February/March 2004
Volume 19, Number 1

# ASAM News

Newsletter of The American Society of Addiction Medicine

## Inside

### ASAM at Work for You:



### Also see:



www.asam.org

## ASAM's Med-Sci Conference and 50th Anniversary Gala Set for Washington, DC

ASAM's 35th Annual Medical-Scientific Conference and 50th Anniversary celebration are set for April 23-25 in Washington, DC. The conference is preceded by three special events: the Ruth Fox Course for Physicians and an ASAM Forum on Pain and Addiction, both scheduled for Thursday, April 22nd, and ASAM Legislative Days, set for April 21-22. It concludes on Sunday, April 25th, with a Buprenorphine Training Course. All events will take place at the historic Marriott Wardman Park Hotel, overlooking scenic Rock Creek Park.

A highlight of the conference is a black-tie Gala celebrating ASAM's 50th Anniversary (see page 2 for details). At the Gala, set for Saturday evening, April 24th, ASAM will bestow awards for outstanding service on Andrea G. Barthwell, M.D., FASAM, Deputy Director of the Office of National Drug Control Policy, and Alan I. Leshner, Ph.D., former director of the National Institute on Drug Abuse. The John P. McGovern Award and Lecture on Addiction and Society, which honors an individual who has made highly meritorious contributions to public policy, will be presented to David C. Lewis, M.D.

For additional information and conference registration, consult the ASAM web site or contact ASAM's meetings staff at EMAIL@ASAM.ORG. Participants also are welcome to register on-site. To reserve a place at the Anniversary Gala, phone Jan Kary at 202/338-6100 x 114 or email JKARY@OAI-USA.COM.

## ASAM Textbook an "Essential Resource," JAMA Reviewer Says

"Truly comprehensive in its coverage of the field" and an "essential resource for anyone involved in the direct care of patients with addictions"—so says a review of ASAM's textbook, *Principles of Addiction Medicine, Third Edition*, in the January 7th *Journal of the American Medical Association*.

Reviewer Annette Matthews, M.D., notes that *Principles'* 13 sections cover "basic science, diagnosis, management of withdrawal, treatment and early intervention, pharmacological and behavioral interventions, medical disorders and complications of addictions, co-occurring substance and psychiatric conditions, pain and addiction, and children and adolescents." She finds that "each of the chapters within these sections is detailed, practical, and clearly written."

Dr. Matthews concludes that, in addition to physicians, *Principles* is an essential resource for nurse practitioners, social workers, and addiction counselors, as well as managers and supervisors of residential and outpatient treatment programs.

*Principles of Addiction Medicine* can be ordered from the ASAM web site (WWW.ASAM.ORG) or by phoning 1-800/844-8948. The price is $175 for ASAM members and $199 for nonmembers.

# Help Us Celebrate ASAM's 50th Anniversary!

*Eileen McGrath, J.D.*

ASAM has many achievements to celebrate in its 50-year history, most notably its very existence-the creation of the first national association for physicians in the field of addiction! Our recent member survey confirmed that ASAM members value the education and networking opportunities provided by the Society. Sometimes we need a reminder, however, of why we exist. Let me share this story from one of our ASAM Board members.

"I was called by Ms. A's psychiatrist, who thought Ms. A might be drinking too much. The psychiatrist had tried to intervene and guide Ms. A, but didn't know what to do next. When I saw Ms. A for an evaluation, she had all the symptoms of severe alcohol dependence. She couldn't stop drinking, her life was constricted, her family was worried and puzzled, and she was depressed and anxious most of the time. She suspected she might have a drinking problem, but thought the solution was to cut down or get herself under control. When I summarized my impressions at the end of the evaluation, I told Ms. A she had all the signs of alcohol dependence, that she was an alcoholic, and my recommendation was for her to stop drinking. No cutting down for her. She began to cry; she hoped I would tell her that there was no problem, or that there was an easy solution. She couldn't imagine quitting alcohol! Then I really floored her by recommending that, because of her age, medical problems, level of alcohol use and physical dependence, she needed to go into inpatient treatment for a safe detoxification and stabilization. She was really afraid of inpatient treatment-especially that she would be locked up or treated badly. I was able to reassure her that I could refer her to people I knew—colleagues from ASAM who were experts in stabilization and detoxification, physicians I would call on to care for my own family and friends.

"After a few weeks of trying unsuccessfully to stop drinking on her own, Ms. A went into treatment. She bonded with her treatment physician and plunged headfirst into treatment and recovery. That was over five years ago; she has been sober ever since. She is an active member of AA, volunteers at the inpatient program where she was treated, and uses recovery principles in all parts of her life. She was sober when her first grandchild was born! She is very grateful for her sobriety and her treatment. I am grateful to the ASAM colleagues who teamed with Ms. A, her psychiatrist, and me to help her along this journey of recovery."

While this story represents just one experience, I'm sure every member of ASAM has a similar story to share. All of us on the ASAM staff hope that our upcoming 50th anniversary gala will be your celebration, because you are the everyday heroes who make a difference in patients' lives. All of the educational opportunities we can provide for you, and all of the networking opportunities, really boil down to the "one patient, one doctor" relationship that is needed to help an individual achieve an addiction-free life. So we hope that you will participate in our upcoming gala, which celebrates not just the first 50 years of an organization, but also honors all of you for your commitment and dedication to the field of addiction medicine.

Thank you for giving ASAM such a wonderful legacy. We look forward with great anticipation to the next 50 years!

***Join us at ASAM's 50th Anniversary Gala, to be held in conjunction with ASAM's 35th Annual Medical-Scientific Conference:***

**Saturday, April 24, 2004 ★ Marriott Wardman Park Hotel ★ Washington, DC**

*You as an individual member or your practice or company may purchase gala tables at $5,000 and up or individual tickets for this black-tie event at $450. You may register via the response form on the web at WWW.OAI-USA.COM/ASAM (print out the form, complete the information, and fax it to the number on the form) or by calling Jan Kary at 202/338-6100 x 114.*

*If you cannot join us for the celebration, your donation will be appreciated—just note the donation box on the response form.*

**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.



**ASAM News**
is an official publication of the American Society of Addiction Medicine. It is published six times a year. Please direct all inquiries to the Editor at ASAMNEWSLETTER@AOL.COM or phone 410/770-4866.



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

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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).

## Treatment Funding Bill Clears Hurdle; ASAM Criteria Cited

A House-Senate conference committee has approved a budget plan that gives impressive increases to federal addiction treatment and prevention programs, including $100 million for President Bush's proposed treatment voucher program. In doing so, the committee made it clear that it wants programs to use the ASAM Patient Placement Criteria or other objective standards in deciding which services each patient needs.

House and Senate conferees agreed to fund the voucher program as part of an omnibus appropriations bill, and to add $36 million to the $1.753 billion federal addiction block grant, which funds the nation's public treatment programs. While the addiction field embraced President Bush's call for a $600 million investment in treatment, many have been wary about the types of programs that would be funded, particularly given the administration's interest in faith-based interventions.

But lawmakers stressed that voucher money should go only to programs with a proven record of effectiveness. "The conferees expect that the new voucher program will support evidence-based practice and will provide medically appropriate treatment for individuals needing care," the House-Senate conference report said. "To this end, the conferees expect that states and providers receiving funds under this program will use assessment and placement criteria developed by national experts, such as the American Society of Addiction Medicine.

"The conferees support the administration's goal of opening new pathways to treatment," the report added. "At the same time, however, the conferees direct that all providers participating in the Access to Recovery program should be held accountable to the same standards of care, performance, licensure, and certification requirements as other licensed or certified drug and alcohol programs in their respective states." This language mirrors ASAM's policy.

Jenny Collier of the Legal Action Center credited President Bush for making the voucher plan a budget priority by highlighting it in his State of the Union address and in official visits to treatment programs across the country. Despite fears that a conservative Congress and administration might turn away from demand-reduction strategies, Collier said that treatment and prevention have become nonpartisan issues. "Lawmakers see this as a problem that affects their communities," she said. "In a year where we had tight funding levels, you would be hard-pressed to find another block grant with a $35 million increase."

Beyond the voucher program and the block grant, Congress continued its strong support for the National Institutes of Health and addiction-related research, giving increases of $35 million and $15 million, respectively, to the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). With the increase, NIDA stands on the brink of being a billion-dollar agency, with its 2004 budget set at $997 million. If the spending plan is approved, NIAAA's budget next year would be $431 million. In addition, the Center for Substance Abuse Prevention (CSAP) received an increase of $3 million rather than the $50 million cut proposed by the Bush administration.

"For the most part, the field did unbelievably well," said Sue Thau of the Community Anti-Drug Coalitions of America, who attributed the positive results to the fact that "the field has really come together on appropriations [advocacy]." *Source: Join Together Online, December 5, 2003.*

## Methadone Deaths Not Linked to Opioid Treatment Programs, Experts Say

The recent increase in methadone-related deaths is not caused by misuse of methadone obtained from opioid treatment programs, but appears related to increased use of the drug to manage pain, according to a consensus report released by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The report captures the deliberations of a panel of experts convened by SAMHSA to address an increase in hospital emergency visits and deaths involving methadone (such ED visits rose 176% between 1995 and 2002). The consensus panel, which was tasked with determining whether SAMHSA's methadone regulations were allowing diversion of methadone from clinics, included researchers, epidemiologists, pathologists, toxicologists, medical examiners, coroners, and specialists in pain management and addiction medicine. In reaching their conclusions, panel members reviewed data on methadone formulation, distribution, and prescribing and dispensing patterns, as well as relevant data on drug toxicology and drug-associated morbidity and mortality.

The panel found that most methadone-related deaths fell into one of three categories: (1) illegally obtained methadone used in excessive or repetitive doses to achieve euphoric effects; (2) methadone, either legally or illegally obtained, used in combination with other prescription medications, such as anti-anxiety medications, alcohol or other opioids; or (3) methadone accumulated to harmful serum levels in the first few days of treatment for addiction or pain, before tolerance is established. Panelists concluded that greater availability of methadone as a result of its use to treat pain was the primary source of drugs involved in methadone-related overdoses and deaths.

To address the situation, panelists formulated a series of recommendations, urging better training of clinicians who use methadone in addiction treatment or pain management, as well as improved data collection and case-finding to permit more rapid identification of problems.

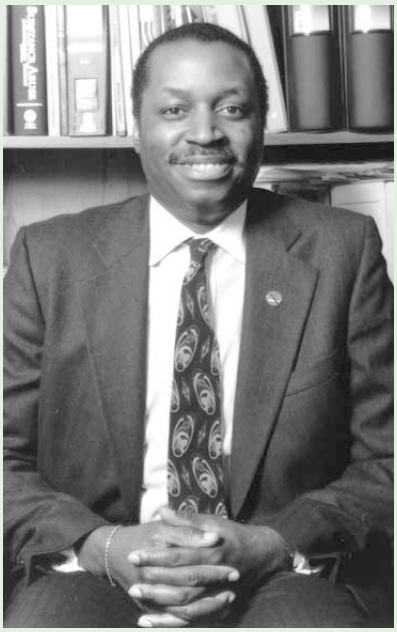
SAMHSA Administrator Charles Curie said that SAMHSA will continue to monitor the situation. *Source: Substance Abuse and Mental Health Services Administration, February 6, 2004.*

## Canadian Judge Stops Tobacco Lawsuit

A judge of the Ontario Superior Court has stopped a class-action lawsuit against Canadian tobacco companies, ruling that the suit does not meet the legal requirements for class-action certification. The multi-million dollar suit claimed that the three major Canadian tobacco companies conspired to prevent the public from knowing the risks of smoking.

In issuing his ruling, Judge Otto Winkler said that besides being smokers, the plaintiffs had little in common. "In essence, the plaintiffs seek certification of an amorphous group of people comprised of individuals of different ages, covering different decades, who knew different things concerning the risks inherent in smoking and who began to smoke for different reasons," he said.

Garfield Mahood, executive director of the Non-Smokers' Rights Association, said he was "extremely disappointed" over the ruling, calling it "a major setback for public health." *Source: Toronto Star, February 6, 2004.*



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

### *Here are three steps you can take to help us achieve addiction parity:*

1. Use the form enclosed with this issue of ASAM News to register for ASAM's Second Legislative Day, April 21-22 in Washington, DC. The ASAM staff will arrange for you to meet with your Senators and member of Congress, so that you can educate them about the importance of addiction parity.
2. If you cannot join us in Washington, send a letter to your members of Congress. It's never been easier, thanks to a web site maintained by the National Council on Alcoholism and Drug Dependence (NCADD). Simply go to www.ncadd.org/programs/advocacy, then click on "Parity Kit" for a form letter, or compose one of your own. Go to "Take Action" to find the addresses of your members of the House and Senate. And there's no reason to use the information here only once—in fact, repeated messages are the best way to reinforce your message!
3. Call your Senators' and Congress member's local office. Tell the staff person you are interested in a 5- to 10-minute conversation with your Senator or Congressman/Congresswoman to discuss the need to end discrimination against addiction treatment. If the member is not available, ask to speak to the staff person who handles health issues.

# Join Us for ASAM Legislative Day to Fight for Addiction Parity

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

Addiction is a complex illness. It is characterized by compulsive—at times uncontrollable—drug craving, drug seeking, and drug use, which persist even in the face of extremely negative consequences. Like diabetes and hypertension, it is a chronic disorder, with relapses possible even after long periods of abstinence. For all these reasons, addiction treatment is never simple. Yet scientific research and clinical practice have yielded a variety of effective treatment approaches. In fact, extensive research shows that such treatment is as effective as the treatments for most other chronic disorders.

Despite these successes, the physicians who specialize in addiction medicine and the patients who need their care often are not regarded or compensated in the same way as the victims of other medical disorders and the dedicated physicians who care for them. Examples of the discriminatory practices confronting such patients and their caregivers include:

- Annual and lifetime caps that are more restrictive than those imposed on other medical disorders;
- More stringent limits on days of inpatient care and number of outpatient visits than are imposed on the treatment of other conditions;
- Imposition of higher co-pays and deductibles for employees and their families who seek treatment for addiction; and
- Use of arbitrary and often undisclosed criteria by insurers and employers to determine whether treatment services are "medically necessary."

The reasons for this disparity are many, and include lack of awareness or information, stigma, and economics. The results can be devastating for patients and demoralizing for the physicians who treat them. The solution has a short title—addiction parity—that embodies three important concepts:

1. Physicians who wish to specialize in addiction medicine must have training opportunities comparable to those for other medical specialties.
2. Patients and their families must have access to treatment that is comparable to the care provided for other medical disorders; and
3. Physicians who provide addiction-related services must be compensated on par with physician compensation for delivering comparable medical services.

Your Society's leadership and staff advocate for addiction parity at every opportunity, in ways large and small, every day of the year. Now it is our turn to ask you, our ASAM colleagues, to lend your energy and wisdom to the struggle. ASAM has scheduled its Second Annual Legislative Day for April 21-22, 2004, immediately preceding ASAM's 35th Annual Medical-Scientific Conference in Washington, DC. We have arranged for a group of distinguished speakers to brief participants on our progress in the struggle for parity. But the most important feature of Legislative Day involves arranging for our members to go to Capitol Hill to educate lawmakers about the urgent need for parity.

This is an opportune time for us to act. President Bush is providing real leadership to win increased funds for addiction treatment. Lawmakers are debating ways to expand access to care. The Office of National Drug Control Policy has reached out to ASAM for advice and assistance. Moreover, the need is urgent: No disease costs society more. The group Professional Leadership on National Drug Policy (PLNDP) has documented that untreated addiction costs the nation six times more than heart disease ($133.2 billion), six times more than diabetes ($130 billion) and four times more than cancer ($96.1 billion).

ASAM's excellent staff has organized Legislative Day to be a rewarding experience for our members and an eye-opening one for our lawmakers. Please do your part, for your own sake and that of your patients and our profession. I look forward to joining you there.

# ASAM Board Acts on Fiscal, Program Measures

*At its November 2003 meeting, the ASAM Board of Directors took the following actions:*

- Amended the wording of ASAM's Bylaws to add "suspension of a medical license" as one of the conditions under which an individual would lose membership in the Society (unless and until the licensee is restored to active status).
- Approved the addition of two Directors-at-Large to the Board of Directors, raising the number of Directors-at-Large from four to six.
- Approved the addition of the Chair of the Membership Committee to the Board as a non-voting member. (The Chairs of the Physicians-in-Training Committee and the Chapters Committee previously were added to the Board as non-voting members.)
- Reviewed a demonstration of the algorithmic version of ASAM's Patient Placement Criteria, being developed with input from two Board members, Dr. Paul Earley and Dr. David Gastfriend. The algorithm currently is undergoing field trials here and abroad, with a target date of late 2004 for release to the public.
- Voted down proposals from the Membership Committee to approve a new category of Associate/Affiliate membership and to admit physician assistants and nurse practitioners as non-voting members.
- Rejected a motion by the California Society of Addiction Medicine (CSAM) to limit the availability of the "Alternate Pathway" to certification (that is, allowing physicians who are not board-certified to apply to sit for ASAM's Certification Examination) to one cycle, rather than two (the 2004 and 2006 exam years), as originally approved.
- Agreed to frame a mission statement for the Ruth Fox Memorial Endowment Fund that reflects the mission of the Fund, as well as lines of accountability and authority to the donors and the funds' managers.
- Adopted a number of measures to continue the strict fiscal controls instituted to address the revenue shortfall resulting from cancellation of the 2003 Medical-Scientific conference.
- Approved plans and a budget for the Society's 50th Anniversary Gala dinner at the 2004 Medical-Scientific conference.

At its January 2004 meeting (by conference call), the Board approved the Public Policy Statement on Rights and Responsibilities of Physicians in the Use of Opioids in the Treatment of Pain.

# ONDCP Director Meets with ASAM Board

John Walters, Director of the Office of National Drug Control Policy (ONDCP), attended ASAM's November 2003 Board meeting to discuss elements of the President's drug control strategy and seek input from ASAM's leadership.

In welcoming Director Walters, ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, described ASAM's support for ONDCP's message that the issue of addiction is critical to the nation's health, and particularly for initiatives such as the administration's voucher program, which promises to enhance access to care. Dr. Brown told Mr. Walters that ASAM stands ready to support ONDCP in conveying these messages.

Director Walters in turn expressed appreciation for ASAM's support and updated the Board on the status of legislation to fund the President's treatment initiative. He said that, beginning with the President's 2003 State of the Union message about addictive disorders, ONDCP has tried to build on the educational process, to improve medical education to incorporate screening for addictions.

He added that, beginning in January 2004, ONDCP is to release a new series of advertisements as part of it Youth Anti-Drug Campaign. Some of those ads are targeted to parents, while others are targeted to youth. The 30-second ads encourage listeners to realize their need for more education, thus beginning a two-step process to connect people with prevention and treatment modalities.

The Director said that he had begun to aggressively push student drug testing, adding, "I think we're at an historic moment where we can 'connect the dots.' I think the argument for addiction being a disease is now overwhelming… In order to apply public health models, we cannot shy away from the fact that the principal way in which the disease is spread is by young people in their teenage years and below, who begin using drugs and who, as non-dependent users, initiate their friends… The carriers of the disease are not addictive drug users, and drug testing, when it's done the way it has to be done to be legal, will find those who are engaged in this behavior and get them help. To use the knowledge that we have to intervene or treat in more effective settings is critical. Over 20% of the people we have to treat for illegal dependency today are teenagers. We know that if we intervene sooner, the outcomes are much better."

Finally, Mr. Walters described his visits to a number of states in which marijuana legalization measures were pending or passed. He expressed appreciation for whatever support ASAM can put forward, as the voice of professionals, in opposition to these measures. He noted that the purpose of the measures is to confuse the issue, so as to make voters feel that if they oppose legalization, they are making people suffer.

Dr. Brown commented on the summit meeting, which he had attended. He pointed out that ASAM includes not only physicians trained in treatment, but physicians trained and specializing in drug testing and who are familiar with the strengths and weaknesses of what the science has to offer.

President-Elect Elizabeth Howell, M.D., FASAM, applauded Mr. Walters' support of improvement and expansion of medical education in the addictions. She questioned what would happen with school students identified through testing as drug users, pointing out that the U.S. does not have an adequate number of addiction medicine specialists throughout the country, and there is not an adequate level of expertise within the general medical community to respond adequately to the number of persons who might be identified.

Mr. Walters observed that, in many instances, the need has to become obvious before there is a will to develop the capacity, adding that "I'm trying to make the problem less invisible." He pointed out that one problem absorbing more of everyone's attention is the misuse and diversion of prescription drugs. He called for medical education regarding the appropriate use of prescribable drugs with abuse potential, and said that ONDCP is trying to enlist the support and participation of many entities in the government and in the private sector. Dr. Howell emphasized the apparent availability of prescribed drugs over the Internet, which increases the opportunities for diversion or abuse.

ASAM Treasurer James Halikas, M.D., urged Mr. Walters to consider reviving the now-defunct Career Teachers' Program, in which Dr. Halikas had participated, whose impact has been felt well beyond the individuals directly trained. He proposed as a worthwhile goal adoption of a program that would make it possible, by 2012, to make every medical

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# Nominating Council Announces Candidates for ASAM Officers, Board

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

ASAM's Nominating & Awards Council has announced a full slate of candidates for the Society's next President-Elect, Secretary, and Treasurer, as well as Regional representatives on ASAM's Board of Directors. Candidates will stand for election in November 2004 for terms of office to begin in April 2005. The candidates are:

**President Elect**
Louis E. Baxter, Sr., M.D., FASAM
Michael M. Miller, M.D., FASAM

**Secretary**
Richard A. Beach, M.D., FASAM
A. Kenison Roy III, M.D., FASAM

**Treasurer**
James A. Halikas, M.D., FASAM *(incumbent)*
Donald J. Kurth, M.D., FASAM

**Regional Director for Region I (NY)**
Marc Galanter, M.D., FASAM, New York, NY
Peter A. Mansky, M.D., Albany, NY *(incumbent)*

**Regional Director for Region II (CA)**
Peter Banys, M.D., San Francisco, CA
Lori D. Karan, M.D., FASAM, Burlingame, CA *(incumbent)*
Donald J. Kurth, M.D., FASAM, Rancho Cucamonga, CA

**Regional Director for Region III (CT, ME, MA, NH, RI, VT)**
Mark L. Kraus, M.D., FASAM, Waterbury, CT
Ronald F. Pike, M.D., FASAM, Worcester, MA *(incumbent)*

**Regional Director for Region IV (NJ, OH, PA)**
Louis E. Baxter, Sr, M.D., FASAM, Lawrenceville, NJ *(incumbent)*
Trusandra E. Taylor, M.D., Philadelphia, PA
John J. Verdon, Jr., M.D., FASAM, Shrewsbury, NJ

**Regional Director for Region V (DE, DC, GA, MD, NC, SC, VA, WV)**
Timothy L. Fischer, D.O., St. Matthews, SC
Martha J. Wunsch, M.D., Blacksburg, VA

**Regional Director for Region VI (IL, IA, IN, KY, MI, MN, TN, WI)**
Thomas L. Haynes, M.D., FASAM, Grand Rapids, MI *(incumbent)*
Paul S. Board, M.D., Des Plaines, IL

**Regional Director for Region VII (AR, KS, LA, MO, NE, OK, TX)**
John P. Epling, Jr., M.D., Shreveport, LA
Howard C. Wetsman, M.D., New Orleans, LA

**Regional Director for Region VIII (AK, AZ, CO, HI, ID, MT, ND, NV, NM, OR, SD, UT, WA, WY)**
Marvin Seppala, M.D., Newberg, OR
Berton J. Toews, M.D., FASAM, Casper, WY *(incumbent)*
Richard E. Tremblay, M.D., FASAM, Olympia, WA

**Regional Director for Region IX (Canada & International)**
Joao C. Dias da Silva, M.D., Rio de Janeiro, Brazil
Raju Hajela, M.D., M.P.H., FASAM, Kingston, Ontario, Canada

**Regional Director for Region X (AL, FL, MS, PR,, VI)**
Terry L. Alley, M.D., FASAM, Warrior, AL
Jeffrey D. Kamlet, M.D., Miami, FL
C. Chapman Sledge, M.D., FASAM, Hattiesburg, MS

Ballots will be mailed to members in good standing by November 1, 2004, and must be returned by December 1. In addition to a ballot, the election packages will contain campaign statements, biographical sketches and photos of the candidates. ASAM's campaign guidelines prohibit the use of "restricted or unrestricted written or electronic communication" by candidates or their advocates. Election results will be announced in the January-February 2005 issue of **ASAM News**.

***If you have not already done so, be sure to renew your ASAM membership so that you are eligible to vote!***

## ONDCP Director Meets with ASAM Board *continued from page 5*

school graduate knowledgeable about the identification, management and treatment of addictive disorders.

Board member A. Kenison Roy III, M.D., FASAM, observed that in discussing other major chronic diseases, such as heart disease and diabetes, we speak not only of federal funding for treatment, but also of funds for research, identification, and prevention. He asked about the energy level in the White House regarding parity and expansion of private sector treatment.

Director Walters referred to discussions with private insurers and state officials and said he doubted the wisdom or viability of trying to mandate treatment parity. Instead, he said, ONDCP has tried to educate state policymakers and private sector purchasers as to the cost reductions and other realities of treatment parity, so as to encourage the states to adopt such initiatives. "People who are cost-sensitive are doubtful about claims of savings and interpret it as an attempt to simply force them to assume the cost burden," he said.

Board member David Lewis, M.D., observed that on the parity issue, the White House has been consistently positive. However, he said that the insurance providers would be the last people he would appeal to; instead, he would approach the purchasers of insurance, particularly for state and federal employees. Most of the savings come from the criminal justice side, which is more difficult for the average person to understand, and which does not appeal directly to insurers. Dr. Lewis also observed that one of the major concerns about the President's proposed voucher system is that it may be used to make an "end run" around the requirements for certification and licensure of treatment professionals that the profession has worked so hard to achieve. This pertains particularly to the faith-based facilities. He asked where the administration stands on this.

Mr. Walters responded that the President's goal has been to provide access to appropriate treatment and, toward that end, to expand overall treatment capacity. While it is true that the President genuinely believes that the effectiveness of faith-based treatment is underestimated, the number of faith-based providers currently is very small and Mr. Walters believes that it will remain small, even with the issuance of vouchers. The test of facilities, under the voucher plan, will be a test of their treatment outcomes, which would be evaluated after an appropriate period of time. Mr. Walters observed that the legislation also should provide support for many ASAM members.

Dr. Brown concluded the session by applauding Mr. Walters' "courage, intelligence and wisdom," and invited Mr. Walters to participate in ASAM's 2004 Medical-Scientific Conference in Washington, DC.

# ASAM Member To Lead AMA Task Force

*Stuart Gitlow, M.D., FASAM*
*ASAM Representative to the AMA House of Delegates*

The American Medical Association's House of Delegates came together for its semi-annual meeting in early December 2003. Coinciding as it did with President Bush's signing of the Medicare prescription drug bill, the general mood of the meeting was upbeat. Dr. Lloyd Gordon and I provided testimony on behalf of ASAM throughout the meeting. We were ably assisted by ASAM Executive Vice President Eileen McGrath and our colleague Michael M. Miller, M.D., FASAM, who is a delegate of the Wisconsin State Medical Society but also speaks knowledgeably and effectively about addiction issues.

## Task Force on Alcohol

Our own Dr. Lloyd Gordon was named Chair of the AMA's Task Force on Alcohol. Established just a few months ago, the new task force is taking on the critical issue of reducing underage drinking. Funded in part by the Robert Wood Johnson Foundation, the task force has the strong support of the AMA's incoming president, Dr. John Nelson of Utah. Support literature and excellent visual media (either CD-Rom or videotape) are available from the task force.

## Membership Matters

The AMA has frozen the size of its House of Delegates for a one-year period. As you know, our organization is at risk of losing our seat in the AMA if we do not increase the percentage of our members who are also members of the AMA (see the September-October **ASAM News**). While it initially seemed that we had been given an additional six months in which to increase the number of AMA members in ASAM by approximately 150 individuals, this turned out not to be the case, even though the size of the House of Delegates was frozen.

The AMA requires that, to retain a seat in the House, 35% of the members of a medical specialty society also must be members of the AMA-a percentage that ASAM misses by a few points. It has been noted that this percentage significantly exceeds the percent of American physicians who are members of the AMA. Therefore, ASAM is introducing a resolution at the June 2004 HOD meeting asking that the percentage of membership required of small societies be equivalent to the percentage of all physicians who are members of the AMA. However, even if this resolution passes, there will be a delay before such a bylaw change can take effect. As a result, we must be even more active in encouraging ASAM members to join the AMA, if they haven't already done so.

## Physician Health Programs

The AMA's Council on Ethical and Judicial Affairs (CEJA) currently offers monitoring to AMA member physicians who are participating and compliant in Physician Health Programs. Many physicians are unaware of CEJA's judicial function and its review of physicians subsequent to sanctions by licensing boards that might arise as a result of impairment. As a result of one such review, the AMA's Board of Trustees will examine the CEJA's work in this arena; we will pass along the results of the review as soon as it is made available to us.

## Forensic Activities

Many members of ASAM participate in forensic activities involving expert witness testimony. The AMA has taken an increasing interest in this arena, particularly focusing on a set of guidelines with respect to the nature of such testimony. The AMA's Board of Trustees will be studying the guidelines over the next few months. Again, we will pass along the results of their deliberations and any associated recommendations as soon as they are made available.

Your input is crucial in assisting your delegation as it pursues ASAM policy within the AMA. Please contact me at DRGITLOW@AOL.COM if you have suggestions, questions, or comments. Also, we are most interested in adding to our delegation by including medical students, residents, fellows, and young physicians (those under 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 set for June 12-16, 2004, in Chicago and December 4-7, 2004, in Atlanta. ASAM members are encouraged to join us at the meetings; all AMA members are welcome to address House Reference Committees and, given the small size of our delegation, we can use the additional support. Equally valuable would be your participation in the National Advocacy Conference, scheduled for Washington, DC, March 29-31. If you're interested, drop me a note.

# AMA Weighs In on UPPL

Joining ASAM and other addiction field organizations, the AMA is calling on states to repeal statutes that effectively prevent alcohol and drug screening from being conducted on patients who come to emergency departments. Based on a widely adopted model called the Uniform Accident and Sickness Policy Provision Law (UPPL), many states allow health insurers to deny coverage for emergency services that arise from an injury related to alcohol or other drug use. Most states adopted UPPL laws more than 50 years ago, when addiction treatment and trauma centers were not widely available.

As a result, emergency department staff are reluctant to screen for alcohol and other drug use because patients' care won't be covered by their health plans, according to Michael E. Migliori, M.D., a member of AMA's House of Delegates from Rhode Island.

According to data presented at the AMA's December meeting, more than 40% of patients treated in hospital emergency departments are either under the influence of alcohol or another drug. However, fewer than 15% of patients are screened or referred for assessment and treatment.

House members agreed that the UPPL creates missed opportunities for helping patients. "Emergency physicians…around the country stand in a unique position to intervene," said Jo Linder, M.D., an emergency physician from Falmouth, Maine. "But these laws are a strong deterrent." As a result, the AMA has joined ASAM in calling for repeal of UPPL provisions in every state. *Source: American Medical News, January 5, 2004.*

## HEDIS Adds Measures for Alcohol Treatment

A tool that most health plans already use to assess their performance in treating asthma, diabetes, and high blood pressure henceforth will include measures of how well plans do in engaging individuals with alcohol and other drug problems in treatment.

The National Committee for Quality Assurance (NCQA), a nonprofit organization that accredits managed care organizations, developed and maintains a leading tool to measure health care value and improve quality: the Health Plan Employer Data and Information Set (HEDIS). Almost 90% of America's health plans now use HEDIS to measure their performance in delivering care for many different health conditions, making it possible to compare the performance of health care providers in both the private and public sectors on an "apples to apples" basis.

NCQA's announcement that it will begin to measure performance in treating alcohol problems has heightened expectations for quality improvement in addiction treatment. The performance measures, developed in cooperation with the Washington Circle Group, mark a milestone, as health plans are asked for the first time to account for their results in engaging and retaining patients in treatment.

Robert Harris of Jim Gonzalez & Associates, which collaborates with the California Society of Addiction Medicine in advocating for parity, hailed the move, saying: "This may provide a market solution to providing parity. If the large purchasers of health insurance…pay close attention to this new information when purchasing coverage-and they should, because the Washington Business Group on Health data show marked savings in Workers' Comp, absenteeism, and long term health care costs-then the health plans will become the drivers of quality improvement and capacity expansion."

The emphasis on performance and quality improvement is not limited to managed care accrediting organizations such as NCQA. The federal government uses HEDIS and other performance measures to stimulate quality improvement in addiction treatment for veterans. It will soon begin using them to hold states more accountable for the funding they receive to prevent and treat alcohol and other drug problems. In addition, the National Business Coalition on Health, which represents more than 7,000 employers and 34 million workers and their families, now includes alcohol performance measures in a tool that can be used to drive quality improvement in the private health care benefits offered to employees. *Sources: Ensuring Solutions to Alcohol Problems, The George Washington University; Jim Gonzalez & Associates, Sacramento, CA.*

## National Panel Challenges Purchasers to Improve the Quality of Addiction Treatment

ASAM's Dr. Sheila Blume is one of a national panel of experts that has called for a fundamental change in the payment system for treating alcohol and drug disorders. The group, chaired by Jerome Jaffe, M.D., says that payment should be based on results achieved. Treatment programs that do a better job helping their patients improve would be paid more, while programs with poor results would be paid less and ultimately might be forced to change or close.

The panel was convened by Join Together, a project of the Boston University School of Public Health, to develop specific recommendations to improve the treatment of addictive disorders. The panel was composed of physicians, researchers, treatment providers and representatives of sectors that purchase treatment services, including employee assistance programs, managed care organizations, and criminal justice systems.

In its recommendations, the panel urged employers, insurers and others to embrace the concepts of quality and outcomes in addiction treatment, in the same way that quality and outcomes are being used throughout the health care system. Dr. Jaffe warned that, "Unless there are real and continuing incentives to provide quality treatment, quality will always take second place to treatment program survival or expansion." He continued: "What is needed to drive quality improvement is a commitment by those who pay for treatment to reward good outcomes."

According to the panel, policymakers and those who purchase treatment services should demand information about outcomes and reward programs that succeed. The panel's report provides guidance to payers and providers as to the steps they should take to implement a results-based reimbursement system:

- The federal government, as the single largest purchaser of treatment services, should drive the expansion of systems for measuring performance and outcomes of individual treatment programs.
- Other purchasers—such as state and local governments, public welfare agencies, the criminal justice system, and employers-should begin to use the tools they already have to manage for results.
- Community leaders should advocate for the development of comprehensive results-oriented treatment systems by holding institutions accountable for assuring collection of local data to feed the results management systems and for improving treatment quality.

The report also is being submitted to the Subcommittee on Criminal Justice, Drug Policy and Human Resources of the U.S. House of Representatives as part of Dr. Jaffe's testimony before a February 12th Congressional oversight hearing on measuring the effectiveness of drug addiction treatment.

### *Members of the Treatment Quality Panel are:*

- Jerome H. Jaffe, M.D., Chair, Clinical Professor of Psychiatry, University of Maryland School of Medicine; former Special Consultant to the President for Narcotics and Dangerous Drugs and first Director of the Special Action Office for Drug Abuse Prevention, The White House
- Sheila Blume, M.D., Clinical Professor of Psychiatry, State University of New York at Stony Brook
- Lee P. Brown, Ph.D., Mayor of Houston, Texas
- Ronald P. Corbett, Ed.D., Executive Director, Massachusetts Supreme Judicial Court
- Gloria DeRobles, Associate Executive Director, East Bay Community Recovery Project
- Saul Feldman, Ph.D., Chairman and CEO, United Behavioral Health
- Martin Iguchi, Ph.D., Director, Drug Policy Research Center, Rand Corporation
- Michael Massing, School of Journalism, Columbia University
- Dennis McCarty, Ph.D., Professor, Department of Public Health and Preventive Medicine, Oregon Health Sciences University
- Tara Wooldridge, LCSW, Manager, Employee Assistance and Work/Life, Delta Air Lines.

Copies of *Rewarding Results: Improving the Quality of Treatment for People with Alcohol and Drug Problems* are available on-line at WWW.JOINTOGETHER.ORG/QUALITY or by phoning 617/437-1500.

## Parity is Cost-Effective, But Must Be Enforced, Studies Find

Requiring insurers to cover addiction and mental illness at parity with other medical disorders raises insurance premiums just 0.2% annually, according to a new study of state parity laws.

Ensuring Solutions to Alcohol Problems, a research group based at The George Washington University Medical Center, reviewed 11 previously published studies by states that examined the impact of their own parity laws. Generally, the state studies found that parity eases pressure on state budgets by cutting health, criminal justice, and welfare costs, and increases the number of individuals entering treatment. For example, Minnesota's report said that 80% of addiction treatment costs were offset in the first year by reduced use of hospital, emergency department, and detoxification services, as well as reduced arrests. California's study found that treatment parity yielded a 66% reduction in criminal activity and 33% fewer hospitalizations. To date, 38 states have passed laws mandating some form of parity for mental illness, and seven states also require parity for addiction treatment.

However, Ensuring Solutions also found that simply having a parity law on the books does not guarantee equal coverage. In fact, a second Ensuring Solutions study, of 70 health plans in 36 states, found that at least 10 major health plans in five states-Florida, Georgia, Nevada, New York, and West Virginia-have failed to comply with state laws governing insurance coverage for addiction treatment. "The most common violation we discovered was that they aren't allowing people…to remain in treatment-either inpatient or outpatient-as long as the laws in their states require," Dr. Goplerud said. Typical violations included charging higher co-payments for addiction care than for other types of treatment, or covering some services (such as detoxification) but not others.

Other problems are illustrated in a separate study that examines the first five years of experience under Vermont's 1998 addiction and mental health parity law. Conducted by Mathematica Policy Research for the Substance Abuse and Mental Health Services Administration, the study found that, contrary to predictions by parity opponents, most employers in Vermont did not drop coverage or self-insure to avoid the mandate. On the other hand, about half the employers surveyed didn't even know that parity existed in Vermont.

The bad news is that while access to mental health treatment improved after Vermont's parity law was adopted, access to addiction treatment actually declined. Analysts attributed the reduction to growing reliance on managed care by Vermont's two major health plans. Blue Cross Blue Shield of Vermont, which had provided addiction and mental health services through indemnity contracts before the law was adopted, switched to a behavioral managed care carve-out system once the parity mandate was in place. The Kaiser/Community Health Plan, which already had a managed care plan, used it to increase use of partial hospitalization and group therapy and to reduce the use of inpatient treatment.

The Mathematica analysts concluded that "the recent managed care environment introduces new issues and challenges for the state, employers, and employees that will require continued education and monitoring." *Sources: Ensuring Solutions to Alcohol Problems and Mathematica Policy Research.*

## Parity Costs Calculated Differently by Different Employers, Expert Says

Why pay for addiction treatment? The classic answer is that workers with untreated alcohol problems cost U.S. businesses nearly $134 billion a year in sick leave, on-the-job accidents, and workers' compensation claims-costs that can be saved by providing timely and appropriate addiction treatment.

However, the economic impact is not the same for all employers, and that may be a key to understanding why some resist parity. For example, Norman Hoffmann, Ph.D., of Brown University, pointed out that "employee replacement costs can vary from $25 to $150,000. If it's going to cost you $150,000 to replace somebody who runs a train or fixes an airplane, you can afford to spend some money to keep that person well and on the job." On the other hand, Dr. Hoffman said, "a fast-food chain could replace an employee with alcohol problems for the cost of a newspaper ad." Advocates need to address these economic realities in making the case for parity. *Source: Join Together Online, February 3, 2004.*

## 2004 ASAM DUES

ASAM membership dues were to be sent to the ASAM office by January 1, 2004. Don't miss out on ASAM News and the Journal of Addictive Diseases, member discounts on conferences and publications, and other valuable member benefits. Contact the ASAM Membership Department at 301/656-3920 to renew your membership today!

## Resource: Review of Parity Studies

The *Join Together* program of Boston University's School of Public Health has summarized the recent literature on the costs and benefits of implementing parity for substance abuse. State data and links to recent research reports also are included. The report can be downloaded from the *Join Together* web site (HTTP://WWW.JOINTOGETHER.ORG/SA/FILES/PDF/PARITYREVIEW.PDF) or requested by phoning 617/437-1500.

## Pain and Addiction: Common Threads V

Thursday, April 22, 2004, 8:00 am - 5:30 pm
Marriott Wardman Park Hotel
Washington, DC

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

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

Course registrants will receive two valuable reference tools: a course Syllabus and a CD-Rom containing the Syllabus plus additional reference materials.

The course is approved for 8.25 credit hours of Category 1 continuing education credit. To register, visit the ASAM web site (WWW.ASAM.ORG) or email EMAIL@ASAM.ORG.

# DEADLINE NEARS TO REGISTER FOR 2004 ASAM EXAM

*C. Chapman Sledge, M.D.*
*Chair, ASAM Credentialing Council*

The final date to register for ASAM's 2004 examination for physicians who wish to be certified/recertified in addiction medicine is April 30, 2004. The examinations will be given Saturday, December 4, 2004, at three sites: Atlanta, GA; Los Angeles, CA; and New York City.

Applications to sit for the examination are to be sent automatically to all ASAM members. All applications will be reviewed and candidates notified by mail as to whether they qualify.

Physicians who pass the examination become ASAM certified/recertified in addiction medicine. Since the exams first were offered in 1986, more than 3,500 physicians—including many of the nation's top addiction treatment professionals-have been certified.

***Dr. C. Chapman Sledge***

For more information on ASAM certification or recertification and the examination, contact Christopher M. Weirs, M.P.A., Credentialing Program Director, at CWEIR@ ASAM.ORG or 301/656-3920, or visit ASAM's web site at WWW.ASAM.ORG. Also, watch **ASAM News** for details of the ASAM Review Course for examination candidates and other interested physicians, to be held November 4-6, 2004, in Toronto, Ontario, Canada.

# Canadian Society Certifies 35 Physicians in Addiction Medicine

*Raju Hajela, M.D., M.P.H., FASAM*
*Chair, Standards Committee, Canadian Society of Addiction Medicine*

With the addition of 14 new Certificants, the total number of physicians certified by the Canadian Society of Addiction Medicine (C*SAM) has reached 35. The new Certificants, who won the designation CCSAM, were recognized at C*SAM's Annual Awards dinner in October 2003.

The Certification process in Canada was begun in 2000, with considerable assistance from ASAM. C*SAM developed a practice evaluation and interview format that was acceptable to the ASAM Board. C*SAM President David Marsh, M.D., and Michael Lester, M.D., were the first physicians to be certified through the Canadian Society, earning their certification in 2001. Four more physicians, Dr. Morag Fisher, Dr. Bonnie Madonik, Dr. Wendy Tolmie and Dr. Ross Wheeler, won their CCSAM designation in 2003. Another 10 physicians qualified for CCSAM after winning certification from ASAM; they are Dr. Robert Cooper, Dr. Jeff Daiter, Dr. David Evans, Dr. Paul Farnan, Dr. Kumar Gupta, Dr. Karen Kennedy, Dr. Leo Lanoie, Dr. Larina Reyes-Smith, Dr. Michael Varenbut and Dr. Johan Wouterloot.

The CCSAM designation increasingly is recognized by governmental and regulatory bodies as an indicator of specialist qualification. However, we need 100 certified physicians to achieve the "critical mass" needed, and to be a notable presence in each province, to achieve the credibility that is deserved for Addiction Medicine in Canada. At present, the distribution of certified physicians by province or territory is as follows: British Columbia (8), Alberta (2), Saskatchewan (1), North West Territories (1), Manitoba (2), Ontario (20) and Quebec (1). The efforts of all the current pioneers are well appreciated. I hope our network will continue to grow in strength and vigor. Our ongoing collaboration with ASAM is most appreciated by the leadership and membership of C*SAM, which now number just over 200.

Applications for the 2004 examination will be mailed to members in spring 2004. Several Canadian physicians are planning to sit for the ASAM Certification examination in November 2004. Hence, I hope our CCSAM numbers will top 50 within the next two years. Additional information is available on the C*SAM web site at WWW.CSAM.ORG.

# ASAM Review Course to Meet in Toronto

The 2004 ASAM Review Course in Addiction Medicine, which prepares students to sit for the certification/recertification examination, will meet November 4-6 in Toronto, Ontario, Canada.

Under the direction of Co-Chairs Shannon Miller, M.D., FASAM, and Edwin Salsitz, M.D., FASAM, the course provides a review and update on the core content of addiction medicine. It is designed for several audiences:

- Physicians who are planning to sit for the ASAM certification/recertification examination in addiction medicine.
- Addiction specialists seeking an update on recent developments in addiction practice.
- Non-specialist physicians who seek a succinct summary of the knowledge needed to successfully identify and manage patients whose problems are caused or exacerbated by alcohol, tobacco, and other drug use.

ASAM's textbook, *Principles of Addiction Medicine, Third Edition*, is the basic text for the Review Course. As a supplement to Principles, participants in the Review Course will receive the 2004 Study Guide (with an accompanying CD-Rom), containing outlines of the speakers' talks, copies of their slides, and key readings. The Study Guide also contains sample questions from past examinations, as well as information on the topics covered in the examination.

To allow sufficient study time to those who are preparing for the examination, the Study Guide will be mailed September 1 to all persons who have registered for the Review Course by that date. Late registrants will be sent the Study Guide as their registrations are received.

To register for the Review Course, check the box on the application form for the certification/recertification examination, visit ASAM's web site (WWW.ASAM.ORG), or phone ASAM's Department of Meetings and Conferences at 301/656-3920.

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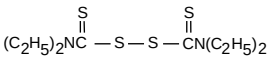

$C_{10}H_{20}N_2S_4$ M.W. 296.54

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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**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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# CSAM's Legislative Day a Smashing Success!

*Donald J. Kurth, M.D., FASAM*
*President, California Society of Addiction Medicine*

*Gary Jaeger, M.D., FASAM*
*Chairman, CSAM Public Policy Committee*

"My older brother died of a heroin overdose and my younger brother is in jail with Hepatitis C," began California Senator Debra Ortiz, who added, "I know the disease of addiction as few of my fellow legislators do. That is why we need all of you to keep coming back to Sacramento to educate them about the disease of addiction." Senator Ortiz spoke to a group of 70 CSAM physicians and other California health professionals at CSAM's "Legislative Day II," January 28th in Sacramento.

"I know it can be discouraging sometimes and I know you all have busy schedules back home," Senator Ortiz continued, "but if you don't take the time to teach my colleagues about addiction nobody else will." In addition to Senator Ortiz, six other members of the California legislature—Senators Aanestad, Chesbro, and Vasconcellos and Assembly members Goldberg, Nakanishi, and Richman-took time out of their busy schedules to address the CSAM Legislative Day participants. Other speakers included Kathy Jett, Director of the state's Department of Alcohol and Drug Programs, and Richard Figueroa, representing the California Managed Risk Medical Insurance Board.

The day featured policy discussions on treatment parity, California Proposition 36 (which mandates treatment instead of incarceration for some offenders), Hepatitis C, and opiate replacement therapy. The CSAM members also met with 30 more California legislators from their home districts. We explained who we are and why we had come all the way to Sacramento to talk about addiction. Reactions were mixed, to say the least. Some lawmakers had never heard of CSAM, ASAM, or treating addiction as a disease! Others told us we were "preaching to the choir" and pledged their dedication to our efforts. Still others related poignant and sometimes tragic personal stories about loved ones who had not been able to get help in time.

At a debriefing session at the end of the day, everyone was filled with enthusiasm and ready to redouble their commitment to return next year to carry our message of recovery to our legislators. "We need to find a way to better educate our lawmakers," said David Pating, M.D., President-Elect of CSAM and Chair of the Education Committee. "It is simply a matter of education. We have to teach them about what we do to help people suffering from addiction."

Gary Jaeger, M.D., added: "Our efforts to educate our legislators and to learn more about their concerns and issues is one of the most significant things we can do to help Californians who still suffer from the disease of addiction. Make plans to join us in January 2005. You will be enriched by the experience."

For further information on CSAM's Legislative Day, visit WWW.CSAM-ASAM.ORG. Information on ASAM's next Legislative Day, scheduled for April 2004 in Washington, DC, can be found at WWW.ASAM.ORG.

## Texas Chapter Lays Out 2004 Agenda

Robert N. Jones, M.D., President of the Texas Society of Addiction Medicine, outlined an active agenda in a recent issue of the TSAM newsletter. High-priority activities for the Texas chapter include:

- Repealing the Uniform Accident and Sickness Policy Provision Law in the State of Texas. Trauma surgeon Larry Gentilello, M.D. (LARRY.GENTILELLO@UTSOUTHWESTERN.EDU) has been working systematically for the past several years to have all states repeal the law and or any regulations that pose barriers to screening or treatment for addictive disorders in Emergency Departments or trauma units.
- Ensuring the continued presence of ASAM in the American Medical Association and continued recognition of the ADM specialty code by AMA to designate addiction medicine specialists. To do so, at least 35% of ASAM members must also be members of the AMA. Dr. Jones said, "We cannot allow the AMA to quit using the ADM code! If you have not joined the AMA, please consider membership one of your highest priorities. If your AMA membership has lapsed for any reason, please renew at you earliest convenience. Your specialty depends on your rapid reaction to this problem!"
- Recruiting new members in Texas. Dr. Jones urged TSAM members: "Talk with pride about your specialty! If you know of any addiction medicine specialists who are not members, please arrange to get them a membership application and explain the benefits of belonging to ASAM and TSAM. If there are questions that you cannot answer regarding membership, do not hesitate to contact the Region VII office in Louisiana or this office in San Antonio."

For additional information on TSAM's programs, contact Dr. Jones at DOCJONES1@SBCGLOBAL.NET.

## RUTH FOX COURSE FOR PHYSICIANS

Thursday, April 22, 2004
8:00 am – 5:30 pm
Marriott Wardman Park Hotel
Washington, DC

**COURSE DIRECTORS:**
**Louis E. Baxter, Sr., M.D., FASAM, and Anthony H. Dekker, D.O., FASAM**

The Ruth Fox course is designed to highlight new directions and concepts in clinical practice and to offer an update on selected areas of research. The 2004 course reflects the continuing interests, developments, diversity and richness in the field of Addiction Medicine by presenting a variety of important and timely topics.

### Topics and faculty members include:

- **Remembering Dr. Ruth Fox** (Stanley E. Gitlow, M.D., FACP, FASAM)
- **Literature Review** (David R. Gastfriend, M.D.)
- **Science, Practice and Policy: The Commitment to Quality** (Andrea G. Barthwell, M.D., FASAM)
- **Dual Diagnosis** (Penelope P. Ziegler, M.D., FASAM)
- **Spirituality in Addiction Recovery** (Graeme M. Cunningham, M.D., FASAM)
- **Gambling and Sex: Overlaps with Chemical Dependencies** (Margaret A.E. Jarvis, M.D.)
- **Adolescent Substance Abuse: New Drugs on the Street** (Marie Armentano, M.D.)
- **Providing Wellness and Caring for the Caretakers** (David E. Smith, M.D., FASAM)

*This course is eligible for 8 credit hours of Category 1 Continuing Education credit. Course registrants will receive a Syllabus containing copies of speakers' slides and related materials.*

To register, visit the ASAM web site (WWW.ASAM.ORG) or email ASAM at EMAIL@ASAM.ORG.

# Family Physicians Active in Education

*Norman Wetterau, M.D.*
*Chair, Family Medicine Committee*

ASAM's Work Group on Family Medicine organized a continuing education program on "Mobilizing Family Medicine to Address Substance Abuse" at the September 2003 meeting of the Society of Teachers of Family Medicine (STFM). The program featured a talk by Richard Brown, M.D., on "The Status of Substance Abuse Education in Family Practice." Dr. Brown directs Project Mainstream, which is dedicated to improving health professionals' education on addiction. Committee members Edna Jones, M.D., Steve Colameco, M.D., and Jerome Schulz, M.D., discussed the successes and challenges they have encountered in introducing addiction education in their own educational programs. Norman Wetterau, M.D., addressed the subject, "Substance Abuse Education as Part of Family Practice: Hope or Despair?"

The Work Group also developed a proposal for an addictions learning station at the 2004 annual meeting of the American Academy of Family Physicians (AAFP). To be funded by Join Together, the station was designed to include four one-hour modules on screening, adolescent prevention, smoking cessation, and treatment of pain in the patient at risk for addiction. The modules were designed to include a 30-minute talk, followed by a discussion of how to incorporate the new information into one's own clinical work, and an opportunity to practice the newly learned skills. The learning station also was to feature self-learning materials, plus resource materials that physicians could use in their offices.

Unfortunately, AAFP's program committee did not accept the learning center proposal. This was a disappointment, as AAFP has had few programs on the subject. Also, a recent monograph on prevention, distributed to all AAFP members, failed to mention drug or alcohol use as high-risk behaviors.

Following the rejection of the proposal, members of the Family Medicine group met with AAFP leaders, including the current president, to discuss the situation. The New York Academy of Family Physicians is considering introducing a resolution urging AAFP to be more proactive in this arena. (Dr. Lynda Hohmann, past president of the Academy's New York State chapter, Dr. Jose David, chairman of the AAFP's education commission, and Dr. Norman Wetterau, chairman of the Academy's state public health commission, all are ASAM members.) Further developments will be reported as they arise.

## VOLUNTEERS NEEDED

The Work Group on Family Medicine is seeking family physicians who are willing to help out with several activities currently underway. These include:

- ✔ Organizing interest groups on alcohol and other drug problems at regional and national STFM meetings.
- ✔ Working with state AAFP chapters to promote identification and treatment of patients with alcohol and other drug problems.
- ✔ Mentoring family physicians who are interested in using buprenorphine to treat opioid dependence.

Although ASAM and other organizations sponsor approved training courses on buprenorphine, family physicians need additional help in learning how to use this new medication in their practices. One strategy is to establish mentoring relationships with other family physicians who have had success in using buprenorphine. Also, many counselors in rural treatment centers have had little experience in treating heroin addiction and none with patients on methadone or buprenorphine. Any family physician with experience who would be willing to help train counselors in rural areas thus would be welcome.

If you have an interest in any of these volunteer opportunities, please email Dr. Wetterau at NORMWETTERAU@AOL.COM. All of the foregoing issues will be fully discussed at the Primary Care Component Session at ASAM's 2004 ASAM Med-Sci Conference, but please don't wait till then to volunteer!

## NIAAA to Shelve ETOH Database

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) plans to discontinue its ETOH Alcohol and Alcohol Problems Science Database, saying it largely duplicates other information repositories. Diane Miller, a spokesperson for NIAAA, pointed to a recent evaluation by NIAAA, which concluded that 72 of the 112 medical journals abstracted in the ETOH database also are available through the National Library of Medicine's Medline/PubMed database. Miller said that less than 5% of the articles in the ETOH database are from journals unique to ETOH.

But many researchers and librarians say that NIAAA's is a unique resource that cannot be duplicated elsewhere. "The idea that ETOH is duplicative of Medline/PubMed is ludicrous," said Andrea Mitchell, M.L.S., director of the Alcohol Research Group Library in Berkeley, Calif., and executive director of the Substance Abuse Librarians and Information Specialists (SALIS). She called ETOH a valued resource to researchers worldwide. "There is no other alcohol database like it in the world," said Mitchell, adding that ETOH may be NIAAA's most visible and valued contribution to the international research community.

Penny Page, director of information services at the Center for Alcohol Studies at Rutgers University, called the announcement of ETOH's termination "very disturbing," adding: "NIAAA's funding is supposed to support alcohol research... The way to do that is to support the documentation of that research. If they drop this task then they really are kind of dropping the ball."

NIAAA's Miller said that while ETOH no longer would be updated, it would be archived as an historical resource for researchers. She added that some of the non-journal materials currently compiled by ETOH, such as NIAAA's own research monographs, would be available through the National Clearinghouse on Alcohol and Drug Information (NCADI). *Source: Join Together Online, January 13, 2004.*

## SAMHSA Adds Accrediting Body for Methadone Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA) has announced the addition of the National Commission for Correctional Health Care to the group of organizations approved to conduct accreditation surveys of opioid treatment programs (OTPs). The Commission becomes the sixth organization so approved, joining the Commission on Accreditation of Rehabilitation Facilities (CARF); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the Council on Accreditation for Children and Family Services; the Washington State Division of Alcohol and Substance Abuse; and the Missouri Division of Alcohol and Drug Abuse.

Oversight of OTPs was transferred to SAMHSA from the Food and Drug Administration in May 2001. The SAMHSA accreditation process was created at that time. All facilities that treat addiction with methadone, including stand-alone detoxification units and detoxification units in hospitals and residential facilities, must be accredited at least once every three years.

Accreditation bodies also are required to notify SAMHSA within 48 hours of becoming aware of any practice or condition in an opioid treatment program that may pose a serious risk to public health or safety or patient care. *Source: Substance Abuse and Mental Health Services Administration, January 30, 2004.*

## DOJ Ends Program to Test Arrestees for Drug Use

Blaming budget cuts, the Department of Justice has ended the Arrestee Drug Abuse Monitoring (ADAM) program, which tests individuals entering jail for drugs of abuse. Created in 1986, ADAM was implemented in 35 cities. It was used as a tool by law enforcement officials and criminal justice experts to spot emerging drug use patterns and help fight drug-related crime.

"This is a real loss," said Mark A. R. Kleiman, Ph.D., professor of public policy at the University of California, Los Angeles and editor of The Drug Policy Analysis Bulletin. "Closing down ADAM indicates a complete lack of seriousness about getting a handle on the drug abuse problem in this country."

An official of the Office of National Drug Control Policy said the Bush administration is working on a less expensive version of ADAM. *Source: New York Times, January 28, 2004.*

## SCHOLARSHIPS AVAILABLE

The University of Utah School on Alcoholism and Other Drug Dependencies is offering scholarships to medical students to attend the 53rd Annual Session, June 20-25, 2004, in Salt Lake City.

Scholarships cover full tuition, six nights in campus dormitory housing, and up to a $300 travel allowance. They will be awarded on a first-come, first-served basis. Interested students should email Sue Langston (SLANGSTON@UTAH.GOV) with questions or to obtain an application, or visit the Utah School's web site (HTTP://UUHSC.UTAH.EDU/ADS/) for more information.

## ASAM Announces Buprenorphine Training Schedule

ASAM has announced a schedule of 35 buprenorphine training courses in 2004-a substantial increase from the 20 courses offered in 2003. Federal law requires that physicians who wish to use buprenorphine and who are not certified in Addiction Medicine or Addiction Psychiatry, or who do not meet certain other qualifications, must complete not less than 8 hours of training in the care of opioid-addicted patients.

Directed by David Fiellin, M.D., and conducted in partnership with the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) and ASAM's state chapters, ASAM's courses meet federal requirements for training physicians to use buprenorphine in office practice for the treatment of addiction. Physicians who attend the full 8 hours receive certificates of attendance to send to the Secretary of Health and Human Services, along with a request for a waiver indicating their intent to prescribe buprenorphine.

For information and a 2004 course schedule, visit ASAM's web site (WWW.ASAM.ORG) or contact Gionne Graetz, ASAM Program Assistant for Buprenorphine Initiatives, at 301/656-3920 x 119.

## Senate Bill Would Lift Buprenorphine Restrictions

Senate Judiciary Committee chair Orrin Hatch (R-UT) has introduced legislation to lift the 30-patient limit on group practices that prescribe buprenorphine for the treatment of addiction. The move is intended to correct a widely criticized provision of the Drug Addiction Treatment Act of 2000 (DATA). While DATA broke new ground by allowing certified physicians to prescribe the buprenorphine preparations Subutex® and Suboxone® in office settings, it limited the number of patients who can be treated to 30 at a time. Federal regulators have been applying the 30-patient limit even to large HMOs and entire academic medical centers, on the grounds that each constitutes a single "group practice" under the terms of the law.

Senator Hatch's legislation (S.1887) would eliminate the 30-patient limit altogether. The bill, which was cosponsored by Senators Joseph Biden (D-DE) and Carl Levin (D-MI), currently is in the Judiciary Committee. *Source: Federal Register, February 4, 2004.*

## Combining Medication with Counseling Improves Treatment Outcomes

Combining medication with counseling could improve treatment outcomes for individuals addicted to heroin, a University of Buffalo study finds. For the study, 124 men who were entering treatment for heroin addiction were assigned either to a treatment program that combined administration of the medication naltrexone with behavioral family counseling or a program that employed naltrexone alone. In behavioral family counseling, a family member watched the patient take his naltrexone doses; in the individual treatment, the patient was not observed.

Investigators report that, of the patients who received behavioral family counseling, 81% were drug-free during treatment and 69% remained heroin-free a year after discharge. Among patients who received the naltrexone alone, 56% remained drug-free during treatment and 49% were drug-free a year later.

Lead researcher William Fals-Stewart, Ph.D., concludes that, "although use of naltrexone with patients who abuse heroin is effective, few patients are willing to take it. As a result, it is very rarely prescribed in clinical practice. However, family members supporting the patients' daily use of naltrexone increases their compliance and leads to better outcomes. This combination of family support with naltrexone therapy appears to be an effective method to increase compliance with this powerful and effective medication." *Source: Journal of Consulting and Clinical Psychology, December 2003.*

# DEA Articulates Policy on the Use of Buprenorphine for Pain

*The following letter was sent to Dr. Howard Heit by an official of the U.S. Drug Enforcement Administration and therefore should be considered an official clarification of federal policy.*

Dear Dr. Heit:

This is in response to your correspondence dated October 14, 2003, in which you requested the Drug Enforcement Administration (DEA) to respond to the following questions: Can a clinician prescribe off-label use of buprenorphine with or without naloxone (Suboxone(r)/Subutex(r)) for the treatment of pain? If a clinician uses buprenorphine (Suboxone(r)/Subutex(r)) for the treatment of pain, does the prescriber have to have a DEA registration or does he or she need the special waiver that is required to prescribe buprenorphine for addiction?

The buprenorphine products Suboxone(r) and Subutex(r) are the two Schedule III narcotic medications currently approved for the treatment of opioid dependence under the federal Drug Addiction Treatment Act of 2000 (DATA). The off-label use of the sublingual formulations of buprenorphine (Suboxone(r)/Subutex(r)) for the treatment of pain is not prohibited under DEA requirements. However, off-label use does pose a dilemma for pharmacists. Currently, there is no requirement under the DATA for a qualified practitioner to put the Unique Identification Number (UIN) on a prescription for Suboxone(r) or Subutex(r) for maintenance or detoxification treatment.

On June 24, 2003, the DEA published a Notice of Proposed Rulemaking (NPRM) that will require qualified practitioners to include the UIN on all prescriptions written for either Suboxone(r) or Subutex(r) for narcotic addiction treatment. This requirement will be the only way to determine whether a prescription for Suboxone(r) or Subutex(r) was written for maintenance or detoxification treatment or some other condition. Buprenex(r), a Schedule III, injectable formation of buprenorphine, is approved and marketed in the United States as an analgesic and is widely used in the treatment of pain.

If a physician prescribes, dispenses or administers buprenorphine (Suboxone(r)/Subutex(r)) for the treatment of pain or for any other reason, a DEA registration is required because both products are Schedule III controlled substances. The DATA waiver specifically authorizes qualified practitioners to treat narcotic dependent patients, using FDA approved Schedule III-V narcotic controlled substances for maintenance and detoxification. The DATA waives the requirement for obtaining a separate DEA registration as a narcotic treatment program for physicians using the approved drugs for maintenance and detoxification; however, it does not apply to physicians using Suboxone(r) or Subutex(r) for the treatment of pain. A physician using Suboxone(r) or Subutex(r) for the treatment of pain would be required to register with DEA as practitioner with Schedule III privileges.

The Narcotic Addict Treatment Act of 1974 and the DATA amend the Controlled Substances Act (CSA) to allow for the use of opioid drugs to treat addiction either through maintenance or detoxification under specific criteria. Schedule II opioids approved for addiction treatment are limited to methadone and LAAM, and may only be administered and dispensed (not prescribed) by DEA registered Narcotic Treatment Programs. Schedules III through V opioids specifically approved by the Food and Drug Administration for use in addiction treatment may be prescribed, administered and dispensed by certified practitioners who have obtained the appropriate waivers from the Center for Substance Abuse Treatment.

The above legal allowances were established to allow for the treatment of addiction with opioid controlled substances. These limitations and requirements in no way impact the ability of a practitioner to utilize opioids for the treatment of pain when acting in the usual course of medical practice. Consequently, when it is necessary to discontinue a pain patient's opioid therapy by tapering or weaning doses, there are no restrictions with respect to the drugs that may be used. This is not considered "detoxification" as it is applied to addiction treatment.

I hope this information is of assistance to you in your continued efforts to promote the effective and responsible treatment of pain. If I can of further assistance, please do not hesitate to contact me…. Sincerely,

Patricia M. Good, Chief
Liaison and Policy Section, Office of Diversion Control
Drug Enforcement Administration, U.S. Department of Justice

## COMMENTARY: Same Drugs, Different Regulations

*Howard A. Heit, M.D., FACP, FASAM*
*Edwin A. Salsitz, M.D., FASAM*

A federal regulation (21 CFR 1306.070) requires that a physician who wishes to use methadone to treat addicted persons for the disease of addiction must have a special registration with the DEA as a narcotic treatment program (NTP).

But the same federal regulation does not restrict the use of methadone to treat addicted persons for pain, if such prescribing is deemed medically appropriate within standards set by the medical community. (Of course, the physician must keep good records to document that the patient is being treated for pain and not opiate addiction.)

Another federal law, the Drug Addiction Treatment Act of 2000, allows a physician to treat addicted patients in an office setting with buprenorphine, but only if the physician is specially trained in an approved CME program and has obtained a waiver from the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Now, another wrinkle: in response to an inquiry, a DEA official has sent a letter (dated December 24, 2003) stating that a physician may prescribe buprenorphine (with or without naloxone) for the treatment of pain without obtaining the special training or a federal waiver. All that is required is a DEA registration allowing the physician to prescribe Schedule III controlled drugs.

It seems to us that these different requirements for use of the same drugs to treat patients for different indications serve only to perpetuate the undertreatment of both pain and addiction. We believe education rather than regulation is the way to improve clinical practice surrounding the use of both methadone and buprenorphine, and would be a step forward in making opioid agonist therapy available to all patients who need it.

**DR. HEIT** is engaged in the private practice of pain and addiction medicine in Fairfax, VA. He is co-chair of ASAM's courses on *Common Threads: Pain & Addiction*. **DR. SALSITZ** directs an opioid treatment program in New York City and is co-chair of ASAM's *Review Course in Addiction Medicine*.

# Ruth Fox Memorial Fund

*Dr. Ruth Fox*

## Dear Colleague:

As ASAM celebrates its 50th anniversary year, we hope you will look at the amount and timing of your gifts to the Ruth Fox Memorial Endowment Fund in order to support our Society and maximize your 2004 tax savings.

The Endowment was established to create a fiscally sound base to assure ASAM's continued ability to realize its mission: to provide ongoing leadership in newly emerging areas affecting the field of Addiction Medicine, to continue its commitment to educating physicians, to increasing access to care and to improving the quality of care. With your professional and financial support, ASAM will achieve its mission.

In 1990, the Ruth Fox Memorial Endowment Fund was launched by Jasper G. Chen See, M.D., and William B. Hawthorne, M.D., who-along with ASAM's Board of Directors and staff-were the Fund's first donors. In 1991, after organizing and receiving pledges/contributions from the Campaign Leaders, the Fund began to solicit donations from ASAM members. It was the commitment and support of ASAM members that helped the Endowment reach its first million dollars in March 1992.

We want to thank all of our donors and especially our major donors, who have contributed or pledged the following significant gifts:

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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., FASAM, Chair, Endowment Fund*
*James W. Smith, M.D., FASAM, Chair, Resources & Development Committee*
*Claire Osman, Director of Development*

*As of February 15, 2004 Total Pledges: $3,827,583*

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Martha J. Wunsch, M.D.

# ASAM Supports National Alcohol Screening Day

This April 8th, tens of thousands of Americans are expected to participate in the sixth National Alcohol Screening Day at thousands of locations across the U.S. ASAM is an official co-sponsor of the event, which offers free and confidential screening at workplaces, hospitals, shopping centers, health clinics and churches, as well as online at WWW.ALCOHOLSCREENING.ORG. Simply getting screened has been shown to motivate some individuals to cut back on their drinking. For others, it opens the door to treatment and recovery.

"For people who may not know how much is too much to drink or that the amount they are drinking puts them at risk for injury, illness and possibly addiction, alcohol screening is very useful," said Stacia Murphy, Executive Director of the National Council on Alcoholism and Drug Dependence. "What they learn can prompt them to diminish or curtail their drinking or signal the need for more detailed evaluation and treatment."

National Alcohol Screening Day is a highlight of activities marking April as Alcohol Awareness Month, which draws public attention to the ways that employers, loved ones, friends and neighbors can promote the identification and treatment of alcohol problems that affect them and the people they care about. According to the National Institute on Alcohol Abuse and Alcoholism, nearly 8 million Americans have the disease of alcoholism. An additional 6 million have problems because of their drinking. More than half of all adults have a family history of alcoholism or problem drinking.

For more information on National Alcohol Screening Day, visit the web site WWW.ALCOHOLSCREENING.ORG



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# ASAM Conference Calendar

## ASAM

**April 21-22, 2004**
ASAM Legislative Days
Marriott Wardman Park Hotel
Washington, DC
[For information, email CPUEN@ASAM.ORG]

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

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

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

**April 25, 2004**
Buprenorphine Training Course
Marriott Wardman Park Hotel
Washington, DC
8 Category 1 CME credits
[For information, phone 1-888/362-6784]

**October 30-November 1, 2004**
Review Course in Addiction Medicine
Sheraton City Centre Hotel
Toronto, Ontario, Canada
21 Category 1 CME credits

**November 18, 2004**
Forensic Issues in Addiction Medicine
Washington, DC
8 Category 1 CME credits

**November 19-21, 2004**
ASAM Medical Review Officer (MRO) Training Course
Washington, DC
18 Category 1 CME credits

**December 4, 2004**
ASAM Certification/ Recertification Exam
Atlanta, GA
Los Angeles, CA
New York, NY
5 Category 1 CME credits

### Other Events of Note

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

**June 2-5, 2004**
International Society of Addiction Medicine
6th Annual Medical-Scientific Conference
Helsinki, Finland
[For information, visit WWW.PALY.FI/ISAM2004.HTM]

*Except where otherwise indicated, additional information is available on the ASAM web site (WWW.ASAM.ORG) or from the ASAM Department of Meetings and Conferences at 4601 No. Park Ave., Suite 101, Chevy Chase, MD 20815-4520; phone 301/656-3920; fax 301/656-3815; email EMAIL@ASAM.ORG.*

### Buprenorphine Training Courses

**March 19, 2004**
Tucson, AZ

**March 20, 2004**
Indianapolis, IN

**March 27, 2004**
Newark, NJ

**April 1, 2004**
San Francisco, CA*

**April 25, 2004**
Washington, DC

**May 5, 2004**
Chicago, IL

**May 15, 2004**
Orlando, FL

**May 22, 2004**
Fall River (Boston), MA

**To register for this course, phone 415/345-8667 or visit www.familydocs.org. To register for all other courses, phone 1-888/362-6784 or visit the ASAM web site at www.asam.org/conf/Buprenorphineconferences.htm.*