January/February 2003
Volume 18, Number 1

ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

ASAM at Work for You:

Also see:

See the important member survey enclosed.

www.asam.org

ASAM Med-Sci Conference to Convene in Canada

Toronto will host addiction medicine specialists from around the world during ASAM's 34th Annual Medical-Scientific Conference, May 1st-4th. The conference—to be held in cooperation with the Canadian Society of Addiction Medicine—welcomes ASAM and CSAM members as well as nonmember physicians, nurses, psychologists, counselors, students and residents. It is preceded by two special events: the Ruth Fox Course for Physicians and an ASAM Forum on Pain and Addiction, both scheduled for Thursday, May 1st. It concludes on Sunday, May 4th, with a training course designed to qualify ASAM members and other physicians to prescribe the recently approved drug buprenorphine.

A traditional highlight of the conference is the annual Awards Dinner, set for Saturday, May 3rd. At the dinner, the ASAM award for outstanding contributions to the growth and vitality of the Society will be presented to Andrea G. Barthwell, M.D., FASAM, Deputy Director of the Office of National Drug Control Policy. The award for expanding the frontiers of Addiction Medicine is to be given to Alan I. Leshner, Ph.D., former director of the National Institute on Drug Abuse, while the John P. McGovern, M.D., Award and Lecture on Addiction and Society, which honors an individual who has made highly meritorious contributions to public policy, will go to David C. Lewis, M.D.

For additional information and registration, consult the ASAM web site or contact ASAM's meetings staff at EMAIL@ASAM.ORG.

ASAM Elects New Officers, Members of the Board of Directors

ASAM members have elected the Society's next President-Elect, Secretary, and Treasurer, as well as a full slate of Directors at Large. In balloting completed December 1, Elizabeth F. Howell, M.D., FASAM, was chosen President-Elect, David C. Lewis, M.D., was elected Secretary, and James A. Halikas, M.D., FASAM, was named Treasurer.

Three Directors-at-Large also were elected: David R. Gastfriend, M.D., Stuart Gitlow, M.D., M.P.H., and Penelope P. Ziegler, M.D., FASAM. Anthony H. Dekker, D.O., FASAM, was voted Director-at-Large representing Osteopathic Medicine.

The newly elected officers and directors will be installed during the Society's 2003 Medical-Scientific Conference in Toronto. ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, and Immediate Past President Marc Galanter, M.D., FASAM, will continue to hold those posts until April 2005. Profiles of the new officers and directors appear on pages 6-7 of this issue of ***ASAM News***.

Field Unity and Our Legislative Goals

Eileen McGrath, J.D.

Eileen McGrath, J.D.

I am pleased to report that our ongoing search for unity among organizations representing the addiction field took a step forward recently, when leaders of 15 such organizations gathered in Washington, DC. In addition to ASAM, groups represented included Physicians Leadership on National Drug Policy, the National Association of State Alcohol and Drug Abuse Directors, the National Council on Alcoholism and Drug Dependence, and the Community Anti-Drug Coalition of America.

The meeting was called to discuss both message development and collaboration on a broader public policy agenda. We agreed that the addiction field can and should speak with a single voice on issues of mutual concern, such as the need for better funding of prevention and treatment services and the fight against stigma.

As one outcome of the meeting, the group adopted a consensus statement articulating our common principles: "Alcohol and drug addiction is a disease that can be prevented and treated. People in recovery from this disease can and do lead productive lives, and should not be discriminated against." Other areas of discussion ranged from budget issues to the effects of the administration's faith-based initiative on training and certification standards.

Two working groups were formed at the meeting: One, led by Paul Samuels of the Legal Action Center, will develop a public policy agenda; the other, led by Pat Ford-Roegner of the National Association of Alcohol and Drug Abuse Counselors and lobbyist Carol McDaid of Capitol Decisions, Inc., will craft messages to support the consensus agenda.

The group plans to bring in other participants from within and outside the addiction field, such as individuals representing law enforcement and the faith community. The research community, which has been very successful in changing public attitudes about the disease of addiction, also will be engaged. I will keep you posted on future developments.

A Legislative Opportunity

Shortly before Christmas, ASAM received a request from the office of Senator Joseph Biden (D-DE) for comment on his bill S.1966, the "Health Professionals Substance Abuse Education Act." Sen. Biden first introduced the bill in 2002. A companion House bill, H.R.3793, was introduced by Rep. Patrick Kennedy (D-RI); however, the bills were not voted on and are being revised for reintroduction in the new session.

The bills would provide $45 million in new funds to the federal Substance Abuse and Mental Health Services Administration's Addiction Technology Transfer Centers, to the Association for Medical Education and Research in Substance Abuse for its Interdisciplinary Project, and to medical schools to support teaching faculty and training activities.

ASAM was able to offer Sen. Biden specific language covering physicians who are specialists in addiction medicine—a group that largely had been overlooked in the original bill. We also recommended loan forgiveness as a powerful inducement for physicians to enroll in addiction medicine fellowships. Dr. David Lewis reports that our suggested language was well received. Other organizations are being consulted, and ASAM probably will be asked to comment on a revised bill. This is a significant collaboration.

Watch the ASAM web site (**WWW.ASAM.ORG**) for news of the reintroduction of S.1966/H.R.3793. When the bills are reintroduced, please contact your members of Congress and ask them to support this important legislation.

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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Web Site
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).

President Bush Proposes Voucher Program, Expansion of Treatment Funding and Capacity

Asserting that "too many Americans in search of treatment cannot get it," President Bush used his January 28th State of the Union address to unveil a $600 million proposal to expand addiction treatment capacity. Combined with prior year requests, the increase in funding would fulfill the President's commitment to provide an additional $1.6 billion for treatment services over five years. The President said his "Recovery Now" program would allow an additional 300,000 persons to obtain treatment.

In a meeting with field leaders to elaborate on the President's announcement, officials of the White House Office of National Drug Control Policy (ONDCP) described the initiative as featuring an increase in treatment funding, use of government-issued vouchers to pay for treatment services, expansion of eligible treatment providers to include so-called "faith-based" organizations, and an emphasis on measuring and rewarding treatment outcomes.

ONDCP Director John P. Walters said the initiative is designed to help any individual with an alcohol or drug problem who is without private coverage for treatment services and who has been assessed as being in need of such services. After assessment (which could take place in a hospital emergency department, a clinic or physician's office, or in a schools, workplace, or community-based organization), such an individual would be presented with a voucher to pay for the indicated services and referred to a variety of treatment providers. Vouchers would be issued by the states and funded through competitive federal grants to Governors' offices. States would be required to monitor the services delivered by providers and to adjust reimbursements to reflect patient outcomes.

Charles Curie, administrator of the Substance Abuse and Mental Health Services Administration, pointed out that the President's initiative encompasses many of the core concepts of the National Treatment Plan, such as individualized treatment planning and multiple points of entry into the treatment system. Acknowledging the importance of this "no wrong door" approach, Ann S. Uhler, President of the Alcohol and Drug Problems Association of America, said the proposed voucher system offers a powerful opportunity to link a community's service network with persons in need of treatment and, in some states, may save treatment programs that are threatened by reductions in funding and other resources.

Issues to be Resolved

Enthusiasm for the President's plan was tempered by concerns that Congress will be willing to fund it in a time of massive federal budget deficits. However, observers said the new Republican-controlled Congress may be willing to support the President's plan. Rep. Jim Ramstad (R-MN), a long-time advocate for treatment expansion, said, "I've discussed the voucher proposal with the President and consider it an important first step in addressing the lack of access to treatment for people who are chemically dependent."

Others focused on the implications of opening up federal treatment funds to faith-based programs. While voicing general support for the initiative, ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, cautioned that vouchers should be used only for treatment in programs that are "accredited and licensed by the appropriate state agency, making them subject to quality assurance, regulation and inspection by the state" *[ED: see accompanying article]*.

"Let us bring to all Americans who struggle with drug addiction this message of hope: The miracle of recovery is possible, and it could be you."
President George W. Bush

ONDCP Director Walters reassured treatment advocates that the Recovery Now initiative would increase, not decrease, accountability. The voucher program would "bring new levels of access, choice, and accountability to a national treatment system that is currently challenged with meeting the needs of 5.7 million drug-dependent Americans," Director Walters said.

Others hailed the plan's ability to direct resources where they are needed most. Mark Parrino, President of the American Association for the Treatment of Opioid Dependence, said, "We are strongly encouraged that the initiative will provide greater access to opioid treatment. It builds on the principle of supporting evidence-based practices so that drug-dependent individuals will gain access to care."

Summing up the plan's benefits, Linda Hay Crawford, Executive Director of Therapeutic Communities of America, said, "By increasing access to evidence-based approaches to alcohol and drug abuse treatment, we all stand to benefit by a decrease in emergency room visits, violence, job accidents, auto fatalities, workplace absenteeism, Medicaid and Medicare costs." *Sources: Office of National Drug Control Policy, February 5, 2003; JoinTogether Online, January 29, 2003; White House press office, January 29, 2003.*

ASAM Reacts to President's Proposal

ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, responded positively to President Bush's message. "ASAM and its members are profoundly encouraged by the prominence President Bush gave to treatment and recovery from addiction in his State of the Union Address," he said, adding that "President Bush's confidence in the effectiveness of treatment for addiction is scientifically sound."

Dr. Brown said, "ASAM strongly supports the intent of the voucher program to make treatment accessible to a larger proportion of those in need, and to their families," but cautioned that "ASAM's commitment to quality in treatment leads us to recommend that any system of vouchers be used only for treatment by programs that are accredited and licensed by the appropriate state agency, making them subject to quality assurance, regulation and inspection by the state."

To achieve the President's goal of increasing access to individualized, cost-efficient, effective treatment, Dr. Brown said that determination of the need for specific treatment services must be a clinical judgment based on objective guidelines supported by clinical research and consensus, such as the *ASAM Patient Placement Criteria (ASAM PPC-2R)*. Dr. Brown pointed out that the ASAM criteria for adults and adolescents already are required or recommended by treatment agencies in more than 20 states.

Addressing the President's focus on faith-based programs, Dr. Brown said that ASAM recognizes the importance of spirituality in recovery and the positive role of clergy. He added that, because addiction also is "a disease with complex physical and psychological ramifications that require evidence-based medical assessment and treatment by qualified licensed professionals," treatment always should be directed by a physician who also is skilled in the assessment and treatment of co-occurring psychiatric and medical disorders (such as HIV and hepatitis C virus infections), which must be an integral part of patient care.

Realigning ASAM's Structure to Meet Our Goals

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

ASAM, like many medical societies, has both a challenging mission and limited resources. If we are to realize our mission and expand our resources, it is imperative not only that we plan strategically, but also that we align our governance structure with our Strategic Plan. In this way, we will ensure that we have an effective and efficient approach to reaching our goals.

In many democratically governed associations, including medical societies, committee structures have evolved to reflect the varied interests of members. Today, as all medical societies are faced with declining membership, streamlining governance structures to prioritize the work of the organization is critical.

Among my chief responsibilities as your President is to recommend to you a governance structure that will maximize ASAM's ability to accomplish the goals set forth in our Strategic Plan. It is a difficult task. The optimal governance structure certainly is not self-evident. Even the best proposal probably contains an element of arbitrariness. The historic existence of a committee usually ensures that there are advocates for its continuance. Unfortunately, the functioning and contributions of many committees have been inconsistent or unreliable and thus this endeavor offers an opportunity for ASAM to achieve some degree of efficiency.

Some of you have inquired about the range of committees, councils, and task forces that currently exist in ASAM and how you may participate. The outline below provides some insight. ASAM represents the "big tent" for addiction medicine and should offer opportunities to everyone who desires to contribute. The goal is to improve the improve the efficiency and effectiveness of our "big tent."

After much deliberation and consultation with ASAM's leaders, including the Board, I have developed a proposal that aligns ASAM's governance structure with the priorities in the Strategic Plan. I am submitting it to you for your consideration and comment.

I ask each of you, as ASAM members, to review and comment on the proposal from the perspective of the good of the Society as a whole. In other words, I ask you to seriously review your particular interests in the work of individual committees, so that the Board can come to a consensus regarding a governance structure that will optimize the attainment of ASAM's overall goals, as delineated in our Strategic Plan. Please provide your e-mail or written comments to the ASAM office by April 1, 2002. I look forward to your comments and suggestions.

Proposed ASAM Governance Structure

COUNCILS (SECTIONS): Councils (this term is used in place of "Sections") are organizational structures that carry out the Mission of the Society and oversee the execution of the strategies and attainment of the operational objectives determined by the Board. Councils are chaired by a member of the Board and are composed of members of the Society and its Board. Subcommittees of Councils may be established to address specific functions or products of the Council. Councils and Council Subcommittees shall receive staff support.

Advocacy Council (advocates for recovering persons, including recovering physicians; composed of the Chairs of all Committees and Task Forces; Chair is a member of the Board).

Certification Council (Chair is a member of the Board).

- Eligibility and Application Committee
- Examination Committee
- Fellow Committee

Chapters Council (composed of Chapter Presidents; Chair is an *ex officio* member of the Board).

Constitution and Bylaws Council (Chair is a member of the Board).

Finance Council (Chair is Treasurer of the Society)

- Development Committee (Chair is a member of Board)
- Finance Committee (Chair is Treasurer of the Society)

Medical Education Council (Chair is a member of Board)

- Medical Scientific Conference Program Committee
- CME Committee (for all other ASAM sponsored and co-sponsored educational programs).

Medical Society Council (Chair is the ASAM President)

- American Academy of Child and Adolescent Psychiatry Liaison
- American Academy Family Physicians Liaison
- American Academy of Pediatrics Liaison
- American Association of Addiction Psychiatry Liaison
- American College Emergency Physicians Liaison
- American College of Obstetrics and Gynecology Liaison
- American College of Physicians/American Society of Internal Medicine Liaison
- American College of Surgeons Liaison
- American Medical Association Delegation
- American Psychiatric Association Liaison
- Osteopathic Medicine Liaison

Organization Relations Council (Chair is the ASAM President)

- American Association for the Treatment of Opiate Dependence
- Association for Medical Education and Research in Substance Abuse Liaison

Drug Abuse Directors Liaison

- National Council on Alcoholism and Drug Dependencies Liaison
- National Institute on Alcohol Abuse and Alcoholism Liaison
- National Institute on Drug Abuse Liaison

Membership Council (Chair is the Membership Committee Chair, who becomes an *ex officio,* non-voting member of Board).

- Membership Committee
- Physicians-In-Training Committee

Nominations and Awards Council (Chair is the Immediate Past President of the Society)

Public Affairs Council (Chair is the Secretary of the Board)

- Legislative Advocacy Committee
- Media and Public Information Committee
- Policy Development Committee

Publications Council (Medical Editor is Chair)

- Journal Committee
- Newsletter and Web page Committee
- Textbook and Handbook Committee

Quality Improvement Council (Chair is a member of the Board)

- Practice Guidelines Committee
- Treatment Criteria, Treatment Outcomes and Clinical Care

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STANDING COMMITTEES OF THE BOARD: Standing Committees of the Board are organizational structures of the Society that carry out the Mission of the Society and serve the interests of its members. Each has a Mission Statement that identifies the work of the committee. Standing Committees of the Board are composed of members of the Society or its Board, and are chaired by a member of the Board.

Performance Measures Committee

- CARF Liaison
- JCAHO Liaison
- NCQA Liaison

TASK FORCES OF THE SOCIETY: The mission of Task Forces (this term is used instead of "committee" to avoid confusion) is to address the needs of a subset of patients; to address a particular aspect of substance use and addiction; or to address a medical condition or co-morbidity of addiction. Most Task Forces promote access to and improvement of treatment and prevention services for substance use and substance use disorders. Member participation in Task Forces serves the additional function of advancing involvement of individual members in the Society's activities. Task Forces of the Society will receive staff support from the Society for funded projects or activities, but not for other efforts.

- Child and Adolescent
  - Criminal Justice
  - Cross Cultural Concerns
  - Family and Generational Issues
  - Forensic Medicine
  - Infectious Diseases
- Medical Review Officer
  - Medications Development
  - Nicotine Dependence
  - Opioid Agonist Therapies
  - Pain and Addiction
  - Therapeutic Communities

Dear Colleague:

Four times a year, your Board of Directors gathers to conduct ASAM's business: twice by conference call (in January and July) and twice in face-to-face meetings (in October and in April, prior to the Med-Sci Conference). Members are welcome to attend the October and April meetings. I want to keep you informed about the issues deliberated and the actions taken by the Board. The report that follows describes the Board's January 23rd conference call.

I also want to alert you to an important event designed to give ASAM members an opportunity to have direct input to the work of the Board: the annual Membership Business Meeting and Open Forum, scheduled for 7:15 a.m. Friday, May 2nd, in Toronto (preceded by a sumptuous breakfast buffet at 6:30 a.m., courtesy of the Smithers Foundation.)

I know the time of the meeting is early! However, it is critical to the health of our society for the leadership to hear from our members, and there will be ample time for that at the Membership meeting. I urge you to add this important event to your calendar and to come prepared with questions and ideas. If you cannot join us in Toronto, please feel free to set forth your ideas in letters to me or to the editor of ***ASAM News***.

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

Board Actions in January Meeting

Activities to implement ASAM's recently adopted Strategic Plan were the subject of Board discussion in its January conference call. The Board had prioritized the five-year Plan (adopted at its April 2002 meeting) during a working session in October, under the guidance of Drs. Michael Miller, Lloyd Gordon, Beth Howell, and Lawrence Brown.

As called for in the Plan, the Board has been considering a proposal to reorganize the Society's sections and committees to better reflect ASAM's priorities. While this proposal requires additional review, it formed the backdrop for Board consideration of the committee structure and how well it reflects member concerns. For example, recent revisions to the program of federal block grants to the states to fund addiction treatment programs, as well as ongoing developments in addiction research, were considered as possibly requiring some redirection of ASAM's strategic priorities, which should remain flexible to allow the Society to respond to demands as they arise.

Buprenorphine Training Planned

Reflecting increased interest in office-based opioid treatment (OBOT), spurred by FDA's approval of buprenorphine compounds for the treatment of addiction, the Board approved a plan to schedule multiple 8-hour buprenorphine training courses in 2003 to qualify physicians to prescribe the drug. The resulting demands on the members of the Opioid Agonist Treatment Committee's Ad Hoc Work Group on Office-Based Opioid Treatment led the Board to vote that ASAM members who serve as buprenorphine training course directors will be given a $1,000 honorarium, which is to be paid from the CSAT grants that underwrite the courses.

At the recommendation of the Work Group on Office-Based Treatment, the Board voted to submit a formal request to CSAT to make two draft documents on Opioid Agonist Medical Maintenance Treatment final and available as quickly as possible. In the opinion of the Work Group, the two panel-authored booklets are of high quality and would be useful to physicians.

MRO Certification Change

At the recommendation of ASAM's Certification Council, the Board approved a proposal to drop the special MRO section from future Certification Examinations and to discontinue ASAM's activities in certifying MROs. This decision reflected both the relatively small number of MROs who have applied to ASAM for certification and questions about the appropriateness of the MRO questions appearing on the examination, which is attracting a growing number of physicians from outside the U.S. Physicians who already certified as MROs by ASAM, including those certified in 2002, will be recognized by the U.S. Department of Transportation, and the Society will continue to offer its very successful MRO training courses, each followed by a certification examination administered by the MRO Certification Council.

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New ASAM Officers, Directors Elected

The following officers and Directors-at-Large will be installed during ASAM's Annual Medical-Scientific Conference, May 1st-4th in Toronto.

President-Elect: Elizabeth F. Howell, M.D., FASAM

Elizabeth F. Howell, M.D., FASAM, is Medical Director of Metro Atlanta Recovery Residences, Inc., in Atlanta, GA; Clinical Assistant Professor in the Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine; engaged in the part-time private practice of general psychiatry, addiction medicine and addiction psychiatry; and a consultant to private and public programs and agencies throughout the U.S. Dr. Howell also served as State Alcohol and Drug Abuse Director for the Georgia Department of Human Resources from July 1997 through December 1999.

She is a founding member, Secretary-Treasurer (1989-1991), and President (1991-1993) of the Georgia Society of Addiction Medicine. A member of ASAM since 1985, Dr. Howell has been a member of the Certification Council; the Fellowship Committee; the Constitution & Bylaws, Nominating & Awards, and Examination Committees; and chairs the Communications Section and Publications Committee. She also is a deputy chair of ASAM's Strategic Planning Task Force and the Society's Treasurer. She was certified by ASAM in 1986, recertified in 1996, and is a Fellow of ASAM.

Dr. Howell says: "I am excited about and committed to the mission and goals of ASAM, and interested in the `bigger picture' of medicine.... My work in a variety of addiction medicine experiences, organized medicine activities, and non-medical activities has given me a unique perspective about the field and a wealth of ideas."

Secretary: David C. Lewis, M.D.

David C. Lewis, M.D., is Professor of Medicine and Community Health and Donald G. Millar Distinguished Professor of Alcohol and Addiction Studies at Brown University, Providence, RI.

Dr. Lewis has been a member of ASAM's Board of Directors, represented ASAM on the Council of Medical Societies of the American College of Physicians, arranged for ASAM's participation in the Physician Leadership on National Drug Policy (PLNDP), and facilitated ASAM's links with national primary care organizations.

Dr. Lewis says: "ASAM has remarkable accomplishments over the past decade as the primary multispecialty voice for addiction medicine in the United States.... Implementation of evidence-based treatment, including new pharmacotherapies, should enhance the positive relationship of ASAM to the rest of medicine and will be critical for our growth. Also, we need to be in the forefront of the transformation that electronic communication will make in the relationship between primary care physicians and specialists of all kinds. Finally, we now have the infrastructure to grow into a greater force to advocate for the benefit of our patients and thereby to become a more major force in influencing public policy."

Treasurer: James A. Halikas, M.D., FASAM

James A. Halikas, M.D., FASAM, is engaged in the private practice of addiction medicine and General Psychiatry in Naples, FL. He is retired from posts as Professor of Psychiatry, Director of Chemical Dependency Treatment Program, and Director of the Addiction Medicine Fellowship at the University of Minnesota.

A member of ASAM for almost 25 years, Dr. Halikas has served the Society as chair of the Continuing Medical Education Committee, chair of the Finance Committee, and member of the Board of Directors. He participated in the development of the ASAM Certification process from its inception in the 1980s, was certified by ASAM in 1988, and served as chair or co-chair of the Fellowship Committee of ASAM from its inception. Dr. Halikas also has been a member of ASAM's Medical-Scientific Conference Program Committee for 20 years.

Dr. Halikas says: "In this time of medical cost containment, I believe the most important duty of the Treasurer will be to see to it that our members can survive professionally, have a place at the table of managed care, and continue to have the opportunity to treat the chemically dependent patient."

Director-at-Large: David R. Gastfriend, M.D.

David R. Gastfriend, M.D., is Director of the Addiction Research Program at Massachusetts General Hospital and Associate Professor of Psychiatry at Harvard Medical School. He founded the Fellowship in Addiction Psychiatry at the MGH and now directs the expanded Addiction Psychiatry Fellowship for the Partners Healthcare System at Harvard. He also teaches and provides outpatient clinical care at the MGH.

Among his many research interests, Dr. Gastfriend initiated the first multisite study to validate the *ASAM Patient Placement Criteria*. He also is a founding member of the Washington Circle Group, a national policy coalition devoted to measuring and comparing the performance of managed care companies.

Dr. Gastfriend says: "Our field is the most severely damaged by the past decade of managed care. Our patients are under attack by a financial industry that exploits the stigma of their illness to convert the costs of patient care into short-term profits. We all are doing something to address this attack, every day, when we help patients into recovery in our offices and programs. My personal contribution to this battle is to shine the light of science through this dismal fog."

Director-at-Large: Stuart Gitlow, M.D., M.P.H.

Stuart Gitlow, M.D., M.P.H., has served as teaching faculty at Harvard Medical School and now is engaged in the private practice of psychiatry. He is board-certified in General Psychiatry, with added qualifications in both addiction and forensic psychiatry.

Within organized medicine, Dr. Gitlow is a member of the AMA's House of Delegates representing ASAM. He is a former chair of both the AMA's Young Physicians Section and the Pennsylvania Medical Society's Resident Physician Section. He also has served as a representative to the AMA's Medical Student Section from the Medical Society of the State of New York and later to the AMA's Resident Physicians Section from the Pennsylvania Medical Society. He has received numerous top-level AMA Outreach Awards

for membership recruitment, and currently serves as vice chair of the AMA's eMedicine Advisory Committee, as well as the Executive Committee of the Forum for Medical Affairs.

Dr. Gitlow says: "It is critical that we combine the best of the past with the best of the future.... One example of our future needs is that of differentiating between addiction medicine and addiction psychiatry.... It is up to us to define, educate, and to pursue the goal of continued acceptance of addiction medicine."

Director-at-Large: Penelope P. Ziegler, M.D., FASAM

Penelope P. Ziegler, M.D., FASAM, has been Medical Director of Williamsburg Place and the William J. Farley Center in Williamsburg, VA, since 1996. She also holds an appointment as Associate Clinical Professor in the Department of Psychiatry at the Medical College of Virginia.

Dr. Ziegler is board-certified in psychiatry, with a CAQ in addiction psychiatry. A member of ASAM since 1986, Dr. Ziegler was certified in 1987 and became a Fellow of ASAM in 2000. She has been active on the ASAM Infectious Disease Committee, helping to develop the ASAM Guidelines for HIV Infection and AIDS in Addiction Treatment. She also has worked with state chapters, helping to start the Pennsylvania Society of Addiction Medicine and serving on its first Board of Directors. Since moving to Virginia, she has been involved with the Virginia chapter and the local Tidewater ASAM group.

Dr. Ziegler says: "Resources for treatment are decreasing in both the private and public sectors as government funding streams are cut back at the federal, state and local levels and managed care continues to reduce access to insurance benefits.... ASAM must represent both the medical profession and the public interest by continuing to support research, education, prevention, and treatment."

Director-at-Large Representing Osteopathic Medicine: Anthony H. Dekker, D.O., FASAM, FAOAAM

Anthony H. Dekker, D.O., FASAM, FAOAAM, is Associate Director of the Phoenix Indian Medical Center of the Indian Health Service, where he also serves as Director of Ambulatory Care and Community Health.

Before joining the IHS, Dr. Dekker practiced adolescent and addiction medicine at the Chicago College of Osteopathic Medicine, the Rush Medical College, and the Christ Hospital and Medical Center-University of Illinois Programs. Dr. Dekker is board certified by the American Osteopathic Board of Family Practice and holds CAQs in adolescent and young adult medicine, sports medicine and addiction medicine.

Since joining ASAM in 1987, Dr. Dekker has served as co-director of the Ruth Fox Course for Physicians, been active in the Adolescent Committee, and have chaired the Osteopathic Medicine Committee. He also has served as ex officio member of the ASAM Board as Liaison to the American Osteopathic Academy of Addiction Medicine.

Dr. Dekker says: "My hope is that the expertise of ASAM members will become more visible and available to patients, their families, and the organizations that would benefit from our services."

Brain Cannabinoids May Regulate Drinking

Scientists have discovered a new chemical pathway in the brain that could play a role in regulating alcohol consumption. In animal studies conducted at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and several research institutions in New York State, scientists found that brain molecules similar to the active compound in marijuana may greatly reduce alcohol intake.

Using a strain of mice known to have a high preference for alcohol, researchers found reduced alcohol consumption in mice specially bred without CB1, the brain receptor for marijuana-like substances known as endocannabinoids. They further found that the endocannabinoid system activates the nucleus accumbens region of the brain, which plays a major role in the alcohol reward system.

NIAAA Director Ting-Kai Li, M.D., called the findings important, noting that "implicating yet another neurochemical mechanism in alcohol consumption opens another potential avenue for the development of new pharmacologic agents to prevent and treat alcohol problems." *Source: Journal of Neurochemistry, January 20, 2003.*

Research Lends Support to Gateway Theory

New research may lend support to the controversial theory that use of marijuana increases the risk that users will go on to try other drugs. To test the relationship, Michael T. Lynskey, Ph.D., and colleagues at the Queensland Institute of Medical Research, Brisbane, Australia, and at the Washington University School of Medicine and the University of Missouri, examined whether the association between early cannabis use and subsequent progression to use of other drugs problems persists after controlling for genetic and shared environmental influences. To do so, they analyzed data from 311 sets of young adult monozygotic and dizygotic twins in Australia. In each twin pair, only one twin had smoked marijuana before age 17.

Their analysis showed that the early cannabis users had odds of other drug use, alcohol dependence, and drug abuse or dependence that were 2.1 to 5.2 times higher than those of co-twins who did not use cannabis before age 17. When the investigators controlled for known risk factors (such as early-onset alcohol or tobacco use; parental conflict or separation; and childhood sexual abuse, conduct disorder, major depression, or social anxiety), there was only a small change in the results. The associations did not differ significantly between monozygotic and dizygotic twins.

However, in an accompanying editorial, Denise Kandel, Ph.D., cautioned that the study does not explain whether there is a true causal link between marijuana and other drugs. Added Dr. Lynskey, "It is often implicitly assumed that using cannabis changes your brain or makes you crave other drugs, but there are a number of other potential mechanisms, including access to drugs, willingness to break the law, and likelihood of engaging in risk-taking behavior."

The debate over marijuana as a gateway drug has intensified in recent years as states deal with ballot initiatives that would allow use of marijuana for medical purposes and otherwise relax restrictions on its use. *Source: Journal of the American Medical Association, January 22/29, 2003.*

Study Examines How Alcohol Damages Fetus

Consuming beverage alcohol (ethanol) during pregnancy interferes with the ability of cells destined to become the brain and nervous system to bind together during fetal growth, new research shows. But administering octanol and other non-beverage alcohol appears to block ethanol's disruptive effect on the L1 molecules that help cells attach to one another, according to researchers at Harvard Medical School and the National Institute on Child Health and Human Development.

Investigators also found that two peptides that protect nerve cells from toxins, known as NAP and SAL, protect L1 molecules from ethanol as well.

Lead author Michael E. Charness, M.D., a neurologist at Harvard and the VA Boston Healthcare System, said the study provides "valuable tools for identifying the target sites through which ethanol disrupts brain development and for designing drugs to prevent Fetal Alcohol Syndrome (FAS)." *Source: Journal of Pharmacology and Experimental Therapeutics, October 20, 2002.*

COVER THE UNINSURED WEEK

March 10 - 16, 2003

Some of the most influential organizations in the United States are cosponsoring "Cover the Uninsured Week" (CTUW), a weeklong series of national and local events that will take place coast to coast from March 10-16, 2003. Cover the Uninsured Week represents a major effort to establish the issue of the uninsured as a top national priority and to encourage policymakers to seek solutions for the more than 41 million Americans who have no health insurance. More than 8 million of the uninsured are children. Former Presidents Gerald Ford and Jimmy Carter are honorary co-chairs of the nonpartisan effort.

Cover the Uninsured Week is cosponsored by the American Medical Association, the American Nurses Association, the American Hospital Association, the Federation of American Hospitals, the Catholic Health Association of the United States, the Healthcare Leadership Council, the Health Insurance Association of America, Blue Cross and Blue Shield Association, Families USA, the U.S. Chamber of Commerce, the AFL-CIO, The Business Roundtable, the Service Employees International Union, the AARP, and the United Way of America, as well as two health foundations: The Robert Wood Johnson Foundation and The California Endowment.

The success of Cover the Uninsured Week depends on the willingness of organizations and individuals across the country to come together around the issue of the uninsured and to plan activities in their communities. ASAM encourages its members to support this important effort.

For more information on Cover the Uninsured Week, visit the CTUW web site at **CoverTheUninsured.org.** At the site, visitors can obtain information, order free materials, register their support, and receive periodic updates on CTUW efforts.

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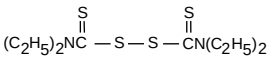
WARNING:
Disulfiram should *never* be administered to a patient when he is in a state of alcohol intoxication, or without his full knowledge. The physician should instruct relatives accordingly.

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



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

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

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

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

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

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

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

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

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

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

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

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

WARNINGS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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 PIOPA-521

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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Naltrexone and Acamprosate in Relapse Prevention

Naltrexone and acamprosate have been shown to be effective in relapse prevention of alcoholism, acting through different pharmacologic mechanisms. To determine whether the two drugs are equally efficient and whether a combination of the drugs potentiates their efficacy, Falk Kiefer, M.D., and colleagues at the University Hospital of Hamburg, Germany, conducted a controlled study of the two compounds.

Following detoxification, 160 alcoholic patients were enrolled in a randomized, double-blind, placebo-controlled protocol under which they received naltrexone or acamprosate alone, a combination of naltrexone with acamprosate, or placebo for 12 weeks. Patients were assessed weekly by interview, self-report, questionnaires, and laboratory screening. The primary outcome measures were time to first drink, time to relapse, and cumulative abstinence time.

Investigators found that naltrexone, acamprosate, and the combined medications were significantly more effective than placebo. Overall, the combined medications were most effective, with significantly lower relapse rates than placebo or acamprosate (but not naltrexone). The naltrexone group did slightly better on time to first drink and time to relapse.

These results support the efficacy of naltrexone and acamprosate, especially in combination, in enhancing relapse prevention in the treatment of alcoholism. *Source: Archives of General Psychiatry, January 2003.*

CM and CBT in the Treatment of Cocaine Addiction

The efficacy of Contingency Management (CM) and Cognitive-Behavioral Therapy (CBT) approaches as adjuncts to methadone maintenance treatment for cocaine dependence were examined by Richard A. Rawson, Ph.D., and colleagues at UCLA.

For the study, 120 cocaine-dependent patients who were receiving methadone maintenance treatment were randomly assigned to one of four conditions: CM, CBT, combined CM and CBT (CBT+CM), or treatment as usual (such as methadone maintenance treatment). The CM procedures and CBT materials were comparable to those used in previously published research. The active study period was 16 weeks, requiring three clinic visits per week. Participants were evaluated during treatment and at 17, 26, and 52 weeks after admission.

Urinalysis results during the 16-week treatment period showed significantly better results for participants assigned to the two groups featuring CM, whereas urinalysis results from participants in the CBT group were not significantly different than those in the methadone-only group. At week 17, self-reported days of cocaine use were significantly reduced from baseline levels for all three treatment groups but not for the methadone-only group. At 26-week and 52-week follow-up, CBT participants showed substantial improvement, resulting in performance equivalent to that of the CM groups, as indicated by both urinalysis and self-reported cocaine use data.

The researchers concluded that there is solid evidence for the efficacy of CM and CBT in the treatment of methadone-maintained patients for cocaine addiction. Although the effect of CM is significantly greater during treatment, CBT appears to produce comparable long-term outcomes. There was no evidence of an additive effect for the two treatments in combination. *Source: Archives of General Psychiatry, October 2002.*

Resource: JAMA "Patient Pages"

Every week, the Journal of the *American Medical Association* publishes a health information page called the "Patient Page" that is written specifically for patients. Patient Pages are designed to be used for patient education and may be freely copied and distributed for that purpose. Each Patient Page addresses a topic of interest to patients and is related to an article published in that week's issue of *JAMA*. Some Patient Pages also are available in Spanish.

Topics of Patient Pages of interest to addiction medicine specialists include "Treating Drug Dependency" (2000), "Cocaine Addiction" (also available in Spanish; 2002), "Treating Tobacco Dependence" (2000), "Do You Have a Drinking Problem?" (1999), "Driving Safely by Avoiding Alcohol" (2000), and "Benefits and Dangers of Alcohol" (1999).

Patient Pages can be clipped from copies of the journal, or downloaded from the AMA's web site at WWW.AMA-ASSN.ORG/PUBLIC/JOURNALS/PATIENT/INDEX.HTM.

SAMHSA Posts List of Physicians Qualified to Use Buprenorphine

A registry of office-based physicians who are qualified to use buprenorphine in the treatment of opioid addiction is now available on the web site of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), at WWW.BUPRENORPHINE.SAMHSA.GOV. ASAM members can be helpful to their colleagues by reminding them that they cannot prescribe buprenorphine for the treatment of addiction unless they qualify under the conditions established by the Drug Addiction Treatment Act of 2000 (DATA). DATA requires that physicians who wish to use buprenorphine in office-based practice must be certified in addiction medicine by ASAM or by AOAAM or hold a Certificate of Added Qualifications in Addiction Psychiatry, or attend an approved 8-hour buprenorphine training course.

As an approved provider of such training, ASAM has scheduled the following courses for 2003:

April 12, 2003, in Washington, DC

May 4, 2003, in Toronto, Ontario, Canada

November 2, 2003, in Washington, DC

Physicians seeking information on the federal requirements for use of buprenorphine should contact the SAMHSA Buprenorphine Information Center (1/866-BUP-CSAT) Monday through Friday between 8:30 AM and 5:00 PM EST. Those who wish to register for a training course should visit the ASAM web site at WWW.ASAM.ORG or contact Tracy Gartenmann, ASAM Buprenorphine Training Program Manager, by e-mail at TGART@ASAM.ORG or by phone at 301/656-3920.

AGENCIES WARN OF RISING ABUSE OF PRESCRIPTION DRUGS

Abuse of prescription drugs is rising rapidly in the United States, according to the federal Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA data indicate that, in 2001, almost 3 million youths aged 12 to 17 and almost 7 million young adults aged 18 to 25 reported use of prescription-type drugs for other than medical purposes at least once in their lifetimes.

Even more worrisome, data from SAMHSA's National Household Survey on Drug Abuse (NHSDA) show that the number of new non-medical users has been increasing steadily since the mid-1980s, particularly among youth and young adults (Figure 1). For example, the number of new non-medical users of opioids increased from 400,000 annually in the mid-1980s to about two million in 2000. There were 200,000 new non-medical users of stimulants in 1991, but almost 700,000 in 2000. The number of new non-medical users of tranquilizers increased slowly throughout the 1980s and 1990s, then spiked, increasing from 700,000 new users in 1999 to almost a million in 2000. The number of new non-medical users of sedatives held steady at around 100,000 per year between 1988 and 1995, then rose to 175,000 in 2000.

"Young adults—even teens—are taking opioids, antidepressants and stimulants for recreation," said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment. Dr. Clark told a recent press conference that young people "do not seem to realize that this misuse can lead to serious problems with addiction."

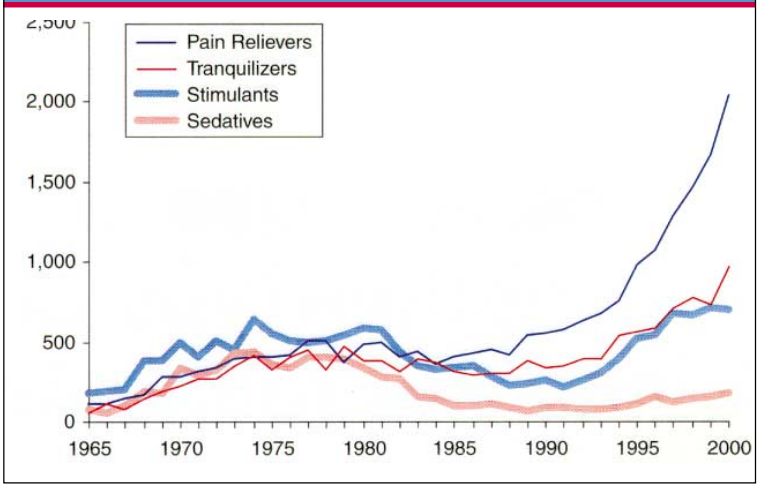
NHSDA data for 2001 show that about 15% of 18- and 19-year-olds used prescription medications non-medically in the past year. Among persons 12 to 17, 7.9% reported past year non-medical use of prescription medications. Among those aged 18 to 25, 12.1% used prescription medications non-medically in the past year. Of these, 6.4% of 12- to 17-year-olds and 9.6% of 18- to 25-year-olds used opioid analgesics; 2.2% of 12- to 17-year-olds and 3.4% of those aged 18 to 25 used stimulants; and 1.7% of 12- to 17-year-olds and 4.2% of 18- to 25-year-olds used tranquilizers non-medically.

John K. Jenkins, M.D., FACCP, Director of the FDA's Office of New Drugs, who joined Dr. Clark at the press conference, noted that when opioid analgesics are used correctly and under a doctor's supervision, the benefits outweigh the risks. But, he cautioned, "abuse them, or mix them with illegal drugs or alcohol, and you can wind up dead. Even using them with other prescription drugs can lead, in some cases, to life-threatening problems."

A separate report released by SAMHSA from its Drug Abuse Warning Network (DAWN) shows that visits to hospital emergency departments related to prescription opioids increased significantly from 1994 to 2001. Visits related to oxycodone increased 352%; those related to methadone rose by 230%; those for morphine rose 210%; and those for hydrocodone rose 131%. Of the visits related to analgesics, 15% of the users said they used the drugs for their psychoactive effects, while another 44% said they were dependent on them (Figure 2). The data show that multiple drugs were mentioned in 72% of the emergency department visits involving opioid analgesics.

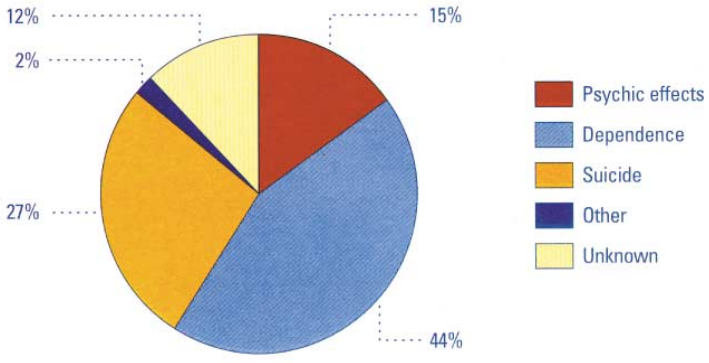
To address the problem, FDA and SAMHSA have joined to launch a public education campaign. The first products of this cooperative endeavor include posters, brochures, and print advertisements. The educational materials are targeted to 14- to 25-year-olds, but the agencies say the materials are relevant to all consumers who use prescription analgesics for non-medical purposes. The reports and other materials can be downloaded from SAMHSA's web site at www.samhsa.gov. FDA consumer information on the abuse of prescription pain relievers is available by calling 1-888-INFO-FDA. *Source: Substance Abuse and Mental Health Services Administration, January 13, 2003.*

Figure 1. Annual Numbers of New Nonmedical Users of Presciption-Type Drugs, by Drug Category: 1965-2000



Source: NHSDA Report: Non-Medical Use of Prescription-Type Drugs Among Youths and Young Adults (Substance Abuse and Mental Health Services Administration, January 16, 2003), page 2.

Figure 2. Narcotic Analgesic-Related ED Visits, by Motive for Abuse: 2001



Source: The DAWN Report: Narcotic Analgesics (Substance Abuse and Mental Health Services Administration, January 2003), page 8.

Treatment Called Key to Public Safety

Iowa Attorney General Tom Miller has called on state legislators to increase funding for addiction treatment, arguing that "It's the most important thing we can do now to fight crime." He asked the Legislature to pay for the programs with a 25 cent increase in the cigarette tax, which hasn't been raised in more than a decade.

The Attorney General's proposal calls for $29 million of new spending on drug treatment and prevention. It also asks for $15 million in increased spending for anti-tobacco programs. In framing the proposal, Miller said, "It is important to understand...addiction as a disease instead of a result of personal weakness and moral failing." He added that 6.7 million Americans are affected by drug addiction and 13.8 million by alcoholism—roughly equivalent to the 21 million Americans affected by heart disease.

Miller said the overwhelming connection between drugs and crime is what makes treatment essential to public safety. "The number one thing we can do to fight crime is fight drugs, and the number one thing we can do to fight drugs is to do a better job with drug treatment. This is a crucial public safety measure," he added, pointing to federal statistics showing that 80% of persons in prison have been identified as having a problem with drugs or alcohol. In Des Moines, he said, 57% of persons arrested test positive for drugs, and 35% were at risk for alcohol dependence. The Iowa Department of Corrections has reported that 75% to 80% of all correctional clients admit to a history of alcohol or drug problems, and a federal study shows that one-third of state prison inmates reported being under the influence of drugs at the time of their offenses.

To deal with the problem, the Attorney General said, requires a three-pronged approach composed of prosecution, prevention, and treatment. He noted that "Drug shipments crossing our Interstate highways are being intercepted. Meth labs are being discovered. Drug dealers and users are being arrested and prosecuted." However, he cautioned that "Tough prosecution is very important, but it will only work when it's used in conjunction with effective drug and alcohol treatment. Increasing the money available for substance abuse treatment will reduce crime and make Iowans safer."

"Drug treatment reduces crime more than any other single thing we can do," Miller said. "It's proven to succeed and pay off." The Attorney General cited research by the University of Iowa showing that, among persons receiving addiction treatment, the number reporting no arrests increased by 51%, while the number reporting 1 to 3 arrests decreased by 51%. Miller also noted that the economic benefits of treatment are much greater than its costs. "Drug treatment saves money," he said, pointing to studies that show a dollar spent on drug treatment pays a $4 to $7 dollar return, mostly in health care savings and increased productivity.

The Attorney General asked that resources for substance abuse treatment and related programs be increased by about $44 million, saying that the funds would be used to get more people into treatment, and let them stay in treatment long enough to obtain the maximum benefit. *Source: Press release, Iowa Attorney General, January 12, 2003* **[WWW.IOWAATTORNEYGENERAL.ORG].**

Treatment Funds in Jeopardy

Reacting to voters' rejection of a January 28th referendum that would have temporarily increased tax revenues, Oregon officials warned that a major budget deficit is threatening the state's entire social and health service system, including publicly funded addiction treatment. In the absence of new revenues, officials said, the deep budget cuts required to balance the state's budget will force programs to close and patients to drop out of treatment.

Lawmakers already have eliminated $3 million from the state's addiction treatment budget, mostly affecting outpatient treatment. Additional cuts are expected to eliminate addiction, mental health, and dental benefits for 110,000 persons enrolled in the Oregon Health Plan (29,000 of whom actually received addiction or mental health services in 2001), and to close 115 residential treatment beds.

Treatment advocates in other states are bracing for similar cuts, as the majority of states have projected significant deficits in 2003 and 2004. (Unlike the federal government, Oregon and most other state governments are required by law to operate a balanced budget). *Source: CBS News, January 29, 2003; Alcoholism & Drug Abuse Weekly, January 13, 2003.*

Comprehensive Treatment Plan Launched

As many states cut social services spending, Wyoming has enacted a remarkable piece of legislation that offers a ray of hope to advocates for treatment and prevention nationwide.

In March 2002, the Wyoming legislature passed House Bill 59 (H.B.59), a comprehensive alcohol and drug control plan that is funded with proceeds from the state's share of the tobacco settlement. The measure received bipartisan support and was signed into law by Republican Governor Jim Gehringer. "For years, legislators have grappled with how to deal with an increase in criminal sentences," the Governor said, adding, "what we haven't done is deal with the root cause."

"Treatment saves money, and we're tired of building prisons," said State Rep. Doug Osborn, the Wyoming lawmaker who sponsored H.B.59. "Warehousing prisoners is part of a revolving-door policy."

Remarkably, the law commits Wyoming to spending about $50 for every state resident in support of addiction prevention, early intervention, and treatment. To fund the program, $50 million in tobacco money has been placed in a trust fund; interest on that fund, plus annual settlement payments going forward, have been set aside. (To put those figures in perspective, the state of California would have to spend about $1.5 billion to make the same kind of per capita investment in addiction treatment, according to consultant Dennis Embry, Ph.D., who worked with the Substance Abuse Division of the state Department of Health to craft a 2001 report on the scope of Wyoming's drug problem and possible solutions.)

Key elements of the Wyoming plan include a statewide adult and juvenile drug court system, investment in outpatient and residential treatment programs, incentives for establishing drug-free workplaces, and use of community coalitions to coordinate local efforts. The plan funds increased inspection of alcohol outlets to prevent sales to minors, as well as a social marketing plan aimed at reducing public tolerance for underage drinking. DUI laws are toughened as well. The plan requires adherence to treatment standards and certification, use of science-based treatment interventions, data reporting, and outcome measurements.

The Wyoming strategy is based in part on "Reclaiming Wyoming: A Comprehensive Blueprint for Prevention, Early Intervention,

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Comprehensive Treatment Plan Launched *continued from page 13*

and Treatment of Substance Abuse," a report authored by Embry and Rodger McDaniel, a consultant with the state health department. They say the legislation can be traced back to 1997, when an advisory panel was formed to tackle the then-new problem of methamphetamine use and production in the state. "Methamphetamine hit hard and ruggedly in Montana," notes Embry, with drug-related arrests increasing tenfold between 1990 and 2000. Significantly, problems with the drug crossed racial and socioeconomic lines, bringing the drug problem home to middle- and upper-class families as well as the state's poorer communities.

Faced with a deluge of methamphetamine-related crime, Wyoming's Department of Criminal Investigation director, Tom Pagel, began canvassing the state, telling community groups that his officers "could not arrest their way out of the problem." Meanwhile, Wyoming received federal funds to conduct its first comprehensive epidemiologic study, which found that 40% of the pregnant women seen in state clinics were using alcohol and tobacco during their pregnancies, while 14% were using illicit drugs.

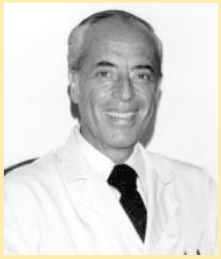
"People did a good job of tying all this together" in support of H.B.59, said Embry. Osborn added that casting the legislation as a child-protection measure was critical to its passage. "The reason [addiction] is not a hot-button issue with most legislators is that they do not understand the crisis they have on their hands," he said. "Most of our folks readily supported the plan when they came to understand the impact alcohol and other drugs were having on our kids, our social structure, and our state expenditures."

Wyoming's treatment community was instrumental in educating lawmakers over a three-year period about the extent of the state's problems and how they could be addressed. By 2002, officials from the governor on down recognized that most of what had been done in the past hadn't worked, said Osborn. "We took some initial action to shore up what we knew worked: the drug courts," he said, adding that "We demanded a comprehensive plan with accountability." Ultimately, the law received support from groups as diverse as the state's treatment providers and the Wyoming Business Alliance.

With the addition of a federal State Incentive Grant, funding for Wyoming's plan could go as high as $34 million annually. "I think we have a viable, external revenue stream that makes sense to most people," said Osborn. "So far, Wyoming has not suffered the effects of the economic downturn because of our minerals-based economy." Still, he said, there are no guarantees that the funding will be permanent, so advocates need to remain vigilant. Embry strongly urged foundations and other government agencies with an interest in addiction issues to get involved in studying and supporting Wyoming's bold initiative. "People are always talking about comprehensive approaches. Well, here it is," he said. *Source: Bob Curley, Join Together Online, November 15, 2002.*

Board Report *continued from page 5*

Focus on Membership



Stanley Gitlow, M.D., FASM

Reflecting the need of all medical societies to increase membership and to engage younger physicians, the Board approved a motion to encourage all committee chairs to appoint an assistant chair who is younger than 45 years of age or with less than 10 years of practice. (ASAM staff will circulate a list of eligible members to committee chairs.) Continuing that emphasis, the Board voted to add the Chair of the Physicians-in-Training Committee to the Board of Directors as an *ex officio,* non-voting member.

At the same time, in recognition of the many contributions of more senior members of ASAM, the Board bestowed Emeritus membership on Stanley Gitlow, M.D., FASAM, one of the founders of ASAM, twice its President, and a member of the Board of Directors for 44 years.

Dr. Stuart Gitlow, ASAM's delegate to the AMA, was authorized to attend forthcoming meetings of the AMA's Organization of Organizations Committee, which is to decide whether the AMA of the future will be composed of individual physician members, or whether it will become an umbrella organization of state chapters and medical specialty societies. A number of proposals currently are under consideration, and the Board wants ASAM to have a say in this momentous decision.

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Dr. Nora Volkow Named New NIDA Director

Nora D. Volkow, M.D., has been named Director of the National Institute on Drug Abuse, succeeding long-time NIDA Director Alan I. Leshner, Ph.D., and Acting Director Glen R. Hanson, D.D.S., Ph.D. She is expected to assume her new duties April 15th.

Dr. Volkow currently is Associate Director for Life Sciences at Brookhaven National Laboratory, where she also serves as Director of Nuclear Medicine and Director of the NIDA-DOE Regional Neuroimaging Center. She also is Professor of Psychiatry and Associate Dean of the Medical School at SUNY-Stony Brook.

Known for her work on the brain's dopamine system, Dr. Volkow focuses her research on the mechanisms underlying the reinforcing, addictive and toxic properties of drugs of abuse in the human brain. As a scientist, she has been supported by grants from NIDA, the National Institute on Alcohol Abuse and Alcoholism, and the U.S. Department of Energy.

A recipient of multiple awards, Dr. Volkow has been elected to membership in the Institute of Medicine of the National Academy of Sciences and was named "Innovator of the Year" in 2000 by U.S. News & World Report. She is the author of more than 275 peer-reviewed articles, has edited three books, and has published more than 50 book chapters and other manuscripts. Dr. Volkow received her medical degree from the National University of Mexico and her postdoctoral training in psychiatry at New York University.

ASAM Members Retire As AMA Delegates

Two ASAM members, Lee H. McCormick, M.D., and Samuel W. Cullison, M.D., recently completed long and distinguished tenures as members of the House of Delegates of the American Medical Association—that organization's chief policymaking body.

Dr. McCormick, a fellow in the American Academy of Family Physicians since 1978, was a delegate to the AMA House representing the Pennsylvania Medical Society from 1990 through 2002, serving as vice chair of the PMS delegation since 1998 and chair of the Governing Council of the AMA's Organized Medical Staff Section from 1992 to 1996. Dr. McCormick also served as President of the Pennsylvania Medical Society from 1997 to 1998, and has been President of ASAM's Pennsylvania Chapter.

Family physician Sam Cullison, M.D., of Seattle, WA, has represented the Washington State Medical Society in the AMA's House of Delegates and chaired the state society's delegation to the AMA House. He recently relinquished that post to assume the Presidency of the Washington State Medical Society.

ASAM PPC Is The Focus of NIDA Research

ASAM Board member David Gastfriend, M.D., reports that the National Institute on Drug Abuse (NIDA) has initiated a nationwide process to develop large-scale multisite trials of the *ASAM Patient Placement Criteria*. NIDA recently announced development of the Treatment Matching Interest Group (TMIG) to researchers and treatment programs participating in its Clinical Trials Network. The first TMIG meeting is to be held in Miami in January; Dr. Gastfriend plans to attend.

Dr. Wetterau Speaks Out on Adolescent Alcohol Use

Norman Wetterau, M.D., chair of ASAM's Family Practice Committee, is featured in an article in the January 13th issue of *American Medical News*, published by the American Medical Association. In the article, by Victoria Elliott, Dr. Wetterau recounts his experiences treating adolescent patients injured as a result of alcohol use: one in a motorcycle crash, one from a gunshot wound, and one as the result of a fall.

"Substance abuse is the No. 1 medical problem of young people, and alcohol is the No. 1 substance," Dr. Wetterau says. "When a teenager comes into a physician's office for a physical and we do not ask about alcohol use, we're doing this teenager a great disservice. We're letting them know that we don't think alcohol is a problem. The medical profession needs to start dealing with this in a responsible way."

The article goes on to recount the AMA's efforts to reduce adolescents' alcohol use. At its 2002 Interim meeting, AMA's House of Delegates accepted a report, entitled "Harmful Consequences of Alcohol Use on the Brains of Children, Adolescents and College Students," that summarizes recent research on the effects of alcohol on the developing brain. Information on the AMA's alcohol policies is available at WWW.ALCOHOLPOLICYSOLUTIONS.NET **and** WWW.AMA-ASSN.ORG/AMA/PUB/ARTICLE/**3342-3626**.HTML.

ASAM Conference Calendar

ASAM

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

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

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

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

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

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

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

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

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

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

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

November 21-23, 2003
Medical Review Officer (MRO) Training Course
Washington, DC
20 Category 1 CME credits

Other Events of Note

April 10, 2003
National Alcohol Screening Day
[For information, contact 781/239-0071 or visit WWW.MENTALHEALTHSCREENING.ORG]

June 13-19, 2003
NIDA International Forum:
Building International Research—
Emerging Trends and Patterns in Drug Abuse
Miami, FL
[For information, contact MJONES@NGMSMTP.NIDA.NIH.GOV]

June 21-25, 2003
Research Society on Alcoholim
26th Annual Scientific Meeting
Ft. Lauderdale, FL
[For information, visit WWW.RSOA.ORG]

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

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