Summer 2005
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ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

ASAM at Work for You:

Also see:

Plan to attend ASAM's State of the Art Course in Washington, DC, October 27-29, 2005

www.asam.org

ASAM's Course on the State of the Art in Addiction Medicine To Meet October 27-29 in Washington, DC

ASAM's 2005 Course on the State of the Art in Addiction Medicine, which focuses on cutting-edge developments and their implications for clinical practice, has been scheduled for October 27-29, 2005, at the Hyatt Regency Capitol Hill Hotel in Washington, DC. The course is accompanied by a Buprenorphine Training Course on Sunday, October 30th at the same hotel.

Co-chaired by Shannon C. Miller, M.D., CMRO, FASAM, and Martha J. Wunsch, M.D., FAAP, the course is designed to meet the needs of several audiences: (1) addiction specialists who seek an update on recent developments in addiction research and practice; (2) researchers; (3) educators who are tasked with translating science to services, and (3) physicians, nurses, counselors and others who seek a succinct review of the latest knowledge about the causes, identification, and management of addictive disorders.

To register for the State of the Art 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 course should be emailed to SOACOURSE@AOL.COM. (For more information, see pages 20-21.)

Federally Funded Studies Support Use of ASAM Patient Placement Criteria

A series of studies published in a recent issue of the *Journal of Addictive Diseases* examines ASAM's Patient Placement Criteria. The reports agree that use of the ASAM Criteria to match patients to treatment services and modalities is associated with reduced morbidity, better post-treatment outcomes, and lower overall service utilization. ASAM Board member David R. Gastfriend, M.D., served as editor of the special issue, titled "Addiction Treatment Matching: Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria."

The research studies — all conducted by independent investigators with funding from the National Institute on Drug Abuse — include: "Determining Service Variations Between and Within ASAM Levels of Care"; "Impact of Patient Placement Criteria on Substance Abuse Treatment Under the Oregon Health Plan"; "Reliability of Multidimensional Substance Abuse Treatment Matching: Implementing the ASAM Patient Placement Criteria"; "Development of Service Intensity Criteria and Program Categories for Individuals with Co-Occurring Disorders"; "Feasibility of Multidimensional Substance Abuse Treatment Matching: Automating the ASAM Patient Placement Criteria"; and "Predictive Validity of the ASAM Patient Placement Criteria for Naturalistically Matched vs. Mismatched Alcoholism Patients."

Editors of the current edition, titled the *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised* (ASAM PPC-2R) are David Mee-Lee, M.D., Gerald Shulman, M.S., FACATA, David R. Gastfriend, M.D., Marc Fishman, M.D., and Julia H. Griffith, M.S.

As a next step, ASAM is embarked on creating a series of supplements to the Criteria to address the use of pharmacotherapies in addiction treatment. The first volume in the series, on pharmacologic therapies for alcoholism, is expected to be published in 2006.

Eileen McGrath, J.D.

Support H.R. 1402 to Achieve Addiction Parity

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

This is one of those moments when every member of ASAM has a chance to make a difference. Please contact your member of Congress and urge him or her to co-sponsor H.R. 1402, "The Senator Paul Wellstone Mental Health Equitable Treatment Act of 2005." H.R. 1402 is identical to H.R. 953, introduced in the 108th Congress, except that unlike last year's version, H.R. 1402 also covers treatment for addictive disorders.

You will find useful information to share with your Representative in the following letter, which Representatives Patrick Kennedy (D-RI), Jim Ramstad (R-MN), John Sullivan (R-OK), and Grace Napolitano (D-CA) recently sent to their Congressional colleagues, and in the legislative analysis that follows.

We Cannot Afford to Leave Brain Disorders Untreated

Dear Colleague:

We Members of Congress have health care plans that fully cover diseases of the brain. Most of our constituents are not so lucky. Most private sector plans provide full coverage of some brain disorders (such as Parkinson's disease, stroke) but have strict limits on coverage for many others (such as schizophrenia, depression, bipolar disorder, or alcoholism). This shortsighted approach to health coverage costs families, businesses, and society:

- **Lost Productivity.** Behavioral brain disorders account for more than one in five lost days of productive life through disability and premature death, exceeding heart disease, cancer, and all others. (WHO) Businesses lose an estimated $31 billion annually in lost productivity from depression alone. This figure does not include health care or disability costs. (Stewart et al., JAMA, 2003)
- **Suicide.** There are nearly two suicides for every homicide in the U.S. More than 25 kids and young adults take their own lives daily, making it the third-leading cause of death for people from age 10 to 34. (CDC)
- **Preventable Crime.** In 2003, 68% of women and 67% of men tested positive at the time of their arrests for crack, powder cocaine, heroin, marijuana, or methamphetamines. (NIDA)
- **Broken Families.** In 2001, 12,700 children with serious brain disorders from 19 states were taken from their parents and put in state custody as a condition of accessing needed care; the national total would be much higher. (GAO)
- **Lost opportunities.** Only 40% of students in special education for behavioral disorders graduate. (Dept. of Education)
- **Cost Shifting.** Public spending for mental health has increased from 57% of all mental health spending in 1991 to 63% in 2001; public substance abuse spending increased from 62% to 76% during that period. (Mark et al., Health Affairs, 2005)

"H.R. 1402 eliminates the archaic disparities in health coverage for mental illnesses and addiction to help mitigate these enormous costs. A new HHS study of the Federal Employee Health Benefit Program [FEHBP], which instituted full inclusion of these brain disorders in 2001, has concluded that 'the parity policy was implemented as intended with little or no significant adverse impact on access, spending, or quality, while providing users of MH/SA [mental health/substance abuse] care improved financial protection in most instances'."

"The experience of the FEHBP, like that of every state with a parity law, has a clear lesson: it is not the treatment of brain disorders that is expensive; it is our failure to treat them. We encourage you to cosponsor H.R. 1402 and give our constituents the same coverage we and our families enjoy…."

Sincerely, [signed]

Jim Ramstad, M.C. Patrick J. Kennedy, M.C. John Sullivan, M.C. Grace Napolitano, M.C.

*See **PROVISIONS OF H.R. 1402** on page 4*

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

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For members visiting ASAM's web site (WWW.ASAM.ORG), entrance to the on-line Membership Directory requires the Username "asam" and the password "asam" (in lower case letters).

Supreme Court Strikes Down State "Medical Marijuana" Laws

In a decision announced in June, the U.S. Supreme Court found that state laws cannot protect "medical marijuana" users from being prosecuted by the federal government. The high court ruled 6-3 against medical marijuana advocates from California, who argued that state residents should have the right to grow and use marijuana for medical use without fear of federal prosecution.

The case was framed as a states' rights issue, with marijuana supporters saying that state law should trump federal law as long as no crime is committed across state lines. The commerce clause of the Constitution is intended to limit the federal government's power over state issues to instances where interstate commerce is involved.

The majority opinion, written by Justice John Paul Stevens, suggested that the issue should be settled in Congress. Voters and lawmakers in California, Alaska, Colorado, Hawaii, Maine, Montana, Nevada, Oregon, Vermont and Washington already have voted to approve medical marijuana use.

The dissent, by Justice Sandra Day O'Connor, said that the state laws should triumph over federal interest on this issue. "The states' core police powers have always included authority to define criminal law and to protect the health, safety, and welfare of their citizens," said O'Connor, who added that the court was wrong in "making it a federal crime to grow small amounts of marijuana in one's own home for one's own medicinal use."

John Walters, Director of the Office of National Drug Control Policy (ONDCP), hailed the decision as marking "the end of medical marijuana as a political issue. Our Nation has the highest standards and most sophisticated institutions in the world for determining the safety and effectiveness of medication. Our national medical system relies on proven scientific research, not popular opinion…. For years, pro-drug groups seeking the legalization of marijuana and other drugs have preyed on the compassion of Americans to promote their political agenda and bypass FDA's rigorous standards, which have safeguarded our medical supply for over 100 years. Marinol — the synthetic form of THC and the psychoactive ingredient contained in marijuana — is already legally available for prescription by physicians whose patients suffer from pain and chronic illness."

Emergency Patients with Untreated Addictions Use More Services

Emergency department patients whose alcohol or drug problems are not appropriate addressed ultimately incur higher costs for hospital and emergency services than other patients, a new study has found. According to the authors of "Unmet Substance Abuse Treatment Need, Health Services Utilization, and Cost: A Population-Based Emergency Department Study," emergency patients with unmet treatment needs are 81 percent more likely to be admitted during their emergency visit and 46 percent more likely to have reported making at least one emergency department visit in the preceding 12 months.

Ian Rockett, Ph.D., and colleagues at the West Virginia University Department of Community Medicine and Center for Rural Emergency Medicine focused on emergency department patients in Tennessee, where less than 10 percent of patients needing addiction treatment were currently receiving it. They found that patients with unmet addiction treatment needs received emergency medical services totaling $777.2 million in extra hospital charges in 2000, which translates to an additional $1,568 for each emergency patient with an addiction problem that was not addressed.

Based on their findings, the researchers predict that systematically addressing substance use disorders in emergency departments "would produce major savings in time, resources, and costs," Dr. Rockett said, adding: "In exacerbating the workloads of very busy hospital staff, emergency patients with unmet substance abuse treatment need add many millions of dollars to annual health care costs. Our research findings speak to the importance of identifying them as substance abusers — either for a brief intervention or to refer them to substance abuse treatment, as appropriate. The emergency department visit itself can represent a teachable moment for a patient."

Source: Online edition of Annals of Emergency Medicine.

Settlement Talks Under Way in Tobacco Case

U.S. District Court Judge Gladys Kessler is pushing for a settlement in the government's racketeering case against the tobacco industry, the Los Angeles Times reported June 18th. Judge Kessler called in tobacco industry leaders for a meeting in hopes of crafting a settlement in the case, which has entered its 9th month. John Coffee, a Columbia University legal expert, told the *Times* that "The only reason you would bring a chief executive in at this point in this case is to try to cajole, induce and intimidate them into a settlement. It is not unusual for judges to call in senior representatives of both sides, try to knock heads together and force them to negotiate a settlement."

Experts say there is a good chance that Kessler will rule that the industry violated the RICO racketeering law by deceiving the public about the risks of smoking. But rulings by other courts have restricted the range of punishments available in the case, and the government recently slashed its own demands for industry fines for the alleged RICO violations from $130 billion to $14 billion. In their closing argument, Justice Department lawyers asked that the judge require the tobacco industry to spend $10 billion on a five-year, nationwide smoking prevention program, plus $4 billion to fund a 10-year tobacco education program.

Legal observers say that by reducing its demand, the Justice Department may have set the stage for a settlement. "I'm confident you will not see a verdict in this case," said one source with ties to the Justice Department trial team, who said the lower demand was intended to help negotiators "reach a number that is not too politically offensive."

However, the tactic has sparked outrage among public health organizations and anti-tobacco advocates (see the related commentary on page 7). As a result, a group of health organizations — including the American Cancer Society, the American Heart Association, the American Lung Association, Americans for Nonsmokers' Rights, the National African American Tobacco Prevention Network and the Tobacco-FreeKids Action Fund — is petitioning the court to become a party to the lawsuit. Arguing that the government's actions indicate that "the interests represented by the proposed interveners are no longer being adequately represented," the groups are seeking standing with the court to press the case for stronger remedies to prevent the tobacco industry from continuing to misrepresent the dangers of smoking and marketing to children.

Dr. Howell Assumes ASAM's Presidency

Elizabeth F. Howell, M.D., FASAM, assumed the office of ASAM President during the Society's 2005 Medical-Scientific Conference in Dallas. She will serve a two-year term in that post.

Dr. Howell was State Alcohol and Drug Abuse Director for the Georgia Department of Human Resources from July 1997 through December 1999, and until her recent move to New Mexico was Medical Director of Atlanta West Intake and Treatment Center (an outpatient methadone maintenance and drug-free treatment program). She also has served as Director of the Addictive Disorders Unit inpatient services at Emory University Hospital, Instructor in Psychiatry at the Medical University of South Carolina, and Assistant Medical Director of Fenwick Hall Hospital in Charleston, SC.

Dr. Elizabeth Howell

In addition, Dr. Howell was appointed Clinical Assistant Professor in the Department of Psychiatry and Behavioral Sciences of Emory University School of Medicine. She also has been engaged in the private practice of General Psychiatry, Addiction Medicine and Addiction Psychiatry; and is a consultant to private and public programs and agencies throughout the U.S.

Dr. Howell is a founding member of the Georgia Society of Addiction Medicine, which she also served as Secretary-Treasurer (1989-1991) and President (1991-1993). She has been a member of ASAM since 1985; a member of the Certification Council; the Fellowship Committee; the Constitution & Bylaws, Nominating & Awards, and Examination Committees. She has been a member of the Editorial Board for Principles of Addiction Medicine; Chair of the Communications Section and Publications Council; Deputy Co-Chair of the Strategic Planning Task Force; and Treasurer of ASAM.

Dr. Howell is a Fellow of the American Psychiatric Association and a member of the American Medical Association, the American Academy of Addiction Psychiatry, and the Georgia Association for the Prevention and Treatment of Substance Abuse. She also serves on the board of the Mission New Hope community substance abuse coalition.

She was board-certified in Psychiatry in 1985 and earned a CAQ in Addiction Psychiatry in 1993. She was certified by ASAM in 1986, recertified in 1996, and subsequently elected a Fellow of ASAM.

Asked her greatest contribution to the field of addiction medicine, Dr. Howell said, "I have been committed to providing excellent addiction care; educating residents, fellows, other physicians, medical students, and others about addiction medicine; working with medical boards; communicating hopefulness about recovery and respect for addicted patients; mainstreaming addiction medicine; and improving care for all who need it." She added, "I am excited about and committed to the mission and goals of ASAM. . . I enjoy working with stimulating colleagues, and have many ideas about how to strengthen and grow our organization."

Dr. Howell succeeds ASAM's longest serving President, Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, who will continue to serve the Society as Immediate Past President.

PROVISIONS OF H.R. 1402 continued from page 2

PROVISIONS OF THE SENATOR PAUL WELLSTONE MENTAL HEALTH EQUITABLE TREATMENT ACT OF 2005 (H.R. 1402)

Introduced by Reps. Patrick Kennedy and Jim Ramstad

Equal Coverage for All Brain Disorders

- Expands the Mental Health Parity Act of 1996 (MHPA) to prohibit a covered group health plan from imposing treatment limitations or financial requirements on mental health and chemical dependency treatment benefits that differ from limitations on medical and surgical benefits.
- The Act only applies to group health plans that opt to provide mental health benefits and is modeled after the mental health benefits provided through the Federal Employees Health Benefits Program (FEHBP).
- Provides full parity for mental health conditions listed in the latest version of the Diagnostic and Statistical Manual of Mental Disorders, the industry standard diagnostic manual used by Medicare, Medicaid, the FEHBP, the FDA, the legal system, and 13 states' parity laws.

Requirements and Exemptions

- Coverage is contingent on the diagnosis being included in an authorized treatment plan that is in accordance with standard protocols and meets medical necessity criteria.
- There is a small business exemption for companies with 50 or fewer employees.

Costs and Cost Offsets

- A new study of the FEHBP program has shown that access to care improved and costs were negligible.
- Research shows that better mental health care results in savings to businesses in the form of lower absenteeism and higher productivity. According to the World Health Organization over one-fifth of lost days of productivity are the result of mental and addictive disorders.
- Every credible study of states experiences with mental health parity have shown that mental health costs rise minimally or fall after the implementation of parity, as people have greater access to less expensive forms of treatment.

The Need for Parity

- The Surgeon General has estimated that roughly 20 percent of the U.S. population has a diagnosable mental disorder in any given year, but only one in three receives treatment.
- Untreated depression costs American businesses $70 billion each year in lost productivity and worker absenteeism according to the Wall Street Journal; NIMH has found the U.S. loses $180 billion per year due to all mental illness.
- The GAO reports that 87 percent of health plans routinely force patients to pay more for mental health care than other health care, put stricter limits on mental health treatment than on other health treatment, or both.

Please do your part to support parity for addiction treatment. Your active participation is vital to the success of this effort!

Dr. Raju Hajela

Region IX (International) Certification Update

Raju Hajela, M.D., M.P.H., CCSAM, FASAM, FCFP

Region IX currently has 187 members from 27 different countries. This includes 143 from Canada, 4 from Australia, 4 from Iceland, 4 from Japan, and 3 from Brazil. Of this group, 121 were certified by ASAM (CASAM) between 1986 and 2002. I am pleased to report that an additional 27 Canadians passed the 2004 ASAM Certification Examination, bringing the number for Region IX to 148, of whom 140 are Canadian. An additional 11 Canadians have recertified (including the author).

Since 2000, 7 Canadians have successfully completed the ASAM Certification Exam after becoming eligible through the practice evaluation route established by the Canadian Society of Addiction Medicine (C*SAM). Most recently, Dr. Wilna Wildenboer-Williams of Saskatchewan did so, thus becoming the 37th Certificant of C*SAM, having been successful in the 2004 ASAM Certification Exam. Congratulations are due Dr. Wildenboer-Williams and the six previous candidates: Drs. Michael Lester and David Marsh in 2000 and Drs. Morag Fisher, Bonnie Madonik, Wendy Tolmie and Ross Wheeler in 2002. All of these members also will receive ASAM certification, per our agreement with the ASAM Board of Directors.

Congratulations also go to the following Canadians who passed the 2004 ASAM Certification Exam: Drs. Hussein Alhumaid (AB), Pauline Armour (ON), Chris Cavacuiti (ON), Karen Clements (ON), Sharon Cirone (ON), Nathan Frank (ON), Gary Horvath (BC), Gary Horvath (BC), Crain Kuhn (ON), Jan Malat (ON), Charles MacKay (QC), Ian Martin (BC), Tania Nordli (AB), Jon Novick (ON), Anthony Ocana (BC), Gary Richardson (BC), Todd Sakakibara (BC), Nader Sharifi (BC), Conrad Sichler (ON), Jose Maria Alves Silveira (ON), Anita Srivastava (ON), Ray Steinman (ON), Pamela Stewart (ON), Vera Tarman (ON), Harry Vedelago (ON), and Melanie Willows (ON).

All C*SAM members who are certified by ASAM are encouraged to seek their C*SAM certification as well. Certification adds to the credibility of, and gives a stronger voice to, Addiction Medicine in Canada. I hope the number of physicians with C*SAM certification will exceed 50 by the time of the C*SAM annual meeting in Vancouver in 2005 October.

Finally, I would like to take this opportunity to thank the members of Region IX for electing me to this position. I hope to hear from you regarding any matters related to your membership in ASAM and/or any collegial assistance I may be able to provide.

Dr. Hajela represents Region IX as a member of the ASAM Board of Directors. He can be reached at RAJUHAJELA@HOTMAIL.COM.

WHO Adds Methadone, Buprenorphine to List of Essential Medicines

A high-level official of the World Health Organization (WHO) has notified ASAM that methadone and buprenorphine have been added to the WHO Model List of Essential Medicines. In his letter, Vladimir Poznyak, M.D., Ph.D., explained that the change was recommended in a report by a WHO Expert Committee and approved in June.

Dr. Poznyak, who heads the WHO Department of Mental Health and Substance Abuse, thanked ASAM and other collaborating organizations for their help with the process, which included submitting background papers for use by the Expert Panel. Dr. Poznyak noted that the listing of methadone and buprenorphine inaugurated a new section in the WHO Model List of Essential Medicines, explicitly for medications used in the treatment of addiction. He suggested that this innovation represents "an opening for other medicines used for treatment of substance dependence." For additional information, consult the WHO website at HTTP://WWW.WHO.INT/SUBSTANCE_ABUSE/

CSAT Offers Risk Management Courses

The Center for Substance Abuse Treatment (CSAT) is offering a series of innovative training programs for medical directors, clinical staff and treatment program administrators. "Managing Individual and Program Liability Risk" will be offered regionally four times in 2005.

Sponsored by CSAT's Division of Pharmacologic Therapies, the workshops focus on recent developments in clinical and legal areas that affect the care of opioid treatment patients-particularly those with co-occurring medical and psychiatric disorders. In addition to a review of recent court decisions that pose new liability risks for treatment programs and their staffs, the workshops will review strategies for use of accreditation as a tool to minimize risk, balancing Federal confidentiality requirements with increasing pressures to report to prescription monitoring systems, managing referrals to other service providers, preventing accidental poisonings of children by preventing their access to adults' treatment medications, and distinguishing between the program's responsibility and legal liability for patients' actions.

There is no fee to register for the workshops; however, capacity is limited and advance registration is required. For information on upcoming dates and locations, contact Janeane Gibbs by phone at 240/645-4851 or by email at JGIBBS@JBS.BIZ.

SAMHSA Issues Guide to Licensing and Certification

This volume contains a national overview of state-by-state information on licensing, certification, and credentialing standards for alcohol and drug treatment facilities and programs, as well as those for counselors and prevention professionals. It reviews each state's substance abuse facility and program approval process, including steps in the application process, fees charged, types of treatment services approved by the state, and national accreditations accepted in lieu of state accreditation.

The volume is available at no charge from SAMHSA's National Clearinghouse on Alcohol and Drug Information (NCADI) at 11420 Rockville Pike, Rockville, MD 20852, or by phone at 1-800/729-6686, or on NCADI's website at HTTP://STORE.HEALTH.ORG/CATALOG/.

New Journal Focuses on Opioid Prescribing

At a time when physicians' use of opioids for analgesia is under increasing scrutiny, *The Journal of Opioid Management* has been launched to address the appropriate and adequate prescription of opioids.

Under Editor-in-Chief Robert E. Enck, M.D., the journal will cover topics such as opioid types, dosages, routes, and intervals; patient expectations and reactions to opioid treatment; "seven sins" that physicians commit when prescribing opioids; the use of adjuvant analgesics; legal and ethical issues; the ongoing regulatory environment; and addiction to opioid analgesics. Dr. Enck adds that the new bimonthly publication will address all aspects of the safe use and management of opioids. "There is a clear need for education in the use and abuse of opioids in clinical practice," said Dr. Enck, who also edits the *American Journal of Hospice and Palliative Medicine*. "The difference between tolerance, physical dependence, and addiction is frequently misunderstood." The journal also has a team of defense and prosecution attorneys available to discuss the legal aspects of opioid use.

Subscription information is available from *The Journal of Opioid Management*, 470 Boston Post Road, Weston, MA 02493; by phone at 781/899-2702, or on the journal's website at WWW.OPIOIDMANAGEMENT.COM.

"Know Your Rights" Brochure Published

The Center for Substance Abuse Treatment and the Legal Action Center collaborated to develop this brochure, which is designed to help persons in recovery know their rights under Federal laws that protect against discrimination. The brochure also outlines the legal consequences of alcohol- and drug-related conduct that can limit their rights, as well as what individuals in treatment or recovery can do to prevent or remedy violations to their rights and overcome barriers that result from current or past drug- or alcohol-related conduct.

The brochure is available at no charge from SAMHSA's National Clearinghouse on Alcohol and Drug Information (NCADI) at 11420 Rockville Pike, Rockville, MD 20852, or by phone at 1-800/729-6686, or on NCADI's website at HTTP://STORE.HEALTH.ORG/CATALOG/.

Directory of Addiction Study Programs Published

A new directory lists institutions that offer certificate, bachelor's, master's and/or doctoral degrees in substance use disorders, as well as those with related programs that offer a concentration, specialty or minor in the addictions.

Data for the directory were compiled by the Addiction Technology Transfer Center National Office, using information provided by the National Association of Alcohol and Drug Abuse Counselors (NAADAC), the Peterson's Guide, the International Consortium for Addiction Studies Educators (INCASE), and the ATTC Regional Centers.

Published in 2004, the directory can be obtained from the Addiction Technology Transfer Center National Office (NATTC), 5100 Rockhill Road. Kansas City, MO 64110-2481, or by phone at 816/482-1100, or via the NATTC website at WWW.NATTC.ORG/RESPUBS/PUBCAT/.

Untangling the Web: A Guide for Treatment Programs

This guide helps readers

(1) determine the benefits of getting their treatment program or other agency online,

(2) make good decisions when buying computer equipment,

(3) ask informed questions when choosing vendors, and

(4) locate the best online resources for treatment professionals and clients in recovery.

The guide is available from the Addiction Technology Transfer Center National Office (NATTC), 5100 Rockhill Road. Kansas City, MO 64110-2481, or by phone at 816/482-1100, or via the NATTC website at WWW.NATTC.ORG/RESPUBS/PUBCAT/.

JOIN TOGETHER
to advance effective alcohol and drug policy, prevention, and treatment

Addiction Leaders Urged to Protest the Proposed Tobacco Settlement

Dear Colleague:

The *Los Angeles Times* [recently reported]… that the [Department of Justice] lawyers representing the people of the United States in the fraud trial against the tobacco industry were forced to reduce their demands "by higher level, politically appointed officials of the Justice Department." The change in the government's demands was so abrupt that even the tobacco industry's lead lawyer was quoted in the *Washington Post* as saying, "We were very surprised. They've gone down from $130 billion to $10 billion without any explanation."

Complex cases like this often settle by agreement between the parties before a final ruling from the judge. The government's sudden change in court may be a signal that it is getting ready to settle the case with no finding of liability against the tobacco industry and only small voluntary corrective actions by the industry.

If this happens, the decades of struggle to improve the health of the American people by getting them to stop or never start smoking may end in partial failure. More than 45 million people in this country still smoke and 440,000 die from smoking related causes every year. Thousands of teens are still getting lured by the industry into tobacco dependence to replace those who die.

I urge all of our readers to send a loud and clear message to senior political leaders: we are watching and we want the strongest possible public health remedies to prevent and end smoking paid for by the industry — not a weak, politically motivated settlement that favors the tobacco industry. Please use the following links to send your personal message now. Thank you.

Sincerely,

David Rosenbloom
Director, Join Together
Boston University School of Public Health

CONTACT:

President George W. Bush: PRESIDENT@WHITEHOUSE.GOV

Attorney General Alberto Gonzalez: ASKDOJ@USDOJ.GOV.

Your Senators: Go to WWW.SENATE.GOV

Your Member of Congress: Go to WWW.HOUSE.GOV.

President's FY 2006 Drug Control Budget Shifts Funds Away from Treatment, Prevention

The Bush administration's proposed budget of $12.4 billion for drug control for FY 2006 signals major changes in federal drug control policy. While the Administration's FY 2006 request of $12.4 billion represents a 2.2 percent increase over the FY 2005 level, and the proposed budget increases funding for supply reduction activities, it also proposes an overall cut in funding for demand reduction programs. It also would reduce or eliminate certain state and local law enforcement programs and shift more of the responsibility and cost of domestic drug control activities to state and local governments.

The $4.8 billion proposed to fund demand reduction activities in FY 2006 represents a decline of about $270 million from the level appropriated by Congress for FY 2005.

The FY 2006 request also changes the ratio of spending for demand reduction versus supply reduction. As reported to Congress by the Office of National Drug Control Policy, in the FY 2005 drug control budget, the Administration requested 55 percent for supply reduction and 45 percent for demand reduction. This year's proposed budget requests 61 percent for supply reduction and only 39 percent for demand reduction.

SHIFT IN RESPONSIBILITIES

Reductions in substance abuse and its damaging consequences are not solely the responsibility of the federal government. Achievement of national strategy goals requires that the federal government work in partnership with state and local governments, private entities, and individuals. The FY 2006 budget signals a shift in the relationship between the federal government and its other partners. For example, in the FY 2006 budget, the federal government assumes greater responsibility for programs exclusively under its purview — international and border control programs — and reduces funding to state and local governments for prevention and law enforcement.

The elimination of state grants for school-based prevention, the changes to the High-Intensity Drug Trafficking Areas (HIDTA) program, and other reductions in discretionary programs redefine the federal government's role and likely will require state and local governments to assume greater fiscal responsibility for solutions to drug use and trafficking problems.

DRUG TREATMENT REDUCED

The budget proposes to increase fundng for criminal justice-based drug treatment and for the President's Access to Treatment voucher initiative. In the criminal justice area, the budget requests an increase from $19.5 million to $44.1 million for the Residential Substance Abuse Treatment Program, which funds treatment in correctional and detention facilities, and an increase from $40 million to $70.1 million for drug courts.

The budget proposes to increase funds for the Access to Recovery (ATR) voucher program by $51 million, to $150 million. Meanwhile, the budget requests level funding at $1.7 billion for the Substance Abuse Block Grant program, which is the cornerstone of the nation's substance abuse treatment system. Overall, funding for the Center for Substance Abuse Treatment (CSAT) would increase as a result of the requested increase for the Access to Recovery program, but funding for CSAT's other Programs of Regional and National Significance would be reduced by $26 million, with "Best Practices" discretionary grants particularly hard hit.

PREVENTION ACTIVITIES CUT

Prevention funding is slated for a sharp reduction. Although increased funds were requested for the Strategic Prevention Framework Initiative, overall funding for the Center for Substance Abuse Prevention would decline by $14.4 million unless the Congress intervenes.

The most notable change in the prevention budget is proposed for the Safe and Drug-Free Schools and Communities (SDFSC) program, where the administration requested $233 million in drug-related funding for national discretionary programs and attempted to cut all funds for the discretionary State Grant program (funded in FY 2005 at $440.9 million). The elimination of state grants — which the Congress is unlikely to accept — would leave state and local governments responsible for the support of school-based prevention programs. Similar cuts are requested for programs that help states and local communities identify effective prevention programs, policies, and practices.

OVERSEAS PROGRAMS EXPAND

The administration's FY 2006 request would increase funding for State Department programs targeting source nations. For example, funding for the Andean Counterdrug Initiative — a longstanding effort that targets drug cultivation and trafficking in South America — would grow by $10 million to $735 million. Other funding for overseas narcotics control and law enforcement would increase by $167 million to $341 million in FY 2006.

Funding to stop drugs at the nation's borders also would increase, as the budget requests an additional $305.4 million for Customs, the Coast Guard, and other border control activities.

QUICK FACTS

- The President's budget requests $12.4 billion for the federal drug control program in FY 2006 — the fiscal year starting October 1, 2005, and ending September 31, 2006.
- The President's budget requests $12.4 billion for the federal drug control program in FY2006 — the fiscal year starting October 1, 2005, and ending September 31, 2006.
- The FY 2006 request is 2.2 percent more than the $12.2 billion budget approved by Congress in FY 2005, but increased at less than the rate of inflation.
- The FY 2006 request cuts funding for the Office of National Drug Control Policy (ONDCP) by almost half ($239 million).
- The percent of the budget allocated to demand reduction in the FY 2006 request is 39 percent; demand reduction received 45 percent of last year's request.
- Resources proposed for supply reduction — including interdiction, international, and law enforcement activities — would increase by 8 percent to $7.6 billion.
- Funding for the state-based Prescription Drug Monitoring Programs would be cut in half, from $10 million in FY 2005 to a proposed $5 million in FY 2006.

Sources: Carnevale Associates; Office of National Drug Control Policy; Join Together Online.

NIAAA, NIDA Directors Report on Research Activities

Scientific advances have offered remarkable insights into how the human brain works and how it molds behaviors that affect drug addiction, say Nora D. Volkow, M.D., Director of the National Institute on Drug Abuse (NIDA) and Ting-Kai Li, M.D., Director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the National Institutes of Health. Building on these foundations, scientists can now investigate issues that were previously inaccessible, such as how environmental factors and genes affect how the brain responds to drugs of abuse to drive the process of addiction.

"Drug addiction is a brain disease," says Dr. Volkow. "Although initial drug use might be voluntary, once addiction develops this control is markedly disrupted. Imaging studies have shown specific abnormalities in the brains of some, but not all, addicted individuals. While scientific advancements in the understanding of addiction have occurred at unprecedented speed in recent years, unanswered questions remain that highlight the need for further research to better define the neurobiological processes involved in addiction."

Recent studies have increased our knowledge of how drugs affect gene expression and brain circuitry, and how these factors affect human behavior, the Directors say. Studies have shed new light on the relationship between drug abuse and mental illness, and the roles played by heredity, age, and other factors in increased vulnerability to addiction. New knowledge from future research, say Dr. Volkow and Dr. Li, will guide new strategies and change the way clinicians approach the prevention and treatment of addiction. Topics of future investigations will include:

- ★ Studies that further explain the brain's circuitry involved in making addicted individuals more responsive to biochemical changes caused by drugs of abuse;
- ★ Explorations that look more deeply into the genetic and environmental factors associated with addiction, as well as the relationship between addiction and co-occurring mental illness;
- ★ Developing tailored preventive interventions that take socioeconomic, cultural, age, and gender characteristics into consideration;
- ★ Investigating new and existing medications that show potential as therapeutic options; and
- ★ Pairing cognitive-behavioral strategies with medications to treat the brain changes brought about by chronic drug exposure.

"These new methodologies will provide us with a greater understanding of drug addiction," the Directors say. "But, to effectively treat and prevent drug addiction, we need to remove the condition's social stigma and enhance the involvement of the medical community. We also need to boost the contributions of the pharmaceutical industry in developing new medications and encourage the participation of insurers." *Source: The report, by NIDA Director Dr. Nora D. Volkow, and NIAAA Director Dr. Ting-Kai Li, is published in the December 2004 issue of Nature Reviews Neuroscience.*

Receptors May Be Key to Nerve Damage from Drug Abuse

Scientists at the National Institute on Drug Abuse have published a report suggesting that the use of compounds that promote the production of myelin — the protective sheath that surrounds the axons of nerve cells — may prevent nerve damage from cocaine or methamphetamine use.

Earlier studies have suggested that cocaine and methamphetamine cause damage to the myelin sheath. The sheath, an insulating layer of protein and fatty substances, allows impulses to travel rapidly and efficiently between cells. If the myelin is damaged through drug abuse or a disease process such as multiple sclerosis, the impulses are disrupted.

Through a series of experiments on rat nerve cells, the NIDA researchers determined that proteins called sigma-1 receptors are involved in promoting the development of myelin.

Because myelination continues in humans until about the age of 20, the use of very selective, pure sigma-1 receptor agonists to stimulate the process may protect against nerve damage in young substance abusers.

Clinical Implications: Compounds that promote the production of sigma-1 receptors may act as shields against myelin degeneration processes related to cocaine and methamphetamine use. Future research will help clarify the mechanisms involved in these processes.

Source: Dr. Tsung-Ping Su and Dr. Teruo Hayashi published their findings in the October 12, 2004 issue of the Proceedings of the National Academy of Sciences.

Young Opioid Users Suffer Greater Brain Damage

Young people who abuse opioids risk brain damage similar to the early stages of Alzheimer's disease, according to a team of Scottish researchers. Neuropathology professor Jeanne Bell and colleagues at the University of Edinburgh reached this conclusion after examining the brains of 34 deceased young drug addicts who had no history of HIV or head injuries and comparing them to the brains of 16 control subjects. They found that the young injection drug users were up to three times more likely to have incurred brain damage than the non-users.

"Damaged nerve cells were identified in the key areas of the brain involved in learning, memory and emotional well-being," Dr. Bell explains, adding: "We found that the brains of these young drug abusers showed significantly higher levels of two key proteins associated with brain damage." The researchers report that, in a previous study, they found that drug abuse causes low-grade inflammation in the brain.

Clinical Implications: Taken together, the two studies suggest that abuse of opioids via injection may be linked to premature aging of the brain.

Source: Dr. Jeanne Bell and colleagues published this research in the journal Neuropathology and Applied Neurobiology.

Co-Occurring Disorders Common In Private Patients, Study Finds

Past research on the prevalence of medical and psychiatric conditions in patients receiving treatment for alcohol and other drug problems has focused on inpatients and patients in publicly-funded programs. Much less is known about the prevalence of such problems in insured outpatients receiving treatment through managed care programs.

Using patient questionnaires and clinical records, this study compared the 12-month prevalence of medical and psychiatric conditions among 747 patients entering alcohol and/or drug treatment, and age- and sex-matched controls from the same large group-model health maintenance organization. Patients were young (mean age of 38), and 59% had alcohol dependence.

Compared with controls, patients with alcohol and/or other drug problems had a higher prevalence of the following (among others): depression (29% vs. 3%), anxiety (17% vs. 2%), traumatic injury/overdoses (26% vs. 12%), major psychoses (7% vs. 0.4%), lower back pain (11% vs. 6%), headache (9% vs. 4%), asthma (7% vs. 3%), hypertension (7% vs. 3%), acid-related disorder (5% vs. 2%), and arthritis (4% vs. 1%). Findings were similar among patients with alcohol dependence, who also were more likely than controls to have cirrhosis of the liver (1% vs. 0.1%).

Clinical Implications: Writing in the newsletter *Alcohol and Health: Current Evidence,* Kevin Kraemer, M.D., of Boston University noted that the study findings "support the practice of screening for substance abuse problems in medical clinics and for medical problems in substance abuse treatment programs." In this regard, Dr. Kraemer added, "private and managed-care substance abuse treatment programs should follow the lead of many publicly-funded treatment programs and address linkages to primary care services."

Sources: Alcohol and Health: Current Evidence, and Mertens JR, Lu YW, Parthasarathy S et al. (2003). Medical and psychiatric conditions of alcohol and drug treatment patients in an HMO. Archives of Internal Medicine 163: 2511-2517.

Medication Reduces Inhalant-Seeking Behavior In Animal Study

Scientists at the U.S. Department of Energy's Brookhaven National Laboratory have found that the anticonvulsant drug vigabatrin (also known as gamma vinyl-GABA or GVG) may block the addictive effects of toluene, a substance found in many household products that are abused as inhalants.

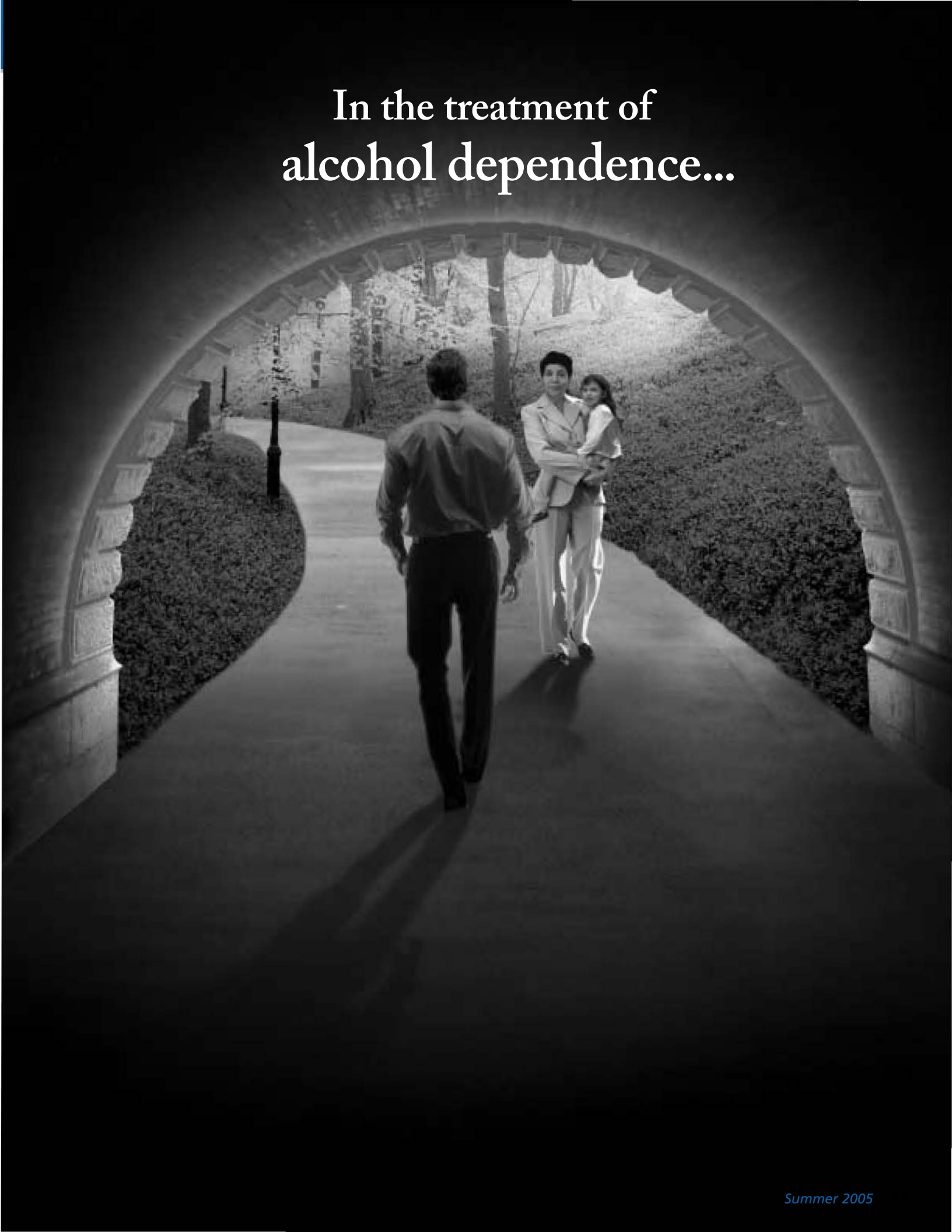
In the study, rats learned that one of three chambers contained toluene vapors, and they would spend more of their time in that chamber than the others. On the final day of the study, the rats received either saline or vigabatrin one hour prior to testing. When the rats were given access to the three chambers, those that had been treated with vigabatrin spent only 80 seconds in the toluene-containing chamber. The rats pretreated with saline spent 349 seconds in that chamber.

Human abuse of inhalants remains a health concern in the United States, where many young people inhale vapors from common household products that contain volatile solvents or aerosols. National surveys indicate that more than 22.9 million Americans have abused inhalants at least once in their lives. Results from the annual Monitoring the Future (MTF) survey of 8th-, 10th-, and 12th-grade students show that lifetime inhalant use for 8th-graders increased significantly during 2004.

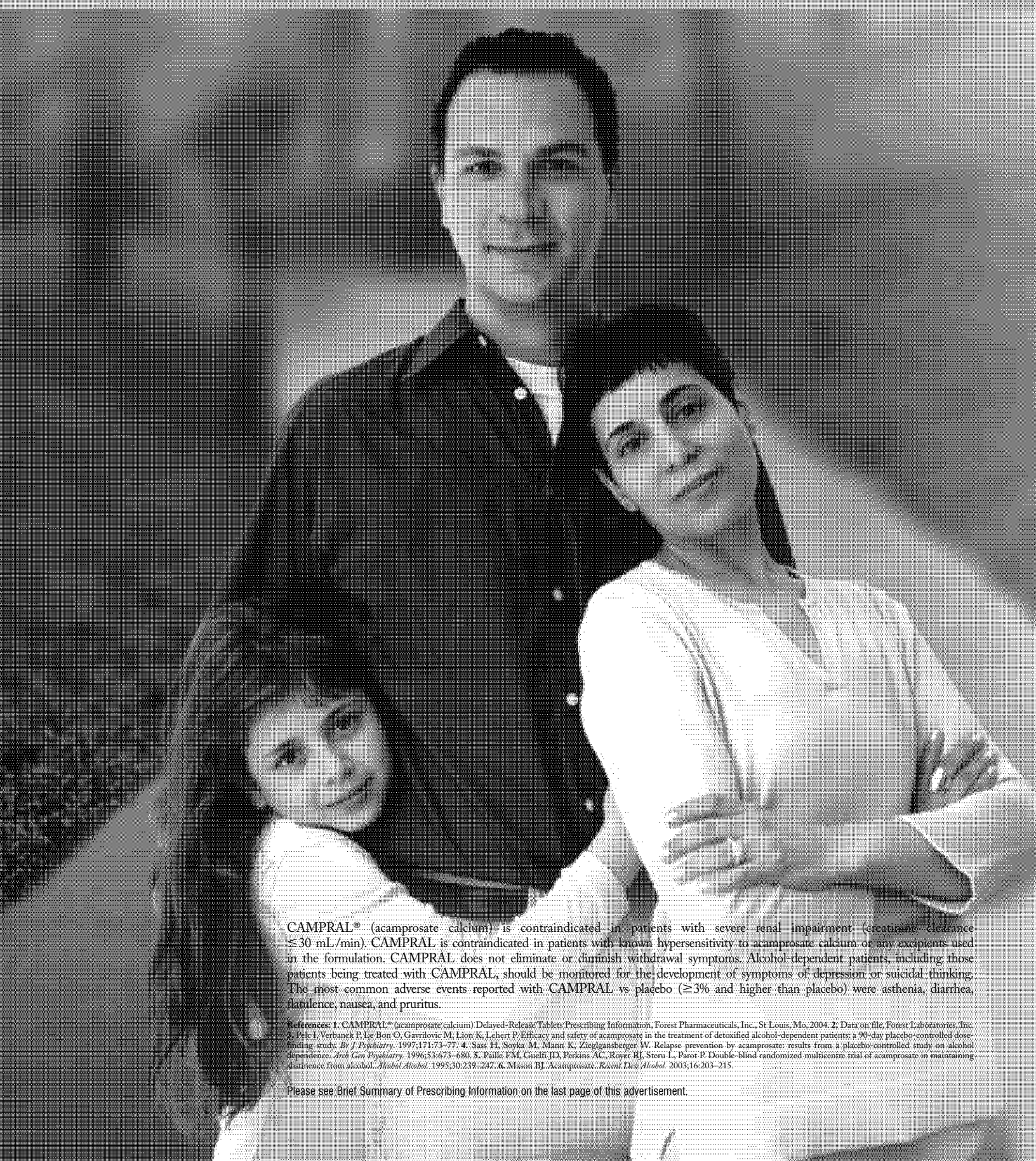
Clinical Implications: Vigabatrin appears to block toluene-seeking behavior in rats. Further research that explores the value of this drug as a treatment for inhalant abuse in humans may prove useful.

Source: Dr. Stephen Dewey and colleagues published this study in the December 1, 2004, issue of the journal Synapse.

In the treatment of alcohol dependence...



An Effective Treatment for the from Alcohol in Combination



CAMPRAL® (acamprosate calcium) is contraindicated in patients with severe renal impairment (creatinine clearance ≤30 mL/min). CAMPRAL is contraindicated in patients with known hypersensitivity to acamprosate calcium or any excipients used in the formulation. CAMPRAL does not eliminate or diminish withdrawal symptoms. Alcohol-dependent patients, including those patients being treated with CAMPRAL, should be monitored for the development of symptoms of depression or suicidal thinking. The most common adverse events reported with CAMPRAL vs placebo (≥3% and higher than placebo) were asthenia, diarrhea, flatulence, nausea, and pruritus.

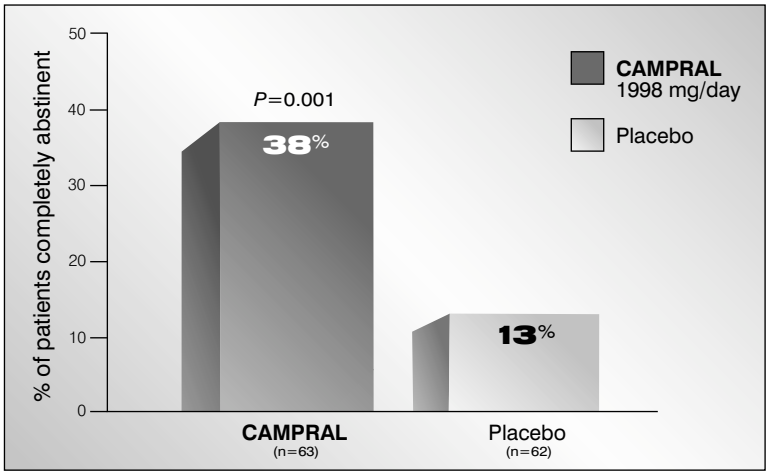
References: 1. CAMPRAL® (acamprosate calcium) Delayed-Release Tablets Prescribing Information, Forest Pharmaceuticals, Inc., St Louis, Mo, 2004. **2.** Data on file, Forest Laboratories, Inc. **3.** Pelc I, Verbanck P, Le Bon O, Gavrilovic M, Lion K, Lehert P. Efficacy and safety of acamprosate in the treatment of detoxified alcohol-dependent patients: a 90-day placebo-controlled dose-finding study. *Br J Psychiatry.* 1997;171:73–77. **4.** Sass H, Soyka M, Mann K, Zieglgansberger W. Relapse prevention by acamprosate: results from a placebo-controlled study on alcohol dependence. *Arch Gen Psychiatry.* 1996;53:673–680. **5.** Paille FM, Guelfi JD, Perkins AC, Royer RJ, Steru L, Parot P. Double-blind randomized multicentre trial of acamprosate in maintaining abstinence from alcohol. *Alcohol Alcohol.* 1995;30:239–247. **6.** Mason BJ. Acamprosate. *Recent Dev Alcohol.* 2003;16:203–215.

Please see Brief Summary of Prescribing Information on the last page of this advertisement.

Maintenance of Abstinence with Psychosocial Support[1]

In a 13-week study*†[2]

CAMPRAL helps 3 times more patients maintain complete abstinence‡ vs placebo, in combination with psychosocial support



Study design: Multicenter, randomized, double-blind, placebo-controlled study of CAMPRAL in alcohol-dependent patients. 188 patients were randomized at study start to receive acamprosate 1332 mg/day (63 patients), CAMPRAL 1998 mg/day (63 patients), or placebo (62 patients). Patients were 18 to 65 years old, met DSM-III-R criteria for alcohol dependence, and had undergone a 14-day detoxification program prior to treatment start. All patients in this study received counseling based on the routine practices of the individual participating study sites.[2,3]

In separate 48- and 52-week studies*†‡[2]

2 times as many CAMPRAL patients maintained abstinence vs placebo

CAMPRAL provides excellent safety and tolerability[1–6]

- Favorable side-effect profile with discontinuation rates due to adverse events similar to placebo (8% for CAMPRAL-treated patients vs 6% for placebo)[1]
- Minimal potential for drug interactions; not metabolized by the liver[1]
- Can be taken with antidepressants,§ anxiolytics, hypnotics, sedatives (including benzodiazepines), nonopioid analgesics, disulfiram, and naltrexone[1]
- Used for more than a decade; over 1.5 million patients treated worldwide[6]

Unique mechanism of action‖[1]

- Thought to restore neurotransmitter balance

Visit our website at **www.campral.com**

*All efficacy studies included psychosocial support.

†Results are for the intent-to-treat population over the study treatment phase.

‡Complete abstinence was defined as no alcohol consumption. Assessment included patient and/or family reports, laboratory tests, and either urine alcohol levels, blood alcohol levels, or breathalyzer tests.[3–5]

§Patients taking CAMPRAL concomitantly with antidepressants more commonly experienced weight gain or weight loss than patients taking either agent alone.

‖The mechanism of action of acamprosate in the maintenance of abstinence is not completely understood. Chronic alcohol exposure is hypothesized to alter the normal balance between neuronal excitation and inhibition. *In vitro* and *in vivo* studies in animals have provided evidence to suggest acamprosate may interact with neurotransmitter systems centrally, and has led to the hypothesis that acamprosate restores this balance. The clinical significance in humans is unknown.

CAMPRAL is a registered trademark of Merck Santé s.a.s.
Subsidiary of Merck KGaA, Darmstadt, Germany

NEW

Campral®
(acamprosate calcium)
Delayed-Release Tablets

Strengthens the will to say no

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Campral®
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Delayed-Release Tablets

Rx only

Brief Summary:
For complete details, please see full Prescribing Information for CAMPRAL

INDICATIONS AND USAGE
CAMPRAL (acamprosate calcium) is indicated for the maintenance of abstinence from alcohol in patients with alcohol dependence who are abstinent at treatment initiation. Treatment with CAMPRAL should be part of a comprehensive management program that includes psychosocial support. The efficacy of CAMPRAL in promoting abstinence has not been demonstrated in subjects who have not undergone detoxification and not achieved alcohol abstinence prior to beginning CAMPRAL treatment. The efficacy of CAMPRAL in promoting abstinence from alcohol in polysubstance abusers has not been adequately assessed.

CONTRAINDICATIONS
CAMPRAL is contraindicated in patients who previously have exhibited hypersensitivity to acamprosate calcium or any of its components. CAMPRAL is contraindicated in patients with severe renal impairment (creatinine clearance ≤30 mL/min).

PRECAUTIONS
Use of CAMPRAL does not eliminate or diminish withdrawal symptoms. **General: Renal Impairment** Treatment with CAMPRAL in patients with moderate renal impairment (creatinine clearance of 30-50 mL/min) requires a dose reduction. Patients with severe renal impairment (creatinine clearance of ≤30 mL/min) should not be given CAMPRAL (see also CONTRAINDICATIONS). **Suicidality** In controlled clinical trials of CAMPRAL, adverse events of a suicidal nature (suicidal ideation, suicide attempts, completed suicides) were infrequent overall, but were more common in CAMPRAL-treated patients than in patients treated with placebo (1.4% vs. 0.5% in studies of 6 months or less; 2.4% vs. 0.8% in year-long studies). Completed suicides occurred in 3 of 2272 (0.13%) patients in the pooled acamprosate group from all controlled studies and 2 of 1962 patients (0.10%) in the placebo group. Adverse events coded as "depression" were reported at similar rates in CAMPRAL-treated and placebo-treated patients. Although many of these events occurred in the context of alcohol relapse, no consistent pattern of relationship between the clinical course of recovery from alcoholism and the emergence of suicidality was identified. The interrelationship between alcohol dependence, depression and suicidality is well-recognized and complex. Alcohol-dependent patients, including those patients being treated with CAMPRAL, should be monitored for the development of symptoms of depression or suicidal thinking. Families and caregivers of patients being treated with CAMPRAL should be alerted to the need to monitor patients for the emergence of symptoms of depression or suicidality, and to report such symptoms to the patient's health care provider. **Information for Patients** Physicians are advised to discuss the following issues with patients for whom they prescribe CAMPRAL. Any psychoactive drug may impair judgment, thinking, or motor skills. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that CAMPRAL therapy does not affect their ability to engage in such activities. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised to notify their physician if they are breast-feeding. Patients should be advised to continue CAMPRAL therapy as directed, even in the event of relapse and should be reminded to discuss any renewed drinking with their physician. Patients should be advised that CAMPRAL has been shown to help maintain abstinence only when used as a part of a treatment program that includes counseling and support. **Drug Interactions** The concomitant intake of alcohol and CAMPRAL does not affect the pharmacokinetics of either alcohol or acamprosate. Pharmacokinetic studies indicate that administration of disulfiram or diazepam does not affect the pharmacokinetics of acamprosate. Co-administration of naltrexone with CAMPRAL produced a 25% increase in AUC and a 33% increase in the Cmax of acamprosate. No adjustment of dosage is recommended in such patients. The pharmacokinetics of naltrexone and its major metabolite 6-beta-naltrexol were unaffected following co-administration with CAMPRAL. Other concomitant therapies: In clinical trials, the safety profile in subjects treated with CAMPRAL concomitantly with anxiolytics, hypnotics and sedatives (including benzodiazepines), or non-opioid analgesics was similar to that of subjects taking placebo with these concomitant medications. Patients taking CAMPRAL concomitantly with antidepressants more commonly reported both weight gain and weight loss, compared with patients taking either medication alone. **Carcinogenicity, Mutagenicity and Impairment of Fertility** A carcinogenicity study was conducted in which Sprague-Dawley rats received acamprosate calcium in their diet at doses of 25, 100 or 400 mg/kg/day (0.2, 0.7 or 2.5-fold the maximum recommended human dose based on an AUC comparison). There was no evidence of an increased incidence of tumors in this carcinogenicity study in the rat. An adequate carcinogenicity study in the mouse has not been conducted. Acamprosate calcium was negative in all genetic toxicology studies conducted. Acamprosate calcium demonstrated no evidence of genotoxicity in an *in vitro* bacterial reverse point mutation assay (Ames assay) or an *in vitro* mammalian cell gene mutation test using Chinese Hamster Lung V79 cells. No clastogenicity was observed in an *in vitro* chromosomal aberration assay in human lymphocytes and no chromosomal damage detected in an *in vivo* mouse micronucleus assay. Acamprosate calcium had no effect on fertility after treatment for 70 days prior to mating in male rats and for 14 days prior to mating, throughout mating, gestation and lactation in female rats at doses up to 1000 mg/kg/day (approximately 4 times the maximum recommended human daily oral dose on a mg/m^2 basis). In mice, acamprosate calcium administered orally for 60 days prior to mating and throughout gestation in females at doses up to 2400 mg/kg/day (approximately 5 times the maximum recommended human daily oral dose on a mg/m^2 basis) had no effect on fertility. **Pregnancy Category C Teratogenic Effects** Acamprosate calcium has been shown to be teratogenic in rats when given in doses that are approximately equal to the human dose (on a mg/m^2 basis) and in rabbits when given in doses that are approximately 3 times the human dose (on a mg/m^2 basis). Acamprosate calcium produced a dose-related increase in the number of fetuses with malformations in rats at oral doses of 300 mg/kg/day or greater (approximately equal to the maximum recommended human daily oral dose on a mg/m^2 basis). The malformations included hydronephrosis, malformed iris, retinal dysplasia, and retroesophageal subclavian artery. No findings were observed at an oral dose of 50 mg/kg/day (approximately one-fifth the maximum recommended human daily oral dose on a mg/m^2 basis). An increased incidence of hydronephrosis was also noted in Burgundy Tawny rabbits at oral doses of 400 mg/kg/day or greater (approximately 3 times the maximum recommended human daily oral dose on a mg/m^2 basis). No developmental effects were observed in New Zealand white rabbits at oral doses up to 1000 mg/kg/day (approximately 8 times the maximum recommended human daily oral dose on a mg/m^2 basis). The findings in animals should be considered in relation to known adverse developmental effects of ethyl alcohol, which include the characteristics of fetal alcohol syndrome (craniofacial dysmorphism, intrauterine and postnatal growth retardation, retarded psychomotor and intellectual development) and milder forms of neurological and behavioral disorders in humans. There are no adequate and well controlled studies in pregnant women. CAMPRAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic Effects** A study conducted in pregnant mice that were administered acamprosate calcium by the oral route starting on Day 15 of gestation through the end of lactation on postnatal day 28 demonstrated an increased incidence of still-born fetuses at doses of 960 mg/kg/day or greater (approximately 2 times the maximum recommended human daily oral dose on a mg/m^2 basis). No effects were observed at a dose of 320 mg/kg/day (approximately one-half the maximum recommended human daily dose on a mg/m^2 basis). **Labor and Delivery** The potential for CAMPRAL to affect the duration of labor and delivery is unknown. **Nursing Mothers** In animal studies, acamprosate was excreted in the milk of lactating rats dosed orally with acamprosate calcium. The concentration of acamprosate in milk compared to blood was 1.3:1. It is not known whether acamprosate is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when CAMPRAL is administered to a nursing woman. **Pediatric Use** The safety and efficacy of CAMPRAL have not been established in the pediatric population. **Geriatric Use** Forty-one of the 4234 patients in double-blind, placebo-controlled, clinical trials of CAMPRAL were 65 years of age or older, while none were 75 years of age or over. There were too few patients in the ≥65 age group to evaluate any differences in safety or effectiveness for geriatric patients compared to younger patients. This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function (See CLINICAL PHARMACOLOGY, ADVERSE REACTIONS, and DOSAGE AND ADMINISTRATION).

ADVERSE REACTIONS
The adverse event data described below reflect the safety experience in over 7000 patients exposed to CAMPRAL for up to one year, including over 2000 CAMPRAL-exposed patients who participated in placebo-controlled trials. **Adverse Events Leading to Discontinuation** In placebo-controlled trials of 6 months or less, 8% of CAMPRAL-treated patients discontinued treatment due to an adverse event, as compared to 6% of patients treated with placebo. In studies longer than 6 months, the discontinuation rate due to adverse events was 7% in both the placebo-treated and the CAMPRAL-treated patients. Only diarrhea was associated with the discontinuation of more than 1% of patients (2% of CAMPRAL-treated vs. 0.7% of placebo-treated patients). Other events, including nausea, depression, and anxiety, while accounting for discontinuation in less than 1% of patients, were nevertheless more commonly cited in association with discontinuation in CAMPRAL-treated patients than in placebo-treated patients. **Common Adverse Events Reported in Controlled Trials** Common, non-serious adverse events were collected spontaneously in some controlled studies and using a checklist in other studies. The overall profile of adverse events was similar using either method. Table 1 shows those events that occurred in any CAMPRAL treatment group at a rate of 3% or greater and greater than the placebo group in controlled clinical trials with spontaneously reported adverse events. The reported frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed, without regard to the causal relationship of the events to the drug.

Table 1. Events Occurring at a Rate of at Least 3% and Greater than Placebo in any CAMPRAL Treatment Group in Controlled Clinical Trials with Spontaneously Reported Adverse Events

Body System/ Preferred Term	CAMPRAL 1332 mg/day	CAMPRAL 1998 mg/day[1]	CAMPRAL Pooled[2]	Placebo
Number of Patients in Treatment Group	**397**	**1539**	**2019**	**1706**
Number (%) of Patients with an AE	**248(62%)**	**910(59%)**	**1231(61%)**	**955(56%)**
Body as a Whole	**121(30%)**	**513(33%)**	**685(34%)**	**517(30%)**
Accidental Injury*	17 (4%)	44 (3%)	70 (3%)	52 (3%)
Asthenia	29 (7%)	79 (5%)	114(6%)	93 (5%)
Pain	6 (2%)	56 (4%)	65 (3%)	55 (3%)
Digestive System	**85 (21%)**	**440(29%)**	**574(28%)**	**344(20%)**
Anorexia	20 (5%)	35 (2%)	57 (3%)	44 (3%)
Diarrhea	39 (10%)	257(17%)	329(16%)	166(10%)
Flatulence	4 (1%)	55 (4%)	63 (3%)	28 (2%)
Nausea	11 (3%)	69 (4%)	87 (4%)	58 (3%)
Nervous System	**150(38%)**	**417(27%)**	**598(30%)**	**500(29%)**
Anxiety**	32 (8%)	80 (5%)	118(6%)	98 (6%)
Depression	33 (8%)	63 (4%)	102(5%)	87 (5%)
Dizziness	15 (4%)	49 (3%)	67 (3%)	44 (3%)
Dry mouth	13 (3%)	23 (1%)	36 (2%)	28 (2%)
Insomnia	34 (9%)	94 (6%)	137(7%)	121(7%)
Paresthesia	11 (3%)	29 (2%)	40 (2%)	34 (2%)
Skin and Appendages	**26 (7%)**	**150(10%)**	**187(9%)**	**169(10%)**
Pruritus	12 (3%)	68 (4%)	82 (4%)	58 (3%)
Sweating	11 (3%)	27 (2%)	40 (2%)	39 (2%)

*includes events coded as "fracture" by sponsor; **includes events coded as "nervousness" by sponsor
[1] includes 258 patients treated with acamprosate calcium 2000 mg/day, using a different dosage strength and regimen. [2] includes all patients in the first two columns as well as 83 patients treated with acamprosate calcium 3000 mg/day, using a different dosage strength and regimen.

Other Events Observed During the Premarketing Evaluation of CAMPRAL
Following is a list of terms that reflect treatment-emergent adverse events reported by patients treated with CAMPRAL in 20 clinical trials (4461 patients treated with CAMPRAL, 3526 of whom received the maximum recommended dose of 1998 mg/day for up to one year in duration). This listing does not include those events already listed above; events for which a drug cause was considered remote; event terms which were so general as to be uninformative; and events reported only once which were not likely to be acutely life-threatening.
Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring in at least 1/100 patients (only those not already listed in the summary of adverse events in controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. **Body as a Whole** – *Frequent:* headache, abdominal pain, back pain, infection, flu syndrome, chest pain, chills, suicide attempt; *Infrequent:* fever, intentional overdose, malaise, allergic reaction, abscess, neck pain, hernia, intentional injury; *Rare:* ascites, face edema, photosensitivity reaction, abdomen enlarged, sudden death. **Cardiovascular System** – *Frequent:* palpitation, syncope; *Infrequent:* hypotension, tachycardia, hemorrhage, angina pectoris, migraine, varicose vein, myocardial infarct, phlebitis, postural hypotension; *Rare:* heart failure, mesenteric arterial occlusion, cardiomyopathy, deep thrombophlebitis, shock. **Digestive System** – *Frequent:* vomiting, dyspepsia, constipation, increased appetite; *Infrequent:* liver function tests abnormal, gastroenteritis, gastritis, dysphagia, eructation, gastrointestinal hemorrhage, pancreatitis, rectal hemorrhage, liver cirrhosis, esophagitis, hematemesis, nausea and vomiting, hepatitis; *Rare:* melena, stomach ulcer, cholecystitis, colitis, duodenal ulcer, mouth ulceration, carcinoma of liver. **Endocrine System** – *Rare:* goiter, hypothyroidism. **Hemic and Lymphatic System** – *Infrequent:* anemia, ecchymosis, eosinophilia, lymphocytosis, thrombocytopenia; *Rare:* leukopenia, lymphadenopathy, monocytosis. **Metabolic and Nutritional Disorders** – *Frequent:* peripheral edema, weight gain; *Infrequent:* weight loss, hyperglycemia, SGOT increased, SGPT increased, gout, thirst, hyperuricemia, diabetes mellitus, avitaminosis, bilirubinemia; *Rare:* alkaline phosphatase increased, creatinine increased, hyponatremia, lactic dehydrogenase increased. **Musculoskeletal System** – *Frequent:* myalgia, arthralgia; *Infrequent:* leg cramps; *Rare:* rheumatoid arthritis, myopathy. **Nervous System** – *Frequent:* somnolence, libido decreased, amnesia, thinking abnormal, tremor, vasodilatation, hypertension; *Infrequent:* convulsion, confusion, libido increased, vertigo, withdrawal syndrome, apathy, suicidal ideation, neuralgia, hostility, agitation, neurosis, abnormal dreams, hallucinations, hypesthesia; *Rare:* alcohol craving, psychosis, hyperkinesia, twitching, depersonalization, increased salivation, paranoid reaction, torticollis, encephalopathy, manic reaction. **Respiratory System** – *Frequent:* rhinitis, cough increased, dyspnea, pharyngitis, bronchitis; *Infrequent:* asthma, epistaxis, pneumonia; *Rare:* laryngismus, pulmonary embolus. **Skin and Appendages** – *Frequent:* rash; *Infrequent:* acne, eczema, alopecia, maculopapular rash, dry skin, urticaria, exfoliative dermatitis, vesiculobullous rash; *Rare:* psoriasis. **Special Senses** – *Frequent:* abnormal vision, taste perversion; *Infrequent:* tinnitus, amblyopia, deafness; *Rare:* ophthalmitis, diplopia, photophobia. **Urogenital System** – *Frequent:* impotence; *Infrequent:* metrorrhagia, urinary frequency, urinary tract infection, sexual function abnormal, urinary incontinence, vaginitis; *Rare:* kidney calculus, abnormal ejaculation, hematuria, menorrhagia, nocturia, polyuria, urinary urgency. **Serious Adverse Events Observed During the Non-US Postmarketing Evaluation of CAMPRAL (acamprosate calcium)** Although no causal relationship to CAMPRAL has been found, the serious adverse event of acute kidney failure has been reported to be temporally associated with CAMPRAL treatment in at least 3 patients and is not described elsewhere in the labeling.

DRUG ABUSE AND DEPENDENCE
Controlled Substance Class Acamprosate calcium is not a controlled substance. **Physical and Psychological Dependence** CAMPRAL did not produce any evidence of withdrawal symptoms in patients in clinical trials at therapeutic doses. Post marketing data, collected retrospectively outside the U.S., have provided no evidence of CAMPRAL abuse or dependence.

OVERDOSAGE
In all reported cases of acute overdosage with CAMPRAL (total reported doses of up to 56 grams of acamprosate calcium), the only symptom that could be reasonably associated with CAMPRAL was diarrhea. Hypercalcemia has not been reported in cases of acute overdose. A risk of hypercalcemia should be considered in chronic overdosage only. Treatment of overdose should be symptomatic and supportive.

Manufactured by: Merck Santé s.a.s.
Subsidiary of Merck KGaA, Darmstadt, Germany
37, rue Saint-Romain
69008 LYON FRANCE

Manufactured for FOREST PHARMACEUTICALS, Inc.
Subsidiary of Forest Laboratories, Inc.
St. Louis, MO 63045
07/04

Forest Pharmaceuticals, Inc.
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Court Vacates OxyContin Patent

The U.S. Court of Appeals in Washington, D.C., has ruled that pharmaceutical manufacturer Purdue Pharma misrepresented some of the research that led to development of its analgesic OxyContin, and thus must forfeit its patent on the drug. The court found in favor of Endo Pharmaceuticals, which asked the court to invalidate Purdue's OxyContin patent so that Endo could begin making a generic version of the drug.

A three-judge appeals panel upheld a lower court ruling that Purdue had falsely claimed in its patent application to have clinical evidence that OxyContin was easier for doctors to use than other analgesics. In addition to allowing for generic oxycodone drugs to be made and sold, the court's ruling exposes Purdue to possible litigation totaling billions of dollars. Already, 65 separate lawsuits have been filed by insurers and others, asking that Purdue be forced to return profits derived from its patent on OxyContin. Purdue officials said they would appeal the latest decision. "Purdue believes that the court's decision is contrary to principles of patent law," the company said.

Industry sources report that Endo immediately began to ship its generic version of OxyContin. Israeli pharmaceutical maker Teva already sells a generic version of the 80 mg OxyContin in the U.S. Enforcement officials, who noted with alarm the rapidity with which the Teva product appeared in illicit markets, are braced for an upsurge in diversion of Endo's generics.

Clinical Implications: U.S. law does not require generic drug makers to maintain risk management programs like those required of brand name manufacturers. Moreover, it appears unlikely that Purdue will be able to sustain its sophisticated risk management program. It thus appears likely that enforcement officials will have less information about diversion and abuse of the drug even as it becomes more widely available for illicit use.

Computer Program Helps Detect Substance Use Disorders in Older Adults

A new computerized screening tool may help primary care practitioners detect older substance misuse and abuse in older adults.

Users of the Drug Abuse Problem Assessment for Primary Care (DAPA-PC) first answer a brief series of questions about trauma, then progress to a brief questionnaire about alcohol and drug use. Asking about trauma, the researchers say, is a predictive yet non-threatening way to determine an individual's level of drug and alcohol use or abuse.

A study to validate the diagnostic capabilities of the DAPA-PC found that older and younger adults had similar rates of alcohol and drug abuse. The study, which involved 266 adults aged 18-54 and 61 adults aged 55-86, also found that older adults were less likely to view their drug use as problematic than their older counterparts. Moreover, they were less likely to report that they felt their use of alcohol and/or drugs was excessive. When compared with younger respondents, older adults also were less likely to report that they had tried to stop, control, or reduce their alcohol, tobacco or other drug abuse during the preceding six months.

Researchers at Danya International, Inc., which developed the DAPA-PC, predict that the number of older adults who abuse alcohol and other drugs will greatly increase over the next several decades. Because virtually all of today's alcohol and drug screening devices have been developed and validated with younger adults, they say there is a need for tools to help identify older substance abusers.

Clinical Implications: Computerized screening instruments for drug and alcohol abuse can help identify substance abuse in older adult patients, who may not report substance-related problems and appear to be less likely than younger adults to seek help for them.

Source: Dr. Susanna Nemes and her colleagues published the study in the October 12, 2004 issue of The American Journal of Drug and Alcohol Abuse.

Sex, Drug Use Increase Risk of Teen Depression, Suicide

Young people who engage in sexual intercourse and/or drug abuse (including abuse of alcohol and tobacco) are significantly more likely than youth who abstain from such activities to become depressed, have suicidal thoughts, and attempt suicide.

Researchers at the Pacific Institute for Research and Evaluation (PIRE) and the University of North Carolina at Chapel Hill analyzed sexual activity and drug use patterns among 18,924 adolescents from 132 U.S. schools. The data were gathered from September 1994 to December 1995 as part of the National Longitudinal Study of Adolescent Health.

The data showed that young people who had not initiated sexual activity or alcohol, tobacco or drug use had the lowest levels of depression, suicidal thoughts, and suicide attempts. The highest levels were seen in youth with patterns that included illegal drug use and risky sexual behavior. The scientists also observed that although girls were less likely than boys to pursue high-risk behaviors, girls who did so were more vulnerable than their peers to depression and suicidal behaviors.

Clinical Implications: Health care professionals should consider screening young patients for depression and suicidal tendencies if they suspect the youth are engaging in risky behaviors. Further research is warranted to understand whether causal links exist between such behaviors and mental health status.

Source: Dr. Denise Hallfors and her colleagues published this study in the October 2004 issue of the American Journal of Preventive Medicine.

CALIFORNIA SOCIETY OF ADDICTION MEDICINE

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

CSAM Executive Director Kerry Parker, CAE, reports that SB.573, which would repeal California's UPPL statute, passed out of the state Assembly by a vote of 43 to 27, with 9 members not voting. Kerry predicts that the next hurdle is to get the bill through the state Senate (which passed an earlier version) and then finding cases in which trauma centers were not paid because of the UPPL provisions, to use in persuading the Governor's office not to veto the measure. CSAM members have been extremely active in passing this measure, and received a real boost from testimony given to the Assembly by trauma surgeon Larry Gentilello, M.D.

In other news, CSAM's Immediate Past President Gary Jaeger, M.D., FASAM, has been appointed by Gov. Arnold Schwarzenegger to the state's Mental Health Services Oversight and Accountability Commission, which is tasked with developing strategies to overcome stigma and accomplish the objectives of the recently passed Mental Health Services Act (Proposition 63). The Commission will advise the Governor and the Legislature regarding actions the state may take to improve care and services for persons with mental illnesses, including addictive disorders. The Commission is required to annually review and approve each county mental health program's budget. If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Mental Health.

Dr. Jaeger currently is chief of addiction medicine at Kaiser Foundation Hospital, South Bay. As a member of Southern California Permanente Medical Group, he also serves as regional chair of the Transitional Residential Recovery Service Committee and the Behavioral Health Management Information Systems Committee. In addition to his activities in CSAM and ASAM, Dr. Jaeger is a member of the California Medical Association and a former chair of the California Healthcare Association's Behavioral Health Advisory Board.

LOUISIANA SOCIETY OF ADDICTION MEDICINE

Reporter: Lisa Stolier, Executive Director

Past President Ken Roy, M.D., reports that the National Conference of State Legislatures has a limited amount of funds to underwrite technical assistance to state legislatures concerning performance measurement in substance abuse treatment. NCSL can support a half-day conference, briefing, or workshop for a legislative committee or study commission, in which one of the leading expert in the nation, A. Thomas McLellan, Ph.D., executive director of the Treatment Research Institute, provides information and/or testimony.

Dr. Roy says that the Louisiana Society of Addiction Medicine has used the NCSL service, which comes at no charge, and that he recommends it highly to other chapters. Additional information is available from Allison Colker at NCSL by phone at 202/624.3581 or by email at ALLISON.COLKER@NCSL.ORG. Also, Dr. Roy is willing to provide information on LSAM's experience. He can be reached at KENROYMD@COX.NET.

NEW YORK SOCIETY OF ADDICTION MEDICINE

Reporter: Merrill Herman, M.D.

The New York Society of Addiction Medicine successfully lobbied the state legislature to enact S.5578 / A.5158, which would repeal the state's UPPL law. An ally in the battle has been trauma surgeon Larry Gentilello, M.D., FACS, whose expertise is fueling anti-UPPL activities across the country. Dr. Gentilello points out that the UPPL statute, by allowing insurers to refuse payment for emergency services related to alcohol and drug use, has contributed to the severe problem of uncompensated care in New York's trauma system. NYSAM's Norman Wetterau, M.D., reports that the Medical Society of the State of New York also has been a strong ally. Repeal of UPPL also has been endorsed by the American College of Surgeons and its Committee on Trauma, the New York Chapters of the College, and the New York Regional Committee on Trauma.

The bill now goes to Governor George Pataki, who vetoed a similar measure two years ago. In the interim, however, New York State physician groups have waged an educational campaign to help the Governor and his advisors understand the need to repeal UPPL.

REGION VII

Reporter: Howard Wetsman, M.D.

The officers of Region VII — which incorporates State Societies in Louisiana, Texas, Arkansas, and Oklahoma, as well as the Midwest Chapter (Kansas, Nebraska, and Missouri) — are pleased to announce the Third Annual Region VII Symposium, to be held at the Drury Inn and Suites Riverwalk in San Antonio, Texas, September 10-11, 2005.

Course Director C. Gordon King, M.D., who is on the faculty at the University of Texas Health Science Center in San Antonio, has recruited an expert faculty, ranging from university-based scientists and researchers, to medical directors of addiction treatment programs, to representatives of the NIH. For example, Donald R. Vereen, Jr., M.D., M.P.H., Special Assistant to the Director for Medical Affairs at the National Institute on Drug Abuse, will address the conference on "Neuro-Imaging and Addiction, and Current Information Available from NIH/NIDA."

Carlton K. Erickson, Ph.D., Director of Addiction Science Research and Education Center and Professor of Pharmacology/Toxicology at The University of Texas at Austin, has been invited to speak on the Neuroscience of Addiction. John D. Roache, Ph.D., Professor of Psychiatry and Chief of the Division of Alcohol and Drug Addiction at the University of Texas Health Science Center at San Antonio, will deliver a neuroscience update and discuss "Novel Experimental Medications: Pharmacotherapy for Addiction Treatment." Michael Wilkerson, M.D., Medical Director of Talbott Recovery Campus, will present the "Results of Talbott's 96-Hour Assessments," and Thomas J. Brady, M.D., M.B.A., Vice President and Chief Medical Officer of the CRC Health Group, will present on "Evidenced-Based Analysis of Treatment Modalities."

The faculty also includes Katie McQueen, M.D., of the Baylor College of Medicine and UTHSC-Houston, speaking on "Brief Intervention, Screening and Triage"; Tom Cammack, M.D., Director of Utilization Review at the Starlite Recovery Center, discussing "Third-Party Payors and Utilization Review for Substance Abuse Treatment," and John Keppler, M.D., of the Texas Department of State Health Services, speaking on "Political Factors in Allocating Government Money for Addiction Treatment."

A Buprenorphine Training Course, presented by the American Osteopathic Academy of Addiction Medicine and directed by Anthony Dekker, D.O., FASAM, is scheduled for Friday, September 9th, also at the Drury Inn and Suites Riverwalk.

Information on the Conference and the Buprenorphine Training Course is available from Lisa Stolier, Executive Director of Region VII, by email at ESTOLIER@BELLSOUTH.NET, or on the Region VII website at WWW.ASAMREGIONVII.ORG.

REGION VIII AND NORTHWEST CHAPTER

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.
Also, the Nevada legislature has passed AB.63, repealing the state's UPPL law. Governor Guinn signed the measure into law May 17th.

RHODE ISLAND SOCIETY OF ADDICTION MEDICINE

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

The Rhode Island Senate has passed, in concurrence, House Bill H.5778, which would eliminate the exclusion of alcohol-related injuries from insurance coverage under the state's UPPL law. Region III Director Mark Kraus, M.D., FASAM, reports that the bill has been transmitted to Governor Don Carcieri for signature, and that Rhode Island's health insurance commissioner has advised the governor that the bill represents "good health policy." In their efforts to pass the bill, RiSAM leaders worked closely with David C. Lewis, M.D., of Brown University and Kathryn Cates-Wessel, executive director of PLNDP.

SOUTH CAROLINA SOCIETY OF ADDICTION MEDICINE

Reporter: Jeff Craddock, M.D.

The South Carolina Society of Addiction Medicine has launched a new website and invite their South Carolina and ASAM colleagues to visit it at WWW.SCSAM.ORG. In his initial message on the site, SCSAM President Jeffrey Craddock, M.D., wrote that the website project "has been a couple of years in the making." The website, he explains, is SCSAM's "attempt to connect with patients, other treatment professionals, and other professional organizations. My hope is that this will be a collaborative effort between professionals, recovering patients, families, and addicts who are still suffering. Our members are encouraged to contribute articles, links, resources, anecdotes, and information on how to contact their offices to accept patients. Other physicians are encouraged to become members of the South Carolina Society of Addiction Medicine and members of the American Society of Addiction Medicine."

STATE LEADERS TO MEET IN OCTOBER

ASAM State Society and Chapter leaders will meet October 29-30, 2005, in Washington, DC.

The October meeting will feature special sessions for the State Membership Chairs, as well as for chapter and society Presidents and Staff Directors, as well as ASAM's Regional Directors.

In the small groups, state representatives will make plans for their 2006 membership programs, while in the plenary sessions, state leaders will report on their plans and exchange ideas on how states can help one another achieve their 2006 goals. At the lunch break, there will be a separate working lunch for SMSS Managers, so that they can get to know one another and make plans for their monthly calls. For more information, contact SMSS Project Director James F. Callahan, D.P.A., by email at JCALL2@COMCAST.NET.

IN MEMORIAM: *Richard Morin, M.D.*

Richard A. Morin, a psychiatrist who specialized in addiction medicine, died March 24, 2005, in Rancho Mirage, California. He was 76.

Dr. Morin graduated in 1958 from the University of Michigan Medical School. For 20 years, he was a general practitioner in private practice in Durand, Michigan, in Standish, Michigan, and in Lancaster, California. In 1982, Dr. Morin completed his residency in psychiatry at Wayne State University Lafayette Clinic. He subsequently was certified by the American Board of Psychiatry and Neurology and the American Society of Addiction Medicine.

Dr. Morin served as director of the Department of Alcoholism and Substance Abuse at the University of Michigan Health System; as medical director of the Alcoholism Treatment Program at Samaritan Health Center in Detroit, Michigan; as co-medical director at Brighton Hospital in Brighton; and as medical director of both the Chemical Dependency Program and the Traumatic Brain Injury Unit at Detroit Riverview Hospital. He also was a lecturer and author on the subject of addiction and dual diagnosis and was actively involved in International Doctors in Alcoholics Anonymous, the American Society of Addiction Medicine, and the Michigan State Medical Society Committee for Impaired Physicians.

Dr. Morin is survived by his wife of 57 years, Annabelle (nee Sauve); daughters Julie (Ron Miller) of Cincinnati, Ohio; Pamela (Robin) Sanders of Ann Arbor, Michigan; and Patricia (Gary) Barnard of Saline, Michigan; and his son David, of Manchester, Connecticut; 18 grandchildren and six great-grandchildren. The family requests that memorial contributions be sent to Arbor Hospice, 2366 Oak Valley Drive, Ann Arbor, MI 48103.

Nominees Sought for ASAM Officer, Director-at-Large Posts

ASAM members are invited to submit names of potential candidates for Officer and Director-at-Large to the Nominating & Awards Council, which will select two candidates for each position. Such nominations are to be submitted by October 15, 2005, to the Nominating & Awards Council C/O ASAM, 350 Third Avenue – #352, New York, NY 10010.

NOMINEES FOR OFFICER POSITIONS

Nominees for Officer positions must be current members of the ASAM Board of Directors, or have served on the Board within the past four years. An exception may be made in the case of a nominee for the office of Treasurer, who may be a member of the general membership who has qualifications for the position and has been a member of the Finance Council within the past four years. (On this basis, James W. Smith, M.D., FASAM, and Max A. Schneider, M.D., FASAM, are eligible to be nominated as Treasurer in addition to the individuals listed below.)

The term of office for ASAM Officers is two years (2007-2009). No member may hold the office of President or President-Elect for more than one term, successively. A Secretary or Treasurer may succeed himself/herself once without hiatus, and may subsequently be re-elected after a hiatus of two years.

The Nominating & Awards Council has determined that the following individuals are eligible for nomination to Officer positions:

Louis E. Baxter, Sr., M.D., FASAM
Peter Banys, M.D.
Richard E. Beach, M.D., FASAM
Lawrence S. Brown, Jr., M.D., M.P.H., FASAM
Anthony H. Dekker, D.O., FASAM
Paul H. Earley, M.D., FASAM
John P. Femino, M.D., FASAM
Timothy L. Fischer, D.O.
Marc Galanter, M.D., FASAM
David R. Gastfriend, M.D.
Stuart Gitlow, M.D., M.P.H.
R. Jeffrey Goldsmith, M.D.
Lloyd J. Gordon III, M.D., FASAM
Raju Hajela, M.D., M.P.H., FASAM
James A. Halikas, M.D., FASAM
Thomas L. Haynes, M.D., FASAM
Lori D. Karan, M.D., FACP, FASAM
Kevin B. Kunz, M.D., M.P.H., FASAM
Donald J. Kurth, M.D., FASAM (Treasurer — eligible for re-election)
David C. Lewis, M.D.
Peter A. Mansky, M.D.
Ronald F. Pike, M.D., FASAM
A. Kenison Roy III, M.D., FASAM (Secretary — eligible for re-election)
Marvin Seppala, M.D.
C. Chapman Sledge, M.D., FASAM
Barry Stimmel, M.D., FASAM
Trusandra E. Taylor, M.D.
Berton E. Toews, M.D., FASAM
Howard Wetsman, M.D.
Martha J. Wunsch, M.D., FAAP
Penelope P. Ziegler, M.D., FASAM

NOMINEES FOR DIRECTOR-AT-LARGE:

In accordance with the ASAM Bylaws, there shall be twice the number of nominees as available positions for Director-at-Large, which currently number six. In addition, at least two doctors of osteopathy must be nominated for the Director-at-Large seat reserved for a D.O. The membership will vote for 5 of the 10 candidates and for one of the two D.O.'s nominated for the reserved seat, so that six Directors-at-Large will be elected.

Directors-at-Large are elected to four-year terms. A Director-at-Large may succeed himself/herself only once, and may subsequently be re-elected after a hiatus of four years away from the Board. On this basis, the Nominating & Awards Council has determined that following incumbents are eligible for re-election as Directors-at-Large (current Director-at-Large David R. Gastfriend, M.D., is not eligible because he will have served two consecutive four-year terms at the time of the next election):

Anthony H. Dekker, D.O., FASAM
Stuart Gitlow, M.D., M.P.H.
R. Jeffrey Goldsmith, M.D.
Trusandra E. Taylor, M.D.
Penelope P. Ziegler, M.D., FASAM

All candidates must disclose any potential conflicts of interest and candidates with actual conflicts of interest should not consider service to ASAM in these offices.

NOMINATION AND ELECTION SCHEDULE

Profiles of the candidates nominated for election as Officers and Directors-at-Large posts will appear in the September-October 2006 issue of ASAM News. Ballots will be mailed to members in good standing by November 1, 2006, and must be completed and returned by December 1, 2006. 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 2007 issue of ASAM News, and the newly elected Officers and Director-at-Large will assume their posts during the 2007 Medical-Scientific Conference.

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

ASAM's 36th Annual Conference a Success

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

Dallas, Texas, attracted addiction medicine specialists from around the world during ASAM's 36th Annual Medical-Scientific Conference, April 14-17th. As in years past, the conference welcomed ASAM members as well as nonmember physicians, nurses, psychologists, counselors, students and residents. It was preceded by two special events: the Ruth Fox Course for Physicians and a Course on Pain and Addiction: Common Threads VI. The conference concluded on Sunday, April 17th, with a training course designed to qualify ASAM members and other physicians to prescribe the recently approved drug buprenorphine.

SYMPOSIUM ON ADOLESCENT ALCOHOL PROBLEMS

A day-long Symposium on "Translating Science to Practice for the Treatment of Adolescent with Alcohol Problem" was jointly sponsored by ASAM and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

During the symposium, noted scientists Sandra Brown, Ph.D., and Duncan B. Clark, M.D., reviewed the rationale, epidemiology, and goals of the NIAAA's Underage Drinking Initiative. Ronald E. Dahl, M.D., and Mark S. Goldman, Ph.D., then summarized the proliferating research on the neurobiochemical changes occurring in adolescence and how these processes are disrupted by alcohol use. They also discussed issues related to the use of DSM-IV criteria to identify youth who require treatment and how practitioners can learn to identify potential points of intervention earlier in the alcohol disorder trajectory.

The symposium concluded with presentations by Christopher S. Martin, Ph.D., and Howard Moss, M.D., who reviewed interventions for adolescent drinking that employ both behavioral and pharmacological tools.

SYMPOSIUM ON PRESCRIPTION DRUG ABUSE

"Prescription Drug Abuse: Science to Practice," a Symposium pertaining to multiple aspects of this complex problem, was jointly sponsored by the National Institute on Drug Abuse (NIDA), the Center for Substance Abuse Treatment (CSAT), and ASAM.

Prescription drug abuse is a major problem in our society. In the 2002 National Survey on Drug Abuse and Health, 6.2 million Americans age 12 and older reported that they had used a prescription drug for other than medical purposes. Moreover, the 2003 Monitoring the

Future Survey found that 10% and 4% of 12th graders said they had used Vicodin and Oxycontin non-medically.

Symposium presenters discussed the multiple factors that contribute to non-medical use of prescription drugs, including prescription opioids, psychostimulants, and sedative-hypnotics and their risk factors among adults, adolescents, women, and the elderly. Presenters also discussed the neurobiological mechanisms underlying prescription drug abuse, including tolerance and dependence, drug-drug interactions, and appropriate screening and patient management. Behavioral and pharmacologic treatments for prescription drug problems also were reviewed.

AWARDEES HONORED

Each year, ASAM honors a distinguished group of individuals who have made outstanding contributions to the field of Addiction Medicine and to the Society itself. ASAM's 2005 awards were presented to the following outstanding leaders in addiction medicine at a gala Awards Luncheon:

The 2005 R. Brinkley Smithers Distinguished Scientist Award was bestowed on Herbert D. Kleber, M.D., researcher, educator, and former Deputy Director of the White House Office of National Drug Control Policy. Dr. Kleber delivered the Smithers Distinguished Scientist lecture at the opening plenary session of the conference on April 15th.

The John P. McGovern Award on Addiction and Society went to Congressman James Ramstad, The McGovern Award was established in 1997 to recognize and honor an individual who has made "highly meritorious contributions to public policy, treatment, research, or prevention which has increased our understanding of the relationship of addiction and society." The award is sponsored by an endowment from the John P. McGovern Foundation.

An ASAM Annual Award for "expanding the frontiers of the field of Addiction Medicine and broadening our understanding of the addiction process through research and innovation" was presented to ASAM member Walter Ling, M.D., for his work in research and education.

An ASAM Annual Award for "outstanding contributions to the growth and vitality of our Society, for thoughtful leadership in the field, and for deep understanding of the art and science of addiction medicine" was presented to ASAM past President Anne Geller, M.D., FASAM.

The Medical-Scientific Conference Award for the abstract that earned the highest rating for scientific was presented to Richard N. Rosenthal, M.D., past President of the American Academy of Addiction Psychiatry.

The Young Investigator Award for the best abstract submitted by an author who is within five years of receiving a doctoral degree was presented to Matthew W. Warren and Steven L. West, Ph.D., CRC.

ASAM congratulates all the award recipients for their important contributions to addiction medicine.

"Addiction Across the Lifespan" is Theme of 2005 State of the Art Course

Shannon C. Miller, M.D., FASAM, CMRO
Martha J. Wunsch, M.D., FAAP

Please join us for ASAM's 2005 Course on the State of the Art in Addiction Medicine, October 27-29 at the Hyatt Regency Capitol Hill Hotel in Washington, DC. The theme of this year's course is "Addiction Across the Lifespan." Our program has been organized in cooperation with the Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration, and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) of the National Institutes of Health. The co-sponsorship of these agencies assures that the course is a centerpiece of addiction medicine education.

The expert faculty who teach the course are asked to provide a concentrated review of recent scientific advances and how they will influence clinical care. The audience has been so enthusiastic about the course that many faculty members return every two years for an update. Increasingly, faculty presenters choose to stay for the course beyond their own sessions, affording our participants an unparalleled opportunity for networking with leaders in the field.

COURSE GOALS. ASAM's Course on the State of the Art in Addiction Medicine provides an important link between cutting-edge scientific research and clinical practice. The course showcases the most recent findings in addiction research, reported by the nation's leading addiction researchers. It is designed specifically for the physician or other professional who seeks an advanced level of understanding of the scientific underpinnings of addiction practice. The course employs an innovative teaching approach that integrates epidemiology, basic science, therapeutics, health services and policy. Clinical cases within each track will organize key questions and set the stage for discussion.

WHO SHOULD ATTEND. Physicians, medical students and residents, psychologists, nurses, social workers, researchers, educators, and others who need the most up-to-date information on the mechanisms, prevention and treatment of alcohol, tobacco and other drug addictions.

As Co-Chairs, we invite you to join us for one of the few educational events where you can listen, learn, and ask without distractions or demands, and enjoy the excitement of burgeoning knowledge in our vibrant field. We hope to see you there!

Shannon C. Miller, M.D., FASAM, CMRO
Martha J. Wunsch, M.D., FAAP, Co-Chairs

ASAM'S 2005 COURSE ON THE STATE OF THE ART IN ADDICTION MEDICINE
"Addiction Across the Lifespan"

PROGRAM FOR THURSDAY, OCTOBER 27, 2005

THEME FOR THE DAY:
Our Emerging Understanding of the Dynamic Aspects of Addiction

SESSION 1 (MORNING).

BIOLOGICAL PLASTICITY: RISK AND PROTECTIVE FACTORS

- Development of Brain Circuits Relating to Addiction, from Fetus to Young Adults
- The At-Risk Brain I-Biological Risk and Protective Factors: Perspectives from the Cellular Level
- The At-Risk Brain II-Biological Risk and Protective Factors: Perspectives from Functional Imaging
- The At-Risk Brain III-Delta FosB: A Molecular Switch for Long-Term Plasticity

SESSION 2 (AFTERNOON).

DEVELOPMENTAL ASPECTS OF SUBSTANCE USE DISORDERS — IMPLICATIONS FOR PREVENTION AND TREATMENT

- The New NIAAA Alcohol Guidelines: Changes from Earlier Editions and Application to Specific Populations
- "Performance Enhancement" as an Emerging Pattern of Drug Use Among Adolescents and Young Adults
- Adolescent Tobacco Use: Psychosocial and Environmental Factors and Interventions
- Substance Use in the Baby-Boomer Generation: Predicting Future Service Needs

SESSION 3 (EVENING).

AN UPDATE ON NEW AND PIPELINE ANTI-ADDICTION MEDICATIONS

- Featuring Presentations on Acamprosate and Other New and Promising Medications for the Treatment of Alcohol and Drug Addiction and Relapse Prevention

PROGRAM FOR FRIDAY, OCTOBER 28, 2005

THEME FOR THE DAY:
Recent Developments in Prevention and Treatment Research

SESSION 4 (MORNING).

PREDICTING MEDICATION RESPONSE — INSIGHTS FROM THE RESEARCH

- Pharmacogenomics of Medications for Alcohol Addiction and Relapse Prevention
- Pharmacogenomics of Medications for Tobacco and Drug Addiction and Relapse Prevention
- Simplifying Compliance: Depot and Vaccine Therapies
- Prescribing Controlled Drugs: Clinical and Policy Considerations

SESSION 5 (AFTERNOON).

CONTEMPORARY ISSUES IN PREVENTION AND TREATMENT

- Proposition 36: Outcomes and Controversies
- Buprenorphine and the Use of Anti-Addiction Medications in Office Practice
- The Economic Benefits of Drug Treatment: A Critical Review of the Evidence
- Ethical Considerations in the Use of Anti-Addiction Vaccines

PROGRAM FOR SATURDAY, OCTOBER 29, 2005

THEME FOR THE DAY:
Challenges in Translating Science to Services

SESSION 6 (MORNING).

CO-OCCURRING DISORDERS: PREVENTION AND TREATMENT IMPLICATIONS

- PTSD and SUDs in Military Personnel Returning from Operation Enduring Freedom and Operation Iraqi Freedom
- Women and Alcoholism: New Research Into Trauma as a Contributing Factor
- Childhood Trauma as a Risk Factor for Later Child and Adolescent Addiction
- Pain and Addiction: Recent Clinical and Policy Developments

SESSION 7 (AFTERNOON).

ENCOURAGING THE ADOPTION OF EVIDENCE-BASED PRACTICES

- Undergraduate Medical Education: Changing the Curriculum to Reflect Emerging Scientific Knowledge
- Residency Training: Integrating the Needed Skills into Clinical Teaching
- Continuing Medical Education: The NIDA Primary Care Physician Outreach Project
- Can Clinical Trials Be Made More Relevant to Clinical Practice?

GENERAL INFORMATION

HOTEL. The State of the Art Course will be held at the Hyatt Regency Capitol Hill Hotel, 400 New Jersey Avenue, N.W., Washington, DC 20001. A limited number of rooms are being held at the special conference rate of $189 single or double. Rates are subject to state and local taxes, currently 14.5% (subject to change).

Reservations must be made no later than September 28, 2005. To receive the conference rate, phone the hotel's Reservation Department at 1-800/233-1234 or 202/737-1234. Identify yourself as attending the ASAM State of the Art Course. All reservations require a deposit for the first night's room by check or major credit card. Deposits are refundable only if the reservation is cancelled in advance.

CONTINUING EDUCATION. *ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION (ACCME):* The American Society of Addiction Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

AMERICAN MEDICAL ASSOCIATION (AMA): The American Society of Addiction Medicine designates th is continuing medical education activity for a maximum of 21 credit hours in Category 1 toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the activity.

PSYCHOLOGISTS: The American Society of Addiction Medicine's Continuing Medical Education (CME) has been approved for renewal of certification by the APA Practice Organization's College of Professional Psychology. ASAM CME credits may be applied toward the APA Practice Organization's "Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders."

COUNSELORS: ASAM has been approved as an Education Provider (#152) by the National Association of Alcoholism and Drug Abuse Counselors. Individuals who are applying for NAADAC credit should report their hours directly to NAADAC.

CONFERENCE FEES/REGISTRATION. Please register by phone or mail before Friday, October 7, 2005. For more information, see the ASAM website (www.asam.org) or phone ASAM's Department of Meetings and Conferences at 301/656-3920.

Payment must accompany all registrations. Registrations received after October 7, 2005, will be processed as on-site registrations and a late fee of $50 will be added.

The ASAM Registration Desk will be open for on-site registration at the following hours:

- Wednesday, October 26, 5:00 pm - 8:00 pm
- Thursday, October 27, 7:00 am - 5:00pm
- Friday, October 28, 7:30 am - 5:00pm
- Saturday, October 29, 7:30 am - 5:00pm

Continental breakfast will be offered in the Registration Area on Thursday, Friday, and Saturday mornings before the program begins.

Ruth Fox Memorial Endowment Fund

The Ruth Fox Memorial Endowment Fund thanks all of our donors and especially our major donors, who have contributed or pledged the following significant gifts over the years:

Distinguished Fellows' Circle ($250,000)

Joseph E. Dorsey, M.D.
Peter I. A. Szilagyi, M.D.*

Colleagues' Circle ($100,000+)

George W. Nash, M.D.*
Anthony B. Radcliffe, M.D.
Dr. & Mrs. James W. Smith
Richard Tyson, M.D.
Dr. & Mrs. Alan A. Wartenberg

Benefactors' Circle ($50,000+)

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Jasper G. Chen See, M.D.*
Elizabeth F. Howell, M.D.
Walter K. Kemp, M.D.
Brian A. McDevitt, D.O.
Michael Michalek, M.D.
Melvin Pohl, M.D.
Jokichi Takamine, M.D.
**deceased*

Dr. Ruth Fox

Dear Colleagues:

The gala Ruth Fox Donor Reception during the Medical-Scientific Conference honored the generosity of those who have made donations to the Fund, as well as recipients of the Ruth Fox Fund scholarships. As in past years, the cost of the reception was underwritten by a generous gift from ASAM member Joseph E. Dorsey, M.D., and Mrs. Dorsey.

Each year, the Reception provides an opportunity to recognize all donors to the Fund, and especially major donors, who have contributed or pledged significant gifts over the years. It also provides an opportunity to recognize the achievements of this year's recipients of the Ruth Fox Scholarships, given to an outstanding group of physicians-in-training to attend ASAM's Annual Medical-Scientific Conference and Ruth Fox Course for Physicians.

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

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

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IT'S TIME TO DEVELOP OUR FUTURE LEADERS

Donald J. Kurth, M.D., FASAM

As our founding leaders have grown older and moved on, or are no longer with us, we have heard talk of "the graying of ASAM." Nationwide, there has been a perception of a leadership void facing our specialty and the entire field of Addiction Medicine. We have wrung our hands over the situation for too long. So CSAM acted to begin developing our future leaders, and has thrown down the gauntlet for the rest of ASAM to follow suit. Through its new program, the California Society has developed a plan to reach into our membership and develop bright, new leaders from within. And, more importantly, we have given them the "authority" to step forward and begin to assume their roles as future leaders in Addiction Medicine.

Before I get too far ahead of myself, let me fill you in on a little history. Several years ago, Nancy Kaufman, then Vice President of the Robert Wood Johnson Foundation, approached Dr. John Slade, long-time ASAM member and visionary leader, to help create a program to develop addiction medicine leaders. Ms. Kaufman and Dr. Slade recognized that ASAM — and indeed the entire field of addiction medicine — had been blessed over the years by great leaders. But they were concerned that as those leaders got older, there might not be any young leaders to take their places.

Under the guidance of Dr. Slade, the Foundation addressed this issue by developing the "Developing Leadership in Reducing Substance Abuse Fellowship Program." Now in its final year of funding, the Fellowships set out to develop leadership among a group of Fellows selected from a nationwide pool of applicants. I was fortunate to be selected in the last group of Fellows. The leadership training and encouragement provided through the program have been invaluable to my own research, public policy, and clinical work. But, most importantly, I have been able to bring skills acquired in the program back to my fellow physicians in Addiction Medicine. As evidence, I recently helped CSAM organize its first Leadership Development Retreat for 35 CSAM leaders (past, present, and future) in Monterey, California. With the help of leadership development expert Tony Reilly, Ph.D., and CSAM Education Chair and President-Elect David Pating, M.D., CSAM created an innovative and

Dr. Donald Kurth

powerful program for physician leadership development.

CSAM Past President Peter Banys, M.D., led off Friday evening with a fireside chat on "Controversies in Addiction Medicine," which allowed the group to explore a range of issues in our field. On Saturday, after an early morning beach walk, Dr. Reilly facilitated a workshop on "The Role of the Physician Leader in Addiction Medicine," in which he encouraged the group to explore creativity in leadership and the physician's role.

Peter Reilly, Senior Hewlett Fellow in the Program on Conflict Resolution and Legal Problem Solving at the Georgetown University Law Center, then led a workshop on "Negotiation: The Essence of Leadership." Participants were encouraged to discuss the skills of effective leaders and to learn some of the techniques that leaders use to get results. Each of us discovered talents we never knew we had!

After lunch we were off to the sand dunes for a talk on "Careers in Addiction Medicine" by three of our outstanding CSAM leaders. These were not about CVs, but rather personal accounts of how they advanced their careers, what experiences meant the most to them, and how they found their places in addiction medicine. This was followed by a public speaking class led by veteran Toastmaster Suzanne Harrington-Cole.

CSAM Past President Gary Jaeger then led a workshop on "The Politics of Addiction Medicine." The wide-ranging discussion covered areas from reimbursement and authorization to the discrimination and stigma against physicians who treat patients suffering from addiction. We looked at the roadblocks each of us face in our daily lives, as well as strategies for overcoming these barriers to effective treatment.

On the final day of the workshop, participants were divided into five teams, each of which was tasked with identifying the core issues facing addiction medicine and developing a plan to address those issues. With the timer running for each step of the process, team members were forced to quickly identify core issues and develop policies. The process was intense, but the rewards exhilarating.

The chairs of the CSAM Education, Membership, and Public Policy Committees then presented "Visions and Mandates" to help our future leaders understand the inner workings of the CSAM committee structure and how their skills could contribute to the Society. As CSAM President, I was in charge of wrapping up the session with remarks on "The Journey Ahead of Us." The energy was still pumping. We had covered so much territory in three short days that it was a challenge for each of us to hold on to all these new ideas. Judging from the enthusiastic feedback, we all left energized to recommit ourselves to the vital work we are so fortunate to be able to do every day. More importantly, however, we were able to set ourselves on the path to improve the health of our patients, ensure the success of CSAM, and focus on the future of Addiction Medicine.

***DR. KURTH** is President of the California Society of Addiction Medicine as well as Chair of the Legislative Advocacy Committee and Treasurer of the American Society of Addiction Medicine. He is Chief of Addiction Medicine at the Loma Linda University Behavioral Medicine Center and holds an appointment as Associate Professor in the Department of Psychiatry at Loma Linda University. He can be reached at DONKURTH@AOL.COM.*

ASAM Conference Calendar

ASAM

July 29-31, 2005
ASAM Medical Review Officer (MRO) Training Course
Westin Cincinnati Hotel
Cincinnati, Ohio

October 27-29, 2005
ASAM Course on the State of the Art in Addiction Medicine
Hyatt Regency
Capitol Hill Hotel
Washington, DC
[Approved for 21 Category 1 CME Credits]

December 8, 2005
ASAM Forensic Issues in Addiction Medicine Course
Westin Embassy Row Hotel
Washington, DC

December 9-11, 2005
ASAM Medical Review Officer (MRO) Training Course
Westin Embassy Row Hotel
Washington, DC

May 4-7, 2006
ASAM 37th Annual Meeting and Medical-Scientific Conference
San Diego Sheraton Hotel & Marina
San Diego, California

OTHER EVENTS OF NOTE

September 12-13, 2005
"Managing Individual and Program Liability Risk"
Sponsored by the Center for Substance Abuse Treatment
Providence, RI
[Approved for 10.5 Category 1 CME Credits]
[For information or to register, email JGIBBS@JBS.BIZ]

September 23-26, 2005
Caron Foundation and ASAM present
"Families and Addiction"
Caron Foundation, Wernersville, PA
[For information or to register, phone 610/743-6402]

September 29-30, 2005
American Society for Clinical Pharmacology and Therapeutics
"Adverse Drug Events and Medication Errors: Impact on Medical Care in the 21st Century"
Loews Philadelphia Hotel,
Philadelphia, PA
[For information, phone Bethany Oxer at 703/836-6981 or email INFO@ASCPT.ORG]

April 22-26, 2006
American Association for the Treatment of Opioid Dependence (AATOD) National Conference: "Working with Criminal Justice and Health Care Systems"
Hyatt Regency Hotel, Atlanta, GA
[For information, phone 856/423-7222 x 360, or visit WWW.AATOD.ORG]

BUPRENORPHINE TRAINING

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

August 6, 2005
ASAM
St. Louis, Missouri
Contact: WWW.DOCOPTIN.COM
or phone 888/362-6784

September 3, 2005
ASAM - Hawaii Society of Addiction Medicine
Honolulu, Hawaii
Contact: WWW.DOCOPTIN.COM
or phone 888/362-6784

September 9, 2005
AOAAM - ASAM Region VII
San Antonio, Texas
Contact: WWW.DOCOPTIN.COM
or phone 888/362-6784

September 9, 2005
NYSAM - ASAM
Saratoga Springs, New York
Contact: WWW.DOCOPTIN.COM
or phone 888/362-6784

September 11, 2005
CSAM - ASAM
San Francisco, California
Contact: WWW.DOCOPTIN.COM
or phone 888/362-6784

October 30, 2005
ASAM (follows the State of the Art Course)
Hyatt Regency Capitol Hill Hotel
Washington, DC
Contact: WWW.DOCOPTIN.COM
or phone 888/362-6784

Mark your calendar for ASAM's 2005 Course on the State of the Art in Addiction Medicine, October 27-29 in Washington, DC.

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.