Special Election Issue 2006
Volume 21, Number 4

ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

ASAM at Work for You:

Other News:

Voting for ASAM officers takes place in November. See pages 12-23 for news from the candidates!

www.asam.org

ASAM's Review Course in Addiction Medicine Set For Chicago

ASAM's 2006 Review Course in Addiction Medicine will meet at the Westin O'Hare Hotel in Chicago,October 26th-28th. The course is followed on Sunday, October 29th, by ASAM's course on *Pain & Addiction: Common Threads.*

Co-chaired by Karen Drexler, M.D., and Edwin A. Salsitz, M.D., FASAM, the Review Course is designed to meet the needs of multiple audiences, including: (1) physicians who are preparing to take the ASAM Certification/Recertification Examination; (2) addiction specialists who seek an update on recent developments in addiction practice; and (3) primary care physicians, nurses, counselors and others who seek a succinct review of the knowledge needed to successfully identify and manage patients whose problems are caused or complicated by alcohol, tobacco or other drug use.

This year's course will give special attention to the use of newly available pharmacotherapies for alcohol and drug use disorders, including buprenorphine for the treatment of opioid addiction and acamprosate and long-acting injectable naltrexone for the prevention of relapse to alcohol use.

For additional information or to register for either the Review Course of the Pain Course, visit the ASAM website at www.asam.org or contact ASAM's Department of Meetings and Conferences at 301/656-3920. *(See pages 6-7 and 32 for more information on education and training opportunities.)*

ASAM Members to Elect New Officers, Directors

ASAM members are about to choose the Society's next President-Elect, Secretary, and Treasurer, as well as a full slate of Directors at Large. Ballots will be mailed to members in good standing by November 1, 2006, and must be returned to ASAM by December 1st.

Candidates for election are: (*for President-Elect*) Louis E. Baxter, Sr., M.D., FASAM, Richard A. Beach, M.D., FASAM, and Donald J. Kurth, M.D., FASAM; (*for Treasurer*) Stuart Gitlow, M.D., M.P.H., M.B.A., Lori D. Karan, M.D., FACP, FASAM, and James W. Smith, M.D., FASAM; (*for Secretary*) Peter A. Mansky, M.D., and A. Kenison Roy III, M.D., FASAM; (*for Director at Large; five to be elected*) Richard A. Beach, M.D., FASAM, Stuart Gitlow, M.D., M.P.H., M.B.A., R. Jeffrey Goldsmith, M.D., James A. Halikas, M.D., FASAM, Merrill S. Herman, M.D., Lori D. Karan, M.D., FACP, FASAM, Mark L. Kraus, M.D., FASAM, Donald J. Kurth, M.D., FASAM, A. Kenison Roy III, M.D., FASAM, James W. Smith, M.D., FASAM, and Penelope P. Ziegler, M.D., FASAM; (*for Director representing Osteopathic Medicine; one to be elected*) Allan M. Ebert, D.O., FASAM, Scott Smolar, D.O., and John C. Tanner, D.O., FASAM.

Election results will be announced in the January-February 2007 issue of ***ASAM News***. The newly elected officers and Directors will be installed during the Society's April 2007 Medical-Scientific Conference, when current President-Elect Michael M. Miller, M.D., FASAM, will assume the ASAM Presidency. Profiles of the candidates appear on pages 12-23 of this issue of ***ASAM News***.

Physician Support System Exceeds Goals

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

Eileen McGrath, J.D.

As the Physician Clinical Support System (PCSS), an ASAM-coordinated mentoring network for clinicians who use buprenorphine for the treatment of opioid dependence, approaches the midway point of a three-year pilot phase, early data show that it is exceeding organizers' goals. The system, which is funded by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration, is operated by ASAM and a consortium of cosponsoring organizations.

Early outcomes data on the PCSS, which now serves nearly 1,000 physicians through 70 training mentors, were presented at the 2006 annual meeting of the College on Problems of Drug Dependence. The data show that PCSS is having a positive impact on access to buprenorphine treatment by helping physicians incorporate such treatment into their practices.

Organizers also announced that a number of new online resources created for PCSS are being well utilized. These include the www.PCSSMENTOR.ORG website, which is updated continuously, and the PCSS listserv, which allows users to share information on clinical best practices and to provide mentoring resources. The PCSS also has developed three clinical guidances that are available free of charge through the PCSS website. In addition, the PCSS "warm line" (1-877/630-8812) provides a national system of telephone triage by registering participants and matching them with an appropriate mentor within 48 hours. The warm line fields approximately 25 inquiries a week from individuals seeking general information about buprenorphine and provides an important referral service for individual physicians by engaging them in the PCSS and by directing them to the SAMHSA buprenorphine website and information service.

Information about the PCSS has appeared in more than 35 professional and lay publications, including *American Medical News*, *American Family Physician*, *AAFP News*, *SGIM News*, *USA Today*, and the newsletters of 14 state medical associations. In addition, the PCSS project was cited favorably in a Capitol Hill press conference hosted by Senator Carl Levin (D-MI) to mark the success of the DATA 2000 Act, which reversed many years of legal limitations by allowing physicians to treat opioid addiction in office-based settings.

To access the PCSS, to find or become a mentor, or for additional information, phone 1-877/630-8812 or visit WWW.PCSSMENTOR.ORG.

JOIN THE PCSS!

The Physician Clinical Support System (PCSS), a national mentoring network offered free of charge to physicians treating opioid dependence, is a service supported by SAMHSA and coordinated by ASAM to help physicians implement buprenorphine in their practices. To learn more, visit www.PCSSmentor.org or call 1-877/630-8812.

ASAM Dues Structure to Change

ASAM's Membership Department has announced that national membership dues will change in 2007 for members in the following categories:

- Regular membership will be $300 (was $290)
- Resident membership will be $35 (was $70)
- Medical student membership will be $0 (was $20)

A renewal notice will be mailed to all members in October 2006, and dues are payable by January 1, 2007.

For more information, contact the ASAM Membership Department at 301/656-3920.

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

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

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

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

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

Cigarette Sales Drop to Lowest Level in 50 Years

Cigarette sales in the United States have reached the lowest point since 1951. According to data compiled by the U.S. Department of Agriculture, the number of cigarettes sold in the U.S. rose steadily from 375 billion in 1950 to a peak of 640 billion in 1981, then declined to 485 billion in 1993. From 1993 to 1997, the trend line flattened, then began to decline again in 1998, dropping to a new low in 2005, when 378 billion cigarettes were sold.

Experts speculate that factors influencing the decline include advertising restrictions and increased cigarette prices stemming from the 1998 tobacco Master Settlement Agreement, legislation restricting where people can smoke, and greater knowledge of the health risks associated with smoking.

Tobacco sales data used in the report were compiled by the U.S. Department of Agriculture from reports of the Alcohol and Tobacco Tax and Trade Bureau, U.S. Department of Treasury.

Internet Offers Lessons in Drug Tampering

Internet users can readily access explicit advice on methods of tampering with prescription medications so as to extract abusable substances, says a recent report. Commenting on his investigation, pharmacologist Edward J. Cone, Ph.D., said: "I just touched the tip of the iceberg.... Nothing parallels this phenomenon. The amount of information now available is staggering."

In surveying Internet sites that support recreational drug use, Dr. Cone found instructions on crushing, separating, purifying and chemically altering specific formulations to allow changes in dosage, route of administration, and time course of effects. Even products containing features designed as "barriers" to tampering are not immune, Dr. Cone says.

He also found that successful tampering methods that have widespread appeal evolve into recipes and become archived on multiple websites. Examples include: (1) how to separate opioid analgesics (containing codeine, hydrocodone, or oxycodone, for example) from excipients and non-desirable active ingredients like aspirin, acetaminophen, or ibuprofen; (2) overcoming time-release formulations employing beads, layers, or matrices; (3) removing active drug from high-dose formulations (such as patches and pills); and (4) alteration of dosage forms for alternate routes of administration.

Based on his review, Dr. Cone advises that "development of successful formulations that inhibit or prevent drug/formulation tampering with drugs of abuse should take into consideration the scope and practice of tampering methods available to recreational drug users on the Internet."

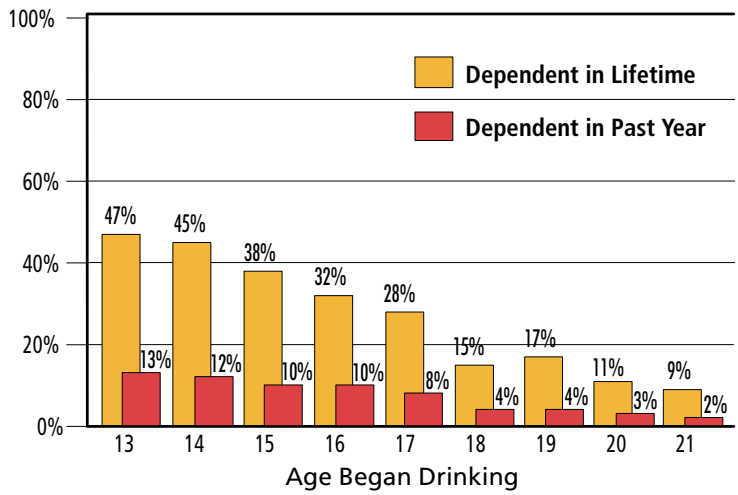
Source: Cone EJ (2006). Ephemeral profiles of prescription drug and formulation tampering: Evolving pseudoscience on the Internet. Drug and Alcohol Dependence *83(Suppl.1):S31-S39.*

Measures to Deter Early Alcohol Use Called Essential

Early alcohol use increases the likelihood of subsequent alcohol dependence, according to an analysis of data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a face-to-face survey of a multistage probability sample of 43,093 adults age 18 years and older conducted in 2001–2002. NESARC data were collected from 26,829 respondents who reported ever drinking alcohol.

In analyzing the data, investigators Ralph Hingson, Sc.D., M.P.H., and colleagues found that almost half (47 percent) of persons who began drinking before age 14 went on to become alcohol-dependent at some point in their lives, compared to only 9 percent of those who began drinking after age 20. Early drinking also was positively associated with higher rates of dependence within 10 years of onset of drinking and to the development of dependence before age 25. The findings held even after investigators controlled for family history of alcohol use disorders and other relevant factors.

PERCENT OF ADULTS 18 AND OVER WHO ARE DEPENDENT ON ALCOHOL, BY AGE OF ONSET OF ALCOHOL USE



Summing up the data, the researchers concluded that "[T]his study reinforces important concerns about youth starting to drink at early ages. The human brain is still developing into the middle 20s. Some investigators have reported that, compared with demographically matched non-dependent adolescents from similar communities, adolescents who are dependent exhibit decrements in memory, spatial relations, and planning, and in magnetic resonance imaging studies exhibited less hippocampal development. Whether these decrements preceded and contributed to the development of alcohol dependence and whether these problems will resolve if drinking is curtailed are not known...."

They called for more research into the types of interventions that might delay the onset of alcohol use among adolescents and, in turn, reduce the development of alcohol dependence during adolescence and the adult years, describing such research as having "vast medical, social, and public health importance."

Source: Hingson RW, Heeren T & Winter MR (2006). Age at drinking onset and alcohol dependence. Archives of Pediatrics and Adolescent Medicine *160(7):739-746. Graphic courtesy of CESAR, No. 15-30.*

ASAM Board Approves Policy Updates on Buprenorphine, Marijuana

At its May 2006 meeting in San Diego, ASAM's Board of Directors gave final approval to three revisions of previously adopted Public Policy Statements on "Buprenorphine," "Marijuana," and "Highway Safety." Each of these had been debated and scrutinized by members of the Public Policy Committee, by representatives of the State Chapters (eight of whom serve on the Committee), and by members of the Board over the course of many weeks of consideration and revision.

Dr. Elizabeth F. Howell

As is true of many topics, some basic disagreements emerged among various schools of thought regarding details of the first draft revisions. These were worked through carefully and with broad participation to achieve compromises which would retain the tradition and quality of meaningful statements by the Society, while incorporating the diverse views of its members.

The policy statement on "Buprenorphine" is particularly timely in its strong recommendations for relaxation of the 30-patient rule for individual practitioners treating patients for opioid addiction in office-based practice. Federal legislation signed by President Bush earlier this year amends the Drug Addiction Treatment Act (DATA) by lifting the 30-patient limit on group practices, but leaves intact the limit for individual practitioners. Draft legislation sponsored by Senators Carl Levin (D-MI) and Orrin Hatch (R-UT), to be introduced in Fall 2006, addresses the limit on individual physicians. The Board feels that ASAM's support of this effort, organizationally and by individual physicians, will be important to the outcome of the legislative initiative.

The policy statement on "Marijuana" updates a statement originally adopted in 1987 and revised several times since. It introduces stronger recommendations for funding research into the possible medical benefits of cannabinoids, as well as alternative delivery systems for medical marijuana. The statement argues against the use of inhalant forms of delivery, describing them as having many of the same risks associated with tobacco smoking.

All of ASAM's Public Policy Statements can be accessed on ASAM's website (www.asam.org) by selecting "ASAM General" and "Public Policy" on the home page. The site also offers both a chronological and a topical listing of all ASAM Public Policy Statements, including the dates of revision, where applicable. All of ASAM's Public Policy Statements have been copyright-protected since 2005 but may be used freely within the terms of the copyright.

ASAM Public Policy Statement on Marijuana

Marijuana is a mood-altering drug capable of producing dependency. Its chief active ingredient is delta-9-Tetrahydrocannabinol, but there are many other ingredients.

Marijuana has been shown to have adverse effects on memory and learning, on perception, behavior and functioning, and on pregnancy. Because of the widespread use of this drug, its effects on mind and body, and the increasing potency of available supplies, ASAM strongly recommends:

1. Education about drugs, beginning in the earliest grades of elementary school and continuing through university level. Drug education should contain scientifically accurate information on the dangers and harmful effects of marijuana, and on the disease of marijuana dependence.
2. Health and human service professionals should be educated about marijuana and marijuana dependence as a required part of their curriculum.
3. Persons suffering from alcoholism and other drug dependencies should be educated about the need for abstinence from marijuana and its role in precipitating relapse, even if their original drug of choice is other than marijuana. Treatment programs providing addictions treatment for chemically dependent patients should include tests for cannabinoids with other drug test panels and consider test results when designing treatment plans.
4. Marijuana-dependent persons, like other drug-dependent people, should be offered treatment rather than punishment for their illness. Treatment of marijuana dependence should be part of the plan for rehabilitation of any person convicted of a drug-related offense, including driving under the influence of alcohol and/or drugs, who is found to be marijuana dependent.
5. Medical uses of pharmaceutical delta-9-tetrahydrocannabinol (such as Marinol() for the treatment of illnesses associated with wasting, such as AIDS, the treatment of emesis associated with chemotherapy, or for other indications, should be carefully controlled. Smoking marijuana is dangerous to the health of any user, and produces health risks of passive smoke akin to risks of exposure to passive tobacco smoking. Inhaled smoke is a suboptimal delivery method for any agent intended to be health-promoting in any way. ASAM supports continued evidence-based research into alternative delivery systems of cannabinoid applications.
6. Research on marijuana, including both basic science and applied clinical studies, should receive increased funding and appropriate access to marijuana for study. The mechanisms of action of marijuana, its effect on the human body, its addictive properties, and any appropriate medical applications should be investigated, and the results made known for clinical and policy applications. In addition, ASAM strongly encourages research related to the potential and actual effects of marijuana-related public policy.
7. Physicians should be free to discuss the risks and benefits of medical use of marijuana, as they are free to discuss any other health-related matters. Recognized scientific researchers following established research protocols should be free to conduct research on marijuana and pharmaceutical cannabinoids.

Adopted by ASAM Board of Directors April 1987; revised April 1997, October 1997, July 1998, December 2000 and May 2006.

ASAM Public Policy Statement on Buprenorphine for Opioid Dependence and Withdrawal

BACKGROUND: Federal legislation has been passed that enables qualified physicians to prescribe Schedule III-IV medications approved by the federal Food and Drug Administration (FDA) for treatment of opioid dependence. The National Institute on Drug Abuse (NIDA), in collaboration with a pharmaceutical company, has developed buprenorphine for the treatment of opioid dependence, and a New Drug Application was submitted to and approved by the FDA for two formulations of sublingual buprenorphine tablets (one containing buprenorphine alone, and one containing buprenorphine in combination with naloxone). Buprenorphine is a partial opioid agonist and has clinical utility in the management of pain and in the treatment of heroin and prescription opioid dependence.

Like other opioids, buprenorphine can produce reinforcing effects. When used outside the confines of a physician-patient relationship, buprenorphine has the potential (akin to other opioid agonist therapies) to be diverted for unauthorized use. The formulation of buprenorphine in combination with naloxone is expected to have less potential for misuse, especially via intravenous routes of administration, and is generally the formulation preferred for unobserved maintenance or withdrawal therapy.

When used for the treatment of opioid dependence, and when prescribed by a physician for opioid withdrawal, buprenorphine has been shown to be a safe and effective treatment, although relapse to opioid use following withdrawal is common. In a sublingual form, buprenorphine has been shown to be an important therapeutic tool for addiction medicine specialists, when prescribed in a private physician's office or an addiction treatment facility. As a clinical tool, buprenorphine would have limited utility were the federal Drug Enforcement Administration (DEA) to classify it as a Schedule II medication or were it assigned solely to the regulatory structure for methadone.

Buprenorphine is a unique medication that has offered a unique and unprecedented opportunity for addiction medicine. Since its approval by the FDA in 2002, buprenorphine has led to expansion of the treatment system for opioid dependence. However, the Drug Addiction Treatment Act of 2000 and subsequent legislation have included caps on the number of patients who can be treated with buprenorphine, such as a 30-patient limit per registered practitioner.

Recommendations:

1. ASAM recommends that physicians appropriately trained and qualified in the treatment of opioid withdrawal and opioid dependence should be permitted to prescribe buprenorphine in the normal course of medical practice and in accordance with appropriate medical practice guidelines, and that federal controlled substance scheduling guidelines and other federal and state regulations should permit buprenorphine to be made available for physicians to prescribe for maintenance and withdrawal in opioid dependent patients.
2. ASAM strongly opposes any action to restrict access to buprenorphine for the treatment of opioid addiction or withdrawal through either rescheduling under the U.S. Controlled Substances Act or international agreement under the umbrella of the World Health Organization. Either of these courses of action would unnecessarily and inappropriately reduce physicians' ability to use this medication to address the pressing public health problem of opioid addiction.
3. Arbitrary caps on the number of patients who can be treated by a physician, the dosage of medication which is allowed, or the duration of treatment with buprenorphine, that are not supported by medical evidence, should not be imposed by law, regulation, or health insurance practices.
4. Standards of professional practice should outline that psychosocial supports should be offered to patients receiving agonist medications for opioid dependence or undergoing detoxification from opioids.

Adopted by the ASAM Board of Directors April 1998; revised September 2001; October 2002; May 2006.

ASAM Course Offers Review and Update of Addiction Science, Clinical Practice

ASAM's 2006 Review Course, which covers the core content of addiction medicine, is scheduled for the Westin O'Hare Hotel in Chicago, October 26th-28th. The course is followed by ASAM's course on *Pain & Addiction: Common Threads*, on Sunday, October 29th.

Dr. Edwin A. Salsitz

Dr. Karen Drexler

Co-chaired by Karen A. Drexler, M.D., and Edwin A. Salsitz, M.D., FASAM, the Review Course is designed to meet the needs of multiple audiences, including:

- ★ Physicians who are planning to sit for the ASAM Certification/Recertification Examination in Addiction Medicine will find the course a highly effective adjunct to their preparations for the exam.
- ★ Addiction specialists will find the Review Course a useful "refresher" because of its clinical orientation and focus on recent developments in addiction practice.
- ★ Non-specialist physicians and other clinicians will find in the course a succinct summary of the knowledge needed to identify and manage problems related to alcohol, tobacco and other drug use, which studies show are present in one of every 10 patients seen in primary care settings.

This year's course gives special attention to the use of newly available pharmacotherapies for alcohol and drug problems, including buprenorphine for the treatment of opioid addiction and acamprosate and long-acting injectable naltrexone for the prevention of relapse to alcohol use.

2006

PAIN & ADDICTION COURSE

ASAM's 2006 ***Pain and Addiction Course*** will be held Sunday, October 29, 2006, also at the Westin O'Hare Hotel in Chicago.

See the ASAM website (WWW.ASAM.ORG) for program and registration information.

SPECIAL SESSIONS

In addition, the course features three special sessions on topics of current interest:

What to Expect of the Certification Exam: Test developers and recent examinees explain how questions are developed, administered and scored; what to expect the day of the exam; how to use the Review Course, Study Guide and *Principles* textbook to prepare for the examination.

Stigma and the Vocabulary of Addiction: How the language clinicians use affects their attitudes and self-image, patients' understanding and adherence, and the public's perception of addictive disease.

Challenges in Pain Management: The emerging consensus on management of pain, particularly in patients at risk for or recovering from a substance use disorder, and how addiction specialists can help their primary care colleagues improve the care of all patients suffering from pain while minimizing the risk of addiction.

TEXTBOOK AND STUDY GUIDE

ASAM's textbook, *Principles of Addiction Medicine, Third Edition*, is the basic reference text for the Review Course. Speakers will refer to and draw from this text often as part of their presentations. (*Principles* must be purchased separately: order from 1-800/844-8948; prices are $175 for ASAM members, $199 for nonmembers. Copies will also be available for purchase onsite at the course.)

As a supplement to *Principles*, participants in the Review Course will receive a Study Guide that outlines and supplements the material to be covered in the course. The Study Guide is a useful clinical reference and, for those who plan to sit for the Certification/Recertification Exam, provides advice on how to prepare and what to expect of the exam. The Study Guide will be shipped September 15, 2006, to all persons who have registered for the Review Course by that date. Those whose registrations are received after the Friday, October 13, 2006, will receive the Study Guide in Chicago at the ASAM Registration Desk.

LEARNING OBJECTIVES

Participants who complete the Review Course should be able to demonstrate knowledge of current clinical practice across the spectrum of Addiction Medicine. For example, they will be able to:

- Describe the effects of alcohol, tobacco and other drugs in both tolerant and non-tolerant individuals;
- Describe the process for diagnosing addiction and differentiating the symptoms of addiction from those of other medical or psychiatric disorders;
- Discuss important instruments for screening and assessing patients for alcohol, tobacco and other drug problems;
- Explain the various approaches to pharmacologic and behavioral treatment of addictive disorders, and describe the factors that should be considered in selecting a treatment modality to match a particular patient's needs.

CME CREDITS

The American Society of Addiction Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education activities. The American Society of Addiction Medicine designates this educational activity for a maximum of 21 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

ASAM REVIEW COURSE IN ADDICTION MEDICINE

Thursday, October 26 – Saturday, October 28, 2006

WESTIN O'HARE HOTEL

CHICAGO

Wednesday, October 25, 2006

5:00 – 7:00 pm
Registration opens

Thursday, October 26, 2006

7:00 am – 5:00 pm
Registration

7:00 – 8:00 am
Mutual Help Meeting

8:00 – 9:00 am
Continental Breakfast

9:00 – 9:15 am
Welcome and Acknowledgements
Elizabeth F. Howell, M.D., FASAM, President of ASAM
Karen Drexler, M.D., and Edwin A. Salsitz, M.D., FASAM, Co-Chairs

9:15 – 10:15 am
Epidemiology
Rosa M. Crum, M.D., M.H.S.

10:15 – 10:30 am
Refreshment Break

10:30 – 11:45 am
Neurobiology
Eliot L. Gardner, Ph.D.

11:45-1:00 pm
Lunch (on your own)

1:00 – 2:00 pm
Screening and Brief Intervention
Theodore V. Parran, Jr., M.D.

2:00 – 3:00 pm
Psychiatric Comorbidities
Richard K. Ries, M.D., FASAM

3:00 – 3:15 pm
Refreshment Break

3:15 – 4:15 pm
Medical Comorbidities
Todd W. Mandell, M.D.

4:15 – 5:15 pm
Pregnancy and Addiction
Martha J. Wunsch, M.D., FAAP, FASAM

5:15 – 5:30 pm
Announcements and Review of the Day
Karen Drexler, M.D., and Edwin A. Salsitz, M.D., FASAM

5:30 – 7:00 pm
Dinner (on your own)

7:00 – 8:00 pm
What to Expect of the Certification Exam:
Presiding: Louis E. Baxter, Sr., M.D., FASAM

8:00 – 9:00 pm
Stigma and the Vocabulary of Addiction
Presiding: Edwin A. Salsitz, M.D., FASAM

9:00 – 10:00 pm
Mutual Help Meeting

Friday, October 27, 2006

7:00 am – 5:00 pm
Registration

7:00 – 8:00 am
Mutual Help Meeting

8:00 – 8:45 am
Continental Breakfast

8:45 – 9:00 am
Overview of Day 2
Karen Drexler, M.D., and Edwin A. Salsitz, M.D., FASAM

9:00 – 10:30 am
Alcohol
Peter Banys, M.D.

10:30 — 10:45 am
Refreshment Break

10:45 – 11:45 am
Sedative-Hypnotics
George E. Woody, M.D.

11:45 – 1:00 pm
Lunch (on your own)

1:00 – 2:00 pm
Behavioral Therapies
George E. Woody, M.D.

2:00 – 3:00 pm
Opioid Agonist Therapy – Part I (Methadone)
Edwin A. Salsitz, M.D., FASAM

3:00 – 3:15 pm
Refreshment Break

3:15 – 4:15 pm
Opioid Agonist Therapy – Part 2 (Buprenorphine & Other Agents)
Edwin A. Salsitz, M.D.

4:15 – 5:15 pm
Twelve Step Programs
John N. Chappel, M.D., FASAM

5:15 – 5:30 pm
Review of the Day
Karen Drexler, M.D., and Edwin A. Salsitz, M.D., FASAM

5:30 – 7:00 pm
Dinner (on your own)

7:00 – 9:00 pm
Challenges in Pain Management
Presiding: Herbert L. Malinoff, M.D., FACP
Faculty: Scott Fishman, M.D. (President, American Academy of Pain Medicine)

9:00 – 10:00 pm
Mutual Help Meeting

Saturday, October 28, 2006

7:00 am – 4:30 pm
Registration

7:00 – 8:00 am
Mutual Help Meeting

8:00 – 8:45 am
Continental Breakfast

8:45 – 9:00 am
Overview of Day 3
Karen Drexler, M.D., and Edwin A. Salsitz, M.D., FASAM

9:00 – 10:30 am
Stimulants (including Methamphetamine)
Karen Drexler, M.D.

10:30 – 10:45 am
Refreshment Break

10:45 — 11:45 am
Clinical Uses of Drug Testing
Robert L. DuPont, M.D.

11:45 am – 1:00 pm
Lunch (on your own)

1:00 – 2:00 pm
Marijuana
Carl L. Hart, Ph.D.

2:00 – 3:00 pm
Dissociatives, Hallucinogens, Steroids, and Inhalants
Shannon C. Miller, M.D., FASAM, FAPA, CMRO

3:00 – 3:15 pm
Refreshment Break

3:15 – 4:15 pm
Tobacco
Richard D. Hurt, M.D., FASAM

4:15 – 4:30 pm
Appreciations
Elizabeth F. Howell, M.D., FASAM

Wrap up and Adjournment
Karen Drexler, M.D. and Edwin A. Salsitz, M.D., FASAM

Once-Weekly Buprenorphine/ Naloxone Treatment Called Effective

Once-weekly doses of buprenorphine/naloxone, combined with psychotherapy and delivered in a physician's office, were just as effective in treating opiate addiction as thrice-weekly doses and extensive counseling, researchers report. "We've demonstrated the safety and efficacy of providing this type of treatment in a primary-care setting, and that had never been done before," commented lead author David A. Fiellin, M.D. "We've also identified a moderate or minimum counseling therapy and medication dispensing that is safe and effective."

For the study, Dr. Fiellin and colleagues assigned 166 opiate-addicted patients to one of three treatment regimens: standard medical management (20 minutes of counseling once a week) with either once-weekly or three-times-a-week medication dispensing, or enhanced medical management (with 45 minutes of counseling) and three-times-a-week medication dispensing. At the end of the 24-week treatment period, the researchers found that the three treatments were equally effective in promoting abstinence and retaining clients in treatment, with each judged effective in about 4 of 10 patients.

Dr. Fiellin noted that the results could be attributed to the effectiveness of the medication, and said that less contact might actually be beneficial to recovery, adding: "For some of these patients, it may be a deterrent if you have them coming in too frequently or attending too much to issues around addiction, especially if they are doing well and are abstinent."

Source: Fiellin DA et al. (2006). Counseling plus buprenorphine — naloxone maintenance therapy for opioid dependence. New England Journal of Medicine *355(4):365-374.*

Only Half of Adolescent Treatment Programs Address Co-Occurring Disorders, SAMHSA Study Finds

Only half the programs that treat significant numbers of children and adolescents for substance use disorders conduct comprehensive mental health assessments, despite the relatively high rates of co-occurring substance use and mental health disorders in this population. A new study sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) found the deficit, which is in sharp contrast to the 97 percent of adolescent treatment programs that conduct comprehensive substance abuse assessments.

Data collected for SAMHSA's National Survey on Drug Use and Health (NSDUH) shows that 5.3 percent of adolescents ages 12-17 meet the *DSM* criteria for drug dependence or abuse. Among those who abuse or are dependent on illicit drugs, 14.5 percent have had a major depressive episode within the past year. Accordingly, SAMHSA recommends that adolescent treatment address psychiatric, medical, family and environmental problems as well as substance abuse. The study used 2003 data to determine if treatment centers were following these best practice recommendations.

Researchers from ThomsonMedstat and SAMHSA found that only half the facilities surveyed offered special programs for adolescents suffering co-occurring mental and substance use disorders. On a positive note, investigators did determine that many facilities were conducting discharge planning and providing aftercare, counseling and relapse prevention groups, all strongly recommended.

SAMHSA Administrator Charles Curie commented: "Over the past few years, the systems of services that promote recovery from substance abuse and mental illnesses have evolved in exciting ways. Clearly, we have made great strides towards the day when co-occurring substance use and mental disorders are the expectation. However, this report points out we have yet to achieve a system that allows any door to be the right door for the services an individual needs." The full report of the study can be accessed at www.journals.elsevierhealth.com/periodicals/sat.

Source: Mark TL, Song X, Vandivort R et al. (2006). Characterizing substance abuse programs that treat adolescents. Journal of Substance Abuse Treatment *31(1): 59-65.*

CSAT Offers Methamphetamine Treatment Resources

A structured approach to the treatment of adults who abuse or are dependent on methamphetamine, cocaine, and other stimulants is outlined in a new resource package, *Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders (IOP)*, recently released by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA).

The Matrix IOP Model is a comprehensive package that provides substance abuse treatment professionals with a year-long intensive outpatient model for patients and their families. Components of the package include:

- *Counselor's Treatment Manual* (Inventory Number: BKD546)
- *Counselor's Family Education Manual* (Inventory Number: BKD547; includes a CD-Rom)
- *Client's Treatment Companion* (Inventory Number: BKD549)
- *Client's Handbook* (Inventory Number: BKD548)

The approach followed in the treatment package was developed by the Matrix Institute in Los Angeles and adapted by SAMHSA's Center for Substance Abuse Treatment. It is evidence-based and was tested and evaluated during the SAMHSA/CSAT-sponsored Methamphetamine Treatment Project.

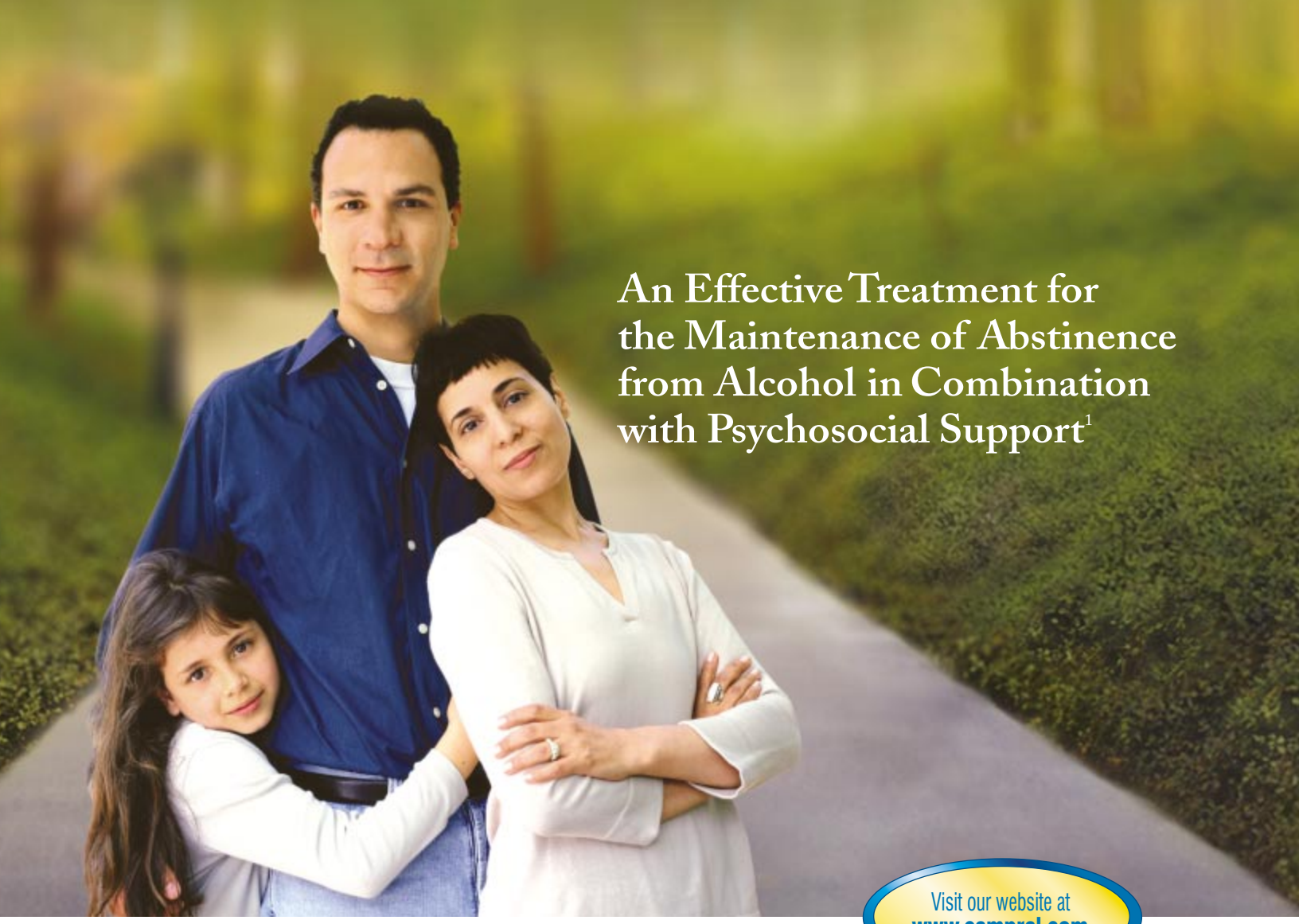
Copies of the publication package are available free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686 or electronically through www.ncadi.samhsa.gov.

Presentations from Veterans' Conference Available Online

Selected presentations from "The Road Home — The National Behavioral Health Conference On Returning Veterans And Their Families: Restoring Hope and Building Resiliency" are available online and can be accessed at no charge. Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with Therapeutic Communities of America (TCA), the March 2006 conference featured presentations on:

- Returning Vets: Understanding Who We Are Serving
- Providing Mental Health, Substance Abuse, and Co-Occurring Disorders Services for Returning Veterans and Their Families: The Rhode Island "Blueprint"
- Veteran-to-Veteran Peer Support
- Meeting the Needs of the Children and Families of Returning Veterans
- Strengthening Behavioral Health Systems Through Community Coordination and Collaboration
- Resources for Meeting the Needs of Veterans With Severe Injuries
- Financing the Needed Services
- How to Become a VA Tricare Provider

These and other presentations can be downloaded as PDF files from SAMHSA's website at: http://presentations.samhsa.gov/va_conference/index.html.



An Effective Treatment for the Maintenance of Abstinence from Alcohol in Combination with Psychosocial Support[1]

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

- **2 to 3 times more patients maintained abstinence vs placebo in long- and short-term studies, respectively**[2]
- **Works well with a variety of psychosocial therapies**[3–6]
- **Excellent safety and tolerability profile**[1–7]
- **Unique mechanism of action is thought to restore neurotransmitter balance***[1]
- **Used in over 1.5 million patients worldwide**[7]

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.

*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.

References: 1. CAMPRAL® (acamprosate calcium) Delayed-Release Tablets Prescribing Information, Forest Laboratories, 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.** Pelc I, Ansoms C, Lehert P, et al. The European NEAT Program: an integrated approach using acamprosate and psychosocial support for the prevention of relapse in alcohol-dependent patients with a statistical modeling of therapy success prediction. *Alcohol Clin Exp Res.* 2002;26:1529–1538. **7.** Mason BJ. Acamprosate. *Recent Dev Alcohol.* 2003;16:203–215.

Please see Brief Summary of Prescribing Information on the following page.

Forest Pharmaceuticals, Inc.
Pharmaceuticals • Therapeutics • Healthcare • Ethicare • Managed Care • Specialty Sales

 42-126187 1/05

Campral®
(acamprosate calcium)
Delayed-Release Tablets

Strengthens the will to say no

Campral®
(acamprosate calcium)
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.

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Geographic Variations in Rates of Alcohol Abuse or Dependence

In a newly released report using data for the years 2002 through 2004, federal experts estimate that nationally, 7.7 percent of persons aged 12 or older has experienced alcohol dependence or abuse.

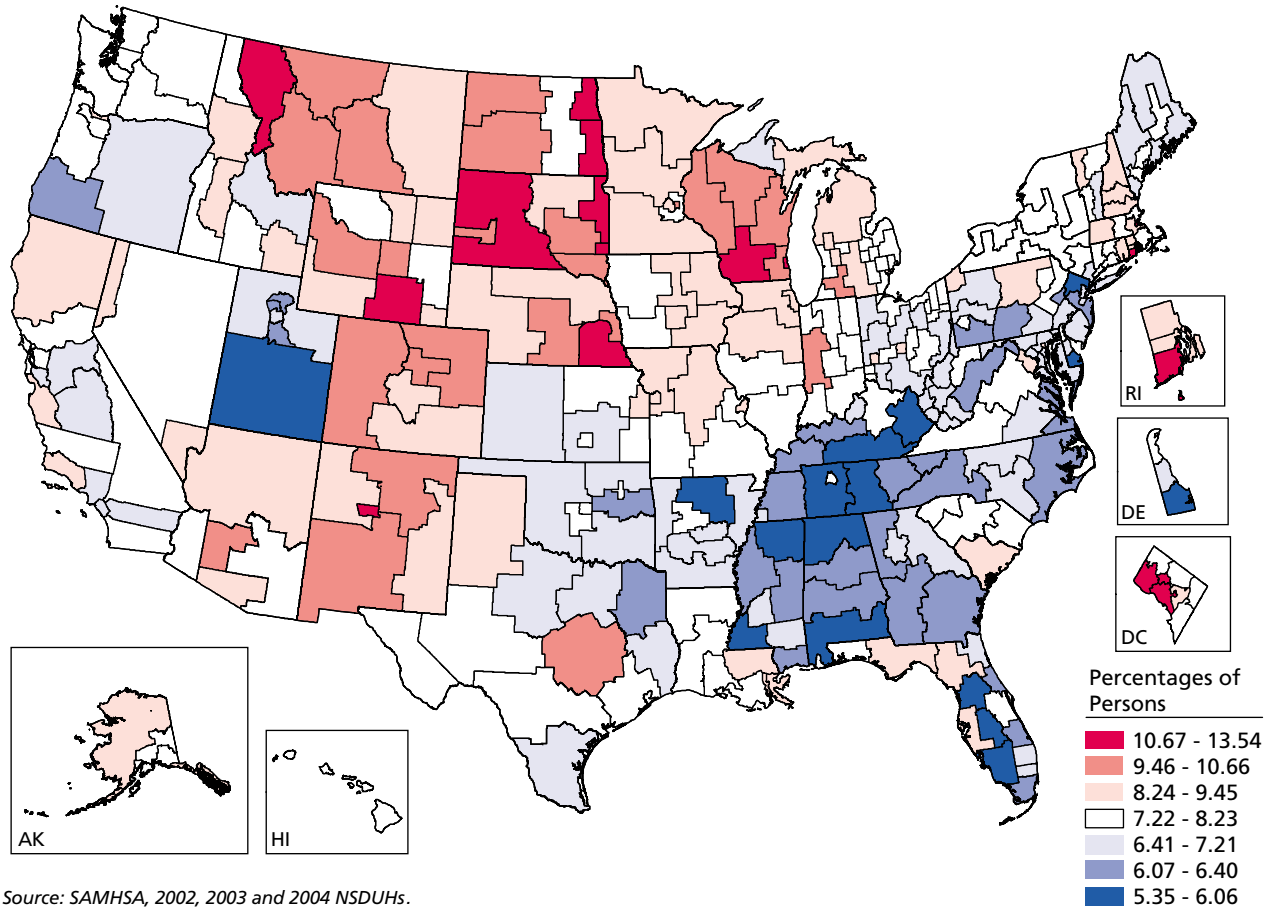
However, there were significant geographic variations in rates of alcohol abuse and dependence, which varied from a low of 5.4 percent in southern Utah and in north central Florida to a high of 13.5 percent in south central Wyoming.

Of the 15 substate areas with the highest rates of past year alcohol dependence or abuse, most were in northern States in the West and Midwest (Montana, Nebraska, New Mexico, North Dakota, South Dakota, Wisconsin, and Wyoming). Rhode Island and the District of Columbia also were represented in the top 15. The District of Columbia, North Dakota, South Dakota, and Wisconsin all had more than one substate area in the top 15.

Only 4 of the top 15 substate areas for alcohol dependence or abuse also were in the top 15 for illicit drug dependence or abuse: the District of Columbia's Wards 1 and 2, Bernalillo County in New Mexico, and Washington County in Rhode Island. The correlation among the substate areas between alcohol dependence or abuse and illicit drug dependence or abuse was only 0.26.

Alcohol dependence or abuse levels among all the substate areas tend to be highly correlated with levels of past month binge alcohol use (0.79). For binge use of alcohol, 9 of the top 15 substate areas were also in the top 15 for alcohol dependence or abuse. Those nine areas included the top six areas for alcohol dependence or abuse.

Alcohol Dependence or Abuse in the Past Year Among Persons Aged 12 or Older, by Substate Region: Percentages, Annual Averages Based on 2002, 2003, and 2004 NSDUH Data



Source: SAMHSA, 2002, 2003 and 2004 NSDUHs.

Estimates were derived from the National Survey on Drug Use and Health (NSDUH), which asks persons aged 12 or older to report on their use of cigarettes, alcohol, and illicit drugs in the past year and in the past month. NSDUH defines alcohol dependence and abuse according to criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).*

The full NSDUH report contains estimates for 21 other measures of substance use among persons aged 12 or older, including illicit drug use, tobacco use, substance dependence or abuse, needing but not receiving treatment, and serious psychological distress. The report is available online at HTTP://OAS.SAMHSA.GOV/METRO.HTM.

Source: Office of Applied Studies (2006). Alcohol dependence or abuse in substate areas. The NSDUH Report *Issue 25, page 3.*

ASAM MEMBERS TO CHOOSE NEW PRESIDENT-ELECT

ASAM members will choose among three outstanding candidates for the office of President-Elect:Louis E. Baxter, Sr., M.D., FASAM, Richard A. Beach, M.D., FASAM, and Donald J. Kurth, M.D., FASAM

The President-Elect serves a two-year term and is expected to assume the Presidency in April 2009. No member may hold the office of President-Elect or President for more than one term, successively. Candidates for the post must have served on the Board of Directors within the past four years.

The ASAM Constitution & Bylaws provide that *"The President-Elect shall, in the absence or disability of the President, exercise the powers of the President. The President-Elect shall perform such other duties as may be assigned by the President."*

CANDIDATES FOR THE OFFICE OF PRESIDENT-ELECT

LOUIS E. BAXTER, SR., M.D., FASAM

LAWRENCEVILLE, NEW JERSEY

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

My dedication and absolute commitment to ASAM and its mission, as evidenced by my professional activities and accomplishments, is my greatest contribution to ASAM and the field of Addiction Medicine.

At every opportunity, I have advanced and promoted the mission, goals, and policies of ASAM, as represented in our Strategic Plan, in the local, state, and federal policy-making, medical education, and addiction treatment arenas in which I have been involved. These include the addiction treatment policies, standards and regulations promulgated by the New Jersey and Pennsylvania Departments of Health, the Treatment Improvement Protocols published by the Center for Substance Abuse Treatment, the Food and Drug Administration's Substance Abuse Committee, the Substance Abuse and Mental Health Services Administration's "Changing the Conversation" conferences, and the National Football League's Substance Abuse Committee.

I have written, reviewed, and published articles and chapters in ASAM's Principles of Addiction Medicine, Third Edition, and Legal Medicine, 6th Edition, as well as numerous CSAT publications. I also have contributed to the National Strategic Plan for Interdisciplinary Faculty Development that made the recommendation that addiction education become part of "the core curriculum of all allied health educational programs" in the nation.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

Over the past 18 years, I have been responsive to the concerns and needs of ASAM's members, as evidenced by my service as chair of the Ruth Fox Course for Physicians, the Best Practices Course, the Constitution & Bylaws Council, and many other activities.

My election as President-Elect would allow me to continue to advocate for the ideals and mission of ASAM. As President-Elect, I would work to promote ASAM's recognition as the specialty society for Addiction Medicine, and of its members as experts in all matters concerning addictive disorders, their prevention and treatment.

I believe that my relationships with the aforementioned agencies, my experience as a treatment provider, and my ability to execute ASAM mandates at the local, state and federal levels make me the best candidate to foster ASAM's growth and development and to help the society win even greater acceptance in mainstream medicine. I recognize the value and worth of every ASAM member and I intend to make ASAM membership a true value, with real and meaningful career opportunities for its members.

ASAM's campaign guidelines prohibit the use of "restricted or unrestricted written or electronic communication" by candidates or their advocates.

Ballots will be mailed to members in good standing by November 1, 2006, and must be returned to ASAM by December 1st.

CANDIDATES FOR THE OFFICE OF PRESIDENT-ELECT

CONTINUED

RICHARD A. BEACH, M.D.

NAVARRE, FLORIDA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

During my 12-year tenure as a member of the ASAM Board, I served on many committees, including two years with ASAM's delegation to the AMA. However, I feel my greatest contribution has been through my service as chair of the State Chapters Committee.

My first charge as chair of that committee was to begin a reorganization to help the state chapters better execute ASAM's mission and strategic plan. The State Medical Specialty Society (SMSS) program was created to achieve this goal. With the assistance of grant funding, we began the reorganization with a pilot program involving six state chapters and a regional chapter. In less than two years, the SMSS program had helped 14 chapters to establish central administrative offices, organize CME programs and conferences to achieve credibility and financial stability, and secure an official presence in their individual state medical societies.

Through the vision, dedication, and hard work of its members, the SMSS program has begun a real grassroots reorganization that will provide ASAM with a vehicle to influence state and local policymaking for years to come.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

Our current challenges with practice standards, reimbursement issues, and ethical guidelines have been repeatedly debated by our ASAM Board and members. During my tenure on the Board, early mentoring by our organization's stalwarts imbued in me the notion that ASAM has always endeavored to achieve the highest code of medical and personal ethics. As our Society continues to evolve, the questions may change, but solutions tendered by past leaders have been consistent with being "open, honest, and willing" (the principle of transparency) and the tradition that, as an organization, ASAM puts "principles before personalities."

My predecessors took Addiction Medicine from social blight to a respected medical specialty. Now ASAM's charge is to continue its prevention and education efforts, but also to investigate and direct implementation of new treatment strategies (both pharmacological and behavioral) and standards of evidence-based practice in ways that make them readily available to individual Addiction Medicine practitioners.

I look forward to continuing this work and would be privileged to represent ASAM as we take our place as integral members of the health care treatment team in the 21st century.

DONALD J. KURTH, M.D., FASAM

RANCHO CUCAMONGA, CALIFORNIA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine? How do you feel your election would benefit ASAM and the field of Addiction Medicine?

My answers to these questions are best summarized as follows:

Leading Public Policy Development and Legislative Change. As President of the California Society of Addiction Medicine, I gained experience to guide ASAM into the future. We broke new ground in physician-driven public policy, spearheading Prop 36, UPPL repeal and near-passage of California parity. Through my CSAM experience, I founded the ASAM Legislative Advocacy Committee, ASAM's Legislative Day, and ASAM's Legislative Advocacy Newsletter. I co-chair our ASAM Parity Action Group, fighting to ensure fair reimbursement for us all.

Innovative Leadership Development. My Robert Wood Johnson Fellowship in Developing Leadership in Reducing Substance Abuse helped me learn better leadership skills and how to develop those leadership skills in others. As CSAM President, we gathered 30 California members for the cutting-edge CSAM Leadership Conference. Now, as co-chair of our ASAM Leadership Development Action Group, we will bring leadership development to a national level.

Raising the Bar for Educational Standards. I broke new ground and helped create ASAM's Public Policy Plenary programs at our Medical-Scientific Conferences. The TC Workshop I co-chaired at the Dallas Med-Sci received the highest ratings of any course given that year. I will apply those same high standards as co-chair of Pain & Addiction: Common Threads VII. And, as President-Elect, I will maintain ASAM's commitment to educational excellence.

Sound Financial Management. During my service as ASAM Treasurer and Finance Chair, I have instituted thoughtful policies to ensure financial stability. As City Council member in Rancho Cucamonga, California, I gained valuable financial experience, overseeing a combined annual budget of almost $100 million.

Policy innovations at ASAM — including increased checks and balances, reserve fund development, and improved investment policies — have paid strong dividends and we are now on sound financial footing.

Board Certification for Addiction Medicine. Our single greatest challenge is to achieve board certification for Addiction Medicine. The time has come to marshal our resources, develop a sound strategy, and achieve our goal.

If you want to see what I will do, just look at what I have done. With your help and support, we can achieve the board certification status our specialty deserves.

CANDIDATES FOR THE OFFICE OF **TREASURER**

Voters will choose among three candidates for the office of Treasurer: Stuart Gitlow, M.D., M.P.H., M.B.A.,Lori D. Karan, M.D., FACP, FASAM, and James W. Smith, M.D., FASAM.

The ASAM Constitution & Bylaws require that the Treasurer *"shall be the custodian of the Society's funds from whatever source those may derive. The Treasurer or individual designated by the Board of Directors shall deposit these funds in the Society's name in such depositories as the Finance Committee, following the guidelines of the Bylaws and the Board of Directors, shall recommend. The Treasurer shall dispense funds as authorized by the Board of Directors. The Treasurer shall report an accurate amount of all transactions at the Annual Meeting of the Society, and at all Board meetings. The Treasurer shall be a member of the Finance Committee."*

The Constitution & Bylaws also require that nominees for the office of Treasurer must be from or have served on the Board of Directors within the past four years or, in the case of a nominee from the general membership who has qualifications for the position, must have been active on the Finance Committee within the past four years.

Officers, including the Treasurer, have a two-year term of office. A Treasurer may succeed himself/herself once without hiatus, and may subsequently be reelected after a hiatus of two years.

STUART GITLOW, M.D., M.P.H., M.B.A.

WOONSOCKET, RHODE ISLAND

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

Last year, I successfully raised over $12 million as an endowment to launch the Annenberg Physicians Training Program in Addictive Disease. Over the years to come, hundreds of medical students will have the opportunity to spend one or two months immersed in the addiction rehabilitation process. Each student also will receive an ASAM membership and travel expenses toward attending our annual meeting. Our mission is to get students interested in the field, and to follow them longitudinally to determine what would work best to keep them involved and active.

This year, the second edition of my textbook, *Substance Use Disorders: A Practical Guide*, will be released. The text, designed primarily for an in-training audience, encourages active participation in ASAM and provides an overview of our public policies and placement criteria.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

I've been representing ASAM to the American Medical Association, first to the Resident Physician Section, then as Chairman of the AMA's Young Physician Section, and now to the AMA House of Delegates. There, I chair the Action Team on Alcohol and Health. Since 1993, I have attended all but one of the ASAM Board meetings. I've presented courses at ASAM annual meetings and have chaired several committees.

I understand where ASAM has come from and have a solid feel for the possibilities that represent ASAM's future. ASAM has achieved much over the past decades, but it is our task to define, educate, and pursue the goal of continued acceptance of Addiction Medicine. As a psychiatrist, I recognize that we need to differentiate Addiction Medicine from Addiction Psychiatry. Many wonder about how the two possible pathways and career options overlap; it is up to ASAM to present a central pathway for all physicians. I feel that a true Board certification remains a critically important goal. I look forward to continuing to serve you as ASAM's Treasurer.

Election results will be announced in the January-February 2007 issue of ASAM News.

CANDIDATES FOR THE OFFICE OF TREASURER

CONTINUED

Lori D. Karan, M.D., FACP, FASAM

SAN FRANCISCO, CALIFORNIA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

I pioneered the treatment of nicotine addiction within chemical dependency treatment and collected the experiences of similarly innovative programs around the country in a seminal issue of the Journal of Substance Abuse Treatment, titled "Towards a Broader View of Recovery."

I designed and co-chaired the nine consecutive Nicotine Research Roundtable Discussions (1991-1999) that set the stage for the formation of the Society for Research on Nicotine and Tobacco. I am now taking the initiative to assist the California Smoker's Helpline to develop a model physician referral system so that smokers with chemical dependency can be referred to capable physicians.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

During my tenure on ASAM's Finance Council, ASAM overhauled its accounting practices. We attained successful 2004 and 2005 reviews by external auditors BDO Seidman, LLP. We created a much-needed reserve fund and derived significant monetary benefit from fine-tuning our investment strategies.

There have been fiscal challenges and successes. Although there have been external exigencies, ASAM's operating budget has run in the red for three of the past four years. In the future, our budgetary projections need to be tempered with greater fiscal conservatism and our fundraising needs to be increasingly active but ethically responsible.

Our focus should be on generating the greatest impact for each dollar spent. Redesigning our website can facilitate increased internal dialogue and enhance our public relations. While partnering with a commercial publisher will afford increased visibility for our publications in both print and digital forms, we must manage the contract carefully to ensure a satisfactory financial return.

By leveraging our greatest resources, passion and knowledge, I believe that we can generate even greater excitement and camaraderie within our field. Whether persuading policymakers for substance abuse parity, gaining recognition within the ABMS as a medical discipline, strengthening our state chapters, or mentoring trainees, I believe that we need to provide increased opportunities for our members to make a difference. At the same time, each endeavor that we foster needs to be evidence-based, free from conflicts of interest, and fiscally responsible.

The ASAM Treasurer sets the pulse for the vibrancy and sustainability of our organization. I will bring integrity, hard work, and commitment to this role.

James W. Smith, M.D., FASAM

OLYMPIA, WASHINGTON

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

I am Board-certified in Family Medicine but I have been practicing Addiction Medicine for 46 years. I joined ASAM (then called the American Medical Society on Alcoholism) in 1968. I was first certified by ASAM in 1986, recertified in 1996, and am a Fellow of ASAM (FASAM). I was the recipient of the ASAM Annual Award in 2006.

I am a member of the Research Society on Alcoholism and the International Society for Biomedical Research on Alcoholism, and a Clinical Associate Professor in the Department of Psychiatry and Behavioral Sciences of the University of Washington School of Medicine.

I have always promoted addiction medicine in educating medical students, nurses, and addiction counselors. I was one of the faculty of the Curriculum Committee that made Addiction Medicine one of the core constituents of the curriculum at the University of Washington School of Medicine. I also was adjunct professor for the alcoholism training program at the University of Washington School of Nursing and adjunct professor of the addiction studies program at Seattle University.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

I have served on many committees of ASAM, including the Public Policy Committee and the Clinical Practice Committee. Based on my corporate experience, I am convinced that no organization will survive unless it has adequate financial support and sound fiscal management. Therefore, I have been a long-time member of the Finance Committee and, in the past, the Treasurer of ASAM. I believe that my experience on the Board of Directors and my experience in financial management will help ASAM reach its goals.

Candidates for the Office of **Secretary**

Voters will choose between two candidates for the office of Secretary: Peter A. Mansky, M.D., FASAM, and A. Kenison Roy III, M.D., FASAM.

The ASAM Constitution & Bylaws require that the Secretary *"shall: (a) keep an accurate record of the proceedings of the meetings of the Society and the Board of Directors; (b) preserve records, documents and correspondence; (c) cause notice to be given of elections and of meetings of the Society and the Board; (d) advise the Board on parliamentary procedure in the conduct of its meetings, and (e) perform all other duties incident to the Office of the Secretary."*

The Constitution & Bylaws also require that nominees for the office of Secretary must be from or have served on the Board of Directors within the past four years.

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Peter A. Mansky, M.D., FASAM

HENDERSON, NEVADA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

How do you feel your election would benefit ASAM and the field of Addiction Medicine? The four functions of professional organizations have been noted to be (1) social or collegial activities, (2) support by advocacy for the profession, individual practitioners and patients, (3) dissemination and sharing of scientific information, and (4) service to the public and to the organization. To indicate how my election could benefit ASAM and the field of Addiction Medicine, I can best utilize this framework.

Social: Throughout my 17 years as a member of ASAM, I have contributed in the social and collegial area by attending annual and area meetings of ASAM regularly and by being helpful to other members in their clinical, research and administrative activities.

Advocacy: I have given support in many ways by lobbying for ASAM, giving presentations and conducting workshops at meetings in several states and nationally. I have helped treatment centers in various areas of the country develop addiction programs and physician health programs. At the local and national levels, I have been dedicated to helping my colleagues who suffer from addictive illnesses, as well as individuals who are recovering from addiction. I have given this support through Physician Health Programs (PHPs), as a practitioner, and as an individual.

Scientific: I began my scientific career in Addiction Medicine as a Fellow at the National Institute of Health Addiction Research Center from 1969 to 1971. Since that time, I have conducted research and contributed to research planning at various national meetings. I have published many articles, as well as lecturing about my research, clinical activities and Addiction Medicine.

Service: Finally, I have served for eight years on the Board of ASAM: four years as an Alternate Director and four years as the Regional Director for New York. I was instrumental in developing the New York Society of Addiction Medicine and served as vice president of that chapter for nine years. I was the liaison from the Federation of State Physician Health Programs to ASAM and served on the ASAM Physician Health Committee. I also contributed to the field as the Medical Director of the New York Physician Health Program for 12 years and then as Director of the Nevada Physician Health Program since 2004.

A. Kenison Roy III, M.D., FASAM (incumbent)

METAIRIE, LOUISIANA

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine?

I was first elected to the Board of Directors of ASAM in 1988 and re-elected in 1992, 1998 and 2002. In April 1997, I was named a Fellow of ASAM.

I have served on the Review Course Committee and have chaired the Membership Committee. I have been active in the State Medical Specialty Society (SMSS) program — now the Chapters Council — and have been asked by ASAM President Elizabeth Howell, M.D., to head the Parity Action Group.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

In my work in ASAM, I have helped to maintain a focus within ASAM on the development of criteria-based, medically-directed treatment models across multiple levels of care. I also have helped to develop the implications of addiction as a primary disease and a brain disease.

I have identified parity in insurance coverage as essential to the adequate treatment of addictive disease, attraction of physicians to the field, development of training for physicians. and the development of an active Addiction Medicine specialty in medicine.

As Secretary, I would continue attention to these issues at a high level of leadership and apply the benefits of elected office to advance the work of the Parity Action Group.

CANDIDATES FOR DIRECTOR AT LARGE

(FIVE TO BE ELECTED)

Candidates for Director at Large are selected by the Nominating Committee and by petition. As specified in the Bylaws, candidates must have been active members of ASAM for at least three years, must have demonstrated a commitment to ASAM's mission by engaging in activities such as service on a committee, task force, or other significant national or state endeavor, and must be willing to attend two Board meetings a year at their own expense.

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RICHARD A. BEACH, M.D.

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CANDIDATES FOR DIRECTOR AT LARGE
(CONTINUED)

Merrill S. Herman, M.D.

BRONX, NEW YORK

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

As President of the New York Society of Addition Medicine (NYSAM) since 1995, I have been involved in the development of ASAM at a local and national level. Under my leadership, NYSAM has grown significantly. We have incorporated, with an executive committee supported by an administrator. We have sponsored excellent CME events, including our Annual Medical-Scientific Conferences and regional meetings. We have launched a bi-annual newsletter. In addition, we have become involved in policy and legislative issues, including UPPL, medical marijuana, and parity. The development of NYSAM has been a model for other state chapters, resulting in a stronger national ASAM.

As an Associate Professor of Clinical Psychiatry at the Albert Einstein College of Medicine/Montefiore Medical Center, I have been intimately involved with the clinical care and academic development of Addiction Medicine at my institution. As the Chief of Service of the Montefiore Methadone Program, I helped support the development of integrated on-site primary care and mental health services. At the medical school, I chaired the Aid for Impaired Medical Student (AIMS) Committee and helped develop appropriate policy and treatment for impaired students. In 2002, I was appointed Director of the Einstein Addiction Psychiatry Fellowship, through which I coordinate the training of medical students, residents and fellows. I have presented at local and national conferences and published papers on issues as varied as cocaine and acupuncture, integration of primary care and substance abuse treatment, impaired medical students, and co-occurring substance abuse and psychiatric disorders.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

Because of my passion about the care of addicted persons, I feel my election would greatly benefit ASAM and the field of Addiction Medicine. I strongly believe in the expansion of training opportunities for all physicians interested in addiction, including a board certification for Addiction Medicine. My ability to relate to physicians from multiple specialties, to non-physician addiction professionals, and to community and government leaders allows me to effectively promote parity for addiction treatment and relevant policy issues. The privilege of being elected to the ASAM Board of Directors would afford me the unique opportunity to promote the education of physicians in addiction and expand the provision of the care to those who so desperately need treatment to turn their lives around.

James A. Halikas, M.D., FASAM

NAPLES, FLORIDA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

I am engaged in the private practice of addiction medicine and general psychiatry in Naples, Florida, after retiring from posts as Professor of Psychiatry, Director of the Chemical Dependency Treatment Program, and Director of the Addiction Medicine Fellowship at the University of Minnesota.

I have been an active participant in ASAM for more than 25 years, as Treasurer, as chair of the Medical Education Committee, as co-chair of the Fellowship Committee, as a member of the Board, and as an active presenter at our annual Medical-Scientific Conferences. In fact, if you've taken an ASAM course or received CME credits from ASAM, I probably helped organize or approve the course, and my signature is on your certificate.

I've also contributed more than 100 articles to the addiction medicine professional literature, including reports on the development of cocaine pharmacotherapies. I am particularly proud to be the senior author of the original patient placement criteria in 1987, known as the "Cleveland Criteria," along with David Mee-Lee and Norman Hoffman, which became the ASAM Patient Placement Criteria — the national standard for our field. Yet, I believe that my most important contributions to ASAM and the field of addiction medicine are still to come.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

My goals are to strengthen our Society and its membership so that ASAM can be an effective voice for our specialty, in order to improve reimbursement for our services and establish ASAM's position as a medical specialty society.

I have had the great opportunity to be in clinical practice for the last eight years, after a 28-year academic and research career. I have now participated in all aspects of this great biomedical revolution in addiction medicine: research into the brain mechanisms of the addictions; appreciation of the biological and genetic components of the addictions; development of breakthrough medications for treatment; understanding the importance of support groups, social networking and spirituality to maintain recovery; development of a teaching curriculum that became the model for addiction medicine fellowships around the country; and now the wonder of clinical continuity in patient care. I have concluded that we are truly *blessed* as specialists in Addiction Medicine! We can change people's lives! We can get people well!

CANDIDATES FOR DIRECTOR AT LARGE
(CONTINUED)

R. Jeffrey Goldsmith, M.D.
(INCUMBENT)

CINCINNATI, OHIO

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

My greatest contribution to Addiction Medicine is my 25 year career as a medical teacher. I have mentored medical students, psychiatry residents, Addiction Psychiatry fellows, and Addiction Medicine fellows. I have designed summer internships for students, a PGYI rotation for psychiatry residents, advanced psychotherapy series for outpatient psychiatry residents, and an ACGME accredited fellowship for Addiction Psychiatry.

I have supervised and lectured doctors in all aspects of their training, from medical school to ASAM. This has taught me the basics of Addiction Medicine, what is important to understand and what the doctors' stumbling blocks are. It has taught me the vulnerabilities that Addiction Doctors have in working in this field and what they need to sustain a lifelong passion in the face of cultural disinterest and stigma.

It is in this arena that I have made my contribution to ASAM, as a speaker at conferences, contributor to *Principles of Addiction Medicine*, chair of the CME committee (and adapting to the new ACCME guidelines), and a member of the Board of Directors. This leadership in the nurturance of Addiction Medicine doctors is what I can offer ASAM.

I come from a background in clinical care and private practice, as well as a 10 year stint in clinical trials research, including being site principal investigator for the buprenorphine/naloxone clinical trial, a member of the VA/NIDA Medications Development Research Unit, and two NIDA Clinical Trials Network teams.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

I can keep ASAM vital through my leadership in offering new continuing medical education products, products that bring us up to date and appeal to the newer generation of physicians, through the ethical incorporation of pharmaceutical companies' financial support of these products, and through my understanding of what Addiction Doctors need to grow and sustain their enthusiasm. I have been a Board member for nine years over three different terms, and bring that experience to ASAM in this election.

Lori D. Karan, M.D., FACP, FASAM

SAN FRANCISCO, CALIFORNIA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

I have participated extensively in the leadership of ASAM and CSAM for more than 20 years. This has included chairing 13 national conferences and serving as co-editor of the pharmacology section of ASAM's textbook, *Principles of Addiction Medicine*, and authoring two of its chapters. I have been a member of the editorial boards of the Journal of Addictive Diseases and the Journal of Substance Abuse Treatment and have designed workshops for the ASAM Med-Sci conferences on how to critically review the scientific literature.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

I am seeking your vote for Director-at-Large because I wish to enact change within our organization. On a process level, I will work to bring about a streamlined Board structure and improved communications to enable more efficient and inclusive decision-making. For example, I would like to see key council and product chairs have increased input in Board deliberations.

I will strive to revive the clinical heart of ASAM. We need to regain our leadership in areas such as pain management, medical care in recovery, hepatitis C and HIV, and nicotine dependence. The establishment of clinical work groups could be an important avenue for fostering active participation and mentoring new talent within our organization.

In 2007, ASAM will launch a new journal. I will continue to advocate its quality and success. Our textbook is stellar, with future editions and an addictions handbook planned. Our new commercial publisher will improve the marketing and distribution of our scholarly work, enabling international impact. As an active member of the Publications Council with a voice on the Board, I will help navigate these advances.

Our most important priorities are achieving specialty status within ABMS and improving reimbursement for addiction treatment. Doing this will attract new physicians to our field, improve access to treatment, enhance quality of care, and further our ability to advocate for our patients.

ASAM is a vibrant organization with a rich history, a dedicated mission, and quality products. I have served ASAM over the years from both coasts and value our traditions. We now need to focus on achievable goals, including attaining specialty status, improving reimbursement for our services, fostering our publications, reviving our clinical heart, and bettering our communications and governance.

CANDIDATES FOR DIRECTOR AT LARGE (CONTINUED)

MARK L. KRAUS, M.D., FASAM

WATERBURY, CONNECTICUT

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

My greatest contributions to ASAM and the addiction field have been made through the following activities:

1. Original clinical research into the use of beta blockers in alcohol withdrawal syndrome. This research laid the ground-work for future research into pharmacological treatment strategies for other drug withdrawal syndromes.
2. Implementation and planning of the use of Suboxone in primary care settings.
3. Participation in clinical research into methadone maintenance treatment in a primary care general internal medicine office setting.
4. Serving as a founder of the Connecticut Society of Addiction Medicine and being elected its first President.
5. A founding member of the State Medical Specialty Society (SMSS) program.
6. Gaining recognition of Addiction Medicine as a subspecialty by the Connecticut State Medical Society, and acquiring a seat in that Society's House of Delegates.
7. Chairing the Connecticut Governor's Blue Ribbon Task Force on Substance Abuse, which created a blueprint for public policy on addiction treatment that has had a "ripple effect" in other states.
8. Becoming a member of the Connecticut Alcohol and Drug Policy Council, a body that creates, promotes, and executes public policy.
9. Serving as a member and current co-chair of the ASAM Public Policy Committee.
10. One of the principal organizers of an ONDCP Leadership Conference on Medical Education in Substance Abuse, which addressed the challenges of incorporating addiction medicine training into the education of medical and osteopathic students, residents, and attendings.
11. Creating and implementing an Addiction Medicine rotation in the Yale Primary Care General Internal Medicine Residency Program.
12. Promoting collaboration among the principal addiction societies: ASAM, AMERSA, AAAP, and AOAAM.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

As an Addiction Medicine educator, clinical researcher, clinical administrator, public policymaker, and a practitioner with 30 years' experience, I am acutely aware of the outside pressures, clinical barriers, and financial problems we face daily. If I am elected Director at Large, I will bring my talents and strong voice to the Board, representing the views of our membership and advocating for our patients, so that we can continue to deliver high quality care.

It would be an honor and a privilege to have the opportunity and challenge to serve our members on the Board of Directors.

DONALD J. KURTH, M.D., FASAM

RANCHO CUCAMONGA, CALIFORNIA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine? How do you feel your election would benefit ASAM and the field of Addiction Medicine?

My answers to these questions are best summarized as follows:

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Sound Financial Management. During my service as ASAM Treasurer and Finance Chair, I have instituted thoughtful policies to ensure financial stability. As City Council member in Rancho Cucamonga, California, I gained valuable financial experience, overseeing a combined annual budget of almost $100 million.

Policy innovations at ASAM — including increased checks and balances, reserve fund development, and improved investment policies — have paid strong dividends and we are now on sound financial footing.

Board Certification for Addiction Medicine. Our single greatest challenge is to achieve board certification for Addiction Medicine. The time has come to marshal our resources, develop a sound strategy, and achieve our goal.

If you want to see what I will do, just look at what I have done. With your help and support, we can achieve the board certification status our specialty deserves.

CANDIDATES FOR DIRECTOR AT LARGE
(CONTINUED)

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

METAIRIE, LOUISIANA

What do you consider to be your greatest contribution to ASAM and the field of Addiction Medicine?

I was first elected to the Board of Directors of ASAM in 1988 and re-elected in 1992, 1998 and 2002. In April 1997, I was named a Fellow of ASAM.

I have served on the Review Course Committee and have chaired the Membership Committee. I have been active in the State Medical Specialty Society (SMSS) program – now the Chapters Council — and have been asked by ASAM President Elizabeth Howell, M.D., to head the Parity Action Group.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

In my work in ASAM, I have helped to maintain a focus within ASAM on the development of criteria-based, medically-directed treatment models across multiple levels of care. I also have helped to develop the implications of addiction as a primary disease and a brain disease.

I have identified parity in insurance coverage as essential to the adequate treatment of addictive disease, attraction of physicians to the field, development of training for physicians. and the development of an active Addiction Medicine specialty in medicine.

As a Director at Large, I would continue attention to these issues at a high level of leadership and apply the benefits of elected office to advance the work of the Parity Action Group.

James W. Smith, M.D., FASAM

OLYMPIA, WASHINGTON

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

I am board certified in Family Medicine but I have been practicing Addiction Medicine for 46 years. I joined ASAM (then called the American Medical Society on Alcoholism) in 1968. I was first certified by ASAM in 1986, recertified in 1996, and am a Fellow of ASAM (FASAM). I was the recipient of the ASAM Annual Award in 2006.

I am a member of the Research Society on Alcoholism and the International Society for Biomedical Research on Alcoholism, and a Clinical Associate Professor in the Department of Psychiatry and Behavioral Sciences of the University of Washington School of Medicine.

I have always promoted addiction medicine in educating medical students, nurses, and addiction counselors. I was one of the faculty of the Curriculum Committee that made Addiction Medicine one of the core constituents of the curriculum at the University of Washington School of Medicine. I also was adjunct professor for the alcoholism training program at the University of Washington School of Nursing and adjunct professor of the addiction studies program at Seattle University.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

I have served on many committees of ASAM, including the Public Policy Committee and the Clinical Practice Committee. Based on my corporate experience, however, I am convinced that no organization will survive unless it has adequate financial support and sound fiscal management. Therefore, I have been a long-time member of the Finance Committee and, in the past, the Treasurer of ASAM. I believe that my experience on the Board of Directors and my experience in financial management will help ASAM reach its goals.

New officers and Directors will be installed during the Society's April 2007 Medical-Scientific Conference, when current President-Elect Michael M. Miller, M.D., FASAM, will assume the ASAM Presidency.

CANDIDATES FOR DIRECTOR AT LARGE *(CONTINUED)*

PENELOPE P. ZIEGLER, M.D., FASAM (INCUMBENT)

WILLIAMSBURG, VIRGINIA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

Since joining ASAM in 1986, I have tried to be active in advancing our mission. I have been on the Publications Council and the Infectious Disease Committee since the early 1990s, and have been active in the state chapters in Pennsylvania and Virginia. Over the past 15 years, my work in Addiction Medicine has been focused on treating addicted health care professionals, with a special interest in women professionals.

I believe my greatest contribution has been in recognizing and exploring the complexities of pathology in addicted patients, and the need for individualized treatment planning. Some of my patients are addicted to alcohol, some to opioids, sedatives or stimulants. But in addition, many have complicated, comorbid illnesses — problems ranging from untreated mood disorders to chronic pain syndromes, to sexual trauma and PTSD, to personality disorders — which put them at high risk for being either unable to maintain abstinence or for being able to stay abstinent, but to remain at high risk for suicide, divorce, stress-related illness and disruptive behavior. My experience has taught me to look more deeply, to treat the whole person, and I have tried to teach this to addiction medicine specialists and other professionals in the addiction field.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

It has been my privilege to serve on the ASAM Board of Directors as a Director at Large for the past four years. The Board has worked hard to develop a Strategic Plan and has had training designed to help us implement this plan. Now comes the fun part – putting the plan into action and bringing these new ideas to fruition. I want to be involved in making this happen, in making ASAM the pivotal health care organization treating addicted patients and advocating for the rights and needs of persons with addictive disease, their families, and all who are touched by this devastating illness. My experience and dedication to ASAM will continue to bring value to this essential work.

CANDIDATES FOR DIRECTOR REPRESENTING OSTEOPATHIC MEDICINE *(ONE TO BE ELECTED)*

ALLAN M. EBERT, D.O., FASAM

FLINT, MICHIGAN

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

More than 20 years ago, I organized the first Caduceus meeting in Genesee County, Michigan. I have been involved in medical education in the addictions since 1983, organizing multiple day-long seminars at Flint (Michigan) Osteopathic Hospital and Genesys Regional Medical Center. This was followed by involvement in the Michigan Society of Addiction Medicine (MiSAM) as chair of the CME Committee for four of the past five years. During that time, I organized two 6-hour CME courses and one 8-hour OBOT course in southeastern Michigan. I now serve as President of MiSAM. In that role, and as a member of the boards of the Flint National Council on Alcoholism & Addictions and the Greater Flint Project VOX, and a member of the Partners For Parity, I continue to advocate for the highest quality addiction treatment to be available to all patients who need it.

As a member of the Physicians' Recovery Network (a collaborative project of the Michigan Osteopathic Association and the Michigan State Medical Society), I worked with many others to develop and pass the law that created the Michigan Health Professional Recovery Program (H.P.R.P.), an advocacy/monitoring program for licensed health care professionals in Michigan. I have been a provider to that agency since its inception, and persuaded our largest local HMO to reverse its previous policy and begin to pay for most treatment mandated by the H.P.R.P.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

Having been in practice in the osteopathic community for more than 36 years and having experienced the development of a more collegial atmosphere between the allopathic and osteopathic medical communities over the past several decades, I feel I can continue the wonderful work of my osteopathic predecessors on the ASAM Board in speaking to the need to continue to incorporate the osteopathic philosophy in the treatment of addiction.

My experiences in working with MiSAM and with ASAM's Chapters Council have taught me that grassroots efforts at the local level are paramount to the success of any organization, so I will be a strong advocate for the state chapters within ASAM.

CANDIDATES FOR DIRECTOR REPRESENTING OSTEOPATHIC MEDICINE *(CONTINUED)*

Scott Smolar, D.O.
(INCUMBENT)

SACATON, ARIZONA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

At this point in my career, my primary contribution to ASAM has been at the chapter level. I have had experience in the planning of the California Society of Addiction Medicine (CSAM) conferences, and participated as a speaker at CSAM educational courses as a two-year research and clinical fellow at the University of California, San Francisco.

Since that time, I have helped to educate medical students, residents and family practitioners in the identification, diagnosis and treatment of addictive disease. Through these educational activities, I have raised awareness of CSAM and ASAM, providing assistance with recruitment of new members.

As an adult, child, and addiction psychiatrist, I have gained an appreciation of the role that culture plays in addiction. In my current position as medical director of a residential treatment facility for Native American youth, as well as in a previous position as attending psychiatrist at San Francisco General Hospital and as medical director of opiate treatment programs for the San Francisco Veterans Administration, I have been dedicated to the care of underserved populations. As a result, I will bring to the ASAM Board a clinical perspective on the treatment of addictive disease in minority populations.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

From the beginning of my psychiatric training, I have had an interest in and dedication to understanding the interrelationship of addiction medicine and addiction psychiatry. I have come to understand that the human brain's reward system is strongly related to the ability both to create and to destroy; hence, our understanding of addiction is vital to the survival of humankind.

I feel that my breadth of training, academic background, and professional experience position me to provide a unique and fresh perspective on the treatment of substance dependence and its political and individual implications. It is for these reasons that I believe ASAM would benefit from my election to the Board of Directors.

John C. Tanner, D.O., FASAM

JACKSONVILLE, FLORIDA

What do you consider to be your greatest contributions to ASAM and the field of Addiction Medicine?

I am fortunate to have had varied experiences in and made multiple contributions to addiction medicine since I entered the field in 1984.

I have worked almost continuously as medical director of addiction and psychiatric centers for 21 years. Currently, I am medical director for Wekiva Springs Center for Women, a 76-bed facility offering all levels of care. I also provide addiction evaluations for health professionals and attorneys, and have been Assistant Medical Director of Florida's Professionals Resource Network, with whom I continue to work.

I have had the pleasure of training psychiatric and family practice residents in Addiction Medicine. I have been a member of the planning committee for ASAM's Ruth Fox Course since 1997, and was honored to be named co-director of the course. In addition, I have lectured at many conferences, including Buprenorphine training and ASAM courses. Since the 1980s, my service to ASAM has included an active role on several committees, including the Osteopathic Medicine Committee.

I was certified by ASAM in 1986, recertified in 1996, and plan to recertify again this year. I was named a Fellow of ASAM in 1998.

How do you feel your election would benefit ASAM and the field of Addiction Medicine?

If elected, I will honor this position. I will be a strong advocate for parity, for evidence and outcomes-based research, and for improved education of physicians in Addiction Medicine, beginning in the first years of medical or osteopathic education. I will support increased member involvement with ASAM's state and regional societies, develop improved collaborations between ASAM and affiliated originations, and political actions that help our patients who suffer from addictions. I will support efforts to increase M.D. and D.O. entry into ASAM-approved fellowships, and will continue to work to enhance the quality of ASAM's CME courses.

We have a truly great organization, with many members who possess a wealth of knowledge and a passionate commitment to help our patients. If elected, I hope to work to promote the expertise of our membership and the resources we can offer to our communities, our medical institutions, and our government. I will strive to further elevate the field of Addiction Medicine to its rightful place among the medical specialties.

Treat the Condition

Opioid Dependence Is a Chronic Medical Condition

Long-term, fundamental changes to structure and function of the brain occur.[1,2]

Intravenous misuse of buprenorphine, usually in combination with benzodiazepines or other CNS depressants, has been associated with significant respiratory depression and death.

SUBOXONE has potential for abuse and produces dependence of the opioid type with a milder withdrawal syndrome than full agonists.

Cytolytic hepatitis and hepatitis with jaundice have been observed in the addicted population receiving buprenorphine.

There are no adequate and well-controlled studies of SUBOXONE (a category C medication) in pregnancy.

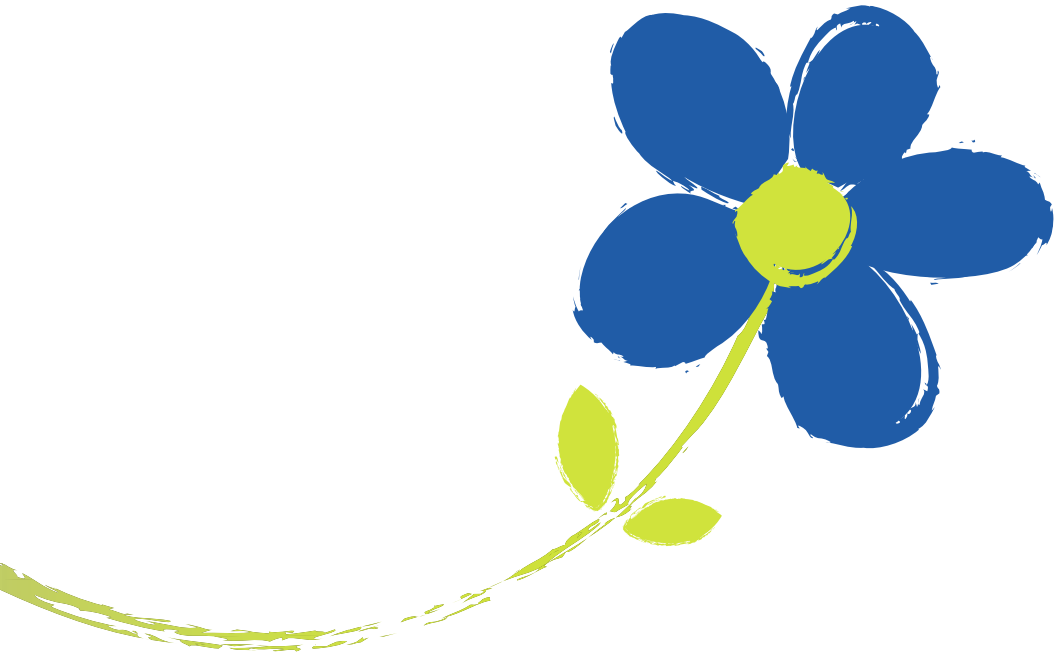
Due caution should be exercised when driving cars or operating machinery.

The most commonly reported adverse events with SUBOXONE include: headache (36%, placebo 22%), withdrawal syndrome (25%, placebo 37%), pain (22%, placebo 19%), nausea (15%, placebo 11%), insomnia (14%, placebo 16%), and sweating (14%, placebo 10%).

Please see adjacent Brief Summary of Prescribing Information.

References: 1. Leshner AI, Koob GF. Drugs of abuse and the brain. *Proc Assoc Am Physicians.* 1999;111(2):99-108. 2. Leshner AI. Addiction is a brain disease, and it matters. *Science.* 1997;278:45-47.

Transform the Life



In the Privacy and Convenience of Your Office

SUBOXONE, combined with counseling, can be used to treat opioid-dependent patients with privacy,* as other chronic, medical conditions are treated.

Target the Biological Basis of Opioid Dependence

SUBOXONE suppresses withdrawal symptoms, decreases cravings, and improves treatment retention. With the support of pharmacotherapy and counseling, patients may gain control over opioid dependence and be able to address other aspects of their lives.

To learn more, call 1-877-SUBOXONE or visit suboxone.com

*Under the Drug Addiction and Treatment Act of 2000 (DATA 2000), physicians who meet certain qualifying requirements may prescribe SUBOXONE. **Visit OpioidDependence.com** for information about qualifying.

Suboxone®
(buprenorphine HCl/naloxone HCl dihydrate) C III sublingual tablets

Because Treatment Transforms Lives

SUBOXONE (CIII)
(buprenorphine HCl and naloxone HCl dihydrate sublingual tablets)
SUBUTEX (CIII)
(buprenorphine HCl sublingual tablets)
Rx only

Brief Summary: Consult the SUBOXONE package insert for complete prescribing information.

Under the Drug Addiction Treatment Act of 2000 (DATA) codified at 21 U.S.C. 823(g), prescription use of this product in the treatment of opioid dependence is limited to physicians who meet certain qualifying requirements, and have notified the Secretary of Health and Human Services (HHS) of their intent to prescribe this product for the treatment of opioid dependence.

INDICATIONS AND USAGE

SUBOXONE and SUBUTEX are indicated for the treatment of opioid dependence.

CONTRAINDICATIONS

SUBOXONE and SUBUTEX should not be administered to patients who have been shown to be hypersensitive to buprenorphine, and SUBOXONE should not be administered to patients who have been shown to be hypersensitive to naloxone.

WARNINGS

Respiratory Depression: Significant respiratory depression has been associated with buprenorphine, particularly by the intravenous route. A number of deaths have occurred when addicts have intravenously misused buprenorphine, usually with benzodiazepines concomitantly. Deaths have also been reported in association with concomitant administration of buprenorphine with other depressants such as alcohol or other opioids. Patients should be warned of the potential danger of the self-administration of benzodiazepines or other depressants while under treatment with SUBUTEX or SUBOXONE.

IN THE CASE OF OVERDOSE, THE PRIMARY MANAGEMENT SHOULD BE THE RE-ESTABLISHMENT OF ADEQUATE VENTILATION WITH MECHANICAL ASSISTANCE OF RESPIRATION, IF REQUIRED. NALOXONE MAY NOT BE EFFECTIVE IN REVERSING ANY RESPIRATORY DEPRESSION PRODUCED BY BUPRENORPHINE.

SUBOXONE and SUBUTEX should be used with caution in patients with compromised respiratory function (e.g., chronic obstructive pulmonary disease, cor pulmonale, decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression).

CNS Depression: Patients receiving buprenorphine in the presence of other narcotic analgesics, general anesthetics, benzodiazepines, phenothiazines, other tranquilizers, sedative/hypnotics or other CNS depressants (including alcohol) may exhibit increased CNS depression. When such combined therapy is contemplated, reduction of the dose of one or both agents should be considered.

Drug Abuse and Dependence: SUBOXONE and SUBUTEX are controlled as Schedule III narcotics under the Controlled Substances Act.

Buprenorphine is a partial agonist at the mu-opioid receptor and chronic administration produces dependence of the opioid type, characterized by moderate withdrawal upon abrupt discontinuation or rapid taper. The withdrawal syndrome is milder than seen with full agonists, and may be delayed in onset.

Neonatal withdrawal has been reported in the infants of women treated with SUBUTEX during pregnancy (See PRECAUTIONS).

SUBOXONE contains naloxone and if misused parenterally, is highly likely to produce marked and intense withdrawal symptoms in subjects dependent on other opioid agonists.

Hepatitis, Hepatic Events: Cases of cytolytic hepatitis and hepatitis with jaundice have been observed in the addict population receiving buprenorphine both in clinical trials and in post-marketing adverse event reports. The spectrum of abnormalities ranges from transient asymptomatic elevations in hepatic transaminases to case reports of hepatic failure, hepatic necrosis, hepatorenal syndrome, and hepatic encephalopathy. In many cases, the presence of pre-existing liver enzyme abnormalities, infection with hepatitis B or hepatitis C virus, concomitant usage of other potentially hepatotoxic drugs, and ongoing injecting drug use may have played a causative or contributory role. In other cases, insufficient data were available to determine the etiology of the abnormality. The possibility exists that buprenorphine had a causative or contributory role in the development of the hepatic abnormality in some cases. Measurements of liver function tests prior to initiation of treatment is recommended to establish a baseline. Periodic monitoring of liver function tests during treatment is also recommended. A biological and etiological evaluation is recommended when a hepatic event is suspected. Depending on the case, the drug should be carefully discontinued to prevent withdrawal symptoms and a return to illicit drug use, and strict monitoring of the patient should be initiated.

Allergic Reactions: Cases of acute and chronic hypersensitivity to buprenorphine have been reported both in clinical trials and in the post-marketing experience. The most common signs and symptoms include rashes, hives, and pruritus. Cases of bronchospasm, angioneurotic edema, and anaphylactic shock have been reported. A history of hypersensitivity to buprenorphine is a contraindication to SUBUTEX or SUBOXONE use. A history of hypersensitivity to naloxone is a contraindication to SUBOXONE use.

Use in Ambulatory Patients: SUBOXONE and SUBUTEX may impair the mental or physical abilities required for the performance of potentially dangerous tasks such as driving a car or operating machinery, especially during drug induction and dose adjustment. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that buprenorphine therapy does not adversely affect their ability to engage in such activities. Like other opioids, SUBOXONE and SUBUTEX may produce orthostatic hypotension in ambulatory patients.

Head Injury and Increased Intracranial Pressure: SUBOXONE and SUBUTEX, like other potent opioids, may elevate cerebrospinal fluid pressure and should be used with caution in patients with head injury, intracranial lesions and other circumstances where cerebrospinal pressure may be increased. SUBOXONE and SUBUTEX can produce miosis and changes in the level of consciousness that may interfere with patient evaluation.

Opioid Withdrawal Effects: Because it contains naloxone, SUBOXONE is highly likely to produce marked and intense withdrawal symptoms if misused parenterally by individuals dependent on opioid agonists such as heroin, morphine, or methadone. Sublingually, SUBOXONE may cause opioid withdrawal symptoms in such persons if administered before the agonist effects of the opioid have subsided.

PRECAUTIONS

General: SUBOXONE and SUBUTEX should be administered with caution in elderly or debilitated patients and those with severe impairment of hepatic, pulmonary, or renal function; myxedema or hypothyroidism, adrenal cortical insufficiency (e.g., Addison's disease); CNS depression or coma; toxic psychoses; prostatic hypertrophy or urethral stricture; acute alcoholism; delirium tremens; or kyphoscoliosis.

The effect of hepatic impairment on the pharmacokinetics of buprenorphine and naloxone is unknown. Since both drugs are extensively metabolized, the plasma levels will be expected to be higher in patients with moderate and severe hepatic impairment. However, it is not known whether both drugs are affected to the same degree. Therefore, dosage should be adjusted and patients should be watched for symptoms of precipitated opioid withdrawal.

Buprenorphine has been shown to increase intracholedochal pressure, as do other opioids, and thus should be administered with caution to patients with dysfunction of the biliary tract.

As with other mu-opioid receptor agonists, the administration of SUBOXONE or SUBUTEX may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

Drug Interactions: Buprenorphine is metabolized to norbuprenorphine by cytochrome CYP 3A4. Because CYP 3A4 inhibitors may increase plasma concentrations of buprenorphine, patients already on CYP 3A4 inhibitors such as azole antifungals (e.g., ketoconazole), macrolide antibiotics (e.g., erythromycin), and HIV protease inhibitors (e.g., ritonavir, indinavir and saquinavir) should have their dose of SUBUTEX or SUBOXONE adjusted.

Based on anecdotal reports, there may be an interaction between buprenorphine and benzodiazepines. There have been a number of reports in the post-marketing experience of coma and death associated with the concomitant intravenous misuse of buprenorphine and benzodiazepines by addicts. In many of these cases, buprenorphine was misused by self-injection of crushed SUBUTEX tablets. SUBUTEX and SUBOXONE should be prescribed with caution to patients on benzodiazepines or other drugs that act on the central nervous system, regardless of whether these drugs are taken on the advice of a physician or are taken as drugs of abuse. Patients should be warned of the potential danger of the intravenous self-administration of benzodiazepines while under treatment with SUBOXONE or SUBUTEX.

Information for Patients: Patients should inform their family members that, in the event of emergency, the treating physician or emergency room staff should be informed that the patient is physically dependent on narcotics and that the patient is being treated with SUBOXONE or SUBUTEX.

Patients should be cautioned that a serious overdose and death may occur if benzodiazepines, sedatives, tranquilizers, antidepressants, or alcohol are taken at the same time as SUBOXONE or SUBUTEX.

SUBOXONE and SUBUTEX may impair the mental or physical abilities required for the performance of potentially dangerous tasks such as driving a car or operating machinery, especially during drug induction and dose adjustment. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that buprenorphine therapy does not adversely affect their ability to engage in such activities. Like other opioids, SUBOXONE and SUBUTEX may produce orthostatic hypotension in ambulatory patients.

Patients should consult their physician if other prescription medications are currently being used or are prescribed for future use.

Carcinogenesis, Mutagenesis and Impairment of Fertility: *Carcinogenicity.* Carcinogenicity data on SUBOXONE are not available. Carcinogenicity studies of buprenorphine were conducted in Sprague-Dawley rats and CD-1 mice. Buprenorphine was administered in the diet to rats at doses of 0.6, 5.5, and 56 mg/kg/day (estimated exposure was approximately 0.4, 3 and 35 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis) for 27 months. Statistically significant dose-related increases in testicular interstitial (Leydig's) cell tumors occurred, according to the trend test adjusted for survival. Pair-wise comparison of the high dose against control failed to show statistical significance. In an 86-week study in CD-1 mice, buprenorphine was not carcinogenic at dietary doses up to 100 mg/kg/day (estimated exposure was approximately 30 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis).

Mutagenicity: SUBOXONE: The 4:1 combination of buprenorphine and naloxone was not mutagenic in a bacterial mutation assay (Ames test) using four strains of *S. typhimurium* and two strains of *E. coli*. The combination was not clastogenic in an *in vitro* cytogenetic assay in human lymphocytes, or in an intravenous micronucleus test in the rat.

SUBUTEX: Buprenorphine was studied in a series of tests utilizing gene, chromosome, and DNA interactions in both prokaryotic and eukaryotic systems. Results were negative in yeast (*Saccharomyces cerevisiae*) for recombinant, gene convertant, or forward mutations; negative in *Bacillus subtilis* "rec" assay, negative for clastogenicity in CHO cells, Chinese hamster bone marrow and spermatogonia cells, and negative in the mouse lymphoma L5178Y assay. Results were equivocal in the Ames test: negative in studies in two laboratories, but positive for frame shift mutation at a high dose (5 mg/plate) in a third study. Results were positive in the Green-Tweets (*E. coli*) survival test, positive in a DNA synthesis inhibition (DSI) test with testicular tissue from mice, for both *in vivo* and *in vitro* incorporation of [^{3}H]thymidine, and positive in unscheduled DNA synthesis (UDS) test using testicular cells from mice.

Impairment of Fertility: SUBOXONE: Dietary administration of SUBOXONE in the rat at dose levels of 500 ppm or greater (equivalent to approximately 47 mg/kg/day or greater; estimated exposure was approximately 28 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis) produced a reduction in fertility demonstrated by reduced female conception rates. A dietary dose of 100 ppm (equivalent to approximately 10 mg/kg/day; estimated exposure was approximately 6 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis) had no adverse effect on fertility.

SUBUTEX: Reproduction studies of buprenorphine in rats demonstrated no evidence of impaired fertility at daily oral doses up to 80 mg/kg/day (estimated exposure was approximately 50 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis) or up to 5 mg/kg/day *im* or *sc* (estimated exposure was approximately 3 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis).

Pregnancy: *Pregnancy Category C:*

Teratogenic effects: SUBOXONE: Effects on embryo-fetal development were studied in Sprague-Dawley rats and Russian white rabbits following oral (1:1) and intramuscular (3:2) administration of mixtures of buprenorphine and naloxone. Following oral administration to rats and rabbits, no teratogenic effects were observed at doses up to 250 mg/kg/day and 40 mg/kg/day, respectively (estimated exposure was approximately 150 times and 50 times, respectively, the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis). No definitive drug-related teratogenic effects were observed in rats and rabbits at intramuscular doses up to 30 mg/kg/day (estimated exposure was approximately 20 times and 35 times, respectively, the recommended human daily dose of 16 mg on a mg/m^2 basis). Acephalus was observed in one rabbit fetus from the low-dose group and omphacele was observed in two rabbit fetuses from the same litter in the mid-dose group; no findings were observed in fetuses from the high-dose group. Following oral administration to the rat, dose-related post-implantation losses, evidenced by increases in the numbers of early resorptions with consequent reductions in the numbers of fetuses, were observed at doses of 10 mg/kg/day or greater (estimated exposure was approximately 6 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis). In the rabbit, increased post-implantation losses occurred at an oral dose of 40 mg/kg/day. Following intramuscular administration in the rat and the rabbit, post-implantation losses, as evidenced by decreases in live fetuses and increases in resorptions, occurred at 30 mg/kg/day.

SUBUTEX: Buprenorphine was not teratogenic in rats or rabbits after *im* or *sc* doses up to 5 mg/kg/day (estimated exposure was approximately 3 and 6 times, respectively, the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis), after *iv* doses up to 0.8 mg/kg/day (estimated exposure was approximately 0.5 times and equal to, respectively, the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis), or after oral doses up to 160 mg/kg/day in rats (estimated exposure was approximately 95 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis) and 25 mg/kg/day in rabbits (estimated exposure was approximately 30 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis). Significant increases in skeletal abnormalities (e.g., extra thoracic vertebra or thoraco-lumbar ribs) were noted in rats after *sc* administration of 1 mg/kg/day and up (estimated exposure was approximately 0.6 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis), but were not observed at oral doses up to 160 mg/kg/day. Increases in skeletal abnormalities in rabbits after *im* administration of 5 mg/kg/day (estimated exposure was approximately 6 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis) or oral administration of 1 mg/kg/day or greater (estimated exposure was approximately equal to the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis) were not statistically significant.

In rabbits, buprenorphine produced statistically significant pre-implantation losses at oral doses of 1 mg/kg/day or greater and post-implantation losses that were statistically significant at *iv* doses of 0.2 mg/kg/day or greater (estimated exposure was approximately 0.3 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis).

There are no adequate and well-controlled studies of SUBOXONE or SUBUTEX in pregnant women. SUBOXONE or SUBUTEX should only be used during pregnancy if the potential benefit justifies the potential risk to the fetus.

Non-teratogenic effects: Dystocia was noted in pregnant rats treated *im* with buprenorphine 5 mg/kg/day (approximately 3 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis). Both fertility and peri- and postnatal development studies with buprenorphine in rats indicated increases in neonatal mortality after oral doses of 0.8 mg/kg/day and up (approximately 0.5 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis), after *im* doses of 0.5 mg/kg/day and up (approximately 0.3 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis), and after *sc* doses of 0.1 mg/kg/day and up (approximately 0.06 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis). Delays in the occurrence of righting reflex and startle response were noted in rat pups at an oral dose of 80 mg/kg/day (approximately 50 times the recommended human daily sublingual dose of 16 mg on a mg/m^2 basis).

Neonatal Withdrawal: Neonatal withdrawal has been reported in the infants of women treated with SUBUTEX during pregnancy. From post-marketing reports, the time to onset of neonatal withdrawal symptoms ranged from Day 1 to Day 8 of life with most occurring on Day 1. Adverse events associated with neonatal withdrawal syndrome included hypertonia, neonatal tremor, neonatal agitation, and myoclonus. There have been rare reports of convulsions and in one case, apnea and bradycardia were also reported.

Nursing Mothers: An apparent lack of milk production during general reproduction studies with buprenorphine in rats caused decreased viability and lactation indices. Use of high doses of sublingual buprenorphine in pregnant women showed that buprenorphine passes into the mother's milk. Breast-feeding is therefore not advised in mothers treated with SUBUTEX or SUBOXONE.

Pediatric Use: SUBOXONE and SUBUTEX are not recommended for use in pediatric patients. The safety and effectiveness of SUBOXONE and SUBUTEX in patients below the age of 16 have not been established.

ADVERSE REACTIONS

The safety of SUBOXONE has been evaluated in 497 opioid-dependent subjects. The prospective evaluation of SUBOXONE was supported by clinical trials using SUBUTEX (buprenorphine tablets without naloxone) and other trials using buprenorphine sublingual solutions. In total, safety data are available from 3214 opioid-dependent subjects exposed to buprenorphine at doses in the range used in treatment of opioid addiction.

Few differences in adverse event profile were noted between SUBOXONE and SUBUTEX or buprenorphine administered as a sublingual solution.

In a comparative study, adverse event profiles were similar for subjects treated with 16 mg SUBOXONE or 16 mg SUBUTEX. The following adverse events were reported to occur by at least 5% of patients in a 4-week study (Table 1).

Table 1. Adverse Events (≥5%) by Body System and Treatment Group in a 4-week Study

Body System /Adverse Event (COSTART Terminology)	N (%) SUBOXONE 16 mg/day N=107	N (%) SUBUTEX 16 mg/day N=103	N (%) Placebo N=107
Body as a Whole			
Asthenia	7 (6.5%)	5 (4.9%)	7 (6.5%)
Chills	8 (7.5%)	8 (7.8%)	8 (7.5%)
Headache	39 (36.4%)	30 (29.1%)	24 (22.4%)
Infection	6 (5.6%)	12 (11.7%)	7 (6.5%)
Pain	24 (22.4%)	19 (18.4%)	20 (18.7%)
Pain Abdomen	12 (11.2%)	12 (11.7%)	7 (6.5%)
Pain Back	4 (3.7%)	8 (7.8%)	12 (11.2%)
Withdrawal Syndrome	27 (25.2%)	19 (18.4%)	40 (37.4%)
Cardiovascular System			
Vasodilation	10 (9.3%)	4 (3.9%)	7 (6.5%)
Digestive System			
Constipation	13 (12.1%)	8 (7.8%)	3 (2.8%)
Diarrhea	4 (3.7%)	5 (4.9%)	16 (15.0%)
Nausea	16 (15.0%)	14 (13.6%)	12 (11.2%)
Vomiting	8 (7.5%)	8 (7.8%)	5 (4.7%)
Nervous System			
Insomnia	15 (14.0%)	22 (21.4%)	17 (15.9%)
Respiratory System			
Rhinitis	5 (4.7%)	10 (9.7%)	14 (13.1%)
Skin and Appendages			
Sweating	15 (14.0%)	13 (12.6%)	11 (10.3%)

The adverse event profile of buprenorphine was also characterized in the dose-controlled study of buprenorphine solution, over a range of doses in four months of treatment. Table 2 shows adverse events reported by at least 5% of subjects in any dose group in the dose-controlled study.

Table 2. Adverse Events (≥5%) by Body System and Treatment Group in a 16-week Study

Body System/Adverse Event (COSTART Terminology)	Buprenorphine Dose* Very Low* (N=184) N (%)	Low* (N=180) N (%)	Moderate* (N=186) N (%)	High* (N=181) N (%)	Total* (N=731) N (%)
Body as a Whole					
Abscess	9 (5%)	2 (1%)	3 (2%)	2 (1%)	16 (2%)
Asthenia	26 (14%)	28 (16%)	26 (14%)	24 (13%)	104 (14%)
Chills	11 (6%)	12 (7%)	9 (5%)	10 (6%)	42 (6%)
Fever	7 (4%)	2 (1%)	2 (1%)	10 (6%)	21 (3%)
Flu Syndrome	4 (2%)	13 (7%)	19 (10%)	8 (4%)	44 (6%)
Headache	51 (28%)	62 (34%)	54 (29%)	53 (29%)	220 (30%)
Infection	32 (17%)	39 (22%)	38 (20%)	40 (22%)	149 (20%)
Injury Accidental	5 (3%)	10 (6%)	5 (3%)	5 (3%)	25 (3%)
Pain	47 (26%)	37 (21%)	49 (26%)	44 (24%)	177 (24%)
Pain Back	18 (10%)	29 (16%)	28 (15%)	27 (15%)	102 (14%)
Withdrawal Syndrome	45 (24%)	40 (22%)	41 (22%)	36 (20%)	162 (22%)
Digestive System					
Constipation	10 (5%)	23 (13%)	23 (12%)	26 (14%)	82 (11%)
Diarrhea	19 (10%)	8 (4%)	9 (5%)	4 (2%)	40 (5%)
Dyspepsia	6 (3%)	10 (6%)	4 (2%)	4 (2%)	24 (3%)
Nausea	12 (7%)	22 (12%)	23 (12%)	18 (10%)	75 (10%)
Vomiting	8 (4%)	6 (3%)	10 (5%)	14 (8%)	38 (5%)
Nervous System					
Anxiety	22 (12%)	24 (13%)	20 (11%)	25 (14%)	91 (12%)
Depression	24 (13%)	16 (9%)	25 (13%)	18 (10%)	83 (11%)
Dizziness	4 (2%)	9 (5%)	7 (4%)	11 (6%)	31 (4%)
Insomnia	42 (23%)	50 (28%)	43 (23%)	51 (28%)	186 (25%)
Nervousness	12 (7%)	11 (6%)	10 (5%)	13 (7%)	46 (6%)
Somnolence	5 (3%)	13 (7%)	9 (5%)	11 (6%)	38 (5%)
Respiratory System					
Cough Increase	5 (3%)	11 (6%)	6 (3%)	4 (2%)	26 (4%)
Pharyngitis	6 (3%)	7 (4%)	6 (3%)	9 (5%)	28 (4%)
Rhinitis	27 (15%)	16 (9%)	15 (8%)	21 (12%)	79 (11%)
Skin and Appendages					
Sweat	23 (13%)	21 (12%)	20 (11%)	23 (13%)	87 (12%)
Special Senses					
Runny Eyes	13 (7%)	9 (5%)	6 (3%)	6 (3%)	34 (5%)

*Sublingual solution. Doses in this table cannot necessarily be delivered in tablet form, but for comparison purposes:
"Very low" dose (1 mg solution) would be less than a tablet dose of 2 mg
"Low" dose (4 mg solution) approximates a 6 mg tablet dose
"Moderate" dose (8 mg solution) approximates a 12 mg tablet dose
"High" dose (16 mg solution) approximates a 24 mg tablet dose

OVERDOSAGE

Manifestations: Manifestations of acute overdose include pinpoint pupils, sedation, hypotension, respiratory depression and death.

Treatment: The respiratory and cardiac status of the patient should be monitored carefully. In the event of depression of respiratory or cardiac function, primary attention should be given to the re-establishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated.

IN THE CASE OF OVERDOSE, THE PRIMARY MANAGEMENT SHOULD BE THE RE-ESTABLISHMENT OF ADEQUATE VENTILATION WITH MECHANICAL ASSISTANCE OF RESPIRATION, IF REQUIRED. NALOXONE MAY NOT BE EFFECTIVE IN REVERSING ANY RESPIRATORY DEPRESSION PRODUCED BY BUPRENORPHINE.

High doses of naloxone hydrochloride, 10-35 mg/70 kg may be of limited value in the management of buprenorphine overdose. Doxapram (a respiratory stimulant) also has been used.

Manufactured by: Reckitt Benckiser Healthcare (UK) Ltd, Hull, UK, HU8 7DS

Distributed by: Reckitt Benckiser Pharmaceuticals, Inc., Richmond, VA 23235

#138274BS July 2005

Substance Abuse and Mental Health Services Administration
SAMHSA NEWS
SAMHSA's Award-Winning Newsletter July/August 2006, Volume 14, Number 4

Disaster Preparedness is Focus of SAMHSA Newsletter

The July-August issue of SAMHSA News distills lessons from a forum convened by the agency to examine what has been learned from the 2005 hurricanes and related disasters. SAMHSA convened the national summit — "The Spirit of Recovery: All-Hazards Behavioral Health Preparedness and Response — Building on the Lessons of Hurricanes Katrina, Wilma, and Rita" — in New Orleans in May.

During the three-day event, more than 600 participants — state disaster management leaders, crisis counselors, researchers, first responders, consumers of mental health services, hurricane survivors, and others — took stock of last year's disaster response, discussed ongoing challenges, and shared improved methods for coping with a disaster of any kind.

The summit report and related articles on disaster preparedness can be accessed on SAMHSA's website at: http://www.samhsa.gov/SAMHSA_News/index.asp.

NACoA to Make Research Database Available

The National Association for Children of Alcoholics (NACoA) has entered into a private-public partnership to transfer the tracking system for research materials and other references on alcohol and drug abuse developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to NACoA. The tracking system, developed over 20 years, will now be updated by NACoA and maintained on a site available to the public.

Sis Wenger, President and CEO of NACoA, said, "The database contains entries on over 100,000 research studies, prevention and treatment materials, and policy papers and speeches, each abstracted and indexed according to a Drug and Alcohol Thesaurus developed jointly by SAMHSA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The history of substance abuse prevention and treatment for the last 20 years is covered along with all current research."

The database is available to the public at no charge at the web address http://ida.nacoa.org. Abstracts and indexing information are available for all entries, as are the full documents in the case of non-copyrighted studies, reports and papers.

The National Association for Children of Alcoholics, located in Rockville, Maryland, is a national membership and affiliate organization whose mission is "to advocate for all children and families affected by alcoholism and other drug dependencies." It is an Internal Revenue Service approved 501(c)3 non profit corporation founded in 1983 and has been operational since that time.

Board & Chapters Council to Meet in October

The next meeting of ASAM's Board and Chapters Council is set for Thursday–Saturday, October 19th–21st, at the Hyatt Regency Capitol Hill Hotel in Washington, DC.

The schedule follows:

Thursday, October 19, 2006

2:00 p.m. – 5:00 p.m. Finance Committee Meeting
7:00 p.m. – 9:30 p.m. ASAM Board Meeting

Friday, October 20, 2006

9:00 a.m. – 5:00 p.m. ASAM Board Meetings
7:00 p.m. – 9:30 p.m. Joint Board and Chapters Council Dinner Meeting

Saturday, October 21, 2006

8:00 a.m. – 5:00 p.m. Chapters Council Meeting

For more information, contact Nancy Brighindi, MBA, CAE, ASAM Director of Membership and Chapter Development, at nbrig@asam.org *or by phone at 301/656-3920.*

Florida Society Sets Date for Annual Meeting

New FSAM Executive Director John Harden, LCSW, CAP, M.P.H., reports that FSAM has scheduled its Annual Conference for March 1–4, 2007, at the McKnight Brain Institute of the University of Florida College of Medicine. Thanks go to Mark Gold, M.D., and the University's Division of Addiction Medicine for hosting the event.

Visit www.fsamonline.org *for ongoing updates on the conference program and to register online.*

Tennessee Society Works with State Medical Association

TN-SAM President Richard Soper, M.D., J.D., M.S., reports the following recent developments in Tennessee:

171st Tennessee Medical Association Meeting. The Tennessee Medical Association remains on record as supportive of: an increase in the tobacco tax as a disincentive to smokers and potential smokers; smoke-free public buildings; a repeal of preemption laws that would allow local governments to establish their own ordinances to promote clean air and smoke-free conditions; an increase in the legal age to purchase tobacco products; and a ban on tobacco sales in businesses that sell medications and through unsupervised vending machines.

President's Commentary. In the current TN-SAM newsletter, Dr. Soper offers a commentary entitled "It's Time For Physicians to Support the Maintenance Model." Excerpts follow:

"Imagine if diabetes were treated like opiate addiction. When your blood sugars or dietary habits are poorly controlled, you are sent to a 5 day sugar detoxification program, or 30-day rehabilitation program, and then considered cured. What if your doctor stopped your insulin when you relapsed to eating sugar again, or even discharged you from the practice for 'non-compliance'? What if, after you stabilized your diabetes on insulin, your doctor insisted that you 'detox' off of insulin, or told you that your dependence on insulin was just covering up your addiction to sugar?

"The comparison to Type II diabetes is helpful for developing an understanding of opiate addiction as a chronic disease. Both illnesses have genetic components and run in families. Both are lifelong conditions that are affected by the lifestyle choices that each individual makes. And both diseases have well-defined pathological processes that respond well to medical treatment. Why, then, do we treat these chronic illnesses in very different ways?…

"In a recent article published in the *Boston Herald*, a physician stated that outpatient buprenorphine treatment was like giving 'candy' to patients with opiate addiction. He went on to say that he would not treat outpatients with buprenorphine because he feared he would not be able to get these patients off the medication. These comments show a either a complete ignorance of or a complete disregard for numerous studies conducted over the last 40 years supporting the effectiveness of opiate maintenance therapy in decreasing drug use, overdose deaths, crime, and HIV transmission in patients with opiate addiction. Calling buprenorphine 'candy' for patients with opiate dependence is likely calling insulin 'candy' for patients with diabetes: pure nonsense…

"Buprenorphine is a life-saving medication for people with a serious and life-threatening chronic illness, and a remarkable innovation in the treatment of opiate addiction. It is a safe alternative to methadone maintenance and is bringing patients into treatment who are younger, earlier in the course of addiction, and who never have been treated before6. In the first three years of its use, buprenorphine is showing great promise in meeting the treatment needs of hundreds of thousands of opiate addicts who have either not been able or not been willing to enter treatment in the past. …Despite these developments, while appearing before the mental health subcommittee of the Tennessee House of Representatives, I listened to another physician testify that Buprenorphine was unproven and still risky to provide to patients. This physician is the medical director of a methadone clinic in our state.

"At this critical juncture, it is time for physicians in Tennessee and nationwide to put aside their personal biases and support the maintenance model for treating opiate addiction. The evidence is clear: maintenance works, both with methadone and buprenorphine. Detoxification, regardless of the method or medication used, results in patients dropping out of treatment and relapsing to drug use*. It is irresponsible and dangerous for medical professionals to send mixed messages about what treatment is effective for opiate addiction. Uninformed comments that may keep patients with opiate addiction from receiving effective treatment will cost these patients their lives."

**Collins ED, Kleber HD et al. (2005). Anesthesia-assisted vs buprenorphine- or clonidine-assisted heroin detoxification and naltrexone induction: A randomized trial [see comment].* Journal of the American Medical Association *294(8):903-913.*

Physician Locator: TN-SAM and the federal Center for Substance Abuse Treatment are asking all Tennessee physicians who hold waivers to prescribe buprenorphine in office-based practice and who are not currently listed on the SAMHSA physician locator to please consider participating. Certified physicians may call 1-866/BUP-CSAT (1-866/287-2728) or e-mail INFO@BUPRENORPHINE.SAMHSA.GOV to add their names to the locator or to make changes in their listings.

Contact TNSAM by mail at P.O. Box 10074, Murfreesboro, TN 37129; by phone at 615/292-1917; by fax at 615/292-1919; or by email at tnsam@comcast.net.

Connecticut Society Meets

Dr. Stephen A. Wyatt

The following news notes are excerpted from a report by President Stephen A. Wyatt, D.O., in a recent CtSAM Newsletter:

"Since our last communication, we have had two very successful meetings. The first was the February meeting in Cromwell. …Pat Rehmer, Deputy Director of DMHAS, presented on the status of the implementation of Medicare Part D drug coverage in Connecticut. She explained the history of the States development of the plan. She reviewed the status of the implantation and the opportunities for clarification and assistance. There was brisk discussion of the formulary development as it applies to addiction medicine.

"The second meeting was in early June. …the speaker was Senator Chris Murphy. He related the most recent battles in the Public Health Committee and his efforts at taking a strong and critical look at the health care situation in Connec ticut and the Nation. He is an impassioned speaker and very informative. …There was plenty of time to discuss the various current issues in the State that we all face. Senator Murphy is not running for re-election for the State Senate but instead is running for the U.S. House of Representatives position currently held by Nancy Johnson.

"We had the setback of the Physician's Health Program plan not being voted on by the legislature this spring. We have had multiple assurances that when it comes up again, which is expected to be soon, there is little chance it will not get the support it needs to pass.

"On the State Medical Specialty Society front, I had the opportunity to meet with other State Chapter Presidents and officers of ASAM,. including current President Beth Howell, in January and again at the Med-Sci meeting in May. At these meetings, there …was a call for the State chapters to be more involved in policy development at the national ASAM level [and]discussion of the budgetary problems both National and State organizations face. On this front, there is clearly going to be a need for the State Chapters to establish more sustainable methods for funding. Connecticut has attempted to do this through our membership drives and CME activities. There was a commitment by those present to establish a slide set for members to use locally to promote knowledge of addiction treatment to colleagues and the community. …I think these slides will be of value to many of you, as you are asked to speak on various issues within your community.

"The Nominations Committee has put forth the following slate of officers: *for President*: Ken Freedman, M.D., M.B.A., FASAM; *for Vice President:* Peter Strong, M.D.; *for Treasurer/ Secretary:* Sam Silverman, M.D. Voting will take place at the October 2006 meeting. Other nominations will be accepted at that meeting as well."

Contact CtSAM by mail at P.O. Box 88, Hartford, CT 06141; or visit the Society's website at HTTP://WWW.CTSAM.ORG.

Ruth Fox Memorial Endowment Fund

Dr. Ruth Fox

Dear Colleague:

The Ruth Fox Memorial Endowment Fund was established to assure ASAM's continued ability 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. An important component of this mission is fulfilled each year when the recipients of the Ruth Fox Scholarships — an outstanding group of physicians-in-training — join us at ASAM's Annual Medical-Scientific Conference. The scholarships cover travel, hotel and registration expenses for recipients to attend the Med-Sci Conference and Ruth Fox Course, as well as one year's free membership in ASAM.

The four scholarship recipients for 2006 are Kathleen Ang-Lee, M.D. (Seattle, Washington), Katrina Ball, D.O. (Loma Linda, California), Norana Irene Caivano, M.D. (West Hollywood, California), and Mark Hrymoc, M.D. (Harbor UCLA Medical Center, Los Angeles). All told, 24 such scholarships have been awarded.

Now we invite you to join us in the pleasant task of nominating a group of promising young physicians-in-training as candidates for the 2007 Ruth Fox Scholarships. Simply use the special form enclosed with this issue of ASAM News, and return it ASAM no later than [date?]. Scholarship winners will be announced in the March-April 2007 issue.

With your participation, and the professional and financial support of ASAM's members and friends, the Fund will continue to fulfill its mission. If you have not already pledged or donated to the Endowment Fund, please do so now. 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.

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IN MEMORIAM: VINCENT P. DOLE, M.D.

Vincent P. Dole, M.D., died August 2, 2006, at the age of 93. Dr. Dole (an internist) and his late wife, Marie Nyswander, MD (a psychiatrist), began their collaborative research with methadone with a handful of long-term heroin-dependent individuals in 1964. They did so in the face of overt threats of harsh criminal and civil action by enforcement agencies. Their courageous, pioneering work demonstrated that methadone maintenance is an effective treatment of a chronic medical disorder.

After the remarkable transformation they observed in their first few patients, Dr. Dole and Dr. Nyswander went on to provide direct supervision of the first "methadone maintenance treatment program" at Beth Israel Medical Center in New York. In so doing, they demonstrated that it was possible to replicate on a large scale the therapeutic success they achieved in the small, controlled, research environment of the Rockefeller Institute (now Rockefeller University). As a result of their work, well over three-quarters of a million people throughout the world are able to lead healthy, productive, self-fulfilling lives.

Dr. Dole also was responsible in the early 1970s for convincing the New York City Department of Corrections that detoxification of heroin-dependent inmates in the city's main detention facility at Rikers Island was imperative to save lives and reduce suffering. As evidence, he pointed to a wave of suicides among prisoners that had been attributed to untreated severe opiate withdrawal. The detoxification program continues to this day, and has become a model for enlightened corrections officials in other countries.

Dr. Dole and Dr. Nyswander had prescience to hypothesize, years before the discovery of the morphine-like "endorphine system" in the human body, that addiction is a disease, and one that can and must be treated like any other chronic illness. What was at the time a brilliant insight on their part is today almost universally accepted by scientists and clinicians alike, and remains the foundation on which all rational policies and practices in the field rest.

Dr. Dole's efforts in recent years were devoted to fighting the stigma that remains so widespread against the illness of addiction, the patients who suffer from it, and their treatment.

Mark Parrino, President of the American Association for the Treatment of Opioid Dependence, observed that "Some people are put on this earth to do remarkable things with their talents. [Dr. Dole] represented the very best of science and humanity. His lasting contributions have saved hundreds of thousands of lives and have preserved dignity for countless people throughout the world who have found their way into methadone treatment programs. His work relieved suffering and provided hope to people who were largely disenfranchised.... We are all deeply fortunate to have been touched by his brilliance and his deeply giving nature. He will be very greatly missed but his accomplishments will live on, especially through the people who continue to benefit from his work."

ASAM Conference Calendar

ASAM

October 26-28, 2006
ASAM Review Course in Addiction Medicine
Westin O'Hare Hotel
Chicago, Illinois
[21 Category 1 CME Credits]

October 29, 2006
ASAM Course on Pain & Addiction
Westin O'Hare Hotel
Chicago, Illinois
[8 Category 1 CME Credits]

November 18, 2006
Best Practices: Clinical Drug Testing in Addiction Treatment IV
Hilton Palmer House Hotel
Chicago, Illinois
[7.5 Category 1 CME Credits]

December 9. 2006
Certification and Recertification Examination in Addiction Medicine
[5 Category 1 CME Credits]
Los Angeles, New York, and Atlanta

December 8-10, 2006
Medical Review Officer (MRO) Training Course
(Level I and Level II)
Marriott Metro Center Hotel
Washington, DC
[12 Category 1 CME Credits]

OTHER EVENTS OF NOTE

November 2-4, 2006
Association for Medical Education and Research in Substance Abuse
30th Annual National Conference
Washington, DC

[Note: NIAAA has funded 20 scholarships for individuals who would be attending an AMERSA conference for the first time. Applicants must be health professional educators or researchers who are conducted alcohol-related research or are interested in the field. They must be providing training or research to underserved populations such as Latinos, African-Americans, or women. For more information, email Isabel@amersa.org or phone 401/349-0000.]

BUPRENORPHINE TRAINING

Online Any Time
Clinical Tools, Inc. & ASAM
Contact: 919/960-8118 or go to www.BuprenorphineCME.com

All courses are approved for 8 Category 1 CME credits.

September 7, 2006
San Francisco, CA
Sponsored by ASAM & the California Medical Assn.

September 23, 2006
New Haven, CT

October 6, 2006
New York, NY

October 7, 2006
Edison/New Brunswick, NJ

November 17, 2006
Boston, MA

December 2, 2006
Atlanta, GA

December 3, 2006
Anaheim, CA

December 2, 2006
Atlanta, GA

December 9, 2006
Raleigh, NC

December 15-16, 2006
Columbus, OH

To register for any of the buprenorphine courses, please go to www.DocOptIn.com or phone 1-888/362-6784.

For information regarding the December 2nd Atlanta course only, please go to www.naatp.org/secad or phone 1-866/293-5510.

Except where otherwise indicated, additional information is available on the ASAM website (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.