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Scientific Management Review Board
National Institute of Health

Dear Board Members,

Thank you for the opportunity to address the Board. My name is Dr. Ray Anton. I am a Distinguished University Professor, Director of the Center for Drug and Alcohol Programs at the Medical University of South Carolina (MUSC), and Scientific Director of a P50 NIAAA-funded Alcohol Research Center. I am a Distinguished Fellow of the American Psychiatric Association, a Fellow in the American College of Neuropsychopharmacology (ACNP), and Vice-Chair of the Board of the ABMRF- The Foundation for Alcohol Research. I am also a recent past President of the Research Society for Alcoholism.

First, I want to thank the members of the Board for their interest and commitment in assisting NIH and all of its grantees, myself included. My association with alcohol could be considered genetic since my grandfather, an Italian immigrant, might have been considered a bootlegger during prohibition. While not an alcohol abuser himself, his attempts to sell liquor cost him his once lucrative canning business. His son, my father, inherited from him a liquor store business where I spent many days of my youth, watching and helping provide alcoholic packaged goods. It struck me then that many people coming to buy beer, wine, and liquor were different—and not in a good way. Therefore, it is somewhat ironic that I found my way to alcohol research, perhaps to undo what my family had unintentionally fostered in so many people. However, this story does point out some important issues.

One issue is that alcohol is a ubiquitous and an ever-present part of our culture with many good, and some not-so-good, aspects. Alcohol use is not going away – we tried that and it failed. Ninety percent of Americans have had exposure to alcohol but 20% of the population consumes 80% of the alcoholic beverages. Therein lies the dilemma – sometimes alcohol does good things, sometimes it does bad things, and many times these are confused and misunderstood. The general population has little appreciation that alcohol works on the brain, never mind that there are exact chemicals and brain areas involved in alcohol dependence. The number one cause of essential hypertension is heavy alcohol consumption, but most primary care doctors are unaware of this and their patients' drinking habits, and therefore, prescribe unnecessary antihypertensives. Alcohol is a leading cause of depression but psychiatrists prescribe unneeded antidepressants. Why? Mostly, because their patients do not tell them about their alcohol use or they do not ask. Reasons behind this are still being detailed but what is clear is that the "stigma" of possibly being labeled an alcoholic plays a large role and weighs on an individual's choice to seek treatment or not. Insurance and employment discrimination continue to be an issue, which we hope the passage of the mental health and substance abuse parity legislation will mitigate. Even if people do seek treatment, medication treatment options are limited and used by only a small portion of the treatment seeking population. The reasons for this are many, but one is that the medications that are available are not universally or powerfully effective. The good news is that ten years ago there were no U.S. pharmaceutical companies interested in developing medications for alcoholism; today there are six to seven large pharmaceutical companies actively engaged in development of medications for alcohol dependence, in large part through NIAAA efforts.

Why am I telling all of this? Well, I am telling all of this to highlight several points that should be considered strongly in contemplating a merger between NIAAA and NIDA. First and foremost in my mind is that alcohol abuse and dependence is just now reaching the early stages of de-stigmatization. We are 15 years behind depression and 20-30 years behind cancer. Second, alcohol permeates all aspects of our health care delivery system. We are just beginning to make inroads into teaching various health care professionals how to screen for, never mind treat, alcohol use disorders. Third, pharmaceutical companies and insurers are just coming around to the idea that preventing and treating alcohol use disorders is a worthwhile and economically sound investment, not to mention being "the right thing to do."

I and many of my colleagues are concerned that public association of alcohol use disorders with other licit and illicit substance abuse will set back the momentum to de-stigmatize and legitimize alcohol prevention (primary and secondary) and treatment. This is an important public health and policy issue which should not be forgotten in the debate regarding a merger of NIAAA and NIDA.

I also want to correct several potential misrepresentations that I saw in the testimony of others as posted on the Board's website. First, it has been stated that most substance abusers are also alcoholics. While this may be true, most alcoholics do not abuse other substances. If one looks at statistics from public clinics, one might come to the first conclusion, but the vast majority of individuals with alcohol use disorders are not in public clinics but are "free-ranging," living and working in our communities. I know this because when we advertise in our local paper or on our local radio for clinical trial subjects, they come out of their "hiding-places" in droves and the vast majority are only addicted to alcohol, not other substances. Second, it has been suggested that all addictions use a common neurochemical and neuroanatomical pathway. While there is some commonality across addictive substances, at this time it would be reductionistic to assume they are "all alike." For instance, we know alcohol is more toxic to neurons than most other abused substances and affects many more neurochemical systems.

Therefore, on both public health and scientific grounds, I think the Board should proceed with great caution and hesitancy to recommend a merger of NIAAA and NIDA. There is likely more to be lost than gained. Complimentary goals and collaborations can be achieved between the Institutes in more constructive and less harmful ways.

Thank you for giving me the time to express my views, and I wish you well in your deliberations.

Sincerely,

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