Winter2004-2005
Volume 19, Number 6

ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

ASAM at Work for You:

Also see:

Watch for the next issue of ASAM News for full coverage of ASAM election results.

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

www.asam.org

ASAM MRO Course to Meet in California

A comprehensive review of the federal drug-free workplace requirements, as well as the clinical aspects of MRO practice, will be presented in ASAM's Medical Review Officer Training Course, set for March 18-20, 2005, at the Marriott Marina del Rey in Marina del Rey, California.

Under the direction of course chair James L. Ferguson, D.O., an expert faculty will review the impact of the revised Federal Part 40 rule, as well as recent developments in alcohol and drug testing technologies in terms of their implications for the work of Medical Review Officers. The course also prepares candidates to sit for the MRO certifying examination. Course participants can earn up to 18 hours of Category 1 continuing medical education credits. For additional information and registration, consult the ASAM web site or contact ASAM's meetings staff at EMAIL@ASAM.ORG.

ASAM Awarded CSAT Mentoring Contract

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

The Substance Abuse and Mental Health Services Administration (SAMHSA) has announced a cooperative agreement with ASAM to develop a mentoring program for internal medicine and family medicine practitioners and other primary care physicians, as well as pain specialists, psychiatrists, and other physicians who are treating patients for opioid addiction with buprenorphine.

Using a three-year SAMHSA grant of almost $500,000 per year, ASAM will create a national clinical support network of 50 trained physician mentors who have expertise in treating opioids (including heroin and prescription analgesics) with buprenorphine. The mentors will be drawn from several addiction and other specialty organizations with which ASAM is collaborating.

The mentors' role will be to assist physicians who have undergone the required training and received federal waivers to use buprenorphine, but who would like additional "hands on" guidance from colleagues who are experienced in using the drug. David Fiellin, M.D., who chairs ASAM's Buprenorphine Training subcommittee, adds that even addiction medicine specialists may find the mentoring helpful because delivering "this type of care in office-based settings is so revolutionary."

Anton C. Bizzell, M.D., medical director with SAMHSA's Center for Substance Abuse Treatment, said that while SAMHSA routinely conducts training and offers technical assistance, the mentoring program qualifies as a new type of educational initiative for the agency, and one that is expected to increase access to treatment. SAMHSA's goal is to have 6,000 trained and certified physicians actively treating patients by the end of 2006.

ASAM Joins Government Leaders in Call for Better Physician Education

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

I was pleased to represent ASAM at a recent Leadership Conference on Medical Education in Substance Abuse, which brought together more than 60 high-level officials from Federal agencies, medical organizations, and licensure and certification bodies to discuss ways to enhance physicians' motivation and ability to prevent, diagnose, and manage substance use disorders.

The conference was organized by the Office of National Drug Control Policy (ONDCP) in the Executive Office of the President, The White House, in cooperation with the the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration, as well as the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse of the National Institutes of Health. Support also was provided by The Robert Wood Johnson Foundation.

Speakers at the Leadership Conference-including Surgeon General of the United States Richard Carmona, M.D., and trauma surgeon Jeffrey Runge, M.D., who heads the National Highway Transportation Safety Administration — addressed the fact that although primary care physicians are the professionals cited by patients and families as the "most appropriate" source of advice and guidance about issues related to the use of alcohol, tobacco, and other drugs, they also are ranked as the "least helpful" in actually addressing such issues. Dr. Carmona pointed to studies showing that the diagnosis of substance abuse or addiction often is missed by physicians and that, even when such a diagnosis is made, many physicians do not know how to perform a brief intervention or develop a plan for patient referral. He concluded that physicians need help in acquiring basic clinical skills in screening, assessment, presenting the diagnosis, negotiating a treatment plan, and referring patients with substance use disorders — all skills that they routinely employ in the management of other chronic diseases.

In his address to the conferees, ONDCP Director John P. Walters noted that organized medicine and medical education groups have a pivotal role to play in addressing this challenge. Accordingly, he asked the medical leaders to develop specific plans for public and private sector actions to improve the training of physicians through undergraduate, graduate, and continuing medical education. Director Walters pledged that ONDCP and other Federal agencies will continue to support basic research that enlarges our understanding of the causes and consequences of alcohol, tobacco and drug misuse and abuse, including prescription drug abuse. He also promised support for clinical research that leads to development of better tools to identify and intervene with patients who present with substance use disorders in primary health care settings.

In response, the medical leaders agreed on a series of specific action steps. Their recommendations include:

1. Ask the Surgeon General to convene a working group of medical organizations to draft a strong ethical statement that says physicians may not ignore the signs or symptoms of alcohol and drug problems: "Substance use disorders are medical illnesses and may not be ignored or go untreated: We do not choose the illnesses we treat." (Conferees noted that anti-stigma education is not enough, saying "You can't educate away prejudice. Someone at the top needs to say `We're not going to tolerate discriminatory behavior'.")
2. Work with medical student organizations to help them advocate for better undergraduate medical education on the identification and management of substance use disorders.

(continued on page 3)

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

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

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

Immediate Past President
Marc Galanter, M.D., FASAM

President-Elect
Elizabeth F. Howell, M.D., FASAM

Secretary
David C. Lewis, M.D.

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

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

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

Chair, Publications Council
Elizabeth F. Howell, M.D., FASAM

Newsletter Review Board
LeClair Bissell, M.D.
Sheila B. Blume, M.D., FASAM
Max A. Schneider, M.D., FASAM

Founding Editor, 1985-1995
Lucy Barry Robe

Editor
Bonnie B. Wilford

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

Advertising
Advertising rates and schedules are available on request. Please direct inquiries to the Editor at 410/770-4866 or email ASAMNEWSLETTER@AOL.COM.

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).

Generic OxyContin Appearing in Illicit Markets

Enforcement officials report that generic versions of the analgesic OxyContin are being sold in illicit markets, even ahead of the drugs' arrival in pharmacies. Both Teva Pharmaceuticals and Endo Pharmaceuticals have received approval from the U.S. Food and Drug Administration to sell generic versions of the sustained-release product tradenamed OxyContin, which is manufactured by Purdue Pharma LLP.

Dan Smoot, chief detective for Operation UNITE, an anti-drug task force in Eastern Kentucky, said: "When we first got the pills, we didn't know what they were. They look nothing like the OxyContin we were familiar with." Karen Engle, executive director of Operation UNITE, added that "We knew when the FDA approved generic OxyContin that it would end up in the region. But we didn't think it would be here before the pharmacies got it."

Anti-drug groups and enforcement authorities are concerned that the generic versions will attract new users by lowering prices on the illicit market. Their appearance also complicates the task of identifying the sources of drugs that are diverted to abuse. For example, the generic drugs first seen in street markets are unlikely to be traced to misdirected prescriptions from physicians or thefts from pharmacies because the generic products were not yet available from licit sources. That leaves thefts from wholesalers, illegal importation, or counterfeits as possible sources-all of which are much more difficult to track than pharmaceutical products that move through the licit distribution system. Dan Smoot, chief detective for Operation UNITE, an anti-drug task force in Eastern Kentucky, said: "When we first got the pills, we didn't know what they were. They look nothing like the OxyContin we were familiar with."

Court to Hear Medical Marijuana Case

The U.S. Supreme Court will hear a case on the medical use of marijuana during its 2004-2005 term, which opens in October. The case is based on an appeal by the Bush administration in the case of two California women. The court will consider whether the federal government can prosecute seriously ill individuals whose physicians recommend marijuana to ease their chronic pain or other medical problems.

In a separate action, Americans for Safe Access, a coalition of physicians and patients who support easing access to marijuana for research and medical use, has filed a petition with the U.S. Department of Health and Human Services, calling on DHHS to lift restrictions on the drug.

In its complaint, the Berkeley, California-based group charges that DHHS disseminated inaccurate information about the medicinal value of marijuana. The petition is based on the Data Quality Act of 2000, which gives citizens the right to challenge scientific information disseminated by federal agencies. Under the law, DHHS has two months to respond to the petition.

The petition says it seeks to correct the government's "scientifically flawed statements" about marijuana published in the Federal Register. The change would also allow the Drug Enforcement Administration to declare marijuana a Schedule II drug that could be prescribed for certain conditions and obtained more easily for research.

ASAM Joins Government Leaders in Call for Better Physician Education *continued from page 2*

3 Develop collaborative projects across multiple government agencies and private-sector organizations to design useful clinical models and tools. For example, the VA system could begin to develop models for medical education, then use its clout to renegotiate contracts with medical schools to incorporate them. Or HRSA could provide funding for the development and implementation of clinical training models for physicians who work with its target populations (e.g., practitioners in rural areas).

4 Use information that is already available (such as the SAMHSA Treatment Improvement Protocols or the VA clinical practice guidelines) to support implementation of the clinical models.

5 Work with NIDA, NIAAA, CSAT, CSAP, and HRSA to design and fund a program (similar to the Career Teacher program of the 1980s) that would support the recruitment and training of medical school faculty to become experts on substance use disorders. Experience shows that such faculty members go on to become "champions" for expanding addiction-related content of undergraduate and graduate medical education.

6 Establish an expert panel to assist the National Board of Medical Examiners in developing licensing and certification exam test questions on substance use disorders. For a model, look at the case simulation materials developed by Barry Stimmel, M.D., and colleagues at the Mount Sinai Medical School.

7 "Mainstream" physician education about prescribing drugs with abuse potential (that is, teach about prescribing and prescription drug abuse in the same way other areas of clinical knowledge and skills are taught). To reach practicing physicians, employ multiple focused interventions, in the same way pharmaceutical manufacturers do with the roll-out of a new drug.

8 Amend state licensure and medical specialty certification and recertification standards to require that, at the time of recertification, relicensure, or re-registration with DEA, physicians present evidence of CME credits and/or focused self-assessment to achieve competency in this vital area.

9 Through public/private partnerships, identify and/or develop educational materials that physicians can give to patients to educate them about substance use disorders.

10 Schedule a follow-up meeting of the conference participants in one year to revisit the objectives, strategies, and action steps and to measure progress toward achieving them.

A number of actions to implement the conferees' recommendations have been initiated by ONDCP and the participating agencies and organizations. I expect ASAM to be an active partner in this work, as our Mission statement and Strategic Plan call for the Society to help educate non-specialist physicians about the importance of identifying and managing substance use disorders in the same way they do other medical problems.

For more information about the Leadership Conference and its follow-up activities, contact Dr. Brown at LBROWN@ARTCNY.ORG or conference facilitator Bonnie Wilford at BBWILFORD@AOL.COM.

ASAM Chapters and State Societies Set a Rapid Pace of Activities

Richard A. Beach, M.D., FASAM
Chair, State Medical Specialty Societies Program

CALIFORNIA

Reporter: Kerry Parker

The California Society is closely monitoring an effort to merge the state's addiction treatment agency with the state Department of Mental Health. CSAM opposes the merger. Instead, it is proposing that the current state addiction treatment director's office be elevated to a cabinet-level position.

In society news, CSAM has had 275 persons register for its Review Course in Addiction Medicine, scheduled for October in San Diego.

CONNECTICUT

Reporter: Mark Kraus, M.D.

In the public policy area, the Connecticut Society is working for repeal of the UPPL in Connecticut, and opposing (for the third time) a ballot initiative on medical marijuana.

The Connecticut Community for Addiction Recovery (CCAR) and CtSAM are joining forces to encourage our Connecticut U.S. Representatives to join the addiction caucus in the U.S. House of Representatives. We plan to ask Senators Lieberman and Dodd to do same thing in the Senate. CCAR also will sponsor a rally to promote better funding for addiction treatment.

CtSAM currently has 65 members and is growing. The state Commissioner of Addictions spoke at the Society's most recent meeting.

The Rhode Island, Massachusetts and Connecticut societies will sponsor a joint conference in February. In addition, a Fellows/Residents Addiction Conference is being planned with UConn and Yale. The Connecticut Society has secured funding to maintain the addiction medicine grand rounds on the Connecticut State Medical Society's website.

Dr. Kraus suggested that the ASAM national office include information about the state societies in the ASAM membership packet sent to new members. Others on the call agreed that this would benefit the state-level organizations and asked to have it discussed at the October meetings. Ms. McGrath, Ms. Brighindi and Ms. Hotaling agreed that the ASAM office can do this, if the states will define what they want sent and supply the materials to the national office.

HAWAII

Reporter: Kevin Kunz, M.D.

The Hawaii chapter sponsored a Buprenorphine Training Course in September, which attracted 35 registrants and was very successful. The course was timed to coincide with the first day of the Hawaii Medical Association (HMA) annual meeting. On the second day of the HMA meeting, Drs. Donald Wesson and Ray Baker were the keynote speakers, and it was the best-attended meeting the state society has ever held. HISAM gave its first "Advocate for Recovery Award" to Mayor Harry Kim.

Parity issues are making progress in Hawaii. Insurers now are allowing two inpatient treatment episodes per year, whereas until recently they limited care to two episodes in a lifetime. HISAM is advocating for a requirement that pain medicine specialists should take a buprenorphine treatment course and demonstrate an understanding of the difference between dependence and addiction.

ILLINOIS

Reporter: Sarz Mazwell, M.D.

The Illinois Society has been invited to participate in a meeting sponsored by the Join Together "Demand Treatment!" project. ISAM is collaborating with ASAM to sponsor pre-conference workshops at the November ASAM Review Course in Toronto. Marty Doot, M.D., continues to represent ISAM to the Illinois State Medical Society.

MASSACHUSETTS

Reporter: Ronald Pike, M.D.

Vermont defeated a medical marijuana ballot initiative, with strong support from the Office of National Drug Control Policy in the White House. The Massachusetts Society is collaborating with John Femino, M.D., to organize an October meeting with the American Academy of Addiction Psychiatry, and a February 2004 meeting with the Connecticut and Rhode Island Societies of Addiction Medicine. I am a delegate to the Massachusetts Medical Society and will promote the creation of an addiction committee within that organization.

MICHIGAN

Reporter: Tom Haynes, M.D., FASAM

The Michigan Society's meetings are held quarterly in conjunction with the state physician monitoring program. That program, unfortunately, is in disarray and its meetings have been postponed. There will be a February conference where the use of buprenorphine will be the featured topic. Indiana and Minnesota are in the process of establishing state chapters.

NEW YORK

Reporter: Merrill Herman, M.D.

The New York Society's Annual Medical-Scientific Conference is scheduled for January 29-30. The New York office of the Drug Enforcement Administration is sponsoring a traveling exhibit, now being displayed in Times Square, and NYSAM is going to "piggyback" on their space at no cost to NYSAM. The theme of the conference will be "Diversity, Addiction & Recovery." Presenters will address adolescents, women, and geriatric patients; criminal justice issues; crystal methamphetamine, and other current topics. A half-day "Buprenorphine 101" course also will be offered in conjunction with the conference.

OREGON

Reporter: Andris Antoniskis, M.D.

The quarterly meeting of the Oregon Society drew 18 or ORSAM's 25 members, as well as several prospective members. A major topic of discussion was the SMSS Program and how to contact and welcome new members. For the moment, this will be done by the Executive Committee.

A medical marijuana bill is pending in the state senate. Pro-marijuana advocates are lobbying for expanding the existing law to broaden the definition of whocan prescribe marijuana, expand the criteria for who can possess the drug and the amount they can possess (up to 6 lbs). These measures would essentially legalize marijuana in the state of Oregon. ORSAM is working with the Oregon Medical Association to defeat the measure and is donating money to develop a pamphlet to include in the voters' package. John Walters, Director of the Office of National Drug Control Policy, also has agreed to be part of a news conference to discuss the bill. ORSAM's Dr. Antoniskis will participate to educate voters.

REGION III: NORTHWEST

Reporter: Bert Toews, M.D.

The Wyoming legislature is focused on tort reform: at present, Wyoming law does not cap plaintiffs' damages, and the state medical society is lobbying to change that. As a result, UPPL repeal and parity are on the back burner.

Communication among members in our large territory is largely by email. An educational program has been scheduled for October 23rd in connection with the Buprenorphine Training course. Immediately following that course, the Northwest Chapter will hold its first organizing meeting, featuring a panel discussion of pain management. In January, the chapter will sponsor a conference on methamphetamine, because it is a drug of great concern in the region.

RHODE ISLAND

Reporter: John Femino, M.D.

The Rhode Island Society's board of directors met with the executive director of the DATA treatment office (an advocacy group) to negotiate a central office for RISAM. The DATA representatives said they are happy to do this and want to increase their collaboration with RISAM.

A joint meeting with the American Academy of Addiction Psychiatry will be held October 13th. This is the third year for such a joint endeavor. The Physician Initiative Project now is working with Blue Cross/Blue Shield to develop a code for physicians to be paid for office-based screening. Working with Kathryn Cates-Wessel, RISAM representatives are trying to identify the best screening instruments. An ideal instrument would not have to be administered by the physician, but could be handled by an employee and billed to another code. Stu Gitlow, M.D., has been helpful in getting this accomplished; he is medical director of Rhode Island Beacon Managed Care. BC/BS will track costs of doing this, the referrals, etc. Mark Kraus asked if this could be promoted as a Blues pilot project.

TEXAS

Reporter: Robert Jones

The second annual Region VII meeting coincided with a hurricane, but still was successful. It featured some good panel discussions such as a panel on "Cultural Sensitivity and Addiction Treatment" (chaired by Rudy Arredondo, M.D.), a session on "Addiction as a Disease."

The departments of mental health and addiction have been merged within the state government and this will not be good news for addiction treatment. Several member of TSAM also are members of the Texas Medical Association's House of Delegates and are vocal, but it is not likely that TMA will ever admit TSAM as a medical specialty society.

Dr. Jones reported that medical marijuana is likely to come up for debate in Texas and asked how it got started in Oregon. Dr. Antoniskis replied that it began as a ballot initiative (with 100,000 signatures) to help the chronically ill. George Soros and other wealthy businessmen funded it.

WISCONSIN

Reporter: Lance Longo, M.D.

The Wisconsin Society has grown from about 40 members to nearly 100 members since becoming involved in the SMSS initiative. Twenty members attended the August dinner meeting, which featured election of officers and a lively discussion of public policy issues, the structure and functions of ASAM, and buprenorphine.

The third issue of WisSAM News is hot off the press and will be mailed at the end of September. WisSAM has created a public policy committee, to be chaired by Michael Miller, M.D., which will meet during the State Bureau of Mental Health and Substance Abuse Conference in October.

No formal CME events are in the works, but we hope to organize and promote ASAM through educational programs around the launch of acamprosate (which affords a great opportunity regarding overall recognition and treatment of alcoholism), physician health, and buprenorphine. Michael Bohn, M.D., will be available on the conference call to update the chapter and will represent WiSAM in Washington in October.

FDA Approves Acamprosate for Relapse Prevention

Acamprosate, a medication intended to help recovering alcoholics avoid relapse, has been approved by the U.S. Food and Drug Administration, ending years of anticipation by the field. The new medication, which has been used in Europe for 15 years, should be available in the U.S. early in 2005. The FDA had rejected the new drug application for acamprosate in 2002, asking the manufacturer to conduct additional clinical trials.

Lipha Pharmaceuticals, a subsidiary of German drug maker Merck KGaA, manufactures the drug, which is to be marketed in the U.S. by Forest Laboratories under the trade name Campral.

While it is not entirely clear how acamprosate works, study subjects who used it were more likely to maintain abstinence from alcohol than those who were given a placebo. "Campral is thought to act on the brain pathways related to alcohol abuse," the FDA wrote. It may not work for patients who are actively drinking or who are abusing other substances, the FDA cautioned in announcing the approval. Common side effects include diarrhea, nausea, vomiting and abdominal pain.

Another company, Alkermes Inc., is in late-stage clinical trials of its drug Vivitrex in alcoholic men. Other approved treatments, including the generics naltrexone and disulfiram, have been available in the U.S. for a number of years.

Alcoholism continues to be a widespread problem: federal researchers recently reported that 17.6 million adults abused alcohol in 2001-2002, while studies funded by the National Institute on Alcohol Abuse and Alcoholism has found that men and adults age 18 to 44 are the most likely to drink heavily.

ASAM Conducts Pilot Program with VA

ASAM partnered with the Department of Veterans Affairs' Stars and Stripes Network 4 Mental Illness Research, Education and Clinical Center (VISN 4 MIRECC), as well as the Center for Excellence for Substance Abuse Treatment and Education (CESATE) and the University of Pittsburgh, to deliver two groundbreaking buprenorphine training courses for VA personnel.

Physicians who completed the courses were able to submit notification of intent to prescribe forms to the Substance Abuse and Mental Health Services Administration (SAMSHA) to allow them to use buprenorphine in accordance with the Drug Addiction Treatment Act of 2000 (PL 106-310, Section 3502). DATA 2000 permits physicians who are trained or experienced in opioid addiction treatment to obtain waivers to prescribe certain opioid drugs in Schedules III, IV, or V of the Controlled Substances Act, in their office practices or in a clinic setting, for the treatment of opioid dependence. Physicians also qualify for such waivers if they are certified in addiction medicine or addiction psychiatry. Physicians who are not otherwise qualified must complete not less then 8 hours of training to obtain a waiver.

The 8-hour trainings, conducted at the VA Pittsburgh Healthcare System and the Philadelphia VA Medical Center, were the first such courses ever conducted in VA facilities and specifically targeted to the needs of VA medical staff. Among the 90 participants were physicians, residents and other clinical staff. While more than 6,500 physicians have received buprenorphine training and more than 3,600 have received waivers to prescribe the drug in office-based settings, only a very small number of these physicians practice in the VA system.

ASAM member Laura McNicholas, M.D., Ph.D., of the University of Pennsylvania Medical School, was instrumental in developing the course curriculum. Adam Gordon, M.D., of the VA, served as a Director of both courses. Other members of the course faculty included Drs. Scott Golden, George Woody, Steve Forman, Kyle Kampman, Joseph Liberto and Samuel Rice. Dr. McNicholas commented that "we should use the lessons learned from this partnership as a model for other VISNs in developing similar trainings…to help provide mentoring capacity as these physicians begin to prescribe buprenorphine."

Dr. McNicholas and Dr. Gordon already are working to provide clinical support services to physicians within the VA system to ensure that the 8-hour training is just one part of a larger continuum of support. Over the coming years, the MIRECC and CESATE will continue to monitor the use of buprenorphine, work with the VISN to make buprenorphine products part of the formulary, establish a formal referral and transfer network to allow seamless transfer of patients on buprenorphine from one provider to another, and work to improve education regarding office-based treatment through V-Tel educational programs and future certification conferences. In 2003, Drs. McNicholas and Gordon collaborated in developing national guidelines for non-formulary use of buprenorphine within the VA (the guidelines can be accessed at http://www.vapbm.org/criteria/Buprenorphine.pdf).

Progress in Finding Effective Treatments for Cocaine Addiction Reported

In a symposium at the annual meeting of the American Psychiatric Association, leading addiction experts discussed their frustrations and successes in finding effective ways to treat cocaine addiction. The need for such treatments is acute, they agreed, pointing out that more than 14% of the U.S. population aged 12 years or older (34 million persons) report having used cocaine at least once, according to the 2002 National Survey on Drug Use and Health, sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). Some 2.5% reported having used cocaine in the past year, and 0.9% said they had used it in the past month. According to SAMHSA officials, most of those who need treatment for addiction do not receive it.

Although addicted patients often are not compliant and thus can be a source of frustration for physicians, effective evidence-based treatments are available, said David A.Gorelick, M.D., Ph.D., chief of the clinical pharmacology section of the intramural research program at the National Institute on Drug Abuse (NIDA). Unrealistic expectations on the part of patients and physicians may contribute to the frustration, he cautioned, adding: "You don't expect to cure diabetes. Treating drug abuse is not conceptually that different."

Dr. Gorelick, who also is a section editor for ASAM's Principles of Addiction Medicine textbook, explained that patients who abuse drugs such as cocaine and methamphetamine often need help with lifestyle changes in addition to their medical treatment. They may require ongoing monitoring and may need multiple "doses" of treatment. He added that while few patients say, "Doctor, I have a cocaine problem," physicians should consider that possibility in patients who present with depression, anxiety, and other psychological complaints, as well as in those with medical problems such as hypertension or cardiac arrhythmia that are new or not responsive to treatment. Symptoms that suggest a myocardial infarction or stroke in individuals younger than 45 years also should raise a red flag.

Pharmacologic Therapies: Dr. Gorelick, who chaired the symposium, attributed the difficulty in finding a proven, broadly effective medication to treat cocaine addiction to the psychopharmacology of the drug itself. Cocaine probably activates the brain's reward system directly, he said. It reaches the brain rapidly (for example, in only 6 to 8 seconds when smoked) and provides an intensely pleasurable reward experience. Moreover, unlike opioids and sedative drugs, chronic use of cocaine leads to sensitization rather than tolerance, and also may trigger changes in the brain that promote both neurotransmitter depletion and receptor up-regulation.

Dr. Gorelick outlined four pharmacological approaches that theoretically might work for treating cocaine dependence: (1) using substitution treatment with a cross-tolerant stimulant (like nicotine replacement therapy for tobacco dependence), (2) using an antagonist medication to block binding of cocaine to its site of action (like naltrexone treatment for heroin dependence), (3) using a medication that acts at other sites to functionally antagonize the effects of cocaine (similar to naltrexone treatment for alcoholism), or (4) altering cocaine's pharmacokinetics to ensure that less drug reaches the brain or remains at its sites of action in the brain. Preclinical research is exploring all of these approaches, he said.

NIDA-supported researchers are screening medications approved for other indications in the search for drugs that warrant additional evaluation for the treatment of cocaine dependence. Of the medications assessed to date, Dr. Gorelick said the most promising include disulfiram, which presently is used to treat alcohol addiction, and modafinil, a nonstimulant approved for the treatment of narcolepsy, shift work sleep disorder, and obstructive sleep apnea. A phase 3 trial of disulfiram for cocaine dependence is now in progress, he reported. In addition, a recent phase 1 trial found that a "cocaine vaccine" was well tolerated and produced detectable levels of anti-cocaine antibodies for up to nine months following administration.

Psychosocial Therapies: Psychosocial interventions currently are the cornerstone of cocaine addiction treatment, said Douglas Ziedonis, M.D., M.P.H., professor of psychiatry and director of the division of addiction psychiatry at the University of Medicine and Dentistry of New Jersey. Such approaches focus on recovery as a process, he said. They help motivate individuals to commit to a drug-free life, work toward that goal, and regain self-esteem. Some focus on abstinence, advocating a lifestyle that avoids exposure to cocaine, while others recognize the chronicity of addiction and teach patients strategies for managing cravings and dealing with relapses.

Dr. Ziedonis added that common individual and group treatments include cognitive therapy, which uses Socratic questioning to help patients identify and correct maladaptive beliefs, and supportive-expressive therapy, which explores interpersonal as well as emotional and cognitive functioning that impedes recovery. Efforts to foster better relationships with others may include family therapy and couples therapy. Therapists also assess and address co-occurring psychiatric disorders.

Twelve Step support groups such as Cocaine Anonymous and Narcotics Anonymous are an important adjunct to treatment, Dr. Ziedonis said. Participation in such programs requires individuals to accept responsibility for their behavior and to work toward improvement. For example, he pointed to Step 4, which entails writing and reflecting about the impact of substance use on their lives. The programs also offer peer support and camaraderie, often lifelong, while associated groups provide help for families and children.

Patients who participate in such programs may talk about "being in recovery" or "working a program" — that is, doing their daily reading, self-evaluation, and more-terms that primary care physicians need to understand and feel comfortable using in talking with their patients, Dr. Ziedonis said.

Psychiatric Comorbidities: Also complicating the treatment picture is the presence of co-occuring psychiatric disorders, according to Richard N. Rosenthal, M.D., professor of clinical psychiatry at Columbia University and chair of psychiatry at St. Luke's-Roosevelt Hospital Center, New York City. In fact, he said, the presence of such comorbid conditions is the rule rather than the exception, noting that cocaine users' risk for mental disorders not related to their substance use is 11 times that of the general population.

For patients with psychotic illnesses, Dr. Rosenthal said, a new approach to treatment is a "sufficient services" model rather than a comprehensive approach, which such patients often find overwhelming. Its core is a supportive group focused on motivational enhancement, psychoeducation, and relapse prevention. Sobriety is a goal of such treatment but not a requirement, he added.

Patient-Treatment Matching: Matching patients' needs to specific treatment services through the use of standardized criteria can improve outcomes, reported David Gastfriend, M.D., director of the Addiction Research Program at Massachusetts General Hospital and a member of ASAM's Board of Directors.

ASAM developed such criteria in the 1990s to help match patients to the appropriate level of care, Dr. Gastfriend explained. For example, the ASAM Patient Placement Criteria specify that frequent cocaine users need a very intensive program of care, which may involve residential treatment. When matched according to ASAM criteria, nearly two-thirds of 240 frequent cocaine users presented for treatment, Dr. Gastfriend and his co-investigators found. But when assigned to less intensive care than deemed appropriate, only one-third showed up.

New Treatment Improvement Protocol Released

The Center for Substance Abuse Treatment has released a Treatment Improvement Protocol (TIP 39) on "Substance Abuse Treatment and Family Therapy." The TIP addresses the ways in which substance use disorders affect entire family systems and how treatment providers can use the principles of family therapy to alter the interactions among family members.

Intended for addiction treatment professionals, TIP 39 presents the models, techniques, and principles of family therapy, with special attention to motivation and the stages of change. The discussion also encompasses clinical decision-making and training, supervision, cultural considerations, special populations, funding, and research.

TIP 39 can be obtained at no cost from the National Clearinghouse for Alcohol and Drug Information (NCADI), by phoning 1-800/729-6686 or 301/468-2600. Ask for publication order number BKD504.

TAKE ACTION

Is your Representative on the caucus list yet?
If not, send a message encouraging him or her to join!

Members of the Bipartisan Addiction, Treatment, and Recovery Caucus:

ARKANSAS
Vic Snyder, 2nd
CALIFORNIA
Joe Baca, 43rd
Lois Capps, 23rd
Gary Miller, 42nd
Henry Waxman, 30th
Lynn Woolsey, 6th
COLORADO
Bob Beauprez, 7th
CONNECTICUT
Rob Simmons, 2nd
HAWAII
Neil Abercrombie, 1st
Ed Case, 2nd
IDAHO
Mike Simpson, 2nd
Illinois
Ray LaHood, 18th
INDIANA
Mark E. Souder, 3rd
MAINE
Michael Michaud, 2nd
MARYLAND
Elijah Cummings, 7th
Chris Van Hollen, 8th
MASSACHUSETTS
William Delahunt, 10th
James McGovern, 3rd
Richard E. Neal, 2nd
John Olver, 1st
MICHIGAN
Dale Kildee, 5th
MINNESOTA
James L. Oberstar, 8th
Jim Ramstad, 3rd
NEBRASKA
Lee Terry, 2nd
NEW JERSEY
Rush Holt, 12th
NEW YORK
Eliot Engel, 17th
Carolyn McCarthy, 4th
Michael R. McNulty, 21st
NORTH CAROLINA
Mike McIntyre, 7th
David Price, 4th
OHIO
Sherrod Brown, 13th
Robert W. Ney, 18th
Rob Portman, 2nd
OKLAHOMA
Tom Cole, 4th
John Sullivan, 1st
OREGON
Peter DeFazio, 4th
PENNSYLVANIA
Joseph M. Hoeffel, 13th
RHODE ISLAND
Patrick Kennedy, 1st
Jim Langevin, 2nd
TENNESSEE
Lincoln Davis, 4th
Bart Gordon, 6th
TEXAS
Gene Green, 29th
UTAH
Jim Matheson, 2nd
VIRGINIA
Eric Cantor, 7th
WASHINGTON
Brian Baird, 3rd
Jim McDermott, 7th
WEST VIRGINIA
Shelley Moore Capito, 2nd
Alan B. Mollohan, 1st
WISCONSIN
Tammy Baldwin, 2nd
Ron Kind, 3rd
Gerald D. Kleczka, 4th
PUERTO RICO
Anibal Acevedo-Villa,
Resident Commissioner
VIRGIN ISLANDS
Donna M. Christensen, Delegate

ASAM Sponsors Capitol Hill Event

An ASAM-sponsored luncheon briefing at the Rayburn House Office Building on Capitol Hill drew more than 70 people, including Congressional staff, leaders of other medical societies, ASAM Board members and members.

The purpose of the October event was to focus attention on issues pending before the Congress that affect the addiction treatment field. Presenters included Nora Volkow, M.D., Director of the National Institute on Drug Abuse; ASAM Board member David Gastfriend, M.D., who directs the Addiction Research Program at Massachusetts General Hospital, and Mark Kraus, M.D., FASAM, who chairs ASAM's Public Policy Committee.

Dr. Kraus moderated the event and discussed ASAM's role in educating Congress about the true nature of substance use disorders and the importance of federal legislation (such as the HEART Act) that responds to the needs of addiction professionals and their patients.

Congressional Addiction Caucus Off to Strong Start

A historic Congressional caucus built around the issue of addiction treatment and recovery is off to a strong start, with 54 members of the House of Representatives signed up and the group already holding briefings for lawmakers' staffers.

Rep. Jim Ramstad (R-MN), an outspoken advocate for addiction services and in recovery himself, announced the formation of the Addiction, Treatment, and Recovery Caucus during a meeting with the chairman's council of The Betty Ford Center. Ramstad described the caucus' mission as educating lawmakers on the problems of addiction and the need for expanded treatment access. Observers say that the group could address a wide range of issues, from treatment parity to discrimination to budgetary issues.

Co-chaired by Rep. Patrick Kennedy (D-RI)-another lawmaker who has spoken openly about his own struggles with addiction-the bipartisan caucus has attracted 54 members in its first few months. "It's definitely encouraging, but when you consider that one in 10 Americans have people in their families with addictions, it's not surprising," said Karin Hope, legislative aide on Rep. Ramstad's staff. Nonetheless, she acknowledged that the formation of the caucus is "a pretty big milestone" for the addiction recovery movement. "It's a statement by Congress that this is a serious problem…and we also hope it will help erase the stigma of trying to get help for this problem," she said.

Hope said the mission of the caucus is broad enough to attract members from across the political spectrum, from liberals concerned about human suffering to fiscal conservatives faced with an estimated $400 billion per year in costs related to untreated addictions. She added that the visibility and attention generated by the caucus could spur more interest in grassroots recovery advocacy, even as advocates work to get more lawmakers to join the caucus. "It's a chicken-and-egg kind of thing," she said.

Howard Shapiro, director of the State Associations of Addiction Services (SAAS), called the caucus "an important effort that may serve as a focal point for reaching members of Congress to support the resources needed to make positive changes for alcohol and other drug abuse." Everyone in the treatment and recovery field is "extremely pleased that this has come together," he added .

The caucus has held informational meetings, bringing staff from members' offices together to hear a presentation on the administration's Access to Recovery program delivered by John Walters, Director of the Office of National Drug Control Policy, as well as an overview of the Ensuring Solutions to Alcohol Problems project at the George Washington University Medical Center by project director Eric Goplerud, Ph.D.

Advocates for treatment and recovery are currently working to create a similar caucus in the Senate. *Source: JoinTogether Online [www.jointogether.org].*

Federal Report Highlights Diverging Licit, Illicit Drug Use Trends

The 2004 National Survey on Drug Use and Health, recently released by the Substance Abuse and Mental Health Services Administration (SAMHSA) shows no change in the overall rate of drug use between 2002 and 2003 and no significant change in current or past month drug use for any illicit drug monitored by the survey. However, the rate of new users of prescription drugs was disturbingly high.

Overall, more than 19.5 million Americans (8.2 percent of the population age 12 and older) were engaged in current use of an illicit drug in 2003. Almost half of all Americans have used an illicit substance (most likely marijuana) at least once in their lifetimes. By contrast, only 6.3 million Americans (or 2.7 percent of the population age 12 and older) were engaged in current non-medical use of a prescription drug. However, the rate of first-time users jumped dramatically.

Of those who reported non-medical use of a prescription agent, 4.7 million used pain relievers, 1.8 million used tranquilizers, 1.2 million used stimulants, and 0.3 million used sedatives. There was a significant increase from 2002 to 2003 in the number of persons aged 12 and older reporting lifetime non-medical use of pain relievers: from 29.6 million to 31.2 million.

ADDICTION AND TREATMENT

Some 21.6 million Americans abused or were addicted to illicit drugs or alcohol in 2003; this represents no change between 2002 and 2003. In 2003, 6.8 million persons were addicted to illicit drugs and 3.1 million were addicted to both an illicit drug and alcohol.

An estimated 3.3 million persons received some kind of addiction treatment in 2003. This represents 15 percent of the 21.6 million who were addicted to any illicit drug or alcohol.

While the number of persons dependent on illicit drugs or alcohol did not change in 2003, the number receiving treatment declined. Treatment in specialized addiction treatment programs, hospital-based programs, or mental health programs declined from 2.3 in 2002 to 1.9 million in 2003. This decrease is statistically significant and is driven by a decrease in treatment admissions among adults aged 26 or older. For more information about the survey, visit WWW.SAMHSA.GOV.

YOUTH DRUG USE

The 2003 survey shows no change in the overall rate of current illicit drug use among those aged 12 to 17 from 2002. The 2003 rate of 11.2 percent was not significantly different from the 2002 rate of 11.6 percent.

The rate of current marijuana use also was unchanged: 8.2 percent used marijuana in 2002 compared with 7.9 percent in 2003. Again, the difference is not statistically significant.

Heavy marijuana use by youth declined in 2003: The number of young people using marijuana daily or almost daily declined from 358,000 in 2002 to 282,000 in 2003. The number using marijuana 20 or more days per month declined from 603,000 in 2002 to 482,000 in 2003.

FIRST-TIME USE

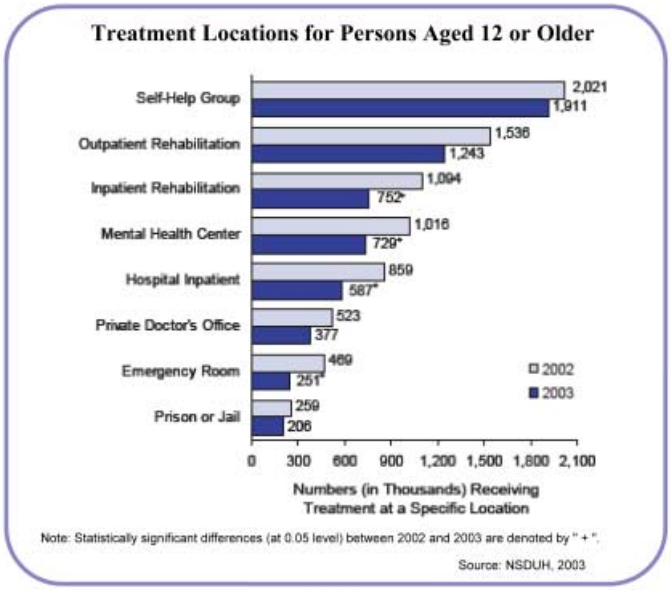
Information on first-time use is especially helpful in identifying emerging drug trends. Results of the 2003 survey suggest that the most significant emerging problems involve prescription drugs, Ecstasy, marijuana, and cocaine.

Prescription Drugs. The survey reports the largest increase in new or first-time users occurred among persons using opioid analgesics. The number of first-time users of pain relievers increased from 2 million in the decade ending in 1999 to 2.5 million from 2000 to 2002. More than half (55 percent) of the new users in 2002 were females, and more than half (56 percent) were 18 years of age or older.

Ecstasy. The number of new users of Ecstasy began to increase sharply in 1999. While the number of new users declined in 2003, that number remains the fourth highest in the past 22 years.

Marijuana. The number of new users of marijuana reached a low point in 1990, but rose each subsequent year until 1995, after which there was no consistent trend. Estimates vary between 2.4 million and 2.9 million per year.

Cocaine. The number of first-time users of cocaine is increasing. In fact, the number of new users each year since 2000 exceeds any annual estimate for the previous decade. While the number of new users is not large — over 1 million each year-it compares with estimates during the late 1970s, when the last cocaine epidemic began. Given the level of illness and death caused by cocaine, this trend bears close scrutiny.



QUICK FACTS About Drug Trends

- *An estimated 19.5 million Americans aged 12 and older used illicit drugs in 2003.*
- *Almost half of all Americans have tried an illicit drug at least once in their lifetime.*
- *The rate of illicit drug use among youth was 11.2 percent.*
- *The number of persons treated in specialized addiction treatment programs declined from 2.3 million in 2002 to 1.9 million in 2003.*
- *When asked why they don't seek treatment, the reason most often given by adults is cost or insurance barriers.*

Ruth Fox Memorial Endowment Fund

Dr. Ruth Fox

Dear Colleagues:

We are pleased to report that the Fund has received a number of excellent applications for the 2005 Ruth Fox Scholarship Program. Since 2002, when the Scholarship program was established, we have sponsored 20 physicians-in-training to attend ASAM's Annual Medical-Scientific Conference and Ruth Fox Course for Physicians, and we look forward to hosting another group of physicians-in-training in Dallas at the 2005 Medical-Scientific Conference. Please make a point of greeting these outstanding young physicians at the Ruth Fox Donor Reception, which will be held on Friday evening, April 15, 2005. As in past years, the Fund is grateful to long-time benefactor Joseph S. Dorsey, M.D., FASAM, and Mrs. Dorsey, for their gracious gift of funds to underwrite the event. Please make a point of acknowledging their generosity when you greet them at the Reception.

Invitations to the reception are extended only to Ruth Fox donors, so if you have not already contributed or pledged to the Endowment Fund, please do so now. 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.

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

ASAM Staff

Except where noted below, ASAM staff can be reached by phone at **301/656-3920**, or by fax at **301/656-3815**.

Eileen McGrath, J.D.
Exec. Vice President/CEO
EMCGRATH@ASAM.ORG

Berit Boegli
Conferences & Meetings Asst.
BBOEG@ASAM.ORG

Nancy Brighindi
Dir. of Membership &
Chapter Development
NBRIG@ASAM.ORG

Ruby Bailey Edmondson
Office Mgr./Receptionist
RBAIL@ASAM.ORG

Valerie Foote
Data Entry Operator
VFOOT@ASAM.ORG

Joanne Gartenmann
Exec. Assistant to the EVP
JGART@ASAM.ORG

Tracy Gartenmann
Confs. & Meetings Asst. Consult.
TGART@ASAM.ORG

Alexis Geier
Government
Relations Assistant
AGEIER@ASAM.ORG

Gionne Graetz
Confs. & Meetings Asst. Consult.
GGRAETZ@ASAM.ORG

Alexis Geier Horan
Membership Asst.
AGEIER@ASAM.ORG

Amy Hotaling
Member & Chapter
Development Manager
AHOTA@ASAM.ORG

Lynda Jones
Director of Finance
LJONE@ASAM.ORG

Sandra Metcalfe
Acting Dir., Conferences
& Meetings
SMETC@ASAM.ORG

Claire Osman
Director of Development
Phone: 1-800/257-6776
Fax: 718/275-7666
ASAMCLAIRE@AOL.COM

Noushin Shariate
Accounts Payable
NSHAR@ASAM.ORG

Christopher Weirs
Dir. of Credentialing/IT Mgr.
CWEIR@ASAM.ORG

NOTE NEW ADDRESS!
Bonnie B. Wilford
Editor, ASAM News
29261 Pin Oak Way
Easton, MD 21601-4631
Phone: 410/770-4866
Fax: 410/770-4711
BBWILFORD@AOL.COM

COMMENTARY:
Purchasers Must Be Engaged in Parity Discussions

Carol Girard

Blame for the limits on health-insurance coverage for substance use is often laid at the feet of insurers and managed care firms. But while these entities are no innocents, it is important to remember that purchasers have a huge voice and choice in the design of group health plans offered to employees.

The basis of all insurance coverage is a contract-a legally binding set of terms agreed upon by two parties. In this case, the parties are the health plans or insurers and the purchasers — employers, unions, or associations. Individual members of a group are not parties to the contract; they only get a health insurance certificate and/or summary plan description detailing their health coverage.

Private health plans-no matter the form-are businesses, not charities. Coverage is not determined by whether insurers (or the public) believe something should be covered. It is determined by what is agreed upon by the two parties to the contract. Coverage can be changed, but the purchaser must negotiate it and pay for those services.

Coverage for substance abuse treatment was abysmal for a long time before managed care came along. Since the 1950s and 1960s, when coverage for alcohol and drug problems began getting tacked onto existing health insurance policies, there have been extreme limits on the number of outpatient visits that were covered, serious calendar-year and lifetime dollar limits on benefits, and higher co-payments for addiction treatment. Some older plans even had separate deductibles for this chronic health problem.

Because the addiction treatment system is not thoroughly integrated into the larger health care system, coverage for people with alcohol and other drug problems continues to be held separate and handled differently than that of other chronic illnesses. Some of the old stereotypes about both psychiatric and substance abuse care have continued in newly designed managed-care plans-the belief that people can "will" themselves to better health, and that they shouldn't need too many encounters with a professional to do it.

Pressure from purchasers can drive the design of all types of products, and health coverage is no exception. Managed care came into existence because the costs of all health-care services were skyrocketing, and because so many providers of all types of services took advantage of generous payments that the system became too expensive. Employers, unions, and associations told insurers to curb costs or they'd take their business elsewhere.

When the pendulum swung too far back towards restrictions on coverage, patients and families who had difficulty with managed-care plans were sometimes able to influence employers to re-think some of their decisions. The press got involved in reporting on the plans that had set up serious barriers to necessary treatment. The long-term result was that most managed care plans relaxed some of their most egregious requirements.

Health care coverage is complex and can be difficult to navigate. The relegation of treatment and coverage for substance abuse problems to subcontractors may make the process even more difficult. But if enough employers can be educated on the link between treatment for addiction and lower costs for treatment of other chronic diseases and traumatic injuries, and if enough brokers understand the importance of treatment for substance-use disorders in keeping other health and disability costs down, they will start demanding appropriate coverage on par with coverage for other diseases.

It remains important to push for parity through legislation and through pressure on the companies hired to administer plans. But it is equally important to bring those who decide which plans to buy and offer to their constituents into the conversation. Purchasers need to be educated about the importance of parity coverage, and should be encouraged to discuss costs — and benefits — with health plans during their negotiations.

CAROL GIRARD is manager of Join Together's Demand Treatment! Project at the Boston University School of Public Health.

*Printed courtesy of **Join Together Online**.*

ASAM Conference Calendar

ASAM

March 18-20, 2005
ASAM Medical Review Officer (MRO) Training Course
Marina del Rey, CA
18 Category 1 CME credits

April 12, 2005
Buprenorphine & Office-Based Treatment of Opioid Dependence
Washington, DC
8 Category 1 CME credits

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

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

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

April 17, 2005
Buprenorphine & Office-Based Treatment of Opioid Dependence
Hyatt Regency Hotel
Dallas, Texas
8 Category 1 CME credits

OTHER EVENTS OF NOTE

January 29-30, 2005
New York Society of Addiction Medicine
2nd Annual Conference
"Diversity, Addiction and Recovery"
New York City
(co-sponsored by Albert Einstein College of Medicine)
9 Category 1 CME credits
[For information, phone 518/689-0142]

March 3-4, 2005
Washington Society of Addiction Medicine
7th Annual Conference
"Fundamentals of Addiction Medicine"
Seattle, WA
(co-sponsored by Providence-Everett Medical Center)
15 Category 1 CME credits
[For information, phone 425/261-3691]

March 28-30, 2005
ASAM Region X Conference on Addictions
Kissimmee, FL
(hosted by the Florida Society of Addiction Medicine)
[For information, e-mail FSAM.ASAM@USA.NET]

Register for ASAM's 2005 Med-Sci Conference *TODAY!*
Phone **301/656-3920**
or email **Email @asam.org**

BUPRENORPHINE TRAINING

(The following courses are approved for 8 Category 1 CME credits)

March 19, 2005
Madison, WI
ASAM – WisSAM
Contact: www.DocOptIn.com
or 888/362-6784

April 15, 2005
San Francisco, CA
ASAM – CSAM
Contact: www.DocOptIn.com
or 888/362-6784

April 17, 2005
Dallas, TX
ASAM
Contact: www.DocOptIn.com
or 888/362-6784

April 29-30, 2005
Columbus, OH
ASAM – CWRU School of Medicine
Contact: Case Western Reserve University
at 216/368-2408

May 14, 2005
New Orleans, LA
ASAM – LSAM
Contact: www.DocOptIn.com
or 888/362-6784

May 21, 2005
Portland, ME
ASAM - Region III
Contact: www.DocOptIn.com
or 888/362-6784

June 4, 2005
Cincinnati, OH
ASAM
Contact: www.DocOptIn.com
or 888/362-6784

June 18, 2005
Chicago, IL
ASAM – ISAM
Contact: www.DocOptIn.com
or 888/362-6784

August 6, 2005
St. Louis, MO
ASAM
Contact: www.DocOptIn.com
or 888/362-6784

September 9, 2005
San Antonio, TX
AOAAM – ASAM – Region VII
Contact: www.DocOptIn.com
or 888/362-6784

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.