ASAM NEWS

SEPTEMBER-OCTOBER 2001 VOLUME 16, NUMBER 5

NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

INSIDE

ASAM AT WORK FOR YOU:

ALSO SEE:

California Assembly Considering Parity Legislation

Dr. Donald J. Kurth

Parity legislation (SB.599), which has been vigorously supported by the California Society of Addiction Medicine, has been passed by a key committe of the California Assembly despite strong and coordinated HMO and insurance lobby opposition.

Donald J. Kurth, M.D., FASAM, and Charles D. Moore, M.D., both testified before the Health Committee on behalf of CSAM. Dr. Kurth reports that Robert Harris of Jim Gonzalez and Associates received a round of applause when he pointed out that persons convicted of drug crimes could receive addiction and alcoholism treatment in California [under the recently enacted Proposition 36], while persons with jobs and health insurance often cannot.

Many organizations and community leaders testified in favor of the bill, which was opposed by almost a dozen HMO and insurance lobby witnesses. Dr. Kurth says that he was disappointed to see the vote split strictly along party lines, "but it was obvious that the Republicans on the Health Committee were under extreme pressure from their caucus to vote against the bill,

▶ **PARITY LEGISLATION,** *continued on page 2*

ASAM'S MESSAGE ABOUT THE EVENTS OF SEPTEMBER 11

★ ★ ★ ★ ★ ★

"As an organization of physicians dedicated to caring for our patients' physical, emotional and spiritual well-being, ASAM decries the horrific loss of life resulting from the recent terrorist attacks. The Society's members and leadership extend heartfelt sympathy to the victims, the rescuers, and their families. God bless us all."

Andrea G. Barthwell, M.D., FASAM

Dr. Barthwell to be Nominated to White House Post

President Bush has announced his intention to nominate ASAM President Andrea G. Barthwell, M.D., FASAM, to serve as Deputy Director for Demand Reduction of the Office of National Drug Control Policy.

Dr. Barthwell is Executive Vice President of the Human Resources Development Institute, President of Encounter Medical Group, and President and CEO of the BRASS Foundation, an addiction treatment center in Chicago, IL.

In addition to her service to ASAM, Dr. Barthwell sits on the boards of several alcohol and drug treatment and prevention organizations, including the American Methadone Treatment Association and the Legal Action Center. She also serves on the National Advisory Board of the Center for Substance Abuse Treatment, the Drug Enforcement Administration's professional advisory committee, the Illinois Department of Alcoholism and Substance Abuse's AIDS Committee, and the National Black Alcoholism and Addictions Council.

A graduate of Wesleyan University in Connecticut and the University of Michigan Medical School, Dr. Barthwell long has focused on the psychological and sociological impact of substance abuse on our nation's communities. An author and lecturer on the problems and challenges associated with alcohol and drug abuse, she regularly consults with government agencies and the community-based organizations and counseling centers that deal with the very personal side of addiction. In 1997, Dr. Barthwell was selected by her peers as one of the "Best Doctors in America" in Addiction Medicine and featured in *Chicago Magazine*. ■

▶ *see related story on page 2*

Dr. James F. Callahan

Support a Colleague and Friend

James F. Callahan, D.P.A.

ASAM is honored that President Bush has announced his intention to nominate ASAM's President, Dr. Andrea Barthwell, to serve as Deputy Director for Demand Reduction of the Office of National Drug Control Policy. Indeed, Dr. Barthwell's nomination already has received significant support from the alcohol and drug treatment and prevention field, whose members are pleased that the Administration has selected such an exceptional addiction medicine professional for this key post in the Office of National Drug Control Policy.

Field leaders are praising Dr. Barthwell's combination of clinical and policy expertise, citing that these qualifications will make her invaluable in Washington. Many field leaders applauded President Bush for Dr. Barthwell's nomination, and viewed it as a positive statement about the Administration's commitment to working on drug and alcohol treatment and prevention issues.

The position of Deputy Director for Demand Reduction requires Senate confirmation. While it is unclear at this time when the Senate Health, Education, Labor, and Pensions Committee will hold a confirmation hearing on Dr. Barthwell's nomination, we can support our colleague and friend by writing or phoning members of the Senate to express support for Dr. Barthwell's confirmation.

Communications should be directed to your own Senators, as well as to the members of the Senate Committee on Health, Education, Labor and Pensions (it would be particularly effective to contact any member of the committee who represents your state). Committee members are:

Edward M. Kennedy (D-MA), *Chairman*
Judd Gregg (R-NH), *Ranking Member*
Jeff Bingamon (D-NM)
Christopher Bond (R-MO)
Hillary Rodham Clinton (D-NY)
Susan Collins (R-ME)
Mike DeWine (R-OH)
Christopher Dodd (D-CT)
John Edwards (D-NC)
Mike Enzi (R-WY)
Bill Frist (R-TN)
Tom Harkin (D-IA)
Tim Hutchison (R-AR)
James Jeffords (I-VT)
Barbara Mikulski (D-MD)
Patty Murray (D-WA)
Jack Reed (D-RI)
Pat Roberts (R-KS)
Jeff Sessions (R-AL)
John Warner (R-VA)
Paul Wellstone (D-MN)

Letters to committee members may be addressed to: The Honorable [name], Committee on Health, Education, Labor, and Pensions, 428 Dirksen Senate Office Building, Washington, DC 20510-6300, or phone 202/224-5375. Letters should be copied to Senator Kennedy, who is committee chair. ■

▶ **PARITY LEGISLATION,** *continued from page 1*

regardless of their own beliefs or convictions regarding addiction parity."

If it passes the Assembly, the fate of the bill will rest with Governor Gray Davis. Advocates are concerned that Gov. Davis feels he needs the support of the HMO and insurance lobbies in his re-election campaign in 2002 and thus may be inclined to veto the bill. Dr. Kurth believes it will require a massive lobbying effort—including letter writing and phone calls—to convince the Governor that it is in his best interest to sign the Addiction Parity Bill into law.

Dr. Kurth concludes that, "If he still won't sign it, we will have to bring it back again next year. Senator Chesbro has made the commitment to bring the Addiction Parity Bill back every year for as long as he is in office until it passes and becomes law. His commitment has been unswerving and we owe him and his staff a debt of gratitude for all their hard work."

Appraising the overall situation, Dr. Kurth concludes that "It is nothing short of a miracle that we have moved SB.599 as far as we have in this process. When we organized the CSAM Public Policy Committee just over a year and a half ago, I don't think any of us dreamed that we could have come this far in such a short period of time." ■

▶ *see related story on* **BENEFIT PARITY,** *page 15*

American Society of Addiction Medicine

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Chevy Chase, MD 20815

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

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

AA Conversations Not Admissable as Evidence

A federal judge has ruled that comments made in an Alcoholics Anonymous (AA) meeting cannot be admitted as evidence. In overturning the manslaughter conviction of a 33-year-old White Plains, NY, man, U.S. District Court Judge Charles Brieant ruled that comments made in an AA meeting could not be used as evidence against him.

Paul Cox was convicted of two counts of manslaughter for the 1988 stabbings of two persons in their home. Cox did not know the couple, but they lived in the home where he grew up. Cox claimed during his trial that he had no memory of the attack. However, the prosecution submitted subpoenaed testimony from AA members who said that Cox had discussed memories of the stabbings at AA meetings.

Cox appealed his 16-year prison sentence, claiming that his statements to fellow AA members were confidential and should not have been admitted as evidence. District Attorney Jeanine Pirro had argued that the testimony was not privileged because "there was no evidence whatsoever that Alcoholics Anonymous is a religious organization as required by statute, or that another member is a clergyman."

In his ruling, Judge Brieant agreed that conversations among AA participants may not be used as evidence because the exchanges are a form of confidential religious communication. He also wrote that the entire AA relationship "is anonymous and confidential." He cited a 1999 federal appeals court ruling that AA is a religious organization and a state Court of Appeals finding stated that "adherence to the AA fellowship entails engagement in religious activity and religious proselytization."

Source: Associated Press, August 2, 2001.

FDA Warns About OxyContin, Maker to Reformulate Drug

The U.S. Food and Drug Administration (FDA) has ordered the makers of OxyContin® to place a "black-box" warning on the prescription drug. A black-box warning is the highest-level warning for an FDA-approved drug.

The FDA told the drug's manufacturer, Purdue Pharma of Stamford, CT, to make the change after receiving increasing reports of addiction, emergency room visits, and overdose deaths. The agency also sent a notice to physicians and pharmacists warning them of OxyContin's potential for addiction and misuse.

In response, a spokesman said Purdue Pharma is developing a new painkiller that will be more difficult to misuse. "Addicts and abusers are going to find this very undesirable," said J. David Haddox, M.D., senior medical director for Purdue Pharma. "Before long they're going to say, 'Don't mess with that stuff; that's no good.'"

The new analgesic, yet to be named, contains embedded microscopic "beads" of the anti-opiate drug naltrexone that are released if the drug is crushed into a powder and snorted or injected. OxyContin abusers typically break open the pill and snort or inject the powder to get a heroin-like high.

Dr. Haddox said that Purdue Pharma is conducting tests of the reformulated drug and said it expects it to reach the market within three years.

Source: Reuters News Service, July 25, 2001; Associated Press, August 8, 2001.

House Passes Drug-Free Communities Bill

The U.S. House of Representatives has overwhelmingly approved legislation reauthorizing the federal Drug-Free Communities Act, authorizing $400 million to develop and support community-based anti-drug coalitions over the next five years.

The House voted 402-1 in favor of the measure, HR.2291. The legislation also calls for the creation of a national institute to provide education and technical support to existing coalitions, and provides a funding mechanism for successful coalitions to mentor those that are struggling to get established.

Both the original Drug-Free Communities Act and the reauthorization legislation were sponsored by Rep. Rob Portman (R-OH), who is president of a community coalition in his hometown of Cincinnati. The Senate has yet to vote on its version of the measure, S.1075.

Source: Washington Post, September 7, 2001.

U.S. Moving Forward with Tobacco Lawsuit

An attorney in the U.S. Justice Department said the federal government's lawsuit against the tobacco industry is strong and will proceed. "The case is proceeding and it is proceeding well," said Stuart Schiffer, who is acting assistant attorney general in charge of the Department's civil division.

Congressional Democrats recently accused the Bush administration of trying to drop or settle the case. For several months, Sen. Richard Durbin (D-IL) said he was trying to get an official confirmation from U.S. Attorney General John Ashcroft as to whether the lawsuit would move forward. "He has had seven months to review this case," said Durbin. "Yet despite repeated Congressional inquiries, including more than a few from me, the admin-istration's official position remains that it is still reviewing the case."

The lawsuit seeks $20 billion to recoup what the government says the tobacco industry earned through fraud.

Source: Associated Press, September 5, 2001. ■

ASAM's Database and You

Nancy Brighindi
Director of Membership and Chapter Relations

ASAM is updating its database records. If you wish to have your name excluded from the products of this database (such as mailing lists or membership directories in print or on our Web site), just send a written request to headquarters by e-mail (***nbrig@asam.org***), fax (301/656-3815) or mail (ASAM Membership Department, 4601 No. Park Ave., Suite 101 Upper Arcade, Chevy Chase, MD 20815-4520). When you write to us, please include your full name and complete address, as they appear on the mailing label of your copy of *ASAM News*.

We will exclude your information from our lists for one year. Please note that you may continue to receive marketing materials from companies that do not use our data, or that have previously purchased our information to compile lists.

A Powerful Tool Against Addiction

Andrea G. Barthwell, M.D., FASAM

As physicians, we know the impact of alcohol on adolescent brain development. We also know the probability of alcohol addiction corresponds directly to the age at which alcohol use begins. The younger the drinker, the greater the chance of addiction. The *Journal of the American Medical Association* recently published a study showing a negative correlation between the age at which an individual begins drinking and the lifetime risk of alcohol-related injury.

Dr. Andrea G. Barthwell

Dr. Norman Wetterau, chair of ASAM's Family Practice Committee, succinctly summarizes the lessons from the research literature: "Simply put, reducing underage drinking is our most powerful tool to reduce alcohol addiction and injury. Primary care physicians can talk with adolescents in their offices about the good medical reasons for postponing alcohol use. All physicians can become involved in supporting environmental strategies to reduce underage drinking. Physician support for such initiatives is important. When we are silent, our silence is deafening."

I want to tell you about an opportunity to be involved. The American Medical Association, with funding from the Robert Wood Johnson Foundation, is testing environmental changes and their impact on underage drinking at 12 sites nationwide. The project, called "Reduce Underage Drinking through Coalitions" (RUDC), funds community coalitions that use public policies to reframe community environments. For example, requiring beer keg registration creates a link of accountability to the adult purchasers who supply underage keg parties. More impressively, research has shown that even modest increases in alcohol excise taxes will reduce alcohol consumption by adolescents. Despite the predictions of the alcohol beverage industry, "Joe Six-Pack" continues to drink, even with higher taxes. But "Joe Jr." is priced out of the market.

Through RUDC, adolescents are actively involved in local leadership and in the creation and implementation of large and small environmental changes. I was impressed to learn that in Houston, an 18-year-old RUDC participant asked the local zoo to remove signs introducing two lizards as "Frankie and Louie"—the characters in a popular Budweiser beer ad. The young advocate politely explained that the names created a positive attitude toward alcohol among children visiting the zoo. The zoo responded by removing the sign. That's advocacy!

Research continues to demonstrate that treating addiction requires a variety of treatment options. The same is true of environmental change. Public policy options need to be adopted and tested to determine their efficacy. As physicians, we should assist in exploring options to prevent addiction. I believe that the 12 RUDC sites listed below are making a valuable contribution to our understanding of the public policy alternatives that curb alcohol addiction.

In my first message as your President, I promised to seek out productive partnerships for ASAM. Now I am asking you to pursue a productive partnership. I hope you will contact an RUDC site in your area. Your participation in an RUDC program benefits your community and strengthens our most powerful tool to prevent alcohol addiction. ■

Local RUDC Coalitions

Connecticut Coalition to Stop Underage Drinking
30 Arbor St.
Hartford, CT 06106
1-800/422-5422 or
860/522-8042

Georgia Alcohol Policy Partnership (GAPP)
6045 Atlantic Blvd.
Norcross, GA 30071
770/239-7442

Indiana Coalition to Reduce Underage Drinking
39 Boone Village
Zionsville, IN 46077
317/873-3900

Louisiana Alliance to Prevent Underage Drinking
5700 Florida Blvd., Suite 604
PO Box 65242
Baton Rouge, LA 70806
225/216-0910

Minnesota Join Together Coalition to Reduce Underage Drinking
2829 Verndale Ave.
Anoka, MN 55305
763/662-7303

Missouri's Youth/Adult Alliance
1648 East Elm St.
Jefferson City, MO 65101
573/635-6669, Ext. 112

North Carolina Initiative to Reduce Underage Drinking
200 Park Offices Dr., Ste. 212
PO Box 13374
Research Triangle Park, NC 27709
919/990-9559

Oregon Coalition to Reduce Underage Drinking
6443 SW Beaverton-Hillsdale Hwy.
Portland, OR 97221-4230
503/244-5211

Pennsylvanians Against Underage Drinking (PAUD)
Northwest Office Bldg., Rm. 603
Harrisburg, PA 17124-0001
717/705-8068

Puerto Rico Coalition to Reduce Underage Drinking (COPRAM)
65 Infantry Station, PO Box 29132
Rio Piedras, PR 00929-0132
787/641-1154

Texans Standing Tall—A Statewide Coalition to Prevent Underage Drinking
611 S. Congress Ave., Ste. 506
Austin, TX 78704
512/442-7501

National Capital Coalition to Prevent Underage Drinking
1875 Connecticut Ave., NW
Suite 732
Washington, DC 20009
202/265-8922, Ext. 18

AMA Delegates Deal with Policy, Personnel Issues

Stuart Gitlow, M.D.
ASAM Delegate to the AMA House of Delegates

The AMA House of Delegates opened its June meeting in Chicago after several days of section and council meetings, caucuses, and extended telephone conferences. As usual, the entire handbook of resolutions considered by the House was many inches thick. Dr. Lloyd Gordon, our alternate delegate, and I actively participated in matters before the Section Councils on Psychiatry and Preventive Medicine, the Specialty and Service Section, and several state and section coalitions. Special thanks go to ASAM's new delegate to the AMA Medical Student Section, Shantanu Agrawal, whose input and support were very helpful.

Medical Marijuana

Of significant interest to ASAM members was a report from the AMA Council on Scientific Affairs on "medical marijuana." As initially drafted, the report said that AMA supported the compassionate use of marijuana and related cannabinoids in carefully controlled programs designed to provide symptomatic relief or palliative effects.

Your delegation felt certain that such wording would be misconstrued as support for the use of a substance that has yet to be shown to have any meaningful medical effects. Historically, the AMA never has supported the use of an unapproved medication for any purpose, and we argued that the report under consideration had been shaped in response to political rather than scientific concerns. The House voted down the wording to which we objected. As a result, AMA policy does not support the medical use of marijuana (the text of the report can be viewed on the AMA's Web site at *www.ama-assn.org*). However, this clearly is not the end of the issue.

Your delegation held talks with members of the Council on Scientific Affairs, in which we encouraged them to provide the ASAM Board with draft language before a report is submitted to the House. A compromise may be possible, but at this time, your delegation believes that supporting the medical use of an unproven substance is inappropriate.

Management of Pain

In the course of the debate, the issue of drug diversion was raised, with special attention to the press reports related to abuse of OxyContin®. The House determined that the AMA will support the prevention and treatment of pain disorders through aggressive and appropriate means, coupled with continued education of physicians in the use of opioid preparations. AMA will support education of medical students and physicians to recognize addictive disorders, to minimize the diversion of opioid preparations, and to appropriately treat or refer patients as needed. The AMA also will work with organizations such as ASAM to serve as an educational resource to the media on the management of pain disorders.

There was much testimony regarding the inadequacy of insurance benefits for patients with chronic pain. The AMA Board of Trustees will refer this issue for further study, probably to the Council on Scientific Affairs.

Other Drug-Related Issues

Other substances were discussed as well:

- The AMA will call for a coordinated effort by government, academics, and organized medicine to address the problem of the use of anabolic/androgenic steroids by students. They will further encourage development of public awareness programs and identify potential funding for this effort from numerous sources.
- Extensive testimony was heard regarding tobacco control efforts. Henceforth, AMA staff will, at the request of member organizations, analyze legislation suggested or supported by any representative of the tobacco industry or entity with strong ties to the tobacco industry. Further, they will compare such legislation with recommendations for effective tobacco control programs. ASAM members are encouraged to notify headquarters of any tobacco control legislation that is brought forward in their states or municipalities, so that we can take advantage of the AMA's extensive political analysis capabilities.
- Further AMA involvement in tobacco control activities is expected, as Dr. Ron Davis, an outspoken advocate of tobacco control and a strong supporter of ASAM, won a four-year term as member of the AMA's Board of Trustees.
- In other issues related to substance use, the House agreed to advocate for increased federal funding for hepatitis C research, prevention, and treatment commensurate with the magnitude of the public health impact of the disease. New policy was formed with respect to disposal of syringes, needles, and other sharps. The House agreed that AMA will now support action in government to identify, develop, implement, and evaluate strategies to ensure safe sharps disposal in the community. The Council on Scientific Affairs released an extensive report on this topic now available at the AMA's Web site.

DUI Policy

The House adopted a new and significant policy concerning driving under the influence (DUI) of alcohol or other drugs. The new AMA policy encourages enactment of state legislation that mandates screening all DUI offenders for substance use disorders. The policy also calls for addiction treatment when medically indicated, in addition to but not in place of other sanctions. The policy also calls for appropriate adjunct services to be provided to or encouraged among family members.

The AMA also will encourage continued research and testing of devices that may incapacitate vehicles owned or operated by DUI offenders.

At its interim meeting in December 2000, the House adopted a policy opposing so-called "carved out" benefit plans for the delivery of mental health services. At the June meeting, additional wording was adopted to indicate that AMA opposes carve-outs when they result in denial of necessary or appropriate care; reduce access to care, interfere with integrated care, interfere with physicians' ability to initiate needed referrals, or create additional burdens for patients or physicians. Clearly, the AMA House opposes carve-outs.

▶ *continued on page 6*

▶ continued from page 5

AMA Business

Members of the House of Delegates were concerned about a new business partnership formed by the AMA with the Axciom Corporation, which has resulted in a new business enterprise called HealthCarePro Connect (HCPC). HCPC is designed to help physician manage mail from marketing companies. The AMA long has rented mailing lists based on its Physician Masterfile—the database that contains information about every physician in the U.S., whether or not they are members of the AMA. The masterfile does not contain information about patients, but does have office (and, in some cases, home) addresses and telephone numbers, education and specialty information for each physician. Renting mailing lists based on this database brings the AMA significant non-dues revenues. It also assures that the information is maintained in a professional manner.

For many years, to be removed from these mailing lists has required nothing more than a phone call to the AMA. Unfortunately, in addition to stemming the flow of unwanted mail, such removal also results in the loss of some desirable journals and pharmaceutical information. The HCPC venture is designed to allow physicians to selectively opt in or out of a variety of possible mailing lists, thus allowing them to receive desired items without receiving unwanted materials.

The House debate centered on the "default" selection that is assigned to those physicians who do not proactively choose those mailings they wish to receive, because it allows for the release of physicians' home addresses in some cases. The AMA Board will be reviewing this further over the coming months.

Organization Structure

Given the continuing decline in the percentage of physicians who are members of the AMA, the House gave concentrated attention to the issue of AMA membership and the resulting organization structure. Over the next year, the AMA will be intensively discussing and exploring several possible options, among which are to entirely overhaul the current membership structure of the organization. Options under consideration include: (1) recreating the AMA as an organization of organizations, in which each specialty and state society would pay dues according to the size of its own revenues or membership; (2) enrolling all physicians as AMA members at the time they graduate from medical school (in which case, there is a question of how or even whether to collect dues); (3) recreating the AMA as a combination of individual and organizational members; or (4) modeling the AMA's organization structure on the U.S. House and Senate, with one side having physicians as the representatives and the other having members of the lay public.

A final report on this topic is expected to be presented at the interim meeting of the House in December.

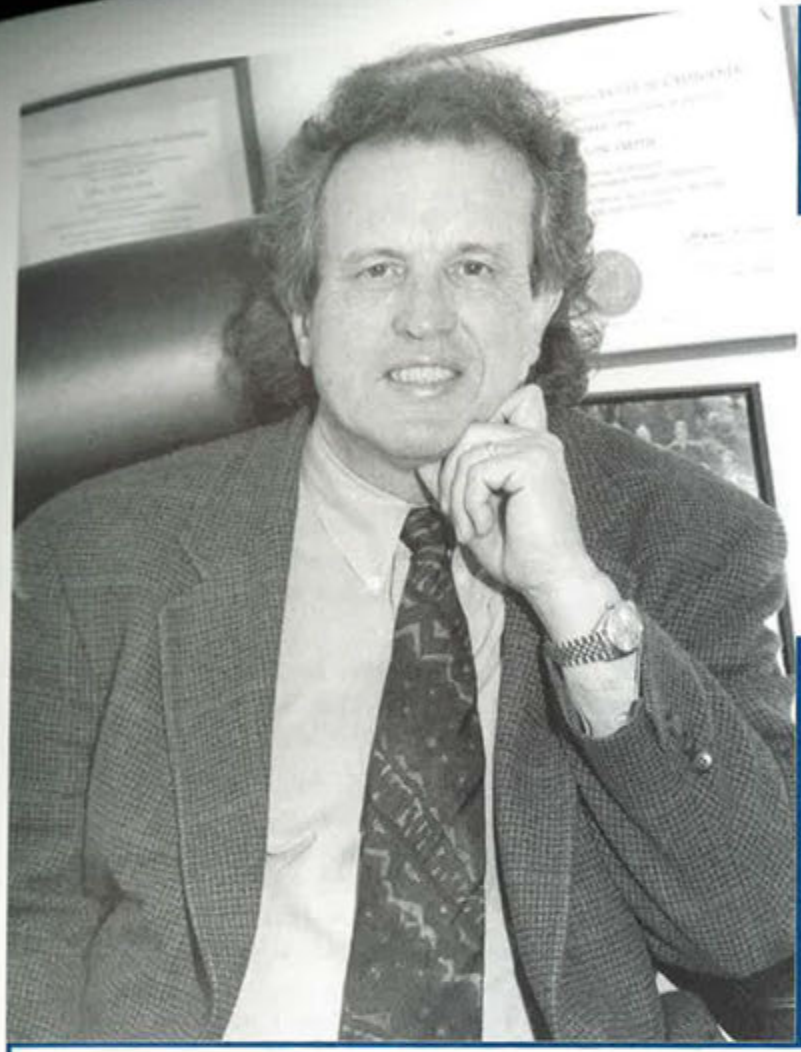
Personnel Matters

Many of the important events of the week were overshadowed by a flurry of press releases from E. Ratcliffe Anderson, Jr., M.D., then AMA Executive Vice President and CEO, and Ted Leuwers, M.D., Chair of the AMA's Board of Trustees. In his memos, Dr. Anderson announced that he had filed a lawsuit against the Board and its Chairman-Elect, Timothy Flaherty, M.D., alleging that the Board had interfered with his prerogatives as CEO in making personnel decisions. Dr. Anderson further charged that certain members of the Board and staff were complicit in a decision to sell the parcel of real estate known as "Block 241" (site of the old AMA headquarters building) at what he said was considerably less than current market value. In its memos, the Board indicated that it would "vigorously defend against Dr. Anderson's claims." Front page news stories followed, with the result that the mood of the delegates became somewhat agitated. (Shortly after the close of the meeting, the Board terminated Dr. Anderson's employment. His lawsuit against the Board continues.)

Because resolutions often pass or fail based on the prevailing spirit of the House, there were some clear departures from usual within the meeting. Despite these difficulties, your delegation is pleased with the results of House deliberations of interest to ASAM members.

Member input is critical to the success of your Society's delegation as it pursues ASAM's interests within the AMA House. Please contact me at ***drgitlow@aol.com*** with suggestions, questions, or comments. We also are most interested in adding to our delegation by including an additional medical student, a resident, and a young physician as alternate delegates. If you would like to volunteer, please contact me.

The next two meetings of the House of Delegates are scheduled for early December 2001 in San Francisco and in mid-June 2002 in Chicago. ASAM members are welcome to join us at the meeting. Any AMA member is allowed to address the Reference Committees, which hear testimony on draft reports and resolutions and make recommendations to the House of Delegates. Given the small size of ASAM's delegation, additional support would be most helpful. ■



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

Procedures for 2002 Election of Officers

The ASAM Board of Directors has approved the following procedure for the Society's next election of officers, to take place in November 2002.

Term: The term of office shall be two years. No member may hold the office of President or President-Elect for more than one term, successively. A Secretary or Treasurer may succeed himself/herself once without hiatus, and may subsequently be re-elected after a hiatus of two years.

Criteria: Nominees for the offices of President-Elect, Treasurer, and Secretary must be from, or have served on, the Board within the past four years. An exception may be made in the case of a nominee for the office of Treasurer, who may be a nominee from the general membership, having qualifications for the position, and having been active on the Finance Committee within the past four years.

Nominations: The Nominating and Awards Committee has determined that the individuals whose names are listed below are eligible for nomination to officer positions. Individual ASAM members may nominate candidates whose names appear on this list for consideration by the Nominating and Awards Committee. *(Such nominations are to be submitted by November 15, 2001, to the Nominating and Award Committee, ASAM, 350 Third Ave., No. 352, New York, NY 10010.)* The Nominating and Awards Committee will select only **two** candidates for each of the officer positions from among the eligible candidates, taking into consideration nominations from the membership at large.

Balloting: All ASAM members in good standing are eligible to vote. Officers shall be elected by a simple majority vote of the entire membership.

Eligible Candidates

The Nominating and Awards Committee has determined that the following members are eligible to be nominated for officer positions:

Louis E. Baxter, Sr., M.D., FASAM
Richard E. Beach, M.D., FASAM
Anthony H. Dekker, D.O., FASAM
Paul H. Earley, M.D., FASAM
Timothy L. Fischer, D.O.
Marc Galanter, M.D., FASAM
David R. Gastfriend, M.D.
Anne Geller, M.D., FASAM
R. Jeffrey Goldsmith, M.D.
Lloyd J. Gordon III, M.D., FASAM
James A. Halikas, M.D., FASAM
Thomas L. Haynes, M.D., FASAM
Elizabeth F. Howell, M.D., FASAM
(not eligible for Treasurer position)
Lori D. Karan, M.D., FASAM
Christine L. Kasser, M.D.
David C. Lewis, M.D.
Peter A. Mansky, M.D.
Peter E. Mezciems, M.D., FASAM
Michael M. Miller, M.D., FASAM
(not eligible for Secretary position)
Norman S. Miller, M.D., FASAM
Ronald F. Pike, M.D., FASAM
Peter Rostenberg, M.D., FASAM
Ken Roy, M.D., FASAM
John Slade, M.D., FASAM
David E. Smith, M.D., FASAM
James W. Smith, M.D., FASAM
Barry Stimmel, M.D., FASAM
G. Douglas Talbott, M.D., FASAM
Berton E. Toews, M.D., FASAM
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Dr. Alan Leshner

The Essence of Drug Addiction

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

The word "addiction" calls up many different images and strong emotions. But what are we reacting to? Too often we focus on the wrong aspects of addiction so our efforts to deal with this difficult issue can be badly misguided.

Any discussion about psychoactive drugs, particularly drugs like nicotine and marijuana, inevitably moves to the question "but is it really addicting?" The conversation then shifts to the so-called types of addiction—whether the drug is "physically" or "psychologically" addicting. This issue revolves around whether or not dramatic physical withdrawal symptoms occur when an individual stops taking the drug, what we in the field call "physical dependence."

The assumption that follows then is that the more dramatic the physical withdrawal symptoms, the more serious or dangerous the drug must be. Indeed, people always seem relieved to hear that a substance "just" produces psychological addiction, or has only minimal physical withdrawal symptoms. Then they discount its dangers. They are wrong. Marijuana is a case in point here, and I will come back to it shortly.

Defining Addiction

Twenty years of scientific research, coupled with even longer clinical experience, has taught us that focusing on this physical versus psychological distinction is off the mark, and a distraction from the real issue. From both clinical and policy perspectives, it does not matter much what physical withdrawal symptoms occur. Other aspects of addiction are far more important.

Physical dependence is not that important because, first, even the florid withdrawal symptoms of heroin and alcohol addiction can be managed with appropriate medications. Therefore, physical withdrawal symptoms should not be at the core of our concerns about these substances.

Second, and more important, many of the most addicting and dangerous drugs do not even produce very severe physical symptoms upon withdrawal. Crack cocaine and methamphetamine are clear examples. Both are highly addicting, but stopping their use produces very few physical withdrawal symptoms, certainly nothing like the physical symptoms of alcohol or heroin withdrawal.

What does matter tremendously is whether or not a drug causes what we now know to be the essence of addiction: uncontrollable, compulsive drug-seeking and use, even in the face of negative health and social consequences. This is the crux of how many professional organizations all define addiction, and how we all should use the term. It is really only this expression of addiction—uncontrollable, compulsive craving, seeking and use of drugs—that matters to the addict and to his or her family, and that should matter to society as a whole. These are the elements responsible for the massive health and social problems caused by drug addiction.

Drug craving and the other compulsive behaviors are the essence of addiction. They are extremely difficult to control, much more difficult than any physical dependence. They are the principal target

Too often we focus on the wrong aspects of addiction, so our efforts to deal with this difficult issue can be badly misguided.

symptoms for most drug treatment programs. For an addict, there is no motivation more powerful than drug craving. As the movie "Trainspotting" showed us so well, the addict's entire life becomes centered on getting and using the drug. Virtually nothing seems to outweigh drug craving as a motivator. People have committed all kinds of crimes and even abandoned their children just to get drugs.

Rethinking Addiction

Focusing on addiction as compulsive, uncontrollable drug use should help clarify everyone's perception of the nature of addiction and of potentially addicting drugs. For the addict and the clinician, this more accurate definition forces the focus of treatment away from simply managing physical withdrawal symptoms and toward dealing with the more meaningful, and powerful, concept of uncontrollable drug-seeking and drug use. The task of treatment is to regain control over drug craving, seeking and use.

Rethinking addiction also affects which drugs we worry about and the nature of our concerns. The message from modern science is that, in deciding which drugs are addicting and require what kind of societal attention, we should focus primarily on whether taking them causes uncontrollable drug seeking and use. One important example is the use of opiates, like morphine, to treat cancer pain. In most circumstances, opiates are addicting. However, when administered for pain, although morphine treatment can produce physical dependence—which now can be easily managed after stopping use—it typically does not cause compulsive, uncontrollable morphine seeking and use, addiction as defined here. This is why so many cancer physicians find it acceptable to prescribe opiates for cancer pain.

An opposite example is marijuana, and whether it is addicting. There are some signs of physical dependence or withdrawal in heavy users, and withdrawal has been demonstrated in studies on animals. But what matters much more is that every year more than 100,000 people, most of them adolescents, seek treatment for their inability to control their marijuana use. They suffer from compulsive, uncontrollable marijuana craving, seeking and use. That makes it addicting, certainly for a large number of people.

Treating Addiction

It is important to emphasize that addiction, as defined here, can be treated, both behaviorally and, in some cases, with medications, but it is not simple. We have a range of effective addiction treatments in our clinical toolbox, although admittedly not enough. This is why we continue to invest in research, to improve existing treatments and to develop new approaches to help people deal with their compulsive drug use.

Our national attitudes and the ways we deal with addiction and addicting drugs should follow the science and reflect the new, modern understanding of what matters in addiction. We certainly will do a better job of serving everyone affected by addiction—addicts, their families and their communities—if we focus on what really matters to them. As a society, the success of our efforts to deal with the drug problem depends on an accurate understanding of the problem.

Source: National Institute on Drug Abuse. ■

Ecstasy Trends Mirror Those of Crack Cocaine

With ecstasy use among young people in the United States increasing at a rapid pace, experts say it could become as destructive as the crack cocaine epidemic of the 1980s. Jim Hall, director of a drug-information center in Miami, FL, told an international conference convened by the National Institutes of Health that ecstasy use is on a course similar to that of the crack-cocaine epidemic that moved through the United States in the 1980s. Experts also expressed concern that the large number of young people using ecstasy today could be prone to cognitive impairment and depression in future years.

"In the short term, ecstasy can cause dramatic changes in heart rate and blood pressure, dehydration, and a potentially life-threatening increase in body temperature," said Alan I. Leshner, Ph.D., director of the National Institute on Drug Abuse. "In the longer term, research shows that ecstasy can cause lasting changes in the brain's chemical systems that control mood and memory."

The conference coincided with introduction of bipartisan legislation in the U.S. Senate that is aimed at increasing education efforts about ecstasy and establishing a federal task force to coordinate efforts to fight the drug. "Ecstasy dealers are selling the lie that by taking ecstasy, young people can get high without harming themselves," said Senator Bob Graham (D-FL), who drafted the bill. "But the truth is, what we know about the effects of ecstasy on the brain is frightening. And what we don't know is likely to be more so."

Source: Reuters News Service, July 19, 2001.

CLINICAL RESEARCH FELLOWSHIPS FOR PHYSICIANS

The Intramural Research Program (IRP), National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH), has clinical research fellowship positions for physicians at the Johns Hopkins University Bayview campus in Baltimore, Maryland. Available scientific technologies may include brain imaging, 24-hour physiological monitoring, computerized neurophysiological and neuropsychological testing, and drug pharmacokinetics. Duties include developing an individual research program and collaboratingas a Medically Responsible Physician with other investigators.

The successful candidate must be able to provide clinical care to human research subjects participating on various protocols. Candidates must have an M.D. or D.O. degree, be a U.S. citizen, Permanent Resident (or eligible to apply for permanent residency), and be licensed to practice medicine in Maryland (or eligible to obtain a license). Experience in substance abuse clinical research and treatment is desirable but not required. Salary levels are competitive and include a full Federal benefits package. The successful candidate also may qualify for up to $35,000 in annual repayment of student loans. In addition, relocation expenses may be paid.

Interested candidates must submit a Curriculum Vitae with bibliography, a statement of research interests and goals, a copy of the doctoral degree (if in a foreign language, include a certified English translation), and three (3) letters of recommendation from noncollaborators to: **Morgan DuBrow, Chief, Human Resources Management Section, NIH/NIDA/IRP, 5500 Nathan Shock Drive, Building C, Room 247, Baltimore, MD 21224. Mr. DuBrow is available at 410/550-1638, Fax 410/550-2224, or e-mail: MDUBROW@intra.nida.nih.gov.** The position(s) is open until filled; however, a cut-off date for consideration of applications received will be established as appropriate. You may apply by mail, in person, by fax, or by e-mail. Applications from women and minority candidates are strongly encouraged. *NIDA is an Equal Opportunity Employer.*

Highlights from the CEWG June 2001 Advance Report

The Community Epidemiology Work Group (CEWG), a network of epidemiologists sponsored by the National Institute on Drug Abuse, meets twice a year to discuss current and emerging drug problems. At its most recent meeting, in June 2001, the 21 CEWG areas reporting were Atlanta, Baltimore, Boston, Chicago, Denver, Detroit, Honolulu, Los Angeles, Miami, Minneapolis, Newark, New Orleans, New York, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, Seattle, Texas, and Washington, DC. Researchers from those areas identified the following trends:

- Heroin mentions increased in 15 CEWG reporting areas. Heroin use appears to be spreading to younger populations, as well as to suburban and rural communities. The purity of heroin is reaching peak levels nationwide. In South Florida, for example, "heroin is at its highest purity level (23%) and its lowest price ($1.03 per mg.)."
- Abuse of prescription opioids, while relatively small compared with other drug categories, continued to increase in urban, suburban and rural areas. Epidemiologists reported that hydrocodone and oxycodone are being used as substitutes for heroin. The drugs are being abused by long-term prescription drug users, as well as by youth and young adults.

Abuse of prescription opioids...continued to increase in urban, suburban and rural areas. The drugs are being abused by long-term prescription drug users, as well as by youth and young adults.

Number of ER Episodes Involving Hydrocodone and Oxycodone, 1994-2000

- Club drugs, including MDMA (ecstasy), GHB and ketamine, are being abused by small but growing numbers of young people in many CEWG areas. Ecstasy indicators increased in 13 CEWG reporting areas, while GHB use increased in nine areas.
- While remaining at high levels, use of cocaine and crack were stable or declined slightly in most CEWG reporting areas. In New York City, for example, researchers reported that "cocaine trends continued to show declines, but the drug still accounts for major problems."
- Marijuana indicators leveled off in 1999-2000 in 14 CEWG reporting areas, but continued to rise in seven CEWG areas. In some areas, substantial proportions of marijuana users are under age 18.

Source: National Institute on Drug Abuse, Community Epidemiology Work Group, Epidemiologic Trends in Drug Abuse, Advance Report, June 2001.

Resource: Hallucinogens and Dissociative Drugs

Hallucinogens and Dissociative Drugs: NIDA Research Report summarizes current knowledge about rates of use, methods of action, effects, and acute and long-term dangers of two important classes of drugs of abuse. The report, from the National Institute on Drug Abuse, describes hallucinogenic drugs, including LSD and mescaline, which act on the serotonin system to produce profound distortions of the user's sense of reality, as well as the dissociative drugs include the anesthetic agents PCP and ketamine and the cough suppressant dextromethorphan, all of which cause feelings of separation from the body. The report says that ketamine use has increased in recent years and that, in addition to its conscious abuse, it also has been given to unsuspecting victims to incapacitate them for sexual assaults. The report can be viewed at ***http://165.112.78.61/ResearchReports/Hallucinogens/Hallucinogens.html***, or a print copy may ordered from NIDA at 6001 Executive Boulevard, Bethesda, MD 20892, or by phone at 888/644-6432. Refer to NIH Publication No. 01-4209.

Drug Use and Hepatitis C Treatment

In opposition to an announced policy of the National Institutes of Health, researchers at the University of California, San Francisco (UCSF), are recommending that persons who use illicit drugs should receive treatment for the hepatitis C virus.

The 1997 Consensus Statement on the Management of Hepatitis C by the National Institutes of Health (NIH) recommends that persons who use illicit drugs should be denied treatment for hepatitis C until they have stopped their drug use for at least six months. But the UCSF researchers urge that those who use illicit drugs be given treatment immediately, arguing that "Controlling hepatitis C will require providing treatment to people who use illegal drugs. We believe that when treatment is guided by evidence, tolerance, and compassion, this can be done," said Brian R. Edlin, M.D., director of Urban Health Study in the UCSF Department of Family and Community Medicine and that university's Institute for Health Policy Studies.

The researchers recommend that, rather than deny hepatitis C treatment to all those who use illicit drugs, treatment decisions should be based on an individualized risk-benefit assessment. Factors that should be taken into consideration, they argue, are the patient's willingness to stay on medication, mental health and risk of depression, access to safe injection equipment and knowledge of safe injection practices.

The researchers' recommendation is supported by the Hepatitis C Illicit Drug User Treatment Policy Group, which is composed of 38 national and international experts in AIDS, liver disease, addiction, and health policy. "Illicit drug users are a stigmatized group with many health problems. A recommendation to withhold medical treatment from them raises questions about fairness and discrimination," the authors wrote in their recommendation.

Source: New England Journal of Medicine, July 19, 2001.

Moderate Alcohol Consumption Shows Mixed Effects on Brain

Moderate alcohol consumption evokes complex responses in the brain, resulting in fewer white matter abnormalities but a higher prevalence of brain atrophy, according to a report in the September edition of the journal Stroke.

White matter infarcts and brain atrophy are associated with poorer neurological and cognitive function, as well as greater declines in cognitive function over time, the authors explain. Whether moderate alcohol consumption by elderly individuals brings subclinical MRI findings had not been reported before now.

Dr. Kenneth Mukamal and colleagues at Beth Israel Deaconess Medical Center in Boston studied the relationship between alcohol consumption and MRI findings in 3,376 adults aged 65 years and over who participated in the Cardiovascular Health Study. An inverse relationship emerged between alcohol consumption and white matter infarcts, they found, with heavier drinkers (at least 15 drinks a week) facing only 57% of the white matter infarct risk faced by abstainers.

However, alcohol consumption and brain atrophy were found to be linearly related. According to the report, the heaviest drinkers showed brain atrophy scores approximately 0.2 grades higher than those shown by long-term abstainers. These associations changed little when the groups were stratified by gender, race, HDL level, apoE4 allele status, and type of beverage (beer, wine, or liquor) consumed, the researchers wrote.

"Alcohol consumption is consistently associated with lower risk of cardiovascular disease, but studies on alcohol use and cerebrovascular disease have been far more mixed," Dr. Mukamal said. "I think the final story on alcohol use and brain function hasn't been told yet." Dr. Mukamal added that the study results underscore the importance of physicians making individualized recommendations to their patients about alcohol use.

Source: Stroke, September 2001.

Smoking Declines Among Pregnant Women, Not Teens

Smoking has declined among adult pregnant women, but more pregnant adolescents are smoking, accordng to data released by the U.S. Centers for Disease Control and Prevention (CDC).

The CDC study shows that 12.3% of women smoked during pregnancy in 1999, a drop from 18.4% in 1990. Specifically, pregnant women aged 25 to 34 smoked 40% less often in 1999 than they did in 1990. However, the study also found an increase in smoking among pregnant adolescents since the mid-1990s. While smoking among pregnant 18- and 19-year-olds declined early in the decade, it increased to nearly one in five by 1999.

Noting that smoking during pregnancy is linked to low birthweight and other adverse neonatal outcomes, Dr. Alfred Munzer, past president of the American Lung Association, said "We're very concerned. The problem seems to be getting worse. Those [adolescent] are high-risk pregnancies to begin with."

Tommy Thompson, Secretary of the Department of Health and Human Services, added that "While the overall trend is encouraging, it's clear that we must do more to ensure young women understand smoking's real health risks for them and for their children."

Source: Associated Press, August 28, 2001. ■

Messages to Policymakers and the Public Need to Overcome Old Prejudices

Messages aimed at increasing treatment resources and preventing the stigmatization of persons with addictive disorders must overcome an old foe: blame.

So concludes a report on language and public attitudes, commissioned by the Center for Substance Abuse Treatment (CSAT). "Those in the ...addiction field tend to minimize the individual's role and responsibility in becoming addicted or needing treatment," noted the report, prepared by the Lewin Group consulting firm. In contrast, "Those in the general public tend to focus largely on personal weakness and responsibility, paying little attention to the scientific evidence of physical (brain) changes, the contributory role of mental illness for some, and the role of genetic predisposition," the report said.

CSAT initiated the study at the request of a panel on reducing stigma and changing attitudes, formed as part of the agency's National Treatment Plan initiative. The report drew upon a series of focus groups with members of the addiction field and the public, as well as an audit of the language currently used by field agencies and organizations.

Researchers said that little field consensus currently exists as to which terms should be used to describe addictive disorders and the persons who have them. "For example, some participants considered "substance abuse" to be an acceptable and appropriate term for use within the treatment community; others considered the term to be stigmatizing because of its link to other forms of criminal abuse, such as child, domestic, and sexual abuse," the report noted.

Illustrating this lack of agreement was an accompanying terminology review conducted by Lewin researchers, who looked at materials published by the Office of National Drug Control Policy, the Substance Abuse and Mental Health Services Administration, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, as well as field groups like ASAM, Narcotics Anonymous, and the National Council on Alcoholism and Drug Dependence. They found that, while most of the groups use the term "substance abuse," for example, many also used "alcohol and drugs" or "alcohol and other drugs" to describe the same concept. Federal agencies were more likely than field organizations to refer to addicted persons as "abusers," and NIDA, ASAM and ONDCP did not use the term "recovery."

Field organization representatives in the focus groups preferred language that focuses on individuals, separate from their behavior, environment, or disease. Members of the focus groups also preferred terms that support the disease concept of addiction and do not reinforce criminal stereotypes about persons with addictive disorders.

Many participants called for encouraging the use of more clinical language, expressing a preference for terms such as "relapse" and "remission," while others cautioned that overly technical language would simply encourage the public to continue using more familiar, stigmatizing terms.

The public still does not accept the fact that addictive disorders cross all socioeconomic and geographic boundaries, those in the focus groups agreed. "Broadly speaking, focus-group discussions centered on the need to recognize individuals who suffer from...addiction as normal people who have a treatable disease," the report said.

Public Doesn't Accept Disease Concept

The results of focus groups with members of the public make clear the challenges inherent in getting such messages across. The report noted that when members of the general public think about those with addictive disorders, their thoughts focus on issues of personal responsibility and weakness. "People often find it difficult to sympathize with substance abusers, who are seen as shirking their responsibilities by choosing a destructive lifestyle," the report noted.

Treatment is viewed by the public with skepticism, and many members of the public distrust persons in recovery, fearing that they could be a "time bomb" waiting to go off. "Few participants seemed to understand the addiction process as a disease, and fewer still knew how to approach someone close to them who they suspected might be a substance abuser," according to the report.

On the other hand, the CSAT report holds out hope that the public is ready to accept a well-crafted education campaign on addiction. "Most participants indicated being touched by the issue of substance abuse in some way, and this personal experience—both individual and familial—has made the public more open to hearing, learning, and talking about the subject," the report concluded.

While public knowledge about addiction is not extensive, many focus group members had a basic understanding of the disease, the report said. Even though many do not believe that treatment works, the public does accept the idea of seeking treatment for addiction.

Support for treatment as an alternative to incarceration remains strong; however, the public fails to grasp the chasm between treatment need and availability. "Almost all of [the focus-group members] believe that treatment is easy to access, if a substance abuser is serious about getting help," the report said.

Conclusion: Be Clear

To overcome these attitudes, field messages need to be clear, educational and informative, delivered by a trusted messenger. They also should be delivered through effective media, from TV commercials to billboards, the report said.

Messages also should focus on the areas of commonality found between the addiction field and the public. "The message should focus on success stories—those who have fought addiction and won," the CSAT report stressed. "One option would be to design a message focusing on family members who take pride in the determination that their loved one displayed.... From this perspective, those in recovery are portrayed as individuals who have summoned their strength to overcome a major problem."

Copies of the report, Language and Attitudes: Report of Preliminary Research (June 2001) are available from Yesenia Flores at CSAT, National Treatment Plan, 5600 Fishers Lane, Rockwall II Bldg., Suite 618, Rockville, MD 20857.

Source: Join Together, September 7, 2001. ■

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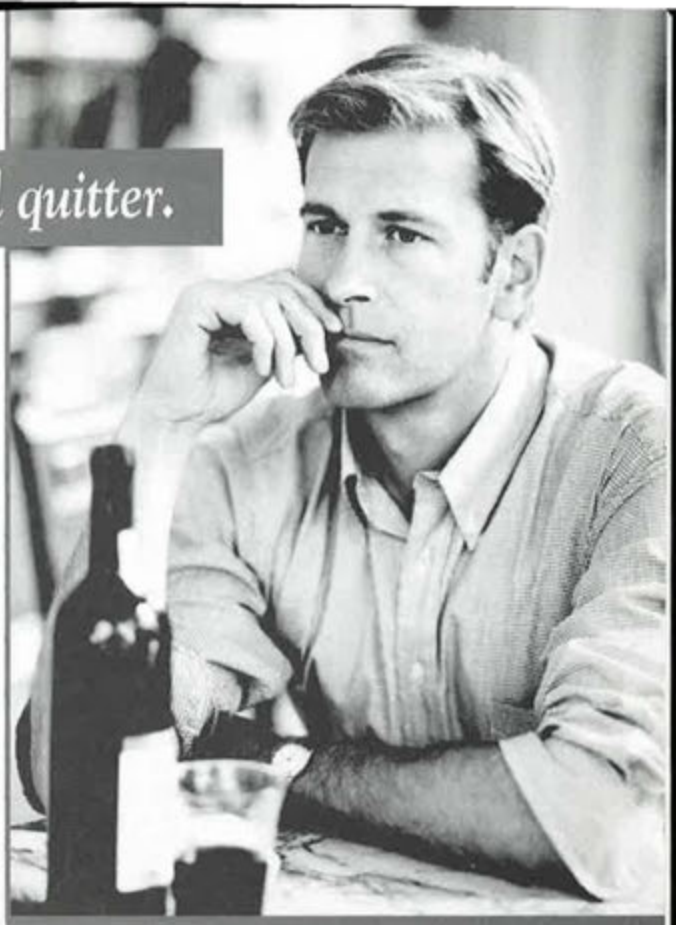

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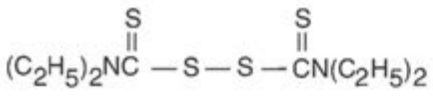

$C_{10}H_{20}N_2S_4$ M.W. 296.55

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

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

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

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

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

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

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

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

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

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

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

WARNINGS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TREATMENT NEWS


Dr. H. Westley Clark

Treatment Is More Effective When Children Are Involved

Women addicted to alcohol and other drugs have better outcomes if their children are involved in their treatment programs, according to a new federal study.

In a survey of 5,000 addiction treatment patients conducted by the federal Center for Substance Abuse Treatment between 1993 and 2000, investigators found that women were less likely to continue their addiction or commit crimes when their children were involved in their treatment programs. In addition, women who entered treatment during pregnancy had fewer premature or low-birthweight babies and lower infant mortality rates compared to those not receiving treatment.

Commenting on the survey results, CSAT Director H. Westley Clark, M.D., J.D., M.P.H., FASAM, observed that "Keeping children with their parents while their mothers learned parenting skills, as well as how to live drug- and alcohol-free, is itself a laudable goal."

Source: Associated Press, September 6, 2001.

Women's Smoking-Cessation Needs

Women have gender-specific issues that make it difficult for them to quit smoking, recent research shows. Dr. Kenneth Perkins, professor of psychiatry at the University of Pittsburgh Medical School, found that many women are concerned about weight gain and mood changes, and their chances of quitting are influenced by hormonal factors.

Experts recommend that women seek professional help when trying to stop smoking. Studies show that, overall, only 5% to 10% of those who try to stop smoking on their own are able to stop for a year. With help, the quit rate increases to 20% to 30%.

Dr. Michael Fiore, who chaired a panel that drafted a recent Surgeon General's report on smoking, said women may benefit more than men from the use of buproprion as a cessation aid, because the drug helps women deal with the higher rate of depression they experience when trying to quit.

"We still have a long way to go to understand the gender differences when it comes to quitting smoking," noted Michele Bloch, M.D., medical officer in the Tobacco Control Research Branch of the National Cancer Institute. "But we have some clues now."

Source: ABCNews.com, July 10, 2001.

Prison and Non-Prison Treatment Compared

Women derive different benefits from prison-based addiction treatment programs and those located off prison grounds, a new study finds.

Elizabeth Hall, who directs the Forever Free Substance Abuse Treatment Program Outcomes Study at the University of California, said the study found that women who received prison-based treatment initially did better on parole and in reducing drug use. On the other hand, women treated in non-prison programs fared better at finding jobs.

A year later, however, when researchers conducted a review of study participants, they found that 35% of the prison group had used alcohol or other drugs during the month before the interview, compared with 8% of the non-prison group. Also, 75% of the prison group reported using alcohol or other drugs at some time during their parole period, compared with half of the non-prison group.

The study findings were presented at a Research and Evaluation Conference sponsored by the National Institute of Justice.

Source: Substance Abuse Funding News, August 14, 2001. ■

Resource: Addiction and the Mature Woman

Under the Rug: Substance Abuse and the Mature Woman offers a comprehensive analysis of substance abuse and addiction involving alcohol, prescription drugs and tobacco among the 25.6 million mature American women—those age 60 and older. The introduction and executive summary are available on-line at http://www.casacolumbia.org/pubs/jun98/contents.htm. Print copies of the full report can be ordered for $25 from the Center on Addiction and Substance Abuse, Columbia University, 152 West 57th Street, New York, NY 10019-3310, or by phone at 212/841-5200.

BENEFIT PARITY

New Jersey Coalition Forming

George Sollami, M.D., of Brick, NJ, is interested in forming a coalition to press for benefit parity legislation in that state. Colleagues who wish to join the venture should contact Dr. Sollami at Ocean Pulmonary Associates, 525 Jack Martin Blvd., Brick, NJ 08724.

Web Site Simplifies Contacting Elected Officials

Writing to your members of Congress in support of benefit parity has never been easier, thanks to a Web site maintained by the National Council on Alcoholism and Drug Dependence (NCADD). Simply go to www.ncadd.org/programs/advocacy, then click on "Parity Kit" for a form letter, or compose one of your own. Go to "Take Action" to find the addresses of your members of the House and Senate. And there's no reason to use the information here only once—in fact, repeated messages are the best way to reinforce your message!

Minnesota Blues Settle Parity Suit

Blue Cross and Blue Shield of Minnesota have decided to settle out of court a parity lawsuit brought by the state Attorney General. The Blues have agreed to form a three-member Administrative Review Committee, which will have broad discretion to overturn denials of benefits for addiction and mental health services. The review committee's decisions will be binding on the insurers in all cases not covered by the federal Employee Retirement Income Security Act (ERISA).

Under the terms of the settlement, Blue Cross and Blue Shield will be required to transmit claims to the committee within 24 hours of denial, along with supporting documentation. In most cases, the review committee will make a decision to affirm or reverse the denial within one business day. (The review is automatic and does not require any action on the part of the consumer.)

A copy of the settlement agreement and the lawsuit complaint can be downloaded from www.ag.state.mn.us.

Source: Alcoholism & Drug Abuse Weekly, July 16, 2001. ■

RESEARCH NOTES

Nucleus Accumbens and Craving

The nucleus accumbens region of the brain, which anticipates reward, may play a role in addicts' craving, according to researchers at the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Researchers tracked changes in the brain activity of eight volunteers who participated in a video game where money was at stake. They found that anticipation of monetary rewards activates the nucleus accumbens of the ventral striatum—the same brain region involved in drug self-administration. After playing the game, the volunteers rated their reactions to various cues. Researchers found that higher-reward cues evoked increased self-rated happiness as well as nucleus-accumbens activity.

The report "Emphasizes the specific importance of the nucleus accumbens in the anticipation of reward and adds valuable new information toward understanding the role of reward in addiction," said NIAAA Director Enoch Gordis, M.D. "Since craving is a major problem that many alcoholics face on an ongoing basis, NIAAA is committed to understanding brain mechanisms related to craving and developing interventions that can help alcoholics to withstand the urge to drink."

Source: Neuroscience, August 10, 2001.

Cocaine and Craving

Even after users stop using cocaine, craving for the drug increases over time, rather than decreasing. The finding arises from work by researchers at the National Institute on Drug Abuse (NIDA).

Studying drug craving using laboratory rats, NIDA scientists found that sensitivity to the drug-associated environmental cues that often accompany drug craving and relapse increased over a 60-day withdrawal period. The researchers noted that, in humans, environmental cues often stimulate cocaine craving and accompany relapse to drug-using behavior. They report that, "The data from this study suggest that an individual is most vulnerable to relapse to cocaine use well beyond the acute drug-withdrawal phase."

"This phenomenon helps explain why addiction is a chronic, relapsing disease," said NIDA Director Alan I. Leshner, Ph.D. "Craving is a powerful force for cocaine addicts to resist, and the finding that it persists long after last drug use must be considered in tailoring treatment programs."

Source: Nature, July 12, 2001.

Alcohol-Related Genes Identified

Researchers at the University of Colorado Health Sciences Center in Denver have identified 41 genes that play a role in whether a person becomes an alcoholic. Dr. James M. Sikela and colleagues examined two types of mice, inbred long-sleep (ILS) and inbred short-sleep (ISS). The two different strains of mice have considerably different responses to alcohol; ILS mice can be compared to a human less likely to develop alcoholism, while ISS mice would be similar to a human alcoholic.

The researchers compared their genes and discovered 41 genes that were expressed differently in the brain cells of the two types of mice. "We have applied a new tool, high-density DNA chips—[which have] sprung out of the Human Genome Project—to the study of alcohol action in the brains of two strains of mice that differ in their sensitivity to alcohol," explained Dr. Sikela. "We found 41 genes that were different, and some of these are likely to be part of molecular pathways in the brain through which alcohol acts. This work provides insight into specific new molecular pathways and genes through which alcohol may work, and thus may be useful in prevention and treatment of alcohol abuse."

Source: Alcoholism: Clinical and Experimental Research, June 2001.

Alcohol Hinders Immune-System Action

Alcohol consumption blocks an immune-system protein that protects against pneumonia, according to animal studies conducted by Dr. Judd Shellito and colleagues at the Louisiana State University Health Sciences Center. The finding could explain why alcoholics are prone to developing lung infections.

The investigators set out to examine how alcohol abuse weakens the body's defenses against pneumonia. For the research, one set of mice was given water with alcohol added to it, while water only was given to another group of mice. After exposing the mice to the pneumonia bacteria, the researchers found that the mice fed only water produced the protein asinterleukin-17 (IL-17) to fight the infection, whereas the mice exposed to alcohol did not.

The researchers also discovered that injecting the gene for the IL-17 protein into the mice that had ingested alcohol reversed the harmful effects of alcohol consumption.

Source: Alcoholism: Clinical and Experimental Research, June 2001.

Alcohol and Breast Cancer

Women who consume alcohol daily and have a family history of breast cancer could double their risk of developing the disease, say researchers at the Mayo Clinic. "Our findings suggest that women with a family history of breast cancer, primarily close relatives, are placing themselves at further risk by consuming alcohol daily," said Thomas A. Sellers, M.D., professor of epidemiology at the Mayo Clinic Cancer Center and co-author of the study.

While previous studies have shown a link between breast cancer and drinking, this is the first study to focus on women who used alcohol daily and have a close relative with breast cancer.

For the study, researchers looked at 426 families with a history of breast cancer, including 9,032 women who were either blood relatives of patients or who had married into those families. Researchers then questioned the women on how much alcohol they had consumed throughout their lifetimes. They found that women who were first-degree relatives (mother, sister, daughter) of women with breast cancer and who used alcohol daily had twice the risk of developing breast cancer as first-degree relatives who never drank.

On the other hand, women who had married into a family with a breast-cancer history were no more at risk for breast cancer if they used alcohol daily compared to those who never drank. Women with second-degree relatives, such as grandparents and aunts, who had breast cancer had a slightly higher risk of developing breast cancer if they drank daily.

"Our intent was to evaluate the possibility that the importance of alcohol consumption as a risk factor for breast cancer may depend upon underlying genetic factors," Dr. Sellers said. "How individuals metabolize alcohol may relate to their risk of breast cancer."

Source: Cancer, July 15, 2001.

Methamphetamine and Pregnancy

Women who use methamphetamine during pregnancy increase the risk of brain damage in their male offspring, according to researchers at the University Of Chicago Medical Center.

In a study performed on mice, the researchers discovered that exposure before birth makes males, even as adults, much more susceptible to the drug's brain-

damaging effects. If the males who were prenatally exposed to methamphetamine take the drug themselves as adolescents or adults, the increased toxicity could hasten the onset of brain disorders such as Parkinson's disease, the researchers said.

"No one who values his or her brain should take this drug," said neurotoxicologist Alfred Heller, M.D., professor of neurobiology, pharmacology, and physiology at the University of Chicago and director of the study. "If you're male, and if your mother took methamphetamine...you should not go near this drug."

The impact on female offspring is not as severe—a fact researchers think could be connected with the rise in body temperature associated with use of the drug. Methamphetamine increases core temperatures more in males than in females.

Source: Journal of Pharmacology and Experimental Therapeutics, June 2001.

Gene Therapy for Alcoholism

Gene therapy has the potential to prevent and treat alcoholism, early research suggests.

In an experiment using rats, scientists at the U.S. Department of Energy's Brookhaven National Laboratory found that by increasing the level of a brain protein important for transmitting pleasure signals, rats that prefer alcohol could be turned into light drinkers, and those with no preference into nondrinkers.

"This is a preliminary study, but when you see a rat that chooses to drink 80% to 90% of its daily fluid as alcohol, and then three days later it's down to 20%, that's a dramatic drop in alcohol intake—a very clear change in behavior," said Dr. Panayotis Thanos, lead researcher for the study.

Dr. Thanos added that the study results could have implications for the prevention and treatment of alcoholism in humans. "This gives us great hope that we can refine this treatment for future clinical use," he said.

Source: Journal of Neurochemistry, September 2001.

Brain Differences Seen in Alcohol-Dependent Families

Adolescents in families with several generations of alcoholic ancestors exhibit differences in brain function when compared to children without a family history of alcoholism, a new study suggests.

For the study, 17 adolescents considered to be at high risk for alcohol dependence because of a strong family history of alcoholism underwent MRI scans. Their results were compared with MRIs from 17 teens without such a family history.

Researchers found that adolescents with a family history of alcoholism had a smaller amygdala (the right side of an area of the brain that controls basic emotions). "When we looked at some of the children who hadn't had any drugs or alcohol to speak of, the same pattern of smaller right amygdala volume was seen," said Dr. Shirley Y. Hill of the University of Pittsburgh. "Why the right amygdala? We are not sure."

The amygdala is part of a "reward circuit" within the brain, which other research has associated with some addictive behaviors. Dr. Hill explained that a smaller amygdala could indicate a developmental delay that affects this circuit. "The paper is the first demonstration that a brain structure that is part of a circuit that is involved in both emotion and cognition may be smaller in adolescents from families with a high loading of alcohol dependence," even before they drink, she said.

Source: Biological Psychiatry, June 2001. ■

Certification/ Recertification Deadline Nears

Christopher M. Weirs, M.P.A.

The deadline for early registration for ASAM's next Certification/ Recertification Examination for physicians who wish to be certified/ recertified in Addiction Medicine is October 31, 2001. 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:

- Early Registration ends Wednesday, October 31, 2001;
- 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.

PREVENTION RESEARCH

Warning Pregnant Women About Dangers of Drinking

Health campaigns should continue to focus on educating pregnant women about the dangers of drinking alcohol, according to a report from the Alcohol Research Group, Berkeley, CA. The report urges that health campaign should particularly target the needs of women who are most at risk. Report author Lee Ann Kaskutas, Ph.D., said statistics show that Native American and African-American women are at especially high risk for alcohol use during pregnancy.

Dr. Kaskutas said that women who already use alcohol at the time they become pregnant are unlikely to stop drinking altogether. "We want to give [them] the message not to drink," she said, but "while abstinence should be the goal, any reduction can have positive effects."

Programs are needed to educate women about the effects of alcohol use during pregnancy, Dr. Kaskutas said. "I was surprised so few women could identify a birth defect, or knew that it helps to cut down alcohol consumption," she added. "We should have health campaigns that address these issues."

The study was funded by the National Institute on Alcohol Abuse and Alcoholism.

Source: Reuters News Service, August 16, 2001.

Science-Based Programs Needed in Schools: DoED

A recently released analysis of the federal Safe and Drug-Free Schools and Communities program found that few school districts and communities use science-based programs that effectively reduce drug abuse and violence.

Authors of the report, entitled Progress in Prevention: National Study of Local Education Activities, looked at four principles established by the federal Department of Education. The principles give state and local educational agencies accountability-based measures on how to prevent and reduce student drug abuse and promote school safety. They require prevention programs to:

- Be based on a thorough assessment of objective data about drug and violence problems in schools and local communities;
- Provide activities that meet measurable goals and objectives for drug and violence prevention;
- Be based on research and evaluation that gives evidence that effective strategies are used to prevent or reduce drug use and disruptive behavior; and
- Evaluated periodically to assess progress toward achieving goals and objectives.

According to report author Scott Crosse, researchers found that most school districts—particularly the smaller ones—are greatly in need of assistance in implementing the four principles. "Unless these districts dramatically shift resources away from direct prevention activities for students or receive additional funding, such districts will be unable to afford activities that include evaluating progress towards goals and objectives," the report concluded.

The report is available on-line at http://www.ed.gov/offices/OUS/PES/progressinprevention.doc.

Source: Criminal Justice Funding Report, December 6, 2000.

Smoking Prevention Program Called Ineffective

A $15 million program designed to help school children resist peer pressure to smoke has been proven ineffective, researchers report. The program, developed by the National Cancer Institute and conducted in Washington State schools over the past 14 years, featured special classes for children in grades 3 to 10. However, a recent evaluation by the Fred Hutchinson Cancer Research Center found that more than a quarter of the schoolchildren in the study are regular smokers—about the same rate as those who did not participate in the special classes.

The program was based on a "social influences" approach. It included classes designed to equip children with the skills to ignore social pressures to smoke, to teach them about the dangers of smoking, and to provide motivation to remain smoke-free throughout life. In addition, students were taught to resist advertising, peer persuasion and negative influences at home.

"It simply didn't work," said Arthur V. Peterson Jr., the project's lead researcher. "It was a surprise. It was a disappointment." He said that researchers are now looking into new approaches for controlling youth tobacco use. "It is time for researchers to go back to the drawing board," said Peterson.

Source: Associated Press, December 19, 2000.

Dr. Baxter Cares for His Colleagues

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

Jeanne Erdman

Perhaps physicians who personally suffer from the disease of addiction represent the "last taboo" in medicine. Yet if the general population has problems with alcohol and drugs, why do we expect a medical degree to confer some sort of immunity? In fact, the incidence of impairment among physicians is at least equal to that in the general public, says Louis E. Baxter, Sr., M.D., who directs the Physician's Health Program of the Medical Society of New Jersey.

Dr. Baxter calls this last taboo the "M.D.-iety syndrome," adding that "Physicians themselves and patients often put physicians on pedestals. That's an unrealistic expectation." What happens, then, if the physician on that pedestal develops a drinking problem, or a drug problem, or becomes inflicted with any impairing disorder? In New Jersey, the physician would be referred to the Physician's Health Program, where Dr. Baxter and his staff identify and manage any condition that would impair a physician's ability to practice. Although drug and alcohol abuse top the list, other disorders for which help is available through the program include psychiatric illnesses, medical problems such as strokes, and psychosexual disorders.

Although a few physicians enter the program through self-referral, most case reports come from colleagues, department chairs, family members, or pharmacists. For example, a pharmacist may contact the program because a physician is engaged in unusual prescribing practices, such as writing multiple prescriptions for an anti-anxiety drug and then picking up the prescription at the pharmacy "for the patients." Or a physician may be writing prescriptions for personal use or for family members.

"When we receive complaints or concerns, we will reach out to the individual physician," says Dr. Baxter. Unless the person lodging the complaint is willing to give his or her name, Dr. Baxter usually waits until he receives complaints from more than one source before taking action. Of course, if the allegation is serious, Dr. Baxter calls the physician and provides an opportunity to come in and discuss the problem. "If a pharmacist is willing to go on record and say 'I'm lodging this complaint', that's sufficient for the staff to begin action, although caution is always used," he says. "In the current environment with managed care, when you get complaints from just one physician. You have to be careful that it's not a political thing," he adds. "Unfortunately, that happens also."

If a physician denies a complaint lodged by a pharmacist, Dr. Baxter asks for copies of prescriptions the physician has written. "Then I'll call them back and say, 'Listen, I have these things in front of me and if you don't do this, I may report you to the State Board of Medical Examiners,'" notes Dr. Baxter. "They will usually show up then."

Physicians who don't agree to enter the program "voluntarily" have a decision in front of them. And make no mistake: Dr. Baxter intends those quotation marks around the word "voluntary." Physicians can face Dr. Baxter or face the State Medical Board, which begins an immediate investigation. "If they find out there's some wrongdoing going on, the physician is in a world of trouble. The Board will suspend the medical license, and that gets reported to the national databank. Once the databank receives the information, the HMOs get it and the insurance companies get it and the physician will be dis-enrolled from those programs," notes Dr. Baxter. "So it's pretty devastating."

As harsh as this may sound, physicians who do agree to treatment in Dr. Baxter's program receive protection, advocacy, and a full treatment regimen, which is a three-part process: detoxification, rehabilitation, and maintenance, including regular attendance at a Twelve-Step recovery program. A program called Alternative Resolution allows physicians anonymity during this process. "We're always trying to get the word out so physicians and hospitals know that reporting a colleague is not a death sentence, but an act of love," says Dr. Baxter.

When physicians enter the program, they encounter what perhaps can be called "tough love", but it works. Following evaluation and assessment of treatment needs, using the Addiction Severity Index and the ASAM Patient Placement Criteria, the physician begins treatment geared toward the severity of the problem. He or she may attend outpatient therapy once a week, intensive outpatient treatment at least three times a week, or residential treatment.

During the year 2000, Dr. Baxter's program followed over 600 active cases, only 26 of whom were reported to the State Medical Board. His results reflect the addiction rate of physicians nationwide. "The literature tells us that when an individual has a full treatment experience, at the end of one year, 77% of the general public still are abstinent, [whereas] physicians who have a full treatment experience recover at a rate of 92%."

Although the New Jersey program was developed in 1982 primarily for physicians, over the years Dr. Baxter and his staff have treated other health care professionals. He says that the 1999 NIH report on medical errors has brought the impairment of other health care professionals into focus. "We find ourselves between a rock and the Hippocratic Oath, asking for help because there aren't any professional assistance programs here in New Jersey other than the Physicians Health Program. Unfortunately, New Jersey is the only state that has no program for pharmacists. We don't turn them away. Non-physician heath care professionals are welcomed into our program."

Because the additional patient load is straining his staff and the budget, Dr. Baxter is applying to the Center for Substance Abuse Treatment (CSAT) for an expansion grant to formally develop a treatment program for non-physicians. "It's very important when we are considering health care dollars to consider not just addiction treatment but the general health of the American citizen. It's not just physicians, but nurses, pharmacists, and respiratory therapists. They are who I'd like to term the "forgotten health care professionals," he says. "There's plenty of literature and research on physicians and nurses, but as we start to talk about some of these other health care professionals, the data drop off drastically and there's a huge gap in the information." ■

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

ASAM CONFERENCE CALENDAR

ASAM

October 6, 2001
Buprenorphine Training Course
St. Louis, MO
8 Category 1 CME Credits

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

November 4, 2001
Buprenorphine Training Course
Washington, DC
8 Category 1 CME Credits

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

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

April 25, 2002
Pain & Addiction: Common Threads III
Atlanta, GA
7 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

OTHER EVENTS OF NOTE

September 7-11, 2001
Addictions 2000+1: Challenges and Opportunities for a New Millennium
Jerusalem, Israel
[For information, e-mail *jorge.gleser@moh.health.gov.il*]

September 12-14, 2001
ISAM Annual Conference:
Addictions — Sharing International Responsibilities in a Changing World
Trieste, Italy
[For information, e-mail isam@theoffice.it]

September 26-29, 2001
Carolina Conference on Addiction and Recovery
Charlotte, NC
22.5 Category 1 CME Credits
[For information, phone 877-392-9973 or e-mail *info@carolinaconference.com*]

October 7-10, 2001
American Methadone Treatment Association Conference 2001: Opiod Treatment in the 21st Century—Implementing the Vision
St. Louis. MO
[For information, visit www.americanmethadone.org]

October 18-21, 2001
Canadian Society of Addiction Medicine
13th Annual Scientific Meeting
Rimrock Resort Hotel, Banff, Alberta
[For information, e-mail *sweeney@ucalgary.ca*]

October 21-24, 2001
Advancing the Conversation:
Alcoholism and Substance Abuse Prevention and Treatment in the Empire State
Saratoga Springs, NY
[For information, e-mail asap@asapnys.org or phone 518/426-3122]

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]

March 14-17, 2002
American Pain Society 21st Annual Scientific Meeting
Baltimore, MD
[For information, visi www.ampainsoc.org]

ASAM: CONFERENCES WILL BE HELD

ASAM's Conference on Tobacco Dependence, scheduled for September 13-16, was cancelled because the terrorist attacks in New York, Washington, DC, and Pennsylvania led to the temporary grounding of the U.S. air transport network.

After careful deliberation, the Society's leadership has determined that all other conferences through the end of the year will go forward as scheduled. While sensitive to the potential inconvenience posed by new travel restrictions, ASAM believes the pursuit of knowledge is a goal that supports President Bush's call for a return to normalcy, and that honors the memory of those whose lives were lost.

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