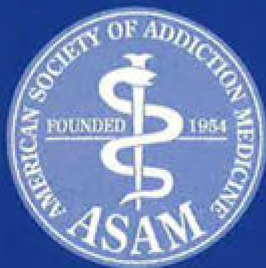

May/June 2002
Volume 17, Number 3

ASAMNews

Newsletter of The American Society of Addiction Medicine

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President Bush Urges Congress to Pass Parity Legislation

President George W. Bush has urged the U.S. Congress to pass parity legislation that would require health insurers to cover mental disorders as comprehensively as other medical illnesses. "Remarkable treatments exist and that's good; yet many people—too many people—remain untreated," the President said. While the House and Senate versions of the legislation do not cover addiction treatment, field leaders still regard them as a milestone. See the full story on page 7.

ASAM Names New Executive Vice President

ASAM's Board of Directors has confirmed the appointment of Eileen McGrath, J.D., as the Society's Executive Vice President and Chief Executive Officer. Ms. McGrath succeeds James F. Callahan, D.P.A., who is retiring.

In announcing the appointment, ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, explained that Ms. McGrath was selected after an intensive search process, guided by a committee composed of the Society's officers, a former President, veteran ASAM members, and an ASAM member who recently completed her residency. With the assistance of an outside firm, the committee defined the knowledge, skills, and experience required of a new EVP/CEO.

"After an exhaustive search and review of nearly 100 applicants," Dr. Brown recalled, "it became clear that Eileen was the right person for the job! In addition to being competent and experienced, Eileen's personality displayed a warmth that was irresistible to all." He added, "while we all knew that finding a successor to Jim would be difficult, upon meeting and spending time with Eileen, we knew we had found a person who would provide the leadership to further improve ASAM's position as a leader in addiction medicine."

Ms. McGrath has more than 14 years' relevant experience, most recently as Executive Director of the American Medical Women's Association, a national organization of 10,000 women physicians and medical students. Before joining AMWA, she was director of county alcoholism services in Fairfax County, VA.

She is a graduate of the State University of New York and the University of Virginia, where she earned a master's degree in planning, and holds a law degree from the George Mason University School of Law.

She will assume her new duties June 24th.

Achieving ASAM's Mission to Establish the Specialty of Addiction Medicine

James F. Callahan, D.P.A.

I have had the privilege of serving as your Executive Vice President and CEO for 13 years. In this, my last message to you as your EVP, I want to share my understanding of what you have achieved since the founding of ASAM, the major challenges that confront you in the immediate future, and my view of who you are, as individuals and as a Society, and why you will achieve continued success.

Achievements

Since ASAM's founding in 1954, you and your predecessors have documented the science and practice, and have gained recognition for a new medical specialty, the specialty of addiction medicine.

When Ruth Fox and her associates agreed that alcoholism was a preventable and treatable disease, there were few physicians and lay persons who shared their vision. There was no infrastructure for demonstrating that it truly *is* a disease. There was no group of physicians within organized medicine to treat the disease, and to speak out on behalf of patients.

Today, 50 years later, you have two Institutes of the National Institutes of Health dedicated to research on the addictions. You have a federal agency, the Center for Substance Abuse Treatment, whose mission is to improve the effectiveness of addiction treatment. You have a special office in the White House, the Office of National Drug Control Policy, to provide coordination and national leadership. You and your colleagues helped to create these research, treatment and policy bodies, and a number of you have provided leadership through service in the scientific and executive ranks of those agencies.

Within organized medicine, you have created in ASAM *the* national medical specialty society for addiction medicine. In 1988, the AMA officially recognized your Society and granted you a seat in the AMA's House of Delegates. In 1990, the AMA officially recognized addiction medicine as a medical specialty. From that moment, your specialty has gained wide recognition as a primary medical specialty, and ASAM certification in addiction medicine has become accepted as the equivalent of board certification. For example, in 1996, the National Committee on Quality Assurance (NCQA)—the body that accredits managed care organizations—recognized that physicians certified in addiction medicine are eligible treatment providers for addictive disorders. And in 2000, President Clinton signed into law the Addictions Treatment Act, which affirms that physicians certified in addiction medicine by the American Society of Addiction Medicine are recognized as qualified providers to prescribe for treatment of opiate dependence.

Over the past 50 years, you have, in essence, realized Ruth Fox's dream to have addiction accepted as a preventable and treatable disease. But this realization in essence is not yet full achievement of your mission.

The Price of Success

Your achievements have not come easily. You have sacrificed and have paid a very high price for your success. You have had to overcome great obstacles, and to daily fight the stigma against alcoholics and others suffering from addictive disorders.

- The stigma that addicts place on themselves through the shame they feel for becoming addicted;
- The stigma family members place on the addicted member and on the family itself, because of the suffering the addiction has caused the family, and because of the shame the family feels.
- The stigma insurers, ER personnel, hospital administrators and physicians place on addicts when they deny them treatment, and place on you when they deny you payment when you do provide treatment.

Continued on page 16

American Society of Addiction Medicine
4601 North Park Ave., Suite 101
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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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ONDCP Director Calls Anti-Drug Ads a Failure

John Walters, Director of the Office of National Drug Control Policy (ONDCP), recently told members of Congress that the government's five-year, $289 million anti-drug advertising campaign has failed to reduce drug use, especially among children. Citing recent survey data, Mr. Walters added that the National Youth Anti-Drug Media campaign may even have encouraged some youngsters to try marijuana.

The campaign is up for reauthorization for an additional five years. The administration is urging the Congress to appropriate $180 million for FY 2003—the same as this year's amount. While acknowledging that the campaign thus far has failed to achieve its goals, Mr. Walters said support should continue so that changes can be implemented. As an example of what he has in mind, Mr. Walters said that ONDCP henceforth will test all commercials for effectiveness before they air. He added that the campaign would be redirected toward older adolescents, rather than the 12- and 13-year-olds who are its present target. *Source: Wall Street Journal, May 14, 2002.*

Measures Would Fund Health Professions Training

Bills introduced in the U.S. Senate by Sen. Joseph Biden (D-DE) and in the House of Representatives by Rep. Patrick Kennedy (D-RI) call for the federal government to spend $45 million over the next five years to train physicians and other health professionals to recognize and treat addictive disorders.

Titled the "Health Professionals Substance Abuse Education Act" (S.1966 and HR.3793), the measures would fund educational programs for physicians, nurses, physician assistants, nurse practitioners, social workers, psychologists, and pharmacists. Educational interventions would be designed to help the practitioners identify and treat alcohol- and drug-related problems, as well as become effective advocates for their patients.

Funds would be allocated through the Addiction Technology Transfer Centers of the federal Center for Substance Abuse Treatment (CSAT) and, in the private sector, the Interdisciplinary Project of the Association for Medical Education and Research in Substance Abuse (AMERSA). *Source: Alcoholism & Drug Abuse Weekly, March 18, 2002.*

Florida Drug-Reform Ballot Initiative Withdrawn

Sponsors of a drug-reform initiative have withdrawn the measure from the state's November ballot, citing delays by the Florida Supreme Court. The measure calls for treatment instead of incarceration for first- and second-time nonviolent drug offenders.

"It has been eight months since we submitted signatures to trigger Supreme Court review, but the court still has not ruled," said Dave Fratello, political director of the Campaign for New Drug Policies, which sponsors the initiative. "With barely more than two months left to collect signatures, it would be far too expensive and uncertain to try to make this November's ballot." Fratello said the campaign would work to place the initiative on the November 2004 ballot.

Drug court professionals, state officials, and some state lawmakers said they were pleased that the initiative had been withdrawn. John Daigle, executive director of the Florida Alcohol and Drug Abuse Association, called the initiative "seriously flawed." Opponents also charge that the measure distracts attention and resources from implementing Gov. Jeb Bush's (R) drug strategy, which is focused on closing the treatment gap in the state. *Source: Alcoholism & Drug Abuse Weekly, April 22, 2002.*

NY Governor Wants to Reform Drug Laws

In his third attempt in 18 months, Governor George Pataki (R) has announced a proposal that would ease sentencing guidelines for drug offenses. The so-called "Rockefeller drug laws" were enacted in the 1970s.

State Democrat leaders long have argued that the draconian laws do not give judges the latitude they need to send arrestees to treatment rather than prison. Currently, only prosecutors are allowed to make such determinations. Under the Pataki proposal, prosecutors would retain authority for treatment referrals, but defendants could appeal those decisions to the courts.

The governor's proposal also would create a new schedule of sentences for drug crimes, which would reduce prison terms for nonviolent drug offenders, impose a mandatory five-year sentence on offenders who carry a gun while committing a drug offense, and increase prison sentences for those who run drug rings involving more than three people. *Source: New York Times, May 8, 2002.*

MA Budget Bill Would Close Most Methadone Clinics

A budget bill under consideration in the Massachusetts House of Representatives would close all but 40 of the state's methadone clinics. House Ways and Means Chairman John Rogers (D-Norwood) has described the clinics as a "nightmare" for neighbors.

Tom Scott of the Massachusetts Department of Public Health's Division of Substance Abuse confirmed that the $21.8 billion budget pending in the House does not provide funds for 282 clinics operated by the Boston Public Health Commission. "The human impact would be devastating," said John Auerbach, executive director of the commission.

Statewide, the budget proposal also puts in jeopardy 75% of the clinics funded through the state's Medicaid program. *Source: Boston Herald, May 9, 2002.*

FDA Bans Nicotine Lollipops, Lip Balm

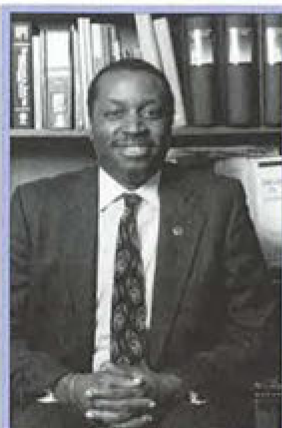
The U.S. Food and Drug Administration (FDA) says nicotine-laced lollipops and lip balm are illegal and cannot be sold because they are made with a form of nicotine that has not been tested for safety. Most such products are sold through Internet pharmacies.

Moreover, FDA attorney David Horowitz said the lollipops pose a danger to children because they look like ordinary candy. "The quantity of nicotine could be potentially dangerous to a small child," he said. The FDA also is reviewing other nicotine products, including nicotine lozenges made by a Virginia company. *Source: Associated Press, April 10, 2002.*

Board Approves Strategic Plan for ASAM

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

I am pleased to report to you that ASAM's Board of Directors has put its stamp of approval on a Strategic Plan designed to guide the Society's growth and to focus its activities over the coming years.


ASAM President Lawrence S. Brown, Jr. M.D., M.P.H., FASAM

At its April 24th meeting, the Board accepted the plan and praised the Strategic Plan Task Force, under the leadership of Chair Richard E. Tremblay, M.D., FASAM, for creating a plan that is "doable, affordable, and consistent with the Mission of our Society."

Board member Lloyd J. Gordon III, M.D., FASAM, who also served on the Task Force, reminded the Board how much effort has gone into the development of the plan. For example, the Task Force submitted its first draft for review at the Board's Planning Day in October 2000. At that time, Board members reviewed and prioritized the draft objectives and provided extensive commentary to the Task Force. In response to the Board's advice to focus on a small number of very important objectives, the Task Force reduced the total number from 108 to 29.

Since then, the draft plan has undergone significant revision, with important input from ASAM's leadership and membership. At its April 2001 meeting, the Board reviewed progress in developing the plan and approved the statement of Objectives. Input also was gathered in a "Town Hall" session during the 2001 Medical-Scientific conference, in which ASAM members were invited to review and comment on the plan. Following that meeting, conference calls were held to acknowledge and implement feedback obtained from the Board and the membership. As a result, the plan was further refined and made more concise. Particular attention was given to the Board's advice to focus the Plan on ASAM's highest priority initiatives.

A revised Plan was presented to the Board of Directors at its October 2001 meeting. Thoughtful suggestions were offered and discussed. To move the work forward, the Board created a Development Committee (under the chairmanship of Mark L. Kraus, M.D., FASAM) and an Implementation Committee (under the chairmanship of Lloyd J. Gordon III, M.D., FASAM). In a face-to-face meeting in January and through subsequent conference calls and correspondence, the Development Committee prepared a final draft of the Plan, containing 29 Objectives and 93 Strategies in support of the six Goals defined by the Board.

The revised Plan was sent to the members of the Board, as well as to all ASAM Chapter Presidents and Committee Chairs, for final review. The result is the document adopted by the Board. I commend it to you, and thank the Board and the Task Force for their vision and energy in crafting this important blueprint for ASAM's future. ❖

Strategic Plan Task Force

Members of ASAM's Strategic Plan Task Force are:
Richard E. Tremblay, M.D., FASAM, Chair; Elizabeth F. Howell, M.D., FASAM, and Michael M. Miller, M.D., FASAM, Deputy Chairs; Peter Banys, M.D., FASAM.; Andrea G. Barthwell, M.D., FASAM; Lawrence S. Brown, Jr., M.D., M.P.H., FASAM; James F. Callahan, D.P.A.; Irving A. Cohen, M.D., M.P.H., FACPM, FASAM; Christina Delos Reyes, M.D.; Stuart Gitlow, M.D., M.P.H.; Lloyd J. Gordon, III, M.D., FASAM; Merrill Scot Herman, M.D.; Mark L. Kraus, M.D., FASAM; J. Patrick Moulds, M.D., M.S.; Gail N. Shultz, M.D., FASAM; Norman Wetterau, M.D.; Daniel E. Wolf, D.O.; and Rebecca Zarko, M.D. Consultants to the Task Force are Ted Tschudy, Ph.D., and Bonnie B. Wilford.

ASAM's Strategic Plan

Mission. The American Society o[f] Addiction Medicine is an association o[f] physicians dedicated to improving th[e] treatment of alcoholism and other addi[c]tions; educating physicians and medica[l] students; promoting research and preven[tion]; and enlightening and informing th[e] medical community, the public, and polic[y] makers about these issues. The Societ[y] serves its members by providing opportun[i]ties for education and sharing of exper[i]ences and by promoting the developmen[t] of a body of professional knowledge an[d] literature to enhance the quality an[d] increase the availability of appropriat[e] health care for persons affected by addi[c]tive disorders.

Types of Objectives

End Point Objectives define a condition necessary for achievement of ASAM's goals.

Implementation Objectives describe steps needed to arrive at the desired End Point.

Infrastructure Objectives characterize the basic structure and operations of the Society.

Goal I

Definition of Addiction Medicine: [...] define the basic and clinical science [...] Addiction Medicine and the scope of [...] practice.

This section of ASAM's Strategic Pl[an] addresses the following:

- Recognition of addiction as a medi[cal] disorder (Objective 1).
- Recognition of Addiction Medicine a[s a] medical specialty (Objective 2).
- Recognition of ASAM as a medi[cal] specialty society (Objective 3).
- Expansion of the body of knowledge [...] Addiction Medicine (Objective 4).
- Recognition of the relationship betwe[en] substance misuse and addict[ion] (Objective 5).

OBJECTIVE 1 (End Point). Addictive [dis]orders are recognized by physicians, hea[lth] insurers, health care organizations, [...] policymakers as biopsychosocial med[ical] disorders.

Strategy 1.1: ASAM will develop an[d] partner with government agencies and [pri]vate sector organizations to sponsor [pro]grams and publish educational mate[rials] that help physicians, other health pro[fes]sionals, and policymakers underst[and] addictive disorders, Addiction Medic[ine]

Continued on pag[e]

Dr. Delos Reyes Writes of Addiction in JAMA

An article by Christina M. Delos Reyes, M.D., entitled "Overcoming Pessimism About the Treatment of Addiction," appeared in the April 10th issue of the *Journal of the American Medical Association*. Dr. Delos Reyes is former chair of ASAM's Physicians in Training Committee.

In the article, Dr. Delos Reyes wrote that "Changing attitudes toward addiction medicine is an ongoing process requiring participation on many levels and has been identified as an important goal by federal agencies as well as private groups. Medical students and physicians would benefit from increased training in the knowledge, skills, and attitudes of addiction medicine. Finally, federal and private financing of addiction treatment needs to better reflect the current understanding that addiction is a chronic and treatable illness."

IN MEMORIAM

ASAM Mourns Richard R. Irons, M.D.

Richard R. Irons, M.D., FASAM, died March 4th at his home in Lawrence, KS. He was 53.

Dr. Irons began his medical practice in Libby, MT. He also practiced in Washington state, Montana, Minnesota, Georgia, and Kansas. Early in his career, he served as a missionary and physician in Papua, New Guinea, and Tansen, Nepal. He later accompanied an expedition to Mt. Everest.

At the time of his death, Dr. Irons was director of the Professional Renewal Center in Lawrence. He is survived by his wife, Kirsten; a daughter, Hillary; three sons, Trevor, Ethan and Lee; and other family members. Memorial services were held at Grace Episcopal Church, Topeka, KS.

Dr. Gitlow a Candidate for the AMA's Board

Stuart Gitlow, M.D., M.P.H., ASAM's representative to the House of Delegates of the American Medical Association, has announced his candidacy for a seat on the AMA's Board of Trustees. Dr. Gitlow's candidacy for the seat—traditionally held by a Young Physician—has been enthusiastically endorsed by ASAM, as well as by the Pennsylvania Medical Society, the AMA Young Physicians Section, and the AMA Section Council on Psychiatry.

Members of the AMA Board are elected by vote of the House of Delegates, which meets in June. *ASAM News* recently asked Dr. Gitlow about his campaign:

Q: Why are you running for a seat on the AMA Board of Trustees?

Dr. Gitlow: The Board needs a well-qualified individual to speak on technology-related issues—to the membership, to entities outside the AMA, and within the Board itself. Patient safety, patient privacy, and confidentiality will be increasing areas of focus for physicians, for the AMA, and for its Board. I look forward to bringing a constructive voice to these deliberations as the Board considers e-commerce and other technological issues with which I am experienced.

The AMA needs to be open to change over the coming years; for a variety of reasons, the AMA of the future must not be the same as the AMA of the past. While retaining a firm respect for the traditions, ethics, and profession status of medicine, we must develop a clear vision of the physician of the future, who will be very different from the physician of the past. As a 'young physician' Trustee, I will have a special responsibility to remain 'connected' with the Young Physicians Section and with younger physicians in general.

Q: What unique qualifications would you bring to the AMA's Board?

Dr. Gitlow: I have a varied clinical practice background and currently work in several states, in outpatient and inpatient settings, in areas as diverse as forensic medicine, private psychotherapy, telemedicine, and medical quality assurance.

My entrepreneurial background has allowed me to assist local and national entities within organized medicine, including the AMA: I've founded and managed several for-profit ventures in the on-line communications industry over the past 15 years, and have served on the Telemedical Services Committee of the American Psychiatric Association and as Vice Chair of both the AMA e-Medicine Advisory Committee and the AMA Online Oversight Panel.

Q: Why is your work with new technologies important to the AMA?

Dr. Gitlow: All physicians—but especially younger physicians—are incorporating computer-based technologies into the daily practice of medicine, and residents and medical students coming up in the field won't think twice about electronic applications for managing their offices, communicating with patients, and decision-support in clinical settings.

My experiences in these areas—clinical, entrepreneurial, and technological—position me to collaborate with other Board members and AMA staff in evaluating how best to improve the effectiveness and efficiency of the AMA as a large commercial organization, how to improve the services it provides to members, and how to connect with younger members of the medical community, who are the profession's future. *[Also see the special message from ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, accompanying this issue.]*

Dr. Smith Receives California Award

David E. Smith, M.D., FASAM, has been selected to receive a 2002 Older Worker and Exemplary Employer Recognition Award of the State of California. The award was presented at a ceremony in Sacramento in May.

As founder and medical director of the Haight Ashbury Free Clinics, Dr. Smith has been at the forefront of clinical, research and educational activities in the addictions field. Through his writing and public speaking, he continues to educate physicians and policymakers alike about the nature of addiction and the practice of addiction medicine. He has served ASAM in many capacities, particularly as its President and as the Society's delegate to the American Medical Association.

Heart Attack, Stroke Risk Tied to Chronic Cocaine Use

Scientists at Harvard University have found that chronic cocaine use slowly causes blood vessels to become inflamed, thickening the arteries and elevating the risk of clots that could lead to a heart attack or stroke.

Dr. Arthur Siegel and colleagues based their conclusions on a study of two groups of cocaine users. Members of one group used cocaine between six and 20 times a week, while members of the other group used it between two and six times a month. Levels of C-reactive protein, which has been linked to thickening in the arteries, as well as two other thickening components called von Willebrand Factor and fibrinogen, were higher in those who used cocaine more frequently.

The investigators concluded that cocaine users are at a constant, ongoing risk of having a clotting event because of the cocaine-provoked rise in their levels of the C-reactive protein, which block the effects of the body's natural blood-thinners. "Instead of just the transient risk that goes away after a single usage, the regular dependent user had an inflammatory response in their system that persisted," said Dr. Siegel, who suggested that drugs to lower cholesterol could benefit cocaine users, based on evidence that statins can decrease C-reactive protein. *Source: American Journal of Cardiology, May 2002.*

Methamphetamine Users Spreading Hepatitis A

Health officials in Polk County, FL, believe that methamphetamine users are responsible for a major outbreak of hepatitis A in the area. According to state health department statistics, 138 persons in Polk County have been documented with hepatitis A this year. About 12 new cases are documented each week among the county's 500,000 residents.

Use of methamphetamine is increasing among Polk County's population of migrant workers, day laborers, food industry employees, and others in low-wage jobs, officials say. They speculate that methamphetamine users are transmitting hepatitis A through sexual contact and the sharing of drug paraphernalia. Those who are infected then transmit the disease to family members and other close contacts. Symptoms of hepatitis A include nausea, abdominal pain, and jaundice.

To address the problem, the Florida Department of Health is launching an aggressive campaign to locate drug users and have them tested and vaccinated. "People are confiding in us so we can help them," said Daniel Haight, director of the department. "Sometimes the drug makes you paranoid.... But we are getting a lot of cooperation." *Source: Associated Press, May 6, 2002.*

Intoxication Exacerbates Blood Loss

Alcohol intoxication hinders the body's ability to recover blood loss in emergency situations, researchers say, pointing to data showing that inebriated patients are more likely to suffer from severe injuries and life-threatening complications, including hemorrhagic shock. "Over 40% of the victims who come into the emergency room because of traumatic injury are legally intoxicated," said Dr. Patricia Molina of Louisiana State University in New Orleans, who authored the study.

For the study, Dr. Molina and her colleagues fed alcohol to laboratory rats and then caused them to experience small amounts of blood loss. They found that the intoxicated rats lost blood faster and experienced steeper drops in blood pressure than did the sober rats. Moreover, the intoxicated rats had a slower recovery time when researchers tried to restore their blood pressure through injection of IV fluids. "Quick restoration of blood pressure after injury is critical because blood pressure determines how much blood reaches the tissues in the body," Dr. Molina said. "The longer a period of time the tissues do not receive adequate perfusion, the longer they are at risk."

Dr. Molina said the results of the study could help emergency physicians and paramedics understand why normal treatment guidelines can "lose their value when the patient is drunk." *Source: Experimental Biology 2002 Conference, New Orleans, LA, May 6, 2002.*

Cocaine Use Can Cause Aortic Dissection

Cocaine use can cause aortic dissection (a tear in the lining of the aorta), according to researchers at the University of California at San Francisco. While cases of aortic dissection are rare, Dr. Priscilla Y. Hsue and colleagues have found an unusually high incidence of the condition among cocaine users. Cocaine is known to stimulate the production of stress hormones, which can increase blood pressure. This could tear the lining of the aorta, allowing blood to enter and rip it even further. As a result, blood is prevented from reaching critical organs and the aorta can rupture.

In reviewing all cases of aortic dissection at San Francisco General Hospital over the past 20 years, the investigators found that 14 of the 38 cases were directly related to cocaine use. All but one patient had used the drug in the form of crack cocaine. Dr. Hsue and her team conducted the study after noticing an increase in the number of young patients coming into the hospital's emergency room with chest pains. "Most patients came to the hospital with chest pain shortly after drug use, and one developed symptoms while smoking crack," she said.

Dr. Hsue urged physicians and emergency room workers to look for aortic dissection whenever a young patient has chest pain, adding, "In urban settings, aortic dissection should be considered when young people come to the emergency room with severe chest pain, especially if they have other risk factors such as high blood pressure and smoking." She cautioned, "It's very important to get a rapid diagnosis," because the mortality rate for untreated aortic dissection can be as high as 35% within the first 24 hours. After 48 hours, the death rate rises to about 50%, said Dr. Hsue, who is a cardiologist. *Source: Circulation, Journal of the American Heart Association, March 2002.*

CME Survey

In compliance with the requirements of the Accreditation Council for Continuing Medical Education (ACCME), a survey of ASAM members' CME interests and experiences accompanies this issue of ***ASAM News***. Please help your Society continue to offer high-quality CME programs that meet your needs by completing and returning your survey form today!

President Bush Backs Federal Parity Legislation

President George W. Bush has called on the U.S. Congress to pass a parity bill that would require health insurers to cover mental disorders as comprehensively as other medical illnesses. "Remarkable treatments exist and that's good; yet many people—too many people—remain untreated," the President said. "Our country must make a commitment: Americans with mental illness deserve our understanding and they deserve excellent care; they deserve a health care system that treats their illness with the same urgency as a physical illness."

The Senate currently is considering the "Mental Health Equitable Treatment Act of 2002." Introduced by Sen. Pete V. Domenici (R-NM), the bill would require insurers to grant parity in benefits for mental health services, but not for addiction treatment.

Even Congresswoman Marge Roukema (R-NJ)—historically a supporter of addiction parity—offered a House bill without an addiction benefit as a companion to the Senate bill. Rep. Roukema said that she is "a long-time supporter of parity" for addiction treatment, but recognizes "the political reality that a parity bill including substance abuse is not likely to move forward in the House." Instead, she said she has concluded that an incremental approach "is the only politically viable option."

The Roukema bill does, however, direct the General Accounting Office (GAO) to determine the cost of adding addiction treatment to parity coverage at a later date. The GAO's study would be due two years after a bill is passed.

Most addiction field leaders agreed with Rep. Roukema. Donald J. Kurth, M.D., FASAM, who is active in lobbying for addiction parity in California and in the Congress, called the President's stand in support of parity "courageous," and said it represents "a great leap forward for addiction parity as well." He added that "President Bush has focused public attention on the success of medical treatment for behavioral disorders. True, addiction treatment has been excluded from the current bill. But the door is now open for us to begin to educate our legislators as to the potential for treatment of addictive disorders.

Donald J. Kurth, M.D., FASAM

"While we would like to be successful in enacting addiction treatment parity now, I think it is important to recognize the incremental success at hand," Dr. Kurth said. "The fact that Congress will not support this bill if it includes addiction treatment simply reflects their lack of education and understanding of the disease process of addiction," he added.

Noting that any parity measure is opposed by the insurance and business lobbies, whose members argue that better mental health and addiction coverage would make health insurance unaffordable, Dr. Kurth cautioned that "the responsibility for that education must fall squarely on our shoulders as ASAM members and as addiction experts. Believe me, if we don't step up to the plate and fulfill our rightful role as the national experts in the treatment of addiction, the insurance company lobbyists will fill that void in short order."

While the addiction field can point to numerous studies showing that addiction care accounts for a very small part of overall health care costs, and that expenditures for addiction treatment are more than offset by subsequent savings in health care costs, Congress in the past has given way to the insurance/business lobby and killed all parity legislation. This year, however, parity advocates hope that the President's leadership will change the equation.

Dr. Kurth concluded that "the opportunity is before us to take the lead in this discussion and to end institutionalized discrimination against addicted patients and the physicians who treat them. Seven to thirteen percent of the U.S. population is denied treatment because our leaders do not understand that they are suffering from a disease. As members of ASAM and addiction experts, the responsibility for educating legislators is ours. The time is now!"

NH Senate Approves Parity Measure

New Hampshire's state Senate has passed a bill that would require health insurers to cover some inpatient and outpatient treatment for addictive disorders. However, insurers would be allowed to cap the number of visits and dollar amounts to be reimbursed.

"We've got a national problem here. Treatment saves money," said Sen. Katie Wheeler (D-Durham), a sponsor of the measure. She added that the bill would give insurers flexibility in designing coverage and raise premiums by only $2.45 per person per year.

The Senate also narrowly approved an amendment to the bill that would require the parity provision to be included in bargaining contracts for state employees. However, some lawmakers said that the amendment actually was intended to sabotage the measure, because a companion bill approved in January by the state's House of Representatives specifically exempts the state employees' plan. As a result, the Senate-passed bill must go back to the House, where lawmakers will decide whether to accept the amendment, reject it, or ask that a negotiating committee be formed to work out the differences. *Source: Nashua (NH) Telegraph, April 24, 2002.*

NJ Study Spurs Parity Legislation

Spurred by a new state-funded study, lawmakers in New Jersey have introduced legislation that would require insurers to pay for alcohol and other addiction treatment on par with other medical benefits.

The study, commissioned by the New Jersey Department of Health, found that 71,000 adults and 9,400 adolescents in the state wanted addiction treatment but could not get it. According to the study's authors, increased use of managed care over the past decade has caused a 43% decline in residential treatment beds and a 36% reduction in outpatient treatment capacity in the state.

Acting on these data, Assemblywoman Mary Previte (D-Haddonfield) and two other legislators introduced the parity measure, which would require the same coverage for addiction treatment as for other chronic illnesses. "Addiction costs us billions of dollars," Ms. Previte said, adding that "We pay in crime, prisons, school failure, broken families, illness, suicide, car accidents, lost productivity, child abuse and spousal abuse. We pay now or we pay later." *Source: Trenton (NJ) Times, May 14, 2002.*

Research Yields New Insights into Molecular Control of Addiction

In research employing fruit flies, scientists at the University of Arizona have provided new insights into how molecules may control addiction, memory formation, and brain plasticity. Their research has provided the first evidence that the molecule AP1, which helps to regulate changes in the manufacture of certain proteins in brain cells, also is required for long-term changes in the function of synapses (the connections between brain cells).

It has been known that long-term behavioral changes, such as drug addiction, are associated with changes in the manufacture of certain proteins in brain cells. Animal studies have identified a few key molecules, such as CREB and AP1, which regulate these changes. For example, a variant form of AP1, called deltaFosB, is produced in the brain after multiple exposures to cocaine and controls long-term sensitization to the drug. However, direct evidence has been lacking until now.

The Arizona researchers analyzed the role of AP1 in synaptic change. A surprise finding, says Dr. Ramaswami, is that the synaptic changes controlled by AP1 are more extensive than those controlled by CREB, and more closely resemble synaptic changes induced by real experience. Also unexpected was the observation that the activity of AP1 was increased by a protein called JNK, which was not previously known to function in synaptic change.

Dr. Ramaswami concluded that "several molecules that affect plasticity at this synapse have a similar function in mammalian brain cells." These findings, he explains, "suggest that pharmacological drugs that activate or inhibit JNK or AP1 could have profound effects on brain plasticity processes that are involved in drug addiction, memory formation and even recovery from brain injury."

Dr. Glen R. Hanson, acting director of the National Institute on Drug Abuse (NIDA), said that "understanding addiction at the molecular level will help in the search for new pharmacologic agents to treat or interrupt the biological processes that result in addiction." NIDA funding supported the research. *Source: Nature, April 25, 2002; NIDA/NIH press release, April 24, 2002.*

Death of Brain Cells Tied to Nicotine Exposure

French researchers have found the first direct biological evidence that smoking destroys brain cells. Pier-Vincenzo Piazza and Djoher Nora Abrous of the National Institute for Health and Medical Research (INSERM) conducted the research, in which three groups of rats were allowed to self-administer low, medium, or high doses of nicotine for an hour a day over 42 days. A fourth group was allowed no nicotine.

The investigators found that the group of rats that took the medium and high doses of nicotine experienced a significantly higher rate of brain cell death, coupled with a 50% reduction in the production of new brain cells, as compared with the non-nicotine group. In addition, all the rats that took nicotine evidenced a drop in the protein PSA-NCAM, which plays a vital role in the adaptability of the brain and is linked to the ability to learn and memorize.

"These results raise an important additional concern for the health consequences of nicotine abuse and open new insight on the possible neural mechanisms of tobacco addiction," the researchers concluded. *Source: Journal of Neuroscience, May 2002.*

Study to Explore Behavioral Responses to Alcoholism

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has funded a five-year, $50 million study to define the brain circuits and mechanisms that bring about behavioral responses to chronic and excessive alcohol consumption. The multidisciplinary Integrative Neuroscience Initiative on Alcoholism (INIA) study will use research from animal, human, and other studies to examine changes in the brain that occur with chronic alcohol exposure and contribute to excessive drinking.

"Neuroadaptation produces a variety of behavioral responses implicated in...alcoholism," said NIAAA Acting Director Raynard Kington, M.D., Ph.D. "In particular, INIA seeks to clarify the mechanisms of reinforcement, tolerance, and sensitization that drive compulsive drinking, and the withdrawal and relapse that complicate successful treatment. As with all alcohol research, INIA has as its ultimate goal improved treatment and preventive interventions."

The INIA initiative involves two principal scientific consortia, led by The Scripps Research Institute (TSRI) in San Diego, CA, and the Wake Forest University School of Medicine, Winston-Salem, NC. Each consortium will pursue three goals: establishing models to identify and study specific neurobiological targets for vulnerability to alcohol intake at the molecular, cellular, and neural circuit levels of analysis; identifying clusters of genes whose expression is regulated by alcohol ingestion and that are specific to a given behavioral model of excessive alcohol consumption; and attracting new and innovative investigators to alcohol research.

"INIA is expected to create new resources for understanding alcoholism mechanisms and to provide opportunities for collaboration between scientists in the alcohol field and prominent investigators from other research areas," said Samir Zakhari, Ph.D., director of NIAAA's Division of Basic Research. *Source: NIAAA/NIH press release.*

Gene Linked to Stress-Induced Drinking

An abnormal stress-response gene may explain why some individuals use alcohol to deal with stress, according to a team of German researchers.

Researchers at the Max Planck Institute of Psychiatry in Munich examined two sets of mice, one with the corticotropin-releasing hormone 1 (CRH1) gene and one without. (The CRH1 gene produces a protein that helps the brain regulate behavioral and hormonal responses to stress.) Both sets of animals were subjected to two different stressors. Investigators found that the mice lacking the CRH1 gene consumed more than twice as much alcohol as normal mice after being subjected to stress.

Lead author Rainer Spanagel wrote that the study's findings could lead to a test that would identify those recovering alcoholics who are most at risk for relapse in response to stressful life events. *Source: Science, May 3, 2002.*

FDA Grants Priority Review to Acamprosate

The U.S. Food and Drug Administration (FDA) has granted priority review status to a new drug application (NDA) for acamprosate for the treatment of alcoholism. Assignment of priority status usually indicates that the agency plans to act on an NDA within six months.

FDA also charged an advisory panel with reviewing available evidence of the drug's effectiveness. In three European trials, acamprosate was found to be more effective than placebo in treating alcoholism; however, a recent U.S. study did not show similar results. "The results of these studies, on their face, paint a conflicting picture," said Cynthia McCormick, M.D., director of the FDA's division of anesthetic, critical care, and addiction drug products. The mission of the FDA advisory panel is to help interpret the differences in the studies, she said.

Forest Laboratories, Inc., of New York City, and Merck KGaA, of Germany, are hoping to bring acamprosate to the U.S. market. If approved, acamprosate would be only the third drug approved by FDA for the treatment of alcoholism. The drug currently is available in 40 countries under the brand name Campral®. It is designed for use in conjunction with counseling and other behavioral therapies. *Sources: Alcoholism & Drug Abuse Weekly, April 4, 2002; Reuters News Service, May 9, 2002.*

Health Risk Data Improves Smoking Quit Rates

Providing patients with individualized data about their health risks, such as the likelihood of smoking-related diseases, increases the rate at which they attempt to quit smoking, researchers say.

Dr. Jennifer B. McClure of the Center for Health Studies in Seattle and her colleagues conducted eight studies in which patients were given personal health information. They found that smokers who received personalized data about their carbon monoxide levels and genetic susceptibility to lung cancer were twice as likely to try to quit as were patients who did not receive the personal health information.

Dr. McClure said the study findings call for further research into how and when use of health indicators can help patients make lifestyle changes. *Source: American Journal of Preventive Medicine, April 2002.*

Drug Relieves Symptoms of Alcohol Withdrawal

Results of a small study suggest that the muscle relaxant baclofen may ease the symptoms of alcohol withdrawal. Baclofen (marketed in the U.S. as Lioresal®) is prescribed for multiple sclerosis and spinal injuries because it acts on the central nervous system to control muscle spasm and tightness.

The study focused on five patients who were suffering severe withdrawal symptoms, including tremors, sweating, nausea, and agitation. After receiving baclofen, the withdrawal symptoms diminished within three hours or less in four of the patients, while the fifth patient saw improvement within three days. Participants remained on the drug for 30 days. Lead author Dr. Giovanni Addolorato of the Universita Cattolica del Sacro Cuore, Rome, Italy, suggested that baclofen be studied further. *Source: American Journal of Medicine, April 2002.*

Take-Home Methadone Effective for Some Patients

Well-rehabilitated methadone maintenance patients can successfully manage their methadone administration at home, a new study suggests. (Federal requirements were changed in May 2001 to allow treatment programs to give up to a month's supply of methadone in take-home doses, although not all states allow the practice.)

For the study, Dr. Van L. King and colleagues at Johns Hopkins University, Baltimore, compared the results of monthly take-home methadone treatment with the results of standard therapy (involving regular attendance at an outpatient clinic) in 78 patients at two Baltimore clinics. All the patients had full-time employment and had been maintained on methadone for at least a year without relapse to heroin use.

Over the six month study period, the researchers found no differences in methadone compliance between the patients who continued to attend a clinic once or twice a week to receive their medications and those who received 28-day supplies of methadone to take at home. Throughout the study, patients provided urine samples to monitor their drug use and attended monthly counseling sessions.

Dr. King and colleagues report that the patients who received 28-day take-home doses "continued to do extremely well in treatment despite a dramatic reduction in the intensity of their care." *Source: Drug and Alcohol Dependence, January 2002.*

FUNDING OPPORTUNITIES

RWJF to Fund Policy Studies

The Robert Wood Johnson Foundation Substance Abuse Policy Research Program has issued a special solicitation for proposals to conduct policy research in the following areas: policies and systems that facilitate or impede progress in getting new therapies or interventions adopted into practice; implementation of legal agreements and regulations resulting from the Tobacco Master Settlement Agreement; interventions to address driving under the influence of alcohol; studies relevant to legalization or decriminalization of marijuana and other drugs; studies of child welfare and substance abuse; mental health and substance abuse; and alternative nicotine delivery systems.

Experts in public health, law, political science, medicine, sociology, criminal justice, economics, and other behavioral and policy sciences are encouraged to apply. Awards are funded up to $400,000 and may extend for a maximum of three years.

Deadline for receipt of letters of intent for this special solicitation is August 22nd. For the full text of the Call for Proposals, visit the foundation's web site at WWW.RWJF.ORG. Once at the site, click on "Applying for a Grant," then "Calls for Proposals."

SAMHSA Grants

Applications are due July 10th for grants to underwrite treatment in minority communities affected by addiction and HIV/AIDS. The grants, totalling $24.5 million, will be awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Center for Substance Abuse Treatment (CSAT) will administer the awards, which will average $500,000 over five years. For an application, phone 1-800/729-6686 and refer to program announcement TI-02-009. For information, contact David Thompson at 301/443-6523 or e-mail DTHOMPSON@SAMHSA.GOV.

Alcohol, Drug Abuse an Increasing Problem for Older Adults

Problem use of alcohol and prescription drugs by older adults is a well recognized phenomenon. However, a new federal report suggests that an increasing number of older people also are using illicit drugs such as cocaine, heroin, and marijuana. Population projections in the National Household Survey on Drug Abuse, released by the Substance Abuse and Mental Health Services Administration, suggest that 568,000 persons aged 55 or older used illicit drugs in the past month.

The report's authors conclude that the number of older adults engaged in such use will grow over the next decade, as "baby boomers," who used more illicit drugs and alcohol than their parents all through their lifespans, continue their alcohol and other drug use in their later years. Experts say that serious problems with alcohol and other drugs occur later in life for about a third of older addicts. "Older people have to deal with tremendous issues of loss, from retirement to the death of a spouse. So they begin to rely on alcohol and other things," says Cynthia Morley, a specialist in the treatment of older adults at Crouse Chemical Dependency Services in Syracuse, NY. The other two-thirds, on the other hand, are long-term users.

Federal data show that, between 1995 and 1999, alcohol was the primary problem for most of the more than 50,000 persons over age 55 who entered the publicly funded addiction treatment system. But over that four-year period, alcohol admissions declined by 9%, while admissions for illicit drug use increased by 25% for men and 43% for women.

The data suggest a series of challenges for addiction treatment providers. The first is that older addicts are far more difficult to identify than younger persons, whose problems with alcohol and other drugs often become evident at work, in school, or through the criminal justice system.

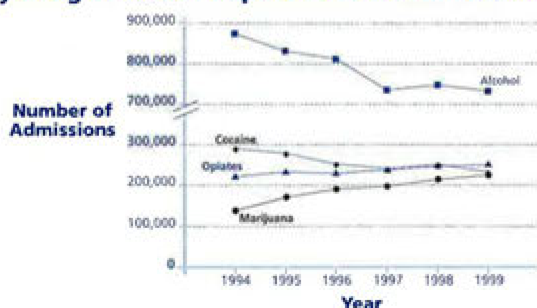
A second problem is related to stigma. Older adults "are more likely to hide their substance abuse and less likely to seek professional help" than younger users, according to H. Westley Clark, M.D., FASAM, director of the federal Center for Substance Abuse Treatment. "And relatives of elders with substance abuse problems often are not willing to confront them," Dr. Clark added.

Finally, once older addicts are identified, there is a problem in finding appropriate treatment. Few programs are designed specifically to meet the needs of older adults. "These individuals have struggled through life, brought up families, paid taxes, and they've somehow never been able to quit this thing," says Peter Provet of Odyssey House in New York City. "What we try to do is give people an opportunity to move toward life closure and find inner peace with themselves and hence with their families." *Source: Substance Abuse and Mental Health Services Administration; Christian Science Monitor, March 27, 2002.*

Alcohol a Leading Cause of Treatment Admissions

Alcohol was mentioned three times more often than any other drug by persons seeking admission to publicly funded addiction treatment programs, according to data collected for the federal Treatment Episode Data Set (TEDS). TEDS data show that in 1999 (the most recent year for which data are available), there were 737,429 admissions related to alcohol. By contrast, 257,426 admissions were related to opiates, 228,206 to cocaine, and 223,597 to marijuana.

Primary Drug of Abuse Reported at Treatment Admission, 1994-1999



The full TEDS data set can be viewed online at WWW.SAMHSA.GOV/OAS/TEDS/99TEDS/99TEDS/PDF. *Source: Substance Abuse and Mental Health Services Administration.*

ONDCP Releases Trend Data

The price and purity of heroin and cocaine remained stable over the last six months of 2001, according to John P. Walters, Director of the Office of National Drug Control Policy, but diversion and abuse of the prescription analgesic OxyContin® increased. In releasing ONDCP's biannual *Pulse Check* report, Director Walters warned that the new data on OxyContin constitute "a wake-up call" to those who dismissed illicit use of the drug as limited to rural areas. "We are now seeing OxyContin abuse breaking out in new areas and spreading across economic, ethnic, and regional lines. It's a problem for all of us to take seriously," he said.

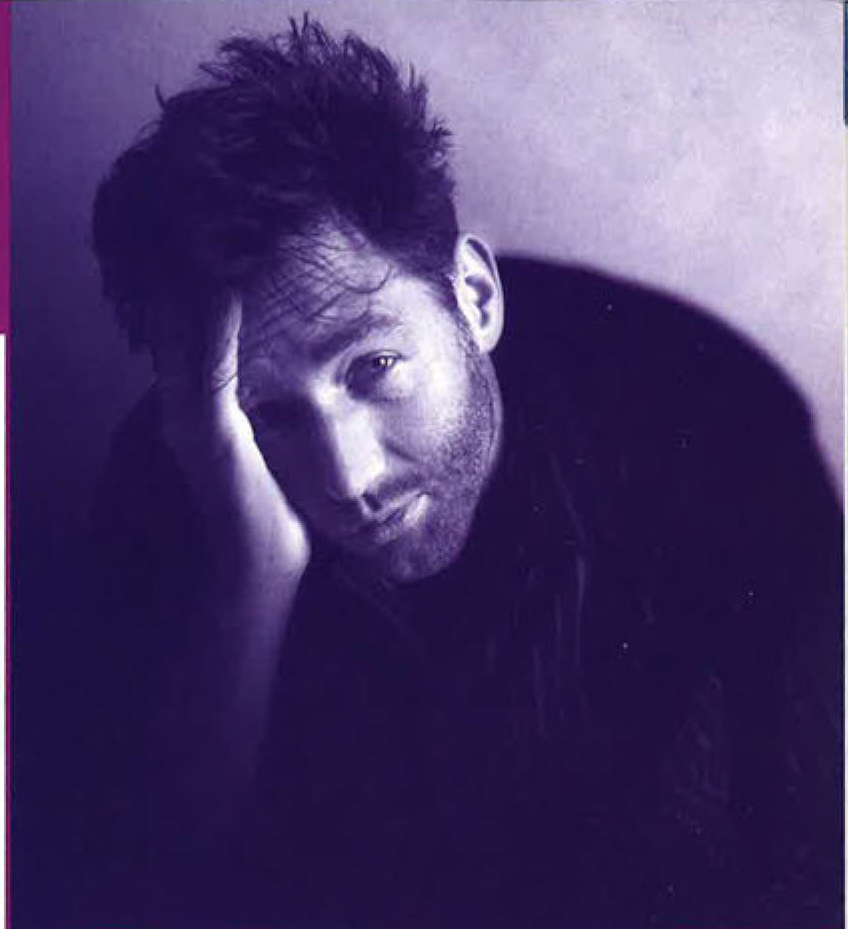
Pulse Check reports are based on data gathered from epidemiologists, ethnographers, law enforcement officials, and treatment providers. Data are collected from more than 80 different sources in 21 sites across the country. In addition to the OxyContin data, trends reported in the latest *Pulse Check* include:

- Heroin and crack cocaine are associated with more serious adverse consequences than any other illicit drugs;
- The trend toward mixing heroin with other drugs, such as MDMA and cocaine, is increasing;
- Marijuana remains the most widely abused illicit drug, as reported at 19 sites. More potent, hydroponically grown varieties of marijuana from British Columbia are becoming widely available.
- Use of club drugs, including MDMA ("Ecstasy") is expanding across ethnic, age, and economic backgrounds. Its use appears to be spreading from nightclubs and "rave" parties to high schools, neighborhoods, and other community venues;

The overall drug problem was described as "very serious" by 68% of respondents, as "somewhat serious" by 37% of respondents, and as "not very serious" by 3% of respondents.

A full copy of the *Pulse Check* report is available at WWW.WHITEHOUSEDRUGPOLICY.GOV. *Source: Office of National Drug Control Policy.*

This time he's really ready to stop drinking.



Antabuse® can help.

Active, effective support for the patient committed to recovery

Proven to aid in reducing alcohol consumption and sustaining abstinence from alcohol as part of an overall psychosocial program.

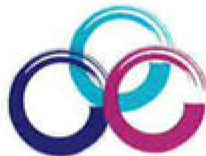
An integral part of an integrated system of support for more than 30 years

Adjunctive therapy for patients who want pharmaceutical assistance in maintaining sobriety.

Disulfiram should *never* be given to a patient who is in a state of alcohol intoxication or without their 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 full prescribing information on next page for more information.

Please see Full Prescribing Information on adjacent page.



In alcoholism

ANTABUSE®

(Disulfiram, USP)

250-mg tablets

Support for the committed quitter

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In alcoholism

ANTABUSE®
(Disulfiram, USP)
250-mg tablets

Support for the committed quitter

Antabuse® (Disulfiram, USP) Tablets
IN ALCOHOLISM

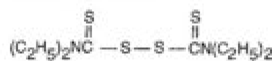
> **WARNING:**
> Disulfiram should *never* be administered to a patient when he is in a state of alcohol intoxication, or without his full knowledge. The physician should instruct relatives accordingly.

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.

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, 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.

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 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). [SEE USP]

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Rev. 9/01

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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Nominating Committee Announces Candidates for Officer, Director Posts

Marc Galanter, M.D., FASAM
Chair, Nominating and Awards Committee

A slate of candidates for the Society's next election of officers and directors has been selected by ASAM's Nominating and Awards Committee and approved by the Board of Directors. Candidates are to be elected in November 2002 for terms to begin in April 2003.

The Nominating and Awards Committee is composed of the Immediate Past President, as chair; the President; two ASAM committee chairs who have been elected by all committee chairs; two chapter presidents who have been elected by all chapter presidents; and two members of the Board of Directors who have been elected by the full Board.

Nominations by Petition: Nominations also may be made by petition. Each such petition must be signed by at least 100 members in good standing. All persons nominated by petition must meet the requirements contained in the by-laws, which are outlined below.

Before submitting nominating petitions, the Board encourages nominators to verify a potential candidate's qualifications and willingness to serve. *Nominating petitions must be received at the ASAM office by July 15, 2002.*

Nominees for Officer, 2003-2005: Nominees for the offices of President-Elect, Treasurer, and Secretary must have served on the Board of Directors within the past four years. An exception may be made in the case of a nominee for the office of Treasurer, who may be an individual from the general membership who has qualifications for the position and who also has been an active member of the Finance Committee within the past four years.

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

President-Elect
Elizabeth F. Howell, M.D., FASAM
James W. Smith, M.D., FASAM

Secretary
Lloyd J. Gordon III, M.D., FASAM
David C. Lewis, M.D.

Treasurer
Paul H. Earley, M.D., FASAM
James A. Halikas, M.D., FASAM

Nominees for Director at Large, 2003-2007: Three Directors at Large, and one Director at Large representing Osteopathic Medicine, are to be elected.

Candidates must have been active members of ASAM for at least three years, must have demonstrated a commitment to ASAM's mission by engaging in activities such as service on a committee, task force, or other significant national or state endeavor, and must be willing to attend two Board meetings a year for four years at his/her own expense. The nominees for Director at Large are:

David R. Gastfriend, M.D.
Stuart Gitlow, M.D., M.P.H.
R. Jeffrey Goldsmith, M.D.
Elizabeth F. Howell, M.D., FASAM
Donald J. Kurth, M.D., FASAM
Michael M. Miller, M.D., FASAM
James W. Smith, M.D., FASAM
Trusandra E. Taylor, M.D., FASAM
Penelope P. Ziegler, M.D., FASAM

Nominees for Director at Large representing Osteopathic Medicine are:

Anthony H. Dekker, D.O., FASAM
Timothy L. Fischer, D.O.

Balloting: Profiles of the candidates for all positions will appear in the July-August issue of **ASAM News**. Ballots will be mailed to all ASAM members in good standing no later than November 1, 2002. Voted ballots must be received at the ASAM office no later than December 1, 2002.

Results: Election results will be announced in the January-February 2003 issue of **ASAM News**. New officers will be installed during the Society's May 2003 Medical-Scientific Conference in Toronto, Ontario, Canada.

CHAPTER UPDATES

Michigan

President: Michael L. Fox, D.O.
Regional Director: Thomas L. Haynes, M.D., FASAM

Educational Conference: The Michigan Society of Addiction Medicine (MISAM) sponsored an educational conference at Lansing, April 13-14th, in partnership with the Michigan Psychological Association. Guest speakers included William Cope Moyers, Vice President of the Hazelden Foundation, and Sonia Parks, M.D., Medical Director of Blue Cross/Blue Shield of Michigan.

Quarterly Meeting: The Michigan Society and the Michigan Health Professional Recovery Corporation (MHPRC) will host MISAM's quarterly meeting in cooperation with the Addictionists of Michigan, June 5th at Lansing. The meeting will feature discussion of case presentations.

State Ballot Initiative: The "Michigan Campaign for New Drug Policies" is an initiative to reform Michigan's drug laws, much as Proposition 36 did in California. It is expected to appear on the ballot in November 2002. The initiative seeks to create a treatment alternative for first-time, non-violent drug offenders.

All members of MISAM are invited to register their opinions as to whether the Society should formally endorse the ballot initiative. Members of the Parity Committee are actively polling the membership on this issue.

Blue Cross/Blue Shield: MISAM has initiated discussions with representatives of Michigan Blue Cross/Blue Shield in an effort to gain recognition of addiction medicine and of its practitioners as a network of specialists who can provide cost-effective patient care under Blue Cross/Blue Shield contracts. As part of these discussions, MISAM is working to document the cost-effectiveness of timely, comprehensive care for addictive disorders.

Communications Director: Cathy Pisano has joined MISAM as Communications Director to help the Society grow. You can reach Cathy at the MISAM office, 27550 Joy Road, Livonia, MI 48150; by phone at 734/261-3290; or by fax at 734/261-0755.

33rd ASAM Conference a Success

Addiction medicine specialists from around the world gathered in Atlanta for ASAM's 33rd Annual Medical-Scientific Conference. Program chair Marc Galanter, M.D., FASAM, and his committee planned a mixture of symposia, courses, workshops, papers and poster sessions, affording participants many opportunities to interact with experts in the field.

Major events included special day-long sessions organized by the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Centers for Disease Control and Prevention. Here, ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, greets a representative of the National Institute on Drug Abuse.

Outstanding Achievements Recognized

At its annual Awards Luncheon, ASAM honored outstanding contributions to the field of addiction medicine. The Annual ASAM Award for outstanding contributions to the growth and vitality of the Society, for thoughtful leadership in the field, and for deep understanding of the art and science of addiction medicine went to J. Thomas Payte, M.D.

An award for expanding the frontiers of Addiction Medicine and broadening our understanding of the addiction process through research and innovation was presented to George F. Koob, Ph.D. The Young Investigator Award went to Kevin P. Hill, M.D., while the Medical-Scientific Program Committee Award was bestowed on Michael Dennis, Ph.D. Monsignor William B. O'Brien, President of Daytop Village in New York City, received the John P. McGovern Award and delivered the McGovern Lecture on Addiction and Society.

J. Thomas Payte, M.D.

The well-attended exhibit area featured displays by groups ranging from pharmaceutical manufacturers to federal agencies, and included treatment programs, publishers, and service providers.

Exhibitors and Contributors

A major factor in the success of the conference was the generosity of the following individuals and organizations, which provided unrestricted educational grants:

Abbott Laboratories
Agouron Pharmaceuticals, Inc.
Betty Ford Center at Eisenhower
Bio-Rad Laboratories
Caron Foundation
Center for Substance Abuse Treatment
COPAC, Inc.
Daytop
Dr. and Mrs. Joseph E. Dorsey
Endo Pharmaceuticals, Inc.
William J. Farley Center
Forest Laboratories
The Gables
Georgia Society of Addiction Medicine
GlaxoSmithKline, Inc.
Haworth Press
Hazelden/Springbrook
Janssen Pharmaceutica, Inc.
Mallinckrodt, Inc.
Manisses Communications Group
Metro Atlanta Recovery Residences
Marworth, Inc.
John P. McGovern Foundation
Odyssey Pharmaceuticals, Inc.
Ortho-McNeil Pharmaceutical
Pfizer, Inc.
Pharmacia/Upjohn, Inc.
Pine Grove/Next Step
Purdue Pharma L.P.
Ridgeview Institute
Rush Behavioral Health
Schering Laboratories
Schick Shadel Hospital
Sierra Tucson
The Christopher D. Smithers Foundation, Inc.
Talbott Recovery Campus
Willingway Hospital

Scientific and Clinical Sessions

The conference featured a rich mix of learning experiences. Courses and workshops presented clinical material to complement the scientifically oriented symposia. In addition, component sessions were organized by ASAM's Sections, Committees and Task Forces to report on their activities and concerns, and to obtain feedback from the ASAM membership.

Greeting Colleagues and Remembering Friends

The conference welcomed educators, researchers, clinicians, and state and federal administrators.

The 33rd Medical-Scientific Conference was dedicated to the memory of four outstanding leaders of ASAM who died within the past year: Jasper Chen See, M.D.; John D. Slade, M.D., FASAM; Percy E. Ryberg, M.D.; and Emanuel M. Steindler, M.S., as well as to the late Ian MacPherson, who with his wife, Louisa, lent expertise to the organization of the Med-Sci Conference over many years.

New Interactive PPC-2R Previewed

Representatives of the Earley Corp. demonstrated the new interactive version of the *ASAM Patient Placement Criteria* (*ASAM PPC-2R*). Like many registrants, Dr. Allan Graham took advantage of the opportunity for a "hands on" trial of the exciting new product, as ASAM Executive Vice President Jim Callahan, D.P.A., President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, and a representative of Earley Corp. looked on.

Plan now to attend ASAM's 34th Annual Medical-Scientific Conference, May 1-4, 2003, in Toronto, Ontario, Canada!

Continued from page 2

Despite these obstacles, despite the stigma which manifests itself in dozens of ways, you have pressed on and have had great success, for which you deserve great praise. You have achieved this success because you are men and women who love greatly. In 1989, when my predecessor, Manny Steindler, retired from the directorship of ASAM, I had the good fortune to be present at the Awards Luncheon when he made his departing remarks. Manny said that he would be forever grateful for the privilege of being associated with men and women who have such great compassion for those suffering from the compulsion of addiction.

You truly are men and women of great compassion. You live and give from your hearts. You are loving, and it is this love that will guarantee your continued success in mastering the daunting challenges that face you in the future. I recall that Bob DuPont once said to me, "ASAM is an organization with a heart." In agreeing with Bob, I answered, "Yes, and that heart is the Twelve Step philosophy that runs through all of ASAM's work." ASAM's heart is the "attitude of gratitude" by which you live, and which motivates everything you do for ASAM and for your patients.

A Structure for Future Success

In 1954, the field of addiction medicine did not exist. All that existed was a handful of men and women, physicians and laypersons in the National Council on Alcoholism, who believed that alcoholism was a preventable and treatable disease. Today, you, too, believe, as did your predecessors, that alcoholism and other addictions are preventable and treatable disorders. But, unlike your predecessors, you are not a small handful. You are 3,000 physicians who are members of a national medical specialty society. You are practitioners of a new medical specialty of addiction medicine, which you have created.

Your medical society and your specialty have been formally and officially received into the house of organized medicine, when the AMA gave you a seat in the House of Delegates, and officially recognized your specialty.

In 1954, when your colleagues organized as the New York Medical Society on Alcoholism and held their first scientific meeting, fewer than 25 registered. At this week's Medical-Scientific Conference, close to 1,000 registered.

In 1954, there was no textbook in addiction medicine. This year, ASAM will publish the Third Edition of its *Principles of Addiction Medicine* and, at its April meeting, the Board appointed four editors for the Fourth Edition, which will be published in 2006.

In 1954, there were no national guidelines for determining the need for treatment and the appropriate level of treatment. Today, the *ASAM Patient Placement Criteria* are required or recommended in 21 states and by an increasing number of managed care companies.

In 1954, there were no practice guidelines. Today, ASAM has a Practice Guidelines Committee, which already has published two guidelines in *JAMA*, and which has three more nearing completion.

You have a strong active medical society whose membership again is beginning to grow.

You have documented and continue to document the science and practice of addiction medicine in your textbook, your journal, your practice guidelines, your placement criteria, and your newsletter.

You have an outstanding series of annual conferences and courses. You have a nationally recognized certification examination and credentialing process. You are financially sound, with a strong endowment for the future. You have two internationally renowned research institutes at the NIH. You have a president, Dr. Lawrence Brown, who has vision and who is fully dedicated to carrying out the mission of the Society. You have a Board made up of members who have been through the mill, who know what the issues are, and who have the wisdom to guide the Society to success.

You have a Strategic Plan approved by the Board, and which lays out the Society's mission and goals, as well as specific strategies to pursue them over the next five years.

And you have an intelligent, well-trained and dedicated staff eager to support your work. And, finally, you will soon have a new and highly qualified Executive Vice President with a proven track record, who will effectively manage the Society and work in partnership with you.

So the structure is in place, and you are now ready to move aggressively into a new, challenging and demanding phase: your endeavor is to establish the specialty of Addiction Medicine.

You will do this by achieving parity for addictive diseases, for it is the key to achieving our vision. Parity includes three things: (1) full access to treatment for patients and their families, equal to access given for other diseases; (2) reimbursement to physicians who provide treatment; and (3) the opportunity for physicians to be trained as specialists in addiction medicine. Parity is a three-part concept, and we wil not have true parity until all three parts are realized.

Take Action

ASAM's vision and mission will not be achieved without strategic action on ou part, and on the part of those who com after us. Today, our actions must b focused on parity, for that is today's oppor tunity. Each of our members must work fo parity within their states and other medica societies. Your Society will work, too, a the national level, to have parity legisla tion passed in the Congress, and to hav managed care organization policie changed to provide for parity.

Christopher Reeve, the spinal cord injur victim who has inspired all of us, is a coura geous and effective activist for mor research on spinal cord injury. Of his pe sistence in pursuit of this goal, he has sai "So many of our dreams at first see impossible. Then they seem improbabl And then, when we summon the will, the become inevitable."

Parity *is* inevitable. We will, at a date the not-too-distant future, celebrate th achievement of full parity. On that day, w will look back on parity as an achievemer as today we look back on so many oth achievements.

In closing, I wish to thank each of you f the love, support and friendship you ha given me over the past 13 years. I cou never express in words what an absolu and utter joy it has been to work with yo and to work on your behalf and on beh of your patients.

ADDICTIONOLOGIST

ASAM certified or eligible addictionologist who is board-certified in family or internal medicine is sought for a thriving family/internal medicine practice. The practice is located in a 5,000 square foot building just four blocks from the ocean in beautiful Jacksonville Beach, Florida.

The work involves a variety of medical care, including inpatient addiction treatment, outpatient chemical dependency evaluations, general primary care in an office setting, hospital and nursing home patients. Direct inquiries to John C. Tanner, D.O., FASAM, by phone at 904/247-1911, by fax at 904/246-6312, or by e-mail at JTANNER@POL.NET.

The list of those to whom I owe thanks is too long to enumerate here. So please allow me to say "thank you" to every one of you, to our members, to the Board, to the wonderful staff, and to our very special corps of consultants. And please convey my thanks to your husbands, your wives, your significant others, and your family members, who have supported your endless hours of volunteer work on behalf of ASAM and your patients. I, too, want to thank my wife, Claire Lyons, for the insights and consultation she has provided over the years and for her constant support, love and sacrifices on your behalf and on behalf of your patients.

I am moving into a new phase of my life, and you are moving into a new phase of ASAM's mission to establish the specialty of Addiction Medicine. You and I have given our all for many years, and we know well the daunting challenges before us. Were Samuel Beckett, the great Irish playwright, to offer this farewell, he might say for me, as he did of himself: "Perhaps my best years are gone, but I wouldn't want them back. Not with the fire in me now."

Methadone Accreditation Bodies Named

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has named four organizations to accredit programs that use methadone and similar medications for the treatment of opiate addiction. The organizations are the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation for Children and Family Services (COA), and the State of Washington's Department of Social and Health Services, Division of Alcohol and Substance Abuse.

Because accreditation indicates that a particular organization has complied with key performance standards, it should enhance community confidence in opiate treatment programs, said H. Westley Clark, M.D., FASAM, director of SAMHSA's Center for Substance Abuse Treatment.

Accreditation is part of a larger SAMHSA initiative to improve the quality and oversight of opioid treatment programs, according to SAMHSA Administrator Charles G. Curie. Dr. Curie added that "accreditation can help reduce stigma and discrimination by moving drug abuse treatment into mainstream medicine." *Source: Substance Abuse and Mental Health Services Administration.*

ASAM Welcomes New Members

Donald J. Kurth, M.D., FASAM
Chair, Membership Committee

The Society welcomes the following new members. Individually and collectively, their diverse backgrounds, clinical and research interests promise to bring added strength and vitality to ASAM.

Charles B. Alexander, M.D., of Ellsworth, ME, practices internal medicine at Maine Coast Memorial Hospital.

Osama Al-Samkari, M.D., a family practitioner, is with MVHE, Inc., Dayton, OH.

William Cornelius Bauer, M.D., a psychiatrist, lives in Las Vegas, NV.

Michelle A. Bensen, M.D., whose specialty is internal medicine, is with the Marshfield Clinic, Minocqua, WI.

Terrold B. Butler, M.D., a resident in pediatrics, lives in Chicago, IL.

Jean L. Cadet, M.D., a psychiatrist, is Clinical Director with the NIH/NIDA Intramural Research Program, Baltimore, MD.

Sandra Chapkowski, M.D., a psychiatrist, practices with Gateway CSB, Savannah, GA.

Robert F. Cooper, M.D., a specialist in internal medicine, lives in Beverly Hills, CA.

Richard Cunningham, M.D., FACOG, a specialist in obstetrics and gynecology, lives in Tomball, TX.

L. D. Empting, M.D., a neuropathologist, directs a neurodiagnostic clinic in Atlanta, GA.

Paula Fabrizio, D.O., a psychiatrist, practices at the Bridge Back To Life Center, Brooklyn, NY.

Hubert Fernandes, M.D., a specialist in internal medicine, is Medical Director of Chicago REACH.

W. Ronald Gaertner, M.D., a psychiatrist, practices at Henrico Doctors Hospital, Richmond, VA.

Carlos J. Giron, M.D., a specialist in pain management, is director of Interventional Pain Management and CEO of the Georgia Pain Institute, Macon, GA.

Junius Goslen, M.D., a specialist in internal medicine, lives in Charlotte, NC.

Jan C. Green, M.D., a urologist, practices with Victory Clinical Services in South Bend, IN.

Lucinda Grovenburg, M.D., a family practitioner, is with Samaritan Village Health Services, Kerhonkson, NY.

Clayton S. Hall, D.O., a psychiatrist, is with the University of Louisville, in Kentucky.

Joseph R. Holtman, Jr., M.D., Ph.D., an anesthesiologist, is associate professor of medicine at the University of Kentucky, Lexington.

Gordon Ifill, M.D., a psychiatrist, is with Georgia Therapy Associates, Savannah.

Lynleigh Immelman, M.D., is Director of Psychiatry Services at Edgewood, Nanaimo, British Columbia, Canada.

David Karney, M.D., a psychiatrist, lives in San Antonio, TX.

Jaya G. Kutha, M.D., a psychiatrist, lives in Warren, MI.

Heather M. MacAdam, M.D., a specialist in internal medicine, is with Cornerstone Recovery Services, Ithaca, NY.

Roger A. Maltz, M.D., a specialist in physical medicine and rehabilitation, is a staff physician with the Orthopedic Center, Highland Park, IL.

Joseph M. Matta, M.D., is a psychiatry resident at New York Presbyterian Hospital.

Wayne Gerald Miller, D.O., an infectious diseases specialist, is an attending physician at Internal Medicine Associates, Norristown, PA.

Seyed M. Mirakbari, M.D., a specialist in emergency medicine, is a research associate with St. Paul's Hospital, Vancouver, British Columbia, Canada.

Robert Oliver Morton, M.D., a specialist in internal medicine, is with the University of Oklahoma in Oklahoma City.

Ghulam Murtaza, M.D., is with the Bronx Lebanon Hospital Center in Huntington Station, NY.

William Nemeth, M.D., CPE, a specialist in orthopedics and musculoskeletal oncology, is medical advisor to the Texas Workers Compensation Commission, Austin, TX.

Ray Noel, M.D., is a family practitioner in Kalama, WA.

Robert O'Connor, M.D., a specialist in internal medicine, lives in St. Clair, PA.

Thomas P. O'Toole, M.D., a specialist in internal medicine, is at the Johns Hopkins University, Baltimore, MD.

William C. Rainer, M.D., a specialist in addiction medicine, is Medical Director of Sunset House Foundation, Lafayette, NJ.

Charles L. Rivenbark, M.D., a psychiatrist, lives in Forest City, NC.

Sabiha Samee, M.D., a pediatrician, is with the Cook County Juvenile Intensive Center in Darien, IL.

Ralph Silas Smith, Jr., M.D., is with the Charleston Psychiatric Group in Charleston, WV.

Steven E. Stoller, M.D., an ophthalmologist, lives in Richmond, IN.

Janusz Swiatkowski, M.D., is medical director of Outpatient Psychiatric Services at NCB Hospital, Bronx, NY.

Roger C. Tengson, Jr., M.D., is chief of the Division of Adol Medicine at St. Joseph's Children's Hospital, Paterson, NJ.

H. King Wade III, M.D., a specialist in internal medicine, lives in Englewood, CO.

Wayne Weaver, M.D., lives in Homesville, OH.

Leonard J. Weiss, M.D., a psychiatrist, lives in Atlanta, GA.

Kelley A. Wilson lives in Birmingham, AL. [no degree indicated; is this a medical student?]

Jennifer C. Yolles, M.D., a psychiatrist, is at the SUNY Upstate Medical University Syracuse, NY.

Continued from page 4

and the medical and societal aspects of substance use, misuse, and addiction.

Strategy 1.2: ASAM will secure funds from external sources to distribute its publications to selected policymakers and other stakeholders.

OBJECTIVE 2 (End Point). Addiction Medicine is recognized by physicians, health insurers, health care organizations, and policymakers as a medical specialty with a multidisciplinary body of knowledge.

Strategy 2.1: ASAM will widely disseminate the definition and content of Addiction Medicine.

OBJECTIVE 3 (End Point). ASAM is recognized by physicians, health insurers, health care organizations, policymakers as an authoritative source of credible, scientifically validated, up-to-date information about addictive disorders and their diagnosis and treatment.

Strategy 3.1: Through multiple communication methods, ASAM will inform its members about scientific, clinical, and policy developments, and the activities of related organizations.

Strategy 3.2: ASAM will publish updated editions of *ASAM News*, the *Journal of Addictive Diseases, Principles of Addiction Medicine*, the *ASAM Patient Placement Criteria*, and clinical practice guidelines developed by ASAM.

Strategy 3.3: ASAM will publish a pocket-sized *ASAM Handbook of Addictive Disorders* for house officers and physicians who are not specialists in Addiction Medicine.

Strategy 3.4: ASAM will link the *www.asam.org* web site to other web sites to promote the availability of ASAM publications to ASAM members, non-member physicians, and others.

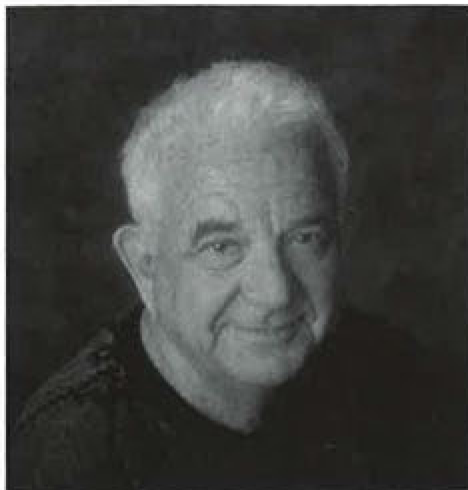
Strategy 3.5: ASAM's Board will appoint a Task Force to evaluate and report on the feasibility of publishing an *ASAM Diagnostic Manual of Addictive Disorders.*

OBJECTIVE 4 (Implementation). ASAM fosters and advocates for addiction research and disseminates research findings to advance the body of knowledge of addiction medicine.

Strategy 4.1: ASAM will advocate for basic and clinical research on the nature of addictive disorders and their treatment.

Strategy 4.2: ASAM will advocate for establishment of a national data repository for addiction treatment outcome data.

Strategy 4.3: ASAM will promote member participation in clinical trials.



Richard E. Tremblay, M.D., FASAM, Chair of the Strategic Plan Task Force

Strategy 4.4: ASAM will disseminate the results of research on substance use, misuse, and addiction.

OBJECTIVE 5 (Implementation). ASAM fosters professional understanding of the prevention and treatment of problem use of alcohol, tobacco, and other drugs.

Strategy 5.1: ASAM will collaborate with health care providers and organizations that address the needs of those at risk for, or experiencing, the harmful use of alcohol, tobacco, and other drugs, as well as those whose harmful use is a risk factor for the development of addiction.

Strategy 5.2: ASAM will develop clinical guidelines and policies for the evaluation and management of persons at risk for, or experiencing, the development of harmful use of, or addiction to, prescription drugs, including those persons with chronic pain syndromes and chronic psychiatric syndromes.

Goal II

Treatment Access and Treat-ment Improvement: To increase access to addiction treatment and improve its effectiveness.

This section of ASAM's Strategic Plan addresses the following:

- Recognition of addiction as a medical disorder (Objective 6).
- Access to treatment for addictive disorders (Objective 7).
- Addiction treatment services are delivered by Addiction Medicine specialists or other appropriately trained professionals (Objective 8).
- Use of clinical practice guidelines in the treatment of addiction (Objective 9).
- Development of pharmacologic and other therapies for the treatment of addiction (Objective 10).
- Parity in insurance coverage for addiction treatment (Objective 11).

OBJECTIVE 6 (End Point). Patients with addictive disorders are recognized as having an illness and as candidates for treatment, rehabilitation, and restoration to their premorbid level of function.

Strategy 6.1: ASAM will promote policies that emphasize the biopsychosocial nature of addictive disorders and the necessity of treatment.

Strategy 6.2: ASAM will expand its advocacy efforts on behalf of all recovering persons, and will collaborate with other medical organizations to pursue the elimination of discrimination against those who are recovering from addictive disorders.

OBJECTIVE 7 (End Point). Comprehensive treatment of addictive and other substance-related disorders is readily available to all persons who need it, including those in the criminal justice system, those who have co-occurring mental disorders, and those who are physicians or other health professionals.

Strategy 7.1: Through its policy statements, conferences, and publications, ASAM will identify the range of treatment services that constitute a comprehensive continuum of care for addictive disorders.

Strategy 7.2: ASAM will expand its advocacy efforts on behalf of recovering physicians and will collaborate with other medical organizations to pursue the elimination of discrimination against physicians and other health professionals who are recovering from addictive disorders.

OBJECTIVE 8 (End Point). Services for the evaluation and management of addictive disorders are delivered by Addiction Medicine specialists or, as appropriate, by general medical or mental health providers in consultation with Addiction Medicine specialists.

Strategy 8.1: ASAM will compile data on patterns of consultation and referral between primary care physicians and ASAM-certified Addiction Medicine specialists.

Strategy 8.2: ASAM will compile data on the policies of major health plans as they affect referrals to ASAM-certified Addiction Medicine specialists.

Strategy 8.3: ASAM will disseminate information to assure that physicians, other health care providers, and patients can identify and locate ASAM-certified

Addiction Medicine specialists in their communities.

Strategy 8.4: ASAM will promote appropriate linkages between Addiction Medicine specialists and primary care providers.

OBJECTIVE 9 (End Point). Addiction Medicine practice incorporates research-based clinical practice guidelines developed by ASAM and other medical organizations.

Strategy 9.1: ASAM will develop and publish additional clinical practice guidelines.

Strategy 9.2: ASAM will compile, evaluate, and disseminate clinical practice guidelines relevant to Addiction Medicine that are developed by other medical organizations and government agencies.

Strategy 9.3: ASAM will collaborate in the development and dissemination of clinical practice guidelines and consensus documents developed by government agencies and other organizations.

OBJECTIVE 10 (End Point). Information about and access to new medications and other treatments for addictive disorders are available to Addiction Medicine specialists and other appropriately trained physicians.

Strategy 10.1: ASAM will compile, evaluate, and disseminate information about newly available medications and those under development to its members and other physicians.

Strategy 10.2: ASAM will compile, evaluate and disseminate information about newly available treatment modalities for addictive disorders—including alternative medicine approaches and nonpharmacologic therapies—to its members and other physicians.

Strategy 10.3: ASAM members will testify in the Congress, before the FDA and in other appropriate venues at each appropriate opportunity in favor of continued development of medications and other therapies for the management of addictive disorders, including substance intoxication syndrome and substance withdrawal syndrome.

OBJECTIVE 11 (End Point). Addiction Medicine services are a covered benefit under public and private health insurance plans, at full parity with general medical benefits with regard to coverage of services and reimbursement for such services.

Strategy 11.1: ASAM will advocate for all patients to have access to the full range of treatment services they need, guided by the current edition of the *ASAM Patient Placement Criteria*.

Strategy 11.2: ASAM will advocate for specialists in Addiction Medicine to be compensated fairly for the services they provide.

Strategy 11.3: ASAM will advocate for all physicians who evaluate and manage patients with addictive disorders to be compensated fairly for the services they provide.

Strategy 11.4: ASAM will strive to ensure that third-party payers provide coverage for clinical preventive, assessment and treatment services, as well as funding for treatment outcome studies.

Strategy 11.5: ASAM will assist its Chapters in the pursuit of benefit parity, and will report regularly to the Board and the membership on the Chapters' activities and progress in the pursuit of parity until parity is a reality in each State, district and territory of the United States.

Strategy 11.6: ASAM will collaborate with other addiction organizations and with the National Coalition for Substance Abuse Parity to achieve full parity for the treatment of addictive disorders.

Goal III

Medical Education and Recognition of Expertise: To educate Addiction Medicine specialists and other physicians about the identification, diagnosis, treatment, and prevention of addictive disorders, and to achieve recognition of the specialty of Addiction Medicine.

This section of ASAM's Strategic Plan addresses the following:

- Education of medical students (Objective 12).
- Education of residents (Objective 13).
- Education of Fellows (Objective 14).
- Education of practicing physicians (Objective 15).

OBJECTIVE 12 (End Point). (Undergraduate Medical Education) All schools of allopathic and osteopathic medicine incorporate appropriate information about addictive disorders and Addiction Medicine in their core curricula.

Strategy 12.1: ASAM will promote the adoption of basic requirements for the Addiction Medicine content of undergraduate medical education.

Strategy 12.2: ASAM, in collaboration with other medical organizations and government agencies, will promote the inclusion of basic knowledge and skills in Addiction Medicine in the curriculum for all medical students.

OBJECTIVE 13 (End Point). (Residents) All residency training programs include appropriate content on addictive disorders in their essential requirements.

Strategy 13.1: ASAM will compile and disseminate information on the Addiction Medicine content of residency training programs.

Strategy 13.2: ASAM will develop standards for appropriate content on addictive disorders for use in residency training programs.

Strategy 13.3: ASAM will collaborate with the appropriate institutions and organizations (such as ACGME and RRCs, as well as AMERSA, AOA, AAAP, ACOG, et al.) to promote adoption of its Core Content of Addictive Medicine in all residency training programs.

OBJECTIVE 14 (End Point). (Fellows) ASAM-approved Fellowships in Addiction Medicine, leading to certification, are available to all physicians who are interested and qualified.

Strategy 14.1: ASAM will compile information on Fellowship training in Addiction Medicine to determine the number and content of available Fellowships and their accreditation status.

Strategy 14.2: ASAM will collaborate with the appropriate training institutions, organizations and funding sources to promote adoption of ASAM's Guidelines for Fellowship Training Programs in Addiction Medicine.

Strategy 14.3: ASAM will advocate for an increase in the number of approved Fellowships in Addiction Medicine.

OBJECTIVE 15 (End Point). (Practicing Physicians) ASAM offers appropriate training, education and certification in Addiction Medicine through multiple modalities.

Strategy 15.1: ASAM will offer continuing medical education (CME) programs to Addiction Medicine specialists and other interested physicians through multiple modalities (such as its newsletter, journal, web site, conferences, telephone symposia, and web-based CME programs).

Strategy 15.2: ASAM will promote cultural competency at all levels of training.

Strategy 15.3: ASAM will offer certification in Addiction Medicine to all qualified physicians who successfully complete its examination.

Strategy 15.4: ASAM will continue to engage with physicians from around the world who practice Addiction Medicine, and to promote Addiction Medicine education internationally.

Goal IV

Policy and Communication: To develop and promote a wider understanding of the prevention, recognition and treatment of, and research on, addictive disorders and the role of Addiction Medicine.

This section of ASAM's Strategic Plan addresses the following:

- ASAM's advocacy role (Objective 16).
- Developing ASAM's policy statements (Objective 17).
- Communicating ASAM's policy statements (Objective 18).
- Strategic use of ASAM's policy statements (Objective 19).

OBJECTIVE 16 (Implementation). ASAM is an active participant in organized medicine.

Strategy 16.1: ASAM will enhance its visibility as a medical specialty society.

Strategy 16.2: ASAM will increase the participation of ASAM members in national and state medical associations and specialty societies, and will build coalitions with those organizations.

Strategy 16.3: ASAM will identify members who are willing to serve as liaisons to national and state medical associations and specialty societies.

Strategy 16.4: ASAM and its chapters will identify members who are willing to develop CME programs on addictive disorders and related topics for the scientific meetings of the state and national medical associations and specialty societies in which they are active.

OBJECTIVE 17 (Implementation). ASAM continuously updates its policies to address emerging issues in addiction prevention, intervention, treatment, and research.

Lloyd J. Gordon III, M.D., FASAM, Chair of the Strategic Plan Implementation Commitee

Strategy 17.1: ASAM will monitor legislative initiatives and policies developed by other medical organizations, as well as the needs of its Chapters and members, to identify areas in need of new or revised ASAM policy statements.

OBJECTIVE 18 (Implementation): ASAM has a comprehensive communication strategy for the effective dissemination of information about developments in Addiction Medicine to physicians, health insurers, health care organizations, and policymakers.

Strategy 18.1: ASAM will recruit members to serve as liaisons with specific local, state, and national organizations.

Strategy 18.2: ASAM will encourage its members to: (1) promote awareness of addictive disorders and ASAM in their presentations to professional groups; (2) collaborate with state medical associations, specialty societies, and other medical groups to obtain training, mentoring, and technical assistance for ASAM members who are involved in legislative advocacy and governmental activities; and (3) serve as spokespersons for ASAM to the media or in legislative testimony on specific clinical and policy issues.

Strategy 18.3: ASAM will collaborate with organizations that represent the addiction and recovery constituencies to mobilize their efforts in support of common goals, such as reduction of stigma, basic knowledge of addiction science, and the need for parity in health insurance coverage.

OBJECTIVE 19 (Implementation). ASAM members promote the adoption of sound policies related to addictive disorders and their treatment.

Strategy 19.1: ASAM will obtain grant support to fund an annual ASAM Public Policy Fellowship.

Strategy 19.2: ASAM will increase its members' awareness and knowledge of policy issues related to Addiction Medicine.

Strategy 19.3: ASAM will increase its members' awareness of the interrelatedness of Addiction Medicine, public policy, and public health.

Strategy 19.4: ASAM's Chapters will identify members who are willing to serve as liaisons with state and federal agencies.

Strategy 19.5: ASAM will offer a forum on policy issues in Addiction Medicine for members and the media at its annual Medical-Scientific Conference.

Strategy 19.6: ASAM will design and execute a comprehensive strategy for legislative advocacy. The strategy will include developing a key contact list for every member of the U.S. Congress, hosting legislative receptions during selected ASAM conferences, inviting key legislative staff to attend ASAM conferences, and sponsoring an Addiction Medicine Day on Capitol Hill.

Goal V

Membership Development, Involvement, and Recognition: To build a strong, unified Society, and to mobilize ASAM members in the pursuit of the Society's Mission and Goals.

This section of ASAM's Strategic Plan addresses the following:

- ASAM provides value to its members (Objective 20).
- Engaging members in ASAM's activities (Objective 21).
- Recruiting and retaining members (Objective 22).
- Welcoming and mentoring new members (Objective 23).
- Recognizing members' achievements (Objective 24).

OBJECTIVE 20 (Infrastructure). ASAM provides value to its members.

Strategy 20.1: ASAM will continuously collect and analyze data on member needs and wants, including CME evaluations and satisfaction ratings for current or envisioned member services.

Strategy 20.2: ASAM will provide training in skill areas that increase members' "marketability" (for example, in areas such as pain management, MRO practice, hepatitis management, office-based opioid therapy, and the like).

OBJECTIVE 21 (Infrastructure). ASAM's members are fully engaged in formulating and executing the Society's policies and programs through service in elective office, in Chapters, on Committees, and in other ways.

Strategy 21.1: ASAM will encourage networking among Chapter Presidents and Committee Chairs.

Strategy 21.2: ASAM will encourage residents to participate in ASAM Committees.

OBJECTIVE 22 (Infrastructure). ASAM employs innovative and effective programs to retain existing members and to recruit new members.

Strategy 22.1: ASAM will refine and implement member satisfaction measurements (such as focus groups and surveys) to determine members' wants and needs and what members, non-members, and former members desire from ASAM.

Strategy 22.2: ASAM will design and execute targeted pilot projects on recruitment

and retention of members. The success (in terms of costs and results) of such campaigns will be measured, with the results used to refine subsequent projects and strategies.

Strategy 22.3: ASAM will develop innovative methods for membership application and renewal, such as web-based application forms and mechanisms for automatic renewal of membership.

Strategy 22.4: ASAM will target recruitment efforts so that ASAM membership more closely reflects the diversity of medicine (as in age, gender, and race/ethnicity).

Strategy 22.5: ASAM will give special attention to recruiting medical students, residents, and fellows.

Strategy 22.6: ASAM will amend its bylaws to make the Chair of the Physicians-in-Training Committee an *ex officio* (non-voting) member of the Board.

OBJECTIVE 23 (Infrastructure): ASAM welcomes and mentors new members.

Strategy 23.1: ASAM will encourage newer and younger members to become active in its Committees and to become involved in their state Chapters.

Strategy 23.2: ASAM's experienced members will mentor new members to help them engage in the policy and program activities of the Society.

OBJECTIVE 24 (Infrastructure): ASAM recognizes its members' achievements.

Strategy 24.1: ASAM will present awards to deserving members at its Annual Awards Dinner, plaques to Chairs of ASAM-sponsored conferences, and certificates to conference attendees and physicians who have achieved ASAM Certification.

Strategy 24.2: ASAM will promote its Fellows program and will note in its Directory the names of those members who are Certified by the Society and those who are Fellows of the Society.

Strategy 24.3: ASAM will regularly note its members' achievements in its newsletter, web site, and other appropriate venues.

Strategy 24.4: ASAM will provide recognition as well as financial incentives to those members who demonstrate success in recruiting new members.

Goal VI

Management and Finance: To maintain a strong governance and management capability for the Society.

This section of ASAM's Strategic Plan addresses the following:

- ASAM's governance (Objective 25).
- ASAM's Chapter structure (Objective 26).
- ASAM's membership (Objective 27).
- ASAM's management structure and practices (Objective 28).
- ASAM's future, including finances, strategic planning, and ongoing monitoring of implementation of the Strategic Plan (Objective 29).

OBJECTIVE 25 (Infrastructure). ASAM's Board and organization structure are dedicated to attaining the Society's Mission.

Strategy 25.1: ASAM's Board will engage in developing and implementing a clear, attainable Strategic Plan to achieve the Society's Mission and will authorize its periodic review and revision, as needed.

Strategy 25.2: ASAM's committee structure will be modified to promote attainment of the Society's Mission, as described in the Strategic Plan.

OBJECTIVE 26 (Infrastructure): ASAM's Chapters are dedicated to attaining the Society's Mission, employing strategies described in the Strategic Plan.

Strategy 26.1: ASAM's Regional Directors will work with the Chapter Presidents to foster activities that are strategically aligned with the Society's Mission.

Strategy 26.2: ASAM will encourage its Chapters to adopt a committee structure that supports ASAM's Mission, Goals and Strategic Plan.

OBJECTIVE 27 (Infrastructure). ASAM's members are engaged in activities that support the Society's Mission.

Strategy 27.1: ASAM's Board will appoint members to a Strategic Plan Implementation Committee, which is charged with providing leadership in implementing the Plan.

Strategy 27.2: All ASAM Committee members and leaders will be enlisted in implementing relevant portions of the Plan.

OBJECTIVE 28 (Infrastructure). ASAM's management structure and practices are focused on activities designed to facilitate achievement of the Society's Mission, as described in the Goals, Objectives and Strategies outlined in the Strategic Plan.

Strategy 28.1: ASAM's Executive Vice President/Chief Executive Officer will be responsible for overseeing the development, implementation and evaluation of the Strategic Plan, in accordance with an implementation plan developed by the Board (or by a Committee appointed by the Board), and for reporting on its progress to the Board and the membership.

Strategy 28.2: ASAM's staff will be engaged in the development and implementation of the Strategic Plan, both directly and through support of the Committees and Programs designated by the Board to carry out the Plan.

Mark L. Kraus, M.D., FASAM,
Chair of the Strategic Plan Development Committee

Strategy 28.3: ASAM will maintain a sufficient number of competent and well-trained staff.

Strategy 28.4: ASAM's staff compensation, benefits, and total rewards will be competitive with other national medical specialty societies of comparable size.

Strategy 28.5: ASAM will increase staff development efforts to improve staff performance and maximize staff retention.

Strategy 28.6: ASAM's headquarters will have space, equipment, and other facilities sufficient to support implementation of the Plan.

OBJECTIVE 29 (Infrastructure). ASAM's financial resources and operating budget are appropriate to the Society's Mission and programmatic Goals.

Strategy 29.1: ASAM will have a stable fiscal planning process and a positive financial balance sheet every year.

Strategy 29.2: The allocation of ASAM's income and expenses will reflect the priorities laid out in the Strategic Plan.

Strategy 29.3: ASAM's Finance Committee will closely monitor the performance of the Society's investments and report results to the Board.

Strategy 29.4: ASAM will broaden the base of its funding beyond dues revenues (as by increasing revenues from conferences, publications, and grants).

Strategy 29.5: ASAM will establish an e-commerce system for online sales of its publications, conference registrations, subscriptions, and other products and services.

Ruth Fox Memorial Endowment Fund

Dear Colleague:

During ASAM's recent Medical-Scientific Conference in Atlanta, we were pleased to welcome the first seven recipients of scholarship awards funded through the interest income from the Ruth Fox Memorial Endowment Fund. With the aid of the scholarships, these physicians-in-training were able to participate in all aspects of the conference. We were pleased to have them join us at the Ruth Fox Donor Reception. They are James M. Adams, M.D. (California), Janice E. Bach, M.D. (New York), Dean Michael DeCrisce, M.D. (California), Keith Heinzerling, M.D. (New Jersey), Kevin P. Hill, M.D. (Massachusetts), Christine O'Brien, M.D. (Pennsylvania), and Nancy Wu, M.D. (California). With your continued generous support, we look forward to offering more scholarships to physicians-in-training to attend ASAM's 34th Medical-Scientific Conference in Toronto.

The Donor Reception was, as always, a lovely evening, with a bountiful table, beautiful flowers and exquisite music. Once again, the reception was underwritten by a generous gift of Dr. and Mrs. Joseph E. Dorsey. The Dorseys are good friends of the Ruth Fox Fund and of ASAM, and we salute them.

Dr. Ruth Fox

ASAM Past President G. Douglas Talbott, M.D., FASAM (left), greets fund benefactors Joseph E. Dorsey, M.D., FASAM, and Mrs. Dorsey at the Ruth Fox Donor Reception.

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

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The Kellys Are Partners in Life and in Medicine

Jeanne Erdmann

A few years ago, Timothy Kelly, M.D., FASAM, and his wife Rebecca Kelly, M.D., FASAM, were returning to Indiana after receiving acupuncture training. He wanted to head from the airport straight to the hospital so that they could use their newly acquired skills with a patient who was threatening to leave treatment against medical advice. She argued for a more gradual approach. Here's how the conversation went:

She said: "I don't know if we can do that until we have all the policies and procedures written."

He said: "Come on, this guy is going to leave if we don't help out."

Dr. Tim Kelly prevailed, and they literally did drive from the airport to Fairbanks Hospital, an addiction treatment program in Indianapolis. Fairbanks became the only program in Indiana to offer acupuncture as a therapy for addictive disorders, and it became an overnight success.

She says: "We used the group room for the first treatment. The next morning, when we got to group, 26 people were lined up waiting for acupuncture. It's been like that ever since."

He says: "It's a nice thing to offer people. It's not dangerous, it's inexpensive, and it has an extremely low rate of side effects or complications—really, almost zero. Most patients try it at least once." The Kellys don't charge for acupuncture; they offer the treatment as a gift to their patients.

For 22 of the 23 years they have been married, the Kellys have practiced addiction and internal medicine at Fairbanks, a freestanding, not-for-profit hospital that was founded in the late 1940s. Named after Charles Fairbanks, a Hoosier who served as Vice President under Franklin Roosevelt, the hospital is the oldest treatment center in the state, and provides what Dr. Tim Kelly calls "the old standard of care". Services offered include inpatient detoxification, rehabilitation, intensive outpatient treatment, and supportive living services, including transitional living for those patients who need a safe environment, or who are at high risk of relapse. Program staff take a personal approach to their patients, encouraging responsibility without being punitive. Since most patients already have experienced significant trauma and seek treatment in the acute stages of their illness, they appreciate a compassionate approach, says Dr. Becky Kelly.

The Kellys met while attending the Indiana University School of Medicine. They married in 1978. Today, although their medical offices sit across the hall from one another, they rarely see each other during their busy, often chaotic, work days. The best time to reach them is after 9:00 in the evening—although you might pull Dr. Tim away from watching basketball. When he's in town, he works every day, holidays included.

In fact, Dr. Tim Kelly holds several jobs. He is President and Medical Director at Fairbanks and continues to provide direct patient care. He also sees private internal medicine patients at nearby General Hospital and is an Associate Professor at Indiana University Medical School, where he lectures on the neurobiology of addiction and conducts research.

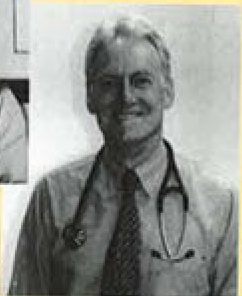
Dr. Becky Kelly chose what today is called the "mommy track," but what the 1970s generation of young mothers called "we can have it all". That meant working part-time so that she could be at home when the Kellys' children—Megan, Erin, and Patrick—were young. Here is what she crams into her 32-hour "part-time" workweek: she is an attending physician at Fairbanks for the Women's Program, the Partial Program, the Adolescent Program, and the Intensive Outpatient Program. She also is working with colleagues to plan a high school for adolescents in recovery.

Her comment: "You know what they say about a part-time job? It's a full-time job with no benefits. Tim can't be here for a lot of the daily chores and I felt somebody had to be available when the kids got home from school, so I chose myself."

Patients are referred to the Kellys and to Fairbanks by other physicians, but also by "word of mouth" from alumni and their families. Because the hospital has a reputation for targeted care, and also has a Research and Training Institute and an Employee Assistance Program, many referrals come from businesses in the surrounding communities.

She says: "The thing Tim won't say is that he's really well known in Indiana, he has a really good reputation, and so I'm bragging about him."

Rebecca Kelly, M.D., FASAM


Timothy Kelly, M.D., FASAM

He says: "We're the only ones who want to do this."

Tim's life mission has been caring for addicted people, says Becky. Both have experienced alcoholism in their families. Tim's father has been sober for 23 years. His dad's AA sponsor, who recently died, had been sober for 50 years. "Tim grew up around people who were successful in recovery. It is positive and encouraging to see people do well," says Becky.

That healing philosophy carries over to the volunteer program at Fairbanks. Recovering patients are encouraged to return as volunteers. The program is so large that the volunteers can choose from among 15 jobs, such as driving patients to AA meetings or working in the gift shop. Volunteers serve as role models, and often as sponsors, for patients. Dr. Tim Kelly recalls a Fairbanks volunteer-of-the year who logged more than 600 hours in the gift shop and worked with new patients, all while struggling with organ failure. Dr. Becky Kelly mentions a volunteer with a serious neurological condition who was homeless when he came to Fairbanks and who has been in recovery for three years. When the hospital was seeking donations for the first AA group in western Kenya, that volunteer collected 30 books on AA, mostly from homeless people. A person who owned little thus found a way to help others.

He says: "We want to have people envision themselves as volunteers right from the beginning, so they have something to shoot for. They respond to that amazingly well. They feel like they are helping people, so that gives them a big boost."

She says: "I do think these stories of courage are heartening for health care professionals as much as they are for everyone else. It gets discouraging if you never get to see people do well after treatment."

She adds: "I guess you can tell: these people are my heroes."

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

ASAM Conference Calendar

ASAM

July 18, 2002
Forensic Issues in Addiction Medicine
Washington, DC
8 Category 1 CME credits

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

October 24-26, 2002
Review Course in Addiction Medicine
Chicago, IL
21 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

Other Events of Note

June 27-30, 2002
Talbott Recovery Campus
26th Annual Education Retreat
[For information, phone 1-800/445-4232]

July 3-6, 2002
National Association of Alcoholism and Drug Abuse Counselors
26th Annual Conference on Addiction Treatment
Boston, MA
[For information, visit www.naadac.org]

August 7-11, 2002
International Doctors in Alcoholics Anonymous (IDAA) Conference
Palm Desert, CA
[For information, visit www.IDAA2002.com]

September 15-17, 2002
Addictions 2002: Integrating Substance Abuse Treatment & Prevention in the Community
Eindhoven, The Netherlands
[For information, visit www.addictions2002.com]

September 19-22, 2002
15th Cape Cod Symposium on Addictive Disorders: Addiction as a Brain Disorder: Prevention, Treatment and Healing
Hyannis, Cape Cod, MA
[For information, phone 1-800/767-9061 or e-mail nriverfound@earthlink.net]

October 2-5, 2002
4th Annual Conference of the International Society of Addiction Medicine & SAA 25th Annual Conference
(ASAM is a supporting organization)
Reykjavik, Iceland
[For information, visit www.saa.is or e-mail conference@saa.is]

October 16-19, 2002
International Conference on Physician Health: "Physician Health: Self, Service, Leadership"
Co-sponsored by the American Medical Association and the Canadian Medical Association
Vancouver, British Columbia
[For information, e-mail Roger_Brown@ama-assn.org]

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

November 13-15, 2002
7th Stapleford International Conference on Addiction—From Addiction to Abstinence: New Pharmacological Techniques for Making and Maintaining Change
Nijmegen, Holland
[For information, visit www.staplefordcentre.co.uk/ConferenceNov 2002.htm]

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 BBoeg@asam.org.

Northern California

WANTED:

Physician to work addiction clinics in two Northern California cities: Modesto and Merced.
Approximately 36 hours a week.

Aegis offers competitive compensation and benefits.

Contact Suzie Hernandez,
Director of Clinical Services, at
(818) 398-8539 or (661) 631-084

Review and Update on Addiction Medicine!

October 24-26, 2002
Westin O'Hare Hotel, Chicago

Join a panel of experts in discussing the most important topics in Addiction Medicine today! Attend the ASAM Review Course in Addiction Medicine for a timely review and update of the core content of Addiction Medicine. This course is designed for:

- Physicians who are planning to sit for the ASAM Certification/ Recertification Examination in Addiction Medicine.
- Addiction specialists who seek a timely "refresher" on recent developments in addiction science and practice.

Participants will receive a Study Guide and CD-Rom containing outlines of the speakers' talks, copies of their slides, and key readings. To maximize study time for registrants who are preparing for the Certification/ Recertification Examination in Addiction Medicine, the Study Guide and CD-Rom will be mailed September 1, 2002, to all who have registered for the Review Course by that date. The course is approved for up to **21 credit hours** in Category 1 CME Credits.

REGISTER TODAY! Phone ASAM's Department of Conferences and Meetings at 301/656-3920, or fax ASAM at 301/656-3815.