May/June 2003
Volume 18, Number 3

ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

ASAM at Work for You:

EVP's Report / **2**

From the President / **4**

ASAM Board Actions / **5**

Membership / **6**

Committee Report / **7**

Chapter News / **12**

Ruth Fox Fund / **14**

People in the News / **15**

Calendar / **16**

Also see:

ADM News / **3**

Clinical Notes / **8**

Perspectives / **11**

Progress Toward Parity / **13**

www.asam.org

MRO, Best Practices Courses Scheduled for Chicago

A new course on "Best Practices: Clinical Drug Testing in Addiction Treatment" will be offered for the first time July 17 in Chicago. Organized by Louis E. Baxter, Sr., M.D., FASAM, the course features expert speakers on drug test selection and interpretation. The faculty includes ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, and Dr. J. Michael Walsh, former director of the White House Office on a Drug-Free Workplace. The course offers 7 hours of Category 1 continuing education credit.

The Best Practices course immediately precedes ASAM's Medical Review Officer training course, scheduled for July 18-20, also at the Chicago Westin Michigan Ave. Hotel. The MRO course features an update on implementation of the new federal Part 40 rule. Under the direction of course chair Donald Ian Macdonald, M.D., FASAM, the faculty also will review recent developments in alcohol and drug testing technologies in terms of their implications for the work of Medical Review Officers. The course, which prepares candidates to sit for the MRO certifying examination, is approved for 18 hours of Category 1 CME credits.

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

SARS Forces Cancellation of Med-Sci; Pain Course Rescheduled to Autumn 2003

Faced with a travel advisory from the World Health Organization and concerns about the health risks posed to ASAM's members, their families and patients by Canada's outbreak of severe acute respiratory syndrome (SARS), the Society's Board of Directors reluctantly decided to cancel the 34th Annual Medical-Scientific Conference, scheduled for Toronto in early May.

Although the Med-Sci conference cannot be rescheduled for logistical reasons, the Board has rescheduled the course on Pain & Addiction: Common Threads IV for Sunday, November 2, 2003, immediately following ASAM's course on the State of the Art in Addiction Medicine. Both courses, as well as a November 2 Buprenorphine training course, will be held in Washington, DC.

ASAM's meetings staff has been in touch will every registrant for the Toronto conference to offer a range of options, including transferring their registration fees to the fall courses. Watch ***ASAM News*** for further details.

ASAM Needs Your Support Now, More than Ever

Eileen McGrath, J.D.

Eileen McGrath, J.D.

As I'm sure you can imagine, the cancellation of ASAM's Medical-Scientific Conference in Toronto has caused considerable hardship to all involved—registrants, faculty, organizers, exhibitors, and staff. You can be assured that your Board and staff are doing everything in their power to reduce that hardship. Registrants are to be offered the option to transfer their registration fees to other ASAM conferences. Exhibitors will be offered opportunities to reach the ASAM audience through the Society's newsletter and in other ways.

Cancellation of the Toronto program has imposed a significant financial hardship on ASAM, as well. The cancellation resulted in a significant loss of revenues from meeting registrations, as well as sales of ASAM publications, including the newest edition of our textbook, *Principles of Addiction Medicine.*

To help the Society emerge from this difficult period without compromising our mission or the quality of our programs, we are asking ASAM's members and friends to make a one-time donation to a special "SARS Relief Fund." All donations to the fund, which are fully tax-deductible, will be used to support ASAM's programs and member services.

A special account to receive donations has been established at ASAM's headquarters office. Checks should be made payable to ASAM and sent in care of Ms. Joanne Gartenmann at the ASAM office, 4601 No. Park Ave., Suite 101, Chevy Chase, MD 20815.

As a gesture of appreciation, each donor will receive a special "Toronto tote bag" containing:

- A booklet of accepted abstracts for the 34th Medical-Scientific Conference.
- A CD-Rom that accompanies the 2003 course on Pain & Addiction: Common Threads IV.
- A fully searchable CD-Rom containing Section 10, "Medical Disorders and Complications of Addiction," from ASAM's new textbook, *Principles of Addiction Medicine, Third Edition.* (The CD-Rom is available only as a gift to donors and will not be offered for sale.)

In these difficult times, we all have been heartened by the generous support offered by so many of ASAM's member and friends. With your help, your Society will overcome this setback and move on to even greater accomplishments in the future.

Foundation to Recognize Health Leaders

September 22 is the deadline for letters of intent for the latest round of awards under the Robert Wood Johnson Foundation's Community Health Leadership Program.

The program recognizes community leaders who tackle complex health problems such as those related to alcohol and other drug abuse.

Each award includes a grant of $120,000 to $150,000 for the leader's organization, as well as a personal stipend of $15,000. Mid-career leaders working in local communities across the U.S. may be nominated.

For more information, see the program's web site at WWW.RWJF.ORG.

American Society of Addiction Medicine
4601 North Park Ave., Suite 101
Chevy Chase, MD 20815

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

Officers

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

Immediate Past President
Marc Galanter, M.D., FASAM

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

Secretary
Donald C. Lewis, M.D.

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

Executive Vice President/CEO
Eileen McGrath, J.D.

ASAM News
is an official publication of the American Society of Addiction Medicine. It is published six times a year. Please direct all inquiries to the Editor at ASAMNEWSLETTER@AOL.COM or phone 703/538-2285.

Chair, Publications Committee
Elizabeth F. Howell, M.D., FASAM

Newsletter Review Board
LeClair Bissell, M.D.
Sheila B. Blume, M.D., FASAM
Max A. Schneider, M.D., FASAM

Founding Editor, 1985-1995
Lucy Barry Robe

Editor
Bonnie B. Wilford

Subscriptions
Free to ASAM members; $99 a year (six issues) to nonmembers. To order, phone 1-800/844-8948 or fax 301/206-9789.

Advertising
Advertising rates and schedules are available on request. Please direct inquiries to the Editor at 703/538-2285 or e-mail ASAMNEWSLETTER@AOL.COM.

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).

SAMHSA Publishes Buprenorphine Final Rule

An interim final rule that will permit addiction treatment programs to offer buprenorphine treatment in addition to methadone and LAAM has been announced by the Substance Abuse and Mental Health Services Administration (SAMHSA). The rule, which enables programs that are certified by SAMHSA to use the newly approved buprenorphine products, Subutex® and Suboxone®, for the maintenance or detoxification treatment of opioid dependence, the rule became effective May 22. It has a comment period open for 60 days, until July 21, 2003.

Treatment programs that wish to offer buprenorphine are advised by SAMHSA to review their state's licensing laws and regulations and to modify their registrations with the federal Drug Enforcement Administration (DEA). The modification process can be initiated by sending a fax or letter to the DEA, giving the program's DEA registration number and requesting a modification to include Schedule III narcotic drugs. The letter must be signed by the program director or medical director and should be faxed to Ms. Ghana Giles at 202/353-1125 or mailed to Ms. Giles at DEA, Registration Unit-ODRR, Washington, DC 20537.

Once the application is approved, DEA will issue a modified registration certificate, enabling the program to order Subutex and Suboxone directly from the products' manufacturer by phoning 866/882-2107. *[See the related stories on page 7.]*

FTC Reviews Liquor Marketing Practices

The Federal Trade Commission (FTC) has asked eight beer and spirits companies to submit information about steps they are taking to prevent marketing of their products to an underage audience. Specifically, Allied Domecq, Anheuser-Busch, Brown-Forman, Coors, Diageo, Jim Beam Brands, Miller Brewing Co. and the Mark Anthony Group, makers of Mike's Hard Lemonade, were told by the FTC to detail their marketing practices, ad content, and target audiences.

The FTC review follows a September 2002 report from the Center on Alcohol Marketing and Youth at Georgetown University, charging that magazine readers aged 12 to 20 viewed significantly more ads for beer and distilled spirits than those over age 21.

In 1999, the FTC recommended that alcohol companies establish independent review boards to focus on responding to public complaints, that they restrict advertising to media where more than 50% of the audience is 21 or older, and that they develop a set of best practices, such as prohibiting ads on television shows and media with a large underage audience.

In this year's appropriations bill, Congress asked the FTC to prepare a six-month study of the beverage alcohol industry's marketing practices. A draft is expected in August. *Source: AdWeek, May 16, 2003.*

Heroin Epidemic Tied to Treatment Cutbacks

Massachusetts' commissioner of public health has warned legislators that a heroin epidemic engulfing the state will intensify if lawmakers pursue a current plan eliminate funding for methadone clinics. "We have a heroin epidemic in this state and we need to address it," said Commissioner Christine Ferguson. "We have to attack this problem head on. Every tool that we have at our disposal should be used."

Department of Public Health officials say that the number of deaths related to abuse of opioids increased by 156% between 1990 and 1998. State data also show that 42% of patients entering publicly funded treatment programs in 2002 said they had used heroin within the preceding year, compared with 19% in 1992. In addition, 60% of persons entering detoxification programs reported using heroin—the same number as reported alcohol addiction.

Despite the data, a budget approved earlier this year by the state's House of Representatives would force more than 24 treatment programs that offer methadone to drop the service. The budget not only cuts $5 million from treatment funding, it explicitly prohibits state funds from being "awarded to those organizations providing methadone services." Gov. Mitt Romney has proposed to cap funding of treatment programs at $37 million—the same amount budgeted in the last fiscal year. *Source: Associated Press, May 20, 2003.*

Suit Challenges Use of Vouchers to Fund Addiction Treatment

In a case that has clear implications for the Bush administration's faith-based initiative, a Wisconsin federal appeals court has been asked to determine whether the state's Department of Corrections can use state-funded vouchers to send drug offenders to a religiously oriented outpatient treatment facility.

The Freedom From Religion Foundation, a group advocating separation of church and state, brought the lawsuit against the state Corrections Department and Faith Works Milwaukee, a residential treatment program. Earlier, a U.S. District Court ruled that corrections officials could use vouchers to fund treatment at Faith Works because offenders chose the provider voluntarily after being made aware of its religious nature. Richard Bolton, attorney for the Foundation, argued that the Department of Corrections endorsed a religion by referring people to Faith Works, in violation of the fourth amendment of the U.S. Constitution. *Source: Chicago Tribune, May 13, 2003.*

Support Builds for FDA to Regulate Tobacco

After years of discussion, experts say this may be the year Congress enacts legislation to give the Food and Drug Administration (FDA) power to regulate tobacco products.

Antismoking activists long have pushed for FDA control, but this year even tobacco companies are calling for increased federal regulation. Philip Morris, for example, wants the FDA involved because it plans to market so-called "safer" cigarettes, and wants to be able to make health claims about the new product.

A Philip Morris spokesperson said there is a better than even chance that Congress will pass such a bill in the current session. James Manley, a spokesman for Sen. Edward Kennedy (D-MA) agreed that the odds of passage are improving. "If there's a year to get it done, this is it," Manley said. "Senator Kennedy feels that the closer we get to the elections, the more difficult it gets, so he'll be pushing this year." *Source: Join Together Online, June 6, 2003.*

Moving Forward

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

Although we all are disappointed that the SARS outbreak forced cancellation of ASAM's 2003 annual meeting, scheduled for Toronto, I am heartened at the splendid manner in which your officers, staff and Board members rose to the challenge.

First, the Board participated fully in monitoring the situation in Toronto—through almost daily contact with ASAM members in that city, and my own conversations with high-level officials of the Centers for Disease Control and Prevention, as well as by closely monitoring the official media—and clearly acted in the best interests of the Society's members.

Next, ASAM's staff quickly organized a two-day meeting in Washington, DC, so that the Board could immediately address the organizational repercussions of the cancellation, as well as fulfill its constitutional obligation to meet in person twice a year.

Addressing Implications of the Cancellation

After careful consideration of financial models and projections prepared by staff, the Board voted to reschedule the Pain & Addiction Course to follow ASAM's State of the Art Course in November 2003. Consideration was given to rescheduling other components of the Med-Sci meeting, but significant logistical and financial considerations persuaded the Board that to do so would not result in the high-quality programs participants have come to expect, and thus would not be in the best interests of the organization or its members. Instead, some of the key aspects of Med-Sci, such as the presentation of awards to leaders in our field and the Ruth Fox Scholarship Program, will be carried over to the 2004 Medical-Scientific Conference, already scheduled for Washington, DC.

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

The Board also was careful to verify that ASAM members who turn to our conferences to meet their continuing education obligations will be able to do so, as the 2003 State of the Art Course (scheduled October 30-November 1) offers 21 Category 1 CME credits, in addition to 8.25 credits for the Pain Course (rescheduled to November 2) and 8 credits for the Buprenorphine training course (scheduled for November 2).

Finally, the Board took a number of steps to minimize the adverse impact of the Med-Sci cancellation on the Society's finances.

Monitoring Progress

The Board carefully monitored the Society's progress toward its goals in several significant areas, including publications and continuing education offerings, committee structure, policy developments, and member services.

In the membership arena, Board members were encouraged to become personally involved in recruiting new members. The Board also approved continuation of the State Medical Society Project, and initiated the next round of applications for Fellow status. The Board also approved 296 Certificates to physicians who passed the 2003 Certification Examination.

New Officers Installed

Finally, the officers and Board members elected in last fall's balloting were installed and immediately began their work. I was pleased to swear in Elizabeth F. Howell, M.D., FASAM, as the Society's President-Elect; James A. Halikas, M.D., FASAM, as Treasurer; David C. Lewis, M.D., as Secretary; and Anthony Dekker, D.O., FASAM, David R. Gastfriend, M.D., Stuart Gitlow, M.D., M.P.H., and Penelope P. Ziegler, M.D., FASAM, as at-large members of the Board. We welcome them and look forward to working with them, as with all our Board members, to create in ASAM an ever-stronger voice for our profession and the patients we serve.

FUNDING SUPPORT ACKNOWLEDGED

ASAM acknowledges with gratitude the generosity of the following organizations and individuals for their support of the 34th Annual Medical-Scientific Conference, the Ruth Fox Course for Physicians, the Buprenorphine Course, and the Course on Pain & Addiction: Common Threads IV. Those courses, scheduled for Toronto, were cancelled because of the World Health Organization's travel advisory related to outbreaks of severe acute respiratory syndrome (SARS).

Agouron Pharmaceuticals, Inc.
Aliton Long-Term Care Pharmacy, Inc.
Alkermes, Inc.
Bendiner & Schlesinger, Inc.
Bristol-Myers Squibb
Canadian Society of Addiction Medicine
Caron Foundation
COPAC, Inc.
Dr. and Mrs. Joseph E. Dorsey
Endo Pharmaceuticals, Inc.
The William J. Farley Center
Forest Laboratories
GlaxoSmithKline, Inc.
The Haworth Press
Hazelden
Janssen Pharmaceutica, Inc.
Mallinckrodt Pharmaceuticals
Manisses Communications Group
Metropolitan Recovery Residences
John P. McGovern, M.D., Foundation
Odyssey Pharmaceuticals
Pfizer, Inc.
Pharmacia
Pine Grove/Next Step
Purdue Pharma, L.P.
Reckitt & Benckiser Pharmaceuticals
Shick Shadel Hospital
The Christopher D. Smithers Foundation
Talbott Recovery Campus
Vista Pharma
Willingway Hospital

Cooperating Organizations

Center for Substance Abuse Treatment
Centers for Disease Control & Prevention
National Institute on Alcohol Abuse and Alcoholism
National Institute on Drug Abuse

Board Approves Alternate Pathway to Certification

Lloyd J. Gordon III, M.D., FASAM

ASAM Certification enhances physicians' career opportunities and recognizes their expertise in addiction medicine. The ASAM Board of Directors recently approved an alternate pathway for physicians who have not completed a residency training program in an ACGME-recognized medical specialty, so that they also will have an opportunity to earn this prestigious credential. Under the new policy, physicians who have not completed an ACGME-recognized residency training program may be accepted to sit for the 2004 Certification Examination if they meet certain new criteria (see accompanying article).

The history of the ASAM Certification examination dates from 1986. The examination, which was given every year for the first three years, initially was open to any physician who spent a significant amount of time in the practice of addiction medicine. Over time, the criteria to sit for the exam became more restrictive; for example, a requirement was added that applicants must have completed 50 hours of continuing education credits in the two years preceding the examination.

In keeping with this trend, the Board voted in 1990 that applicants must have completed an ACGME-recognized residency training program in any medical specialty. The purpose of this requirement was to upgrade the application criteria to a level that would be acceptable to the American Board of Medical Specialties, because ASAM's primary goal was to become recognized by the ABMS.

ASAM the "Gold Standard"

However, the ASAM Board came to realize that ASAM's Certification had garnered wide acceptance by state governments, insurance companies, and managed care organizations, which had begun to view certification by ASAM as the "gold standard" in addiction medicine. At about the same time, ASAM published its *Patient Placement Criteria* and the *Principles of Addiction Medicine* textbook, which further legitimized the Society's place in medicine.

On the other hand, residency and fellowship programs in addiction medicine did not develop as quickly as we expected and hoped. Thus, there were not enough training programs to accommodate all physicians who wished to sit for the Certification examination.

As Chair of the Certification Committee, it became apparent to me, as it did to other committee members, that many applicants for the Certification examination, while technically qualified under the criteria, were trained in an unrelated medical specialty and had little experience in addiction medicine. On the other hand, we saw applicants who were well qualified in addiction medicine but who had not completed a residency training program and thus could not sit for the ASAM examination.

With that in mind, the Credentialing Committee urged the Board to open an alternate pathway to Certification, and the Board recently agreed to do so. In opening it, the Board made clear that it wished to provide a mechanism by which physicians who have not completed an approved residency and who are not board-certified (nearly 25% of all physicians, according to the AMA) can become certified in addiction medicine, while maintaining a rigorous standard for certification in addiction medicine. In doing so, ASAM joins several other medical organizations that have taken similar actions.

Although I no longer chair the Credential ing Committee, I still believe that this is the appropriate thing to do. Thus, it is with a great sense of anticipation that I approach the 2004 examination cycle. I urge applicants to take advantage of this opportunity, as the Board will reexamine the policy in 2006 and there is no guarantee that the alternate pathway will remain open after that time.

Dr. Gordon, who is a member of the ASAM Board of Directors, is Medical Director of COPAC, Inc., Brandon, MS.

Requirements for the Alternate Pathway

Candidates for ASAM Certification who have not completed an ACGME-recognized residency training program may be accepted to sit for the 2004 Certification Examination if they:

1. Document that a substantial portion of their practice over a five-year period (three of which are continuous) has been devoted to the treatment of alcoholism and other drug dependencies.

2. Provide letters of reference from two ASAM-certified physicians, attesting to the candidate's good standing in the medical community. (At least one of these letters must be from a physician who has had direct contact with the applicant in his/her practice of addiction medicine.)

3. Document completion of 250 hours of continuing medical education credits in the two years preceding the examination, half of which must have been in addiction medicine and addiction-related topics.

Applications for the 2004 ASAM certification examination will be available in July 2003. To be added to the mailing list to receive an application, contact the ASAM office at 301/656-3920 and ask for the Credentialing Department. Additional information is available on ASAM's web site at WWW.ASAM.ORG.

Addiction Fellowships Available

University of Florida

Beautiful beach community fellowships in Jacksonville, St. Augustine, and Daytona Beach, as well as Gainesville, Florida. Positions available for Board-certified or Board-eligible physicians who can be licensed by the State of Florida. One-year or two-year positions as an ASAM or AAAP Addiction Fellow in the University of Florida College of Medicine's Division of Addiction Medicine, under the direction of Mark Gold, M.D. Extensive training in tobacco, alcohol and other drug evaluations, as well as detox, forensic evaluation, drug court, impaired physician, and treatment. Addiction Fellows also have research and teaching opportunities at the University of Florida College of Medicine in Gainesville. **Contact William Jacobs, M.D. FASAM, University of Florida, Department of Psychiatry, College of Medicine at 352/392-6686.** *EEO/AA Employer.*

Should ASAM Accept Non-Physicians As Members?

In the January-February issue of ASAM News, President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, reported that the Membership Committee had recommended that the Board consider opening membership in the Society to non-physicians. Dr. Brown asked ASAM's members to weigh in on this important matter by completing a survey enclosed with that issue. The survey was designed to collect information that would provide insights into members' attitudes toward opening the Society's membership to various categories of non-physicians, either as regular members or through a special class of "affiliate member."

All told, 301 responses were received (a 10% response rate). Respondents were broadly representative of the ASAM membership as a whole in terms of gender and age. The distribution of respondents' primary specialties (Figure 1) also was broadly representative of the distribution of these specialty categories among all ASAM members.

FIGURE 1.
Primary Specialty of Survey Respondents

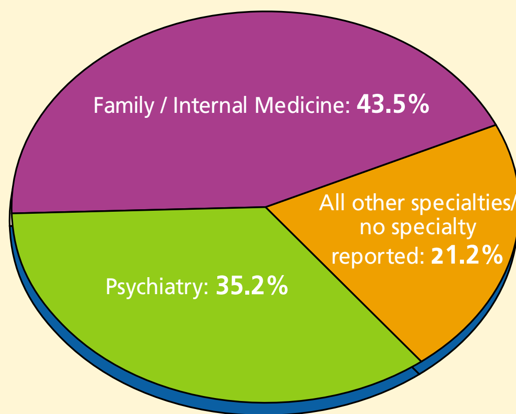
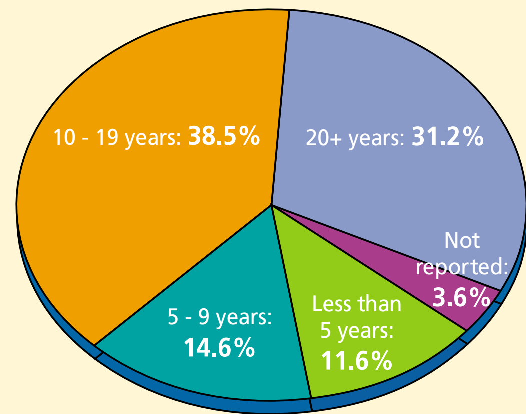


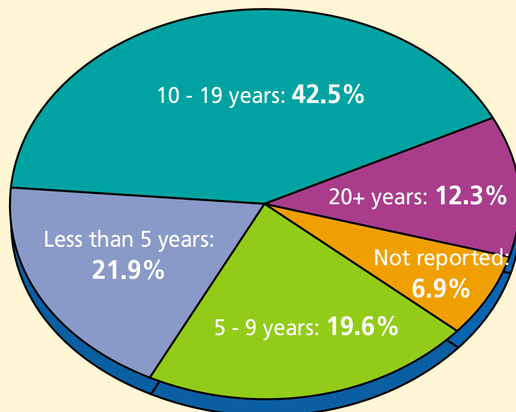
FIGURE 2.
Years Spent Practicing Addiction Medicine



Respondents represented a diverse group in terms of the number of years spent in the practice of Addiction Medicine (Figure 2).

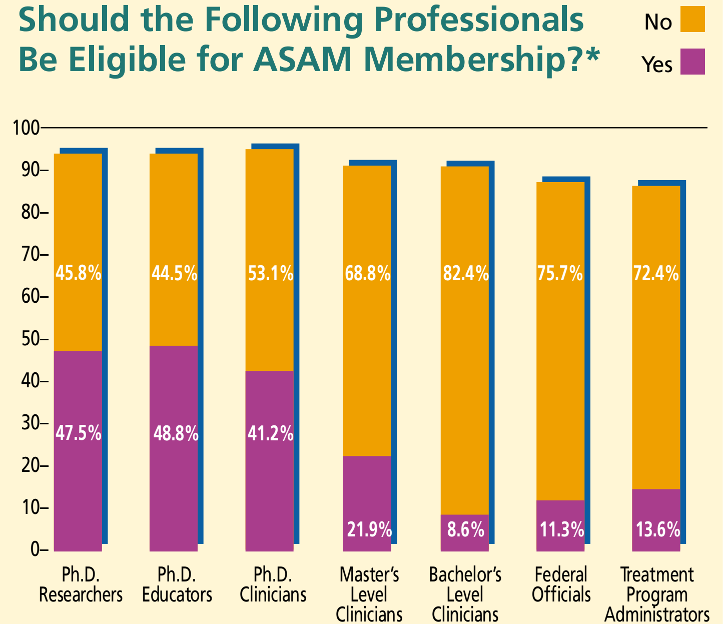
The largest number of respondents had been members of ASAM for more than 10 years (Figure 3).

FIGURE 3.
Years Spent as a Member of ASAM



The survey asked if addiction professionals in various categories should be admitted to membership in ASAM (Figure 4). Responses varied considerably with the academic credentials of the group in question. For example, "yes" and "no" responses were divided almost evenly on the question of whether to admit Ph.D.-level researchers and educators. At the other extreme, "no" votes outnumbered "yes's" by an 8-to-1 margin on the question of whether to admit bachelor's level counselors.

FIGURE 4.
Should the Following Professionals Be Eligible for ASAM Membership?*



* *Where numbers do not total 100%, the balance of the surveys were marked either "No opinion" or there was no response.*

Update on New Medications

Donald R. Wesson, M.D.
Chair, ASAM Medications Development Committee

The Medications Development Committee will contribute a regular column to ***ASAM News*** to update members about developments in new medications for the treatment of addiction and related disorders.

Progress on Buprenorphine

The long anticipated dream of office-based buprenorphine to treat opioid dependence finally is becoming a reality. Physicians have begun to treat opioid-dependent patients with Suboxone® within their office-based practices, and some report receiving referrals from the Substance Abuse and Mental Health Services Administration's physician locator web site. The manufacturer, Reckitt & Benckiser Pharmaceuticals, has formally "launched" the products with a sales force of about 30 regional representatives. Suboxone is sent to pharmacies as they request it. Thus, it is important for a physician who intends to prescribe the drug to alert the pharmacy in advance. The manufacturer has agreed to the FDA's request that it distribute the drug through this "demand distribution" system. Any pharmacy can order the drug from its normal drug wholesaler, and some pharmacies are beginning to stock it.

DATA 2000 Extended

Some key provisions of DATA 2000 recently were extended to October 2005. The law allows qualified physicians to dispense or prescribe Schedule III, IV, or V narcotic medications approved by the Food & Drug Administration for the treatment of opioid dependence. It also contains a provision that prohibits states from enforcing current laws or creating new regulations that would preclude physicians from prescribing or dispensing the medications; in effect, states cannot prohibit physicians from prescribing "narcotics" for the treatment of addiction.

At the time DATA 2000 became law, the provision was written for three years. At that time, the Food and Drug Administration's approval of Suboxone® and Subutex® seemed imminent. However, FDA did not approve Subutex and Suboxone until October 2002. By that time, the legislative clock had been running for two years, so the preemption provisions of DATA 2000 would expire in October 2003. However, a paragraph embedded in a 2002 appropriations bill amended the DATA 2000 three-year provision to begin on the date that the FDA approved Subutex/Suboxone. Thus, the protections from state restrictions on use of buprenorphine now extend to October 8, 2005.

Guidelines for Medical Boards

The Federation of State Medical Boards has published guidelines for "Opioid Addiction Treatment in the Medical Office" (available on the Federation's web site at www.fsmb.org.) The guidelines are intended to assist state medical boards when they investigate allegations of improper practice by physicians. They outline six key elements that medical boards should look for in cases that come to them for review: (1) The patient must have been properly evaluated, including a history and physical examination that support the diagnosis for which the narcotic is indicated. (2) A treatment plan must be specified, with clear goals for the treatment. (3) The patient must be monitored to determine whether treatment is working. (4) The patient's informed consent and agreement for treatment must be obtained in writing. (5) Consultation must be employed when appropriate (such as use of psychosocial treatment for addiction, or neurologist consultation for intractable pain). (6) Clear and legible medical records must be readily available for review.

The guidelines provide the standard by which a state medical board is to investigate a complaint against a physician who prescribes Subutex or Suboxone for the treatment of opioid addiction. Physicians who follow the Federation's guidelines have considerable protection against overzealous prosecution or disciplinary action.

Forums on CSAM and ASAM Web Sites

Moderated Internet forums are available to physicians who wish to post questions and share experiences in prescribing Suboxone. Accessing the CSAM web site is straightforward: go to the home page at www.csam-asam.org and click on "discussion board." Accessing the ASAM web site at www.asam.org is a bit more complex. After connecting to the site, scroll down to "ASAM Discussion Bulletin Board" on the left side of the screen below "ASAM Membership." Clicking the "ASAM Discussion Bulletin Board" will bring up a pop-up screen asking for a "user ID" and a password. Type "ASAM" in the user ID box and "ASAM" in the password box. Then click the "push to log-in" button. It is necessary to click the "push to log-in" button; hitting the "enter" (or "return") key after entering the user ID and password does not work. After getting past this log-on, there is a second log-on that requires a personal log-on name and password. If you don't have one, contact the web master.

Acknowledgements: Gail Jara and Judy Martin reviewed successive drafts of this article and made substantial contributions.

Buprenorphine Brand Names in Addition to Suboxone®, Subutex®, and Temgesic®

Brand Name & Formulation	*Dosage*	*Package & Ampule Size*	*Manufacturer*
Buprigesic®			
For injection	0.3 mg/ml	10x2 ml	Neon
For injection	0.3 mg/ml	10x1 ml	Neon
Norphin®			
For injection	0.3 mg/ml	2 ml	Unichem
For injection	0.3 mg/ml	1 ml	Unichem
For injection	200 mcg	10	Unichem
Pentorel®			
For injection	0.3 mg	1 ml	Khandelwal
For injection	0.3 mg/ml	2 ml	Khandelwal
Tidigesic®			
Sublingual tablet	0.2 mg	10	Sun Pharma, India
For injection	0.3 mg/ml	1 ml	Sun Pharma
For injection	0.3 mg/ml	2 ml	Sun Pharma

Alcohol + Antiretroviral Therapy Accelerates HIV Progression

Alcohol consumption increases HIV disease progression in patients receiving antiretroviral therapy, recent research shows. Both alcohol abuse and HIV infection are believed to compromise immune function. A new study by researchers at Boston University School of Medicine evaluates the relationship between alcohol consumption and HIV disease progression among patients receiving highly active antiretroviral therapy (HAART does not refer specifically to any particular medication, but to a minimum of three antiretroviral medications that are known to work against HIV.)

For the study, researchers examined 349 HIV-infected individuals (276 men and 73 women) who had a history of alcohol problems. Subjects' HAART use during the preceding month was determined, as was their alcohol consumption, and then quantified as "none," "moderate," or "at risk." In addition, two markers of HIV disease progression were assessed: CD4 cell counts and HIV ribonucleic acid (RNA) levels.

Investigators found that HIV-infected patients with a history of alcohol problems and who were treated with HAART and also consumed alcohol at moderate or at-risk amounts had higher HIV RNA levels and lower CD4 cell counts than did patients who did not drink. No significant differences were found in HIV RNA levels or CD4 cell counts among HIV-infected patients who consumed alcohol but were not on antiretroviral therapy.

Lead author Jeffrey H. Samet, M.D., professor of medicine and public health at Boston University, said, "In the urban setting where I work, a substantial number of patients—with or without HIV, but even more so with HIV—have had alcohol problems. In the world before HIV, we knew that chronic alcohol use led to problems that are more common in immunodeficiency states such as tuberculosis and pneumonia. Of course, we also know that HIV attacks the immune system. So you can pose the question, "could these two things—HIV and alcohol—be interacting in some way that makes the immune state worse than just HIV alone?"

Amy C. Justice, a researcher with the University of Pittsburgh School of Medicine and the VA Pittsburgh Healthcare System, added that the indirect effects of alcohol also are cause for concern. "Heavy alcohol consumption is known to limit a person's ability to adhere to HIV treatment," she said, "and nonadherence is known to lead to more rapid disease progression. Further, alcohol is known to exacerbate common comorbid conditions among those with HIV infection, such as hepatitis C or chronic hepatitis B. Finally, heavy alcohol consumption may also lead to increased rates of serious toxicity from antiretroviral therapy, as both can be toxic to the liver and bone marrow. Thus, heavy alcohol consumption may lead to nonadherence and even complete cessation of antiretroviral therapy through a multitude of mechanisms."

Dr. Samet cautioned that the data aren't strong enough to make recommendations, particularly about moderate alcohol use, but added: "Obviously we have concerns. These individuals need to be cautious. Furthermore, I think it's a reasonable hypothesis that lots of alcohol use by HIV-infected individuals, even by those who haven't had past alcohol problems, may raise the same issues. But that's a future line of research." *Source: Addiction Technology Transfer Center National Office. Based on Samet JH, Horton NJ, Traphagen ET et al. (May 2003). Alcohol consumption and HIV disease progression: Are they related? Alcoholism: Clinical & Experimental Research 27(5), 862-868, May.*

PART-TIME CONTRACT PHYSICIAN

Medication-assisted outpatient drug treatment day program in Baltimore, Maryland, is seeking a part-time physician to conduct medical evaluations, prescribe/monitor medications, and assist in the coordination of our medical/clinical team. Experience in addiction medicine and a Maryland license are required.

Send resume along with salary requirements to the attention of
Kelly Valentine at KAValentine@ibrinc.org
or 2457 Maryland Ave., Baltimore, MD 21218.

Addiction Treatment Patients Say They Self-Medicate for Untreated Pain

Many persons enrolled in addiction treatment programs report that they used alcohol and other drugs to ease chronic pain, researchers say. Writing in the *Journal of the American Medical Association*, a group of researchers at the National Development and Research Institutes and the New York State Office of Alcoholism and Substance Abuse Services report on a study of 309 patients enrolled in two New York methadone maintenance programs and 531 patients in short-term residential treatment programs.

In interviews, 37% of the methadone patients and 24% of the short-term residential patients reported that they experienced chronic severe pain, while pain of any type or duration during the preceding week was reported by 80% of the methadone patients and 78% of the residential patients. Among those with chronic severe pain, residential patients were less likely than the methadone patients to have been prescribed medications for pain relief (52% vs. 67%), and were significantly more likely to have used illicit drugs and alcohol to relieve pain (51% vs. 34%).

"Because patients are treated for addiction does not imply that their pain is being treated. They may have two disorders, addiction and chronic pain…"

Summarizing the data, lead author Andrew Rosenblum, Ph.D., said that rates of chronic pain among persons with alcohol or drug use disorders appear to be "at least as high" as in the general population. He added: "Because patients are treated for addiction does not imply that their pain is being treated. They may have two disorders, addiction and chronic pain, although each can complicate the other." *Source: Rosenblum A, Joseph H, Fong C et al. Prevalence and characteristics of chronic pain among chemically dependent patients in methadone maintenance and residential treatment facilities. Journal of the American Medical Association 289 (18):2370-2378; May 14.*

This time he's really ready to stop drinking.

Antabuse® can help.

Active, effective support for the patient committed to recovery

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

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

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

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

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

Please see Full Prescribing Information on adjacent page.

In alcoholism

ANTABUSE®

(Disulfiram, USP)

250-mg tablets

Support for the committed quitter

Visit our web site at www.OdysseyPharm.com.

Odyssey Pharmaceuticals is a wholly owned subsidiary of Sidmak Laboratories, Inc.
Antabuse is a registered trademark of Odyssey Pharmaceuticals, Inc.

PHARMACEUTICALS, INC.™

72 DeForest Avenue
East Hanover, NJ 07936
Tel: 1-877-427-9068

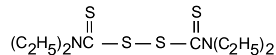
© 2002, Odyssey Pharmaceuticals, Inc. PIOPA-520

Support for the committed quitter

Antabuse® (Disulfiram, USP) Tablets IN ALCOHOLISM

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

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



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

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

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

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

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

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

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

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

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

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

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

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

WARNINGS:

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

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

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

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

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

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

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

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

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

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

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

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

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

Odyssey Pharmaceuticals is a wholly owned subsidiary of Sidmak Laboratories, Inc.

© 2002, Odyssey Pharmaceuticals, Inc. 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]

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

P08-0706 Rev. 9/01
c/n.1

72 DeForest Avenue
East Hanover, NJ 07936
Tel: 1-877-427-9068
Fax: 1-877-427-9069

One Day at a Time

Cathy Cerullo

One of the most challenging endeavors that I have ever undertaken has been volunteering at Bellevue Hospital. The power of this experience has confirmed my desire to become a physician and has affected my outlook on life. With this experience, I strive to improve myself by asking, "What can I do today to make things better tomorrow? Can I say or do something differently today to help bring someone closer to recovery?"

I direct a weekly discussion group on the Dual Diagnosis unit for people who are both mentally ill and chemically addicted. During the group, the patients talk about what it is like to have an addiction and what it could be like not to have one. Over and over, they describe the struggles they face each day they awake and the disappointments they go to bed with each night. Groups are a challenge for both the patients and for me: I want them to get better, and some of them want to get better, but how do we get there?

Each week, I extract a theme for the group from the things the patients say as they introduce themselves. We talk; they give advice to one another; and I try to create a supportive and honest atmosphere. They share their lives with me, and although I do not know how it feels to be addicted to a drug or to hear voices in my head, to be homeless or hungry, I do know that we will share one hour together that day, and that I can learn from them, and they can learn from me.

One thing I have learned is that some of these people desire change and some do not. One patient says how much better—or, at best, how different—his life could be without self-destructive abuse, while another expresses that one day of using is just one day of using, until he finds himself in a pool of vomit and realizes that his life has quickly passed him by, one day at a time.

With each group, I feel that some patients are pulling through, getting stronger and more prepared for the world outside the hospital's doors. Some patients are encouraged, while others know how hard it is to start a new life and stay away from those "people, places, and things" that nurture their illness. Yet, I feel confident that when the time has arrived, some of these people have a chance.

When I leave, I feel stronger and I hope that they do, too. But then, on some Saturday night, I am not pleased to see someone who was in my group just last week, telling me how he wants to make his life "different, better, clean," talking to a plastic shopping bag in the middle of Astor Place. I am not encouraged by the patient that I now see regularly panhandling at my subway stop with a paper-bagged beer and jingling change in an "I love NY" coffee cup. No, I do not feel encouraged and I am not satisfied with my efforts to help these people recover. In fact, I feel somewhat defeated, as if I made no difference at all. I begin to feel disappointed, not just in the patients, but in myself. "One day at a time" is how I am learning to cope with people who do not get better. "One day at a time" is how an addict has taught me to cope with life.

Yet, despite disappointments, there is still hope. I know that medicine cannot save everyone, but I still want to pursue it because I am encouraged to do better. I ask myself, "What can I do differently today to make things better tomorrow? How can I better myself so that, one day at a time, I can have a positive impact on someone that I want to help?"

Cathy Cerullo is a premedical student at Columbia University, New York City. She has been volunteering on the Dual Diagnosis Training Unit (20 East) at Bellevue Hospital since the spring of 2000. Ms. Cerullo's weekly "discussion group" is one of the most popular and successful activities on the unit. This essay was submitted by Petros Levounis, M.D., who chairs ASAM's Medical Education Committee.

Now accepting applications
for the 2003-2004
Addiction Psychiatry Fellowship

The Department of Psychiatry at University Hospitals of Cleveland and Case Western Reserve University School of Medicine offers undergraduate, graduate and postgraduate psychiatry training opportunities. As the primary affiliate of CWRU School of Medicine, UH is a major site for medical student and residency education in psychiatry.

Fellows in Addiction Psychiatry benefit from supervised clinical experiences in hospital and community-based, inpatient, outpatient and consultative settings. Fellows participate in a structured academic curriculum emphasizing the management of substance use disorders utilizing psychosocial, pharmacologic and psychotherapeutic interventions. Opportunities are available for research and academic development.

For further information, please contact
Christina Delos Reyes, M.D.
Director, Addiction Psychiatry Fellowship
at **216/844-3450** *or* **DrDelosReyes@aol.com**

ADDICTION PSYCHIATRIST POSITION

The Albert Einstein College of Medicine seeks applications from psychiatrists for a full-time faculty position in the Division of Substance Abuse of the Department of Psychiatry and Behavioral Sciences. The Division provides integrated mental health services and primary care to drug users enrolled in substance abuse treatment. The position includes clinical responsibilities and work with the interdisciplinary treatment team in our opiate replacement and substance abuse treatment programs, supervision of psychiatry residents and addiction fellows and, depending on the individual's interests, the potential for a variety of research and additional teaching opportunities.

Applicants must be board-certified or board-eligible in psychiatry. Addiction psychiatry certification is desirable.

An attractive salary and benefit package will be offered.

Please send a letter and current CV to Marc Gourevitch, M.D., M.P.H., Medical Director, Division of Substance Abuse, Department of Psychiatry & Behavioral Sciences, Albert Einstein College of Medicine, 1500 Waters Place, 6th Floor, Bronx, NY 10461. *An Equal Opportunity Employer*

CSAM Wins Prestigious Award

The California Society of Addiction Medicine has been honored by the California Medical Association (CMA) with the 2003 Samuel R. Sherman Award for Meritorious Achievement in Continuing Medical Education.

The award cites CSAM's conferences, which it says are "characterized by the highest quality of each of the different elements of a CME program, including educational content and teaching methods, demonstrating respect for the learner. Conferences are carefully crafted and monitored by the organization's Executive Council and Education Committee to assure continuity in program planning standards from one conference to the next."

Dr. David Pating, who chairs CSAM's Education Committee, will accept the award during CSAM's Annual Awards Dinner on Friday, October 10th.

Connecticut Chapter Helps Defeat Medical Marijuana Bill

With the encouragement of Connecticut's ASAM chapter, that state's House of Representatives has defeated a bill (HB 5100) that would have approved the use of marijuana by seriously ill patients. As the bill was defeated by a 79-to-64 vote, opponents voiced concerns that it could lead to the legalization of marijuana or encourage young adults to use the drug.

The Connecticut Society of Addiction Medicine voiced strong opposition to the bill, according to Mark L. Kraus, M.D. The Chapter's statement said: "As an organization that is dedicated to the treatment of those afflicted by the disease of addiction, ASAM's position is that the legalization of marijuana for medical purposes would contribute to a far greater problem than it proposes to help. Cannabis is often the first illicit substance to which the young people of Connecticut are introduced. There is a body of literature establishing that the use of this substance on a regular basis in adolescence is a strong marker for ensuing drug problems later in life.

"There is also clear evidence that the use of cannabis can result in dependency. Individuals dependent on this drug will make the choice to use it in physically compromised situations, and will continue to use it, putting their education, jobs, interpersonal relationships, and legal status at significant risk.

"To lower the level of current control of marijuana would only serve to exacerbate an already grave societal and medical problem. To characterize those who do not support the legalization of marijuana as less than supportive of those who are suffering is no more than self-serving political propaganda. This propaganda should be seen for what it is: misinformation and deception."

Since 1981, Connecticut law has allowed physicians to prescribe marijuana for medical purposes. However, no doctor has issued a marijuana prescription out of fear of federal prosecution. The defeated measure would have allowed physicians to write certificates in place of prescriptions to avoid the threat of arrest.

"I would do anything to give sick people relief, but I absolutely oppose this bill because it is a cruel hoax," said Rep. Robert Farr (R-West Hartford). "This bill is sending the wrong message: that marijuana not only is not bad for you, it's good for you." *Source: New London Day, May 22, 2003.*

Buprenorphine and Office-Based Treatment of Opioid Dependence

Sunday, November 2, 2003, 8:00 am - 5:30 pm • Hyatt Regency Capitol Hill • Washington, DC

COURSE DIRECTOR: DAVID FIELLIN, M.D., YALE UNIVERSITY MEDICAL SCHOOL

This course is designed for physicians who have an interest in or experience with treating opioid-dependent patients, and who wish toqualify to use buprenorphine in office-based treatment of opioid dependence. Federal law requires that physicians who are not certified inAddiction Medicine or Addiction Psychiatry, or who do not meet other qualifications, must complete not less than 8 hours of training. This workshop offers 8 hours of training in the use of buprenorphine and the care of opioid-dependent patients. Those who attend the full 8 hours will receive a certificate of attendance suitable to send to the Secretary of Health and Human Services with notification of intent to prescribe buprenorphine for the treatment of opioid dependence.

Buprenorphine (alone and in combination with naloxone) has been approved by the U.S. Food and Drug Administration for use in the treatment of opioid dependence, and placed in Schedule III of the federal Controlled Substances Act. ASAM encourages interested physicians to prepare for office-based treatment by obtaining appropriate training and organizing the elements necessary to safe and effective treatment.

Topics to be addressed by an expert course faculty include:

- ★ The governing federal legislation and regulations: creating opportunities for office-based treatment
- ★ Opioid abuse and dependence: An overview
- ★ Pharmacology and neurobiology of opioids
- ★ Methadone and LAAM maintenance
- ★ Models integrating psychosocial care with office-based opioid pharmacotherapy
- ★ Medically supervised opioid withdrawal
- ★ Use of naltrexone and drug-free modalities in the treatment of opioid dependence
- ★ Pharmacology of buprenorphine
- ★ Induction, maintenance and detoxification with buprenorphine
- ★ Psychiatric comorbidities and opioid dependence
- ★ Medical comorbidities and opioid dependence
- ★ Clinical management, office procedures, and confidentiality.

The course is approved for up to 8 credit hours of Category 1 continuing education credit. (Only those who attend the full 8-hour program are eligible for a certificate of attendance.)

A separate registration fee is required for this course. Attendance is limited; so be sure to register early! (On-site registration opens at 7:15 am Sunday, Nov. 2.)

California Commission Calls for Sweeping Changes in Addiction Treatment

Gary Jaeger, M.D., FASAM, and Donald J. Kurth, M.D., FASAM

"One in nine Californians suffers from an addiction to alcohol or other drugs," according to a letter to Gov. Grey Davis that accompanies a new report from the "Little Hoover Commission" of California's state legislature. Formally known as the "Milton Marks `Little Hoover' Commission on California State Government Organization and Economy," the Commission is an independent oversight agency created by the legislature in 1992. It is composed of five public members appointed by the Governor, four public members appointed by the Legislature, two Senators and two members of the state's General Assembly.

Over the past year, the Commission has accepted testimony, organized work groups, and hosted subcommittee meetings throughout California in an effort to understand the role that the state plays in combating drug and alcohol addiction. Its conclusions recently were submitted to the Governor and the Legislature for their consideration. In the past, Commission recommendations often led to legislative change. The current report is likely to shape public policy on addiction treatment in California over the next decade.

The report begins: "Alcohol and drug abuse underlie many of our greatest concerns: Persistent poverty and homelessness. Violence in living rooms and in neighborhoods. The neglect by parents and the squandering of youth. Carnage on highways. Overcrowded jails, prisons, emergency rooms, and foster care systems. In many neighborhoods, the addiction and abuse of alcohol and other drugs are nothing less than a scourge, the plague of our day that is stripping communities of potential, ambition, and hope.

"Recovery, however, is possible. Treatment works. Managed correctly, alcohol and drug treatment is a cost-effective response to these expensive maladies—saving $7 for every dollar spent, by two analyses. As part of a larger effort to reduce drug and alcohol abuse, treatment can restore lives, revive communities, and reduce the growing demand on public programs."

Noting that they were "impressed by the dedication and professionalism of the people working to help the addicted recover," the Commissioners nevertheless found "evidence that we could do much more to coordinate drug control efforts, target our resources, improve the quality of treatment, integrate necessary interventions to improve effectiveness, and make the most of available funding."

Findings and Recommendations

The report contains five specific findings, each supported by detailed information and accompanied by specific recommendations.

Finding 1: "The state's efforts to reduce alcohol and drug abuse through prevention, treatment and law enforcement programs are fragmented and not focused on cost-effectively curtailing the expense and misery of abuse and addiction in California."

Finding 2: "The state does not make the most of available resources by prioritizing treatment to serve those whose drug and alcohol abuse imposes the greatest consequences on Californians and their communities."

Finding 3: "The state has not structured substance abuse treatment programs to provide a statewide basic level of quality or encourage continuous quality improvement."

Finding 4: "To be effective, substance abuse treatment must be coordinated and integrated with other social services to effectively reduce the social and financial costs of alcohol and drug abuse."

Finding 5: "Even if the state integrated its drug control efforts and improved alcohol and drug treatment services, as presently funded, available treatment would be inadequate to respond to the costs and misery inflicted on California communities by substance abuse."

The influence of ASAM and CSAM is apparent throughout the report. CSAM President Gary Jaeger, M.D., Past ASAM President David E. Smith, M.D., and experts Charles Moore, M.D., Kathryn Jett, and Joan Ellen Zweben, Ph.D. all provided expert testimony. Many of the concepts and ideas endorsed in the document are those we have been discussing and promoting for years in our public policy statements, and at our conferences across the country. Perhaps this should not be surprising, since ASAM and CSAM have struggled to bring an evidence-based understanding of addiction and treatment into public policy. However, in the political arena where metaphors of war rather than medicine often are employed, it is a "breath of fresh air" to see a major policy document guided by scientific evidence.

A Useful Tool

The report is full of valuable data, graphs, and charts—all presented in a form that is easily understood by educators or legislators, as well as the general public. Addiction is clearly defined, the extent of the problem is identified, and statistical comparisons are provided between California and the U.S. as a whole. (Unfortunately, California leads the nation in all the areas of drug and alcohol use presented except binge drinking.)

As members of ASAM, we each can use this document to inspire our own home-state governors or legislators to develop similar studies to look at addiction treatment where we live. Wouldn't it be great if we could have a similar document for each of the 50 states—a snapshot of where we are today and a road map for where each state is headed in the future? This is a living, breathing document that lays the foundation for saving the lives of thousands or even millions of people who suffer from the disease of addiction.

Copies of the report can be downloaded from WWW.LHC.CA.GOV. *The authors are, respectively, President and President-Elect of the California Society of Addiction Medicine.*

STATUS OF PARITY LEGISLATION

The National Conference of State Legislatures reports that six states—Connecticut, Delaware, Minnesota, Vermont, Virginia and West Virginia—now require private insurers to cover alcohol or other drug treatment at parity with other diseases for plans written in those states. Additionally, federal and state employees and their dependents (9 million people, at least) in Indiana, North Carolina, and South Carolina have full parity, and 21 states have adopted some partial parity mandates.

However, the mandated benefits often are not enforced. For example, providers report that in Pennsylvania, insurers routinely deny coverage for detoxification, delay authorization for admissions, and approve only 3 to 7 days of care despite a law that requires a minimum of 30 days. *Source: Advocates for Recovery through Medicine, May 25, 2003.*

Ruth Fox Memorial Endowment Fund

PAIN AND ADDICTION: COMMON THREADS IV

SUNDAY, NOVEMBER 2, 2003, 8:00 AM - 5:30 PM

WASHINGTON COURT HOTEL WASHINGTON, DC

COURSE DIRECTORS: Howard A. Heit, M.D., FACP, FASAM, and Seddon R. Savage, M.D., FASAM

COMMON THREADS IV is a scientific program thatbrings together professionals from the fields of painmedicine and addiction medicine to explore issues of current importance at the interface of pain and addiction. A key feature of the Common Threads course is the opportunity for extensive interaction between faculty and audience around each of the issues presented.

The 2003 program focuses on mechanisms of pain, as well as clinical assessment and pharmacologic treatment of pain in individuals with addictive disorders. The morning program will explore physiologic, psychological and motivational aspects of pain: clinical assessment; and the structuring of pain treatment in persons with addictive disease. The afternoon program will focus on pharmacologic approaches to the treatment of pain, including both opioid and non-opioid analgesic options, as well as strategies for the withdrawal of opioids when continued use is not appropriate. A luncheon speaker will address the search for balance in regulations and laws related to pain management.

This course is eligible for 8.25 credit hours of Category 1 continuing education credit.

SYLLABUS, MANUAL AND CD-ROM: *Course registrants will receive **three** valuable reference tools: a course Syllabus, a manual on the use of urine drug testing in pain patients, and a CD-Rom containing the Syllabus plus additional reference materials.*

Dr. Ruth Fox

Dear Colleague:

The cancellation of ASAM's 2003 Medical-Scientific Conference because of the SARS-related travel alerts in Toronto has led to some changes in plans for the Ruth Fox Memorial Endowment Scholarship Program. As in 2002, the Fund had offered seven scholarships to physicians-in-training, to allow them to attend ASAM's 34th Annual Medical-Scientific Conference. Instead, the 2003 scholarship recipients will be offered an opportunity to attend the 2004 Annual Medical-Scientific Conference, in Washington, DC, along with seven additional scholarship winners to be selected (an application form will accompany the July-August issue of ***ASAM News***).

We congratulate the 2003 scholarship recipients and look forward to having them join us at the 35th Med-Sci Conference. They are Jeffrey D. Baxter, M.D. (Massachusetts), Anita Chakrabarti, M.D. (Thunder Bay, Ontario, Canada), William Huang, M.D. (California), Jack Kuo, M.D. (California), Romana Markvitsa, M.D. (California), Michael F. Osborne, M.D. (North Carolina), and Sandrine Pirard-Janne d'Othee, M.D. (Massachusetts).

We also wish to acknowledge Joseph E. Dorsey, M.D., FASAM, and Mrs. Dorsey, who had offered to underwrite the cost of the Ruth Fox Fund Reception scheduled for Toronto. Dr. and Mrs. Dorsey are long-time benefactors of the Ruth Fox Fund, and we thank them for their continuing generosity.

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. Let us know if you have included the Endowment Fund in your estate plans so that we can acknowledge your generosity. All contributions to the Endowment Fund are tax-deductible to the full extent provided by law.

If you have not already participated in the Endowment Fund, please do so now. We need and value your support!

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

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

Claire Osman, Director of Development

ASAM Staff

Except where noted below, ASAM staff can be reached by phone at **301/656-3920**, or by fax at **301/656-3815**.

Eileen McGrath, J.D.
Executive Vice President/CEO
EMCGRATH@ASAM.ORG

Berit Boegli
Meetings Consultant
BBOEG@ASAM.ORG

Nancy Brighindi
Director of Membership & Chapter Development
NBRIG@ASAM.ORG

Valerie Foote
Data Entry Operator
VFOOT@ASAM.ORG

Joanne Gartenmann
Exec. Assistant to the EVP
JGART@ASAM.ORG

Tracy Gartenmann
Buprenorphine Program Manager
TGART@ASAM.ORG

Lynda Jones
Director of Finance
LJONE@ASAM.ORG

Sherry Jones
Office Manager
SJONE@ASAM.ORG

Sandra Metcalfe
Director of Meetings and Conferences
SMETC@ASAM.ORG

Claire Osman
Director of Development
Phone: 1-800/257-6776
Fax: 718/275-7666
ASAMCLAIRE@AOL.COM

Celso Puente
Membership & Chapter Development Manager
CPUEN@ASAM.ORG

Noushin Shariati
Accounting Assistant
NSHAR@ASAM.ORG

Christopher Weirs
Credentialing Project Manager
CWEIR@ASAM.ORG

Bonnie B. Wilford
Editor, ASAM Publications
Phone: 703/538-2285
Fax: 703/536-6186
BBWILFORD@AOL.COM

Dr. Barthwell Hailed for Bringing Scientific Approach to Drug Policy

Former ASAM President Andrea G. Barthwell, M.D., FASAM, now Deputy Director of Demand Reduction in the White House Office of National Drug Control Policy (ONDCP), is the subject of a recent profile in the *San Mateo (CA) County Times*. The article focuses on the "scientific and humanitarian approach" that Dr. Barthwell brings to policymaking. The article says Dr. Barthwell describes her approach as "a completely different strategy than the War on Drugs." Rather, "It shifts the focus away from the drugs and instead focuses on the impact substances have on people, communities, and our nation as a whole."

Dr. Barthwell, who was appointed to her post by President Bush in January 2002, says her experience as former medical director of Illinois Treatment Alternatives for Safe Communities, founder of the Chicago AIDS Task Force, and former president of the Illinois Society of Addiction Medicine has persuaded her of the importance of reaching out to the nation's addicted individuals as well as to occasional drug users.

In a series of appearances around the country, Dr. Barthwell discussed her work with ONDCP Director John Walters to implement President Bush's Access to Recovery Initiative, which is aimed at expanding what Dr. Barthwell calls "the national conversation" about addiction to incorporate a new focus on recovery. The initiative, which awaits Congressional approval, would enable at least 100,000 persons to pay for treatment with state-issued vouchers. The states would vie for funding to underwrite the voucher plan. Overall, the President has proposed spending a total of $1.6 billion over five years, as well as opening public funding to support care given by faith-based programs, in an effort to expand access to addiction treatment. *Sources: Join Together Online, May 29, 2003; Rutland (VT) Herald Online, June 15, 2003.*

Beverly Watts Davis is New CSAP Director

Beverly Watts Davis has been named director of the Center for Substance Abuse Prevention (CSAP) of the federal Substance Abuse and Mental Health Services Administration (SAMHSA). In announcing the appointment, SAMHSA Administrator Charles G. Curie pointed to Ms. Watts Davis' "proven leadership and extensive experience in community mobilization," which he said "will be pivotal as we work to reinvigorate CSAP and design and implement a strategic framework for prevention in communities nationwide."

Ms. Watts Davis comes to CSAP from the United Way of San Antonio and Bexar County, Texas, where she served as senior vice president. She also was executive director of the United Way's San Antonio Fighting Back program and, before that, statewide coordinator for the Texans' War on Drugs. During her career, she has served as principal investigator for the Center for Disease Control and Prevention health promotion grants and as a co-principal investigator for the University of Texas Health Science Center's Community Outreach Partnership Center Grant.

Dr. Goldman to Join NIAAA

Mark S. Goldman, Ph.D., has been named Associate Director of the National Institute of Alcohol Abuse and Alcoholism, reporting to new NIAAA Director Ting-Kai Li, M.D.

Dr. Goldman joins NIAAA from the University of South Florida, where he has served since 1985 as Distinguished Research Professor and Director of the Alcohol and Substance Abuse Research Institute. While serving in that post, he co-chaired (with Father Edward A. Malloy, President of the University of Notre Dame) NIAAA's Task Force on College Drinking. "One of the first tasks that I have asked Dr. Goldman to undertake is to develop a similar initiative for underage drinkers from 9-15 years old," Dr. Li said. "I also have asked him to assist in better integrating behavioral and biomedical research at NIAAA."

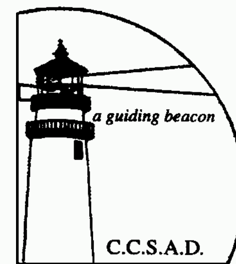
Before joining the USF faculty, Dr. Goldman served on the faculty of Wayne State University. His major research interests involve alcohol expectancies and cognitive mediators of alcoholism risk, and the development of drinking and risk for drinking in children, adolescents, and young adults—areas in which he has more than 260 articles and presentations. He also has served as Psychology Field Editor for the *Journal of Studies on Alcohol*.

James Stone Named to SAMHSA Post

James L. Stone will join the Substance Abuse and Mental Health Services Administration (SAMHSA) as Deputy Administrator, according to Administrator Charles G. Curie.

Before joining SAMHSA, Mr. Stone was Commissioner of the New York State Office of Mental Health, where he supervised the New York State public mental health system. "Those who suffer from mental illness or substance abuse deserve to be treated with the same compassion and medical attention as those who suffer physical ailments," said Health and Human Services Secretary Tommy Thompson. "James Stone's stellar record in New York shows we have the right man for the job."

During the crisis of 9/11/01, Mr. Stone worked with SAMHSA and City of New York officials to establish a command center to provide mental health and substance abuse services to those affected by the terror attack. He also created Project Liberty to focus on services to special populations and a media campaign to address the general public.



SIXTEENTH
Cape Cod Symposium on Addictive Disorders
September 11-14, 2003
Sheraton Hyannis Resort
HYANNIS, CAPE COD, MA

To request a copy of the brochure, please call 651/487-3001 or mail your request to AMEDCO, PO Box 17980 St. Paul, MN 55117.

Visit WWW.CCSAD.COM for more information.

The Medical College of Georgia School of Medicine designates this educational activity for a maximum of 30 category I credits toward the Physician's Recognition Award of the American Medical Association.

ASAM Conference Calendar

ASAM

July 17, 2003
Best Practices in Clinical Drug Testing
Chicago, IL
7 Category 1 CME credits

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

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

November 2, 2003
Pain & Addiction: Common Threads IV
Washington, DC
8.25 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
18 Category 1 CME credits

April 22, 2004
Pain & Addiction: Common Threads V
Washington, DC
8 Category 1 CME credits

April 22, 2004
Ruth Fox Course for Physicians
Washington, DC
8 Category 1 CME credits

April 23-25, 2004
34th Annual Medical-Scientific Conference
Washington, DC
21 Category 1 CME credits

October 30-November 1, 2004
ASAM Review Course in Addiction Medicine
Toronto, Ontario, Canada
21 Category 1 CME credits

OTHER EVENTS OF NOTE

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]

September 11-14, 2003
Sixteenth Cape Cod Symposium on Addictive Disorders
Sheraton Hyannis Resort
Hyannis, Cape Cod, Massachusetts
[For information, visit WWW.CCSAD.COM]

September 14-16, 2003
Alcohol & Drug Problems Association
Fifteenth Women's Issues Conference — Women, Trauma, and Addictions
Buffalo, NY
[For information, visit WWW.ADPANA.COM]

October 18-22, 2003
4th Annual Centerforce Summit
Inside/Out: New Directions for Integrating Services for the Incarcerated
(Pre-course for clinicians, Oct. 18-19)
Milbrae, CA
[For information, e-mail SUMMIT@CENTERFORCE.ORG]

November 6-8, 2003
Association for Medical Education and Research in Substance Abuse (AMERSA)
27th Annual National Conference
Baltimore, MD
[For information, visit WWW.AMERSA.ORG]

February 5-7, 2004
Beth Israel Medical Center
6th International Conference on Pain & Chemical Dependency
New York, NY
[For information, phone 404/233-6446]

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.

ASAM COURSE ON THE STATE OF THE ART IN ADDICTION MEDICINE

An Update on the Unifying Concepts of Addiction:
Drug Development, Emerging Therapies, and Individualized Treatment

Thursday, October 30 – Saturday, November 1, 2003
Hyatt Regency Capitol Hill, Washington, DC

Co-sponsored by the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse

This course is designed for the clinician who seeks an advanced-level review of cutting-edge developments in the science and practice of Addiction Medicine.

COURSE DIRECTORS:
David Gastfriend, M.D., and
Terry K. Schultz, M.D., FASAM

This course is approved for 21 credit hours of Category 1 continuing education credit.

The course features major program sessions on the following topics:

★ The neurobiology of addiction and implications for treatment
★ Drug-seeking behavior and the transition to dependence
★ Accountability and outcomes
★ Developmental issues in adolescent alcohol and drug use
★ The role of spirituality in addiction treatment
★ Terror, trauma and addiction

AND: A special update on cocaine addiction

To register, phone **301/656-3920** or visit the ASAM web site at **WWW.ASAM.ORG**