September/October 2003
Volume 18, Number 5

# ASAM News

Newsletter of The American Society of Addiction Medicine

## Inside

### ASAM at Work for You:



### Also see:



www.asam.org

## ASAM Courses Offer Unparalleled CME Opportunities

Over four days this fall, ASAM will offer three outstanding educational programs in Washington, DC. During ASAM's course on ***The State of the Art in Addiction Medicine*** (Wednesday, October 30 through Saturday, November 1) an expert faculty will discuss the most recent findings in addiction research and explore their implications for clinical practice. The course is approved for 21 CME credits.

***Pain & Addiction: Common Threads IV*** (Sunday, November 2; 8.25 CME credits) brings together professionals from the fields of pain medicine and addiction medicine to review clinical and policy issues of current importance.

***Buprenorphine and Office-Based Treatment of Opioid Dependence*** (Sunday, November 2; 8 CME credits) is designed for physicians who have an interest in or experience with treating opioid-dependent patients and who wish to become qualified to use buprenorphine in office-based treatment.

For more information or to register for the courses, consult the ASAM web site at WWW.ASAM.ORG, or contact ASAM's meetings staff at EMAIL@ASAM.ORG or 301/656-3920, or see the brochure that accompanies this newsletter.

## ASAM, CSAT Collaborate on Buprenorphine Mentoring

In an effort to encourage more physicians to become trained and certified to prescribe buprenorphine, ASAM leaders are meeting with officials of the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) to discuss establishment of a mentoring program. Such a program would address the fact that many physicians who become trained and certified to use buprenorphine do not go on to actually use the drug in clinical practice. In addition, primary care physicians are not becoming certified in the numbers federal officials had hoped.

According to Robert G. Lubran, M.P.A., director of the division of pharmacologic therapies at CSAT, a mentoring program for primary care physicians would be designed to make them "a little more comfortable with the population they are treating."

ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, said that engaging addiction medicine specialists in mentoring and offering guidance to other physicians is a "significant and valuable step" in fostering the appropriate use of buprenorphine in clinical practice. Dr. Brown added that such assistance also could be extended to non-physician professionals, including nurses, physician assistants, pharmacists, and nurse practitioners. Those professionals "need to be aware of the medication and its merits and clinical limitations," he said.

To follow future developments related to buprenorphine and the mentoring program, consult the ASAM and CSAT web sites (WWW.ASAM.ORG and WWW.CSAT.SAMHSA.GOV) and watch future issues of **ASAM News**.

# ASAM Uses Survey to Gain Insight Into Members' Interests, Needs

*Eileen McGrath, J.D.*

*Eileen McGrath, J.D.*

In the past, I have written that ASAM's elected leadership and staff value the opinions of ASAM members and use members' views to shape the Society's programs. This month, I want to tell you about a recent effort to learn what members think.

ASAM commissioned Westat, Inc., a survey research firm, to conduct telephone interviews with ASAM members and prospective members, using questions developed by ASAM's leadership and staff and a list of potential interviewees drawn from ASAM's membership database. During June and July 2003, Westat staff conducted telephone interviews with 57 current ASAM members and 34 prospective members. In most instances, the sampling error for the survey does not exceed ±6.9% at the 95% level of confidence.

## Member Opinions of ASAM

The members surveyed had been members for an average of 12 to 13 years. The principal reasons they cited for their decision to join ASAM were (1) to affiliate with the nation's largest medical specialty society in addiction medicine (81% of members surveyed); (2) to establish professional contacts and relationships (72%); and (3) to participate in ASAM's certification program (70%). The most common reasons for renewing their memberships were similar: (1) affiliation (33%); (2) professional contacts (33%); and (3) advocacy (30%).

Two-thirds of those surveyed rated the effectiveness of ASAM at the national level as "high," while another third rated it "average." Asked to rate the effectiveness of state chapters, 21% rated their effectiveness as "high," while 51% rated them "average" and 16% rated their effectiveness as "low."

Asked how ASAM could enhance its relevance to members' practical needs, the survey group offered a variety of ideas: 12% suggested holding more regional events; 11% asked for better lobbying on managed care policies; 10% supported more practical publications, more involvement in reimbursement/parity issues, and more public education; 5% cited more continuing education, better communication with members, and more use of email and the Internet; while 4% pointed to the need for ASAM to be on the forefront of practical research, to gain more recognition by the rest of the medical community, and to offer more treatment guidelines. Four percent said the Society should continue its current activities.

In the area of advocacy and representation, 19% of those surveyed asked for more public relations and education activities; 9% wanted more efforts on reimbursement and parity issues, while 7% wanted more efforts at specialty board recognition; and 4% asked that ASAM continue to seek member input, use more electronic communications, and strengthen state-level activities regarding certification. Nine percent said the Society is doing a good job already. Four percent said ASAM should not include nicotine/tobacco in substance abuse.

The following ASAM features were identified as strengths of the organization: the Medical-Scientific Conference (70% of those surveyed); fees for programs or services (68%); responsiveness of staff to member requests (67%); members' ability to assume leadership positions (49-65%); promotion of programs and services available to members (53%); and the *ASAM Patient Placement Criteria* (46%).

## Future Challenges Identified

Asked to name the greatest challenges or opportunities the addiction field will face over the next three years, 32% of the respondents pointed to reimbursement/parity issues, 26% said maintaining funding/financial issues, 25% cited public education about addiction treatment and 19% said lack of affordable treatment, 14% felt it was lack of recognition by the medical community, 9% pointed to legislation/government policies, and 5% cited the integration of addiction care into mainstream medical treatment. Four percent referred to managed care issues, increases in patient relapse rates, opiate abuse/treatment, and adding tobacco/nicotine to addiction medicine. Five percent of the 57 had no opinion.

*continued on page 3*

**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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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).

## Alcohol Report Hailed by Field, Denounced by Industry

Two government groups have released important reports on alcohol consumption. The first, a much-anticipated report on underage drinking by the National Research Council (NRC) of the National Academy of Sciences, calls for cooperation among the alcohol industry, health organizations, governments, parents, and others to combat what it describes as the nation's most significant youth drug problem.

The report also calls for raising excise taxes on alcohol to discourage drinking and asks the alcohol industry to reform its voluntary advertising codes, noting that "a substantial portion of alcohol advertising reaches an underage audience or is presented in a style that is attractive to youth." The panel's report also recommends that alcohol manufacturers fund an independent, nonprofit foundation to prevent underage drinking, rather than funding its own untested prevention messages.

Alcohol industry groups, along with their allies in Congress and the Bush administration, actively worked to derail or discredit the NRC report before it was released, and succeeded in delaying its publication. Interestingly, the NRC report finally was released on the same day as a report from the Federal Trade Commission (FTC), which cited improvements in the alcohol industry's attempts at self-regulation.

The FTC report, which focuses on advertising of so-called "alternative" beverages to youth, applauds "significant improvement in standards for the placement of alcohol ads, as well as improvement in the adoption of external advertising review mechanisms."

J. Edward Hill, M.D., a trustee of the American Medical Association, said the AMA supports the NRC's recommendations. "This study provides a blueprint for a comprehensive, national plan to combat underage drinking, which is turning into an epidemic among our nation's youth." Dr. Hill said.

Visit the Alcohol Policies web site of the Center for Science in the Public Interest at www.cspinet.org/booze for links to both the NAS and FTC reports. *Sources: Center for Science in the Public Interest and Join Together Online, September 10, 2003.*

## FDA Denies Ariva Petition

In December 2001, 18 groups—including ASAM, the American Medical Association, the Campaign for Tobacco-Free Kids, the American Cancer Society, the American College of Preventive Medicine, the American Thoracic Society, and the American Society of Clinical Oncologists—petitioned the U.S. Food and Drug Administration (FDA) to assert jurisdiction over OMNI® and Advance® "low carcinogen" cigarettes, Eclipse® and Nicotine Water®, and Ariva® lozenges, which contain tobacco and nicotine.

The FDA granted the petition for Nicotine Water and sent a warning letter to the maker of Nicotine Lollipop® and Nicotine Lip Balm,® but it denied the citizens' petition for Ariva Tobacco Lozenges.

In denying the petition, the FDA said that Ariva meets the definition of "smokeless tobacco" and is a "customarily marketed" tobacco product that is not subject to FDA regulation under current law. *Source: American Medical Association, August 24, 2003.*

**EVP** *continued from page 2*

To meet these challenges, members said ASAM should: continue to work toward recognition of addiction medicine by the American Board of Medical Specialties (81%); create an online employment service for members (68%); offer CME courses online (67%); offer computer-based certification examinations (65%); establish a Political Action Committee (PAC) (61%); continue to offer **ASAM News** online (60%); offer the Membership Directory only online (46%); and create a non-voting class of membership to permit non-physician addiction professionals to join ASAM (42%).

In a future column, I will write about the opinions of the prospective members surveyed. As always, I would welcome your feedback on the survey results, as well as any other subject of concern to you.

## New Survey Tallies Overlooked Drug Users

About 19.5 million Americans, or 8.3% of the population aged 12 and older, used illegal drugs in 2002, according to a new survey for the Substance Abuse and Mental Health Services Administration (SAMHSA). The annual National Household Survey on Drug Abuse, newly renamed the National Survey on Drug Use and Health, also estimates that 22 million Americans are addicted to alcohol and other drugs.

Researchers used enhanced methods to identify drug users overlooked in previous studies, as well as a $30 incentive payment, with the result that more than 68,000 persons participated in the research. "We know that for a number of years we've undercounted," said John Walters, director of the White House Office on National Drug Control Policy. Director Walters said the incentive payment encouraged younger people and potential drug users to participate in the survey.

The survey report contains estimates that about 14.6 million persons used marijuana, 2 million used cocaine, and 1.2 million used hallucinogens (such as Ecstasy) in 2002. In the same year, an estimated 54 million persons engaged in binge drinking and 16 million in heavy drinking.

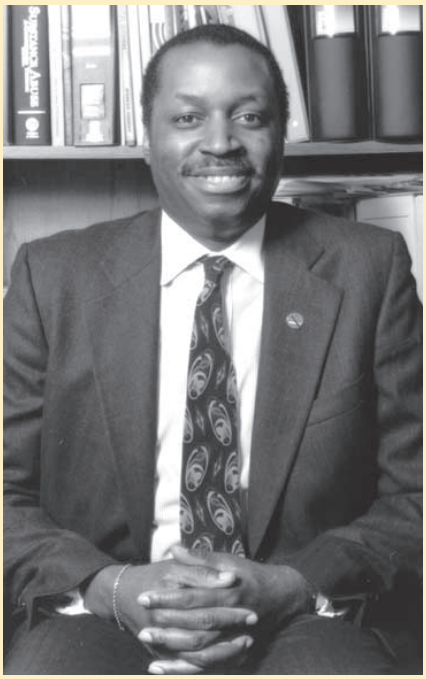
The report's authors also found that many addicted persons are not obtaining the help they need. For example, an estimated 7.7 million persons (3.3% of the total population aged 12 and older) needed treatment for a diagnosable drug problem and 18.6 million (7.9% of the population) needed treatment for a serious alcohol problem in 2002, but only 1.4 million received treatment for an illicit drug problem and 1.5 million received treatment for an alcohol problems.

"There is no other medical condition for which we would tolerate such huge numbers unable to obtain the treatment they need," said Health and Human Services Secretary Tommy G. Thompson in releasing the report. "We need to enact President Bush's Access to Recovery Program to provide treatment to those who seek to recover from addiction and move on to a better life."

According to survey estimates, rates of illicit drug use are highest among young adults 18 to 25 years old, 20% of whom currently use drugs. The survey also found that 30% of the population 12 and older—or 71 million people—use tobacco.

On a positive note, the number of new daily smokers decreased from 2.1 million per year in 1998 to 1.4 million in 2001. Among youth under age 18, the decline was from 1.1 million per year in each year between 1997 and 2000 to 757,000 in 2001. This represents a decrease from about 3,000 new youth smokers per day to 2,000 per day.

Findings from the 2002 National Survey on Drug Use and Health are available on the web at www.DrugAbuseStatistics.samhsa.gov. *Source: Press Release, U.S. Department of Health and Human Services, September 4, 2003.*



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

***Act by November 15th to send your member of Congress or Governor a copy of* Principles of Addiction Medicine *at the low introductory price of $155 for ASAM members. Regular prices go into effect after that date. Phone 1/800-844-8948 today, and remember to ask for the special bookplate!***

# Good Science Helps Us Advocate for Parity

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

## *I recently sent the following letter to Senator Hillary Rodham Clinton:*

"On behalf of the American Society of Addiction Medicine (ASAM) and the Addiction Research and Treatment Corporation (ARTC), I am honored to present to you the textbook *Principles of Addiction Medicine, Third Edition,* the most comprehensive reference in the field of addiction medicine.

"As the President of ASAM, the nation's medical specialty society dedicated to educating physicians and improving the treatment of individuals suffering from alcoholism and other addictions, and the Senior Vice President of ARTC, an organization founded in 1969 to help New Yorkers overcome addiction, I have admired your commitment to and leadership on the issues of health care. It has been outstanding....

"As a voter registered in New York, I would like to offer my assistance to you and your staff as you consider the underlying factors associated with substance use (alcohol, tobacco, and other drugs), which affects New Yorkers and all Americans. In fact, in early November I plan to visit Washington and hope to spend some time with you or members of your staff.

"Please accept my best wishes for your continued success and enjoyable reading."

## Advocating for Our Cause

I am asking the members of ASAM's Board of Directors to send a similar letter and a copy of *Principles* to their members of Congress, Governors, and other influential policymakers, and I hope each of you will consider doing the same. In *Principles*, ASAM has given us the most potent tool we can have in advocating for addiction parity: the power of science. The third edition of ASAM's *Principles of Addiction Medicine* comprehensively explores the nature of addiction, as well as science-based strategies for its prevention and treatment. As such, *Principles* provides powerful support for the concept of addiction as a medical disorder, and it exhaustively documents proven approaches to effective addiction treatment. Why not harness the power of science, through this impressive volume, in our efforts to achieve parity? ASAM will even provide a special bookplate to denote the book as your gift.

Another opportunity to advocate for addiction parity will occur with ASAM's Addiction Medicine Days on Capitol Hill. On Monday, November 3, and Tuesday, November 4, 2003, you are invited to join your Board and fellow members in Washington, DC, as we visit members of Congress to personally enlighten them about the nature of addiction and the need for parity in insurance coverage.

Better yet, plan to be in Washington on October 30-November 1 for ASAM's outstanding course on *The State of the Art in Addiction Medicine*, then choose between the course on *Pain & Addiction: Common Threads or the Buprenorphine Training Course* on Sunday, November 2. Then you will be armed with the very latest information on addiction science and practice when you meet with your lawmakers on November 3 and 4.

Should you have any questions about Addiction Medicine Days, see the flyer enclosed with this issue of **ASAM News**, or contact Celso Puente at ASAM headquarters by phone at 301/656-3920 or by email at CPUEN@ASAM.ORG.

If each of us does our part, we can make important strides in advocating for our profession and our patients. ASAM has given us the tools. It is up to each of us to use them wisely to achieve progress toward our goals.

# ASAM Members Urged to Join the AMA

*Richard A. Beach, M.D., FASAM, Stuart E. Gitlow, M.D., M.P.H., Lloyd J. Gordon III, M.D., FASAM, Michael M. Miller, M.D., FASAM, and David E. Smith, M.D., FASAM*

- ✔ Alcoholism is a medical disorder, and should be treated by a physician.
- ✔ Drug addiction is a disease rather than a moral failing.
- ✔ Physicians who are impaired by their own addiction to alcohol or other drugs are in need of advocacy, rehabilitation and, whenever possible, restoration to practice.

Not one of these statements sounds radical today. But each was intensely controversial at the time it was adopted as policy by the House of Delegates of the American Medical Association. Without the AMA's proactive stance, it might have taken many more years for such policies to win widespread acceptance within the medical profession, on the part of policymakers, and by the public.

## Contributions to the Field

The AMA's contributions to the field of addiction medicine extend to its programs as well. For example, it was the AMA that lobbied against the old "drunk tanks" and the practice of arresting persons found inebriated in public. AMA successfully argued that alcoholics belong in treatment, not in jails.

It was the AMA that persuaded state medical societies to create programs to assist impaired physicians, arguing that physician health and effectiveness is a legitimate area for medical society action. AMA also lobbied the state medical boards for more humane treatment of impaired physicians.

It was the AMA that launched the PADS program to curb the abuse of prescription drugs, and that first urged the states to adopt BAC levels below 0.1%.

It was the AMA that lobbied for creation of the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse to foster scientific research into the addictions.

And it was the AMA that lent its imprimatur to the notion that all physicians have an obligation to be knowledgeable about the identification and care of patients with addictive disorders (in a policy statement adopted in 1979), and then helped them fulfill that obligation by publishing its *Manual on Alcoholism* and its handbook *Drug Abuse: A Guide for the Primary Care Physician*.

The AMA also had a direct role in creating ASAM as a national specialty society. AMA staff member (and later ASAM Executive Director) Emanuel M. Steindler helped to organize the 1984 meetings at the Kroc Ranch that led to the formation of ASAM. And the AMA also was instrumental in acknowledging our specialty of Addiction Medicine when it admitted ASAM to a voting seat in its House of Delegates in 1988, and again when it agreed to accept ADM as a specialty designation in its Masterfile database of U.S. physicians in 1990.

## Progress At Risk

This is indeed a glorious record. But, as physicians who have represented ASAM in the AMA House of Delegates, we write not with an eye to the past but to the future, and we are concerned. The AMA has a requirement that, to retain formal representation and a vote in its House of Delegates, a medical specialty society must be able to demonstrate that at least 35% of its members also are members of the AMA. Unfortunately, ASAM presently cannot meet this requirement. As verified by a recent audit, your Society needs to enroll about 200 new AMA members by December 31, 2003, in order to retain its seat in the AMA House and its influence on AMA policies.

The leadership of our Society is considering a range of creative approaches to achieving the required membership in the AMA, including offering complimentary memberships in ASAM to selected leaders of state medical associations and allied medical societies who already are AMA members. Of course, we hope that once those physicians experience the benefits of ASAM membership, they will choose to renew their memberships in ASAM in years to come.

## ASAM Members Needed

However, the most straightforward solution to the problem rests in your hands. Simply put: Join the AMA. If you already are an AMA member, renew your membership (if you are not certain whether your AMA membership is current, check the ASAM web site.) And encourage a colleague in ASAM to join as well. Then let the ASAM office know what you have done, so that our staff can keep track of progress toward the "magic" number to retain ASAM's seat in the AMA House of Delegates.

We understand that there are many reasons why ASAM members have chosen either not to join the AMA, or have let their AMA memberships lapse. For some, the problem is that an employer no longer will reimburse the cost of AMA dues. For others, it arises out of a disagreement with AMA policy on one issue or another. For yet others, it is a feeling that the AMA's activities are not relevant to their interests. Each of these reasons may seem compelling and, in fact, each has some validity. However, there are two larger goals at stake here: (1) retaining ASAM's voice and vote in the AMA House of Delegates, and (2) by doing so, helping sustain AMA as an advocate for the addiction field and the interests of physicians who practice addiction medicine.

ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, recently renewed his own membership in the AMA, and has asked every member of the Board of Directors to do so as well. In a letter to ASAM's leadership, Dr. Brown said: "As we move toward celebration of 50 years of existence, we need to be very aware that the existence of ASAM is due, in large part, to the

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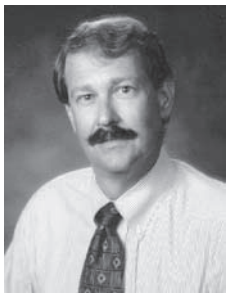
*Dr. Beach*

*Dr. Gitlow*



*Dr. Gordon*

*Dr. Miller*

*Dr. Smith*

*Louis E. Baxter, Sr., M.D., FASAM*

# Best Practices Course Charts New Areas of Knowledge

*Louis E. Baxter, Sr., M.D., FASAM*
*Course Director*

A new ASAM course entitled "Best Practices: Clinical Drug Testing in Addiction Treatment" debuted July 17th in Chicago, preceding ASAM's Medical Review Officer training course. Judging by participants' evaluations, the course was a solid success.

The idea for the course arose when a national consensus panel of addiction experts met in November 2002. The group was assembled by the Center for Substance Abuse Treatment (CSAT) to develop a new Treatment Improvement Protocol (TIP) on drug testing. Panel members examined the issues of drug and alcohol testing in the treatment milieu and how such testing differs from testing required by the Department of Transportation (DOT). They concluded that, while there are well-established federal guidelines for drug and alcohol testing in the workplace, there are no similar guidelines for testing as part of addiction treatment.

The panel went on to enumerate issues unique to treatment settings and urged that treatment providers be involved in discussions that could lead to the development of a standard of care for drug testing in treatment settings.

ASAM agreed to initiate such a discussion through sponsorship of the Best Practices course. Issues addressed in the course included the various testing modalities and the utility of each test for treatment purposes. Participants also discussed tradeoffs between point-of-collection and certified laboratory testing, how cutoff levels for positive results should be established, when and how to use confirmatory tests, and the merits of using testing devices approved by the FDA and CLIA. Faculty and audience members debated which testing modalities and media are best under various circumstances encountered in treatment settings. The use of drug testing as a deterrent versus use of drug testing as a method of monitoring treatment efficacy also was discussed. Case studies were used to illustrate key points and common treatment dilemmas.

## Expert Faculty Enlisted

Faculty members for the course were Louis E. Baxter, Sr., M.D., FASAM, who also served as Course Director; ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM; Edward J. Cone, Ph.D., of Pinney Associates, Inc.; Susan Neshin, M.D., Medical Director of Jersey Shore Medical Center; J. Michael Walsh, M.D., principal of the Walsh Group, Inc.; Robert E. Willette, Ph.D., President of Duo Research, Inc.; and Donna Bush, Ph.D., of the Workplace Program at the Center for Substance Abuse Prevention.

In their evaluations, participants reported that the course was "worthwhile" and "added a lot to my knowledge base." Encouraged by the response, organizers hope to schedule the course again in 2004, preceding an ASAM MRO Training Course.

***DR. BAXTER** is Executive Medical Director of the Physicians' Health Program at the Medical Society of New Jersey. In addition to chairing the Best Practices course, Dr. Baxter is a member of ASAM's Board of Directors, where he represents Region IV. He can be reached by email at* LBAXTER@MSNJ.ORG.

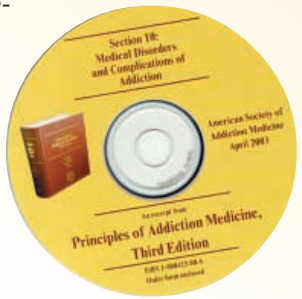
# SARS FUND APPEAL CONTINUES

Under the leadership of Board member Paul H. Earley, M.D., FASAM, 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.

*Dr. Paul Earley*

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.)



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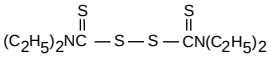

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Disulfiram occurs as a white to off-white, odorless, and almost tasteless powder, soluble in water to the extent of about 20 mg in 100 mL, and in alcohol to the extent of about 3.8 g in 100 mL.

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

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

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

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

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

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

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

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

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

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

**WARNINGS:**

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

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

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

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

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

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

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

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

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

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

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

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

**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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**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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# 296 Physicians Earn ASAM Certification, Recertification

*C. Chapman Sledge, M.D., FASAM*

C. Chapman Sledge, M.D., Chair of the ASAM Credentialing Committee, has announced that 226 Physicians passed the ASAM examination in November 2002 and thus earned Certification in Addiction Medicine. An additional 70 physicians passed the examination to be Recertified in Addiction Medicine.

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Patricia A. Pade, M.D.
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Terry A. Payton, M.D.
Jean-Luc Pelletier, M.D.
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John A. Peterson, M.D.
Dan E. Phillips, M.D.
Todd Pinter, M.D.
Phillip E. Prior, M.D.
Mary H. Rabb, D.O.
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Frank Raymond, M.D., FACEP
Larina Reyes-Smith, M.D., CCFP
Sara C. Rochester, M.D.
Stephen Ross, M.D.
Susan M. Rowley, M.D.
Joseph D. Scuderi, M.D., Ph.D.
Stanton L. Segal, M.D.
Jeffery A. Selzer, M.D.
James G. Shames, M.D.
Dennis M. Shaughnessy, M.D.
J. M. Simson, M.D.
Alka Singal, M.D.
Baljeet Singh, M.D.
Abhinav Singla, M.D.
C. Chapman Sledge, M.D., FASAM
Jennifer G. Smith, M.D.
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Michael Stone, M.D.
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William B. Swafford, Jr., M.D.
Merrill F. Swiney, M.D.
Diana L. Sylvestre, M.D.
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Johan Wouterloot, M.D., B.Sc.
Steven L. Wright, M.D.
Martha J. Wunsch, M.D.
Jeffery T. Young, M.D.
Dykes M. Young, M.D.

# ASAM Members Invited to Nominate New Regional Directors, Officers

*Marc Galanter, M.D., FASAM*
*Chair, Nominating & Awards Committee*

The following ASAM members have been elected to serve on the Society's Nominating & Awards Committee (for terms from 2003 to 2005).

- Thomas L. Haynes, M.D., FASAM (Board Member)
- Penelope P. Ziegler, M.D., FASAM (Board Member)
- Kevin B. Kunz, M.D., M.P.H. (President, Hawaii Chapter)
- Berton J. Toews, M.D., FASAM (President, Wyoming Chapter)
- Louis E. Baxter, Sr.,M.D., FASAM (Committee Chair)
- David R. Gastfriend, M.D. (Committee Chair)

The newly elected members will join the following individuals, who are assigned a place on the committee under ASAM's Constitution & Bylaws:

- Marc Galanter, M.D., FASAM (Immediate Past President), *Chair*
- Lawrence S. Brown, Jr., M.D., M.P.H., FASAM (President), *voting member*
- Elizabeth F. Howell, M.D., FASAM (President-Elect), *non-voting member*
- Eileen McGrath, J.D. (Executive Vice President/CEO), *non-voting member*

The Committee is to select a Slate of Officers for the ASAM elections to be held in 2004 (for officers to serve 2005-2007). ASAM members are invited to participate in nominating the Society's next President-Elect, Secretary, and Treasurer, as well as a full slate of Regional Directors.

As required by ASAM's Bylaws, the Nominating & Awards Committee has determined which members meet the qualifications for officer positions. Those who meet the requirements may be nominated by the Committee or by individual ASAM members.

Nominations 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.

## CA Lawmakers Approve Treatment in Correctional Settings

CSAM President-Elect Donald J. Kurth, M.D., FASAM, reports that California Assembly Bill 1308, which establishes standards for the treatment of addicted persons in correctional settings, has passed both the state Senate and Assembly, and is on its way to Gov. Grey Davis (D) for signature. While some amendments were required to win passage, Dr. Kurth says that "the bone and muscle of the bill remain intact."

The bill's provisions include:

- A requirement that medical care be provided for withdrawal when addicted persons are incarcerated (thus prohibiting the use of "cold turkey" withdrawals).
- Explicit recognition of ASAM's guidelines on the care of incarcerated persons as the standard of care for such treatment.
- A provision that prevents judges and corrections personnel from requiring discontinuation of opioid replacement therapy before individuals can participate in programs that allow treatment in lieu of incarceration, unless such discontinuation is recommended by a treatment provider.
- A sliding fee scale so that methadone maintenance can be legally and affordably provided to indigent persons who are addicted to heroin and other opioids. (Current law makes it illegal to charge indigent patients less than the reimbursement provided by Medi-Cal, Medicaid, or Medicare.)

Dr. Kurth credits enactment of the bill to the work of ASAM's and CSAM's Public Policy Committees. "ASAM developed the language on which the bill is based, while CSAM members did the legislative footwork to persuade lawmakers to enact the measure," he said. Gov. Davis's action on the bill will be reported in the next issue of **ASAM News**.

## VT Parity Law Found Effective at Cost Control

Vermont's groundbreaking parity law is effective in controlling costs, according to a study conducted for the Substance Abuse and Mental Health Services Administration (SAMHSA). The law, which became effective in 1998, requires insurers to provide coverage for mental health and addiction services at parity with other medical care.

The SAMHSA study found that in the first two years after the parity law took effect, spending for mental health and addiction treatment in Vermont actually declined by 8% to 18%. The study's authors attribute much of the reduction to managed care. They conclude that "Overall, parity for mental health and substance abuse benefits was achieved in Vermont."

U.S. Senator Jim Jeffords (I-VT), sponsor of national parity legislation, requested the SAMHSA study. He hailed the study's findings, noting that the Vermont parity law allows state residents "to access more effective services, at lower costs to themselves, and at minimal cost to employers." He said that the Vermont law could be a model for a national parity measure. (A PDF version of the SAMHSA report can be accessed at WWW.MATHEMATICA-MPR.COM.) *Source: Associated Press, September 4, 2003.*

## PA Regulators: Doctors Have Final Say on Addiction Treatment

The Pennsylvania Insurance Department has notified health insurers doing business in the state that physicians, not managed care organizations (MCOs), are the final authority regarding referrals and placement for inpatient and outpatient addiction treatment. Treatment providers applauded the state's action, saying that the state's residents have been unable to obtain care or have received inadequate services because of MCO policies.

Pennsylvania law requires that insurers cover seven days of detoxification services per year and 30 days of residential rehabilitation per year. Physicians and other providers maintain that the law says only the treating physician can determine treatment levels. Insurers, on the other hand, have denied or limited such care, arguing that the law allows them to review cases and deny minimum coverage if their criteria are not met.

Deb Beck, president of the Pennsylvania organization of addiction treatment providers, said the state's policy directive affirms the primacy of physicians in making treatment determinations. "The rights of the treating physician have been upheld; that ought to be the case in every state."

On the other hand, health insurers are complaining the state directive could adversely affect their costs and contractual relationships. "It really throws managed care out the window as to drug and alcohol treatment benefits," said Jonathan Vipond III, a lawyer who represents Magellan Behavioral Health's interests before the Pennsylvania General Assembly. *Source: Alcoholism & Drug Abuse Weekly, August 25, 2003.*

## Manufacturer Discontinues ORLAAM® Distribution

The sale and distribution of ORLAAM® (levomethadyl acetate HCL), a synthetic opioid agonist solution indicated for the management of opiate dependence, will be discontinued, the manufacturer has announced. ORLAAM is a second-line therapy for the treatment of opioid-addicted patients who fail to show acceptable response to other treatments. First-line treatment options still available for the management of opioid dependence include methadone and buprenorphine.

ORLAAM was removed from the European market in March 2001 following reports of severe cardiac-related adverse events, including QT interval prolongation, Torsades de Pointes and cardiac arrest.

Roxane Pharmaceuticals, the manufacturer, estimates that the available inventory of ORLAAM will be depleted by February 2004. Roxane is encouraging health care providers to transfer patients to alternative treatments as soon as possible.

The FDA's MedWatch 2003 safety summary, including links to the "Dear Healthcare Professional" letter and a previous (2001) MedWatch safety alert, can be accessed at HTTP://WWW.FDA.GOV/MEDWATCH/SAFETY/2003/SAFETY03.HTM#ORLAAM. *Source: FDA CDER MedWatch, September 10, 2003.*

***"Helping Patients With Alcohol Problems: A Health Practitioner's Guide"***

***The National Institute on Alcohol Abuse and Alcoholism offers this 28-page guide to screening of and brief intervention with patients in whom an alcohol-related problem is suspected.***

***An excellent resource for non-specialist colleagues or in-service training, the guide covers core information on risky drinking patterns, screening instruments, diagnostic criteria, and how to refer patients for treatment.***

***The guide can be ordered at no charge from NIAAA or downloaded from the Institute's web site at WWW.NIAAA.NIH.GOV.***

## Buprenorphine + Naloxone Found Safe and Effective

Office-based treatment with buprenorphine + naloxone is a safe and effective treatment for opioid addiction, according to a study report in the *New England Journal of Medicine*. In a multicenter trial, 326 persons addicted to opioids were randomized to office-based treatment with 16 mg buprenorphine in combination with 4 mg naloxone, 16 mg buprenorphine alone, or placebo given daily for four weeks. To reduce the potential for misuse of buprenorphine via parenteral injection, the ratio of buprenorphine to naloxone was 4:1.

When interim analysis revealed that buprenorphine + naloxone in combination and buprenorphine alone were more effective than placebo, the double-blind trial was terminated early. Compared with patients receiving placebo, patients receiving either of the active treatments reported less opiate craving ($P < .001$). The proportion of urine samples that were negative for opiates was 17.8% in the buprenorphine + naloxone treatment group, 20.7% in the buprenorphine group, and 5.8% in the placebo group ($P < .001$ for each treatment versus placebo).

Adverse event rates were similar in all groups, and an open-label follow-up study of buprenorphine + naloxone in 461 opiate-addicted persons indicated that the combined treatment was safe and well tolerated. *Source: New England Journal of Medicine, September 4, 2003.*

## Education May Predict Post-Treatment Alcohol Use

A study reported in *Alcoholism: Clinical & Experimental Research* has found that educational attainment may predict drinking outcomes following alcohol treatment. Past studies have shown that alcohol use may hinder educational achievements; the new research examines whether education may serve as a protective factor against the development of, or relapse to, alcohol use disorders.

Between 1993 and 1996, researchers consecutively recruited 101 individuals (60 men and 41 women) who were hospitalized for alcohol dependence, then monitored their progress for one year following discharge. Each study participant was interviewed during his or her hospital stay and at monthly intervals following discharge. Investigators examined the relationship between the patients' educational attainment prior to treatment and their post-discharge drinking outcomes, including time to relapse. They found that years of education significantly predict alcohol treatment outcomes.

"People have been interested in the association between educational attainment and alcohol disorders because education is a modifiable factor," said Shelly F. Greenfield, M.D., assistant professor of psychiatry at Harvard Medical School and medical director of the alcohol and drug abuse ambulatory treatment program at McLean Hospital. "Education is something you might have influence over. Although previous studies have looked at this association, none to our knowledge have looked at the influence of educational attainment on the outcome of inpatient alcohol treatment."

Dr. Greenfield suggested that future research should address issues related to better matching of patients to various kinds of treatment. "Our results should make people question how individuals with different levels of educational attainment mesh with the treatment program that they're in. The bottom line is trying to make treatment optimal for people who are trying to help themselves with an alcohol problem." *Source: Alcoholism: Clinical & Experimental Research, August 2003.*

**AMA** *continued from page 5*

encouragement and practical support of the AMA." Dr. Brown added, "As always, ASAM is indebted to its outstanding members for their voluntary efforts to realize shared goals. We are grateful for your willingness to consider joining this campaign to help ASAM retain its seat in the AMA House of Delegates."

We add our voices to Dr. Brown's in making this personal plea to you, our valued colleagues in ASAM, to follow the leadership and join (or renew your membership in) the AMA. Don't let this important voice for addiction medicine be stilled. Time is short, so please don't delay. Join the AMA today.

***To join the AMA, or verify that your membership is current, simply phone 1-800/621-8335 and mention the half-price membership offer. ($210 for physicians who have not been AMA members in 2003). Then drop an email to Joanne Gartenmann at the ASAM office (JGART@ASAM.ORG) and tell her that you've joined.***

***DR. GITLOW** is ASAM's current Delegate to the AMA House of Delegates and **DR. GORDON** is ASAM's Alternate Delegate. **DR. BEACH** and **DR. MILLER** are past ASAM Delegates to the AMA. **DR. SMITH** was ASAM's first Alternate Delegate, working with the late Jess Bromley, M.D., FASAM, who was ASAM's first Delegate.*

# RWJ Offers Substance Abuse Policy Research Program

November 7, 2003, is the deadline for letters of intent to apply for the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program. The program supports policy research that is relevant to reducing the harm caused by use of tobacco, alcohol and illicit drugs in the U.S. It is intended to encourage experts in medicine and public health, law, political science, sociology, criminal justice, economics and other behavioral and social sciences to address issues related to substance abuse.

Proposals must address one of the following research topics:

- State fiscal crises and substance abuse policy.
- Disparities in substance abuse treatment needs and services based on race/ethnicity.
- The role of consumer involvement and advocacy in substance abuse policy.
- Tobacco use in substance-abusing populations.
- The intersection of substance abuse treatment and other related systems, such as mental health and welfare.
- Policies and systems that facilitate or impede progress in getting new therapies and interventions adopted in practice.

Total awards for individual policies will range from $100,000 to $400,000 and may extend up to a maximum of three years. For complete information and eligibility requirements, visit WWW.RWJF.ORG/CFP/SAPRP.



*Dr. Ruth Fox*

## Dear Colleague:

Plans are moving ahead for the Ruth Fox Memorial Endowment Fund to offer Scholarships 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 2003 scholarship recipients, who were unable to attend the cancelled Med-Sci Conference in Toronto and who will be welcomed to the 2004 conference as well.)

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. 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*

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*CSAP Director Beverly Watts Davis*

# CSAP Director Challenges ASAM Members to "Get Involved!"

Preventing alcohol and drug abuse "is the most effective and humane thing we can do," says Beverly Watts Davis, newly named Director of the federal Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration. In an interview with **ASAM News**, Ms. Watts Davis urged ASAM members to become involved in community-level prevention efforts.

The new Director formed her convictions through direct experience: before joining CSAP in May, she was Senior Vice President of the United Way of San Antonio, Texas, as well as Executive Director of San Antonio's Fighting Back Anti-Drug Community Coalition. She recalls that at the time the coalition formed in 1992, almost a quarter of San Antonio was a drug-riddled "war zone," dominated by some 16,000 gang members and regularly punctuated by gunfire.

Organizers of the San Antonio coalition used graphic techniques like geomapping to persuade city leaders that neighborhoods saturated by illicit drugs were the same areas where the city was struggling with gang activity, high crime rates, teen pregnancy, school dropouts, and other signs of social breakdown. Coalition members argued that preventing drug abuse would have a beneficial effect on other urban problems as well.

Although the drug gangs fought back, the community coalition persisted, and eventually found success. Crime rates were reduced by 35%, crack houses and gang hangouts were demolished, billboards advertising tobacco and alcohol products were removed, and volunteers were enlisted in community clean-up projects. Not coincidentally, the average age of first drug use increased from 9.2 to 17.5 years.

The Director's goals for CSAP include working to identify the key elements of prevention programs like San Antonio's and to replicate them in communities across the country. The agency's goal is to improve the overall quality of life in the community, whether urban, suburban or rural. In fact, Ms. Watts Davis points out that the problems faced by inner city and rural areas are strikingly similar: both struggle with inadequate resources and weakened infrastructures, which make them an easy target for drug dealers in search of quick money.

## Creating a Stable Environment

The Director is seeking stability not only for communities, but also for the prevention field itself. Substance abuse prevention is not a quick-fix issue, she says, but in the past, it has been funded that way. Such erratic funding leads to erratic policymaking, she warns.

By contrast, Ms. Watts Davis is convinced that stable funding will allow state and local governments to make longer term commitments to prevention, to engage in long-term planning, and to take political risks in adopting prevention-friendly policies. In pursuit of this goal, CSAP will use its State Incentive Grant (SIG) program to create a stable funding base for the states and, through them, the local communities. She expects community groups to respond in a strategic way—they must avoid shaping programs according to what can be funded, she says, and instead find funding to support what needs to be done.

## Partnering With Addiction Medicine

Ms. Watts Davis sees CSAP working collaboratively with ASAM and other addiction organizations to help communities connect with researchers. She sees this as benefitting both the addictionists and the communities, by fostering the creation of "natural laboratories" for research and speeding the adoption of effective approaches. As she sees it, such collaboration would be a two-way street, with the experiences of community providers informing the work of researchers, just as new research helps to improve service delivery.

To make the point, she describes how ethnographers and other experts from the federally funded Community Epidemiology Work Group (CEWG) have helped community groups understand local drug use patterns. Community coalitions "have the passion" to fight addiction, she adds, but "need the smarts" that addiction specialists bring to the table. In defining the ways in which individual physicians can become involved, Ms. Watts Davis points out that every anti-drug community coalition has a place on its board for a physician.

As for her own role, the Director says what helped her decide to accept the directorship is that at CSAP, "every decision makes a difference. Every decision affects someone's life." Her goal, she adds, is to send a message that "what we bring to the table as preventionists is valuable. Prevention is not a hobby, nor should it be an afterthought. Prevention creates the environment and skills to help people make good and healthy choices."

# ASAM Conference Calendar

## ASAM

**October 30-November 1, 2003**
ASAM Course 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
Washington Court Hotel
Washington, DC
8 Category 1 CME credits

**November 20, 2003**
Forensic Issues in Addiction Medicine Workshop
Loew's L'Enfant Plaza Hotel
Washington, DC
7 Category 1 CME credits

**November 21-23, 2003**
Medical Review Officer (MRO) Training Course
Loew's L'Enfant Plaza Hotel
Washington, DC
18 Category 1 CME credits

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

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

**April 23-25, 2004**
ASAM's 50th Anniversary Medical-Scientific Conference
Washington, DC
21 Category 1 CME credits

**October 30-November 1, 2004**
Review Course in Addiction Medicine
Toronto, Ontario, Canada
21 Category 1 CME credits
Other Events of Note

**October 8, 2003**
Update on Addiction Medicine
(Sponsored by the Michigan Society of Addiction Medicine)
Grand Blanc, MI
[For information, email SWILSON@GENESYS.ORG]

**October 11, 2003**
ASAM Region VII Conference: Addiction Medicine 2003 — Research, Practice, Collaboration
Houston, TX
[For information, phone 504/780-2766]

**November 6-8, 2003**
Association for Medical Education and Research in Substance Abuse (AMERSA)
27th Annual National Conference, held in collaboration with the International Nurses Society on Addictions
Baltimore, MD
[For information, visit WWW.AMERSA.ORG or phone 401/349-0000]

**December 3-6, 2003**
SECAD 2003: An International Conference for Addiction Professionals
(Sponsored by the National Association of Addiction Treatment Providers)
Atlanta, GA
[For information, phone 888/506-7394]

## OTHER EVENTS OF NOTE

**March 4-7, 2004**
American College of Legal Medicine
Annual Meeting
Las Vegas, NV
[For information, email INFO@ACLM.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.*