ASAMNEWS

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NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

INSIDE

ASAM AT WORK FOR YOU:

ALSO SEE:

ASAM Leaders Meet with New ONDCP Director

ASAM's leaders acted swiftly to meet with John P. Walters, newly confirmed Director of the Office of National Drug Control Policy, for a discussion of issues of concern to the addiction field. The Society's President-Elect, Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, joined EVP Dr. James F. Callahan in a face-to-face meeting with Mr. Walters in January. In the session, Dr. Brown provided a medical perspective on issues surrounding pain and addiction, and emphasized the need for continued federal support of basic and clinical addiction research.

Dr. Lawrence S. Brown

Summing up the meeting, Dr. Callahan reports that he came away encouraged that Mr. Walters will be open to an ongoing dialogue with the field, adding that "he listened carefully to everyone who spoke."

In a follow-up letter, Dr. Callahan laid out specific issues ASAM wants to see addressed in the National Drug Control Strategy that Mr. Walters and his staff currently are drafting for President Bush. Dr. Callahan noted that the Society's recommendations can help the administration "engage the nation's 700,000 physicians in your campaign to prevent illicit drug use, drug dependence and addiction." The letter continued:

"The National Drug Control Strategy has been an effective vehicle for establishing the nation's blueprint for action on a problem that has a $246 billion dollar cost to our society.

"The important role of physicians in preventing and treating drug use, dependence and addiction has been severely underrepresented in past Strategies. None of our nation's 700,000 physicians can responsibly practice medicine, regardless of their specialty, without an understanding of the medical effects and consequences of the use of alcohol and other drugs. ASAM urges the ONDCP to aggressively reach out to the medical community through ASAM, through the AMA, and through the primary care medical specialty societies to enlist their participation in prevention and treatment.

"ASAM also suggests that the President's Strategy set goals and objectives for four key areas affecting the physician's role in prevention and treatment. These areas are:

- ✔ access to care
- ✔ parity of insurance coverage for treatment

▶ **LEADERS MEET,** *continued on page 11*

ASAM EVP Jim Callahan to Retire

James F. Callahan

ASAM Executive Vice President and CEO James F. Callahan, D.P.A., has announced his intention to retire April 30, 2002. Dr. Callahan has led the Society since 1989.

In a letter to ASAM President Andrea Barthwell, M.D., FASAM, Dr. Callahan thanked her and the members of the Board for their support, adding that "no one could have asked for or could have had more personal and professional support than I have been given."

Recalling that "ASAM has achieved much since its beginnings in 1954," Dr. Callahan also said that "much remains to be done." However, he added that ASAM has been fortunate to have had Presidents, Officers and Board members "who are committed to the Society's Mission" and who have "the vision and generous heart to carry it out."

Pledging to assist the Board with a smooth transition, Dr. Callahan pointed out that the Society's staff is "the finest a director could wish to have" and assured the Board that "the Society's work is in very capable and caring hands." ■

ASAM's Board of Directors has initiated a nationwide search for Dr. Callahan's successor as Executive Vice President and CEO. A position description and details on how to apply for the position are posted on ASAM's Web site at www.asam.org.

Dr. James F. Callahan

Parity Defeat Will Not Stand Unchallenged

James F. Callahan, D.P.A.

The Congress' action in withdrawing a proposal for mental health parity (see *Addiction Medicine News*, page 3) is but the latest turn in our long struggle to see addictive and mental disorders treated by insurers in the same way as other medical disorders. But it is only a setback, not a defeat.

For a thoughtful analysis of the situation, we turn to Ken Libertoff, Director of the Vermont Association for Mental Health. You will recall that in 1997, Ken led a campaign that resulted in Vermont's adoption of the nation's most comprehensive parity act, covering both mental health and addiction treatment. Ken's comments were delivered in a January 3rd interview with Join Together Online.

Ken Libertoff: "The recent rejection and defeat of a proposal for a comprehensive national parity bill for mental health signals the beginning of a new era of debate on this issue. Despite a good deal of strong support, certainly in the U.S. Senate and in various pockets of the House of Representatives, it is now more apparent than ever that in order to pass a meaningful bill, there will have to be a major national grassroots campaign coordinated and united by many Washington-based organizations in the coming year. But advocates in Washington, DC, will be hard pressed to achieve victory unless there is a clear partnership with organizations within the 50 states.

"Because there was such strong support in the Senate, with the impressive partnership of Sen. Pete Domenici of New Mexico and liberal Democrat Sen. Paul Wellstone of Minnesota, it appeared that the momentum within Congress had shifted in its favor on this issue. In fact, there was a good deal of support within the national press, including important editorials in daily newspapers throughout the country.

"However, one cannot nor should not underestimate the strong conservative foundation of our current U.S. House of Representatives, as well as the powerful influence of the business and insurance lobby 'inside the Beltway.' These latter forces combined to stop the momentum cold and ultimately led to the defeat of the parity initiative....

"Proponents for the bill in Washington worked hard to move this legislation forward and they deserve credit and support. At the same time, there lingers a sense of bitter disappointment, if not anger, over the outright rejection of such a discriminatory practice. Certainly one key issue now is to take that anger and frustration and transform it into a new campaign for a major parity bill that might include not only mental health but also substance abuse.

"One of the lessons learned from the experience of this congressional session is that the 'royal opposition' will fight any meaningful proposal, whether it be for comprehensive or partial parity.

Working together, leaders in Washington as well as mental health and substance abuse advocates from throughout the country must unite in a major campaign that is focused on both the U.S. House and Senate as well as with President George Bush, who seemingly was unsupportive of this year's bill but pledged to consider this matter next year. And 'next year' comes around sooner than you think." ■

American Society of Addiction Medicine

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

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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).

House, Senate Negotiators Drop Parity Requirement

House Republican negotiators removed Senate-passed mental health parity language from the fiscal 2002 spending bill for the Department of Health and Human Services. (The proposed language would have covered mental health but not addiction services.)

The chairmen of the three House committees with jurisdiction over the issue each wrote to Appropriations Committee leaders asking them to drop the provision from the spending bill. House Republican negotiators said they were sympathetic to the concept that people with mental illnesses should not be discriminated against, but agreed with business and insurance company claims that the measure could prove too expensive at a time when health insurance premiums are already spiraling. Instead, House members offered—and Senate negotiators accepted—an amendment that would reinstate for one year the law that expired in September. That law required that insurance plans that offer mental health coverage not have annual or lifetime dollar limits for that coverage different from those for other benefits.

But advocates charged that the old law was relatively ineffective, because insurers simply replaced the dollar limits with per-day or per-visit limits. "So what?" was the response of Sen. Paul Wellstone (D-MN) to the proposed extension of the old law. Noted Senator Pete Domenici (R-NM), sponsor of the Senate parity provision, "over the past 10 years, the House committees that oversee the issue haven't even cared enough to hold a hearing."

Nevertheless, parity advocates remained upbeat. "This year, we took mental health parity deep into the 'red zone.' Next year, we hope to push it over the goal line," the Federation of American Hospitals said in a prepared statement.

Ralph Ibson, vice president for government affairs at the National Mental Health Association, said he was encouraged by a promise from Sen. Domenici to reintroduce the measure next year and by the broad spectrum of national organizations that had joined the parity effort. "More and more people have come to appreciate the importance of mental health and the stinging inequity of insurance barriers to needed treatment," Mr. Ibson said. "Members of Congress will remember the barrage of phone calls and letters urging them to support mental health parity. He added that proponents did win several less-publicized concessions, including a $142 million increase in funding for the National Institute of Mental Health.

He also noted that the chairman of the powerful House Energy and Commerce Committee, Rep. Billy Tauzin (R-LA), has agreed to hold a hearing on the issue in 2002 and that President Bush reportedly has offered to help rekindle the debate next year.

But while refusing to give up on the measure, Ibson and other supporters acknowledged that passage of the legislation would be an uphill battle. "As we move forward with our advocacy, we must keep in mind that legislation that is opposed by powerful deep-pocketed interests is not easily won," he said.

Source: Reuters News Service, December 19, 2001.

Congress Votes to Extend HIPAA Deadlines

Both the Senate and House of Representatives have passed bills that would extend by one year the deadline for compliance with the administrative simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Senate bill (S.1684) simply allows the extension for health care and state and local entities, while the House bill (HR.3323) includes requirements for states and entities to document their reasons for needing an extension and an implementation strategy for reaching compliance. The two versions will have to be reconciled.

HIPAA requires that all electronic health care transactions be in a standard format by the compliance date, currently October 16, 2002. The bills would extend that deadline to October 2003. They would have no impact on HIPAA's privacy requirements, which have a compliance date of April 14, 2003.

Experts who counsel addiction and behavioral health providers are warning them not to let the possible extension slow their efforts toward implementation. "Their plans should continue—they should still be talking with their software vendors about how to come into compliance with transaction standards and they should still be thinking about preparing for the privacy standards," says Paul Litwak, an attorney in Virginia Beach, VA, who consults with health care organizations and state and county governments. Renee Popovits, an attorney with Chicago-based Popovits & Robinson, has reminded her clients that if the House bill passes, they would have to submit an implementation plan by October 2002. Popovits & Robinson has been retained by the Center for Substance Abuse Treatment (CSAT) to compare HIPAA's privacy requirements with existing federal privacy protections for addiction clients.

Source: Alcoholism & Drug Abuse Weekly, December 1, 2001.

Medical Marijuana Proponents Persist Despite Court Ruling

The U.S. Supreme Court has ruled that federal law prohibits the distribution of marijuana to medical patients, but proponents of medical marijuana in California have vowed to continue to fight for the drug's approval.

The Court ruled that marijuana could not be distributed as a "medical necessity" because it has been classified as an illegal drug under federal law. But lawyers for the Oakland Cannabis Buyers Cooperative noted that the Supreme Court ruling failed to address other constitutional questions brought up in the case, including whether states have the right to set their own laws on the issue.

"I can see how on the issue of medical necessity they might have come down as they did, but I was surprised that the Supreme Court chose completely to sidestep the other issues we raised in the case," said Robert Raich, an Oakland attorney who worked on the case. "The next step is to go back to the lower courts and address fully these important constitutional questions."

California voters approved a medical marijuana ballot initiative that would allow patients to use marijuana for pain relief on a doctor's recommendation.

Source: Reuters News Service, November 14, 2001.

Lawmakers Angry at NBC for Airing Alcohol Ads

Members of the U.S. House of Representatives have sharply criticized executives of the NBC television network for their decision to air liquor advertisements. In so doing, NBC became the first major national network to break a longstanding voluntary ban on hard liquor advertising on television.

"It is a sad commentary that NBC's bottom line today is more important to the company than the lives of young people tempted to drink, or recovering alcoholics trying to beat their disease," said Rep.

▶ **ADDICTION,** *continued on page 8*

ASAM Will Co-Sponsor the National Alcohol Screening Day

Andrea G. Barthwell, M.D., FASAM

I am pleased to tell you that ASAM will again co-sponsor and participate in the National Alcohol Screening Day (NASD), set for April 11, 2002. NASD is a program of the not-for-profit organization Screening for Mental Health and is supported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP).

In 2002, NASD will expand its focus to include raising awareness about the consequences of at-risk drinking and alcohol's effects on health, in addition to the traditional objective of identifying and providing referrals to individuals with signs of alcohol abuse or dependence.

In return for our co-sponsorship, the NASD office will provide ASAM members with the guidelines and materials for conducting local campaigns, including tips from successful sites, suggestions for recruiting special populations such as older adults or college students, and publicity materials you can download and customize for use in your community. The package of materials consists of:

Dr. Andrea G. Barthwell

- A step-by-step Procedure Manual.
- Publicity materials, including sample news releases and suggested scripts for Public Service Announcements and Op-Ed pieces.
- Educational materials (brochures and flyers) for the public.
- Sample presentations on alcohol-related problems, with slides and a videotape.
- Multiple copies of the NASD screening form, with scoring instructions and referral guidelines.

In addition, supplemental Spanish-language materials are available, including a new Spanish-language videotape as well as Spanish language brochures and posters. The Spanish language videotape features native Spanish speakers from a variety of cultures and backgrounds discussing alcohol's effect on work, relationships and overall health, as well as the challenges and rewards of recovery.

To register for NASD, simply complete the registration form enclosed with this issue of **ASAM News** or call the NASD office at 781/239-0071. It's a good thing to do for your patients and your community! ■

▶ **ADDICTION MEDICINE,** *continued from page 3*

Frank Wolf (R-VA). Rep. Wolf, along with Rep. Lucille Roybal-Allard (D-CA), sent a letter to NBC executives criticizing the network for putting profits before concerns about underage drinking and other social costs. Rep. Wolf has called on the Federal Communications Commission and the Federal Trade Commission to investigate the matter. In addition, he announced that he is considering introducing legislation that would make the voluntary ban a federal law.

Source: Reuters News Service, December 20, 2001.

Ecstasy Use Stabilizes Among High School Students

For the first time since 1999, use of ecstasy (MDMA) among 12th grade students has not increased significantly, according to newly released data from the national Monitoring the Future Survey. In 2001, 9% of high school seniors reported that they had used ecstasy in the preceding year, compared with 8% in 1999. At the same time, the percentage of seniors who said they perceived "great risk" of harm from using ecstasy even once or twice increased significantly, from 38% in 2000 to 46% in 2001. Past research has shown that as the perception of harmfulness rises, levels of use fall.

While these findings suggest that ecstasy use may decline in future years, there has been a continued increase in the perceived availability of the drug. In 2001, 62% of seniors reported that ecstasy was "fairly easy" or "very easy" to obtain, compared to 22% when this question first was asked in 1989. Study director Lloyd D. Johnston of the University of Michigan commented that "even if fewer students are willing to use ecstasy in the schools where it has been present, that decline very likely has been more than offset by the continuing rapid diffusion of the drug to additional areas."

Source: Adapted by CESAR from data from the University of Michigan, Monitoring the Future press release, "Rise in Ecstasy Use Among American Teens Begins to Slow," December 19, 2001. For more information, contact Dr. Johnston at 734/763-5043. ■

CHAPTER UPDATES

Connecticut

President: Mark L. Kraus, M.D.
Regional Director: Ronald F. Pike, M.D.

President Mark Kraus, M.D., reports that the Connecticut Chapter has been meeting quarterly and is pursuing an active agenda:

CCAR: The chapter has established a close working relationship with the recovering community, which recently led to formation of the Connecticut Community for Addiction Recovery (CCAR). The new organization's mission is to ensure that "people in recovery from drug and alcohol addiction will be treated with dignity and respect in their recovery process, regardless of the type of addiction, treatment or support." The organization seeks to involve recovering people, their families, significant others, and friends in educating policymakers, service providers, legislators, and the general public about the addiction recovery process. Its goal is "to empower recovering people in their physical, emotional and spiritual growth and provide the opportunity for them to make significant contribution to themselves, their families, and our society."

Alcohol Awareness: The chapter supported a public rally for Alcohol Awareness Month in September in Hartford that reached approximately 2,000 people.

Quarterly Meetings: Speakers at the Connecticut chapter's quarterly meetings have come from state government and local universities. Topics discussed include use of naltrexone in the treatment of alcohol dependence and of buprenorphine in the treatment of opioid dependence, as well as issues in physician health.

ASAM Forensics Course organizer and chair Robert L. DuPont, M.D., FASAM (center) enlisted an expert faculty to present the popular course in Washington, DC, in December, 2001.

CME: Chapter members have served as workshop facilitators during the state medical society's Addiction Medicine/Psychiatry Grand Rounds (which are supported by a grant from the Robert Wood Johnson Foundation). These are Web-cast lectures to hospitals affiliated with Yale University and the University of Connecticut on the following topics: "The Disease Concept of Addiction" (by Tim Condon, Ph.D., of NIDA), "Screening and Brief Intervention" (by Drs. Gail D'Onofrio and Thomas Babor), "Addiction: Pharmacological Intervention" (by Drs. Richard Schottenfeld and Patrick O'Connor), and "Dual Diagnosis/Concurrent Diagnosis" (by Drs. Douglas Ziedonis and Henry Kranzler). The lectures can be viewed at www.csms.org (note that a real-time player is needed).

Students and Residents: Chapter members are planning a scientific/informational day in spring 2002 for medical students and residents as an introduction to addiction medicine.

New Jersey

President: Michael DeShields, M.D.
Regional Director: Louis E. Baxter, Sr., M.D., FASAM

Dr. Baxter writes: "Happy New Year! We are off and running in New Jersey!"

CME: The CME Committee of the New Jersey Society of Addiction Medicine is planning presentations in concert with the state Department of Health and Social Services and the Physician's Task Force on Addiction. For example, Dr. Wayne Draesel reports that in June, NJASAM will sponsor its Third Annual Symposium on Addictions in Toms River, NJ, with a panel of nationally-known speakers.

Review Course: NJASAM will sponsor its own Review Course for physicians planning to sit for the ASAM Certification Examination in November. Details will be announced as arrangements are made. ■

ASAM CERTIFICATION

Final Date to Register for Certification/Recertification Exam

Christopher M. Weirs, M.P.A.

The final date to register for ASAM's next Certification/Recertification Examination for physicians who wish to be certified/recertified in Addiction Medicine is April 30, 2002.

The examinations are set for Saturday, November 16, 2002, at three sites: Atlanta, GA; New York, NY; and Los Angeles, CA.

Physicians who wish to sit for the examination must submit an application, which have us avaulable on the ASAM web site. Applications will be reviewed and candidates notified by mail as to whether they qualify to sit for the examination. The fee for the examination is $100 for ASAM members; $1,150 for nonmembers.

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 M. Weirs, M.P.A., Credentialing Program Director, at the ASAM office at CWeir@asam.org or 301/656-3920, or visit ASAM's Web site at www.asam.org. There, you will find suggested reading material, sample examination questions, examination criteria, an application for the examination, and much more.

Also, watch **ASAM News** for details of the Review Courses for examination candidates and other interested physicians, to be held in Chicago and California. ■

Register Complaints About Managed Care

The AMA has established a central registry on its Web site where physicians can detail the types and severity of problems they encounter with managed care plans.

The Health Plan Complaint Form was developed by AMA's Private Sector Advocacy initiative to make it easier for physicians to provide detailed information on managed care-related problems in a confidential, secure online setting. AMA staff will use the data collected to identify trends, in negotiations with health plans, and to promote the AMA's legislative and regulatory agenda. "Health plans no longer will be able to dismiss our real frustrations as random anecdotes," said AMA Secretary-Treasurer Donald J. Palmisano, M.D. "We've been told we need concrete evidence—soon enough, we will."

The Health Plan Complaint Form is confidential: no names or other identifying information is required. The form asks only for limited information about the reporting physician's specialty, as well as demographic and geographic data. Physicians who use the form will, however, be required to register for and use an Internet ID—a digital certificate developed by the AMA to ensure that only physicians can register complaints.

For additional information, consult the AMA's Web site at www.ama-assn.org.

AMA Offers Information to Fight Bioterrorism

Timothy T. Flaherty, M.D., Chairman of the American Medical Association's Board of Trustees, has announced that the AMA is making a range of educational products and services available to help physicians address issues raised by recent threats of bioterrorism. "Never before in my experience have physicians been so hungry for credible, timely material about a threat to the public health. And never before in my experience has the AMA dedicated so much time and effort to reaching out to physicians about a potential public health crisis."

Specifically, new and updated information is available, 24 hours a day, seven days a week, on AMA's "disaster response" Web site at http://www.ama-assn.org/go/disasterpreparedness. In addition to using this site to access the latest clinical information or to look up local public health officials, physicians also can use it to view two broadcasts that were co-sponsored by the AMA in cooperation with the federal Centers for Disease Control and Prevention: "Anthrax: What Every Physician Should Know" and "Coping with Bioterrorism: How are Laboratories Responding."

For those who lack the technology to watch these broadcasts online, they can be obtained on a videotape that is free to individual physicians. To order a copy, phone 877/252-1200, or make your request at the Web site of the Public Health Foundation (http://www.phf.org/).

Finally, the *Journal of the American Medical Association* continues to keep physicians on the forefront of care, most recently through its November 28, 2001, theme issue on bioterrorism. JAMA released several articles from this issue several weeks before publication, so that physicians would have access to the most up-to-the-minute information about anthrax. These articles, as well as others from *JAMA* and the *Archives* journals, are available through the AMA disaster response Web site.

Dr. Flaherty says that this is just the beginning of an ongoing AMA effort. "Even if the anthrax scares of October fade from the headlines, the threat of bioterrorism will not fade from the AMA's consciousness," he says. "We understood the danger of a biological threat long before the first envelope of suspicious white powder arrived in Florida, and recent events have only further convinced us that we have an obligation to stay focused on this issue. In the coming weeks and months, we will be expanding and strengthening our initiatives related to biological and chemical warfare. These efforts will range from public service announcements on local television stations to active lobbying in Congress. Most important, however, we will continue—alongside state, county, and specialty societies—to focus our efforts on physician education and information. Though we hope that our country will never face a biological assault, the fact remains that we must be ready for one. And, for now, education is still the foundation of physician preparedness."

Source: American Medical News, December 3, 2001. ■

2002 ASAM Membership Directory

ASAM's 2002 Membership Directory and Resource Guide is about to be published. Only members in good standing will receive the directory, so be sure your membership is up to date.

Dues were to be sent to the ASAM office by January 1, 2002. If you have not already done so, contact the ASAM office at 301/656-3920 to renew your membership for 2002.

AGENCY NEWS


Dr. H. Westley Clark

CSAT: Sept. 11 Grants Planned

The federal Center for Substance Abuse Treatment (CSAT) plans to award an array of grants to address addiction problems related to the September 11 terrorist attacks.

CSAT Director H. Westley Clark, M.D., J.D., M.P.H., FASAM, said a media campaign warning about the risk of post-attack abuse of alcohol, tobacco, and other drugs—including prescription medications—is planned. Dr. Clark added that public service announcements and other materials on prescription drug abuse are being targeted at persons aged 14 to 25.

Addiction experts are concerned about the potential for problems arising out of a spike in prescriptions and use of antidepressants, sleeping pills, and painkillers in the wake of the terrorist attacks in New York and Washington, DC.

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

DEA: Medical Marijuana Study Approved

The U.S. Drug Enforcement Administration (DEA) has granted final approval for a study of medical marijuana, to be conducted at the University of California at San Diego (UCSD) Medical Center. Announcing the approval, DEA Administrator Asa Hutchison said, "The question of whether marijuana has any legitimate medical purpose should be determined by sound science and medicine."

UCSD researchers will study the effects of marijuana on patients with multiple sclerosis and those who suffer neuropathic pain associated with AIDS. The research will be conducted at the university's Center for Medicinal Cannabis Research.

Source: Alcoholism & Drug Abuse Weekly, December 17, 2001.

NIDA: Dr. Hanson Named Acting Director

Glen R. Hanson, D.D.S., Ph.D., has been named Acting Director of the National Institute on Drug Abuse by Ruth Kirschstein, M.D., Acting Director of the National Institutes of Health.

Dr. Hanson succeeds Alan I. Leshner, Ph.D., who left NIDA December 3 to become chief executive officer of the American Association for the Advancement of Science.

Dr. Hanson, who is recognized as an expert on psychostimulants, is particularly known for his work on the neurotoxic properties of ecstasy (MDMA) and amphetamines, as well as the role of brain peptides in psychiatric and neurological functions. He joined NIDA in September 2000 as director of the Division of Neuroscience and Behavioral Research. ■

PEOPLE IN THE NEWS

Dr. Galanter Receives APA Award

ASAM Immediate Past President Marc Galanter, M.D., FASAM, is the recipient of the Seymour Vestermark Award of the American Psychiatric Association. Dr. Galanter receives the award for his contributions to the establishment of addiction psychiatry as a subspecialty training area, and will give an associated lecture at the APA's annual meeting on Tuesday, May 21, 2002, in Philadelphia.

Dr. Galanter published the first federal report on Alcohol and Drug Abuse Education in 1980. He was instrumental in launching addiction fellowships and related curricula, resulting in the subspecialty Certificate of Added Qualification in 1991, and related fellowships in 1995. His Center for Medical Fellowships in Alcohol and Drug Abuse has organized information on addiction residency programs for the past 15 years.

He is the author or editor of more than 250 articles and books, including numerous publications on therapy with addictions. With Dr. Herbert V. Kleber, Dr. Galanter is editor of the "Textbook of Substance Abuse Treatment," which is a standard work in the field.

Dr. Galanter's contributions also have been recognized with the McGovern Award for Excellence in Medical Education from the Association for Medical Education and Research in Substance Abuse, which he also served as president. ■

ASAM to Participate in Medical Student Career Fair

ASAM will be represented at the 2002 American Medical Student Association (AMSA) Specialty/Career Fair, to be held in conjunction with AMSA's annual meeting in Houston, TX.

From noon to 4:00 p.m. on Wednesday, March 6, in the Arboretum Room of the Hyatt Regency Houston Downtown, medical students will be able to learn more about the practice of addiction medicine, as well as other medical specialties.

If you or a student you know would like more information, contact Celso Puente, Membership and Chapter Development Manager, at cpuen@asam.org or phone 301/656-3920.

Study Calls Naltrexone Ineffective

Researchers at Yale University report that naltrexone was not effective in helping patients with severe alcohol problems to stop drinking, according to a report in the *New England Journal of Medicine*. Their work contradicts previous studies that found naltrexone moderately effective in treating alcohol addiction. The U.S. Food and Drug Administration has approved naltrexone for the treatment of alcohol dependence.

Previous studies have found that naltrexone (marketed as ReVia®) reduced the pleasurable effects of alcohol, thus contributing to lower consumption and craving. The Yale study, however, involved a much larger sample than the previous effort.

For the study, the researchers randomly assigned 627 veterans with chronic, severe alcohol dependence to three groups: one group received naltrexone for 12 months, while another group received naltrexone for three months followed by nine months on a placebo, and a third group received a placebo for 12 months. In addition, all patients received individual counseling and were encouraged to attend Alcoholics Anonymous meetings.

Seventy-three percent of the patients completed the trial. The researchers report that, at 13 weeks, they found "no significant difference in the number of days to relapse between patients in the two naltrexone groups and the placebo group." At 52 weeks, "there were no significant differences among the three groups in the percentage of days on which drinking occurred and the number of drinks per drinking day."

The researchers reported that, "relative to an inactive placebo, naltrexone did not prevent or delay relapse to heavy drinking, reduce the number of drinking days, or decrease the amount of alcohol consumed during episodes of drinking," said Dr. John H. Krystal, who led the Yale research team. The research team did not rule out the possibility that a different dose of naltrexone or the use of other medications along with naltrexone might have been effective with their patients.

In an editorial accompanying the report, Enoch Gordis, M.D., Director of the National Institute on Alcohol Abuse and Alcoholism, and Richard K. Fuller, M.D., Director of NIAAA's Division of Clinical and Prevention Research, called for more research to determine whether naltrexone works and to identify which patients are likely to benefit and which are not. They advised that, until more information is available, physicians should continue to prescribe naltrexone for patients who they think might benefit from it (such patients appear to be those who have been drinking heavily for 20 years or less and who have stable social support and living situations).

Source: New England Journal of Medicine, December 13, 2001.

FDA Asked to Approve Acamprosate to Treat Alcohol Addiction

Two pharmaceutical companies are seeking approval by the U.S. Food and Drug Administration (FDA) for the drug acamprosate as a treatment for alcohol addiction. Lipha S.A., a French subsidiary of the giant drugmaker Merck, and New York City-based Forest Laboratories have said they plan to file a New Drug Application with the FDA in early 2002.

Forest officials said acamprosate could be used in conjunction with counseling and other behavioral therapies. "You would have to be a motivated patient to use it," said Charles Triano, vice president of investor relations.

Currently, disulfiram and naltrexone are the only two drugs approved in the U.S. to treat alcohol dependence. Patients in Europe have been using acamprosate, under the brand name Campral®, for several years.

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

Women Need Help to Quit Smoking

A new study that examined why women with cardiovascular disease continued to smoke found that they need either antidepressant drugs or nicotine-replacement therapy to help them quit.

In the study, which was presented with two others at a recent meeting of the American Heart Association, researchers at the University of California at San Francisco (UCSF) interviewed 277 women with heart disease who were smokers. The women, all of whom had been smoking for about 40 years, said they were willing to quit. About 57% of the women in the study were found to fit the criteria for clinical depression. "Smoking acts as an antidepressant. "A lot of women [use tobacco to] self-medicate for depression by smoking," said Dr. Erika Froelicher, professor at UCSF's School of Nursing and Medicine.

Another study looked at the effectiveness of the antidepressant Zyban® in helping women to stop smoking. The study involved 629 women with heart disease who were defined as heavy smokers. Investigators reported that 47% of patients given Zyban for seven weeks along with motivational counseling were able to quit tobacco, compared with 19% who received placebos. At 12 weeks, 34% of the Zyban group were not smoking, compared with 15% of the control group.

A third study conducted at UCSF looked at the effectiveness of nicotine-replacement therapy on women smokers. The researchers found that nicotine-replacement therapy is underused for women smokers with cardiovascular disease, with just 9% to 22% using the therapy to quit smoking. They recommended that women smokers receive more education and counseling, including instruction in the use of smoking-cessation products.

Source: Reuters News Service, November 12, 2001.

Addiction Increasing Among Homeless Persons

Rates of addiction and mental illness are rising among the homeless population, according to data reported to the annual meeting of the American Public Health Association.

A team of researchers led by Dr. David E. Pollio of Washington University in St. Louis, MO, compared data from three studies of homeless men and women in St. Louis conducted in 1980, 1990 and 2000. They found significant increases in rates of alcoholism and other drug use among homeless persons in 2000 compared with the data for 1980. In addition, there were increases in major depression, bipolar disorder, and schizophrenia.

According to the study, drug use among homeless men and women increased six-fold over the 20-year period, with nearly 60% of homeless persons having been diagnosed with an addictive disorder at some point in their lives.

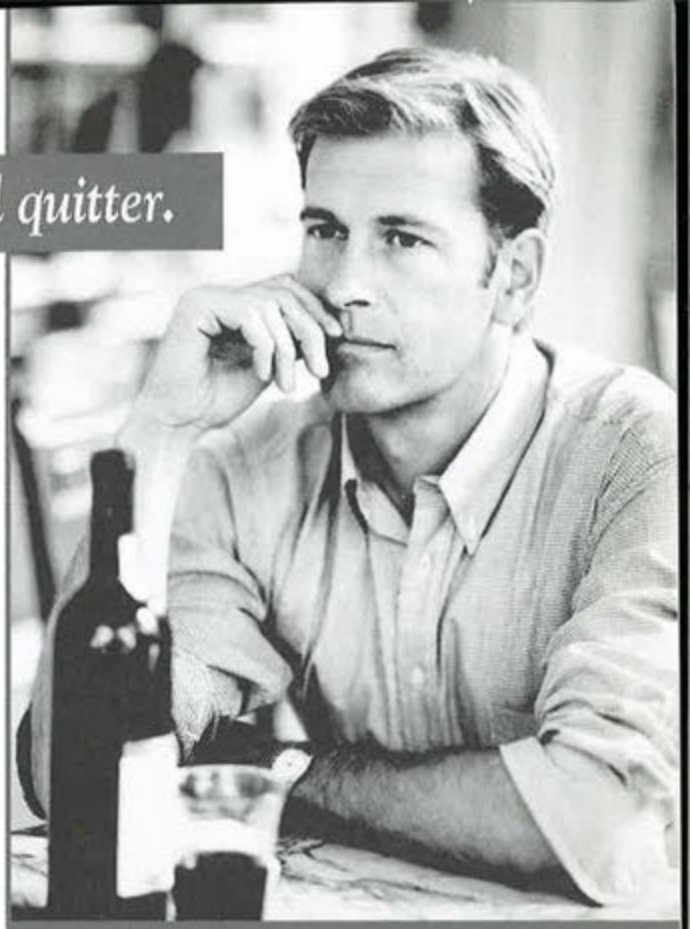
Among homeless women, the rate of alcoholism nearly doubled over the 20-year period to about 40%. Alcoholism rates remained unchanged among homeless men.

"The findings support the need for increased access to mental illness and substance abuse treatment for homeless populations," the researchers concluded. Dr. Pollio added, "Services need to be focused in on the changing nature of the homeless population," which increasingly are afflicted with addictive and mental disorders and multiple diagnoses.

Source: Reuters News Service, October 24, 2001.

The moment of truth for the commited quitter.

Help him conquer the moment with Antabuse®



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

When your patient with chronic alcoholism needs a behavioral modification tool to keep his commitment to sobriety, Antabuse can help.

Unique and effective, but it won't work alone.

Use Antabuse as part of an integrated program that includes professional counseling and family support, and it can help the committed quitter look the moment of truth in the eye — and win.

Antabuse Identification Cards are available free of charge to patients. Call 1-877-427-9068 or visit our web site at www.OdysseyPharm.com for details.

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

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

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Antabuse® (Disulfiram, USP) Tablets IN ALCOHOLISM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WARNINGS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

▶ **LEADERS MEET,** *continued from page 1*

✔ training and credentialing of physicians and other health professionals, and

✔ medications development.

"**Access to treatment** has been severely limited by managed care companies, which routinely deny care on the premise that treatment either is not required for the condition (medical necessity), or is too expensive to provide.

"In response to these two erroneous excuses widely used to deny needed addiction treatment, ASAM developed the Patient Placement Criteria for the Treatment of Substance-Related Disorders. First issued in 1991, the ASAM Criteria are now in their third iteration.... The Criteria are objective guidelines by which to assess a patient's need for care and the level of care to be provided.... The Criteria are in use nationally and are required for use in 21 states, as well as in the Department of Defense's Tricare program.

"ASAM also conducted a study of ...insurance coverage and the value of the insurance benefit for addictive disorders and learned that the value of substance abuse coverage declined by 75% between 1988 and 1998 for employees of mid- to large-size companies.

"Access to treatment has been severely limited by managed care companies, which routinely deny care on the premise that treatment either is not required for the condition (medical necessity), or is too expensive to provide.

"**Parity for treatment** is the complement of the issue of access to care. Scientifically, it has been shown that addictive disease is a biomedical condition with treatment outcomes comparable to those for other chronic medical disorders, such as diabetes and heart disease. Further, every objective and independent study has demonstrated that parity is not only affordable, but the most cost-effective approach to health care. We enclose a copy of the ASAM Public Policy Statement on "Parity in Benefit Coverage," which was issued jointly by ASAM and the American Managed Behavioral Healthcare Association (AMBHA).

"In order to assure that patients receive the highest quality care and effective care, physicians should receive **training**, either through their specialty residency training programs or in special fellowships established for clinical training in addiction medicine. Most medical students receive little, if any, education in the addictions. Most residents (physicians in training) also receive little, if any, education in this area. The Strategy can address this deficiency by setting an objective to require a minimum number of hours of training during residencies, and by setting an objective to establish clinical training programs in addiction medicine.

"Many health care professions play a role in prevention, intervention, treatment and continuing care for addicted individuals. While each profession should have education and training for their members in this disorder, physicians play a unique role and should have specialized training. The ASAM Public Policy Statement, "A Guideline for Credentialing and Privileging of Clinical Professionals," jointly issued with AMBHA, describes the roles of the various professions and the unique role of the physician.

"**Medications development** is our fourth area of concern that deserves particular attention in the Strategy. The National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) have done exemplary work in their research on new medications and in fostering an interest on the part of the pharmaceutical industry in this important area. All physicians rely on medications for patient care. In fact, it is almost inconceivable to think of treatment of any major disease or illness that would not include pharmacotherapy as the basis of treatment of the disease. Yet, specialists in addiction medicine have few medications they can use for treatment of this major, chronic medical condition.

"In summary, we urge the ONDCP to reach out to and enlist the nation's physicians. In order to engage physicians in this very important medical and social issue, patients must have access to care and parity of coverage, and physicians must have basic training and medications with which to provide care."

Dr. Callahan assured Mr. Walters that "ASAM is fully committed to collaborating with the ONDCP in the development of President Bush's initial Strategy and in carrying out the Strategy" and invited him to call on the Society's leaders and members for advice and support. ■

RESEARCH REPORTS

Binge Drinking Hinders Brain Cell Growth

Binge drinking not only damages the brain, but interferes with the repair of brain cells as well, according to a report delivered at a recent meeting of the Society for Neuroscience.

Investigators at the Center for Alcohol Studies at the University of North Carolina at Chapel Hill studied inebriated rats. They found that new cell growth in the brain's key memory center dropped below half of normal following extended periods of intoxication.

"We found that the number of newly-formed cells was decreased by 57% when compared to the no-alcohol group," said Dr. Kim Nixon, lead investigator. One month after alcohol exposure, Nixon said, "the number of newly formed cells was decreased by 97%."

Since rat and human brains are similar in many aspects of structure and function, Nixon said the study's findings suggest that high doses of alcohol negatively affect the formation of new brain cells in humans as well.

Source: Reuters News Service, November 15, 2001.

Ecstasy Component Isolated

Researchers in Spain have isolated the component of ecstasy that seems to cause brain damage, allowing them to measure the long-term damage from the drug in human users, according to a press release from the American Chemical Society.

Lead researcher Rafael de la Torre of the Municipal Institute of Medical Research in Barcelona said that HHMA (3,4 dihydroxymethamphetamine) is partially responsible for ecstasy's harm to the human brain. Previous research had linked HHMA to many of ecstasy's known side-effects.

Using Dr. de la Torre's findings, researchers will be able to measure the amount and concentration of HHMA in a person's body and provide new insight into ecstasy. "This observation concerns not only ecstasy's acute effects, but more interestingly, its mid- and long-term neurotoxicity," Dr. de la Torre said. "The detection of HHMA was hampered up to now by problems measuring it in humans, which we have solved." The report was published in the September issue of the journal *Chemical Research in Toxicology.*

Source: American Chemical Society, November 16, 2001. ■

Resource: Fetal Alcohol Exposure and the Brain

Nearly 30 years ago, scientists first coined the term "fetal alcohol syndrome" (FAS) to describe a pattern of birth defects found in children of mothers who consumed alcohol during pregnancy. Today, FAS remains the leading known preventable cause of mental retardation. Behavioral and neurological problems associated with prenatal alcohol exposure may lead to poor academic performance as well as legal and employment difficulties in adolescence and adulthood. Despite attempts to increase public awareness of the risks involved, a growing number of women are drinking during pregnancy. This bulletin updates Alcohol Alert No. 13 with new data on the prevalence and nature of the neurobehavioral problems associated with alcohol use during pregnancy, explores potential mechanisms underlying alcohol-induced damage to the developing brain, and discusses prevention research.

A copy of the *Alcohol Alert* is available online or by contacting the National Clearinghouse for Alcohol and Drug Information at 1-800/729-6686.

Cocaine Use a Hidden Cause of ER Visits

Cocaine use is the hidden cause of a number of chest pain complaints seen in emergency departments, according to a recent study. Specifically, cocaine is responsible for 30% of all drug-related emergency department visits in the U.S. during 1999. Cocaine can trigger a heart attack by causing a sudden rise in blood pressure and heart rate, as well as increasing contractions of the left ventricle of the heart.

The traditional treatment for chest pain is beta blockers. However, if cocaine use is involved, beta blockers could be dangerous to the patient. "Cocaine causes the arteries to constrict, and if you use a beta blocker on patients who are taking cocaine, it can worsen the constriction of the blood vessel," said Dr. Richard Lange, a professor of medicine at the University of Texas Medical Center, Dallas, and author of the new study.

"If a young person...comes to an emergency room complaining of chest pain, and there aren't any risk factors for having a heart attack, most physicians wouldn't even consider the cocaine connection," Dr. Lange says. "But since cocaine can actually precipitate a heart attack, we need to pay attention to young people who present with chest pain and inquire to see if that's a possibility," he added.

Source: New England Journal of Medicine, August 2, 2001.

Women More Susceptible to Ecstasy Brain Damage

A preliminary study has found that women may suffer more brain damage than men from taking the drug ecstasy.

For the study, Dutch researchers compared brain scans of people who had taken 50 or more ecstasy tablets in their lifetimes with a group who had never taken the drug. They found that ecstasy (MDMA) caused more damage to certain brain cells in women, even though the men had taken more ecstasy over the years.

The researchers said more studies are needed to confirm the results. Commenting on the report, Dr. Kathryn Cunningham, professor of pharmacology and toxicology at the University of Texas Medical Branch in Galveston, said it's not surprising that men and women respond differently to ecstasy. She pointed out that amphetamines leave the body more quickly in the presence of testosterone. "Estrogen-dependent changes in the serotonin transporter might regulate the brain response, and thus toxicity, to MDMA. And it's conceivable that women may be more vulnerable to brain damage at certain times of the month," Dr. Cunningham said.

Source: Lancet, November 29, 2001.

Ultrasound Could Help Prevent Prenatal Drinking

Physicians may be able to use ultrasound to identify fetal alcohol damage in time to warn mothers about the dangers of their continued drinking. Using prenatal ultrasound scans, the researchers found that about a quarter of the fetuses carried by women who consumed more than six drinks daily at the time of conception exhibited a shrunken frontal cortex in their brains. By contrast, the abnormality showed up in just four percent of fetuses whose mothers had fewer than two drinks a day at conception. A reduced frontal cortex is linked to memory problems, short attention span, and other brain function problems.

Lead researcher Dr. Tara S. Wass said that the ultrasound results could give doctors a tangible tool to convince mothers to stop drinking, which is important because even ending alcohol use by the third trimester can improve outcomes for infants.

Source: American Journal of Obstetrics and Gynecology, September 2001.

Drinking Increases Risk of Breast Cancer

New research supports the hypothesis that drinking may increase the risk of breast cancer in some women. For example, a study on diet and cancer from the American Institute for Cancer Research (AICR) shows that the risk of breast cancer could increase by 25% to 30% for women who consume an average of 1.5 drinks a day. Women who consume six drinks a day double their risk compared to non-drinkers.

Moreover, a report recently published in the journal *Cancer* found that women who had a mother or sister with breast cancer had 2.5 times the risk of contracting the disease if they drank daily, when compared to non-drinkers. The study also found that women with a more distant family link to breast cancer had a 27% increase in risk if they drank alcohol, while women with no genetic family link to breast cancer showed no relationship between alcohol intake and breast cancer risk.

A third study, published in the journal *Epidemiology*, suggests that women with a deficiency in the B vitamin folate may also be more at risk for cancer. Women with low folate who consumed more than two alcoholic drinks a week increased their breast cancer risk by almost 60%.

Sources: American Institute for Cancer Research, November 23, 2001; Cancer, October 2001; Epidemiology, November 2001.

▶ **CLINICAL NOTES,** *continued on page 13*

▶ CLINICAL NOTES, *continued from page 12*

Alcohol Affects Ability to Learn

Alcohol, even in small amounts, affects the ability of college students to learn and remember new information. "There's no time when a person is called on to learn more than in college, but this is exactly the time when alcohol has its greatest negative effects on learning," said lead author of the study Scott Swartzwelder, M.D., clinical professor of medical psychology at Duke University. The Veterans Affairs Medical Center also was involved in the research.

In the study, two groups of participants (one group aged 21 to 24, and another aged 25 to 29) were given two alcoholic drinks over an hour and then tested for verbal and visual memory acuity. "There was a much more powerful effect at inhibiting people's ability to learn in the younger range," said Dr. Swartzwelder.

In addition, the researchers found that alcohol had a negative effect on energy and sleep cycles. "The brain acts like a spring compressed by alcohol—when you release the alcohol, the spring bounds back again and overshoots to a period of hyperexcitability, which wakes you up and disrupts your sleep cycle. And impairing the quality of your sleep impairs the quality of your ability for remembering things," added Dr. Wilkie Wilson, professor of pharmacology at Duke. "The message is, don't drink on the night you want to consolidate information in your brain."

Source: Duke University Chronicle, October 9, 2001. ■

FUNDING NEWS

RWJ Chief: "Grant Makers Must Attack Substance Abuse"

Abuse of tobacco, alcohol, and illegal drugs is the nation's No. 1 preventable health problem, yet few foundations focus on it, according to Steven A. Schroeder, chief executive officer of the Robert Wood Johnson Foundation.

In a commentary published in the Chronicle of Philanthropy, Mr. Schroeder said that one reason foundations and others ignore this important issue has to do with stigma—the distaste some have for working with addicted persons. The U.S. public has a defining "free-choice" ethos, he said, through which they view addicts as having the right to abuse themselves. "And yet when people do that," he added, "we blame them for it and are less inclined to help them."

Mr. Schroeder described it as "a real paradox" that, as a nation, we are willing to spend money to try to cure patients with diseases that have a dismal prognoses, such as pancreatic cancer, yet we dismiss addiction treatment programs with higher success rates. He called on foundations to help Americans overcome this double standard.

Beyond the stigma issue, he said, a key problem facing the addiction field is a dearth of good leadership, especially at the grassroots level. For example, he noted that "We have few if any parents' groups up in arms over youth smoking. And families devastated by drug abuse are not mobilizing for more treatment or prevention programs in the way that families devastated by mental illness joined forces in the 1980s."

At the national level, Mr. Schroeder said, "leadership is noticeably fragmented, creating an obstacle to effective policy change." He added that "People become exceptionally invested in a particular approach and thus close-minded to others. Sporadic, unpredictable, and fragmented financial support has left "orphans" who resent others getting funds ahead of them. They have become martyrs, and it is difficult for them to shed that embattled mentality. The substance-abuse field is wracked by infighting and a sense that some players value being correct more than being successful."

The field also lacks sufficient incentives to draw in the best and brightest, and the leadership suffers from a lack of diversity, he said, noting that "Most experts are white males. Fostering better leadership is, in fact, an area where foundation support could prove essential. Providing grants brings not only dollars but also prestige to the field of addiction prevention and treatment. That prestige would help leaders in the addiction arena to gain access to other community leaders."

While the lack of better leadership is a formidable obstacle, Mr. Schroeder said, another has been the power of the tobacco and alcohol industries to block policy changes and the fact that these industries deal with legal substances. "These companies use sophisticated marketing to drive sales," he said, "and we all know that they play hardball with anyone who tries to get in their way. Philanthropy needs to become just as powerful in the war on substance use."

Demand for treatment of substance abuse far outstrips the supply of legitimate programs, Mr. Schroeder added, suggesting that "Community foundations and other local grantmakers could help develop more treatment options at the local level and use their grant money and their clout to bring about speedy and substantial results. Community foundations can also help to enforce laws about sales of tobacco and alcohol to under-age youth. They can work with schools and parents to assure that students are aware of the real facts about substance abuse, including the reality that not all their peers smoke and drink. They can work with the local news media to inform people about the magnitude of the problem of substance abuse and to combat the pervasive pessimism that nothing can be done. And they can support the stalwarts who already are working on prevention and treatment, celebrating the accomplishments of these often-invisible local heroes and heroines."

Mr. Schroeder concluded that "National foundations can do all that too, but in multiple sites simultaneously. They also can support research in substance abuse, particularly on topics that do not get enough money from the National Institutes of Health: how to change attitudes and behavior, what aspects of treatment are most promising, what causes people to begin abusing alcohol, drugs, or tobacco, and what transforms experimenters into addicts.

"National grantmakers also can work to shape substance-abuse policy, encourage the news media to educate the public, and support leaders in the substance-abuse field.... The challenge now for us and other grant makers will be to continue to attack substance abuse by building leadership, the scientific knowledge base, and public and political will. Whether the initial impulse of substance abuse comes from loneliness, despair, peer pressure, curiosity, or the understandable desire to expand feelings and consciousness, too many people end up trapped with a dangerous addiction they never contemplated."

Source: Join Together Online. ■

INTERNATIONAL ADDICTION MEDICINE

England: Alcohol-Related Deaths Increase

Alcohol-related deaths in England increased significantly in the late 1990s, new government data show. According to a report by the national advocacy group Alcohol Concern, the number of alcohol-related deaths increased from 3,853 in 1994 to 5,508 in 1999.

The data further indicate that twice as many Britons are addicted to alcohol than other drugs: specifically, one person in 13 is dependent on alcohol, compared to one in 26 addicted to either illegal or prescription drugs.

The report also says that government spending on alcohol prevention and treatment in England and Wales was about $1.45 million during the period under study, compared to the $132.6 million spent on issues pertaining to illegal drugs.

"The sheer breadth and scale of the problems reinforce the need for urgent joined-up action at a national level," said Alcohol Concern Director Eric Appleby. "What we need is a coordinated strategy that concentrates on prevention of harm, and tackles alcohol misuse on all fronts—education, public campaigns, community safety, counseling, and treatment."

Source: Associated Press, November 15, 2001.

Canada: Youth Drinking Rates Rise

A new survey shows that while tobacco use among Ontario youth has declined, more young people are binge drinking, according to press release from the Centre for Addiction and Mental Health (CAMH).

According to the 2001 Ontario Student Drug Use Survey (OSDUS), student cigarette use dropped from 29% to 24% between 1999 and 2001. This is the lowest the rate has been since 1977. The survey also found that fewer Ontario students are using alcohol, tobacco, or marijuana at an early age. However, binge drinking increased from 18% of the student population to 25%, and drinking levels increased across the board.

"We're very pleased that smoking has declined among Ontario students," said Andrea Stevens Lavigne, director of CAMH's Communications, Education and Community Health department. She credited numerous national, provincial, and community tobacco-prevention initiatives, including anti-smoking laws, for the decline. "OSDUS is a great tool for showing us where we've been successful in our prevention and education efforts and the work we still have left to do."

Source: Centre for Addiction and Mental Health (CAMH), November 19, 2001.

Ruth Fox Memorial Endowment Fund

Dear Colleague:

On behalf of ASAM and the Ruth Fox Memorial Endowment Fund Committee, we wish to thank you for your generosity and continued support, and extend to you and your family our warmest wishes for a healthy, prosperous and peaceful New Year.

We look forward to meeting with you during the Ruth Fox reception at ASAM's Medical-Scientific Conference in Atlanta. Remember, this event is limited to donors only, so watch the mail for your invitation!

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

Max A. Schneider, M.D., FASAM, Chair, Endowment Fund

Howard G. Komfeld, M.D. & James W. Smith, M.D., FASAM, CO-Chairs, Resources & Development Committee

Claire Osman, Director of Development

TREATING ADDICTION IN PRIMARY CARE: A ONE-DAY COURSE FOR PRIMARY CARE PHYSICIANS

Friday, April 26, 2002

During ASAM's 33rd* MEDICAL-SCIENTIFIC CONFERENCE *in Atlanta, Georgia

WE INVITE YOU TO ATTEND the American Society of Addiction Medicine's one-day course on Treating Addiction in Primary Care on Friday, April 26, 2002. Composed of primary care physicians and a broad cross-section of specialists working toward progress in the treatment of addictive disorders, ASAM is the nation's medical specialty society dedicated to educating physicians and improving the treatment of individuals suffering from alcoholism and other addictions. Treating Addiction in Primary Care is a one-day course that provides 5 hours of continuing education credits and is approved for AMA Category I, Prescribed AAFP and AOA credits.

The course includes two workshops and an opportunity to attend the Medical-Scientific Conference Opening Session, which features the R. Brinkley Smithers Distinguished Scientist Lecture, "The Natural History of Smoking and Nicotine Dependence," as well as contributions from the Directors of the National Institute of Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). ASAM's 2002 Distinguished Scientist is Denise Kandel, Ph.D., Professor of Public Health in Psychiatry at Columbia University College of Physicians and Surgeons. In addition, a two-hour lunch break provides ample opportunity to review poster displays, speak with authors, and visit the exhibits of participating governmental agencies, treatment programs and Twelve Step groups.

The course workshops are as follows:

Morning Course:	Brief Interventions in an Office Practice
Afternoon Course:	Pharmacological Agents in the Treatment of Addictions in Primary Care, Inpatient and Outpatient Detoxification
Case Studies:	Entrees to Treatment through Primary Care

For more information or to register, phone 301/656-3920.

Dr. Miller Serves His Country and His Patients

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

Jeanne Erdman

A focus on the brain as an organ explains how Major Shannon C. Miller, M.D., USAF, Wright Patterson Air Force Base, Ohio, came to practice addiction medicine. Dr. Miller began residency training at Wright-Patterson AFB, expecting to work with schizophrenia and inpatient psychiatry. In 1996, his first assignment was TriSARC (Tri-Service Addiction Recovery Center) at Andrews Air Force Base, Maryland. Just before he arrived, the armed services implemented a "divide and conquer" plan for psychiatric services in the National Capital area. Rather than having each hospital offer a full spectrum of psychiatric services, National Naval Hospital took child and adolescent psychiatry and Walter Reed took adult psychiatry. "That left Andrews with the addictions," Dr. Miller explains. "Suddenly I found myself working in a field which I knew absolutely nothing about, and in a hospital that was quite uncertain about its new mission."

Attending conferences helped him acquire knowledge. Then he decided to sit for ASAM's certification examination in addiction medicine. "I had a real interest in schizophrenia and in the neurobiology behind how the brain hallucinates and how it does all the strange things that it does," he says. "When I was studying for the ASAM certification exam, I found that the neurobiology behind addiction crosses a number of identical areas of the brain as does the neurobiology of schizophrenia, so it was kind of a natural jump" into an interest in addictive disorders.

Eventually, Dr. Miller became Chief of TriSARC, affording him an opportunity to modernize both staff attitudes and services. For example, physicians had been only peripherally involved in addiction treatment. Dr. Miller worked with the staff to create a service line with physicians at the center and inaugurated an aggressive marketing campaign. "I treated it like a civilian addiction service. We kept track of the number of referrals, the civilian dollar value of the services we provided, salary costs, and service costs. Monthly, we produced a bottom line to our commander. We were able to move to the center of the hospital's radar because we were the only place in the hospital that could show a financial bottom line, cost-effective to boot. In the end we all felt we had a much better product." This activity culminated with the USAF Inspector General recognizing TriSARC with a "Best Practice Award."

The Air Force also has supported Dr. Miller's involvement in ASAM committee work and provided him time to publish and speak regularly on addiction medicine. Adding to his laurels, Dr. Miller has received several teaching awards as well as the military medical school's "Humanism in Medicine Award" for activities relating to rebuilding TriSARC as a teaching site for addiction medicine.

In general, active duty troops with drug problems usually are separated from the military following treatment. For example, the Air Force recently addressed Ecstasy use. In 1999, the Air Force added an Ecstasy screen to the urine tests. "Since then, the Air Force has implemented a number of strategies to find and prosecute individuals. But more specifically, and I think more helpfully, the Air Force has implemented prevention protocols to educate commanders and troops about this drug, the harm associated with it, and as well that the Air Force is testing for it. You have to understand that it's not the physician's responsibility to decide whether to keep somebody in the military; it's the commander's," adds Dr. Miller. "We simply advise them."

In 2001, Dr. Miller was transferred from Andrews back to Wright-Patterson AFB, where he currently divides his time between addiction psychiatry and general psychiatry. He will soon take over as Residency Training Director. The addiction clinic at Wright-Patterson is smaller than the one at TriSARC, where Dr. Miller and his staff received referrals from military bases around the world.

While at Wright-Patterson, Dr. Miller continues work on a program he began at Andrews. He is lead agent for the Department of Defense, working with addiction specialists in the VA to develop evidence-based practice guidelines for substance use disorders (the final product can be viewed at http://www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm).

As he looks to the future, Dr. Miller wavers between remaining in the Air Force or practicing medicine in the civilian world. "I very much want to stay [in the Air Force]," he says. "I have a real sensitivity in serving this population, but I also am actively exploring civilian opportunities."

He says the biggest challenge in practicing addiction medicine in the Air Force is no official recognition for the field. Each type of physician or clinician has a number or code identifying the type of medicine. Psychiatry has specific codes to designate a physician as a child and adolescent psychiatrist versus a forensic psychiatrist, for example. There is not yet a designation for addiction medicine. Even though Dr. Miller is certified in addiction medicine and as a medical review officer, in the eyes of the Air Force, he's a general psychiatrist. "The Air Force has very generously invested in sending me to conferences and in getting me ASAM certified," Dr. Miller says. "But despite my keen interest in practicing in this field I have no assurances and there is no system in place to support my career field," he adds.

"I can still be very happy" practicing medicine in the Air Force, Dr. Miler concludes. "As far as lots of docs wanting to come in and practice addiction medicine in the Air Force, that's something that hasn't been trailblazed yet. If you're going to be in the Air Force, and you want to practice addiction medicine, you have to be a strong and creative advocate for such a career and for the patients you serve." ■

The views expressed in this article are those of the author(s)/subject(s) and do not reflect the official policy or position of the United States Air Force, Department of Defense, or the U.S. Government.

Jeanne Erdmann is a St. Louis-based medical writer who also writes for Science and CBS HealthWatch. AF photo by Deb Mercurio.

ASAM CONFERENCE CALENDAR

ASAM

February 1-3, 2002
Medical Review Officer (MRO) Training Course
Orlando, FL
20 Category 1 CME credits

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

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

April 26-28, 2002
33rd Annual Medical-Scientific Conference
Atlanta, GA
Up to 21 Category 1 CME credits

April 28, 2002
Office-Based Treatment of Opioid Dependence
ASAM Medical-Scientific Conference
Atlanta, GA
8 Category 1 CME credits

July 19-21, 2002
Medical Review Officer (MRO) Training Course
Washington, DC
20 Category 1 CME credits

September 20-22, 2002
Medical Review Officer (MRO) Training Course
Scottsdale, AZ
20 Category 1 CME credits

OTHER EVENTS OF NOTE

February 1-2, 2002
25 Years of Addiction Treatment
(sponsored by the Harvard Medical Center)
Boston, MA
[For information, phone 617/503-3460
or e-mail cme@challiance.org]

February 20-23, 2002
Society for Research on Nicotine and Tobacco
8th Annual Meeting
Savannah, GA
[For information, e-mail smt@tmahq.com
or phone 608/838-3787 x144]

February 20-24, 2002
American College of Preventive Medicine
Prevention Medicine 2001
San Antonio, TX
[For information, visit
www.PreventiveMedicine2002.org,
or phone 202/466-2044]

February 27-March 3, 2002
American Academy of Pain Medicine
Annual Meeting & Review/Refresher Course
San Francisco, CA
[For information, phone 847/375-4731
or visit www.painmed.org]

March 14-15, 2002
National Institute on Drug Abuse conference on
Blending Clinical Practice and Research:
Forging Partnerships to Enhance Drug Treatment
New York, NY
[For information, phone 301/443-6245]

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

May 10-20, 2002
National Association of Addiction Treatment
Providers
2002 Annual Conference
Scottsdale, AZ
[For information, visit www.naatp.org]

May 14-16, 2002
Maintenance Therapy: Evidence-Based
Practice and Integrated Treatment
5th Europad Conference
Oslo, Norway
[For information, visit
www.med.uio.no/ipsy/skr/conf.htm]

October 28-30, 2002
International Society for the Prevention
of Tobacco-Induced Diseases
First Annual Scientific Meeting
Essen, Germany
[For information, visit www.ptid2002.info
or e-mail toxicol98@aol.com]

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Register now for ASAM's 33rd Annual
MEDICAL-SCIENTIFIC CONFERENCE
Hyatt-Regency Hotel
ATLANTA, GEORGIA

THURSDAY, APRIL 25
- ★ Ruth Fox Course for Physicians
- ★ Pain and Addiction III: Common Threads
- ★ Component sessions begin
- ★ Welcome reception (Exhibit Hall)

FRIDAY, APRIL 26
- ★ ASAM Business Meeting
- ★ Distinguished Scientist Lecture
- ★ Scientific sessions begin
- ★ Ruth Fox Fund reception
- ★ Dessert reception (Exhibit Hall)

SATURDAY, APRIL 27
- ★ Scientific sessions continue
- ★ Component sessions continue
- ★ Awards Dinner

SUNDAY, APRIL 28
- ★ Scientific sessions continue
- ★ Component sessions continue
- ★ Med-Sci Conference ends at noon
- ★ Office-Based Treatment of Opioid Dependence