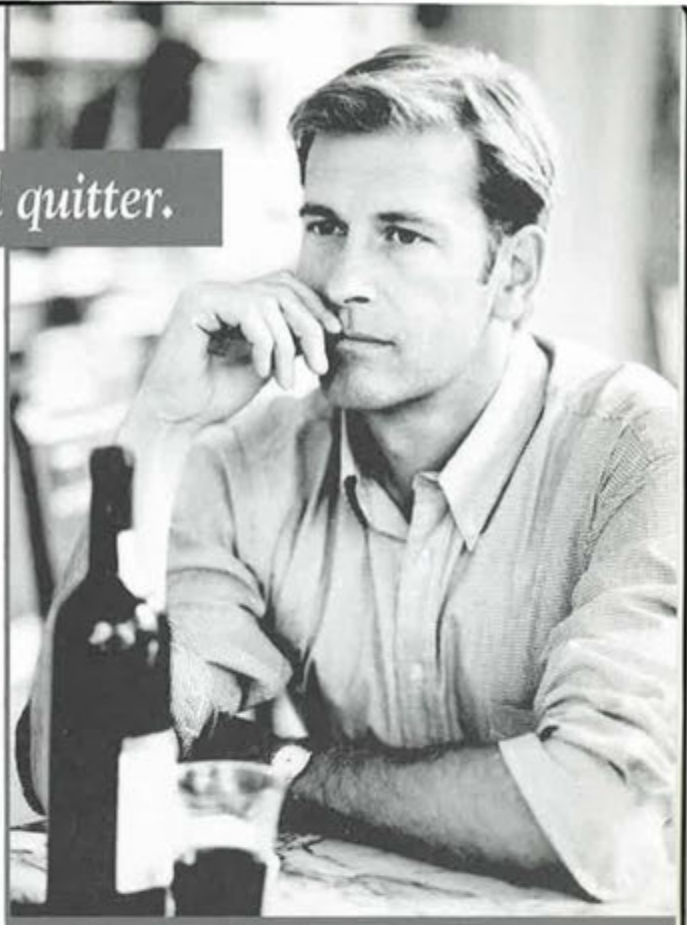

Now, for alcoholism, from Odyssey Pharmaceuticals — Antabuse, an integral part of an integrated system of support for the patient with chronic alcoholism.

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Disulfiram should *never* be administered to a patient who is in a state of alcohol intoxication or without their full knowledge. Relatives should be instructed accordingly.

Patients who have recently received metronidazole, paraldehyde, alcohol or alcohol-containing products should not receive Antabuse. Antabuse is contraindicated in severe myocardial disease or coronary occlusion, psychoses, and hypersensitivity to disulfiram. Antabuse should be used with caution in patients receiving phenytoin and its congeners. Please see complete prescribing information on next page for more information.

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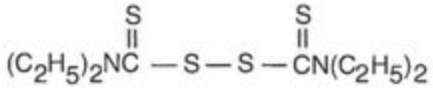
Antabuse® (Disulfiram, USP) Tablets IN ALCOHOLISM

WARNING:
Disulfiram should never be administered to a patient when he is in a state of alcohol intoxication, or without his full knowledge.
The physician should instruct relatives accordingly.

DESCRIPTION: CHEMICAL NAME:
bis(diethylthiocarbamoyl) disulfide.
STRUCTURAL FORMULA:



$C_{10}H_{20}N_2S_4$ M.W. 296.55

Disulfiram occurs as a white to off-white, odorless, and almost tasteless powder, soluble in water to the extent of about 20 mg in 100 mL, and in alcohol to the extent of about 3.8 g in 100 mL.

Each tablet for oral administration contains 250 mg disulfiram, USP. Tablets also contain colloidal silicon dioxide, anhydrous lactose, magnesium stearate, microcrystalline cellulose, sodium starch glycolate, and stearic acid.

CLINICAL PHARMACOLOGY: Disulfiram produces a sensitivity to alcohol which results in a highly unpleasant reaction when the patient under treatment ingests even small amounts of alcohol.

Disulfiram blocks the oxidation of alcohol at the acetaldehyde stage. During alcohol metabolism following disulfiram intake, the concentration of acetaldehyde occurring in the blood may be 5 to 10 times higher than that found during metabolism of the same amount of alcohol alone.

Accumulation of acetaldehyde in the blood produces a complex of highly unpleasant symptoms referred to hereinafter as the disulfiram-alcohol reaction. This reaction, which is proportional to the dosage of both disulfiram and alcohol, will persist as long as alcohol is being metabolized. Disulfiram does not appear to influence the rate of alcohol elimination from the body.

Disulfiram is absorbed slowly from the gastrointestinal tract and is eliminated slowly from the body. One (or even two) weeks after a patient has taken his last dose of disulfiram, ingestion of alcohol may produce unpleasant symptoms.

Prolonged administration of disulfiram does not produce tolerance; the longer a patient remains on therapy, the more exquisitely sensitive he becomes to alcohol.

INDICATIONS: Disulfiram is an aid in the management of selected chronic alcohol patients who *want* to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage.

Disulfiram is not a cure for alcoholism. When used alone, without proper motivation and supportive therapy, it is unlikely that it will have any substantive effect on the drinking pattern of the chronic alcoholic.

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, e.g., cough syrups, tonics and the like, should not be given disulfiram.

Disulfiram is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, and hypersensitivity to disulfiram or to other thiuram derivatives used in pesticides and rubber vulcanization.

WARNINGS:

Disulfiram should never be administered to a patient when he is in a state of alcohol intoxication, or without his full knowledge.
The physician should instruct relatives accordingly.

The patient must be fully informed of the disulfiram-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of the possible consequences. He should be warned to avoid alcohol in disguised forms, i.e., in sauces, vinegars, cough mixtures, and even in aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting disulfiram.

The Disulfiram-Alcohol Reaction: Disulfiram plus alcohol, even small amounts, produce flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of disulfiram and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg per 100 mL. Symptoms are fully developed at 50 mg per 100 mL, and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes, to several hours in the more severe cases, or as long as there is alcohol in the blood.

Drug Interactions: Disulfiram appears to decrease the rate at which certain drugs are metabolized and therefore may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

DISULFIRAM SHOULD BE USED WITH CAUTION IN THOSE PATIENTS RECEIVING PHENYTOIN AND ITS CONGENERS, SINCE THE CONCOMITANT ADMINISTRATION OF THESE TWO DRUGS CAN LEAD TO PHENYTOIN INTOXICATION. PRIOR TO ADMINISTERING DISULFIRAM TO A PATIENT ON PHENYTOIN THERAPY, A BASELINE PHENYTOIN SERUM LEVEL SHOULD BE OBTAINED. SUBSEQUENT TO INITIATION OF DISULFIRAM THERAPY, SERUM LEVELS OF PHENYTOIN SHOULD BE DETERMINED ON DIFFERENT DAYS FOR EVIDENCE OF AN INCREASE OR FOR A CONTINUING RISE IN LEVELS. INCREASED PHENYTOIN LEVELS SHOULD BE TREATED WITH APPROPRIATE DOSAGE ADJUSTMENT.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status, the disulfiram should be discontinued if such signs appear.

In rats, simultaneous ingestion of disulfiram and nitrite in the diet for 78 weeks has been reported to cause tumors, and it has been suggested that disulfiram may react with nitrites in the rat stomach to form a nitrosamine, which is tumorigenic. Disulfiram alone in the rat's diet did not lead to such tumors. The relevance of this finding to humans is not known at this time.

Concomitant Conditions: Because of the possibility of an accidental disulfiram-alcohol reaction, disulfiram should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

Usage in Pregnancy: The safe use of this drug in pregnancy has not been established. Therefore, disulfiram should be used during pregnancy only when, in the judgement of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: Patients with a history of rubber contact dermatitis should be evaluated for hypersensitivity to thiuram derivatives before receiving disulfiram (see CONTRAINDICATIONS).

It is suggested that every patient under treatment carry an *Identification Card* stating that he is receiving disulfiram and describing the symptoms most likely to occur as a result of the disulfiram-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in an emergency. (Cards may be obtained from ODYSSEY PHARMACEUTICALS upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates and disulfiram have been administered concurrently without untoward effects; the possibility of initiating a new abuse should be considered.

Baseline and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with disulfiram therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

Patients taking disulfiram tablets should not be exposed to ethylene dibromide or its vapors. This precaution is based on preliminary results of animal research currently in progress that suggest a toxic interaction between inhaled ethylene dibromide and ingested disulfiram resulting in a higher incidence of tumors and mortality in rats. A correlation between this finding and humans, however, has not been demonstrated.

ADVERSE REACTIONS: (See CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS.)

OPTIC NEURITIS, PERIPHERAL NEURITIS, POLYNEURITIS, AND PERIPHERAL NEUROPATHY MAY OCCUR FOLLOWING ADMINISTRATION OF DISULFIRAM.

Multiple cases of hepatitis, including both cholestatic and fulminant hepatitis, have been reported to be associated with administration of disulfiram.

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy, or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

DOSAGE AND ADMINISTRATION: Disulfiram should never be administered until the patient has abstained from alcohol for at least 12 hours.

Initial Dosage Schedule: In the first phase of treatment, a maximum of 500 mg daily is given in a single dose for one to two weeks. Although usually taken in the morning, disulfiram may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

Maintenance Regimen: The average maintenance dose is 250 mg daily (range, 125 to 500 mg), it should not exceed 500 mg daily.

Note: Occasionally patients, while seemingly on adequate maintenance doses of disulfiram, report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily disulfiram tablets (preferably crushed and well mixed with liquid), it cannot be concluded that disulfiram is ineffective.

Duration of Therapy: The daily, uninterrupted administration of disulfiram must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

Trial with Alcohol: During early experience with disulfiram, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg daily, a drink of 15 mL (1/2 oz) of 100 proof whiskey, or equivalent, is taken slowly. This test dose of alcoholic beverage may be repeated once only, so that the total dose does not exceed 30 mL (1 oz) of whiskey. Once a reaction develops, no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

Management of Disulfiram-Alcohol Reaction: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95% oxygen and 5% carbon dioxide), vitamin C intravenously in massive doses (1 g) and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored, particularly in patients on digitalis, since hypokalemia has been reported.

HOW SUPPLIED: Disulfiram Tablets, USP:
250 mg - White, round, unscored tablets in bottles of 100.
Debossed: OP 706
Dispense in a tight, light-resistant container as defined in the USP.
Store at controlled room temperature 15°-30°C (59°-86°F).

Distributed by Odyssey Pharmaceuticals, Inc., East Hanover, New Jersey 07936
Manufactured by Sidmak Laboratories, Inc., East Hanover, NJ 07936

FDA: Sales of Non-Approved Drug Test Kits Cited

The U.S. Food and Drug Administration (FDA) has filed an administrative complaint against Worldwide Medical Corporation for selling drug test kits before receiving agency approval.

The kits, which are used to screen urine for marijuana, cocaine and heroin, are sold over the counter for $12.99 to $29.99. In its complaint, the agency alleges that Worldwide Medical began selling the kits as early as July 1999 — long before the kits received FDA approval on June 23, 2000.

Worldwide Medical has 30 days to request a hearing before an administrative law judge.

Source: Los Angeles Times, February 7, 2001.

NIAAA: Addiction Science Programs Sponsored

Free presentations on addiction science by faculty at the University of Texas' Addiction Science Research and Education Center are available to groups of clinicians, other health professionals and the public in Texas, New Mexico, Colorado, Oklahoma, Arkansas and Louisiana. The presentations are funded by grants from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). Detailed information on the program is available at ***www.utexas.edu/research/asrec/web_brochure.html***.

Source: University of Texas at Austin.

CDC: More Funding Needed for Anti-Smoking Efforts

The Centers for Disease Control and Prevention (CDC) is urging states to allocate more of their tobacco settlement funds to anti-smoking campaigns.

According to a recently released CDC report, states have earmarked $883.2 million in 2001 for programs to reduce tobacco use — an amount that is only 60% of CDC's recommended minimum investment. The CDC was especially critical of the District of Columbia, Connecticut, North Carolina, North Dakota, Pennsylvania and Tennessee for not using any of their tobacco funds for anti-smoking efforts.

On the other hand, the agency cited seven states (Arizona, Indiana, Maine, Massachusetts, Mississippi, Ohio and Vermont) for meeting its recommendations on tobacco program spending. "Not since the polio vaccine has this nation had a better opportunity to make a significant impact in public health," noted CDC Director Dr. Jeffrey Koplan.

Source: CDC News release, February 14, 2001. ■

Item-Writing Workshop Scheduled by Exam Committee

An Item-Writing Workshop, which provides an opportunity for members to participate in the process of developing items for ASAM's Certification and Recertification Examination, has been scheduled for 7:00 to 8:30 a.m. on Sunday, April 22, during ASAM's Medical-Scientific Conference in Los Angeles.

Workshop participants will gain insight into the test development process, will learn how to write effective test items, and will have an opportunity to submit items to ASAM's Examination Committee for possible use in future examinations.

The workshop is an outgrowth of ASAM's plan to increase the number of trained item writers, to increase the number of items available for future examinations, and to increase the number of items that test the higher-level reasoning skills required in clinical practice. Participants will learn how to:

- Identify appropriate topics for items;
- Write concise items with focused stems;
- Write plausible incorrect answers;
- Convert recall items into reasoning items;
- Identify and remove typical item flaws;
- Select the best items for future examinations.

Afterward, physicians will be given an opportunity to break into small groups to practice writing questions. Several items will be selected for review and discussion by the group. The workshop will be co-facilitated by Sidney H. Schnoll, M.D., Ph.D., FASAM, member of the ASAM Examination Committee, and Jennifer Stevens Pappas, M.A., an Evaluation Officer at the National Board of Medical Examiners.

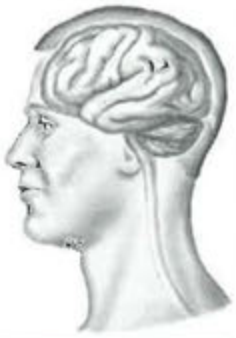
If you are interested in attending, please call Christopher Weirs at 301/656-3920 immediately. Registration is limited to the first 30 physicians who apply. ■

ASAM 2001 MED-SCI CONFERENCE

Pain and Addiction: Common Threads II

THURSDAY, APRIL 19, 2001

Century Plaza Hotel & Spa • Los Angeles, California



"Pain and Addiction: Common Threads II" provides a scientific and clinical evaluation of the current state of pain management. This year's conference focuses on methadone as an analgesic for patients with or without the disease of addiction. Faculty also will discuss the risks involved in opioid treatment for chronic pain and aberrant use of opioids on "the street," as well as the role of anti-convulsants (AEA) in the treatment of pain. New directions in analgesia will be reviewed. Case discussions will provide an ample opportunity for interaction between faculty and audience members.

PROGRAM

8:15-8:30 am
Welcoming Remarks and Introductions
Howard A. Heit, M.D., FACP, FASAM, Course Co-Director
Seddon R. Savage, M.D., FASAM, Course Co-Director

MORNING:
Methadone as an Analgesic Medication

8:30-9:00 am
Pharmacology of Methadone
Gavril Pasternack, M.D., Ph.D., Memorial Sloan-Kettering Cancer Center

9:00-9:30 am
Methadone for Pain in the Non-Addict
Scott Fishman, M.D., Division of Pain Medicine, UC-Davis

9:30-10:00 am
Acute and Chronic Pain Treatment in the Methadone Dependent Patient
Karen Lea Sees, D.O., FAOAAM, Consultant

10:00-10:10 am
Is the Methadone Clinic the Last Resort for the Pain Patient?
Howard A. Heit, M.D., FACP, FASAM, Georgetown University School of Medicine

10:10-10:30 am
Methadone for Pain and Addiction: Legal and Regulatory Issues
Patricia M. Good, B.A., U.S. Drug Enforcement Administration

10:30-10:45 am
Questions and Answers

10:45-11:00 am
Refreshment Break

11:00 am-12:00 pm
Facilitated Case Discussions*
Douglas Gourlay, M.D., M.Sc., FRCPC (Facilitator), Wasser Pain Management Centre, Mt. Sinai Hospital, Toronto, ON

12:00-1:30 pm
Luncheon and Guest Speaker:
AIDS, Pain & Chemical Dependency
William Breitbart, M.D., Chief of the Psychiatry Service, Memorial Sloan-Kettering Cancer Center, and Professor of Psychiatry, Cornell University College of Medicine, New York, NY

AFTERNOON: An Assesment of Opioid and Adjunctive Analgelsics

1:45-2:15 pm
Risk of Increased Pain Due to Chronic Opioid Use
Peggy Compton, R.N., Ph.D., Acute Care Section, UCLA School of Nursing

2:15-2:45 pm
Aberrant Use of Opioids: A "Street" Perspective
Brian Goldman, M.D., FACEP, Emergency Physician, Mt. Sinai Hospital, Toronto, ON

2:45-3:15 pm
The Role of Anticonvulsants (AEA) in Pain Treatment
Brian McGeeney, M.D., Pain Management Group, Boston Medical Center

3:15 -3:45 pm
New Directions in Analgesic Drug Development
William K. Schmidt, Ph.D., President, North Star Research & Development

3:45-4:00 pm
Questions and Answers

4:00-4:15 pm
Refreshment Break

4:15-5:00 pm
In Depth Q&A: The Audience and Speakers
Sidney H. Schnoll, M.D., Ph.D., FASAM (Facilitator), Division of Addiction Medicine, Medical College of Virginia, Virginia Commonwealth University

5:00-5:15 pm
Wrap up and Adjournment
Howard A. Heit, M.D., FACP, FASAM
Seddon R. Savage, M.D., FASAM, Pain Consultant, Manchest (NH) VAMC and Associate Professor of Anesthesiology, Dartmouth Medical School

*** Facilitated Case Discussions**

During the final hour of the morning session, participants will join facilitated small groups to discuss several problem-based case studies. These cases will be developed from data collected from registrants in advance of the conference (through a link on the ASAM web site) and will represent a synthesis of common problems in clinical practice. This link will be restricted to conference registrants and will be available only to those who preregister for the course by March 15, 2001. Details as to how to access the link and the deadline for submitting cases will be sent with confirmation letters once registrations have been processed.

Continuing Medical Education Credits

The American Society of Addiction Medicine designates this continuing medical education activity for 7.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Application has been made to the American Osteopathic Association (AOA) for CME credit for this course.

▶ **ADDICTION MEDICINE**
continued from page 3

Hatch Introduces Drug Prevention/Treatment Bill

Senator Orrin Hatch (R-UT) has introduced an anti-drug bill aimed at providing new resources for drug treatment, education and prevention programs. The Drug Education, Prevention and Treatment Act of 2001, which has strong bipartisan support, is cosponsored by Sen. Patrick Leahy (D-VT), the ranking Democrat on the Senate Judiciary Committee, and Sens. Joseph Biden (D-DE), Mike DeWine (R-OH) and Strom Thurmond (R-SC).

"To succeed in the battle against drugs, our nation cannot merely focus on the supply side. We must provide a substantial commitment to reduce the demand for these harmful substances that are poisoning our society," Sen. Hatch said. "We need to do more to lead America's youth away from the destructive path of drug abuse. We also must find ways to treat those who have become trapped in addiction."

The measure would authorize new funding for school and community-based drug prevention programs that are research-based and demonstrated to be effective; provide additional money for eligible community-based organizations to implement after-school or out-of-school programs that include a strong focus on developing character; and authorize funding for community-based organizations that provide counseling and mentoring services to children who have a parent or guardian in prison.

In addition, the measure would provide funding to the National Institutes of Health to continue research toward identifying more effective research-based prevention and treatment programs. Also included in the bill are grants to the states to provide drug treatment services to inmates and in residential treatment facilities, some specifically designed to treat drug-addicted juveniles.

The bill is supported by President George W. Bush, according to a press release from Sen. Hatch's office. The Senator is quoted as saying, "I am extremely pleased that this bipartisan bill has a friend in the White House. President Bush has indicated on several occasions — and in the plan he unveiled last fall — that he also believes in a comprehensive drug-control strategy."

The bill was referred to the U.S. Senate Judiciary Committee, which Sen. Hatch chairs.

Source: Press release, Office of Sen. Orrin Hatch, February 20, 2001.

Primary Care Physicians Don't Intervene with Addicted Patients

Primary care physicians frequently fail to intervene with their addicted patients, according to a report in the *Archives of Internal Medicine*. Researchers at Brown University surveyed 1,080 physicians, one-third of whom said they do not routinely ask new patients if they use illicit drugs. Further, 15% said they do not routinely offer any intervention to patients even when they do know they are abusing drugs. Of those physicians who said they would offer intervention, 61% recommend Twelve Step programs, while just 55% routinely recommended addiction treatment programs.

Peter Friedmann, M.D., lead author of the study and an assistant professor of medicine and community health at Brown University, said the findings indicate that many physicians do not understand that addiction is a medical problem like diabetes, high blood pressure or other chronic disorders. Others fail to discuss illicit drug use with patients out of pessimism about being able to do anything to help, and skepticism about the success of drug treatment programs, he explained. In addition, some doctors believe talking about drug abuse with patients is taboo, or feel it is outside their role.

Source: Archives of Internal Medicine, January 22, 2001.

Fewer Women Stop Drinking During Pregnancy

A new report from the Centers for Disease Control and Prevention (CDC) says that younger women are as likely as older women to use alcohol and tobacco, but less likely to stop using those substances during pregnancy.

The study was based on the CDC's Behavioral Risk Factor Surveillance System (BRFSS), a state-based monthly telephone survey of adults in the U.S. The report looked at 10 years of data, from 1987 to 1997. Although there was a decrease in combined tobacco and alcohol use among reproductive age and pregnant women in the late 1980s, the survey found that rates remained unchanged during the 1990s.

Among women 18 to 20 years old who were pregnant, use of tobacco or alcohol remained unchanged at 4% in the 1990s, after declines in the 1980s. For 18- to 20-year-old women who were not pregnant, use of both substances increased from 13.5% to 13.7%. In 1997, 74% of pregnant women in the 18- to 20-year-old age group stopped using alcohol and tobacco, compared with 83% of older pregnant women.

Dr. Shahul H. Ebrahim of the CDC, who was lead author of the report, said "Counseling on avoiding tobacco and alcohol misuse should be an important part of care for women of childbearing age."

Source: Obstetrics & Gynecology, November 2000.

Older Smokers Benefit from Quitting

New research shows that even older adults benefit from quitting and should be given more support to do so, according to a recent press release from the Center for the Advancement of Health. "As individuals in our society live longer, a larger number of smokers who are over age 60 will seek medical care and will benefit from cessation efforts," said study author David M. Burns, M.D., of the School of Medicine at the University of California, San Diego. "This is a population where preventive services should not be ignored."

Research showed that older smokers who quit lower their risk of lung cancer and heart disease, Dr. Burns said. Although the benefits of quitting may be proportionally less for elderly smokers, quitting at any age "can have a substantial effect on rates of smoking-induced disease and remains the most effective method of reducing smoking-induced disease risk for elderly smokers," he added.

As part of his research, Dr. Burns analyzed various studies on smoking by older adults. He found that older smokers have traditionally been less likely than younger smokers to try to quit, but that those who do try are more likely than younger smokers to seek assistance and to be successful in their efforts. Dr. Burns' research also found that smoking exacts a heavier toll on older adults because it causes cumulative damage that increases the risk of death and of smoking-related diseases every year. "Cigarette smoking can be conceptualized as a disease contracted in adolescence that causes death and disability predominantly at older ages," he said.

Source: American Journal of Health Promotion, July/August 2000.

Health Effects of Modified Tobacco Products Uncertain

Modified tobacco products designed to reduce the health risks of smoking cannot yet be proved to reduce tobacco-related disease, according to a new report from the Institute of Medicine (IOM) of the National Academy of Sciences. Products developed to lessen the risk of disease by reducing exposure to toxic chemicals are scientifically feasible, but in the absence of rigorous research, no one knows if these products decrease the incidence of tobacco-related disease or actually *increase* it by encouraging smoking.

Even if a product is shown to reduce the risk of disease for an individual who gives up conventional tobacco, the committee cautioned that the overall effect on the population could be negative because smokers who might have quit, or young people who have not yet started, will use these products instead. The report calls for immediate development of a comprehensive surveillance system to track and assess how the introduction and marketing of products affect public health and to what extent the prevalence of tobacco use changes. Key aspects would involve tracking the distribution, sales, and use of tobacco products, identifying the chemicals they contain, and determining impact on disease. The prompt collection and reporting of data would help public health officials determine if these products negatively affect health.

At the same time, new biomedical and behavioral research will be essential to show conclusively the health effects of these products.

A strategy of harm reduction is likely to succeed, the committee warned, only if manufacturers have the incentive to develop and market products that reduce harm; consumers are accurately informed of all known and potential consequences of using these products; if advertising and labeling are firmly regulated to prevent false or misleading claims; if basic, clinical, and population studies are conducted to indicate reduced harm; and if health effects of using these products are continually monitored. Most important, the committee stressed the need to make harm reduction a component of a comprehensive national approach that includes the prevention of smoking initiation and relapse, as well as the promotion of smoking cessation.

The study was sponsored by the U.S. Food and Drug Administration. Pre-publication copies of "Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction" are available from the National Academy Press; phone 1-800/624-6242. The cost is $55.00 (prepaid) plus shipping.

Source: Press release, Institute of Medicine, National Academy of Sciences, February 22, 2001. ■

Expectations for Faith-Based Programs Defined

The effectiveness of individual faith-based groups is the "bottom line" for determining how well the White House's faith-based initiative will work, according to ASAM member H. Westley Clark, M.D., J.D., M.P.H., FASAM, who heads the federal Center for Substance Abuse Treatment (CSAT).

As a first step, Dr. Clark said, the Bush administration and Congress must agree on a definition of the term "faith" and determine whether faith plays a role in the nature and function of every selected federal agency. He added that addiction is "a complex issue," so faith-based programs must be able to deal with such complexities as co-occurring psychiatric and medical disorders.

Noting that faith-based organizations must provide the standard components of addiction treatment, such as case management, needs assessment, medical care, mental health, vocational care, child care, social services, and transportation, Dr. Clark said they also must answer the kinds of questions posed to all treatment providers by funders and federal agencies: What did you do with the money? Did the addicts improve? Are the children of the addicts safe? Is the addict at risk of driving with alcohol in his or her blood? Does the addict have a place to live?

Despite the multitude of issues that need to be addressed, Dr. Clark said that CSAT is "very supportive of the President's initiative and very optimistic about faith-based groups."

Source: Substance Abuse Funding News, February 13, 2001.

Treament Access a Problem for Dually Diagnosed Youth

Treatment services for mentally ill young people with addictive disorders are "fragmented, isolated and rigid," according to a new report of a two-year study conducted in California, the District of Columbia, Georgia, Illinois, Kansas, Maine, New Mexico, and West Virginia.

The report, "Blamed and Ashamed: The Treatment Experiences of Youth with Co-occurring Substance Abuse and Mental Health Disorders and their Families," is based on focus groups involving more than 150 ethnically diverse people. Based on the findings, the report recommended that gaps in treatment be addressed with peer support for youth and families and combined treatment. It further recommended to providers that youth and their families be involved in the process for developing treatment services.

The report also suggested development of a public awareness campaign on mental illness and positive models of treatment that could be disseminated in schools, to families, and through youth groups.

The study, sponsored by the Substance Abuse & Mental Health Services Administration (SAMHSA), was conducted by the Federation of Families for Children's Mental Health in Alexandria, VA, and Keys for Networking Inc., in Topeka, KS, with support from SAMHSA's Center for Mental Health Services.

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

Benefits of Smoking Reduction Questioned

A new study indicates that cutting back on smoking without quitting might not result in health benefits, as previously believed. Researchers at the Mayo Clinic determined that heavy cigarette smokers who cut back on their smoking might not see any improvements in thier health.

"Many people—smokers and medical professionals alike—assume that if smokers can simply cut back, there will be some health benefits," said ASAM member Richard Hurt, M.D., who heads the Mayo Clinic's Nicotine Cessation Center and was the principal researcher on the study. "Our results didn't show that."

The research involved 23 heavy smokers, defined as adults who smoked more than 40 cigarettes a day. Over the course of nine weeks, the participants gradually cut back to 10 cigarettes a day. At the end of 12 weeks, researchers measured several biomarkers that indicate harm from cigarettes.

"One biomarker improved, showing less harm," said Hurt. "Four stayed the same, meaning no health benefits, and one got worse, indicating increased harm. We don't know why results were so varied." Dr. Hurt added that the study's findings led researchers to conclude that more research is needed before promoting smoking reduction as a treatment strategy.

Source: Nicotine and Tobacco Research, December 15, 2000.

Factors in Successful Addiction Treatment

A recent study examined the factors that are most likely to lead to successful completion of drug treatment for men and women. Researchers at Kaiser Permanente Medical Care Program in Oakland, CA, conducted the study to identify the gender-based differences between men and women regarding retention rates in outpatient programs.

After tracking 317 women and 599 men for two-years, the scientists found that men with addictive disorders were more likely to complete treatment if they are over age 40 or pressured by an employer. For women, completion of treatment is more likely if they

are unemployed, married, or making more than $20,000 a year.

The researchers said the study could help addiction treatment providers tailor their programs more effectively for either gender, and identify and prevent dropout risks.

Additional information is available from the Kaiser Permanente Medical Care Program's research library at 510/450-2000 or e-mail ***jrm@dor.kaiser.org*** (refer to "Predictors of Substance Abuse Treatment Retention Among Women and Men in an HMO").

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

Combining Treatment with Harm Reduction

Some question whether mainstream treatment can work with harm reduction, but San Francisco, CA, is establishing itself as a model to show that the two concepts can work together.

While San Francisco is working on providing addiction treatment services on demand in the public system, the city is simultaneously trying to convince local providers that adopting harm-reduction approaches is critical to making treatment on demand successful.

Part of the challenge is to erase the misconceptions about harm reduction, mainly that the approach leads to legalization. "Any strategy that reduces the harm from substance abuse is harm reduction," explains Alice Gleghorn, director of research, epidemiology and grants at San Francisco's Community Substance Abuse Services agency. "That might be methadone or needle exchange, or it might simply be an abstinence-based treatment program agreeing to accept clients who are on methadone."

In order to integrate harm reduction into its existing provider system, the city's Health Commission passed a resolution requiring all treatment providers to include in their program design and objectives details on how they would provide harm reduction treatment options. The resolution also requires the development of harm reduction guidelines.

"Initially there was a lot of fear and a lot of anger over how this was being imposed by the city," said Michael Siever, program director of the Stonewall Project and Stimulant Treatment Outpatient Program (STOP) treatment programs in San Francisco. "Now there are still a lot of questions, but it's definitely a different level of discourse."

Source: Alcoholism & Drug Abuse Weekly, January 29, 2001.

ASAM 2001 MED-SCI CONFERENCE

Awards Dinner Honors Drs. Gordis, Primm, Radcliffe, New ASAM Fellows

Dr. Gordis

The ASAM Awards Dinner on Saturday, April 21, will feature presentation of the John P. McGovern Award on Addiction and Society to Beny J. Primm, M.D., Executive Director, Addiction Research & Treatment Corp., Brooklyn, NY, and former director of the federal Center for Substance Abuse Treatment. The McGovern Award was established in 1997 to recognize and honor an individual who has made highly meritorious contributions to public policy, treatment, research, or prevention which has increased our understanding of the relationship of addiction and society. The award is sponsored by an endowment from the John P. McGovern Foundation.

Also at the dinner, an ASAM Annual Award for "outstanding contributions to the growth and vitality of our Society, for thoughtful leadership in the field, and for deep understanding of the art and science of addiction medicine" will be presented to ASAM past President and Board member Anthony B. Radcliffe, M.D., FASAM.

An ASAM Annual Award for "expanding the frontiers of the field of Addiction Medicine and broadening our understanding of the addiction process, through research and innovation" will be presented to ASAM member Enoch Gordis, M.D., Director of the National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health.

ASAM's Young Investigator Award for the year 2000 will go to Renee M. Cunningham-Williams, Ph.D., MPE, for the best abstract submitted by an author who is within five years of receipt of a doctoral degree. Also to be recognized is Peter L. Selby, M.D., who will receive the first Medical-Scientific Program Committee Award as author of the abstract judged best overall of those submitted for the conference.

Candidates who successfully completed the 2000 ASAM Certification and Recertification examination will be recognized and welcomed into the company of the 3,100 physicians who have been certified by ASAM.

Newly elected ASAM Fellows also will be honored at the Awards Dinner. They join the growing number of ASAM colleagues who have attained Fellow status by being certified in addiction medicine, making significant contributions to the field and giving significant service to ASAM, and by maintaining ASAM membership for at least five consecutive years.

The Awards Dinner is an extra fee event. Tickets may be ordered in advance or purchased at the ASAM registration desk on-site. ■

Open Forum for Prospective Fellows

ASAM members who are interested in becoming a Fellow of the Society are invited to attend an open forum on Saturday, April 21, at 6:30 a.m.

President Marc Galanter, M.D., FASAM, President-Elect Andrea Barthwell, M.D., FASAM, and Immediate Past President G. Douglas Talbott, M.D., FASAM, will join Richard E. Tremblay, M.D., FASAM, who Chairs the Membership Committee, and Kevin O'Brien, M.D., FASAM, Chair of the Fellow Subcommittee to answer questions about the benefits, requirements and process for becoming a Fellow of ASAM.

Certification Open Forum Scheduled

An Open Forum for discussion of issues related to ASAM's Certification and Recertification procedures has been scheduled for 7:00 to 8:30 a.m. on Saturday, April 21, during ASAM's Medical-Scientific Conference in Los Angeles.

Issues to be addressed include the criteria to be applied for the 2002 Certification/Recertification Examination in Addiction Medicine and MRO.

The Forum will be moderated by the Chair of the Credentialing Committee. Additional information is available from Christopher Weirs at the ASAM office, 301/656-3920.

A Wealth of Scientific and Clinical Sessions Scheduled

Scientific symposia, courses and workshops planned for ASAM's Medical-Scientific Conference include the following:

Symposia

"The Challenge of Psychostimulant Addiction," organized by Anna Rose Childress, Ph.D., Franck Vocci, Ph.D., and Dorynne Czechowicz, M.D. Sponsored by the National Institute on Drug Abuse. *(Friday, April 20, 10:30 a.m.-12:30 p.m. and 1:30-5:00 p.m.)*

"Medical Education in Addiction Medicine," organized by Norman S. Miller, M.D., FASAM, and co-sponsored by ASAM and the Association for Medical Education and Research in Substance Abuse. *(Friday, April 20, 10:30 a.m.-12:30 p.m.)*

"Placement Criteria Come of Age," organized by David R. Gastfriend, M.D. *(Friday, April 20, 10:30 a.m.-12:30 p.m.)*

"Acamprosate: New Clinical and Preclinical Research," organized by Barbara J. Mason, Ph.D. *(Friday, April 20, 1:30-5:00 p.m.)*

"Pregnancy and Addiction: A Complex Issue," organized by Sidney H. Schnoll, M.D., Ph.D., FASAM. *(Friday, April 20, 1:30-5:00 p.m.)*

"Neurobehavioral Aspects of Adolescence: Factors Contributing to Developing Alcoholism," organized by Enoch Gordis, M.D., Sam Zakhari, Ph.D., Walter Hunt, Ph.D., and Richard K. Fuller, M.D. Sponsored by the National Institute on Alcohol Abuse and Alcoholism. *(Saturday, April 21, 8:30-10:30 a.m., 1:00-3:00 p.m., 3:30-5:30 p.m.)*

"Club Drugs," organized by Joan E. Zweben, Ph.D. *(Saturday, April 21, 8:30-10:30 a.m.)*

"Linking Medical and Addiction Services: Beneficial, Pragmatic, Cost Effective?," organized by Jeffrey H. Samet, M.D., M.A., M.P.H. *(Saturday, April 21, 1:00-3:00 p.m.)*

"Diversion of Prescription Drugs: What Do We Know?," organized by Sidney H. Schnoll, M.D., Ph.D., FASAM and Anne Geller, M.D., FASAM. *(Saturday, April 21, 3:30-5:30 p.m.)*

"Buprenorphine; Part I: Training Course," organized by H. Westley Clark, M.D., J.D., M.P.H., FASAM, and Marc Galanter, M.D., FASAM. *(Sunday, April 22, 8:30 a.m.-12 noon)*. Note: this is the first part of the full-day buprenorphine training, and is the prerequisite for attending the afternoon session.

"Underage Drinking," organized by Norman S. Miller, M.D., FASAM and Norman Wetterau, M.D. *(Sunday, April 22, 8:30 a.m.-12:00 noon)*

Courses and Workshops

Courses and workshops feature clinical presentations that complement the scientific symposia. They are organized by ASAM members and nonmembers alike, and have been carefully reviewed by the ASAM Conference Program Committee for their content and quality.

Seating for these events is limited and is assigned on a first-come, first-served basis.

Course 1: "Choosing the Right Approach to Detect and Monitor Heavy Drinking in the New Millenium"; Pamela Bean, Ph.D., M.B.A., Course Director *(Friday, April 20, 10:30 a.m.-12:30 p.m.)*

Workshop A: "The Internet: The New 'Crack Cocaine' for Sexual Addicts and Compulsives"; Jennifer Schneider, Workshop Director *(Friday, April 20, 10:30 a.m.-12:30 p.m.)*

Workshop B: "Using an Evidence-Based Intervention in Clinical Practice — Motivational Interviewing"; Jeanne L. Obert, MFT, MSM and Chris Farentinos, M.D., CADC II, NCDC II, Workshop Co-Directors *(Friday, April 20, 10:30 a.m.-12:30 p.m.)*

Course 2: "Adolescent Treatment Models: A CSAT Multisite Project"; Marc Fishman, M.D., Course Director *(Friday, April 20, 1:30-5:00 p.m.)*

Workshop C: "Journal Club: Improving Your Skills in Reading the Scientific Literature";

Lori Karan, M.D., FASAM, Workshop Director *(Friday, April 20, 1:30-5:00 p.m.)*

Workshop D: "What Every Addictionologist Needs to Know About Hepatitis C and HIV"; David G. Ostrow, M.D., Ph.D. and Marc N. Gourevitch, M.D., M.P.H. *(Friday, April 20, 1:30-5:00 p.m.)*

Course 3: "Closing the Gap Between Research and Practice: Major National Initiatives"; Walter Ling, M.D., Course Director *(Saturday, April 21, 8:30-10:30 a.m.)*

Course 4: "Operation of Therapeutic Communities: Principles and Practices"; G. Douglas Talbott, M.D., FASAM, Course Director *(Saturday, April 21, 8:30-10:30 a.m.)*

Workshop E: "Society Confronts Substance Abuse"; Peter J. Cohen, M.D., J.D., Workshop Director *(Saturday, April 21, 8:30-10:30 a.m.)*

Course 5: "More Prison Inmates Getting More Treatment: Can We Learn from the California Experience?"; H. Blair Carlson, M.D., and James T. Hamilton, M.D., J.D., Course Co-Directors *(Saturday, April 21, 1:00-3:00 p.m.)*

Course 6: "Combining Medications and Behavioral Interventions in Alcoholism Treatment: The COMBINE Study"; Robert Swift, M.D., Ph.D., Course Director *(Saturday, April 21, 1:30-5:00 p.m.)*

Course 7: "Physician Health Impairment and Restoration"; Louis E. Baxter, Sr., M.D., FASAM, Course Director *(Saturday, April 21, 3:15-5:45 p.m.)*

Workshop F: "Integrating Treatment and Court Supervision: The Drug Court Movement"; Andrew Morral, Ph.D., Workshop Director *(Saturday, April 21, 3:30-5:30 p.m.)*

Workshop G: "The Therapeutic Community"; Gregory C. Bunt, M.D., Workshop Director *(Sunday, April 22, 8:30 a.m.-12 noon)*

Workshop H: "The New ASAM Patient Placement Criteria, Second Edition-Revised: Understanding the Adult and Adolescent Criteria and the New Assessment Software"; David Mee-Lee, M.D., Workshop Director *(Sunday, April 22, 9:15-11:45 a.m.)*

Workshop I: "The Matrix Model of Outpatient Treatment for Stimulant Abuse"; Richard Rawson, Ph.D., Workshop Director *(Sunday, April 22, 8:30 a.m.-12 noon)*

Paper Sessions

Papers based on accepted abstracts will be presented in three consecutive sessions:

Paper Session 1 (Saturday, April 21, 8:30-10:30 a.m.)

Part 1: Alcohol Screening and Monitoring: Psychometric and Behavioral Measures

(1) Biochemical Markers as Aids for Evaluating Medications for Alcohol Treatment (John P. Allen, Ph.D., Raye Z. Litten, Ph.D., Joanne B. Fertig, Ph.D.)

(22) CDT Positive Subjects Identified by the EDAC Test Despite Normal Liver Enzymes (J. Harasymiw, Psy.D., E. Kleaver, P. Bean, Ph.D.)

(64) Standardized Alcohol Screening in a Primary Care Practice (S. A. Wolfe, M.Ed., N. V. Dawson, M.D., R. D. Cebul, M.D., R. McCormick, M.D., D. Einstadter, M.D., C. L. Thomas, B.A., T. V. Parran, M.D.)

Part 2: Characteristics Related to Treatment Engagement and Outcome

(18) It is Low, Not High, Self-Efficacy that Correctly Specifies that Relationship between Self-Efficacy and the Cessation of Alcohol- and Drug-Dependent Behavior (R. Fiorentine, Ph.D., M. P. Hillhouse, Ph.D.)

(19) Motivational Structure as a Predictor of Post-Treatment Drinking in a Male Alcoholic Sample (Suzette V. Glasner, M.A., W. Miles Cox, Ph.D., Eric Klinger, Ph.D., Carolyn Parish)

(59) Attempting to Engage/Retain Substance Users in Treatment (C. C. Thornton, Ph.D., E. Gottheil, M.D., Ph.D., S. P. Weinstein, Ph.D.)

Paper Session 2 (Saturday, April 21, 1:00-3:00 p.m.)

Part 1: Basic Studies: Stimulants, Opiates and Marijuana

(46) Molecular Basis of Therapeutic Properties of delta-9-Tetrahydrocannabinol (THC) (Nicholas Pace, Kenneth Sutin, Gabriel Nahas)

(54) Opposing Effects of Psychostimulants on Dopamine Neurons (W.-X. Shi, Ph.D.)

(65) Red Blood Cell Abnormalities Among Opiate Abusers (A. R. Zeiger, Ph.D., R. Fitzgerald, A. A. Patkar, M.D., S. K. Ballas, M.D., A. Lundy, Ph.D., S. P. Weinstein, Ph.D.)

Part 2: Studies of Gambling, Smoking, Drinking and Eating

(3) Descriptive Statistics of Symptomatology Changes as a Measure of Treatment Outcome in Females with Eating Disorders (P. Bean, Ph.D., E. Kemppainen, P. Timmel, T. Holbrook, M.D.)

(14) Problem Gambling and Cocaine Dependence: Implications for Diagnostic Screening (R.M. Cunningham-Williams, Ph.D., L. B. Cottler, Ph.D., W. M. Compton, M.D., A. Ben-Abdallah, M.S., E. L. Spitznagel, Ph.D.) *(Dr. Cunningham-Williams is the recipient of this year's ASAM Young Investigator Award.)*

(20) Characteristics of Outpatient Veterans Who Are Cigarette Smokers and Have Alcohol Use Disorders (K. M. Grant, M.D., S. Agrawal, M.S., D. M. Olsen, M.S., J. H. Northrup, M.A., D.J. Romberger, M.D.

Exhibitors Offer New Products, Services

REGISTERING FOR MED-SCI

To register for the Medical-Scientific Conference, visit the ASAM Web site at ***www.asam.org***, contact the ASAM Conference and Meetings Department by phone at 301/656-3920, or register on-site in Los Angeles.

The ASAM Conference Registration and Information desk will be open the following hours during the conference:

Wednesday, April 18 ... 5:00 p.m.-8:00 p.m.

Thursday, April 19 ..... 6:30 a.m.-5:30 p.m.

Friday, April 20 ..... 7:00 a.m.-5:00 p.m.

Saturday, April 21 ..... 8:00 a.m.-5:00 p.m.

Sunday, April 22 ..... 7:45 a.m.-1:00 p.m.

The ASAM Board of Directors has voted to waive the registration fee for medical students, interns, residents and fellows attending the Society's 2001 Medical-Scientific Conference. Documentation of status is required in order to receive the waiver of registration fee.

Hotel reservations should be made directly with the Century Plaza Hotel & Spa, 2025 Avenue of the Stars, Los Angeles, CA. Phone the hotel directly at 310/277-2000, or call the Westin Hotels central reservation office at 1-800/WESTIN-1. Special conference rates of $185 single/$210 double/$235 triple/$260 quad have been arranged. To receive the conference rate, be sure to tell the reservation agent that you are attending the ASAM Medical-Scientific Conference.

The following organizations will sponsor exhibits during ASAM's Medical-Scientific Conference. A gala welcoming reception from 6:00 to 8:00 p.m. on Thursday, April 19th, opens the exhibit hall at the Century Plaza Hotel & Spa. Exhibit hours thereafter will be 9:00 a.m. to 2:00 p.m. and 3:00 to 5:00 p.m. on Friday, April 20; 8:00 a.m. to 1:30 p.m. and 3:00 to 5:00 p.m. on Saturday, April 21; and 8:00 a.m. to 11:00 a.m. on Sunday, April 21.

Events scheduled for the exhibit hall include Poster Sessions and continental breakfasts on Saturday and Sunday, as well as daily refreshment breaks.

Organizations/Associations/ Agencies

American Society of Addiction Medicine ..... (Booths 174-176)
Alcoholics Anonymous ..... (Booth 106)
American Academy of Addiction Psychiatry ..... Literature table)
APA Practice Organization ..... (Literature table)
Center for Substance Abuse Treatment ..... (Booth 115)
Centre for Addiction and Mental Health ..... (Booth 160)
International Society of Addiction Medicine ..... (Booth 157)
Narcotics Anonymous World Services ..... (Booth 150)
National Institute on Alcohol Abuse and Alcoholism ..... (Booth 172).
National Institute on Drug Abuse ..... (Booth 167)
Navajo Nation, The ..... (Booth 145)

Book and Software Publishers

ASAM Books ..... (Registration area)
Addiction Recovery Resources ..... (Booth 144)
American Psychiatric Publishing Group ..... (Literature table)
Drug Abuse Sciences ..... (Booth 119)
Earley Corporation ..... (Booth 161)
Manisses Communications Group ..... (Booth 164)
Medem ..... (Booth 173)

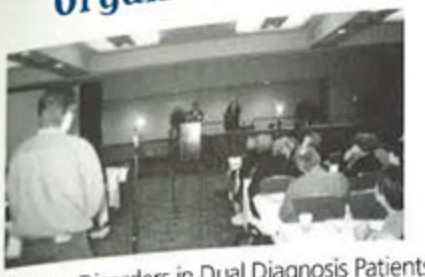
Pharmaceutical Manufacturers

Bio-Rad Laboratories ..... (Booth 158)
Endo Pharmaceuticals, Inc. ..... (Booth 168)
GlaxoSmithKline Consumer Health ..... (Booth 139)
Jant Pharmacal Corp. ..... (Booth 154)
Mallinckrodt Inc. ..... (Booth 134)
Ortho-McNeil Pharmaceuticals (Booth 114)
Schering-Plough ..... (Booth 113)

Treatment Programs

Advanced Recovery Center ..... (Booth 143)
Amity, Inc. ..... (Booth 135)
Anacapa by the Sea—STEPS .... (Booth 109)
Betty Ford Center ..... (Booth 112)
Caron Foundation ..... (Booth 120)
COPAC, Inc. ..... (Booth 136)
Cri-Help, Inc. ..... (Booth 146)
Crossroads Center at Antigua .. (Booth 128)
Del Amo Hospital ..... (Booth 166)
Edgewood ..... (Booth 148)
Father Martin's Ashley ..... (Booth 132)
Gables, The ..... (Booth 137)
Guest House Inc. ..... (Booth 101)
Hazelden ..... (Booth 116)
Keystone Center ..... (Booth 153)
Little Hill-Alina Lodge ..... (Booth 129)
Loma Linda Behavioral Medicine Center ..... (Booth 123)
Marworth ..... (Booth 156)
Masters & Johnson ..... (Booth 131)
Meadows of Wickenberg, LP ... (Booth 130)
Menninger Clinic ..... (Booth 162)
Metro Atlanta Recovery Residences, Inc. ..... (Booth 121)
Michael's House ..... (Booth 138)
Palmetto Addiction Recovery Center ..... (Booth 105)
Professionals at Risk Treatment Services ..... (Booth 142)
Professional Renewal Center .... (Booth 169)
Progressive Health Center ..... (Booth 165)
Promises Treatment Centers ..... (Booth 151)
Ridgeview Institute ..... (Booth 108)
Rogers Memorial Hospital ..... (Booth 149)
Rush Behavioral Health ..... (Booth 122)
Sante Center for Healing ..... (Booth 140)
Seabrook House ..... (Booth 141)
Sierra Tucson, Inc. ..... (Booth 107)
Springbrook Northwest ..... (Booth 155)
St. Christopher's ..... (Booth 111)
Talbott Recovery Campus ..... (Booth 133)
Williamsburg Place ..... (Booth 118)
Willingway Hospital ..... (Booth 159)

ASAM Committees and Task Forces Organize Component Sessions



Interwoven throughout the conference schedule are a series of component sessions on timely topics. These are organized by ASAM committees, sections and task forces, and include:

"Sleep Disorders in Dual Diagnosis Patients," organized by the Committee on Dual Diagnosis. *(Thursday, April 19, 8:00-10:00 p.m.)*

"Dual Competency in Addiction Medicine and Pain Medicine: What is It and How Can It Be Recognized?," organized by the Committee on Pain and Addictive Disease. *(Thursday, April 19, 8:00-10:00 p.m.)*

"On-Line Communications: ASAM's New Initiative with MEDEM," organized by the Electronic Communications Committee. *(Thursday, April 19, 8:00-10:00 p.m.)*

"Update on Tobacco," organized by the Committee on Nicotine Dependence. *(Thursday, April 19, 8:00-10:00 p.m.)*

"Developing a Family Practice Response to the CASA Report: 'Missed Opportunity: National Survey of Primary Care Physicians'," organized by the Committee on Family Practice. *(Friday, April 20, 8:00-10:00 p.m.)*

"Update on Forensic Science of Addiction Medicine," organized by the Committee on Forensic Science. *(Friday, April 20, 8:00-10:00 p.m.)*

"ASAM's Strategic Five-Year Plan for the Future of Addiction Medicine and Its Practice," organized by the Strategic Plan Task Force. *(Friday, April 20, 8:00-10:00 p.m.)*

Chapters Committee to Meet

ASAM's Chapter Presidents and Regional Directors' Committee will meet during the annual Medical-Scientific Conference on Thursday, April 19, from 5:30-6:45 p.m. Check the final conference program for the meeting location.

Chapter Development Workshop

A chapter development workshop is scheduled for Thursday, April 19th, at 7:00 p.m. Presented by Robert Donofrio of Health Systems Consultants, Inc., this two-hour program will focus on techniques and resources for establishing state chapters, leadership development, and chapter support systems (including fund-raising). There is no registration fee for this workshop. Participants who are interested in organizing a state or regional chapter, or in helping an existing Chapter grow, are urged to attend.

Meet Your Regional Director

Members will have an opportunity to meet informally with ASAM's Regional Directors and to discuss issues of concern to their Regions during the Dessert Reception on Friday, April 20, from 9:00 to 11:00 p.m. ■

CALL FOR MENTORS AND STUDENTS

A new program to be inaugurated at this year's Medical-Scientific Conference matches students with ASAM members in a Mentoring Program. The program is designed to afford a learning experience and is an excellent way for students to begin to build a network within the field of addiction medicine.

ASAM members are urged to volunteer as mentors to students attending the conference. Mentors will be matched with a student or small group of students and asked to provide them with guidance, directions, and information at the conference. For example, mentors may choose to meet with their assigned student(s) during the conference for a tour of the Exhibit Hall, lunch, or to attend a session together.

For more information about volunteering as a mentor, or about the student program, contact Cheryl Kim via e-mail at ***ckim@asam.org***.

Buprenorphine Training Course

SUNDAY, APRIL 22, 2001

Century Plaza Hotel & Spa • Los Angeles, California

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. This is such a course.

CME Credits & Certificates

Physicians who attend both Part I and Part II of the training are eligible for 8 credit hours in Category I of the Physician's Recognition Award of the American Medical Association. Application has been made to the American Osteopathic Association (AOA) for CME credit for this course.

Certificates will be awarded only to physicians who attend both the morning and afternoon sessions.

Fees

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.

Part I: 8:30 AM - 12 NOON

Organizers: *H. Westley Clark, M.D., J.D., MPH, FASAM and Marc Galanter, M.D., FASAM*

Speakers: *Warren K. Bickel, Ph.D., Laura McNicholas, M.D., Ph.D., Eric C. Strain, M.D., Frank Vocci, Ph.D.*

Educational Objectives: After participating in this session, the physician should be able to describe (1) the development of buprenorphine and buprenorphine/naloxone, the basic and applied pharmacology of these drugs, the epidemiology of the addicted population, patient assessment, evaluation and clinical management in an office-based practice; and (2) the prerequisites for physicians who wish to use buprenorphine in office-based treatment of opioid addiction.

Part II: 1:00 PM - 7:00 PM

(Open only to those who attended the morning session)

Organizers: *Donald Wesson, M.D. and Gail Jara*

Speakers: *Dr. Wesson, Andrea Barthwell, M.D. FASAM, Walter Ling, M.D. and members of the ASAM Medications Development Committee*

Eductional Objectives: After participating in this training, the physician should be able to (1) decide if a patient is an appropriate candidate for treatment with buprenorphine in an office-based setting; (2) describe the clinical care that an opioid addicted patient would receive with the buprenorphine or buprenorphine/naloxone treatment regimen; (3) decide if, as a practitioner interested in treating patients with this new treatment paradigm, he or she can manage the treatment of opioid addicted patients with buprenorphine or buprenorphine/naloxone; (4) develop a plan for treatment when the patient and the physician believe treatment with buprenorphine or buprenorphine/naloxone in an office-based setting is appropriate; and (5) identify areas in which more training or experience may be helpful.

ASAM Committees to Meet During Med-Sci

The following committees have planned meetings in connection with ASAM's Medical-Scientific Conference. Please note that times are preliminary and should be checked against the official schedule on-site in Los Angeles.

Committee on...

Addiction Medicine in Correctional Institutions *(Thursday, April 19, 7:00-9:00 p.m.)*
AIDS & Infectious Diseases *(Friday, April 20, 8:00-10:00 p.m.)*
Chapter Presidents *(Thursday, April 19, 5:30-6:45 p.m.)*
Children & Adolescents *(Friday, April 20, 8:00-10:00 p.m.)*
Constitution & Bylaws *(Tuesday, April 17, 6:30-7:30 p.m.)*
Continuing Medical Education *(Friday, April 20, 8:00-10:00 p.m.)*
Criteria *(Friday, April 20, 8:00-10:00 p.m.)*
Cross-Cultural Concerns *(Friday, April 20, 8:00-10:00 p.m.)*
Finance *(Tuesday, April 17, 2:00-6:00 p.m.)*
Forensic Science *(Thursday, April 19, 7:30-9:00 p.m.)*
Geriatric Alcohlism & Substance Abuse *(Saturday, April 21, 6:30-8:15 a.m.)*
Health Professionals *(Saturday, April 21, 6:30-8:15 a.m.)*
International Society of Addiction Medicine *(Friday, April 20, 8:00-10:00 p.m.)*
Med-Sci Conference Program *(Friday, April 20, 5:15-7:15 p.m.)*
Membership *(Friday, April 20, 12:30-1:30 p.m.)*
Native American Issues *(Saturday, April 21, 6:15-8:15 a.m.)*
Nicotine Dependence *(Saturday, April 21, 7:00-8:15 a.m.)*
Nominating and Awards *(Wednesday, April 18, 9:30-11:00 p.m.)*
Opioid Agonist Treatment *(Thursday, April 19, 7:00-9:00 p.m.)*
Osteopathic Medicine *(Friday, April 19, 8:00-10:00 p.m.)*
Pain and Addictive Disease *(Thursday, April 19, 6:00-8:00 p.m.)*
Pregnancy and Neonatal Addiction *(Thursday, April 19, 8:00-10:00 p.m.)*
Public Policy *(Saturday, April 21, 7:00-8:30 a.m.)*
Ruth Fox Course Program *(Thursday, April 19, 9:30-11:00 p.m.)*
Strategic Plan Task Force *(Sunday, April 22, 8:30-10:30 p.m.)*
Therapeutic Communities *(Thursday, April 19, 7:00-9:00 p.m.)*

FUNDING OPPORTUNITIES

RWJ Seeks Treatment Partnerships

A major new funding initiative by the Robert Wood Johnson Foundation (RWJF) will support efforts to provide comprehensive addiction and other services to youth in the juvenile-justice system, with the aim of reducing both alcohol and other drug abuse and delinquency.

> **"The initiative will help juvenile courts, treatment providers, policymakers, community stakeholders, youth and their families collaborate in creating comprehensive, integrated community systems of care for substance-abusing youth,"**

The $21 million "Reclaiming Futures" project encompasses both systems change and infrastructure development. "The initiative will help juvenile courts, treatment providers, policymakers, community stakeholders, youth and their families collaborate in creating comprehensive, integrated community systems of care for substance-abusing youth," according to the foundation. Services to be delivered to youth include addiction treatment as well as developmental and other needed supports.

In its grant announcement, the foundation notes that community capacity to provide addiction treatment is severely limited, and that youth with alcohol and other drug problems often end up in the juvenile justice system. Therefore, the justice system "presents an opportunity to intervene strategically with a large number of substance-abusing youth."

The juvenile justice system also is currently not up to the task of treating young people with addiction problems, the foundation says. Model integrated care programs have been developed, however, and the Reclaiming Futures grants can be used to create the collaboration and infrastructure needed to create a coordinated, comprehensive system of care for young offenders. Grants also can be used to implement any systems changes needed.

Funding cannot be used to pay for providing treatment services. Rather, grants should be used to provide staff support to partnerships and system change efforts, conduct service analyses and assessment, implement treatment enhancement projects, support ongoing capacity-building activities, deliver community education and to get citizens involved in the initiatives, and improve management information system capacity.

Letters of intent for the Reclaiming Futures are due May 18. Full proposals from those invited to apply are due August 24. Grants will be announced January 30, 2002. For information, visit the Reclaiming Futures Web site or phone 503/725-8911.

Source: Press release, Robert Wood Johnson Foundation, February 26, 2001.

HUD Announces Public Housing Grants

The U.S. Department of Housing and Urban Development (HUD) is accepting applications for its Public Housing Drug Elimination Technical Assistance (DETAP) grants program.

DETAP awards help improve the management and effectiveness of HUD's Public Housing Drug Elimination Program. Public housing authorities, residential management corporations, Indian tribes and other housing agencies are eligible to apply. A total of $12 million is available.

Applications are due July 27, 2001. For information, contact Bertha Jones at HUD: 202/708-1197 ext. 4237.

ASAM 2001 MED-SCI CONFERENCE

Ruth Fox Course for Physicians

THURSDAY, APRIL 19, 2001
8:00 a.m. - 5:30 p.m.
Century Plaza Hotel and Spa
Los Angeles, California

The Ruth Fox Course for Physicians is dedicated to the founding President of ASAM, provides the practicing physician with current trends in the field of addiction.

The course reflects the continuing interests, developments, diversity and richness on the field of Addiction Medicine through a variety of important and timely topics. Some explore basic areas of practice, while others focus on cutting edge issue.

Welcome from the Course Co-Directors
Louis E. Baxter, Sr., M.D., FASAM, Medical Director, Physicians Health Program, Medical Society of New Jersey, Lawrenceville, NJ

Anthony H. Dekker, D.O., FASAM, Associate Director, Phoenix Indian Medical Center; Director, Ambulatory Care and Community Health, Phoenix, AZ

Remembering Dr. Ruth Fox
Stanley E. Gitlow, M.D., FASAM, Professor of Medicine, Mount Sinai School of Medicine, New York, NY

What's New In Addiction Research
Alan Leshner, Ph.D., Director, National Institute on Drug Abuse (NIDA), Rockville, MD

Medical Complications of Eating Disorders in Adolescents
Iris F. Litt, M.D., Professor of Pediatrics, Department of Pediatrics and Director, Division of Adolescent Medicine, Stanford University School of Medicine, Stanford, CA

Fetal Alcohol Effects: The New Challenge
Ann P. Streissguth, Ph.D., Department of Psychiatry & Behavioral Sciences, University of Washington, Seattle, WA

Clinical Spirituality: A New Paradigm
Edward Reading, M.Div., CADC, Assistant Director, Physicians Health Program, Medical Society of New Jersey, Lawrenceville, NJ

Literature Review
David R. Gastfriend, M.D., Director, Addiction Services, Massachusetts General Hospital; Associate Professor of Psychiatry, Harvard Medical School, Boston, MA

Teenage Girls in the New Millennium
Marla Kushner, D.O., Director of Adolescent Healthcare, Louis Weiss Memorial Hospital, Chicago, IL

Nicotine and Tobacco Addiction: Burning Topics
Lori D. Karan, M.D., FASAM, Assistant Professor of Medicine and Psychiatry, Division of Clinical Pharmacology and Experimental Therapeutics, University of California, San Francisco, CA

Ethical Aspects of Addiction Treatment in a Managed Care Environment
Michael M. Miller, M.D., FASAM, Director, Behavioral Services Meriter Hospital, Madison, WI; Assistant Clinical Professor of Psychiatry, University of Wisconsin School of Medicine, Madison, WI

Office-Based Opioid Therapy
H. Westley Clark, M.D., J.D., M.P.H., FASAM, Director, Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville, MD

This program has been awarded 8 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association and 8 credit hours in Category 2A of the American Osteopathic Association.

▶ **TREATMENT PLAN** *continued on page 18*

insurance benefit package. It also calls for reimbursement mechanisms to be aligned with treatment goals, performance measures and outcome standards, and for reimbursement rates sufficient to cover costs, with a surplus for reinvestment.

Second, the report articulates the principle that there should be *no wrong door to treatment*. When a patient presents for treatment of any condition at any point in the health care system and gives indication of a substance use disorder, he or she should be guided toward treatment. In addition, other vital service systems (such as social services, the judicial and education systems) should be engaged in efforts to find persons with substance use disorders and bring them into treatment. To be effective, Dr. Clark said, this will require that physicians and other primary health care workers, social workers, teachers and school administrators become more knowledgeable about addiction and the importance of timely intervention.

Third, the report urges a *commitment to quality* at all levels of care. It says that the national treatment workforce should be composed of men and women of diverse ethnic groups and cultural backgrounds who can be responsive to their patient populations. Treatment professionals should be well-trained and appropriately credentialed and certified, and fairly compensated for their professional expertise.

Fourth, the report calls for continued efforts to achieve a *change in attitudes* toward addiction. It notes that there is widespread agreement in the medical community that addiction is a chronic, relapsing disorder that can be treated successfully, but that this belief is not shared by most members of the general public. Convincing the public that recovery is possible thus is key to reducing persistent stigma and discrimination against persons in recovery.

Fifth, the report notes that to achieve continuing improvements in the quality of care, *partnerships must be built*. Among the most important of these is the partnership between the research community and the treatment community. Such a partnership is vital if the best evidence-based research is to be made available to and adopted by treatment professionals.

In addition to Dr. Clark, ASAM members who have been instrumental in developing the National Treatment Plan and the report are Andrea G. Barthwell, M.D., FASAM; Louis E. Baxter, Sr., M.D., FASAM; Marc Galanter, M.D., FASAM; David R. Gastfriend, M.D.; David C. Lewis, M.D.; David Mee-Lee, M.D.; Anthony B. Radcliffe, M.D., FASAM; and David E. Smith, M.D., FASAM. ASAM Executive Vice President James F. Callahan, D.P.A., also served as a panel member.

The full text of "Changing the Conversation: Improving Substance Abuse Treatment" can be accessed on-line at ***www.natxplan.org***. ■

Ruth Fox Memorial Endowment Fund

Dear Colleague:

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.

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 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, 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

Member Update: The Nigerian Scam

In response to a warning in the January-February **ASAM News**, ASAM staff have received a large number of messages from members. All e-mails, faxes and mailed communications have been forwarded to the U.S. Secret Service and/or the Postal Inspection department of the U.S. Post Office. In addition, all e-mail messages have been forwarded to e-mail providers, which have cooperated in closing many accounts.

The Nigerian desk officer at the U.S. State Department reports that one physician (not an ASAM member) was bilked out of more than $500,000 through one of these scams.

The ultimate responsibility for dealing with the perpetrators rests with the U.S. Secret Service, which initiates action only where actual financial transactions have taken place with resulting loss of money. If any ASAM member has committed money to, or lost money as a result of, a financial transaction with any African correspondent, please contact Agent Tom Freesmeier by fax at 202/406-9450.

Also, because this affects the entire Society, please do NOT respond to any of the communications directly. This can only encourage more broadcasting of messages.

This is a worldwide scam. ASAM is a small part of the overall picture. Nigerians ordered and received 70 copies of the ASAM Membership Directory from our distribution center in late 2000. In February, ASAM was informed that the purchase had been made on a stolen credit card. ASAM is working with the authorities to recover more than $7,000 owed from that transaction and identify the culprits. An additional order for 70 copies placed in January was intercepted and refused. ASAM will henceforth screen orders for the Membership Directory and ship directly from the main office.

If you receive a suspicious e-mail message, please take the following steps:

1. Forward the entire incoming e-mail (including the complete heading) to the e-mail service named, as well as to ***jgart@asam.org***.
2. Send a copy of your report to ***abuse@[domain].[com or net]***, or use the following specific addresses.
   - Yahoo: ***personals-abuse@yahoo-inc.com***
   - Lycos (and Angelfire and Tripod): ***antispam@staff.angelfire.com***
   - List "Spam Complaint" and the offending e-mail address in the subject line.

Anthony H. Dekker, D.O., FASAM, Finds the Spirit of Healing in the Indian Health Service

ASAM News is proud to showcase the many ways in which ASAM members contribute to the field of addiction medicine

Jeanne Erdmann

On his first day of work as Associate Director of the Phoenix Indian Medi cal Center, Anthony H. Dekker, D.O., FASAM, was sitting at his desk, putting things away, when his two assistants—one Hopi and one Navajo—came in to see him. They said: "We want you to know that we are glad you are here. We know that you have been called here and that our paths and your path have been meant to cross. We do not know what gifts you bring to us and we do not know what gifts you will receive from us. We know that your being called here is something that we support and that we look forward to working with you."

Of all the broken hearts scattered across a landscape of addiction, the Indian hearts bring Dr. Dekker his greatest challenges. "But I have also been working with very talented people all of my life, and the most dedicated and the most talented people I have ever worked with are also here," comments Dr. Dekker. "At this hospital, 60% of our 900 employees are Native. They are absolutely committed to the healing process of their people."

By the time he joined the Indian Health Service in 1998, Dr. Dekker was indeed capable of bringing many gifts. While in medical school at Michigan State, Dr. Dekker volunteered in clinics that treated migrant workers. Following his residency at Rush-Presbyterian Hospital in Chicago, he settled into an office on the city's south side and asked for patients that no one else wanted to see. He got drug addicts, gang members, child abuse victims, teenagers who cycled in and out of jail, and gay men with a strange disease that puzzled everyone. "I had my first HIV patient in 1984. By 1986, I had the largest adolescent HIV clinic in the city. On the north side of Chicago, you find educated white gay males. But on the South side, you have uneducated Black and Hispanic kids, and half the patients were HIV infected, injecting drug users," says Dr. Dekker.

He remained for 16 years, until his hospital was purchased by a for-profit institution that he refused to work for. Faced with a restrictive covenant, Dr. Dekker left for Kansas City in 1994, where he worked in an academic medical center for the next 2 years. He was tempted to return to Chicago by an offer of what he calls "an obscene amount of money" to take care of suburban kids with drug problems and eating disorders. But "I said I could not do that," he adds.

Instead, he joined the Indian Health Service. His wife, Patricia Roe, R.N., M.S., Psy.D., also joined the staff as a psychologist and nurse practitioner. They went to

Phoenix because he and Patti believed he was called there. At the time, neither knew what that move would come to mean.

As he did in Chicago, Dr. Dekker works in Phoenix with a multidisciplinary team, who staff an outpatient treatment program and residential programs. Unlike Chicago, his staff also uses Native Healers in addition to classic intervention techniques. "Most Indian people feel that when a person loses harmony with all of the sacred things around them that there is a great sense of void inside of them and that alcohol or drugs temporarily numb the spirit so the pain of that void is no longer there," adds Dr. Dekker. "Although Hopis, Navahos and Apaches all see God in different ways, they believe that if you are not right with God, if you are not right with the spirit world, you are not right," says Dr. Dekker. "It is only by returning to harmony in body, mind and spirit that a person can escape the entrapment of addiction. It is a philosophy very similar to Alcoholics Anonymous."

Dr. Dekker sees high rates of substance abuse in the Native population. He also sees their strength and their caring, which now extends to a devastating need in his own family. Several months ago, Patricia Dekker was diagnosed with breast cancer. The Native Healers and the Native people have enfolded his family into a circle of harmony and spirituality. "In my mind it is an answer to make everything fit," adds Dr. Dekker.

One of the social workers gave both Patti and Tony Dekker a Grandfather rock to rub like a worry stone. When the rock is smooth, their path through this difficult time will be finished, and then the rocks will be returned to the earth along with their pain and suffering. "It is an amazing thing," remarks Dr. Dekker. "Because my rock, which was very rough, is getting smooth on one side."

Dr. Dekker always has believed in miracles. Although many rules in the outside world may not fit the Native culture, miracles are seen on a regular basis, side by side with tragedy. From his office at the medical center, he can watch the helicopter bring new trauma cases from the reservation to the emergency room, which handles 65,000 visits a year. With only six treatment rooms, patients often wait all day to be seen. The facility is old, and short-staffed. Last year, Dr. Dekker began a program to recruit high school students for rotations through the hospital. He wants to entice them to the health-care field.

"A lot of people ask me why I went to the Indian Health Service, an under-funded program that is not appreciated. When I went to the south side of Chicago, I was told the same thing, that people won't appreciate it, that I was throwing my career away," says Dr. Dekker. "I am 20 years into my practice and I am recharged. I know I am in the right place, not just for the community and me, but also for my family." ■

***Jeanne Erdmann** is a St. Louis-based medical writer who also writes for Science and CBS HealthWatch.*

ASAM CONFERENCE CALENDAR

ASAM

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

June 1-3, 2001
Medical Review Officer (MRO) Training Course
St. Louis, MO
20 Category 1 CME credits

September 13-16, 2001
Conference on Tobacco Dependence
Atlanta, GA
16.5 Category 1 CME credits (plus up to 6 CME credits for preconference workshops)

November 1-3, 2001
Conference on the State of the Art in Addiction Medicine
Washington, DC
20 Category 1 CME credits

November 29, 2001
Forensic Issues in Addiction Medicine
Washington, DC
7 Category 1 CME credits

November 30-December 2, 2001
Medical Review Officer (MRO) Training Course
Washington, DC
20 Category 1 CME credits

April 25, 2002
Pain & Addiction: Common Threads III
Atlanta, GA
7.5 Category 1 CME credits

April 25, 2002
Ruth Fox Course for Physicians
Atlanta, GA
8 Category 1 CME credits

April 26-28, 2002
33rd Annual Medical-Scientific Conference
Atlanta, GA
Up to 19 Category 1 CME credits

*For additional information, visit the ASAM Web site at **www.asam.org**, or contact the ASAM Department of Meetings and Conferences at 4601 North Park Ave., Suite 101 Upper Arcade, Chevy Chase, MD 20815-4520, or phone 301/656-3920, or fax 301/656-3815, or e-mail **email@asam.org**. Information on ASAM's Web site will be updated as meetings are scheduled.*

ASAM MED-SCI CONFERENCE

OVERVIEW

Thursday, April 19
Ruth Fox Course for Physicians
Pain and Addiction II: Common Threads
Component sessions begin
Welcome reception (Exhibit Hall)

Friday, April 20
ASAM Business Meeting
Distinguished Scientist Lecture
Scientific sessions begin
Ruth Fox Fund reception
Dessert reception

Saturday, April 21
Scientific sessions continue
Component sessions continue
Awards Dinner

Sunday, April 22
Scientific sessions continue
Component sessions continue
Med-Sci Conference ends at noon
Buprenorphine training offered

The ASAM Conference Registration and Information desk will be open the following hours during the conference:

Wednesday, April 18: 5:00 p.m.-8:00 p.m.
Thursday, April 19: 6:30 a.m.-5:30 p.m.
Friday, April 20: 7:00 a.m.-5:00 p.m.
Saturday, April 21: 8:00 a.m.-5:00 p.m.
Sunday, April 22: 7:45 a.m.-1:00 p.m.

To register for the Medical-Scientific Conference, visit the ASAM Web site at ***www.asam.org***, contact the ASAM Conference and Meetings Department by phone at 301/656-3920, or register on-site in Los Angeles.

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