

# ASAM NEWS



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NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

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## Dr. McGovern Wins ASAM Leadership Award



Dr. John P. McGovern

Physician and philanthropist John P. McGovern, M.D., FASAM (honorary), has been selected to receive ASAM's National Leadership Award. In voting the award, ASAM's Board of Directors cited Dr. McGovern's notable achievements in promoting education and training in addiction medicine; his role in establishing a visiting lectureship in addiction medicine; his support for ASAM's specialty status endeavor; his generosity in supporting the annual John P. McGovern, M.D., Award and Lecture on Addiction Medicine and Society; and his many other significant contributions, which "demonstrate his wisdom, generosity and respect for people suffering from addiction." The Board concluded that "Dr. McGovern's work and life bring honor and acclaim to ASAM."

He was hailed by ASAM's leaders as "one of the real giants of contemporary medicine, a physician in the model of Sir William Osler, who has grounded his distinguished career in clinical medicine."

Dr. McGovern was one of the founders of the modern medical specialty of allergy and immunology and created the world's largest allergy clinic in Houston, TX. Later in life, he built on this solid medical foundation to become one of the nation's leading philanthropists, focusing on two major goals: the compassionate basis of scientific medicine, and creative ways to help the neediest members of our society. Over the past decade, Dr. McGovern has focused on the problem of addiction to alcohol and other drugs as a unique opportunity to bring to bear his commitments to both science and compassionate care. In pointing to these accomplishments, Robert DuPont, M.D., FASAM—Dr. McGovern's colleague and co-author—said that they demonstrate the degree to which Dr. McGovern "is a man of great scholarship and even greater wisdom."

Dr. DuPont recalls that Dr. McGovern chose to help ASAM "because he saw our Society as a unique national organization of physicians across all specialties who are committed to bringing both the highest level of science and the deepest level of compassion to the care of addicted persons and their families." ASAM's Executive Vice President James F. Callahan, D.P.A., summed up: "We could set no more worthy goal for ourselves as human beings and as a Society than to emulate Dr. McGovern's life and career." ■

## Long-Time Leaders Leave Posts at NIAAA, NIDA, NIMH

Suddenly, there's a leadership vacuum in the world of addiction and mental health research: Alan I. Leshner, Ph.D., announced in October that he will be leaving the National Institute on Drug Abuse (NIDA) director's job for the private sector, just weeks after longtime National Institute on Alcohol Abuse and Alcoholism (NIAAA) director Enoch Gordis, M.D., announced his intention to retire at the end of this year. Also in October, Stephen E. Hyman said he will leave the National Institute on Mental Health (NIMH) after five years as director.

Dr. Leshner, who has headed NIDA since 1994, said he is leaving the agency to become the CEO of the American Association for the Advancement of Science (AAAS), which publishes the journal. Dr. Gordis, on the other hand, said he will be retiring, but plans to stay involved in the field. Dr. Hyman will return to Harvard as university provost.

► LEADERS LEAVE, continued on page 8

## ASAM MEMBERS ASKED TO COMPLETE SURVEY

Andrea G. Barthwell, M.D., FASAM  
ASAM President

In pursuit of its mission to improve medical education in addiction medicine, ASAM is conducting a survey of members to ask about their educational opportunities, interests and activities.

A brief questionnaire is enclosed with this issue of **ASAM News**. Please take a few minutes to review it and share your experiences and insights with your Society. Results will be compiled and published in a future issue of **ASAM News**.



Dr. James F. Callahan

## WARNING to ASAM Members: Nigerian Scam Continues

James F. Callahan, D.P.A.

This month, I am using this space to report to you, not on any of ASAM's considerable achievements, but on our activities to protect you from a group of "scam artists" intent on defrauding physicians and others, because I am acutely aware that the activities of these individuals have caused considerable annoyance if not hardship to some of our members.

ASAM members report that they continue to receive letters, e-mails and occasional faxes from Nigeria and some other African countries, attempting to lure them into fraudulent schemes to transfer funds into a foreign bank account, with the offer of a substantial commission for the cooperating party.

If you have been the recipient of any of these overtures, please visit the web site of the U.S. Secret Service at [www.treas.gov/usss/](http://www.treas.gov/usss/) and read the section on "4-1-9 schemes." As described on the web site, the schemes can be extremely expensive. Individuals who have responded to the schemes have lost substantial sums of money. For example, 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. They also can be dangerous: one American lost his life in Nigeria, while other foreign nationals are missing.

The schemes involve worldwide mass

mailings, with ASAM members a tiny part of their overall reach. Nevertheless, it is ASAM members who are our principal concern.

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 now screens orders for the Membership Directory and ships them only to members.

If you receive a suspicious e-mail message, do not respond to the communication directly. This only encourages more broadcasting of the messages. Instead, please forward the entire incoming e-mail (including the complete heading) to [jgart@asam.org](mailto:jgart@asam.org). ASAM staff will forward such messages to the Internet Service Provider (ISP) named in the return address. ISPs cooperate by canceling the mailbox and retaining the name of the offender to preclude their opening new mailboxes in the future. At the least, such action indicates that a given individual is not a good prospect for future scam efforts. At best, it may significantly impede the ability of the perpetrators to operate.

Thank you for your help, and please be assured that the staff and I are doing everything in our power to protect you and all our members. ■



### American Society of Addiction Medicine

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

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

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



### NEW! From ASAM Books

## ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R)

Edited by David Mee-Lee, M.D. and a panel of experts, the ASAM PPC-2R features all-new criteria for patients with co-occurring mental health and substance use disorders. Criteria for adults and adolescents also have been extensively revised and updated to respond to treatment research and changes in the health care marketplace.

Adopted by many states and managed care organizations, the ASAM criteria are the most widely used and comprehensive clinical guidelines for placement of patients with alcohol and other drug problems.

Phone **1-800/844-8948** for your copy of the ASAM PPC-2R

UPDATE YOUR PROFESSIONAL LIBRARY WITH THIS IMPORTANT VOLUME!

### Addiction Budgets Increase

A Senate committee has approved significant increases in 2002 spending for most federal addiction prevention, treatment and research programs—in some cases, more than the Bush administration had requested.

The Senate Appropriations Committee's Labor, Health and Human Services, and Education subcommittee approved \$14 million year-over-year increase for the Center for Substance Abuse Prevention (CSAP), to \$189 million; a \$20 million boost for the Center for Substance Abuse Treatment (CSAT), to \$276 million; and a \$70 million increase in the Substance Abuse Block Grant, to \$1.725 billion.

In the research arena, the National Institute on Drug Abuse (NIDA) budget saw a whopping \$121 million increase, to \$902 million, while the National Institute on Alcohol Abuse and Alcoholism (NIAAA) received a more modest \$50 million increase, to \$391 million.

In an exception to the trend, the Department of Education's Safe and Drug-Free Schools and Communities program was flat-funded at \$644 million, in line with both the House of Representatives and the administration's recommendations. However, the House bill called for shifting \$88 million from the department's national program to its state program (which groups like Community Anti-Drug Coalitions of American favors), while the Senate proposed shifting only \$5 million between the two.

The Senate's budget proposals for CSAT, CSAP, and NIDA each fell somewhere between the request from the administration and the House numbers; the House and Senate were in agreement on the block-grant spending figures, which exceeded the administration's request by \$30 million. Only in the case of NIAAA did the Senate call for more spending than both the House and administration officials.

Priority programs identified in the Senate budget document include drug courts, services for the homeless, methamphetamine abuse, residential treatment for women, ecstasy use, and fetal alcohol syndrome.

Next, a conference committee will meet to resolve differences between the House and Senate versions of the budget bill. Even if approved, however, there is a possibility that the administration may elect not to spend all the funds allocated (see the following report).

Source: *Alcoholism & Drug Abuse Weekly*, October 22, 2001.

### War Causes Budget Shifts

Government officials report that, as part of the war on terrorism, federal budget priorities are being refocused on national security and defense, suggesting that other programs may be targeted for reduction or elimination.

To avoid large budget deficits, officials say that non-defense spending may have to be cut. "Many lesser priorities will have to yield while we ensure that the essential functions of government are provided for," said White House budget director Mitchell E. Daniels, Jr. "The alternative is to discard discipline totally and imperil our long-term economic health." Mr. Daniels said the administration opposes new taxes or higher overall spending.

The 2002 federal budget is expected to go into deficit spending for the first time in five years. The Bush administration's tax cut, a slowing economy, and the September 11 attacks all have contributed to the current budget crunch.

Source: *Washington Post*, October 16, 2001.

### State Funds Likely to be Cut

Bureaucratic belt-tightening and declining revenues could spell trouble for addiction related programs that rely on public sources of funding. Advocates worry that revenues from funding sources such as alcohol and tobacco taxes and the nationwide tobacco settlement could be reallocated in the face of state budget shortfalls. Lee M. Dixon, director of health policy and tracking services for the National Conference on State Legislatures, said that some states are anticipating across-the-board budget cuts of 2% to 5% or having to take other steps to deal with decreased revenues.

Even before the Sept. 11 terrorist attacks, states were being warned that a slowing economy could lead to budget shortfalls. States in the Midwest and Southeast could be hit hardest, according to a report from the Nelson A. Rockefeller Institute of Government.

Source: *Substance Abuse Funding News*, October 9, 2001.

### Emergency Grants Awarded

As part of its continuing response to the September 11 terrorist attacks, the Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded \$20 million in grants to eight states and the District of Columbia for addiction and mental health services.

SAMHSA previously awarded \$27 million for these services in the wake of the attacks

on New York City and Washington, DC. "The foremost aim of these grants is to ensure that support is available for Americans affected by the September 11 attacks and the ongoing war on terrorism," said Tommy Thompson, secretary of Health and Human Services.

States may use the funds for addiction treatment and prevention, mental health services, or unmet training or planning needs. A special emphasis is placed on meeting the needs of children and adolescents. Recipients include the District of Columbia and the states of Connecticut, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, and Virginia.

Source: SAMHSA web site.

### Physicians Urged: Don't Amplify Terror's Effects

The long-term social and psychological damage from bioterrorism may be worse than the acute consequences if care is not taken, says an editorial in the *British Medical Journal*. Biological and chemical agents are so limited as military weapons that their only real purpose is to "wreak destruction via psychological means—by inducing fear, confusion, and uncertainty in everyday life," the authors remark.

The editorial urges physicians and others in positions of authority to beware of inadvertently amplifying psychological responses to bioterrorism. "It's sometimes difficult for physicians to not get swept up in the general anxiety," according to co-author Dr. Simon Wessely, who is on the faculty of Guy's, King's and St. Thomas' School of Medicine in London. "They should remember their training and stay cool."

Dr. Wessely pointed to Irish Republican Army bombings in Belfast and London as examples of how civilians can cope with a continuing threat. "It becomes an irritation. For some people, it was an appalling tragedy, but for society it was something to get used to. The quicker that happens, the better."

The only way terrorists can bring society to its knees, he said, is if the response is to shut down government, media, commerce, and industry. "That is the purpose of it. [Terrorists] couldn't do it by any other way, because the weapons themselves are not particularly effective."

"We can easily underestimate the powers of resilience of civic society," Dr. Wessely concluded. "We can easily underestimate

► ADDICTION, continued on page 4

## ASAM's Board Moves Forward with Strategic Plan

Andrea G. Barthwell, M.D., FASAM

I want to bring you up to date on activities to complete and implement ASAM's new Strategic Plan. At its October meeting, ASAM's Board of Directors reviewed and commended the work done to date by the Strategic Plan Task Force, under the capable leadership of chairman Richard E. Tremblay, M.D., FASAM. The quality of this well-developed and thoughtful statement of ASAM's goals and objectives was evident to all members of the Board. Members spent a good portion of the planning day discussing and working with the goals and objectives and made several suggestions for refining the draft. All of this was done in the spirit of engagement with the Strategic Plan and appreciation for the quality of the Task Force's work.



Dr. Andrea G. Barthwell

The Board and I are anxious to move forward with the strategic planning process. Toward that end, the Board established two subcommittees of the Strategic Plan Task Force to assume primary responsibility for the next phases of work on the plan. The Development Committee will refine the Strategies developed by the Task Force and use them as a basis for involving ASAM Committees and Chapters in developing a final set of Strategies to accomplish each of the Goals and Objectives in our plan. The Implementation Committee will work to win the support of the Chapters and Committee Chairs for the plan.

We are forming the Development Committee immediately and expect it to work on a timeline that will assure a final draft is ready for review and approval by the Board next April. Specific tasks to

be undertaken by the Development Committee include:

- Review the work product to date, as well as the Board's response.
- Review ASAM's organization chart and consider how the Objectives and Strategies might relate to the work of specific Committees.
- Review the current plan by which ASAM organizes its work to assess how it drives what we do, so as to understand the significance of a Strategic Plan.
- Review the draft Strategies and revise them to be more specific and targeted to achievement of the Board-approved goals and objectives.
- Prepare a draft of the Strategic Plan for circulation to ASAM's Chapters, Committees and Officers.
- Incorporate their input in a final Strategic Plan document, ready for presentation to the Board of Directors at its meeting in April 2002.

The timeline for this work is driven by our determination to share the Strategic Plan with ASAM's membership at the Medical-Scientific Conference in April 2002.

I look forward to working with all of ASAM's members and with the Task Force as we move into this exciting phase of the process, in which we ask our members to help us put into final form the Strategic Plan that will map ASAM's future. ■

### ► ADDICTION MEDICINE, continued from page 3

people's capacity to absorb adversity." Source: *British Medical Journal*, October 20, 2001.

### Border Drug Traffic Resumes

Federal officials report that it's almost business as usual for drug traffickers at the Mexico-U.S. border, even though tighter security measures have been put in place following the September 11 terrorist attacks on the United States. Among the security measures are checkpoints at major crossing points. Customs and U.S. Immigration and Naturalization Service inspectors now search every car and question every driver.

In the days following the attacks, the added security appeared to discourage the traffickers. For example, U.S. Customs Service figures show that between September 11 and 23, drug seizures dropped by nearly half along the 2,000-mile-long border. But since that time, trafficking activity has increased to usual levels.

"The drug traffickers probably thought the security was a temporary situation, but now they know it's not going away," said U.S. Customs spokesman Roger Maier. "They're getting back to work."

Source: *Reuters News Service*, October 3, 2001.

### Court to Advise on Drug Tests

The U.S. Supreme Court has announced that it will give more guidance to schools that want to conduct drug testing. The justices are following up on their 1995 ruling that allowed an

Oregon school district to test athletes for drugs. They agreed to hear a case involving an Oklahoma school district in which an appeals court ruled that random drug testing of students violated the Constitution's ban on unreasonable searches.

Under the Oklahoma school district's drug policy, students involved in extracurricular activities are subject to random testing. In

its ruling, the appeals court said the school district had no justification for the drug testing because there are few problems with drugs in schools.

The justices said they will decide whether school administrators must demonstrate that schools have a serious drug problem before randomly testing certain students.

Source: *Associated Press*, November 8, 2001.

### Ecstasy to Be Studied as PTSD Treatment

For the first time since the drug was banned 10 years ago, the U.S. Food and Drug Administration (FDA) has approved a proposal to test MDMA ("ecstasy") as a treatment for post-traumatic stress disorder (PTSD).

The research is to be conducted at the Medical University of South Carolina in Charleston. Researchers there are awaiting

► ADDICTION, continued on page 5

## CLINICAL ALERT

# Cipro-Methadone Interaction

Health authorities warn that there is a significant potential for drug interaction between ciprofloxacin (Cipro®) and methadone.

Studies show that Cipro may significantly inhibit the action of cytochrome, the enzyme responsible for metabolizing methadone. Thus concurrent use of Cipro and methadone may lead to elevated levels of methadone, resulting in clinical opioid overdose. Such a scenario is described in a case report in the journal *Lancet* (356:2069-70, 12/16/2000, Research Letters) from researchers at Sweden's Karolinska Institute. The authors report that ciprofloxacin, given to a 42-year-old woman who had been successfully treated with methadone for more than 6 years, caused profound sedation, confusion, and respiratory depression. They suggest that this was caused by ciprofloxacin inhibition of CYP1A2 and CYP3A4 activity, two of the cytochrome p450 isozymes involved in the metabolism of methadone.

This is a potentially serious problem for methadone patients. Because of the stigma of methadone treatment, such patients often do not share information about their methadone use with health care providers. Many Americans are, or soon will be, taking ciprofloxacin because of actual or potential exposure to anthrax. Physicians who prescribe Cipro need to inquire carefully about other medications patients may be taking. Addiction medicine practitioners who care for patients on methadone need to be similarly alert to their patients' possible use of Cipro and prepare to adjust their methadone dose as needed. ■

### ► ADDICTION MEDICINE, *continued from page 4*

university review board approval before the project can proceed. If approved, the research would be supervised by psychiatrist Michael Mithoefer, M.D., and Annie Mithoefer, R.N., a psychiatric nurse.

The proposed study would involve 20 persons undergoing therapy for PTSD. Twelve participants would be given ecstasy, while eight would receive a placebo. All participants also would receive 16 hours of counseling and behavioral therapy.

The study is to be financed by the Multidisciplinary Association for Psychedelic Studies, a group that advocates therapeutic use of psychedelic drugs. Dr. Mithoefer said the research should be allowed even though ecstasy is a popular drug among young people. "It's ironic that when these drugs become illegal, the legitimate research goes to zero, and the illegal and recreational use goes way up," he said. "It seems foolish to me to have a situation where millions are using the drug in an uncontrolled way and yet physicians who want to do careful research are not allowed."

Source: *Associated Press*, November 6, 2001. ■

## ASAM Mourns the Death of Jasper Chen See, M.D.



Long-time ASAM member and Past President Jasper G. Chen See, M.D., died at St. Joseph's Hospital in Reading, PA, on November 8, 2001.

Dr. Chen See was a founding member of ASAM and organizer of the Ruth Fox Memorial Endowment Fund, which he served as Chair Emeritus. His seminal work in the field was recognized with the ASAM Annual Award in 1994.

Earlier this year, his work was recognized by the National Association of Addiction Treatment Providers with its Nelson J. Bradley Lifetime Achievement Award. In bestowing its award, NAATP noted that Dr. Chen See "has unselfishly given himself to his community, the state of Pennsylvania [and] the nation, providing leadership and guidance to establish programs to effectively diagnose, treat and counsel" addicted persons and their families. Representing ASAM at the award ceremony, ASAM Executive Vice President James F. Callahan, D.P.A., said that Dr. Chen See's "vision and his genius for administration and strategic planning are matched by the largeness of his love and sincerity, and by his total commitment to those who suffer from addictive disorders." ASAM Immediate Past President Marc Galanter, M.D., FASAM, added that "Jasper was a very kind man. He epitomized the support and caring that have made ASAM a resource for those who so badly need our help."

Board member Ken Roy, M.D., FASAM, recalled Dr. Chen See's ascendancy to leadership in ASAM as "the point in time when ASAM began to mature. He was the first national leader to call for the financial stability of our group. This vision on his part has created a mindset that has helped us weather the hardships of the '90s and the changes in our field. It is because of Jasper's vision that we will have the resources to grow and learn and teach and therefore ultimately realize our dream." Past President David E. Smith, M.D., FASAM, concurred with Dr. Roy's assessment, adding that "ASAM's stability now is a testament to Jasper's vision." Another ASAM Past President, G. Douglas Talbott, M.D., FASAM, summed up the sentiments of many when he said, "He was a mentor and inspiration. Like so many, I will miss him."

Dr. Callahan and Claire Osman represented ASAM at funeral services for Dr. Chen See were held November 14 at Reading. Expressions of sympathy may be sent to Mrs. Colleen Chen See, 447 Brighton Ave., Reading, PA 19606. The family has asked that memorials be directed to the Caron Foundation, Box A, Galen Hall Road, Wernersville, PA 19565. ■

## BENEFIT PARITY

### Senate, House Act on Parity Legislation

In the House of Representatives, Rep. Marge Roukema (R-NJ) has written a measure similar to the Senate bill that also would extend parity to the treatment of addictive disorders. The bipartisan bill has gained 175 co-sponsors, but has not passed the House, where the Republican leadership and committee chairs have stalled its progress.

Meanwhile, the U.S. Senate has passed the "Mental Health Equitable Treatment Act," replacing a more limited parity law passed in 1996 that expired September 30. The measure was added as an amendment to the \$407 billion fiscal 2002 spending bill for the departments of Education, Labor, and Health and Human Services. The bill does not provide for parity in coverage of addiction treatment.

The 1996 law required that companies that offer mental health benefits not maintain annual or lifetime limits for those services that are different than those for other health services. Although the law did not require insurers to cover mental health care as part of employee health benefits, it did require those who provide such coverage to offer the same level of benefits for mental health care that they do for physical health care. With the new measure, sponsors Sen. Pete Domenici (R-NM) and Sen. Paul Wellstone (D-MN) are seeking to close loopholes in the 1996 law that allowed insurers to limit mental health coverage in other ways, as by restricting the number of outpatient visits per year.

In order to append the mental health measure to the spending bill, the sponsors agreed to delay the effective date of the measure for a year beyond the date that was specified when the bill was approved by the Senate Health, Education, Labor and Pensions Committee last summer. They also agreed to exempt businesses with fewer than 50 workers from the parity requirement—an increase from 25 in the original bill. "We can't get everything in one swoop," said Sen. Domenici.

The American Medical Association, American Psychiatric Association, and more than 150 other medical, mental health, religious and community organizations have backed the measure, which received strong bipartisan support in Congress this year. In the Senate, the measure garnered 65 co-sponsors and unanimous approval by the Health, Education, Labor and Pensions Committee. However, Majority Leader Tom Daschle (D-SD) was prevented from scheduling a vote on the measure in late September. At that time, Sen. Judd Gregg (R-NH) and others raised objections to the bill, saying it likely would raise premiums and cause some employers to drop mental health coverage.

But when Sen. Domenici offered the legislation as an amendment to the Labor-HHS spending bill, they let it go through without a fight. Only Sen. Phil Gramm (R, Texas) offered a note of criticism. However, even Sen. Gramm admitted that the provision had overwhelming support in the Senate. "If I thought we had more than 15 people who would vote against it, I would demand a [recorded] vote," he

said. Instead, the amendment was accepted on a voice vote as part of the Labor-HHS appropriations bill. Senate approval "is long overdue and the right thing to do for millions of American suffering from mental illness," said Sen. Domenici, who, along with Sen. Wellstone, also wrote the original 1996 mental health parity law.

At press time, the Senate had not yet approved the overall spending package. When it does, the measure will go to a House-Senate conference committee, which is charged with resolving the differences between the two versions. A question remains as to whether the Senate-passed parity language will be able to survive these upcoming negotiations. The House has approved the reauthorization of the mental health parity law, but without any expansion.

If the Senate-passed mental health parity language encounters strong opposition from House negotiators, it is possible that the language ultimately would be dropped from the final House-Senate agreement. That is clearly what Sen. Gramm has in mind. After acknowledging that Senate passage was inevitable, he said, "I am hoping that the administration and the House will not go along with this amendment." So far, the White House has not signaled its position on the Domenici-Wellstone language.

Business groups and insurers have been lobbying hard against the mental health parity expansion, charging that it would raise health insurance costs and cause some employers to drop mental health coverage. Sen. Wellstone said the bill's cost—an estimated \$1.5 billion over 10 years—is appropriate.

"For \$150 million a year you don't think it's worth it to end the discrimination, to provide the coverage...that could be a matter of life or death?" he asked.

Supporters say they think there is a good chance that the administration will not mount opposition to the mental health parity measure when it is considered by the conference committee. They point out that not only are there a large number of Congressional Republicans who support expanding mental health parity, but also that there is a growing level of awareness about the importance of providing access to needed mental health services.

Sources: *American Medical News*, November 19, 2001; *Associated Press*, October 30, 2001.

#### NH Bill Seeks Parity

The New Hampshire House of Representatives is considering a bill that would require insurance companies to cover treatment of addiction on the same basis as other illnesses.

Under the measure, the same level of care provided for physical disorders would be required for addictive disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Currently, health insurers are required to provide parity coverage for mental health disorders, a mandate included in a law passed six years ago. The New Hampshire Partners

#### RAND REPORT OUTLINES EVIDENCE FOR PARITY

Dr. Peter Banyas of the California Society of Addiction Medicine recommends that all ASAM members take a few minutes to read a July 2001 report from the RAND policy center, which evaluates the available evidence in favor of benefit parity for addiction treatment. Prepared by Roland Sturm, the report is entitled "The Costs of Covering Mental Health and Substance Abuse Care at the Same Level as Medical Care in Private Insurance Plans." The 28-page report can be viewed (or downloaded as a PDF file) at the RAND web site: [www.rand.org/publications/CT/CT180/](http://www.rand.org/publications/CT/CT180/).

## BENEFIT PARITY

for Parity, a coalition of 19 mental health and addiction treatment agencies, formed last fall to push for the same parity requirement for addictive disorders.

In an October 24 hearing, opponents argued that the measure would drive up health care costs and questioned whether addiction is a disease. "It's not like doing bypass," said Yvonne Nanasi, director of government relations for Anthem Blue Cross and Blue Shield in New Hampshire, who also said that parity could cut coverage for other diseases. She called parity "very complex."

Joseph Harding, executive director of Friends of Recovery-New Hampshire, responded that the "complexity" lies in prejudice toward addictive disorders. He also pointed to an actuarial report by PriceWaterhouse Coopers, which indicated that the actual cost of implementing full parity in New Hampshire would be only 50 cents per person per month. Further hearings have been scheduled. Source: *Nashua Telegraph*, October 15, 2001; report by Joseph Harding, October 31, 2001.

### CA Measure Stalled

In California, a parity bill (SB.599) has passed the State Senate and both the Health Committee and the Appropriations Committee of the State Assembly.

Although this is described by proponents as a truly bipartisan issue, the votes have been strictly along party lines with the Democrats in favor. Since the Assembly is controlled by the Democrats, the bill appears certain to pass the Assembly in January.

However, there is a question as to whether Gov. Gray Davis (D) will sign the measure into law. Gov. Davis, who is running for re-election in 2002, wants to retain the support of insurers and HMOs in his campaign. On the other hand, he does not want to engender public

disapproval by refusing to sign a measure with strong public support.

In the closing days of the current session, after it became apparent that SB.599 would easily pass the Assembly, the Governor approached sponsors to suggest that they work with his office to craft a bill that he could sign but that also would offer the protections sought by treatment advocates. However, the two camps were unable to come to agreement in the closing hours of the session, so the discussion was postponed and the bill was carried over to the next session.

Advocates have mounted a letter-writing campaign in support of Addiction Treatment Parity and SB.599, in addition to sending letters and editorials to local newspapers. They also have solicited support from cities, counties, hospitals, labor unions and a variety of other organizations.

The opening session of the California Society of Addiction Medicine's "State of the Art Conference" in October focused on passage of SB.599. CSAM President-Elect Don Kurth, M.D., FASAM, reports that State Sen. Wesley Chesbro (author of SB.599) received a standing ovation from the 300 attendees for his deeply inspirational talk in support of addiction treatment.

Dr. Kurth reports that he and Dr. Gary Jaeger will meet with the Governor's staff in late November to continue negotiations toward a mutually acceptable bill. Sen. Chesbro has warned us advocates not to accept a bill that would not provide the necessary level of care. He has assured supporters that he is willing to bring the bill back as many times as necessary to pass a law with substance.

Source: Report by Dr. Kurth, November 7, 2001. ■

## Developing Leadership in Reducing Substance Abuse

The Robert Wood Johnson Foundation® is requesting applications for a three-year fellowship program from persons who have been in the field of substance abuse focusing on alcohol, tobacco, or other drugs for between three and ten years.

The Developing Leadership program provides a three-year mentoring experience for ten fellows per year from the substance abuse field in the domains of education, advocacy, service delivery, policy, or policy research. Each fellow receives \$25,000 per year to support the individual's personal leadership development plan. The program is designed for fellows to remain in their current positions, and intends to offer participants the experience, insights, competencies, and skills necessary to achieve or advance in leadership positions in the substance abuse field.

For further information contact Cindy Happel, EdD, Deputy Director, Developing Leadership in Reducing Substance Abuse, School of Public Health, University of Medicine and Dentistry of New Jersey, 317 George Street, Suite 201, New Brunswick, NJ 08901-2008, phone: 732-235-9609, or visit our Web site: [www.SALeaders.org](http://www.SALeaders.org).

The deadline for applications is February 1, 2002.



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FOUNDATION.

## Dr. Gordis Retires from NIAAA

In a letter to colleagues, Dr. Gordis wrote, "I am turning 71 in February, and have been with the Institute for 15 years. This decision did not come easily or quickly. These years have been the most rewarding of my career, and I have been fortunate to have worked with so many of you across the various disciplines that make up our field. Your support, advice and friendship have been invaluable as we have worked to foster progress in alcohol research. I will miss you all greatly, and I hope to continue to think hard about our field and to remain involved in a way yet to be determined."



ASAM Past President Marc Galanter, M.D., FASAM, recalled Dr. Gordis' service on ASAM's Board of Directors and described him as a visionary leader with a deep commitment to building NIAAA's research agenda and an equal commitment to strengthening clinical practice.

## Dr. Leshner Leaves NIDA



Alan I. Leshner, Ph.D., will assume his new post as chief executive officer of the American Association for the Advancement of Science (AAAS), the world's largest general science organization, on December 3.

During his tenure at NIDA, Dr. Leshner worked to achieve the Institute's overarching goal of bringing the full power of science to bear on drug abuse by supporting research across a broad range of disciplines and ensuring the rapid and effective dissemination and use of research findings to improve the prevention, treatment, and policy of drug abuse and addiction. Dr. Leshner was particularly active in disseminating the results of the science of drug abuse to both practitioners and the general public.

In a message to NIDA's National Advisory Council on Drug Abuse, Dr. Leshner said, "Our institute and the science we conduct and support has never been stronger....Our work is clearly bettering prevention and treatment practice in the field, and, more generally, it is significantly influencing public understanding of drug abuse and addiction and resultant policies."

## Dr. Hyman Resigns from NIMH

Before joining NIMH in 1996, Dr. Hyman was director of Harvard's Interfaculty Initiative in Mind/Brain/Behavior and director of research in the department of psychiatry at the Massachusetts General Hospital.

In leading NIMH, Dr. Hyman is widely credited with broadening the institute's research agenda and increasing its relevance to the needs of the mental health treatment community. He said in 1997 that the institute must be guided by the dual considerations of scientific opportunity and public health need. He also pushed for NIMH to capitalize on advances in the understanding of genetic pathways associated with vulnerability to psychiatric disorders.

"He has been on the cutting edge of bringing modern science to the study and treatment of mental illness," said Jay Cutler, director of government relations and special counsel at the American Psychiatric Association.

## Future of Institutes Unclear

Inevitably, the multiple announcements sparked speculation as to their timing and their impact on the future of the institutes.

The National Institute on Health's (NIH) director's office has said it will convene search committees to find successors, but many expect little progress on that front before a permanent head of NIH itself is named. Don Rabovsky, an NIH spokesperson, said that the search process likely will begin in a few weeks, but will take months to complete. Meanwhile, acting directors will be named, he said.

In response to questions as to whether the Bush administration might be interested in bringing in its own leaders for the agencies, Beverly Jackson, a spokesperson for NIDA, said that the timing of the announcements was purely coincidental. "There was no political pressure whatsoever," she said.

Nevertheless, the departures are likely to fuel rumors about possible mergers. Many field leaders have argued that NIAAA and NIDA ought to be merged into a single institute of addiction research, although such a scenario also has vociferous opponents. More recently, rumors have arisen that all three institutes might be folded into a larger institute of neurological disorders. Either move would reflect current sentiments within NIH favoring a reduction in the overall number of institutes.

Sources: *Alcoholism & Drug Abuse Weekly*, November 12, 2001; *Join Together on-line*, October 25, 2001; NIDA and NIAAA web sites.

## ASAM CERTIFICATION

### Certification/Recertification Registration Date Nears

Christopher M. Weirs, M.P.A.

The next deadline to register for ASAM's next Certification/Recertification Examination for physicians who wish to be certified/recertified in Addiction Medicine is January 31, 2002. The examinations are set for Saturday, November 16, 2002, at three sites: Atlanta, GA; New York, NY; and Los Angeles, CA.

Physicians who wish to sit for the examination must complete and submit an application. Applications are to be sent automatically to all ASAM members. Completed applications will be accepted on the following schedule:

■ Standard Registration extends through Thursday, January 31, 2002;

■ Late Registration extends through Tuesday, April 30, 2002.

All applications will be reviewed and candidates notified by mail as to whether they qualify to sit for the examination.

Physicians who pass the examination become ASAM certified/recertified in Addiction Medicine. Since the exams first were offered in 1986, over 3,300 physicians—including many of the nation's top addiction treatment professionals—have been certified.

For more information on ASAM certification and the examination, contact Christopher Weirs at the ASAM office at 301/656-3920.



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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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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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In alcoholism

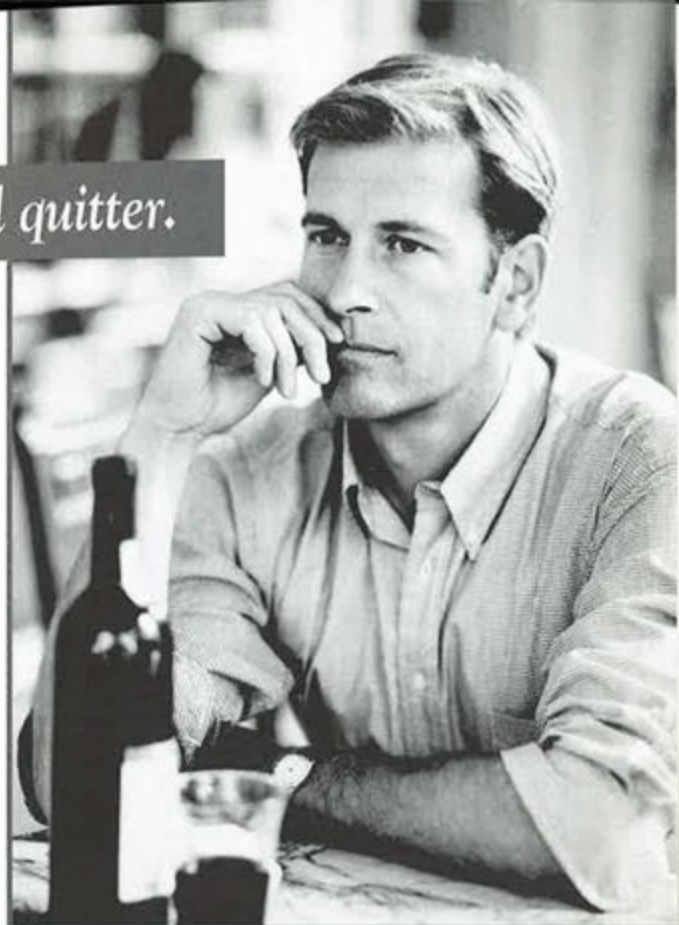
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## Antabuse® (Disulfiram, USP) Tablets IN ALCOHOLISM

### 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<sub>10</sub>H<sub>20</sub>N<sub>2</sub>S<sub>4</sub>

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 thiamur 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 thiamur 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, acneiform 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.

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Dispense in a tight, light-resistant container as defined in the USP.

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## COMMITTEE REPORTS

# Family Practice Committee Has Full Agenda

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

ASAM's Family Practice Committee has developed a full agenda of activities. As a first step, Dr. James Callahan, Dr. Patricia Chandler and I met with the leadership of the American Academy of Family Physicians to discuss specialty status and the promotion of addiction medicine through academy activities. AAFP leaders in attendance included Board Chair Bruce Bagley, M.D., President Richard Roberts, M.D., President-Elect Warren Jones, M.D., and Executive Vice President Douglas Henley, M.D. They told us that AAFP is not completely opposed to specialty status for addiction medicine, but also were not ready to endorse it.

### Liaison Appointed

Dr. Sharon Sweede, a member of ASAM and of the AAFP Public Health Commission, has been appointed a liaison between the AAFP Public Health commission and the ASAM Family Practice committee. AAFP does not have a separate commission on addictive disorders, but has agreed to create a subcommittee of the commission to deal with addiction issues.

The AAFP executives pointed out that much of their programming occurs at the state level, and they encouraged ASAM members to become involved in the AAFP state chapters as well as at the national level. Accordingly, ASAM is encouraging members who are family physicians to become involved in their state AAFP chapters in order to advocate for addiction medicine. Ten ASAM members from seven states (NY, NC, CA, AL, TX, OR, and IL) already have agreed to do so. Their names have been submitted to the offices of the AAFP state chapters and to their respective ASAM Chapter presidents.

### Scientific Exhibit

One of the major goals of the Family Practice Committee is to make family physicians more aware of addictive disorders. The committee took an important step in this direction at AAFP's Annual Scientific Assembly in Atlanta by sponsoring an educational exhibit

## PRACTICE GUIDELINES COMMITTEE SEEKS MEMBERS

Committee chair Richard Saitz, M.D., M.P.H., reports that the ASAM Committee on Practice Guidelines is recruiting new members. The committee, which meets monthly by telephone, is particularly interested in members who have the expertise and interest to lead a work group to develop new evidence-based practice guidelines.

In the past, guidelines developed by the committee have been published in the *Journal of the American Medical Association* and in ASAM's textbook, *Principles of Addiction Medicine*.

Topics under consideration for future guidelines include opiate detoxification, psychosocial treatments for alcoholism, and management of chronic pain in addicted persons. Ideas for new topics also are welcomed.

Interested members should contact Dr. Saitz at his office at Boston University School of Medicine at 617/414-7744, or by e-mail at [rsaitz@bu.edu](mailto:rsaitz@bu.edu).



Family Practice Committee members Norman Wetterau, M.D., FASAM, and Marsha Holleman, M.D., greet colleagues at their exhibit, "Talking with Teens About Substance Abuse," during the American Academy of Family Physicians' Annual Scientific Assembly in Atlanta.

entitled "Talking to Teenagers About Substance Abuse." The exhibit offered basic principles on talking with adolescents about alcohol and drug use. Vignettes were organized around assessing risk, reinforcing non-use, encouraging alternative activities, and encouraging development of a refusal plan. In addition, the exhibit offered literature about adolescent drug use, a sample of the GAPS questionnaire, and information about ASAM.

About 70 physicians visited the exhibit; most said they had not heard of GAPS and had no office literature about alcohol and drug use for their adolescent patients. About a dozen signed up to receive additional information about ASAM.

The booth was staffed by Dr. and Mrs. Wetterau, Dr. Jack White and Dr. Holleman of the Family Practice Committee.

### 2002 Med-Sci Conference

Many primary care physicians might be interested in learning about addiction medicine, but would not join our organization. To reach them, we are planning to offer two special programs for Friday at the 2002 Med-Sci meeting. They will be targeted to family physicians and internists who live in the southeastern region of the U.S. The committee plans to arrange for special advertisements to be sent to all family physicians and internists living in Georgia and neighboring states. Recipients will be offered an opportunity to sign up for just one day of our conference or for the whole conference if they wish.

One part of the component session will be a workshop on office-based screening for addictive disorders. Another will focus on the use of medications in treating addictions in a primary care setting, as well as detoxification in an office setting or general hospital. Thus, a primary care physician could attend the conference on Friday, hear the opening session, attend the exhibits and poster displays, and participate in the special workshops component sessions. This would provide a good introduction to addiction medicine and, we hope, interest some physicians in attending the entire conference and/or joining ASAM.

The Family Practice Committee looks forward to working with ASAM members who are trained in internal medicine and other primary care specialties. Many of our issues are similar and we need to work together nationally and in our chapters. ■

## AGENCY NEWS

### ONDCP: Senate Committee Approves Walters' Nomination

By a vote of 14-5, the U.S. Senate Judiciary Committee has approved President Bush's nomination of John Walters as director of the Office of National Drug Control Policy. "Mr. Walters is eminently qualified," said Sen. Orrin Hatch (R-UT), the committee's ranking Republican. "He is the right person for this job." Mr. Walters' nomination now moves to the full Senate, where confirmation is expected.

Opposing the nomination were Sens. Edward M. Kennedy (D-MA), Joseph R. Biden (D-DE), Patrick J. Leahy (D-VT), Charles Schumer (D-NY), and Richard J. Durbin (D-IL). In voting against the nomination, they cited objections by former first lady Betty Ford and several addiction field organizations, which voiced concerns over Mr. Walters' past statements about the effectiveness of addiction treatment.

Mr. Walters first joined ONDCP at its inception in 1989, as chief of staff to then-director William J. Bennett. He later moved up to the post of acting director and then

was deputy director for supply reduction. He resigned when the Clinton administration took over in 1993, and currently serves as president of the Philanthropy Roundtable. Source: *Reuters News Service, November 8, 2001.*

### SAMHSA: New Administrator Confirmed

Charles G. Curie has been confirmed by the Senate as new administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), succeeding acting administrator Joseph H. Autry III, M.D.

Mr. Curie comes to the post from state government in Pennsylvania, where he served as deputy secretary of the Department of Welfare's Office of Mental Health and Substance Abuse Services.

Source: *Alcoholism & Drug Abuse Weekly, November 5, 2001.*

### DEA: New Director Says Club Drugs a Top Priority

Asa Hutchinson, new director of the U.S. Drug Enforcement Administration (DEA), says that club drugs such as ecstasy and

methamphetamines are among his top concerns.

Mr. Hutchinson said club drugs are harder to intercept than other illegal drugs because they come in pill form and are easier to conceal. Another of Hutchinson's priorities is to emphasize the need for drug education and rehabilitation, especially for nonviolent offenders. "You're not going to arrest your way out of this problem," he said. "The risk itself is not enough."

Mr. Hutchinson, who assumed his role with the DEA in September, is familiar with some tragic aspects of drug addiction: despite numerous treatment episodes, his addicted nephew committed suicide at age 16. "It's extraordinary the battles people face when it comes to substance abuse and addiction," Hutchinson said.

He added that seeing the "human side" of drug trafficking and addiction is important in his role as DEA director, and noted that it is equally important for "the public to understand that you see the human side of it."

Source: *New York Times, September 3, 2001.*

## CHAPTER UPDATES

### Virginia

President: Mark R. Publicker, M.D., FASAM

Regional Director: Mark R. Publicker, M.D., FASAM

VSAM Vice President and Treasurer James M. Miner, M.D., reports that the Tidewater/Hampton Roads area is the scene of considerable activity on the part of local addiction medicine specialists. Under the leadership of program chair Michael E. Bohan, M.D., the Tidewater group has hosted monthly forums, with speakers, at Sam's Restaurant in Hampton. The forums draw participants from the cities of Chesapeake, Hampton, Newport News, Norfolk, Suffolk, Virginia Beach and Williamsburg. (Specialists in this area provide most of the addiction treatment in the Tidewater region of Virginia, which has a population of 1.8 million.)

With the November meeting, Dr. Bohan turned over program responsibilities to Mark T. Schreiber, M.D., FAPA, FASAM, of Virginia Beach. The meeting featured a case presentation and roundtable discussion.

December Meeting: The group's next meeting, set for December 13 at 6:30 p.m. at Sam's Restaurant, will feature Dr. Bohan discussing the use of Buprenex® in office-based practice. All addiction medicine specialists in the area are invited to attend. For information, contact Dr. Mark Schreiber at Atlantic Psychiatric Services (phone 757/468-0550 or fax 757/468-9992).

Inquiries: Information about the Virginia chapter is available by e-mail from VSAM President Mark R. Publicker, M.D., FASAM, at Mark.R.Publicker@kp.org, or from Vice President and Treasurer James Miner, M.D., at JMinerMD@aol.com.



Leaders of the California Society of Addiction Medicine gather at the Society's recent conference on the State of the Art in Addiction Medicine. From left, they are CSAM President Gary Jaeger, M.D.; Immediate Past President Peter Banyas, M.D.; ASAM President-Elect Lawrence Brown, M.D., FASAM; President-Elect Donald J. Kurth, M.D., FASAM; and David Pating, M.D., Co-Chair of the 2001 SOA Course and Medical Education Committee.

## Experience Innovation Leadership

*Experience, Innovation, Leadership... David Smith has devoted his career to improving treatment of alcohol and substance abuse and dependence. In 1967, he founded the Haight Ashbury Free Clinics, the first of its kind in the U.S., to assure that health care was available to everyone. Dr. Dave's vision and devotion has led the medical community's transition to evidence-based treatment of addictions.*

### David E. Smith, MD

Founder, President and Medical Director,  
Haight Ashbury Free Clinics  
Associate Medical Director and Medical Review Officer,  
Betty Ford Center's Professional Recovery Program  
Medical Director, California State Department of  
Alcohol and Drug Programs  
Past-President and Fellow, American Society  
of Addiction Medicine  
Co-author, Clinicians Guide to Substance Abuse  
Founder and Editor, Journal of Psychoactive Drugs  
Medical Director, DrugAbuse Sciences, Inc.  
Editor-in-Chief, AlcoholMD.com

DrugAbuse Sciences' sole mission is to develop effective medications for the treatment of alcohol and substance abuse and dependence. Under the guidance of the field's leading researchers and clinicians, we have invested over \$30 million in the continuing development of our portfolio of innovative new product candidates.

David Smith joined DrugAbuse Sciences because of our vision of bringing leading-edge science to the treatment of addictions. David and the rest of the DrugAbuse Sciences team represent a

combined expertise consisting of hundreds of years of training, clinical practice, and cutting-edge research in addiction medicine. With every **Naltrexone HCl Tablet** you purchase from DrugAbuse Sciences, you support not only this product development program, but also the continuing development of a growing array of addiction-specific educational programs.

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DAS 003

### Report Examines State Tobacco Laws

A new report from the American Lung Association says that more state tobacco laws were enacted in the year 2000 than ever before. "There were 113 new tobacco-related laws adopted by 43 states, spelling both good news and bad news for the public's health," said John R. Garrison, chief executive officer of the association. "Unfortunately, Big Tobacco continues to wield undue influence in statehouses around the country."

Most of the new laws enacted in 2000 focused on limiting youth access to tobacco products. Also, a total of 49 states and the District of Columbia in some way restricted smoking in public places, compared to 42 states with such restrictions in 1991. In addition, between 1991 and 2000, the average state cigarette excise tax nearly doubled, from an average of 24 cents per pack in 1991 to 42 cents per pack in 2000.

The report also looked at the legislative focus during 2000, in particular the number of states that spend their share of the 1998 Master Settlement Agreement on tobacco-prevention programs. "Of the 44 states that have decided how to spend their settlement dollars, only a handful have allocated even the minimum amount of funding recommended by the Centers for Disease Control and Prevention for comprehensive tobacco use control and prevention," said Garrison. "As a result, tobacco companies are spending 10 times more to market their products than all 50 states combined are spending on tobacco prevention and cessation."

The 2000 State Legislated Actions on Tobacco Issues report, produced with support from the American Legacy Foundation, provides an up-to-date, comprehensive guide to state tobacco-control laws. The report has been published annually since 1988.

Source: *Join Together*, March 12, 2001.

### CA: Pain Course Required

Effective January 1, 2002, California physicians who treat patients in pain will be required to complete 12 hours of continuing medical education in pain management as a requirement for licensure renewal. California is the first state to adopt such a requirement.

*American Medical News* reports that the new mandate is being met with mixed opinions. Some physicians favor it because pain is a complex condition that often is either overtreated or undertreated. Other physicians worry about the precedent of the state

mandating which CME courses they must take to keep their medical licenses current. "The bill is well-intended," said Philip M. Lippe, M.D., executive medical director of the American Academy of Pain Medicine. "We support more training for pain management. But we didn't feel comfortable with the state telling physicians what they need to do."

While some physicians are concerned about the precedent, Dr. Leonard Fromer, president of the California Academy of Family Physicians, said that organized medicine supported the legislation because it focused on education rather than punishment. By contrast, earlier versions of the bill would have allowed the state medical board to view undertreatment of pain as "unprofessional conduct."

Source: *American Medical News*, November 19, 2001.

### FL: Tobacco Campaign Faces More Funding Cuts

Florida's acclaimed "Truth" youth anti-smoking campaign, whose funding already has been cut in half by state lawmakers, is facing another round of deep budget cuts as legislatures grapple with dwindling revenues.

Initially funded in 1998 with \$70 million in tobacco-settlement dollars, the program's budget subsequently has been cut to \$37 million, despite data showing that the campaign has helped to cut youth smoking rates in half. Now, the Florida House is proposing to cut up to \$15.6 million more from the program, while the state Senate wants to slash \$9.2 million.

State health officials point to a survey of 23,000 students, which found that the campaign helped cut smoking rates among middle school students by more than half, and lowered smoking rates among high school students by 24%. "The legislature is slowing destroying a successful program," commented Ralph DeVitto of the American Cancer Society.

Source: *St. Petersburg Times*, October 24, 2001.

### MA: Court Reinstates Tobacco Disclosure Law

The 1st U.S. Circuit Court of Appeals has revived a Massachusetts law that requires tobacco companies to disclose the ingredients in their products. In a 2-1 decision, the court found that the law "is a valid exercise of the police power" to protect public health.

"In short, disclosure under the Disclosure Act will put consumers in a better position to know if their brand contains harmful additives, and to assess the health risks involved," the court said. The ruling reverses a decision by a federal judge who found the law unconstitutional because it would force companies to reveal their trade secrets.

Passed in 1996, the disclosure law requires tobacco companies to submit lists and amounts of the substances added to cigarettes, snuff, and chewing tobacco to the Massachusetts Department of Public Health. The lists would be kept confidential unless the health department found that the ingredients posed a public health risk. Companies refusing to comply with the law would be prohibited from doing business in Massachusetts.

The law was never enforced because Philip Morris Inc., R.J. Reynolds Tobacco Co., Brown & Williamson Tobacco Corp., Lorillard Tobacco Co., and U.S. Tobacco Co. filed a lawsuit in 1997. The tobacco companies are considering an appeal of the court's decision.

Source: *Associated Press*, October 16, 2001.

### MD: Agency Reaches Out to Physicians

Hoping to engage primary care physicians in screening patients for addiction problems and referring them to treatment, the Baltimore County Bureau of Substance Abuse recently mailed an information package out to nearly 4,000 area physicians.

The Physicians Reaching Out to Understand Drugs (PROUD) package includes a variety of materials, including screening and intervention tips prepared by the American Society of Addiction Medicine. "They are really fantastic, because they really talk to physicians in their own language," said Michael Gimbel, director of the Bureau. "This is an area that most doctors really aren't trained in, so we wanted to get them something they could use," he added.

Other materials came from a variety of sources, including a wall chart on common drugs of abuse published by the National Institute on Drug Abuse, information about on-line resources provided by Join Together, a Newsweek article on abuse of painkillers such as OxyContin® and Vicodin®, and fact sheets on addiction and medication management.

Information on local treatment programs and how to make a referral also is included. "We believe that as a Baltimore County

## AROUND THE STATES

physician, you can make a difference," Mr. Gimbel wrote in a letter mailed with the PROUD kit. "By asking the right questions, observing a specific behavior and by learning the availability of local resources, you can enhance your opportunity to provide the best health care possible to your patients."

Baltimore officials also sent an evaluation form with the PROUD materials, and have been pleasantly surprised to receive more than 150 responses. Most physicians said that the information was helpful to them, and that they would use it to assess their patients' addiction-related needs. Few said they were seeing a big increase in requests for OxyContin and Vicodin from patients, but said they would welcome further information on alcohol and other drugs.

"This was a good first step," said Mr. Gimbel. "Now it's up to us to continue to do mailings and keep pulling doctors into our network."

Source: Baltimore County Bureau of Substance Abuse, August 2001.

### MO: .08 BAC Limit Adopted

Missouri has become the 28th U.S. state to lower its blood-alcohol limit for DUI offenses to .08%. Gov. Bob Holden signed the legislation into law, which lowers the state's current legal limit from .10 percent to .08 percent. "Today is truly a momentous day in Missouri," he said. "Because of our action, more lives will be saved on Missouri highways, and more of our children will live to build Missouri's future," he added.

The law, which took effect September 29, also increases penalties for repeat offenders and requires treatment programs for drivers whose BAC levels are .15% or higher. However, because Missouri's penalties for repeat offenders still do not meet federal standards, and open containers are allowed in vehicles, the state will lose \$10 million a year in federal highway construction funds.

Source: Kansas City Star, June 12, 2001.

### NE: Addiction Funding Increased

Governor Mike Johanns has announced that state funding for addiction and mental health services would increase by \$95 million over the next two years. "Over the next couple of years, we need to concentrate on a community-based and state system of services," Gov. Johanns said.

With the increased funds, \$20 million will be reserved for behavioral health providers, mental health and addiction

programs, emergency protective care, and a study of mental health. In addition, \$3 million will be used to expand early childhood education programs; \$1 million will fund addiction programs for inmates; \$3 million will provide additional housing and staff at youth treatment centers; and \$4 million will assist counties in developing community-based programs for juvenile offenders.

To provide the additional funding, the state will use \$33 million from state funds, \$31 million from the national tobacco settlement, \$30 million in federal funding, and other funding.

Source: Omaha World-Herald, June 6, 2001.

### NM: Alcohol Costs Outweigh Tax Revenues

A state Department of Health report documents that in the year 1998, health problems associated with alcohol use caused \$51 million in hospital costs. By comparison, the state's tax on beer, wine and liquor sales raised only \$35 million. "The income from the product is exceeded by the costs of the product," concluded Glenn Wieringa, a public health administrator who specializes in alcohol policy. "Hopefully, a discussion will focus on that."

Mr. Wieringa said the report demonstrates why the policy focus on alcohol-related problems needs to go beyond impaired driving. "That might be the tip of the iceberg," he said. "There are all sorts of other alcohol-related problems and costs."

According to the report, half of lip, oral and throat cancers are considered to be alcohol-related. In addition, of the total \$51 million in hospital costs, about a third can be attributed to injuries and one-fifth to alcohol-specific diagnoses. The second highest cost, at \$7 million, was for treatment of alcohol dependence syndrome. Care of patients with alcoholic cirrhosis cost \$5.9 million, while treatment of acute pancreatitis cost \$4.6 million.

Source: Albuquerque Journal, January 18, 2001.

### TX: Open Alcohol Containers in Vehicles Banned

Drivers in Texas no longer can have open containers of alcohol within reach of a vehicle's occupants under legislation enacted in Texas. Texas thus joined 32 other states in implementing the open-container ban. Legislators approved the measure to avoid losing \$80 million in federal highway funds.

Before the law was changed, drivers could not be charged for having an open container unless they were seen actually drinking its contents. Under the new law, possessing an open container of alcohol in a moving vehicle is a misdemeanor punishable by a \$500 fine.

Republican State Rep. Fred Hill said the law is intended to save lives. Texas led the nation with 1,734 alcohol-related traffic deaths in 1999. "This law begins to finally say Texas has had enough," said Hill.

Wendy Hamilton, national vice president of Mothers Against Drunk Driving (MADD), added, "The importance is the safety of everybody, not just the driver, but the passengers in the vehicle and everyone else on the road. We need to...make sure everybody is safe."

Source: Associated Press, September 1, 2001.

## ASAM's Database and You

Nancy Brighindi  
Director of Membership and  
Chapter Relations

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### Buprenorphine Approval Delayed

Federal approval of buprenorphine for the treatment of opioid addiction is unlikely to happen this year, but may finally occur early in 2002, according to officials familiar with the approval process.

Charles O'Keeffe, president of Reckitt & Colman Pharmaceuticals, Inc., which applied to market the drug for the treatment of opioid addiction, told *Alcohol & Drug Abuse Weekly* that his company currently is responding to questions from the U.S. Food and Drug Administration (FDA). The company expects to submit its answers to the FDA in December, Mr. O'Keeffe said, adding that not much information had been requested, "so it shouldn't take that long to review." He described the FDA's inquiries as "very technical questions" and said they involve dosing, including the number of tablets to be given and the language to be used in information provided to physicians. The FDA routinely withholds comment on pending drug applications.

The delay has caused frustration for many practitioners, given that buprenorphine already is marketed for other indications, and anxiety for many field organizations, which responded to earlier assurances of quick approval by moving ahead to train addiction specialists in its use.

Early in 2001, following Congressional action to make it easier for physicians to treat addicted patients in office-based practice, the federal Center for Substance Abuse Treatment announced that it would issue proposed regulations in connection with the use of buprenorphine in office-based practice. However, the government subsequently issued an advisory to addiction treatment professionals, reminding them that buprenorphine had not yet been approved for the treatment of opioid addiction and warning them not to use it for that purpose.

Buprenorphine has been approved for use in other countries, with Reckitt & Colman involved in marketing it in 26 countries, Mr. O'Keeffe said.

Douglas Tieman, president of the Caron Foundation, recently wrote in the newsletter of the National Association of Addiction Treatment Providers (NAATP) that if similar delays occurred in approving a drug for a disease such as cancer, "there would be a public outcry urging the FDA to stop 'dragging its feet' and grant approval."

Source: *Alcohol & Drug Abuse Weekly*, November 5, 2001.

### Primary Care Helps Addicted Patients

A combination of primary care and addiction treatment triples the ability of patients to avoid using alcohol and other drugs, according to Constance Weisner, Ph.D., a professor of psychiatry at the University of California at San Francisco. While addiction treatment traditionally has been separated from other types of health care, with patients sent to outpatient clinics or residential programs, Dr. Weisner's study examined whether integration would result in better outcomes.

For the study, 285 patients were sent to a program where their medical care was combined with addiction treatment and managed by a primary care physician. Another 307 patients received traditional addiction treatment. Participants in both groups attended Twelve Step programs. After eight weeks of treatment and 10 months of aftercare, the researchers found that the group that received integrated services was three times more likely to remain abstinent.

**"One of the concerns is that many primary care physicians who are treating their patients for health care may be completely unaware of a patient's addictions, and therefore are not assessing the patient for other related conditions."**

"There's very strong literature showing people with addiction conditions have a higher rate of other medical conditions when compared to the general population," said Dr. Weisner. However, "one of the concerns is that many primary care physicians who are treating their patients for health care may be completely unaware of a patient's addictions, and therefore are not assessing the patient for other related conditions. And there is also a large body of literature that shows that primary care physicians seldom screen for addiction or substance abuse problems."

A second study, by Dr. Richard Schottenfeld of Yale University, found that care by a primary care physician could help seriously addicted patients. Specifically, Dr. Schottenfeld and colleagues found that individuals undergoing methadone treatment

for heroin addiction had good outcomes even if part of their treatment was delivered in a primary care setting.

"It's been very hard to expand current treatment opportunities, so one of the main impetuses of our study was to look for an alternative location to provide both access and treatment," Dr. Schottenfeld said. "Patients did about as well when they moved to a physician's office when compared to a regular program. There also were some advantages to primary health care in terms of patient satisfaction. And satisfaction is one of the things that leads people to enter and stay in treatment, so we consider that important."

Source: *Journal of the American Medical Association*, October 10, 2001.

### Craving Strategies Needed

A new study suggests that people with addictions need to develop strategies to combat craving. Research shows that drug use sensitizes the brain so that certain smells, sights, or situations can bring on powerful cravings. Cravings can be experienced even years after patients complete formal treatment.

Dr. Kent C. Berridge, a psychology professor at the University of Michigan and co-author of the study, said that persons in recovery need to develop anti-craving strategies. "Sensitized people can develop strategies to not give into it," said Dr. Berridge. "But if they have been sensitized, they are still exposed and vulnerable to those cravings."

Dr. Roger Weiss, head of the American Academy of Addiction Psychiatry's research section, added, "It's a well-known phenomenon. Individuals who are in early recovery from substance abuse need to be aware they are vulnerable to these cravings. The urges they experience are correlated with real brain changes and are not fully in their control."

While previous studies have suggested explanations for "cue-triggered" cravings, Dr. Berridge's animal study is among the first to uncover the psychological causes of the cravings. "Drug use is known to sensitize certain neural systems within the brain, causing changes that are relatively permanent," he said. "This study shows the brain is vulnerable to cues that trigger irrational 'wanting,' even after a long period of remaining drug-free."

Source: *Journal of Neuroscience*, October 2001.



## Free Management Consulting Offered to Treatment Providers

Treatment programs that need help with the business and management side of their operations can receive free management consulting services from the National Leadership Institute (NLI), sponsored by the federal Center for Substance Abuse Treatment.

Over its four-year history, NLI has provided consulting services to more than 130 groups nationally, including individual treatment providers (typically non-profits, but also some for-profit methadone programs), community coalitions that have treatment programs as members, and state provider associations.

Michelle Daly, NLI's deputy project director, recently told *Join Together* that the organization typically receives three to five new requests for assistance each month. "We get a mix of people who call knowing exactly what they want and those who call needing help in formulating their request," she said.

NLI does not offer assistance with clinical matters; rather, the Institute's mission is defined as enhancing "the business and management acumen of community-based organizations serving critical populations," including racial and ethnic minorities, children and adolescents, women, gays and lesbians, homeless people, and persons with mental illnesses.

Through off- and on-site consultation, a variety of assistance is offered, including help with: leadership and vision, such as strategic planning and developing business plans; governance and management, including board development and risk management; developing a comprehensive array of services; understanding utilization review; managed care performance contracting; marketing and public relations; customer service; business and financial management; management information systems (MIS); human resources; organizational-learning culture; quality improvement and management inter-organizational relationships; and readiness-to-change assessments.

"One of our biggest areas of request is strategic planning for organizations, coalitions, and networks," noted Ms. Daly. Board development is another area where groups often need help, she said. With the emergence of managed care contracting in the public sector, many treatment providers have come to NLI looking for help in adjusting to the new demands of managed care. "They learn to compete in a managed care environment and how to market their organization to get managed care contracts," Ms. Daly said. In 1999, for example, NLI consultants helped New Mexico's Rio Arriba Family Care Network (RAFCN) develop a financial plan, change its mission from a social focus to a business focus, and identify new funding sources. As a result, RAFCN won six federal grants and a managed care contract, increasing its annual revenues from \$45,000 to \$780,000.

Similarly, Alcohol and Drug Recovery Centers (ADRC) of Connecticut came to NLI with another common request: assistance with winning accreditation from the Joint Commission of Healthcare Organizations (JCAHO). NLI worked with ADRC for six months to determine its level of compliance with JCAHO standards, then provided technical assistance to help the group develop a strategic plan for winning accreditation. Soon thereafter, ADRC gained its JCAHO accreditation, with a score of 90.

The most common form of technical assistance delivered by NLI is on-site consulting; Ms. Daly said her group has relationships with consultants all over the country who are on call to help local programs. In a typical year, NLI consultants make 70 site visits, she said. For example, a strategic-planning consultation might "bring together the board and key staff for two or three days on-site; then the consultant will run a workshop with the board on how to develop a plan," according to Ms. Daly. While relationships between NLI and its clients tend to be long-lasting, building capacity within organizations is a key goal for the Institute and its staffers. Help from NLI also is available via the group's web site, e-mail, and through its extensive library of resource materials, she said.

NLI's deep understanding of the treatment field may be its greatest asset, according to Kevin Norton, president of CAB Health and Recovery Services, Inc., a network of 14 treatment programs serving the communities north of Boston, MA. CAB tapped into NLI's services two years ago as it tried to reorganize its management structure. "Like many community-based non-profits, we grew larger over the years, but everything was contract-based," Mr. Norton said. As a result, the under-capitalized organization never had any money for infrastructure or start-up costs.

CAB recognized that it needed to restructure an organization that was a "patchwork quilt" of funding streams and provided very little in the way of support for functions like MIS, human resources, and transportation. "Most of our senior management are incredibly dedicated clinical folks who haven't had to think on the business side as much as they should, and haven't received any money to do that, anyway," Mr. Norton said.

That's where the NLI consultants came in, visiting CAB twice in 2000 to help staff conduct an operational assessment and develop and execute a plan for minimizing expenses and maximizing resources. "Having NLI consultants come in who understood our business inside and out, and the challenges of running things on a close margin, got our staff to open up well," said Mr. Norton. "Most of the challenge is not wanting to tell anyone what your weaknesses are, but NLI is not a competitor, so in that sense it was easy to open up to them." CAB was determined to reform itself, said Mr. Norton, but NLI's consultants gave a tremendous boost to their efforts. "I don't know if our progress would have been as good, or if we would have gotten the results we did without them," he said.

Organizations that wish to receive assistance from NLI can visit [www.samhsa.gov/hli/](http://www.samhsa.gov/hli/) or call 1-800/411-0814. Groups are expected to provide some general information about their operations and complete a self-assessment to identify their strengths and weaknesses; NLI then assigns their case to a facilitator, who will follow up on requests for help.

NLI's current CSAT funding runs through March 2002; program officials are hopeful that continuation funding will be forthcoming, but treatment providers should keep that deadline in mind when requesting assistance.

Source: *Join Together on-line*, October 22, 2001. ■

## INTERNATIONAL ADDICTION MEDICINE

### Britain: Marijuana Laws Eased

Britain's 30-year-old laws on use of marijuana, which are the most stringent in Europe, would be relaxed by next year under plans announced by Home Secretary David Blunkett.

Mr. Blunkett stated his position before a House of Commons committee. Under his plan, marijuana would be classified as a "Class C drug," the same as anabolic steroids. Under such a classification, those possessing marijuana would not be subject to arrest. Marijuana presently has a "Class B" classification, with a five-year maximum prison sentence for simple possession.

The Home Secretary also indicated that he would license the medical use of marijuana to treat multiple sclerosis and other illnesses, once research trials are completed. Mr. Blunkett told members of Parliament that the changes would not detract from the message that all drugs were harmful, but it would make a clearer distinction between marijuana and drugs such as heroin and cocaine.

Britain is in the midst of a political debate about marijuana, with all three major political parties calling for a review of the 1971 cannabis laws. Any change in the legislation would require Parliamentary approval.

Source: *Manchester (England) Guardian Weekly, November 7, 2001.*

### Canada: Quebec Adopts Mandatory Treatment

In an effort to crack down on drinking and driving, the province of Quebec, Canada, has implemented several measures, including mandatory participation in alcohol treatment programs for offenders. "A convicted driver will be subjected to an evaluation. If the evaluation shows that the driver has an alcohol dependency, then he will attend a program for six to nine months," said Transport Minister Guy Chevrette.

In addition to mandatory treatment, Quebec plans to introduce ignition interlocks, which prevent drivers with chronic alcohol problems from starting their cars until they take a 'Breathalyzer' test. Another measure would require drunken-driving convictions to remain on a person's record for a minimum of five years.

"Progress has been realized over the last 20 years," said Mr. Chevrette, adding that "We should be proud of our accomplishment, and this should indicate to us that we must continue with our efforts. We still have a way to go."

Source: *Reuters News Service, October 30, 2001.*

### New Zealand: Medical Group Asks Review of Drinking Age

In response to an increase in binge drinking and drunken fights among teens, the New Zealand Medical Association filed a request that the legal drinking age be returned to 20. "New Zealand teenagers already have a binge culture when it comes to alcohol, and many don't hesitate to flout the law to drink underage," said Dr. John Adams, chairman of the association. "With the age limit now set at 18, it seems that even young teens are now gaining access to alcohol."

"New Zealand has a major problem with teenage binge drinking," commented Justice Minister Phil Goff. "What we need to do is clarify the extent to which trends have altered as a result of the lowering of the drinking age [in 1999]. It's not a new problem, but nor have I seen any evidence that the situation is improving."

Mr. Goff said the review would look into the "negative social indicators" of the 1999 law change. Among the factors that would be taken into consideration are the effects the law is having on adolescent vehicle crashes, hospital admissions, youth crime, and school behavior.

Dr. Adams said that if the drinking age law is not changed, then a strict identity-check process must be implemented to prevent young people from buying alcohol. Police spokesman Sgt. Bob Burns confirmed that young adults buying alcohol for underage friends and siblings, and parents supplying alcohol to their teenage children, are major problems.

Source: *Associated Press, July 10, 2001.*

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## MY PRACTICE

# Dr. Kurth Works with Policymakers and Patients

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

Jeanne Erdman



Writing opinion pieces for the local newspaper or scheduling time away from a demanding medical practice to testify before legislators may not be routine activities in every physician's busy day. However, for Donald J. Kurth, M.D., FASAM, Chief of Addiction Medicine at the Behavioral Medicine Center of Loma Linda University, Redlands, CA, these activities are a routine part of daily life, as he spends many hours as a volunteer lobbying to pass legislation favorable to patients struggling with addiction and the physicians who treat them.

Dr. Kurth volunteered for the California Society of Addiction Medicine's Public Policy Committee after watching colleagues drop out of addiction medicine. "Year after year, I would go to ASAM conferences and ask about physicians that I'd met and become friends with from different parts of the country. I'd be told 'Oh, they don't do addiction anymore; their treatment center closed; they lost their practice and they're back working in an urgent care center'. The reason is they're not being paid," he concludes, adding "You can't do it and not get paid for it."

After watching addiction centers close in his own area, Dr. Kurth saw volunteer work as a way to keep his specialty alive. In January 2000, he and his colleagues in CSAM learned that the first California parity bill (SB.599) was heading to the Insurance Committee in the California Assembly. But the bill was modified so that it only called for a study of parity, which delayed any action for a year. Six months later, CSAM was asked to support Proposition 36, which allows treatment rather than incarceration for non-violent drug offenders.

Not everyone in California's addiction treatment community supported Proposition 36. Officials at the Betty Ford Center and drug court opposed the measure, and many of their arguments, says Dr. Kurth, were reasonable. Although the legislation excluded those who were convicted of selling drugs, or of violent crimes, it does not require (or fund) urine testing. Dr. Kurth says, "This was a dilemma for us. I was the least supportive of Proposition 36. Not that I didn't believe in it, but I work closely with the drug court judges. That's a good program in Loma Linda. It does a lot of good for a lot of people and I didn't want to alienate these people through our activities. But a huge number of people aren't receiving treatment they need."

After intensive discussion, CSAM supported Proposition 36. Soon, TV commercials

aired, and editorial pages filled with letters and opinion pieces. As the issue heated up, Dr. Kurth and his CSAM colleagues organized educational activities to generate discussion and to get information out. After putting substantial time and effort into organizing seminars and day-long conferences, they found that nobody came. "None of the drug court judges would come." Dr. Kurth says. "They were afraid that this was a set-up and that they would be placed in an embarrassing situation, or be verbally attacked," he explains.

However, in voting in November 2000, the proposition passed by a 61% margin, which gave CSAM confidence and showed the members of the Public Policy committee that public support exists for addiction treatment. Today, Dr. Kurth and his colleagues are back at work on the parity bill, which recently passed an important committee of the California Assembly.

Dr. Kurth encourages all addiction medicine practitioners to become involved in parity legislation in their own states. He says the best way to begin is to call local legislators to ask where they stand on benefit parity for addiction treatment. If the legislator is not available, ask for the chief of staff or medical legislative analyst. If you can't speak with the legislator, then speak with staff members, they are in tune with what the legislators believe. "If the staff member

is on board you don't need to do anything else," he says. Then follow up with a letter explaining your support for parity.

Physicians with more time to give can obtain a list of legislative addresses and ask a transcriber to print mailing labels. "Once you've got that, you've got some power," Dr. Kurth says. "Everyone sends a lot of e-mails. It's much more effective to write a letter."

"Just write one letter to your representative and then send everyone else a copy," he advises. "While you are in a writing mode, put together an op-ed piece mentioning your governor or local legislator. Politicians read and clip every word that's printed about them." Dr. Kurth recalls that when he wrote an article that appeared in the local newspaper, it gave credibility to the cause.

Physician involvement makes a difference, says Dr. Kurth, because lawmakers often don't know about medical issues until they are educated. The opinion of physicians is highly regarded, as are visits by physicians. Dr. Kurth has made several trips to Sacramento to meet with Assembly members and, during a recent trip to Washington, D.C., he used a few spare hours to meet with members of California's Congressional delegation. Dr. Kurth says appointments are helpful but not necessary, because lawmakers are impressed to have a physician stop by. "When we go in to see legislators about health matters, we are the experts, and they know that we are not paid lobbyists. We are the ones working in the trenches, treating patients day in and day out," he says.

Dr. Kurth says that finding time for these activities is a difficult but worthwhile effort. He finds time at the beginning of the day by waking earlier and devotes time on weekends as well. The staff at Loma Linda Hospital is even becoming accustomed to his lobbying. "It's really hard for me to get time off work because I work in a hospital-based detox program and there's only a handful of physicians who can cover for me."

To physicians who specialize in addiction medicine, Dr. Kurth says, "If you're not willing to get involved in the struggle for parity, maybe you need to think about doing something else for a living, because without parity, I don't think our reimbursement is going to be there."

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

## ASAM

### 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

### February 1-3, 2002

Medical Review Officer (MRO) Training Course  
Orlando, FL  
20 Category 1 CME credits

### April 25, 2002

Pain & Addiction: Common Threads III  
Atlanta, GA  
7 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 21 Category 1 CME credits

### July 19-21, 2002

Medical Review Officer (MRO) Training Course  
Washington, DC  
20 Category 1 CME credits

## OTHER EVENTS OF NOTE

### December 13-16, 2001

American Academy of Addiction Psychiatry  
12th Annual Meeting and Symposium  
Amelia Island, FL  
[For information, phone 913/262-6161  
or e-mail info@aaap.org]

### February 1-2, 2002

25 Years of Addiction Treatment  
(sponsored by the Harvard Medical Center)  
Boston, MA  
[For information, phone 617/503-3460  
or e-mail cme@challiance.org]

### February 20-23, 2002

Society for Research on Nicotine and Tobacco  
8th Annual Meeting  
Savannah, GA  
[For information, e-mail smt@tmahq.com  
or phone 608/838-3787 x144]

### February 20-24, 2002

American College of Preventive Medicine  
Prevention Medicine 2001  
San Antonio, TX  
[For information, visit  
www.PreventiveMedicine2002.org,  
or phone 202/466-2044]

### September 20-22, 2002

Medical Review Officer (MRO) Training Course  
Scottsdale, AZ  
20 Category 1 CME credits

### February 27-March 3, 2002

American Academy of Pain Medicine  
Annual Meeting & Review/Refresher Course  
San Francisco, CA  
[For information, phone 847/375-4731  
or visit www.painmed.org]

### March 14-17, 2002

American Pain Society  
21st Annual Scientific Meeting  
Baltimore, MD  
[For information, visit www.ampainsoc.org]

### May 14-16, 2002

Maintenance Therapy: Evidence-Based  
Practice and Integrated Treatment  
5th Europad Conference  
Oslo, Norway  
[For information, visit  
www.med.uio.no/ipsy/skr/conf.htm]

### October 28-30, 2002

International Society for the Prevention  
of Tobacco-Induced Diseases  
First Annual Scientific Meeting  
Essen, Germany  
[For information, visit www.ptid2002.info  
or e-mail toxicol98@aol.com]

## San Francisco Bay Area

We are actively seeking an Addiction Medicine specialist with a background in internal medicine or family practice and a thorough understanding of addiction treatment and recovery. ASAM certification is preferred; certification-ready is required.

We provide consultation-liaison services to two general hospitals and direct comprehensive chemical dependency treatment services including residential, partial hospitalization and intensive outpatient at multiple locations. We also participate as a test site in addiction-related pharmacological research. We operate utilizing a treatment team at all levels of care, including addiction counselors, licensed therapists and nurse practitioners. A competitive compensation package is included.

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## DUES AND VERIFICATION FORMS MAILED

Membership dues notices for calendar year 2002 have been mailed to all members, along with a 2002 Membership Directory verification form. Please return your dues payment and completed verification form by January 1, 2002.

## ASAM STAFF

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

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

Berit Boegli  
Meetings Consultant  
BBOEG@ASAM.ORG

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

Valerie Foote  
Data Entry Operator  
VFOOT@ASAM.ORG

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

Lynda Jones  
Director of Finance  
LJONE@ASAM.ORG

Sherry Jones  
Office Manager  
SJONE@ASAM.ORG

Stacey Kocan-McCormick  
Membership and Chapter  
Development Assistant  
SKOCA@ASAM.ORG

Sandra Metcalfe  
Acting Director of  
Meetings and Conferences  
SMETC@ASAM.ORG

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

Celso Puente  
Membership and Chapter  
Development Manager  
CPUEN@ASAM.ORG

Noushin Shariati  
Accounting Assistant  
NSHAR@ASAM.ORG

Christopher Weirs  
Credentialing  
Project Manager  
CWEIR@ASAM.ORG

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