July/August 2004
Volume 19, Number 3

ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

ASAM Election of Officers: Watch for the next issue of ASAM News for candidate profiles and election information.

Don't miss an issue; join ASAM or renew your membership today!

www.asam.org

ASAM's Review Course in Addiction Medicine Set for November 4-6 in Toronto

ASAM's 2004 Review Course, which covers the core content of addiction medicine, will be hosted by the Canadian Society of Addiction Medicine at the Sheraton Centre Hotel in Toronto, Ontario, Canada, November 4-6. The course is preceded by five half-day workshops sponsored by the Canadian Society of Addiction Medicine and the Illinois Society of Addiction Medicine.

Co-chaired by Shannon C. Miller, M.D., CMRO, FASAM, and Edwin A. Salsitz, M.D., FASAM, the course is designed to meet the needs of several audiences: (1) physicians who are planning to sit for the ASAM Certification/Recertification Examination; (2) addiction specialists who seek an update on recent developments in addiction practice; and (3) primary care physicians, nurses, counselors and others who seek a succinct review of the knowledge needed to successfully identify and manage patients whose problems are caused or exacerbated by alcohol, tobacco or other drug use.

To register for the Review Course, phone the ASAM Department of Conferences and Meetings at 301/656-3920 or consult the ASAM web site at WWW.ASAM.ORG. Questions about the Review Course should be emailed to REVIEWCOURSE@AOL.COM. *(For more information, see page 5)*

ASAM Launches First Online CME Course

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

For more than a decade, ASAM's courses on the State of the Art in Addiction Medicine have offered a unique perspective on cutting-edge research and how that research is enriching the practice of addiction medicine. Organized in cooperation with the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, the courses showcase the most recent findings in addiction research, reported by the nation's leading addiction researchers. As a result, the courses have attracted enthusiastic audiences and received very positive evaluations from attendees.

As the next step in extending the impact of this outstanding educational offering, ASAM has created an online CME program based on the November 2003 State of the Art course, to make science-based knowledge accessible to busy clinicians everywhere.

Like the live event on which it is based, the online State of the Art course employs an innovative teaching approach that integrates basic research, prevention and treatment research, epidemiology and services research. Clinical vignettes provide an organizing framework for integrating the information.

Technical support for the online course was provided by Marathon Multimedia. In addition to course co-chairs David R. Gastfriend, M.D., Director of the Addiction Research Service at Massachusetts General Hospital, and Terry K. Schultz, M.D., FASAM, of Kaiser Permanente in Fairfax, VA, and the course faculty, major contributions were made by ASAM's planning team and ASAM's President, Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, and Board of Directors, who demonstrated a sustained commitment to excellence in addiction medicine education.

To take the course, visit ASAM's web site at WWW.ASAM.ORG. The course is approved for 15 hours of Category 1 CME credits.

Moving Forward With ASAM's New Governance Structure

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

Like many medical societies, ASAM has both a challenging mission and limited resources. If we are to realize our mission and expand our resources, it is imperative that we plan strategically and align our governance structure with our Strategic Plan. In this way, we will ensure that we have an effective and efficient approach to reaching our goals.

Among my chief responsibilities as your President has been to recommend to the Board of Directors a governance structure that will maximize ASAM's ability to accomplish the goals set forth in the Strategic Plan. I have done so, and am pleased to report that the Board approved the new structure at its most recent meeting.

ASAM Governing Councils

Councils (this term is used in place of the old term, "Sections") are organizational structures that carry out the mission of the Society and oversee the execution of the strategies and attainment of the operational objectives determined by the Board. Each council is to be chaired by a member of the Board and may have oversight of one or more Standing Committees. In addition, Councils may establish Subcommittees to address specific functions or products of the Council. Councils and Council Subcommittees will receive staff support. The newly approved Councils and their Chairs are:

- Advocacy Council *(Chair: Peter Mansky, M.D.)*
- Certification Council *(Chair: Lloyd J. Gordon III, M.D., FASAM)*
  - Eligibility and Application Committee
  - Examination Committee
  - Fellow Committee
- Chapters Council *(Chair: Richard A. Beach, M.D., FASAM)*
- Constitution and Bylaws Council *(Chair: Louis E. Baxter, Sr., M.D.)*
- Finance Council *(Chair: James A. Halikas, M.D., FASAM)*
  - Development Committee
  - Finance Committee
- Medical Education Council *(Chair: Lawrence S. Brown, Jr., M.D., M.P.H., FASAM)*
  - Medical Scientific Conference Program Committee
  - CME Committee (for all other ASA sponsored and co-sponsored educational programs).
- Medical Society Council *(Chair: Lawrence S. Brown, Jr., M.D., M.P.H., FASAM)*
  - American Academy of Child and AdolescentPsychiatry Liaison
  - American Academy Family Physicians Liaison
  - American Academy of Pediatrics Liaison
  - American Academy for Addiction Psychiatry Liaison
  - American College of Emergency Physicians Liaison
  - American College of Obstetrics and Gynecology Liaison
  - American College of Physicians/American Society of Internal Medicine Liaison
  - American College of Surgeons Liaison
  - American Medical Association Delegation
  - American Osteopathic Association Liaison
  - American Psychiatric Association Liaison
- Organization Relations Council *(Chair: Lawrence S. Brown, Jr., M.D., M.P.H., FASAM)*
  - American Association for the Treatment of Opiate Dependence Liaison
  - Association for Medical Education and Research in Substance Abuse Liaison
  - National Association of Addiction Treatment Providers Liaison
  - National Association of State Alcohol and Drug Abuse Directors Liaison
  - National Council on Alcoholism and Drug Dependencies Liaison
  - National Institute on Alcohol Abuse and Alcoholism Liaison
  - National Institute on Drug Abuse Liaison
- Membership Council *(Chair: Donald J. Kurth, M.D., FASAM)*

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

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

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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).

House Subcommittee Increases Funds for Prevention and Research

The House Appropriations Subcommittee on Labor, Health, Human Services and Education has passed a fiscal year 2005 funding bill that would increase funds for many federal drug and alcohol treatment and prevention programs. The Center for Substance Abuse Treatment (CSAT) received level funding, aside from $100 million for President Bush's "Access to Recovery" treatment voucher program. The Substance Abuse Prevention and Treatment block grant, which supports publicly funded treatment programs in the states, received a $10 million increase, while the Center for Substance Abuse Prevention (CSAP) received an increase of $1.6 million despite the Administration's request for a $2 million budget cut.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) received a $13 million increase in funding, while the National Institute on Drug Abuse (NIDA) received a $28 million increase.

The Senate Appropriations Subcommittee has not yet marked up its version of the funding bill, and may not do so until after the August Congressional recess. Watch **ASAM News** for further developments.

Drug Courts Are Effective, New ONDCP Study Finds

Research documenting the effectiveness of drug court programs is found in a report recently released by John Walters, Director of the Office of National Drug Control Policy (ONDCP), and Karen Freeman-Wilson, Executive Director of the National Drug Court Institute. Titled "Painting the Picture: A National Report Card on Drug Courts and Other Problem-Solving Court Programs in the United States," the report finds that drug courts increase access to and retention in drug treatment, reduce criminal activities, and save money at the state and local levels.

At present, there are 1,183 drug court programs operating nationwide. The courts divert non-violent drug offenders from the criminal justice system into substance abuse treatment. Drug courts offer alcohol, drug and mental health treatment, case management, drug testing, and probation supervision. Many drug courts also provide job skill training, family/group counseling and other life-skill enhancement services.

For more information about the report and drug courts in general, visit WWW.NDCI.ORG.

Approximately 4 Million Live With Co-Occurring Disorders

Adults with a substance use disorder were almost three times as likely to have a serious mental illness (20.4%) as those who did not have a substance use disorder (7.0%), according to a new report from the Substance Abuse and Mental Health Services Administration (SAMHSA). The report, "Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders," presents information on the prevalence and treatment of serious mental illness and the association between mental illness and substance use among adults aged 18 or older in 2002.

According to the report, 33.2 million adults age 18 or older had a serious mental illness or a substance use disorder in 2002. Of those adults, 40.4% (13.4 million) had a serious mental illness; 47.4% (15.7 million) had a substance use disorder; and 12.2% (4.0 million) had both serious mental illness and a substance use disorder. The data also indicate that while 47.9% of adults with both a serious mental illness and a substance use disorder received some type of treatment, only 11.8% received both mental health and addiction treatment services.

Of the three age groups examined, adults age 18 to 25 had the highest rate of serious mental illness (13.2%), followed by adults age 26 to 49 (9.5%) and those age 50 or older (4.9%). Overall, the rate of serious mental illness was almost twice as high among women than it was among men.

Commenting on the report, SAMHSA Administrator Charles Curie said, "The time has come to ensure that all Americans who experience co-occurring mental and substance use disorders have an opportunity for treatment and recovery. Clearly, our systems of services must continue to evolve to reflect the growing evidence base that promotes integrated treatment and supportive services. Both disorders must be addressed as primary illnesses and treated as such."

The report can be accessed at WWW.OAS.SAMHSA.GOV. *Source: SAMHSA, "Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders," July 2004.*

Mark your calendar for ASAM's 2005 Med-Sci Conference, April 14-17 in Dallas, Texas.

Decade-Long Rise in Opioid-Related Treatment Admissions Reported

Treatment admissions for abuse of opioid analgesics more than doubled in the decade from 1992 to 2002, according to newly published data from the Substance Abuse and Mental Health Services Administration (SAMHSA). Data published in the report, "Treatment Admissions Involving Narcotic Painkillers, 2002 Update," show that analgesic-related admissions increased for all age groups, but especially among persons age 20 to 30.

According to the report, between 1997 and 2002, the proportion of new users—those entering treatment within three years of beginning use—increased from 26% in 1997 to 39% in 2002. The median duration of use before first seeking treatment decreased from nine years of use in 1992 to seven years of use in 1997, to four years of use in 2002.

In 2002, there were about 84,000 admissions to treatment in which the primary, secondary or tertiary substance of abuse was an opioid analgesic. Such medications were cited as the primary substance of abuse in about half of these admissions. In the other half, abuse of pain medications was secondary to abuse of another substance—usually alcohol or heroin.

The report is based on data compiled in SAMHSA's Treatment Episode Data Set, which collects information on the demographic characteristics and alcohol or drug problems of persons admitted to publicly funded addiction treatment programs. The full report can be downloaded from the SAMHSA web site at WWW.SAMHSA.GOV (click on the "Statistics & Data" link). *(See the related article on page 4.)*

ASAM Board Approves Policy on the Use of Opioids to Treat Pain

At its April 2004 meeting, ASAM's Board of Directors approved a major policy statement on "The Rights and Responsibilities of Health Care Professionals in the Use of Opioids for the Treatment of Pain." The text of the statement follows:

Background

Health care professionals' concerns regarding the potential for harm to patients, as well as possible legal, regulatory, licensing or other third party sanctions related to the prescription of opioids, contribute significantly to the mistreatment of pain. HCPs are obligated to act in the best interest of their patients. This action may include the addition of opioid medication to the treatment plan of patients whose symptoms include pain. Though many types of pain are best addressed by non-opioid interventions, opioids are often indicated as a component of effective pain treatment. It is sometimes a difficult medical judgment as to whether opioid therapy is indicated in patients complaining of pain because objective signs are not always present.

A decision as to whether prescribe opioids may be particularly difficult in patients with concurrent addictive disorders, or with risk factors for addiction, such as a personal or family history of addictive disorder. For such persons, exposure to potentially rewarding substances may reinforce drug taking behavior and therefore present special risks. It is, nonetheless, a medical judgment that must be made by a HCP in the context of the provider-patient relationship, based on knowledge of the patient, awareness of the patient's medical and psychiatric conditions and on observation of the patient's response to treatment.

The selection of a particular opioid or combination of opioids, and the determination of opioid dose and therapeutic schedule, similarly must be based on full clinical understanding of a particular situation and cannot be judged appropriate or inappropriate independent of such knowledge. All Schedule II-V opioids, including methadone, may be appropriate choices for pain control in different circumstances; it is critical that clinicians understand the special pharmacologic characteristics of each medication in order to prescribe them safely and effectively for pain.

Despite appropriate medical practice, health care professionals who prescribe opioids for pain may occasionally be misled by patients who wish to obtain medications for purposes other than pain treatment, such as diversion for profit, recreational use or perpetuation of an addicted state. Health care professionals who are willing to provide compassionate, ongoing medical care to challenging and psychosocially stressed patients, where that treatment includes the prescription of opioids, assume an additional obligation to understand the risks and management of addictive disease because they risk complications of care more often than professionals unwilling to treat this population.

Addiction to opioids may occur despite appropriate opioid therapy for pain in some susceptible individuals. Persistent failure to recognize and provide appropriate medical treatment for the disease of addiction is poor medical practice and may become grounds for practice concern. Similarly, persistent failure to use opioids effectively when they are indicated as part of the treatment of pain, including in persons with active or recovering addiction, is poor medical practice and may also become grounds for practice concern. It is important to distinguish, however, between HCPs who are knowingly complicit in diversion or other illegal prescribing activities and physicians who may inappropriately prescribe opioids due to misunderstandings regarding addiction or pain. HCPs traditionally have received little or no education on addiction or clinical pain treatment in the course of training. This omission is likely a basis for inadequate detection and management of addiction and inadequate assessment and treatment of pain.

Recommendations

1. Health care professionals (HCPs) who prescribe opioids for the treatment of pain should use clear and reasonable medical judgment to establish that a pain state exists and to determine whether opioids are an indicated component of treatment. Opioids should be prescribed in a lawful and clinically sound manner. Patients should be followed at reasonable intervals for ongoing medical management, to confirm as nearly as is reasonable that the medications are used as prescribed, that the goals of treatment are met and to revise therapy as indicated. Such initial decision-making and ongoing management should be appropriately documented.
2. HCPs who are practicing medicine in good faith and who use reasonable medical judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-medical purposes. It is an appropriate role of the Drug Enforcement Administration (DEA), pharmacy boards and other regulatory agencies to inform physicians of the behavior of such patients when it is detected.
3. Interventions to correct the clinical care practices of HCPs who consistently fail to recognize addictive disorders, medication misuse, or medication diversion in their patients are appropriate. Interventions may include education and/or licensing or legal sanction, as indicated after careful and appropriate review of records and other available information.
4. Interventions to correct the clinical care practices of HCPs who consistently fail to appropriately evaluate and treat pain in their patients are appropriate. Interventions may include education and/or licensing or legal sanction, as indicated after careful and appropriate review of records and other available information.
5. For the purpose of performing regulatory, legal, quality assurance and other clinical case reviews, it should be recognized that judgments regarding (a) the medical appropriateness of the prescription of opioids for pain in a specific context, (b) the selection of a particular opioid drug or drugs, and (c) the determination of indicated opioid dosage and interval of medication administration, can only be made properly with full and detailed understanding of a particular clinical case.
6. Regulatory, legal, quality assurance and other reviews of clinical cases involving the use of opioids for the treatment of pain should be performed, when they are indicated, by reviewers with a requisite level of understanding of pain medicine and addiction medicine.
7. Appropriate education in addiction medicine and pain medicine should be provided as part of the core curricula at all medical and other health care professions training schools.
8. Legal and/or licensing actions against health care professionals who are proven to be knowingly complicit in the diversion of scheduled drugs or other illegal prescribing activities are appropriate.

Adopted by the American Society of Addiction Medicine April 1997; revised April 2004; Adopted by the American Academy of Pain Medicine, March 2004; Adopted by the American Pain Society, March 2004.

ASAM Review Course to Meet in Toronto

ASAM's Review Course in Addiction Medicine is designed to cover the core content of addiction theory and practice. Scheduled for November 4-6, 2004, and hosted by the Canadian Medical Association, the course is approved for 21 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association, and for 21 hours in Category 2-A of the American Osteopathic Association. Additional credits can be earned by completing one of five pre-conference workshops organized by the Canadian Society of Addiction Medicine and the Illinois Society of Addiction Medicine.

Co-chairs Shannon C. Miller, M.D., CMRO, FASAM, and Edwin A. Salsitz, M.D., FASAM, report that the Planning Committee has assembled a panel of lecturers who are not only recognized experts in their respective domains, but also excellent communicators and teachers. In designing the curriculum, the Planning Committee carefully reviewed the content and evaluations of past Review Courses. This year's course also reflects the input of physicians who have taken the exam in recent years, as well as collaboration with the host organization, the Canadian Society of Addiction Medicine.

ASAM's textbook, *Principles of Addiction Medicine, Third Edition*, is the basic text for the Review Course. Speakers will refer to and draw from this text often as part of their presentations. As a supplement to *Principles*, participants in the Review Course will receive a Study Guide on CD-Rom, containing key readings and sample questions from past Certification/Recertification Exams, as well as a Course Syllabus with outlines of the presentations and copies of speakers' slides.

To allow participants extra time to prepare for the Review Course and the exam, the Study Guide CD-Rom will be mailed September 1 to everyone who has registered for the Review Course by that date. Late registrants will be sent the Study Guide as their registrations are received.

Register for the Review Course by phoning the ASAM Department of Conferences and Meetings at 301/656-3920 or visiting the ASAM web site at WWW.ASAM.ORG. Course fees are $375 for ASAM members, $450 for non-member physicians, $250 for residents (with documentation of status), and $50 for medical students (with documentation of status). A one-day registration fee of $150 also is available.

Reserve a room at the Sheraton Centre Toronto Hotel, 123 Queen Street West, Toronto, Ontario M5H 2M9, Canada, by phoning the hotel directly at 416/947-4955, ext. 4440, or calling Sheraton's Central Reservation Office at 1-800/325-3535. Special conference rates of $182 single or double have been arranged. To receive the conference rate, make your reservation by Sunday, October 30, and mention that you will be attending the "ASAM 2004 Review Course." Hotel space is limited, so make your reservation early!

Questions about the content of the ASAM Review Course, the pre-conference workshops, or study materials should be emailed to REVIEWCOURSE@AOL.COM.

ASAM's 2004 Review Course in Addiction Medicine honors the life and work of ASAM Board member and C*SAM President-Elect Peter E. Mezciems, M.D., CCFP, FASAM

California Society's Review Course to Meet in San Diego

The California Society of Addiction Medicine will offer its Review Course and Annual Meeting on October 6-9, 2004, at the San Diego Marriott La Jolla Hotel. The course is designated for 30 hours of Category 1 CME credit. For more information, phone Michael Barack at 415/927-5730 or visit the CSAM web site at WWW.CSAM-ASAM.ORG.

ASAM 2004 REVIEW COURSE IN ADDICTION MEDICINE

THURSDAY, NOVEMBER 4, 2004

7:00-8:00 am
Registration opens
Continental Breakfast
Mutual Help Meeting

8:00 am-12:00 noon
Pre-Conference Workshops
(choose one)

Workshop 1:
Pain and Addiction

Workshop 2:
Management of the Pregnant Woman and Newborn

Workshop 3:
Principles of Detoxification

Workshop 4:
Applying Principles of Harm Reduction to Addiction Medicine

Workshop 5:
Ethical and Medicolegal Issues: *Confidentiality, Prescribing Regulations, Liability Risk Reduction, and More*

12:45-5:00 pm
ASAM Review Course
Welcome
Epidemiology
Neurobiology 101
Marijuana
Tobacco
Pregnancy and Addiction
Review of the Day

7:00-9:00 pm
Optional Evening Session:
Clinical Issues in Addiction Medicine I: *A panel of experts engage the audience in an interactive discussion of issues raised by the day's speakers.*

9:00-10:00 pm
Mutual Help Meeting

FRIDAY, NOVEMBER 5, 2004

7:00-8:00 am
Mutual Help Meeting
Continental Breakfast

7:00-8:00 am
(Optional Session)
What to Expect of the Certification Exam: *What to expect the day of the exam; how to use the Review Course, the Syllabus and CD-Rom, and the **Principles** textbook to prepare for the examination.*

8:15 am-5:00 pm
Overview of Day 2
Dissociative Anesthetics and Hallucinogens
Alcohol
Sedative-Hypnotics
Opioids
Opioid Agonist Therapy
Behavioral Therapies
Medical Comorbidities
Review of the Day

7:00-9:00 pm
Optional Evening Session:
Clinical Issues in Addiction Medicine II

9:00-10:00 pm
Mutual Help Meeting

SATURDAY, NOVEMBER 6, 2004

7:00-8:00 am
Registration
Mutual Help Meeting
Continental Breakfast

8:00-9:00 am
MRO: Principles and Practice

9:00 am-4:30 pm
Review of the Day
Psychiatric Comorbidities
Inhalants and Steroids
Amphetamines, Methamphetamine, MDMA and Cocaine
Twelve Step Programs
Prevention, Screening, and Brief Intervention
Clinical Uses of Drug Testing
Wrap up and Adjournment

NIAAA Publishes Report on Moderate Alcohol Use

Researchers at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) have completed an extensive review of current scientific knowledge regarding the health risks and potential benefits of moderate alcohol consumption. The report of their findings—with a focus on cardiovascular disease, breast cancer, obesity, birth defects, breastfeeding, and aging–constitutes the National Institutes of Health's formal position on the issue of moderate alcohol consumption. Key findings include:

- Moderate levels of alcohol consumption do *not* increase the risk of heart failure, myocardial infarction or ischemic stroke and may actually provide protective effects in terms of coronary heart disease among older adults and those otherwise at risk.
- The relationship between moderate alcohol consumption and weight gain, body mass index, and/or obesity remains unclear; however, moderate consumption *does* appear to be associated with a reduced risk of diabetes and metabolic syndrome (which often co-occur with or develop from obesity).
- Alcohol consumption averaging one drink a day appears to be associated with a 10% increase in the risk of breast cancer in the overall population; the risk may be higher among women with a family history of breast cancer as well as those on hormone replacement therapy.
- Low-to-moderate drinking during pregnancy does not appear to be associated with an increased risk of fetal physical malformations, but may have behavioral or neurocognitive consequences. There is some evidence for a dose-response association but, so far, there is no "threshold" below which consumption may be safe. Heavy drinking during pregnancy is clearly unsafe.
- Although elderly drinkers reach higher blood alcohol concentrations at lower levels of consumption than younger drinkers, there is no evidence that moderate alcohol consumption causes cognitive impairment as one ages. However, given the complex nature of Alzheimer's, the researchers suggest that elderly individuals refrain from altering moderate levels of alcohol consumption in an attempt to affect risk.

Lorraine Gunzerath, Ph.D., NIAAA Branch Chief for Strategic Research Planning and a co-author of the study, said that the review findings can be condensed into three key "take-away" messages. First, more research is needed on the lifetime accumulation of benefits and/or risks. "The effects of 20 to 30 years of moderate drinking begun at age 45 may not be comparable to the effects of 50 to 60 years of moderate drinking begun at age 22," Dr. Gunzerath explained. For example, the medical consequences of chronic alcoholism—such as cirrhosis and cardiac myopathy—appear to be related to lifetime consumption levels. "Although these diseases are normally associated with excessive rather than moderate consumption, it remains unclear if the 25-year-old moderate drinker might lower his risk of heart disease by age 65, only to succumb to cirrhosis by that age instead," she said.

Second, drinking patterns are at least as important as total consumption in terms of alcohol's harms and benefits. Dr. Gunzerath noted that low per-occasion consumption occurring regularly—for example, one or two drinks per day, four days a week—generally confers greater benefits and poses less harm than the same total amount consumed all at once. Third, the relationship between moderate alcohol consumption and disease outcome is influenced by numerous individual differences, such as age, sex, genetic susceptibility, lifestyle factors, metabolic rate, etc. Protective and detrimental levels of alcohol consumption cannot be generalized across the population but instead should be determined by an individual in consultation with her or his health care provider.

Summarizing the findings, NIAAA Director T. K. Li, M.D., commented: "Our reviewers have found that the lowest total all-cause mortality occurs at the level of one to two drinks per day. The state of current science does not advocate drinking; these findings simply point out what the research says about the health-related effects of moderate drinking. In short, except for those individuals at identifiable risk, consuming two drinks per day for men and one drink per day for women is unlikely to cause problems." *Source: Gunzerath L, Faden V, Zakhari S et al. (2004). National Institute on Alcohol Abuse and Alcoholism Report on Moderate Drinking. Alcoholism: Clinical & Experimental Research 28(6) 829-847.*

SAMHSA Updates Treatment Program Directory

The 2004 edition of the *National Directory of Drug and Alcohol Abuse Treatment Programs* is now available from the Substance Abuse and Mental Health Services Administration (SAMHSA). The directory provides information on thousands of alcohol and drug treatment programs throughout the U.S. It also includes information on types of services provided, types of facilities, and levels of care.

To obtain a copy of the updated directory, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686.

Moving Forward

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- Membership Committee
- Physicians-in-Training Committee

- Nominations & Awards Council *(Chair: Marc Galanter, M.D., FASAM)*
- Public Policy Council *(Chair: David C. Lewis, M.D.)*
  - Policy Development Committee
  - Legislative Advocacy Committee
- Publications Council *(Chair: Elizabeth F. Howell, M.D., FASAM)*
  - Newsletter and Web Page Committee
  - Journal Committee
  - Textbook and Handbook Committee
- Quality Improvement Council *(Co-Chairs: David R. Gastfriend, M.D., and David Mee-Lee, M.D.)*
  - Practice Guidelines Committee
  - Treatment Criteria, Treatment Outcomes and Clinical Performance Measures Committee
  - JCAHO Liaison
  - CARF Liaison
  - NCQA Liaison

Your participation as a member of a Council, Subcommittee or Work Group will strengthen our Society and directly contribute to the personal rewards you experience as a member of ASAM. I invite you to become involved!

BUPRENORPHINE TRAINING COURSES

September 3, 2004
ASAM – Hawaii Society of Addiction Medicine
Honolulu, Hawaii
Contact: GGRAETZ@ASAM.ORG

September 11, 2004
ASAM – Region VIII
Anchorage, Alaska
Contact: Linda Clary at 541/464-8883

September 14, 2004
ASAM – NYS AIDS Institute
Albany, New York
Contact: Abigail Gallucci at 518/262-6864

September 18, 2004
ASAM – Region X
Nashville, TN
Contact: TBALDWIN@XPERIENCE-NY.COM

October 2, 2004
ASAM – Illinois Society of Addiction Medicine
Chicago, IL
Contact: TBALDWIN@XPERIENCE-NY.COM

October 8, 2004
New York Society of Addiction Medicine
Syracuse, NY
Contact: Lyn Stevens at 315/464-5593

October 10, 2004
ASAM – California Society of Addiction Medicine
San Diego, CA
Contact: TBALDWIN@XPERIENCE-NY.COM

October 15 & 22, 2004
NYS AIDS Institute
Brooklyn, NY
Contact: David Odegaard at 718/270-4752

October 16, 2004
ASAM – AATOD
Orlando, FL
Contact: TBALDWIN@XPERIENCE-NY.COM

October 16, 2004
ASAM – Region VIII
Salt Lake City, UT
Contact: ESIMGT@WORLDNET.ATT.NET

To register for these courses, phone **1-888/362-6784** or visit the ASAM web site at **WWW.ASAM.ORG/CONF/BUPRENORPHINECONFERENCES.HTM.**

FDA Approves Acamprosate for the Treatment of Alcoholism

Ending months of anticipation, the Food and Drug Administration (FDA) has approved the Campral® brand of acamprosate (calcium acetyl homotaurinate) for the treatment of alcoholism. "Alcoholism, or alcohol dependence, is a disease...that places a tremendous burden on society in terms of health care costs, lost wages and personal suffering," the FDA said in announcing the approval.

Acamprosate has been widely used in Europe for 15 years to prevent relapse in alcoholics. FDA officials acknowledged that it is not clear how the drug works, but studies showed that more patients who took the drug abstained from drinking than those who took a placebo. "While its mechanism of action is not fully understood, Campral is thought to act on the brain pathways related to alcohol abuse," the FDA statement said.

"Acamprosate works by stabilizing a brain chemical system called the glutamate system," explains Ray Anton, M.D., Distinguished Professor and director of the Center for Drug and Alcohol Programs at the Medical University of South Carolina. "The glutamate system is one of the most strongly affected by chronic alcohol use," Dr. Anton said, adding: "Following the initiation of abstinence, it takes considerable time for the brain chemistry of this system to become `normal' again. It is thought that acamprosate helps speed this process so that the person has a greater chance of staying abstinent by not 'turning to the bottle' to feel normal. Acamprosate is well tolerated but needs to be taken a few times per day, unlike disulfiram and naltrexone, which can be taken once per day."

The FDA rejected the initial application for Campral in 2002, asking the manufacturer to conduct additional clinical trials. Lipha Pharmaceuticals, a subsidiary of German drug maker Merck KGaA, makes the drug. Forest Laboratories Inc. owns the licensing rights to sell the drug in the United States and has announced plans to start selling it later this year. Another firm, Alkermes Inc., is in late-stage clinical trials to test its drug Vivitrex® in alcoholic men. Other approved treatments, including disulfiram (Antabuse®) and naltrexone (ReVia®), have been on the market for a number of years.

Dr. Anton added that a "new era of advancement in the treatment of alcoholism" is imminent. "There are a number of emerging possibilities," he said, "ranging from acamprosate, naltrexone and disulfiram to anticonvulsants and novel compounds working on heretofore untested neurochemical systems. The neuroscience of addiction is rapidly advancing, and the future is brighter than it has ever been."

Sources: U.S. Food and Drug Administration press release; Brasser SM, McCaul ME & Houtsmuller EJ (2004). Alcohol effects during acamprosate treatment: A dose-response study in humans. Alcoholism: Clinical & Experimental Research 28(7) 1074-1083.

PET Study Highlights Mechanism Involved in Nicotine Craving

Researchers at UCLA's David Geffen School of Medicine have used positron emission tomography (PET) to understand the mechanism through which bupropion works in the brain to reduce cigarette craving. (Bupropion is marketed as Zyban® for smoking cessation.)

The scientists used PET imaging to examine brain activity in bupropion-medicated and unmedicated smokers who were exposed to smoking cues, such as the sight and feel of a cigarette. They were able to show that in the presence of bupropion, brain cells in the anterior cingulate cortex—a region known to be involved in drug craving—do not activate in response to cigarette-related cues. Until now, scientists and clinicians knew that bupropion reduced the urge to smoke, but the central nervous system process by which it did so was unknown.

Thirty-seven otherwise healthy smokers participated in the trial. Seventeen received bupropion for an average of 5.6 weeks; 20 were unmedicated. All participants were given two PET scans, during which they either watched a smoking-oriented video and held a cigarette or viewed a nature video and held a neutral object such as a pen. The researchers also assessed the participants' cravings for cigarettes through analysis of their scores on the Urge to Smoke Scale. Bupropion-treated smokers had lower Urge to Smoke scores than untreated smokers. They also reported smoking fewer cigarettes per day.

Smelling and seeing a cigarette can drive the impulse to smoke.

WHAT IT MEANS:

This study illuminates the basic nervous system mechanisms involved in drug craving, as well as how cues like smelling and seeing a cigarette can drive the impulse to smoke. A more complete understanding of these mechanisms can aid in the development of more effective treatment and relapse prevention strategies.

The study, by Dr. Arthur Brody and colleagues, was funded by the National Institute on Drug Abuse (NIDA) and published online in the April 2004 issue of *Psychiatry Research: Neuroimaging*.

Antiseizure Drug May Be Useful in Treating Cocaine Addiction

Combining the antiseizure medication topiramate with one form of behavioral therapy may effectively treat cocaine addiction, a recent study suggests. Researchers with the University of Pennsylvania School of Medicine in Philadelphia enrolled 40 subjects in a 13-week, placebo-controlled, double-blind study. Participants received placebo or an escalating daily dose of topiramate for 8 weeks (they initially received a dose of 25 mg daily, which was increased by 25 mg per week until the maximum dose of 200 mg per day was reached during the 8th week of the study). This maximum once-daily dose was maintained through week 12. During week 13, the dose of the drug was decreased daily until participants were weaned from it.

All study participants also received twice-weekly, individual cognitive-behavioral therapy designed to help them avoid relapse by learning to recognize the environmental cues and potentially stressful situations that trigger strong drug cravings and to develop avoidance strategies.

The investigators reported that participants who received topiramate were more likely than those who received a placebo to be abstinent from cocaine after the 8th week of the study. In addition, data from the 36 subjects who returned for at least one evaluation visit after starting the medications showed that those who received topiramate and counseling were significantly more likely than the placebo group to achieve three or more weeks of continuous cocaine abstinence (59% versus 26%, respectively).

WHAT IT MEANS:

A recognized treatment for seizure disorders, topiramate also has been studied for the treatment of alcoholism and opiate dependence. This study, however, is one of the first to explore its usefulness as a potential treatment for cocaine addiction. It is important because it demonstrates that topiramate can successfully produce a stable period of cocaine abstinence, which previous research indicates is a predictor of long-term abstinence.

Dr. Kyle Kampman led this NIDA-funded study, which was published online in the May 2004 issue of *Drug and Alcohol Dependence*.

Cocaine Craving Activates Different Brain Regions in Men, Women

New neuroimaging data show that cocaine-dependent women experience changes in regional cerebral blood flow that are different from the changes experienced by cocaine-dependent men. (Cerebral blood flow is a correlate of neural activity in the brain.)

Dr. Clinton Kilts and colleagues at Emory University School of Medicine in Atlanta used positron emission tomography (PET) to examine blood flow related to drug craving in the brains of eight abstinent, cocaine-craving women; their results were compared with samples from eight matched cocaine-craving men subjected to the same process. Craving was provoked by mental imagery induced by a one-minute narration describing past individual cocaine use. The scientists also assessed regional cerebral blood flow when the study participants listened to narrations of drug-neutral experiences.

The researchers found that cue-induced craving was associated with greater activation of the central sulcus and frontal cortex in women, and less activation of the amygdala, insula, orbitofrontal cortex, and ventral cingulated cortex. Both men and women demonstrated activation of the right nucleus accumbens. Perhaps most notable was the neural activity measured in the amygdalas of study subjects; the women experienced a marked decrease in activity, as compared to the increase observed in men. (The amygdala is involved in controlling social and sexual behavior and emotions.)

Research results precisely define gender differences in drug use patterns…

WHAT IT MEANS:

The gender differences noted in this study, coupled with the results of research that more precisely defines gender differences in drug use patterns, suggests that there may be a need to develop gender-specific strategies to treat men and women for substance use disorders.

This NIDA-funded study was published in the February 2004 issue of the *American Journal of Psychiatry*. *Source: News Scan—NIDA Addiction Research News, July 19, 2004.*

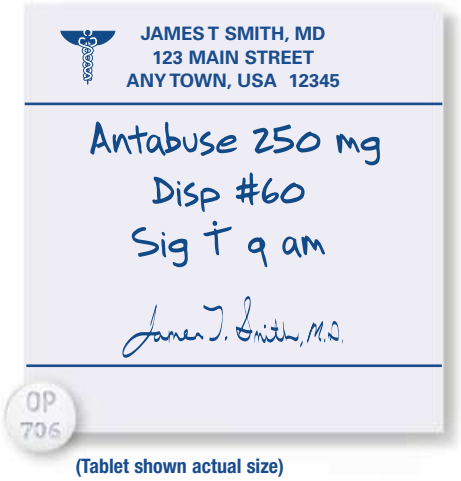
HELPS ALCOHOL ABUSERS SUCCESSFULLY STAY SOBER

Antabuse: Proven to reduce alcohol consumption for committed quitters

- Patients who are economically and socially stable, compared with those who are not, experience greater positive outcomes with Antabuse[1,2]
- Supervision and support are crucial to patient compliance with treatment with Antabuse[3,4]
- Adequate dosing and appropriate duration of therapy also impact treatment success with Antabuse[4,5]

Prescribe Antabuse with confidence—once a day, every day for patients who have too much to lose

Patients who have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing products should not receive Antabuse. Antabuse is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, and hypersensitivity to disulfiram. Antabuse should be used with caution in patients receiving phenytoin and its congeners.



(Tablet shown actual size)

Please see full prescribing information on adjacent page.

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

Complimentary patient education materials and identification cards are available from your Odyssey representative or through our Web site at www.OdysseyPharm.com.

In alcoholism

ANTABUSE®

(Disulfiram, USP)

250-mg Tablets

Support for the committed quitter

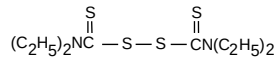
Odyssey PHARMACEUTICALS, INC.®

Visit our Web site at www.OdysseyPharm.com

Antabuse® (Disulfiram, USP) Tablets
IN ALCOHOLISM

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

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



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

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

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

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

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

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

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

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

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

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

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

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

WARNINGS:

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

The patient must be fully informed of the disulfiram-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of the possible consequences. He should be warned to avoid alcohol in disguised forms, i.e., in sauces, vinegars, cough mixtures, and even in afters have 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.

Drug Interactions: Disulfiram appears to decrease the rate at which certain drugs are metabolized and therefore may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

DISULFIRAM SHOULD BE USED WITH CAUTION IN THOSE PATIENTS RECEIVING PHENYTOIN AND ITS CONGENERS, SINCE THE CONCOMITANT ADMINISTRATION OF THESE TWO DRUGS CAN LEAD TO PHENYTOIN INTOXICATION. PRIOR TO ADMINISTERING DISULFIRAM TO A PATIENT ON PHENYTOIN THERAPY, A BASELINE PHENYTOIN SERUM LEVEL SHOULD BE OBTAINED. SUBSEQUENT TO INITIATION OF DISULFIRAM THERAPY, SERUM LEVELS OF PHENYTOIN SHOULD BE DETERMINED ON DIFFERENT DAYS FOR EVIDENCE OF AN INCREASE OR FOR A CONTINUING RISE IN LEVELS. INCREASED PHENYTOIN LEVELS SHOULD BE TREATED WITH APPROPRIATE DOSAGE ADJUSTMENT.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status, the disulfiram should be discontinued if such signs appear.

In rats, simultaneous ingestion of disulfiram and nitrite in the diet for 78 weeks has been reported to cause tumors, and it has been suggested that disulfiram may react with nitrites in the rat stomach to form a nitrosamine, which is tumorigenic. Disulfiram alone in the rat's diet did not lead to such tumors. The relevance of this finding to humans is not known at this time.

Usage in Pregnancy: The safe use of this drug in pregnancy has not been established. Therefore, disulfiram should be used during pregnancy only when, in the judgement of the physician, the probable benefits outweigh the possible risks.

Pediatric Use: Safety and effectiveness in pediatric patients have not been established.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Since many drugs are so excreted, disulfiram should not be given to nursing mothers.

Geriatric Use: A determination has not been made whether controlled clinical studies of disulfiram included sufficient numbers of subjects aged 65 and over to define a difference in response from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal or cardiac function, and of concomitant disease or other drug therapy.

ADVERSE REACTIONS: (See **CONTRAINDICATIONS, WARNINGS,** and **PRECAUTIONS.**)

OPTIC NEURITIS, PERIPHERAL NEURITIS, POLYNEURITIS, AND PERIPHERAL NEUROPATHY MAY OCCUR FOLLOWING ADMINISTRATION OF DISULFIRAM.

Multiple cases of hepatitis, including both cholestatic and fulminant hepatitis, as well as hepatic failure resulting in transplantation or death, have been reported with administration of disulfiram.

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy, or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

OVERDOSAGE: No specific information is available on the treatment of overdosage with disulfiram. It is recommended that the physician contact the local Poison Control Center.

DOSAGE AND ADMINISTRATION: Disulfiram should never be administered until the patient has abstained from alcohol for at least 12 hours.

Initial Dosage Schedule: In the first phase of treatment, a *maximum* of 500 mg daily is given in a single dose for one to two weeks. Although usually taken in the morning, disulfiram may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

Maintenance Regimen: The average maintenance dose is 250 mg daily (range, 125 to 500 mg), it should not exceed 500 mg daily.

Note: Occasionally patients, while seemingly on adequate maintenance doses of disulfiram, report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily disulfiram tablets (preferably crushed and well mixed with liquid), it cannot be concluded that disulfiram is ineffective.

Duration of Therapy: The daily, uninterrupted administration of disulfiram must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

Trial with Alcohol: During early experience with disulfiram, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg daily, a drink of 15 mL (1/2 oz) of 100 proof whiskey, or equivalent, is taken slowly. This test dose of alcoholic beverage may be repeated once only, so that the total dose does not exceed 30 mL (1 oz) of whiskey. Once a reaction develops, no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

Management of Disulfiram-Alcohol Reaction: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95% oxygen and 5% carbon dioxide), vitamin C intravenously in massive doses (1 g) and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored, particularly in patients on digitalis, since hypokalemia has been reported.

HOW SUPPLIED: Disulfiram Tablets, USP:
250 mg - White, round, unscored tablets in bottles of 100.
Debossed: OP 706
Dispense in a tight, light-resistant container as defined in the USP.
Store at controlled room temperature 15°-30°C (59°-86°F). [SEE USP]

Distributed by Odyssey Pharmaceuticals, Inc., East Hanover, NJ 07936
Manufactured by PLIVA, Inc., East Hanover, NJ 07936

Iss. 1/03

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ACHIEVING NON-DISCRIMINATION IN HEALTH INSURANCE

A. Kenison Roy III, M.D., FASAM

"Non-discrimination in health insurance"—which is an alternative and perhaps more apt term for what we also call "parity"—describes a state in which insurance benefits for mental health and addiction services are provided at the same level as insurance benefits for other medical conditions. By contrast, the present situation is one in which these areas are either not covered or covered with arbitrary or ridiculously low limits. The result is a catastrophic level of confusion that causes untold damage to individuals and their families.

There are several analogies that can be made to the current situation. What if you could have treatment for only one heart attack per year or per lifetime? Alternatively, what if you were allotted only $2,000 per year to pay for care for heart attacks and no coverage for high cholesterol? Or what if you could have only outpatient or only inpatient care? What if your insurance paid only for doctors' visits for chest pain that resulted in heart attacks and not for those that were not life-threatening?

The origin of our current system has roots in a very insidious and difficult-to-dislodge "Moral Model" of addiction and mental health. This insidious "Moral Model" is the idea that a person with an addictive disorder can and should "cut it out" and "get with it" so that they can resume or accept society's values and discard the values of an addictive lifestyle. The unstated principle is that addicted people are not good people with a bad disease, but bad people who have made a decision to continue to drink and/or use drugs.

The existence of the public system as a primary modality of treatment in our society allows us to vicariously "punish" those of us with addiction by assuring that treatment will be less comfortable (overcrowded and under-funded), yet allows us to take comfort in the notion that we are addressing the problem. Our confusing and unreasonable health insurance system deprives people of treatment until they are so broken that they cannot easily be fixed. Then, we expect them to access an inadequately funded system and to embrace a lifestyle of disease maintenance and preventive care. This situation costs patients with addiction, and all of us, dearly.

Not so long ago, patients were hospitalized for months and even years for psychiatric illnesses, and patients with substance use disorders were automatically hospitalized for 28 days, or longer if they were difficult. Fortunately, such programs and forms of treatment—with their attendant expenses—are a thing of the past. Today we have criteria-based levels of care, so that most courses of treatment involve few, if any, inpatient stays.

What that means is that patients must meet recognizable criteria for severity of disease in order to be treated at a particular level of care. Professional treatment always should last at least a year, including continuing care (aftercare), but the intensity of services does not have to be intrusive or expensive. For instance, a patient with a house, a spouse and a job will actually have a better outcome if he or she is treated in an outpatient setting while continuing to work. However, individuals with a greater degree of illness require more intensive treatment over a longer period of time. The *RAND Report* and other studies demonstrate that the combination of managed care and a full spectrum of services for addictive disease will result in a minimal immediate increase in insurance premiums and a probable reduction of costs after the benefits of treatment result in a reduction in other health care costs.

What are the benefits of non-discrimination in health insurance? They are HUGE! A great deal of our national budget is spent on drug control, police work related to substance use, and efforts at supply reduction at the federal level. However, the greatest opportunity for reducing both supply and demand, as well as the collateral damage that arises from drug and alcohol use, will be seen when patients and their families have easy, early access to appropriate treatment for addiction.

It also is true that all treatment for addiction is values-based. Treatment teaches that dishonesty, theft, greed, hate, lust and anger are components of relapse. Professional treatment encourages a rejection of those values and an embrace of generosity, courage, fairness, industry, restraint and wisdom. Would these attitudes go a long way toward solving the ills of our society? You bet they would! Since all good treatment includes family, these values will spread beyond the person in treatment to the larger group of family members as well.

Do I believe that non-discrimination in health insurance will solve all of the ills of our world? No: there is no one thing that will solve all of the ills of our world, but non-discrimination will help. Non-discrimination in health insurance is simple and easy to do. Non-discrimination can be accomplished by a grass-roots effort, aimed at legislators and officials, to voice the will of the people. Non-discrimination in health insurance *is* a big deal!

Dr. Roy is President and Medical Director of Addiction Recovery Resources, Metairie, LA. He also is a member of the ASAM Board of Directors representing Region VII.

FACULTY POSITION — Addiction Psychiatrist

The University of Vermont (UVM) College of Medicine is seeking an Addiction Psychiatrist for the full-time faculty. This position is being offered at the Assistant or Associate Professor level on a clinical non-tenure track. This psychiatrist will join a nationally recognized substance abuse research program. The individual will further develop empirically-based substance abuse treatment programs offered by our affiliated health care system, Fletcher Allen Health Care (FAHC), located on the university campus. As part of this clinical role, he/she will serve as Medical Director of the first methadone treatment program in Vermont, located at the FAHC/UVM campus.

This psychiatrist also will be responsible for strengthening training programs and providing direct teaching to medical students, residents, and other FAHC/UVM trainees in substance abuse treatment. This individual will be strongly encouraged to participate in ongoing NIH-funded research and scholarly activities within the Department of Psychiatry and will have the opportunity to develop his/her own research agenda.

Applicants must have a medical degree and be board-certified or board-qualified in Psychiatry. Applicants must have either completed or be enrolled in specialty training or have extensive experience in Addiction Psychiatry.

The University of Vermont is located in a beautiful area, with recreational and cultural opportunities in the Lake Champlain region of Vermont and upstate New York, the Burlington metropolitan area and nearby Boston and Montreal. Interested applicants should send a curriculum vitae and contact information for three references to:

Stacey C. Sigmon, Ph.D.
Search Committee Chair
UVM Department of Psychiatry
1 South Prospect St.; Room 1415
Burlington, VT 05401

Applications will be accepted until this position is filled, but we strongly encourage submission of required materials as soon as possible, with an anticipated start date of Fall 2004.

The University of Vermont is an Equal Opportunity and Affirmative Action Employer. Applications from women and individuals from diverse racial, ethnic, and cultural backgrounds are encouraged.

Recovery Month Toolkit Available

September marks the 15th annual National Alcohol and Drug Addiction Recovery Month, which celebrates people in recovery who have overcome stigma, denial, and other barriers to treatment, and as a result are leading healthy and productive lives.

This year's Recovery Month focuses on improving access to recovery among the large number of Americans who have difficulty obtaining treatment for alcohol or other drug use disorders. To support the effort, the Center for Substance Abuse Treatment (CSAT) has created a comprehensive, user-friendly toolkit containing a series of fact sheets on alcohol and drug use. The fact sheets are camera-ready and can be readily reproduced and distributed to patients, policymakers, the media, and other audiences.

Electronic versions of Recovery Month materials can be downloaded from WWW.RECOVERYMONTH.GOV. The web site also contains additional planning resources, media updates and alerts, web events, and news about Recovery Month activities planned in cities across the U.S. To order hard copies of the toolkit at no cost, phone 1-800/662-HELP. *Source: SAMHSA press release, July 2004.*

2004 Election Guide Offered

A free guide to candidates and issues in the 2004 elections can be obtained from the Community Anti-Drug Coalitions of America (CADCA) at HTTP://CADCA.ORG/COALITIONRESOURCES/PP=MAIN.ASP. *(Once on the Public Policy home page, click on the link titled Election Guide 2004, found on the navigation bar to the left.)*

The CADCA Guide contains a variety of resources to help advocates raise and address addiction issues with candidates at every level, from President of the United States to local government, including:

- A list of candidates running for election in 2004 and their contact information;
- Suggestions on how to raise alcohol and drug issues with candidates;
- Sample questions to get the candidates on record, with a follow-up form to document the candidates' positions;
- Sample op-ed pieces for newspapers; and
- Information on how to organize a campaign event and register voters.

Source: CADCA Action Alert, April 26, 2004.

Finding Hidden Information on the Web

The "invisible web" refers to sites on the World Wide Web that Google and other search engines are unable to find. In fact, experts estimate that as much as 99% of the Web is invisible to general search engines. The vast majority of the "invisible" sites are found in databases from universities, libraries, associations, and government agencies from around the world. These databases tend to focus on a particular topic and usually are more authoritative, better indexed, and provide higher quality information than the Web as a whole. Here are just a few of the free, high-quality databases relevant to alcohol and other drugs that are available on the "invisible" Web:

- Alcohol and Drug Problems Science Database (ETOH) (HTTP://ETOH.NIAAA.NIH.GOV) *[NOTE: not updated since 12/03 because funding has been discontinued]*
- Alcohol Policy Information System (HTTP://ALCOHOLPOLICY.NIAAA.NIH.GOV)
- Alcohol Studies Database (HTTP://WWW.SCC.RUTGERS.EDU/ALCOHOL_STUDIES)
- Drugscope DrugData Database (HTTP://WWW.DRUGSCOPE.ORG.UK/LIBRARY)
- European Gateway on Alcohol, Drugs, and Addictions (HTTP://WWW.ELISAD.UNI-BREMEN.DE)
- Fetal Alcohol Spectrum Disorders Database (HTTP://WWW.FASCENTER.SAMHSA.GOV/SEARCH)
- Legacy Tobacco Documents Library (HTTP://LEGACY.LIBRARY.UCSF.EDU)
- Project Cork Database (HTTP://WWW.PROJECTCORK.ORG/DATABASE_SEARCH)
- Smoking and Health Database (HTTP://WWW.CDC.GOV/TOBACCO/SEARCH)
- Substance Abuse Information Database (SAID) (HTTP://SAID.DOL.GOV)

Source: Center for Substance Abuse Research (CESAR), Vol. 13, No. 21, University of Maryland, College Park.

CALIFORNIA SOCIETY OF ADDICTION MEDICINE

Reporter: Donald J. Kurth, M.D., FASAM

To help ensure member retention, Romana Markvitsa, M.D., CSAM's new Membership Chair, arranged a conference call to welcome new members and engage them in CSAM endeavors. In addition, Dr. Markvitsa has identified members who have expressed an interest in committee work and asked them to call members who have not yet renewed. She has encouraged the callers to stress the benefits of membership, including reduced rates for upcoming conferences and the camaraderie of participation.

CONNECTICUT SOCIETY OF ADDICTION MEDICINE

Reporter: Mark L. Kraus, M.D., FASAM

The CtSAM-sponsored Buprenorphine Training Course recently held in New Haven attracted an audience of 69, and the chapter hopes to follow up with a second course.

Plans for a Northeast Regional conference are progressing. Joint sponsorship with the University of Connecticut and Yale University is being considered for a meeting that would target Fellows, Residents and Medical Students.

In other activities, CCAR (the Connecticut Community of Addiction Recovery, which as 3,000 members) and CtSAM are planning to send a joint letter of support to the Connecticut members of the Addiction Caucus in the U.S. House of Representatives. They also will ask Connecticut's Senators to create a similar caucus in the U.S. Senate.

Through the Connecticut State Medical Society, CtSAM plans to give more visibility to the UPPL issue, as well as information on the medical marijuana ballot initiative. CtSAM also is collaborating with the state medical society to seek a second grant from the Robert Wood Johnson Foundation to reproduce the Addiction Grand Rounds, a series of four lectures (to view the lectures, visit WWW.CSMS.ORG).

HAWAII SOCIETY OF ADDICTION MEDICINE

Reporter: George Carlson, M.D.

The Hawaii legislature recently passed House Bill 2003, requiring parity in addiction treatment, and the Governor is expected to sign the measure into law. Dr. Gerald McKenna has been instrumental in championing this important piece of parity legislation.

ILLINOIS SOCIETY OF ADDICTION MEDICINE

Reporter: Sarz Maxwell, M.D., FASAM

Dr. Aghin Singla has been named ISAM Membership Chair. Also, the Illinois Society has completed its first 12-month strategic plan.

MICHIGAN SOCIETY OF ADDICTION MEDICINE & REGION VI

Reporter: Thomas L. Haynes, M.D., FASAM

MiSAM staff person Cathy Pisano is sending welcome letters to all new members. Mark Weiner, M.D., has been named Membership Chair. MiSAM is planning additional educational programs in conjunction with the Buprenorphine Training Course scheduled for February 2005.

Dr. Robert Larsen is working to establish an ASAM chapter in Minnesota, and Dr. Alfonso Holliday is working to establish a chapter in Indiana by the time of the 2005 Med-Sci conference. If the Iowa chapter can be reactivated, Region VI would have chapters in every state.

NEW YORK SOCIETY OF ADDICTION MEDICINE

Reporter: Gregory C. Bunt, M.D.

The New York Society's annual conference is scheduled for January 29, 2005, in a Times Square location. The focus of the conference is to be "Special Populations: AIDS, Adolescents, Geriatrics, and Women."

The first Buprenorphine Training Course sponsored by NYSAM was successful, and support is being sought from CSAT to allow NYSAM to another training in conjunction with the chapter's January educational conference.

The NYSAM newsletter will debut this summer, with an article from the OASIS Commissioner. The New York legislature has strongly endorsed medical marijuana, and NYSAM is responding by using the ASAM policy statement, emulating the approach employed by the Connecticut chapter.

NORTHWEST CHAPTER & REGION VIII

Reporter: Berton J. Toews, M.D., FASAM

The Northwest Chapter is planning Buprenorphine Training Courses for Denver, CO, Salt Lake City, UT, and Billings, MT.

RHODE ISLAND SOCIETY OF ADDICTION MEDICINE

Reporter: John P. Femino, M.D., FASAM

RISAM continues to work toward formal representation in the Rhode Island Medical Society. To that end, the chapter submitted a list of RISAM members, indicating each member's specialty, to the CEO of the state medical society. The state society's Medical Council is to take up the RISAM request at its August meeting.

The other major issues in Rhode Island continue to be the Prevention Task Forces and the Rhode Island Physician Initiative. As a result, the chapter is beginning to receive some statewide attention for its activities. Dr. Stuart Gitlow is arranging a meeting between RISAM's leadership and the head of behavioral medicine at Rhode Island Blue Cross and Blue Shield to discuss a potential joint project on adolescent screening for substance abuse in primary care physicians' offices.

Dr. Walter Fitzhugh has agreed to serve as RISAM Membership Chair. RISAM's summer general meeting will be replaced by a joint meeting between AAAP and the ASAM Massachusetts and Rhode Island chapters in the fall.

SOUTH CAROLINA SOCIETY OF ADDICTION MEDICINE

Reporter: William Scott, M.D.

Dr. Michael Laughlin has agreed to serve as SCSAM Membership Chair. A high priority activity for the chapter is investigating the status of the UPPL law (which allows insurers to exclude coverage for persons who become ill or injured as the result of alcohol or drug use) in South Carolina.

TEXAS SOCIETY OF ADDICTION MEDICINE

Reporter: Robert Jones, M.D.

The Second Annual Region VII Conference will be held September 17-18th in San Antonio. The Texas chapter will open the event with a Texas barbecue in the hill country. The chapter also has scheduled a business meeting during the conference to nominate a Membership Chair and organize several committees.

A state senator from Galveston has agreed to sponsor legislation addressing UPPL in the Texas legislature. TSAM members also are leading Grand Rounds at local hospitals. A monthly newsletter has been launched, featuring articles on membership renewal and TSAM activities.

ASAM State Society and Chapter leaders will meet October 14-15, 2004, in Washington, DC.

Ruth Fox Memorial Endowment Fund

Dr. Ruth Fox

Dear Colleague:

We are pleased to report that the Ruth Fox Scholarship Program, which is supported by interest income from the Ruth Fox Endowment Fund, has been a great success. Since 2002, when the Scholarship program was established, we have sponsored 20 physicians-in-training to attend ASAM's Med-Sci Conference and Ruth Fox Course. We would like to quote from just a couple of the letters we received from scholarship recipients:

"I think this meeting will be a cornerstone in my future career as an addiction specialist. I especially appreciated the opportunity for all the scholars to meet. The evening spent with the members of the Board giving their own stories was certainly one of the key points of those meetings."

"I arrived thinking how much I would enjoy exploring Washington, D.C., in the springtime, but found myself drawn to meetings and sessions from 7:00 a.m. to nearly 10:00 p.m. each day. I wouldn't have had it any other way—the conference far exceeded my expectations, both in the quality of the educational programming and in the opportunities for networking. I returned to work full of ideas and energy for innovation in my work environment."

All of the letters received from the scholarship recipients expressed their appreciation for the opportunity to attend the ASAM Medical-Scientific Conference and Ruth Fox Course. This program would not have been possible without your support for the Endowment Fund.

With the support of our members and friends, the Endowment Fund has come very close to achieving its next goal, as we need only a little more than $97,000 to reach $4 million. In particular, we thank Dr. Brian McDevitt of West Virginia and Dr. Joel Nathan of New York for their recent very generous pledges, which place them in the Founders' Circle.

The next Ruth Fox Donor Reception is scheduled for Friday evening, April 15, 2005, in Dallas during the Med-Sci Conference. It is by invitation to donors only, so if you have not already contributed or pledged to the Endowment, please do so now and help us reach our goal. Also let us know if you have included the Endowment in your estate plans so that we can acknowledge your generosity. Your support will be greatly appreciated.

For information about making a pledge, contribution, bequest, memorial tribute, or to discuss other types of gifts in confidence, please contact Claire Osman by phone at 1-800/257-6776 or 1-718/275-7766, or email Claire at ASAMCLAIRE@AOL.COM. She welcomes your calls. Now may be an opportune time to examine the amount and timing of your gifts in order to maximize your tax savings this year. All contributions to the Endowment Fund are tax-deductible to the full extent allowed by law.

Max A. Schneider, M.D., FASAM, Chair, Ruth Fox Memorial Endowment Subcommittee
Claire Osman, Director of Development

As of August 15, 2004
TOTAL PLEDGES: $3,902,917

NEW DONORS, ADDITIONAL PLEDGES AND CONTRIBUTIONS
January 1, 2004 – August 15, 2004

FOUNDERS' CIRCLE ($25,000-$49,999)

Brian A. McDevitt, D.O.
Joel A. Nathan, M.D.

LEADERSHIP CIRCLE ($5,000-$9,999)

Louis E. Baxter, Sr., M.D.
George L. Lagorio, M.D.
(Keys to Recovery-Holy Family Medicine)
Joseph C. Mancini, M.D.
John M. McRae, M.D.
Richard J. Ready, M.D.
Jokichi Takamine, M.D.

DONORS' CIRCLE (UP TO $2,999)

Steven L. Batki, M.D.
Jung Ki Cho, M.D.
Timothy L. Fischer, D.O.
Marc Galanter, M.D.
Theodore M. Hunter, M.D.
David G. Jones, M.D., M.P.H.
James C. Macke, M.D.
David D. Goldberg, D.O.
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Beny J. Primm, M.D.
Seddon R. Savage, M.D.
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Barry Spiegel, D.O.
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Walter D. Fitzhugh, III, M.D.
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Mr. Charles J. Jacklin
Robert E. Larsen, M.D.
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John A. Peterson, M.D.
Craig T. Pratt, M.D.
Mary H. Rabb, D.O.
J.V. Simmering, M.D.
Agha Shahid, M.D.
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IN MEMORIAM

Peter E. Mezciems, M.D., CCFP, FASAM

Peter E. Mezciems, M.D., CCFP, FASAM, and his wife, Laurie Nicholls, died May 16, 2004, in a plane crash. Dr. Mezciems, age 56, was a founding member and President-Elect of the Canadian Society of Addiction Medicine and represented Region IX (International) on the ASAM Board of Directors. Laurie Nicholls, also age 56, was a physiotherapist.

Dr. Mezciems was a 1972 graduate of the Faculty of Medicine at the University of Toronto and practiced since 1990 at the Homewood Health Centre, Guelph, Ontario—Canada's largest physician recovery program—where he had "the privilege of working with impaired health professionals," as he described it. He also was an educator, with appointments as Clinical Assistant Professor at McMaster University and contributing author for the *Oxford Textbook of Family Medicine*. He liked to point out that two teaching modules on the addictions that he co-authored for Project CREATE (Curriculum Renewal and Evaluation of Addiction Training and Education) were helping to improve the education of physicians and nurses at five schools in Ontario.

He also worked to foster international collaboration as a founding member of the International Society of Addiction Medicine (ISAM) and creator of the ADD_MED Listserv, which attracted more than 300 members from some 20 countries and serves as a resource for medical professionals to network and exchange addiction-related information worldwide with colleagues.

Dr. Mezciems is survived by his children Rebecca, Rachel and Mathew, his parents, and his first wife, Karen. Ms. Nicholls is survived by her daughters, Sarah and Adrienne, and their father, Jim Nicholls. Their many friends and professional colleagues also are touched by their loss. Dr. David Marsh, President of the Canadian Society of Addiction Medicine, said "Peter's sudden and tragic death is a blow to both our organizations and to the profession." Fellow ASAM Board member Penny Ziegler, M.D., added that "Peter has been such a powerful role model as a physician, spouse, and parent. He will be greatly missed."

Funeral services for Dr. Mezciems and Ms. Nicholls were held May 22 at Guelph. The family has requested that memorial contributions be directed to the Hospital for Sick Children Foundation in Toronto.

ASAM's 2004 Review Course in Addiction Medicine, to be held November 4-6 in Toronto and hosted by the Canadian Society of Addiction Medicine, will be dedicated to the life and work of Dr. Mezciems.

Dr. Hajela to Represent Region IX

ASAM's Board of Directors has named Raju Hajela, M.D., M.P.H., FASAM, to serve the balance of Dr. Peter Mezciems' term as Region IX representative to the Board. Dr. Hajela is a past President of the Canadian Society of Addiction Medicine. He will serve for the duration of the current term, which expires in April 2005.

Dr. Barthwell Leaves ONDCP

Andrea G. Barthwell, M.D., FASAM

Andrea G. Barthwell, M.D., FASAM, resigned her position as Deputy Director for Demand Reduction in the White House Office of National Drug Control Policy (ONDCP) in July. She had held the post since January 2002.

A former President of ASAM and longtime advocate of evidenced-based addiction treatment, Dr. Barthwell is widely recognized as a champion of prevention, intervention, treatment, and recovery. ONDCP Director John Walters said: "Through her tireless service to this Nation, Andrea Barthwell has helped to educate Americans about the harms of illegal drugs. Her passion for protecting the health of all Americans has been inspiring."

Reflecting on her service at ONDCP, Dr. Barthwell said, "I was given an opportunity by President Bush to serve our country at a critical time. I am proud of the progress we have made." After leaving ONDCP, Dr. Barthwell briefly pursued a Senate bid from her home state of Illinois. She is expected to continue to play a major role in the formulation of national drug policy.

ASAM ELECTIONS

SCHEDULE FOR ASAM ELECTION OF OFFICERS

Profiles of the candidates for ASAM President-Elect, Secretary, Treasurer, and Regional Directors will appear in the September-October issue of **ASAM News**.

Ballots will be mailed to members in good standing by November 1, 2004, and must be completed and 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!

ASAM Conference Calendar

ASAM

November 4-6, 2004
ASAM 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
Westin Embassy Row Hotel
Washington, DC
7 Category 1 CME credits

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

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

2005

April 14, 2005
Ruth Fox Course for Physicians
Hyatt Regency Hotel
Dallas, TX
8 Category 1 CME credits

April 14, 2005
Pain & Addiction:
Common Threads VI
Hyatt Regency Hotel
Dallas, TX
8 Category 1 CME credits

April 15-17, 2005
ASAM's 36th Annual
Medical-Scientific Conference
Hyatt Regency Hotel
Dallas, TX
20 Category 1 CME credits

OTHER EVENTS OF NOTE

October 2, 2004
University of Medicine &
Dentistry of New Jersey
and New Jersey Medical Society
"Perinatal Substance Abuse
and FASD: No Safe Time"
Newark, NJ
[For information, email
ADUBATSU@UMDNJ.EDU]

October 6-9, 2004
California Society of Addiction
Medicine
Review Course and Annual
Meeting
San Diego, CA
[For information, phone
Michael Barack at
415/927-5730 or visit
WWW.CSAM-ASAM.ORG]

October 13-16, 2004
American Medical Association
and Canadian Medical Association
2004 International Conference
on Physician Health
Oak Brook, IL
[For information, email
PHC@AMA-ASSN.ORG]

October 16-20, 2004
American Association for
the Treatment of Opioid
Dependence (AATOD)
20th Anniversary National
Conference
Orlando, FL
[For information, phone
856/423-7222 x 360,
or visit WWW.AATOD.ORG]

November 11-13, 2004
Association for Medical
Education and Research
in Substance Abuse
28th Annual National Conference
Hilton Embassy Row Hotel
Washington, DC
[For information, visit
WWW.AMERSA.ORG]

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:

SEE PAGE 7 FOR A COMPLETE LIST OF UPCOMING COURSES, DATES AND LOCATIONS.