March-April 2007
Volume 22, Number 2

# ASAM News

Newsletter of The American Society of Addiction Medicine

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***See pages 8-11 for an overview of ASAM's Med-Sci Conference!***

**www.asam.org**

## Welcome to ASAM's 38th Medical-Scientific Conference

Miami, Florida, welcomes ASAM members and their families, addiction medicine practitioners, educators and researchers, students and residents from around the world to ASAM's 38th Annual Medical-Scientific Conference, set for April 27th-29th. The conference features three full days of outstanding scientific and clinical offerings, as well as ASAM's annual Business Meeting on Friday morning, April 27th.

The Med-Sci Conference is preceded by the Ruth Fox Course for Physicians and ASAM's course on Pain and Addiction: Common Threads VIII, both scheduled for Thursday, April 26th. Educational activities conclude on Sunday, April 29th with a Buprenorphine Training Course. All the events take place at Miami's Marriott Doral Resort and Spa.

For additional information or to register, visit the ASAM website at WWW.ASAM.ORG or contact ASAM's Department of Meetings and Conferences at 301/656-3920. *(See pages 8-11 for an overview of the conference program.)*

## New Supplement to the ASAM Criteria to be Previewed During Med-Sci

A new Supplement to ASAM's widely-used *Patient Placement Criteria* will be unveiled during the Society's Med-Sci Conference. The Supplement is designed to help users of the *Criteria* successfully integrate the new pharmacologic therapies for alcoholism with other components of addiction care.

The Supplement will be discussed and review copies distributed during a special CME program on "Achieving Treatment Success in Alcohol Dependence: Integrating Pharmacological and Psychosocial Approaches," scheduled for Saturday evening, April 28th. The CME program is to begin with dinner at 6:00 p.m., followed by presentations from 7:00 to 8:30 p.m. Thanks to an unrestricted educational grant from Alkermes/Cephalon, there is no registration fee, but advance registration is required.

Marc J. Fishman, M.D., of the Johns Hopkins University and Maryland Treatment Centers, chairs both the CME program and the Supplement drafting committee. Other members of the drafting committee are ASAM Criteria developers David Mee-Lee, M.D., and Gerald D. Shulman, M.A., FACATA; George Kolodner, M.D., of Georgetown University and the Kolmac Clinic; and Bonnie B. Wilford, M.S., of the Center for Health Services & Outcomes Research at JBS International, Inc..

In addition, the developers are collaborating with a distinguished group of advisers, including Henry R. Kranzler, M.D., of the University of Connecticut Health Center; Edward V. Nunes, M.D., of the New York State Psychiatric Institute; Charles P. O'Brien, M.D., Ph.D., of the University of Pennsylvania School of Medicine; Richard N. Rosenthal, M.D., Chairman of Psychiatry at New York's St. Luke's — Roosevelt Hospital, and Mark Willenbring, M.D., of the National Institute on Alcohol Abuse and Alcoholism.

For more information about the *PPC Supplement*, watch future issues of **ASAM NEWS**. To register for the CME program, visit the ASAM website at *www.asam.org* or contact Angela Warner at *awarner@asam.org*.

# A Victory for the Field: Medicaid to Pay for SBI

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

***Eileen McGrath, J.D.***

Thanks to the efforts of ASAM member David C. Lewis, M.D., and other stalwarts, the federal Medicaid program has changed its reimbursement policies to allow payment for screening and brief intervention (SBI) for alcohol and other drug problems.

Working with field leaders such as Eric Goplerud, Ph.D., Director of the Ensuring Solutions to Alcohol Problems program at the George Washington University Medical Center, Dr. Lewis persuaded the Centers for Medicare and Medicaid Services (CMS) to add two new reimbursement codes for insurance claims: one for screening, the other for brief-intervention services. The change was made to the HCSPCS Level II coding system effective January 1, 2007.

Lack of reimbursement long has been regarded as an obstacle to expanded use of SBI, despite the demonstrated effectiveness of these techniques in identifying and curtailing alcohol and drug problems.

The new codes will be essential to expansion of SBI in public-sector programs, such as community health centers, Indian Health Service clinics, public hospitals, community mental-health centers, and migrant health centers. Dr. Goplerud says that they will provide "a financial base for the sustainability of these programs," including those created under the *Screening, Brief Intervention, Referral and Treatment (SBIRT)* initiative by the federal Center for Substance Abuse Treatment.

The CMS codes won't have directly affect SBI in private-sector facilities, but CSAT, Ensuring Solutions, ONDCP, and the group Physicians and Lawyers for National Drug Policy (PLNDP) have asked the American Medical Association (AMA) to add SBI to its Current Procedural Terminology (CPT) codes, which would clear the way for reimbursement through private insurance and Medicare.

Meanwhile, ASAM has joined Ensuring Solutions, PLNDP, and Faces and Voices of Recovery to continue our efforts to repeal state Uniform Policy Provision Laws (UPPL), which allow insurers to deny payment for health care services if the victim of an accident is found to be under the influence of alcohol. UPPL is a major impediment to implementation of hospital-based SBI programs.

Ensuring Solutions has developed a guide to using the HCSPCS reimbursement codes, which can be accessed online at HTTP://WWW.ENSURINGSOLUTIONS.ORG/RESOURCES/RESOURCES.

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



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

## Alcohol Use by U.S. Military Personnel Tied to Violent Acts

Some of the most violent crimes committed by U.S. troops in Iraq were fueled in part by alcohol, according to a report in the *New York Times*. Although U.S. military personnel are barred from drinking alcohol while serving in Iraq and Afghanistan, alcohol and other drugs were involved in 240 of 665 Army criminal prosecutions that resulted in convictions in the two war zones. Crimes involving alcohol and other drugs included murder, rape, armed robbery, and assault.

Iraqi moonshine is reportedly cheap and easy to find despite Islamic and military prohibitions on consumption. Some soldiers also ask relatives in the U.S. to mail them gin or rum colored with food coloring in mouthwash bottles.

Drinking rates appear to be rising in the Army and Marine Corps, the branches of the service most directly involved in combat operations. For example, research indicates than binge drinking in the Army rose 30 percent between 2002 to 2005. One in four soldiers say they drink heavily — the highest rate since 1985. The trend may reflect changes in recruiting standards that allow more individuals with past alcohol or other drug problems to join the military.

Despite the indicators of a growing problem, the Pentagon has cut spending on alcohol prevention from $12.6 million in 2005 to $7.74 million this year.

"I think the real story here is in the suicide and stress, and the drinking is just a symptom of it," said Charles P. O'Brien, M.D., Ph.D., of the University of Pennsylvania School of Medicine and the Philadelphia VA Medical Center, pointing to the increase in suicides recorded in active-duty service personnel. *Source:* New York Times*, March 13, 2007*.

## Judge Bars "Low Tar," "Light" Cigarette Claims

The judge in a U.S. racketeering case has ordered tobacco companies to stop marketing cigarettes using terms like "low tar" and "light" — not just in the United States but overseas as well

Judge Gladys Kessler rejected a bid by defendant Philip Morris USA to continuing using the terms when selling cigarettes internationally. Judge Kessler ruled that the prohibition on "implied health messages" applied to both domestic and international tobacco operations.

In a ruling last summer, Judge Kessler found that the tobacco industry violated U.S. racketeering laws and intentionally lied to the public about the dangers of smoking. In the present ruling, she said it made no sense "to tell the rest of the world that 'low tar/light' cigarettes are less harmful to health when they are prohibited from making such fraudulent representations to the American public."

The tobacco firms said they would appeal the ruling on the grounds that it infringed on the rights of other countries to regulate cigarette sales. *Source: Associated Press, March 17, 2007.*

## HBO "ADDICTION" PROJECT SPURS LOCAL EFFORTS

The series "Addiction," which aired on the Home Box Office (HBO) cable channel beginning March 15th, has spurred action at the community level to increase public understanding that addiction is a treatable disorder.

A collaboration between HBO, the Robert Wood Johnson Foundation, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, the 14-part HBO documentary series is the linchpin of a campaign that includes a companion book, a comprehensive addiction information website, and a national community outreach program featuring town-hall style meetings in more than 35 states, where advocates and residents could discuss some of the key themes and issues raised in the documentary.

The centerpiece documentary provides a candid depiction of the emotional, psychological, social, and political toll of addiction, as well as a focus on the fact that addiction is treatable and that there are millions of Americans in long-term recovery. Experts interviewed in the documentary included Nora D. Volkow, M.D., Director of the National Institute on Drug Abuse; Mark Willenbring, M.D., of the National Institute on Alcohol Abuse and Alcoholism; alcohol researcher Bankole Johnson, M.D., Ph.D., D.Sc., of the University of Virginia; and Kathleen Brady, M.D., Ph.D., of the Medical University of South Carolina.

Critics generally lauded the series. David Kronke, television critic for the *Los Angeles Daily News,* described it as delivering a message of hope, writing that. "HBO's series posits the malady as a medical, not moral, condition afflicting brains which have ceased to function correctly, and argues addicts don't have to hit bottom to seek help…[T]he portraits of resolve and suggestions that new medications and programs can provide some semblance of hope might help wrest the monkeys off addicts' backs."

The "Addiction" series can be viewed on computer at HTTP://WWW.HBO.COM/ADDICTION/THEFILM/. The DVD and accompanying book, *Why Can't They Just Stop?*, are available for purchase at $24.99 each from retail outlets and online bookstores such as Amazon.com.

## AMA Calls for Ban on Alcohol Advertising in College Sports

The American Medical Association is sponsoring a series of advertisements in college newspapers that call on the schools to stop accepting alcohol advertising during college sports events. The ads, timed to coincide with the beginning of the NCAA basketball "March Madness" tournament, call on the colleges to "stop the madness" of alcohol advertising aimed at youth. The ads appeared in the Chronicle of Higher Education and student newspapers at Georgia Tech, the University of Iowa, the University of Wisconsin, Indiana University, the University of Mississippi, and DePaul University.

The AMA documents that the alcohol industry spent more than $52 million on advertising during college sports events in 2006. Richard Yoast, Ph.D., who directs the AMA's Office of Alcohol and Other Drug Abuse, said alcohol advertising during school sports events undermines campus prevention efforts. "Almost every college president would agree that heavy drinking is their major student health problem," he said. *Source: Associated Press, March 9, 2007.*

*Dr. Elizabeth F. Howell*

# ASAM Awards Honor Scientific Achievements

*Elizabeth F. Howell, M.D., FASAM*

One of the great pleasures of ASAM's Annual Medical-Scientific Conference is the opportunity to recognize a distinguished group of individuals who have made outstanding contributions to the field of Addiction Medicine and to the Society itself. This year's group of awardees represents the highest standards in our field, and I know you join me in extending congratulations to each of them.

The R. Brinkley Smithers Distinguished Scientist Award will be presented at the Opening Plenary Session at 9:00 a.m. Friday, April 27th. The award for 2007 goes to Lee Ann Kaskutas, Dr.P.H., Senior Scientist with the Alcohol Research Group, Public Health Institute, Berkeley, California, and Associate Adjunct Professor, Department of Social and Administrative Health Services, School of Public Health, University of California at Berkeley. Dr. Kaskutas' award lecture is titled, "AA Effectiveness – Faith Meets Science."

The following awards will be presented during the annual Awards Luncheon at 12:15 p.m. Saturday, April 28th.

The John P. McGovern Award on Addiction and Society goes to William L. White, M.A., Senior Research Consultant with Chestnut Health Systems, Bloomington, Illinois, and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.*

The ASAM Annual Award for "outstanding contributions to the growth and vitality of our Society, for thoughtful leadership in the field, and for deep understanding of the art and science of Addiction Medicine" will be presented to former ASAM Executive Vice President James F. Callahan, D.P.A.

An ASAM Annual Award for "expanding the frontiers of the field of Addiction Medicine and broadening our understanding of the addiction process through research and innovation" will be presented to Jerome H. Jaffe, M.D.

The Young Investigator Award for the best abstract submitted by an author who is within five years of receiving a doctoral degree will be presented to Martha J. Wunsch, M.D., FAAP, FASAM.

The Medical-Scientific Program Committee Award for the abstract receiving the highest rating for scientific merit goes to Professor Philippe Lehert.

The Awards Luncheon is an extra-fee event. Tickets for the luncheon are available in advance or on-site for $50 per person. (Business attire is requested.) Visit the ASAM Registration Desk for tickets so that you can join us in recognizing the achievements of this distinguished group.

# IN MEMORIAM: RICHARD E. TREMBLAY, M.D., FASAM

RICHARD E.. TREMBLAY, M.D., FASAM, died peacefully in his sleep at his home in Olympia, Washington, March 27, 2007. A former Marine, Dr. Tremblay was well-known for his work in addiction medicine, both through his private practice and as medical director of public and private-sector inpatient and outpatient treatment programs serving both adult and adolescent patients.

He was the founding President of the Washington Society of Addiction Medicine, and worked to build that chapter to reflect the unique character of the region, its medical community and population.

Dr. Tremblay was active in ASAM for almost 20 years, serving as Region VIII's representative to the Board of Directors and on many committees, including the Membership, Chapters, Fellowship, Methadone, Physician's Health, and Constitution & Bylaws Committees. He was particularly proud of his appointment to chair the task force that developed ASAM's first Strategic Plan. Asked about his goals for the Plan, Dr. Tremblay said they were to "improve the quality of life for our members and the quality of care for their patients."

Dr. Tremblay is survived by his sons, Jon, Rolf, and Eric Tremblay, and his good friend Judy Hartman. A memorial service was held April 4th at St. Michael Parish Church in Olympia, Washington.

# An Invitation to "Just Show Up"

*Michael M. Miller, M.D., FASAM, FAPA*

*Dr. Michael M. Miller*

When someone becomes ASAM President, it's not as if the job sneaks up on you. More than two years pass between the time a candidate is elected and the time he or she actually assumes the office of President. So I've had time to think a lot about what can happen and what my own experiences can bring to our Society.

The first thing that comes to mind is that ASAM is a *membership society*. It is nothing more than its members, each of whom offers a dues check and then *volunteers* to do things within and for ASAM. We all have busy practices, most of us have families, and we have personal lives to nurture. Some of us also have personal recovery journeys that require time and attention. So whatever any physician does as an ASAM member represents a choice among competing priorities.

That thought leads to the idea that ASAM needs better methods of communicating with you, the general member. We need to know your interests and needs, and what *you* define as valuable among the things ASAM provides or could provide to you. We know that we are different from other medical organizations, that our annual meetings have a different "feel," that collegiality and bonds and caring really are present among us. Physicians who care for persons with addictive disorders are relieved and delighted to know they are not alone, that there are others who share their intellectual interests and their passion for improving patient care. ASAM provides their "home" within organized medicine. Our annual meeting and other events truly serve as a "homecoming" for many of us and allow us to renew professional and personal friendships.

But for ASAM to succeed and grow, more of its members need to be *involved* in the workings of the Society. Therefore, a major goal for my two years as President is to develop electronic real-time dialogue among ASAM members — web-based processes through which ASAM leaders and staff can better understand what members want ASAM to do, and what *you would like to do* for ASAM or your State Chapter. We need more member input in terms of what public policy positions we adopt, what CME courses we offer, and even how the annual meeting is structured. Such electronic dialogue will not only serve the organization by improving its "member knowledge," it will directly serve members by providing a means for them to communicate with each other.

We know that some ASAM members believe that the organization remains as it was in the early years, when a very small circle of leaders met in Ruth Fox's apartment in Manhattan. Members sometimes report that they feel distant from the Officers and Board and don't know how to contribute meaningfully, much less assume a position of leadership themselves. As I think about such comments, I remember my favorite bumper sticker, which says, "The World Is Run By People Who Show Up." That's how I became involved in ASAM 18 years ago: By showing up at a Reimbursement Committee Meeting in Phoenix, showing up at the first ASAM PPC Conference in Atlanta, showing up at the Nicotine Conferences and at a Component Session for what used to be called the Medical Care in Recovery Committee. I was no insider then, although I guess people call me that now.

What ASAM needs more than anything is more practicing addictionists, more academic addictionists, and more addiction researchers who make a simple decision to "show up" — they attend a Chapter meeting in their locale, or participate in a CME conference, or volunteer to teach residents or medical students and add an ASAM logo to their slide sets (as I do every time). ASAM needs physicians who are a bit more than those "checkbook members" who kindly send their dues checks each year and show up at the annual meeting every year or two. We need more people who take on a task that interests them. And ASAM needs to develop the next generation of leaders, who will come from the general members and readers of our Newsletter.

One of Beth Howell's legacies as President is her initiative to establish Action Groups, which are focused, time-limited groups that work to achieve measurable results in a specific area of the Society's Strategic Plan. I co-chair one such group, the Medical Specialty Action Group. There also is a Parity Action Group doing great work, and a Buprenorphine Action Group, which led the successful fight to expand the 30-patient limit. Two others of critical importance are our Financial Development Action Group, which is exploring new income streams, and our Leadership Development Action Group, which is exploring ways to identify and nurture talent amongst us and to expand the diversity of ASAM Committee Chairs, Work Group Chairs, Chapter Officers, and national Board Members. I promise to do my best to help these Action Groups succeed, so that we can look back in four years and say "Yes, we really did accomplish some of those ambitious goals we identified in the Strategic Plan." If you haven't read the Strategic Plan, please check it out on ASAM's newly reformatted website. And if you have any spark within you to become one of ASAM's

*continued on page 14*

*Dr. Mark Willenbring*

# Updated NIAAA Guide Offers New Tools and CME Credits

## *Instructors Encouraged to Order Free Copies & PowerPoint Show*

An updated version of *Helping Patients Who Drink Too Much: A Clinician's Guide*, produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), is being provided to all ASAM members with this issue of **ASAM NEWS**. A pocket-sized version of the Guide is included as well.

The Clinician's Guide and its "family of products" has grown to include an expanded medications section, a new patient education handout, an updated PowerPoint presentation, a web page dedicated to the Guide and related materials, and a continuing medical education activity.

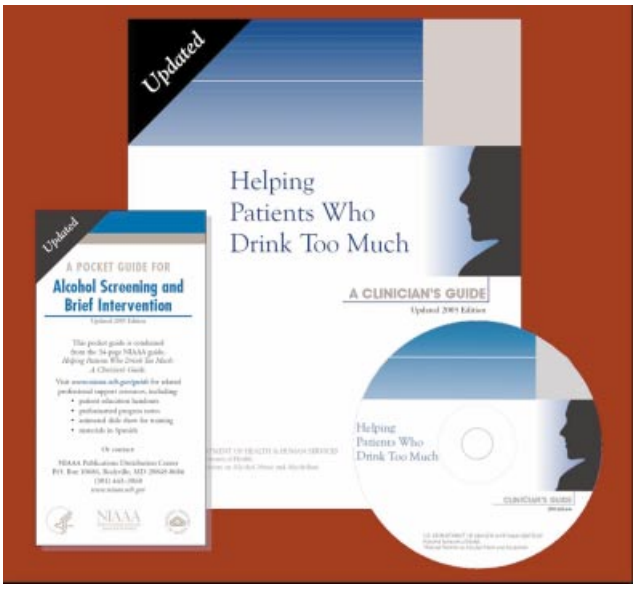
Produced under the direction of Mark Willenbring, M.D., Director of NIAAA's Division of Treatment and Recovery Research, the updated Guide provides the latest information on FDA-approved medications, including a newly approved, extended-release injectable formulation of naltrexone, which joins three previously approved medications: oral naltrexone, acamprosate, and disulfiram. The section also contains a user-friendly, evidence-based program of behavioral support for patients taking medications for alcohol dependence. The program consists of brief, structured outpatient sessions designed for easy use by physicians, nurses, and other health care professionals.

Dr. Willenbring notes, "As with many other chronic illnesses such as depression or diabetes or high blood pressure, treatment with medications for alcohol dependence only works if it involves active management on the part of providers. This includes follow-up that focuses on adherence to the medication regimen and encourages the patient to make lifestyle changes."

The updated Guide also provides a new patient education handout, "Strategies for Cutting Down." The handout may be photocopied from the Guide or downloaded in English or Spanish from a new NIAAA web page dedicated to the Guide and related resources (WWW.NIAAA.NIH.GOV/GUIDE, see sidebar on page 7).

While the Guide has changed in some ways, the approach to alcohol screening and intervention presented in the original 2005 Guide remains the same. That edition established a number of new directions compared with earlier versions, including a simplified, single-question screening question and more guidance for managing alcohol-dependent patients.

NIAAA has received feedback from medical and nursing school instructors that the Guide and its accompanying PowerPoint presentation provide a user-friendly, well-structured, and informative mini-course on screening, diagnosing, and managing patients with unhealthy drinking and alcohol use disorders. NIAAA encourages instructors to order free, bulk quantities of the Guide along with the free PowerPoint slide presentation for their courses or workshops. A new, free continuing medical education (CME) program based on the Guide (see the accompanying article) is expected to generate interest in professional audiences.




To order the Guide and related products, visit WWW.NIAAA.NIH.GOV/GUIDE, phone 301/443-3860, or write to the NIAAA Publications Distribution Center, P.O. Box 10686, Rockville, MD 20849-0686.

***For more information, visit the NIAAA exhibit at Booth 214 during Med-Sci or visit NIAAA on the Web at www.niaaa.nih.gov/Guide!***

# TOOLS AVAILABLE ONLINE

In addition to updating the *Clinician's Guide*, NIAAA also has produced a "one-stop shopping" web page dedicated to the Guide and related resources (WWW.NIAAA.NIH.GOV/GUIDE). The page pulls together many NIAAA products that support practitioners, educators, and students who want to learn more about helping patients who drink too much. NIAAA will continually update this page. Current offerings and links include the following:

## ENGAGING, ADAPTABLE POWERPOINT SHOW.

Of particular interest to ASAM members who are medical educators, NIAAA has updated its slide show to introduce health professionals to the Guide. This animated PowerPoint presentation walks viewers step-by-step through the Guide's clinical approach to screening and brief intervention and highlights the helpful appendix materials. Instructors can readily adapt the 60 slides (or 80 views in PDF form) to teach medical students, mental health providers, and other health care professionals. The slide show can be downloaded from *www.niaaa.nih.gov/guide* or a free CD ordered by phoning 301/443-3860 or sending an email with your name and address to NIAASSLIDESHOW@NIH.GOV.

## GUIDE-BASED CME/CE ACTIVITY.

Visit WWW.NIAAA.NIH.GOV/GUIDE for a link to a new, free Guide-based CME activity, now available from Medscape®. Physicians can earn up to 1.5 AMA PRA Category 1 Credit(s) and nurses can earn 1.5 nursing contact hours (0.25 of which are in the area of pharmacology).

**Patient Education Materials.** The following one-page handouts are available in both English and Spanish:

- Strategies for Cutting Down
- What's a Standard Drink?
- U.S. Adult Drinking Patterns

**Forms for Downloading.** The following forms can be downloaded from the NIAAA website:

- Screening instrument: The Alcohol Use Disorders Identification Test (AUDIT) in English and Spanish
- Assessment support materials
- Pre-formatted baseline and follow-up progress notes
- Medication management support templates
- Medication wallet cards

### Medications for Treating Alcohol Dependence

| | Naltrexone (Depade®, ReVia®) | Extended-Release Injectable Naltrexone (Vivitrol®) | Acamprosate (Campral®) | Disulfiram (Antabuse®) |
|---|---|---|---|---|
| **Action** | Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking. | Same as oral naltrexone; 30-day duration. | Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear. | Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol. |
| **Contraindications** | Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure. | Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the injection site. | Severe renal impairment (CrCl ≤ 30 mL/min). | Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives. |
| **Precautions** | Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*. | Same as oral naltrexone, plus hemophilia or other bleeding problems. | Moderate renal impairment (dose adjustment for CrCl between 30 and 50 mL/min); depression or suicidal ideation and behavior. Pregnancy Category C. | Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hypothyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*. |
| **Serious adverse reactions** | Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses). | Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior. | Rare events include suicidal ideation and behavior. | Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions. |
| **Common side effects** | Nausea, vomiting, decreased appetite, headache, dizziness, fatigue, somnolence, anxiety. | Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps. | Diarrhea, somnolence. | Metallic after-taste, dermatitis, transient mild drowsiness. |
| **Examples of drug interactions** | Opioid medications (blocks action). | Same as oral naltrexone. | No clinically relevant interactions known. | Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol. |
| **Usual adult dosage** | *Oral dose:* 50 mg daily.<br>*Before prescribing:* Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, administer a naloxone challenge test. Evaluate liver function.<br>*Laboratory followup:* Monitor liver function. | *IM dose:* 380 mg given as a deep intramuscular gluteal injection, once monthly.<br>*Before prescribing:* Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition.<br>*Laboratory followup:* Monitor liver function. | *Oral dose:* 666 mg (two 333-mg tablets) three times daily; or for patients with moderate renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily.<br>*Before prescribing:* Evaluate renal function. Establish abstinence. | *Oral dose:* 250 mg daily (range 125 mg to 500 mg).<br>*Before prescribing:* Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over-the-counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash).<br>*Laboratory followup:* Monitor liver function. |

***Note:*** This chart highlights some of the properties of each medication. It does ***not*** provide complete information and is ***not*** meant to be a substitute for the package inserts or other drug reference sources used by clinicians. For patient information about these and other drugs, the National Library of Medicine provides MedlinePlus (*http://medlineplus.gov*). Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is ***not*** a substitute for a provider's judgment in an individual circumstance, and the NIH accepts no liability or responsibility for use of the information with regard to particular patients.

# 38th Medical-Scientific Conference Opens APRIL 27th in MIAMI

Tropical Miami is the site of ASAM's 38th Annual Medical-Scientific Conference, where addiction experts from around the world will gather for a program rich in scientific symposia, clinical courses and workshops, and research papers and poster sessions. The conference — which welcomes ASAM members as well as non-member researchers, educators, and clinicians — is preceded on April 26th by the *Ruth Fox Course for Physicians* and the course on *Pain and Addiction: Common Threads VIII*. It concludes on Sunday, April 29th, with a Buprenorphine Training Course designed to qualify ASAM members and other physicians to prescribe buprenorphine in office-based practice.

Program chair Jeffrey Samet, M.D., M.A., M.P.H., co-chairs Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, and Marc Galanter, M.D., FASAM, and the members of the committee have created a program that affords participants an opportunity to interact with diverse experts in the field. Major events include special symposia organized by the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, as well as a symposium on prescription drug abuse organized by the Center for Substance Abuse Treatment.

The Annual Business Meeting and Breakfast will be gaveled to order at 7:30 a.m. Friday, April 27th, by ASAM President Elizabeth F. Howell, M.D., FASAM. Early risers will be rewarded with a delicious buffet breakfast, to be served from 7:15 a.m., courtesy of The Christopher D. Smithers Foundation. The meeting affords an opportunity for members to offer their views on ASAM's needs and priorities. At the session, Michael M. Miller, M.D., FASAM, FAPA, will be installed as ASAM's President for 2007-2009.

The official opening of the conference, which immediately follows the business meeting at 9:00 a.m., features an address by Lee Ann Kaskutas, Dr.P.H., Senior Scientist with the Alcohol Research Group of the Public Health Institute, and Associate Adjunct Professor in the Department of Social and Administrative Health Services, School of Public Health, University of California at Berkeley. Dr. Kaskutas, who is the recipient of the 2007 R. Brinkley Smithers Distinguished Scientist Award, will deliver the award lecture on *"AA Effectiveness — Faith Meets Science."* Other distinguished speakers scheduled for the opening plenary are Mark Willingbring, M.D., of the National Institute on Alcohol Abuse and Alcoholism; Tim Condon, Ph.D., of the National Institute on Drug Abuse; and H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director of the Center for Substance Abuse Treatment.

The ASAM Awards Luncheon, set for 12:15 to 2:00 p.m. Saturday, April 28th, honors outstanding contributions to the addiction field, as well as those who have made notable contributions to the Society. A traditional highlight of the luncheon is the John P. McGovern Award and Lecture on Addiction and Society, established in 1997 to honor an individual who has made highly meritorious contributions to public policy, treatment, research, or prevention and who has increased our understanding of the relationship of addiction and society. The award is sponsored by an endowment from the John P. McGovern Foundation. This year's recipient is William L.White, M.A,, Senior Research Consultant with Chestnut Health Systems, Bloomington, Illinois, and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. (The Awards Luncheon is an extra fee event.)

An overview of the conference schedule is found on the following pages of **ASAM NEWS**. The complete program is available on ASAM's website at WWW.ASAM.ORG.

## "Common Threads" Focuses on Buprenorphine for Pain, Addiction

Pain & Addiction course co-chairs Donald J. Kurth, M.D., FASAM, and Herbert Malinoff, M.D., FACP, FASAM, have planned a cutting-edge program featuring the following topics:

**The Development of Buprenorphine in the Laboratory and in Practice**
Donald Jasinski, M.D., *Johns Hopkins University, Baltimore, MD*

**Heterogeneity of the Mu Receptor**
Gavril Pasternak, M.D., Ph.D., *Cornell University Medical Center, New York, NY*

**Use of Buprenorphine for Pain: A Literature Review**
Michael Weaver, M.D., *Virginia Commonwealth University Medical Center, Richmond, VA*

**Use of Buprenorphine in Pain Management: Practical Applications**
Herbert Malinoff, M.D., FACP, FASAM, *Medical Director, Pain Recovery Solutions, PA; and Clinical Faculty, Department of Anesthesiology, University of Michigan Medical Center, Ann Arbor, MI*

**To X or Not to X: The Off-Label Use of Buprenorphine for Chronic Pain**
Mark Caverly, *Chief, Liaison and Policy Section, Office of Diversion Control, U.S. Drug Enforcement Administration, Washington, DC*

**Buprenorphine for Addiction and Pain in the Pregnant Patient**
*Hendree Jones, M.D., Johns Hopkins University, Baltimore, MD*

**Strategies for Pain Management in the Buprenorphine-Maintained Patient**
Howard Heit, M.D., FASAM, *George Washington University Medical Center, Washington, DC*

**PANEL DISCUSSION: *Buprenorphine in the Trenches: Practical Aspects of a Successful Buprenorphine Practice***

The course is approved for 8 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

## CONFERENCE REGISTRATION AND FEES

Register on-site at the ASAM Conference Registration and Information Desk, which will be open during the following hours:

Wednesday, April 25th ..... 5:00 to 9:00 pm

Thursday, April 26th, 6:30 a.m. to 6:30 p.m.

Friday, April 27th, 7:00 a.m. to 5:00 p.m.

Saturday, April 28th, 7:00 a.m. to 5:00 p.m.

Sunday, April 29th, 7:00 a.m. to 1:00 p.m.

The following fees apply to on-site registrations only:

### Ruth Fox Course for Physicians

(Thursday, April 26th)

ASAM member ..... $315

Non-member physician ..... $375

Non-physician professional *(R.N., Ph.D., CAC, LCSW, etc.)* ..... $290

Resident, Fellow, Intern *(with proof of status)* ..... $265

Student *(with proof of status)* ..... $190

### Pain & Addiction: Common Threads VIII

(Thursday, April 26th)

ASAM member ..... $315

Non-member physician ..... $375

Non-physician professional *(R.N., Ph.D., CAC, LCSW, etc.)* ..... $290

Resident, Fellow, Intern *(with proof of status)* ..... $265

Student *(with proof of status)* ..... $190

### 38th Annual Medical-Scientific Conference

(April 27th-29th)

ASAM member ..... $550

Non-member physician ..... $660

Non-physician professional *(R.N., Ph.D., CAC, LCSW, etc.)* ..... $550

Paper presenter ..... $425

Resident, Fellow, Intern *(with proof of status)* ..... No charge

Student *(with proof of status)* .... No charge

### Daily Registration for the Medical-Scientific Conference

..... $250 per day

### ASAM Awards Luncheon

(Saturday, April 28th, 12:15 p.m.)

..... $50

for Medical-Scientific Conference registrants

## MED-SCI PROGRAM COMMITTEE

*Chair*: Jeffrey Samet, M.D., M.A., M.P.H.

*Co-Chair:* Lawrence S. Brown Jr., M.D., M.P.H., FASAM

*Co-Chair:* Marc Galanter, M.D., FASAM

### Members:

Gregory C. Bunt, M.D.

David A. Fiellin, M.D.

Mark S. Gold, M.D.

R. Jeffrey Goldsmith, M.D.

Enoch Gordis, M.D.

David A. Gorelick, M.D., Ph.D.

Edward Gottheil, M.D., Ph.D.

James A. Halikas, M.D., FASAM

Jag H. Khalsa, Ph.D.

Donald J. Kurth, M.D., FASAM

Alfonso Paredes, M.D.

Richard K. Ries, M.D., FASAM

Barry Stimmel, M.D., FASAM

Anton Che' Bizzell, M.D., *CSAT Liaison*

Dorynne Czechowicz, M.D., *NIDA Liaison*

Carlton K. Erickson, Ph.D., *RSA Liaison*

Norman Wetterau, M.D., *AAFP Liaison*

Mark Willenbring, M.D., *NIAAA Liaison*

Joan Ellen Zweben, Ph.D., *Consultant*

### Staff:

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

Sandy S. Metcalfe, *Director of Meetings and Conferences*

## MUTUAL HELP MEETINGS

***Mutual help meetings will be held each morning and evening of the conference. Times will be listed in the final conference program, or check at the Conference Registration Desk.***

## Ruth Fox Course for Physicians Welcomes AMA's President-Elect

The 26th Ruth Fox Course for Physicians is scheduled for Thursday, April 26th, from 8:00 a.m. to 5:30 pm. The course is dedicated to providing practicing physicians with cutting-edge knowledge about current trends in the field of addiction medicine.

Organized by the late Maxwell N. Weisman, M.D., the first Ruth Fox Course was held in 1980 in Seattle, Washington, in conjunction with the National Alcoholism Forum. Over the ensuing years, the course has educated thousands of physicians.

The 2007 course, which is chaired by Margaret A. E. Jarvis, M.D., FASAM, and co-chaired by Louis E. Baxter, Sr., M.D., FASAM, and John C. Tanner, D.O., FASAM, features a special luncheon address by Ronald M. Davis, M.D., President-Elect of the American Medical Association, as well as the following outstanding presenters:

- **Remembering Dr. Ruth Fox – Looking Back/Looking Forward:** Stanley E. Gitlow, M.D., FACP, FASAM
- **Trends in Adolescent Drug Use:** Martha J. Wunsch, M.D., FAAP, FASAM.
- **Eating Disorders:** John C. Tanner, D.O., FASAM
- **Fetal Alcohol Spectrum Disorders: Impact on the Fetus to Adults:** Bruce B. Peters, D.O., FAAP, FACOP
- **Conscious Contact: Religious Experience in Search of the Spiritual:** Rev. Edward Reading, Ph.D., LCADC
- Luncheon (provided): **The Global March of the Marlboro Man and the Growing Pandemic of Tobacco-Related Disease:** Ronald M. Davis, M.D.
- **Family Effects of Addiction:** Neil A. Capreto, D.O., FASAM
- **Problematic Online Sexual Behavior:** Elizabeth J. Griffin, M.A., LMFT, and David L. Delmonico, Ph.D.
- **Neurochemistry Review: Advances in Anti-Relapse Pharmacotherapy of Alcoholism:** Steven C. Boles, D.O.
- **Addiction Medicine Literature Review: What's New and What It Means:** Michael Weaver, M.D., FASAM

# QUICK GUIDE TO MED-SCI PROGRAM EVENTS

## THURSDAY, APRIL 26, 2007

### 6:00 - 8:00 pm

**Welcome Reception and Opening of the ASAM Exhibit Hall** (sponsored by the Florida Society of Addiction Medicine and Cephalon, Inc.)

### 8:00 - 10:00 pm

**COMPONENT SESSION I: Coding for Screening and Brief Intervention, Pharmacotherapy and Psychotherapy**
*CHAIRS: John P. Femino, M.D., FASAM, and A. Kenison Roy III, M.D., FASAM*

**COMPONENT SESSION II: Addiction Medicine and Primary Care**
*CHAIR: Norman Wetterau, M.D., FAAFP; SPEAKERS: Richard D. Blondell, M.D.; Peggy Murray, Ph.D., and Bonnie B. Wilford, M.S.*

**COMPONENT SESSION III: ASAM Sub-Work Groups on Opioid Agonist Treatment and Buprenorphine Training**
*CHAIR: Edwin A. Salsitz, MD, FASAM; SPEAKERS: Anton C. Bizzell, M.D.; Ruth Finkelstein; Angel A. Gonzalez, M.D.; David C. Marsh, M.D., CCSAM; Judith C. Martin, M.D., and Joshua Sharfstein, M.D.*

**COMPONENT SESSION IV: Public Policy in Addiction Medicine: Past, Present, and Future**
*CHAIRS: Mark L. Kraus, M.D., FASAM, and Petros Levounis, M.D., M.A.*

## FRIDAY, APRIL 27, 2007

### 7:30 am

**ASAM Annual Business Meeting & Breakfast**
Sponsored by The Christopher D. Smithers Foundation (*ASAM Members only – breakfast service begins at 7:15 am*)

### 9:00 am

**Opening Scientific Plenary and R. Brinkley Smithers Distinguished Scientist Lecture *"AA Effectiveness — Faith Meets Science"***
*SPEAKER: Lee Ann Kaskutas, Dr.P.H., Senior Scientist, Alcohol Research Group, Public Health Institute, Berkeley, CA; Associate Adjunct Professor, Department of Social and Administrative Health Services, School of Public Health, University of California, Berkeley, CA*

### 10:30 - 11:00 am

**Refreshment Break** *(ASAM Exhibit Hall)*

### 11:00 am – 1:00 pm and 3:00 - 5:00 pm

**SYMPOSIUM 1: Update on Medical Complications of Heavy Drinking**
Sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA)
*SPEAKERS: Larry Gentilello, M.D.; David M. Guidot, M.D.; Adolf Pfefferbaum, M.D.; Raphael Rubin, M.D., and Mark L. Willenbring, M.D. (ORGANIZER)*

### 11:00 am - 1:00 pm

**SYMPOSIUM 2: Clashing Icons About Addictions Treatment Outcome Research**
*ORGANIZER: Michael M. Miller, M.D., FASAM, FAPA; SPEAKERS: A. Thomas McLellan, Ph.D.; John C. Norcross, Ph.D., ABPP; Bruce E. Wampole, Ph.D., ABPP, and Joan E. Zweben, Ph.D.*

**COURSE 1: Prescription Stimulant Abuse as "Performance Enhancement" — The Need for a New Paradigm**
*ORGANIZER: Robert L. DuPont, M.D., FASAM; SPEAKERS: Mark S. Gold, M.D.; Theodore V. Parran, Jr., M.D., M.P.H., and David E. Smith, M.D., FASAM*

**WORKSHOP A: The ASAM Member as Teacher: Working with Students and Residents**
*SPEAKERS: Rita Azalos, M.D.; Richard D. Blondell, M.D. (ORGANIZER.; Mark L. Kraus, M.D., FASAM; Peggy Murray, Ph.D., and Norman Wetterau, M.D., FAAFP, FASAM (ORGANIZER)*

**WORKSHOP B: Management of Chemical Dependency and Pregnancy: Experience from the Eleonore Hutzel Recovery Center**
*SPEAKERS: Carl Christensen, M.D., Ph.D., MRO (ORGANIZER), and Cathy Christensen, R.N.*

**PAPER SESSION 1**
See the official program for a list of papers and first authors.

### 1:00 - 3:00 pm

*LUNCH BREAK*

### 1:30 - 2:30 pm

**POSTER SESSION — Exhibit Hall**
See the official program for a list of posters and first authors.

### 3:00 - 5:00 pm

**SYMPOSIUM 3: Anabolic Steroids: Is There Evidence for an Addiction?**
*ORGANIZER: Lawrence S. Brown, Jr., M.D., M.P.H., FASAM;*
*SPEAKERS: Gen Kanayama, M.D., Ph.D.; John Lombardo, M.D.; Harrison G. Pope, Jr., M.D., M.P.H., and Ruth I. Wood, Ph.D.*

**COURSE 2: Treating Adults vs. Adolescents with Co-Occurring Substance Use and Mental Disorders: Research-Based Assessment and Treatment**
*SPEAKERS: Jorielle R. Brown, Ph.D. (ORGANIZER), and Charlene E. LeFauve, Ph.D.*

**WORKSHOP C: Medication-Assisted Treatment for Opiate Addiction in Correctional Settings**
*SPEAKERS: Jeffrey Baxter, M.D. (ORGANIZER); Joshua Lee, M.D.; Chief Timothy Ryan; Stacy Seikel, M.D., and Jina Thalman, LCSW*

**WORKSHOP D: Renaissance in the Therapeutic Community: From Research to Practice**
*ORGANIZER: Gregory C. Bunt, M.D.; SPEAKERS: Stanley Evans, M.D., FASAM, PA, and George DeLeon, Ph.D.*

**PAPER SESSION 2**
See the official program for a list of papers and first authors.

### 3:00 - 6:00 pm

**SYMPOSIUM 4: Prescription Drug Use, Misuse and Abuse**
Sponsored by the Center for Substance Abuse Treatment (CSAT)
*SPEAKERS: H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM; Anton C. Bizzell, M.D. (ORGANIZER); Nathaniel Katz, M.D., and Theodore V. Parran, Jr., M.D.*

### 6:30 - 8:30 pm

**Ruth Fox Memorial Endowment Fund Donors' Reception**
Sponsored by Dr. and Mrs. Joseph E. Dorsey (By invitation only)

### 8:00 - 10:00 pm

**COURSE 3: PTSD and Addictions: Current Neurobiology, Diagnosis and Treatment**
*SPEAKERS: J. Douglas Bremner, M.D.; Steven N. Gold, Ph.D., and Charles L. Whitfield, M.D. (ORGANIZER)*

**COURSE 4: Teaching Addiction Medicine to Medical Students, Residents and Primary Care Physicians**
*SPEAKERS: R. Jeffrey Goldsmith, M.D., and Edwin A. Salsitz, M.D., FASAM (ORGANIZER)*

**WORKSHOP E: Rock Bottom: The Methamphetamine Experience and Implications for Treatment Strategies**
*SPEAKERS: Jay Corcoran; Steven J. Lee, M.D. (ORGANIZER); Petros Levounis, M.D., M.A., and Colin A. Weil*

**WORKSHOP F: Case Studies in Pain and Addiction**
*ORGANIZER and SPEAKER: Mary G. McMasters, M.D.*

**WORKSHOP G: Integrated Treatment for Women with Substance-Related Disorders and Eating Disorders: Where Angels Fear to Tread**
*SPEAKERS: Mark S. Gold, M.D.; Deborah V. Gross, M.D.; and C. Chapman, Sledge, M.D., FASAM (ORGANIZER)*

## SATURDAY, APRIL 28, 2007

### 7:00 - 8:00 am
**Continental Breakfast** *(ASAM Exhibit Hall)*

### 8:00 am — 9:30 am
**PUBLIC POLICY PLENARY: Parity for Substance Abuse Treatment: Why is it Difficult to Make it Happen?**
Sponsored by ASAM's Public Policy and Legislative Advocacy Committees
*SPEAKERS: Ken Libertoff, Ph.D.; Mark L. Kraus, M.D., FASAM; Petros Levounis, M.D., M.A, and Bertha Madras, Ph.D.*

### 9:30 - 10:00 am
**Refreshment Break — ASAM Exhibit Hall**

### 10:00 am — 12:00 Noon and 2:00 - 4:00 pm
**SYMPOSIUM 5: Treatment of Stimulant Dependence: The State of the Science**
Sponsored by the National Institute on Drug Abuse (NIDA)
*ORGANIZER: Frank J. Vocci, Jr., Ph.D.*

### 10:00 am — 12:00 Noon
**SYMPOSIUM 6: Controversies in the Treatment of Anxiety and Depression in Early Addiction Recovery: What to Diagnose, With What to Treat?**
*SPEAKERS: Robert Anthenelli, M.D.; R. Jeffrey Goldsmith, M.D. (ORGANIZER); Ned Nunes, M.D., and Richard K. Ries, M.D., FASAM (ORGANIZER)*

**COURSE 5: Third Party Payor Audits: Strategies for Successful Appeals and Compliance Strategies to Avoid Third Party Payor Audits**
*ORGANIZER: Abby Pendelton, Esq.*

**WORKSHOP H: Addressing the Epidemic of Benzodiazepine Overprescribing**
*SPEAKERS: James Berry, M.D. (ORGANIZER), and Gerry Mugford, Ph.D.*

**WORKSHOP I: Pain and Addiction: Concepts, Challenges and Best Practices**
*SPEAKERS: Raju Hajela, M.D., M.P.H., FASAM (ORGANIZER), and Jennifer Schneider, M.D., Ph.D.*

**WORKSHOP J: The Presidential Forum: A Three Part Series — Controversies and Quandaries in Addiction Medicine**
Part I. The Nature of Addiction
*MODERATOR: Howard Wetsman, M.D., FASAM; SPEAKERS: Robert L. DuPont, M.D., FASAM; Petros Levounis, M.D., M.A.; Michael M. Miller, M.D., FASAM, FAPA; and David E. Smith, M.D., FASAM*

### 12:15 — 2:00 pm
**ASAM Awards Luncheon** (Extra fee event)

### 2:00 - 4:00 pm
**SYMPOSIUM 7: Research on Twelve-Step Recovery and Clinical Application**
*SPEAKERS: Marc Galanter, M.D., FASAM (ORGANIZER); Richard K. Ries, M.D., FASAM, and Kirk J. Brower, M.D., FASAM*

**SYMPOSIUM 8: Parity: Over the Horizon?**
*ORGANIZER: Donald J. Kurth, M.D., FASAM; SPEAKERS: Ken Libertoff, Ph.D.; R. Jeffrey Goldsmith, M.D.; Dominic Hodgkin, Ph.D.; A. Kenison Roy III, M.D., FASAM, and Paul N. Samuels, J.D.*

**SYMPOSIUM 9: Promising Early Interventions in Adolescent Substance Abuse**
*ORGANIZER: Norman Wetterau, M.D., FAAFP, FASAM; SPEAKERS: William DeJong, Ph.D.; John Femino, M.D., FASAM, and Scott McIntosh, Ph.D., M.A.*

**COURSE 6: Physicians' Health Programs in the United States — Phase I Results of a National Study**
*ORGANIZER: Robert L. DuPont, M.D., FASAM; SPEAKERS: Louiss E. Baxter, Sr., M.D., FASAM; A. Thomas McLellan, Ph.D.; Gregory E. Skipper, M.D., FASAM, and William L. White, M.A.*

**WORKSHOP J: The Presidential Forum: A Three Part Series — Controversies and Quandaries in Addiction Medicine**
Part II. The Nature of Recovery
*MODERATOR: Stuart Gitlow, M.D., M.P.H., M.B.A.; SPEAKERS: Stanley E. Gitlow, M.D., FASAM, and Michael M. Miller, M.D., FASAM, FAPA*

**WORKSHOP K: Pain and Addiction Treatment — With and Without Opioids — Including Physical and Psychological Methodologies**
*SPEAKERS: Mel Pohl, M.D. (ORGANIZER); Barry Rosen, M.D.; Jim Tracy, D.D.S., CADCII, and Penny Zeigler, M.D.*

**WORKSHOP L: Physician-in-Training Opportunities to Improve Substance Abuse Curricula in Medical Education**
*SPEAKERS: Brian Hurley, M.D. Candidate (ORGANIZER); Michael Dekker, D.O., M.P.H. Candidate*

### 3:00 pm
Exhibit Hall closes

### 6:00 - 8:30 pm
**DINNER AND CME PROGRAM: Achieving Treatment Success in Alcohol Dependence: Integrating Pharmacological and Psychosocial Approaches**
*ORGANIZER: Marc J. Fishman, MD, FASAM*

## SUNDAY, APRIL 29, 2007

### 8:00 - 9:45 am
**Special Morning Session and Breakfast**

### 10:00 am — 12:00 Noon
**SYMPOSIUM 10: Neurobiology, Clinical Consequences, and Treatment of Cannabis Dependence**
*SPEAKERS: Ahmed M. Elkashef, M.D.; Jag H. Khalsa, Ph.D. (ORGANIZER), and Frank J. Vocci, Jr., Ph.D.*

**SYMPOSIUM 11: Community-Based Rehabilitation: A Multi-Model Comparative Analysis**
*ORGANIZER: Gregory C. Bunt, M.D.; SPEAKERS: Donald J. Kurth, M.D., FASAM; Marvin Seppala, M.D.; Joseph A. Troncale, M.D., and Richard N. Rosenthal, M.D.*

**COURSE 7: Using the Abstinence-Based "Minnesota Model" of Addiction Treatment for Disadvantaged Populations**
*ORGANIZER: Robert L. DuPont, MD, FASAM; SPEAKERS: Garrett O'Connor, M.D.; Marvin D. Seppala, M.D., and William L. White, M.A.*

**COURSE 8: Ethics, Assessment and Monitoring Boundary Issues in Addicted Professionals and Their Patients**
*ORGANIZER: James C. Montgomery, M.D.; SPEAKER: M. Deborah Corley, Ph.D.*

**WORKSHOP J: The Presidential Forum: A Three Part Series — Controversies and Quandaries in Addiction Medicine**
Part III. The Nature of Success in Addiction Treatment
*MODERATOR: Michael M. Miller, M.D., FASAM, FAPA; SPEAKERS: Marc J. Fishman, M.D., FASAM; Stuart Gitlow, M.D., M.P.H., M.B.A.; Judith C. Martin, M.D., and Mark L. Willenbring, M.D.*

**WORKSHOP M: Analyzing and Understanding Positive EMIT Urine Screening Tests in Methadone Patients: Cases, Discussion and Review**
*ORGANIZER and SPEAKER: Peter L. Tenore, M.D., FASAM, MRO*

***End of Conference***

# 284 Physicians Earn ASAM Certification, 35 Are Recertified in Addiction Medicine

ASAM's Certification Council has announced that the following physicians meet the requirements for ASAM Certification or Recertification in Addiction Medicine. Their achievement will be recognized at the Awards Luncheon during ASAM's 38th Annual Medical-Scientific Conference, April 28th in Miami.

## Certified in Addiction Medicine

Mohamed A. Abdelaziz, M.D.
Joseph Andrew Adams, M.D.
Gregory F. Adams, M.D.
Brendan Douglas Adams, M.D., B.Sc., M.Sc.
William Wright Adams, M.D.,MBA
Samson G. Adegbite, M.D.
Adekola Alao, M.D.
Ronald Craig Albucher, M.D.
Nadia Aleem, M.D.
Robert James Allen, M.D.
Sybil Ann Allen, M.D.
Charles Bailey Alpert, M.D.
Stephen Amadala, M.D.
Richard Patrick Amar, M.D.
Srinvasu M. Ammisetty, M.D.
Pierre Andre, M.D.
Rudolph Antoncic, III, M.D.
Lorenzo Araujo, M.D.
Stan Paul Ardoin, M.D.
Darrell Gene Arnett, M.D.
Roy Delbert Ary, Jr., M.D.
Nelson K. Asante, M.D.
Tin Tun Aung, M.D.
Nabila Saeed Babar, M.D.
Katrina Ball, D.O.
Laurie K. Ballew, D.O.
Michael J. Baron, M.D., M.P.H.
Edward Mitchell Baruch, M.D.
William Clark Becker, M.D.
Frank B. Benson, M.D., M.P.H.
Scott I. Bienenfeld, M.D.
Florian Birkmayer, M.D.
Gregory Xavier Boehm, M.D.
Jean Joseph Ernest Bonhomme, M.D., M.P.H.
Patricia J. Bonitatibus, M.D.
James Carroll Boone, M.D.
Eugene Francis Boss, M.D.
William T. Boyett, Jr., M.D.
Daniel W. Bradford, M.D., M.P.H.
Betty Toloria Braswell, M.D.
Laurel Evans Broadhurst, M.D.
William Maxwell Burns, M.D.
Joanna Edyta Caban, M.D.
Jose Calderon-Abbo, M.D.
Christine Capio, M.D.
Dana Edward Castro, M.D.
Irene Grguric Cergnul, M.D.
Eran Chemerinski, M.D.
Darwyn Borja Chern, M.D.
Laura Zue Childress-Hazen, M.D.
Nurul Chowdhury, M.D.
Warren B. Churg, M.D.
Peter Ronald Cohen, M.D.
John R. Colaluca, D.O.
Joyce Victoria Coutts, M.D.
David Neil Crockford, M.D.
Cynthia C. Cudjoe, M.D.
Katherine Joy Czudyjowycz, M.D.
Gerald Edward Daigler, M.D.
Michael E. Davison, D.O.
Dean Michael De Crisce, M.D.
Richard J. DeFranco, M.D.
Stephen Scott Dominy, M.D.
Antoine Douaihy, M.D.
Andrew F. Drake, D.O.
Susan Marie Drymalski, M.D.
Wei Du, M.D.
Jeremy Dubin, D.O.
Eamon Kaylan Dutta, M.D.
Michael Eadie, M.D.
Corazon Corpus Elliott, M.D.
Maria Dolores Encarnacion, M.D.
Mary Eno, M.D., M.P.H.
Eric Edward Erickson, D.O.
Eduardo Del Rosario Espiridion, M.D.
Alex Etienne, M.D.
Dillon Carmickle Euler, M.D.
William Thomas Fannin, M.D.
David Faulk, M.D.
Jay Grayson Fernando, M.D.
William Fisher, M.D.
Terrence Thomas Fitzgerald, M.D.
Gregory L. Fortner, M.D.
Michael Edward Foster, M.D.
Charissa Fotinos, M.D.
Hugo Carvalho Franco, M.D.
Joel Freedman, M.D.
Jack Friedman, M.D.
D. Timothy Gammons, D.O.
David F. Garrell, M.D.
Stephen Frederick Garrison, M.D.
Carolyn Gerald, M.D.
Murtuza Z. Ghadiali, M.D.
Richard C. Gicking, M.D.
Barry D. Glasser, M.D.
Timothy Alwyn Gooden, M.D.
Raman Nurani Gopalakrishnan, M.D.
Michael Andrew Gordon, M.D.
Jeffrey Harold Gottlieb, M.D.
Bernard J. Gottschalk, M.D.
Richard I. Gracer, M.D.
Deborah Reynolds Greene, M.D., M.P.H.
Denise Elizabeth Greene, M.D.
Jaime L. Grodzicki, M.D.
Deborah Virginia Gross, M.D.
Frank Haglund, M.D.
Gregory Mark Haines, M.D.
Yuncheng Han, M.D.
Angela Dauby Harper, M.D.
Bernard Amiel Harris, M.D.
James Christopher Harvanko, M.D.
Syed Mahmood Hasan, M.D.
Luther M. Hegland, M.D.
Kenneth A. Hetzler, M.D.
Marc Richard Hilaire, M.D.
Clifton M. Hocker, Jr., M.D.
Scott M. Hogan, M.D.
Susan Catherine Holman, M.D.
Mark Honzel, M.D.
K Dane Howalt, M.D.
Ben Jagiello, M.D.
Vijaya Lakshmi Jaleel, M.D.
Shah Arshaduddin Jalees, M.D.
Jean Carl Jarda, M.D.
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## CERTIFIED IN ADDICTION MEDICINE *continued*

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## RECERTIFIED IN ADDICTION MEDICINE

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ASAM will offer the next Certification/Recertification Examination on December 6, 2008. For information or to apply to sit for the examination, contact Christopher Weirs, ASAM Director of Credentialing, at CWEIR@ASAM.ORG.

# BUPRENORPHINE AND OFFICE-BASED TREATMENT OF OPIOID DEPENDENCE

Sunday, April 29, 2007 • 8:00 am – 5:30 pm • Marriott Doral Resort & Spa • Miami, Florida

***The goal of this course is to help participants acquire the knowledge and skills needed to provide optimal care to opioid-addicted patients.***

### Topics to be addressed by an expert faculty include:

- *OVERVIEW OF OPIOID ADDICTION* — Describe the rationale for and effectiveness of opioid pharmacotherapy in the treatment of opioid addiction.
- *BUPRENORPHINE EFFICACY AND SAFETY* — Summarize the literature on the efficacy and safety of buprenorphine treatment.
- *LEGISLATIVE REQUIREMENTS* — Summarize the Drug Addiction Treatment Act of 2000 (DATA 2000) and recent amendments, which provide the legal basis for the treatment of opioid addiction in office-based settings.
- *PATIENT SELECTION* — Describe the essential aspects of assessing and selecting patients who are appropriate candidates for office-based opioid treatment.
- *CLINICAL USE OF BUPRENORPHINE* — Describe induction, stabilization and maintenance protocols for treating opioid-addicted patients with buprenorphine.
- *NONPHARMACOLOGIC INTERVENTIONS* — Describe the efficacy, components and uses of non-pharmacologic treatments for opioid addiction.
- *MANAGING CO-OCCURRING MEDICAL AND PSYCHIATRIC CONDITIONS* — Summarize common medical and psychiatric comorbidities, including HIV/AIDS, hepatitis B and C, depression and anxiety, found in opioid-addicted patients.
- *SPECIAL TREATMENT POPULATIONS* — Describe the management of pain in patients with addictive disorders and the management of adolescents and pregnant women who are addicted to opioids.
- *OFFICE PROCEDURES* — Describe and be able to apply clinical tools (such as treatment contacts, consent forms and protocols) needed to set up office-base treatment with buprenorphine. Describe the confidentiality and record keeping requirements for treating opioid-addicted patients in office-based settings.

*The course is approved for up to 8 credit hours of Category 1 continuing education credit. (Only those who attend the full 8-hour program are eligible for a certificate of attendance.) A separate registration fee is required for this course.* ***ATTENDANCE IS LIMITED, SO BE SURE TO REGISTER EARLY!***

*Visit ASAM's web site at* ***WWW.ASAM.ORG****, or register on-site (registration opens at 7:00 a.m.).*

## FROM THE PRESIDENT-ELECT

*continued from page 5*

leaders of the future, please let us know — talk to any Officer or Board Member or to your Chapter President. There's plenty to do, and no "closed shop" or "glass ceiling" to keep you from becoming more involved and generating results that give you a sense that the time you give as a volunteer has been well spent.

I have ambitious ideas about how I'll communicate with you during the coming two years: Maybe you'll see lots of emails or web-based "Reports from the President." I've already written a column for the next issue of **ASAM NEWS** to share some of my views about what it means to be an ASAM President. For now, I'll simply thank you for your membership and, even more important, for what you do for your patients and their families every day. Whether you spend full-time in addiction medicine or spend most of your time in primary care, a medical or surgical specialty, or in psychiatry, you know you're providing an incredible service to your patients and your community. You come to ASAM conferences to learn more about the science and practice of addiction medicine so that you can do a better job with each at-risk, addicted, or recovering patient you see.

Thanks for showing up on the front lines every day, in clinical roles you weren't trained for during medical school. And thanks for showing up in ASAM and in your State Chapter, to help our medical specialty and our Society succeed. I am honored to be your President.

# Stress, Alcohol Cues Target Brain Differently to Produce Craving

Both stress and alcohol cues (reminders of drinking) can produce craving and lead to relapse in alcoholic patients who are trying to avoid drinking. However, new findings indicate that they work on the brain differently, suggesting that independently addressing the effects of stress and alcohol cues may increase the likelihood of maintaining abstinence.

Researchers already knew that both stress and alcohol cues can produce cravings. However, in an article published in the March issue of Alcoholism: Clinical & Experimental Research, researchers from Yale University and the Medical University of South Carolina reported that these two major causes of relapse have a very different psychobiological profile. For their study, the researchers exposed 20 treatment-seeking alcoholic patients to a five-minute guided imagery procedure that involved three conditions: a recent personal, stressful situation; a personal alcohol cue-related situation; and a neutral, relaxing situation. One image was presented in random order in each session. Alcohol craving, anxiety and emotion ratings, cardiovascular levels, and salivary assessments of the stress hormone cortisol were measured and compared across the three conditions.

The researchers found that while both stress and alcohol cues produced increases in anxiety associated with alcohol craving, the specific psychobiology associated with each appeared to be distinct. MUSC scientist Dr. Suzanne Thomas explained: "While stress-related craving was associated with an increase in negative emotions such as anxiety, anger, fear, and sadness, cue-induced craving was associated with an anxiety or fear state and a decrease in positive mood such as joy or a relaxed state." The results also indicated differences in physiological arousal. "In the stress-imagery condition, increased alcohol craving was accompanied by an increase in blood pressure," according to co-investigator Dr. Helen Fox of Yale University. "In the cue-imagery condition, increased alcohol craving was accompanied by an increase in salivary cortisol." Such differences may be important in understanding stress and alcohol-cue-related relapse susceptibility, she noted.

"We have known for several years that craving is multifaceted," added Dr. Thomas, "that is, it has several different elements, similar to how different musical notes comprise a chord. The present study suggests that the notes that result from stress and the ones that result from cues are different… and either one is sufficient to induce a detectable feeling of craving. Furthermore, prior work from animal studies suggests that together, stress and cues may produce an additive effect — a chord so compelling that resisting alcohol may feel impossible."

Dr. Thomas added. "It might be possible to improve alcoholism treatment by attending to these differences…to develop new treatments that individually target both stress-induced and cue-induced craving to give the person in recovery the best possible chance to succeed in his or her efforts to stay sober."

*Source: Bergquist K, Hong K & Sinha R (2007). Stress-induced and alcohol cue-induced craving in recently abstinent alcohol dependent individuals. Alcoholism: Clinical & Experimental Research Feb; 31(epub ahead of print).*

## New England Chapters to Co-Sponsor 20th Annual Cape Cod Symposium

ASAM's New England Chapters have agreed to co-sponsor the 20th Annual Cape Cod Symposium on Addictive Disorders, scheduled for September 6-9, 2007, at the Four Points by Sheraton West End Circle Resort in Hyannis, Massachusetts,

The Symposium features more than 50 workshops on topics such as "Co-Occurring Disorders in Adolescents," "Domestic Violence and Substance Abuse," "Motivational Interviewing," and "Relapse Prevention." Presenters include Andrea Barthwell, M.D., FASAM; Carlton Erickson, Ph.D.; Paul Earley, M.D., FASAM; and other addiction experts. The program includes a full-day session on dual diagnosis; a full day on ethical issues, and a full day on self-injury.

Program organizers have applied for 30 Category 1 CME credits. For more information, to request a brochure, or to register for the Symposium, visit the website at WWW.CCSAD.COM or phone Symposium coordinator Dee McGraw at 616/475-4210.

PCSSmentor.org
Physician Clinical Support System
An Educational Resource for Those Treating Patients with Opioid Dependence

## *Expanding Your Buprenorphine Practice?*

## Get Help from the PCSS

The Physician Clinical Support System (PCSS), an ASAM-coordinated mentoring network for physicians who use buprenorphine in the office-based treatment of opioid dependence, is a valuable resource for physicians who plan to treat more than 30 patients under the newly expanded buprenorphine treatment limits.

Expert help is available from the PCSS "warm line" — 877/630-8812 — a national system of telephone triage that can put physicians in touch with one of 70 experienced mentors within 48 hours. The warm line also links physicians to valuable information on the PCSS website (WWW.PCSSMENTOR.ORG). Other resources available through the website include free clinical guidance documents on a variety of topics as well as access to the PCSS listserv, which allows users to share information about their clinical experiences and best practices.

*Funded by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration, the PCSS is operated by ASAM and a consortium of cosponsoring organizations.*

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

## ASAM CHARTERS NEW CHAPTERS

Five new chapters will be officially recognized by ASAM at the Annual Business Meeting, Friday, April 27th in Miami.
The new chapters are in the District of Columbia, Indiana, Minnesota, Utah, and West Virginia.

*Congratulations to the organizers!*

## CtSAM Supports Physician Health Legislation

The Connecticut Society of Addiction Medicine once again is working with the State Medical Society's Physician Health Program to support legislation that would allow the creation of Health Care Professional Assistance Programs (HCPAs) for a variety of health care professionals.

The authorizing legislation is similar to a bill (HB 5718) introduced last year, which would have permitted the formation of HCPAs to promote increased patient safety and the health and well-being of all health care professionals, including physicians, dentists, nurses, physician assistants, veterinarians, and others who have or are at risk for impairment from substance abuse, emotional disorders, mental or physical illness, and other concerns.

The HCPA concept is based on a cooperative and mutually supportive relationship between medical professionals, medical organizations, the Department of Public Health, and its respective Boards and Commissions. Such programs encourage confidential peer identification, crisis intervention, referral assistance and support services. Services provided typically include comprehensive continued monitoring of the recovering physician for many months or years. The system is designed to assure that the medical professional maintains abstinence and good physical or mental health, while protecting and promoting patient safety.

CtSAM leaders are asking members to support the bill, which can be tracked on the state medical society's website at WWW.CSMS.ORG. Questions can be directed to the Physician Health Program's office at 203/865-0587.

# SAMHSA Report Provides State-Level View of Substance Use Trends

Past month underage drinking (age 12 to 20) was lowest in Utah (21.3 percent) and highest in Wisconsin (39.5 percent) in 2004-2005, according to a new state-by-state report from the Office of Applied Studies (OAS) of the Substance Abuse and Mental Health Services Administration. *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health (NSDUH)* provides 23 measures of substance use and mental health problems for each state. Measures include rates of binge drinking, use of illegal drugs, and tobacco use. The SAMHSA report combined two years of data (2004-2005) from the annual NSDUH surveys to enhance the precision of estimates for less populous states. For each state, estimates are provided for four age groups: all persons 12 years or older, as well as persons 12 to 17, 18 to 25, and 26 or older.

Data presented in the report show that use of illegal drugs in the past month by persons aged 12 or older ranged from a low of 5.9 percent in Iowa to a high of 12.2 percent in Alaska. Colorado, Oregon, Rhode Island and Vermont had the highest rates of past-month illegal drug use for all age groups. North Dakota had the lowest rate of past year cocaine use by those 12 years and older (1.7 percent), while Washington, DC had the highest rate (3.4 percent).

The lowest rate of past-year nonmedical use of prescription opioids by persons 12 years and older occurred in South Dakota (3.4 percent), while the highest rate was recorded in Utah (6.5 percent). Five states — Alabama, Arkansas, Florida, Mississippi, and West Virginia — shared the lowest rate of past-year marijuana use: 1.4 percent. Alaska had the highest rate of first-time use of marijuana (2.6 percent) as well as past-month use of marijuana (10.1 percent).

Whereas there was no significant change in the national rate of underage drinking between 2003-2004 and 2004-2005, significant reductions occurred in six states: Hawaii, Michigan, New Hampshire, New Mexico, North Dakota, and Washington. During the same time period, Texas and Utah experienced significant increases in underage drinking. "We see some encouraging state-level improvements in this report, particularly with illicit drugs and tobacco," said SAMHSA Administrator Terry Cline, Ph.D. "But a continuing pattern of underage drinking and binge drinking indicates that many people still do not understand that alcohol can also be a dangerous drug when used in large amounts or by those who are underage."

The report marks the first time that comparable state estimates have been available for three consecutive time periods (2002-2003, 2003-2004, and 2004-2005). A Web-only supplement to the report compares these time periods for all measures. *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health (NSDUH)* is available on the OAS website at HTTP://OAS.SAMHSA.GOV/2K5STATE/TOC.CFM. Copies also may be obtained free of charge by phoning SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877/726-4727) and requesting inventory number SMA 07-4235.

# 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.

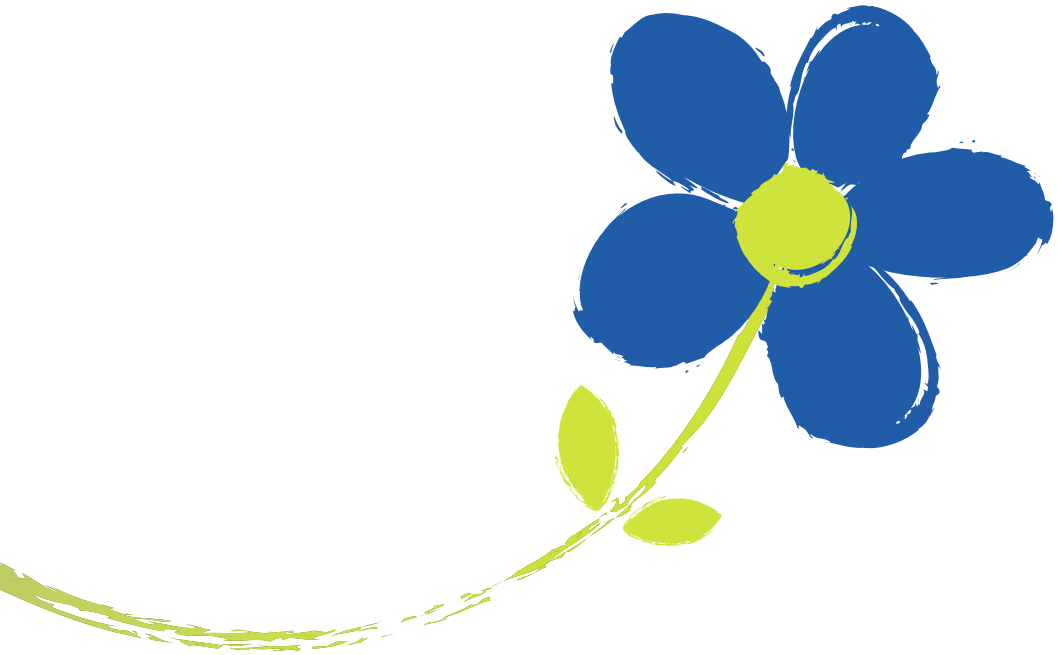
Due caution should be exercised when driving cars or operating machinery.

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

# New Tools Aid Workforce Development

The Substance Abuse and Mental Health Services administration (SAMHSA) has announced the availability of two online resources to help organize and strengthen the addiction treatment workforce.

***Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce*** summarizes trends in addictions treatment and the challenges that confront the treatment workforce. The report addresses current trends in funding, staff recruitment and retention, patient characteristics and clinical practice. It also articulates a vision for the treatment and recovery support workforce by presenting a series of recommendations aimed at strengthening the field's professional identity. Recommendations are offered in the following six areas: infrastructure, leadership and management, recruitment, education and accreditation, retention and studies priorities. SAMHSA says the recommendations are intended to provide momentum for ongoing discussions among stakeholders about specific implementation strategies.

***Strengthening Professional Identity*** focuses on all professionals who provide addictions treatment and recovery support services, e.g., addictions counselors, physicians, psychologists, nurses, outreach and intake workers, case managers, social workers, marriage and family therapists, recovery support workers and clergy.

***An Action Plan for Behavioral Health Workforce Development*** provides an overview of key findings developed through a multi-year process that showed how public and private collaboration by diverse stakeholders can strengthen the professional workforce. The process was funded by the SAMHSA Office of the Administrator and all three centers within SAMHSA: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP). It was conducted by the Annapolis Coalition, a not-for-profit organization focused on improving workforce development The resulting Action Plan articulates specific, actionable objectives to assist the Nation in transforming the behavioral health service delivery systems.

Both publications are available on the Web at HTTP://WWW.SAMHSA.GOV/MATRIX2/MATRIX_WORKFORCE.ASPX. For related publications and information, visit HTTP://WWW.SAMHSA.GOV/.

# Ruth Fox Memorial Endowment Fund



*Dr. Ruth Fox*

Dear Colleague:

While you are in Miami for ASAM's 38th Annual Medical-Scientific Conference, please make time in your busy schedule for the annual Ruth Fox Reception, from 6:30 to 8:30 p.m. on Friday evening, April 27th. A by-invitation-only event, the reception honors the generosity of donors who have supported the Ruth Fox Memorial Endowment Fund over the years. As in years past, the reception is being underwritten by a generous gift from ASAM member Joseph E. Dorsey, M.D., and Mrs. Dorsey.

A highlight of the reception is the opportunity to welcome an outstanding group of physicians-in-training who have been chosen to receive the 2007 Ruth Fox Scholarships. An important component of ASAM's educational mission, the scholarships make it possible for these young people to attend the Medical-Scientific Conference and the Ruth Fox Course for Physicians. The scholarships cover travel, hotel and registration expenses, as well as one year's membership in ASAM. The four scholarship recipients selected for 2007 are: Richard P. Amar, M.D., Emory University; Bachaar Arnaout, M.D., St. Luke's — Roosevelt Hospital, New York City; Bernard Fischer, M.D., University of Maryland — Sheppard Pratt Institute, Baltimore; Catherine R. Friedman, M.D., Western Psychiatric Institute, Pittsburgh; Nathan Kolla, M.D., University of Toronto, Ontario; Eric Smiltneek, M.D., Columbia St. Mary's Family Medicine, Milwaukee; Emjay Tan, M.D., University of Illinois at Chicago; and Sara G. West, M.D., University Hospital — Case Medical Center, Cleveland. With their selection, the number of scholarships supported by the Endowment Fund has grown to 32.

The scholarships are but one example of the work of the Fund, which was established to assure ASAM's ability to provide leadership in addiction medicine through its commitment to educating physicians, to increasing access to care, and to improving the quality of care.

Invitations to the Ruth Fox Endowment Reception are extended only to donors, so if you have not already contributed or pledged to the Endowment Fund, please do so now. With your participation and continued support, the Fund will continue to fulfill its mission. For information about making a pledge, contribution, bequest, memorial tribute, or to discuss other types of gifts in confidence, please contact Claire Osman by phone at 1-800/257-6776 or 1-718/275-7766, or email Claire at ASAMCLAIRE@AOL.COM. She welcomes your calls. All contributions to the Endowment Fund are tax-deductible to the full extent allowed by law.

*Max A. Schneider, M.D., FASAM*
*Chair, Ruth Fox Memorial Endowment Subcommittee*

*Claire Osman*
*Director of Development*

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# ASAM Conference Calendar

## ASAM

**April 26, 2007**
Ruth Fox Course
for Physicians
Marriott Doral Resort & Spa
Miami, Florida
[8 Category 1 CME Credits]

**April 26, 2007**
Pain and Addiction:
Common Threads VIII —
Buprenorphine for
Addiction and Pain
Management
Marriott Doral Resort & Spa
Miami, Florida
[8 Category 1 CME Credits]

**April 27-29, 2007**
38th Annual Medical-
Scientific Conference
Marriott Doral Resort & Spa
Miami, Florida
[22.5 Category 1 CME Credits]

**April 29, 2007**
Buprenorphine and
Office-Based Treatment
of Opioid Addiction
Marriott Doral Resort & Spa
Miami, Florida
[8 Category 1 CME Credits]

**October 25 — 27, 2007**
ASAM Course on the
State of the Art
in Addiction Medicine
Hyatt Regency Capitol Hill
Washington, DC
[21 Category 1 CME Credits]

**October 28, 2007**
Buprenorphine and
Office-Based Treatment
of Opioid Addiction
Hyatt Regency Capitol Hill
Washington, DC
[8 Category 1 CME Credits]

## OTHER EVENTS OF NOTE

**May 8-9, 2007**
Conference on Drug Abuse and Risky Behaviors:
The Evolving Dynamics of HIV/AIDS
(Sponsored by the National Institute on Drug Abuse)
Natcher Auditorium, NIH Campus
Bethesda, Maryland
For more information, visit
HTTP://CONFERENCES.MASIMAX.COM/RISKYBEHAVIORS/

**May 21-22, 2007**
14th Annual Nicotine Dependence Conference
Siebens Bldg., The Mayo Clinic
Rochester, Minnesota
[14 Category 1 CME Credits]
For more information, contact
Mayo Nicotine Dependence Program
at 507/266-1093 or
MULHOLLAND.MICHELLE@MAYO.EDU

**June 21-24, 2007**
7th International Conference on
Pain and Chemical Dependency
Sheraton New York Hotel
New York City
[20 Category 1 CME Credits]
For more information or to register,
visit WWW.IAPCD.COM

*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.*

## BUPRENORPHINE TRAINING

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*All courses are approved for 8 Category 1 CME credits.*

**April 29, 2007**
Miami, Florida
*Sponsored by ASAM and the Florida Society of Addiction Medicine*

**May 11, 2007**
Boston, Massachusetts
*Sponsored by ASAM and the Massachusetts Society of Addiction Medicine*

**May 12, 2007**
Cleveland, Ohio
*Sponsored by ASAM and the Ohio Society of Addiction Medicine, Case Western Reserve University School of Medicine, and the VA Addiction Recovery Center*

**June 16, 2007**
Houston, Texas
*Sponsored by ASAM and the Texas Society of Addiction Medicine*

**August 4, 2007**
Honolulu, Hawaii
*Sponsored by ASAM and the Hawaii Society of Addiction Medicine*

**August 8, 2007**
Boston, Massachusetts
*Sponsored by ASAM and the Massachusetts Society of Addiction Medicine*

**August 18, 2007**
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