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ASAM News

Newsletter of The American Society of Addiction Medicine

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State of the Art, Pain, Buprenorphine Courses to Meet in DC

In an unprecedented educational offering, ASAM will sponsor three outstanding courses in Washington, DC, this fall. Under the stewardship of Course Directors David R. Gastfriend, M.D., and Terry K. Schultz, M.D., FASAM, the course on The State of the Art in Addiction Medicine (October 30-November 1) will showcase the most recent findings in addiction research, reported by the nation's leading addiction researchers.

Buprenorphine and Office-Based Treatment of Opioid Dependence (November 2) is designed for physicians who have an interest in or experience with treating opioid-dependent patients. Under the direction of David Fiellin, M.D., the course is intended to help physicians qualify to use buprenorphine in office-based treatment.

Pain & Addiction: Common Threads IV (November 2) brings together professionals from the fields of pain medicine and addiction medicine to explore issues of current importance. Course Directors Howard A. Heit, M.D., FASAM, and Seddon R. Savage, M.D., FASAM, predict that a key feature of the course will be the opportunity for extensive interaction between faculty and audience. For more information, consult the ASAM web site at WWW.ASAM.ORG or contact ASAM's meetings staff at EMAIL@ASAM.ORG.

ASAM Members Invited to Nominate New Regional Directors, Officers

ASAM's Nominating & Awards Committee invites all members to participate in nominating the Society's next President-Elect, Secretary, and Treasurer, as well as a full slate of Regional Directors. Candidates will stand for election in November 2004 for terms of office to begin in April 2005.

As required by ASAM's Bylaws, the Nominating & Awards Committee has determined which members meet the qualifications for officer positions. Nominations for Regional Director are to be sent to Regional Nominating Committee Chairs (see page 6).

Nominations for officer positions are to be submitted by October 15, 2003, to the Nominating & Awards Committee care of ASAM, 350 Third Avenue, #352, New York, NY 10010. The Nominating & Awards Committee will select two candidates for each position from among the eligible candidates, taking into consideration nominations from the membership.

Qualifications for nominees for the Presidency and other ASAM offices, as well as a list of eligible candidates, are found on page 6 of this issue of **ASAM News**.

Urge Congress to Increase Funds for Addiction Prevention and Treatment

Eileen McGrath, J.D.

Eileen McGrath, J.D.

In early September, Congress will make final decisions about funding a series of programs that support addiction prevention, treatment, research and education. At present, the appropriations bills are subject to across-the-board cuts that will reduce funding to below current levels. Now is the time to speak out for our field, and for the needs of your patients!

Please phone, fax, or email your Representative, Senators, and their staffs. (The U.S. Capitol switchboard number is 202/224-3121. A sample letter follows.) Tell them you oppose the 1% to 2% across-the-board cuts proposed for all programs. Instead, ask for funding increases for alcohol and drug treatment, prevention, research and education. Use examples from your own experience as an addiction medicine specialist to make your request personal and persuasive.

SAMPLE LETTER

Dear Senator/Representative _____:

I am writing to ask you to support increased funding for alcohol and drug treatment, prevention, research and education in FY 2004.

Adequate drug and alcohol prevention services need to be available for all young people to reduce their risk of poor health, diminished academic performance, and involvement with the criminal justice system. Effective treatment also is vitally important, yet the unmet need for alcohol and drug treatment services is overwhelming. While 13 to 16 million Americans need treatment for alcohol and drug problems in any given year, only 3 million (or 20%) actually receive care. This leaves 80% with their treatment needs unmet, which translates into waiting lists for treatment as long as six months. We would not tolerate such waits for treatment in any other area of health care.

For many people, federal- and state-funded programs are the only means available to obtain treatment and prevention services. In fact, public spending accounts for more than 60% of the annual support for alcohol and drug treatment and prevention. Today, we have solid evidence that funds spent on treatment and prevention services are a good investment: each $1 invested in alcohol and drug treatment saves taxpayers $7, while each $1 invested in alcohol and drug prevention saves $5.60.

The funding levels that I ask you to support are:

- ✔ $1.803 billion for the Substance Abuse Prevention and Treatment Block Grant.
- ✔ $427 for the Center for Substance Abuse Treatment (CSAT), including $100 million for the President's "Access to Recovery" program.
- ✔ $198 million for the Center for Substance Abuse Prevention (CSAP).
- ✔ $431 million for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and $998 million for the National Institute on Drug Abuse (NIDA) to continue their vital research programs.
- ✔ $624 million for the Safe and Drug Free Schools Program, including $469 million for the State grants portion of that program.

Investment in alcohol and drug treatment, prevention, education, and research will save lives and help protect the health of Americans in these challenging times. Thank you for your support of these vital programs.

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.

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

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

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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).

Congress Gives Voucher Plan Mixed Reviews

The Bush administration's proposal to expand treatment capacity through increased funding and the use of vouchers is encountering a mixed reception in the Congress.

The President unveiled the $600 million capacity expansion program during his State of the Union address in January. In its 2004 budget, the administration asked for $200 million for the Access to Recovery program, which would provide vouchers that individuals could redeem at the treatment program of their choice, including faith-based programs.

The budget approved by the House of Representatives' Appropriations Committee during the last week of June expressed support for vouchers but earmarked only $100 million for the program. In its conference report, the House Appropriations Committee said the funds should be used by the Substance Abuse and Mental Health Services Administration (SAMHSA) to support a pilot study before full implementation of the Access to Recovery program.

Subsequently, the Senate Appropriations Committee dealt the proposal a blow when it refused to spend any money for treatment vouchers in 2004, citing tight budgets and concerns about implementation. "The committee has noted with interest the administration's Access to Recovery initiative to provide vouchers to states for substance abuse treatment services," the committee's report said. "However,…the committee has concerns that many implementation issues have not been resolved, such as the role of professional assessment, certification requirements, and the administrative costs of setting up a voucher program for treatment." The report concluded that the committee is "supportive of the administration's desire to expand the pathways to treatment, but believes that more details need to be resolved before major resources are provided to a new program." House and Senate negotiators will meet to try to work out the differences between the two measures.

SAMHSA Provides Details

The Senate committee's comments echo the concerns of some advocacy groups, which worry that the voucher program could open up public funding to programs—particularly faith-based programs—that do not meet current state certification and training standards. In an effort to allay those concerns, SAMHSA has issued several fact sheets that outline three guiding principles for the initiative: (1) consumer choice, (2) results orientation, and (3) increased treatment capacity. However, the SAMHSA documents do not address the issue of provider certification.

Instead, SAMHSA says the states will be responsible for establishing eligibility criteria for treatment providers, in much the same way that states currently establish licensure standards for physicians and other health professionals. However, there is no federal requirement that would prohibit a state from setting the eligibility criteria so low that programs that fall short of accepted levels of training and staff education could receive federal funds.

In fact, SAMHSA envisions Access to Recovery as essentially a state-run program, with the Governors' offices serving as the conduit for funding. The Governors would apply for voucher funds through a competitive grant process. They would be required to use Access to Recovery funds to supplement, not supplant, expenditures for existing programs, particularly the treatment block grant. The SAMHSA fact sheet says that "States will have considerable flexibility in designing their approach, and may target efforts to areas of greatest need, to areas with a high degree of readiness, or to specific populations, including adolescents." Grant applicants would be required to provide plans for screening, assessing, referring, and placing addicted individuals. SAMHSA will require that individuals be assessed wherever they present for treatment, which the administration calls the "no wrong door" approach. States would have to detail in their funding applications "how the provider base will be expanded and how a broad array of provider organizations will become eligible for voucher reimbursement," the fact sheet says.

An Access to Recovery working group within SAMHSA is drafting a Request for Applications (RFA) for the program, and is examining issues such as state standards, performance measurement, service costs, and assessment and placement tools. The goal is to have the RFA ready to release when, and if, Congress funds the program. *Source: Bob Curley, Join Together Online, July 3, 2003.*

Canada Approves International Tobacco Treaty

The government of Canada has approved an international treaty aimed at reducing tobacco use and banning most forms of tobacco advertising. At a United Nations ceremony, Canadian Health Minister Anne McLellan signed the Framework Convention on Tobacco Control. Canada thus joins 41 other nations—but not the United States—in approving the Convention.

"As a direct result of this treaty, tobacco-control laws around the world will be greatly strengthened," said Rob Cunningham of the Canadian Cancer Society. "This means that fewer people worldwide will die of tobacco-related disease."

To take effect, the treaty must be formally ratified by at least 40 signatories. To date, only Norway has done so. *Source: Canadian Broadcasting Company, news report, July 15, 2003.*

FDA Bill Expected in September

A measure that would authorize the U.S. Food and Drug Administration (FDA) to regulate tobacco products is being promoted to colleagues by key Republican lawmakers, and legislation is expected to be introduced in September.

Senators Judd Gregg (R-NH) and Mike DeWine (R-OH), both of whom sit on the Senate committee overseeing the FDA, are pushing for passage of the measure, which would authorize the agency to monitor the marketing, production, and distribution of tobacco products. "I think we've drafted a pretty good bill, and I think the chances of passage are excellent," Sen. Gregg told the Associated Press.

Sen. DeWine, who cosponsored similar legislation with Sen. Edward Kennedy (D-MA) in 2002, predicted that the new measure would win bipartisan support. The bill contains some provisions favorable to the tobacco industry that were not in the 2002 version, such as a prohibition against the FDA banning cigarettes and a requirement that states not pass more stringent production or labeling standards than those established by the FDA. *Source: Associated Press, July 31, 2003.*

Your Board Acts to Strengthen ASAM's Committee Structure

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

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

As I reported to you in the January-February **ASAM News**, one of my priorities as President of your Society has been to realign ASAM's governance structure with its Strategic Plan. This realignment also holds the promise to meet the challenges (both fiscal and otherwise) that we are currently experiencing, in large part due to the successes and growth of the Society. There is an unquestionable need to enhance the Society's ability to responsibly guide its valuable products (such as the *Principles of Addiction Medicine* textbook, the Certification Examination, and educational programs, to name just a few) and to respond to evolving needs of the "owners" of the Society: our members. This spells: "ACCOUNTABILITY" Thus, realignment is but one more instrument to ensure that the Society is positioned to reach its goals.

I am pleased to report that your Board of Directors has completed work on the Committee realignment. This was not an easy task. I recommended changes to the Board only after careful consideration, and the Board adopted the changes after thoughtful deliberation. The comments of the committee chairs and the membership have been enormously helpful in this process, and I thank you for them.

I hope that you will consider this realignment a sign of the continuing vitality of our Society, and consider expanding your participation in the work of the various Committee and Work Groups. As I wrote to you in January, ASAM represents the "big tent" for addiction medicine and should offer opportunities for everyone who desires to contribute. The Committee and Council structure outlined below is, I am convinced, a significant step toward improving the efficiency and effectiveness of our "big tent."

COUNCILS: Councils (this term is used instead of the term "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. Councils have oversight of one or more Standing Committees. 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; the Chair is a member of the Board).*

Certification Council *(the Chair is a member of the Board).*
- Eligibility and Application Committee
- Examination Committee
- Fellow Committee

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

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

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

Medical Education Council *(the 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 *(the Chair is the ASAM President)*
- American Academy of Child and Adolescent Psychiatry Liaison
- American Academy of Family Physicians Liaison
- American Academy of Pediatrics Liaison
- American Academy 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 *(the Chair is the ASAM President)*
- American Association for the Treatment of Opiate Dependence
- Association for Medical Education and Research in Substance Abuse Liaison
- National Association of State Alcoholism and 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 *(the Chair is the Membership Committee Chair, who also serves as an ex officio, non-voting member of Board).*
- Membership Committee
- Physicians-in-Training Committee

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

Public Affairs Council *(the Chair is a member of the Board)*
- Legislative Advocacy Committee
- Media and Public Information Committee
- Policy Development Committee

Publications Council *(the Medical Editor is Chair)*
- Journal Committee
- Newsletter and Web Page Committee
- Textbook and Handbook Committee

Quality Improvement Council *(the Chair is a member of the Board)*
- Practice Guidelines Committee
- Treatment Criteria, Treatment Outcome and Clinical Performance Measures *Committee (CARF, JCAHO, NCQA)* Liaisons

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. *(These committees are listed above, under their respective Councils.)*

WORK GROUPS OF THE SOCIETY: The mission of Work Groups *(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 Work Groups promote access to and improvement of treatment and prevention services for substance use and substance use disorders. Member participation in Work Groups serves the additional function of advancing involvement of individual members in the Society's activities. Work Groups of the Society will receive staff support from the Society for funded projects or activities, but not for other efforts.

In the next issue of the newsletter, I will share with you the activities in which I have been involved and that advance the importance of our medical specialty and Society.

AMA House of Delegates Acts on Issues of Interest to ASAM

Stuart E. Gitlow, M.D., M.P.H.
ASAM Delegate to the AMA

During the June meeting of the American Medical Association's House of Delegates, ASAM's Alternate Delegate Lloyd Gordon III, M.D., FASAM, and I actively participated in matters before the Section Councils on Psychiatry and Preventive Medicine, the Specialty and Service Section, and several state and section coalitions. We particularly appreciated the great work of Eric Smiltneek, who represented ASAM in the Medical Student Section. Michael M. Miller, M.D., FASAM, who is a past ASAM Delegate to the AMA, was present as part of the Wisconsin Medical Society's delegation and spoke frequently on matters of importance to ASAM as well.

Youth Alcohol Use

The AMA's Council on Scientific Affairs issued a report that examines evidence of the physiologic and medical consequences of alcohol use by young people, particularly with respect to alcohol's neurotoxic and cognitive effects. The report recommends that the AMA work with specialty societies to increase awareness of these adverse effects. The full text of the report is available for review at the AMA's web site; select CSA Report 11.

Tobacco Resolutions

A flurry of resolutions relating to tobacco were adopted by the House of Delegates. As a result, the AMA will support legislation requiring picture-based warning labels on tobacco products and encourage states to sponsor anti-tobacco poster contests to educate children about the harmful effects of tobacco use.

The AMA will urge the Secretary of Health and Human Services to adopt the recommendations of the Interagency Committee on Smoking and Health, which include establishment of a Smokers' Health Fund (to be funded by increasing the federal excise tax on cigarettes by $2.00 a pack); clinician education; a research agenda; and evidence-based counseling and treatment for tobacco use cessation.

Pharmaceutical Contacts

A number of physicians report that they have been approached by pharmaceutical company representatives, who ask for (and often offer to pay for) permission to "shadow" the physician during a day of seeing patients. This issue was addressed by the House of Delegates, which adopted a policy opposing the practice.

There was clear consensus that the presence of industry representatives during patient-physician encounters is problematic and should be avoided. The AMA will continue to work with the pharmaceutical industry to promulgate guidelines protecting patient privacy and confidentiality.

Friends of Medicine

The AMA will begin to explore the development of a fee-based patient organization, Friends of American Medicine, as an affiliated membership network. As a first step, AMA will contract for a telephone survey of the public to assess interest in such an organization and willingness to participate. If the response is favorable, an implementation plan will be developed.

AMA Elections

The outcome of the AMA election of officers went very well for ASAM, as nearly all the candidates we supported were elected. We were especially pleased at the reelection of J. Edward Hill, M.D., to the AMA's Board of Trustees, and the election of Jeremy Lazarus, M.D., to the post of Vice Speaker of the House of Delegates.

Dr. Hill, a family physician from Mississippi, has been an outspoken advocate for alcohol issues as they relate to public health. Dr. Lazarus is a psychiatrist from Colorado; his election is the first for a psychiatrist to this key policy-making position, and indicates the degree to which the house of medicine has become more accepting of mental health issues and the specialists who treat them.

Along those lines, your delegation is gratified to find a continuing improvement in the House's acceptance of issues important to addiction medicine. As an example, the AMA has agreed to circulate a letter to state and specialty medical societies for signature, urging the U.S. Congress to bring parity legislation to a vote during the 108th Congress.

Your Involvement Welcomed

Your input is crucial to your delegation as it pursues ASAM policy within the AMA. Please contact me at DRGITLOW@AOL.COM if you have suggestions, questions, or comments. We also are most interested in adding to our delegation by including medical students, residents/fellows, and young physicians (those under age 40 or in their first five years of practice). If you would like to volunteer, please let me know. The next two meetings of the House of Delegates are in early December 2003 in Honolulu and in mid-June 2004 in Chicago. ASAM members who live near those locations are encouraged to join us at the meeting. All AMA members are welcome to address House Reference Committees and, given the small size of our delegation, we can use the additional support.

AMA Concerned About Physician Harassment

The AMA is asking that state and specialty societies submit examples of physicians who have been harassed by agents of the U.S. Drug Enforcement Administration (DEA) and other enforcement agencies as a result of prescribing opioid analgesics for pain management. The AMA will use this information in communicating to the appropriate government agencies its strong opposition to such actions against physicians.

ASAM members who feel they have been subject to harassment are asked to share their experiences *[NOTE: email the Editor, ASAM News, at BBWILFORD@AOL.COM, or fax to 703/536-6186].* Any information provided will be forwarded to the AMA's Office of General Counsel.

The AMA has a proud history of defending physicians' rights to use controlled drugs for patient care, while assisting enforcement authorities in identifying those few physicians and other health care professionals who misprescribe. The AMA's PADS program, launched in the early 1980s, was hailed by the Inspector General of the Department of Health Human Services as "one of all too few stories of real success" in national efforts to curb prescription drug abuse.

Nominees for the offices of ASAM President-Elect, Treasurer and Secretary must be current members of the Board of Directors or have served on the Board within the past four years. An exception may be made in the case of a nominee for the office of Treasurer, who may be a member who possesses the other qualifications for the position and who has been active on the Finance Committee within the past four years.

ELIGIBLE CANDIDATES

The Nominating & Awards Committee has determined that the following members are eligible to be nominated for the office of President, Secretary or Treasurer:

Louis E. Baxter, Sr., M.D., FASAM
Richard E. Beach, M.D., FASAM
Anthony H. Dekker, D.O., FASAM
Paul H. Earley, M.D., FASAM
Timothy L. Fischer, D.O.
Marc Galanter, M.D., FASAM
David R. Gastfriend, M.D.
Stuart Gitlow, M.D.
R. Jeffrey Goldsmith, M.D.
Lloyd J. Gordon III, M.D., FASAM
James A. Halikas, M.D., FASAM
(incumbent Treasurer; eligible for re-election)
Thomas L. Haynes, M.D., FASAM
Lori D. Karan, M.D., FACP, FASAM
David C. Lewis, M.D.
(incumbent Secretary; eligible for re-election)
Peter A. Mansky, M.D.
Peter E. Mezciems, M.D., CCFP, FASAM
Michael M. Miller, M.D., FASAM
Norman S. Miller, M.D., FASAM
Ronald F. Pike, M.D., FASAM
Peter Rostenberg, M.D., FASAM
A. Kenison Roy III, M.D., FASAM
James W. Smith, M.D., FASAM
Barry Stimmel, M.D., FASAM
Trusandra E. Taylor, M.D.
Berton E. Toews, M.D., FASAM
Richard E. Tremblay, M.D., FASAM
Penelope P. Ziegler, M.D., FASAM

TREASURER

Candidates for the post of Treasurer must have served on the Finance Committee within the past four years. In addition to the candidates listed above, the following individuals are eligible for this office:

Alfonso D. Holliday, M.D.
David Mee-Lee, M.D.

REGIONAL DIRECTOR

Nominations must include (1) a brief statement summarizing the individual's involvement in ASAM at the state or national level; (2) a summary of the individual's qualifications for the position of Regional Director; and (3) a brief statement explaining why the individual wishes to serve as a Regional Director. Nominations are to be submitted to the Regional Nominating Committee Chair *no later than October 15, 2003*.

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

As specified in ASAM's Bylaws, the candidate in each Region who receives the most votes will be elected Regional Director, and the candidate who receives the next largest number of votes will be elected Alternate Regional Director.

The Regional Nominating Committee will nominate at least two candidates in each Region.

The following incumbent Regional Directors and Alternate Regional Directors are eligible to run for re-election. (Dr. Paul Earley [Region V], Dr. Ken Roy [Region VIII] and Dr. Peter Mezciems [Region IX] are not eligible for re-election because they will have served the maximum two consecutive terms as Regional Director.)

Peter A. Mansky, M.D. (Region I)
Merrill S. Herman, M.D. (Region I)
Lori D. Karan, M.D., FACP, FASAM (Region II)
Donald J. Kurth, M.D., FASAM (Region II)
Ronald F. Pike, M.D., FASAM (Region III)
Peter Rostenberg, M.D., FASAM (Region III)
Louis E. Baxter, Sr., M.D., FASAM (Region IV)
R. Jeffrey Goldsmith, M.D. (Region IV)
Timothy L. Fischer, D.O. (Region V)
Thomas L. Haynes, M.D., FASAM (Region VI)
Norman S. Miller, M.D., FASAM (Region VI)
John P. Epling, Jr., M.D., FASAM (Region VII)
Berton J. Toews, M.D., FASAM (Region VIII)
Richard E. Tremblay, M.D., FASAM (Region VIII)
Saul Alvarado, M.D. (Region IX)
Lloyd J. Gordon III, M.D., FASAM (Region X)
C. Chapman Sledge, M.D., FASAM (Region X)

Qualifications for Officeholders

REGIONAL NOMINATING COMMITTEE CHAIRPERSONS

If you meet the qualifications and are interested in running for Regional Director, or wish to nominate someone else for that post, contact the Nominating Committee Chairperson for your Region.

Region I (NY)
Gregory C. Bunt, M.D.
Tel: 845/888-0318
Email: gbunt@daytop.org

Region II (CA
Gary A. Jaeger, M.D., FAAFP, FASAM
Kaiser Foundation Hospital
Tel: 310/816-5380
Email: gary.a.jaeger@kp.org

Region III (CT, MA, ME, NH, RI, VT)
Mark L. Kraus, M.D., FASAM
Tel: 203/755-4577
Email: marklk@cox.net

Region IV (NJ, OH, PA)
Michael S. DeShields, M.D.
Camden County Health Service Center
Tel: 856/374-6507
Email: mdeshields@cchsc.com

Region V (DC, DE, GA, MD, NC, SC, VA, WV)
Timothy B. Gibson, M.D.
Prince Avenue – Primary Care, LLC
Tel: 706/227-2027
Email: prince92@bellsouth.net

Region VI (IL, IN, MI, MN, ND, SD, WI)
Helen L. Morrison, M.D.
The Evaluation Center
Tel: 312/944-1781
Email: HLMDTEC@AOL.COM

Region VII (AR, IA, KS, LA, MO, NE, OK, TX)
Douglas W. Cook, M.D.
Palmetto Addiction Recovery Center
Tel: 318/728-2970
Email: DOCDOUG1012@MSN.COM

Region VIII (AK, AZ, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY)
Michel A. Sucher, M.D., FASAM
Greenberg & Sucher, PC
Tel: 480/990-3111
Email: GSMONITORING@HOTMAIL.COM

Region IX (Canada and International)
Nady El-Guebaly, M.D.
Foothills Hospital (ISAM)
Addiction Center
Tel: 403/944-2350
Email: NADY.EL-GUEBALY@CALGARYHEALTH.CA

Region X (AL, FL, KY, MI, TN, Puerto Rico, Virgin Islands)
Terry L. Alley, M.D., FASAM
Bradford Health Services
Tel: 205/647-1945
Email: TALLEY@BRADFORDHEALTH.NET

HEART Act Would Provide Parity

The U.S. Congress is considering legislation that would provide parity in addiction treatment benefits under group health plans and health insurance coverage.

The Help Expand Access to Recovery and Treatment (HEART) Act of 2003 is aimed specifically at employer-sponsored health insurance coverage. Introduced by Sen. Norman Coleman (R-MN) in the Senate and Rep. Jim Ramstad (R-MN) in the House of Representatives, the measure would require health insurers to offer addiction treatment coverage that is comparable to that for other medical and surgical care. The bill—which addresses co-payments, deductibles, and treatment stays—specifically prohibits treatment limitations or financial requirements for addiction treatment that are different from those imposed on other benefits.

According to Congressman Ramstad, only 2% of the 16 million addicted persons who are covered by health plans are able to obtain adequate treatment. "People living with chemical dependency have been discriminated against by our nation's health care system for far too long," he said. "It's time to knock down the barriers to chemical dependency treatment and to end the discrimination against people with addiction."

Dan Elling, a legislative assistant for Rep. Ramstad, said the addiction parity legislation has strong support in the U.S. Senate, but could face challenges in the House of Representatives. "The legislation in the House is not as popular with the leadership," he explained. *Source: Alcoholism & Drug Abuse Weekly, June 16, 2003.*

Report: PA Insurers Fall Short

Commercial managed care plans in Pennsylvania are not adequately delivering the minimum coverage for addiction treatment that is required under state law, a legislative report says.

The policy audit, performed by the state's Legislative Budget and Finance Committee, found deficiencies in benefits for outpatient treatment and residential rehabilitation services. For example, state law requires insurers to cover a 30-day minimum stay for inpatient, non-hospital treatment. However, the average length of stay at three behavioral health care programs was less than nine days because of managed care limitations.

The policy audit…found deficiencies in benefits for outpatient treatment and residential rehabilitation services.

"What is clear from the data we collected is that the average duration of delivered services for the commercial managed care plans does not begin to approach the minimum provisions that the law requires insurers to include in their coverage," said Bob Frymoyer, the committee's assistant chief analyst.

The audit uncovered numerous "problematic areas," including cost-shifting from the private to the public sector and plans' requirements that treatment providers document claims in a manner that violates state confidentiality regulations. Managed care plan executives counter that the law does allow them to deny minimum coverage when the conditions for treatment are not met.

State lawmakers said the report supports their efforts to pass a bill that would make commercial insurance companies more accountable for complying with the law. Copies of the report, "Drug and Alcohol Treatment Services in a Managed Care Environment," can be obtained by phoning 717/783-1600. *Source: Alcoholism & Drug Abuse Weekly, June 16, 2003.*

TREND DATA

HIV Increasing Among Drug Users

New cases of HIV among injecting drug users increased in 2000 after five years of steady decline, according to a new report from the federal Centers for Disease Control and Prevention (CDC). For the report, CDC collected data in 25 states, and found 2,514 new cases of HIV.

Asked to explain the increase, Tanya Sharpe, a behavioral scientist and an AIDS expert with the CDC, said "It could be that some of the prevention messages have lost their fervor in the communities and the advances in anti-retroviral drug treatment may have lulled some people into a false sense of security." CDC plans to conduct further research to determine how to stem the increase. Source: Centers for Disease Control and Prevention (2003). Morbidity and Mortality Weekly Report, July 11.

Emergency Visits Involving Opioid Analgesics Double

The number of visits to emergency departments for problems related to the nonmedical use of opioid analgesics has doubled since 1996, according to newly released data from the federal Drug Abuse Warning Network (DAWN). DAWN data show that there were 90,232 visits related to opioid analgesics in 2001, compared to 44,028 visits in 1996.

The DAWN data mirror those of the National Household Survey on Drug Abuse, which show an increase in the number of first-time non-medical users of prescription pain relievers—including oxycodone, hydrocodone, and methadone—during the 1990s. *Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2003). Narcotic analgesics. The DAWN Report, January. Available online at* WWW.SAMHSA.GOV/OAS/2K3/PAIN/DAWNPAIN.PDF.

Boston Sees Sharp Rise in Drug Deaths

An annual health report for the city of Boston (MA) shows a 76% increase in the number of deaths from heroin and other illegal drugs between 1998 and 2001.

Public health officials attribute the change to what they term "a flood" of cheaper and more potent heroin into New England. "We have a clear indication that we have a heroin epidemic in the state of Massachusetts, including Boston," said Deborah Klein Walker, assistant commissioner of the Massachusetts Department of Public Health. The report found an increase in the number of both women and white men who died of drug overdoses or drug-related suicides.

Health officials expect the trend to continue as budget cuts lead to the elimination of treatment programs. "We fear but expect that drug-related deaths will dramatically increase in 2003, and we're already seeing some indication of that," said John M. Auerbach, executive director of the Boston Public Health Commission. *Source: Boston Globe Online, July 25, 2003.*

Inadequate Funding Leads to Inadequate Care

Eric Goplerud, Ph.D.

A recent study from the RAND Corporation, reported in the June 26 issue of the *New England Journal of Medicine* [ED: see the accompany synopsis], found that alcoholism—an illness that is the third leading cause of preventable death in this country—goes largely untreated. The study indicates that the quality of care for alcohol is abysmal, that screening is not routinely done, and that, when identified, patients aren't being referred to treatment specialists. And this isn't surprising.

What's keeping people from getting the treatment they need? Like many things, it has mostly to do with money. Alcohol treatment is singled out for particularly harsh coverage limits by health plans and insurers, making proper medical management of these illnesses financially impossible. This deters hospitals and physicians from aggressively screening for the condition and referring patients for care. Why bother when there is no way to pay for the treatment?

While many states have passed laws requiring that private health insurance companies cover various illnesses and injuries, we found, in our own study, that the largest health plans in one-third of the states did not even meet the minimum statutory requirements for coverage of alcohol treatment. Worse, state laws actually discourage the health system from doing its job. Insurance laws in 38 states exempt insurers from having to pay for treatment costs if a person is injured while under the influence of alcohol.

Public health insurance programs often miss the mark. Medicare requires patients to pay 50% of the costs for outpatient alcohol treatment, but only 20% for other illnesses. The State Children's Health Insurance Program (SCHIP), which provides health insurance for millions of poor children, does not require coverage of alcohol treatment, despite high rates of alcohol problems among youth.

We can afford to do a lot better. For example, the 9 million government workers and their families covered by the Federal Employees Health Benefit Program have equitable coverage. The cost to the program has been insignificant—an increase of far less than 1% of the premium. Covering treatment for alcohol problems in the same way as other illnesses would increase costs by only $5.11 per person per year—about the same as two lattes at Starbucks.

What the businesses and insurance communities do not seem to realize is that the longer alcohol problems go untreated, the more costly they are to the patient, to the family, to the workplace and ultimately, to the taxpayer. The annual bill for treating alcohol-related illnesses and injuries is close to $20 billion. But that's just a fraction of the $185 billion drained from America's coffers each year to cover the costs generated by alcohol-related problems — costs resulting from traffic accidents, subsequent illness and hospital fees, and unproductive missed work days. It becomes a vicious cycle when, in fact, an investment in treatment would actually bring down both the costs and the number of alcohol-related problems.

Companies and government should encourage treatment by investing in coverage. Although they are pinched by rapidly escalating health care costs, the RAND researchers have pointed them toward a real opportunity: investing in increased access to quality alcohol treatment is good medicine and good economics.

***Eric Goplerud, Ph.D.**, is executive director of Ensuring Solutions to Alcohol Problems, located at The George Washington University Medical Center.* *Ensuring Solutions is a project to increase access to alcohol treatment and is supported by a grant from The Pew Charitable Trusts. This commentary is reprinted with permission of the publisher from Join Together Online, a project of the Boston University School of Public Health.*

Alcohol Guidelines Not Used Routinely

Many physicians fail to follow recommended treatment guidelines for helping patients with alcohol addiction. Elizabeth McGlynn, a researcher with the RAND Corporation, drew that conclusion after examining the medical records of 6,712 patients in 12 cities to learn how often physicians followed the latest treatment recommendations and guidelines for particular medical conditions.

Dr. McGlynn reported that individuals addicted to alcohol received the least standardized care of all the health conditions studied: of 280 patients diagnosed with alcohol problems, only 11% received recommended treatment procedures. Doctors were especially lax in suggesting specific treatment programs, following this recommendation less than 5% of the time. *Source: McGlynn E, Asch S, Adams J et al. (2003). The quality of health care delivered to adults in the United States. New England Journal of Medicine 348(26):2635-2645.*

Physicians Overlook Intervention Opportunities

Although alcohol-dependent persons are frequent users of medical and mental health services, a new study finds that doctors often fail to discuss problem drinking during office visits.

"We found that the problem and dependent drinkers we interviewed were using medical and mental health services at fairly high rates," said study author Constance Weisner, Ph.D., professor of psychiatry at the University of California at San Francisco. "Almost all reported at least one medical visit during the previous year. However, doctors and mental health professionals were not using the opportunity of the visit to talk to them about their drinking."

The study was based on interviews with 672 alcohol-dependent and problem drinkers who did not enter treatment and 926 problem drinkers who enrolled in private and public alcohol treatment programs in northern California in 1995 and 1996.

Dr. Weisner found that two-thirds of the problem drinkers had at least one medical visit during the time period, but only 24% said their drinking problem was addressed during the visit. Mental health professionals did a better job of screening: of the one-third of study participants who had a psychiatric appointment, 65% said their drinking was addressed during the visit. Dr. Weisner concluded that the data suggest "a missed opportunity to address alcohol problems and refer people to counseling and treatment if needed." *Source: Health Day News, July 15, 2003.*

In alcoholism

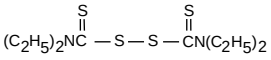
ANTABUSE®
(Disulfiram, USP)
250-mg tablets

Support for the committed quitter

Antabuse® (Disulfiram, USP) Tablets IN ALCOHOLISM

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

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



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

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

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

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

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

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

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

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

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

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

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

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

WARNINGS:

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

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

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

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

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

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

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

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

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

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

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

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

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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ASAM Joins Amicus Brief

The fight for Regina McKnight's freedom has taken a step closer to the U.S. Supreme Court. Professional medical and health groups from across the country have filed an *amicus* brief asking the high court to review the case of the 26-year-old woman, who is serving 12 years in prison for using cocaine while pregnant. McKnight was convicted of murder after her child, Mercedes, was stillborn in 1999. In January, the South Carolina Supreme Court upheld McKnight's conviction, leading to the current appeal.

ASAM joined 25 public health and medical groups July 29 in filing a brief with the Supreme Court. In addition to ASAM, organizations joining the brief include the American Psychiatric Association, American Public Health Association, American Nurses Association, American Academy of Addiction Psychiatry, National Council on Alcoholism and Drug Dependence, and the South Carolina Medical Association. If the Supreme Court decides to take McKnight's case, the 26 groups will file another brief urging the court to rule in favor of McKnight.

The groups… fear McKnight's case will set a precedent for prosecuting mothers who have stillborn children, even if the stillbirth is not their fault.

Speaking for the groups, Judith Appel, an attorney with the Drug Policy Alliance, said they fear McKnight's case will set a precedent for prosecuting mothers who have stillborn children, even if the stillbirth is not their fault. She added that placing a pregnant woman in fear of prosecution could lead to the mother not taking advantage of the medical options available to her.

On the other side is Charlie Condon, the former South Carolina attorney general who originally prosecuted McKnight. He maintains that the policy protects viable unborn children from illegal substances. McKnight is one of more than 100 women in South Carolina to have been charged for cocaine use while pregnant in the past 15 years. South Carolina is the only state that uses child abuse laws to prosecute women who use drugs during pregnancy. *Source: Phillip Caston, Charleston (SC) Post and Courier.com, July 30, 2003.*

Removing SSI Benefits a Failed Policy

Making addicted individuals ineligible for benefits under the federal Supplemental Security Income (SSI) program has not led most of them to return to work, as the architects of the policy had hoped.

In the past, the SSI Drug Addiction and Alcohol program provided low-income addicted individuals with about $500 a month in benefits. Recipients also were eligible for health care coverage through the Medicaid program so long as they remained in treatment. Nationally, an estimated 170,000 persons were enrolled in the program.

The Drug Addiction and Alcohol program was terminated by the U.S. Congress as part of a 1996 overhaul of the nation's welfare system. "There was widespread observation in Congress that when benefits were terminated, people would go back to work," said Dr. Jim Baumohl of Bryn Mawr College, one of the researchers who examined the outcome of the policy change.

Conducted over two years, the study by Dr. Baumohl, Dr. Jean Norris and their colleagues at the Public Health Institute of California involved interviews with about 2,000 persons in nine cities and counties who had their benefits terminated. The researchers found that 37% of participants re-qualified for SSI by proving that they had other disabilities, while another 27% replaced at least half the money lost through other welfare programs, wages, or help from family and friends.

Those who lost their benefits and were unable to replace them were 60% to 70% more likely to suffer material hardships and were less likely to receive treatment, the study concluded. They also were unlikely to return to work. *Source: Contemporary Drug Problems Online, July 21, 2003.*

Effectiveness of Anti-Alcohol Campaigns Challenged

"Social norms" marketing campaigns implemented at many colleges and universities not only have failed to reduce student drinking, but actually may have increased it, says a new study from the Harvard School of Public Health. The popular campaigns—often promoted by the alcohol industry—are designed to curb alcohol use by employing posters and advertisements to persuade students that their peers are abstaining or using alcohol in moderation.

To test the effectiveness of this approach, the Harvard College Alcohol Study examined 37 schools that used the social norms campaign and 61 that did not. Researchers measured seven student drinking behaviors, from casual to heavy drinking. They found that students were drinking just as much (and, in many cases, more) at schools that had adopted the campaign than at schools that had not.

"It's simple, it's cheap, it makes everybody look good. It makes the college look good because it says there's less drinking there than people think," said Dr. Henry Wechsler, director of the Harvard study. "The only problem is, it doesn't seem to work."

The creators of the social norms campaign disagree. "To this day, as we stand here, this is the most effective program in the country. It has more data to show its efficacy than any other program out there," said Dr. Michael Haines, director of the National Social Norms Resource Center. Schools that have adopted the social norms campaign include the University of Arizona, the University of Virginia, and the University of North Carolina. *Source: Weschler H (2003). Report of the College Alcohol Study. Journal of Studies on Alcohol, July.*

Alcohol Impairs Cognitive Function Longer than Expected

When alcohol is consumed, stimulation initially is prominent, while blood alcohol levels are rising during the "ascending limb" of the blood alcohol concentration (BAC) curve. During the "descending limb" of the BAC curve, when blood alcohol levels are falling, sedation becomes the prominent experience. In an important study, researchers have found that executive cognitive functioning (ECF) is more impaired during the descending limb of the blood alcohol concentration curve. Their findings suggest that alcohol's intoxicating effects last much longer than previously believed.

ECF encompasses a number of "higher order" cognitive abilities, such as attention, abstract reasoning, organization, mental flexibility, planning, self-monitoring, and the ability to use external feedback to moderate personal behavior. "Executive functioning is basically a metaphor for frontal lobe functioning," explained Robert O. Pihl, Ph.D., professor of psychology and psychiatry and study author. "This area of the brain, the prefrontal cortex, arguably defines us as a species; it is roughly 120% larger in humans than in our closest primate relatives. In fact, some Russian neurophysiologists refer to it as the area of the brain that pulls the past, the present, and the future together."

The investigators, all at McGill University, confirmed earlier studies showing that alcohol impairs ECF. Surprisingly, they also found that the impairment is more pronounced on the descending than on the ascending trajectory (or limb) of the BAC curve.

In the study, participants (N=41) were divided into two groups. Subjects in the first group were given 1.32 ml of 95% alcohol per kg of body weight mixed with orange juice, while those in the second group were given a placebo. Participants were randomly assigned to either an ascending or descending limb group. All of the participants were given six tests of ECF when a breath measure of their BAC reached 0.08.

Intoxicated participants on both limbs demonstrated ECF impairment. However, the descending alcohol limb group showed greater ECF impairment than their ascending limb counterparts, particularly in spatial functioning. "Our results were unexpected," said Dr. Pihl. "Based on prior research, we had expected cognitive deficiencies to be greater on the ascending limb. Although intoxication clearly lasts a long time, you don't have the same feedback of feeling intoxicated on the descending limb. You have a different perception of what your decrements are when you feel intoxicated and energized, versus when you think, "hey, I'm getting sober." Yet our findings show that even when you're at the same blood alcohol level on the downward limb, you have more pronounced deficits."

"Research on alcohol's effects on ECF is important primarily because it sheds light on the relationship between intoxication and aggression," added Dr. Jordan B. Peterson, associate professor of psychology at the University of Toronto. "Approximately 50% of murderers are intoxicated at the time of their crime. The same holds true of their victims." He added that, "the descending limb lasts a very long time. This means that the drinker in the process of re-attaining sobriety is likely to be more dangerous, for example, than the drinker who is still imbibing. As the authors point out, this may also be relevant with regards to impaired driving: it could be that the drinker at a BAC of 0.08 is less qualified to drive while immediately recovering from a drinking episode than while actively drinking."

The amounts of alcohol given in the study "are clearly in keeping with the levels of intoxication that drinkers reach when drinking for pleasure in bars and at parties," Dr. Peterson added. He suggested that future research examine how long the detrimental descending-limb cognitive effects last. Dr. Pihl added, "People who think they've waited their two hours before driving home may need to actually wait six hours. Or else, maybe at the time when you least expect it, you're the most vulnerable." *Sources: Pihl RO, Paylan SS, Gentes-Hawn A et al. (2003). Alcohol affects executive cognitive functioning differentially on the ascending versus descending limb of the blood alcohol concentration curve. Alcoholism: Clinical & Experimental Research 27(5):773-780, and the Addiction Technology Transfer Center, under a cooperative agreement from the Center for Substance Abuse Treatment. (For more information, see "The Pharmacology of Alcohol" by Dr. John Woodward in ASAM's Principles of Addiction Medicine, Third Edition, 2003).*

Drug Reduces Rewarding Effects of Alcohol

Mecamylamine, a drug that blocks the effects of nicotine in the brain, is believed to reduce the rewarding effects of cigarette smoking. In a new study, it also has reduced the self-reported stimulant and euphoric effects of alcohol, as well as subjects' desire to drink more.

Scientists have suspected for some time that the same mechanisms may be involved in both nicotine and alcohol reward, and prior research has suggested that mecamylamine blocks the reinforcing effects of alcohol in animals.

Based on a new study, Dr. Harriet de Wit of the University of Chicago and her co-investigators have concluded that, "Of all the drugs that act in the brain to produce their rewarding effects, alcohol has some of the most complex and varied effects on neurotransmitter receptor systems. One of the receptor systems where alcohol may act is the nicotinic acetylcholine (NACh) receptor system—the same system where nicotine acts. By acting at these NACh receptors, alcohol also increases the activity of another neurotransmitter system, the dopamine system, which is where most drugs are thought to produce their reward-

MEMBERS RESPOND TO FUNDS APPEAL

ASAM's members and friends have rallied to help the Society recover from the SARS-related cancellation of its Medical-Scientific Conference through their donations to a special "SARS Relief Fund." All donations, which are fully tax-deductible, are to be used to restore financial reserves that 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 CD-Rom containing Section 10, "Medical Consequences 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.)

ing effects. We hypothesized that mecamylamine would block the effects of alcohol on the NACh receptors which would, in turn, reduce the activity of the dopamine system, resulting in a dampening of the rewarding effects of the alcohol."

The researchers recruited 27 non-smoking social drinkers (14 men and 13 women) to participate in six laboratory sessions lasting roughly four hours each. At the beginning of each session, study subjects received either a placebo or one of two doses of mecamylamine (7.5 or 15 mg), followed two hours later by either an alcohol (0.8 g/kg) or a placebo beverage. For two hours following beverage consumption, physiological and subjective-effect measures were taken at 30-minute intervals. The physiological measures included heart rate and blood pressure; the subjective effects included stimulation and euphoria.

"Our findings extend previous observations made in animals," said Dr. de Wit, "that alcohol produces its mood-altering effects, in part, through actions on the nicotinic receptor system. These findings also fit nicely with observations that alcohol users are often also smokers, and smokers tend to drink more than non-smokers. This suggests that these associations may have a biological basis, that is, they reflect shared actions on some of the same receptor systems."

Only one other published human study, by Drs. Ola Blomqvist and Henry Kranzler, has examined the effects of mecamylamine on subjective responses to alcohol. The present study expanded on their findings by testing a different dose of mecamylamine, and by including a placebo beverage as a control condition. "Clearly this study extends our findings," said Dr. Kranzler, of the department of psychiatry at the University of Connecticut Health Center, "and provides another step in linking pre-clinical, animal findings with the effects of alcohol in humans.... It should be noted, however, that as with our study, the humans were healthy subjects, so additional work is needed to evaluate the clinical significance of these findings in heavy drinkers. It is likely, based on other research, that these effects can be extended to heavy drinkers."

Researchers also found some unexpected gender differences in the results. "First, we found that male subjects reported more of a stimulant effect from the alcohol than the females," said Dr. de Wit, "regardless of whether they were pretreated with mecamylamine. Second, mecamylamine reduced the stimulant effects of alcohol more in men. Third, women reported more effects from the mecamylamine alone, specifically, self-reported feelings of sedation." Drs. de Wit and Kranzler both cautioned that these differences may be due to gender differences in pharmacokinetics.

Notwithstanding the possible gender differences, Dr. Kranzler is optimistic about the study's clinical implications. "This study, in conjunction with other research findings, shows that the nicotinic cholinergic system is a promising one for evaluation as a pharmacotherapeutic target in alcoholism," he said. He cautioned that "mecamylamine is not particularly well tolerated in high doses; however, other, possibly more selective drugs that are active at the nicotinic receptor are becoming available, and may provide better tolerability." *Sources: Chi H & de Wit H (2003). Mecamylamine attenuates the subjective stimulant-like effects of alcohol in social drinkers. Alcoholism: Clinical & Experimental Research 27(5):780-787, and the Addiction Technology Transfer Center, under a cooperative agreement from the Center for Substance Abuse Treatment. (For more information, see "Pharmacologic Interventions for Alcoholism" by Dr. Henry Kranzler and Dr. Jerome Jaffe in ASAM's Principles of Addiction Medicine, Third Edition, 2003.)*

Ruth Fox Memorial Endowment Fund

Dr. Ruth Fox

Dear Colleague:

As in 2002, the Ruth Fox Memorial Endowment Fund will offer a Scholarship Program to bring seven physicians-in-training to ASAM's 35th Annual Medical-Scientific Conference, scheduled for April 2004 in Washington, DC. (This is in addition to the seven 2003 scholarship recipients, who were unable to attend the cancelled Med-Sci Conference in Toronto.)

An application form is enclosed with this issue of **ASAM News**. If you know a physician-in-training who has an interest in addiction medicine (or in whom you would like to kindle an interest!), please encourage him or her to apply. Contact Claire Osman with any questions or requests for additional information.

Please continue to support the Endowment Fund that makes the scholarships possible. 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 email 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 value your support!

Max A. Schneider, M.D., FAS M, Chair, Endowment Fund
James W. Smith, M.D., FASAM,
Chair, Resources & Development Committee
Claire Osman, Director of Development

As of August 1, 2003: Total Pledges: $3,635,816

New Donors, Additional Pledges and Contributions

JANUARY 1, 2003 - AUGUST 1, 2003

President's Circle ($10,000-$25,000)

Stanley E. Gitlow, M.D.

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

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Circle of Friends ($3,000-$4,999)

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Dina Vaynberg, M.D.
George E. Woody, M.D.

In memory of Dr. Lee Gladstone
The Illinois Society of Addiction Medicine

In memory of Dr. Wayne Draesel
The Furente, Esposito, Davis & Stewart families

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New ASAM Fellows Honored

Fellows Subcommittee Chair Donald J. Kurth, M.D., FASAM, has announced the names of 26 ASAM members who were elected Fellows of the Society in 2003.

Fellow status recognizes an individual's certification in addiction medicine, significant contributions to the field of addiction medicine, and service to ASAM. The new Fellows join a select group of 202 previously elected Fellows. The new Fellows are:

Paul Casola, M.D., FASAM, Toronto, Ontario, Canada
Avtar Dhillon, M.D., FASAM, Williamsburg, VA
Steven Ey, M.D., FASAM, Laguna Beach, CA
Timothy L. Fischer, D.O., FASAM, Orangeburg, SC
Kenneth I. Freedman, M.D., FASAM, Middletown, CT
Marc N. Gourevitch, M.D., FASAM, Bronx, NY
Douglas Gourlay, M.D., FASAM, Waterdown, Ontario, Canada
Roland William Gray, M.D., FASAM, Brentwood, TN
William Jerry Howell, M.D., FASAM, Birmingham, AL
Margaret Jarvis, M.D., FASAM, Waverly, PA
Steven Kipnis, M.D., FASAM, Orangeburg, NY
Howard Kornfeld, M.D., FASAM, Mill Valley, CA
Kevin Kunz, M.D., FASAM, Kailua Kona, HI
Sarz Maxwell, M.D., FASAM, Chicago, IL
Michael J. Meyers, M.D., FASAM, Carson, CA
Shannon C. Miller, M.D., FASAM, Wright Patterson AFB, OH
Richard K. Ries, M.D., FASAM, Seattle, WA
Bryce Barton Roher, M.D., FASAM, Goshen, IN
Richard Saitz, M.D., FASAM, Boston, MA
Edwin A. Salsitz, M.D., FASAM, New York, NY
Barry Solof, M.D., FASAM, West Covina, CA
Kenneth W. Thompson, M.D., FASAM, Gainesville, FL
Dorothy Tompkins, M.D., FASAM, Charlottesville, VA
Michael F. Weaver, M.D., FASAM, Richmond, VA
Norman Wetterau, M.D., FASAM, Dansville, NY
Elmer Yu, M.D., FASAM, Wilmington, DE

For further information on the Fellows program, contact ASAM's Membership and Chapter Development Manager, Celso Puen, at cpuen@asam.org.

AGENCY NOTES

NAS Recommends Merging NIDA, NIAAA

In a newly released report, the National Academy of Sciences (NAS) has recommended that the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) be merged into a single institute. The two leading addiction research agencies "have overlapping missions and substantive foci and would work more effectively together than apart," according to a report from the NAS's National Research Council. The report also argues that separation of the institutes has led to the segregation of the alcohol and other drug research communities, and "Balkanized research studies."

The recommendation comes as part of a comprehensive review of the National Institutes of Health (NIH). The committee's report, "Enhancing the Vitality of the National Institutes of Health: Organizational Changes to Meet New Challenges," suggests that Congress or the NIH launch an evaluation of the proposed NIDA-NIAAA merger and assess support for combining the institutes.

Over the years, the report notes, members of Congress and the research community have questioned the decision to create separate research institutes to examine alcohol and other drugs—a decision that dates back to the early 1970s, when NIDA and NIAAA were established as part of the National Institute of Mental Health. "Prevention and treatment approaches are fundamentally similar for alcohol abuse and abuse of other substances," the report says. It also quotes an editorial in a recent issue of the Journal of the American Medical Association, written by current NIAAA Director T.K. Li, M.D., and former acting director Glen Hanson, Ph.D., in which they discussed the overlap between alcohol and other drug research. "There is a strong association among the use of tobacco, illicit drugs, and the abuse of alcohol," they wrote, adding that "There is a similarity of biological and social-risk factors underlying vulnerability to all of these substances, including genetic and environmental factors. Lastly, there are overlapping mechanisms thought to underlie how these substances influence the brain. Hence, it would be desirable from a public health perspective to address all substances of abuse when opportunities arise." A merger of NIDA and NIAAA, the report concludes, "would seem to offer many advantages, scientifically and with respect to improved health, and should be studied carefully."

"Prevention and treatment approaches are fundamentally similar for alcohol abuse and abuse of other substances,"

While Dr. Li and the director of NIDA, Nora Volkow, M.D., remain officially mum on the merger proposal, former NIDA Director Alan Leshner, Ph.D., commented that, "On substantive grounds, it seems to make sense." Now the CEO of the American Association for the Advancement of Science, Dr. Leshner said he would like to see the agencies brought together as a National Institute on Addiction. But his former counterpart, longtime NIAAA director Enoch Gordis, M.D., disagreed, saying that combining the agencies could lead to alcohol research being overwhelmed by research on illicit drugs, which already receives the lion's share of public and legislative attention and money. "The attention to alcohol would be downplayed" in a merged institute, he predicted.

The next step is up to Congress or the leadership of NIDA and NIAAA, which must decide if the NAS recommendation warrants further scrutiny. "Nothing happens until somebody decides to recommend it as an action item," Dr. Leshner said. *Source: Bob Curley, Join Together Online, August 8, 2003.*

ASAM Conference Calendar

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

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

November 2, 2003
Buprenorphine & Office-Based Treatment of Opioid Dependence
Hyatt Regency Capitol Hill Hotel
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
8.25 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

September 8-9, 2003
Blending Clinical Practice and Research
(sponsored by the National Institute on Drug Abuse)
Westminster, CO
[For information, visit www.mac1988.com/blendingcolorado]

September 11-14, 2003
Sixteenth Cape Cod Symposium on Addictive Disorders
Sheraton Hyannis Resort
Hyannis, Cape Cod, Massachusetts
[For information, visit www.ccsad.com]

October 2, 2003
Buprenorphine & Office-Based Treatment of Opioid Dependence
(co-sponsored by ASAM and Providence Everett Medical Center)
Spokane, WA
[For information, email Jeri.Sackett@Providence.org]

October 3, 2003
Buprenorphine & Office-Based Treatment of Opioid Dependence
(co-sponsored by ASAM and Providence Everett Medical Center)
Seattle, WA
[For information, email Jeri.Sackett@Providence.org]

October 8, 2003
Update on Addiction Medicine
(sponsored by the Michigan Society of Addiction Medicine)
Grand Blanc, MI
[For information, email SWilson@genesys.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]

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 email email@asam.org.

September is National Drug and Alcohol Addiction Recovery Month.

Events are designed to highlight the benefits of treatment and the contributions of treatment providers, and to convey the message that recovery is attainable. For more information, visit www.recoverymonth.gov/2003.