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ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

See the accompanying status report on Buprenorphine.

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Alcohol, Drug Problems Persist in Wake of Sept. 11

Research is confirming anecdotal reports of increased alcohol and drug use in the aftermath of the September 11 terrorist attacks. For example, a group of researchers led by Drs. David Vlahov and Sandro Galea of the New York Academy of Medicine found that use of alcohol, marijuana and cigarettes increased among residents of Manhattan in the eight weeks following the attack on the World Trade Center. About 25% of 1,000 survey respondents reported drinking more alcohol, while 10% reported an increase in smoking, and 3.2% reported an increase in marijuana use in the months after the attack.

The researchers found that persons who reported an increase in cigarette or marijuana use were more likely to suffer from both posttraumatic stress disorder (PTSD) and depression, while those who reported increased use of alcohol were more likely to have depression only. *(For more on this subject, see pages 5 and 8)*

ASAM to Designate New Fellows

The prestigious designation as a Fellow of the American Society of Addiction Medicine is granted every second year to selected ASAM members in recognition of their significant contributions to the Society and to the field of addiction medicine. The opportunity is open this year for eligible members to join the distinguished ranks of those who have earned the FASAM designation, by applying to become a Fellow.

Fellowship in ASAM requires that applicants meet specific requirements, which include five years' membership in ASAM, certification by ASAM in addiction medicine, a record of significant service to the Society, and documented contributions to the field of addiction medicine. Fellow applications and policies were mailed earlier this summer to all eligible members. The application and relevant policies also are available on ASAM's web site at HTTP://WWW.ASAM.ORG/FELL/FELLOW.HTM. Candidates are urged to carefully review the requirements and to follow the policies and procedures in completing the application.

The deadline for applications is October 31, 2002. Donald Kurth, M.D., FASAM, Chair of ASAM's Membership Committee, has said that the Fellows Subcommittee will carefully review all submissions during November and December 2002. Applicants will be notified of the subcommittee's decision in January 2003. New Fellows will be recognized at ASAM's annual Medical-Scientific Conference in May 2003 in Toronto, Ontario, Canada.

Questions about the application and selection processes should be directed to Celso Puente, ASAM Membership and Chapter Development Manager, who can be reached by phone at 301/656-3920, ext. 117, or by e-mail at CPUEN@ASAM.ORG.

Defining a Vision for ASAM

Eileen McGrath, J.D.

Eileen McGrath, J.D.

What role should ASAM occupy in addiction medicine today, 5 years from now, or 10 years from now?

Those of you who are veteran members of ASAM may remember why you originally joined the Society, how you expected to benefit from membership, how you expected ASAM to influence addiction medicine. No doubt some of your expectations have been realized and some have not.

I recently asked a number of ASAM leaders what their "vision" is for ASAM's future. Their responses are provocative.

I recently asked a number of ASAM leaders what their "vision" is for ASAM's future. Their responses are provocative.

One leader shared his view that ASAM should be a "big tent," eschewing policy orthodoxy, and instead providing an open forum for scientific debate. The same leader described ASAM as an organization with a deep connection to Twelve Step program philosophy, as distinguished from a psychiatric or psychodynamic approach to addiction. Several leaders described ASAM's challenge as engaging primary care medicine in addiction and encouraging physicians to deal with addiction in their practices. They view ASAM's role as reaching out to physicians in primary care and in other specialties to educate them about all aspects of addiction relevant to their practices. In this view, ASAM should be a resource on the medical issues related to addiction as well as the biopsychosocial issues involved in treatment and recovery.

ASAM's role in advocacy is a central part of the vision of some ASAM members I spoke with, who see ASAM as the leader of an advocacy effort to achieve parity and reduce stigma. They would like to see ASAM "at the table" not only on "pocketbook" issues, which sometimes promote a self-serving appearance, but also on issues related to patients' unmet needs. They point out that achieving parity will be the result of an untiring commitment to building bipartisan support at both the federal and state levels.

I also spoke with ASAM leaders who enthusiastically proposed expanding ASAM's membership to include allied health professionals so as to build unity in the field. Others were equally adamant that in order for addiction medicine to achieve ABMS recognition as a medical specialty, ASAM must remain focused on the needs of physicians in addiction medicine.

I consider listening to members' views and opinions a vital part of my role at ASAM.

My vision for ASAM's future is that ASAM will succeed in advancing addiction medicine only through meeting the needs of its members. We must always begin by asking members about their needs.

ASAM will be contacting each member on a regular basis to provide the Society's leadership with the grassroots input they need to lead responsively. I invite you to contact me directly (by e-mail at EMCGRATH@ASAM.ORG or by mail or phone at the address on the **ASAM News** masthead). You have my commitment, as well as that of the entire ASAM leadership and staff, to attend to your comments and suggestions. What is your vision for ASAM's future? How can ASAM best meet your needs?

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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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For members visiting ASAM's web site (WWW.ASAM.ORG), entrance to the on-line Membership Directory requires the Username "asam" and the password "asam" (in lower case letters).

Pennsylvania Insurers Deny Addiction Coverage

Health insurance plans throughout the state of Pennsylvania are denying coverage for residential treatment of alcohol or other drug problems, according to state officials and treatment providers, who maintain that the practice of refusing coverage is widespread even though it violates state law. Under Pennsylvania statutes, insurers must provide 30 days of inpatient rehabilitation treatment per year, with a cap of 90 days per lifetime.

"That law is pretty much ignored in Pennsylvania," said Ken Ramsey of the Gateway Rehabilitation Institute, who added that even when insurers agree to pay for residential treatment, it's only for six days. "We have to have enough time to make recovery work—to make a dent in the lives of folks who are addicted to heroin, alcohol or whatever. We just aren't given enough time."

Earlier this year, Magellan Health Services, Inc., which manages benefits for 70 million consumers in the state, canceled its contract with the Caron Foundation. Although a Magellan spokesperson said the cancellation was because few patients went to the treatment center, officials at Caron said the real reason is their numerous arguments with Magellan over the insurer's refusal to pay for needed care.

Magellan and other insurers contend that the 30 days of inpatient treatment required under Pennsylvania law is not always necessary. "Current medical research supports the idea that effective [addiction] treatment can be provided by a wide variety of settings, including outpatient, partial hospitalization, and inpatient programs," said a joint statement from Magellan and Highmark, a primary insurer.

The debate raises the question: Who should decide the type and amount of treatment a patient receives, a physician or a health plan? Under Pennsylvania Act 106, a physician is to determine whether care is necessary; however, Magellan maintains that its physicians, not the patient's or the treatment program's, are entitled to make the determination. According to Pennsylvania Deputy Attorney General Larry Otter, however, the law is clear: "The person who makes that evaluation is the treating physician or psychologist."

State Attorney General Mike Fisher is said to be weighing punitive action against the insurance companies. *Source: KDKA-TV, June 10, 2002; Philadelphia Inquirer, June 16, 2002.*

Alcohol Industry Wants Excise Tax Reduced

The alcoholic beverage industry is urging Congress to lower the federal excise taxes on distilled spirits and beer. The proposal comes at a time when many U.S. states are raising their excise taxes on alcoholic beverages to address budget deficits.

The proposal to reduce the tax on distilled spirits is being sponsored by Rep. Ron Lewis (R-KY), while the beer tax measure is being proposed by Rep. Phil English (R-PA). The legislation would reduce the current beer tax from $18 to $9 per barrel. More than 200 U.S. lawmakers, many of whom receive political contributions from the alcoholic beverage industry, have indicated their support for the tax cut proposals. Alcohol industry lobbyists are pushing to have the bill (HR 1305) tacked on to other tax policy legislation that may have a chance of moving to the House floor.

Lobbyists for the beer industry argue that the federal tax is unfair to working-class Americans. "Beer is one of the simple pleasures of this group, a pleasure that most often is enjoyed—responsibly—at night, in the home. Lowering the beer tax means more money in the pockets of these young, hard-working men and women," says a message on an Anheuser-Busch web site.

The measure is opposed by Mothers Against Drunk Driving (MADD), the Center for Science in the Public Interest, and other health care and health policy groups, which point out that it would roll back taxes to pre-1951 levels. Federal excise taxes on beer were raised in 1991 for the first time in 40 years, when the $9 per barrel tax was raised to $18 per barrel (or 32 cents per six-pack.

Opponents predict that lowering the beer tax will have a particularly negative effect on younger drinkers, who are especially price-sensitive. They point to studies funded by the National Institute on Alcohol Abuse and Alcoholism, showing that lower taxes and prices of beer lead to higher levels of consumption by youth and increased traffic fatalities. *Sources: Associated Press, August 26, 2002; Center for Science in the Public Interest, June 10, 2002.*

Methamphetamine Targeted in Senate Bill

A $125 million bill to fund measures limiting the manufacture and sale of methamphetamine has been introduced by Senators Diane Feinstein (D-CA), Tim Hutchinson (R-AR), and Herb Kohl (D-WI). Funds provided under the bill would support police training on how to perform proper meth lab clean-ups, fund the clean-ups themselves, deliver school anti-methamphetamine programs, support research into the effects of methamphetamine, train prosecutors, and treat users.

Language in the bill also would limit bulk purchases of pseudoephedrine, an ingredient in over-the-counter cough and cold preparations that is essential to the manufacture of methamphetamine. Blister packs of pseudoephedrine, which currently can be purchased in unlimited quantities, would be limited to 9 grams, making it much more difficult to process the drug in large-scale manufacturing operations. *Source: Congressional Digest, August 12, 2002.*

HHS Announces Final HIPAA Privacy Rule

The Department of Health and Human Services has released the final rules governing the privacy of medical records, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Addiction treatment providers will have to adjust their practices regarding medical records so as to reconcile the differences between the HIPAA regulations and existing federal confidentiality regulations that apply to addiction treatment. While the HIPAA regulations will not require a complete overhaul of procedures for most treatment providers, experts say they will force significant changes in some areas.

In fact, addiction treatment providers will be affected less by HIPAA than other health care providers, because addiction treatment already is governed by federal confidentiality regulations (41 CFR Part 2). "Substance abuse treatment providers are in a better position than most other providers because they are accustomed to protecting patient information, but there will still have to be some changes," Renee Popovits, an attorney with the Chicago-based law firm Popovits & Robinson and a board member of the National Association of Addiction Treatment Providers, told *Alcoholism & Drug Abuse Weekly.*

Finding Our Voice Through ASAM

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

I want to to report to you the results of a court case in which ASAM filed an *amicus* brief, both because the case itself is important, and because it is an example of how, through our Society, each of us can have a voice in large policy issues.

The case involved Sharon Moss, 23, of Franklin County, Georgia, who was charged with felony murder when her infant daughter died at birth. The State of Georgia alleged that the child's death was the result of Ms. Moss' drug use during her pregnancy.

ASAM joined more than 30 national organizations, including the American Public Health Association and the American Nurses Association, in filing a friend-of-the-court brief in the case. We argued that prosecuting Ms. Moss for exhibiting behavior characteristic of the medical disorder of addiction would discourage other women from seeking prenatal care or help for their alcohol or drug problems.

Ms. Moss, who told the court she is a "lifelong drug addict," has pleaded guilty to possession of cocaine and methamphetamine and has been sentenced to five years' probation. Her attorney reports that she has been in treatment and has been clean and sober for three years.

Of course, this victory does not solve the problem of alcohol and drug use by pregnant women, nor will it end inappropriate prosecutions of persons with addictive disorders. But it is a victory nevertheless for one addicted person, in one state, and it was made possible in no small part by the actions of your Society and other medical groups, speaking on behalf of their members and the patients we serve.

Other evidence of ASAM's increasing voice in public affairs abounds. Recently Dr. Trusandra Taylor, one of ASAM's newly elected and hardworking members of the Board of Directors, and I joined a team of experts asked by the White House Office of National Drug Control Policy to visit Thailand to share information about the scientific basis of drug addiction, its prevention and treatment. Representatives from India, Pakistan, Laos, and Afghanistan also attended the two-day meeting. Obviously, no discussion of this type would be complete if it did not include information about our Society. Members of the audience (including a few physicians) welcomed the ASAM materials we shared with them.

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

ASAM also is one of the medical societies and professional organizations to sign on to a White House campaign to bring to public attention the harm caused by marijuana use, especially to children and adolescents. ASAM was present and recognized in the press conference and in the open letter to parents that appeared in more than 290 newspapers nationwide on September 18. ASAM's participation is another manifestation of our Society's efforts to educate the public about use of substances that can lead to dependence and addiction.

On another front, Eileen McGrath and I represented ASAM at the unveiling by the Association for Medical Education and Research in Substance Abuse (AMERSA) of a strategy to encourage faculty development at medical and other health professions training facilities. The goal of the initiative is to improve the ability of generalists to identify, screen, and appropriately refer patients with substance use disorders. We were pleased to see a number of ASAM members at the meeting and noted that they were instrumental in developing the strategy.

None of these accomplishments would have been possible without your continuing support. Increasing the recognition of ASAM adds tremendous value to you as a practitioner of addiction medicine, to your patients as the recipients of your skills, and to the public, who look to us for leadership. Admittedly, there is much more to do. And here is where you can make additional contributions. Please drop me a line (at LBROWN@ARTCNY.ORG) with your ideas and suggestions. Together, we can have an important voice.

Impact of 911 on Drug Use Assessed

The September 11 terrorist attacks and responses to them had both short- and long-term effects on illegal drug availability, trafficking routes and methods, local marketing strategies and use patterns, according to the latest *Pulse Check* report from the White House Office of National Drug Control Policy. For the report, 75 epidemiologists, ethnographers, law enforcement officials, and treatment providers from 20 cities across the U.S. were interviewed. They reported:

- **A decline in availability:** In 12 of 20 reporting cities, availability of illegal drugs—particularly heroin—declined, possibly due to heightened security at U.S. airports, borders, and other points of entry.
- **Changes in trafficking methods:** In several cities, officials reported that "law enforcement efforts are beginning to focus more on mail and marine smuggling because fewer people are smuggling heroin and cocaine via the airport."
- **Local market changes:** Temporary decreases in purity levels and price gouging were reported in several cities. In New York City, street researchers reported that drug dealers (especially heroin dealers) took advantage of the reassignment of police to other duties and operated openly in the streets.
- **Increase in prescription drug use:** Reductions in heroin availability appear to have led some users to substitute prescription drugs. For example, emergency workers in Baltimore reported increased overdoses from drugs other than heroin, particularly OxyContin® and other prescription opiates. Miami officials reported that both legitimate and illegal use of prescription drugs had increased since September 11, most of it involving persons seeking sedatives and hypnotics in an attempt to self-medicate for sleep problems and added stress. *Source: Office of National Drug Control Policy, August 2002.*

Abuse of Fentanyl by Health Care Workers Reported

Abuse of fentanyl, the analgesic found in the Duragesic® patch, is growing nationwide and especially among health care workers. According to the Substance Abuse and Mental Health Services Administration, 576 persons were treated for fentanyl abuse in emergency rooms nationwide in 2001, up sharply from 337 ER visits recorded in 1999. At least 512 persons were treated for fentanyl abuse in ERs in the first six months of 2002. Agents of the federal Drug Enforcement Administration report that addicts generally extract fentanyl from the patch and then inject or inhale it.

"For many years, fentanyl was actually the drug of choice of the addicted anesthesiologist," said Dr. Joel Nathan of the Addiction Recovery Institute in New York City. "Outside of that, we are probably talking mostly about low-paid people in the nursing industry, like nursing aides and other uncertified health care workers." *Source: Join Together Online (www.jointogether.org).*

Methadone Treatment Practices Improving

The practices of methadone treatment programs are slowly improving, but a sizeable percentage still do not conform to established standards of care. So says a longitudinal study reported in the August 21 *Journal of the American Medical Association*. Investigators Thomas D'Aunno, Ph.D., and Harold A. Pollack, Ph.D., argue that effective treatment of heroin users is more critical than ever and that studies consistently show that addicts who receive inadequate doses of methadone are more likely to continue their opiate use or to have other unfavorable treatment outcomes.

Over a 12-year period, Drs. D'Aunno and Pollack examined the extent to which U.S. methadone treatment programs had made changes to conform to established standards of practice for methadone doses and outcomes assessment. The benchmark most often cited by best-practices panels, which is embodied in National Institutes of Health Consensus Statement 108, calls for dispensing at least 60 mg per day of methadone to a stabilized patient.

For the study, which was funded by the National Institute on Drug Abuse, Drs. D'Aunno and Pollack surveyed a national sample of methadone maintenance programs in 1988 (172 programs), 1990 (140 programs), 1995 (116 programs), and 2000 (150 programs). Programs were selected from the U.S. Food and Drug Administration's list of licensed methadone treatment programs, and were representative of various types of ownership (for-profit, public, or private not-for-profit) and setting (free-standing and hospital-based).

Results showed that the percentage of programs in which patients were given maintenance doses lower than the recommended 60 mg per day declined from 79.5% in 1988 to 35.5% in 2000. However, programs with a greater percentage of African-American patients were especially likely to dispense low doses. On the other hand, programs that had been accredited by the Joint Commission on Accreditation of Healthcare Organizations were more likely to provide adequate doses.

Other improvements noted include:

- Average time in treatment increased from 20 months in 1988 to 21 months in 1995.
- Average upper dose increased during that period from 79 to 93 mg per day.
- The percentage of patients receiving steady reductions in methadone dose declined from 34% to 22%.
- The number of programs that waited more than a year before encouraging patients to detoxify increased from 27% in 1990 to 55% in 1995.

Dr. D'Aunno, of the University of Chicago, and Dr. Pollack, of the University of Michigan School of Public Health, conclude that efforts to improve methadone treatment practices appear to be making progress, but that many patients still are receiving substandard care. *Source: Journal of the American Medical Association, August 21, 2002.*

Commentary:
Methadone Maintenance —The Medicine is Not the Problem

David Rosenbloom

David Rosenbloom, Director of the Join Together program at Boston University's School of Public Health, recently wrote to the Washington Post in response to news accounts of problems of an open-air drug market operating in the parking lot of a Washington, DC, methadone clinic. His letter is reprinted here with the permission of Join Together.

Methadone maintenance is the most effective known treatment for heroin addiction. The medicine is not the problem. Many heroin addicts have been able to return to fully productive lives on methadone and are invisibly among us in our workplaces and neighborhoods.

However, the regulatory framework and the way methadone is dispensed have prevented hundreds of thousands of heroin addicts from getting effective help. Methadone is one of the most tightly restricted drugs in the U.S. because the Drug Enforcement Administration is more worried about possible street diversion of the medicine than how to use it properly for individual patients. The result is continued addiction for many and ready markets for the illicit drugs DEA policy is supposed to stop.

Some clinics, like the ones mentioned in this story, are just dispensing mills that do not address the complex medical, psychiatric and social problems of their clients. They, not the parking lots next door, should be the first focus of reform. Repeated studies have shown that large methadone clinics often provide doses that are too small to be effective for the heroin addiction they are supposed to treat, and [provide] virtually no care for the medical, mental and social problems of their clients.

We can do better. Clinicians in office-based or small group practices should be allowed to provide methadone and a new drug [buprenorphine-naloxone] as part of their therapy, just as they do in Great Britain and other countries. Then there will be no concentrations of vulnerable people to provide a base for open-air drug markets. And, the individual clients can get the medical and other services they need to get and stay well.

2002 "Member Get A Member" Campaign Kicks Off

ASAM's Membership Department has announced that the 2002 "Member Get A Member" campaign kicks off this month. Members who recruit new members between now and December 31 are eligible for the following prizes:

First Place: A complimentary registration for ASAM's 2003 Medical-Scientific Conference in Toronto, plus up to three nights' hotel accommodations at the Sheraton Centre Toronto, May 1-4 (valued at up to $939).

Second Place: A complimentary registration to either of ASAM's two MRO courses in 2003 (scheduled for San Diego, CA, in March, and in Washington, DC, in December), plus a complimentary registration to ASAM's October 2003 course on the State of the Art in Addiction Medicine in Washington, DC (valued at up to $925).

Third Place: A one-year ASAM membership renewal (valued at $425).

You can download a membership application from ASAM's web site (WWW.ASAM.ORG). To receive credit for the membership, be sure your name is entered in the box that asks "How did you hear about ASAM?"

NIAAA: Dr. Li is New Director

Ting-Kai Li, M.D., a professor of medicine, biochemistry and molecular biology at Indiana University, has been named Director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Dr. Li, who also heads the Indiana Alcohol Research Center, succeeds Enoch Gordis, M.D., who retired at the end of 2001, and interim Director Raynard Kington, M.D., Ph.D. Dr. Li is expected to assume his new duties by the end of the year.

In announcing the appointment, National Institutes of Health Director Elias A. Zerhouni, M.D., hailed Dr. Li's "illustrious career" at the forefront of discovery in alcohol research, adding, "I am looking forward to working closely with him on the strategic issues facing this field."

Dr. Li's areas of research have included alcohol metabolism and animal models of alcoholism. He is a major participant in two NIAAA-funded research consortia: the Collaborative Study of the Genetics of Alcoholism (COGA) and the Integrative Neuroscience Initiative on Alcoholism (NIA). The author of more than 400 journal articles and book chapters, Dr. Li also is the editor of the journal *Alcoholism: Clinical & Experimental Research*.

Dr. Li received his medical degree from Harvard University in 1959 and joined the faculty at the Indiana University School of Medicine in 1971. He is the recipient of the Research Society on Alcoholism Award for Research Excellence and ASAM's R. Brinkley Smithers Distinguished Scientist Award.

DOT: New Role for SAPs

Changes in Department of Transportation (DOT) regulations have significantly expanded the role and responsibilities of Substance Abuse Professionals (SAPs), who evaluate employees under DOT drug-free workplace regulations and make recommendations for their education, treatment, follow-up testing and aftercare. The changes became effective in 2002.

Changes triggered by the revised regulations (49 CFR Part 40) include a refocusing of SAPs' primary responsibility away from care of individual employees and toward protecting the safety of the general public. Experts say that this redefinition will affect the way SAPs conduct assessments, prepare reports, determine compliance, and receive compensation for their services. The revised regulations also contain detailed specifications for training and require that SAPs pass an examination given by a recognized professional or training organization by December 31, 2003. SAPs also will be required to complete 12 hours of professional development training every three years from the date they pass the examination in order to maintain their certification to deliver services. *Source: Alcoholism & Drug Abuse Weekly, September 9, 2002.*

NIMH: Dr. Insel Named Director

Thomas R. Insel, M.D. a professor of psychiatry and Director of the Center for Behavioral Neuroscience at Emory University School of Medicine, has been appointed Director of the National Institute on Mental Health (NIMH).

Dr. Insel has worked at NIMH, where he investigated obsessive-compulsive disorders and the use of serotonin reuptake inhibitors to treat the condition.

In Atlanta, he directed the Yerkes Regional Primate Research Center, a research facility in the nation's AIDS vaccine program.

Dr. Insel will assume his new post at NIMH in November. He succeeds Dr. Steven E. Hyman, who left the agency in late 2001 to become provost of Harvard University.

CSAP: Dr. Sanchez-Way to Retire

Ruth Sanchez-Way, Ph.D., Director of the Center for Substance Abuse Prevention (CSAP), has announced her intention to retire effective January 3, 2003. In the interim, she has accepted an assignment with the HHS Center for Faith-Based and Community Initiatives (CFBCI). In announcing the change, Charles Curie, Director of the Substance Abuse and Mental Health Services Administration, said that Dr. Sanchez-Way was tapped for the new assignment because she is "a senior leader who can help this program build a solid foundation."

Elaine Parry has been named CSAP's Acting Director. *Source: Substance Abuse and Mental Health Services Administration.*

Study Documents Psychological Effects of September 11

A study published in the *Journal of the American Medical Association* documents symptoms of acute stress, posttraumatic stress, and global distress associated with the September 11 terrorist attacks.

For the study, Dr. Roxane Cohen Silver and colleagues at the University of California, Irvine, interviewed 2,729 persons at 9 to 23 days after the attacks. Subsets of the study population also completed surveys at 1 month and 6 months after the attacks. The survey showed that 17% of the U.S. population outside New York City reported symptoms of 911-related posttraumatic stress 2 months after the attacks and 5.8% did so at 6 months. High levels of posttraumatic stress symptoms were associated with female gender, marital separation, physician-diagnosed depression or anxiety disorder or physical illness, severity of exposure to the attacks, and early disengagement from coping efforts (e.g., giving up, denial, or distraction).

The researchers conclude that the psychological effects of a major national trauma are not limited to those who experience it directly, and that the degree of response is not predicted simply by objective measures of exposure to or loss from the trauma. *Source: Journal of the American Medical Association, September 11, 2002.*

Medical Textbooks Condone Alcohol Use in Pregnancy

The majority of 81 obstetrics textbooks reviewed in a recent study still condone alcohol use by pregnant women, even though most public health organizations have promoted abstinence during pregnancy for more than two decades. Multiple studies have demonstrated a link between alcohol consumption during pregnancy and physical and mental problems in the offspring.

Researchers at Virginia Commonwealth University found that only 14 of 81 textbooks contained consistent recommendations not to drink. Of 29 textbooks published since 1991, only 7 consistently recommended against alcohol use during pregnancy. "I didn't expect so many recent textbooks to actually condone drinking," said Dr. Mary Nettleman, professor of medicine at Virginia Commonwealth University and lead author of the study. "All the major organizations, such as the American College of Obstetricians and Gynecologists, [and] the American Academy of Pediatrics... advocate zero drinking during pregnancy." ASAM's policy is that pregnant women should avoid alcohol use.

Data from the federal Centers for Disease Control and Prevention show that the rate of binge and frequent drinking among pregnant women has not declined since 1995. As a result, the number of children born with FAS between 1995 and 1997 in the states sampled in the study (Alaska, Arizona, Colorado, and New York) ranged from 0.3 to 1.5 per 1,000 live births. The highest rates were found among African-Americans and American Indian/Alaska Natives. *Source: American Journal of Preventive Medicine, July 2002.*

Guidelines for Managing Hepatitis Released

Substantial advances in the treatment of chronic hepatitis C and a decline in the number of new infections were highlighted in the recent report of a panel convened by the National Institutes of Health (NIH). Experts predict a fourfold increase in the number of persons with chronic hepatitis C infection within the next decade, largely as a result of unsuspected infection from contaminated blood and blood products, occupational exposure, and injection drug use. "However, the good news is that new combination therapies are having a beneficial impact on this disease," said panel chair James Boyer, M.D., Ensign Professor of Medicine and Director of the Liver Center at Yale University School of Medicine.

More than four million Americans are infected with hepatitis C, which is the most common blood-borne infection; its transmission occurs primarily through injection drug use, high-risk sexual behaviors, occupational exposure through accidental needle sticks, and mother-to-infant transmission. The panel recommended expanding the scope of patients eligible for treatment to include those who use inject drugs, consume alcohol, suffer from comorbid conditions such as depression, or who are coinfected with HIV.

A summary of the evidence report prepared by the Johns Hopkins University School of Medicine for the panel is available at HTTP://WWW.AHRQ.GOV/CLINIC/EPCIX.HTM. Copies also are available from the AHRQ Publications Clearinghouse, by calling 1-800/358-9295. *Source: Agency for Healthcare Research & Quality.*

More Types of Cancer Linked to Smoking

Tobacco use is linked to even more types of cancer than originally believed, new research shows. A group of researchers from 12 countries was convened by the International Agency for Research on Cancer, a branch of the World Health Organization. By combining the results of more than 3,000 previous studies involving millions of persons, the researchers were able to show that cancers of the stomach, liver, cervix, uterus, kidney, nasal sinus, and myeloid leukemia all are linked to cigarette smoking. They also found that the risk of cancers previously linked to smoking is higher than previously thought. Dr. Paul Kleihues, director of the United Nations' cancer research agency, explained that, "for tumors of the bladder and the renal pelvis, previously we thought the elevated risk was maybe three to four times that of a nonsmoker. Today, it looks like the risk is elevated five to six times."

The new approach allows researchers to track more than one generation of smokers to form a more comprehensive picture of the dangers of tobacco. The research findings also have greater statistical power because of the size of the combined study sample. As a result, the study found that smoking was not related to cancer of the breast and endometrium, despite previous speculation that there was a link.

The researchers concluded that quitting smoking is the best way to prevent cancer deaths caused by tobacco. Currently, an estimated 1.2 billion persons worldwide smoke cigarettes or use other tobacco products. "Our group concluded that any possible public health gains from changes in cigarette characteristics or composition would be minimal by comparison. Changes in cigarettes are not the way to prevent cancer," Dr. Samet said.

A full report of the findings is to be published later this year. *Source: World Health Organization.*

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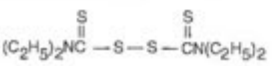

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Disulfiram occurs as a white to off-white, odorless, and almost tasteless powder, soluble in water to the extent of about 20 mg in 100 mL, and in alcohol to the extent of about 3.8 g in 100 mL.

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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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.

Olivier Ameisen, M.D., a pediatric cardiologist, is affiliated with the Weill Cornell University Medical College in Paris, France.

Morris E. Antebi, M.D., of Northfield, NJ, is a pain management specialist.

Ahmad Beheshti Ardekani, M.D., a psychiatrist, is President of the Ardekani Stress Clinic in Saint Louis, MO.

Gregory K. Baca is a student at the University of New Mexico School of Medicine in Albuquerque.

Janice E. Bach, M.D., of Fayetteville, NY, is a pediatrician.

John J. Baga, M.D., a specialist in internal medicine, practices at Lake Superior Treatment Center in Duluth, MN.

Victor Russell Barnes, M.D., is a staff psychiatrist with Carolina Psychological Health Services in Jacksonville, NC.

Dennis B. Barson, D.O., a specialist in internal medicine, serves at the Portsmouth Naval Medical Center in Virginia Beach, VA.

John Frank Bennetts, M.D., of Monterey, CA, is a family practitioner.

Donald Howard Berghman, M.D., is Chief of Child Psychiatry at the Dewitt Army Community Hospital in Fort Belvoir, VA.

Paulo Bettega, M.D., a psychiatrist, is affiliated with Psychiatric and Family Services of Houston, TX.

Susan P. Blank, M.D., a psychiatrist, is Medical Director of the Summit Ridge facility of the Gwinnett Hospital System, Lawrenceville, GA.

Joy Bluemenrich, M.D., a family practitioner, is affiliated with the University of Texas in Houston.

Vicky K. Borck, D.O., of Dallas, TX, is a psychiatrist.

Laura M. Bowen, of Augusta, GA, is a student at Dartmouth Medical School.

Laurie S. Bumgarner, M.D., of Huntersville, NC, specializes in family practice.

Ramona Nancy Cahiwat, M.D., a specialist in internal medicine, is a medical consultant to Catholic Community Services, East Orange, NJ.

Brazell H. Carter, M.D., lives in Oakland, CA.

Miguel A. Casillas, M.D., is Medical Director of the C.A.T.A.R. Clinic in San Diego, CA.

Lourdes C. Corman, M.D., who practices internal medicine, is with the University of Alabama Huntsville Campus.

Steven G. Crawford, M.D., a specialist in internal medicine, is Medical Director of the Discovery Institute of Addictive Disorders in Marlboro, NJ.

Dileck S. Delvers, M.D., of Milford, NJ, a family practitioner, is a staff physician with Stateline Medical Group.

Jerry L. Dennis, M.D., a psychiatrist, is Medical Director of Arizona State Hospital in Phoenix.

Kevin D. Dishman, M.D., practices internal medicine with Stormont Vall Healthcare in Topeka, KS.

Charl Els, M.B.Ch.B., F.C.Psych., a psychiatrist, is a Clinical Fellow with the Centre for Addiction and Mental Health in Toronto, Ontario, Canada.

Todd Estroff, M.D., a psychiatrist, practices in Atlanta, GA.

John Frounfelter, M.D., a specialist in internal medicine, practices at the Salvation Army Harbor Light Center in Detroit, MI.

Sally J. Garhart, M.D., a specialist in internal medicine, is Medical Director of Bedford Occupational Care in Bedford, NH.

Veeraindar Goli, M.D., a psychiatrist, is affiliated with the Duke University Medical Center in Durham, NC.

Luis Roberto Gonzalez, M.D., a psychiatrist, is Medical Director of Blue Hills Hospital in Hartford, CT.

Jody Griswold, D.O., a specialist in internal medicine, practices in San Benito, TX.

John David Hall, M.D., a psychiatrist, is affiliated with the University of Florida at Gainesville.

Keith Heinzerling, M.D., practices in Jersey City, NJ.

John Holtsclaw, M.D., a specialist in internal medicine, practices in Hagerstown, MD.

Scott Curtis Howell, D.O., M.P.H., a specialist in family practice, is Medical Director of the Broward Addiction Recovery Center in Coral Springs, FL.

Jerry Benson Hunt, M.D., a specialist in internal medicine, is Medical Director of Druid Heights Treatment and Counseling Center in Baltimore, MD.

Chiraq Jani, M.D., of Worcester, MA, is a specialist in otology and neurotology.

George Aloysious Johnson, M.D., of West Orange, NJ, is a urologist.

Michael E. Kelley, M.D., a psychiatrist, practices with Community Clinical Services in Lewiston, ME.

Leonard Krivitsky, M.D., a specialist in internal medicine, practices with North Philadelphia Health Systems, Philadelphia, PA.

Theodore B. Krouse, M.D., a specialist in anatomic pathology, practices with Parkside Recovery-Camden in Camden, NJ.

Robert Salvatore La Morgese, M.D., a specialist in internal medicine, is Medical Director of LEL Clinics, Inc., in Irvington, NJ.

Reid W. Lofgran, D.O., a specialist in family practice, is with the Smith Medical Group in Gooding, ID.

Sarah Maudlin, a medical student, lives in Springfield, IL.

Mike John McGrath, M.D., a psychiatrist, is Medical Director of the Kaloni Ola Beahvioral Health Unit in Kealakekua, HI.

Frank W. Morgan, M.D., a specialist in diagnostic radiology, is with Riverside MRI in Riverside, CA.

Christine O'Brian, M.D., practices in Lancaster, PA.

Thomas R. Ortiz, M.D., a specialist in family medicine, is Medical Director of Columbus Horizons in Newark, NJ.

Martin Palmeri, M.D., M.B.A., practices in Greenville, NC.

Leela Andrews Panoor, M.D., a psychiatrist, is affiliated with the Connecticut Department of Mental Health & Addictions, in Hartford.

Arun V. Parikh, M.D., a psychiatrist, is Medical Director of Racine Psychological Services in Racine, WI.

Kantilal Patel, M.D., a general practitioner, is Medical Director of the Baart Chemical Dependency Program in La Puente, CA.

Dan Emory Phillips, M.D., a psychiatrist, is Addiction Services Element Chief with the Malcolmbrow Medical Center at Andrews Air Force Base, MD.

Hayman Kumar Rambaran, M.D., a specialist in internal medicine, is Medical Director of Eva's Medical Clinic in Paterson, NJ.

Naipul Rambaran, M.D., a specialist in internal medicine, is Clinical Director of the Essex County Hospital Centre in Kearny, NJ.

Vani Ray, M.D., is a Staff Psychiatrist with the Aurora Sinai Medical Center in Milwaukee, WI.

Matthew D. Reuter, a medical student, lives in Omaha, NE.

Thomas B. Richardson, D.O., a psychiatrist, is affiliated with the Belmont Hospital in Philadelphia, PA.

Natalie E. Roche, M.D., is Assistant Professor of Obstetrics & Gynecology at the New Jersey Medical School in Newark.

Amy Rowan, M.D., of Bryn Mawr, PA, is a psychiatrist with the University of Pennsylvania Center for Studies on Addiction.

Sanjay S. Sastry, M.D., of Daytona Beach, FL, is an anesthesiology resident at the University of Florida.

Richard N. Scott, M.D., a cardiologist, is Medical Director of New Care Health Services in Annapolis Junction, MD.

Sunil Singh, M.D., a nephrologist, is affiliated with the Neuro Pain Center of Linwood, NJ.

Abhin Singla, M.D., a specialist in internal medicine, is affiliated with Oakbrook Medical Associates in Naperville, IL.

Joseph C. Spagnuolo, M.D., of Fair Haven, NJ, is a specialist in internal medicine with the VA Medical Center.

Daniel Sullivan, M.D., of Casper, WY, is with Medical Testing Laboratories, Inc. [Specialty?]

Mitsuru Umeno, M.D., of Setagaya-Ku, Tokyo, Japan, practices at Tokyo Metropolitan Matsuzawa Hospital.

David Weber, M.D., of White Plains, NY, is a psychiatrist.

Vern R. Williams, M.D., of Beaverton, OR, specializes in internal medicine.

Bernd Arthur Wollschlaeger, M.D., of North Miami Beach, FL, practices with the Aventura Family Health Center.

Nancy Wu, M.D., a resident, lives in San Francisco, CA.

Dixon Young, M.D., of Beverly Hills, CA, is a specialist in internal medicine.

Discrimination Against Addicted Persons Continues

Bob Curley

People in recovery face discrimination in the workplace, health care, and everyday life, and litigation may be the only way to force changes in some cases, according to experts testifying at the 2002 annual meeting of the American Bar Association (ABA) in Washington, DC. The ABA's Panel on Discrimination Against Individuals in Treatment and Recovery heard more than a dozen experts describe the effects of such discrimination.

Among the most impressive testimony was that of Former First Lady Betty Ford, who said that whereas up to 80% of patients at the Betty Ford Center used to be able to pay for their addiction treatment through their health insurance plans, today only 20% to 25% can access those benefits.

Not even lawyers are immune to addiction-related discrimination, she said. When the Betty Ford Center recently tried to establish a residential treatment program for attorneys, physicians, and other professionals, nearby residents picketed and confronted the patients. "They threatened to videotape our patients going to and from the homes and make public their tapes," Mrs. Ford said. "The ignorance and hate were surreal. A few residents stood up and spoke in our support, but were shouted down. So, the Betty Ford Center, perhaps the best-known treatment center in the world, has to find alternative housing for our patients." She concluded, "NIMBY is alive and well in 2002."

Robert Newman, M.D., director of the Baron Edmond de Rothschild Chemical Dependency Institute at Beth Israel Medical Center in New York, told the panelists that persons with addictive disorders are "subjected to conditions that would be unthinkable in any other medical practice," such as having their medication levels capriciously reduced or eliminated, or being told to deal with their problems through behavior modification rather than medical intervention. "Eighty-five percent of narcotics addicts in U.S. have no access to methadone treatment," Dr. Newman said. "My doctor can treat a patient for pain relief with methadone, but if he does so for addiction, it is illegal."

Even patients in long-term recovery routinely face discrimination, the experts said. Susan Rook, director of communications and outreach for the advocacy group Faces and Voices of Recovery, said a recent survey by the Peter D. Hart organization found that one in four persons in recovery have experienced discrimination in the workplace or in seeking health care, and one in five fear being fired if their employer were to find out that they are in recovery from an addictive disorder.

Citing a pattern of "systematic and illegal discrimination against people who are in recovery," Ms. Rook added, "When personal prejudices influence my ability to get a job, receive an earned promotion, get and keep health insurance, life insurance, housing and other basic benefits of being a member of a community, then someone else's opinion of me matters. And that personal prejudice is not merely stigma ... [it's] discrimination."

Adele Rappaport, an attorney in the Detroit office of the federal Equal Employment Opportunities Commission (EEOC), said that persons with addictive disorders often are the target of what she called "hysterical terminations." She recounted the experience of an individual who told his employer that he needed addiction treatment, and instead was fired for violating the company's "zero tolerance" policy. "What kind of personnel decision is that?" she asked.

Unfortunately, the Americans with Disabilities Act (ADA), which ostensibly provides some protection for persons with addictions, actually affords little help, Ms. Rappaport said. She estimated that 95% of persons with addictive disorders fail to meet the ADA's standard for disability (involving impairment in a major life function), while others run afoul of the law's exclusion from coverage of current users of illicit drugs.

Nevertheless, addiction remains the most common problem in most workplaces, accounting for 20% of voluntary employee-assistance program referrals and 50% of supervisory referrals, according to Dorothy Blum, vice president of the Employee Assistance Professionals Association. Employers should be warned that discriminating against people with addictive disorders not only will harm their bottom line in the long run, but also makes them liable to litigation, Ms. Blum added.

Alfred P. Carlton, President-Elect of the ABA, summarized the testimony given by the many speakers when he told the panel that "We must work to end discrimination of any kind, but especially for people seeking treatment for addiction. It's a disease and should be treated as such." *Source: Join Together Online (www.jointogether.org).*

ASAM's Database and You

ASAM is updating its database records. If you have a correction to your record or wish to have your name and address excluded from the print or electronic membership directory or mailing lists that are provided to other organizations, just send a written request to ASAM's Membership Department. Requests may be sent by e-mail to VFOOT@ASAM.ORG, by fax to 301/656-3815, or by mail to ASAM Membership Department, 4601 North Park Ave., Suite 101 Upper Arcade, Chevy Chase, MD 20815-4520.

When you write, please include your full name and complete address as they appear on the mailing label of your copy of **ASAM News**.

If you request it, ASAM will exclude your name from its mailing lists for one year. Please note that you may continue to receive marketing materials from companies that do not use ASAM's mailing lists, or that previously purchased information from ASAM to compile lists that still are in use.

New In Print

Barry Stimmel, M.D., FASAM

Alcoholism, Drug Addiction, and the Road to Recovery: Life on the Edge, *by Barry Stimmel, M.D., FASAM (Haworth Medical Press, ISBN No. 0-7890-0553-0, 414 pages, $59.95 hard cover, $29.95 soft cover).* This well-referenced book by Barry Stimmel, M.D., FASAM, who edits ASAM's *Journal of Addictive Diseases,* helps readers with little or no background in science or health care understand the complex issues surrounding drug use and abuse. It provides current, reliable and unbiased information on methods of dealing with addiction to alcohol and CNS depressants, hallucinogens, heroin, nicotine, marijuana, caffeine, amphetamines, designer drugs, and steroids. A glossary listing common street names is helpful in identifying specific substances.

Originally published in 1992 as *The Facts About Drug Use,* this updated edition contains new information about the effects of alcohol and mood-altering drugs on the body. It presents, intelligently and interestingly, ways to identify persons at risk and problems addicted persons typically encounter in their attempts to become drug-free. For a complete list of contents, visit the publisher's web site at WWW.HAWORTHPRESS.COM.

Screening for Alcohol Problems: An Update (Alcohol Alert No. 56). *National Institute on Alcohol Abuse and Alcoholism, Bethesda, MD.* The quarterly *Alcohol Alert* bulletins provide current research findings in a succinct, readable format. The latest issue covers questionnaires and laboratory tests for use in screening patients for alcohol use disorders and risky drinking patterns. It describes the tools available and gives the most recent findings as to their effectiveness.

The *Alcohol Alert* series debuted in 1988; to date, 57issues have been published. Each issue focuses on a specific alcohol research subject (with references) and includes a commentary from the NIAAA Director. All the *Alcohol Alert* issues are available at NIAAA's web site: WWW.NIAAA.NIH.GOV/PUBLICATIONS/ALALERTS.HTM.

Print copies of No. 56 and other *Alcohol Alerts* are available free of charge from the NIAAA Publications Distribution Center, P.O. Box 10686, Rockville, MD 20849-0686.

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals. *Center for Substance Abuse Treatment, Rockville, MD.* Published by the federal Center for Substance Abuse Treatment, this monograph is the product of a consensus process involving experts in medicine and human services. It provides statistical and demographic information, prevalence data, case studies, suggested interventions, treatment guidelines and approaches, and sample organizational policies and procedures. It is available as a PDF document, which can be downloaded at no charge from HTTP://WWW.HEALTH.ORG/GOVPUBS/BKD392/INDEX.PDF, or it can be ordered in hard copy from CSAT at 301/443-5052.

ASAM Advisory to Members

ASAM has received information concerning Internet and print advertisements that refer to treatment facilities or practices as being "ASAM certified" (or variations of that phrase).

Members are aware that ASAM certifies only individual physicians, and that only physicians who pass the ASAM Certification Examination may claim to be ASAM-certified. ASAM does **not** certify programs, facilities or treament modalities; any statements to the contrary are erroneous and are specifically disavowed by ASAM.

If you become aware of such claims, please notify the national office (by e-mail to JGART@ASAM.ORG or by Fax to 301/656-3815). If possible, include a copy of the advertisement.

Ruth Fox Memorial Endowment Fund

Dear Colleague:

The Ruth Fox Memorial Endowment Fund extends its congratulations to the Christopher D. Smithers Foundation, Inc., on the Foundation's 50th anniversary of charitable giving in the field of alcoholism.

Established in 1952 by R. Brinkley Smithers in memory of his late father, the Foundation pioneered in philanthropy related to alcohol disorders. In a 1992 essay recalling those early days, R. Brinkley Smithers wrote, "It is amazing to think that we were able to get as much done as we have. If you would have asked me [at the beginning] what I was going to do with my life and the Foundation, I am sure I could not have told you. I did know that we wanted to remove the stigma and have alcoholism accepted as a respectable and treatable disease, and I believe in this accomplishment we have done more than any other organization in the world."

In support of its mission, the Foundation has made grants for alcoholism research, public education, training of physicians and other health care professionals, and advocacy for acceptance of alcoholism as a medical disorder. Mr. Smithers personally helped to found the National Council on Alcoholism and the Alcohol and Drug Problems Association, and was instrumental in winning enactment of legislation that created the National Institute on Alcohol Abuse and Alcoholism.

Mr. Smithers' wife, Adele, has been a full partner in the work of the Foundation from its inception, and its leader since Brinkley Smithers' death. Adele (now Adele Smithers-Fornaci) wrote in 1992, "I am proud and humble to have worked with Brink for these many years and seen the progress. Alcoholism and alcohol-related problems besiege our lives, our schools, our families and communities, and our nation. There is still so much that needs to be done, and we will continue to follow the course that Brink has set."

ASAM Past President Marc Galanter, M.D., FASAM, presents an award to Adele Smithers-Fornaci in recognition of her work and that of her late husband, R. Brinkley Smithers, and the Christopher D. Smithers Foundation to increase understanding of alcoholism as a treatable disease.

Over the years, ASAM has benefited from the Smithers' commitment and the Foundation's generosity. Truly, Brinkley and Adele Smithers-Fornaci and the Christopher D. Smithers Foundation have "made a difference," for which we congratulate and salute them.

You can make a difference, too, through your contribution to the Ruth Fox Memorial Endowment Fund of ASAM. 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.

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Dr. Carlson Cares for Society's Castoffs

Jeanne Erdmann

Retirement allows Dr. Carlson time for yet another pursuit: pottery-making, a hobby he took up in the 1960s. Here, he stands in front of 20 ceramic tiles he created to look like a black and white galaxy.

Late one Friday in 1997, near San Diego, California, 35 addiction professionals boarded a bus headed for the R. J. Donovan prison for an ASAM component session organized by Blair Carlson, M.D., FACAP, FASAM. A retired internist, Dr. Carlson has devoted a significant portion of his career and of his retirement to helping physicians deliver health care and addiction treatment in criminal justice settings. He took his colleagues to a prison because, he says, they needed to see what a prison looks like from the inside. "We got to the prison in the evening," he recalls. "It was dark. There were signs all around us that read `beware of rattlesnakes' and `no warning shots'. They're not going to warn you, they are just going to kill you if you do something wrong."

The session was held in the prison's therapeutic community, located on the other side of the compound, so the group had a long walk through a dark prison. Along the way, they passed inmates who were patted down so they could move from one place to another. They saw inmates pumping old, rusty iron weights in the half-dark. But when they reached the therapeutic community, the lights were bright and the inmates were smiling. "They gave us hugs, shook our hands, and thanked us for coming," says Dr. Carlson. "It was a whole different world, a whole different culture."

As with many whose lives have taken unexpected turns, Dr. Carlson spent the early part of his career in his home state of Colorado, working as an internist in private practice, far removed from the culture of prison life. That changed in 1977, when he confronted his own problems with alcohol and drugs. To recover, he lived for one year in a drug-free therapeutic community, a home where people with similar problems live together and help each other. "It's kind of a lock-up for self-help programs," he says. At 49, Dr. Carlson was twice the age of his housemates, but a more significant distinction separated them: many had done prison time. "All they talked about was `the joint this and the joint that'," he recalls. "I decided to find out what `the joint' was like."

He did more than find out. When he left the therapeutic community, Dr. Carlson worked one day a week for a year and a half in the Canyon City Complex of the Colorado Department of Corrections. "The moment I walked into the prison, I felt that I was needed," he says. "I got to respect the prisoners by recognizing that they were people with problems who need and deserve help."

Serving addicted individuals who are accused or convicted of crimes has kept Dr. Carlson very busy. Since 1978, he has served on numerous medical and legal committees, published standards of care for prisons and jails, and then helped to survey institutions to ensure that they are following the standards. He wrote a chapter on withdrawal syndromes for the first textbook on correctional medicine. He also has served on several ASAM committees specializing in the criminal justice system, as well as on committees in the legal system. He has worked in maximum security, minimum security, and women's prisons. He encourages ASAM members to seek part-time work in prisons to supplement their incomes. In view of the staggeringly high rate of inmates with addictive disorders, Dr. Carlson says he "can't imagine who would make a better doctor in a prison than an ASAM member who understands addiction."

Now retired as Medical Director of the Chemical Dependency Treatment Service with Kaiser Permanente in Denver, Dr. Carlson serves on the admissions committee at the University of Colorado School of Medicine, where he is Clinical Professor of Medicine and Clinical Associate Professor of Psychiatry. Those titles are important to him, he says, because they show that an addicted person "can recover and go on to have all the titles that everyone else gets." As successful as his own recovery has been, Dr. Carlson knows that many prisoners will not go on to live clean and sober lives. A few may, but not many. Even so, intervention is worthwhile, he says, because prisoners who go through addiction treatment have a lower re-arrest rate than those who don't. In fact, Dr. Carlson favors long-term monitoring and treatment in lieu of incarceration for non-violent offenders. He is a proponent of therapeutic jurisprudence, a movement in the court system in which judges make decisions based on what's best for the community and in which prosecutors and defense attorneys work together to find the best placement for drug-involved offenders. Drug courts are an example of therapeutic jurisprudence.

The movement has some opponents who want all criminals punished. Instead, Dr. Carlson believes society needs to view offenders as people with the disease of addiction, and not just in terms of moral issues of good or bad. "Justice needs to address what works and not what gets politicians elected," he says. "Some people think that the only justice is retribution. Many think that judges should not be social workers. Maybe not," he adds, "but they can have social workers on their staffs to advise them about what might be an educated societal response to a difficult issue like drug addiction."

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

ASAM Conference Calendar

ASAM

October 24-26, 2002
Review Course in Addiction Medicine &
ISAM Pre-Conference Symposium
Chicago, IL
21 Category 1 CME credits

November 16, 2002
Certification/Recertification Examination
in Addiction Medicine
Atlanta, GA; Los Angeles, CA;
New York, NY

April 13, 2003
ASAM/ATTOD Buprenorphine
and Office-Based Treatment of
Opioid Dependence
Washington, DC
8 Category 1 CME credits

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

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

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

May 4, 2003
ASAM/ATTOD Buprenorphine
and Office-Based Treatment of
Opioid Dependence
Toronto, Ontario, Canada
8 Category 1 CME credits

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

November 2, 2003
ASAM/ATTOD Buprenorphine
and Office-Based Treatment of
Opioid Dependence
Washington, DC
8 Category 1 CME credits

Other Events of Note

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 3, 2002
Substance Abuse Prevention
—Clinical Considerations
(sponsored by Children's Hospital)
Columbus, OH
6 Category 1 CME credits
[For information, phone 614/722-2458]

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 19-23, 2002
26th National Conference on
Correctional Health Care
(ASAM is a supporting organization)
Nashville, TN
[For information, visit
WWW.NCCHC.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 7-9, 2002
Association for Medical Education
and Research in Substance Abuse
26th Annual Meeting
Washington, DC
[For information, visit WWW.AMERSA.ORG
or e-mail ISABEL@AMERSA.ORG]

November 15-17, 2002
Conference on Authority and Power
in Social Systems and the Family
(ASAM is a supporting organization)
Chicago, IL

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.