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Volume 17, Number 6

# ASAM News

Newsletter of The American Society of Addiction Medicine

## Inside

### ASAM at Work for You:



### Also see:



www.asam.org

## ASAM MRO Course to Review New Federal Standards

San Francisco is the setting for ASAM's next Medical Review Officer Training Course, set for March 14-16, 2003. Under the direction of course chair Donald Ian Macdonald, M.D., FASAM, an expert faculty will review the impact of the revised Part 40 rule, which took effect in 2002, as well as recent developments in alcohol and drug testing technologies in terms of their implications for the work of Medical Review Officers. The course also prepares candidates to sit for the MROCC certifying examination. For additional information and registration, consult the ASAM web site or contact ASAM's meetings staff at email@asam.org. *(For more MRO News, see page 11.)*

# FDA Approves Buprenorphine for the Treatment of Opioid Dependence

In a widely anticipated decision, the U.S. Food and Drug Administration has approved two new formulations of the drug buprenorphine for use in the treatment of opioid dependence. The approval letter, issued October 8th, is for buprenorphine hydrochloride (Subutex®) and buprenorphine with naloxone (Suboxone®). Concurrently, the Drug Enforcement Administration (DEA) designated these products (as well as Buprenex®, an injectable form approved for the treatment of pain) as Schedule III narcotics.

The final step in getting Suboxone and Subutex on pharmacy shelves is for the manufacturer, Reckitt Benckiser, to import the tablets from England. Initial shipments are expected to arrive in the U.S. in mid-December. Assuming prompt clearance by customs and the FDA, Suboxone and Subutex could be on pharmacy shelves as early as January 2003. The manufacturer has said that the cost of Suboxone or Subutex at the pharmacy will be something less than $10 a day for the usual maintenance dose.

Assessing the implications of these developments, Charles G. Curie, administrator of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), said, "Buprenorphine will allow patients to be treated for addictions in the same manner as they are treated for other chronic illnesses, such as diabetes or hypertension.... A qualified physician will be able, for the first time, to prescribe an anti-addiction medication in an office setting and treat opiate addiction as any other chronic disease."

In approving the medications, FDA asked Reckitt Benckiser to develop a comprehensive risk management program. Other restrictions include limiting the number of patients treated to 30 per physician or group practice. Physicians who wish to use buprenorphine to treat opiate addiction must register with and obtain a special waiver from the federal Center for Substance Abuse Treatment. *(For more on buprenorphine, see Treatment News, page 7.)*

# Member Input and the Future of ASAM

*Eileen McGrath, J.D.*

In the September-October issue of ***ASAM News***, I asked for your comments about the future of ASAM. I received a particularly thoughtful reply from Anthony Radcliffe, M.D., FASAM, which I share with you as "food for thought." I invite your response.

You will recall that Dr. Radcliffe, who practices addiction medicine in Redands, CA, is a longtime member and Past President of ASAM. His vision for ASAM has several components.

*Anthony Radcliffe, M.D., FASAM*

First, he would have ASAM advocate for parity for addictive diseases, since "parity is access and, without access, effective treatment cannot occur."

The second part of his vision is for ASAM to continue to advocate for all physicians "to learn more about addictions and to create fellowships to train specialists in addiction medicine." Dr. Radcliffe sees traditional medical education as only slightly more predisposed to educating primary care physicians about addictions now than it was in years past.

Third, Dr. Radcliffe wants ASAM to focus primarily on the needs of physicians. Although he works within a multidisciplinary team, he hopes that ASAM will keep its focus on physicians because, he said, "most other disciplines have their own advocacy groups."

Fourth, he wants ASAM "to advocate for evidence-based clinical practices in addiction medicine assessment and treatment."

Fifth, he wants ASAM to "advocate for ongoing evaluation of treatment outcomes." Dr. Radcliffe says that incorporating ongoing outcomes data collection as a routine part of an addiction medicine practice would allow clinicians to more closely tailor their treatment approaches to the needs of patients at various stages of the disease.

Sixth, Dr. Radcliffe wants ASAM to "continue to educate and advocate amongst the lay community for greater understanding of addiction as a chronic primary medical disorder that is treatable." Dr. Radcliffe believes this could help decrease the stigma associated with addiction.

Dr. Radcliffe's vision of practicing addiction medicine as a medical specialty is "for ASAM to be the forum where outcome data from every type of treatment program would be presented, discussed, debated and better understood." He hopes "this would lead to less dogma concerning addictive diseases and their treatment."

The emphasis on advocacy and education in Dr. Radcliffe's vision are incorporated in ASAM's Strategic Plan. At its planning session in October, the ASAM Board of Directors identified the following objectives in the Strategic Plan as the Society's focus for the coming year: identifying member needs, chapter development, membership recruitment and retention, providing value to members, networking with medical and other societies, legislative advocacy, advocacy for recovering people, continuing medical education in addiction medicine, and publications. With regard to the national database advocated by Dr. Radcliffe, ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, has appointed a committee to recommend to the ASAM Board a policy direction for ASAM's involvement in the development of a national treatment database for addiction medicine.

The advice of ASAM members like Dr. Radcliffe enables your Society to be responsive to members' needs and thereby to advance addiction medicine. ASAM's priorities and programs are of value only to the extent that they are of value to you as an ASAM member. For this reason, I hope to continue to hear from you.

Recently I attended a memorial service for the late Senator Paul Wellstone. I was moved by many aspects of the service, but a quote from Senator Wellstone stands out in my memory: "Never separate the life you live from the words you speak." Those are wise words for us to keep in mind, both as individuals and as a Society.

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



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## Most Drug Policy Initiatives Fail on Election Day

Faced with strong grassroots opposition and unprecedented lobbying by federal officials and anti-drug groups, most so-called "reform" ballot initiatives went down to defeat on Election Day.

In their boldest challenge yet to current policy, reform groups succeeded in placing a measure on the Nevada ballot that called for legalizing the sale and possession of small amounts of marijuana. Voters defeated the measure by a wide margin. Arizona's Proposition 203 would have decriminalized possession of up to 2 ounces of marijuana; that, too, was defeated.

In Ohio, sponsors of Issue No. 1 hoped to emulate the success of California's Proposition 36, which requires that courts give first-time drug offenders a chance at treatment in lieu of incarceration. However, the Ohio measure—which was opposed by the state's drug court officials and most of the political establishment, led by First Lady and anti-drug activist Hope Taft—failed by a 2-to-1 margin. Commenting on the results, John Walters, head of the White House Office of National Drug Control Policy, said, "These failed initiatives represent the high water mark of the drug-legalization movement.... Common sense has prevailed."

Initiative sponsors tried to put a positive spin on the outcomes. "These initiatives may have been ahead of their time, but similar initiatives will sweep the country soon enough, as support grows for removing marijuana from criminal laws," said Ethan Nadelmann, executive director of the Drug Policy Alliance.

Independent analysts pointed to three reasons the ballot initiatives failed: First, they said, voters resented "outsiders" trying to dictate state policy. For example, opponents publicized the fact that the Drug Policy Alliance and its affiliate, the Campaign for New Drug Policies, are funded by three wealthy businessmen: international financier George Soros; Peter Lewis, head of Progressive Insurance Company; and John Sperling, founder and CEO of the University of Phoenix, a chain of private adult education facilities. Second, opponents charged that the ultimate motive of the drug policy "reform" initiatives is to legalize marijuana. That argument was reinforced by the fact that failed ballot initiatives sponsored by the Drug Policy Alliance in Nevada and Arizona both would have decriminalized possession of small amounts of marijuana. Finally, opponents charged that the ballot measures would undermine established drug treatment courts and create duplicative systems for first- and second-time drug offenders.

In one of the few referenda to pass, voters in Washington, DC, overwhelmingly approved Initiative 62, another plan to put drug offenders into treatment rather than prison. Like any local legislation passed in the District, however, Initiative 62 is subject to Congressional approval. Congress usually finds a way to block District laws it doesn't like, and that almost certainly will be the fate of Initiative 62. *Sources: Bob Curley, Join Together Online, November 6, 2002; Washington Post, November 6, 2002; Alcohol & Drug Abuse Weekly, November 11, 2002.*

## Tobacco Initiatives Succeeds With Voters

Anti-smoking initiatives on the November ballots generally fared better with voters than the so-called "drug reform" measures. For example, 70% of Florida voters approved a proposal to ban smoking in most public spaces, despite vigorous opposition from the hospitality industry. The measure will end smoking in most workplaces, including bars and restaurants.

In Arizona, 71% of residents approved a plan to raise the state's cigarette tax from 58 cents to $1.18 per pack, with the added revenues used to pay for health care and tobacco-cessation programs. However, a similar measure failed in Missouri by a 51% to 49% margin. Most opposition to the Missouri tax hike came from rural voters.

State legislatures nationally have been roundly criticized for raiding payments under the 1998 tobacco settlement to fund non-tobacco-related programs. In Montana, voters took the issue into their own hands, passing an initiative that earmarks 32% of the state's tobacco settlement funds, or $9.6 million a year, for smoking prevention programs. However, a similar measure failed in Michigan, despite strong backing from groups like the American Lung Association. *Sources: Bob Curley, Join Together Online, November 6, 2002; American Medical News, November 25, 2002.*

## House Endorses President's National Drug Control Strategy

The U.S. House of Representatives has unanimously passed a resolution expressing support for the President's National Drug Control Strategy. Sponsored by Rep. Mark Souder (R-IN) and Rep. Elijah Cummings (D-MD), the resolution praised the President's goal to reduce drug use by 10% over two years and 25% over five years. In remarks supporting the resolution, Congressman Cummings said that the strategy "reflects a recognition of the essential role that treatment plays in reducing drug demand. The President's proposed drug control budget includes a $1.6 billion increase in drug treatment funding over five years, in addition to a solid commitment to the Drug Free Communities Program, the National Youth Anti-Drug Campaign, drug courts, and other vital demand-reduction programs." *Source: National Association of State Alcohol and Drug Abuse Directors, November 22, 2002.*

## Congress Extends Mental Health Parity Act

Just before leaving to campaign in the November elections, members of the House of Representatives and the Senate granted a one-year extension to a law that provides some equality in insurance coverage for mental health services, but they failed to pass a broader parity bill (the Mental Health Equitable Treatment Act, S. 543/H.R. 4066) despite wide bipartisan support.

Enactment of the extender bill, H.R. 5716, ended a coordinated effort by advocates to pass a broad-based parity bill that would close the loopholes in existing laws. Even legislators sympathetic to parity said the Congress simply "ran out of time" to deal with the broader measure. Also, the sudden death of Senator Paul Wellstone (D-MN) deprived the bill of a passionate advocate.

***Parity proponents vowed to bring a broad measure back to the 108th Congress when it convenes in January.***

Parity proponents vowed to bring a broad measure back to the 108th Congress when it convenes in January. *Source: Mental Health Liaison Group, Bazelon Center for Mental Health Law, November 18, 2002.*

## Member Survey to Identify Liaison Resources

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

Your Board of Directors recently adopted a five-year Strategic Plan for the Society. A major focus of our efforts during the coming years will be on issues such as parity of insurance coverage and physician reimbursement, as well as the removal of legal, regulatory, and management obstacles to effective treatment of addictive disorders in any setting. These goals will be pursued in individual states, led by newly vitalized state chapters, as well as at the national level.

Using the survey form enclosed with this issue of ***ASAM News,*** I am asking each of you to identify your special role(s) or office(s) in state and national organizations, and to indicate your willingness to serve as a policy liaison between those organizations and ASAM.

The results of the survey will be made available to state chapters and also will be utilized by the national leadership of ASAM. We believe that our goals are realistic, but they require the efforts of all of us. Thank you in advance for your response.

The ASAM Board also plans to use other mechanisms to enhance the effectiveness of ASAM and increase the value of ASAM membership. In coming months, the Board will review and revise the committee structure to more fully facilitate member participation. This will include, for the first time, a meeting of Committee Chairs at the Toronto Med-Sci Conference.

Also at Toronto, the Annual Business Meeting will feature a special component, which might be called "Let Your Leaders Know." This will be a perfect opportunity for members to meet ASAM's Board of Directors and Officers, and to share their thoughts on how ASAM can continue to be relevant to their professional lives. Stay tuned for more information in future issues of **ASAM News**. We believe that our goals are realistic, but they require the efforts of all of us.

## Members Reminded of ASAM Procedures

President Lawrence S. Brown, Jr., M.D., FASAM, and the ASAM Board of Directors remind members to observe the following procedures in their public appearances, written communications, advertisements (in print or on-line) and web sites:

1. Unless previously invited by ASAM to serve as an official representative of the Society, a member who is invited to participate in a public forum (oral or written) *as a representative of ASAM* should notify the ASAM staff in advance and obtain the agreement of the leadership.
2. Whenever a member serves as an official representative of ASAM, he or she should ensure that the sponsoring organization appropriately credits the Society. Requests for co-sponsorship should be referred to the ASAM staff to ensure that they comply with ACCME requirements.
3. In all appearances or written communications, members should make a clear distinction between official ASAM policies, as expressed in the Society's Public Policy Statements, and their own views.
4. Members who cite their ASAM membership, ASAM certification, and/or ASAM committee or other leadership positions in advertisements, web sites, and other venues are responsible for ensuring that the content of the advertisement or other forum and the activities promoted therein conform to ASAM's practices and positions, as expressed in the Society's Public Policy Statements.

Finally, the leadership would appreciate being informed of instances in which ASAM's name may have been used inappropriately. Please send copies of advertisements and other relevant information to Joanne Gartenmann at the ASAM office. Ms. Gartenmann can be reached by phone at 301/656-3920 or by e-mail at JGART@ASAM.ORG.

# New ASAM Public Policy Sets Standard for Correctional Health Care

*Donald J. Kurth, M.D., FASAM*

Every day, across the United States, patients suffering from addictive disorders are arrested, incarcerated, and allowed to experience acute withdrawal without the benefit of medical care. Although the United States Supreme Court has ruled that all inmates deserve adequate health care, some correctional officials seem to believe that acutely addicted patients somehow are exempt from this policy. To address the problem, ASAM's Board of Directors has adopted a Public Policy Statement on "Access to Appropriate Detoxification Services for Persons Incarcerated in Prisons and Jails" (see the accompanying text).

Acute alcohol withdrawal, of course, carries the risk of seizures and delirium tremens and may be a life threatening medical condition. Other medical conditions may be exacerbated or masked during acute intoxication or acute withdrawal. Opiate withdrawal, either from illicit narcotics or from legally prescribed analgesic or chronic opioid agonist therapy, may cause significant morbidity as well.

In addition to the medical issues, unattended withdrawal in correctional settings is fraught with legal, ethical, and moral issues. If alcoholism is a disease, then society is morally obligated to provide medical treatment for the alcoholic who is incarcerated. Similarly, if chronic opioid agonist therapy is a valid medical treatment, then there is not just a legal but an ethical requirement to provide detoxification from opioids to those who need it.

We should applaud our Board for having had the courage to adopt a clear-cut policy to end the discrimination against incarcerated individuals who suffer from an addictive disease. ASAM members are encouraged to publicize the statement by writing an op-ed article for their local newspapers. Members also are encouraged to use this and other ASAM Public Policy Statements to promote positive change in their communities. For example, members could work to assure that local correctional officials adopt appropriate policies for the evaluation and management of health conditions among inmates. By putting our Public Policy Statement to use in this way, we can provide a valuable tool to help individuals suffering from addictive disease gain access to sorely-needed medical care. *Dr. Kurth chairs the CSAM Public Policy Committee and is an Alternate Director representing Region II on the ASAM Board of Directors.*

## ASAM Public Policy Statement on "Access to Appropriate Detoxification Services for Persons Incarcerated in Prisons and Jails"

**Background.** Addictive diseases are common among people living in the United States, and studies show that the prevalence of addictive diseases among inmates in jails and prisons is higher than occurs in the general population. Many patients with addiction have physiologic dependence on the agent to which they are addicted, such as alcohol, prescription sedatives or opioids, or heroin. When individuals dependent on such drugs experience an abrupt cessation of use, a withdrawal syndrome can ensue with both physiological and psychological components. The acute withdrawal syndrome can constitute a medical crisis, causing significant symptoms, and in some cases causing death even in previously healthy individuals. While opiate withdrawal itself is usually not fatal, it can lead to tremendous discomfort, and fluid and electrolyte disturbances related to the vomiting and diarrhea of withdrawal can exacerbate co-occurring medical problems in the withdrawing individual, potentially precipitating sudden death....

The U.S. Supreme Court has held that the proscription of cruel and unusual punishment by the Eighth Amendment of the United States Constitution requires that proper medical care be rendered, when indicated, to individuals who are incarcerated. In accordance with such rulings, correctional facilities assure that qualified medical personnel are routinely available to treat people in custody for medical conditions such as diabetes mellitus, cardiac disease, and surgical emergencies such as appendicitis. Patients with treatable medical conditions are not required to suffer or die while in custody—except, tragically, in the case of addictive disease.... Health care services in jails and prisons have received increasing attention in recent years as the number of prison beds has mushroomed and the number citizens incarcerated in America has grown dramatically. Correctional facilities can receive guidance on appropriate policies and procedures for screening and referral of health care conditions by consulting a national quality assurance body, the National Commission on Correctional Health Care.

**Recommendations.** In light of these circumstances, ASAM recommends the following:
Individuals brought into custody by criminal justice authorities should receive appropriate general medical screening to assure that their medical needs will not go unaddressed during their incarceration. The circumstance of being under arrest, detained, jailed, or imprisoned should not preclude access to and provision of medically necessary treatment for alcohol and other drug withdrawal.

Individuals with addiction who are placed in jails or prisons should not be discriminated against because of their diagnosis. Prisoners and other detainees with addiction should receive the medical care necessary to manage withdrawal syndromes, just as they receive the medical care necessary to manage any other acute illnesses or injuries.

Given the high prevalence of substance use and addiction among individuals who are arrested or detained in jails or other correctional facilities, individuals should be screened for the presence of, or risk of, addiction and withdrawal at the point of entry into a criminal detention facility. Appropriately trained personnel should conduct screening.

When screening identifies...withdrawal, or a significant likelihood that withdrawal is present or could develop, affected individuals should be seen by a licensed health care professional who can make a definitive diagnosis. When medically necessary, such health care professionals should render appropriate detoxification services for the withdrawing individual, or arrange transfer to a health care facility where services will be provided.

Jails and prisons should revise any policies and procedures that preclude ill detainees from receiving necessary and appropriate health care services, including withdrawal management services, appropriate to their condition.

Whenever possible, jails and prisons should be encouraged to seek accreditation by the National Commission on Correctional Health Care. *Adopted by ASAM's Board of Directors, July 2002. The full text of this statement is available on ASAM's web site at www.asam.org.*

# Agency Report

## SAMHSA: Candidates Sought for Deputy Post

The Substance Abuse and Mental Health Services Administration (SAMHSA) is seeking candidates for the post of Deputy Administrator. An announcement from the agency says that, in addition to serving as SAMHSA's Chief Operating Officer, the Deputy Administrator "shares responsibility with the Administrator for providing leadership, policies, and national goals for the federal effort to strengthen the Nation's prevention and treatment services delivery system for persons with mental and addictive disorders." SAMHSA has a staff of approximately 550 and a fiscal year 2002 budget of $3.1 billion, including $2.1 billion channeled to the publicly funded treatment system through the substance abuse and mental health block grants.

The Deputy's post is a career position in the Senior Executive Service, with a base salary range of $125,972 to $138,200. Additional incentives could include a recruitment bonus, relocation expenses, and (for physicians only) an additional allowance of up to $30,000 annually. SAMHSA's offices and staff are located in Rockville, Maryland, a suburb of Washington, DC.

Detailed information on qualifications and responsibilities is found in the complete vacancy announcement, which can be obtained by visiting HTTP://CAREER.PSC.GOV and searching for announcement EX-02-011, or by contacting SAMHSA's Patricia Bransford by phone at 301/443-3408 or by e-mail at PBRANSFO@SAMHSA.GOV. The closing date for applications is January 15, 2003.

## NIDA: Agreement with CSAT on Research Findings

The National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT) have joined in an intra-agency agreement designed to expedite the adoption of treatment research findings in clinical practice. Agency officials say the $1.5 million agreement will help ensure that findings from NIDA's treatment research will be quickly and readily available to practitioners around the country.

Under the agreement, NIDA will provide funding to support CSAT's Addiction Technology Transfer Centers (ATTC) network of 14 independent regional centers and a national office. The ATTCs are charged with increasing the knowledge and skills of addiction treatment professionals and fostering alliances to support and implement best treatment practices. Through the ATTCs, NIDA hopes to enhance efforts to disseminate and apply findings from its National Drug Abuse Treatment Clinical Trials Network and other studies its supports.

For more information, contact Michelle Person of NIDA at 301/443-6245 or Leah Young at CSAT at 301/443-8956.

## DEA: No Change in Medical Marijuana Policy

The Director of the U.S. Drug Enforcement Administration (DEA) has informed California officials that DEA will not back down on enforcement of federal drug laws that make California's medical marijuana clubs illegal.

Following recent federal raids on California cannabis clubs (which were legalized under state law in a 1996 referendum), state Attorney General Bill Lockyer wrote to Attorney General John Ashcroft and DEA chief Asa Hutchinson, asking for a meeting to work out a compromise. Director Hutchison's response offered no hope of negotiations. "When marijuana is observed in the ordinary course of law-enforcement duties, the DEA is legally mandated to seize it, even if no prosecution results," his reply said. The letter also cautioned that "Your repeated references to 'medical' or 'medicinal' marijuana illustrates a common misperception that marijuana is safe and effective medicine. The scientific community has never determined this to be the case."

The letter also pointed out that, under federal law, the DEA has authority to continue to confiscate marijuana plants until Congress decides otherwise. *Source: San Diego Union-Tribune, October 1, 2002.*

## Medicare: Anti-Smoking Program Launched

Medicare is conducting a pilot program in seven states to determine the most effective way to help older adults quit smoking. Called the Medicare Stop Smoking Program, the project will evaluate several smoking-cessation strategies, including counseling in person and over the phone, nicotine patches, prescription smoking-cessation drugs, and educational materials.

The program is to be implemented in Alabama, Florida, Missouri, Nebraska, Ohio, Oklahoma, and Wyoming. Residents in those states who are age 65 and older can call a toll-free number, 1-866/65BEGIN, to learn if they are eligible for the study. Results of the pilot program are expected to be reported in 2005.

"It is never too late to quit smoking, even if you have smoked heavily for 30 years or more," said Health and Human Services Secretary Tommy Thompson. "In fact, older adults have proven to be more successful at quitting smoking than younger people." *Source: Join Together Online.*

# Funding Opportunities

## SAMHSA Offers Conference Grants

The Substance Abuse and Mental Health Services Administration (SAMHSA) will award up to 30 grants to support conferences that provide information on addictive and mental disorders.

Through the Knowledge Dissemination Conference Grants, SAMHSA plans to give a total of $825,000, including $500,000 for addiction-related meetings and $325,000 for conferences focusing on mental health issues. Individual grants typically range from $25,000 to $50,000. SAMHSA will pay for up to 75% of direct costs of meetings and conferences.

Eligible applicants include public and private not-for-profit organizations, state and local governments, professional associations, voluntary organizations, self-help groups, consumer and provider services-oriented constituency groups, community-based organizations, and faith-based organizations.

Applications are due January 10th and September 10th, 2003. For information on grants related to addiction treatment, contact Kim Plavsic by phone at 301/443-7916 or e-mail KPLAVSIC@SAMHSA.GOV. For information on grants related to addiction prevention, contact Boris Aponte by phone at 301/443-2290 or by e-mail at BAPONTE@SAMHSA.GOV. *Source: Federal Register, November 12, 2002.*

# Buprenorphine Approved for the Treatment of Opiate Addiction

*Donald R. Wesson, M.D.*

*Editor's Note: The following special report is modified from an article Dr. Wesson prepared for CSAM News. ASAM thanks Dr. Wesson and the California Society of Addiction Medicine for sharing this important information.*

Approval of buprenorphine for the treatment of opioid dependence has been a long time coming. The first article suggesting that the drug might have clinical utility as an anti-addiction medication was published in 1978. On October 8, 2002, the Food and Drug Administration (FDA) approved buprenorphine sublingual tablets for use in the treatment of addiction. Concurrently, the Drug Enforcement Administration (DEA) designated all formulations of buprenorphine approved for use in the United States—Buprenex®, Suboxone®, and Subutex®—as Schedule III *narcotics*. (The designation as a narcotic has important regulatory and clinical ramifications independent of the drugs' Schedule III status.)

Suboxone will be produced by the manufacturer, Reckitt Benckiser, as a hexagonal orange sublingual tablet and will be available in two dosages: 2 mg of buprenorphine combined with 0.5 mg of naloxone, and 8 mg of buprenorphine with 2 mg of naloxone. Subutex will be produced as an oval white tablet containing either 2 or 8 mg of buprenorphine.

## Cautions in Using the Drug

ASAM members can be helpful to their colleagues by reminding them that they cannot prescribe buprenorphine for the treatment of addiction unless they qualify under the conditions established by the Drug Addiction Treatment Act of 2000 *[ED: see the accompanying article]*. The Subutex/Suboxone package insert does not alert physicians to this requirement, and it is likely that physicians outside the addiction treatment community will not know of the special requirements for prescribing Suboxone and Subutex. While Buprenex®, an injectable formulation of buprenorphine, is marketed for the treatment of moderate to severe pain, it should not be used in the treatment of addiction. Only formulations of buprenorphine that are FDA-approved for the treatment of opiate dependence (Subutex and Suboxone) can be legally prescribed for that purpose.

Also, a widely misunderstood provision of the Code of Federal Regulations (21 U.S.C. 1307.07) allows physicians to administer a narcotic medication to an opioid addict to alleviate withdrawal symptoms while arrangements are being made to admit such a patient to an addiction treatment program. Many physicians have assumed that this provides a three-day window in which they can administer narcotics such as buprenorphine for detoxification. On the DEA's web site, however, the prohibition against using the drug for this purpose is explicit.

## Conclusions

In the hoopla surrounding the launch of buprenorphine, it is easy to miss the fact that much more is happening here than the availability of a new medication. The conjunction of the Drug Abuse Treatment Act of 2000 and the launch of Suboxone and Subutex reverses over 40 years of prohibition against physician's use of agonist therapy to treat opiate dependence outside of specially licensed clinics. If office-based opiate agonist treatment is ever to become accepted clinical practice, physicians will have to show the FDA and DEA that they can responsibly prescribe opioid agonists to opioid-dependent subjects without creating scandals or public health problems. This is an opportunity we want to cherish and protect.

*Acknowledgements: Gail Jara, Walter Ling and Monika Koch reviewed drafts of this manuscript and provided many useful suggestions. Dr. Wesson chairs ASAM's Medications Development Committee and, with Dr. Ling, has conducted research on buprenorphine.*

## Federal Waiver Required

Physicians who wish to use buprenorphine for the treatment of opioid dependence must notify the federal Center for Substance Abuse Treatment (CSAT) of their intention, using a special form that can be downloaded from WWW.BUPRENORPHINE.SAMHSA.GOV. Qualified physicians will receive a waiver from CSAT and a unique identifying number from the Drug Enforcement Administration (the identifier is the physician's current DEA number with an X replacing the first letter). DEA advises that this identifying number should appear on each prescription written for buprenorphine for the treatment of opioid dependence.

In an effort to facilitate referrals, CSAT plans to establish a nationwide registry of physicians who are qualified to use buprenorphine in the treatment of opioid dependence. The agency also has established a special web site (INFO@BUPRENORPHINE.SAMHSA.GOV) and toll-free telephone number (866-BUP-CSAT) for physicians to call for information. Contact the Buprenorphine Information Center Monday through Friday from 8:30 AM to 5:00 PM EST.

## ASAM Offers Special Buprenorphine Training

Physicians who are not certified in addiction medicine or addiction psychiatry and who wish to use buprenorphine in the treatment of opioid dependence must complete an approved 8-hour training course. As an approved provider of such training, ASAM has scheduled the following courses for 2003:

April 12, 2003, in Washington, DC

May 4, 2003, in Toronto, Ontario, Canada

November 2, 2003, in Washington, DC

ASAM's courses satisfy the training requirements set forth in federal law. (Physicians who are certified in addiction medicine by ASAM or by AOAAM or who hold a Certificate of Added Qualifications in Addiction Psychiatry are eligible to apply for a waiver without attending a buprenorphine training course. However, ASAM recommends participation in such a course to assure that physicians are fully informed about the latest clinical data and regulatory mandates for office-based use of buprenorphine.)

To encourage physicians to participate in buprenorphine training, CSAT is planning a campaign to inform the public about this new treatment option.

For additional information or to register for a training course, visit the ASAM web site at WWW.ASAM.ORG, or contact Tracy Gartenmann, ASAM Buprenorphine Program Manager, by e-mail at TGART@ASAM.ORG or by phone at 301/656-3920.

## Brain Receptor is Key to Relapse Cues

Individuals in treatment for cocaine addiction who encounter people or settings they associate with past drug use often experience—and may succumb—to strong urges to resume such use. Such cue-induced relapse can occur long after patients have stopped using the drug. Now, research teams from Vrije Universiteit Medical Center in The Netherlands and NIDA's Intramural Research Program in Baltimore have shown that they can dramatically reduce cue-induced relapse to cocaine-seeking in rats by blocking a specific type of brain receptor. The study opens a promising new approach to developing medications that may help to prevent cue-induced relapse to cocaine abuse by humans.

In the studies, SR141716, a compound that blocks rats' CB-1 receptors, dramatically reduced resumption of cocaine-seeking behaviors associated with two of the three most common relapse triggers in humans: a priming dose of cocaine and environmental cues associated with cocaine reward. The compound did not reduce cocaine-seeking triggered by stress.

Significantly, the researchers found that the CB-1 antagonist did not alter the rats' ability to experience cocaine's primary rewarding effects, Dr. De Vries said. The CB-1 antagonist also did not deter the rats from continuing to self-administer sucrose, another rewarding substance. Together, these findings indicate that a CB-1 antagonist may be able to selectively block relapse provoked by cocaine's cues or the drug itself without producing undesirable effects such as a general loss of ability to feel pleasure. "We found that blocking cannabinoid (CB-1) receptors in the brain reduces the relapse-provoking effects of stimuli associated with past cocaine use without interfering with the brain's primary reward pathways," said Dr. Taco De Vries, who led the experiments in Amsterdam.

Summing up, Dr. De Vries said, "The next step would be to evaluate whether a CB-1 antagonist can be used in combination with agents that block the release of stress neurotransmitters as relapse-prevention medications." *Source: Robert Mathias, NIDA Notes, Vol. 17.*

## Even Low-Level Maternal Alcohol Use May Cause Long-Term Developmental Harm

A pair of recent studies have found significant deficits in children and adults exposed to even small amounts of alcohol *in utero*.

In an animal study, Daniel Savage, M.D., chairman of the department of neuroscience at the University of New Mexico Medical School, and colleagues found that the equivalent of one and half drinks a day increases the risk of subtle brain damage that may not become apparent until a child is older. They based their conclusion on a study of rats that were given varying levels of alcohol in their diets. The researchers found reduced levels of glutamate, which is involved in learning, in young adult rats exposed even to very low levels of alcohol *in utero*.

In one of the few studies to follow alcohol-exposed infants beyond their early and middle childhoods, Dr. Nancy L. Day and colleagues at the University of Pittsburgh School of Medicine found significant growth deficits among 14-year-olds whose mothers consumed less than one drink a day during pregnancy. The investigators found that the alcohol-exposed 14-year-olds were smaller in terms of their weight, height, head circumference, and skinfold thickness.

Although the relatively small effects on head circumference and growth in themselves are unlikely to have any functional significance, the researchers explain that they suggest potential damage to the brain, which may have serious implications for subsequent cognitive and behavioral development.

Importantly, Dr. Day's study found that growth retardation was related to continuous exposure to alcohol, even at low levels, but not to concentrated or binge drinking. The frequency of heavy or binge drinking (defined as consumption of four or more drinks on one occasion) did not predict growth.

The authors point out that both studies have important implications for prevention and the need to identify and intervene with women at risk earlier in their pregnancies. *Sources: Alcoholism: Clinical & Experimental Research, October (Day et al.) and November (Savage et al.) 2002.*

## Link Between Alcoholism and Major Depression Studied

Some alcoholism experts have suggested that the association between alcoholism and major depression in the general population reflects misdiagnosed alcohol intoxication and withdrawal effects. To investigate this hypothesis, Dr. Deborah S. Hasin, Ph.D., of the New York State Psychiatric Institute, and Dr. Bridget Grant, of the National Institute on Alcohol Abuse and Alcoholism, tested the association of past alcohol dependence with current major depression (that is, non-overlapping timeframes) in individuals who no longer drink or who drink very little.

Using data from the National Longitudinal Alcohol Epidemiologic Survey, the investigators recruited a representative sample of 6,050 former drinkers who had not used drugs or tobacco in the preceding year. Subjects were divided into two groups according to whether they had past *DSM-IV* diagnoses of alcohol dependence. The two groups were compared for the presence of current (i.e., last 12 months) *DSM-IV* major depression. The association between prior alcohol dependence and current major depression was tested with linear logistic regression, controlling for other variables.

***...prior alcohol dependence was associated with a fourfold increase in the rate of current major depressive disorder.***

The investigators found that prior alcohol dependence was associated with a fourfold increase in the rate of current major depressive disorder. The majority of subjects with major depression last used substances two or more years prior to the interview, which eliminated acute intoxication or withdrawal effects as an explanation for their depression. The authors concluded that the strong, specific association between prior alcohol dependence and current or recent major depression in a nationally representative sample of former drinkers indicates that the association is not entirely an artifact of misdiagnosed intoxication and withdrawal effects. *Source: Archives of General Psychiatry, September 2002.*

*In alcoholism*

# ANTABUSE®
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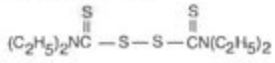
250-mg tablets

**Support for the committed quitter**

## 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:** Disulfiram is an alcohol antagonist drug.
CHEMICAL NAME:
bis(diethylthiocarbamoyl) disulfide
STRUCTURAL FORMULA:



$C_{10}H_{20}N_2S_4$ M.W. 296.54

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 AND USAGE:** 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.

**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.

**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.

Hepatic toxicity including hepatic failure resulting in transplantation or death have been reported. Severe and sometimes fatal hepatitis associated with disulfiram therapy may develop even after many months of therapy. Hepatic toxicity has occurred in patients with or without prior history of abnormal liver function. Patients should be advised to immediately notify their physician of any early symptoms of hepatitis, such as fatigue, weakness, malaise, anorexia, nausea, vomiting, jaundice, or dark urine.

Baseline and follow-up liver function tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with disulfiram therapy. In addition, a complete blood count and serum chemistries, including liver function tests, should be monitored.

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.

**References:** 1. O'Farrell TJ, Allen JP, Litten RZ. Disulfiram (Antabuse) contracts in the treatment of alcoholism. *NIDA Res Monogr.* 1995;150:65-91. 2. Chick J, Gough K, Falkowski W, et al. Disulfiram treatment of alcoholism. *Br J Psychiatry.* 1992;161:84-89.

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**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.

**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.

**Pediatric Use:** Safety and effectiveness in pediatric patients have not been established.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Since many drugs are so excreted, disulfiram should not be given to nursing mothers.

**Geriatric Use:** A determination has not been made whether controlled clinical studies of disulfiram included sufficient numbers of subjects aged 65 and over to define a difference in response from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal or cardiac function, and of concomitant disease or other drug therapy.

**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, as well as hepatic failure resulting in transplantation or death, have been reported with administration of disulfiram.

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

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

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

**OVERDOSAGE:** No specific information is available on the treatment of overdosage with disulfiram. It is recommended that the physician contact the local Poison Control Center.

**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 as 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: DP 706
Dispense in a tight, light-resistant container as defined in the USP.
Store at controlled room temperature 15°-30°C (59°-86°F). [SEE USP]

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## Survey: Employees Fear Job Loss If They Seek Addiction Treatment

Although Americans believe that their employer's health insurance should cover alcohol or drug addiction treatment, more than one in five insured employees believe they would face negative consequences at work if they sought coverage for such treatment. Fears range from being fired outright to losing a license or failing to get a promotion, according to a "Workplace Recovery Benefits Survey" conducted for the Minnesota-based Hazelden Foundation.

The survey also found that more than half of this country's 74 million workers with job-sponsored health insurance would prefer to ask a boss about their company's insurance coverage for treatment of a disease like diabetes rather than risk retribution or punishment for asking about coverage for treatment of problems with alcohol or other drugs.

Whether because of embarrassment, fear of job loss or other work-related disapproval, more than one in six workers say they would be reluctant to use their employer's insurance coverage for drug treatment for themselves or a family member. Nevertheless, a majority of survey respondents (77%) said that employer-paid health insurance should be required to cover addiction treatment. The survey polled a nationally representative sample of 1,101 households that reported having health insurance through an employer. The margin of error was ±3.1%. Other insights drawn from the survey include:

- Older employees are less hesitant to seek benefits for addiction treatment (24% of those between the ages of 18 and 34 said they would be reluctant, whereas only 12% of those 55 and older said they would be).
- More than a third of workers reported that they personally know of a coworker who has a problem with alcohol or other drugs. Most (82%) believe that their fellow employees would benefit from employer-sponsored health insurance coverage for drug treatment.

In fact, untreated addiction is costly to employers: the Bureau of National Affairs estimates that alcohol and drug problems cost American businesses $200 billion annually. Employees who go through treatment, on the other hand, experience significant reductions in employment problems like absenteeism and accidents on the job. "Every dollar spent on employee rehabilitation saves $7 in health and social costs," said William Cope Moyers, vice president of external affairs for Hazelden. He added that "It makes good economic sense for employers to support, rather than punish, workers who seek treatment for alcohol or other drug problems."

### Educating Employees

Hazelden recommends that employers take three steps to alleviate workers' apprehension about accessing health insurance for alcohol or drug treatment.

First, during every new employee orientation, managers should clearly describe available insurance benefits for addiction treatment and emphasize that employees' rights to confidentiality are strictly enforced.

Second, managers should choose an appropriate time to remind employees of the company's insurance benefits. "A designated date like National Substance Abuse Recovery Month (each September) would be a good time to focus on the company's support in paying for addiction treatment services," Moyers said.

Third, human resource and employee assistance program staff should educate employees as to how to use the company's insurance system to access benefits. For example, workers should know that prior approval of services may be required to receive a policy's maximum benefit. "Knowledge is power," Moyers said. "The more employees know about their health insurance and how they'll get the most benefit from it, the more likely they are to be comfortable in accessing the system." *Source: Hazelden Foundation, October 25, 2002.*

## MRO, Forensic Courses Scheduled for 2003

Course chair Donald Ian Macdonald, M.D., FASAM, has announced that the following MRO Training Courses will be held in 2003:

March 14-16, 2003, in San Francisco, CA
July 18-20, 2003, in Chicago, IL
November 21-23, 2003, in Washington, DC

Each course offers 20 hours of Category 1 CME credit.

In addition, ASAM has scheduled a workshop on Forensic Issues in Addiction Medicine for November 20, 2003, in Washington, DC (immediately preceding the MRO Training Course). To be chaired by Robert L. DuPont, M.D., FASAM, the workshop is approved for 7 hours of Category 1 CME credit.

For more information or to register, phone ASAM's Meetings Department at 301/656-3920 or visit ASAM's web site at WWW.ASAM.ORG.

## Health Professionals Key to Helping Pregnant Women Abstain

Health care professionals can play a key role in encouraging low-income women to quit smoking and drinking during pregnancy, researchers say. Dr. Judith K. Ockene, professor of medicine and chief of the division of preventive and behavioral medicine at the University of Massachusetts Medical School, and her co-investigators interviewed 600 pregnant women in the Boston area who were current smokers or who had quit when they learned they were pregnant. All of the participants were receiving prenatal care from a publicly funded program.

They found that 80% of the women had stopped drinking alcohol when they learned they were pregnant, but only 27% had stopped smoking. Those who stopped drinking had social support from family and friends. On the other hand, the women who continued to smoke had a greater addiction to nicotine, as well as a partner who smoked. The researchers determined that health care professionals can play an important role in providing social supports to women who don't receive such support from relatives and friends.

"The frequent contacts women have with health professionals during pregnancy may provide valuable opportunities to discuss alcohol and tobacco use and encourage behavior changes," Dr. Ockene wrote. "It is important for clinicians to be aware of and acknowledge the difficulties these women face, and to help them develop motivation and skills to engage their partners and support systems in their cessation attempts," she added. *Source: American Journal of Preventive Medicine, October 2002.*

## Alcohol and Hormone Therapy Don't Mix

Continuing the bad news about hormone replacement therapy (HRT), new research shows that consuming as little as one and a half drinks a day while on HRT significantly increases a woman's risk of developing breast cancer. A study of 44,187 women who took part in the Nurses' Health Study from 1976 to 1996 found that women on HRT who consumed an average of 1.5 drinks per day had a 30% greater chance of developing breast cancer than women who did not drink at all. Women who took HRT for five years and drank alcohol nearly doubled their risk.

"The public health message is that the two will substantially increase your risk of breast cancer, and you might want to be particularly vigilant about having both of these risk factors," said study co-author Dr. JoAnn Manson of Brigham and Women's Hospital in Boston. *Source: Annals of Internal Medicine, November 19, 2002.*

## Marijuana Can Trigger Depression

Three separate studies show that frequent use of marijuana can lead to depression and other psychiatric disorders.

The first study, by researchers in Australia, tracked 1,600 teenage girls for seven years. Subjects who used marijuana every day were five times more likely to suffer from depression and anxiety than non-users. Girls who used the drug at least once every week were twice as likely to develop depression as peers who abstained.

In the second study, by Swedish researchers, a third of a cohort of men who smoked marijuana in the late 1960s developed schizophrenia.

A third study, by British researchers, found that schizophrenia is more likely in individuals who start using marijuana as adolescents. In a group of 1,000 people in their early 20s, one in 10 who used marijuana as a teen had since been diagnosed with schizophrenia.

As a result of the findings, researchers said that measures are needed to reduce frequent and heavy use of marijuana. They called for educational campaigns to inform the public about the risk of marijuana use and mental illness. *Source: British Medical Journal, November 2002.*

## Study: Alcohol, But Not Smoking, Increases Breast Cancer Risk

Drinking just one glass of wine a day increases a woman's risk for breast cancer, but smoking does not, a group of cancer researchers in Great Britain have concluded.

Since many women both drink and smoke, the researchers analyzed over 50 studies involving more than 23,000 women to separate the effects of tobacco and alcohol. They found that women who consumed just one drink of alcohol a day increased their breast-cancer risk by 6%, while those who consumed five drinks a day increased their risk by 30%. On the other hand, the researchers found no significant association between the breast cancer rates of non-drinking female smokers and non-smokers.

***"...drinking, but not smoking, increases the risk of breast cancer."***

"For the first time, we have undertaken a study large enough and detailed enough to look at the separate effects of tobacco and alcohol reliably, wrote Sir Richard Doll of Oxford University, one of the authors of the study. "When we did this, we found that drinking, but not smoking, increases the risk of breast cancer," he said. *Source: British Journal of Cancer, November 18, 2002.*

## Women Less Likely to Use Drugs to Relieve Stress

Women handle stressful events better than men and are less likely to turn to alcohol or other drugs to deal with their problems, Finnish researchers say. Investigators at the University of Helsinki in Finland measured four major stressful events: death or serious illness of a loved one; serious financial problems; being a victim of psychological or sexual violence; and severe interpersonal conflict, such as divorce.

They assessed the health of 2,991 municipal workers, 73% of whom were female, for links between psychosocial factors and health by examining the number of sick days the study participants had taken from work. They found that stressful events for men were

associated with psychological problems, increased alcohol use, smoking, and health problems.

Although stressful events caused psychological problems and increased smoking among the women participants, there was no increase in the number of sick days taken. *Source: Psychosomatic Medicine, September/October 2002.*

# THE LANGUAGE OF ADDICTION

*Edwin A. Salsitz, M.D. and Shannon C. Miller, M.D., CMRO*

***Editor's Note:*** *The following discussion was disseminated at ASAM's 2002 Review Course in Addiction Medicine by Drs. Salsitz and Miller, who co-chaired the course. It is reprinted here because of its thought-provoking nature. Responses are welcomed and will be published as space allows.*

Over the past two decades, we have witnessed remarkable progress in understanding the disease of addiction. The quality of research into the neurophysiology, psychology, sociology, and various treatment modalities is on a par with the research into any other chronic medical disorder. As a result, one of our most important goals is for addiction medicine to achieve parity with other medical specialties.

An important step in this regard is to develop for addiction medicine a vocabulary based on medical terminology rather than the "street" slang so often used in our field. Why? Because language matters. Slang terms, as well as terms "borrowed" from other domains such as the criminal justice system, tend to stigmatize and stereotype our patients and our discipline. Although often easily understood and sometimes colorful, such terms belong to the domains of sociology and ethnography, not medicine.

Listed below are some of these slang terms, each paired with a more appropriate medical term.

| SLANG TERM | MEDICAL TERM |
|---|---|
| "Addict," "junkie," "dope fiend," "crack head," "pot head," "street addict," "hard-core addict" | Patient with the disease of addiction, opiate-addicted patient, cocaine-addicted patient, et al. |
| "Clean urine" | Urine negative [for drug *x*, *y* or *z*] |
| "Dirty urine" | Urine positive [for drug *x*, *y* or *z*] |
| "Drunk," "smashed," "bombed" | Intoxicated |
| "Speed-balling" | Using heroin and cocaine in combination |
| "Meth" | Methadone or methamphetamine |
| "Strung out" | Debilitated, intoxicated |
| "Cop" | Obtain, purchase |
| "Fix" | Dose |
| "Hooked" | Addicted |
| "Kicking" | Detoxifying [from drug *x*, *y* or *z*] |
| "Recidivism" | Relapse |

We recognize that many of these expressions are deeply imbedded in our field and allow for quick communication. In certain treatment modalities, such terms may be regarded as having therapeutic value. We also understand the value of "meeting patients where they are."

Obviously, communication in a clinical setting is of paramount importance, and the use of "slang" terms occasionally may be necessary for clarity with patients. But in other areas of medicine, patients learn proper medical terminology from their providers (for example, adoption of the term "diabetes" in place of "sugar"). Why shouldn't our medical discipline try to instill a medical vocabulary to describe what we all know is a chronic medical disease?



# New Jersey Chapter Holds First Review Course

The New Jersey ASAM Chapter (NJASAM) sponsored its first Review Course in Addiction Medicine November 1-2, 2002, at the offices of the Medical Society of New Jersey. The course was designed to prepare New Jersey physicians for the ASAM Certification Examination. It was developed in response to a new state regulation (supported by NJASAM) which requires that all medical directors of publicly funded New Jersey addiction treatment facilities be certified in addiction medicine. The certifying bodies designated in the regulation are ASAM and the American Osteopathic Association, as well as the certificate of added qualification (CAQ) of the American Psychiatric Association.

In fact, the course was a significant event in many ways. It represented the first major CME program on addiction medicine offered in New Jersey. It was sponsored and supported through a joint effort of NJASAM and the New Jersey State Division of Addiction Services. The planning committee for the course included Louis E. Baxter, Sr., M.D., FASAM, Program Director and NJASAM CME Committee Chair; Michael S. De Shields, M.D., Co-Program Director and President of the New Jersey chapter; Jeffrey Goldsmith, M.D. (who chairs ASAM's CME Committee); Wayne Draesel, M.D.; and Susan Neshin, M.D., NJASAM Past President, with outstanding assistance from Linda Pleva, the NJASAM Administrator.

The course faculty—all of whom are academic and clinical practitioners in New Jersey and ASAM's Region IV—included Drs. Jeffery Berman, Lawrence Greenfield, Laura McNicholas, James Mulligan, Edward Reading, Trusaundra Taylor, John Verdon, Jill Williams, and Douglas Ziedonis. Drs. Baxter and De Shields also gave presentations.

NJASAM leaders envision that the Review Course will be a stepping stone to future continuing education programs for non-physician addiction treatment providers in New Jersey and the region in 2003 and beyond. A January NJASAM meeting and a June 7th CME activity for Region IV are being planned for 2003. For details, contact NJASAM President Michael DeShields, M.D., at MDESHIELDS@CCHS.COM.

# Ruth Fox Memorial Endowment Fund

Dear Colleague:

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

The Fund has received a very generous bequest of $200,000 from the estate of Peter I.A. Szilagyi, M.D., who passed away in September 2001. Dr. Szilagyi, a long-time member of ASAM and a generous donor, named the Endowment in his will, which we learned only after his passing. Dr. Szilagyi was a frequent participant in ASAM's Med-Sci Conferences; we saw him most recently in Los Angeles, CA, in April 2001, where he was accompanied by his good friend and colleague, Alexander F. DeLuca, M.D. Dr. DeLuca remembers Peter as "a very devoted ASAM member who practiced intense quality care. Peter spent hours with his patients to get to know them very well. He practiced what we preach from a recovery and medical point of view. He was a model of an ASAM doctor." Dr. Szilagyi was certified by ASAM in 1992 and recertified in 1998. We were very saddened to learn of Dr. Szilagyi's death and even sadder that we cannot let him know how very grateful we are for his commitment to ASAM and to securing the Society's future.

For information about making a pledge, contribution, bequest, or memorial tribute, or to discuss other types of gifts in confidence, contact Claire Osman by phone at 1-800/257-6776 or 718/275-7766 or by e-mail at ASAMCLAIRE@AOL.COM. All contributions to the Endowment Fund are tax-deductible to the full extend provided by law.

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

James W. Smith, M.D., FASAM, and Howard G. Kornfeld, M.D., *Co-Chairs, Resources & Development Committee*

Claire Osman, *Director of Development*

As of October 31, 2002

**Total Pledges: $3,584,111**

*Dr. Ruth Fox*

**Colleagues' Circle ($100,000-$249,999)**

*(Late)* Peter I.A. Szilagyi, M.D.

**President's Circle ($10,000-$24,999)**

LeClair Bissell, M.D.
Arnold J. Hill, M.D.

**Leadership Circle ($5,000-9,999)**

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Raymond A. Wertheim, M.D.
Laurence M. Westreich, M.D.
David & Bonnie Wilford *(in memory of Ian Macpherson)*
Jorge Zuniga, M.D.

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# Passing of Sen. Wellstone Mourned by the Addiction Field

Addiction field leaders mourned the death of Senator Paul Wellstone (D-MN) in a plane crash just a week before November elections. Hazelden Foundation's William Cope Moyers said: "Paul Wellstone worked tirelessly on behalf of people in recovery and people suffering from or at risk for alcohol and drug problems. The chief Senate sponsor of legislation to require parity for insurance coverage for alcohol and drug treatment, zealous advocate of increased funding for addiction prevention, treatment and research, staunch defender of the rights and privacy of people in treatment or otherwise in recovery, Paul Wellstone always fought hard for us....

"More than any other member of the United States Senate, Senator Wellstone believed that it is wrong to discriminate against people struggling to overcome problems caused by addiction to alcohol or other drugs. He fought hard, against incredible opposition from powerful lobbyists and ambivalence from his own colleagues, for passage of federal legislation to improve private insurance coverage for treatment.

"In 1996, Senator Wellstone did succeed in improving coverage for mental illnesses, but could not convince Congress to include alcoholism and drug addiction treatment in the legislation. Still, he never gave up. 'In the end, this isn't just about votes,' he once said. 'It is about doing the right thing for people who deserve our help.

"Although his fight to end discrimination and expand addiction treatment did not advance far in Washington, Senator Wellstone's advocacy became a lightning rod that sparked and galvanized grassroots action among people in recovery from across the nation. In places like Madison, Santa Barbara, Atlanta and Portland, advocacy groups sprung up in the late 1990s to take on policy issues related to addiction, treatment and recovery. Today a number of states have adopted laws that make it easier for addicted people to get into treatment and stay there until they are well.... Whether he was your Senator or not, Paul Wellstone was the champion for people who have been touched by addiction or recovery."

## "Addiction Innovators" for 2002 Named

Five individuals have been named the winners of the 2002 Innovators Combating Substance Abuse awards, given by the Robert Wood Johnson Foundation. The 2002 award winners, honored for their contributions to the field of addiction are:

- **Larry Gentilello, M.D.**, of Beth Israel Deaconess Medical Center and Harvard Medical School for his research on brief interventions, trauma injuries, and state insurance laws.
- **Carlo DiClemente, Ph.D.**, of the University of Maryland's Department of Psychology for development of the addiction treatment Transtheoretical Model of Change.
- **James Prochaska, Ph.D.**, of the University of Rhode Island, also for his work on the Model of Change.
- **James Repace**, a Washington, D.C., based researcher on secondhand smoke.
- **Paul J. Samuels, J.D.**, director of the Legal Action Center, for his advocacy work on behalf of people with addictions.

Each award winner received a $300,000 grant to continue his or her work.

# Dr. Blume Receives Award at ISAM-SAA Meeting

A special honor was bestowed on ASAM's own Sheila Blume, M.D., FASAM, at the October meeting of the International Society of Addiction Medicine in Reykjavik, Iceland. Along with Terry Gorski and John Wallace, Dr. Blume was greeted by the President of Iceland, Mr. Olafur Ragnar Grimsson, at Iceland's White House, the Bessastadir, and named a Knight of the Icelandic Falcon.

The award recognizes Dr. Blume's distinguished service to the people of Iceland. Dr. Blume is a founding member and Past President of ASAM, former director of the New York State alcohol and drug abuse agency, and educator, and a clinician.

Also at the ISAM meeting, David R. Gastfriend, M.D., chair of ASAM's Treatment Outcomes Committee, was elected to ISAM's Board of Directors.


*ASAM member David R. Gastfriend, M.D., addressed the ISAM conference on his research into the ASAM Patient Placement Criteria.*

*Olafur Ragnar Grimsson, President of Iceland, bestowed his nation's highest honor for services to the Icelandic people when he named Dr. Sheila Blume a Knight of the Icelandic Falcon. The award recognizes Dr. Blume's help in establishing the Icelandic addiction treatment program, SAA, which celebrated its 25th anniversary this year.*

# ASAM Conference Calendar

## ASAM

**February 27-28, 2003**
Fundamentals of Addiction Medicine
Seattle, WA
(sponsored by the Washington Society of Addiction Medicine)
[For information, e-mail JSACKETT@PROVIDENCE.ORG]

**March 14-16, 2003**
Medical Review Officer (MRO) Training Course
San Francisco, CA
20 Category 1 CME credits

**March 28-30, 2003**
ASAM Region X Conference
Kissimmee, FL
(hosted by the Florida Society of Addiction Medicine)
[For information, e-mail FSAM.ASAM@USA.NET]

**April 12, 2003**
Buprenorphine & Office-Based Treatment of Opioid Dependence
Washington, DC
8 Category 1 CME credits

**May 1, 2003**
Pain & Addiction: Common Threads IV
Toronto, Ontario, Canada
7.75 Category 1 CME credits

**May 1, 2003**
Ruth Fox Course for Physicians
Toronto, Ontario, Canada
8 Category 1 CME credits

**May 2-4, 2003**
34th Annual Medical-Scientific Conference
Toronto, Ontario, Canada
21 Category 1 CME credits

**May 4, 2003**
Buprenorphine & Office-Based Treatment of Opioid Dependence
Toronto, Ontario, Canada
8 Category 1 CME credits

**July 18-20, 2003**
Medical Review Officer (MRO) Training Course
Chicago, IL
20 Category 1 CME credits

**October 30-November 1, 2003**
State of the Art in Addiction Medicine
Washington, DC
20 Category 1 CME credits

**November 2, 2003**
Buprenorphine & Office-Based Treatment of Opioid Dependence
Washington, DC
8 Category 1 CME credits

**November 20, 2003**
Forensic Issues in Addiction Medicine Workshop
Washington, DC
7 Category 1 CME credits

## Other Events of Note

**January 9-11, 2003**
National Association of Drug Court Professionals
4th Annual Training Conference
Washington, DC
[For information, visit WWW.NADCP.ORG]

**January 29-February 1, 2003**
29th Annual Winter Symposium: Addictive Disorders and Behavioral Health
Colorado Springs, CO
[For information, e-mail ADDICTEDUC@AOL.COM]

**February 13-16, 2003**
39th International Alcoholics Anonymous Women's Conference (IWAAC)
Seattle, WA
[For information, visit www.IWC2003.ORG]

**July 7-11, 2003**
Second Annual New England School for the Treatment of Opioid Dependence
Salve Regina University
Newport, Rhode Island
[For information, e-mail NEIAS@NEIAS.ORG]

For additional information, visit the ASAM *web site at* WWW.ASAM.ORG *or contact the* ASAM Department of Meetings and Conferences at 4601 No. Park Ave., Suite 101, Chevy Chase, MD 20815-4520, or phone 301/656-3920, or fax 301/656-3815, *or e-mail* EMAIL@ASAM.ORG.